

# Southampton's Response to the National Alcohol Strategy

## The principles that should underpin the strategy

This is a combined response, correlated by the Southampton DAAT, on behalf of Community Safety, Southampton PCT, Southampton General Hospital, Southampton Service Providers and Southampton Practitioners and wider members of the community.

### **1.**

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

A common theme with alcohol is that of acceptability and visibility. Since the majority of people drink, the general population accepts alcohol in itself. The task of the strategy is to determine at what point alcohol begins to harm the individual and, perhaps more importantly, the point at which these effects begin to harm those with whom the individual comes into contact with.

The government should get involved because these issues affect such a broad sweep of the population. It must bear some responsibility for alcohol since it is a readily available psychoactive (mind-altering) drug that affects, at some point, a large percentage of the population (3). Perhaps this is the most crucial point, that alcohol is a drug and should no longer be placed in a separate category by itself. The only difference is that it is a legal drug (5).

When alcohol is misused the resulting harms can be considerable. These include:

- Physical and mental problems,
- Injury and death on the roads,
- Violence,
- Children stealing from parents in order to gain money for drink,
- Child neglect
- Litter
- Date rape
- Risk of fire in home
- Unsafe sex
- Racial abuse
- General fear of harassment by the public
- Impaired work performance.
- Stealing from employers
- Financial implications of loss of job on the family and the state.
- Loss of time at school
- Family disintegration
- Homelessness / rough sleeping

In annual terms, the social costs are huge. In human terms, the cost is incalculable.

Therefore Government intervention becomes justified either 1) when an individual harms, or seriously affects, another; 2) when an individual is unable to manage their own intake of alcohol; 3) to facilitate / enable statutory authorities to respond when the community requires action to be taken to curb problems associated with alcohol

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?**

Alcohol use by society is influenced by many factors – not the least of these being the £250 million UK advertising budget of the drinks industry and the very mixed messages about alcohol given to young people by the media. In view of the enormous health and economic costs of harmful alcohol use, the government has a responsibility to ensure that balanced information about alcohol is available to the public.

**Individual responsibility**

Alcohol-related harm is not distributed evenly throughout the community. Patterns of alcohol consumption vary, and the personal, social and economic costs of the misuse of alcohol are borne by some groups more than others (3). That said, the actual statistical breakdown of which social group are the heaviest drinkers makes uncomfortable reading for the professional classes, as they are among the heaviest drinkers. The following table shows this.

Table 1.

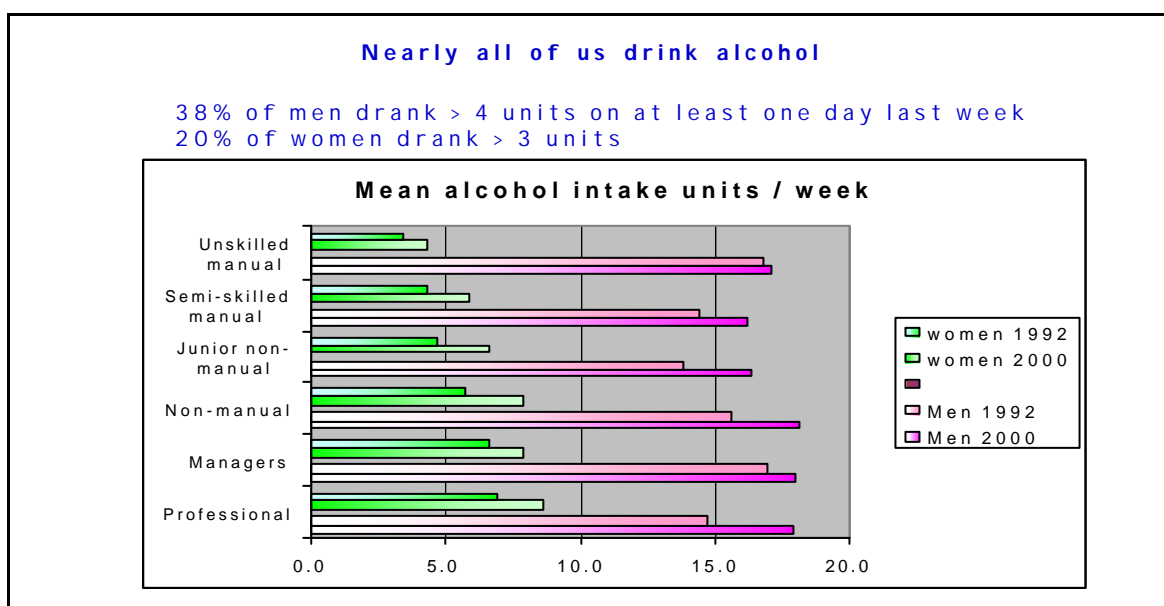


Table supplied by Dr Nick Sheron, Consultant Hepatologist and Senior Lecturer in Medicine, Southampton General.

Therefore, the alcohol strategy needs to account for the fact that the amount of heavy drinkers is spread throughout the social classes. Whether the harm caused by alcohol to others is also spread out so widely among these groups is a matter of debate.

It is certainly true to say that harmful drinking and dependent drinking are different issues. It is quite common for an individual to be damaging their body without being dependant on alcohol. The following table shows this.

Table 2.

