

The Government's Alcohol Strategy



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Presented to Parliament
by the Secretary of State for the Home Department
by Command of Her Majesty

March 2012

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PM Foreword

Binge drinking isn't some fringe issue, it accounts for half of all alcohol consumed in this country. The crime and violence it causes drains resources in our hospitals, generates mayhem on our streets and spreads fear in our communities.

My message is simple. We can't go on like this. We have to tackle the scourge of violence caused by binge drinking. And we have to do it now.

This strategy sets out how we will attack it from every angle. More powers to stop serving alcohol to people who are already drunk. More powers for local areas to restrict opening and closing times, control the density of licensed premises and charge a late night levy to support policing. More powers for hospitals not just to tackle the drunks turning up in A&E – but also the problem clubs that send them there night after night. And a real effort to get to grips with the root cause of the problem. And that means coming down hard on cheap alcohol.

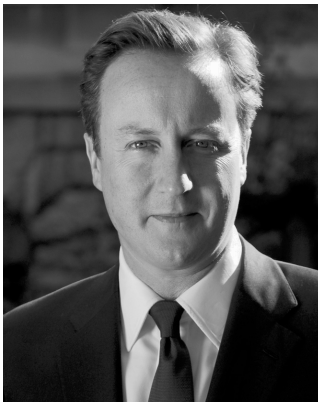
When beer is cheaper than water, it's just too easy for people to get drunk on cheap alcohol at home before they even set foot in the pub. So we are going to introduce a new minimum unit price. For the first time it will be illegal for shops to sell alcohol for less than this set price per unit. We are consulting on the actual price, but if it is 40p that could mean 50,000 fewer crimes each year and 900 fewer alcohol-related deaths a year by the end of the decade.

This isn't about stopping responsible drinking, adding burdens on business or some new kind of stealth tax - it's about fast, immediate action where universal change is needed.

And let's be clear. This will not hurt pubs. A pint is around two units. If the minimum price is 40p a unit, it won't affect the price of a pint in a pub. In fact, pubs may benefit by making the cheap alternatives in supermarkets more expensive.

We are working in partnership with business on all the proposals in the strategy, and I am pleased that the drinks industry are playing their part in promoting responsible drinking - including by giving consumers a wider choice of lower strength products and smaller servings to take one billion units out of the market by 2015.

Of course, I know the proposals in this strategy won't be universally popular. But the responsibility of being in government isn't always about doing the popular thing. It's about doing the right thing. Binge drinking is a serious problem. And I make no excuses for clamping down on it.



A handwritten signature in black ink that reads "David Cameron". The signature is written in a cursive, flowing style. The name "David" is written in a larger, more prominent script than "Cameron".

1. Introduction – a new approach

- 1.1 Fifty years ago, the United Kingdom had one of the lowest drinking levels in Europe but it is now one of the few European countries whose consumption has increased over that period. Over the last decade we have seen a culture grow where it has become acceptable to be excessively drunk in public and cause nuisance and harm to ourselves and others.
- 1.2 In moderation, alcohol consumption can have a positive impact on adults' wellbeing, especially where this encourages sociability. Well-run community pubs and other businesses form a key part of the fabric of neighbourhoods, providing employment and social venues in our local communities. And a profitable alcohol industry enhances the UK economy. The majority of people who drink do so in an entirely responsible way, but too many people still drink alcohol to excess. The effects of such excess – on crime and health; and on communities, children and young people – are clear.
- 1.3 A combination of irresponsibility, ignorance and poor habits – whether by individuals, parents or businesses – led to almost 1 million alcohol-related violent crimes¹ and 1.2 million alcohol-related hospital admissions in 2010/11 alone. The levels of binge drinking among 15-16 year olds in the UK compare poorly with many other European countries² and alcohol is one of the three biggest lifestyle risk factors for disease and death in the United Kingdom after smoking and obesity. It has become acceptable to use alcohol for stress relief, putting many people at real risk of chronic diseases. Society is paying the costs – alcohol-related harm is now estimated to cost society £21 billion annually.
- 1.4 The problem has developed for the following reasons:
 - Cheap alcohol is too readily available and industry needs and commercial advantages have too frequently been prioritised over community concerns. This has led to a change in behaviour, with increasing numbers of people drinking excessively at home, including many who do so before they go on a night out, termed 'pre-loading'. In a recent study, around two-thirds of 17-30 year olds arrested in a city in England claimed to have 'pre-loaded'³ before a night out, and a further study found 'pre-loaders' two-and-a-half times more likely to be involved in violence than other drinkers⁴.
 - Previous governments have failed to tackle the problem. The vibrant café culture, much promised by the previous Government's Licensing Act, failed to

¹ Chaplin, R., Flatley, J. and Smith, K. (2011) Crime in England and Wales 2010/11. Home Office Statistical Bulletin 10/11. London: Home Office. Supplementary Table 7.11- <http://www.homeoffice.gov.uk/science-research/research-statistics/crime/crime-statistics/bcs-supplementary-tabs/>.

² Hibell, B. (et al) The 2007 ESPAD report. Substance use among students in 35 European countries.

³ Barton, A. and Husk, K. (forthcoming) Controlling pre-loaders: alcohol related violence in an English night time economy. Drugs and Alcohol Today.

⁴ Hughes, K., Anderson, Z., Morleo, M. and Bellis, M.A. (2008) 'Alcohol, nightlife and violence: the relative contributions of drinking before and during nights out to negative health and criminal justice outcomes', *Addiction*, 103 (1), pp 60-5.

materialise. Too many places continue to cater for, and therefore remain blighted by, those who drink to get drunk, regardless of the consequences for themselves or others.

- There has not been enough challenge to the individuals that drink and cause harm to others, and of businesses that tolerate and even encourage this behaviour.

The result is a situation where responsible citizens and businesses are paying the price for irresponsible citizens and businesses.

1.5 This strategy signals a radical change in the approach and seeks to turn the tide against irresponsible drinking. Such change will not be achieved overnight. It will require long-term and sustained action by local agencies, industry, communities and the Government. We will:

- Take firm and fast action where immediate and universal change is needed. Chapter 2 sets out how we will end the availability of cheap alcohol and irresponsible promotions. We will introduce a minimum unit price for alcohol and will consult on the introduction of a ban on multi-buy promotions in the off-trade.
- Ensure that local areas are able to tackle local problems, reduce alcohol-fuelled violent crime on our streets, and tackle health inequalities. Chapter 3 sets out the extensive range of tools and powers we are giving to local agencies to challenge those people that continue to behave in an unacceptable way and make it easier to take action against and, if necessary, close down, problem premises. It asks local areas to make decisions for themselves, working effectively in partnership and giving communities the information they need to hold local services to account. We will give stronger powers to control the density of licensed premises and make health a licensing objective for this purpose. We will give areas the powers to restrict alcohol sales if late opening is causing problems through extended powers to make Early Morning Restriction Orders; introduce a new late night levy so that those businesses that trade into the late night contribute towards the cost of policing; and end the notion that drinking is an unqualified right by piloting sobriety schemes for those people whose offending is linked to excessive alcohol consumption. We will also support hospitals to tackle unacceptable drunken behaviour at A&E.
- Secure industry's support in changing individual drinking behaviour. Chapter 4 recognises the crucial role that the industry can play in changing the drinking culture, from one of excess to one of responsibility; and from one where alcohol is linked to bad behaviour to one where it is linked to positive "socialising". It sets out how we will build on the Responsibility Deal to drive greater industry responsibility and action to prevent alcohol misuse, including giving consumers a wider choice of lower strength products in both the on-trade and off-trade, taking one billion units out of the market by 2015. We promise to support and free up businesses that are acting responsibly but, through the Responsibility Deal, extend a challenge to all of industry to make more progress, more quickly on the responsible production, sale and promotion of alcohol.
- Support individuals to make informed choices about healthier and responsible drinking, so it is no longer considered acceptable to drink excessively. Chapter 5

sets out how we will ensure that everyone understands the risks around excessive alcohol consumption to help them make the right choices for themselves and their families, including through asking Dame Sally Davies, the Chief Medical Officer, to oversee a review of the alcohol guidelines for adults. It provides details on the support system that should be available for those that need particular help in changing their behaviour, including an alcohol check within the NHS Health Check for adults.

