

- 3.1. These rights are usually complementary.
- 3.2. There must be mechanisms for the reporting of negative effects on individuals and communities. For example, there should be feedback from Accident and Emergency Departments about injuries and there should be feedback from communities in relation to new alcohol and entertainment license applications. This requires robust interagency reporting mechanisms/consultation with residents. Roles and responsibilities of consumers include the reporting to the police of alcohol related offending, not to behave antisocially and not to be the cause of alcohol related injury or aggression. The roles and responsibilities of voluntary groups, such as Alcohol Concern and Victim Support are to advocate responsible drinking and harm reduction through legislation and local regulation with regard to such issues as the training of door-staff and bar-staff, serving drinks in plastic and toughened glass containers, and compliance with health and safety regulations including the reporting of all injuries sustained in licensed premises. Roles and responsibilities of commercial interests include selling alcohol only to those over the age of 18, not serving alcohol to intoxicated individuals, reporting all violent offences in which injury is sustained, recording all alcohol related injuries in health and safety records for that licensed premises, and ensuring adequate training and registration of door-staff and bar-staff, serving drinks in plastic bottles and where glasses are used, ensuring that high quality glassware is used, ensuring that glasses are not taken out of the premises, and ensuring adequate CCTV surveillance of licensed premises including exits and entrances.
- 5.3. The Strategy should acknowledge that alcohol related harm is a public health issue since it includes injuries psychological harm and alcohol dependence; substantial numbers of alcohol-related offences only come to the attention of health services; and public health expertise is available locally to a far greater extent than police analytic expertise.
- 5.4. The Strategy should incorporate incentives to the alcohol industry, particularly the licensed trade, and individuals to act responsibly. Potential examples include contributions from the licensed trade to Criminal Injury Compensation awarded to victims injured in licensed premises and tough law enforcement with regard to alcohol related aggression and road injury. The Strategy should be built on evidence based interventions and should not be based on interventions which have not been found to be effective in formal quantitative evaluations. The Strategy should also take account of cost-effectiveness. For example, brief alcohol interventions have been shown to be both effective and efficient, particularly if they are applied to those injured while drunk when these individuals have their sutures removed in follow up clinics. There is a relationship between alcohol-related harm and increasing levels of alcohol consumption by young teenagers, particularly girls aged 15-17.
- 8.6 Attention needs to be focused on repeat places, repeat times and repeat individuals (repeat victimisation). Police and other resource

needs to be concentrated at peak times (i.e., between 1am and 3am) at repeat places (which demands local harm surveillance particularly through A&E Departments and police data to identify repeat sites such as street locations and particular bars and nightclubs). The substantial expansion in the night-time economy of UK cities demands that city centre populations are adequately policed. This demands relocation of resource to follow influx of young adults from suburbs and towns within a 50 mile radius.

- 9.1. Education approaches to young men and women need to be evidence based. Some education initiatives have been shown to make things worse i.e., to increase alcohol and drug related harm.
- 11.3. A recognisable English drinking culture relates to peculiarly English “expectations”. Research has shown that research expectations about alcohol are very likely to be realised. Unfortunately, in England, an expectation of alcohol consumption is aggression, assertiveness and violence. These expectations need to be challenged and reoriented with reference to more civilised expectations in other countries such as France, where the expectation is not of violence and aggression. Expectations could be modified if alcohol consumption was more closely associated with meals. Reinforcing negative expectations, for example in relation to hangovers, being sick, unwanted pregnancy, threats to employment prospects and current employment and expectation that alcohol-related antisocial behaviour will result in being caught through CCTV and conviction should be a major objective.
- 12.11. Fashion influences drinking behaviour through choice of bar/night-club. City centre young drinkers are as susceptible to fashions in drinking venue and drink as they are to other fashions. It seems likely that law enforcement focused on particular licensed premises can displace potentially troublesome drinkers to other licensed premises as increased police presence makes venues inevitably less fashionable. This implies the need for area law enforcement rather than premises law enforcement.
- 12.12. Since injury sustained in alcohol-related assault has been shown to be linked with cheap alcohol, proportion of income spent on alcohol and actual alcohol expenditure, marketing which involves cheap drinks increases harm. Family factors include harsh or erratic parenting and parental separation and conflict. Appropriate education interventions can limit alcohol misuse, but some alcohol interventions can actually increase risk. Pre-school education and early family support (Sure Start/Head Start) need to be seen as generic, effective interventions which limit a spectrum of antisocial behaviour. Important environmental factors include limiting overcrowding and loud and specific music (for example, garage music) and through reducing to a minimum the availability of potential weapons. The elimination of glass bottles and poorly toughened glass containers is an achievable evidence-based objective. The alcohol use disorders identification test (AUDIT) provides a good definition of harmful drinking.

