

SUBMISSION ON BEHALF OF QUAKER ACTION ON ALCOHOL AND DRUGS

1. INTRODUCTION

1.1. Quaker Action on Alcohol and Drugs – QAAD, is a listed group of the Religious Society of Friends – QUAKERS. Quakers have maintained their testimony of moderation over 350 years with regard to substances. They have always addressed the harm done by the use of alcohol and other habit forming drugs and ask themselves and others whether they should limit their use of them or refrain from using them altogether. In Britain today, some Quakers are abstinent, others choose moderate consumption of alcohol, and, as in the general population, a number will be struggling with problem use. QAAD aims to assist all members of the Society of Friends by providing balanced information relating to the use and misuse of substances.

1.2. QAAD is an independent national charity concerned with all drugs – legal, illegal, and prescribed - and with gambling. QAAD offers prevention and information services within the Society of Friends: we feel a particular responsibility to children and young people and endeavour to keep them informed with updated facts regarding substance use and misuse. We also liaise with other similar bodies nationally. QAAD Trustees give their time to QAAD freely, and bring voluntary and statutory experience from settings that include prevention, treatment, the medical profession and criminal justice.

1.3. QAAD welcomes the Strategy Unit's Project to tackle the harm associated with alcohol misuse. We are also pleased that the work it undertakes will feed into the formulation of a National Alcohol Strategy by the Department of Health, and we look forward to this much-needed initiative. We are disappointed, however, that changes currently being planned to the licensing laws have taken place in advance of a National Alcohol Strategy, rather than being formulated as part of it. We hope that it is still possible for the points made below in section 3.3. to be considered.

1.4. We find it helpful that the “key questions” in the scoping note address underlying issues such as the “drivers” for alcohol consumption: it is against the background of such broad questions of context that specific problems can be most effectively tackled. Our submission follows this pattern in addressing the principles and approach on which we believe interventions should be based. We then focus on specific areas of policy and practice that evidence suggests would reduce harm.

2. PRINCIPLES/APPROACH

2.1. We believe that policy should be based on the five principles in the 1995 European Charter on Alcohol, which we quote below. The UK is already a signatory. In areas where these principles can be advanced through policy or education, the forthcoming National Alcohol Strategy presents an opportunity for a more rigorous approach than has been employed hitherto.

1. All people have the right to a family, community and working life protected from accidents, violence and other negative consequences of alcohol consumption.
2. All people have the right to valid impartial information and education, starting early in life, on the consequences of alcohol consumption on health, the family and society
3. All children and adolescents have the right to grow up in an environment protected from the negative consequences of alcohol consumption and, to the extent possible, from the promotion of alcoholic beverages.

4. All people with hazardous or harmful alcohol consumption and members of their families have the right to accessible treatment and care
5. All people who do not wish to consume alcohol, or who cannot do so for health or other reasons, have the right to be safeguarded from pressures to drink and be supported in their non-drinking behaviour. “

2.2. Evidence suggests that for some young people (who need not be experiencing personal or social problems) drinking – including heavy drinking - forms part of a repertoire of substance-using behaviours (*Parker, 1998; Eggington, Williams, and Parker, 2002*). We believe that approaches to alcohol and alcohol misuse need to incorporate a recognition that young people have greater access to a wider range of illicit drugs than has been the case in the past. **It is therefore important that approaches to alcohol use and misuse are part of a rational drug policy that considers substances (licit, illicit, and prescribed) in a coherent, harm-indexed framework.**

2.3. Aside from its legal and social status, alcohol does present some particular features. Whilst regular excessive consumption and binge-drinking present clear hazards, “there are many different types of problematic consequences from alcohol consumption, each of which has its own gradient of risk in relation to quantity, frequency and pattern of alcohol consumption.” (*Stockwell et al., 1996*). Research also indicates that some adverse consequences can occur at relatively low levels of use.: for example, Ramstadt’s study, which included wine-drinking countries in Southern Europe as well as Northern European countries including Britain, noted that, “it was not possible to establish a threshold below which no kind of problem was reported”. Thus, the boundaries between harmful and non-harmful drinking are not always easy to define in an absolute way: neither problematic behaviours nor the people enacting them can be considered in discrete categories. It is necessary, therefore, to develop a mixture of targeted and general measures. Policy needs to be based on the considerable body of evidence that:

- Many problems and problem-generating behaviours are widely distributed among the drinking population (and are not confined to heavy drinkers)
- There is a strong relationship between alcohol consumption per capita and alcohol-related problems in the population as a whole
- There is a relationship between the prevalence of heavy drinking and the overall alcohol consumption of the population

(*Evidence is summarised in Raistrick, Hodgson and Ritson, 1999; Edwards, Anderson, Barbor et al., 1994*)

Therefore tackling the alcohol problems mentioned in the scoping report will need to include some measures that address population-level consumption.