1.6 Our ambition is clear – we will radically reshape the approach to alcohol and reduce the number of people drinking to excess. The outcomes we want to see are:

- A change in behaviour so that people think it is not acceptable to drink in ways that could cause harm to themselves or others;
- A reduction in the amount of alcohol-fuelled violent crime;
- A reduction in the number of adults drinking above the NHS guidelines⁵;
- A reduction in the number of people “binge drinking”⁶;
- A reduction in the number of alcohol-related deaths; and
- A sustained reduction in both the numbers of 11-15 year olds drinking alcohol and the amounts consumed.

1.7 Further information on trends in alcohol use and harm and effective practice is available at the Alcohol Learning Centre (<http://www.alcohollearningcentre.org.uk>).

1.8 The taxation aspects of this strategy will apply UK-wide. The provisions on crime and policing, alcohol licensing and pricing set out in this strategy are only intended to apply to England and Wales. We will work closely with the devolved administrations in Scotland and Northern Ireland to ensure a co-ordinated approach to those issues that is in line with the devolution settlement.

⁵ No more regularly than 3 to 4 units per day for men and no more regularly than 2 to 3 units per day for women.

⁶ Measured by those who self-report drinking on their heaviest drinking day in the previous week more than 8 units per day for men and more than 6 units per day for women.

2. Turning the tide

2.1 Over the last decade, we have witnessed a dramatic change in people's attitude to, and the harms caused by, alcohol consumption. We estimate that in a community of 100,000 people, each year:

- 2,000 people will be admitted to hospital with an alcohol-related condition;
- 1,000 people will be a victim of alcohol-related violent crime;
- Over 400 11-15 year olds will be drinking weekly;
- Over 13,000 people will binge-drink;
- Over 21,500 people will be regularly drinking above the lower-risk levels;
- Over 3,000 will be showing some signs of alcohol dependence; and
- Over 500 will be moderately or severely dependent on alcohol.

2.2 These statistics highlight the urgent and unquestionable need for all of those who drink alcohol – no matter who they are or what they do – to take responsibility for their drinking behaviour and establish a less risky approach to drinking as the norm. Such change will require collective action by individuals, communities, local agencies and industry. The following chapters set out how the Government will support, enable and challenge them to achieve this.

2.3 Wherever possible, action to tackle alcohol-related harm, crime and disorder should be taken at the local level by those who understand the problems that their community is facing. However, at times, action is needed to achieve universal and radical change across the country and tackle the underlying issues. This chapter sets out how the Government will lead the way and turn the tide against irresponsible sales and promotion of alcohol.

Reducing the availability of cheap alcohol

2.4 In 2010, £42.1 billion was spent on alcohol in England and Wales alone⁷. Alcohol has been so heavily discounted that it is now possible to buy a can of lager for as little as 20p or a two litre bottle of cider for £1.69. There is strong and consistent evidence that an increase in the price of alcohol reduces the demand for alcohol which in turn can lead to a reduction in harm, including for those who regularly drink heavily and young drinkers under 18.⁸⁹ We can no longer afford to ignore this.

2.5 The Government's Review of Alcohol Taxation in November 2010, recognised that the majority of drinkers consume alcohol in a responsible manner. However, the harms associated with problem consumption of alcohol remain a concern. The Government has already taken action to tackle the availability of heavily discounted alcohol by:

- Raising alcohol duty by 2% above retail inflation (RPI) each year to 2014-15;
- Introducing a 'minimum juice' rule for cider, so that high strength white ciders can no longer qualify for the lower rates of duty that apply to cider; and

⁷ Clancy, G. (2011). Consumer Trends Quarter 1 2011, No. 60. Office for National Statistics. <http://www.ons.gov.uk/ons/rel/consumer-trends/consumer-trends/q1-2011/index.html>.

⁸ Booth, A., Meier, P., Stockwell, T., Sutton, A., Wilkinson, A., Wong, R. (2008) Independent review of the effects of alcohol pricing and promotion. Department of Health.

⁹ The likely impacts of increasing alcohol price: a summary review of the evidence base (2011). Home Office.

- Introducing a new higher rate of duty for high strength beer over 7.5% Alcohol By Volume (ABV) and a new lower rate of duty for beer at 2.8% ABV and below to align duty more closely to alcohol strength.
- 2.6 The UK would support any future changes to the EU rules to allow duty on wine to rise in line with alcoholic strength. The UK will also seek a full impact assessment, including the health aspects, of the EU Commission's proposal on the Reform of the Common Organisation of the Market in Wine due in 2013.
- 2.7 These are significant steps forward but, as there is such a strong link between price and consumption, we need to go further still to end the irresponsible promotion and discounting of alcohol. This is why we will take an ambitious approach to tackling the issue of excessive alcohol consumption.
- 2.8 We will introduce a minimum unit price (MUP) for alcohol meaning that, for the first time ever in England and Wales, alcohol will not be allowed to be sold below a certain defined price. We will consult on the level in the coming months with a view to introducing legislation as soon as possible.
- 2.9 We will also consult on a ban on multi-buy promotions in the off-trade (shops) meaning that multiple bottles or cans could not be sold cheaper than the multiple of one bottle or can. This would put an end to any alcohol promotion or sale that offers customers a discount for buying multiple products in stores and therefore those that encourage and incentivise customers to buy larger quantities than they want.
- 2.10 We do not currently intend to apply this ban to the on-trade (pubs, bars, restaurants etc.) as this is already a more controlled and regulated drinking environment. We will launch a review of current commitments within the Mandatory Code for Alcohol to ensure they are sufficiently targeting problems such as irresponsible promotions in pubs and clubs. We will also consult on applying the Mandatory Code to all sectors involved in the sale of alcohol, where relevant.
- 2.11 Given our intention to introduce MUP, we do not currently intend to implement a ban on the below cost sale of alcohol (defined as Duty+VAT). The introduction of MUP is likely to provide a net benefit to many retailers without a specific tax on any surplus profits. Rather than introducing a new levy or tax on surplus profits, we intend to work with industry to use any additional revenue to provide better value to customers in other areas (ending the situation where loss-leading on alcohol means that moderate drinkers effectively subsidise heavy drinkers through the cost of their weekly shop).

Alcohol Advertising

- 2.12 There is known to be a link between advertising and people's alcohol consumption, particularly those under the age of 18.¹⁰ Some countries have introduced a complete ban on alcohol advertising (Norway) or a ban on TV advertising with other controls (France) to tackle this. So far we have not seen evidence demonstrating that a ban is

¹⁰ Booth, A., Meier, P., Stockwell, T., Sutton, A., Wilkinson, A., Wong, R. (2008) Independent review of the effects of alcohol pricing and promotion. Department of Health.

a proportionate response but we are determined to minimise the harmful effects of alcohol advertising.

