

## 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?

The Government needs to intervene given that alcohol is a dangerous drug and causes substantial harm. The incidence of misuse is high and continues to increase and the negative effects are far reaching. Indeed, the complexity of alcohol misuse combined with the fact that it occurs in so many settings demonstrates the need for a rounded strategy. Alcohol can damage the lives of individuals and families and can cause serious problems for society as a whole. For the individual it can cause physical and mental health problems. It can cause jobs and homes to be lost. It can have harmful effects on children, family and those close to the individual. It brings with it costs to the NHS, social services and the criminal justice system as well as wider costs associated with lost productivity in the workplace. Alcohol may also be linked to other factors such as homelessness, poverty and lack of work opportunities. It may also lead to criminal behaviour.

A Government strategy should bring coherence across the various departments that have an interest in alcohol policy. It would also bring together a wide range of services aimed at preventing and treating alcohol misuse. The criminal justice system, social services, local government, education and a range of non-statutory agencies, as well as health services, all have an important part to play. It would recognise that a strategy should not solely focus on health – if an individual does not have adequate housing, education or access to employment the problems that caused the person to misuse alcohol could return. It must combine a raft of measures that are linked into one action plan, including community safety, safe drinking messages, education and support and treatment for dependent drinkers. It must also be directly linked with other Government led initiatives such as community regeneration, crime and disorder and public health. A Government strategy should bring a joined up approach to alcohol and address all the different causes and consequences of alcohol abuse. The Department of Health and Strategy Unit should be responsible for ensuring that all policies and programmes within and across the different Government departments are well co-ordinated in order to have maximum impact.

A Government led national strategy would help give focus and priority to this important field. The imposition of clear targets within a strategy, backed up with additional resources, would also lend urgency to the tackling of problems. The absence of a national strategy has meant that alcohol misuse has not always

been dealt with adequately at a local level and that the importance attached to tackling alcohol misuse and the quality of response has varied. Experience and good practice may not be shared. In some parts of the country, local commissioners for health and local authorities have been waiting for national priorities to be set before deciding what services to fund and to what level. Other national set priorities may be dealt with first. This has led to a shortage of skilled staff for alcohol services and exacerbated an already worrying situation in which insufficient funding is available to provide an adequate service that meets local needs.

The risks associated with alcohol use need to be profiled and promoted in the same way that the risks of smoking, or indeed, drink driving has been. The range of effects on physical and mental health needs to be understood. The Government has successfully intervened with smoking and has promoted healthy lifestyles and should do the same with alcohol. This is to counteract the popular belief that alcohol consumption is not only harmless for most people but recommended as a vehicle of celebration, pleasure and being grown up or independent.

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?

Many people in society choose to drink and some do so in a responsible manner without endangering themselves others. However, there is evidence to suggest that a considerable number of people drink above the recommended limits with many at risk to themselves or others. One in 13 is dependent on alcohol to some degree (ONS 2001). Twice as many people are dependent on alcohol than on all other drugs. Moreover, significant public health risks and social harm arises from alcohol use with substantial costs, both direct and indirect to the NHS. The Government has a responsibility to intervene on public health grounds to protect individuals, in particular vulnerable groups, such as young people, from the many types of harm linked to the consumption of alcohol. The Ascheson Report identified reducing alcohol related harm as an essential strand of an overall policy to reduce health inequalities. It has as much of a duty of care to its citizens in tackling the health related problems associated with alcohol use as it does in relation to heart disease, cancer etc.

The Government needs to take the lead role in taking forward the alcohol strategy, to provide the impetus for change and to provide funding to ensure that the strategy can be fully implemented on a national and local basis. It can also ensure that alcohol problems are addressed in other relevant strategies and plans. The Government is already involved in social policy and intervenes to prevent anti-social behaviour so it should also get involved in alcohol. It should

also recognise that Government intervention needs to be long term in view of the entrenched patterns of drinking and in order to shift public attitudes towards alcohol. This duty also extends to others that may be affected by an individual's alcohol problems, including families, friends, employers and society as a whole.

The most persuasive argument for Government to intervene is that it receives a substantial amount of revenue from duties on alcohol and has a duty to reinvest this revenue into alcohol harm reduction measures. Given that the Government can intervene to influence the availability of alcohol, it should also take responsibility for the consequences of alcohol misuse.

In summary, the Government has a duty to intervene in three areas:

- To encourage the responsible use of alcohol through health promotion and education and prevention, with particular emphasis on specific groups, such as young people. It can also influence consumption of alcohol via taxation, licensing and drink driving measures.
- To promote treatment and support services and ensure that they are effective, accessible and are tailored to meet the needs of individuals and their families. Without an expansion in treatment programmes, there is a risk that people with alcohol problems will become further marginalised
- To protect individuals, families and communities from anti-social behaviour and sometimes violent and criminal consequences of alcohol problems.

There should be an expectation on Government to report to Parliament on the implementation of the strategy on an annual basis and to formally review the strategy every five years.

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

There is a need to maintain a balance between respecting individual choice and protecting that same individual from the negative effects of alcohol (health risks, crime, disorder and anti-social behaviour). There is also a need to take account of the ill effects of alcohol on society as a whole, including the costs to the taxpayer (NHS) and the wider costs to the economy (absenteeism from work).

Both the individual and the community have rights and responsibilities. Individuals have a right to make choices about their drinking. They should also have a right to accessible impartial information and education on alcohol misuse in order to exercise that choice. Individuals also have a right to expect appropriate services if they develop problematic patterns of drinking and need treatment. That same individual has the right to support if a member of their family has problems with alcohol.

As members of a community, we all share the responsibility and the cost of dealing with alcohol related harm on a day-to-day basis. Individuals have to be

responsible for their personal choices where they cause a nuisance or injury to others. The community has a right to expect safe streets free of drunken violence and litter and an environment free from violent crime, vandalism and other threats to public safety. Employers have a responsibility to safeguard the needs of their employees and develop alcohol policies. Commercial organisations also have responsibilities towards individuals and communities.

Poor communities are often disproportionately affected by alcohol problems. These communities have a right to investment in order to build up their capacity to tackle alcohol related problems and reduce alcohol misuse. Indeed, social regeneration of communities is needed to tackle the causes of alcohol problems and reduce the incidence of problematic alcohol misuse.

Finally, there is a particular duty to young people and children so that they can grow up in an environment protected from the negative consequences of alcohol misuse.

For these reasons, an alcohol strategy needs to balance personal choice with the rationale that drinking behaviours are a matter for societal concern. It follows that measures to combat the problems of alcohol need to be aimed at both the individual and the wider community.

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

There are often competing interests between consumers, voluntary groups and commercial organisations. This reflects the peculiar status of alcohol where health concerns sits uncomfortably with the social acceptability and desirability of alcohol. For example, extending licensing might be held up as beneficial to consumers as well as the drinks industry but may still be damaging to that same individual. For that reason, the strategy needs to be bold in the delivery of its messages. Public health needs to take precedence over the commercial interests of the drinks industry.

However, the strategy will need to encourage a partnership approach involving Government, the voluntary sector, statutory sector and industry. Its success will depend on wide ranging support for the strategy and a willingness to engage with one another. Their commitment to the strategy needs to be made before it is implemented and links with other mainstream programmes need to be identified.

Consumers have a responsibility to check out the facts on alcohol and show a responsible attitude to alcohol use. There were 5,508 deaths directly attributable to alcohol in 1999 (Department of Health 2001). Consumers also have a responsibility to safeguard their health as there was an eight-fold increase in deaths from liver cirrhosis amongst men and seven-fold increase amongst women aged 35-44 over the last 30 years (Department of Health, 2001). Consumers have to take personal responsibility for their problems rather than blaming alcohol itself for behaviour.

Voluntary groups are involved in the treatment, counselling, rehabilitation or support of people harmed by alcohol. Voluntary groups can play a central role in the delivery of the alcohol strategy. They can be involved in education, prevention and treatment as specialist organisations or work alongside local DAT teams. The record of the voluntary sector is one of meeting unmet needs - identifying the gaps in provision and filling them. It meets this objective by providing treatment that is innovative and genuinely person-centred and by meeting changing needs quickly, free of political bureaucracy. It has a unique ability to engage with the hard to reach and those most excluded, such as people from minority ethnic communities and those with complex needs and young people. It often provides specialist niche services that other agencies/statutory sectors are unwilling or unable to provide themselves. It usually secures a better deal for their beneficiaries, not least because the sector has credibility and knowledge of the client group but also because of its unique role in involving users and communities. The voluntary sector can play a role in evaluating current service provision and advocate changes in provision where gaps/shortfalls are identified. There should be a new focus on the skills, training and accredited qualifications of staff with support to enable people to have the confidence to work in multi disciplinary teams and across agency boundaries. Staff should also

be encouraged to plan career paths and provided with a route to professional qualifications.

The voluntary sector can also improve access to treatment by providing training for GPs, teachers and others that may come into contact with users. Awareness raising activities can also be extended to young people in schools.

Commercial organisations span the organisations involved in the drinks industry, including manufacturers, retailers and licensees. They should be under an explicit expectation to promote the principles underpinning the strategy, particularly in relation to sensible drinking. The commercial industry should take responsibility for the negative consequences arising from all patterns of drinking. It is not sufficient for the drinks industry to simply acknowledge that binge drinking is a problem. It should also take responsibility for the long-term damage that alcohol dependency can cause to entrenched drinkers, their families and to society as a whole. Commercial organisations are able to influence patterns and trends in drinking through responsible advertising/ marketing. They should not use marketing techniques that promote harmful use of alcohol. Commercial organisations can also influence the environment in licensed premises and enforce the current law. Commercial organisations could have responsibility to label products with units and carry health warnings. The drinks industry should take the lead in educating young people about the strengths and effects of drinks and promoting alternatives such as soft drinks through marketing and lowering prices.

There are also other groups who have a responsibility to take forward the alcohol strategy. All too often the needs of employees with alcohol problems are ignored or their needs are dismissed as “personal problems that are nothing to do with work.” All employers should be expected to develop an alcohol policy that is understood and communicated to the whole workforce. It should provide training for managers so that they feel better equipped to identify and, where appropriate, respond and intervene when alcohol issues arise in the workplace. This needs to be backed up by advice and support to employees themselves who have problems with alcohol. Police also have a central role to play in implementing a future alcohol strategy. It is important that they are aware of harm reduction approaches and of the benefits of brief interventions and treatment.

A national strategy taskforce drawing together representatives from different Government Departments, business and the voluntary sector should be set up to oversee the implementation of the strategy. Naturally, we would strongly advocate that Turning Point, as the largest provider of substance misuse services, is a member of the taskforce!

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

Turning Point is pleased that the Government is focusing on a harm reduction approach to its national strategy rather than simply a “control in use” approach to alcohol policy. There is a need to review restrictions over access and availability of alcohol in order to ensure that measures are in place to prevent misuse from taking place in the first place, particularly amongst young people. However, it must also be accompanied by measures that support people’s efforts to stop and to reduce harm and control specific drinking behaviours. A harm reduction strategy recognises that alcohol will also be part of some people’s lives. The approach is to target resources on behaviour that causes the most damage to individuals and to the community. This will necessitate tackling alcohol at both individual and population levels and in a variety of settings. Separate harm reduction programmes should be developed for different alcohol related problems or situations. The policy approach should be broad based to cover controls over access to alcohol, taxation matters, education and treatment and support services. It is clear that the reasons leading to alcohol misuse are complex and that a one treatment fits all approach will not work.

The underlining principles that form a central part of the Government’s initial drug strategy ‘Tackling drugs to build a better Britain’ and the subsequent updated drug strategy, Tackling Drugs (2002) could also form the central plank of a Government policy aimed at reducing alcohol misuse. The emphasis in the drug strategy has shifted away from dealing with the consequences of drug misuse to investing in ways to tackle and prevent it happening in the first place, as well as providing treatment for those that need help.

On that basis, the alcohol strategy should advocate a mix of measures aimed at providing a balance between protection, promoting education, reducing harm and offering treatment for the whole population with targeted measures aimed at vulnerable groups, particularly young people. It should also address the needs of dependent drinkers who would benefit from treatment

Protection – It is quite obviously beneficial to protect individuals from alcohol misuse and thus minimise the need for treatment services. Furthermore, there is extensive research to underpin the value and effectiveness of measures at a whole population level. However, despite this, protection is often a much-neglected tool against alcohol misuse. Legislation is a valid tool in the enforcement of a more responsible attitude to alcohol use. Measures in relation to protection would include reducing consumption by increasing the price of alcohol through taxation, reducing permitted blood alcohol levels to reduce motor car accidents and examining the link between controls on advertising and alcohol consumption. The strategy would also embrace efforts to influence patterns and levels of drinking through the impact of licensing controls, enforcing the laws on underage drinking more heavily and restrictions on purchasing times and the

drinking environment.

Prevention – This involves generating greater awareness of alcohol and the risks of misuse through education and information programmes for young people in schools, colleges and youth clubs and workplace interventions. Education can play a role in changing perceptions and attitudes towards alcohol and promote realistic alternatives. It also means promoting clear and consistent messages in relation to alcohol. Credible alcohol education and information will help people understand the risks and dangers of alcohol use, influence perceptions of use and misuse and promote responsible drinking. The aim of education is to explain that there is not one kind of alcohol problem but a range of problems ranging from binge drinking to serious dependency. We also need to educate parents to be role models to their children. Turning Point recommends that a separate awareness and communications strategy is developed

Treatment - To enable people with alcohol problems to overcome them and live healthy and fulfilling lives and in the case of offenders, crime free lives. Treatment should be accessible, free and available to all that need it when they need it. It should be made available to families as well. Treatment should demonstrate best practice. There needs to be a mix of provision that can meet a range of needs. This would include those who are affected by another person's drinking as well as the individual who has the drink problem. There needs to be a balance between specialist and generalist treatment. It is clear that the reasons leading to alcohol misuse are complex and that a one treatment fits all approach will not work. There must be specific measures in place to ensure that treatment attracts women and people from minority ethnic groups and supports them in appropriate treatment. A framework for support and treatment services should be developed

The alcohol strategy should establish some overarching objectives backed up by targets. However, these targets need to be credible so that agencies are motivated to work towards targets that are possible to achieve. It should also promote an evidence-based approach to service provision and have realistic and achievable outcomes. The delivery of the strategy will be dependent on the development of a multidisciplinary approach with the active support, engagement, co-operation and collaboration of a range of partners including, Government, business and the voluntary sector.

The strategy needs to be underpinned by a research programme to ensure up – to-date information of the extent of abuse amongst particular groups, promote the effective targeting of education and to identify any shortfalls in treatment provision. National priorities for research need to be agreed and mechanisms put in place so that the lessons learnt from research into what works can be disseminated. Finally, the strategy needs to be linked in with other measures that address broader social care issues of an individual, such as neighbourhood renewal, housing, education and employment.