2.4. Alcohol use and misuse is the result of a complex interplay of enabling and restraining factors, both within the individual and in societies/sub-groups. The enabling of individual freedom has to be balanced by agreed social constraints. Alcohol supply and consumption is a significant part of the economy, but alcohol-related problems cause major health and social costs. There is a tension for government between enabling the former elements and restraining the latter.

Social and cultural attitudes to drinking – and to intoxication - are also significant. Recent research has been helpful in developing models that analyse this web of interaction (e.g. Holder, 1998). This research supports the common-sense notion that preventative action is more likely to be successful if the system that generates problems is considered and tackled as a whole. Individual measures need to take place within a consistent framework, and to be mutually reinforcing. The

absence of an alcohol strategy to date has meant that government approaches have sometimes tended to be piecemeal rather than concerted and strategic.

- **A holistic and systemic response is most likely to be effective. Within the field of alcohol (as with other substances) we believe that when balancing priorities and interests, the prevailing principles should be the promotion of health and the reduction of harm.**

2.5. QAAD fully agrees with the focus of this review on the social problems when alcohol is misused. We are particularly concerned that partners and children should be supported under these circumstances. As Quakers, we also believe that all people are equal, unique and precious, and that anyone with an alcohol problem who wants assistance deserves it in their own right – even if they have only been harming themselves.

3. POLICIES/ MEASURES

3.1. Drinking and Driving

We believe that the UK should join the majority of EU countries in pursuing a policy about drinking and driving that more closely reflects the first principle of the 1995 Charter on Alcohol. As the Department of Transport states in its own summary of evidence, the risk of a non-fatal accident at blood alcohol levels between 50 mg and the current limit of 80 mg is estimated to be 2 to 2.5 times more than for a sober driver. For fatal accidents this risk loading is 6 times that of a sober driver. (“Combating Drink Driving,” Annex 2, 2000).

- **We recommend the reduction of the permissible limit for drivers to 50 mg of alcohol per 100 ml of blood. We also endorse the other recommendations in relation to driving advanced by Alcohol Concern in its Strategy document of 1999.**

Since the consumption of alcohol increases the risk of accident even at the lower limit of 50 mg, a longer-term aim would be to decrease the permitted level further. Norway has reduced it to 20 mg, and is able to do so because public attitudes sustain and support this policy. Other evidence suggests that public information campaigns can be effective in increasing support for specific policies such as random breath-testing, stricter law enforcement, or control of hazardous drinking behaviour (*Holder, 1994; Casswell and Gilmour, 1989*).

- **We recommend public information campaigns (not only at high-risk times) to increase safety-conscious attitudes and public support for enforcement strategies.**

3.2. Supply controls

In view of the body of evidence cited above, we believe some general measures are necessary to reduce the risk of harm and to encourage moderation in drinking behaviours.

- **We recommend that alcohol policy aims at maintaining annual per capita consumption at or below 8 litres of alcohol: measures should include, but not be confined to, taxation and pricing. Variations in patterns of consumption make this a complex issue, but in broad terms, policy should be aimed at ensuring the average per capita consumption of the drinking population reflects recommended limits.**

As regards binge-drinking and intoxication, there is some evidence that this can also be affected by raised prices. However, this is a complex phenomenon and a mixture of measures is most likely to be most effective. We believe that some of the steps listed below would have an impact.

3.3. Planning/Licensing

There is an increasing body of evidence about the factors that increase the likelihood of intoxication on licensed premises, and subsequent problems that can arise from it (violence, disorder, and drink-driving). Australian evidence (that does seem transferable) suggests that aggression is more likely in bars where drunkenness is frequent and where discounted drinks promotions are the practice. High densities of licensed establishments tend to result in price-cutting promotions that also increase the risk of such behaviour. (*Stockwell, T., Norberry, J., Solomon, R. 1995*). Positive measures that reduce risk include venues with a relaxed social atmosphere with reasonable decorum expectations, server training, codes of responsible practices including the non-serving of intoxicated or under-age patrons, and server intervention to control behaviour. Initiatives such as the “SIPS” approach in Scotland are also helpful.

