

## Response on behalf of the Methodist Church to the Consultation on a National Alcohol Harm Reduction Strategy

### 1. Introduction

1.1 The Methodist Church of Great Britain is pleased to have this opportunity to respond to the consultation on drawing up a National Alcohol Harm Reduction Strategy. Throughout its history the Methodist Church has had a concern for people who are harmed, directly or indirectly, by alcohol misuse. Today many Methodist Churches host Alcoholics Anonymous meetings, and all our public premises remain “alcohol-free zones”. Some churches provide support and treatment to problem drinkers through professionally-run services, such as the St Lukes Centre in south London.

1.2 Contrary to common perception, the Methodist Church does not advocate teetotalism. Some Methodists are committed to abstinence, whilst others drink alcohol in moderation. The Church as a whole adopted the following guidelines on Methodist practice with regard to alcohol and they are printed in its standing orders:

*That all Methodists:*

1. *consider seriously the claims of total abstinence;*
2. *make a personal commitment either to total abstinence or to responsible drinking;*
3. *give support wherever possible and by appropriate means to those who suffer directly or indirectly from alcohol misuse;*
4. *unite to support pressure on government and public opinion for a programme designed to control consumption and reduce harm.*
5. *recognise the importance of example and education in family life and,*
6. *where they practise total abstinence take special care to avoid authoritarian attitudes which may be counter-productive; and*
7. *where they practise responsible drinking take special care to demonstrate that this also involves self-control.*
  
8. *That the Methodist Church actively engage in the promotion of responsible attitudes to alcohol and in the support (whether directly or indirectly) of those suffering the harmful consequences of their own alcohol misuse, or that of others.*

1.3 This response to proposals for a National Strategy arises from a consultation with a group consisting of people with an interest and expertise in alcohol services, medical treatment, addictive behaviours and young people. Our comments are structured according to the structure of your consultation paper, although they do not relate to every question.

### 2. Principles

2.1 The Government clearly has an important role to play in combating alcohol misuse and its consequences. Revenue from duties on alcohol sales are significant,

but the costs of alcohol misuse are likely to be even higher. These costs are not only in terms of the impact on the NHS of ill-health, but also wider social costs of the criminal justice system, unemployment, homelessness and family breakdown. Therefore the Government clearly has a role to play, not just in terms of criminal justice or at the acute medical end when treatment is required, but also in prevention and education. There clearly needs to be a balance between the human rights of people to behave as they will (within limits) and support for vulnerable people. Individuals bear some responsibility for their own drinking behaviour. However if misuse occurs through addiction, where cognitive processes are disrupted, or through a lack of information, there is a need for external interventions.

2.2 The drinks industry also has a role to play. The work of the Portman Group is to be welcomed, particularly in their production of resources and the Code of Practice. However the drinks industry perhaps needs to take greater responsibility for the harm that alcohol can cause to some people. For many drinking is a pleasurable experience and the health consequences are minimal. For a significant minority, however, alcohol misuse can result in ill-health, fatal diseases, the loss of livelihood and family. Perhaps a relevant parallel to draw is the proposed treatment of the gambling industry, in which the Government has accepted the principle that “the polluter pays”. Under current proposals, the gambling industry will have to take responsibility for the harm that gambling causes to some people, by contributing to the costs of prevention and treatment of problem gambling, as well as funding research. The industry has set up a charitable trust to raise and administer this money, but the Government has stated that, if insufficient funds are forthcoming, then a statutory levy will be imposed on the industry.

2.3 We note that the strategy will only be for England. We are certain that the Strategy Unit will be liaising with the relevant bodies in the Scottish Parliament and the Welsh Assembly. It is also important to recall that several policy areas relating to alcohol – for example criminal justice – are reserved matters.

### **3. Cultural and Behavioural Issues**

3.1 There is not one British drinking culture, but several; the most anti-social of which involves drinking the maximum amount in as short a time as possible. This is exacerbated by rigid closing times and a proliferation of “Happy Hours” and “Freshers’ Week” offers at universities. The Government hopes that the Licensing Bill currently going through Parliament will tackle the former, although the negative consequences of this move will need careful monitoring. The question of “Happy Hours” perhaps also needs consideration in this context.