The cultural and behavioural issues around alcohol use and misuse

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

### *Questions*

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

A definition of alcohol misuse is liable to be based on value judgements as to the amounts of alcohol involved to give rise to misuse. This will vary from individual to individual and over time. The starting point would be to define misuse objectively in relation to the quantity of alcohol consumed. Alcohol misuse could be defined as referring to persistent use above the safe drinking limits. There are shortcomings with this approach. Quantity consumed may not always be a reliable indicator of alcohol misuse as alcohol may impact on individuals in different ways. An individual may feel that they have a drinking problem regardless of the amount that is consumed or alternatively that same individual may not perceive himself/herself as misusing alcohol even though alcohol is causing significant problems. Quite low levels of alcohol consumption may be perceived to be problematic if it is detrimental to the functioning of the individual in any meaningful way. Moreover, these same drinking limits are not valid in relation to young people, to adults with specific health problems or women in pregnancy. In any event, any significant amount of alcohol in the body increases the risk of accident compared with zero alcohol. Quite low levels of alcohol consumption may be perceived to be problematic if it is detrimental to the functioning of the individual in any meaningful way. The alcohol strategy needs to recognise that alcohol problems can arise from drinking at different levels.

Alcohol misuse should also be defined in relation to the consequences of alcohol misuse. This would recognise that alcohol misuse causes significant health, social and behavioural problems. They can be psychological, physical or social and vary in severity from individual to individual. Some of the specific negative consequences would include injuries from fights or accidents, unsafe sex and pregnancy, self-harm suicide or death, personal and family relationship problems or reduced productivity. Additional consequences often stem from the environment in which drinking takes place with significant problems arising from drinking alone in unsafe, unsupervised places. Alcohol misuse not only impacts on the individual but also the lives and safety of those close to the individual as well as the wider community around them and society in general.

The definition should encompass all different patterns of drinking. The concepts

of harmful drinking and alcohol dependence have been used to describe different disorders associated with alcohol problems. Specific behaviours such as binge drinking should also be considered.

The terminology used to describe alcohol use and misuse is extensive. Each term/classification brings its own unique problems. It may not be possible to reach a definitive agreement on the factors that govern alcohol misuse. The term, “misusers” is also problematic as it may be stigmatising for the individual. The general term “problems with alcohol” may be preferable as it avoids making a judgement about an individual. In any event, the alcohol strategy should contain a glossary of the different terms used to describe problems associated with alcohol use.

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?

Any alcohol strategy should aim to reduce **all** the harmful patterns of alcohol consumption. These may range from clinical terms and terms that are used by people to describe their drinking patterns. These include: alcohol problems, alcohol misuse, alcohol abuse, acute intoxication, binge drinking, harmful drinking, hazardous drinking, and alcohol dependence and alcohol addiction. A strategy that reduced all patterns of drinking may also reduce some of the long term problems and illnesses that develop from heavy drinking and dependent drinking. Policies for reducing alcohol harm should be aimed at the whole drinking population, in order to tackle the full problems of alcohol, but also target particular groups that are seen to be at risk.

The alcohol strategy needs to be a balanced one that focuses its efforts on addressing all patterns of drinking. It should not concentrate efforts on one pattern of drinking at the expense of another. For example, it is right and proper for an alcohol strategy to tackle high risk, episodic, binge drinking and drinking in unsafe environments. Indeed, news footage of violence and anti-social behaviour around pubs on a Friday evening provides a powerful visual image of the damage caused by binge drinking and makes a compelling case for investment in prevention in this area. The problems relating to drunken behaviour speak for themselves and are easier to understand. Increased investment would also strike a chord with, and be supported by, the general public. This is in line with Government thinking on tackling “yob culture”. However, the strategy should also concentrate on providing greater support for long-term dependent drinkers where problems result from regular heavy drinking over a longer period of time. They may not be as visible as those people who are intoxicated and are displaying overtly anti-social behaviour but the physical and medical problems associated with dependent drinkers are as far reaching. It can lead to potentially fatal illnesses and to psychological and social difficulties such

as increased rates of divorce, acts of violence or suicide. It is certainly as significant and as great a problem as binge drinking.

It is worth dwelling on the different patterns of drinking that the alcohol strategy should address:

Binge drinking refers to people who drink in large quantities on particular occasions but may not drink more than the recommended amount on a regular weekly basis. An individual may drink excessively every few weeks or few months on occasions such as Christmas, weeks off, birthdays, weddings etc. Binge drinking becomes a problem when it occurs frequently. It may also cause acute pancreatitis or acute gastritis. But most of the medical problems associated with binge drinking are accidents and emergencies. It brings its own associated risks involving injuries, violence and loss of control. It also leads to anti-social behaviour. The strategy should reduce binge drinking because of its harmful social and individual consequences.

Harmful use refers to levels of drinking which may not lead to intoxication or dependence but generates a range of negative physical and psychological consequences. It is associated with medical problems with the heart, liver and brain and nervous systems. It also increases risk to emotional and mental illnesses.

Alcohol dependence involves physical dependence accompanied by withdrawal symptoms when the individual tries to stop drinking. Physical dependence arises from drinking regularly at a very high consumption level. Withdrawal symptoms include sweating, shaking, anxiety and insomnia, which are relieved by consuming more alcohol. Other features include a narrowing of the drinking repertoire and a subjective awareness of a compulsion to drink and relief or avoidance of physical symptoms by further drinking. There is also evidence of growing tolerance and that increased dosages are often required to achieve the effects produced by lower dosages. People who are alcohol dependent may also neglect alternative pleasures or interests because of substance use. These are significant. A person's guilt, shame and remorse levels become more burdensome as the drinking continues. Harmful consequences include harm to the liver, mental health problems or impairment of cognitive functioning.

The current cultural context within which recreational alcohol use currently takes place can have negative repercussions for a range of individuals or groups, not least in relation to the anti-social behaviour associated with excessive alcohol use that, in turn, impinges on the general public. An alcohol strategy which places responsibility on licensees to refuse sale of alcohol to individuals who are clearly already very drunk, behaving anti-socially, or behaving irresponsibly (drinking and driving) should also provide licensees with the tools to prevent excessive consumption.

Given that the strategy should address all patterns of drinking, a sound research programme that can give information about drinking patterns and behaviours should underpin it. This will help target resources in education, prevention and treatment as well as helping to identify gaps in provision in these areas.

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?

An increasing number of people enter higher education where peer group culture encourages many people to start drinking excessively. Young people are also being targeted with advertising messages making certain drinks fashionable in an age of increasing youth culture.

Many people have more disposable income, now that increasing numbers of people are living alone or remaining single. There is also an increase in leisure time available which may allow a greater use of alcohol.

There is a clear need to target young people at the start of their drinking behaviour although greater research is needed to establish whether young people can grow out of drinking or are likely to become heavy/dependent drinkers.

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 that we should bring into our analysis?

It is crucial for the alcohol strategy to focus on meeting the needs of people from minority ethnic communities. Drinking patterns may be less visible and so the problems may be underestimated by existing services. Local services should be expected to take a detailed look at patterns of alcohol misuse in black and minority ethnic communities when undertaking needs assessments and consider the diversity of cultures that may require services. Consideration should also be given to developing mainstream and specialist services that are culturally sensitive services and can attract minority ethnic alcohol misusers into treatment. Training in cultural competence can also help staff understand issues affecting minority groups.

From Turning Point's experience as a service provider, we know that drinking is a growing problem in ethnic communities although the patterns can vary from first, second and third generations. For example, many first generation Sikh clients tend to only associate drinking spirits such as whisky as a cause for concern rather than other forms of alcohol such as lager. This may also mean that people

will only seek help in very critical circumstances when their drinking is completely out of control.

There are also different drinking patterns within different ethnic groups. Sikhs may have more problems with excessive drinking whilst Muslims may experience particular difficulties that stem from an abstinence culture. For some Muslims any consumption of alcohol would lead to the risk of being perceived as having a drinking problem. But the stigma associated with drinking in a tightly knit community may mitigate against the active engagement with treatment services. New and often damaging patterns of drinking are emerging. For instance, we have also learnt about drinking problems amongst Chinese women in the north west of England

The diverse needs of refugees and asylum seekers should be assessed to prevent alcohol problems and provide appropriate levels of support and help.

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?

Alcohol enjoys a central and ambivalent position in society. It is an acceptable part of life for the majority of people. It is associated with relaxation, enjoyment and community celebration. It plays a part in marking important occasions. The demand for alcohol clearly exists. It is part of England's culture and identity.

Alcohol is certainly portrayed as a lesser evil to other drugs, even though it causes more deaths than the misuse of illegal drugs. This means that more effort has focused on illegal drug use than alcohol use. Given that alcohol is part of England's culture, this reinforces the need for adults and children to learn to drink without risk.

The medical profession has concluded that drinking small quantities can confer benefits to health. In 1995 the Royal College of Psychiatrists concluded that 1-2 units of alcohol could reduce coronary heart disease for some people. In practice, these benefits are more evident amongst older people. However, there are inherent dangers about promoting the positive benefits of moderate levels of alcohol consumption. Given the known relationship between alcohol consumption and the level of harm, promoting the health benefits of alcohol may serve only to increase consumption and therefore the overall harm in society. Alcohol certainly impairs physiological and psychological functions that impact on individual's social behaviour and safety.

An alternative approach is that people can relax and enjoy the company of others without the need to drink alcohol or the pressure to fit in by drinking alcohol. Alcohol may be excessively consumed in order to try and relax and unwind in

crisis situations. It is also used by people who are unhappy, who feel they cannot cope without 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 that influence it – for example are there sharp regional differences? Does it look different for different ages groups?

Culture refers to a set of norms, beliefs and attitudes that people have towards life. Alcohol is certainly part of an English drinking culture. Traditionally, English drinking culture continues to focus on the pub. But new patterns of consumption have become embedded in the English culture such as drinking wine with meals.

The English culture places great emphasis on drinking to excess and getting drunk in the shortest period of time. People's pattern of drinking in England is often based on a need to have fun, overcome shyness and the pressure to fit in with others. It is often viewed as the only means of "letting your hair down and having a good time." For many, it is perceived as the only available leisure option with few alternatives available particularly in inner city and rural areas. Young people in England are more likely to get drunk, binge drink and experience drunkenness in comparison to their peers in the rest of Europe. This pattern of drinking is for many linked to sociability with people of all ages drinking excessively at the end of the working week and during weekends.

Binge drinking is a particular pattern of drinking or norm that is part of the English culture. The approach to drinking is to drink as much as possible over a short space of time rather than pacing the amount that is drunk and to spreading consumption of alcohol over a much longer period of time. Specific promotions such as happy hours and other forms of marketing have led to irresponsible drinking, particularly among young people.

A worrying trend is that getting drunk is seen to be an unavoidable and acceptable part of the English culture. There is a "macho" culture of heavy drinking where getting drunk is seen as normal behaviour and is tolerated and where drinking excessively and behaving badly is all held up as a badge of achievement and is positively applauded. Drunken behaviour is viewed as acceptable and fun for some people. Binge drinking is celebrated and seen as a cultural rite of passage for young people. In contrast, not drinking is not seen as acceptable. Nowadays, "getting plastered" every weekend seems to be regarded as the cool thing to do. Of course, we know that there is a great pressure to conform among young people. No one likes to be seen to be different from their mates. However, in other countries, it is decidedly uncool to get "blind drunk".

The English culture is a particularly uninformed culture that shows little

understanding of alcohol and displays considerable ignorance about the risks associated with heavy drinking. It is also critical of others who choose not to drink. This is compounded by successive political administrations that have not prioritised tackling the problems of alcohol misuse. As binge drinking becomes more embedded into the culture and English way of life, increases in alcohol related harm will also occur.

There are also socio economic factors that influence the pattern of drinking. Low levels of income, unemployment and living in deprived areas all predict higher levels of drinking. Certainly there are strong links between homelessness and problematic use.

Advertising heavily influences the English culture. The advertising industry promotes alcohol as part of a modern, desirable lifestyle. Particular drinks are seen as trendy and fashionable. Much drinking is aggressively targeted at the younger end of the market. Wine is beginning to make significant inroads as tastes become more sophisticated mainly for the older age group. Specialist whiskies are also being promoted as the market becomes very segmented.

The declining influence of cultural and religious traditions limiting or proscribing alcohol use has also accompanied the recognisable English culture.

The strategy should therefore aim to effect cultural change, in the same way that the anti-smoking campaigns and subsequent health and safety legislation has succeeded around cigarette smoking. It should recognise that attitudes towards alcohol and social norms are embedded into English life and will take substantial time and investment to change.

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?

Fashion and marketing influence behaviour very strongly. Drinking is often portrayed as something that is stylish and fashionable. The media can promote new and emerging trends in drinking and influence beliefs and drinking behaviour. Young people's magazines often carry stories of excessive drinking and many programmes and documentaries reinforce the view that excessive drinking is acceptable.

Drinking also forms a central part of the culture of many television programmes such as Eastenders, where characters frequently meet in the pub. Comedy programmes also exaggerate the use and frequency of alcohol consumption. It is rare for the negative effects of alcohol to be highlighted, except when significant personalities such as the footballers George Best and Paul Gascoigne are involved. Advertising has also become absorbed into the everyday culture,

particularly in the lives of young people.

An individual's family background can influence behaviour, as it is more likely that you will drink if your parents do so. Ethnic background may have an impact - the Sikh community may be more open to alcohol use than the Muslim community. Many other factors influence behaviour such as individuals' learned coping skills, the job the person is doing, stress in their life, relationship with their partner, state of health, peer group influence, amount of money. People are also influenced by the availability of alcohol such as pub opening hours and off-licence shop opening times.

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

The relationship between alcohol and readiness to take risks is complex. People who drink excessively are more likely to engage in a variety of potentially risky or health damaging activities. Alcohol has a disinhibiting effect and can stimulate people to take risks. There is a need to try to separate high-risk drinking behaviours from certain activities that are regarded as high risk, such as unprotected sex (where alcohol is regarded as the main risk indicator in relation to teenage pregnancy) and sports and driving which require a high degree of skill. However, there may also be some acceptable risks associated with consumption of alcohol. One of the purposes of drinking alcohol is to enhance risk taking within acceptable socially prescribed limits. Alcohol may encourage people to talk to others or give people "dutch courage" before embarking on important activities.

Alcohol is associated with a wide range of risks, although, in practice, establishing causal links may be more problematic. There may be a distinction between attitudes towards risk and actual risky behaviour arising from consumption of alcohol. For example, it is commonly believed that people are more likely to engage in crime as a result of drinking alcohol. However, research has confirmed that drinking itself does not cause crime, although drinking and offending may share common causes.

Some people simply take more risks than others, whether they are drinking at the time or not. People who are prepared to take greater risks generally in their lives are more likely to take greater risks with alcohol misuse, for example drinking and driving, drinking when pregnant, drinking when operating machinery.

People are generally uninformed about the risks associated with alcohol. This can influence patterns of drinking and readiness to take misguided risks in relation to alcohol consumption. Many people do not consider the serious consequences arising from alcohol consumption and many wrongly feel that they have the skills to control their own drinking levels.

