

## The principles that should underpin the strategy

Our starting point is one of principle. Before considering how best to tackle the problems associated with alcohol misuse we need a clear understanding of why Government should play a role at all.

1. Why should the Government get involved in managing the harmful effects of alcohol misuse? At what point does Government intervention become justified?

This is a legally regulated substance, from the sale of which, the Govt. generates revenue, and subsequently some responsibility for the distribution of that revenue to counteract the harms that are generated.

2. How far is alcohol misuse a matter of individual responsibility and when does Government have a responsibility to intervene, whether through services, legislation or persuasion?

As the key player in the alcohol Industry, the Govt. is uniquely placed to determine the outcomes of all, and any interventions. Individuals have little or no power in the cost and availability of alcohol, the two areas which influence population levels of consumption. The alcohol production and distribution industry have short term agendas driven by expansion of profit and product development. The alcohol "lobby" is strong, well funded and highly organised. Interestingly, the heroin, cocaine and other substance producers and distributors were not party to the development of a National Drug Strategy, and the whole country needs to acknowledge and recognise the effect of this ambivalent attitude on the decisions made about alcohol use and misuse. "Our favorite Drug" is still a drug, and arbitrary definitions do little to persuade individuals and groups about risk and responsibility.

3. How can we strike a balance between individual and community rights and choices?

Be honest about the cost and benefits associated with the decision-making process. This consultation exercise is a start.

4. What are the respective roles and responsibilities of consumers, voluntary groups, commercial interests and others?

We all have a part to play in the discussions, which should be ongoing, responding to the emergence of evidence and of the consequences of decisions made. By starting a debate you then have to take responsibility for carrying through the results of that debate, and the conclusions that get drawn.

5. What principles should underpin a national alcohol harm reduction strategy?

Change is a process and not an event. Evidence based interventions should be the minimum requirement. Alcohol has the capacity to spread across all sections of society and affects everyone, whether they recognise it or not. By beginning to ask the questions we should be prepared to hear the answers whether we like them or not. Be open and honest, resist horse trading with interest groups and those with vested interests at the centre (the Treasury for example) and at the margins (shroud wavers and disgruntled individuals with a loud voice). Publish what you find and how you found it and take a

public health stance.

## The cultural and behavioural issues around alcohol use and misuse

Alcohol misuse and its impacts play out against a wider canvas of behaviour and attitudes related to alcohol: we need to understand this wider picture in order to understand how to influence and reduce harmful effects.

### *Questions*

6. How do you define alcohol misuse? What factors do you take into account?

Knowledge seems to be emerging that consequences are dose and time specific. The amount you drink is significant. The time over which you drink this amount is significant. The cultural and weather/ latitudinal variations in consumption are very significant when looking at what to do about the dose taken and the effects on the individual. North Europeans binge drink and initially have periods of not drinking in between the binges. Binges mean more violence, accidents, absenteeism, bad decision-making and the individual's body suffers from trying to cope with the acute poisoning effects. There are clear indicators for the physical and psychological effects of taking increasing doses and about the cut-offs when dependence (neuroadaptation) begins to bite. The general population are entirely ignorant of all this information and could benefit enormously from basic and increasingly advanced levels of education depending on the amounts consumed. We work in a Community Alcohol Team which works at Tier 3 (Care Planned Counselling) and 4 (detox) in the Models of Care / ETO West Sussex Pilot through the NTA, and we define our client group as Physically Dependent, with complex needs and issues. I would recommend a stepped approach to problem definition, when looking at alcohol use. We currently have a triage service which tries to direct less complex clients to Tier 2 services. In defining best practice I would direct you to the 15 years of culturally sensitive work of Prof. Heather Velleman and co whose work with the WHO on Screening and Brief Interventions is a masterpiece of careful and well researched interventions, which could have significant impact on the population and reduce pressure on the whole care system.

