Review of the National Alcohol Harm Reduction Strategy for England

Health Impact Assessment

prepared for the Department of Health

Ben Cave Associates Ltd

11th December 2007

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**Contents Amendment Record**

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<td>A&amp;E</td>
<td>Accident and Emergency</td>
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<td>ACPO</td>
<td>Association of Chief Police Officers</td>
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<td>ANARP</td>
<td>Alcohol Needs Assessment Research Project</td>
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<td>APVR</td>
<td>Annual Population Value Review</td>
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<td>ASA</td>
<td>Advertising Standards Authority</td>
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<td>ASE</td>
<td>Alcohol Strategy for England</td>
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<td>ATR</td>
<td>Alcohol Treatment Requirement</td>
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<td>ASB</td>
<td>anti-social behaviour</td>
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<td>BME</td>
<td>Black and Minority Ethnic</td>
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<td>CARATs</td>
<td>Counselling, Assessment, Referral, Advice and Throughcare Services</td>
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<td>CDRPs</td>
<td>Crime and Disorder Reduction Partnerships</td>
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<td>CJS</td>
<td>Criminal Justice System</td>
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<td>DAC</td>
<td>Domestic Affairs Committee</td>
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<td>DCMS</td>
<td>Department for Culture, Media and Sport</td>
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<td>DFES</td>
<td>Department for Education and Skills</td>
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<td>DH</td>
<td>Department of Health</td>
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<td>DID</td>
<td>Drink Impaired Drivers</td>
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<td>EqIA</td>
<td>Equality Impact Assessment</td>
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<td>EU</td>
<td>European Union</td>
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<td>FSA</td>
<td>Food Standards Agency</td>
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<td>Government Offices</td>
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<td>Health Impact Assessment</td>
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<td>HO</td>
<td>Home Office</td>
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<td>LAA</td>
<td>Local Area Agreement</td>
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<td>LACORS</td>
<td>Local Authorities Coordinators of Regulatory Services</td>
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<td>LIAM</td>
<td>Lower Intensity Alcohol Module</td>
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<td>NAO</td>
<td>National Audit Office</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>NKS</td>
<td>NHS National Knowledge Service</td>
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<td>NOMS</td>
<td>National Offender Management Service</td>
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<td>National Probation Service</td>
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<td>Night-Time Economy</td>
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<td>PCT</td>
<td>Primary Care Trust</td>
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<td>RAPt</td>
<td>Rehabilitation for Addicted Prisoners Trust</td>
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<td>RTAs</td>
<td>Road Traffic Accidents</td>
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<td>SSS</td>
<td>Safe. Sensible. Social (title of final strategy review)</td>
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<td>STDs</td>
<td>sexually transmitted diseases</td>
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<td>TVCP</td>
<td>Tackling Violent Crime Programme</td>
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1. Executive summary

1.1 This report considers the potential effects on health and wellbeing of the review of the Alcohol Harm Reduction Strategy for England (ASE). The review resulted in a renewed strategy published as Safe. Sensible. Social The next steps in the National Alcohol Strategy (SSS) (1).

1.2 This is a cross-departmental review involving the Department of Health, the Home Office and the Department for Education and Skills (DFES). The Department for Culture, Media and Sport (DCMS) have had significant involvement as have other Government Departments.

1.3 The Department of Health (DH) commissioned this Health Impact Assessment (HIA) to ensure that the ASE review is subject to a public health focused impact assessment process. The review has also been subject to an Equalities Impact Assessment (EqIA).

1.4 The approach we have adopted has been rapid and desk-based.

1.5 The analysis in this HIA report moves from the strategic to the detailed.
   - We provide a summary and reflection process in section 2.
   - Section 3 provides the context for this HIA and describes the methodology we have used, the timescale and the non-negotiables.
   - Section 4 reviews the priority actions in the strategy review.
   - In section 5 we provide an overview and a model that summarises the links between alcohol consumption and alcohol harm.
   - We finish with a review of each of the priority actions in section 6.

1.6 We make a number of suggestions for ways to enhance the delivery and implementation of the priority actions. This includes suggestions about consultation for and design of the implementation and ways in which to monitor change. We suggest ways in which the strategy review can improve population health beyond the targeted delivery of health services.

1.7 We note that the strategy review is focussed on harm reduction, or addressing the harms related to consumption of alcohol. While harm reduction is important, especially given the nature of harms associated with alcohol, this focus leads to priority actions that mitigate, reduce, minimise or avoid the harms related to alcohol. Opportunities to improve health and to reduce inequalities in the strategy are restricted to service improvements and social marketing initiatives. Health Impact Assessment looks for ways to enhance the potential for health improvement and suggests potential mechanisms by which the strategy fits within broader government aims to improve health and well-being and reduce health inequalities within the UK population.

1.8 Social marketing is a core theme of this strategy review. The implementation of the ASE review needs to identify ways in which individuals, and communities, can help themselves rather than merely providing more, and better quality information.

1.9 We support emphasis on public-private partnerships to address alcohol related harm and suggest that it is the role of Government to specify the terms of these partnering arrangements.

1.10 The strategy should consider independent oversight of industry self-regulation and the potential role of engaged NGOs. Guidelines for interaction with private sector should be developed and monitored.

1.11 Many of the outcomes which are important to health in relation to alcohol-related harm depend on the successful delivery and implementation of other Government strategies. The alcohol strategy must also be formulated and delivered within the wider context of Government strategies, programmes and initiatives, including: encouraging regeneration, building cohesive and sustainable communities; raising productivity; tackling the causes of crime, local incivilities and anti-social behaviour and above all promoting the health and
well-being of deprived individuals and communities. Reducing harm from alcohol requires cross-government work and a combination of social and economic policies directed and delivered at the national, community neighbourhood and individual levels. It is only by targeting social and economic policies and strategies at these various levels of aggregation that will ensure effective implementation and take up of the proposals.
2. **Reflections from the assessment**

2.1 In analysing the review of the strategy and identifying the potential effects of the policies on health and well-being, the HIA team offer the following reflections.

**Focus**

2.2 The potential for health improvement or reducing health inequalities with respect to alcohol consumption does not appear to have been a focus for the priority actions which fall within the agreed scope for the HIA. We make a number of suggestions for health improvement as we look at each priority action in section 6.

2.3 The strategy review is focussed on “harm reduction”, or addressing the harms related to consumption of alcohol. While harm reduction is important, especially given the nature of harms associated with alcohol, this focus leads to priority actions that mitigate, reduce, minimise or avoid the harms related to alcohol and overlooks the potential for improving health and for reducing health inequalities. Health Impact Assessment looks for ways to enhance this potential for health improvement.

**Priority actions**

2.4 There are three main categories of priority action:

- improving the quantity, and quality, of information about alcohol-related harm and improving the quality, efficiency, and effectiveness of alcohol-related harm management and service provision;
- targeting at-risk populations and locations, with interventions specifically aimed at people who drink to levels that cause harm to themselves and/or others and at situations in which the risk of alcohol-related harm is high; and
- stimulating cultural change: encouraging a change in societal attitudes about alcohol and its use.

2.5 There will be some overlap among these three types of actions however this categorisation enables further reflections on the implications of the priority actions. We look at these in more depth in Section 4 starting on page 10.

2.6 The strategy will have more short-term practical relevance for reducing social incivilities and anti social behaviour associated with binge drinking thereby increasing day-to-day quality of life and social cohesion for neighbourhoods and communities. It also has long-term relevance for changing British culture in general and increasing social responsibility.

**Population versus targeted approach**

2.7 While the majority of the priority actions target at risk populations and have a high potential for short-term effects, the actions to encourage a change in societal attitudes and values about alcohol affect the entire population and have a greater potential long-term effect. They also require substantial investment in time and resources. This strategic approach is broadly in line with WHO guidance (2).

2.8 The likelihood of these long-term effects is probably less than the likelihood of the short-term effects: a change in societal attitudes is very difficult to achieve. The timescale is at least 20-25 years.

**Improved service planning and delivery**

2.9 Some of the new priority actions could have an indirect effect on population health through reducing the financial burden of alcohol-related harms on public sector services such as the police, accident and emergency services, and health service. Several actions also carry the potential to increase the cost-effectiveness of service provision, which may provide
opportunities to re-direct any resources saved into other areas of need and/or preventative services.

**Links to other policies**

2.10 Many of the outcomes which are important to health in relation to alcohol-related harm depend on the successful implementation of other Government strategies, e.g. *Road Safety Strategy, Domestic Violence Strategy*. Reducing harm from alcohol requires cross-government work at national, regional, local and community levels.

2.11 The alcohol strategy must also be seen in the wider context of Government priorities and initiatives, including: encouraging regeneration, building cohesive and sustainable communities; raising productivity; tackling the causes of crime and anti-social behaviour and promoting public health.

