

WEST MIDLANDS ALCOHOL FORUM

Introduction

The West Midlands Alcohol Forum is a loose association of commissioners and providers of alcohol services. We have met on several occasions to discuss the questions raised in the consultation document and hope that these comments will be of help in formulating the strategy.

We are delighted that progress is being made to produce a National Alcohol Strategy for England. We consider that the lack of a strategy has discouraged health and local authorities from giving due weight to the need for services to prevent harm caused by alcohol and to help those who have suffered such harm. We are also concerned that the very necessary attention paid to drugs has unbalanced service provision and led to a relative neglect of the quantitatively far larger problems caused by alcohol misuse.

We congratulate the strategy unit on its wide ranging enquiry and its readiness to consider all questions afresh. It is good to see the recognition that problematic drinking cannot be considered in isolation from non problematic drinking. A strategy which seeks to reduce harm caused by drinking must consider all drinking.

We also congratulate the strategy unit on the emphasis it places on evidence. Both policy and treatment must be informed by evidence. We would however caution against the temptation to use incomplete evidence as an excuse for avoiding action. There are very few topics in the alcohol field on which every possible question has been answered and for which no further evidence could be helpful, however in most of these the evidence is sufficient to justify action. At the same time we note the need for further alcohol research and support the conclusion of the recently published report by Alcohol Concern "Alcohol 100% proof" that alcohol research needs to be given a higher priority and much more secure funding.

We have not given references in this report but would be happy to supply references to support any particular statement if so requested.

Responses to key questions in Government Strategy Unit consultation

Principles

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

Government has five main functions in preventing and managing alcohol misuse

- Balancing the rights and liberties of different sections of the community eg the right to relax and enjoy noisy parties vs the right to an undisturbed nights sleep

- Influencing the conditions of trade in alcohol so that all costs of producing, selling and consuming alcohol including the external costs are born by the producers, sellers and consumers.
- Influencing the degree of “wetness” of society so that the benefits to society of alcohol consumption exceed the costs to society.
- Ensuring that people have the information about alcohol content of drinks and consequences of different drinking behaviours so that they can make informed choices.
- Ensuring availability of appropriate treatment and rehabilitation services to help those who have suffered the consequences of alcohol misuse or whose drinking behaviour places them at risk of suffering such consequences.

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?

2.1. Government has a duty to protect the health and safety of its citizens. Drink drive legislation is one way in which government has fulfilled this duty. There are many other ways in which alcohol impacts negatively on the health of the population and government has a responsibility to take what action it can (including legislation) to prevent or minimise these negative impacts.

2.2. Governments have obtained a significant fraction of their income from duties on alcohol. Government has a duty to balance fiscal considerations (the political and economic convenience of revenues from alcohol) against consideration of how drinking affects health and well being of the population.

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

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

5. What principles should underpin a national alcohol strategy?

5.1 A national alcohol strategy needs to cover four issues

- Ensuring settings and occasions in which people drink are managed in such a way as to reduce risk of detriment to drinkers and others without impairing enjoyment of participants (harm minimisation).
- Prevention of drinking patterns that lead to harmful consequences. (This includes prevention of heavy drinking).
- Encourage those with harmful or risky drinking patterns to change to less risky patterns. (Usually this means drinking less)
- Treatment programmes for those who have suffered harm as a result of their drinking.

5.2 When the Government first proposed a Nation Alcohol Strategy for England Alcohol Concern produced a document “Proposals for a National Alcohol Strategy for England” published 1999. This document discussed the elements that

such a strategy might contain. We consider that to be an excellent document and would endorse the analysis and the recommendations contained in it.

Culture and Behaviour

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

There are difficulties in the term alcohol misuse. People use (drink) alcohol. Other people classify their use as use or misuse. The strategy needs to be concerned with all types of drinking that has harmful consequences for the drinker or for others.

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

7.1 Three inter-related characteristics of drinking patterns are associated with harm

- Binge drinking (drinking large amounts in a short period of time)
- High weekly average consumption
- Drinking in inappropriate contexts (driving, work etc)

7.2 Government needs to pay attention to all three but the context of drinking will probably prove least difficult to influence and binge drinking most difficult to influence.

8. Is there a relationship between trends in drinking and wider social changes eg 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?

8.1. Culture changes do occur but it is difficult to direct these changes. In particular we need to ensure that we are not encouraging a culture of heavy drinking (eg 24 hour 7 day city). Advertising of alcohol and leisure products needs to be monitored to ensure is not encouraging undesirable cultural change. Official bodies need to be careful that they are not giving out conflicting messages by inappropriately lavish provision of drinks at entertainments.