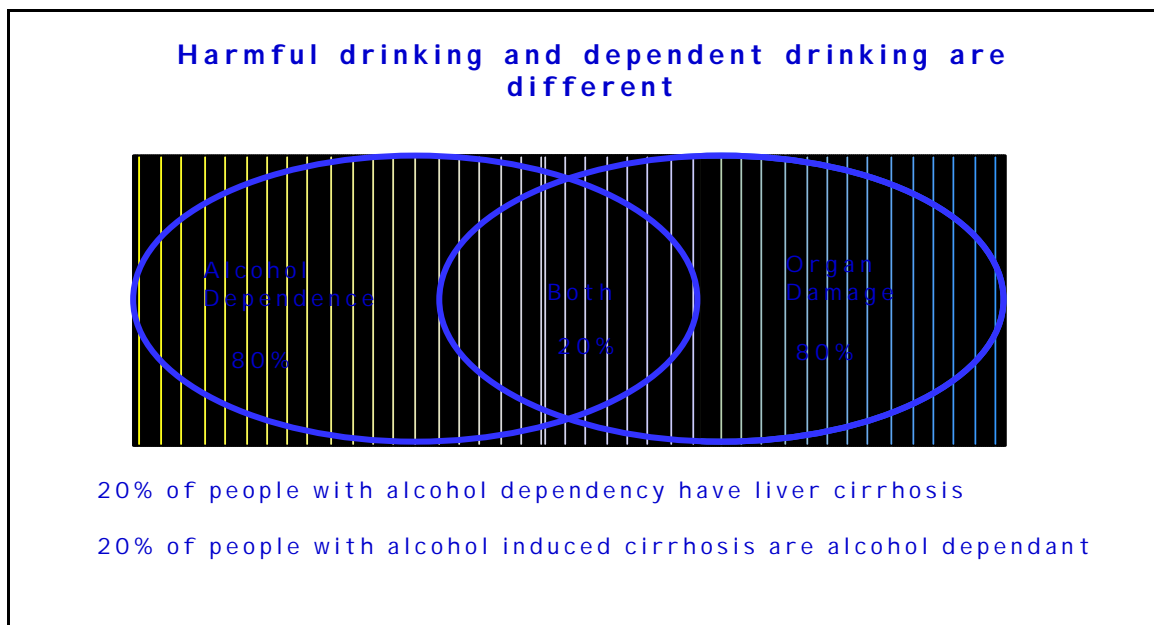


Table supplied by Dr Nick Sheron, Consultant Hepatologist and Senior Lecturer in Medicine, Southampton General.

It would seem that it is a matter of individual responsibility to monitor how much an individual drinks, especially if they are not posing harm to others. However, they may be harming themselves and not realize it. Perhaps this is the point at which the Government should become involved.

### **Government responsibility**

Alcohol is a major financial burden on the N.H.S. In the Royal College of Physicians Report 2001 (1), it was noted that in Accident and Emergency, 1/3 of all patients are above the driving limit, 12% of all attendances are directly related to alcohol and 6% of all hospital admissions are alcohol related. In acute admissions between 7% - 40% are alcohol related, the reason for the variation being that not enough concrete work has been done in this field.

The Royal College of Physicians Report estimates the cost of alcohol misuse to the NHS to be in the region of £3.5 billion (1). Estimates of excess deaths due to alcohol misuse are notoriously inaccurate, ranging from 5000 to 40,000 per year(1). A recent report from the chief medical officer drew attention to

dramatic rises in deaths from alcohol induced liver cirrhosis with 7-8 fold increases in deaths in the 35-44 year age group since the 1970's (2).

Both of these reports pointed out that the consequences of alcohol misuse are in many cases entirely preventable, but to do so will require a concerted approach from the government. It is a problem that the government can no longer ignore.

At its worse, alcohol misuse kills more people directly than illegal drug use and is a factor in many accidents. The scale of alcohol related harm is indisputable (5).

### Table 3.



Table supplied by Dr Nick Sheron, Consultant Hepatologist and Senior Lecturer in Medicine, Southampton General.

3.

### **How can we strike a balance between individual and community rights and choices?**

Consider how the current pro-alcohol culture effectively dilutes, takes away and at best influences, many of our choices. The following are example of how common culture promotes the use of alcohol:

- There are very few credible alternatives to alcohol in most pubs
- Soft drinks are over priced, very often costing the same as an alcoholic drink.
- The “need” to binge drink on a Friday and Saturday night, with the information about recommended units of intake not being user friendly.
- Promotion of high strength alcopops (sweet and ‘mixed’ drinks). These are also seen as ‘cool’ to drink.

- Society remains indifferent, at best giving out mixed messages about alcohol.
- Alcohol is promoted on 'soaps'

The balanced needs to be redressed. Individual choices are already being eroded by the constant message coming from mainstream culture. It would seem that part of the role of the Government is to help redress this balance by providing an alternative and by raising awareness of the dangers of excessive alcohol consumption. Individuals may, in theory, have a choice, but currently they are only being fed one set of arguments.

By equipping agencies with the funds and the training to effectively raise awareness of these dangers, the government would be giving the public a more balanced approach to alcohol. People need reliable information about alcohol, for example the effects that it will have on their health and behaviour. Furthermore, those who decide not to drink should feel comfortable in the knowledge that this is an acceptable option (3).

Once the public has an informed opinion on alcohol, then it is not the role of the state to determine how much an individual will drink or any individual choices relating to that, since that would be taking away an individual's human rights. However, once that alcohol consumption spills over into the community, then the community has a right to act. The principle that individuals should be free to indulge in activities that do not result in harm to other members of society, but restricted in activities that do is a view with widespread acceptance. Clearly the community should be protected from the anti-social and criminal behaviour connected with excessive or illegal alcohol consumption. Sadly, other countries, like Northern Ireland, have similar problems to us, with the incidence of alcohol misuse continuing to rise (5).

The issue of nuisance being associated with alcohol and local communities requires consideration. This would include anti social behaviour, the co-location of pubs / clubs in residential areas and the transport routes to these premises, particularly at night. These are important issues where the individual and community interface and they would need to be addressed by the strategy.

It is worthwhile looking at the achievements in New Zealand (3). They have seen a change in the prevailing culture. The most common reasons people give for drinking less are concerns about drinking and driving, a desire to maintain or increase physical fitness, and a perception that it has become more acceptable to drink less. Amongst young people, having less money to spend on alcohol is also given as a reason for cutting down. Change can be brought about; prevailing attitudes can be turned around. One only has to look at the change in the public attitude towards smoking to understand that this is possible.

4.

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

**Consumers –**

- Too not over indulge and too consume responsibly
- Look out for others and not to pressurise others into drinking too much

**Voluntary groups –**

- Work with those who have an addiction to alcohol
- Make people aware of the health dangers of excessive consumption
- Help people to see the longer term social consequences of excessive drinking

**Commercial interests –**

- Off-licences frequently sell alcohol to underage drinkers. They have a responsibility to not do this. While they are not the only source of alcohol for underage drinkers, they are a major part of it. It is to be hoped that the upcoming change in the Licensing Law will ensure that it is illegal for an adult to enter an Off-licence in order to buy alcohol for an under age drinker.
- Licensed premises have a responsibility to the wider community. Are they making a profit but not minimising the harmful affects on other residents, for example not providing late night transport for customers or not providing the designated driver with free soft drinks.
- Local Authorities have an interest in a healthy city and would seek to encourage the nightlife as a result, in order to promote business and to bring people into the city. However, these aims could be seen to contradict the aims of any Local Authority policy that was seeking to encourage less drinking.
- Dr Nick Sheron notes that alcohol intake for those under 16 had doubled in the last 5 years. Alco pops were the major influence for this. This can be directly linked to the massive amount of money that is now invested in advertising alcohol, some £250 million per year. There is no way that the alcohol health budget can compete with this. It would be worth considering alcohol advertising in relation to that for smoking, which are now banned from television and all come with a health warning.
- Demand reduction strategies should include initiatives that seek to encourage the responsible promotion of alcohol in both on- and off licence premises, monitoring new commercial strategies (particularly those that target youth), and using different tax levers to vary or maintain the price of alcohol in relation to other products (3). Price is an important influence.