Young people may not have the capacity to control or regulate their drinking

behaviours and this may result in them engaging in high risk taking behaviours. Young people's attitudes to risk may be affected by lack of experience of drinking and peer pressures.

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

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

#### *Questions*

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

Problematic drinking can arise if the drinker is putting himself or herself at greater risk by drinking over the recommended safe levels of 21 units for men and 14 units for women per week. The latest figures for average weekly consumption show that 27% of men and 15% of women are drinking over these limits. Nearly half of these men and women are drinking at serious high levels of over 50 units for men and 35 units for women.

Harmful drinking is not measured only by the amount of alcohol that is consumed. Drinking behaviour and its consequences can also indicate problems with drinking (see above).

Factors to take into consideration are symptoms of alcohol dependency such as withdrawal symptoms including sweating, shaking, anxiety and insomnia. Additional factors include impact on work, relationships, physical health and previous history of alcohol use should also be considered.

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?

The evidence for health costs is well established. Deaths from liver cirrhosis have seen an eight fold increase among men and a seven-fold increase among women, aged between 35-44 over the past 30 years (Department of Health, 2001). The former Health Education Authority found that one in six people who attended A and E departments had alcohol-related injuries or problems of one

kind or other. On Fridays and Saturdays that rose to eight in 10. Over 150,000 people admitted to hospital in England in 1998-9 had an alcohol-related disease. Almost 29,000 people were admitted with a primary diagnosis of mental and behavioural disorders due to alcohol. A further 10,900 admission were for alcoholic liver disease and toxic effects of alcohol. The Chief Medical Officer's annual report noted that in 1999 some 4,700 deaths occurred from liver disease, with two thirds of them below the age of 65. Alcohol Concern estimates that alcohol misuse costs the NHS at least £3 billion a year.

Alcohol misuse also carries long-term health risks. About 3% of all cancers can be attributed to alcohol while heavy drinking over a long period increases the risk of heart disease. Around 39% of men and 8% of women who attempt suicide are chronic problem drinkers. Alcohol consumption that precedes attempted overdose is a staggering figure of 70% of men and 40% of women.

A report by Alcohol Concern "100% Proof" highlights the lack of research on the causes and impact of alcohol problems. The alcohol strategy will need a systematic research programme to assess the costs of under age drinking to the NHS in terms of hospitalisation and dependency.

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.

The costs for the NHS have been well documented by the Royal College of Physicians in their report "Alcohol- can the NHS afford it" and by Alcohol Concern in numerous publications. Alcohol misuse costs the NHS up to £3 billion a year on hospital services (Royal College of Physicians 2001). It is also estimated that the cost to the health service is between 2% and 12% of the total amount spent on the NHS. Many of the alcohol related problems are preventable. One in six people attending A and E departments for treatment have alcohol related injuries or problems, rising to eight out of 10 at peak times.

Indirectly there are costs associated with staff who maybe off sick due to alcohol related problems.

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

Prevention stems, in part, from the need to promote education, information and awareness of the problems associated with alcohol use. Prevention of alcohol dependence/alcohol misuse at any level must begin with the provision of accurate information on which individuals can base their lifestyle and behaviour choices. It is about changing the way in which alcohol is perceived and providing

relevant information to people and their families as well as reducing misuse and minimising the risks to alcohol dependence. It is essential that effort is directed to having a clear health prevention message (including that it is acceptable to see your doctor), and to building awareness of where people can go if they have a drink problem and what forms of treatment are available.

Interventions through a range of appropriate services, is particularly critical for young people with alcohol problems. Investment in lower threshold interventions not perceived specifically as "drug" or "alcohol" services is vital. For example, help with numeracy, literacy, education and retraining and anger management. Interventions should be offered early and start in childhood. It is often effective to carry out preventative work to stop problems with later alcohol use from developing.

The "drugs" message is often about deconstructing the more extreme "just say no" messages into a more rational "think about it" approach. In contrast, the alcohol message is often about emphasising the seriousness with which the substance should be viewed. This is based on evidence of health risk, alcohol-related deaths etc. Both are exercises in de-mystification, but approach issues of prevention in different ways. The culture, legal status of the drug and general attitude towards alcohol by the public provides the context to this.

Turning Point advocates greater promotion and uptake of "drink watchers" groups as a means of preventing alcohol dependence. This approach recognises that there may be a long delay between the development of an individual's alcohol problem and their contact with treatment services. Abstinence from alcohol may not be immediately possible or realistic but that individual may be at risk for many years. Drink watchers groups are interventions aimed at supporting people who want to manage and control their drinking habits. The individual is encouraged to compile their own drink diary, to focus on situations in which they are drinking too much and to examine the motivations behind their drinking patterns. The aim is to make people more aware of the trigger points that lead to excessive drinking and raise insight and awareness of their own drinking patterns. This would enable people to learn about the risks associated with their alcohol use and how to avoid them. Such an approach starts with the premise of improving the health or lifestyle of the person. It aims to minimise the harmful effects of drinking by early intervention and prevent escalation of a person's alcohol problems. It may also bring the first crucial step in engagement with services. This form of treatment is usually run by the voluntary sector with courses running for up to six weeks either as group work or on a one- to-one basis. It would be a Tier 2 level of service. It would be a genuine alternative to AA services and represent a middle path between brief interventions and more specialised forms of treatment. This model will need to be publicised widely in order to encourage take up.

Turning Point's experience shows that providing adequate family support, ensuring that the partner has access to counselling, telephone counselling and

group support has had a large impact on dealing with some of the issues in the family that may be leading to an escalation in drinking.

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?

Brief interventions generally take place in community settings and are delivered by non-specialist personnel such as general practitioners and other primary health care staff, hospital physicians and nurses, social workers, probation officers and other generalist professions. They usually consist of a simple screening procedure and a few minutes advice and are designed for use with harmful or hazardous drinkers. They are usually aimed at a goal of moderate ("safe") drinking.

Most studies have found that brief interventions are effective in reducing alcohol consumption for at least 12 months in patients who are not alcohol dependent, and when compared with no intervention or usual care. The major conclusion of several reviews is that minimal interventions can deliver a reduction in drinking of between 20 and 30%. Heavy drinkers who have received a brief intervention are twice as likely to reduce their drinking six to twelve months following that intervention in comparison with heavy drinkers whom received no intervention. Brief interventions are also cost effective and can bring about savings to the health system by intervening early and preventing the need for future expensive treatment for alcohol related diseases.

Brief interventions can serve as effective treatment for those with less severe problems such as hazardous and harmful drinkers. They are mainly used to reduce alcohol consumption in people drinking above recommended levels but who are not dependent. It is only one method of supporting people and will not help people who don't want help or do not acknowledge the harmful effects of their drinking. People with alcohol dependence require more intensive forms of support and management. Brief intervention may be too simplistic for entrenched patterns of drinking. However, they might be useful as initial treatment for dependent patients seeking extended treatment. It also provides a means of supporting referral to more specialised forms of treatment in cases of alcohol dependence.

The aim of brief intervention is to encourage individuals to think differently about their alcohol use and to give help to people at an early stage as soon as they recognize that they have a problem with drinking. It aims to assist people so that they are aware that they need to make changes to their alcohol consumption and to help them moderate their consumption to sensible limits in order to reduce the

risk of future health problems. People at a pre-contemplation stage can be encouraged to recognise the harm that excessive drinking can cause and to think about changing their own behaviour. Those people at the contemplation stage, who know that they are drinking too much and are aware that excessive alcohol use can be harmful, can benefit from counselling in order to support them to reduce consumption. All pilots of brief interventions have proved successful but implementation varies considerably across the country. Turning Point would support the expansion and take up of brief interventions. However, it is only one method of support that can be made available. It will not be suitable for all people who have problems with alcohol.

Primary Care is an excellent setting in which to deliver brief interventions. The GP is uniquely placed to help people who are starting to develop problems. They can identify a problem at an early stage and confront the individual of the damage that they are causing to their lives and the impact on their families. However, many studies have shown that many GPs are not aware of the benefits of the brief intervention approach and have not incorporated it into routine practice. Others barriers include lack of knowledge and skills, (particularly lack of training in counselling), lack of time and concerns about the response of the patient. Secondary care is an alternative setting for delivering brief intervention, particularly to those people who present themselves to A&E wards under the influence of alcohol. Alcohol related accidents are not always followed up in secondary care, however. Many people in hospital beds are not diagnosed with having alcohol related problems and the links to specialist agencies that can provide treatment are not made. This is largely attributable to the fact that A&E wards often do not have the infrastructure in place to support staff or ensure that there is adequate links between primary and secondary care or to develop and maintain close links with CPNs and the voluntary sector. The alcohol strategy should spell out a requirement for each general hospital to develop a strategy for detecting and responding to alcohol problems. There should be an expectation on hospital staff to take an alcohol history from every person who is presented to an A & E ward and to refer the individual to appropriate treatment.

It is clear that much work still needs to be done in order to encourage general practitioners and other health and social care professionals in secondary care to use them in an effective way. The World Health Organisation advocates the use of a self-report, screening test that is distributed to patients when they are in the doctor's waiting room. The Audit Tool, developed by the World Health Organisation has proven to be very successful in identifying hazardous drinkers and helping them to reduce consumption.

Research suggests that alcohol screening and brief interventions should become part of routine health care. Health authorities and Primary Care Trusts need to develop guidelines and protocols for the introduction and implementation of screening and brief interventions in primary care settings. GPs should be encouraged to be proactive in seeking out alcohol problems and introduce

screening for all patients.

General practitioners should be adequately trained to deal with alcohol misuse and offer brief interventions. Training in alcohol misuse should be compulsory and be embedded in the undergraduate medical curriculum and postgraduate General Practice curriculum. It needs to be incorporated into social care courses so that all social care staff can identify and respond to alcohol problems. Training sessions by specialist alcohol agencies and counsellors can help in overcoming some of the limitations along with providing literature. However, GPs are not the only people who can be trained to deliver brief interventions. There is a danger of over medicalising brief interventions that could be delivered by other trained workers. Brief interventions could be delivered by other professionals such as police and teachers or by the voluntary sector. Advice and information should also be in pubs at the point of delivery backed up by additional warnings on packages. There is also a case for delivering brief interventions in different settings in order to target particular groups. One example would be brief interventions in universities in order to reach students directly.

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?

Question 19 focuses on treatment.

The Mesa Grande, an ongoing summary of controlled studies of treatment for alcohol problems from the University of Mexico, concluded that naltrexone and acamprosate were the two most strongly supported pharmacotherapies and brief interventions, social skills training, community reinforcement approach, behavioural contracting were effective psychological treatments. The least supported approaches were those that were designed to educate, confront, shock or foster insight. The results of the Project Match in the USA, the largest trial of treatment for alcohol problems, confirmed that the "12 step" model of cognitive-behavioural therapy is an effective form of treatment. The National Census of UK Treatment Agencies report in 1996 found that the non-statutory sector was supporting two thirds of people who were receiving treatment or advice for alcohol problems. The most common category of staff providing treatment was counsellors and the most common form of intervention was counselling on a one to one basis. 28% of clients were in residential treatment and 60% of clients receiving detoxification were inpatients. Only 9% of clients were concurrently attending AA.

As the largest provider of substance misuse services, Turning Point knows that treatment works for the individual, family and communities as a whole. The

biggest concerns surrounding treatment is the lack of response to alcohol misuse, particularly the lack of provision available in many parts of the country. There is clearly a lack of resources in relation to service provision. Too much treatment has been delivered on a shoestring. Shortfalls in funding are evidenced by lack of growth in existing services, closure of some services, alcohol funding having to piggy back on drugs funding or traditional alcohol only organisations diversifying into drugs because that where funding priorities lie.

Turning Point recommends that the strategy should start with the premise of ensuring equity of provision of services across England. Local and health authorities should map availability of services in order to obtain good baseline information and target areas where there is a shortfall of services. The review should be carried out with the close involvement of former and current service users to determine what works well and otherwise. Resources need to be focused on sustaining existing funding of services and providing new investment in treatment services. This needs to be backed up by investment in training and education and the funding of additional research into the causes and consequences of alcohol problems. There should be a requirement for local and health authorities to provide alcohol services, produce annual plans and establish joint commissioning arrangements. The strategy should have specific targets to increase the number of people in contact with services, to reduce the time waiting for an assessment of needs and reduce the waiting time between assessment and availability of treatment. The NTA needs to assume responsibility for encouraging more responsible, effective and integrated approaches to commissioning of services.

Research is needed to establish a clear link between the cost of alcohol and the saving gained in treatment. For example, Turning Point has been successful in making the case for drugs misuse to be regarded as a health and treatment issue. The importance of drug treatment services has been increasingly recognised. This is backed up by research. The National Treatment Outcome Research study calculated that every £1 spent on treatment brought a return of £3 due to savings in the criminal justice system. A similar case should be made for investment in alcohol services, namely every £1 in treatment saves £X in medical, police, court, social services costs.

Treatment interventions include counselling/psychotherapy, '12-step' programmes, detoxification and pharmacological treatments, as well as treatment or other help to address the problems arising from alcohol misuse. The NHS and social services deal with many aspects of alcohol misuse with general practitioners providing an important front line of engagement. NHS community alcohol services have been developed as a vehicle for providing specialist support and shared care and training, in relation to GP, generalist, NHS and voluntary sector provisions, and social work agencies. Voluntary sector organisations provide specialist support, outreach, day-centre and residential facilities for homeless drinkers, and have also developed counselling and

information centres and support within the criminal justice system

Treatment needs to follow a social model that addresses the underlying reasons for drinking, promotes healthy behaviour and provides aftercare and support rather than a medical model based simply on treating unhealthy use. This stems from the recognition that alcohol misuse problems cannot be considered in isolation and must be combined with social care responses that address broader aspects of drug users' lives. This means ensuring that the entire care pathway is in place and having interventions in education, employment and housing following treatment. Pathways into treatment need to be simple and straightforward regardless of the point of entry. An example of treatment, which follows a social model, can be drawn from Turning Point's services. Turning Point's Sherwood House is a residential rehabilitation unit. Treatment offered includes a 12-month programme focussing on the 12-step model, as well as one to one and group therapy and life skills training. As clients progress towards the end of the programme they are introduced to an aftercare group, which runs weekly at the project, for as long as the client needs to attend. Clients are also offered support from staff for the three months once they have left the project, taking the form of planned sessions to discuss their progress and any current issues. None of this work is funded, but is undertaken by the staff as it has been found that ongoing support is essential for the continued success of the client and their ongoing health.

For treatment to make an impact, it must be based on the principle that there is no one treatment that is appropriate for every drink problem. Different forms of alcohol problems will merit different forms of intervention. Treatment that works for one person may not work for another. Treatment must be designed around the individual and meet their assessed needs, as well as their families. The Government also needs to ensure that people who use services are involved in all aspects of service development, delivery and evaluation. Turning Point's Canterbury Alcohol Project concentrates on the "whole person" addressing the emotional and social circumstances that can lead to a person's drinking in the first place. The Canterbury project regularly assesses the opinions of its clients after receiving treatment and many of their comments and suggestions are fed back into the treatment programme.

