Response to the

‘National Alcohol Harm Reduction Strategy’ consultation

from the

Greater Manchester Public Health Network

Prepared on behalf of the network by:

Zakyeya Atcha
Specialist Registrar in Public Health
Department of Public Health
Salford PCT
St James House
Pendleton Way
Salford
M6 5FW
Tel: 0161 212 4937
Fax: 0161 212 4810
zakyeya.atcha@salford-pct.nhs.uk

Executive Summary

1. Introduction

1.1. This report provides a summary of the key points in response to the National Alcohol Harm Reduction Strategy Consultation Document from the Greater Manchester Public Health Network.

1.2. The comments have been grouped under the eight themes listed in the consultation document.

2. Underlying Principles

2.1. The Government has a responsibility to protect the vulnerable individuals.

2.2. Use and misuse of alcohol is influenced not only by legislation and policies but also cultural, and personal factors. The strategy will therefore require an integrated approach.

2.3. Partners may appear in conflict for example the National Health Service and Police Authority share the concerns about the proposed Licensing Bill but the Bill is supported by the drinks industry.

2.4. The adverse consequences of harmful drinking are costly to the NHS, Local Authorities, Police Authority, Probation Services and communities.

3. Key Issues for Greater Manchester

3.1. There are fourteen Primary Care Trusts represented within the Greater Manchester Public Health Network.

3.2. Data from the Health Survey for England (1994-1996) indicate that in Greater Manchester 27% of people drank 'unsafe' levels of alcohol each week. This compares with an England average of 22%.

4. Cultural and Behavioural Issues Around Alcohol Use and Misuse

4.1. There is some evidence to support general prevention and counselling in the work place. Key statutory agencies should lead by example and develop workplace policies to discourage alcohol consumption when at work or when representing the agency and provide support to those who are identified as harmful drinkers.

4.2. There needs to be greater awareness of harmful drinking in minority religions and cultures where alcohol abstention is considered normal. Access to education or support may be more difficult. Pressure to hide problematic drinking is great.

4.3. The harmful drinking behaviour practiced in England and Wales is not contained within this country but it remains an issue when we travel abroad. Therefore the strategy should link closely to a European-wide policy to reduce harmful drinking.

5. Health: Prevention, Treatment, and Impact on NHS

5.1. Alcohol is thought to be a factor in about 3% of all cancers, cardiovascular disease, suicides and suicide attempts, accidents, harm to the foetus in pregnancy, violence and crime.

5.2. Young people (aged 16-24 years) in particular men, are the heaviest drinkers. It is the most commonly used drug amongst children aged 11-15 years.

5.3. Alcohol consumption is related to socio-economic factors causing concern about the resulting health inequalities relating to alcohol consumption.

5.4. The World Health Organisation (WHO) defines alcohol consumption into hazardous, harmful and dependent consumption. However harmful drinking may vary according to age group and context for example any alcohol may be harmful in young people or when driving or using machinery.

5.5. There is a need for validated screening tools as a means of identifying hazardous drinking: e.g. CAGE, AUDIT and Adolescent Drinking Inventory questionnaires.

5.6. It is essential to recognise the social harm resulting from harmful drinking e.g. effect on relationships and employment or violent aggressive behaviour, as well as physical and psychological harm.

5.7. Staff should be trained to pro-actively seek the influence of alcohol in when patients present with major and minor injuries. Signposted support groups should be available.

5.8. Brief interventions therapy has been found effective in non-dependent alcohol users in the Primary Care setting. It is not a substitute for specialist treatment in more dependent users.

6. Crime Disorder and Anti-Social Behaviour: The Effects on Our Surroundings and Community

6.1. Action is needed to stop the development of inner city ghettos for harmful drinking. The police recognise that at night cities tend to fill with young people drinking in a harmful manner and the absence of role models drinking within safer limits.[1]

6.2. The compulsory use of safety glass, which doesn't shatter when broken and confiscation of glasses and bottles by door staff on exit to the street is supported.

6.3. Town planning to ensure all drinking establishments are not placed in one area but dispersed and mixed with venues, which bring a range of people whose sole aim, is not to drink alcohol.

---

[1] "Alcohol: Friend or Foe" Conference organised by the Greater Manchester Police Authority. November 2002.

6.4. There is strong evidence of the effectiveness of a minimum legal age of drinking. This may be combined by the requirement to produce proof of age documentation.

7. The implications for vulnerable groups, including children

7.1. Parental access to information and education is essential. Knowledge is needed about the alcoholic content of drinks purchased for their children. Permitting consumption of alcohol by children at home should be discouraged.

7.2. Other vulnerable groups in the community include children in homes where parents are drinking excessively, children excluded from schools, people who misuse other drugs and homeless people.

7.3. Certain professions are also recognised as encouraging harmful drinking behaviours for example publicans and other alcohol retailers and the medical and nursing professions.

8. Education and Communication

8.1. A key issue to ensure that health messages relating to alcohol consumption are targeted clearly to the intended audience. This should be comprehensive and targeted at different levels for different groups.