There is emerging evidence that the population are getting to grips with UNIT measures, especially when using  $X \text{ litres} \times Y\% = XY \text{ No of units}$ . eg; 2 litres of 5.6% cider = 11.2 Units. So one intervention that would help is Unit labelling and litre labelling. Unit consumption is a gross measure but can give indicators to likely levels of harms and the development of dependence. Over a time frame this can differentiate risk and harms. There is no level of safe drinking and honesty would help here. People see alcohol in its historic context as a medicine and if you tell them 1 or 2 are good for them, then they will decide that 5 or 6 must be better..

7. What drinking patterns should an alcohol harm reduction strategy seek to affect? How susceptible are such patterns to change? Where should Government concentrate its efforts in prevention?

There are no simple answers to this question. Binge drinking is CULTURAL and should

be seen as such, with the drink/driving legislation and road casualties taking 20 odd years to effect change, then there has to be a long-term view. Cost and availability are the keys. Alcohol is relatively cheap( you can consume 3litres of 7.5% cider at a cost of £2.49p for 7 days a week and still have change out of £20). This represents 22.5 units and could be interpreted as the level at which the body is on average always under the influence of alcohol. Don't listen to the Industry when they claim that revenue hikes lead to a drop in sales. Don't listen to comparisons with european CULTURES where alcohol is much cheaper even than here. When things are relatively expensive then less people do less of it. Market forces work both ways. With availability, there are even more social and cultural changes at work than with the cost . Nearly every city and town in the country has been refurbished /regenerated on the back of commercially developed bars/clubs/restaurants/superpubs and winebars, driving out the traditional clientele in favour of younger higher spending drinking cultures. The current drinkers have no control-group to affect their view of their own and their peers drinking and so overdrinking becomes the norm. Great for profits and employment, but terrible for Livers, Lovers, the Law and Livelihoods. The design of these establishments has changed to favour standing drinking on the Australian model, which is seen as bingeing in the extreme, driven there, by limited opening times. The extension of opening hours will ,I fear, lead to the normalisation of continuous drinking and an increase in the number of younger people with short drinking histories, but significant liver disease. The figures for womens' liver disease could be seen as a precedent.

8. Is there a relationship between trends in drinking and wider social changes – e.g. the spread of higher education, changes in workplace culture, later marriage and/or family formation? Where does this suggest we need to focus attention in influencing behaviour?

As above the issues are personal and sociological. Drinking patterns are driven by the retail industry, which has sophisticated analysis helping shape it's decisions on product development and marketing. Control of advertising should feature highly. The name Bernie Eccleston comes to mind for some reason. You have grasped the nettle with Working life balance proposals , and the need for alternative strategies to alcohol use requires the development of alternative activities. More playing fields, open spaces, leisure and interest activities where alcohol doesn't figure.

9. One group we need to focus on specifically is young people, where the evidence suggests a rise in consumption, particularly by young women. Are there other groups we should be focusing on? For example are there specific issues around minority ethnic attitudes to, and use of alcohol which we should bring into our analysis?

Alcohol use is almost universal, and its the WHY that needs investigation when looking at vulnerability to over drinking. WHO WHAT WHERE WHEN and HOW will tell us all WHY? Evaluation of the groups who present and who DON'T present, but who suffer harms, should uncover some of the answers. In my experience the issues are Poverty, Social exclusion, Parental death and Separation, Significant illness, Sexual, emotional physical abuse and neglect, bullying, trauma, mental health problems and exposure to parental substance misuse. I'll repeat cost and availability , in case you missed it last time.

10. It is easy to focus on the negative aspects of alcohol use and misuse. But what are the positive cultural and behavioural (as opposed to economic) aspects? What parts of our culture would change for the worse if we did not have alcohol?

I'll let the drinks industry tell you about this . They've paid fortunes for the focus group discussions that occur every night in the snug.

11. Is there such a thing as a recognisably English drinking culture and if so what does it look like? What are the factors which influence it – for example are there sharp regional differences? Does it look different for different ages groups?

As Above KEEP IT SIMPLE.

12. What factors influence behaviour – fashion and marketing, family background, education and information, financial, legal and regulatory, scientific, environmental? Which are the most influential in your view? How easy is it to exert influence through those factors?

I'm afraid I don't have time to write this book!Lots of others have written it already!

13. How do attitudes to risk affect use of alcohol?

More interesting is the question, " How does alcohol use affect attitude to risk?"