- 2.13 Alcohol advertising in the UK is already subject to controls that seek to prevent advertisers targeting and appealing to young people. The controls cover broadcast, print and online advertising and are a mix of co-regulation (with Ofcom) and self-regulation, administered by the Advertising Standards Authority (ASA) and the Portman Group. The Portman Code covers marketing such as sponsorship, promotion and product packaging. We will work with the Portman Group to ensure that where unacceptable marketing does occur, it results in the removal of offending brands from retailers.
- 2.14 The existing controls have the ability to address the problems associated with advertising alcohol but the system depends on people being aware of the controls and how they can complain. We will work with industry and other relevant bodies to help raise public awareness of the controls and encourage public feedback.
- 2.15 There are specific rules to prevent adverts being shown in a context which will have ‘a particular appeal’ to people aged under 18¹¹. While these rules restrict the targeting of young people, they still allow potentially large numbers of under-18s to see alcohol advertising. We will work with the ASA and Ofcom to examine ways to ensure that adverts promoting alcohol are not shown during programmes of high appeal to young people.
- 2.16 Due to the proliferation of media channels in recent years, the opportunities to interact with alcohol marketing have increased. It is important that this increased capacity allows advertisers more precisely to minimise young people’s interaction with alcohol marketing. The ASA recently extended its remit further into new media marketing. We will work with the ASA to ensure the full and vigorous application of ASA powers to online and social media and work with industry to develop a scheme to verify people’s actual ages, which will apply to alcohol company websites and associated social media.
- 2.17 As part of the Bailey Review, a range of media regulators, including the ASA and Ofcom, recently set up a single, user-friendly website, called ParentPort, to make it easier for parents to make complaints, get information on regulation, and leave comments if they feel a programme, advertisement, product or service is inappropriate or unsuitable for their children. We will look for opportunities to create links through to ParentPort from high traffic sites to ensure that people can easily report any alcohol adverts they think are unsuitable. We will also work with the ASA and other relevant bodies to look at the rules and incentives that might inhibit the promotion of lower strength alcohol products and the encouragement of responsible drinking behaviours.

¹¹ For broadcast adverts the restriction is triggered when the Broadcasters’ Audience Research Board (BARB) ¹¹ audience index for those aged 10-15 is 120 or more (i.e. more than 20% above their share in the population). Similarly for non-broadcast advertising there is a specific rule that no medium can be used to advertise alcoholic drinks if more than 25% of its audience are under 18.

Responding to emerging issues

2.18 The Government has a responsibility to identify and tackle new and emerging threats or issues, whether they are crime-related such as the increase in alcohol duty fraud; health-related such as the rising incidence of liver disease in young adults; or both such as the growing availability of counterfeit alcohol.

2.19 Alcohol duty fraud costs the Government up to £1.2 billion per year and organised crime groups are responsible for much of this cost. In 2010, HMRC introduced a renewed strategy to tackle all forms of alcohol duty fraud. Despite this, beer duty fraud in particular remains a significant problem. In 2012, Government announced its intention to consult on alcohol anti-fraud measures, including the introduction of fiscal marks for beer, supply chain legislation, and a licensing scheme for wholesale alcohol dealers.

2.20 In the UK, There has been a 25% increase in liver disease between 2001 and 2009. Alcohol-related liver disease accounts for over a third (37%) of all liver disease deaths¹². It is predicted that the cost to the NHS of managing this could be around £1 billion per year by 2015. While liver disease is not caused solely by excessive drinking, alcohol is the major contributor. The recently published liver disease strategy sets out: the reasons why liver disease is an increasing concern for the country; the vital need to prevent this disease better; and what the NHS and local areas will need to do to tackle it.

We will take national action to:

- Tackle the availability of cheap alcohol through the introduction of a minimum unit price for alcohol and consult on a ban on multi-buy promotions in the off-trade.
- Launch a review of current commitments within the Mandatory Code for Alcohol to ensure they are sufficiently targeting problems such as irresponsible promotions in pubs and clubs.
- Consult on alcohol anti-fraud measures, including the introduction of fiscal marks for beer, supply chain legislation, and a licensing scheme for wholesale alcohol dealers.
- Work with the Portman Group to ensure that where unacceptable marketing does occur, it results in the removal of offending brands from retailers.
- Work with the ASA and Ofcom to examine ways to ensure that adverts promoting alcohol are not shown during programmes of high appeal to young people.
- Work with the ASA to ensure the full and vigorous application of ASA powers to online and social media and work with industry to develop a scheme to verify people's actual ages which will apply to alcohol company websites and associated social media.
- Work with the ASA and other relevant bodies to look at the rules and incentives that might inhibit the promotion of lower strength alcohol products.

¹² Deaths from liver disease Implications for end of life care in England (2012). NHS National End of Life Care Programme.

3. Taking the right action locally

3.1 Local communities, services and businesses are best placed to tackle alcohol-related issues in their area and enforce the behaviour and develop the cultures that they want. Over the last year, we have taken significant steps to enable local agencies to take the right action locally. We have set out a new approach to crime, policing and health, reforming the delivery landscape so that:

- From April 2013, upper tier and unitary local authorities will receive a ring-fenced public health grant, including funding for alcohol services. Local authorities will be supported by Public Health England. They will be free to design services to meet local needs, working in partnership where this makes sense for them. This can maximise the scope for early interventions and can better meet the needs of specific groups.
- Health and Wellbeing Boards will bring together councils, the NHS and local communities to understand local needs and priorities through the Joint Strategic Needs Assessment (JSNA) and develop a joint Health and Wellbeing Strategy, which will set out how they will work together to meet these needs. The boards will be able to promote integration of health and social care services with health-related services like criminal justice services, education or housing. This will help join up services around individuals' needs and improve health and wellbeing outcomes for the local population.
- From November 2012, directly elected Police and Crime Commissioners (PCCs) will ensure the public's priorities drive local police force activity and hold chief constables to account on action taken locally. As well as their core policing role, PCCs will have a remit to cut crime and anti-social behaviour and will have commissioning powers and funding to enable them to do this with partners. They will need to work collaboratively with other local leaders – including establishing strong links with Health and Wellbeing Boards, Clinical Commissioning Groups and local authorities – to develop common causes with partners on a range of crime and health issues and achieve the most effective community safety and criminal justice outcomes for communities.

3.2 These local structures will provide mechanisms to ensure that the needs of all populations, and all issues, are considered, from the health of the population through to community safety and the needs of offenders or those dependent on alcohol. Local areas should ensure commissioning for drugs and alcohol services has the right representation, accountability and engagement to deliver on these broad aims.

Changing behaviour at the local level

3.3 Over the last few years, town centres have become increasingly focused on the night time economy and, as a result, we have seen a growth in licensed premises. Areas such as Durham, and schemes such as Best Bar None, Purple Flag, Community Alcohol Partnerships, Pubwatch and Business Improvement Districts across the country have shown that a thriving and growing night time economy can operate where excessive drinking is tackled consistently and robustly by business, the police and local authorities working together.