Treatment should also be widely available throughout the country. A mix of services in a variety of settings is needed. An alcohol strategy should advocate generalist and specialist forms of treatment, acute and long-term treatment and support and include low cost and more expensive alternatives. It should encompass a full range of effective services ranging from information and advice, counselling, detoxification, residential support and after care services. It should combine outpatient treatment for people who have enough social resources and no serious medical conditions, with inpatient support for people with serious medical/psychiatric conditions, and retain residential options for people with few social resources and/or environments that are not conducive to recovery. The

main concern is that there is that there is not enough of it, particularly specialist services for people with alcohol related problems and the availability of all forms of treatment in rural areas. The strategy should also promote the social inclusion of those with misuse problems through provision of learning opportunities and forging links with housing, education, training and employment services. Research is needed to evaluate different forms of treatment from different agencies.

Most dependent drinkers will require a more intensive and specialist form of treatment than either a minimal intervention or a brief treatment as described above. Research has shown that a year after treatment, people show significant improvement in relation to drinking and associated harm. In the main specialist treatments can be delivered in the community but some problems drinkers will require intensive day care or residential care. One of the biggest gaps in provision is in-patient community based detoxification and rehabilitation services. One of the priorities in the alcohol strategy should be to redress the shortfall in service provision in these areas and remove the disparity between availability of alcohol services and drugs services. There also needs to be a balance between residential and community services.

Residential rehabilitation services, at least on a temporary basis may be appropriate for some people in order to help bring stability to their lives and facilitate a move towards alternative housing in the community. It gives patients the chance to move away from the environment that perpetuating their alcohol abuse. It may also prevent people from dropping out of services, as the treatment is often intensive, combining medical care with emotional support and strong links to aftercare. Turning Point's service Ascot House based in Oldham was set up in 1975. It is a residential rehabilitation project for people with alcohol and/or drugs problems. A significant number of our clients also have co-existing mental health problems. Ascot House has 7 group homes, in addition to the main house, offering a total of 22 beds funded under transitional housing benefit (Supporting People from April 2003). The house programme consists of a structured group programme based around cognitive behavioural and twelve step principles. Each client has a designated keyworker and can expect a minimum of one hour's counselling each week. Clients' needs are written into a care plan at the beginning of their stay, and care plans are reviewed regularly. We offer advocacy, resettlement and aftercare in addition to alternative therapies, chiefly auricular acupuncture. All clients are also offered a programme of education, employment and leisure.

Camberwell Alcohol Service, the original Turning Point project, opened in 1964. The aim of the project is to support people who have suffered as a result of long-term misuse of alcohol. Its six month residential programme is based on exploring the causes and effects of problem drinking and based on abstinence of alcohol. Twenty-six clients used the service during the period January to December 2002. The Camberwell service offers a structural group work programme plus weekly

counselling sessions. The purpose is to help clients gain insight into the causes and effects of their problem drinking. The group programme includes goal setting, relapse prevention, alcohol awareness, inter-personal exploration, discussion and reflection. It also offers key working sessions to assist clients with the management of practical matters such as housing issues, returning to work, education and training. It helps clients to learn to relax and cope with anxiety.

An alternative model is to provide outreach support in the community. The Blythe Service is based in the community and works with people in their homes across the north east of England who feel quite isolated from support and can't access treatment in the normal way. It offers intensive support to help people to engage with GPs and other appropriate services whilst remaining in the family home. The overall aim of the service is to help them reduce or stop their alcohol consumption that affects their physical and mental health. It is an example of a low key but crucial service, which are in tune with the local community, and supports the individual as well as their families and neighbours. In many cases, the people the Blythe project works with may otherwise die if the service did not exist.

Alcohol treatment has largely placed a strong emphasis on the medical models of care, focusing on the health needs of alcohol users. Alcohol treatment needs to place more emphasis on providing more integrated packages of support and enlisting mainstream services such as housing, social services and employment. It should also promote opportunities for young people to participate in sports, arts and culture. This is needed to facilitate integration back into the community following treatment.

The current treatment for alcohol misuse involves detoxification. This process which removes alcohol from the clients body is dependent on follow up work and relapse prevention. Maintenance following detoxification is crucial. Without the support of family and friends the client can fall back into drinking patterns very easily. It can also lead to alcohol dependency if the client sees detoxification as an easy way out of the drinking, a 'quick fix' but sees little reason for changing long term habits and patterns. Counselling has a fundamental role to play to enable a person to address their problems with alcohol use. A series of treatment/counselling sessions are needed to tackle problems detected at assessment. This may include relaxation techniques to cope with stress, relapse prevention techniques to promote abstinence and encouragement to make lifestyle changes. Complementary therapies also have a role to play. The use of acupuncture, and some spiritually based therapies can help to bring stability to people's lives.

In terms of treatment, current models are effective but probably tend to both target the most problematic and dependent users and to accommodate the social context of drinking behaviour. Thus, outside the 12 steps model, controlled drinking provides an acknowledgement that a great deal of recreational activity

will involve drinking alcohol somewhere along the line. Follow on support is not well supported due to lack of resources (again, outside the 12 steps model) as the lack of growth in funding for alcohol services has meant targeting the most problematic users whilst they are still actively problematic. More could be done in terms of longer-term relapse prevention. Certainly, there appears to be less innovation in alcohol treatment as it is a less fashionable field than drug misuse and much less attractive of Government investment. Future investment needs to focus on increasing support for dependent drinkers and broadening support to people in the community.

People need to access treatment services in crisis situations and in cases of extreme vulnerability. They need to access services without delay. This is the optimal time to provide treatment interventions that meet an individual's needs. Lengthy waiting lists or lack of information about treatment can drive people away. It may also prevent future engagement with services. Turning Point's experience has shown that service provision is characterised by limited treatment options, lengthy delays and under developed care management. This will need to be addressed. Pathways to treatment need to be straightforward irrespective of the point of entry.

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

The aim of the drug strategy is to target the problems relating to drug use pragmatically and focus on four main aims addressing young people, treatment, communities and availability. Turning Point has suggested that a similar approach should be taken to the proposed alcohol strategy. There are close links between a proposed alcohol strategy and the current drug strategy. We hope that the publication of an alcohol strategy would make it easier to develop services that cover both areas of work. There is a close interdependence between the two areas and many people who access Turning Point's services have problems with both alcohol and drugs. Both drugs and alcohol may be influenced by the same social and cultural factors. However, whilst many drug users will also have alcohol related problems, drug policy will not be as effective without attention and resources being directed to deal with these problems. Examples include: people using alcohol to come off heroin, using alcohol as a substitute when coming off drugs or as a possible gateway to more serious drug use. There is a need for additional research to look at the links between drugs and alcohol and the extent to which alcohol acts as a contributory factor to drug overdose.

There are a number of structural changes that are needed at a national and local level. The role of the National Treatment Agency should be broadened to take account of alcohol treatment. Alcohol services should be included within the

remit of drug action teams and drug reference groups to ensure that there is local co-ordination of services. The various schemes such as arrest referral schemes and the CARAT scheme should be developed to work with problem drinkers as well as drug users. The drugs testing and treatment orders should be expanded to include alcohol in cases in which the individual is dependent on alcohol and will benefit from treatment. These structural changes should ensure that treatment for alcohol is afforded the same priority, in terms of perception and resources available, as drug treatment. It is important that alcohol remains high on the political agenda following the strategy and is not subsumed by drugs. Strategic planning mechanisms should focus on both drugs and alcohol and there should be joint and separate commissioning and delivery of services. There should be separate funding streams for alcohol treatment.

The policy agenda for tackling drugs use has led to a stronger emphasis on treatment. Treatment should take the centre stage in the Government's alcohol strategy. Treatment for alcohol can help people minimise the harm that they do to themselves, reduce the use of drugs and help an individual rebuild their lives. Investment in treatment is also in the wider public's interest given the damage that alcohol can cause to the wider community.

For drug users, there is often a point in the cycle of recovery where people contemplate getting information about treatment. This is the optimal time to provide treatment interventions that meets an individual's needs. Lengthy waiting lists or lack of information about treatment, for illegal drugs or alcohol can drive people away. It may also prevent future engagement with services. We know from our experience in the drugs field that weak assessment procedures, uneven availability of treatment services and lengthy delays make it difficult for people to get the support that they need. Turning Point recommends that there should be an expectation on local Drug Action Teams (assuming they are given responsibility for alcohol) to develop strategies to promote the engagement of hard to reach groups in services, particularly those with multiple or complex needs. Drug Action Teams should also be expected to develop more effective assessment, care planning and co-ordination arrangements so that services fully meet people's needs across both alcohol and illegal drugs fields.

Turning Point recommends that the balance between different forms of treatment should be carefully monitored. The Government have emphasised breaking the relationship between crime and drugs, as a central component of the drug strategy. The relationship is more complicated for alcohol. However, it is expected that the Government will also stress the relationship between alcohol and anti-social behaviour. We recognise the need for enhanced measures aimed at breaking the link between alcohol and criminal/anti-social behaviour. However, it would be self-defeating if measures aimed at tackling anti-social behaviour were to be expanded at the expense of other forms of interventions such as treatment for dependent drinkers who often do not commit crimes or engage in anti-social behaviour.

The vast majority of Turning Point's clients have multiple challenges requiring a range of treatment models. More effective models mean better engagement with the client groups which means improved health for individuals and the community. We recognise that there are many people who present themselves for drug treatment who have a concurrent or secondary alcohol problem. There are many examples in which people have combined alcohol with other drugs that have a depressant effect on the user. In contrast, those people with a primary alcohol problem are less likely to have a secondary drug related problem. It is important that people who use services are regarded as people who may require a variety of different services rather than defining people as needing a particular medical treatment. The crucial issue to be learned is that early intervention is critical so that people are "captured" and are attracted to services at their point of motivation. To that end, it is important for the individual to be presented with balanced information about drugs. People should be presented with objective data on the impact of drugs/alcohol on health, education on the consequences of alcohol/drug use and explore personal barriers to participation in treatment. The individual should be encouraged to consider the pros and cons associated with drug/alcohol use and consider the role of drugs/alcohol has played in their lives/current problems. The overall approach is to ensure that the individual is motivated towards treatment, wherever appropriate. Intervention strategies must be linked to the wider agenda of neighbourhood renewal, health improvement and reducing health inequalities.

In some cases, harm reduction targets have proven to be a more realistic goal than complete abstinence. A harm reduction approach recognises that there may be a long delay between the development of an individual's substance misuse problem, be it illegal drugs or alcohol and their contact with treatment services. Abstinence may not be immediately possible or realistic but that same individual may be at risk for many years. A public health component to the alcohol strategy would enable people to learn about the risks associated with alcohol use and how to avoid them and provide them with the advice on how to minimise the harm arising from alcohol use. Such an approach starts with the premise of improving the health or lifestyle of the person. It may also help to bring about the crucial first step towards engagement with services. To that end, harm reduction is an approach that acknowledges that alcohol/illegal drug use takes place and chooses to minimize its harmful effects rather than simply ignoring or condemning them. Similarly, following treatment, interventions should be put in place that can assist an individual to prevent and manage future relapses. This should be backed up with a holistic programme of after care support.

The Government's drug strategies have emphasised the need for separate services for young people with separate policies, assessment and interventions specifically aimed at young people. Immediate access to services is essential, as young people will often base their views of a service on initial contact. Many

young people will not be motivated to attend ongoing programmes of care and may have additional levels of chaos in their lives, including family breakdown or problems at school. Treatment needs to be backed up by education and interventions that include information on the harmful effects on alcohol. Research shows that education on risks associated with drug use and ways of resisting peer pressure are more effective than messages such as the 'Just say no' campaign.

Targets were set for each of the aims in the original drug strategy of 1998. These targets were widely criticised for being unrealistic and unworkable and three out of four of the initial targets have been dropped in the revised drug strategy. It is essential that the alcohol strategy learns the lessons from the shortcomings in the drug strategy and develops realistic and measurable targets.

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?

Use of more plastic packaging, though this can also present problems with pollution. Street drinkers are a difficult group to engage and often present at hospital A&E departments so more targeted work with this group could help.

Further, the alcohol policies of companies such as London Underground and BP, which have company wide bans on alcohol use and provision of high quality counselling, have shown to reduce alcohol related incidents in the workplace.

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?

There are close links between alcohol misuse and mental health problems. Alcohol misuse is the usual rather than the exception amongst people with severe mental health problems. Alcohol misuse is the most common form of substance misuse. Research has shown increased rates of substance misuse are found in individuals with mental health problems, affecting around a third to a half of people with severe mental health problems. Community Mental Health teams report that 8-15% of their clients had dual diagnosis problems although higher rates may be found in inner cities. It has been associated with worsening psychiatric symptoms, increased rates of violence and suicide and contact with the criminal justice system. Alcohol problems are a major factor in the development of mental health problems among young people and are linked with major depressive disorders. In addition, one third of people who commit suicide

are intoxicated with alcohol at the time of death. Alcohol misuse can create mental health issues, most commonly depression or brain damage or it can mask it. People can drink to cover up a mental health problem. An example could be people with severe mental illnesses who drink to cover their symptoms and it is only when they stop drinking that these mental health issues come to light. More residential provision needs to be in place for people with substance misuse and significant mental health problems.

The term “dual diagnosis” refers to the spectrum of mental health problems and substance misuse problems that an individual may experience. Local services should develop definitions of dual diagnosis, which enable them to respond to the range of needs of the local population.

Historically, little effort has been made to develop services for people with mental health problems and alcohol problems. Services for alcohol misuse and mental health services have evolved separately and the needs of those with dual diagnosis are not addressed adequately. Many have been excluded from services or funding is not made available to treat both areas. Others have been passed between mental health and substance misuse services. The complexity of issues makes diagnosis, care and treatment more difficult, with service users being at higher risk of relapse, readmission to hospital and suicide. The starting point is to develop a multi agency approach to the planning, commissioning and delivery of services that puts an end to people being passed from one institution to another and recognises that many people have complex needs and often lead chaotic lives.

There is already a comprehensive framework for people with mental health problems and substance misuse problems. The National Service Framework for Mental Health emphasises a number of issues in tackling dual diagnosis including the need to consider the potential role of substance misuse for all individuals with mental health problems and the importance of meeting the needs of people with dual problems through existing mental health and drug and alcohol services.

Services should adopt an integrated shared care approach to meeting the needs of people with dual problems. Individuals with dual problems should have their needs delivered within mental health services with care shared and supported by substance misuse services. This may include the support of a specialist dual diagnosis worker or an assertive outreach framework where people do not respond to traditional treatments. In any event, there should be a lead clinician for dual diagnosis issues. They must be able to link up with the specialist advice and support that is available from the voluntary sector. There should be joint commissioning of services across Primary Care Trusts and Drug Action Teams working, wherever possible, to a pooled budget. Integrated services are required over a range of services and professionals need to be trained in the management of dual mental illness and substance misuse. It should be a core competency for

CPNs and psychiatrists.