## Health: prevention, treatment and the impact on the NHS

The effects of alcohol misuse cost the NHS money. There are direct costs both to the NHS and in social care in treating those with alcohol dependence. And there are a host of indirect costs through alcohol-related illnesses and accidents; through violence fuelled by alcohol; and through mental illness and depression associated with alcohol misuse; and through the mixing of alcohol with illicit drugs. But there is also some evidence that moderate alcohol use for some groups can be beneficial to health.

### *Questions*

14. How do you define harmful drinking? What factors do you take into account in deciding whether heavy drinking has become problematic drinking

This our specialist area and it would be wrong to say that this is completely understood. The false distinction arises when individuals and those close to them such as children or partners, employers and the professionals involved, all have a say in the cost/ benefit equation.Harmful drinking begs a further question of " who's harm?"The terms used are in themselves helpful when defining risk and assessing needs and interventions, but, at a personal level the drinking is probably functional, a coping strategy, and as such helpful rather than harmful.Even at dependent levels of drinking the alcohol consumed can be seen as therapeutic because it relieves withdrawal symptoms and helps the individual function. A comprehensive assessment of each individual, their personal , social, psychological and physical needs will reveal the various levels of risk and harm and prove a useful starting point for therapeutic/ motivational/ counselling interventions.Where we see little or only scant regard for the consequences of drinking is

in the way education, health and social services categorise problems by their own inclusion criteria rather than see the individual as AFFECTED by the system which they operate in. An example would be a young boy of 9 or 10 who has a diagnosis of ADDH where the parent(s) drinking might be seen as aetiologically significant. One thing to bear in mind is how individuals personal history giving and self-definition is often retarded. Getting confirmation from significant others can be very helpful. It's not that the drinker is being deceitful, but usually relates to the effects of alcohol on the memory. There are plenty of ready-reckoners (Hard Rain Productions) and Drink and sober diaries can help individuals focus on consumption levels, but at the end of the day it's usually the personal limit that gets broken, which influences the individual to start to change. This may be as simple as getting caught for drink-driving (external locus of control) or as complicated as waking up the next morning, in a stranger's bed. (internal locus of control)

15. How clear is the evidence both for the health costs and the health benefits of alcohol? Are there key pieces of research of which we should be aware? Where are the gaps in the evidence?

We now have clean cheap water delivered to every household in the country the need for "relatively" safe distilled and fermented fluids has declined as a result. The health CONSEQUENCES of alcohol are myriad and represent significant %tages for all the health improvement targets set last year.. Health benefits are of such minute significance that they deserve no mention. The French Govt. has published research which describes equal or better outcomes for alternative less risky activities other than than drinking in order to gain health benefits. Clarity is obscured by the Public Relations (organised lying ) of the drinks industry and the research they commission and DON'T publish. Remember Big Tobacco!

16. What are the costs for the NHS both directly and indirectly due to alcohol? We will be examining evidence on this but would welcome your views and any evidence you think we should be aware of.

You have to ask the right questions and be fearless in your answers. How many people are recorded as having died from or been injured by alcohol? This depends. The medical profession, pathologist and coroner need guidance on the evidence trail for the cause of death. An example would be: an elderly lady falls after consuming a half bottle of sherry and is admitted to hospital where her fractured femur is repaired, but where her recovery is complicated by her dehydration and enforced immobility. She develops pneumonia and subsequently dies. What killed her? How accurately are admitting doctors and nurses in taking drink and drug histories. The hidden problem/ harmful / dependent drinkers can be identified fairly easily outside of their normal drinking routine because they display much higher levels of anxiety, distress, sweating, shakes, GI disturbances, fits etc, when their normal supply is interrupted. Gateway staff should have alcohol assessment as part of their core skills. The development of routine breathalysing will help individuals recognise the normality of this experience. It could even develop a new source of referrals. We are clear that the aetiology of alcohol related harms are little understood by Medical professionals and that's no surprise when it doesn't form any part of their basic training. We have witnessed some interesting connections between the diagnosis of Diabetes and the development of dependent drinking with almost no withdrawal effects.