- 3.4 It is up to local communities to set the standards and behaviours that they want to see in their surrounding area. This is why we have radically reformed our approach to policing with the introduction of directly elected PCCs, and to licensing through the Police Reform and Social Responsibility Act 2011. This gives power back to local agencies for local alcohol issues and more control over the opening and closing hours of local businesses to stop crime and disorder from stretching into the early hours of the morning.
- 3.5 We are giving local areas powers to take firm action to address the harms from alcohol and, if necessary, close down problem premises. From 25 April 2012, licensing authorities and local health bodies will formally become 'responsible authorities' under the Licensing Act 2003, ensuring that they are automatically notified of an application or review, and can more easily instigate a review of a licence themselves. At the same time, new powers will make it easier to refuse, revoke or impose conditions on a licence by reducing the evidential threshold from 'necessary' to 'appropriate', thereby making it easier to challenge irresponsible businesses.
- 3.6 Individuals and local communities will also have more power to input into decisions locally. The vicinity test on licensing will be removed, meaning that anyone – no matter where they live – will be able to input into a decision to grant or revoke an alcohol licence, not just those that live in the immediate vicinity. From October 2012, extended powers to make Early Morning Restriction Orders (EMROs) will enable local areas to restrict alcohol sales late at night if they are causing problems.
- 3.7 There is evidence of a link between the number of venues selling alcohol in one area and levels of harm, whether this is crime, damage to health, or harm to young people¹³. We therefore believe local communities should be able to limit the density of premises where this is contributing to the major types of harm. Cumulative Impact Policies (CIPs) can do this to tackle certain issues, but we want to go further and will amend the statutory guidance on the Licensing Act 2003 to make clear that CIPs apply to both the on-trade and the off-trade and that licensing authorities can reflect the needs of their local area by using measures such as fixed closing times, staggered closing times and zoning where they consider them to be appropriate. We will also strengthen local powers and the public's ability to control the density of premises by making it easier to introduce CIPs by reducing the burden of evidence on licensing authorities when making their decision.
- 3.8 We want to go further and ensure local action on alcohol is even more open and transparent to the public. Police.uk provides communities across England and Wales with street-level crime and anti-social behaviour information, including those occurring on or near a number of key public spaces, hospitals, nightclubs and supermarkets. From May 2012, this will include information on what happens after crimes are recorded occurring in those places, for example information on the action

¹³ Popova, S., Giesbrecht, N., Bekmuradov, D. and Patra, J. (2009) Hours and days of sale and density of alcohol outputs: Impacts on alcohol consumption and damage: A systematic review. *Alcohol & Alcoholism*. Vol. 44, No. 5, pp500-516

taken by the police or the sentence imposed by the court. Locally, some areas may publish even more detailed information, such as details of those individuals subject to Drinking Banning Orders (DBOs).

- 3.8 As part of our reforms to encourage greater community involvement in local alcohol licensing decisions, from April 2012, we will require licensing authorities to publish locally key information about new licensing applications, including details of the address of the relevant premises and guidance on how to make representations to the licensing authority. We will pilot how to provide further information on crime occurring on or near local alcohol hotspots as well as trialling publication of further licensing data online. This could include, for example, work with local authorities to encourage publication of licence conditions for premises online so that the public know what they are and can report when conditions are being broken or information on irresponsible licensed premises whose failure to tackle drunken behaviour results in hospital admissions.

Challenge and enforcement

- 3.9 Communities should not have to tolerate alcohol-related crime and disorder. Almost a quarter (24%) of the public think that drunk or rowdy behaviour is a problem in their local area¹⁴. Individuals should not expect to be able to ignore their responsibilities when drunk. We will ensure local agencies and the police have the powers to make those who cause harm face the consequences of their actions.
- 3.10 Local services already have access to a wide range of tools and powers to challenge those that cause harm to themselves and others. We expect the police and local authorities to take quick and firm action to tackle and punish those premises and individuals that are acting irresponsibly and to protect the most vulnerable in our communities. Proactive visible policing is vital to managing the night time economy – nipping bad behaviour in the bud and setting the tone locally. In many areas the police play a preventative role – focusing targeted effort to reduce problems to prevent the need for greater action later on. The need for an increased police presence on the streets at night to manage the problems from alcohol can put pressure on local resources. From October 2012, a new late night levy will empower local areas to make those businesses that sell alcohol late into the night contribute towards the cost of policing and wider local authority action. This will help enable visible and proactive policing at targeted locations where there are local needs.
- 3.11 We are also making sure local areas have strong powers to protect the vulnerable. We are doubling the maximum fine for persistently selling alcohol to a person under 18 to £20,000 and making it easier to close down premises found to be persistently selling alcohol to young people. The police also have powers to seize alcohol from young people under the age of 18 and can prosecute a further offence of persistently possessing alcohol in a public place. We are working with the Sentencing Council

¹⁴ Chaplin, R., Flatley, J. and Smith, K. (2011) *Crime in England and Wales 2010/11*. Home Office Statistical Bulletin 10/11. London: Home Office.

and others in the criminal justice system to encourage greater use of existing powers to prosecute and sentence those that have committed the persistent sales offence.

3.12 Where we identify that tools and powers are being used insufficiently, we will work with the police and others to change this. For example, it is an offence, under the Licensing Act 2003, to knowingly serve alcohol to a drunk but there were only three convictions for this offence in 2010. This could send a powerful message locally and we will work with the police to tackle the issue of serving alcohol to drunks including exploring how greater use can be made of existing powers and how test purchasing can support this.

3.13 Where local communities think tools are not targeted or effective enough, we will give the police and local partners faster and more flexible powers to tackle local problems. We know, for example, that increasing numbers of licensing teams are now made up of Police Community Support Officers (PCSOs) and support staff and will therefore explore the benefit of an additional discretionary power for PCSOs to enter licensed premises (Section 179 of the Licensing Act 2003) to support the enforcement of licensing locally. We will also tackle problem drinking through our reforms to anti-social behaviour tools and powers.

Rights and responsibilities

3.14 A&E departments can be a particular flashpoint for those who have drunk to excess, causing fear and distress to others awaiting and administering treatment. We should not tolerate any violence or disorder in hospitals and will make a range of measures available to tackle this unacceptable behaviour.

3.15 We will support NHS Trusts and Foundation Trusts to work with their local police to ensure that appropriate action is taken, including through hospital security staff being empowered through the Community Safety Accreditation Scheme. Under this scheme, accredited staff can be given powers to issue Penalty Notices for Disorder (£80 fines) to those individuals whose drunken behaviour is likely to cause harassment, alarm or distress. They can also take action against the consumption of alcohol in a designated public place. Some hospitals have found it effective to place police officers in A&Es. We would encourage forces to look at this model and consider using late night levy funding to support such a role according to local needs.

3.16 Those who seek treatment in A&E departments must respect their surroundings or lose their right to the same service standards as others. The NHS Constitution sets a maximum waiting time for A&E departments of four hours but recognises that abusive or violent behaviour would be reasonable grounds to refuse access to NHS services, meaning staff can refuse to treat drunks who are abusive in A&E. We will go even further to tackle violence against hospital staff. We are developing new injunctions as part of our reforms to anti-social behaviour tools and powers and we will explore giving NHS Protect (the body that leads work to identify and tackle crime across the health service) the power to apply for these injunctions. This would give the NHS the ability to deal with individuals who persistently cause a problem in hospitals, for example those who are regularly drunk and abuse staff.

3.17 We are also giving local areas new powers to take firm action against irresponsible premises which fail to tackle drunken behaviour. From 25 April 2012, licensing authorities and local health bodies will formally become 'responsible authorities' under the Licensing Act 2003. For the first time, local health bodies will be able to instigate a review of a licence. This means that a hospital that is regularly dealing with patients at A&E as a result of alcohol-related violence at a particular pub will now be able to instigate a review of the licence at those premises. If things do not improve, we would expect the premises to lose their licence.