- 14.3. The CAGE questionnaire provides an objective measure of alcohol dependence. Costs for the NHS relate to treatment of alcohol-related injury, alcohol-related psychological harm, dependence and the cost of alcohol-related disorder in NHS facilities. Costs also include the provision of services designed to reduce hazardous alcohol consumption.
- 17.1. In my experience the most appropriate means of prevention of alcohol dependence and serious alcohol misuse are pre-school education, early family support and brief interventions. The most appropriate forms of training are short half-day/one day and repeated courses for nurses in Departments of Oral and Maxillofacial Surgery, Trauma Clinics and Primary Care who see victims of alcohol-related harm for wound care in the aftermath of injury. Although A&E Departments are appropriate places to screen for alcohol-related harm, they are not the best places for treatment since most attenders are drunk and therefore not susceptible to education and advice when they first attend.
- 18.4. A crucial and strategic focus for brief interventions are Oral and Maxillofacial outpatient clinics. This is because almost all hazardous drinkers who sustain assault injury are treated by this specialty since they almost all have facial wounds. Furthermore, for young adults – those most at risk – dependence has yet to become established and individuals, predominantly males, have yet to forge long-term relationships and are therefore susceptible to advice which may reduce both partner abuse and child abuse. A priority for targeted prevention is the training of Oral and Maxillofacial clinic nurses to equip them to institute brief interventions.
- 19.4. The Strategy must only include treatments for alcohol dependence and hazardous drinking which have proven to be effective in properly conducted randomised controlled trials or at least have shown to be promising. There is a great deal of non-evidence-based treatment available.
- 20.1. Injuries can be minimised and prevented through the use of plastic bottles and high quality toughened glass. Although toughened glass has been shown to have injury prevention properties, this is only the case where the toughening process has been carried out to a high standard. Unfortunately, some glassware is not subject to high-quality toughening and this can actually increase injury risk. A British Standard governing glass toughening has been proposed and advocated strongly in the past, but no action has yet been taken. This action is overdue. Evidence is emerging that CCTV prevents alcohol-related injuries through ensuring a more rapid police response to an argument or a fight in a public area.
- 23.1. There is strong evidence that alcohol misuse is but one part of a wider antisocial tendency which includes offending, truancy and teenage pregnancy for example. Alcohol misuse should not be thought of as an isolated behaviour, but a behaviour linked to other antisocial behaviours. Recent evidence shows that childhood predictors of offending and concurrent antisocial behaviour are

strongly linked to injury, particularly assault injury. Evidence also shows that assault injury is replaced by work injury as antisocial individuals get older. The maturation process is also accompanied by specialisation in particular antisocial activities. The impact of alcohol misuse on health in terms of illness (rather than injury) becomes apparent only after the age of about 30 years of age.