It would be most enlightening to know why? Indirect costs can be counted in the courts, civil, criminal and family. Hospital admissions that miss the drinking can be longer and more complicated thereby costing more. Look for teenage and all pregnancy, sexual health and dysfunction, fertility, the victims and perpetrators of violence. Drinkers can present inappropriately to every service there is with issues related to their drinking, both direct and indirect. Mental health, housing, psychology, child and adolescent services, young offenders, probation, all the out patient specialities and many of the primary care clinics, like blood pressure, diabetes, well-man and woman, neonatal, etc., etc.,. Violence to health service staff during the binge period of Friday, Saturday and Sunday morning following heavy drinking and the consequences of heavy drinking by the drinkers and their drunken companions.

17. What, in your experience, are the most appropriate means of prevention of alcohol dependence and serious alcohol misuse? What forms of training are most appropriate for professionals in health and social care, as well as other fields, who play a role in prevention.

Familiar terms might be INFORMATION, INFORMATION and INFORMATION. Two key issues are COST and AVAILABILITY. If we have Folic acid and fluoride, why not have thiamine as an additive? The significant rise in the number of outlets and type of outlets selling alcohol, has to be related to the increase in per capita consumption. There needs to be a National roll-out of the training of front-line staff in all helping agencies in the Screening of and Brief Interventions for alcohol problems. Then to cope with the increased detection rates there will need to be specialist teams with dedicated ring-fenced detox and support services for the people who emerge. These need to be accessible and able to respond when the client is expressing the need for help. Receptiveness to change is enhanced in crisis. Look to the BLACK report (1970)? Try everything and evaluate. Test purchasing for underage drink purchasing. health warnings on packaging, if it's good for tobacco, it must be good for alcohol. Assess the effect of advertising bans by implementing selectively. I would suggest TV and Football to start with. If association didn't work, then brand managers wouldn't buy spaces on footballer's chests. Ask the question about how many outlets you need for a population? It may surprise you to discover how few this might be. (Look at Finland) Attempt to reverse the culture of over-drinking by starting at Primary school and use the excellent smoking example as your guide. This could easily be afforded by hypothecated taxation. Health and social care professionals are notoriously heavy drinkers and would need to address their own consumption and the development of alternative coping strategies to stress relief. This could be seen as part of the working lives agenda and the modernisation agenda. Underlying all alcohol use are the issues mentioned in Q14 and if these are addressed at ever younger ages through, the education/ psychological/ medical/ family therapy/ social inclusion/ primary care settings then the need for excess alcohol will diminish.

18. "Brief interventions" can be offered to patients who have been identified as at risk from alcohol misuse. They may consist of a short session with a doctor or nurse to discuss a patient's drinking and to offer help and support to cut down on alcohol intake, if the patient wishes to do this. How effectively do you think those at risk are

identified? How well have you found brief interventions to work and how might they work better?

The DoH commissioned, but failed to publish the study of "what works" in alcohol interventions, by Heather and Raistrick, which is quoted in the Models of Care paper but remains unavailable. Publish your own research!"Brief" needs clarification ,because it is often misunderstood to mean MINISCULE, when it defines what it isn't,on-going therapy ie .three times per week of psychoanalytic psychotherapy, for several years or until the therapist retires, whichever is soonest.Brief interventions work. They also help individuals to locate their distress and to get appropriate help from the right agency.They are collaberative, non-judgemental, non-threatening, honest, culturally sensitive, gender sensitive, give time to listen and feed back in written form and are targetted at times of greatest receptiveness. Perfect then !.

19. Do current treatments for alcohol dependence and hazardous drinking work? Are they sufficiently tailored to meet differing individual needs? Are there other forms of treatment we should be aware of? Is there a need for guidance for the commissioners of local treatment services? How should individuals best access treatment services?