Services need to work to agreed standards such as those set up in the Quality Standards in Alcohol and Drug Treatment Services (QuADS) to ensure that quality services are delivered. This means working towards maximum waiting times for treatments, having standards in place for alcohol workers and ensuring all treatment programmes meet a national standard

The treatment needs of people with alcohol use and a concurrent mental illness are complex. The evidence base of the nature of effective treatment is weak. Turning Point hopes that the alcohol strategy will stimulate more work in this field.

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

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

### *Questions*

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

The relationship between alcohol and crime is complex. Alcohol is a disinhibitor and can result in crime because the individual has a drink problem. However, whilst there is a direct link between problem drug use and acquisitive crime, this is often not the case with alcohol use. It is difficult to demonstrate that alcohol alone causes crime. However, we do know that alcohol is clearly a contributory factor in many instances of criminal anti-social behaviour. The British Crime Survey suggests that in 40% of violent crimes the offender is under the influence of alcohol at the time of the incident. There are further differences between drugs and alcohol. Whilst the biggest impact in drug-related crime is around acquisitive crime, alcohol related crime is likely to be more related to violence and disorder.

Alcohol is closely associated with a wide range of criminal offences. They are noticeable in three categories: violent crimes in public places, individuals killed or injured through drink driving offences and family members who are subjected to violence or abuse in the home.

The All Party Group on Alcohol Misuse concluded that alcohol is a factor in 60-70% of homicides, 75% of stabbings, 70% of beatings and 50% of fights and domestic assaults. (Alcohol and Crime-Breaking the Link 1995). The report, Alcohol and Crime Taking Stock (Ann Deehan, 1999) suggested that alcohol misuse contributes to an estimated 40% of violent crime, 78% of assaults and 88% of criminal damage cases. The 1998-9 Youth Lifestyle survey found that males aged 12-20 who drank regularly were more likely to be serious or persistent offenders than those who drank occasionally or did not drink at all. The recent British Crime Survey showed that 40% of victims of violent crime thought that their assailant had been drinking.

Alcohol is also closely related to the offences of drink driving and drunkenness in which drinking or excessive drinking defines the offence. One in 7 killed on roads and One in 20 injured on roads were involved in drink-drive accidents in 2000 (Department of Transport local Government and the Regions 2001)

The Crime and Disorder Act 1998 defines anti-social behaviour by focusing on the consequences of certain behaviour. This means that what is meant by anti-social behaviour is open to considerable interpretation. The main forms of anti-social behaviour reported against individuals are noise, intimidation, verbal abuse, violence and offending behaviour. Alcohol may be a factor in anti-social behaviour. Indeed, these problems may arise because of our drinking culture that encourages binge drinking. This can lead to sporadic patterns of drinking and acute intoxication. It is more associated with violence than frequent but moderate drinking. For these reasons, the alcohol strategy should try to encourage a more responsible drinking culture via changes in the drinking environment and changes to the law on licensing.

The Government should not lose sight of the fact that anti-social behaviour is often fuelled by wider problems of social exclusion and deprivation, such as poverty, unemployment, family breakdown, truancy and school exclusions and community disorganisation. Alcohol and drug misuse may be just one of a number of causes that can lead to anti-social behaviour. For that reason it is difficult to determine precisely the extent to which alcohol influences anti-social behaviour. It may interact with numerous individual, environmental and social factors that relate to offending. For these reasons, the alcohol strategy needs to tackle the causes and not just the symptoms of crime. There is a need to increase the effectiveness of enforcement action by the police but this needs to be coupled with increasing the effectiveness of early interventions that may prevent crime and anti-social behaviour from taking place in the first place.

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?

Alcohol consumption is associated with particular forms of anti-social behaviour- especially violent offences. Habitual drinking is greater among young people

who offend and come into contact with the criminal justice system. Drinking may be used prior to the commission of a criminal act, or arise as a consequence of crime. There is a risk that patterns of drinking become ingrained and associated with criminal acts and repeated offending. The National Association of Probation Officers conclude that 30% of offenders on probation and 58% of prisoners have severe alcohol problems and that alcohol is a factor in their offence or pattern of offending.

Alcohol related crime is more commonly linked to violence related offences. Turning Points' Drink Related Offenders Programme (ADROP) in Southwall offers a unique programme to people convicted of drink related offences. The eight-week programme looked at crime and the law, effects of alcohol on the body, reasons for drinking, risky situations, drink diaries, dealing with cravings etc. This very successful programme ensured that the repeat offending rate was very low. Part of the success is also attributed to the fact that the programme is linguistically and culturally appropriate to the client group, with Punjabi speaking facilitators and literature in the community languages.

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?

A Home Office study concluded that growth in beer consumption was the most important factor in explaining growth in crimes of violence against the person. (Home Office Study-1990). Violence is most commonly associated with younger people drinking alcohol at weekends in city centres. Alcohol related crime often results in facial injury with glasses and bottles often used as weapons. However this group is not normally accessing alcohol services. Clients using alcohol services tend to be in their thirties or forties and have a ten year or so drinking history.

Turning Point believes that the present licensing culture contributes to the current drinking culture and that fixed/artificially early closing times leads to problems of violence and binge drinking. Issues of public disorder and anti-social behaviour arise when large groups of people gather around public places and bars, especially late at night. The law on licensing can play a part in allowing people to enjoy their leisure time without fear of violence or disorder. Extending licensing times will remove the perverse incentive to drink as much as possible before 11p.m and should mean that there is less drink-related trouble on the street at that time. It will mean that people do not consume drinks as quickly as possible before drinking time and customers are not forced onto the streets when they are most likely to be drunk. Extending licencing hours will also stagger the times at which people leave pubs and should mean that people cause less problems to themselves and others.

However, changing the licensing system will not in itself change the English drinking culture that is characterised by heavy drinking combined with the over-

riding objective of getting drunk. Binge drinking is part of the English culture rather than a victim of the English licensing system. This stands in contrast to the European culture where long drinking hours in cafes are not associated with anti-social behaviour.

Turning Point feels that responsibility for licensing should lie with local authorities to improve local accountability. There should also be an expectation on local authorities to take into account the cumulative impact of existing licences in a defined area when considering applications for a new licence. That would deal with the problem of saturation—the over-concentration of pubs and nightclubs in a locality—which cannot be dealt with merely by attaching conditions to a new licence application. We agree that local authorities should consider the prevention of crime and disorder, public safety, the prevention of public nuisance and the protection of children from harm as part of their general licensing objectives.

As outlined above, the British Crime Survey suggests that in 40% of violent crimes the offender is under the influence of alcohol at the time of the incident. Naturally, this is based on victim's perceptions at the time of the crime. Victims may be incorrect in their assessment unless they have clear, undisputable evidence which is often not present at the time of the crime. However, these perceptions have been tested by research that has looked into extent and nature of drinking amongst offenders. This confirms that offenders are more likely to drink heavily than the general population with a substantial proportion admitting to consuming alcohol before offending. This is also backed up with information derived from the Youth Lifestyle survey (see below). There is an argument that the 40% figure may be an over-estimate on the basis that offenders under the influence of alcohol may be more likely to get arrested in comparison to offenders who do not drink. However, the case for a link between alcohol and offending behaviour has been well established.

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?

There are many factors that influence crime and disorder. These include unemployment, lack of opportunities, and boredom. For many people, there is no attractive alternative to drinking in the streets. The lack of youth provision is also a factor. New initiatives such as Connexions provide help to 13-19 year olds with advice and guidance. 'Positive Futures', is a scheme used to promote diversionary activities and reduce crime and anti social behaviour in 10-16 year olds. The National Schools Curriculum PSHE should also help in educating in young people.

There are close links between a licensing system and links with the local community plan, the crime and disorder strategy and the regeneration of town centres. These are all factors which may influence patterns of drinking.

The lack of a late night transport system exacerbates the risk of public disorder and accidents from drink driving. Passengers under the influence of alcohol are often abusive to other passengers and staff and other people may be deterred from using public transport in the late evening for fear of alcohol related crime and violence. A twenty-four hour economy will require more transport and more policing to be effective. A change in the licensing system should be accompanied with increased availability of public transport when the pubs close in order to reduce brawls on taxi ranks backed up with a ban on drinking on public transport. This should also be accompanied by banning glasses and bottles on the streets and providing more police to confiscate them. Pubs and bars should be expected to use more plastic and safety glass. But again, this deals only with the symptoms of the disease, not the root cause.

Crime prevention can be built into the early stages of planning and design. The layout of new buildings and the introduction of CCTV can bring security to the general public and act as a deterrent to potential breakers of the law.

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?

Rural communities may have fewer pubs to serve their local populations This may mean that people may choose to start drinking “early on” and choose to drink for a longer period. Higher unemployment rates may also influence patterns of drinking. Alternatively, a rural setting may encourage more people to drink at home rather than in a pub that may be based many miles away. It may also mean families are more likely to support someone with alcohol problems in the family home but less inclined to engage with professional help to avoid the stigma of alcohol in their community.

Young people may be more motivated to drink in a rural setting because of the lack of alternatives. Moreover, what may be considered as anti-social behaviour in an urban setting, such as excessive noise, may go unnoticed in a rural setting.

Urban environments particularly those that are multi cultural, may hold potential for racial attacks and hooliganism. There are also more mixed patterns of drinking as people are from many diverse backgrounds and maybe drinking for a variety of reasons such as loneliness, depression, suicidal tendencies etc.

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?

The environment can be a major influence on whether alcohol causes damage to communities. The lay out and density of licensed premises, the siting of off-licences and development around railway stations can all determine whether a location is subject to alcohol related problems. Simple changes around the design of pubs and clubs can minimise the risk of trouble and promote a safe pleasant and more family friendly environment. One example would be ensuring the toilets are easily accessible and are not at the back of bars or clubs. The provision of recycling bins for bottles would reduce waste and promote more friendly environmental policies. We would support further controls on drinking from bottles and serving drinks at public events in plastic containers.

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?

It is important for different organisations to work together to tackle alcohol related crime and promote treatment for people with alcohol problems. This will include the police, probation, the voluntary sector, licensees and retailers. Poor inter-agency planning can lead to inappropriate responses to crime. There may be a need for local guidance on how these partnerships can be formed and developed at a local level in order to create an incentive for inter-agency planning whilst having enough flexibility to take account of different circumstances at a local level. There will need to be considerable investment in selecting staff that have a track record in partnership work, and who have positive enthusiasm with working with alcohol misusers. There also needs to be clarity of roles and responsibilities, which exploits the skills of all partners and plans better assessment and treatment procedures. There needs to be agreement about the best approaches to tackling crime and how the balance between a punitive response and treatment interventions can be maintained. Above all, there needs to be appropriate referral systems by the police and probation in order to improve referral to treatment that matches the individual's needs (and prevent inappropriate referrals).

Different forms of training for different staff are needed so that non-specialist staff such as the police can recognise problems in relation to alcohol and refer people to appropriate support and treatment. Alternatively, a multi-disciplinary approach to training on drugs and alcohol covering education, prevention, harm reduction and treatment would encourage these partnerships to develop in practice. Organisations may be prevented from taking such approaches for various reasons i.e. not aware of other work in the field, scepticism, reluctant to share information and expertise, differing aims and objectives, lack of resources, staff

etc.

Crime and Disorder Reduction Partnerships need to draw up definitions of anti-social behaviour in partnership with communities and ensure that alcohol is a central component of any strategy. This can ensure referral to treatment as well as promoting a rapid response to anti-social behaviour such as vandalism and graffiti.

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

There is considerable concern about drinking leading to anti-social behaviour amongst young people. Young people are more likely to be unable to control their drinking patterns or control their behaviour when under the influence of alcohol. They may also be more susceptible to anti-social behaviour and crime due to peer pressure, lack of opportunities and family pressures. A number of behavioural consequences stem from alcohol use amongst young people. Young people may get involved in alcohol-related fights or get into trouble with the police or may drive a motor vehicle under the influence of alcohol. An increasing trend has been the large groups of young people congregating on estates or other public places after school, and during the weekends. Local residents raise concerns about noise, vandalism, damage to property and excessive drinking. Often cars are vandalised and burnt out. People feel intimidated to walk in their own neighbourhood. Certain places become no go areas. Under age drinking is common.

The statistics outlined below, taken from the recent National Youth Lifestyle survey make the case for anti-social initiatives to include a specific focus on young people. Young people are also the group that are least likely to see alcohol as a problem as many will not have a long drinking career and are less likely to engage with treatment services. Young people, particularly young males in the 16-24 age group are also most at risk of being a victim of violent crime. This crime usually takes place in pubs/ wine bars or clubs.

The National Youth Lifestyle Survey found that:

- Men under 21 who drank regularly were more likely to be offenders than the occasional or non-drinker.
- Young males (16-24 years) are much more likely to be the perpetrators of alcohol-related violence than any other group.
- 15% of 12-17 years olds have been involved in some form of anti-social behaviour as a result of drinking alcohol.
- 36% of offenders aged 12-17 were frequent drinkers

compared to 20% of non-offenders.

- Young people aged 12-15 years who were disaffected from school, had truanted or been excluded, were twice as likely to drink frequently. However, there is no way of saying which was the cause and which the effect or, indeed, if any other causal factors played a part.
- Children's drinking is linked with their parents' drinking. The majority of young people drink at home with their parents. Consequently parents are important role models in encouraging sensible drinking.
- The more people drank, the more likely they were to be violent offenders.
- 8% of those who drank at least once a month had committed violent offences.
- 15% of those who drank at least five days a week had committed violent offences.
- For females, there was no relationship between drinking and offending over the age of 15. However, girls aged 12 to 15 who drank regularly were five times more likely to offend than those who drank less often.

Anti-social behaviour may occur in any area and across social classes. According to the Ascheson report, however, alcohol dependency is significantly linked with socio-economic position of the individual. Whilst it is important to target the most vulnerable young people, and those in high crime areas, the alcohol strategy must also recognise the link between social deprivation and substance use. It is linked to poor school achievement, truancy, unemployment and problems with relationships. A greater proportion of people living in deprived neighbourhoods are more likely to experience problems with anti-social behaviour.

The Government's response, to date, has been to encourage the police, local authorities and landlords to apply for anti-social behaviour orders in the Magistrates Court. Orders can be issued to persons over 10 years who have acted in an anti-social manner and where the order is necessary to protect the public from further acts. The Order prohibits the person from doing anything described in the order. The current Criminal Justice Bill will introduce the concept of an Individual Support Order, aimed at preventing further anti-social behaviour where an anti-social behavioural order has already been granted against a person under 18. It may require a person to undertake education related activities.