**Achieving behavioural change**

2.12 Empirical evidence from public health and social epidemiology suggests that policies aimed at tackling health inequalities and improving health should simultaneously be directed at the individual, neighbourhood, community and regional levels. It is only by delivering policy at these three levels that adequate coverage of the social, environmental and economic determinants of health and well-being can be achieved and health improvements occur (3). The *Choosing Health White Paper* (4) stresses the role of the individual in improving and maintaining health:

‘Interventions and policies designed to improve health and reduce health disadvantage should provide the opportunity, support and information for individuals to want to improve their health and well-being and adopt healthier lifestyles. Policy cannot – and should not – pretend it can ‘make’ the population healthy. But it can – and should – support people in making better choices for their health and the health of their families. It is for people to make the healthy choice if they wish to’.

2.13 The strategy review does not appear to make explicit links to *Choosing Health* (4) or to the *Wanless review* which outline the rights and responsibilities between the individual and government:

‘... people need to be supported more actively to make better decisions about their own health and welfare because there are widespread, systematic failures that influence the decisions individuals currently make ... These failures can be tackled not only by individuals but by wide ranging action by health and care services, government – national and local, media, businesses, society at large, families and the voluntary and community sector. The main levers for Government Action include taxes, subsidies, service provision, regulation and information” (5).

2.14 Some of the most effective emerging policy interventions of recent years rest as heavily on psychosocial effects as on economic logic – including school-parent and doctor-patient ‘contracts’, parenting classes, and active welfare policies. What may appear to be small changes in the construction of policies or practices can lead to dramatic changes in outcomes. Policy in particular that which seeks a change in culture and attitudes needs to consider the ways in which people actually think and feel, and the social and psychological forces that influence behaviour.

2.15 The review of the Alcohol Harm Reduction Strategy, and its implementation, should not just be about the government and its agencies learning a few extra techniques to ‘make people drink less’. The implementation of the ASE review needs to identify ways in which individuals, and communities, can help themselves. In implementing the priority actions the Government should be aware that the use of compacts, conditionality and other methods of encouraging behavioural change is only part of the process. An equally important part of ‘co-production’ is that there is a partnership in the writing of such compacts and conditions, and in the design and authorisation of more sophisticated methods of behavioural change, between state and citizens and between citizens themselves. Policy tailored around a more realistic understanding of how people really do make choices and engage in society, coupled with consistent dialogue over the implications for the citizen’s and state’s
responsibilities, should lead not only to more effective policy but also enable individuals to feel more in control of their lives.

**Partnering with industry**

2.16 There is a fundamental tension between the alcohol industry’s need to generate revenue and profit and interventions which potentially reduce alcohol consumption. Industry-led information interventions and social marketing campaigns were used in addressing tobacco consumption but they served to increase consumption of tobacco. The potential exists for similar unanticipated effects to occur for alcohol in England.

2.17 SSS should consider independent oversight of industry self-regulation and the potential role of engaged NGOs. Guidelines for interaction with private sector should be developed and monitored.

2.18 We support emphasis on public-private partnerships to address alcohol related harm and suggest that it is the role of Government to specify the terms of these partnering arrangements.

2.19 Government appears to be suggesting legislative action as an intervention if industry self-regulation practices and standards are not effective enough to make progress on protecting those at risk and preventing irresponsible levels of drinking. Industry self-regulatory strategies that have shown promise, and have been the most effective for achieving health goals, are often underpinned by rewards in the marketplace. Improving the effectiveness of industry self-regulation will require finding ways of conferring financial rewards for adherence to voluntary standards.

**Monitoring change**

2.20 The overall aim of the strategy review and the ASE is to achieve significant and measurable reductions over a sustained period of time in the harms caused by alcohol. The health and social effects of alcohol consumption extend beyond the individual to family members and the wider community. In relation to interventions targeted at alcohol harm a major part of the disease burden of alcohol misuse is borne by families and others. Thus confining measurement to effect on individuals will give an incomplete picture. While data relating to the effects on families and how this changes with the adoption of ‘sensible drinking behaviour’ is limited if these wider impacts are excluded the benefits, and shortfalls, of the priority actions will be understated and the performance wrongly evaluated.

2.21 We support the inclusion of benchmarks in the strategy: these will be a vital part of the implementation of strategy should and will enable the tracking of actual reductions in specific time frames. These benchmarks should take into account the long- and variable-lag times between alcohol consumption and alcohol-related morbidity and mortality. Annex A (page 74, SSS) provides broad outcome measures and sources of data but does not give specific indicators or benchmarks.

2.22 It is crucial to determine what the thresholds for success are that will denote whether industry has achieved satisfactory progress in implementing agreed upon product labelling and advertising controls.

**National campaigns including social marketing**

2.23 For many of the priority actions relating to improved quality of information and alcohol-related harm management, the outputs or products will not be available until 2008. Moreover, for some of the outputs, there will be a further process of consideration and decision-making and for others there will be a process of dissemination, assimilation and implementation.

2.24 For instance, priority actions involving social marketing and advertising, cultural change will of necessity precede any effect on health, and cultural change can take time to achieve (~20-25 years), especially on a country-wide basis. However, attitudes to risk and responsibility can change dramatically over time. For example, the overwhelming public support for the compulsory wearing of seatbelts today is far removed from public resistance
to their introduction in the 1970s. It was once unthinkable to ban smoking in public places; now it is the subject of legislation in all countries of the UK.

2.25 Indeed, for some of the interventions targeted at preventing harm in at-risk groups are dependent on the outcomes of reviews, although there may be some effects on health outcomes in the short to medium term.

**Potential policy areas for alcohol-related harm reduction**

2.26 Some of the policy areas it may be fruitful to explore with respect to actions for alcohol-related harm reduction, especially in relation to one or more of the target groups for the strategy are:

- The workplace, employment and occupational health;
- The locations for education (schools, colleges, universities, adult education) and learning.
3. **Context and methodology**

**Context**

3.1 This document is prepared in response to the Department of Health’s request for a Health Impact Assessment (HIA) of the review of the Alcohol Harm Reduction Strategy for England (ASE). The strategy review was a stated commitment in the ASE, and the final document, *Safe. Sensible. Social.* (1) was published in June, 2007.

3.2 The review of the Alcohol Harm Reduction Strategy has two aims: first, to set out new policies and sharpen the focus of existing activity which concentrates on changing the behaviour of the minority of drinkers who cause or experience the most harm to themselves, their communities and their families; second, through investment in public information, to make sure that everyone is equipped with the information they need to make sensible choices about their drinking.

3.3 The population groups that are the focus of the strategy review are:
- young people under 18 who drink alcohol (in particular 11-15-year-olds);
- 18-24 year old binge drinkers; and
- harmful drinkers.

3.4 There is a sole mention of a focus on low income groups. This is on page 55 of the SSS. Health inequalities are strongly associated with alcohol and alcohol harm. We suggest that the Government consider including low income groups as a fourth population group who should benefit from the strategy.

3.5 The strategy review is cross-departmental, the main departmental stakeholders being Department of Health, Home Office and the Department for Education and Skills (DfES). In addition, the Department for Culture, Media and Sport (DCMS) has had significant involvement due to their responsibility for licensing. Other Government Departments with an interest have also been involved.  

3.6 The strategy review has not been only an update of the strategy but has been undertaken with the aim of refreshing it and developing new priorities. As this is a review and involves no new legislation, there has been no public consultation. The Government's legal advice supports this approach. However, the Government will consult upon the implementation of some of the priority actions in the review.

3.7 The strategy review has been through several iterations. Ministers' views on early drafts were sought at an Inter-Ministerial Group (IMG) meeting in March 2007, and officials were asked to take forward work on the actions and priorities resulting from that meeting. The IMG had had overview of the strategy and its review before March 2007 however there had been no substantial drafting before this time. The IMG on alcohol was jointly chaired by Caroline Flint, Minister of State for Public Health, and Vernon Coaker, Under-Secretary of State in the Home Office. The IMG also involved Ministers from other Government Departments. At the IMG meeting actions focussing on promotions, blanket replacement of glassware and taxation were identified as challenging. In subsequent discussions it became clear that the issue was the sole use of taxation to affect price.

3.8 In preparing the strategy review, ideas were discussed with, and critiqued by, selected stakeholders, including health; criminal justice system (police, probation etc) education; and the alcohol industry. On the 25th April 2007, a facilitated meeting with this selected group of stakeholders was held to identify potential pitfalls and contradictions within the strategy. The HIA team requested to observe this meeting. This was not felt to be appropriate by personnel leading the strategy review. The HIA team were given access to summary notes of all meetings, all but one of which took place before drafting began in earnest and before the HIA was commissioned. In order to encourage full and frank discussion from parties with very different interests the meetings were confidential; the

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1 Department of Communities and Local Government, Department for Trade and Industry, Her Majesty's Treasury
strategy team felt that outside parties, *ie* a newly commissioned HIA team, taking detailed records of the meetings may discourage this full and frank discussion.