Stopping and staying stopped are two entirely separate issues.Stopping when dependent can be life threatening and requires comprehensive assessment and appropriate detox arrangements to protect the individual from the potential harms of the process. This means home/ ambulatory supported withdrawal with a significant supevising adult able to attend the individual 24 hrs /day for several days, and able to call emergency help if necessary. Dedicated trained nursing staff to manage detox are essential to visit ,support and monitor the patients' physical/psychological and social situation. All this needs to happen in the context of a collaberative relationship with the individual, their significant others and primary carers. In-patient detox is required for medically unwell individuals and for those who have little or no social support such as the homeless. Edwards and Unnithan propose an alcohol detox facility of 6=8 beds for each population of 250,000 and this was before the development of home and ambulatory detox. These facilities need to be located close to population centres to maximise the accessibility and need to have direct links to community follow-up and post detox relapse prevention and skills based training.It would be helpful for guidance to be given to mental health services on the management of dual diagnosed dependent clients as the tendency is for the alcohol diagnosis to be pushed to the fore. This even after the excellent work of the Sainsbury centre /NSF guidance.Acute in patient services and increasingly day care , need to assess and manage the dependent drinker for the medical condition AND for their alcohol dependence.There needs to be a tiered/ stepped approach to treatment , operating the best practice in conventional and alternative support services, utilising the voluntary sector, statutory and social services.Change is a process, and relapse and lapse are opportunities to learn about vulnerablity and personal skills defecits.The needs of women drinkers are often overlooked in this context and they need special consideration. They are often caring themselves for children and relatives and cannot easily forgo these commitments.There is insufficient collaberation between children's agencies and alcohol services to ascertain the needs of both the children and the parent.Engaging the "system " or usually the family at this stage is essential to help the group change with the

emergence of the sober individual, and to cope with the tension created by the changes. Specifically different groups where sensitive responses are needed include gender, sexual orientation, culture, age, health status and disability. There needs to be capacity at tier/level 3 and 4 interventions for treating the underlying issues of Sexual/physical/emotional abuse and neglect, loss, eating disorders, PTSD etc. & etc. Stopping alcohol use is relatively easy. Staying stopped is relatively hard. The inclusion of alcohol at every level and activity, makes participating socially after stopping very difficult. Local authorities should be made responsible for the availability of alcohol-free environments so that non-drinkers, whether by choice or by habit, can have somewhere to go and something to do. Every swimming pool and leisure centre is subsidised by the bar facilities and this makes for a most unhealthy combination of messages to both young people learning to drink, and to people trying not to drink. By using Project match, UKATT, and Miller's Mesa Grande you might save yourselves an awful lot of work. Commissioners need specialist skills and Public health experience and training to comprehend the way alcohol fits in to all their agendas. If someone can name one where it doesn't fit I'd be most surprised. There are commissioning standards published by Drugscope and Alcohol Concern which should be audited and imposed. The distinct lack of local needs assessment is scary. PCT's tend to be so "young" and undeveloped that we are in danger of losing services on the back of prejudice and shroud waving by lobbyists with personal territories to expand or protect. They have too big an agenda and too little sophisticated analysis to help their decision-making process and they are often overloaded responding to the current reorganisations and initiative culture.

20. What can we learn from drugs prevention and treatment?

Treatment works. Treatment requires funding. Targets create false expectations and distract from service provision. Measuring costs money that could be better spent on treatment. Criminal Justice issues are reduced by the legality of this particular drug. Criminal Justice interventions are cost INEFFICIENT. Funding should be connected to need, not driven by the political agendas, which generally refer to them and us. Models of care is for injecting drug users and users of crack cocaine. It doesn't fit the profile of older people who have alcohol problems, and who don't have criminal justice issues. Children see straight through the hypocrisy that the adult world describes as legal and illegal substances and we wonder why they don't hear the message. The honesty required to convince them should be what convinces us. Compromise is the route of the weak and and ineffectual.

21. How, in your experience, can we minimise and prevent the injuries that are presented to A&E departments as a result of alcohol related assaults (often with glasses and bottles) or home and workplace alcohol-related accidents?

Make servers legally responsible for their customers and train door and serving staff appropriately. Avoid the development of drinking ghettos such as town and city centres, and address the drinking in the general population to reduce the overall incidence of damage, violence, accidents and injuries. Stop the slide towards 24 hour drinking and adjust cultural overdrinking among younger groups who have no moderating cohort to model.

