

National Alcohol Harm Reduction Strategy

A response from Stockport's Alcohol Reference Group in conjunction with the manager of Tameside Alcohol Service.

This response is based on the understanding that the government recognises that it has responsibility for addressing the consequences of harmful drinking. The authors of this response have concerns that legislation to amend licensing hours has been put forward to parliament *before* the consultation exercise has been completed.

It is acknowledged that considerable work is already in place to address many of the issues outlined in the consultation document – but this work is often inadequately *joined up*. It is considered imperative, therefore, that future developments are adequately co-ordinated (e.g. in a similar way to the model for tackling illicit drug misuse).

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?*
- 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?*
- 3. How can we strike a balance between individual and community rights and choices?*
- 4. What are the respective roles and responsibilities of consumers, voluntary groups, commercial interests and others?*
- 5. What principles should underpin a national alcohol harm reduction strategy?*

1- 5. It is generally acknowledged that a national strategy on alcohol could be a major development in aiding the reduction of alcohol related problems. Alcohol treatment services have anticipated such developments for several years. It is hoped that a national strategy would have a significant impact on service development – paralleling the influence that “Tackling Drugs Together” has had on services for users of illicit drugs.

It is important to recognise that heavy alcohol use is embedded in British culture. The past generation has seen a significant increase in alcohol use amongst women and young people - and it may be anticipated, therefore, that there will be a continuing increase in alcohol-related problems in future years. As alcohol problems are common (and becoming more prevalent) a national strategy should acknowledge that this issue is

“everyone’s problem” and that specialist services, other than alcohol services, (such as medical-surgical units) must play a crucial role alongside that of specialist services (such as regional alcohol treatment units and community alcohol teams).

As alcohol use is associated with a wide range of serious health problems it is anticipated that health issues will form a central tenet of this strategy.

The overall strategy should be based on the principle of harm minimization which aims to reduce the harm to communities and individuals related to the manufacture, distribution and consumption of alcohol and to promote positive attitudes to harm free consumption of alcohol

IT should state that none of the actions in the strategy are intended to promote alcohol use. It needs to recognize that some individuals do not use alcohol or will be striving for abstinence or to cut down consumption. The strategy should create an environment where non-alcoholic drinking is seen as a positive option.

Legislation to reduce alcohol-related harm could include raising the age at which alcohol can be purchased (e.g. to 21 years). This course of action is thought to be very unlikely as it would be unpopular with the electorate and could have a negative effect on the U.K. economy.

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.”

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

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?

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?

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?

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?

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 age groups?

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?

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

6. At local level we use the widely used standard definitions of alcohol misuse, problem drinking, alcohol-related harm, alcohol dependency and sensible drinking advocated by Alcohol Concern.

7. A national alcohol strategy should seek to influence all harmful patterns of drinking – include heavy “binge” or “bout” drinking.

8. Drinking patterns have changed markedly. Drinking at home is now much more common/acceptable than in the 1950’s – 60’s. This trend may have been influenced by the greater availability of alcohol in supermarkets and other retail outlets (n.b. expansion of opening times to Sunday, night-time, etc.).

9. A consequence of this change is that young people now have easier access to alcohol (often their parents’) – and this may have contributed towards the increase in alcohol use amongst under 18’s. The authors of this response report low levels of referrals from minority ethnic groups – and therefore are not able to comment authoritatively on this issue. A number of social inequality and social exclusion issues also need to be addressed. There are clear social class differences for alcohol dependence in men for example. Heavy drinkers are more likely to have left school at 16 and are unemployed.

11. The “English drinking culture” of heavy weekend drinking differs markedly from that of countries in Southern Europe (such as Portugal and Italy). It has some similarities, however, with Northern European countries (such as Sweden and Finland) where binge drinking in pubs and clubs is more prevalent. Clinical experience shows that heavy weekend “binge” drinking is often associated with a range of serious problems (inc. accidents, domestic violence, criminal activity, etc.).

13. It is accepted that people (especially the young) can be hedonistic – and find it hard to relate to messages about the dangers of long-term drinking. Perhaps more attention could be focused on the dangers of being intoxicated – and not being able to protect themselves (e.g. fights, sexual assaults, unprotected sex, etc.). An substance misuse prevention approach is needed, but alcohol misuse prevention needs a high profile within this.

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.”

14. *How do you define harmful drinking? What factors do you take into account in deciding whether heavy drinking has become problematic drinking?*
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?*
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.*
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?*
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?*
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?*
20. *What can we learn from drugs prevention and treatment?*
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?*
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?*

14. It should be recognized that “problem drinking” does not necessarily equate with “heavy drinking” e.g. relatively low levels of alcohol consumption prior to driving or operating machinery could increase the risk of an accident due to impaired reaction-time, judgement, etc.