**Health Impact Assessment**

3.9 The DH commissioned a Health Impact Assessment (HIA) to ensure that the ASE review is subject to a public health focused impact assessment process.

3.10 The consideration of health impact assessment in the Government's impact assessment process is mandatory. As part of the White Paper *Choosing Health* (4), the Government gave a commitment to building health into all future legislation by including health as a component in regulatory impact assessment (RIA). Cabinet Office has revised RIA to become impact assessment (IA) and HIA is one of the specific impact tests. This means that health and well-being are designed into national policy (7).

3.11 Owing to time constraints, the approach we adopted was to use desk-based rapid appraisal techniques.

3.12 Impact assessment aims to provide evidence-based information to policy-makers. HIA has been defined as (8):

... a combination of procedures, methods and tools that systematically judges the potential, and sometimes unintended, effects of a policy, plan, programme or project on the health of a population and the distribution of those effects within the population. HIA identifies appropriate actions to manage those effects.

3.13 HIA is based on a socio-environmental model of health which recognises that people's health is not just determined by access to health care services or the absence of illness. Health status affects, and is affected by, a broad range of factors such as housing, education, employment, transport, the environment, crime and social cohesion. HIA is concerned with the differential effect of policies and strategies upon population groups, and with identifying ways to manage those effects.

3.14 The aims of the HIA of the Alcohol Harm Reduction Strategy are as follows:
- to identify the potential effects on health and wellbeing of the 2007 review of the ASE priority actions;
- to identify ways to strengthen the “actions” in the review of the Alcohol Harm Reduction Strategy with respect to reducing harms to health and well-being; and
- to suggest ways to strengthen the implementation of the review of the Alcohol Harm Reduction Strategy with respect to reducing harms to health and well-being.

3.15 An Equalities Impact Assessment (EqIA) was also commissioned. As there are some overlaps between EqIA and HIA, the two teams worked together to minimise duplication and to ease reporting.

3.16 The HIA was commissioned in late April 2007. As the HIA was limited to a desktop study its potential was restricted. The same applies for the EqIA. We suggest that any further impact assessment work is commissioned early in the process of developing the strategy or policy.

**Approach**

3.17 After the HIA was commissioned on the 25th April 2007, drafts of the policy text were made available as were several other documents (6;9-17). A draft of the policy text which had been subject to Ministerial comment was circulated at 5pm on 11th May 2007. The HIA report was issued in draft to the DH for comment on 16th May 2007 and in full on the 18th May 2007. Following publication of the final strategy the DH provided the HIA team with comments on the HIA (11th July 2007). They asked the HIA team to update the report so that the HIA is in line with the final published strategy.

3.18 The HIA team analysed the documents, priority actions and supporting text in the strategy review. The review of priority actions is shown in Section 4 starting on page 10.

3.19 A systematic literature review was not commissioned for the HIA and would not have been feasible in the time available. However, the HIA team conducted a limited review of
literature looking at alcohol consumption and health. We also looked at epidemiological and economic evidence on the burden, drivers and consequences of alcohol consumption. In addition, material was drawn from the Cabinet Office *Interim Analytical Report* (17). International best-practices form part of the evidence base against which strategies were compared. The short literature review informed the analysis and suggestions.

3.20 The HIA is a strategic assessment of the priority actions. The boundaries for the HIA were established at the inception of the work. During the process the issues that were scoped out of the HIA of the strategy review are as follows:

- policies which attempt to affect price solely through taxation;
- advertising bans;
- the blanket national introduction of polycarbonates for bottles/glasses;
- further consultation with affected groups;
- changes to the three population targets identified in the strategy review; and
- the timing for the contract.

3.21 DH comment that the issues which were scoped out were essentially those which were non-flexible *eg* timing or those issues which it had been established were beyond the remit or capability of the strategy review *eg* new legislation.

3.22 Many of the suggestions of the HIA focus on the opportunities for health improvement in the implementation of the reviewed strategy.

3.23 The values for the HIA were harm reduction and equity.

3.24 England was the designated geographical area for the strategy review although the Home Office has jurisdiction in Wales.
4. Review of priority actions

4.1 The overall aim of the strategy review and the ASE is to achieve significant and measurable reductions over a sustained period of time in the harms caused by alcohol.

4.2 Action will be focused on reducing the types of harm of most concern to the public:
   - a reduction in the levels of alcohol-related violent crime, disorder, antisocial behaviour and the wider fear of crime;
   - a reduction in the public’s perceptions of drunk and rowdy behaviour; and
   - a reduction in chronic and acute ill health caused by alcohol, resulting in fewer alcohol-related accidents and hospital admissions.

4.3 The Government also aims to increase the public’s awareness of the risks associated with excessive consumption and how to get help:
   - Most people will be able to estimate their own alcohol consumption in units.
   - Most people will be able to recall the Government’s sensible drinking guidelines and know the personal risks associated with regularly drinking above the sensible limits.
   - Most people will be able to recognise what constitutes their own or others’ harmful drinking and know where to go for advice or support.

4.4 The Government also expects that achievement of these outcomes will result in reductions in the most harmful types of alcohol consumption, and in particular:
   - An increase in the number of people drinking within the Government’s sensible drinking guidelines
   - A reduction in the number of men who are drinking more than 50 units a week and women who are drinking more than 35 units a week or more than twice the sensible daily drinking guidelines on a regular basis
   - A reduction in the number of under-18s who drink and in the amount of alcohol they consume

4.5 Table 1 lists the SSS priority actions, other supporting policy actions upon which the success of the ASE depends, important stakeholders and target groups.

4.6 The priority actions are numbered 1-23 as in Annex B of the SSS (1). The Government have set three strategic priorities for the SSS (1, p48):
   - First: to ‘… ensure that the laws and licensing powers [Government has] introduced to tackle alcohol-fuelled crime and disorder, protect young people and bear down on irresponsibly managed premises are being used widely and effectively.’
   - Secondly: to ‘… sharpen [the] focus on the minority of drinkers who cause or experience the most harm to themselves, their communities and their families.’
   - Finally: for all to ‘… work together to shape an environment that actively promotes sensible drinking, through investment in better information and communications, and by drawing on the skills and commitment of all those already working together to reduce the harm alcohol can cause, including the police, local authorities, prison and probation staff, the NHS, voluntary organisations, the alcohol industry, the wider business community, the media and, of course, local communities themselves.’
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<th>SSS priority action</th>
<th>Supporting policy actions</th>
<th>Stakeholders</th>
<th>Target groups</th>
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<tr>
<td>1. A new programme will help local partnerships and communities tackle alcohol-related crime and disorder – encouraging more and stronger local partnerships and industry participation</td>
<td>Police and Justice Act 2006 Licensing Managing the Night-Time Economy (NTE) Crime &amp; Disorder Reduction Partnership Strategies Local Area Agreements – alcohol-related improvement targets Crime and Disorder Reduction Partnership Strategies Tackling Violent Crime Programme, the regional delivery of which will be the responsibility of the Government Offices from 2007/08 with support from the HO</td>
<td>Police Crime &amp; Disorder Reduction Partnerships (CDRPs) Trading Standards Licensing Officers Local transport providers Planning Environmental Health Fire Officers Primary Care Trusts (PCTs) Representatives of the licensed trade Government Offices (GOs) for the English Regions</td>
<td>Offenders whose behaviour is linked to alcohol</td>
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<tr>
<td>2. Government Offices for the Regions will be asked to ensure strategic regional coordination of the requirement for local partnerships to tackle alcohol-related crime and disorder.</td>
<td>Tackling Violent Crime Programme (TVCP)</td>
<td>Crime &amp; Disorder Reduction Partnerships (CDRPs) Home Office Government Offices (GOs) for the English Regions Local government Police</td>
<td>Offenders whose behaviour is linked to alcohol</td>
</tr>
<tr>
<td>3. To support the roll-out and take-up of targeted identification and brief advice, a healthcare collaboration will be set up to disseminate the early results of the trailblazer research programmes and share learning on implementation</td>
<td>Alcohol Needs Assessment Research Project (ANARP) The Commissioning Framework for Health and Well-being (DH, 2007) Guidance on targeted identification and advice for hazardous and harmful drinkers (DH) Department of Health’s, Alcohol - Misuse Interventions – guidance on developing a local programme of improvement,</td>
<td>Department of Health (DH) NHS Local healthcare organisations Local social care departments CJS</td>
<td>Harmful drinkers</td>
</tr>
<tr>
<td>4. There will be a national review of the cost to the NHS of alcohol-related harm, identifying areas where the greatest savings can be made, through earlier identification and interventions for drinking that could cause harm.</td>
<td>The Department of Health will work with the regulatory bodies to support local health and social care organisations in responding to the findings of any reports produced by the regulatory bodies.</td>
<td>Department of Health Local and regional health and social care organisations</td>
<td>Hazardous, harmful and dependent drinkers</td>
</tr>
<tr>
<td>SSS priority action</td>
<td>Supporting policy actions</td>
<td>Stakeholders</td>
<td>Target groups</td>
</tr>
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</tr>
<tr>
<td>5. The Department of Health will establish a framework to support commissioners in planning local investment.</td>
<td>The Framework will include an interactive web-based commissioning tool; a web-based local alcohol profile; data on the contribution of alcohol to different types of health and crime harm; guidance on developing local indicators; and guidance on the Commissioning Framework for Health and Wellbeing and alcohol.</td>
<td>Local and regional healthcare and social care organisations, Regulatory bodies</td>
<td>Hazardous, harmful and dependent drinkers</td>
</tr>
</tbody>
</table>