8.2. Positive trends such as relaxing with the family and leisurely drinking with leisurely meals need to be encouraged.

8.3. It must be remembered that most heavy drinkers become lighter drinkers as they get older. A major aim of policy must be to support and encourage this “natural” process. Care must be taken to associate the switch to lighter drinking with desirable consequences such as ability to do other enjoyable things.

8.4. While alcohol problems are by no means exclusively associated with deprivation in many situations harmful drinking and deprivation co-exist. Deprivation and social exclusion typically have elements of lack of money, lack of employment and economic opportunities, poor quality housing, lower quality neighbourhood environment, increased risk of being a victim of crime, poor education and high frequency of relationship problems. Heavy drinking may feature in this web of deprivation as a causal factor exacerbating other problems and as a “drug of solace” being one of the few available pleasures in a drab existence. It is important that the many government initiatives intended to tackle social exclusion and deprivation take account of the part played by drinking. Other measures to improve quality of life may be thwarted if harmful drinking by individuals in communities is not addressed at the same time.

8.5. While the main outlines of the relationship between these determinants and drinking are understood this is an area in which more research is needed.

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

See Para 45.2

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?

10.1. Alcohol is so intimately linked with many social and cultural activities that it is difficult to disentangle the consequences of the drinking and non drinking aspects of the activity. There is increasing evidence that building social capital (increasing quantity and quality of social interaction, and mutual trust and support) is good for the health of communities and individuals. The communities that grow up around local pubs and societies undoubtedly contribute to social capital. Shared drinking with friends provides a context in which social capital is built. It should be noted that in all these instances increased social capital comes from the interaction rather than from the drinking but it is debateable whether the interaction would occur without the drinking. Where alcohol is consumed in conditions which do not encourage social interaction none of these benefits accrue.

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

11.1. There are several stereotypes of English drinking, which have some basis in reality. Two which particularly cause concern are

- Young males –“lager louts” -(and now increasingly young females) going out for the purpose of getting drunk and then engaging in antisocial and sometimes criminal behaviour (Vomiting and urinating in streets, Noisy and abusive behaviour, Fighting, petty vandalism)
- Followers of football teams drinking heavily and then behaving badly.

11.2. Legislation has reduced the problem of drunken football followers with alcohol banned on special trains and in football grounds. There is however still a problem with drinking before and after the match in other venues. Also there have been examples of English football followers going to other countries and rioting after heavy drinking.

12. What factors influence behaviour – fashion, 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 these factors?

12.1. Drinking behaviour is determined by individuals factors, cultural environmental factors and physical environmental factors.

12.2. Individual factors affecting alcohol consumption are the individuals beliefs and knowledge about alcohol. Many do not drink because of their religious or personal beliefs. Others limit their drinking because of personal beliefs. Some have a very clear understanding of how alcoholic drinks will affect them and use this understanding to guide their drinking. This understanding may lead some to drink heavily and others to limit their drinking. Ability to afford alcohol is an important factor and some do not drink because they cannot afford it or because they wish to use their money for some other purpose (See para 12.9). Willingness to take risks is also a factor, which influences drinking (see Q13).

12.3. Cultural environment is a powerful driver of consumption. It is well accepted that people drink more in wet cultures. Those who associate with groups that drink heavily are likely to drink heavily. Conversely in the company of a light drinking group people will drink less. Heavy drinkers frequently seek out heavy drinking groups to reinforce the acceptability of their drinking. Clients of alcohol agencies often relate that when they started a period of dangerous drinking they also changed to a new set of drinking friends.

12.4. There are many situations (eg Saturday night out) where heavy drinking is the norm.

12.5. Physical environment is another powerful driver. In situations where alcohol is easily available and especially where it is being promoted people are likely to drink more.

12.6. Factors which lead people to drink in a way with harmful consequences include:-

- Lack of social constraints – For adolescents- parents, for men – wives, for adults – children.
- Situations in which heavy drinking is the norm
- Peer pressure from colleagues to drink heavily or inappropriately
- A lack of alternative occupations (many people look to pubs to find companionship)
- Release from a period of restraint (released prisoners associate drinking with freedom)
- Use of alcohol as a drug of solace (drinking to feel less miserable)
- Reliance on alcohol as a social lubricant (drinking to feel more confident socially)

12.7. Self perception and social norms may both serve to reinforce heavy drinking. Heavy drinkers tend to rate their level of drinking lower than others and frequently consider as moderate or light consumption levels that others would rate as heavy.

12.8. Social trends such as rising divorce rates, later marriage and later child bearing may all put upward pressure on alcohol consumption levels.