"Problem drinking" can sometimes be seen in the change which takes place in the drinker's personality, which can be described as more than 'mood altering' and e.g. result in anti-social behaviour, self-destructive actions or trigger mental disorders (depression, paranoia, anxiety etc).

15. & 16. The relationship between alcohol use and health problems is well researched and documented. The prevalence of alcohol-related health problems, however, is often underestimated (- partly due to hospital admission data collection/coding systems and also because of inadequate screening/assessment procedures). It is also important to “factor in” health

problems caused by alcohol-related violence and accidents e.g. “bar-room brawls”.

In terms of health costs we can not underestimate the cost of the family illness, where non-drinking family members begin to present with symptoms, disorders of their own and inability to function well in school or at work

17. Training and support on alcohol problems should be offered to all staff who have regular contact with problem drinkers, including general practitioners (and other primary care staff), nursing/medical staff on medical-surgical and psychiatric units. Training should include screening/recognition of alcohol-related problems, the provision of relevant advice/guidance and information on support/treatment options. Specialist support provided via the use of hospital alcohol liaison schemes should be seen as standard accepted practice. It should be acknowledged, however, that additional funding/ resources will be required to enable such non-specialist staff to provide effective interventions to problem drinkers.

18. The use of brief intervention techniques is a cost-effective means of changing problem-drinking behaviour. These techniques appear to be particularly effective when targeted at groups in “crisis” situations – for example, following hospital admission. Specialist alcohol treatment services should, therefore, be able to provide a rapid response to such situations. A national alcohol strategy should utilise a broad concept of brief. The use of brief intervention techniques by non-specialist staff (such as general practitioners, nurses on medical wards, etc.) should be encouraged. It should be acknowledged, however, that additional resources may be required to enable such staff to provide these interventions (and also a shift in attitude/belief systems).

19. Several studies have indicated the effectiveness of various forms of treatment/therapeutic interventions (including Project Match). A national alcohol strategy should utilise these findings and emphasise the importance of comprehensive/holistic assessment prior to treatment being offered/commenced. Consideration should also be given to the use of complementary therapies (- such as acupuncture) if empirical research supports their effectiveness. A national alcohol strategy should encourage closer communication between commissioners and service providers (e.g. via the use of local strategy groups). Alcohol treatment services continue to face increasing demands (e.g. for detoxification). A failure to respond promptly to such requests may result in G.P.s commencing detoxification programmes without specialist support. A national alcohol strategy should, therefore, acknowledge the need for adequate funding of specialist alcohol detoxification services. A wider range and number of treatment programmes are needed. This would create a quicker response to individuals when they are most receptive to input

There is currently a lack of dedicated services for young people with alcohol related problems across the board from early intervention to intensive treatment programmes. This is despite increasing numbers of young people requiring services.

20. Drug arrest referral schemes appear to have been effective in ensuring that some drug using offenders receive appropriate treatment. The use of drug education programmes in schools may help to prevent the development of some drug-related problems. Similar programmes, focusing on alcohol problems, may also prove beneficial. In particular, the use of alcohol education programmes for university students, may be an important area for further development/research. The use of the media (including bill- board advertisements and T.V. advertising) should also be considered.

21. Legislation requiring the introduction of toughened glass on renewal of license.

Support for victims of violence by improving case monitoring and support offered via Hospital Accident and Emergency, including links with Victim Support, Police etc.

Investigate potential for additional specialist immediate and follow-up work with people who are injured to educate them about risk behaviour, and help them recover from effects and access further support

Services for people with alcohol dependency/problems should include Support Workers to identify clients at risk of injury and reduce risks.

22. The relationship between heavy alcohol use and mental health problems (especially depression and anxiety) is well documented. In clinical practice difficulties may occur when patients present with symptoms of both alcohol dependency and mental health problems. Diagnosis may be difficult as heavy drinking can produce symptoms similar to those of clinical depression, such as poor appetite, sleep disturbances and memory/concentration difficulties. This can lead to problems around service "ownership" of such patients (i.e. mental health services vs. alcohol treatment services). A national alcohol strategy should seek to address this issue by encouraging the development of district protocols regarding assessment, diagnosis, service responsibility and treatment. The importance of alcohol use in the risk of suicide should be emphasised and generic mental health services should be encouraged to screen for heavy drinking in their service users (especially if there is a known history of deliberate self-harm).