- Alcohol is easily available over the counter, yet it has the capacity to alter mood, thought and behaviour. For these reasons it needs to be marketed responsibly, and with a clear appreciation of its potential for harm (3).

5.

### **What principles should underpin a national alcohol harm reduction strategy?**

Harm related to alcohol results from

- Damage to personal physical and mental health
- Damage to friends, relatives and dependants
- Damage to society through crime and anti-social behaviour

A national alcohol harm strategy should aim to address all these areas. It should also be a pragmatic and practical document, working in ways that have proved successful in the past but also willing to try new methods (3).

#### **Integration**

Alcohol problems do not occur in isolation. They are often tied in with other social problems and affect many other areas. These can include citywide safety, young people, education as well as contributing to many unseen domestic problems such as child abuse and domestic violence (4).

The problem ranges from Off-licences that sell alcohol to underage drinkers to the social taboo that stops people who are being abused seeking help.

#### **Joint Action**

Partnership is not an end in itself. However it is likely that joint action will have a far greater effect on tackling the alcohol problem than individual activity (4). Responding well to alcohol issues requires a co-ordinated approach involving a range of participants, as well as working with local groups to initiate and support community involvement and having a responsibility to implement the strategy at a ground level (3, 4).

A co-ordinated approach must be attained, linking public health strategies and initiatives, in particular in relation to tobacco, drugs, road safety, domestic violence and teenage pregnancy (5).

Reducing alcohol related harm is not, and cannot be, an issue for any one department. Any meaningful attempt to tackle this problem must be based on a community wide effort. Collaboration and partnership must lie at the heart of this strategy, as demonstrated by the Northern Ireland Alcohol Strategy (5).

It is to this end that a Southampton interagency Alcohol Strategy Day took place on December 16<sup>th</sup>, organised by the DAT. A variety of significant players from across the city participated in what was a productive day, with

attendees including health professionals, PCT workers, the Police, magistrate, schools workers and representatives from treatment services.

Currently there is a lack of cohesion within public services; Southampton has now taken the first step in rectifying this. Such action has a significant part to play in the strategy.

### **Consistency of Action**

While activities must relate to local circumstances and priorities, alcohol misuse is a national problem requiring fairness and consistency in the Government's response (4).

The New Zealand National Alcohol Strategy both compliments and extends the Government's National Drug Policy. It provides a framework for action on alcohol issues, a balanced approach to the task of reducing alcohol related harm and a co-ordinated approach to reducing alcohol related harm (3). It is important that the UK Government also takes a co-ordinated approach to the issue and that it follows a constant line.

The Alcohol Strategy should both complement and extend the Government's National Drugs Strategy, this has a goal in the New Zealand Alcohol Strategy (3).

### **Effective communication**

Government needs to be clear and consistent in the message that is sent to young people and society in general (4). At the moment the message is blurred. While the Government has outlined a number of suggested limits for safe alcohol intake per week, these figures are not universally applicable to all people. While some people are safely able to tolerate more alcohol, for others they can only handle a smaller amount. Coupled with this is that many drinkers will feel that they are not damaging their body if they consume the weekly suggested limit of alcohol in one evening.

It is also worthwhile noting that while many people believe that they understand the level of alcohol that it is safe to drink and then drive at, the actual percentage of alcohol taken in a drink was not known. It was thought to be far higher than it is in reality by a variety of professional people.

These figures need to be better communicated, along with the message that while these are suggested limits, they are limits and not targets to be aimed at. Binge drinking is a problem, not just in the U.K, but in New Zealand as well, where despite the notable decrease in the proportion of young people drinking, there was a marked upward trend in the quantity consumed on each typical drinking occasion (3).

The message needs to be communicated that acute drinking is not a good thing, in particular to young people and those who have not yet done

themselves permanent harm. Yet currently alcohol is not seen as an issue for young people, with only a third seeing abusing alcohol as substance misuse.

### **Appropriateness**

Appropriateness involves the development of strategies that are consistent with people's culture, value and behaviour (3).

### **Effectiveness**

Effectiveness is achieved by employing strategies most likely to reduce harm caused by the misuse of alcohol. Effective strategies include those that are targeted, employ evidence-based practice, and have been soundly evaluated (3).

The strategy also needs to adopt a comprehensive approach, seeking to address all significant forms of alcohol related harm (3).

This means giving agencies the practical tools to minimise harm caused by alcohol – strong regulatory, intervention and enforcement powers – as well as advice, assistance and treatment programmes, alongside the resources to deliver these. Perhaps these initiatives could, in part, be paid for by people making a profit out of alcohol.

### **Efficiency**

Efficiency recognises that resources are limited and that choices have to be made. Making choices involves a careful examination of the relative cost and benefits of interventions, and attention to where research or evidence indicates that harm can be most effectively reduced with available resources (3).

### **Empowerment**

Empowerment involves giving people the resources to assume greater control over their health (3).

### **Equity**

Equity means fairness. It means directing more resources to the area of greatest need in order that no one group suffers a disproportionate amount of alcohol related harm (3).

### **Innovation**

Innovation recognises that problems are constantly changing. Harm minimisation strategies need to be innovative and responsive to that change. Innovation recognises also that conventional approaches are sometimes no longer sufficient, and that new approaches are needed to tackle old problems (3).

## **The cultural and behavioural issues around use and misuse.**

6.