12.9. Price relative to income (affordability) is another important factor influencing level and pattern of drinking. People tend to drink less as their income decreases or as cost of drink rises. The price and income elasticities of different drink types have been explored. White cider is a widely consumed by some clients of alcohol agencies because it is one of the cheapest forms of alcohol available (low cost and high alcohol content per unit volume).

12.10. The great increase in personal importation of alcohol and the widespread illegal sale of alcohol on which duty has not been paid effectively increase the affordability and hence availability of alcohol.

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

13.1. Heavy drinking, smoking, illicit drug use are all examples of risk behaviours. Those with a tendency towards risk taking might be more likely to engage in them. There are many recorded cases characterised by polydrug use. Equally there are anecdotes of young people regarding alcohol as deeply uncool while recreational drugs are cool. It has also been observed that some drug misusers when they enter treatment and reduce their drug use may at the same time increase their use of alcohol. The relationship between use of alcohol and other substances is complex. It is very difficult to predict the extent to which changes in use of alcohol would effect changes in use of other substances. It has been observed that some drug users There is some evidence that

- 13.2. The theory that less problematic drugs act as gateways for more problematic drugs has some evidence to support it but is certainly an over simplification of many situations.

Prevention and Treatment

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

- 14.1. Whether drinking is harmful depends on the context and the quantity.
- 14.2. The relation between quantity and harm has been extensively debated. Any guidance on quantity is necessarily arbitrary. However some guidance is necessary and it is important that it should be consistent from all sources, and viewed as reasonably compatible with most lifestyles. The guidance don't drink more than 4 units (3 for women) in any one session is not viewed as compatible with many peoples idea of a reasonable night out. The guidance don't drink more than 21/14 units per week was viewed as restrictive but just about compatible with a reasonably enjoyable lifestyle. We need to refocus these messages in a way that does not invite another crop of "experts got it wrong", "government changes its mind" type headlines.
- 14.3. The harms associated with problematic drinking have been summarised as the four Ls
- Liver – Physical and mental health problems
 - Lover – Family and social problems
 - Law – Offending, violence, anti social behaviour and problems with police
 - Livelihood –Problems at work and economic loss

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

- 15.1. Health costs due to alcohol may be caused through intoxication, chronic heavy consumption or dependency. Health consequences of intoxication are injuries (especially head injuries). In extreme cases intoxication may lead to acute alcohol poisoning with coma and even death. Health consequences of chronic heavy intake are numerous including disease of liver, peripheral nerves, muscle, cerebellum, central nervous system, pancreas, stomach, small intestine etc. These are not seriously questioned though there is considerable debate over the precise dose response and factors, which may modify the risk associated with any particular level of consumption. It is also clear that the risk of harm due to chronic heavy intake depend not only on the total consumption but also on the pattern of intake. In most cases drinking in binges is associated with greater risk than consuming in smaller more frequent amounts.

16. What are the costs for the NHS both directly and indirectly due to alcohol?

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?

17.1. Health and social care professionals need to be aware of the possibility that their drinking may be a contributory factor in their patients/clients problems. In order to intervene effectively they need to

- Be aware of the possibility of alcohol related problems
- Able to identify clients who may have such problems
- Know how and where to seek help and how to refer their clients for further help

17.2. The reasons why health and social care professionals may not do these things are

- Lack of awareness
- Lack of knowledge as to how to do these things
- Lack of confidence in their ability to handle issues uncovered
- Concerns about role legitimacy and whether client will be offended

17.3. Health and social care professionals capacity, readiness and confidence to identify and address alcohol issues can be built in short in service training. Knowledge skills and attitudes can all be enhanced. Provision of such training is a good use of the time and skills of alcohol specialists. Such learning should be a two-way activity allowing the alcohol specialists to learn from the generic professionals about how to intervene most effectively with their clients. However such training is wasted unless the health and social care workers are encouraged and supported to apply the learning they have acquired in their work setting. Disinterested seniors will very rapidly nullify the effect of any training. It is also essential that more intensive support should be available when needed so that there are services to which clients can be referred and experts who can be turned to for advice and support if intervention in a case becomes too complex.

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?

18.1. Brief interventions have undoubtedly been shown to be effective. However further information is needed on what exactly constitutes a brief intervention. Is it a five minute interview or a series of three thirty minute interview? What are the essential elements in a brief intervention? What settings (A&E, primary care, pharmacy, dental surgery, alcohol agency) are most appropriate. Who delivers the intervention most effectively (GP, practice nurse, counsellor, etc). Who delivers the intervention most cost

effectively? These questions need to be answered but are not reasons for not introducing brief interventions now. Interventions already implemented can be improved as further knowledge becomes available.