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.”

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?*

Question 23, 24 &25

There are difficulties in determining the link between alcohol misuse and crime. This includes estimating the level of alcohol that an individual has consumed and to the extent to which alcohol caused or contributed to an incident or problem. The recording of alcohol consumption by individuals who are arrested or admissions to hospital is not systematic or consistent. There are also problems with the consistency and definitions of the severity of incidents. This makes establishing a clear national picture of the size and range of the problems difficult. However, the weight of evidence, for example from the British Crime Survey, surveys of police forces and A&E departments and from specific case studies all shows major links between alcohol use and crime generally and violence in particular.

It has been estimated that 40% of violent crime, 78% of assaults and 88% of criminal damage cases are committed while the offender is under the influence of alcohol, (Home Office)

Aggression following the consumption of alcohol is to a significant degree a consequence of the particular social and cultural norms around consumption. More research is needed on this relationship.

Violent and disorderly behaviour tends to be concentrated around a small number of pubs and clubs, at closing time especially on Friday and Saturday night. A common pattern emerges of criminal damage offences, drunk and disorderly offences and other public order offences. Young males between the ages of 18-30 tend to be the main protagonists. Activity tends to occur in small, distinct entertainment areas and involves travel from the outskirts of town. Coping with this crime imposes a major cost on police forces.

There is a need for more research and pilot projects on preventing alcohol-related offending. Arrest referral schemes (similar to those used for drug-related offences) may be a useful means of reducing alcohol-related offences. Such schemes may be particularly helpful in targeting the perpetrators of alcohol-related domestic violence and those convicted of drink-driving offences. The effectiveness of these schemes would require close collaboration between agencies such as the police, probation service, law courts, etc. – and significant investment as this would be a new direction for services.

The emphasis on tackling alcohol related crime should not be seen in isolation from the wider ‘causes of crime’ and problem drinking itself. Alcohol is both a public health and public order issue. It is important, in particular, to recognise that the same group of people more likely to commit violent crime under the influence of alcohol is often the same as those who are the victim. Appropriate treatment programmes and mechanisms to ensure those who commit alcohol related offences are referred to appropriate agencies are needed.

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?

Regular trouble spots late at night occur around food takeaways and taxi ranks, while public transport is limited. Design and location issues may also exacerbate the problems, for example precinct style shopping / leisure areas. Over 25s tend not to visit an area in which they ‘feel’ unsafe, and this reinforces age-segregation, with certain areas and venues only catering for young people and others mainly for more mature adults.

Broader cultural, marketing and legislative issues are largely beyond the control of local partners and should be best addressed at national level. Local strategies are needed to respond to the local situation.

Marketing, popular culture and general social attitudes condone and promote drinking to excess for adults and young people alike. A cultural shift at national level is needed to changing public perceptions and attitudes about drinking.

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?*

28. Active managing of public spaces should comprise; considering use of legislation to ban drinking in public places, CCTV systems and policing and supervision resources, including ranger services, to target hotspot locations and venues, Seeking to improve late night transport provision, to get people home as quickly and safely as possible, Targeting identified hotspots for environmental improvements, such as improved street lighting

The good practice of the Cardiff and Manchester Initiatives should be extended to other areas.

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?*

29. Stockport has been proactive in introducing a range of initiatives to tackling alcohol-related crime, many preceding any recommendations made by government departments. These initiatives include a local doorsafe, pubwatch and proof-of-age scheme.

Through its ACID group (Alcohol-related Crime Incident and Disorder Group) Stockport has developed a local action plan to implement the local action element of the Home Office's Plan for alcohol-related crime and disorder. Devising a local strategy on the prevention of alcohol-related crime is one of the key elements of this local plan.

Local partnerships, such as Stockport's vital. More evaluated demonstration projects required. These partnerships require written agreements, establishment of ownership, adequate funding, active police involvement and business involvement.

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

These initiatives should be targeted on the group most likely to commit crime. This can only be done with good quality local and national research.

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?*

It is recognised that at a local level, strategies for economic regeneration of the Town and District centres have potential to impact either positively or negatively on levels of alcohol related crime and disorder, and this needs to be taken into account. For example, achievement of a broader age mix in the town centre may have a significant impact on the problem, as well as being desirable in terms of economic development.

Sweden's policy on having a 0.0 legal limit for drink/driving appears quite effective, both as a preventive measure, promoting more sensible drinking habits and curbing sheer intake (where drinkers otherwise would take more risks).

There are mixed messages given by the proposed Alcohol and Entertainment Licensing Bill being introduced before the consultation on the national alcohol harm reduction strategy has taken place.