3.18 It is vital that licensing authorities are able to take health-related harms into consideration in decisions on Cumulative Impact Policies (CIPs). This is a current gap and could make an important contribution to local wellbeing, including in deprived communities that are suffering health inequalities. We will therefore launch a consultation on a new health-related objective for alcohol licensing related specifically to cumulative impact. This will enable health bodies to input into decisions on applications for new licences, so that local health harms, including those seen in A&E departments, are a key factor in deciding whether a new licence is granted.

3.19 We will also end the notion that drinking is an unqualified right without any associated sense of responsibility. We will run innovative trials of enforced sobriety schemes making use of existing powers as part of Conditional Cautions and community sentence orders, for people convicted of alcohol-related crimes. The Conditional Caution scheme will focus on lower level offences such as drunk and disorderly, criminal damage and public disorder. The pilot areas for the conditional caution scheme will be Westminster, St. Helens, Hull, Plymouth and Cardiff. Later this year, we also intend to pilot compulsory sobriety measures for community orders which will focus on more serious offences such as common assault and actual bodily harm. We are also introducing new powers on sobriety in the Legal Aid, Sentencing and Punishment of Offenders Bill.

3.20 Through the trials, we intend to test both the use of breathalysers and specialist electronic tags which monitor alcohol levels to determine what forms of monitoring are most suitable in terms of effectiveness, enforceability and cost. We have already commenced testing this innovative tagging equipment as this will be the first time that it has been trialled for these purposes in this country.

Working across boundaries

3.21 None of this can be achieved by one agency or service alone. The factors contributing to harmful alcohol use are complex and vary significantly from place to place. Effective partnership work to reduce and prevent alcohol-related harm will contribute to a range of other local priorities including improving wellbeing, especially that of young people; reducing crime and disorder; reoffending; improving health; and also supporting the local economy. The Alcohol Learning Centre¹⁵ summarises advice on effective local partnerships. In her recent report, Baroness Newlove¹⁶ set out how the Government is investing £1million to help local agencies, businesses

¹⁵ <http://www.alcohollearningcentre.org.uk>

and, crucially, local people in ten areas to come together and tackle problem drinking head on. The fund is being provided by the Department for Communities and Local Government and the work will be led by Baroness Newlove.

3.22 Good information sharing is critical if local partners are to understand the scale and range of the problems locally, identify vulnerable groups who are likely to be at higher risk of alcohol-related harm and identify priorities for action. The Coalition Programme for Government included a commitment to require hospitals to share non-confidential information with the police, so they know where gun and knife crime is happening. The implementation of this commitment focuses on all types of violent assault – many of which are alcohol-related. To deliver this commitment, we have promoted the College of Emergency Medicine guidance which is based on the ‘Cardiff model’. This sets out the importance of sharing non-personal data with the police, particularly core information on the date, location and type of assault. It highlights the important role of senior clinical, police and local authority leadership in promoting active use of the intelligence to target policing and tackle problem premises.

3.23 In Cardiff, this approach has shown a sustained reduction of violence-related attendances of up to 40%¹⁷. We will encourage all hospitals to share non-confidential information on alcohol-related injuries with the police.

Evidence based action on health harms

3.24 Local Authorities and Clinical Commissioning Groups will need to work together to meet local needs as identified in the Joint Strategic Needs Assessment. Funding through the Public Health Grant will allow local authorities to commission Identification and Brief Advice, which is proven to be effective in reducing the drinking of people at risk of ill health, and specialised treatment for those with greater needs. Alcohol liaison nurses within A&E have been shown to reduce re-presentations and may in future be co-funded by Clinical Commissioning Groups alongside Local Authorities.

3.25 Local areas should work in partnership to support as much integration across clinical pathways as possible, maximising the scope for early interventions and secondary prevention. Working in partnership will allow the needs of specific groups, such as offenders, to be adequately addressed.

3.26 The *Liberating the NHS* White Paper and the NHS Future Forum’s recent report made clear that the NHS will continue to have a responsibility to take every opportunity to prevent poor health and promote healthy living, including healthier choices on alcohol, by making the most of healthcare professionals’ contact with individual patients. The NHS Future Forum working group on the NHS Constitution will consider this as part of its work on strengthening the Constitution.

¹⁷ Florence, C., Shepherd, J. Brennan, I. and Simon, T. (2011) :Effectiveness of anonymised information sharing and use in health service, police, and local government partnership for preventing violence related injury: experimental study and time series analysis. British Medical Journal 2011

ACTIONS: We will ensure that local areas are able to tackle local problems and will:

- Give local agencies powers to reduce alcohol harm through the changes to public health, new Police and Crime Commissioners, and by rebalancing the Licensing Act.
- Give local communities the tools to restrict alcohol sales late at night, if they are causing problems, through extended powers to introduce Early Morning Restriction Orders.
- Give local communities the power to introduce a new late night levy to ensure those businesses that sell alcohol into the late night contribute towards the cost of policing.
- Work with 5 areas to pilot sobriety schemes, removing the right to drink for those who have shown they cannot drink responsibly.
- Strengthen local powers to control the density of premises licensed to sell alcohol, including a new health-related objective for alcohol licensing for this purpose.
- Work with Baroness Newlove, investing £1m to help local agencies, businesses and local people come together and tackle problem drinking head on.
- Pilot how to provide further information on crime occurring on or near local alcohol hotspots as well as trialling publication of further licensing data online.
- Develop new injunctions as part of our reforms to anti-social behaviour tools and powers and explore giving NHS Protect the power to apply for these injunctions.
- Encourage all hospitals to share non-confidential information on alcohol-related injuries with the police and other local agencies.

4. Shared responsibility with industry

4.1 The alcohol industry and wider retail and hospitality industries play a key role in our economy. Of the 200,000 premises licensed to sell alcohol, most make a positive and valuable contribution to their local communities and to the economy with wider tourist, cultural and export benefits. Well-run and responsible community pubs form an important component of the social fabric of our communities and such supervision of drinking can help prevent crime and disorder.

4.2 However, too much of the industry still supports and encourages irresponsible behaviour through poor product location, under age sales, excessively cheap drinks and encouragement of excessive drinking. We have already set out in Chapter Two the action that the Government will take to put an end to irresponsible practices. The Government is clear though that this responsibility is shared with industry and wants industry to go significantly further on action to tackle the harms of excessive alcohol consumption.

Industry's responsibility to change behaviour

4.3 We are clear that it is not just the responsibility of Government or local agencies to tackle the issue of alcohol-related harm. It is the ethical responsibility of the entire industry – alcohol retailers, alcohol producers and both the on-trade and off-trade – to promote, market, advertise and sell their products in a responsible way. This is recognised by the major alcohol producers, who have established the Portman Group as a self-regulator. We are working with the industry in collaboration with Non-Governmental Organisations (NGOs) through the Responsibility Deal, which does not cover pricing issues or other measures that only Government can take.

4.4 The alcohol industry has a direct and powerful connection and influence on consumer behaviours. We know that:

- people consume more when prices are lower;
- marketing and advertising affect drinking behaviour; and
- store layout and product location affect the type and volume of sales.

4.5 Through the Responsibility Deal, the alcohol industry has adopted a core commitment to “foster a culture of responsible drinking, which will help people to drink within guidelines”. We have a way to go to achieve that culture, as 22% of people say they drink regularly above the guidelines. Industry have already taken action by making pledges in a range of areas:

- Product labelling on unit content, NHS guidelines and drinking when pregnant to cover 80% of products by December 2013;
- Unit messaging in the on-trade and off-trade;
- Combating under age sales through Challenge 21 and 25;
- Funding Drinkaware;
- Actions on advertising, including not putting adverts near schools; and
- Supporting Community Alcohol Partnerships (CAPs) and other local schemes.