18.2. Despite the proven effectiveness GPs have proved reluctant to offer brief interventions. This probably reflects both the pressure of other work and also the lack of confidence of many GPs to engage with alcohol problems. Repeated exhortation have not changed the situation markedly and it would probably be better to seek solutions providing increased support to GPs such as developing cooperation between local alcohol agencies and practices and enhancing the role of practice nurses. Examples of good practice will be found in cooperation between specialist services and GPs in Birmingham and Coventry.

18.3. A development, which may well prove valuable is provision of intervention over the internet. Current examples are undoubtedly crude and unlikely to be effective but future developments may produce effective interventions. This approach is likely to be very cost effective.

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?

19.1. There are a wide range of treatment programmes ranging from very expensive in-patient/residential to less expensive home based low contact. There is evidence that most treatment programmes do help some people. It is also probable that different people do better in different programmes although it is still very difficult to predict who will do well in which programme. (The outcome of project MATCH was a big disappointment in that it did not clearly answer this question).

19.2. Community based interventions, suitably structures with well defined methods and procedures is an important element of service. For many people with sever drinking problems community based interventions can safely and effectively replace traditional inpatient provision.

19.3. Various principles are clear

- We need a wide range of different services
- We need a mix of public and voluntary sector service providers
- The current level of provision needs to be increased
- No one method of intervention is clearly better than any other.
- Brief interventions especially those offered through general health services have a useful part to play.
- Home or community based interventions are in general cheaper and therefore more cost effective than residential ones. However there is still a need for residential services for certain clients.

- Generic services (hospital, primary care, social services, probation, police, prison) need to be encouraged to engage with clients who have drinking problems but they need to have easy access to specialist alcohol workers to support them in this.
- AA play a vital role in supporting many people with former or current drinking problems. While they operate outside normal service governance they should be encouraged and supported where this is acceptable to them.

19.4. There is concern that the present target driven culture of the NHS and the public service militates against adequate provision for alcohol. Because alcohol does not feature in the list of priorities for star ratings or chief executive deliverables it is all too easily forgotten. The solution to this is not to add yet another target for alcohol to the already long list but to encourage service providers to make proper assessment of local health priorities and allocate their resources accordingly. Ring fencing of funding for drug services may further distort the local pattern of services. Funding for drug services is very welcome but rapid expansion of drug services has sometimes drawn skilled personnel from alcohol services. Provision of alcohol and drug services need to be planned together so that neither develops at the expense of the other.

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

20.1. The main lesson is that where government takes responsibility for a problem, acts in a determined fashion and gives resources it can be effective. The activities of DAT have made a difference particularly in the area of harm minimisation.

20.2. Prior to the introduction of the NTA service provision in the drugs field was uneven and standards of practice very variable. The NTA has gone some way towards improving commissioning and promoting high standards. The alcohol field might benefit from a similar intervention.

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 or bottles) or home and workplace alcohol related accidents?

21.1. Injuries resulting from alcohol fuelled violence can be reduced by interventions to ensure a safer drinking environment. (See 28.1)

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?

22.1. Problematic drinking and other mental health problems frequently co-exist. Consumption of alcohol is often associated with suicidal and parasuicidal acts. However patients with dual diagnosis can be helped provided clear care pathways are defined. Alcohol specialists and mental health specialists need to work together in caring for such patients. Joint

training is important in raising the capacity of both professional groups to work together with dual diagnosis patients.

Crime and disorder

23. What evidence is there about 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?

23.1. There is a mass of anecdotal evidence demonstrating an association between offending and heavy drinking and a very powerful case would have to be made for any theory that the two were not causally linked. However this is an area where more evidence would be helpful. In particular police should be encouraged to record the frequency with which offending is linked to heavy drinking.

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?

24.1. Alcohol is particularly likely to be involved in offending by older offenders who are repeatedly convicted of relatively minor offences. Again it is difficult to unravel causality but heavy drinking is clearly involved along with repeat offending in the life pattern. It is probably simplistic to suggest that if the alcohol issues were addressed there would be no further offending, but solutions which do not include alcohol among the issues faced are unlikely to be effective. It might be said of these offenders that alcohol is one of the factors that stops them growing out of crime.

24.2. Arrest referral schemes show some promise as an intervention to reduce re-offending. Not only do they divert the offender from court saving valuable police and judicial time but they offer the offender an opportunity of change at a time when he or she (usually he) may be particularly motivated to pursue the opportunity. Service providers may need resources to accommodate clients with multiple and complex needs. In some situations it may be appropriate a single service to provide arrest referral for both alcohol and drug problems. Whether alcohol arrest referral services be provided separately or in combination with drugs they must be adequately funded.