| 6. There will be concerted local and national action to target alcohol-related offenders, using a combination of penalties and health and education interventions to drive home messages about alcohol and risks and to promote behaviour change. | Working with Alcohol Misusing Offenders - A Strategy for Delivery Addressing Alcohol Misuse - A Prison Service Alcohol Strategy (prisoners) Counselling, Assessment, Referral, Advice and Throughcare Services (CARATs) Provision for conditional cautions under Criminal Justice Act 2003 existing arrest referral pilot projects and initiatives Alcohol Treatment Requirement (ATR) Two National Probation Service (NPS) substance misuse group work programmes: …Drink Impaired Drivers (DID) scheme; and …Lower Intensity Alcohol Module (LIAM) (pilot programme) | Criminal Justice System (CJS) Police National Probation Service (NPS) Prison Service National Offender Management Service (NOMS) | Binge drinkers arrested for alcohol related offences - target group for alcohol brief interventions (pre-court) Offenders whose behaviour is related to alcohol - target group for supervision or activity requirement of the community order or suspended sentence order (court) Offenders who are alcohol dependent and require specialist treatment - target group for ATR (court). |

<p>| 7. Work to improve the way alcohol-related offenders are dealt with in custody and in the community and support National Offender Management Service (NOMS) key strategic aims and objectives | n/a | Criminal Justice System (CJS) Police National Probation Service (NPS) Prison Service National Offender Management Service (NOMS) | Alcohol related offenders |</p>
<table>
<thead>
<tr>
<th><strong>SSS priority action</strong></th>
<th><strong>Supporting policy actions</strong></th>
<th><strong>Stakeholders</strong></th>
<th><strong>Target groups</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>8. The Government will support local action to secure the replacement of glassware and bottles with safer alternatives in individual high-risk premises.</td>
<td>Licensing Act 2003  The measures in the existing Licensing Act will be complemented by provisions in the Violent Crime Reduction Act 2006, sections 21–22 of which will allow licensing authorities to fast-track licence conditions, on the application of a senior police officer, in cases of serious crime and disorder.</td>
<td>The alcohol industry but particularly licensed premises  NHS  A&amp;E departments  Ambulance service  Police</td>
<td>Licensed premises where there is a high risk of glass-related injury</td>
</tr>
<tr>
<td>9. An expert group, comprising police, doctors, academics and representatives of the alcohol industry, will be set up to gather further evidence of where targeted interventions might produce benefits and agree how high-risk premises can be best identified.</td>
<td>n/a</td>
<td>police, doctors, academics and representatives of the alcohol industry central government</td>
<td>Alcohol related offenders  Licensed premises where there is a high risk of alcohol-related injury</td>
</tr>
<tr>
<td>10. There will be concerted local action to enforce the law on drink driving and on sales of alcohol to underage people.</td>
<td>Drink driving: Government's Review of Road Safety Strategy, including a public consultation exercise in 2007 with the aim of exploring ways that enforcement by the police can be made easier Underage drinking: In the Rogers Review, Trading Standards can designate underage sales as a local priority</td>
<td>Police  Underage drinkers  Drink drivers  Retailers  Association of Chief Police Officers (ACPO)  Local Authorities Coordinators of Regulatory Services (LACORS)  Trading Standards  DFT</td>
<td>Drink drivers  Underage drinkers</td>
</tr>
<tr>
<td>11. The Government will continue to prioritise reductions in the test-purchase failure rate for underage sales of alcohol. This will mean ensuring that enforcement agencies are making use of good practice and applying tactics and powers effectively.</td>
<td>Alcohol Harm Reduction Strategy 2004  National campaigns led by the Home Office Rogers Review (2007).  Licensing standards Challenge 21</td>
<td>Alcohol industry, licensed premises and retailers  Trading standards</td>
<td>Underage drinkers  Alcohol industry, licensed premises and retailers</td>
</tr>
<tr>
<td>12. The Government will work with the Association of Chief Police Officers and Local Authorities Coordinators of Regulatory Services to develop a data collection model and will provide further guidance to ensure that enforcement activity is efficient and well targeted.</td>
<td>n/a</td>
<td>Association of Chief Police Officers  Local Authorities Coordinators of Regulatory Services  Central Government</td>
<td>Police service  Local Authorities</td>
</tr>
<tr>
<td>SSS priority action</td>
<td>Supporting policy actions</td>
<td>Stakeholders</td>
<td>Target groups</td>
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<tr>
<td>13. The Government will commission an independent national review of evidence of the relationship between alcohol price, promotion and harm, and, following public consultation, will consider the need for regulatory change in the future, if necessary.</td>
<td>Licensing Act 2003 – with respect to point of sale attaching operating conditions to licences/revocation of licences Industry voluntary codes: Portman Group Code of Practice on Naming, Packaging and Promotion of Alcoholic Drinks Social Responsibility Standards for the Production and Sale of Alcoholic Drinks in the UK Independent Complaints Panel operated by Portman Group Local authorities – statutory powers to restrict the sale of alcohol Advertising Standards Authority (ASA) – statutory powers to restrict alcohol advertising</td>
<td>Government The alcohol industry – producers, importers, wholesalers, retailers and trade associations Local authorities Advertising Standards Authority (ASA) Competition Commission – report to come on loss leading and its effect on competition (report expected later in 2007) The public Consumer bodies Alcohol Education and Research Council</td>
<td>Businesses/retailers that sell alcohol Total population (if regulatory change is considered necessary)</td>
</tr>
<tr>
<td>14. A review and consultation will take place on the effectiveness of the industry’s Social Responsibility Standards in contributing to a reduction in alcohol harm and, following public consultation, will consider the need for regulatory change in the future if necessary.</td>
<td>Advertising restrictions to protect children and young people Pricing structures Industry voluntary code: Social Responsibility Standards for the Production and Sale of Alcoholic Drinks in the UK</td>
<td>DH Other Government departments The alcohol industry The public The health sector, The police, Non-governmental organisations Equality groups, (including those most targeted by advertising and those most at risk of absorbing unsafe messages).</td>
<td>Total population (if regulatory change is considered necessary)</td>
</tr>
<tr>
<td>15. Consultation will take place in 2008 on the need for legislation in relation to alcohol labelling, depending on the implementation of the scheme to include information on sensible drinking and drinking while pregnant on alcohol bottles and containers</td>
<td>Agreements by Government and industry on additions to labelling to support sensible drinking made in 2007</td>
<td>Government DH The alcohol industry The public</td>
<td>Population who consume alcohol Pregnant Women</td>
</tr>
<tr>
<td>SSS priority action</td>
<td>Supporting policy actions</td>
<td>Stakeholders</td>
<td>Target groups</td>
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<tr>
<td>16. Sustained national campaigning will challenge public tolerance of drunkenness and drinking that causes harm to health.</td>
<td>Raising unit awareness: Know Your Limits Campaign targeted at 18-24-year-old binge drinkers Alcohol and pregnancy: Re-wording of advice on alcohol consumption for women who are pregnant or trying to conceive recently agreed by DH and devolved administrations of Scotland, Wales and Northern Ireland and each of the Chief Medical Officers (CMOs) Alcohol, diet and nutrition: Drinkaware Trust website</td>
<td>Government The alcohol industry The public Drinkaware Trust Food Standards Agency (FSA) Local partnerships</td>
<td>Families of people whose drinking is affecting themselves or others Parents of 11-15 year olds Friends of people whose drinking is affecting themselves or others Work colleagues whose drinking is affecting themselves or others Total population – emphasis on parents of 11-15 year</td>
</tr>
<tr>
<td>17. Sustained national campaigning will raise the public’s knowledge of units of alcohol and ensure that everyone has the information they need to estimate how much they really do drink.</td>
<td>n/a</td>
<td>Mass media</td>
<td>Total population Vulnerable groups eg women at higher risk</td>
</tr>
<tr>
<td>18. The Government, through its communications campaigns, the NHS and local communities, will target information and advice towards people who drink at harmful levels, and their families and friends.</td>
<td>‘Know Your Limits’ campaign targeting 18-24-year-old binge drinkers, Social marketing research to understand drinking habits of all sectors of society Existing programmes in schools and health care setting</td>
<td>Government The public NHS</td>
<td>Total population but especially 18-24 year olds Total population Vulnerable groups eg women at higher risk</td>
</tr>
<tr>
<td>19. The Government, through its communications campaigns and NHS maternity care, will ensure that the reworded pregnancy advice is communicated to women who are pregnant or trying to conceive.</td>
<td>n/a</td>
<td>DH Chief medical officers in devolved regions</td>
<td>Pregnant women</td>
</tr>
<tr>
<td>SSS priority action</td>
<td>Supporting policy actions</td>
<td>Stakeholders</td>
<td>Target groups</td>
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</tr>
</tbody>
</table>
| 20. The Government will support the development of a range of new kinds of information and advice aimed at people who drink at harmful levels and their families and friends. These will run alongside other kinds of support and advice from the NHS | Identification of harmful drinkers by/within the NHS
Identification of harmful drinkers by/within the CJS
Every Child Matters
Youth Matters
NICE Review on Community-based substance misuse interventions
NICE Review on Alcohol education in schools | Overall
Government
People who drink at harmful levels
Families of people who drink at harmful levels
Friends of people who drink at harmful levels
NHS
CJS
Alternative health providers
Self-assessment of consumption
Pharmacies
Voluntary sector
Healthcare organisations (NHS Trusts, GPs, etc.)
The media
Preventing harms to those under 18 years
Under 18s
Parents
Teachers
Health professionals
Youth support system | Overall
People who drink at harmful levels
Families of people who drink at harmful levels
Friends of people who drink at harmful levels
People who want to reduce their alcohol consumption |
| 21. To help young people and their parents make informed decisions about alcohol consumption, the Government will provide authoritative, accessible guidance about what is and what is not safe and sensible in the light of the latest available evidence from the UK and abroad. | Every Child Matters
Youth Matters | Government | Young people especially under 18s
Parents |
| 22. The Government will convene a panel of paediatricians, psychologists and epidemiologists, to compile and discuss the latest evidence on the effects of alcohol on young people's physical and emotional health, cognitive development and brain functioning. | Government
paediatricians,
psychologists
epidemiologists
other developmental and child health experts, teachers, young people, social workers
Parents
Young people | Parents
Young people |
<table>
<thead>
<tr>
<th>SSS priority action</th>
<th>Supporting policy actions</th>
<th>Stakeholders</th>
<th>Target groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>23. The Government will raise awareness of young people’s alcohol use and will – through a social marketing campaign – work to create a culture where it is socially acceptable for young people to choose not to drink and, if they do start drinking, to do so later and more safely.</td>
<td>Reviews by the National Institute for Health and Clinical Excellence (NICE).</td>
<td>Government</td>
<td>Young people</td>
</tr>
</tbody>
</table>
5. Overview