4.6 Some individual companies have demonstrated particular leadership, by making additional individual pledges including:

- Heineken in reducing the number of units in popular products;
- ASDA in not stacking alcohol at the front of their stores;
- Diageo in supporting training provided by the National Organisation for Fetal Alcohol Syndrome for 10,000 midwives to advise a million women over the next three years about the dangers of drinking during pregnancy; and
- Support of local schemes such as Best Bar None and Community Alcohol Partnerships (CAPs).

4.7 The Responsibility Deal has made good progress though industry, NGOs and the Government have consistently accepted that we need to make more progress, more quickly. We will therefore continue to work with producers, retailers and NGOs to help reshape how people drink and how they think about alcohol in support of the core commitment.

4.8 We welcome the new pledge from industry to give consumers a wider choice of lower strength products in both the on-trade and the off-trade to take one billion units out of the market by 2015. This will bring significant benefits for public health, reduce crime and demonstrates the positive contribution that industry can make.

4.9 The Responsibility Deal Alcohol Network, which includes industry and NGOs, will seek to make further progress in the following areas:

- Giving consumers better information on their consumption by extending the Responsibility Deal agreement on labels to include calorie content;
- Incentivising smaller servings by providing single / small measures as the default and only providing large measures when specifically requested;
- Providing clearer information about unit content, subject to any revised drinking guidelines; and
- Changing the ease of availability of alcohol through responsible product placement, for example ensuring that alcohol sold in shops is not sold alongside any product that appeals to children.

4.10 Subsequently, we would expect to see progress on:

- Delivery of evidence-based, effective education and prevention programmes intended to reduce drinking by young people;
- Better training for bar staff to reduce sales to people who are drunk;
- Workplace alcohol education and prevention programmes;
- A major extension of schemes such as CAPs, Best Bar None, Purple Flags and Business Improvement Districts including a new focus on health and wellbeing;
- A long-term commitment (through to 2020) to an increased scope and funding for Drinkaware, including how it can best direct interventions to the target groups. There is a strategic review this year of Drinkaware and the Government will participate to seek to maximise its effectiveness and accountability; and
- Harnessing the power of industry's own advertising to link positive and responsible behaviour to decisions on the consumption of alcohol. We will work with the Portman Group to ensure their Code of Practice on the Naming, Packaging and Promotion of Alcoholic Drinks is robust, and that it actively encourages advertising which builds more positive associations (for example, between alcohol and

positive socialising) instead of negative ones (for example, between alcohol and wild, disinhibited behaviour).

Supporting growth and responsible businesses

4.11 We are committed to freeing up responsible industries and supporting positive growth. It is estimated that the alcohol industry contributes around £29 billion to the UK's economy. In total, it is estimated that, over 1.8 million jobs in the UK economy are supported by the alcohol industry¹⁸.

4.12 We know that growth and responsibility can exist well together. The Government strongly endorses and welcomes self-regulating and pro-active initiatives, driven by the licensed trade in partnership with the police and local authorities. In particular, licensed premises receiving Best Bar None accreditation; town and city centres achieving Purple Flag status; and Business Improvement Districts are good examples of what can be achieved through a determination to make a difference.

4.13 As well as sending out clear messages that crime and disorder will not be tolerated in pubs, clubs and wider locations, these and other improvement schemes have been proven to increase footfall and stimulate business. For example, over the three year period of taking part in a Best Bar None scheme in Durham, licensees have reported an estimated 75% cumulative increase in trade; a 50% increase in town centre footfall and an expected 87% reduction in violent crime.

Cutting red tape

4.14 We see no merit in making responsible businesses jump through unnecessary hoops, but equally we need to maintain the integrity of the licensing system to protect society from those irresponsible businesses that exploit loopholes to gain business at any cost, regardless of the risks to the individual and to society. We therefore intend to seek views on giving licensing authorities greater freedom to take decisions that reflect the needs of their local community, including:

- Allowing them to introduce simpler, locally-determined processes for issuing a Temporary Event Notice (TEN); and increasing the current limit for TENs that can be used at single premises from 12 to 15 or 18, to enable occasional sales of alcohol at community events;
- Reducing the burden of licensing on certain types of businesses that provide minimal alcohol sales and are not impacting on crime and disorder, for example by removing the need for some premises to hold a personal licence; and
- Giving local areas more flexibility over the licensing of late-night refreshments at premises where alcohol is not sold, enabling them to determine locally where such a licence is necessary.

¹⁸ The economic outlook for the UK drinks sector and the impact of the changes to excise duty and VAT announced in the 2008 Budget and Pre-Budget Report, Oxford Economics (February 2009).

We will drive greater industry responsibility and action in tackling alcohol misuse.

We will:

- Challenge the industry to meet a new set of commitments to drive down alcohol misuse.
- Continue work through the Responsibility Deal to support the alcohol industry to market, advertise and sell their products in a responsible way and deliver the core commitment to “foster a culture of responsible drinking, which will help people to drink within guidelines”.
- Cut red tape for responsible businesses by giving licensing authorities greater freedom to take decisions that reflect the needs of their local community.
- Continue work with industry on areas such as calorie labelling, not serving people when drunk and a renewed commitment to Drinkaware.

5. Supporting individuals to change

5.1 There is no ‘one size fits all’ solution to tackle excessive alcohol consumption and we have already set out the wide range of action that Government, local agencies and the industry should take to achieve this in the preceding chapters. Ultimately, individuals need to take control of and change their behaviours – though some may need help to do so. We know that:

- 83% of those who regularly drink above the guidelines do not think their drinking is putting their long term health at risk¹⁹;
- Whereas most smokers wish to quit, only 18% of people who drink above the lower-risk guidelines say they actually wish to change their behaviour; and
- External and environmental factors can hugely influence – positively and negatively – the amounts that individuals or groups of the population drink and the ways they drink.

5.2 This chapter sets out how we can support individuals to change by:

- Ensuring everyone is aware of the risks of excessive alcohol consumption and can make informed choices about responsible drinking; and
- Recognising that some people will need support to change their behaviour and ensuring that this is available, particularly for the most vulnerable in our communities.

Understanding the risks

5.3 Drinking patterns change as individuals move through life, in response to changing social groups, partners, family, or work pressures. Life events such as becoming a parent, divorce, bereavement, or a health scare may influence drinking patterns and can affect people in different ways.

5.4 Drinking too much too soon is a significant risk to young people’s health and development. Most children under 16 (55%) have never drunk alcohol²⁰. However, despite declining rates of drinking in the last decade, the UK compares poorly with other European countries for drinking by 15-16 year old students in regular European surveys and we cannot be complacent²¹. The Chief Medical Officer for England’s 2009 guidance that young people under 15 should not drink alcohol at all is based on the fact that young people who start drinking alcohol at an early age drink more frequently and more than those who start drinking later; as a result, they are more likely to develop alcohol problems in adolescence and adulthood. We will ensure that young people know the risks associated with alcohol by making it a key feature of a new £2.6 million youth marketing programme aimed to drive further reductions in regular smoking, drinking, drug use and risky sexual behaviour during the teenage years.

¹⁹ Social marketing data, Department of Health (unpublished).

²⁰ Fuller, E. (2011) Smoking, drinking and drug use among young people in England in 2010, Information Centre for Health and Social Care.

²¹ Hibell, B. (et al) The 2007 ESPAD report. Substance use among students in 35 European countries.