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?

25.1. There is a strong association between crime (especially violent crime) and heavy drinking. This is mostly an association between intoxication and crime. People may be quicker to engage in violence when intoxicated. The financial demand of heavy drinking may motivate people towards acquisitive crime. Some of the association may be artifactual in that intoxication may make criminals easier to detect and apprehend. Also pubs may be a convenient meeting place for planning crime and alcohol may be used for Dutch courage.

25.2. The association between alcohol and public disorder is well recognised. Individuals may be more willing to challenge authority when intoxicated. Where a large group have been drinking it is likely that the behaviour of each group member will be reinforced by the others.

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?

26.1. Factors which influence the likelihood of disorderly behaviour associated with drinking include

- peer and family influences
- policing profile, style and level
- law enforcement
- concentration of licensed premises
- availability of food
- transport home
- licensing hours
- partnership working by agencies

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?

27.1. The manifestations of alcohol problems in urban and rural settings may be rather different. In urban settings there is often a wide choice of entertainment venues and although many of these involve drinking, young people do have more choice. In rural settings the local pub may be frequently the only evening entertainment and social venue. In rural settings young people may therefore be under greater pressure to drink. Furthermore the temptation to drink and drive may be much stronger since public transport is usually poor in rural areas especially late at night. Any strategy to reduce rural alcohol problems must consider improved public transport links and alternative entertainment venues to pubs.

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 to be aware of?

28.1. Proper management of the drinking environment has an important part to play in minimising harm due to alcohol. Measures to increase server responsibility may help. There should be full use of powers under licensing law to challenge licensing of premises associated with trouble. Premise managers should be encouraged to require proper behaviour by their customers. Local initiatives to develop skills of bar staff and door staff in

various skills such as conflict resolution and how to defuse tense situations should be encouraged. The law on not selling to people who are intoxicated should be enforced. There is clear evidence that injuries in licensed premises can be reduced by dispensing alcohol in safe (non splintering) glasses. Similarly the sale of drink in bottles has high potential for injury as broken bottles may be used as weapons. These would be simple measures to introduce and would attract strong public support.

28.2. There is a particular problem with off license premises. Police should make it their business to know where public order offenders buy their drink and discuss the problem with owners of premises.

28.3. Planning decisions and regulation of retail activity need to be sure that they do not encourage problematic drinking. In particular decisions involving the creation of 24 hour drinking zones and large concentrations of drinking venues need to be carefully considered.

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

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

30.1. No it is not right. Anti-crime and anti social behaviour initiatives should be targeted at people who commit crime or are anti social. Stigmatising any age group or other group is not helpful.

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?

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 efficient?

32.1. By themselves non drinking zones merely displace problematic drinking. In order to be useful they have to be combined with a range of medical and social services to met the needs of those whose drinking is causing problems in any particular location.

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?

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

- 34.1. Drink drive policies have been successful because they have changed the social acceptability of driving after drinking. This is one example of how a culture that tolerated one aspect of alcohol abuse has been changed.
- 34.2. The history of drink drive legislation demonstrates two things. First a technical device (the breathalyser) made it much easier to define and detect an offence. Second considerable political courage was required in the face of vociferous opposition to introduce a measure, which is now recognised to have been very good law.
- 34.3. There is still a perception (which is well founded) that the chances of detection are low. Breath testing not only detects offences but also serves as a powerful reminder to those who are tested but have not committed an offence that everyone needs to avoid drinking and driving. Police services need to move on from thinking that a negative breath test is a wasted breath test and operational targets for police services should not only give credit for positive tests. Legislative constraints on the circumstance in which the police can ask for a breath test should be removed (unfettered testing).
- 34.4. The introduction of drink drive offender courses with an inducement of a reduced period of disqualification is a good example of reformatory justice. The same principle might be extended to other offences in which excessive drinking has played a part.

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 the link and what would you see as good practice in tackling the interrelationships between domestic violence and alcohol misuse?

- 35.1. Domestic violence and heavy drinking are often associated. It is the experience of those dealing with this problem that when alcohol consumption decreases the frequency and severity of domestic violence also decrease. There needs to be co-operative working between those primarily dealing with domestic violence and those primarily dealing with alcohol problems. There should be joint training and frequent cross referral.

Vulnerable groups

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

- 36.1. There is good evidence that most young people drink. They start drinking well before age 18. A few drink heavily. Some drink with families while others drink alone or with friends. Given that appropriate use of alcohol is a learned behaviour it could be argued that it is desirable for children to learn to drink in the company of responsible adults and good role models. Concern over children's drinking needs to be concentrated on drinking away from adult company and drinking excessive amounts. It is unrealistic to

expect children to drink nothing until the legal age for purchase and then suddenly start drinking reasonably.