Alcohol misuse includes:

- Acutely drinking so much that harm ensues to the individual or society
- Chronically drinking so much that over a period of time physical ill health results in a susceptible individual
- Drinking sufficiently to trigger dependency in a susceptible individual
- Causing excessive strain upon family and job, even losing them
- A person is violent when drunk, including abuse of spouse or children.
- Someone begs or commits an offence to fund their drinking.

In each case individual susceptibilities may vary, dependent upon genetic, cultural and other factors.

7.

An alcohol harm reduction strategy should aim to:

- Affect acute drinking patterns to reduce the incidence of drunkenness and anti-social behaviour e.g. drinking and driving.
- Reduce chronic alcohol intake to prevent long-term physical and mental health damage, this is likely to require a staged approach with different types of intervention or information targeted at different individuals.
- Of these the most difficult drinking patterns to change are those of individuals with features of alcohol dependency, in contrast 80% of subjects with alcohol induced liver problems have no evidence of dependency(11) and drinking patterns are easier to change in a substantial proportion providing they can be identified and accessed.
- We predict that as a result the incidence of alcohol induced liver disease could be reduced by up to 50% by correctly targeted intervention to those drinking at potentially harmful levels.

In view of the massive costs of harmful alcohol drinking to the individual, society and to the NHS the government is obliged to employ all preventative measures that can be shown to be both effective and cost effective.

Addictive behaviours are difficult to change, but this does not mean that it should not be attempted. Government should concentrate on prevention by publicising and advertising all the negative effects of alcohol use, both short and long term, by advertising and education at all levels. As is now the case with cigarettes, alcohol should come with a health warning.

8.

Obvious drinking cultures include: -

- Young People.
- Students.

However, as the table 1 in question 2 showed, drinking culture affects all of society. These may relate with working patterns, particularly if this includes stress and long hours culture.

9.

Young people will always experiment with alcohol – as in all risk behaviour activities it is part of the whole “teenage adult” package. Our approach to alcohol and its use/misuse must be one that involves/connects with young people right from the beginning. We can learn lessons from the “drink-drive” campaign which is significantly more successful with the under 25 year olds than it has been with their parents and grandparents generation. The route we take must be one that informs and builds self-esteem amongst our young people, so they can feel confident in making their own informed choices as far as alcohol is concerned.

What is the message we want to get across:

- Unit consumption
- Damage limitation
- Health damage
- The drink driving message has been well received by the younger population

The consultation document already emphasises the need to focus specifically on young people, and particularly on young women. The ‘ladette’ culture, which rose to prominence in the 1990’s, did much to encourage the hard working/hard playing/hard drinking image of young women. Attitudes are shifting again and it is time to work with young women to identify an approach that will work.

Although no figures are available, there is some evidence of a rise in alcohol use amongst the Asian population of Southampton. Work needs to be done with the City’s cultural leaders and young people to address the needs of this particular group in the city. Advertising and education should attempt to reach all levels and all groups in the community. Are there specific support needs for Muslims with alcohol problems and other BME communities? Or those who are outside of mainstream society, like travelling communities.

Southampton has become a major “student” city and with this has come a rapid increase in drinking venues for young people. We need to work with, not against the management of these venues if we are going to tackle the issues surrounding young people and alcohol misuse. Working alongside the University in its alcohol research would be one effective method

10.

Many 18-25 year olds generally have some disposable income, so most city centre venues are understandably designed around their perceived requirements, taken to be colour, noise, excitement and alcohol. This in itself is not a bad thing, so long as it does not affect others, and is, simply put, a way for people to unwind and relax after a hard day at the office.

It is possible that alcohol would not always be the first choice of the consumer in every case or in every scenario. Its overwhelming and "in your face" availability in every leisure and recreational setting, often to the exclusion of other preferred drinks, such as tea and coffee, might be robbing people of choice. The natural exuberance of youth can be a disincentive for other age groups from going to mainstream entertainment venues.

While the Government should concentrate on the negative effects of alcohol and leave the alcoholic drinks industry to publicise its positive side, it should do so in a manner that does not leave it looking like a nanny state or a killjoy. Certainly some of this extra cost should be shouldered by the alcohol industry.

11.

The English drinking culture has many facets too it. Part of it is one of drinking standing up, and going to the pub at the neglect of the family. Amongst certain parts of the population there is a culture of drinking to get as drunk as possible, perhaps more so among the young.

Perhaps other age groups are more restrained, however alcohol abuse does pervade into all sections of society, it all too easy to point the finger at other groups while not admitting that the upper and professional classes also have a drinking culture. Perhaps it should be noted that the House of Commons has 22 bars and 24hour access to alcohol.

12.

All these factors influence behaviour. I think that highlighting behavioural and health outcomes, and affects on relationships, both short and long term, is most likely to be effective.

13.

Our time frame negates a constructive response. Health: Prevention, treatment and the impact of the NHS

14.

Chronic heavy drinking can become harmful in two entirely independent ways.

Firstly, in subjects with no evidence of dependency epidemiological evidence suggests mild increases in hypertension, stroke, cancer and other problems occur at relatively low levels of alcohol intake (21-28 units / week in men), although this risk is negligible in individual terms it becomes a significant health problem in populations terms. At higher levels of alcohol intake liver disease becomes the most significant problem, although very heavy drinking causes damage to other organs including the heart and pancreas. It is not clear what a 'safe level' of alcohol intake is as far as liver disease is concerned but most epidemiological studies would agree that in normal subjects levels of 50 units / week in men (and probably less in women) are associated with a significant increase in hepatic cirrhosis over a 10-15 year time frame (12;13).

Secondly, in subjects with genetic or other susceptibility to alcohol dependence alcohol drinking becomes uncontrolled with severe mental health and social consequences. Approximately 20-30% of these dependent drinkers will subsequently develop liver disease or other physical problems associated with heavy alcohol intake. There is no clear evidence of what a safe alcohol intake would be in someone with a propensity to become alcohol, dependent – many would argue there is no safe limit in these individuals, and this certainly seems to be the case once a full alcohol dependency syndrome is established.

15 /16.

The Royal College of Physicians report (Appx 1) deals with these questions in detail.

17/18.

The appropriate means of prevention of ill health associated with alcohol is a critical question. Previous approaches to the problem of alcohol induced liver disease are characterised by the approach to the prevention of hazardous drinking cited in a recent report by the Royal College of Physicians(1). Preventative measures aimed at reducing the burden placed by alcohol on hospital services must therefore be directed at the whole population of drinkers and not restricted to heavy drinkers – the so-called ‘prevention paradox’.