From Turning Point's experience, we know that alcohol may well be a mitigating

factor in the offender's behaviour. We have also highlighted that there may well be additional problems in relation to poverty, unemployment, family breakdown, truancy and school exclusions and community disorganisation. Given the range of underlying problems that are causing anti-social behaviour, the Government needs to consider whether prohibitive measures are an appropriate response to a young person's complex needs. It is arguable whether an Order telling people to stop engaging in certain types of anti-social behaviour will ever work unless it is backed up with appropriate interventions around prevention and treatment. It may act as a quick fix rather than a long-term solution.

A more helpful response would be to improve a young person's contact with alcohol treatment via the criminal justice system. Certainly, the criminal justice system has an important role to play in channelling drug users into treatment for alcohol. Alcohol treatment could be imposed via arrest referral schemes that ensure people with alcohol related problems are offered treatment and treatment could be imposed as part of a community sentence. All treatment needs to be tailored to meet the needs of younger people. The effectiveness of any alcohol strategy will also be increased if it is closely integrated with similar policies that tackle drug use and neighbourhood renewal. This will ensure that the social causes as well as symptoms of anti-social behaviour are addressed. Turning Point wants deprivation to be given its full and proper place in any future alcohol strategy. The alternative – a simple punitive response to an individual anti-social behaviour is not sufficient and may be counter productive to the very groups that it is aimed at.

Turning Point already works in at least 35 of the 88 Neighbourhood Renewal areas. Turning Point would like to pilot a Young Citizen scheme with at risk groups in some of the Neighbourhood Renewal areas, a twelve-month programme based on mentoring, education, health and inclusion. Anti-social initiatives also need to be combined with measures that are aimed at reducing problems arising from underage drinking. This would include better enforcement of the law against selling to the under aged, more widespread proof of age schemes and strengthening alcohol education that is extended to young people.

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

People who visit bars and clubs are six times more likely to be victims of violent crimes. The British Crime Survey 2000 found that violent incidents in and around pubs and clubs account for 19% of all violent crime. A culture that is not bound up by closing times may help to go some way towards reducing excessive drinking before closing times. Longer drinking hours would allow people to choose when to drink. Encouraging sensible drinking at home with the family, maybe as part of a meal, can reduce the need for street drinking or drinking to

get drunk.

The reality, however, is that most people drinks in pubs and bars rather than in the family home. This reinforces the need for landlords of pubs to take an enhanced role in promoting how to drink in a socially acceptable manner. There should be an expectation on bar staff to educate and enforce sensible drinking and acceptable standards of behaviour. Staff should be trained so that they can educate people about different drinking patterns. Continuing to serve a person who is obviously severely intoxicated should result in stronger penalties for the server and the establishment.

The law on licensing needs to be combined with other measures to strengthen the obligations of licensees to act in the best interests of local residents. This would mean putting checks and balances in place including sanctions against publicans of poorly performing premises. There should be an enhanced enforcement on obligations on landlords to refuse to serve drinks to people who are known to be drunk and greater use of schemes that keep known troublemakers from pubs and clubs. Licensees should be responsible for injury or damage caused by a customer who has been served too much alcohol when it can be demonstrated that the licensee acted in a negligent fashion. Bar staff and door staff should be trained appropriately and control entry into pubs and should provide police with early warning of potential problems.

Turning Point has considerable concern about 'happy hours' during which alcohol is sold more cheaply than usual, sometimes two drinks being offered for the price of one. There are considerable risks to public order when large amounts of alcohol are consumed in a short space of time. Police should be able to apply for a revocation of licences of premises that have regular happy hours and have become a focus of disorder.

There are still limitations with the extent to which it is possible to change drinking patterns by changing the environment. There is a need to go further and expand education, prevention and treatment programmes similar to those that have worked with drink driving.

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?

Public drunkenness can be addressed by putting more responsibility on drinking venues to monitor behaviour and to not allow people to get to the point that they are no longer responsible for their actions. There also needs to be greater enforcement on shops/retailers that sell alcohol so that they are not selling it to those visibly drunk and the under aged.

There should also be greater enforcement of laws that restrict drinking on the street and confiscation of alcohol. A number of local authorities have introduced an alcohol ban in designated parts of town centres. It gives police officers the authority to target drunken individuals and groups who take bottles and glasses out on the street and to seize alcohol from anyone drinking in the designated areas. People who refuse to hand over intoxicating liquor not contained within a sealed container, or who continue to drink, will be committing an arrestable offence and be liable for a fine. In addition, enhanced street lighting and improved CCTV can help improve the environment. CCTV cameras, which can be moved from place to place to keep an eye on local trouble spots, have been successful in certain areas.

There are inherent difficulties in extending police powers/approaches to public drunkenness. This could lead to perceptions by communities of being over-policed at a time when people are enjoying themselves. The key challenge is for the police to forge better relationships with the local communities they serve, so local people feel that they are partners with the police in tackling anti-social behaviour.

Extending initiatives such as on the spot fines by the police could well be counter-productive. This could strain relationships between the police and the local community. It may also be difficult for police to distinguish between high-spirited drinkers who are unlikely to offend and those whose drunkenness may result in crime. Measures to tackle youth boredom and disaffection would be far more effective than granting greater enforcement powers to the police.

A more co-ordinated effort by the police is also required, to work along with street agencies, and working with alcohol misusers, so that adequate help and support can be provided when it is needed.

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?

Yes, night-clubs should be located away from housing. Pubs in a housing area need to remind customers to be mindful of leaving late at night. Individuals need to take responsibility for their actions and patrons of venues also need to take responsibility for their customers.

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

We have learnt that messages need to be hard hitting but not misleading, clear and unambiguous, firmly policed and properly advertised. The drink driving campaigns demonstrate that campaigns that are closely associated with enforcement and/or social disapproval will resonate more strongly. People

understand the risks when drinking and driving and are fully aware of the penalties that will be imposed if convicted. There is broad support for the campaign and the public generally disapproves of drinking and driving.

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?

Alcohol or drugs do not cause domestic violence. It results from a complex interplay of psychological and social factors. It stems from an imbalance of power between two people but overwhelmingly the male is the perpetrator of violence. Some men/women may have been drinking when they are violent, but drink can provide an easy excuse for someone's behaviour. It certainly should be treated as a serious crime and be accepted by society as serious as drink driving.

Violence is an expression of anger and alcohol acting as a depressant allows bottled up feelings to be freely expressed by taking away the normal reserve or inhibition an individual may have. According to Alcohol Concern, around 60 to 70% of men who assault their partners are under the influence of alcohol. Alcohol Concern have called for greater co-operation between agencies tackling domestic violence and substance misuse, to prevent women falling through the net, and an examination of the impact of programmes designed to work with violent men. Turning Point supports this approach.

#### The implications for vulnerable groups

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

#### *Questions*

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

There are worrying trends in irresponsible and excessive drinking, particularly among young people. 94% of young people have consumed alcohol at least once with 47% having drunk alcohol at least 40 times compared with 20% in France. One third of women aged 16-24 and more than half of young men drink at hazardous levels. There has also been an increase in frequency of drinking

among school children and they amount that they drink. The average weekly consumption by pupils who drink has risen from 5.3 units in 1990 to 10.4 units in 2000. The World Health Organisation estimate that the United Kingdom has one of the highest rates of binge drinking among 15-16 year olds in Europe as well as the highest number of members of that age group who have ever been drunk. 56% of 15-16 year olds drunk more than 5 drinks on a single occasion in the last thirty days. 30% of this age group report this behaviour three or more times in the last thirty days. An increase in the availability, range and popularity of inexpensive drinks are all contributing factors to young people drinking at an earlier age. In particular, young people are the most frequent consumers of alcopops that contain more alcohol than a pint of beer. Their sweet flavour, vibrant colours, and “sexy” names make them very alluring to young people, including under 18s. The advertising industry emphasises a fun and a cool image whilst many young people are unaware of the alcohol content of such drinks.

Many young people are beginning to experiment with alcohol at a younger age. There may be pressure for young people, particularly among their own peers to drink in order to fit in. This gives status a badge of honour to being out of control or “leg-less”. Young people, who drink, especially in their teenage years, are more likely to experience alcohol related problems later in life. There are links between excessive alcohol consumption and other social problems such as teenage pregnancy and anti-social and criminal behaviour. Concerns also stem from the fact that many young people remain ignorant of the risks of drinking alcohol and lack the experience or capacity to modify or control their drinking behaviours. The most vulnerable groups would be pupils excluded from schools, truants, looked after children, young offenders, young homeless people and children of abusing parents. Alcohol problems are more common where social exclusion is evident in areas of high unemployment, crime and poor housing. These areas may lack the capacity to respond fully to alcohol problems. There is also a specific concern surrounding young people in rural areas where boredom and lack of alternatives may lead to increases in consumption of alcohol.

In 1996, Child line reported that during the previous year it had received 3,000 calls from children reporting misuse of alcohol by parents. An estimated 920,000 thousand children live in homes where the drinking of one or both parents has reached risky levels. Specific problems may include breakdown of marriages, an increased risk of physical or sexual abuse, neglect and strain on family finances. Family life is a critical factor in building resilience and reducing anti-social behaviours including alcohol use. For some young people, school attendance and performance may be adversely affected as a result of their drinking or their families’ drinking patterns. Many have to care for the rest of the family in the face of parental neglect due to drinking. Research is needed to establish whether children of parents who drink heavily are more likely to develop drug or alcohol related problems themselves. In addition, further research is needed to establish whether a younger person is more likely to develop a dependency if they drink at a young age.

There is a risk that young people feel excluded from alcohol treatment services. Many do not regard existing services as relevant to them or tailored sufficiently to meet their needs. There is a case for a separate age specific and accessible young person's services that can more fully meet their needs. Investment in prevention and treatment will ensure that young people do not become tomorrow's dependent drinkers. Separate ring fenced budgets could result in higher quality services at a local level. This needs to be backed up with enhanced links with other organisations such as Connexions and Jobs Centre Plus.

Treatment services should also be accessible to those children whose parents are problem drinkers. This is a difficult area as children are often frightened of raising this issue as parents who drink is still regarded as a taboo matter.

Young people are heavily influenced by external factors such as advertising, images and films and are therefore at risk. There should be research into the costs of under age drinking to the NHS in terms of hospitalisation and dependency

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

Alcohol use does not occur in a vacuum and can have long-term consequences for families and family life. Family members should be viewed as a vulnerable group in order to help address the impact that alcohol misuse can have on family life and the impact that family intervention can have on problem alcohol use.

The relatives of people with alcohol and drug problems are known to experience considerable stress, which can be severe and long lasting. Research has shown that these relatives have a high risk of developing mental health problems themselves, and make frequent visits to their GP surgery. Primary care professionals therefore need to be confident that they have the knowledge and skills to provide appropriate help. The relatives should be regarded as victims of their families drinking problems.

Women are also a priority group for concern. There are upward trends in drinking amongst young women and professional women. Increased links are being made between drinking by women and crime and a greater awareness of the damaging effects of alcohol on pregnant women. Support should also extend to partners of men who have alcohol problems. Alcohol problems are still seen as a male dominated issue and there is significant stigma attached to being a woman who drinks. This needs to be addressed alongside increased access to services and interventions specifically tailored towards women.

Turning Point's Substance Using Family Support Service (SUFFS) in Tameside provides a service to substance using parents with children under five and

pregnant women. It provides a holistic approach by providing emotional and practical support in relation to parenting, responding to children's needs and in addressing problematic substance use. The project is a preventative initiative aimed at minimising the need for statutory involvement and engaging with parents in meeting their children's needs. It works closely with housing agencies and maternity services

For many minority ethnic groups alcohol is still a taboo subject and people may be reluctant to come forward for help because of the shame associated with drinking. Within the Muslim religion there is particular stigma associated with the use of alcohol. There is a need to develop separate information for different groups. Services need to be structured to meet the needs of black and minority ethnic groups and to be sensitive to cultural diversity.

The incidence of alcohol problems is very high amongst the country's homeless population. It can be a response to and cause of homelessness. Research in London suggests that at least 60% of rough sleepers have alcohol problems. The 1994 National Survey of psychiatric morbidity among homeless people in Britain found that 44% of people using night shelters were alcohol dependent, as were 51% of people using day shelters. There are often co-existing mental health problems. These groups are harder to engage with and have poor access to care and treatment services. They have difficulties in accessing housing and are more likely to return to the street through tenancy breakdowns. The housing needs of those people coming out of treatment are inadequately met and there is a risk of relapse where an individual is re-housed in communities where alcohol problems and use are rife. Overall, the needs of homeless people in relation to alcohol receive less attention than their needs for food and shelter. Support in relation to alcohol needs to be linked to other forms of support.

Older people - The relative risks of alcohol consumption are greater as people age and are often compounded by factors such as changing diet, mobility and combining alcohol with prescription drugs. Although older people drink less than younger drinkers, a significant proportion of people are hazardous drinkers, with one of the major problems being falls. Older people need age specific treatment that can meet their needs. This needs to be backed up by brief early interventions, screening, assessment and appropriate referrals. For many older people, alcohol is a symptom of wider problems. Turning Point believes that the underlying causes of alcohol such as isolation coupled with bereavement and loss need to be examined alongside treatment measures.

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 contributes to maintaining the problems facing such groups? Which of these factors should interventions be aimed at?

Alcohol needs to be understood as a symptom of underlying problems. Alcohol misuse obviously needs to be addressed with urgency but equally important is dealing with the underlying causes of why it turned into a problem in the first place. There can be many reasons: low self esteem and self worth, loss of a partner or family member, loss of a job, marriage or relationship breakdown, emigration to this country and the associated problems of language, integration, racism etc. Ultimately it is about dealing with the feelings associated with these problems. All too often alcohol represents a coping mechanism in which the pain is numbed or temporarily forgotten. Over time the physical symptoms also start to develop including liver disease, joint problems, lack of energy and vitality, stomach problems. This sets up a vicious cycle increasing the risk of dependency on alcohol.

In dealing with alcohol misuse, it is the individual's emotional state along with their mental, physical and spiritual states that need to be supported through appropriate intervention. Building a strong sense of self and having high self-esteem are important factors in helping people overcome alcohol problems.

There is a close link between a person's alcohol problem and a concurrent mental health problem. There are often gaps in provision for people with alcohol and mental health problems. Some people fall between two stools with neither agency willing to take the lead in meeting someone with a dual diagnosis. There is a need to improve diagnosis of mental health problems in primary care and services need to respond to people with alcohol and mental health problems (see above).

People who are homeless may have an alcohol problem. Indeed, alcohol problems often co-exist with or exacerbate the problems associated with homelessness. For many, alcohol can make living on the street bearable. There are a number of services that can be offered to people who are homeless to help them address their alcohol problems. This may include day centres, wet hostels, and outreach teams as part of Contact and Assessment Teams, that can advise people how to find accommodation and hostels (see above).

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?

See answer to number 40.

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?