8.2. The Greater Manchester Public Health Network believes a better measure of alcohol consumption is needed. The alcoholic content in a "unit" of alcohol will vary greatly depending on the type of drink and by country in which it is consumed. There is poor understanding of how many units are contained in non-standard measures of alcoholic drinks consumed at home.

8.3. Literacy may be a barrier to obtaining information or seeking support.

9. The Shape of the Market and Market Based Solutions

9.1. Prohibit advertising near schools or before the watershed. Impact of hazardous drinking such as increased risk of fatal and road and other injuries, increased aggression and violence, increased high-risk sexual behaviour.

9.2. Clear and consistent labelling of the alcoholic content of drinks and food that contains alcohol.

9.3. The focus should be to promote non-hazardous drinking behaviour.

10. The Economic Costs and Benefits of Alcohol

10.1. The National Health Service, Police Authority and communities carry the costs of harmful drinking. The main benefits are to increase the profits associated with excessive drinking to the drinks industry and in taxation to the Government.

10.2. Current practices of the drinks industry encourages hazardous drinking, e.g. happy hour, availability of alcohol until very close to closing time, no responsibility for the behaviour or safety of their customers once they have left their premises.

1. **Introduction**
    1.1. The Greater Manchester Public Health Network welcomes the development of a national harm reduction strategy for alcohol.

    1.2. We welcome the recognition that the most people who drink alcohol consume it harmlessly. However certain groups in society, young people in particular, are vulnerable to developing harmful drinking behaviour. Injury and road traffic incidents are the greatest cause of death in this age group.

    1.3. The problems identified with long-term, excessive alcohol consumption have tended to focus on medical conditions such as liver cirrhosis, increased risk of cancer and heart disease. In the short-term, it is associated with an increased risk of injuries in all age groups.

    1.4. The recognition of the social and psychological harm of excessive drinking is equally important and this can be harmful to the individual, to close family and friends and the community.

    1.5. Harmful behaviour relating to alcohol consumption includes increased aggressive and violent behaviour; increased likelihood of domestic violence and it is associated with increased criminal activity. It can also bring strain to the family, and where drinking behaviour is problematic absenteeism from work causes loss of earnings for the individual and the employer.

    1.6. The Greater Manchester Public Health Network supports the need for a partnership approach to the strategy in recognition that the effects of harmful drinking behaviour are far-reaching. No single agency or group has the solution to reduce the harm from alcohol consumption. A co-ordinated response is required which is implemented at local and national level.

    1.7. The Government has a crucial role in ensuring that action is taken by all appropriate agencies.

    1.8. The Greater Manchester Public Health Network believes that the key areas have been identified in the consultation document

2. **Underlying Principles**
    2.1. The Government has a responsibility to protect vulnerable individuals.

    2.2. Use and misuse of alcohol is influenced not only by legislation and policies but also cultural, and personal factors. The strategy will therefore require an integrated approach.

    2.3. Partners may appear in conflict for example the National Health Service and Police Authority share the concerns about the proposed Licensing Bill but the Bill is supported by the drinks industry.

2.4. The adverse consequences of harmful drinking are costly to the NHS, Local Authorities, Police Authority, Probation Services and communities.

3. Key Issues for Greater Manchester

3.1. There are fourteen Primary Care Trusts represented within the Greater Manchester Public Health Network. The main City is Manchester but there are thriving town centres within the area. Manchester City is part of the City Safe campaign which prevents people drinking in the streets around the city.

3.2. Data from the Health Survey for England (1994-1996) indicate that in Greater Manchester 27% of people drank ‘unsafe’ levels of alcohol each week. This compares with an England average of 22%.

3.3. The comments have been grouped under the eight themes listed in the consultation document.

4. Cultural and Behavioural Issues Around Alcohol Use and Misuse

4.1. Alcohol use to misuse is a continuum potentially affecting all people not just specific vulnerable groups in society.

4.2. There is some evidence to support general prevention and counselling in the work place. Key statutory agencies should lead by example and develop workplace policies to discourage alcohol consumption when at work or when representing the agency and provide support to those who are identified as harmful drinkers.

4.3. There needs to be greater awareness of harmful drinking in minority religions and cultures where alcohol abstention is considered normal. Access to education or support may be more difficult. Pressure to hide problematic drinking is great.

4.4. The harmful drinking behaviour practiced in England and Wales is not contained within this country but it remains an issue when we travel abroad. Therefore the strategy should link closely to a European-wide policy to reduce harmful drinking.

5. Health: Prevention, Treatment, and Impact on NHS

5.1. Alcohol is thought to be a factor in about 3% of all cancers, cardiovascular disease, suicides and suicide attempts, accidents, harm to the foetus in pregnancy, violence and crime.

5.2. Young people (aged 16-24 years) in particular men, are the heaviest drinkers. It is the most commonly used drug amongst children aged 11-15 years.

5.3. Alcohol consumption is related to socio-economic factors causing concern about the resulting health inequalities relating to alcohol

consumption.

5.4. The World Health Organisation (WHO) defines alcohol consumption into hazardous, harmful and dependent consumption. However harmful drinking may vary according to age group and context for example any alcohol may be harmful in young people or when driving or using machinery.