- 36.2. The problem of under age drinking needs to be considered. It is accepted that it is often difficult for a proprietor to assess the age of younger people. Great emphasis has been laid on the use of proof of age cards. These have the problem of appearing to put requirements on younger people that do not apply to older. These difficulties could be reduced by removing the emphasis on alcohol and linking age related privileges and restrictions. Thus lower age not only implies lack of permission to purchase alcohol and cigarettes, but also right to obtain cheaper tickets for travel and various facilities. Linking these might make use of proof of age cards more acceptable.
- 36.3. Youth offending teams report a link between alcohol and offending behaviour. Recently DATs have been required to produce a plan for the management and prevention of drug problems in younger people. A similar requirement for alcohol problems in younger people would be useful.
- 36.4. It is important to recognise that alcohol like any other substance is often chosen for its effect. Young people can learn to drink responsibly. However there are times when young people feel they may actively seek the depressant properties of alcohol so they no longer have to face up to the responsibilities of everyday. In this situation they may feel that alcohol provides an answer and may go on to experience withdrawals or even become physically dependant on alcohol. This behaviour may have negative impacts on school attendance, work and family relationships. It is important to recognise the links between sexual health and alcohol. Young people's first experience of sex is often after drinking.
- 36.5. Child protection issues related to alcohol use also deserve consideration. Parents who are intoxicated may be unable to ensure the safety and well being of their children. Alcohol related domestic violence may further place children at risk. Area Child Protection Committees need to give a higher priority to alcohol and drug misuse as factors which place children at risk.
- 36.6. Children's services play an important part in reducing the risk that they engage in harmful drinking. They do this not by attempting to focus on alcohol as an issue but by providing a framework of interesting ways to engage with society and thus reducing the competing attractiveness of getting ones thrills from alcohol.

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

- 37.1. See para 45.2

38. Those who are vulnerable to the consequences of alcohol misuse often have complex problems (for example they may be homeless and may have

additional mental health or drugs problems) and such factors may be inter-related. What key factors need to be understood in addition to alcohol use that contribute to maintaining the problems facing such groups? Which of these factors should interventions be aimed at?

39. How can the services provided by the state and others to vulnerable groups with complex problems be joined up most effectively? Are there examples of joined up delivery it would be helpful for us to be aware of? What gets in the way of joining up services?

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

40.1. Mainstream health, housing and social care services find it difficult to meet the needs of individual groups. Non statutory services working in close co-operation with statutory services are able to work in more flexible ways and have a good record of meeting the needs of such groups. Non statutory agencies have to be adequately funded for this work.

Education and communication

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?

41.1 An education and communication strategy should have the following objectives

- Ensuring people understand the alcohol contents of different drinks and have the skills to monitor their own consumption
- Ensuring people know about the possible harmful consequences of alcohol consumption and the relationship between patterns of drinking and risk of harm
- Promoting attitudes that harmful or excessive drinking is not the social norm and is not socially desirable.
- Promoting belief (self efficacy) that people can regulate their own drinking and if heavy drinkers can (with or without help) reduce their consumption.

41.2 It must be recognised that there are different recipients of education and communication and different approaches are needed to communicate with each. The groups include

- Younger Children, (who are not established drinkers)
- Young People
- General adult population
- Adult heavy drinkers
- Adults experiencing alcohol related problems

41.3 The criteria for outcome evaluation of education and communication activities have been widely debated. Possible criteria are

- Knowledge and attitudes about alcohol and effects of drinking
- Attitudes to alcohol
- Drinking behaviour

41.4 Even if a particular alcohol education were only to effect knowledge and attitudes without effecting drinking behaviour it is still worthwhile. Since knowledge and skills are an essential prerequisite for informed choice, it would be hard to justify other probably more effective interventions (such as price, licensing and regulation) if education has not also been used. Secondly education influencing attitudes may help to make other regulatory interventions socially and politically acceptable.

41.5 The difficulty of preventing harmful drinking in society is greatly increased by the ambiguity of societal attitudes to alcohol. Excessive consumption is both stigmatised and esteemed as an indicator of wealth and conviviality. Alcohol education must help people address this ambiguity. It needs to promote the attitude that it is possible to be happy without consuming large amounts of alcohol and that excessive consumption is a reason for sympathy not envy or admiration. Similarly abstention should be seen to be just as much part of the social norm as moderate consumption.

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?

42.1 This section will consider alcohol education of school children and alcohol education of the general adult population.