People need the support of both mainstream and specialist services. We need a holistic response that addresses people's individual, situational and social factors/circumstances that relate to their alcohol problem. It also needs to take account of cultural factors. We need a person centred approach to planning that starts with the individual and reflects their needs, rather than the priorities of services, and covers issues such as mainstream funding for housing, education and employment. People should not be expected to simply fit in with existing services. Indeed, users need to be fully involved in the decisions that can affect their lives.

Care management is the vehicle governing access to services. It is the formal mechanism for linking people to services and delivering individualised support with good links to mainstream plans. Care management is dependent on good inter-agency partnerships. Unfortunately, the type and nature of care management varies substantially from one area to another. Many clients are frustrated by the difficulties in accessing the care management and treatment that they need. Good models of practice are all too often dependent on personalities and motivations of the teams involved.

#### 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?

#### *Questions*

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

Turning Point knows from our experience as a provider of services that abstinence-based education fails. It follows that the over-riding objective should be to increase general knowledge and understanding of alcohol and how to use it safely. It should specifically address safe drinking levels, why people use and

misuse alcohol, the factors that increase the risk of harm and the consequences or risks from misuse of alcohol. This should allow people to make their own informed decisions about drinking based on information made available to them. People should be able to understand the problems that may follow from intoxication and heavy consumption. This involves shifting people's attitudes towards alcohol. It should discourage high risk drinking for those that wish to consume alcohol. For those people who have experienced problems with drinking, the objective should be to improve knowledge of the full range of interventions available and where people can go for help. It should also focus on the impact that alcohol can have on families, relationships, and public order and in the workplace rather than simply concentrating on personal and public health issues. The education and communications strategy should be clear that all patterns of drinking are potentially harmful. It could also develop separate strands that address specific patterns of drinking for example the link between binge drinking and violent behaviour and the long-term effects of high-risk alcohol consumption. Ultimately, the education and communication strand should seek to change attitudes towards alcohol and behaviour.

There are a number of routes for information and education. In schools, it is now seen as part of personal and social education. Further education, the workplace and community groups are also useful points of contact. Education should be grass roots based and carried out in areas outside the education system. This includes GP surgeries, pubs, hospital waiting areas and on public transport. Specific consideration should be given to increasing the promotion of treatment services. Every local authority should have a directory of treatment services that are available locally. They should be made available in alternative formats and be accessible to minority ethnic groups. Posters should be used to publicise services. This could be displayed in education establishments and the wider community including shops, licensed premises and in the workplace. The necessary framework should be put in place to allow service providers to take an enhanced role in the provision of education. They are well placed to identify problems early on and encourage people to seek help.

Education needs to take account of the fact that consuming alcohol is regarded as an acceptable norm in society, in comparison to illegal drugs. For that reason the information should not be wholly negative or it would run the risk of not being credible with a younger audience. It should have the same priority as similar campaigns in relation to drugs and cigarettes. Education should not be limited to those people who have a problem with alcohol but towards the general public to widen the broad knowledge and understanding of all issues relating to alcohol.

One of the biggest difficulties is that people use different terms to describe different patterns of drinking. They also ascribe different harms arising from these different drinking patterns. An education and communications campaign needs to be able to influence the terms that are used in everyday language and ensure that people have accurate information about the problems with alcohol.

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

There are studies that have concluded that education programmes have not been effective in preventing alcohol misuse. Although education has increased knowledge, it has proved less successful in influencing attitudes towards alcohol and bringing about changes in behaviour in relation to use of alcohol. They have also been criticised for reinforcing an expectation that alcohol problems will occur. However, education and communications may influence the debate around alcohol and elevate the issue to one of societal concern. Education is more effective if it is considered alongside other efforts aimed at reducing alcohol-related harm. It is one approach that needs to be adopted alongside prevention and treatment and to provide a check and balance against the popularity of alcohol and the lack of understanding of its associated problems

Evaluation should focus on the effectiveness of the education programme rather than whether they achieve the preventative targets of the strategy. A more meaningful evaluation would examine whether the messages in the education programme were understood and had a positive impact on awareness levels. Evaluation should also focus on whether increases in public understanding are retained over a given period.

The effectiveness can be measured by monitoring the numbers of people presenting at A and E departments, the numbers of people presenting for detoxes, for aftercare, those admitted to hospitals for alcohol related problems, the incidences of liver disease related to alcohol, those convicted of drink driving offences and other crime related to alcohol. All these can be measures of the effectiveness of the campaign.

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

The central focus of the Government's drinking message has been the promotion of sensible drinking limits. However research shows that the majority of people remain unaware of the number of units recommended for sensible drinking or are unaware of the unit content of drinks. There is also a widespread lack of awareness of the harm that alcohol can cause if people drink above these drinking levels, particularly in relation to the health risks caused by alcohol. The drinking message needs to be redefined for particular groups such as young people and pregnant women. It also needs to be set in context against the strength of particular drinks and the size of the glasses (particular wineglasses) and particular settings.

Turning Point believes that the sensible drinking message is not reaching its audience clearly. The public seem to be getting a very mixed message. On the one hand they are shown very positive images of drinking in advertising and the media. This portrays alcohol as pleasurable and risk free. On the other hand people are being told to drink sensibly. The clear message should be to review alcohol advertising and label all alcohol products with units and messages. There should be more campaigns telling people that alcohol is harmful to their health.

The term “sensible drinking” is over paternalistic and should be reviewed. An alternative phrase “responsible drinking” would better describe the balance between individual rights and choices. It will encourage more people to take responsibility for their drinking and assist in explaining the consequences or harm arising from alcohol use.

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

It is essential to clearly define the rationale for alcohol education and then define the forms of research that will inform it. It is unclear what the current priorities are in relation to alcohol education. The medical model advocates particular outcomes of stopping or reducing alcohol. This has been held up as the main success criteria. This has been challenged in recent years and is an unrealistic goal. It is guaranteed to fail in the light of the prevalent youth culture that encourages drinking at an early age. Turning Point would favour an alternative model that sought to facilitate healthy and informed decisions about alcohol in order to prevent or reduce harmful use. In any event, additional research into alternative outcomes such as attitudes towards alcohol is needed. There is also a need for additional research into drinking patterns among all groups but particularly young people. There is still only a partial understanding of drinking practices of young people and the factors that govern people’s behaviour, including the influence of youth culture on the consumption of alcohol. Indeed, the preoccupation with the medical model has meant that there is a considerable gap in research based alcohol education.

It also remains unclear what the main settings for alcohol education should be. This is another area for research. Should schools continue to be the main setting for education or should effort be focused on alternatives, as put forward by Turning Point, such as informal settings where young people drink and delivered by alcohol and drug agencies or young drinkers rather than teachers in schools? Should alcohol education focus on school children or promote whole population strategies focusing on settings, which are at particular risk from alcohol related harm? Turning Point argues that alcohol education needs to examine both areas and that school-based education should be integrated into broader programmes of personal, social, and health and citizenship education.

In conclusion, there is a lot of alcohol education available but little scientific research into “what works” and ensure that lessons learnt are fed back into alcohol education.

Scientific research should be unbiased and impartial and not funded by alcohol organisations such as the Portman group who have their own commercial interests.

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

Communication should be targeted towards particular groups. Young people should be a priority group for information and a priority group for delivering community based education. However, young people who are vulnerable to alcohol misuse are those excluded from school. For this reason, alcohol education programmes should also be directed at vulnerable groups of young children (such as truants, those excluded from school and children in care). It should inform and explain the risks of alcohol and where people can go for support. In addition, it should tackle issues such as parents who drink excessively. Messages for young people must be relevant to the age group and encourage people to seek help and know where to go for treatment. It should also be combined with messages on related issues such as safe sex and alcohol and the risks of mixing alcohol with illegal drugs. Education cannot be considered in isolation from support and treatment services. It also needs to be linked with programmes that promote healthy lifestyles and positive diversionary activities not involving alcohol.

Communications should ensure that all young people from all backgrounds irrespective of race or culture are targeted. Ethnic minority groups could be targeted particularly where a culture of drinking exists such as spirit drinking amongst some Sikh drinkers. Education aimed at the young should be dynamic and inclusive. It should be interactive and make full use of technology such as computer games and the web site. It should encompass participative work with young people delivered in a safe environment and include role modelling, peer education and community work. It should also provide follow up provision of support and advice.

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

Education can play a central role in raising awareness of the effects of alcohol and knowledge about misuse and the skills to resist misuse, in particular among

young people. Education needs to be delivered to a broad range of settings from education institutions, workplaces, youth organisations and local communities. It should provide information about alcohol and consequences of its use. Communicating with young people need not be complicated, but does require the recognition that there is no single 'catch all' approach – there must be a range of messages, appropriate to a range of very diverse individuals.

Education should start at primary school level and extend to secondary school level and beyond. It should form an on-going part of the schools PSHE programme. Education in schools should be balanced and combine warnings of the dangers with promoting greater understanding of the Government's sensible drinking habits. Pupils need to be aware of the health risks of alcohol before they are subjected to pressures that lead to problem drinking. Pupils need to be reminded of obligations under the legal system.

All education should be age specific with targets to provide school-based education to all pupils. The objective should be to increase knowledge about the risks and consequences of alcohol misuse, particularly amongst children under 16. Voluntary sector organisations are well placed to offer advice on the delivery of education in schools and to target groups where alcohol misuse is prevalent

Finally, all education-based institutions should have their own policies of management of incidents of alcohol misuse on the premises.

The education young people receive about alcohol misuse should:

**1. Involve young people in the process** - Use realistic examples and exercises that relate to the client group.

**2. Be realistic** - Set aside any personal preconceptions and start from where young people actually are, not where you think they are or where you'd like them to be. This includes recognising the reality that a high proportion of young people will always experiment with using alcohol under-age, but are not necessarily problematic drinkers at this stage. 'Just say no' or 'wait until you're older/reach the legal age' messages will not be taken seriously.

At the same time, there are a significant number of young people who may not have used alcohol and it should not be assumed that all young people will have used it under-age.

**3. Should be age appropriate** - For example, primary age children to learn about the effects on the body whilst older children should also look at the risks (see page 2 social impacts). Be realistic –12,13,14 is too late – they think they already know it all. This group have to unlearn and then be persuaded to adopt the right messages, which is much harder. Education should start in primary school – ideally targeting 7 year olds.

- Give them the facts that inform and equip them to make the right choices, and provide encouragement and the opportunity to change their own behaviour.

Factual information presented in a straightforward and unbiased way takes away some of the buzz and glamour around alcohol misuse and treats young people as the adults they are aspiring to be.

Messages should also tackle the stigma of alcohol and/or drug use to enable people (of all ages and particularly women), experiencing problems to present themselves for assistance).

Information should focus on what alcohol is, what it does and how to minimise the risks so that people can enjoy it safely.

**4. Acknowledge the legitimate benefits of moderate, recreational alcohol use, in appropriate settings** - Young people should be clear that it is possible to avoid the dangers and drink safely and sensibly, but at the same time, if they are going to misuse alcohol, to be aware of the risks – to themselves and to others. As alcohol is a commonly used substance and is accepted in many households, it must also be made clear that ‘safe’ drinking limits relate to adults and not young people.

**5. Focus on social impacts rather than moral or medical reasons** - Education should acknowledge that although, unlike many other drugs, alcohol is a legal substance (generally, but with specific exceptions, including for young people), the consequences of misusing it are similar and often bring people into contact with the wrong side of the law. Turning Point has found that, particularly for older children, the most effective models are those, which are built around the risk/benefit factors, which affect a young person’s life chances. This includes looking at the different implications eg – what happens if a person starts drinking at age 11, 13, 15 etc.

Messages should be around social effects such as:

‘alcohol misuse: hits your wallet and can affect your family/friends/community’

‘puts you at risk of being excluded from school’

‘may result in a criminal record that stops you from achieving other things – either directly from alcohol use and/or through committing offences while drunk.’

This model encourages young people to re-calibrate their success scale around legal, positive activities instead of illegal, negative ones – emphasising messages like:

**I can** influence my chances later in life

There **are** other, positive and less damaging ways to achieving street credibility and success.

**6. Messages should empower young people and signpost them towards meaningful action to change the quality of their lives.**

**7. Take account of cultural differences**

without assuming that those from different faith groups such as Muslims do not drink or have drink problems, because many (especially amongst young people) do.

**8. Be consistent and sustained at all stages of the curriculum**

Drug and alcohol agencies play a key role, but cannot be the only providers of alcohol education. The role of the police, teachers, school nurses is also significant and messages must be consistent

**9. Be integrated with other healthy lifestyle messages**

Young people generally do not separate alcohol from other drug use, sexual health, and other lifestyle issues and neither should Government initiatives attempt to do so. Ideally, they should be part of programme around drug and alcohol use, sexual health, citizenship, choices, recreational activities etc.

**10. Messages need to be presented in ways which reflect an individual's situation, cultural norms and drinking environment**

It is essential to feature everyday people and people from minority ethnic groups. Too often campaigns feature white men in a pub. In reality the home or street corner are far more likely environments for alcohol misuse and particularly among those from minority ethnic groups.

The tone should be a bit controversial, but avoid extreme/shock tactics and the use of scenarios outside their experience which are therefore irrelevant (or easy for them to dismiss as having nothing to do with **them**)

**11. Routes for information**

Adopt the perspective of a young person/child and consider what information sources have the most influence among young people. These could be very different from conventional channels. Typically young people gain information through teachers (perceived as boring) and peers (often wrong). Therefore, there is an urgent need for factual unbiased information. Also need to present via a **medium** familiar and “now” to them (eg using music/IT etc) and in **language** they use and understand.

Schools current present the only viable way of reaching large numbers of children and young people. This often means that teachers, who through no fault of their own are often ill-informed about the real issues, present alcohol or drugs education in a theoretical way. We recommend that education be carried out by (or in partnership with) independent Young People substance misuse workers based in the communities they are serving.

In addition, it is often after a lesson/ session that real dialogue starts – one lesson, in and out, is not enough. There must be opportunities for follow up and informal dialogue. Wherever possible, alcohol education should be delivered in conjunction with community groups and youth services and include information on support agencies for those young people who may have problematic use. There is also a strong case for delivering training in places where people spend their leisure time such as cafés, bars and even street-corners.

Education needs to be provided for all young people including those excluded from mainstream education. This group will be most at risk and so will benefit from this type of education. Provision should also be ensured for young people with special needs.

There are specific problems associated with alcohol related problems with students in universities and other similar settings. All universities should be expected to develop their own alcohol policies. This would involve providing information and advice for students and staff and direct support services for people who experience problems with drinking. Universities should be encouraged to find alternative sources of funding for sponsorship of events.

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

Turning Point's experience is that parent's drinking habits have influenced the decision their children have made about alcohol use later on in life. They play a central role in reinforcing the messages that young people learn at school. Parents own attitudes to alcohol and the extent to which they are happy to discuss these with their children can help young people mould their own attitudes to alcohol. Adults need to recognise the extent to which their own celebration of alcohol has on their children in terms of modelling etc. It also means that parents are better informed about their son/daughter's drinking habits if a problem does arise. Families members may be the first to realise that their son or daughter has an alcohol person and can support their son/daughter who is experiencing alcohol problems. They can help oversee any programme of treatment that their child receives and help manage their consumption. The young person should also involve their parents in any programme of treatment, where this is appropriate.