22. What are the links between alcohol misuse and mental health problems, including depression and suicide? How are services – both those aimed at prevention and treatment – best co-ordinated?

Alcohol is a depressant as well as a mood enhancer in its complicated multi-factorial chemical effect on the body's various organs. Services need to respond to and be able to fund the treatment for all the aspects that are apparent or which become apparent as treatment progresses. This includes funding for hybrid community and residential services, where individuals can be taught and can learn alternative coping strategies. We need outreach to the single, unemployed, middle aged male heavy drinkers, whose social isolation makes them vulnerable to suicide, and the slow suicide that is drinking to excess. Fund the Sainsbury's centre recommendations and Dual diagnosis treatment modalities, and fund health authorities to treat patients with drugs that work, so that their patients don't feel it's necessary to treat themselves with alcohol. Every dept. of psychiatry has a large number of difficult, so called personality disordered individuals who need specific self help interventions and who drink far more than the average population. These people's keyworkers need specialist training to help their clients with substance use issues.

## Crime, disorder and anti-social behaviour: the effects on our surroundings and community

The most visible effect many of us see from alcohol misuse is in our town and city centres: pavements littered with broken bottles and streets too intimidating to pass through. Links between alcohol and disorder are as much a matter for concern as are links between alcohol and crime.

### *Questions*

23. What evidence is there about the links between alcohol and crime and the links between alcohol and anti-social behaviour? Are there key studies or pieces of evidence you think we should be aware of? Where are there gaps in the evidence?

24. In your experience, is alcohol a factor in habitual re-offending? Does it lead to particular types of crime? How far does it lead to one-off offences?

25. To what extent can alcohol convincingly be demonstrated to be a factor in criminal and disorderly behaviour? How much is perception and how much is reality? What fuels the perceptions and are they accurate?

26. Alcohol is far from being the only factor in crime and disorder. Other factors are involved – for example town centre disorder can be influenced by lack of

availability of transport or design of environment. What other factors might be involved? How easy are these factors to influence? Who is responsible for them?

27. How does the impact of alcohol on urban environments differ from its impact on rural environments? What are the differences between urban and rural drinking patterns and how do they affect those communities and surroundings?

28. To what extent can impacts on the environment (including crime, disorder, noise and waste) be designed out, for example by use of plastic drinking glasses? Are there examples of good practice it would be helpful for us to be aware of?

29. There are some examples of good practice where a range of organisations responsible for dealing with different aspects of alcohol have successfully 'combined efforts' and shared information to tackle alcohol-related crime and disorder together. Should this approach be encouraged more widely? What inhibits organisations or communities from taking such an approach?

30. Is it right that anti-crime and anti-social behaviour initiatives need to be targeted on young people?

31. Should we be encouraging different drinking patterns – in terms of time spent drinking, location of drinking etc – in order to tackle alcohol-related crime and disorder?

Never mind just alcohol related disorder. We should be looking at the whole drinking culture and the enormous increase in drink-related violence as a direct result of the relaxation of licensing laws. But you didn't want to hear that did you?

32. How can the law on, and policing approaches to public drunkenness and street drinking help to tackle these problems? Are existing controls and powers (such as those for local authorities to introduce no drinking zones) effective? Are they sufficient?

There are so many outlets that this must be hard to define.

33. One person's good evening out can be another person's sleepless night. Are there principles to guide the balance of individual rights and responsibilities?

This is about the proliferation of drinking outlets and the extension of opening hours. It is also about the lack of public transport.

34. Drink-drive policies are generally acknowledged to have been successful. What can we learn from them?

Risk taking has consequences. The greater the consequences the less people take risks.

Alcohol reduces the perception of risk and can be seen as its own justifier.

35. Domestic violence is often associated with alcohol misuse – either by the perpetrator, or, on occasion, by the victim. What in your experience, is the nature of this link and what would you see as good practice in tackling the interrelationship between domestic violence and alcohol misuse?

Transgenerational behaviours are not limited to substance use. Experience of violence (see all the literature on school bullying policies) is a key indicator for the normalisation of response in the perpetrators and victims. This is not a individual issue ,it belongs to society and our ambivalence to violence which suits our purpose and that which threatens us.