3.2 As with other consumables, there is likely to be a link between the cost of alcohol and its consumption. Higher prices may help to change drinking behaviour. Similarly, non-alcoholic drinks are often disproportionately expensive in pubs, bars and restaurants, and can discourage people from buying them instead of alcoholic drinks.

3.3 When reflecting on British drinking cultures, there is a danger in mythologising the continental experience. Although the attitude to alcohol is far more civilised in much of mainland Europe, with less hazardous drinking behaviour, levels of alcohol-related disease are still high. Yet there are still lessons that can be learnt from the continental experience. “Mass vertical consumption” of alcohol can be tempered by an increased association with food, perhaps through the growth in the number of “gastro-

pubs”, or by the civilising of drinking environment - for example with “family friendly” pubs. However we recognise that altering culture and behaviour is a much broader and more complex task, and will need the kind of incremental and inter-disciplinary approach that the Strategy Unit is advocating.

3.4 A cultural issue which does not receive attention in the consultation paper is the low number of Black and minority ethnic people who participate in formal treatment for alcohol problems. There may be a lower incidence of alcohol abuse within certain populations, perhaps due to particular religious teachings, or this low participation might instead reflect a lower take-up of services across the board by Black and minority ethnic groups. Indeed teaching concerning alcohol within some communities may serve to increase the sense of shame amongst those who misuse alcohol who then exclude themselves from receiving help as a result.

#### **4. Health**

4.1 We are concerned about the mixed messages concerning the health impact of alcohol. There is minimal evidence for the health benefits of alcohol, whilst the evidence for the health costs is well established. Media articles lauding the health benefits of alcohol cloud what is a very complicated medical issue. Instead public education campaigns need to promote health education messages around alcohol consumption. One way of doing this would be to require all adverts, licensed premises and pre-packaged drinks to carry health warnings or messages, similar to those on cigarette packets. At a very simple level, these could include information about the number of units contained in drinks and the recommended maximum intake for men and women.

4.2 The health of many people could benefit from information about the impact of drinking patterns. Brief interventions do not only need to be offered to those at greatest risk, but basic education should be made available to anyone engaged in excessive consumption. At the moment, however, few doctors and nurses have the time to open up this new area when seeing patients.

4.3 “Brief interventions” require sufficient resources, and also a flexibility of delivery in order to suit people with different patterns of drinking and different forms of contact with professionals. Interventions are likely to be most successful where there is effective partnership and co-operation between different statutory, professional and voluntary groups. One model that has proved successful in the homelessness field is that of “Arrest and Reachout” (as opposed to “Arrest and Referral”). Community workers meet people in police cells or in the courts, and support and accompany them through the criminal justice system, through the benefits system, through treatment, and into housing, working closely and sharing appropriate information with a range of partner agencies throughout. This is a much more rigorous system than that of simply referring people to other agencies, and enables successful work with people who are often considered “beyond help”.

4.4 In the experience of services provided by Methodist churches, the self-help model is effective for many people and provides on-going support. The 12 Steps model integrates well with the psycho-dynamic model of counselling, and an After Care Service helps to reduce the incidence of relapse after the intensive treatment is completed. It is also vital for the family of the client to be actively and positively engaged in the treatment process.

4.5 One issue which was repeatedly emphasised in our internal consultations prior to making this response was that of inadequate resources, particularly in the light of additional money being channelled towards drug treatment. The under-funding of alcohol treatment will result in a less effective harm reduction strategy.

4.6 Conversations with professionals suggest that there is a lack of primary treatment or detoxification services. This leads to the unacceptable and potentially dangerous situation where people are forced to detoxify at home before being accepted for second stage treatment. We recognise that this is the result not only of a lack of funded beds, but also a result of a shortage of qualified staff. The last few years has seen a shift of alcohol workers towards the better resourced drugs field. If alcohol treatment is to be truly effective then those who provide the treatment need to be adequately rewarded in order to retain and motivate staff.