5.1 We have identified three main categories of priority action in the strategy review. These are as follows:

- improving the amount, and quality, of information about alcohol-related harm and improving the quality, effectiveness and cost-efficiency of alcohol-related harm management and service provision through, for example, the publication of guidance, through expert panel reviews and through the evaluation of pilot projects;
- targeting at risk populations and locations: interventions aimed at people who drink to levels that cause harm to themselves and/or others and at situations in which the risk of alcohol-related harm is high, for example brief alcohol interventions, replacing glassware with safer alternatives and enforcing the current limits on drink driving; and
- stimulating cultural change through social marketing and advertising.

5.2 Table 2 shows the ways in which priority actions in the strategy review fit into each of these three main categories.

<table>
<thead>
<tr>
<th>Category of priority action</th>
<th>Priority action number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving the amount, and quality, of information and improving alcohol-related harm management and service provision</td>
<td>1, 2, 3, 4, 5, 9, 13, 14, 15, 20, 21, 22</td>
</tr>
<tr>
<td>Targeting at risk populations and locations</td>
<td>6, 7, 8, 10, 11, 12, 19</td>
</tr>
<tr>
<td>Stimulating cultural change</td>
<td>16, 17, 18, 23</td>
</tr>
</tbody>
</table>

What are the harms?

5.3 Beyond the direct health harms associated with excess alcohol consumption, many social harms including crime/social deviance, family instability and dissolution, decreased productivity and employment, and environmental damage can be attributed to the influence of excess alcohol consumption (17). However, the majority of these harms are borne by persons other than the drinker, the costs of mitigating such harms can also divert resources from the provision of other services.

Who is affected?

5.4 The World Health Organization categorisation of alcohol use disorders specifies three categories (18):

- hazardous drinking: people drinking above recognised ‘sensible’ levels but not yet experiencing harm;
- harmful drinking: people drinking above ‘sensible’ levels and experiencing harm; and
- alcohol dependence: people drinking above ‘sensible’ levels and experiencing harm and symptoms of dependence.

5.5 This categorisation is useful in assessing the level of need in the population and the gap between need and the provision of services appropriate to those needs. Different categories of drinker are likely to need different types of services.

5.6 Figure 1 summarises some of the methodological issues associated with defining drinkers; Figure 2 summarises some of the epidemiologic aspects of identifying alcohol-related harms.
Figure 1: Methodological issues associated with defining drinkers: binge drinking

Consensus about definitions: Binge drinking is a debated term. Since alcohol will affect different people in different ways, there is no fixed relationship between the amount drunk and its consequences. So although many people understand ‘bingeing’ to mean deliberately drinking to excess, or drinking to get drunk, not everyone drinking over 6/8 units in a single day will fit this category. Similarly, many people who are drinking to get drunk, will drink far in excess of the 6/8 units in the unit based definition.

Population Patterns: Binge drinkers are predominantly but not exclusively those aged between 16-24. Both men and women are at greater risk of accidents and alcohol poisoning; young men in this group are far more likely than women both to commit and to experience alcohol-related violence, whilst young women are at increased risk of sexual assault. Both genders are likely to have lower earnings and higher unemployment than other drinkers; chronic drinkers: men over 40 and, to a lesser extent, women are likely to suffer chronic diseases and to die earlier (although for men over 40 and post-menopausal women this has to be offset against lower risk of heart disease). They are less likely than binge drinkers to commit crimes. Up to a point they prosper at work; some very vulnerable groups with multiple problems - for example, rough sleepers; families of drinkers suffer as their health, productivity and ability to cope decline: between 0.78 and 1.3m children suffer from parental drinking; and society as a whole: there are an estimated 1.2m alcohol-related violent incidents every year, and a quarter of the population see alcohol as a problem in their neighbourhood.

The definitions are based on those used in official surveys, which use government weekly and daily guidelines. They are as follows:

- **Binge:** drinking over twice the daily guidelines in one day (8+ for men/6+ for women)
- **Low to moderate drinking:** drinking up to previous weekly guidelines (0-14/21)
- **Heavy to moderate drinking:** drinking between 14/21 and 35/50 units in a week
- **Very heavy:** drinking 35/50+ units in a week
- **Chronic:** sustained drinking which is causing or likely to lead to risk of harm.

The strength of drinks has risen: for example, wine is now frequently 12 per cent or 13 per cent. This has an impact on calculating unit sizes.

Figure 2: Epidemiological aspects of identifying alcohol-related harm

Alcohol misuse does not lead automatically to harm. It does, however, lead to increased risk of harm depending on: individual reactions and circumstances: habitual heavy drinkers can appear near-sober after amounts of alcohol which would incapacitate a non-drinker, although they are at risk of longer-term harm; the nature of the harm: alcohol poisoning, for example, is directly attributable to alcohol whereas other health consequences such as cancer are less directly attributable; and the interaction of alcohol with other factors: an aggressive pub environment can influence the likelihood of violence occurring between drinkers.

Alcohol is a stronger cause of some harms than others: the risk of some harms, such as liver cirrhosis, is disproportionately higher when larger amounts are drunk; in other cases, such as coronary heart disease, the risk of harm decreases with moderate drinking then rises again sharply with higher consumption; the exact relationship between risk and intake may not always be clear - particularly for some of the social harms, such as interpersonal violence - although it appears that heavy consumption under certain circumstances can elevate risk. Often alcohol is one amongst other factors which cause harm such as drug use, mental health or housing problems: for example, about a third of those with serious mental illness have substance abuse problems, and around a quarter of those who use drugs also have problems with heavy drinking.

Drinking patterns vary considerably and are characterised by the frequency of drinking; the quantity per occasion; and the variation between one occasion and another. At the extremes, two harmful drinking patterns in particular stand out: chronic heavy drinking (high frequency/high volume); and heavy single occasion, or ‘binge’, drinking (low frequency/high volume). Because many heavy drinkers develop tolerance to the physical effects of alcohol, chronic heavy drinking does not often lead to evident intoxication, but can still cause physical and psychological damage and lead to dependence. By contrast, drinking to intoxication, even if done so infrequently, can lead to a variety of problems, such as accidents, injuries, interpersonal violence, alcohol poisoning and certain types of acute tissue damage.