Previous approaches by both government and charitable sectors have aimed to reduce overall alcohol consumption by targeting safe levels of consumption, while at the same time giving little information as to the consequences of exceeding these limits. This approach has failed to prevent either problem drinking or the recent massive increases in alcohol related liver disease cited in the CMO’s annual report(2).

The concepts of safe drinking limits are now well known – 70 - 80% recognition factors are common. However liver doctors are very aware that the general public has almost no knowledge of specifically why and how alcohol is dangerous. On the whole the general public knows that lung disease causes cough and breathlessness; they know that heart disease causes chest pain and they know that if your kidneys fail then you can go on a kidney machine. The UK public have no little concept of the liver or of liver disease - at best they may believe that liver disease is something that affects down and out alcoholics, and is therefore socially unacceptable, not a subject for polite conversation, and not relevant to their lives.

By the time patients present with signs and symptoms of alcoholic liver disease they inevitably have severe liver impairment and are commonly cirrhotic even at first presentation. When presenting at this stage a proportion of patients will be unable to control there drinking – even when faced with the prospect of certain death. Remarkably this proportion is similar in nearly all studies of the prognosis of alcohol induced liver disease and appears to be between 25 and 40%. A substantial proportion of these patients will die on

their first admission – of 189 patients admitted to the Royal Free Hospital with a first variceal bleed 66 or 35% died within 30 days (14).

Population figures for mid 2000 estimate a population of 26 million people aged 16-44 in the UK. At current rates of alcohol consumption approximately 1 million young and middle aged men and 390,000 women are drinking at levels likely to cause liver damage. Of these individuals a conservative estimation of published prospective studies would suggest that over 100,000 people (72,800 men and 26,000 women) are seriously at risk of developing cirrhosis over the following 10 years.

Assuming that of these people at least half will continue to drink excessively irrespective of any intervention – this leaves a population of approximately 50,000 in the UK at risk of serious liver disease requiring active intervention to reduce their alcohol intake, and who may be likely to respond to this intervention providing it is targeted correctly.

A strategy for the detection and management of these ‘at risk’ individuals is given in Appendix 2

19.

Current treatments for alcohol dependence were recently the subject of a detailed review by the Health Technology Board of Scotland (appendix 3) which concluded that a number of ‘talking therapies’ and the drug therapy ‘acamprosate’ are clinically and cost effective.

With regard to strategies for the prevention and management of physical end organ damage from alcohol the RCP report{Working party of the Royal College of Physicians 2001 16927 /id} gives clear guidelines for local alcohol strategies based on multidisciplinary teams working across primary and secondary care boundaries. But whereas there are examples of good practise (Liverpool, Walsall, Southampton) there is no clear national implementation of this approach at present.

With regard to secondary care of patients with alcoholic liver disease there is a requirement for guidance for commissioners of local services. Most patients with alcohol-induced liver are currently managed at DGH level. The Department of Health has however accepted that in many cases sick patients with alcoholic hepatitis need to be managed in specialist liver centres. The criteria for specialist liver treatment are given in the **National Specialised Services Definition Set** No 19 (Appendix 4).

20.

Many services are now ‘substance misuse’ services (treatment) and we have found that the issues are similar, although alcohol is a much more volatile and damaging substance.

21.

The options are many and varied, the following in not an exhaustive list:

- More Police presence in areas outside pubs in City centres, etc.
- Better screening in the workplace by Occupational Health.
- Health and Safety involvement in education in workplace.
- TV and radio adverts on drinking coming with a health warning
- Safety in the home similar to drink driving ads
- Better, cheaper, more interesting non/low alcohol drinks.
- Ban or regulate "happy hour"
- More training (compulsory) for bar staff and bouncers
- Check ID on people more, especially in clubs known to allow in under 18's
- Better licensing enforcement

22.

There are many links:

- ❖ Psychosis
- ❖ Depression, suicide and self harm, homicide – see National Suicide/Homicide audit for figures
- ❖ Paranoia
- ❖ Mood swings – aggression.

Services need to be co-ordinated, perhaps on the model of dual diagnosis. Education in schools and youth clubs would seem to be a logical preventative measure.

### **Crime, Disorder and anti social behaviour: the effects on our surroundings and community**

23.

The evidence about the links between alcohol and crime and alcohol and anti social behaviour is very patchy, even in Southampton. Anecdotal evidence overwhelmingly points to a direct link, as does circumstantial evidence, e.g. the rise in violent late night disorder in the areas where there has been a significant expansion of the night time economy. Data however, is not collated appropriately or even accessibly, to support this the recent study undertaken on behalf of the Portman Group, conducted by SIRC called "Counting the Cost", states that

"There clearly exists an association between the consumption of alcohol and violent and disorderly behaviour, particularly in town and city centres on Friday and Saturday night...it does not require social scientists to demonstrate the existence of what, in our society, is the modern manifestation of a timeless and enduring problem"(16).

Research conducted by SIRC and MCM and many other studies have looked at the theoretical perspectives of the nature of the relationship between alcohol and violent behaviour. "Counting the Cost" simply looked at the size of

the relationship and how initiatives taken to reduce the relationship and address the problems can accurately be measured and tested, to allow the most effective strategies to be identified.

The study concluded that whilst it was universally agreed that there were problems, we do not have sufficient data, even at local levels, to do more than hazard a few ill informed guesses. If we cannot identify the true scale of the problem, we cannot identify the true impact of strategies to reduce the problems. Any serious commitment to reducing the problems of drunken violence will require substantial budgets for research, investigation, analysis and eventually interventions and treatment.

24.

Anecdotally, we assume that drunkenness can lead to people behaving out of character, or at least not fearing or even identifying the consequences of their actions, so from that perspective, we would assume that drink has the potential to lead to one off offences. In terms of habitual re-offending, this information might come from a case-by-case study within say, the Probation Service, where drink is a factor in habitual re-offending. What we do know is that if for example, alcohol is the trigger in a domestic violence scenario, and then by its very nature, it could be repeated many times before one offence was reported.

25.

