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?

Because the cost of alcohol-related impact on the criminal justice, health and social care systems is immense and likely to increase. Government intervention is justified whenever an addictive substance is taxed

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?

Government has the responsibility to set the climate for informed individual responsibility by addressing pricing, availability, education and treatment service provision

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

By listening to the majority and being prepared to make decisions which might be unwelcome to a (powerful) minority

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

To work towards a mutual common ground which is a harm reduction compromise to all parties

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

To minimise harm, foster informed choice, accept casualties need to be treated, anticipate threats to stability in levels of harm

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?

Lots of definitions available. Suggest 21 units week for males, 14 units for females be resurrected - or at least some nationally promoted limit in terms of units. Factors include quantity consumed, chronicity, harm to health / social / employment / financial / legal domains

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?

Regular daily intake of >4 units of alcohol and occasional heavy binge drinking seem to be the most damaging patterns. Prevention efforts probably best concentrated on young peoples' binge drinking as this is associated with problems developing in later life

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?

The reducing influene of religion is another change. The trends are mainly underpinned by increasing numbers of outlets and falling real price so focusing attention on social changes which will inevitably occur is not productive

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

Focusing attention on any group, when consumption is rising in all parts of the population, is inefficient. Pointless targetting sons and daughters if mums and dads are overlooked. What evidence is there that targetting groups in similar areas of health care where the whole population warrants targetting is effective?

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?

This question is irrelevant as it refers to an alcohol-free society which is not at issue in a harm reduction strategy. Sensible drinking of alcohol is clearly integral to our society

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

Drinking patterns have evolved from historical factors including licensing laws. The move from off-slaes and home drinking away from pubs in the last 20 years following marketing strategies and price cutting by producers has given rise to problems.

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?

All of these are influential but purchasing behaviour is in the main significantly influenced by price and availability

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

Risk of chronic ill health is usually too far distant and risk of short term consequences like accidents are too low probability. Alcohol after all is an anxiolytic that impairs risk assessment and reduces anxiety about risk

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

Harmful drinking has an adverse effect on the individiual's health, relationships, finances, employment, etc. I do not think it is useful to then distinguish between, harmful, problematic, excessive, drinking as quantities consumed will vary and individuals' thesholds for harm will differ.

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?

A follow up of the 1995 Sensible Drinking guidelines that collated this type of data would have been useful.

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.

Casuaulty admission, psychiatic care, general medical care, G.P. attendances, abulance calls out. Knock on effect of waiting list effects in these areas. Look at admissions to hospitals with diagnosis of alcohol dependency (all wards). Mortality - average age of death in last 350 notifications to our alcohol unit is 46. Costs of caring for the carers - social costs of supporting families to deceased drinkers leaving children. NHS costs of replacing / covering employees with drink 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 best through accurate and informed education from primary school level. Note that professional training courses in medicine, nursing, clinical psychology, occupational therapy, social work carry only vestigial or absent reference to alcohol problems despite their scale

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?

New patient screening for all primary and secondary services should include alcohol questions about intake and frequency. This should be taught pre- and post- aqualification along with the use of devices such as the AUDIT and practical adivice on how to administer a brief inrevention and how to refer on to specialists if this is not 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?

Evidence suggests that treatment generally better than no treatment. Evidence based practice should be promoted as should examples of good practice such as my own service - the Windsor Clinic where we have pioneered evidence based practice, individual treatment choice, service user involvement and treatment outcome evaluation for the last 25 years. We are the only alcohol treatment agency in the country to hold a Charter Mark which acknowledges sensitivity to issues such as access

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

That frightening people generally work. Hard to draw direct comparisons as total abstinence from drugs has been the general message whereas sensible drinking (with some health gains from moderate use) is the more complex message from alcohol

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?

Educate AED staff in recognition and brief interventions. Support staff with specialists who can give access to specialist services for those who are appropriate.

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?

Alcohol can be the main feature underlying depression, anxiety, 'psychotic' symptomatology. Vast majority of heavy drinkers who present with depression need no treatment when abstinent or drinking in moderation - same with agoraphobia, anxiety states. Suicide has been identified as high risk in heavy drinkers - eg HAS themaic review on suicide. Probably a significant factor in increase. in suicides in young men. More than 35% of our problem drinkers have attempted suicide (with associated mental health care and NHS costs) and suicide is third most common cause of death after liver failure and cardiovascular problems

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?

Ann Deehans Home Ofiice pamphlet is a text I use teaching forensic behavioural science. The issue appears to be whether the link is correlation or cause / effect. Large numbers of alcohol dependent clients have (usually) petty crime records but also serious crime mediated by alcohol intake. Some acquisitive crime to get funding for alcohol as for drugs.

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?

Yes - it is also likely to be a factor in being caught. Disinhibitive crime (assault, sexual crime, disorderly behaviour), acquisitive crime or drink defined crime (drink driving, drunk in charge of a child) are themes.

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?

See 23. Alcohol producers might perceive association as not cause-effect. Perception will vary depending on value system

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?

Under age drinking and the relative absence of prosecutions for under age sales are likely to be one factor as young purchasers will have lower tolerance to alcohol generally. ?Are licensing magistrates trained to consider the effect of expanding the numbers of city centre outlets

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 drinking, in my limited experience, tends to become problematical where young adults are alienated from social developments that they see in towns and cities. Urban drinking seems to have more a culture of commercial and peer pressure

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?

To some extent but price, availability, by-laws about drinking outside and enforcement of licensing laws as they stand would also be influential

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?

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

Yes - in respect of drinking these are the heaviest drinking group

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?