- 5.5 We will support those that have the greatest influence on young people to promote healthy drinking. Parenting style is a key influence on whether a child will drink responsibly in adolescence and adulthood but only 17% of parents have a planned conversation with their child about the harm alcohol can cause²². As Baroness Newlove set out in her recent report, parents need to take proper account of the impact of how they behave on their children's attitudes to alcohol as they grow up and become adults themselves. We will ensure that guidance is available for parents through a range of public and community organisations including; NHS Choices, Directgov, Family Lives and NetMums, Mumsnet, Dad Talk, and Contact a Family.
- 5.6 The Government is investing £448 million to turn around the lives of the 120,000 most troubled families in the country. Working with local authorities, we will support them into education and employment and tackle their criminal and anti-social behaviour. A significant number of these families will have other problems including alcohol dependence, mental illness, domestic abuse, poor parenting and long-term benefit dependence. These families are not beyond help and their lives can be turned around with co-ordinated and intensive support.
- 5.7 Good schools play a vital role as promoters of health and wellbeing in the local community. They understand the connections between pupils' physical and mental health, their safety, and their educational achievement, and are well placed to provide good pastoral care and early intervention for problems which may arise from, or lead to, alcohol misuse. The Government's review of Personal, Social, Health and Economic (PSHE) education is focused on improving the quality of PSHE in all schools and its core outcomes. This will include exploring how schools can better decide for themselves what pupils need to know, in consultation with parents and others locally. Schools and out-of-school services will also be able to access information about effective alcohol prevention programmes through the Centre for the Analysis of Youth Transitions (CAYT).
- 5.8 Supportive relationships, strong ambitions and good opportunities are key protective factors against early drinking and young people's misuse of alcohol. These are the key elements of the vision set out in Positive for Youth, which brings together all Government youth policy into a single plan. Assessment of local need through the Joint Strategic Needs Assessment and integrated commissioning and cross-sector partnership will be critical in ensuring young people get early help and advice from practitioners and services they trust, such as youth organisations. Young people's involvement will be key in shaping effective local support.
- 5.9 Up to one-third of alcohol-related A&E attendances are for under 18 year olds and local areas vary significantly in how they approach the care of young people in this situation²³. Health services have a responsibility to ensure this 'treatable moment' is used to advise young people about their drinking. The Department of Health will also work with practitioners, the Royal Colleges and the Association of Directors of Children's Services to develop a model that ensures young people who attend A&E

²² Williams, B., Davies, L. and Wright V. (2010) Children, Young People and Alcohol. Department for Children, Schools and Families.

²³ Data from East Midlands Public Health Observatory (unpublished).

due to alcohol receive proper follow-up and care, including their parents being informed, where appropriate. A recent report has highlighted the opportunities for sexual health services to help tackle alcohol misuse, given the strong links between drinking and poor sexual health in the young²⁴. The Department of Health is piloting interventions which provide alcohol advice in sexual health clinics.

5.10 More people under the age of 25 report getting very drunk than any other adult age group²⁵ and around 50% of students drink more than the lower-risk guidelines²⁶. Under 25s also have the highest risk of being a victim of violent crime²⁷. There have been some good examples of how to make appropriate information easily accessible for young adults such as Drinkaware's "Why let good times go bad?" campaign and we expect to see more campaigns such as this in the future.

5.11 We expect universities to play a key role in helping students to understand and act on the risks of excessive alcohol consumption and ensure that an environment of subsidised bars does not unduly promote drinking. Drinkaware is also funding research in Welsh universities based on the use of 'social norms' - perceptions that a peer group drinks more than is the reality can be countered with information on real (lower) drinking levels. We want to do all we can to ensure that we are not bringing up a generation who believe that you can't have fun without alcohol.

5.12 Around a third of adult men (25-64) and a fifth of women in the same age group say they drink at levels above the lower-risk guidelines. Moreover, 8% of men and 4% of women in this age group admit to drinking at levels more than twice the lower-risk guidelines²⁸. Many in this age group are parents, whose excessive parental drinking will be a risk to their children. It has become acceptable to develop a habit of routinely using alcohol for stress relief, putting many people at risk of chronic diseases, such as liver disease; diabetes; cardiovascular disease; and cancers of the breast and gastrointestinal tract. The latest estimate is that up to 70,000 people could die avoidably over the next twenty years if the wrong actions are taken.

5.13 We are already taking significant steps to address this. In February 2012, we launched a fully-integrated Change4Life²⁹ campaign to communicate the health harms of drinking above the lower-risk guidelines and provide a range of tips and tools to encourage people to drink responsibly. The campaign was based on the insights around how people use alcohol to unwind, and that what starts off at one glass can all too easily become more. The television adverts are backed up by posters for offices and public places, and leaflets for NHS staff to use with patients.

²⁴ Alcohol and sex: a cocktail for poor sexual health, Royal College of Physicians and British Association for Sexual Health and HIV, December 2011.

²⁵ Matthews, S. and Richardson, A. (2005) Findings from the 2003 Offending, Crime and Justice Survey: alcohol-related crime and disorder. Home Office Research Findings 261. Home Office: London.

²⁶ Gill, J. S. (2002) Reported levels of alcohol consumption and binge drinking within the UK undergraduate student population over the last 25 years. Alcohol and Alcoholism.

²⁷ Chaplin, R., Flatley, J. and Smith, K. (2011) *Crime in England and Wales 2010/11*. Home Office Statistical Bulletin 10/11. London: Home Office.

²⁸ Office of National Statistics (2011). Smoking and drinking among adults, 2009. A report on the General Lifestyle Survey.

²⁹ <http://www.nhs.uk/Change4Life/Pages/change-for-life.aspx>

Our intention is to extend this social marketing campaign, if the evidence shows the campaign improves health outcomes and is good value for money.

- 5.14 To support this further, we will ask Dame Sally Davies, the UK Government's Chief Medical Officer, to oversee a review of the alcohol guidelines for adults. This will also take account of available science on how we can best communicate the risks from alcohol, improving the public's understanding of both personal risks and societal harms. This will include whether separate advice is desirable for the maximum amount of alcohol to be drunk in one occasion and for people over 65. This could complement the existing guidelines for young people and women who are pregnant or trying to conceive.
- 5.15 Fetal alcohol spectrum disorders (FASD) result from mothers drinking alcohol during pregnancy. They are lifelong conditions that can have a severe impact on individuals and their families - leading to a wide range of difficulties including low IQ, memory disorders, attention disorders, speech and language disorders, visual and hearing defects, epilepsy and heart defects. They are caused entirely by drinking during pregnancy, and so are completely preventable. We do not have good information about the incidence of FASD, so it is likely that significant numbers of children are not diagnosed. FASD can be caused by mothers drinking even before they know they are pregnant; so preventing them is strongly linked to reducing the levels of heavy drinking in the population as a whole, and especially among women. We will also continue to raise awareness of the need for women who are pregnant or trying to conceive to avoid alcohol, including by increasing the awareness of health professionals.
- 5.16 There are real opportunities, often under-exploited, for health services to identify those at risk and provide advice and support to those that need it, whether via regular contact with NHS staff, or in particular settings such as A&E, through well evidenced brief interventions. Identification and Brief Advice (IBA) is a simple intervention aimed at individuals who are at risk through drinking above the guidelines, but not typically seeking help for an alcohol problem. IBA has been proven to reduce drinking, leading to improved health and reduced calls on hospital services. At least one in eight at-risk drinkers reduce their drinking as a result of IBA. The National Institute for Health and Clinical Excellence (NICE) recommends that NHS health professionals routinely carry out alcohol screening as an integral part of their practice, focusing on groups at increased risk.
- 5.17 The Department of Health will include alcohol identification and any subsequent brief advice needed within the NHS Health Check for adults from age 40 to 75 for the first time from April 2013. It will also look at the data from the recently published Screening and Intervention Programme for Sensible Drinking (SIPS) research to see if it can support further action by GPs via the Quality and Outcomes Framework.
- 5.18 We also encourage Local Authorities, newly responsible for public health, to examine the strong case for further local investment in IBA by primary care staff, using the evidence set out in reports from the SIPS research.