42.2 Alcohol education in schools has been extensively reviewed. Frequently it is treated as part of education about substances (along with tobacco and drugs). There are strong theoretical arguments for this. It is also frequently linked to PSE. There is general agreement that isolated interventions are not successful and alcohol education needs to be firmly located and integrated with other aspects of the formal and informal curriculum. There is some evidence to suggest that interventions based on peer leadership may be promising.

42.3 Alcohol education initiatives in schools have sometimes been evaluated in terms of effect on drinking in the next year or so. Generally school interventions are not shown to alter drinking behaviour. Any model that suggest that influencing knowledge and attitudes will simply alter drinking behaviour is a gross over simplification. However as argued in para 41.3 drinking behaviour should not be regarded as the only worthwhile outcome for school interventions. Also it is plausible that alcohol education in school may have some influence on drinking behaviour many years later in adult life though no evaluation has addressed this question.

42.4 Alcohol education for the general adult population needs to use different approaches to the used in schools. In general it is characterised by low intensity (short duration, low attention) communications with large numbers of individuals. It needs to use all the skills and techniques of social marketing.

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

43.1. Prior to the publication of sensible drinking the 21/14 units per week message was achieving considerable penetrance (see Drinkwise surveys). The publication of “Sensible Drinking” together with the singly unfortunate media handling by the Department of Health damaged credibility and created confusion. It is important to learn from this mistake and ensure that any future adjustment of the message builds on existing understanding. The 3/4 units per day message is not well understood and this is reflected in lower penetrance. (See response to Q14)

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

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

45.1. There is no doubt that interventions need to be appropriate for their intended audience and one size does not fit all. There are also problems in having fragmented messages (for example different drinking guidelines for different ages) since these tend to undermine overall credibility. Targeted interventions also raise problems of equity. Need to be very careful that targeting does not stigmatise any community.

45.2. Areas in which targeting might be appropriate:-

- Those engaged in certain tasks and jobs – Alcohol does not mix with these tasks/jobs. The success of the drink driving message is an example of what this sort of approach can achieve.
- Those with alcohol related medical conditions. Health service staff need to be consistent in indicating to people where alcohol is harming their health.
- Attention to areas where there are public order problems – a focus on maintaining public order and reducing anti social behaviour could incidentally discourage commercial outlets, which encourage excessive drinking.
- Ethnic minority communities. Work with community leaders to increase awareness of services and readiness to reduce denial and encourage help seeking community members with alcohol problems.
- Men and women leaving the armed services – who may find transition from a culture, which is sometimes macho and heavy drinking to a civilian culture difficult.

- Those recently discharged from prison. Released prisoners have to make the transition from a very controlled environment with little or no access to alcohol to a free environment with perhaps little occupation and easy availability of alcohol. Many find it difficult to moderate their consumption.

45.3. It is important to include consideration of elderly drinkers in the strategy (especially in the light of the NSF Older people). The elderly may be particularly vulnerable to physical effects of alcohol because of reduced body mass and other medication. Alcohol may increase their susceptibility to falls and fractured neck of femur (hip).

45.4. At the same time as discussing targeting particular groups it is important to remember that targeted communication has to take place in the context of a whole population strategy.

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?

46.1. Considerable emphasis is laid on education in schools. This is undoubtedly important but it is only one small element in the total policy response and has no hope of success unless supported by numerous interventions in other spheres. There seems to be general agreement that school interventions need to be integrated with the curriculum (formal and informal). They need to concentrate on building self efficacy and self esteem. They need to recognise that most pupils live in a world where adults drink. It is probably unrealistic to assess these interventions on the basis of drinking by the pupils in the next months or year. It is possible that the effect of such programmes may be in long term shifts in attitudes.

46.2. Universities and other Higher Education Establishments are an important part of the education system. For many students this is their first experience of living away from the family and drinking habits acquired at this time may set a pattern for later adult life. It is important that such institutions should adopt and implement a policy on alcohol issues balancing the need to promote harm free drinking patterns against the need for youthful exuberance. Student unions should be encouraged to be guided by such policies and should not be tempted by easy profits to promote a heavy drinking culture.

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

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

48.1. There is a lot of scope to influence the context of drinking. The don't drink and drive message has been very successful. Don't mix drink and work

has also made some progress. Professional athletes don't drink heavily despite the appalling and highly publicised exceptions has some possibilities as a message.

48.2. The need for consistent advice on drinking has already been discussed. There is a need for regular "campaigns" with messages such as winners don't drink heavily (elite sportsmen, conspicuous successes). Again it must be realised that these campaigns achieve virtually nothing by themselves but create a background on which more specific and focused activities can work.