More liberal licensing hours would probably reduce disorder but on-sales purchases are usually supplemented by off-sales whach are cheaper.

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?

Maybe - has an audit of their application and consequent effects been conducted?

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?

That it takes a lot of money and effort to change targetted behaviour and that there will always be a plateau of success leaving a recidivist and unaffected group of offenders

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?

Specific staffing for dealing with alcohol-related domestic violence and potential violence or child care issues would be helpful

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?

Single or unsupported parent families. Those where both parents abuse alcohol. Children who are not visited by professional groups such as Health Visitors. Parents who have co-dependency with drugs or concurrent mental illness. Children who are themselves chronically ill

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

Some ethnic minorities - Asians for instance. The elderly. Those who are chronically ill and take long term medication

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?

As alcohol intake can be voluntarily controlled or eliminated by the individual - given the appropriate incentive - alcohol intake should be prioritised initially. Accurate assessment of mental health and physical problems can only be effective when alcohol is taken out of the equation where presenting problems are contaminated by excessive alcohol

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?

In my view, the state should prioritise service expansion generally and not, at such a low level of current provision, target vulnerable groups. Our experience is that some groups-women and the elderly, for example - prefer to have generic rather than group-targetted treatment for alcohol problems. It should not be assumed that targetting is what a group wants

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-bycase basis? What is your experience?

See above. As there are no treatment outcome data for the relative merits of targetted vs. generic treatment it can only be an opinion rather than evidence-based finding

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 drinkdriving. 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?

The aims should be clear cut and measurable for outcome purposes. The level of awareness about rudimentary information is low and a concerted effort to promote increases in the penetration of familiarity about safe limits and a unit of alcohol should be a first step.The destabilisation of the safe limits caused by the 1995 Sensible Drinking document should be avoided. The target should at first be to inform rather than to change behaviour

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?

The evidence of the understanding of units and limits in the population is good. But I understand that the proportion of respondents accurately replying is falling. Given that only a few hours, if that, of teaching on alcohol goes into professional training, it is likely that the knowledge base of professionals is poor.

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?

See above. Some promotion of the effects of heavy drinking on physical and mental health, family life and finances might be useful if done in a matter of fact rather than shock-tactics way

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?

Much better than it was 20 years ago but little investment in this country means a reliance on the USA and a different drinking culture for a lot of our 'evidence base'.There is no central encouragement on services to carry out audit or outcome evaluation as an integral part of their work - and there should be.

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)?

The whole population should be targetted first given the level of investment underatken to date and the size of the problem

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?

All training courses should have alcohol abuse as a mandatory component given the likely caseload that post-qualification workers will carry. The history, chemistry and biology of alcohol as well as the moral, ecomomic, political and religious aspects should be included in the school curriculum

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?

They need to be good models themselves. Targetting children with poor parental models is inefficient

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?

|The government is well placed to balance the needs and interests of the key players in the field - the NHS, the Treasury, the Home Office, the producers, the advertisers etc. Resurrecting an all party House of Commons with powers might be useful

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

The amount of money invested may not be correlated with outcome. Dramatic high profile campaigns may be politically appealing but a relative dead loss in terms of outcome

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

The code of conduct for media advertising appears to be working but should be reviewed in terms of alcohol advertising. Allowing the industry to police its own advertsising needs impartial supervision

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?

Would be interested to see if producers moved into any decriminalised drugs. how is price harmonisation with Europe (lower taxation) going to be accommodated - is the intention to make up the shortfall in revenue from increased sales or to encourage broadening of the market. If price falls, the government will be confronted with a disasterous increase in costs to the health and criminal justice systems

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?

Long term trends, as opposed to passing fashions in specific drinks, include the move towrds home drinking which was itself determined by pricing differentials. Price will be the chief determinant of consumption and policy should have pricing as a key feature

53. How far do you foresee research and development creating innovative market-

led solutions to the problems of alcohol misuse?

Without investment in research it's hard to answer this one.

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?

There is little that I have seen to change my view that the main motivation of the alcohol industry is to maximise sales and to minimise adverse publicity.

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

The association of alcohol sales with all areas of the leisure industry has the effect of increasing availability and making leisure pursuits not involving drinking more difficult to find

The economic costs and benefits of alcohol

Alcohol has significant costs for the economy. It costs the NHS and the police. It costs business money because of lost productivity and in some cases the need to repair alcohol-related damage. And it can be expensive for individuals who drink heavily and may find themselves unable to hold down a job. But it also has benefits. It brings in tax revenue and contributes to GDP. And it contributes to personal and social wellbeing for many. Part of the work on the project will be to form a clear picture of these costs and benefits.

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 key authors that I have read are Maynard in the U.K. and Holder in the USA

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?

We carried out a brief audit of the health care useage of alcohol abusers (n<40) referred from 1 general practise to this service. We could find little research in the literature of easy to assess information like no. of G.P. contacts, AED contacts, prescriptions written etc. for heavy drinkers and how these costs changed after treatment. Such offset cost savibgs would be powerful in promoting brief interventions

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?

In effect, as the haevy drinking (and smoking) population pay large inderect taxation costs do get covered by individuals. It would be an acknowledgement of the governments intent if the producers were levied a token 'alcohol problems tax' on their product

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

quantify them?

Given that the product is likely to be in demand for the foreseeable future, the benefits are those of a stable emplyer, creator of wealth and contributor to the government purse

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?

At best, moderate useage is benign, excessive useage has been identified as a massive cost - see House of Commons Select Report on Drunkenness 1834

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

Not recently to the best of my knowledge