5.7 Figure 3 provides a general overview of how alcohol consumption by target groups are affected the strategic interventions in ASE. The model developed for the HIA synthesises
several of the models shown in the Interim Analytical Report (17). The model for the HIA shows that alcohol consumption and alcohol harm are on the same spectrum, and can be used to show how the strategy review addresses the transition from consumption to harm for three target groups in the population. In the model, it is also possible to see how harm from alcohol can affect several determinants of health and wellbeing.

5.8 The model for the HIA also displays the main pathways of how alcohol consumption is affected by the ASE strategies:
- by supply-side factors, including availability and accessibility; and
- by demand-side factors, including price, education and marketing.

5.9 The model for the HIA was tailored to accommodate the specifications for the review of the ASE. It shows the three target groups in the population identified in the strategy review. The demand side shows Price rather than Affordability. Affordability is an interaction of socioeconomic context with price and is important when considering the consumption of alcohol but this factor is not mentioned or dealt with in the priority actions for SSS. The Education channel in the model for the HIA represents a broad range of socio-cultural influences that affect patterns of alcohol consumption. The ASE review addresses these factors through education interventions.

5.10 As part of the SSS there will be an independent review of the relationship between price, promotion and harm. We suggest that the Government make a consideration of the affordability of alcohol an explicit part of this review.

5.11 There are important two-way flows in the model. Alcohol harms affect families, which in turn affect alcohol consumption and alcohol-related harm. Such pathways are captured through the two-way arrow from alcohol harm to alcohol consumption. A social determinants approach, for example, seeks to capitalise on these broader channels.

5.12 This conceptual model for the HIA, along with several other policy-analytic approaches, has been used to evaluate the ASE policies. The following sections present the results of this analysis. In Appendix 1, Figure A2 and Table A2 provide an example of how the analytical process was used to generate suggestions for each priority action in the ASE.

Figure 3: Model of alcohol consumption and alcohol harm
6. Impact identification

6.1 During the drafting of SSS the HIA team took the new and emerging actions as the starting point for analysis. There were 11 priority actions each with a host of supporting actions.

6.2 The final published strategy elevates some of these supporting actions so that there are 23 priority actions. These are described in the strategy chapter Action: next steps for delivering change. They are also summarised in Annex B (page 75). In Annex B they are grouped under the following sub-objectives and are considered in the sections below

- support for local partnerships and communities;
- earlier identification interventions and treatment for drinking that could cause harm;
- tackling alcohol-related offending;
- replacing glassware and bottles in high-risk premises;
- drink driving;
- underage sales;
- responsible retailing and promotions;
- review of the Social Responsibility Standards;
- labelling alcohol products;
- promoting a culture of sensible drinking;
- alcohol and pregnancy;
- support for harmful drinkers; and
- preventing harm to those under 18 years of age.

6.3 The chapter begins with an explanation of the way in which wider society, including individuals, all have a role in delivering the strategy. The chapter goes on to state that the Government will have a focus on outcomes and that this will need a long-term approach. The reader is then taken straight into text that sets out the priority actions. We note this as an editorial inconsistency that appears in several places in this chapter. There are also some differences between the chapter describing the actions and the summary of the actions in Annex B. While these are mostly down to the layout and formatting of the text, and so not substantive in and of themselves, they can give the impression that the strategy has actions that have nothing to support them.

6.4 We quote from SSS to show what the Government intends will happen with respect to reducing harms from alcohol, and how the priority actions will be implemented to achieve the goals of the priority actions. In the HIA, we considered the optimal outcome for each action as they are inherently aspirational, and the realisation of their intended outcomes depends upon many other factors.

6.5 We constructed tables where

- the intervention named in the strategy review is stated;
- the expected output is quoted; and
- the intended effect of the intervention is described.

6.6 We identify some ways in which this intended effect may be experienced by different population groups. The intended effect might be direct or indirect, or it might be an effect on services.

6.7 The next step was to identify threats to the successful implementation and delivery of the action. This led to a series of suggestions to strengthen the delivery of the priority actions and where appropriate to improve health and wellbeing.
Support for local partnerships and communities

Priority Action 1.
A new programme will help local partnerships and communities tackle alcohol-related crime and disorder – encouraging more and stronger local partnerships and industry participation.

Priority Action 2.
Government Offices for the Regions will be asked to ensure strategic regional co-ordination of the requirement for local partnerships to tackle alcohol related crime and disorder.

What will happen

6.8 The Government will encourage stronger local partnerships and greater industry participation – one model is cross-agency partnership.

6.9 Local partnerships can focus on tackling violent crime by participating in the Tackling Violent Crime Programme, tackling crime and disorder in general, licensing, and managing the night-time economy.

6.10 The Home Office will work with the Government Offices (GOs) for the English Regions to provide guidance to support this process, and to ensure that a wide range of stakeholder groups represented at local level to help:

- tackle alcohol-related crime & disorder and anti-social behaviour (ASB) associated with the night-time economy in town and city centres;
- develop a co-ordinated approach to intervening with individuals whose offending is linked to alcohol;
- work with alcohol industry to make further progress in the responsible sale and retail of alcohol and eliminate under-age sales;
- adopt new ways of working that use the full range of new and existing powers, while ensuring that particular groups are not targeted inappropriately.

6.11 GOs to ensure strategic regional co-ordination of the requirement for local partnerships to tackle alcohol related crime and disorder.

6.12 Local effort will be contained in the CDRP strategies for tackling crime and disorder which require alcohol-related issues to be addressed - strategy delivery is scheduled for April 2008; alcohol-related improvement targets will be negotiated and agreed in the new Local Area Agreements.

6.13 Performance management against alcohol harm reduction targets will be embedded in existing schemes; however, there will be an exploration of how these can be aligned with other local assessment frameworks to reduce the reporting burden but ensuring consistency with national Public Sector Agreement targets and national priorities.

6.14 There will be an exploration of the role for communications in helping to highlight action and enforcement measures being implemented by local partnerships.

Optimal policy outcome

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Output</th>
<th>Intended effect</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Headline:</strong> Stronger local partnerships and greater industry participation</td>
<td>Improved management of alcohol-related crime and disorder</td>
<td>Improved quality of services Potential to improve cost-effectiveness of service provision</td>
</tr>
<tr>
<td>Local partnerships <strong>tackling violent crime</strong> by participating in Tackling Violent Crime Programme, tackling crime and disorder in general, licensing, and managing the night-time</td>
<td>Alcohol-related crime and disorder addressed in a cross-sectoral cross-agency way</td>
<td>Reduction in alcohol-related crime, violence, ASB, noise, vandalism, accidents and injuries</td>
</tr>
<tr>
<td>Intervention</td>
<td>Output</td>
<td>Intended effect</td>
</tr>
<tr>
<td>--------------</td>
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<td>-----------------</td>
</tr>
</tbody>
</table>
| economy | • domestic violence & child abuse  
Increased safety on public transport  
Reduced burden on:  
• Environmental health  
• Police  
• Ambulance Service  
• A&E  
• NHS  
• CJS  
• Prison Service | |
| HO working with GOs for the English Regions to provide *guidance* to CDRPs | Improved management of individuals whose offending is linked to alcohol  
Improved management of harms associated with alcohol  
Increased effectiveness of using new and existing powers  
Reduced irresponsible sales of alcohol  
Reduced sales of alcohol to under-age people | Reduction in alcohol-related crime  
• crime  
• violence  
• ASB  
• noise  
• vandalism  
• accidents and injuries  
• domestic violence & child abuse  
Reduction in levels of  
• offending  
• consumption of alcohol  
For 18-24 yr old binge drinkers: reduced risk of  
• accidents and injuries  
• alcohol-related disease  
• unprotected sex  
• STDs  
For under 18’s: reduced risk of  
• accidents and injuries  
• alcohol-related disease  
For under 18’s: improved educational performance including reduced levels of truancy and exclusions  
Increased safety on public transport |
| GOs to ensure strategic regional co-ordination of the requirement for local partnerships to tackle alcohol related crime and disorder | Consistency of approach nationally and locally  
Opportunities for:  
• sharing good practice;  
• improved management;  
• organisational and/or partnership learning | Increased effectiveness of CDRPs  
Improved targeting of resources  
Improved management of problems related to alcohol-related crime and disorder |
| Alcohol-related issues addressed in CDRP *strategies* for tackling crime and disorder; alcohol-related improvement targets in new *Local Area Agreements* | Services focussed on alcohol-related crime and disorder | Potential to manage some individuals who may not have received alcohol-related services previously  
Potential to reduce harms associated with alcohol-related crime and disorder with an increased number of offenders receiving interventions  
Higher profile and priority for alcohol-related issues at a local level |

---

2 Now Priority Action 2
Threats to implementation and delivery

6.15 Although this set of priority actions has support for communities as part of its headline, there is no specific new priority action which addresses supporting communities directly or explicitly or which involves them in the planning and development of improved management of alcohol-related crime and disorder.