The night-time economy needs to be actively managed to tackle this, there is little evidence of this at the moment. The good practice of Cardiff and Manchester in initiatives in proactively managing city centres needs to be extended to other areas.

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?

A review of the effectiveness of the powers introduced in the Criminal Justice and Police Act 2001 giving the Police the powers to order the immediate closure, for up to 24 hours, of unruly or excessively noisy licensed premises; and to seize alcohol from those who are drinking in designated public places, the requirement that all staff serving alcohol have legal duty to satisfy themselves that a customer is not underage, would be helpful.

A review of the effectiveness of existing controls and powers and their operation in practice is required. Stockport has established a scrutiny committee review to report on the effectiveness of byelaws prohibiting alcohol consumption on the streets in order to make recommendations on whether to introduce one.

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?

A key aim of a strategy should be to ensure that the overwhelming majority of drinkers, who do not cause any trouble, are not victims of offences committed in or around public or licensed premises.

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

from them?

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?

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.”

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

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

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?

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?

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?

36. The national alcohol strategy should address the problem of increasing alcohol use amongst young people. In particular, it should focus on the importance of trans-generational effects in the development of alcohol problems. Children of problem drinkers should therefore be seen as priority group and offered education/support in order to minimise the risk of them developing alcohol-related problems. Specialist alcohol family workers should be recruited to target heavy drinking parents and to offer relevant treatment, education and therapeutic input (and also to support children acting as carers to heavy drinkers).

37. & 38. A national alcohol strategy should acknowledge that alcohol problems and mental health problems frequently co-exist. Both specialist and non-specialist services should, therefore, be able to respond to such “complex” clients. Local clinical protocols should be developed to clarify service responsibilities and reduce the risk of service users “falling between two stools”. Specialist “dual-diagnosis” staff may be useful in

advancing clinical practice and ensuring effective multi-agency clinical activity.

The elderly should be viewed as a “vulnerable group” in regards to alcohol problems. Elderly problem drinkers often experience a wide range of medical, psychological and social difficulties (- including mobility problems, bereavement, isolation, etc.). Drink-related difficulties in this group are often not identified/diagnosed - and therefore effective therapeutic input is not provided. The recruitment of specialist alcohol workers for the elderly may be a useful means of ameliorating these difficulties by providing training, awareness raising, outreach and direct clinical input. It should also be noted that an increase in alcohol-related “elder abuse” may be anticipated due to the concurrent increase in the elderly population and problem drinkers.

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 drink-driving. These are powerful tools for giving information and shaping perception. Do they alter behaviour?”

“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?”

41, 42 & 48. The long-term goal is to reduce level of misuse. The initial and ongoing objective of public education should be to provide information and education of the implications of alcohol misuse so people can make informed choices about drinking, enabling them to weigh up their options from a position of knowledge and awareness.

Advertising often portrays alcohol as a glamorous or sophisticated product – and this may influence the perception of drink as a desired commodity. As a counter to this process it may be useful for advertising to be used to emphasise the more negative aspects of alcohol use – such as liver disease, relationship breakdown, loss of employment, etc.

The Health Development Agency’s review of effectiveness shows that education is more effective if taken in combination with other interventions and targeted to particular situations rather than general. The “community systems” approach is used in Stockport wherever possible e.g. a comprehensive young peoples substance misuse plan, multi-agency young peoples street drinking initiative.

The role of informal education through settings such as youth services should be recognised.

There is a need for more funded pilots and methodologically sound evaluations of educational initiatives across all age groups and settings.

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?

43. If there is limited awareness of the sensible drinking message, this is due in large part to the very limited resources put into its promotion at national and local level. Alcohol education is allocated a fraction of the budget of, for example the drugs education budget, (approx 1%) or smoking education budget. As a consequence awareness is dependent on low impact educational leaflets and press reporting of official reports. There is an absence of good quality educational materials across all settings and age groups. Very few districts have an alcohol health promotion programme and a dedicated worker, like Stockport does.

Many drinkers appear unable to accurately calculate their consumption of alcohol (especially regarding newly introduced products, the messages and promotional material need to take into account the new strengths of drinks.

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

44. There are considerable gaps in available research as outlined in the H.D.A.'s effectiveness review.

There is a need for good quality accessible interpretation of scientific research and its implications, such as the H.D.A.'s effectiveness review. However, findings can be used effectively only if there are resources and structures at national and local level to design and implement dynamic and flexible programmes.

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?