- **We recommend a code of practice for licencees that embodies these principles, and that this is monitored and enforced (or another effective mechanism devised)**
- **We recommend that such a code ensures the availability of non-alcoholic drinks in licensed venues, and that these are priced at levels to encourage rather than deter consumption**
- **We recommend that Local Authorities are able to plan appropriate densities of licensed premises, and be allowed to refuse licences if these numbers are exceeded**

3.4. Labelling

Some evidence (e.g. most recent ONS results) suggests that higher-level drinkers are more, rather than less likely to understand measuring alcohol intake in units. Fuller interventions (see 3.7) may be more suitable and helpful here. However, clear labelling will obviously assist health and education messages for the majority of drinkers.

- **We recommend comprehensive, mandatory labelling of alcohol products in units per glass/measure and per bottle; that similar information be displayed on prices lists in bars; and that both are set within safe drinking advice**
- **We welcome the progress the industry has made on a voluntary basis**

3.5. Advertising

Publicly funded health/education campaigns aim to give balanced information, but work within a context where far greater sums are spent by the industry on the promotion of alcohol as wholly positive. This is a particularly acute issue as regards advertising aimed at young adults and seen by children and teenagers. Some advertisements associate alcohol with adventurousness or sexual attractiveness, while others suggest alcohol's perception and mood-altering properties. Illicit drugs can also be taken for similar purposes, and some drugs have more obvious effects in these respects than does alcohol. It is vital to be truthful with young people about the effects of substances, but to do this in a responsible and balanced context. When alcohol and drugs education has to work against more powerful but less honest messages, its effectiveness is likely to be diminished.

- **We endorse Alcohol Concern's proposals regarding advertising, and particularly that there be a review of the content and interpretation of advertising codes in relation to young people.**
- **We welcome the initiatives of the alcohol industry that stress safety messages**

3.6. Education/prevention campaign

Social attitudes - in which we all play a part - also have a significant influence on alcohol and its use. Our own experience is that people readily engage with this subject and are keen to have

more information. We also endorse the point made by Raistrick et al., that public education on the nature of policy issues is part of the policy job.

- **We recommend that regular public education campaigns take place along the lines suggested by Alcohol Concern**
- **Health/education messages that stress sensible limits for drinking on a single occasion (in addition to information about weekly/daily limits)**

3.7. Interventions and treatment

Recent initiatives in the drug field have been very welcome in the main, but have strengthened the imbalance between resources devoted drugs and those to alcohol. In the area of staffing, some workers have been drawn from alcohol into the drugs field, and some from practice into increasingly weighty commissioning and monitoring infrastructures. Skills shortages and resourcing need to be addressed in planning, but we welcome the inclusion of alcohol in these initiatives.

- **We are in favour of the remit of the National Treatment Agency being extended to cover alcohol, and thus for all DATS to include alcohol in their planning.**
- **We recommend increased resources for treatment services, and for audits to include information on the proportion of funding devoted to direct service provision and that devoted to supporting/monitoring infrastructures**
- **We recommend HR, organisational and salary policies that reward experienced/able staff for remaining in practice. We recommend that training initiatives use the expertise of these staff in their existing treatment roles, rather than draw them into separate delivery/evaluation structures.**
- **We are in favour of provision being made available through the criminal justice system - including for cases of domestic violence. However, monitoring should keep a check that the demand for services via the criminal justice system does not overwhelm treatment, and result in decreased provision for others needing help.**
- **We recommend that prison treatment programmes and aftercare make specific provision for alcohol misusers.**
- **We recommend greater service provision for family members/significant others.**
- **We recommend the development of alcohol education initiatives on licensed premises: for example, the interesting experiment in Australia, where brief interventions were successfully delivered with the active co-operation of licensees, health and police (*Reilly et al., 1998*).**
- **We recommend the greater use of brief interventions generally, and further experimentation with these approaches (see, for example, *Murgraff et al., 1996*: promising indications regarding brief interventions and binge-drinking behaviours).**

Research

- **We recommend that research into key areas is concerted nationally. We think subjects should include underage and binge-drinking, and also the influence of supply-side factors (licit and illicit alcohol markets) on consumption patterns. Integration with NTA research into treatment effectiveness would also be helpful.**
- **Changes in licensing and in the gambling laws are both pending but have not yet been implemented fully. We recommend prompt joint research with the new Gambling Trust, that would take baseline information, and monitor the effects of alcohol consumption on play and problem play in licensed premises.**

We wish the Strategy Unit every success with its work.

Submitted by Helena Chambers on behalf of QAAD, January 2003

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