6.16 The way in which guidance is developed in terms of gaining ownership at a local level - without local ownership, there may not be effective implementation (19;20).

6.17 Length of time it may take to align performance management targets and the implementation of the new system of reporting.

Suggestions

6.18 We ask the Home Office to consider:
- establishing a process for guidance development that is seen to be inclusive in terms of the stakeholder groups represented at a local level; and
- developing the guidance in ways that allow for adaptation and input at a local level that enables responsiveness to local conditions and circumstances.3

6.19 We ask the Home Office to consider ways of involving communities in the process of tackling alcohol-related crime and disorder at a local level through the CDRPs and their strategies.

Earlier identification interventions and treatment for drinking that could cause harm

Priority Action 3.
To support the roll-out and take-up of targeted identification and brief advice, a healthcare collaboration will be set up to disseminate the early results of the trailblazer research programmes and share learning on implementation.

Priority Action 4.
There will be a national review of the cost to the NHS of alcohol-related harm - identifying areas where the greatest savings can be made, through earlier identification and interventions for drinking that could cause harm.

Priority Action 5.
The DH will establish a framework to support commissioners in planning local investment.

What will happen

6.20 The results of trailblazer programmes offering treatment and advice to hazardous, harmful and dependent drinkers will be widely disseminated to all local partnerships and, in addition, a new healthcare collaboration will be established, to bring areas together to learn from each other and overcome barriers to implementation.

6.21 Over the next year, the National Audit Office (NAO) is considering carrying out a study into the provision of interventions with the potential to reduce health harms and the burden of harmful drinking on the NHS.

6.22 DH will work with the regulatory bodies to support local healthcare and social care organisations in responding to the findings of any reports produced by the regulatory bodies.

6.23 The framework to support commissioners in planning local investment will include:
- an interactive web-based commissioning tool;
- a web-based local alcohol profile (updated June 2007);
- data on the contribution of alcohol to different types of health and crime harm;

3 These two suggestions by the HIA team were adopted in SSS.
• guidance on developing local indicators; and
• guidance on The Commissioning Framework for Health and Well-being (21) and alcohol.

6.24 Local data on levels of health harms are available for each PCT and local authority on www.nwph.net/alcohol/lape

### Optimal policy outcome

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Output</th>
<th>Intended effect</th>
</tr>
</thead>
</table>
| Results of **Trailblazer programmes** will be disseminated through healthcare collaboration | Opportunities to share good practice  
Opportunities for organisational and partnership learning  
Opportunities for earlier identification of people at risk  
Opportunities for better management of at-risk groups | In the long term, reduction of alcohol-related morbidity and mortality  
Improved targeting of NHS resources  
Improved management of alcohol-related health problems  
Increased effectiveness of NHS |
| **NAO considering study into provision of interventions with potential to reduce health harms and burden of harmful drinking on NHS** | Identification of reasons for variation in provision  
Identification of poor, inefficient and non-cost-effective provision | In the long term, reduction of alcohol-related morbidity and mortality  
Improved planning, design and delivery of alcohol-related services in the NHS  
Increased cost-effectiveness of alcohol-harm treatment services in the NHS |
| **DH to work with regulatory bodies to support local healthcare and social care organisations in responding to findings in reports of regulatory bodies** | Increased awareness of regulatory body findings by health and social care sectors | Improved implementation of regulatory body findings by health and social care sectors  
Better identification of alcohol as a priority in local health and social care planning |

### Threats to implementation and delivery of the positive pathway

6.25 The NAO study is not confirmed, and may not be undertaken.

6.26 The wisdom of disseminating Trailblazer results through a healthcare collaboration will depend upon the make-up of the group. Partner agencies may not be aware of the findings if the membership is predominantly health stakeholders: these partner agencies would thus be less capable of supporting implementation (especially as Trailblazers include criminal justice sites). The HIA team understand that it is intended that the healthcare collaboration will include all relevant stakeholders: this suggests that the name of the group should be changed to reflect the broad membership.

### Suggestions

6.27 We ask the Government to consider:

• including other relevant agencies on the collaboration for dissemination of Trailblazer results to enable uptake by and support from organisations other than the NHS;

• gaining commitment for the conduct of a NAO study on the variations in the provision of interventions to reduce harm and the burden of harmful drinking on the NHS;

• liaising with and linking into the NHS National Knowledge Service (NKS) Annual Population Value Review (APVR), and using this as one focal point or lever to help

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4 As a result of the HIA team’s comments, in the final document the new healthcare collaboration has been tasked with bringing “areas together to learn from each other and overcome barriers to implementation”.

5 The HIA team has been informed that this commitment is actively being sought.
primary care trusts assess and adjust, as appropriate, their spending on alcohol-related services.\(^6\)

6.28 As the effects of alcohol harm are far-reaching, impacting for instance on family, employment, and schooling (and many of these wider effects will also influence demands on the NHS), we ask the Government to consider incorporating a social model of health into the methodology for the review, i.e. including the *social or socio-economic determinants of health* in the approach to identifying areas where the greatest savings can be made and thereby not focusing solely on the provision of health services (and biophysical determinants of health).\(^7\)

6.29 It is also suggested that the national review take account of international best practice while also ensuring that any results from other countries can be transferred to the context in England.

### Tackling alcohol-related offending

**Priority Action 6.**

There will be concerted local and national action to target alcohol-related offenders, using a combination of penalties and health and education interventions to drive home messages about alcohol and risks and to promote behaviour change.

**Priority Action 7.**

Work to improve the way alcohol-related offenders are dealt with in custody and in the community and support National Offender Management Service (NOMS) key strategic aims and objectives (summary of full text).

### What will happen

6.30 At each stage of the criminal justice system (CJS) there is an opportunity to identify individuals who are misusing alcohol and to provide appropriate interventions, ranging from brief advice and information through to referral to alcohol specialist treatment and rehabilitation. These provide an opportunity to:

- reduce offenders’ alcohol consumption to sensible drinking levels;
- improve offenders’ understanding of how to drink sensibly and of the risks of not doing so; and
- reduce the likelihood of re-offending.

6.31 Priority Action 7 has no supporting text but the priority itself lists the key strategic aims (and objectives) of the NOMS as including

- publication of an alcohol information pack for offenders under probation supervision;
- issue of revised ATR implementation guidance;
- dissemination across the NPS of learning points from seven alcohol best practice projects;
- research to examine the availability and accessibility of alcohol treatment for offenders to inform policy to improve alcohol provision;
- joint prisoner befriending scheme in seven London prisons; and
- work with the Prison Service National Drugs Programme Delivery Unit and Rehabilitation for Addicted Prisoners Trust (RAPt) to develop two alcohol treatment programmes for prisons.

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\(^6\) The HIA team has been informed that this suggestion will be considered when the Implementation Plan is developed.

\(^7\) The HIA team has been informed that this will be considered when the Implementation Plan is developed.
### Optimal policy outcomes

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Output</th>
<th>Intended effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small number of <em>alcohol referral schemes</em></td>
<td>Improved quality of information about alcohol brief interventions Information about set up and cost-efficient operation of alcohol referral schemes Potential to increase no. of conditional cautions with alcohol referral attendance as a condition</td>
<td>Potential to reduce re-offending Opportunity to develop good practice Opportunity for improved management of at-risk groups</td>
</tr>
<tr>
<td>Assessment of arrest referral pilot projects &amp; initiatives</td>
<td>Improved quality of information on cost-effectiveness of arrest referral schemes</td>
<td>For alcohol-related offenders in the long term: Improved management of alcohol-related problems Reduction in • alcohol consumption • re-offending • risk of alcohol-related disease • homelessness In areas where re-offending is reduced: Reduction in • alcohol-related crime • violence • ASB • noise • vandalism • risk of accidents and injuries • domestic violence &amp; child abuse Increased safety on public transport Improved use of resources through employing effective interventions Cost-efficient service delivery Potential for cost savings and re-direction of resources</td>
</tr>
<tr>
<td>Support NOMS</td>
<td>Achievement of NOMS strategic aims and objectives</td>
<td>Improvement in the way alcohol-related offenders are dealt with</td>
</tr>
</tbody>
</table>

### Threats to delivery and implementation of positive pathway

6.32 With respect to the operation of arrest referral schemes, there needs to be an agreed definition of “cost-efficiency” explaining what is covered by the term.

6.33 The priority action is subdivided into elements, the first of which is lead by HO and the remainder by MoJ/NOMS (see pp76). There is a risk that the tripartite responsibility for delivering this priority action will reduce its effectiveness.
**Suggestions**

6.34 With respect to alcohol referral systems, we ask the Government to include a definition of better value services (taking account of appropriateness, effectiveness and allocation of services), when calculating whether a service is cost-efficient (23).