Parents and carers should be included in school based alcohol awareness, which can be arranged through parents' evenings at school or community groups. This will encourage further discussion around the home and enable parents/carers to be more comfortable and informed in talking about these issues. Parents should have all the information they need to support their children. The priority should be to provide parents with up to date accurate literature on alcohol so that the parent feels confident that they are able to advise their son/daughters of the harm

caused by alcohol use. Parents want to know how to teach their children how to drink sensibly. They need to understand that the law does not prevent them from doing this and that the home is the best place to learn good habits. Young people who feel supported and able to discuss alcohol openly in their home environment with their parents are less likely to develop problematic patterns of drinking. For young people who have developed an alcohol problem, parents need sign posting to information and advice on treatment services that are available locally. Parents also need to be supported in their own right so as to ensure that they are not dealing with problems alone. Support for families should formally be addressed through the development of alcohol services for young people. Better support services for users and families can also ensure that problems associated with alcohol misuse, such as domestic violence are addressed and children grow up with positive images of alcohol.

Education also needs to challenge inappropriate parent attitudes and provide support and advice to them. They should place priority on alcohol and not dismiss alcohol as a "lesser evil" than drugs or adopt an approach that tolerates heavy drinking as long as their children are not taking drugs. This runs the risk of reinforcing alcohol as an acceptable drug. Some parents have even supplied large amounts of alcohol to their own children in the erroneous belief that they are educating them on the risks of consuming too much alcohol. Young people need to be taught how to drink in a responsible manner and practise drinking safely within the family environment. The home environment is an important influence on the development of a sensible outlook towards alcohol. This will mitigate against the "forbidden-fruit effect" associated with alcohol, and minimise against the risk of young people using alcohol as a form of rebellion.

Treatment services should adopt a whole family approach so that the needs of both parents and children are met in cases of young people's drinking.

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

Mass media campaigns in themselves have not proved effective in changing drinking behaviour unless combined with other measures or focus on particular situations. An example would be campaigns at drink driving which have been combined with other measures such as the tighter control over permissible drinking limits and the introduction of random breath testing. Campaigns need to have a clear, unambiguous message and be combined with rigorous enforcement. Media campaigns also need to be backed up by other measures aimed at tackling alcohol related problems. The drink driving campaigns demonstrate that campaigns that are closely associated with enforcement and/or social disapproval will resonate more strongly. People understand the risks when drinking and driving and are fully aware of the penalties that will be imposed if

convicted. There is broad support for the campaign and the public generally disapproves of drinking and driving.

Experience has shown that ambiguous messages are the least effective, such as the 'Stay Low' campaign on drink driving where the message was very unclear and led many people to set their own targets that were often over the limit for driving.

The Government's role should be to review existing literature on alcohol misuse to ensure the availability of information that is age and gender specific and reaches out to targeted and vulnerable groups. This could be backed up by an annual national campaign aimed at raising awareness of the consequences of alcohol misuse and informing people about sensible drinking limits. The campaign should include print and broadcast media in order to reinforce messages and maximise the potential audience.

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

Research in the drugs field has shown that the most effective way to get the message across is to educate children about the risks associated with drug use, and about ways of resisting peer pressure, rather than the campaign 'Just say no'. People should be given balanced and accurate information about alcohol. Shock tactics will not connect with young people. They will not regard the information as credible if the messages do not accord with their own experiences. Above all, people should have accurate information about the dangers and harmful effects of alcohol/drugs. People need to know where to go for more information and treatment and the support to act on this information.

Another important factor is for education to promote other activities that can meet people's needs and provide an alternative lifestyle to alcohol/drugs. Positive Futures have provided diversion programmes for young people in high crime areas.

Drug education is part of the National Curriculum and delivered as part of the PSHE. The Connexions service will work with young people supporting on drug issues.

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

Advertising has played a central role in recruiting new drinkers and increasing sales amongst existing consumers. It serves to promote the use of a product that causes substantial damage to an individual and their families. Advertising is one sided and makes no reference to the negative consequences of alcohol consumption. The alcohol industry has become increasingly sophisticated at targeting alcohol towards young people and promoting alcohol as a means of

obtaining social and sexual success. Alcohol is now associated with dancing, clubbing and risqué activities. Unsurprisingly, this has been accompanied by marked increases in sales of lagers and alcopops. This shows that it is difficult to balance the voluntary codes of the advertising industry with the commercial imperative of sales and profit. Clearly, the alcohol industry has played at best an insufficient role in preventing alcohol-related harm. At worst, intensive marketing by the advertising industry has prevented effective implementation of strategies aimed at reducing the harmful effects of alcohol. There is a need for further controls and limits on advertising, including the introduction of statutory controls on advertising to replace the voluntary code and the creation of an independent regulator, which has teeth to enforce standards and review complaints about alcohol advertising.

There should be more restrictions on advertising on TV and radio so that no advertising is allowed before a watershed of 9.00-10.00 pm. Alcohol advertising should not be shown before sports programmes or in places where sports events are held. In other media, all alcohol advertisements should advise moderation in consumption. There should be a ban on advertising in cinemas. There should be controls on advertising/sponsorship in sport.

Further regulation should be accompanied with clearer warnings placed on products. Alcohol packaging should state the numbers of units of alcohol they contain and this should be clearly communicated to the public so that they understand how much they are drinking. Packaging should also clearly state information on the recommended safe level of alcohol. There should be an expectation on pubs to display information on units and for supermarkets to have similar information at the point of sale.

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

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

### *Questions*

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

The alcohol industry appears to be moving towards targeting young people, offering sugared drinks as a means of getting over the taste barrier for many people. Alcohol is almost being presented as a soft drink. Drinks are being associated with fashion and the markets are becoming more segmented with very specific messages. There is an increasing use of bottled drinks, wine sales

are set to increase whilst bitters and ales are diminishing. There is also an increasing demand for exotic beers such as Cobra, Kirin etc. Vodka and white rum have become extremely popular and also particular brands of whiskeys. People are also buying in bulk from Europe. Bars are making a greater impact such as Edwards, All Bar One and themed pubs such as O' Neils.

There is also a perception that alcohol is too readily available and at too low a cost. In real terms the price of alcohol in bars is falling in comparison to the perceived high price of soft drinks. There should be more incentives in place to encourage people to choose lower strength alcoholic products or soft drinkers as an alternative to high strength alcoholic drinks. Tap water should be freely available in all settings.

We would hope that the alcohol industry taking greater responsibility for reducing alcohol related harm. There should be greater controls on the marketing of alcohol products to ensure that the industry is not undermining the health promotion messages of the strategy.

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?

People drink different types of alcohol according to the context in which the drinking takes place and the drinking venue. There are particular trends in drinking. There has been a growth in wine and spirit consumption in recent years. An increase in wine consumption can be attributed to more people taking holidays abroad. In contrast, certain trends and fashions, such as the increased popularity of alcopops, can operate as a greater influence than normal economic factors such as income and price. It is ironic that fruit flavoured alcoholic drinks have flourished and can prosper, regardless of downturns in the economy or high unemployment. Major changes in taste can have profound impact on patterns of drinking. In contrast, there may well be a negative relationship between rising income and consumption. There has also been an increase in the amount of alcohol that is drunk in alternative settings to the pub, particularly an increase in consumption in the home

Some of the trends associated with young people include drinking more alcopops, vodka, white rum and whiskies and specialist lagers. Consumers appear to be drinking a lot more bottled beers. These are some of the patterns that the Government needs to respond to.

The Government has a duty to intervene to curb advertising that is clearly aimed at young people. Clearly, the industry is promoting certain lifestyles and images and young people are equating drinking as a means of having fun and obtaining

social success. Additional research needs to be carried out into young people's attitudes towards alcohol. This will help make the case for a reduction in some forms of advertising and provide a forceful counter argument to the commercial industry's calls for no further change to the existing framework.

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

There needs to be greater commitment and resources into research and development into lower alcohol alternatives. This should also consider what messages people are susceptible to, on-going trends in fashion and culture and drinking venues. These can all help to plan for solutions to 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 a field?

In many ways there is a conflict of interest, as the alcohol industry wants to maximise profits whilst the Government's priority should be safeguard and promote public health. The Government can work with the alcohol industry in relation to improving awareness of alcohol related harm and to promote safer drinking environments. Some of the things that need to be addressed jointly include responsible marketing and advertising, labelling of products, licensing and opening hours, alcohol content etc. Other areas might include joint planning and management of alcohol at public events, including trained staff and crowd management strategies.

However, Government will need to distance itself from the industry in order to promote measures such as tighter controls on advertising and compulsory (rather than voluntary) labelling on wine bottles and beer cans. The Government should also make it clear that efforts aimed at alcohol reduction are not anti- alcohol but part of a wider strategy to increase awareness of alcohol. The Government needs to develop its own advertising campaign to bring attention to the problems associated with different patterns of drinking.

Turning Point is concerned that the commercial industry appears to be putting profit ahead of protecting young people from problematic use of alcohol. It is apparent that the voluntary codes of practice are not working. The alcohol industry is carrying out a systematic marketing campaign at young people. The commercial industry should not be able to use marketing to create the impression that alcohol drinking contributes to social and sexual success. Many are now drinking at an earlier age and consuming an increasing quantity of alcohol. The Government should introduce a statutory code of advertising practice that should be monitored by an independent body with power to apply sanctions against those commercial organisations that infringe the code.

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

Organisations that place commercial interests over public health matters include businesses that knowingly sell alcohol to underage people and to those people who may be visibly drunk. This approach can affect drinking behaviour and increase social harm to the individual, their families and the wider communities.

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 well being for many. Part of the work on the project will be to form a clear picture of these costs and benefits.

*Questions*

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

The total economic costs of alcohol misuse are made up of healthcare costs, social services costs and criminal justice and emergency services costs. There are also wider economic costs associated with reduction in productivity or premature death from alcohol-related illness. In addition, to the economic costs are the human costs, not least the pain and suffering caused by alcohol misuse.

Alcohol Concern has published many pieces of research on the costs of alcohol misuse. Their recent research, 100% Proof, includes a comprehensive review of alcohol research ever published in this country. The Royal College of Physicians estimate that the resulting use of hospital facilities places a considerable financial burden on the NHS, inpatient costs alone accounting for 2-12% of total NHS expenditure on hospitals. This equates to a total of £3billion a year. The Institute of Alcohol Studies refers to the estimate that alcohol misuse is associated with between 8-14 million days excess absence at a cost to industry in the region of £700 million a year.

The case for the wider economic costs of alcohol has been well documented and in many areas new research is not needed. Calls for research into economic costs not should act as a barrier to the development or implementation of the alcohol strategy. In contrast, it is not easy to assess the benefits from alcohol, apart from recognising that drinking is part of our culture. The demand for alcohol clearly exists although the economic benefits may not be exactly quantified.

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?

There is little research on the impact on families. More needs to be done in this area to document the costs of alcohol use on the partner, days off work, impact on children, health and well-being. There should be additional research into attitudes into alcohol to demonstrate the level of concern felt by the general public in relation to alcohol related problems and to help justify Government interventions and support measures targeted at vulnerable groups, such as young people.

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?

Government sets pricing and taxation regimes. It is well placed to influence the price of alcohol and influence patterns of consumption by increasing taxes. It follows that Government can set the framework for all individual and business responsibility. The Government needs to balance the need to generate revenue along with the need to safeguard public health and its duty to protect vulnerable people in society such as young people and dependent drinkers. On the same basis, the commercial organisations have a responsibility given the economic benefits that they derive from alcohol. The World Health Organisation European Charter on Alcohol proposes that each Member State should: "Promote health by controlling the availability, for example for young people, and influencing the price of alcoholic beverages, for instance by taxation."

In theory, successive Governments are committed to raising taxes on alcohol. In practice, however, whilst, the duty on cigarettes has increased by nearly 90% in real terms (1985-2000), the duty on spirits has fallen by 30% in real terms over the same period. It is also unclear to what extent money raised from taxes on alcohol is actually ring-fenced and invested in alcohol treatment services.

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

The overwhelming majority of the beer that is sold in England is produced in this country. Breweries can be found in every part of England and are responsible for generating considerable levels of employment. There are approximately 53,000 pubs in England and Wales. A large part of the spirits that are sold in England are produced in Scotland. In addition, there are many wholesalers in England, with a large number specifically dealing with alcoholic drinks. The producers, wholesalers and retailers of alcoholic drink are all substantial employers. They also purchase goods and services from a wide range of

organisations.

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?

There are strong links between alcohol and employee absenteeism and reduced productivity. There is also a link between alcohol and what is termed as “presenteeism”, where people are physically present at work but are sick and completely unproductive. The overwhelming majority of employers do not have a work base alcohol policy. Many employers are working with staff with alcohol problems but do not have the skills or resources to respond. The alcohol strategy should promote good practice guidance and promote training materials with personnel managers and employees. Managers would benefit from training in the early identification of alcohol problems and how to ensure referral for people with problems.

Alcohol seldom reduces stress and tension in the workplace. Alcohol is often used as a method to cope with a working environment that pushes people to succeed and will not tolerate failure. It demands people to attain the highest standards at whatever cost.

Alcohol ultimately damages the body. A raised blood alcohol level while at work will jeopardise both efficiency and safety and increases the likelihood of mistakes or errors of judgement. It can also lead to accidents in the workplace, particularly when operating machinery is a key part of a person’s job. It is misleading to suggest that small amounts of alcohol are beneficial, as impairment of skills occurs when there is any significant amount of alcohol in the body.

People who drink regularly and in an excessive manner have particular problems. Heavy or hazardous drinking brings with it an array of physical and social problems. It may also lead to persistent sickness absence, poor appearance and deterioration in interpersonal and social skills. People who are dependent on drinking may drink at inappropriate times and may be under the influence of alcohol in the workplace.

Occupational attainment can be better obtained through other schemes such as therapies, relaxation techniques, teamwork, motivation and goals.

In contrast, alcohol impairs concentration and memory and can therefore only hinder educational achievement.

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

Turning Point understands that BP and London Underground have very clear

policies on alcohol use in the workplace.

Manchester City Council has developed its own alcohol policy for the workplace. This will attempt to:

- alert staff to the problems associated with alcohol
- offer encouragement and assistance to all employees who feel they may have an alcohol problem to seek help voluntarily at an early stage
- offer assistance to an employee with a drink-related problem which comes to light through observation or by the normal disciplinary procedures, for example through poor work performance, absenteeism or conduct.

It will also try to create a working environment which understands the problems that inappropriate consumption of alcohol can cause by:

- promoting and publicising health and alcohol education and information
- demonstrating a sympathetic managerial attitude towards problem drinkers
- not encouraging excessive consumption of alcohol in connection with any of the council's functions, facilities or civil business.