



Quaker Action on Alcohol and Drugs

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## **RESPONSE TO THE DEPARTMENT OF HEALTH CONSULTATION ON ALCOHOL 'SAFE, SENSIBLE, SOCIAL'**

We welcome the Department of Health's review of these matters, and the independent research it has commissioned to inform it.

### **1. How might a new code be made effective in stopping licensed premises from engaging in practices that encourage people to drink excessively and irresponsibly?**

We note, and concur with, the analysis of the KPMG report which states that the main reason for the limited adherence to the existing standards is that 'the commercial imperative generally overrides adherence.' This results in deep cost-cutting promotions that encourage increased and excessive consumption, and generally has the effect of driving down responsible practices rather than enhancing them.

Another important factor is the lack of sanction for breaking the existing codes/legal requirements: in some cases (the serving of already intoxicated customers and those who are under age) breaches are widespread. Particularly in the case of under-age drinking, the law can only be upheld if codes are reliably and consistently enforced. We agree with the KPMG report's conclusion that a new code would need to be mandatory in order to be effective. We also agree that it would need to be led by government but locally sensitive, and involve a variety of stakeholders, including the industry.

This is not to undermine the fact that certain parts of the industry have shown a helpful voluntary commitment, which should be built on.

We welcome the fact that advertising is being considered and would like to see a full review of its role and impact.

### **2. If there continues to be slow progress in implementing a voluntary labelling scheme, should the Government take the next steps to make it a legal requirement to include health and unit information on all bottles and cans?**

The industry has already had ample time to implement the labelling scheme and has not reliably done so. Even if the scheme were more widely adhered to, clear and full labelling should be a baseline requirement: all customers need to have full information to make responsible judgments. Levels of harm are increasing (as the consultation

document summarises) and further time should not be lost. We hope the government will take prompt action on this matter.

### **3. What are the most important issues that need to be addressed in an alcohol retailing code?**

We welcome the fact that the Department of Health is moving towards considering the price of alcohol, as this is evidently a critical factor in the extent of alcohol-related harm. We would like to see an approach akin to the one being explored by the Scottish Parliament, with **a minimum price for alcohol** being set. The principles should involve those they suggest - particularly that it should apply to all retail outlets, and that the price set should be related to the alcohol content of beverages.

A high alcohol content in cheap alcohol is of particular concern in relation to dependent and binge drinking, and the appeal to younger drinkers. We welcome the fact that there was some progress in changing the bottle size for the availability of white ciders, but are concerned that it still has a very low price per unit and is widely discounted. Similarly, the progress on Alcopops is to be welcomed, but the price needs to be higher to reflect the alcohol units they contain.

The KPMG report highlights that supermarkets often use cheap alcohol as a 'loss leader' to bring in customers, while many off-licences 'deep discount' for bulk or larger purchases. This is part of the pattern that enables 'pre-loading' for those drinking excessively, and also has an influence on under-age drinking. Promotions in pubs and clubs (such as buying two glasses of wine and getting the rest of the bottle free) also tend to encourage extra consumption. A retail code should **prevent promotions that sell alcohol at a loss or very cheaply in any outlet.**

The code should also prevent encouragement of excessive drinking by DJs or other staff in night clubs or pubs, and practices such as the requirement that shots are drunk in one gulp at the bar.

The code should ensure **clear information about what measure of alcohol is being sold, and that a choice of measures is available.** We are concerned that an increase has occurred in the standard measures, which has led to public confusion. Wine in 125ml glasses and spirits in 25 ml measures should be available and described as a standard measure. Information on the units various measures contain should also be available. We note the findings of the KPMG report that drinks in clubs are not always measured in standard ways: this too should be part of the code.

The issues of **servicing to under-age and already intoxicated individuals** have been highlighted. We support KPMG's proposal for more stringent identification schemes.

### **4. Should the same restrictions be applied to: all premises selling alcohol; • all premises with some exemptions; only certain types of premises (if so, how would you define these?); all premises within an area experiencing problems; or • a combination of these?**

Health-based restrictions should be generally applied across all premises. We note the findings of the KPMG report that sometimes staff, particularly in large/city centre premises, may not challenge intoxicated customers for fear of violence or because of

lack of time. The code should require businesses to make appropriate provision to ensure that the code is met through adequate staff and training, though the method may vary with the size of venue. The code should place requirements/responsibility on the business corporately, but also on members of staff individually.

We agree that in high risk or high density areas extra standards such as those outlined would need to apply, and that Licensing Authorities and other local partnerships would need to work together to ensure compliance, particularly with reference to local Licensing policies. We would like to see the government leading on this, particularly in encouraging adherence to the code as a condition for premises licences.

We welcome the Alcohol Disorder Zone initiative, but are concerned that this has not been widely adopted, partly because of resourcing implications for Licensing Authorities. We would like to see more action and government leadership on this.

Health information about units should be available to all customers in all settings (for example, posters on pub/club walls) and this should not be confined to 'high risk' venues. In general terms, health-related restrictions (in particular on price, promotions, age, and intoxication) should be general, while those aimed at tackling disorder could be specific to those areas where this is a problem.

#### **5. Should an alcohol retailing code be made mandatory through further legislation? If so, how should it be applied?**

We believe that an alcohol retailing code should be made mandatory through further legislation for the reasons we have outlined.