As identified above, research indicates that data is so inadequate that we cannot identify the size of the relationship between alcohol and crime and disorder. It is also true however, that when residents complain about the anti social behaviour of young people, particularly around convenience stores late at night, there is a wide perception that the bad behaviour is fuelled by drink and/or drugs. We have found many cases where there neither drinks or drugs are involved. It is likely that unruly and noisy teenage behaviour is often just assumed to involve drink or drugs. Perhaps some complainants are actually trying to make "excuses" for what they perceive as unacceptable.

26.

In Southampton, anecdotal evidence suggests that potential flashpoints for crime and disorder late at night include taxi ranks and take-way kebab houses. The common denominator here is that they are places where large mixes of drink fuelled, mostly young people "hang about" or are meant to wait in an orderly fashion. Impatience, drink, and tiredness can play a significant part in anti social behaviour or violent disorder late at night.

Efforts to move large numbers of people efficiently out of the city centre late at night to their ultimate destinations need to be made. Safe, speedy transport routes are a big part of the answer, with enough buses/taxi's to cater for all customers.

27.

In urban environments, noise, litter and criminal damage are often features of young pubbers and clubbers walking homewards after a night out, urban

drinking patterns are not only about city centre and young people, but in sheer incident numbers, is what engages the Police most often on a Friday and Saturday night and impacts on most other residents, residences and businesses.

28.

In Southampton, key agencies identified a feature of the expanding late night economy was rising incidences of violent disorder, and also an increase in complaints from the public about noise, vandalism, litter and abuse from pubbers and clubbers making their way from the city centre late at night to areas outside the city. Bus services were very limited late at night and waits for up to two hours for taxis were not uncommon.

Negotiations were entered into between the City Council and a local bus company known to have concerns about a late night service, and the security of their staff. Advice was taken from Wolverhampton and other areas that had explored this type of approach. In December 2001, with funding from the City Council and GOSE crime reduction monies, a late night bus service was launched to the east and west of the city, with two security guards (with licensing link radios) on board and a flat fare of £2 per head anywhere in the city. Ridership has continued to rise, routes have been adjusted to fit changing scenarios.

29.

There is significant will to share information among local agencies and organisations. Difficulties arise however, when anonymous data simply cannot be accessed in any meaningful way for analysis. This is usually because it is not collected or collated in a way that lends itself to exchange (See above)

30.

Young People are the focus of most complaints concerning anti social behaviour, criminal damage, vandalism, noise and are the highest risk group for being perpetrators of and victims of violent disorder. They are also the target group for the alcohol sellers as having the highest disposable income most likely to be spent on leisure and entertainment, most particularly in pubs and clubs. Although young people most certainly are not the only vulnerable group as regards alcohol and its abuse, they are the group we can do most about.

31.

In Southampton, we are exploring the idea of managing the late night economy through "zoning". An area with most late night activity and fewest residents may be zoned as the "late night" sector, where development which involves pubs and clubs and late night licensed activity will be allowed in terms of the city plan. The rationale behind this is that as a city, we should be able to more effectively manage issues like disorder, transport and design in specific, limited locations.

32.

Southampton has explored "no drinking" zones in the past, but there are two issues which have never satisfactorily been answered. The first is how would it be enforced and by whom? What happens to people who ignore the "no drinking" signs? Will Police respond to complaints and if they do, what will they do? The second issue concerns the vibrance of the city. If the city, its centre and its parks are full of prohibitive notices, it's not very welcoming, not conducive to investment. Our colleagues in Coventry, who piloted this scheme some years ago, have indicated that whilst they felt the action responded to the will of the public at the time, they felt that they may have lost city centre investment and visitors as the signs themselves gave out negative messages.

Drunks and vagrants can be seen in city parks, there may also be mental health issues affecting these individuals. Nevertheless they can be frightening and aggressive, and can seriously inhibit use of public spaces by older people and young families. Where there is extra enforcement, there needs to be corresponding additional support services.

33.

The principles of balance between individual rights and responsibilities are explored in a number of legal and constitutional studies. It is explored every time the state considers intervention in a new area of private life. In English law there is a tort where a third party is injured through a wilful or negligent act. Drinking so much that judgement is seriously impaired is no longer viewed as a defence to an act by magistrates, as we were informed at the Southampton Alcohol awareness day.

Citizenship within the school curriculum is the place to focus on the balance of individual rights and responsibilities. We need to look again at how we educate our young people about alcohol. This must involve consultation with young people.

34.

A major lesson from drink-driving policies is public tolerance. It is not generally fashionable or publicly acceptable to drive while drunk. Attitudes do change slowly over time, the question now is how will the public attitude towards alcohol shift in the next ten years. Different layers of government, and different agencies, can all help to shape this message and to reach a wide variety of people.

35.

Alcohol can be a trigger (as can other things) for domestic violence. As domestic violence issues come more and more into the open, so too are the demands for earlier support mechanisms. At the moment, it is believed that a victim will take several assaults from someone they care about before reporting the incident. What if on the first incident, the whole family decided they needed help to deal with the problem. What services are available? There are anger management courses, substance misuse counselling and treatments etc, but waiting lists to go on them are very long indeed, and some interventions require there to have been court appearances first.

## **The Implications for Vulnerable Groups**

36.

Children and young people looked after by the local authority, survivors of abuse, victims of bullying, those that offend, those that truant and those whose parents drink more than recommended levels. Also those who see themselves as having fewer prospects, particularly in terms of education and employment and those with mental health issues.

However, alcohol misuse amongst young people crosses class boundaries and young people from more affluent backgrounds often fall outside of the net of state support. We need to work alongside schools, both state and independent, to address this issue.

37.

People with mental health issues, including personality disorders, and those who see themselves as having fewer prospects, particularly in terms of education and employment. It would also include those who were mentioned in section 36 but who have now grown older. People who are coming off other drugs, heroin in particular, would be included.

Work is needed with schools, school nurses and Education Welfare Officers to establish any links between anti-social behaviour/exclusion and alcohol use/misuse amongst young people.

38.

A range of responses, including residential rehabilitation and psychological responses, is required to respond to complex needs and problems. In terms of changing behaviour, to maximise effectiveness, services must respond to individuals at the point when they are seeking support to change. The most effective services won't have waiting lists and residential units will have vacancies.

The cyclical nature of addiction should be recognised, and so there should be services to minimise the harm caused by and to people with drink problems who are drinking e.g. health, accommodation. Adopt Care Plan Approach from mental health.

39.

Information sharing, common screenings, assessment, care management etc. Catching the problem as early as possible e.g. A & E Departments, Police Custody. Using Models of Care approach.