45. Targeted messages to particular groups appears to be more effective. Binge drinkers, women under 30, and older people could be target groups

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 healthy learning environment.

46 The further and higher education venues offer the opportunity to deliver health education, which is relevant to young people surrounding issues

such as alcohol, yet this opportunity is not used. Stockport is presently organising a pilot scheme to look at ways of introducing a co-ordinated approach to delivering health education to 16-19 year olds in colleges via the wider key skill Improving own learning and performance.

All these institutions should have policies on alcohol misuse prevention and problem-related service provision. These should incorporate staff, student and parent/community issues. These institutions should contribute to young people's substance misuse plans. The contribution of the informal education setting, e.g. youth service, YOT, connexions should not be overlooked.

Youth workers have voluntary relationships with young people which engage young people in issues of harm reduction.

Heavy drinking appears to be common amongst students in higher education – and alcohol problems in later life can sometimes be traced back to a pattern of heavy drinking at university. This issue may be addressed by the provision of especially tailored alcohol education courses. It may also be useful for schools to provide alcohol education for the parents of schoolchildren (especially the 11 – 15 years age group). It should be acknowledged, however, that influencing the behaviour of young people can be inherently difficult (n.b. the failure of drugs education in reducing cannabis use).

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?

47. There is a need for more research, funded pilots and methodologically sound evaluations of parental roles, attitudes and effective strategies.

Question 48 see 41&42

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

49. As many risk factors for alcohol, drugs and tobacco use are common should be able to learn from effective drugs initiatives, this is a piece of research/interpretation that needs to be carried out and disseminated.

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

50. Modifications to the regulation of alcohol advertising and references to alcohol in broadcast programmes are required to promote a more balanced

portrayal of alcohol consumption and its outcomes. Tighter controls need to be complemented by an increased public education programme.

Young people are susceptible to media suggestions, enhancing the protection of young people should be the focus of change. Tighter regulation of association with sport, cinema advertising, of sponsorship and packaging are needed. The experience of reducing tobacco advertising and sponsorship should be used. Alcohol promotion should be subject to regular audit to ensure a consistent mechanism for failure to comply. An investigation into whether to replace the current voluntary system with statutory regulation and a system of fines should be carried out.

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.”

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

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?

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

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?

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

It should be noted that U. K. alcohol consumption does not always contribute to the U.K. economy (n.b. alcohol imported via “booze cruises”, heavy drinking on holidays abroad, etc.).

51. It may be anticipated that alcohol consumption may continue to increase in future years (perhaps with more young people drinking heavily). It has been suggested that the relaxation of the laws on cannabis effect a reduction in alcohol use – though at present there is little hard evidence to support this view.

52. It should be acknowledged that a large portion of alcohol advertising is targeted at young people (who have the largest amount of disposable income). The government should be aware that alcohol services are already treating young people with serious alcohol-related health problems, such as liver cirrhosis.

53. Clinical experience has shown an association between alcohol dependency and the use of high-strength lagers and ciders. The introduction of similar products in future years may contribute to an increase in alcohol problems.

54 & 55

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.”

*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?*

*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?*

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?

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

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?

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

56, 57, and 59. There is inadequate financially quantified material relating directly to the United Kingdom to give an accurate picture of both the costs and benefits.

What principles could guide us in design? Who is responsible for costs? How far should they fall to individuals, how far to business and how far to Government?

58. Currently substantial costs from misuse are born by government who pays for health impact, welfare impact and crime impact. Investment in an effective alcohol policy should reduce the costs of misuse. The government can influence spending priorities of government departments, local health organisations and local authorities to allocate more resources to treatment services and prevention initiatives.

A levy on the alcohol industry, including an advertising levy, should be introduced to transfer some of the costs of addressing misuse away from the taxpayer and onto industry. This has been used successfully in a number of countries. (Alcohol Concern 1999)

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

60. and 61. We must disagree with this statement. Although some people use alcohol as coping mechanism for work-based stress and tension, it does not reduce workplace stress! Likewise we would dispute alcohol has a recognised function in facilitating networking in the workplace.

It is believed that alcohol should not be seen as a “quick fix” for difficulties in life – and that using alcohol in this way / can lead to the development of alcohol dependency. Alcohol-induced “net-working” is not seen as a positive mechanism for modern businesses

The workplace is a major location that captures many people in the heavier drinking groups; it’s an important setting within which to tackle attitudes and drinking behaviour. The development and evaluation of workplace policies should be actively encouraged,

61. Alcohol workplace policies may be effective in tackling alcohol problems – especially when alcohol treatment services are involved in the preparation, training, implementation and support of such policies.