We also believe that the opportunity should be taken to ensure that other legal frameworks are consistent with the proposed legislation. In particular, we would like to see the 2003 Licensing Act amended to include public health as one of its principles (as is the case in Scotland). Density of licensed premises is a significant issue that local areas should be able to act on in a way they cannot do under existing legislation. This contravenes the principles of local democracy that are outlined in the consultation document.

We would welcome the measures outlined in option 2 of the consultation document, which would enable local Licensing Authorities in conjunction with the police and other agencies to impose particular restrictions on premises in high risk areas. However, such provision would not be effective unless it is appropriately resourced.

We would also welcome the idea in option 3 – that is, a mandatory code that would set out minimum standards, which local areas could then supplement appropriately. This would reflect the KPMG recommendation of a combination of nationally led but locally sensitive measures, which is an approach we would endorse.

We think there are many merits in the idea of an independent regulator. This could strengthen rather than diminish the ability of local Licensing Authorities to tackle poor practice. At present they can be limited by lack of resources from responding to the concerns of residents, for fear of expensive legal bills. Independent assessment and scrutiny could thus strengthen local action and ensure consistency.

**6. Should a mandatory code, if introduced, cover proportionate and necessary actions to prevent health harm as well as crime and disorder?**

We strongly support the idea that a mandatory code should cover action to prevent health harm. At present large profits go to the alcohol industry, but the costs of addressing problems are largely publicly borne.

As indicated, price has a critical relationship to all kinds of alcohol-related harm, and we support efforts to address this through minimum pricing and restriction of promotions.

**7. Do you think there is enough advice available for those who want to drink less? What other kinds of help are needed and who should provide them?**

Study evidence and our own experience suggest that there is not enough advice or support available for those who want to drink less. It is positive that alcohol now comes under the NTA and is included in Models of Care, but resourcing has not matched the strategy. There are deficits at all the four levels of Tiered provision.

Within the Health Service, Alcohol Concern's 2008 survey of various Primary Care Trusts revealed a wide variation, and very low levels of service in many. Screening for lower level problems that respond to brief interventions could be much expanded. The Alcohol Concern survey also showed that some severely dependent drinkers had to wait for up to a year for structured treatment. Budgets for residential treatment are not ring-fenced and have to compete with other needs, which results in a low priority and unmet need. The perceived lack of services then tends to deter referral, so the level of need is under-estimated. In the past two years NTA recommendations have been for commissioners to ensure proper assessment and provision of residential services for drug users: it is an even greater unmet need for alcohol users.

We welcome the alcohol screening for new patients in the Direct Enhanced Service initiative with G.Ps. We would like to see a more proactive and even response across the country, with alcohol to be included in the Quality Assessment Framework and the Common Assessment Framework.

Interventions targeted at alcohol-related admissions to hospitals are resource-efficient, responsive to need, and should be expanded. Our experience is that more services are required at the Tier II/III levels for people who are not yet severely dependent but have significant problems. Those in work or with child-care issues can have difficulties in access to those services that do exist.

In the criminal justice system an imbalance between help for problem drinkers and that for drug users has been widely identified. Both in prison and outside it far more alcohol treatment and aftercare is needed, which should involve appropriately supported accommodation and other 'wrap around' support. We welcome Alcohol Rehabilitation Requirements in Community Orders, but note also that they are relatively little used: these services need to be expanded.

Support for affected families/close others is minimal or non-existent in many areas. This needs to be expanded, both for the sake of these people in their own right (particularly children), but also because this can enhance treatment outcomes. We

would draw attention to the 'network therapy' approaches researched at Birmingham University Psychology Department (Copello et al., 2000, and 2003).<sup>1</sup>

**8. Should alcohol advertising include health and unit information? How could this be achieved?**

Advertising should include health and unit information in a prominent and factual way. We are aware of the evidence cited by Alcohol Concern of the effects of advertising on young people, and favour the idea that there should be no advertising on television before the 9 p.m. watershed.

**9. In addition to providing alcohol treatment for the small number of drinkers with a serious dependency problem, what else could be done, and by whom, to support people who find it difficult to cut down on their drinking?**

We welcome the initiatives that have already been taken and that are detailed within the consultation document.

Those with severe problems need to have detoxification services available (both community and hospital-based) and access to residential provision when they meet Tier IV criteria. This is still far from being the case in many areas.

We are aware of the evidence and analysis being presented to this consultation by Alcohol Concern, and agree that progress across all Tiers of treatment would be improved by the adoption of the methods they suggest.

In our view, policy also needs to be shifted to build on early years prevention work for vulnerable children - and more generally into family focused support. The consultation document summarises the link between deprivation and alcohol problems. We would draw attention to the 'Breakthrough Britain' work of the Social Justice Commission and to the body of research on the importance of attachment (summarized in the 'Attachment Relationships' report of the Open University). Current early years provision is focused on countering poverty and getting parents into work, and is little focused on the emotional support necessary to support healthy child development. Particularly (though not only) in deprived areas and families, support of this nature would be strongly preventative. We would urge exploration and piloting of these approaches, using Health Visitor services (which current developments are weakening) as well as other approaches.

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<sup>1</sup> Copello, A., Velleman, R.D.B., Templeton, L.. (2005) *Family Interventions in the treatment of alcohol and drug problems*. Drug and Alcohol Review: 24(4), 369-385.  
Copello, A.G., Templeton, L., Krishnan, M, Orford, J., Velleman, R.D.B., and Templeton, L.J (2000) *A treatment package to improve primary care services for relatives of people with alcohol and drug problems*. Addiction Research: 8 (5), 471-484