40.

Times frame did not allow for sufficient research.

## Education and Communication

41.

The aims should be along the following lines:

- To raise levels of awareness,
- To inform about specific dangers to health and social issues.
- To change behaviour.
- Peer pressure support schemes.

42.

Time frame did not allow for sufficient research.

43.

The message is not clear and does not reach its intended audience with any great success. It does not appear to have affected the behaviour of young drinkers to any great extent. People remain unclear about what a unit is or what are safer levels.

44.

Appendix 1 gives some insight. Time frame did not allow for further research.

45.

Yes. Certain groups are more vulnerable than others. Children whose parents are alcoholics are a particular group. Elderly drinkers and their carers / health workers would benefit from assistance. When a patient is in A+E following an alcohol related problem, which as noted in question 2 is a high number, then this would be a good time to target them. The same is true when a patient present with a problem that is alcohol related. It is a window of opportunity when a person would be willing to listen that must be used.

46.

The Southampton University School of Nursing and Midwifery is currently working on a project into the drinking habits of students and how this affects their studies. It is the first such piece of work to be done with students. A pilot survey will be carried out in early February and then a full survey will be undertaken in April. The results will then enable the University to better understand the student population. The information will then be used to aid freshers when they first arrive in Southampton, making them aware of the dangers of alcohol as well as being a way to better give guidance to Students throughout the University. In theory this role should be well established in education and support, in reality the picture is not so healthy.

Alcohol use/misuse must form part of the PSHE and citizenship curriculum in secondary schools. Peer mentors need training specifically in alcohol misuse, how to recognise it and respond appropriately to it.

47.

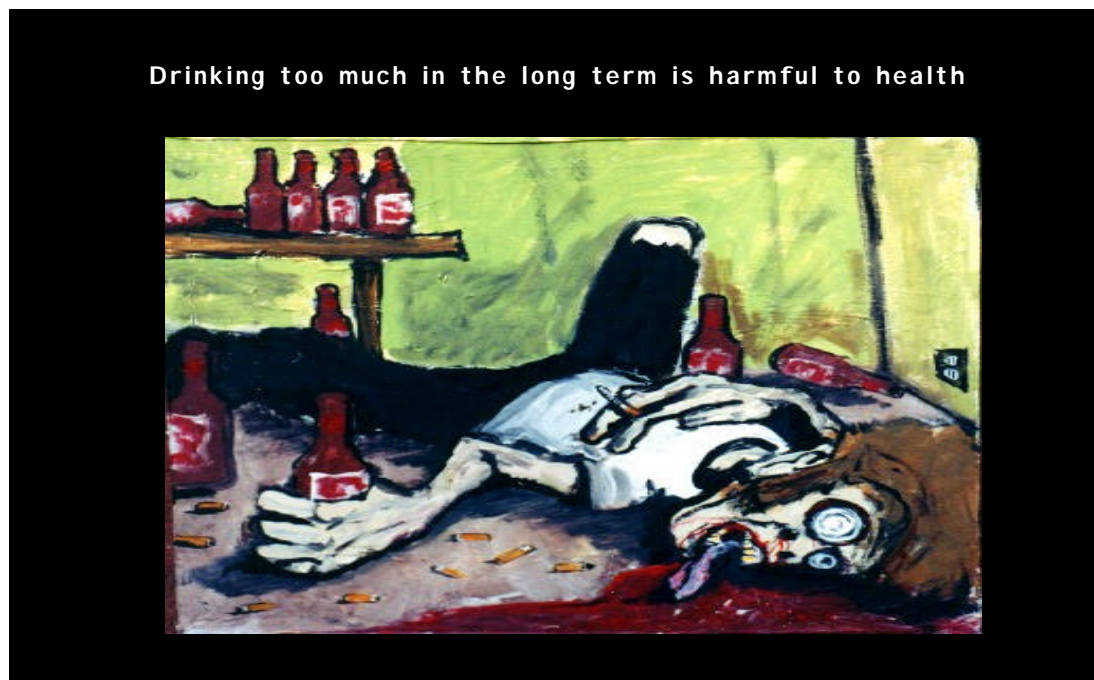
Parents need to be involved in the planning and delivery of alcohol education programmes. Banning alcohol consumption in the home is not the way

forward, but it may be the way most parents are dealing with the issue. We only have to look at our European neighbours to see a different approach to alcohol and its significance to cultural life within the family and community.

While it the responsibility of parents/families to educate there children, they need help from the state in terms of education in school and perhaps information from the Government relating to the harms that alcohol can, potentially, cause. Perhaps this would include showing how it can lead to homelessness and rough sleeping.

48.

The Government has a large role to play. It can inform and engage with a variety of audiences and can pay for a variety of organisations to include alcohol advice on their agenda. This can be carried out in schools, adult education, occupational health, and healthy living courses for all amongst others. The Government can also pay for messages and advice in T.V., radio and newspapers either in the form of Government health warnings or simply as advertising for a healthier lifestyle.



Perhaps shock tactics are one approach that would work.

49.

While the obvious answer is yes, the range of ways that this could be done are multiple. Time did not allow for a full and extensive research to take place, which would be needed.

50.  
Table 4



Table supplied by Dr Nick Sheron, Consultant Hepatologist and Senior Lecturer in Medicine, Southampton General.

This figure explains itself. The advertising needs to be regulated more because at the moment the government is unable to combat this. A higher tax on alcohol sale, perhaps targeting stronger drinks, would be one method. Essentially this would amount to taxing the industry so that it meets some of the costs that it is creating in the U.K, especially in the health care profession. I think that it would be very easy for the UK Government to fear rocking a boat that is a massive source of revenue. This would be foolish as alcohol is an equally massive source of expense.

There are of course the moral dilemmas to confront when we look at the advertising and hard sell approach of the alcohol trade in “alco-pops” and high sugar products aimed directly at young people. The similarities with the tobacco companies are clear, they are looking to recruit the young and uninformed to replace the others they had lost to cigarette related deaths and illnesses. The economic costs and benefits of alcohol to the nation do mirror some of the issues of tobacco, however, unlike with tobacco, drinking can be good in moderation. An alternative route would be to follow tobacco advertising, either through an outright ban or for every advert to come with a health warning of the damage that excess consumption can do. As stated earlier, it is important that the Government does not become seen as a nanny state if it ventures down this path.