5.5. There is a need for validated screening tools as a means of identifying hazardous drinking: e.g. CAGE, AUDIT and Adolescent Drinking Inventory questionnaires.

5.6. It is essential to recognise the social harm resulting from harmful drinking e.g. effect on relationships and employment or violent aggressive behaviour, as well as physical and psychological harm.

5.7. Clearer health messages are needed for the population to understand that the health benefits of alcohol consumption vary with age and pattern of drinking.

- Alcohol consumption and mortality: modelling risks for men and women at different ages indicates that.[1]
- Binge drinking is harmful even if the weekly rate is not exceeded.
- Increased alcohol intake is associated with higher overall mortality.
- The greatest benefit is to men in the older age group but the risk of excessive drinking in those who have previously abstained outweighs any potential benefit. Therefore don't encourage drinking as a protective response in men who normally don't drink alcohol.
- There is no health benefit to drinking alcohol in the younger age group

5.8. Data on drug-related deaths investigated by the Coroners Office held by the office for National Statistics can now identify the presence of alcohol as a contributory factor in certain drug-related deaths.

5.9. Adequate training of professionals to screen and counsel about harmful drinking is essential and additional resources are needed to fund screening, education and counselling services provided. All staff should be trained to obtain accurate drinking history and not just accept "social drinking" as adequate quantification.

5.10. Staff should be trained to pro-actively seek the influence of alcohol in when patients present with major and minor injuries. Signposted support groups should be available.

5.11. The effectiveness of population-wide interventions may vary but have proved very successful in certain campaigns such as the "Don't Drink and Drive" campaign.

5.12. Brief interventions therapy has been found effective in non-dependent alcohol users in the Primary Care setting. It is not a substitute for specialist treatment in more dependent users.

6. Crime Disorder and Anti-Social Behaviour: The Effects on Our Surroundings and Community

6.1. Action is needed to stop the development of inner city ghettos for harmful drinking. The police recognise that at night cities tend to fill with young people drinking in a harmful manner and the absence of role models drinking within safer limits.[2]

6.2. The compulsory use of safety glass, which doesn't shatter when broken and confiscation of glasses and bottles by door staff on exit to the street is supported.

6.3. Town planning that drinking establishments are not all placed in one area but dispersed and mixed with other types of venues, in order to attract people whose aim is not solely to drink alcohol.

6.4. In Greater Manchester, co-ordination of night-time transport routes ensures that people in the city can be safely and efficiently taken home with out leaving frustrated crowds of people with no means of going home.

6.5. There is strong evidence of the effectiveness of a minimum legal age of drinking. This may be combined by the requirement to produce proof of age documentation.

7. The Implications for Vulnerable Groups, Including Children

7.1. Parental access to information and education is essential. Knowledge is needed about the alcoholic content of drinks purchased for their children. Permitting consumption of alcohol by children at home should be discouraged.

7.2. Support mechanisms for parents and schools to tackle alcohol consumption in and out of school are essential. Youth workers and police describe increasing numbers of children who specifically drink to collapse into unconsciousness.

7.3. Other vulnerable groups in the community include children in homes where parents are drinking excessively, children excluded from

schools, people who misuse other drugs and homeless people.

7.4. Certain professions are also recognised as encouraging harmful drinking behaviours for example publicans and other alcohol retailers and the medical and nursing professions.

8. Education and Communication

8.1. A key issue to ensure that health messages relating to alcohol consumption are targeted clearly to the intended audience. This should be comprehensive and targeted at different levels for different groups.

8.2. The Greater Manchester Public Health Network believes a better measure of alcohol consumption is needed. The alcoholic content in a "unit" of alcohol will vary greatly depending on the type of drink and by country in which it is consumed. There is poor understanding of how many units are contained in non-standard measures of alcoholic drinks consumed at home. [3]

8.3. Literacy may be a barrier to obtaining information or seeking support.

9. The Shape of the Market and Market Based Solutions

9.1. Prohibit advertising near schools or before the watershed. Impact of hazardous drinking such as increased risk of fatal and road and other injuries, increased aggression and violence, increased high-risk sexual behaviour.

9.2. Clear and consistent labelling of the alcoholic content of drinks and food that contains alcohol.

9.3. The focus should be to promote non-hazardous drinking behaviour.

10. The Economic Costs and Benefits of Alcohol

10.1. The National Health Service, Police Authority and communities carry the costs of harmful drinking. The main benefits are to increase the profits associated with excessive drinking to the drinks industry and in taxation to the Government.

10.2. Current practices of the drinks industry encourages hazardous drinking, e.g. happy hour, availability of alcohol until very close to closing time, no responsibility for the behaviour or safety of their customers once they have left their premises.

---

[1] Ian R White, Dan R Altmann, and Kiran Nanchahal BMJ 2002; 325: 191

[2] Alcohol: Friend or Foe. Conference organised by the Greater Manchester Police Authority. November 2002.

[3] Webster-Harrison et al Alcohol awareness and unit labelling. Journal of Public Health Medicine 24:4 pp332-3 2002