48.3. In general promotion of healthy lifestyles is desirable. It is also good to present use of alcohol as part of this general package. However this needs to be seen as background supportive activity rather than a solution by itself.

49. What can be learnt from educational initiatives in the field of illegal drugs?

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

50.1. Alcohol is currently controlled by a voluntary code of practice which requires among other things that alcohol advertisements does not associate alcohol with sexual gratification, does not suggest that alcohol increases strength and are not directed at young people. There is concern that the Advertising Standards Authority and the Independent Television Commission are unduly sympathetic to the industry in considering complaints about alcohol advertising. They either fail to give complaints due weight when they are considered by the adjudication panels or reject complaints at the administrative level without passing them to the panels. Even when the panels uphold a complaint there is no effective sanction since the advertisement has already been run and the advertisers have already obtained any economic benefit from the offending advertisement.

50.2. Indirect advertising through sports sponsorship may be a particular problem. Sponsorship of football and rugby events with logos prominently displayed associates sport with drinking. The fact that most elite athletes either do not drink or else drink very moderately and that many promising sporting careers have been destroyed by alcohol is not surprisingly lost.

50.3. The new strategy must give careful consideration to the regulation of alcohol advertising. It should introduce measures that are more restrictive and more effective in preventing advertising that encourages excessive or harmful drinking.

Market and market based solutions

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

51.1. The difference in alcohol taxation between different EU countries is a problem. Harmonisation of duty to European levels would reduce cost of alcohol in England and thus as para 12.9 points out increase consumption.

Already the large scale of personal imports is effectively lowering the price of alcohol and may be affecting consumption. The recent relaxation of amounts allowed as personal imports will not have helped this situation. Drink producers export large quantities of alcohol so that they can be re-imported as personal imports. The alcohol strategy should do all that is possible to prevent increased affordability of alcohol due to illegal resale of drinks brought into England as personal imports. It should also attempt to ensure that any harmonisation of duty will be harmonisation up to UK levels and not harmonisation down to European levels.

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 a useful evidence on which we might draw?

52.1. There have been marked changes in the retail market. There has been a shift from purchasing and drinking on licensed premises to purchasing from off license premises and drinking elsewhere. Access to drink has been increased through opening of many more off license premises and greater availability through general retail outlets. Personal imports and illegal sales of personally imported alcohol have further increased the availability and decreased the cost of alcohol.

52.2. There have also been extensive changes in the structure of the trade with ownership of licensed premises increasingly shifting from brewers to others.

52.3. A feature of the market has been segmentation with the development of themed outlets attracting exclusively young or other age groups. Traditional pubs had a much more mixed clientele and this exerted some social control.

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

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

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

55.1. It is a common complaint that there is a cost disincentive to not drinking alcohol on licensed premises. Often soft drinks cost as much as alcoholic drinks. It is appreciated that people consuming soft drinks tend to drink more slowly and to consume lower volumes than those drinking beer or other forms of alcohol and proprietors may charge higher margins on these drinks to protect their income. None the less there is a clear perception that drinking of non alcoholic drinks is discouraged. The industry should be

encouraged to develop alternatives to alcohol that both them adequate commercial return but do not discourage those (such as drivers) who have come to the premises to be with friends but do not wish to consume alcohol.

The economic costs and benefits of alcohol

- 56. How clear is the evidence both for the wider economic costs and benefits of alcohol? Are there key pieces of research of which we should be aware?**
- 57. Where are the gaps in the available data on the economic costs and benefits of alcohol? Are there any obvious limitations we should be aware of? Are there any particular helpful methods for assessing costs and benefits of which we should be aware?**
- 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?**
- 58.1. It is regrettably true that in general the drinks industry makes more money when more drink is consumed and selling alcoholic drink tends to be more profitable than selling other products. Against this one needs to structure the situation so that the drinks industry has to bear the external costs arising from sales of its product. They need to be very clear that trouble caused by or to their customers will impact negatively on their business. They need to be aware of the costs to them of badly run premises (breakages, loss of desired customers). Examples of entrepreneurs who have made money by diversifying their business with food, other drinks, entertainment and other ways need to be disseminated.
- 59. What are the economic benefits of having an alcohol industry? Can we easily quantify them?**
- 60. Alcohol misuse can increase absenteeism and decrease productivity whilst moderate consumption of alcohol may be beneficial in terms of reducing stress and tension and facilitating networking in the workplace. What in your view are the links between alcohol use and educational and occupational attainment?**
- 61. Are there particularly effective workplace based initiatives designed to tackle alcohol misuse that we should be aware of?**