The adverts on the line of trendy soft drinks present a new way of looking at non-alcoholic drinks, this message could be taken on by the government as these are culturally relevant adverts.

## The shape of the market and market based solutions

51.

The alcohol industry is a major part of the national economy. Alcohol plays an important role in our family, community and national traditions and celebrations. A strategy that ignores this will be doomed to failure. And yet we must find a way to respond both to the growing cost of alcohol misuse on the national economy and the cost in human terms.

The industry will find it challenging if the Government starts putting health warnings on alcohol. Advertising will decrease if the Government increases tax on alcohol advertising. So the Government should give the industry plenty of warning. This is capitalism; companies will adapt or go bust.

52.

The alcohol industry has targeted young people, and encourages drinking to get as drunk as possible, particularly amongst the young. The Government should aim at nothing less than a change in culture. Lessons can be drawn from the change in the public perception of smoking. Also in changing attitudes to driving under the influence of alcohol.

53.

Research and development in this field would be likely to bring about massive benefits to the problem. It would be worth investigating advances that are being made in America and to use this information. A detailed analysis of new plans in other countries would need to be carried out before a decision was made.

54.

The Government should be clear that alcohol is a dangerous drug and that the costs are huge, in terms of health, offending, absenteeism, anti-social behaviour and social costs such as homelessness. The Government should be clear that the aim is a reduction in alcohol consumption and tax and legislate against the alcohol industry to achieve this aim. The Government shouldn't work in partnership with the industry any more than it should work in partnership with drug dealers.

55.

The price of alcohol would be a major influence on a large proportion of the public; however, as we have already established the problem is just as prevalent among the professional classes. Since they have a substantial disposable income, such measures would not affect them. Perhaps other avenues should be thought off, for example of less alcohol was sold in the local supermarket it would become more of an inconvenience to go to the local off-licence in order to buy some drink. Stricter regulations around pubs, clubs and off-licences would help to curb underage drinking, especially if strict penalties were imposed on them if they broke this agreement.

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

56.

Due to time constraints, we were unable to investigate this.

57.

Due to time constraints, we were unable to investigate this.

58.

The alcohol industry should bear the burden of the costs. However, as the industry is already heavily taxed; the Government should divert resources to fund more education, advertising and treatment. Individuals should continue to take responsibility in terms of criminal and contract law.

59.

The extra tax revenue is offset by the massive burden that alcohol adds to the NHS.

60.

Alcohol use has a negative effect on educational and occupational attainment. It is not beneficial in terms of stress or tension or facilitating networking in the workplace.

61.

Due to time constraints, we were unable to investigate this.

## Reference List

- (1) Working party of the Royal College of Physicians. Alcohol – can the NHS afford it? Recommendations for a coherent alcohol strategy for hospitals. Royal College of Physicians Report. 1-2-2001.  
Ref Type: Generic
- (2) Chief Medical Officer of the Department of Health. On the state of the public health. Annual Report. 1-1-0001.  
Ref Type: Generic
- (3) New Zealand's National Alcohol Strategy 2000-2003. Alcohol Advisory Council of New Zealand and the Ministry of Health, March 2001  
<http://www.alcohol.org.nz/resources/publications/NatAlStrat.pdf>
- (4) Tackling drugs to build a better Britain, April 1998.Pg 11
- (5) Strategy for reducing alcohol related harm. (Northern Ireland) Department of Health, Social Services and Public Safety. September 2000.  
<http://www.healthpromotionagency.org.uk/Resources/strategies/alcoholharm.htm>
- (6) Wyllie et al 1996, Drinking in New Zealand: a national survey 1988. Auckland: Alcohol and Public Health research Unit. Quoted in (3)
- (7) Grossman, J et al 1994, Effects of alcohol price policy on youth, Journal of Research and adolescence, Vol. 347-364. Quoted in (3)
- (8) Hermos JA. Drinking by alcoholic cirrhotic patients under medical care: a literature survey. Alcohol Clin Exp Res 1984; 8(3):314-318.
- (9) Borowsky SA, Strome S, Lott E. Continued heavy drinking and survival in alcoholic cirrhotics. Gastroenterology 1981; 80(6):1405-1409.
- (10) Pande NV, Resnick RH, Yee W, Eckardt VF, Shurberg JL. Cirrhotic portal hypertension: morbidity of continued alcoholism. Gastroenterology 1978; 74(1):64-69.
- (11) Wodak AD, Saunders JB, Ewusi-Mensah I, Davis M, Williams R. Severity of alcohol dependence in patients with alcoholic liver disease. Br Med J (Clin Res Ed) 1983; 287(6403):1420-1422.
- (12) Sheron N. Alcoholic liver disease. O'Grady JG, Lake JR, Howdle PD, editors. Comprehensive clinical hepatology. 19.1-19.18. 2000. Harcourt. Ref Type: Generic
- (13) Becker U, Deis A, Sorensen TI, Gronbaek M, Borch Johnsen K, Muller CF et al. Prediction of risk of liver disease by alcohol intake, sex, and age: a prospective population study. Hepatology 1996; 23:1025-1029.

- (14) McCormick PA, Morgan MY, Phillips A, Yin TP, McIntyre N, Burroughs AK. The effects of alcohol use on rebleeding and mortality in patients with alcoholic cirrhosis following variceal haemorrhage. *J Hepatol* 1992; 14(1):99-103.
- (15) Ink O, Dejonghe JP, Hagege H, Sibony-Tua L, Goubet M, Guilliet A et al. Devenir des malades alcooliques apres une hospitalisation en hepatogastroenterologie. [Long-term outcome of alcoholic patients after a stay in a hospital hepatogastroenterology unit]. *Gastroenterol Clin Biol* 1991; 15(8-9):620-628.
- (16) Counting the cost", The measurement and recording of alcohol-related violence and disorder. Research undertaken by SIRC for the Portman Group, published February, 2002

## **Appendix**

### Appendix 1

Royal College of Physicians Report – Alcohol – can the NHS afford it?

### Appendix 2

Possible NHS strategies to reduce mortality from alcohol induced liver disease

### Appendix 3

Consultation assessments report overview – prevention of relapse in alcohol dependence.

### Appendix 4

National Specialised Services Definition Set.

1<sup>st</sup> Edition, December 2001