5.19 Alcohol Liaison Nurses offer a vital NHS contribution to secondary prevention, improving the future health of patients, including those who enter hospital with severe alcohol problems and multiple health problems. We encourage all hospitals to employ Alcohol Liaison Nurses to provide:

- Medical management of patients with alcohol problems in the hospital;
- Liaison with community alcohol and other specialist services;
- Education and support for other healthcare workers in the hospital; and
- Delivery of IBA within the hospital with a focus on key groups, including pregnant women.

5.20 Alcohol is known to be a driver in some cases of domestic violence. Ending violence against women and girls, including domestic violence, is a priority for this Government. Last year the Government published the Call to End Violence Against Women and Girls which set out how we will achieve this. A detailed range of supporting actions was updated this month³⁰ including ensuring that front-line practitioners are equipped so that they can respond appropriately to perpetrators and victims. Understanding how the use of drugs and alcohol can potentially increase the frequency and severity of violence is key to this. We expect all areas to implement the recent NICE guidance and a quality standard on the management of harmful drinking and alcohol dependence³¹.

Treatment and recovery

5.21 It is vital that we provide effective treatment and recovery. The Government's Drug Strategy sets out how we are raising the ambition to support full recovery for those suffering from addiction, including alcohol. Increasing effective treatment for dependent drinkers will offer the most immediate opportunity to reduce alcohol-related admissions and to reduce NHS costs. Treating alcohol dependence, where successful, has also been shown to prevent future illnesses.

5.22 Around 31,000 (33%) of adults in alcohol treatment are parents with childcare responsibilities. A further 20% are parents whose child lives elsewhere³². Local treatment services and children's and family services are increasingly working together – as part of a wider team around the family – to identify and respond to alcohol-related problems. Evidence shows that Family Intervention Projects (FIPs) are effective in tackling these families' entrenched problems including a 34% reduction in drug and alcohol problems, 58% reduction in anti-social behaviour and over 50% reduction in truancy³³.

5.23 Recovery goes beyond medical or mental health issues to include dealing with the wider factors that reinforce dependence, such as childcare, housing needs, employability and involvement in crime. The Government's Drug Strategy sets out how we are working with eight pilot areas developing approaches to paying for

³⁰ Home Office (2012) Call to end violence against women and girls. Taking Action - the next chapter

³¹ www.guidance.nice.org.uk/

³² Data from National Alcohol Treatment Monitoring System, National Treatment Agency (unpublished).

³³ Monitoring and Evaluation of Family Intervention Projects and Services to March 2011.

outcomes for recovery from drug or alcohol dependency. They all plan to commission services from April 2012.

Mental Health

5.24 There is a clear association between having a mental illness and increasing risk of alcohol dependence – if you drink too much, you put your mental health at risk. If you have a mental health problem, you are more likely to drink at levels that put your health at risk. For children, emotional and mental health problems are associated with the misuse of alcohol. Promoting good mental health in children and adults can help prevent alcohol misuse. Parenting programmes and prevention programmes for children can both help, particularly when problems are identified early.

5.25 We will publish the implementation framework for No Health Without Mental Health, the Government's mental health strategy, soon. It will set out what local organisations can do, and what Government and national organisations are doing to support them in the promotion of good mental health and wellbeing, as well as in the treatment of mental illness, including dual diagnosis (co-existing mental health and drug and alcohol problems).

Offenders

5.26 Alcohol contributes to too many crimes. Almost a million (44% of the total) violent crimes are alcohol-related³⁴. There is a high prevalence among the offender population of drinking at higher risk levels, both among adults and young offenders. We need to ensure that entry into the criminal justice system punishes offenders but also provides an opportunity to provide support to overcome alcohol problems and prevent further offending.

5.27 Areas are advised to identify and address problems as early as possible by identifying treatable stages throughout the criminal justice pathway. To support local areas we will produce a cost-benefit analysis to make the case for local investment in alcohol interventions and treatment services for offenders. We will use the learning from evaluations of the eight pilot areas (those developing approaches to paying for outcomes for recovery from drug or alcohol dependency) to inform a potential Payment by Results approach to alcohol treatment for offenders.

5.28 Prisons are important places for rehabilitation and tackling dependency and we will develop, by July 2012, an alcohol interventions pathway and outcome framework in four prisons, to inform the commissioning of a range of effective interventions in all types of prison. From April 2013 the NHS Commissioning Board (NHSCB) will be responsible for commissioning health services and facilities for those in prisons and other places of prescribed detention. This will support the work at a national and local level to prevent and reduce alcohol related ill health and reoffending in the prison population.

³⁴ Chaplin, R., Flatley, J. and Smith, K. (2011) *Crime in England and Wales 2010/11*. Home Office Statistical Bulletin 10/11. London: Home Office. Supplementary Tables 7 <http://www.homeoffice.gov.uk/science-research/research-statistics/crime/crime-statistics/bcs-supplementary-tabs/>.

5.29 We will increase the flexibility of the Alcohol Treatment Requirement imposed by the court as part of a community sentence so areas can tailor treatment to target more serious alcohol-related offending problems. We have consulted on reforms on anti-social behaviour, including a new civil order which could require individuals to undertake positive activities to address underlying issues that may be driving their behaviour, for example by accessing alcohol treatment.

5.30 Many areas are providing an integrated approach to drug and alcohol arrest referrals, for example joint drug and alcohol workers in the police custody suite assessing the needs of offenders and signposting them to appropriate treatment services. Areas can currently, on the basis of local priorities, use the Drug Interventions Programme funding from the Home Office for both drug and alcohol arrest referral.

ACTIONS:

We will challenge people to change their behaviour by giving them the information and support they need. We will:

- Review the alcohol guidelines for adults so that people can make responsible and informed choices about their drinking.
- Integrate alcohol into the wider Change4Life brand for the first time and commit to an on-going social marketing campaign to communicate the health harms of drinking above the lower-risk guidelines.
- Include an alcohol check within the NHS Health Check for adults from April 2013.
- Support parents to have a real impact on their children's behaviour through our social marketing for young people.
- Invest £448 million to turn around the lives of the 120,000 most troubled families in the country, a significant number of which will have alcohol-related problems
- Develop a model pathway to reduce under 18 year olds' alcohol related A&E attendances.
- Develop an alcohol interventions pathway and outcome framework in four prisons, to inform the commissioning of a range of effective interventions in all types of prison.
- Increase the flexibility of the Alcohol Treatment Requirement imposed by the court as part of a community sentence.
- Produce a cost-benefit analysis to make the case for local investment in alcohol interventions and treatment services for offenders
- Work with pilot areas to develop approaches to paying for outcomes for recovery from drug or alcohol dependency.

Next Steps

This strategy sets out a clear commitment to address the harms of alcohol and encourage responsible behaviour. Individuals, communities, local agencies, local premises and national industries all have a role to play. Over the coming months we will launch consultations and take action forward on areas highlighted in the strategy. To keep up to date of these see <http://www.homeoffice.gov.uk/about-us/consultations/>.



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