## The implications for vulnerable groups

Some people may be more vulnerable to the harmful consequences of using alcohol. Certain groups of young people in particular are at higher risk of developing a range of difficulties that include alcohol-related problems (for example children in social care, those excluded from school and youth offenders). Families and carers can play an important role in protecting young people from problems but it is important to recognise that living with a parent or carer with an alcohol problem can itself become a source of vulnerability.

### *Questions*

36. Which children and young people do you see as being most vulnerable to the consequences of alcohol misuse?

SEE q6

37. What other groups would you identify as particularly at risk and vulnerable to the harmful effects of alcohol?

EVERYBODY!!!!!!!

38. Those who are vulnerable to the consequences of alcohol misuse often have complex problems (for example they may be homeless and may have additional mental health or drugs problems) and such factors may be inter-related. What key factors need to be understood in addition to alcohol use that contribute to maintaining the problems facing such groups? Which of these factors should interventions be aimed at?

Many drug users drink enormous amounts of alcohol, but a vast majority of drinkers don't use other substances, except tobacco! All substance use is functional. Young , middle aged and older people need help and guidance on how to enjoy themselves sober and clean.

39. How can the services provided by the state and others to vulnerable groups with complex problems be joined-up most effectively? Are there examples of joined-up

delivery it would be helpful for us to be aware of? What gets in the way of joining-up services?

Care coordination funded for small caseloads which access packages of care for individuals unable to coordinate their own needs.

40. How realistically can these vulnerable groups be dealt with by mainstream services and how far do they need services which are tailored to individual groups and indeed to individuals on a case-by-case basis? What is your experience?

If you use the Assertive outreach model from mental health you may begin to make a dent in this hard to treat group. This is very expensive and resource hungry because individuals are protected from the consequences of their drinking behaviour, and so crises are avoided and change is slowed.

## Education and communication

All of us receive messages about alcohol to some extent. We see advertising for alcohol and respond in various ways depending on our preferences. Information on sensible levels of drinking is also available. And messages on the consequences of getting it wrong can be clear – most obviously for drinkdriving. These are powerful tools for giving information and shaping perception. Do they alter behaviour?

### *Questions*

41. What should be the objectives in this area? Is the aim to raise levels of awareness? Is it to inform more specifically? Is it to change behaviour? Are there any particularly successful or unsuccessful examples we should be aware of?

It is a false premise to assume that there is a "safe" level as mentioned in a previous question. Telling people what to do doesn't work. Asking people what they want to do and then working out how to get there works really well. Your fear of being seen as the "NANNY" state is well justified. Try paradoxical injunctions and see what happens! Awareness and insight are hard won and long on time and effort.

42. Given clear objectives, what is the evidence on the effectiveness of these approaches? What do they actually achieve? How can their effectiveness be measured?

In "measuring the pig", don't forget to feed it!

43. How well is the sensible drinking message reaching its audience? Is it sufficiently clear? What is the evidence on its penetration and its effect on behaviour?

People hear that it is normal to drink and therefore that it is abnormal not to. A message that not drinking can be OK would be novel.

44. How well is scientific research feeding into alcohol education? Is the message based on sound, unbiased and uncontroversial research and are new findings effectively incorporated?

45. Should particular groups be targeted for information and communication? Is there a need to provide more intensive alcohol education to groups other than young people (e.g. elderly drinkers)?

Yes! EVERYBODY

46. What is the role of schools, colleges, universities and other educational institutions in providing alcohol education as well as support for alcohol-related problems? How can we best establish and preserve a healthy learning environment?

47. What role is there for families/parents as role models or in educating their children on sensible levels of alcohol drinking and the risks of alcohol misuse? How can they best be informed and engaged in this effort?

48. What does experience show on the most effective means of getting messages across? Are there circumstances in which the Government is particularly well placed to do so, or conversely might be particularly unsuccessful?