4.7 The Government has previously spoken of an aspiration to merge health and social services. This could effectively simplify services for people with alcohol problems, combining acute treatment and counselling.

4.8 Training for health professionals is key. We have heard of very positive experiences where members of AA groups come to meet with medical and healthcare students and talk about the issues they have faced as alcoholics.

## **5. Crime and Anti-social Behaviour**

5.1 The perception is often that the only crimes associated with alcohol concern public disorder. However people who develop addictive behaviours often steal to fund their addiction, and this is true of alcohol as of other addictive substances.

5.2 The encouragement of different drinking patterns may help to reduce anti-social behaviour associated with hazardous drinking, but it will only work as part of a package of measures. Moving away from a race towards last orders and a single pub closing time may help to spread the impact of the explosion of people spilling out onto the streets, but without wider awareness about the impact of heavy drinking, problems will not be reduced, but will be redistributed. Licensing authorities will need to be sensitive to the fears of local communities concerning longer opening hours, particularly regarding premises situated near residential areas. The Government should continue to monitor the consequences of these changes for public order and anti-social behaviour.

5.3 Although the reasons behind the relative success of anti-drink-driving campaigns would need empirical research, our perception is that there are two main grounds for this. Firstly are the hard-hitting, explicit adverts which show the consequences of drink driving and make it unacceptable to a significant proportion of the population, and secondly there are real sanctions imposed, such as the prospect of the loss of a licence. These two reasons combine to help the majority of people clearly to understand the consequences of their behaviour.

## **6. Vulnerable Groups**

6.1 The Methodist Church works closely with the Methodist children's charity, NCH. They operate 470 projects across the country, and are concerned about the impact of alcohol abuse, directly and indirectly, on children and young people. NCH are making their own submission but it is worth re-emphasising a couple of the points arising from their experience.

6.2 NCH argues that certain groups of children and young people are at "high risk" of developing problems with substance use, including alcohol. These groups, as identified by the Health Advisory Service, include:

- Truanting/excluded children
- "Looked after" children and young people
- Young homeless
- Young offenders
- Young prostitutes
- Children who have suffered physical/mental abuse
- Young people with conduct or depressive disorders.<sup>1</sup>

6.3 NCH projects have noticed that children and young people are starting to drink at an earlier age. There are problems with funding work with young people, and very little alcohol treatment is aimed at this age group, let alone the integrated treatment needed for young people who are poly-drug users. In addition children of parents who misuse alcohol are in need of particular care and support, and child protection professionals need to be aware of the impact alcohol misuse may have on parenting issues.

6.4 Evidence also suggests that students, living away from home for the first time, are vulnerable to alcohol misuse. Bars and pubs near universities offer very cheap alcohol, especially around "Freshers' Week", and the culture places a great expectation on high levels of alcohol consumption. Awareness campaigns, such as the NUS's "Don't Do Drunk", should be strengthened. We would also encourage the Government to examine the whole issue of the impact of the sale of alcohol as a "loss leader".

6.5 Alcohol also takes a particular toll on people who experience poverty. This angle must not be forgotten when the Government is framing a strategy or determining the targeting of treatment.

6.6 In addition to the vulnerability of particular sociological groups, research suggests that there is a familial tendency to develop problems with alcohol. People within such families should be given particular support and help.

## **7. Education and Communication**

7.1 The existing ITC and ASA regulations on the advertisement of alcoholic products are comprehensive and fair. They should be kept under review, particularly in the light of the marketing of new products aimed at young people. The Portman Group's own Code is also important. However we would be concerned if, with the creation of OFCOM, regulation only existed in the form of voluntary Codes.

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<sup>1</sup> (Source: Health Advisory Service, 1996, Children and Young People, Substance Misuse Services – The Substance of Young Needs)

7.2 One of the key tasks has to remain that of increasing awareness of the impact of alcohol. We would therefore ask the Government to consider requiring health information, including unit content, to be printed on every advertisement and product and displayed in licensed premises.

We hope that these comments will be of use, and look forward to the next stage in the Strategy Unit's work.

Rachel Lampard  
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