25. 3. Alcohol misuse is now known to be causally linked to criminal and disorderly victimisation. The main culprit is binge consumption. The mechanisms are decreased physical capability, erosion of competence in decision making, isolation late a night and signals of immunity from prosecution (drunk people cannot identify assailants to the police and identification is essential if assailants are to be brought to justice).
- 26.1. Town centre disorder is influenced by the number of individuals present, and alcohol consumption. The city centre daytime economy is characterised by large numbers of people of all ages, but risks of harm are low. The night-time economy is characterised by large numbers of people of a particular age who drink heavily and are looking for excitement. Crowds must be regulated both in terms of numbers and law enforcement. Soccer crowds are now policed to a high standard, but the same cannot be said of night-time city centre crowds. The alcohol and entertainment industries are responsible for their customers on the premises, but public services are responsible for crowds in public places. The night-time economy means that main entertainment thoroughfares in effect become theme park conduits from bar to bar. On this basis it could be argued that the licensed trade has ownership of these city centre conduits for their customers.
- 28.4. See above.
- 29.1. These examples of good practice have brought about reductions in alcohol-related harm in particular licensed premises but have had little impact on overall levels of violence. Further, better-defined multiagency interventions are necessary. In the meantime, resources should be focused on interventions which are known to work, such as targeted policing and alcohol server training. One of the errors in previous multiagency work has been to adopt a “shotgun” policy with resources sprayed around communities, for example in schools, using advertising on the sides of buses and neighbourhood watch schemes where there is no evidence that these work. Indeed, there are dangers in this indiscriminate approach since some educational interventions can actually increase alcohol-related harm through suggesting new, ‘exciting’ behaviours to susceptible teenagers.
- 30.1. Yes.
- 32.1. Existing controls and powers are not effective because of woefully inadequate levels of policing in city centres at peak times for alcohol-related harm. No legislation will be effective if the means to enforce it are lacking.

- 32.2. So far, local authorities and licensing magistrates have contributed little to law enforcement and responsible drinking. It seems too easy for local authorities to be influenced by commercial interests. Licensing magistrates have not taken account of public order issues to the extent that is necessary. What we can learn from drink-drive policies is mainly that they relate to tackling vulnerability. Drunk drivers cause death and injury through incompetence and disinhibition. The same mechanisms apply to alcohol-related assault: the risk of harm is increased through disinhibition and incompetence.
- 36.6. Boys are more than susceptible to girls on the basis of national, regional and local surveys of assault-related injury. Girls are becoming more like boys however: 15 years ago young male victims outnumbered young female victims by about 6:1. In 2000, this had fallen to about 3:1.
- 38.1. Distinction from offending and antisocial behaviour is associated with moving to a better area, getting a job, getting married and joining the Army. Early onset alcoholism and assault-related injury and deformity can reduce the likelihood of these events.
- 39.1. Pre-school education and early family support have been shown to reduce a wide spectrum of antisocial behaviours. Barriers to joining up services include lack of incentives to do so, a focus on policy makers rather than on the practitioners who are in a position to make a difference, poor management of continuing professional development for practitioners, and a silo mentality among the public service practitioners and strategists.
- 44.1. Scientific research is not feeding efficiently into alcohol education. The evidence-based revolution in medicine has yet to impact significantly on social science practice in England and Wales. The Strategy must be evidence-based.
- 46.2. School interventions which have been found to be effective in high quality scientific evaluations include school and discipline management interventions, interventions which establish norms or expectations for behaviour and classroom instructional management. Self-control or social competence instruction using cognitive behavioural or behavioural instructional methods have also been found to be effective. It is not known whether self-control or social competency instruction without cognitive behavioural or behavioural instructional methods, or counselling, social work and other therapeutic interventions work. Importantly, mentoring, tutoring and work study, and recreation, community service, enrichment and leisure activities have been shown not to reduce alcohol-related harm.
- 47.1. In terms of family based prevention programmes, home visitation, parent education plus day-care/pre-school, school based child training plus parent training and multi systematic therapy have been shown to work. On the other hand, family based programmes of home/community parent training have been found not to be effective. Harmful effects have also been found for parent training. Clinic-

based child training plus parent training has been found to be a promising intervention.

- 51.1. The alcohol industry should be far more responsible particularly in the areas of selling cheap alcohol, door and bar staff training, financing local policing, financing criminal injury compensation for assaults in or near licensed premises, sharing responsibilities for entertainment thoroughfare law and order with community law enforcement agencies (local authorities and the police), recording and disclosure of information relating to alcohol-related harm, serving drinks in plastic containers and high quality toughened glass.
- 53.1. Research and development has great potential in creating innovative solutions to the problems of alcohol misuse particularly in the areas of randomised field trials and design.