49. What can we learn from educational initiatives in the field of illegal drugs?

Telling people not to do something doesn't work. There is even a group who will deliberately do things to show rejection of authoritarian messages. This is incredibly complex, but if you take a leaf out of highly successful advertising and marketing campaigns you will notice that risk taking is normal and that caution has negative connotations.

50. Do you have views on the existing regulation of advertising on alcohol?

Absolutely! The subtlety of some of the messages (tobacco is notorious for this, in associating itself with fast cars, high risk behaviours and sex) are only accessible to the targetted groups, who then see themselves as special. This is toally unacceptable mass manipulation and should be banned. Advertising of potentially lethal products is the forte of modern capitalism, and Governments entrenchment through revenue and tax collecting on the back of these commodities is seen as condoning and complicit. Governments Public Health responsibilities should eb paramount. When Child protection procedures were first introduced it took services a long time to hear the main message. "Childrens' needs are paramount" It is still not heard in some areas.

## The shape of the market and market-based solutions

The drinks industry is a major part of the national economy. It provides large numbers of jobs both in supply and distribution; it influences trends and fashion through its advertising; and it provides a substantial portion of tax revenues. Understanding how that market works, what drives it and how it responds to demand is essential to producing an effective strategy.

### *Questions*

51. Do you have any thoughts on the likely evolution of the alcohol industry over the next decade?

Better targeted products aimed at younger people , niche markets like clubbers and the elderly.It depends on the results of this strategy really doesn't it.?

52. What is the relationship between the creation of trends and fashions in alcohol consumption by the market and consumers responding to trends and fashions? Are there discernible patterns which the Government might use in responding to the effects of alcohol misuse? Is there useful evidence we might draw on?

See q 30

53. How far do you foresee research and development creating innovative market-led solutions to the problems of alcohol misuse?

You'll probably have to pay for better advertising to counter the effects of the existing stuff.

54. How best can Government work with the alcohol industry to reach consumers? What approaches have been shown to be effective in England, the devolved administrations and further afield?

If you asked us whether you should work with the heroin and cocaine producers and distributors we'd be justified in asking you to explain your position . Explain your position in wanting to first and this question might merit an answer.If you supp with the devil you'd better get a very long spoon indeed.

55. Are there other commercial interests which can influence drinking behaviour?

### The economic costs and benefits of alcohol

Alcohol has significant costs for the economy. It costs the NHS and the police. It costs business money because of lost productivity and in some cases the need to repair alcohol-related damage. And it can be expensive for individuals who drink heavily and may find themselves unable to hold down a job. But it also has benefits. It brings in tax revenue and contributes to GDP. And it contributes to personal and social wellbeing for many. Part of the work on the project will be to form a clear picture of these costs and benefits.

### *Questions*

56. How clear is the evidence both for the wider economic costs and benefits of alcohol? Are there key pieces of research of which we should be aware?

Try the chancellors recent budget statement summary. I don't have one to hand but it looked like about £38 BILLION of the revenue (indirect) was from tobacco and alcohol. I know that a parliamentary answer last year put the spend on alcohol treatment at about

£100 million, so I think this answer is already in the frame.

57. Where are the gaps in the available data on the economic costs and benefits of alcohol? Are there any obvious limitations we should be aware of? Are there any particularly helpful methods for assessing costs and benefits we should be aware of?

See treatment and research answers.

58. What principles could guide us in deciding who is responsible for costs? How far should they fall to individuals, how far to business and how far to Government?

If you proportioned it by benefit on a % of cash raised we'd soon see where the bill should be sent.

59. What are the economic benefits of having an alcohol industry? Can we easily quantify them?

Ask Gordon Brown, if he doesn't know then ask the stock market why tobacco and alcohol shares fared best in the recent stock market crash.

60. Alcohol misuse can increase absenteeism and decrease productivity, whilst moderate consumption of alcohol may be beneficial in terms of reducing stress and tension and facilitating networking in the workplace. What in your view are the links between alcohol use and educational and occupational attainment?

These are false assumptions and rather than make bald statements you should source your information so that we can see what's valid and what's the personal view of the writer.

61. Are there particularly effective workplace-based initiatives designed to tackle alcohol misuse that we should be aware of?

Random breath-testing on the railway and underground works well.