6.35 Leadership of, and roles and responsibilities for, Priority Action 7 should be established and the activities of the Government departments be co-ordinated with respect to this priority action.

**Replacing glassware and bottles in high-risk premises**

| Priority Action 8. | Government will support local action to secure the replacement of glassware and bottles with safer alternatives in individual high-risk premises. |
| Priority Action 9. | An expert group, comprising police, doctors, academics and representatives of the alcohol industry will be set up to gather further evidence of where targeted interventions might produce benefits and agree how high-risk premises can be best identified. |

**What will happen**

6.36 The expert group will be in place by autumn 2007 and will be tasked with outlining the evidence base for identifying high-risk premises and subsequent proposals for further action in 2008.

6.37 Government will work with its partners to ensure the actions generated under Priority Action 8 are agreed and implemented

**Optimal policy outcome**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Output</th>
<th>Intended effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expert group to gather further evidence of where targeted interventions might produce benefits and agree how high-risk premises can best be identified.</td>
<td>Information on ways to reduce the risk of glass-related injuries at high-risk premises Information about how to minimise injury from glassware and bottles within existing regulatory framework Improved/effective targeting of regulatory powers to minimise injury from glassware and bottles Identification of effective further actions to minimise injury from glassware and bottles</td>
<td>In areas with high-risk premises: Reduced risk of glass-related injuries Reduced burden on: • Ambulance service • A&amp;E • Surgery departments • NHS • Police Street cleaning</td>
</tr>
<tr>
<td>Government to work with partners to ensure proposals for further action (see above) are agreed and implemented</td>
<td>Agreement on actions to reduce glass-related injuries</td>
<td>In areas with high-risk premises: Reduced risk of glass-related injuries Reduced burden on: • Ambulance service • A&amp;E • Surgery departments • NHS • Police Street cleaning</td>
</tr>
</tbody>
</table>

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8 Cost-efficiency, appropriateness and effectiveness were included as a result of the HIA team's input.
**Threats to implementation**

6.38 With respect to minimising the risks of glass-related injuries, there may be difficulties in gaining agreement on suggested actions for implementation - there may be resistance to the use of some interventions from certain sectors.

**Suggestions**

6.39 We ask the Government to consider extending the work outlined in priority actions under a new programme to help local partnerships and communities tackle alcohol-related crime and disorder to include involvement in the identification of high-risk premises and appropriate targeted interventions.

6.40 We ask the Government to consider developing with partners a set of criteria and definitions to facilitate assessment of which further actions or interventions are agreed for implementation.⁹

**Drink-driving**

Priority Action 10.

There will be concerted local action to enforce the law on drink-driving and on sales of alcohol to underage people

**What will happen**

6.41 The Government will facilitate improved enforcement of the current drink driving limit.

6.42 Public consultation exercise in 2007 will explore ways to make enforcement by police easier.

**Optimal policy outcomes**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Output</th>
<th>Intended effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilitation of improved enforcement of the current drink-driving limit</td>
<td>Increased enforcement of current drink-driving limit</td>
<td>Reduced risk of road traffic accidents</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reduced risk of injuries and fatalities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reduced burden of RTAs on:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ambulance service</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A&amp;E</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Surgery departments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• NHS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Police</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Fire &amp; Rescue Service</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Potential for re-allocation of resources</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Increased resource demand of improving enforcement borne by police</td>
</tr>
</tbody>
</table>

**Threats to implementation**

6.43 In order for drink-driving harms to be reduced, there is an assumption that:

- continuing improvements in enforcement will be able to achieve further reductions in drink-driving behaviours; and
- any reductions will be sizeable enough to have an appreciable population impact.

**Suggestions**

6.44 Public consultation will be critical for influencing the efficiency and effectiveness of law enforcement for drink-driving. Consultation should be transparent and inclusive of all groups, including those identified in the *Equalities Impact Assessment*. It is suggested that

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⁹ The HIA team has been informed that this will be considered during the development of the Implementation Plan.
NGOs and other alcohol reduction groups be invited to participate in the consultation process.

6.45 Although the case for a reduction in the legal alcohol limit for drivers is kept under review, we suggest that other international best-practices for reducing drink-driving and underage sales are considered, including:

- increasing the underage sales limit;
- randomised night-time driving checkpoints.

**Underage sales**

**Priority Action 11.**
The Government will continue to prioritise reductions in the test-purchase failure rate for underage sales of alcohol. This will mean ensuring that enforcement agencies are making use of good practice and applying tactics and powers effectively.

**Priority Action 12.**
The Government will work with the Association of Chief Police Officers and Local Authorities Coordinators of Regulatory Services to develop a data collection model and will provide further guidance by October 2007 to ensure that enforcement activity is efficient and well targeted.

**What will happen**

6.46 Trading Standards can designate underage sales as a local priority (following recommendations of the Rogers Review).

6.47 Success requires commitment from retailers to ensure that they introduce effective monitoring and comprehensive training.

6.48 Government expects the alcohol industry to encourage universal adoption of the Challenge 21 scheme or an equivalent scheme and to secure the commitment of retailers to prevent underage selling.

6.49 To ensure effective internal sanctions and rewards are in place, industry needs to review policies and procedures taking into account lone trading, notifications of test purchase results, employment contracts and tenancy arrangements, etc.

**Optimal policy outcomes**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Output</th>
<th>Intended effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Targeting problem premises that persist in selling alcohol to children</td>
<td>Improved data collection on underage sales, Targeted enforcement activity on underage sales, Potential to reduce access to alcohol for under-18s</td>
<td>Reduction in: access to alcohol for under-18s, alcohol consumption, harms through poor educational performance, truancy and exclusions, alcohol-related disease</td>
</tr>
<tr>
<td>Underage sales: Trading Standards can designate underage sales as a local priority</td>
<td>Underage sales may be a local priority, Potential to reduce access to alcohol for under-18s</td>
<td>Reduction in: access to alcohol for under-18s, alcohol consumption</td>
</tr>
</tbody>
</table>

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Health Impact Assessment
<table>
<thead>
<tr>
<th>Intervention</th>
<th>Output</th>
<th>Intended effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underage sales: Retailers to ensure introduction of effective monitoring and comprehensive training</td>
<td>Improved detection and management of underage sales by retailers</td>
<td>- reduction in:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• access to alcohol for under-18s</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• alcohol consumption</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• harms through poor educational performance, truancy and exclusions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• alcohol-related disease</td>
</tr>
<tr>
<td>Alcohol industry to encourage universal adoption of the Challenge 21 scheme (or equivalent)</td>
<td>Increased adoption of Challenge 21 scheme</td>
<td>- reduction in:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• access to alcohol for under-18s</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• alcohol consumption</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• harms through poor educational performance, truancy and exclusions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• alcohol-related disease</td>
</tr>
<tr>
<td>Reliable and transparent system of collection of the relevant data</td>
<td>Enforcement of underage sales</td>
<td>- reduction in:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• access to alcohol for under-18s</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• alcohol consumption</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• harms through poor educational performance, truancy and exclusions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• alcohol-related disease</td>
</tr>
</tbody>
</table>

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Health Impact Assessment
### Intervention Output Intended effect

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Output</th>
<th>Intended effect</th>
</tr>
</thead>
</table>
| Alcohol industry to review policies and procedures: lone trading, notifications of test purchase results, employment contracts and tenancy arrangements | Potential to improve industry policies and procedures | Reduction in:  
- access to alcohol for under-18s  
- alcohol consumption  
- harms through poor educational performance, truancy and exclusions  
- alcohol-related disease |

### Threats to implementation

6.50 We note that the text for Priority Action 12 in the chapter *Action: next steps for delivering change* includes a deadline (by October 2007). This deadline is not included in the summary table in Annex B.

6.51 The majority of interventions for this policy area are targeted at reducing underage drinking by reducing sales of alcohol to under-age drinkers. However, the evidence shows that many underage drinkers obtain alcohol from family and friends, so although it is important to promote enforcement of the law on underage sales and for industry to comply with that law, these priority actions may have a limited effect because they do not address all the sources of alcohol for under-18s.

6.52 The strategy itself notes the importance of a reliable and transparent system of data collection to police a reduction of underage sales. While Priority Action 12 states a commitment to work with the Association of Chief Police Officers and Local Authorities Coordinators of Regulatory Services to develop a data collection model the action has no supporting text. It will be imperative to ensure this data collection takes place and that the data is made available.

### Suggestions

6.53 We ask Government to make an explicit commitment to link the priority action on underage sales with the priority actions on social marketing and advertising to change cultural attitudes towards alcohol consumption in under-18s. These actions are listed in SSS and contribute to the same outcome but the link will benefit by being made explicit.

6.54 Public consultation is pivotal to improving the enforcement of laws on underage sales. It is suggested that young people, including those at-risk, should be included in the consultations, potentially as focus groups, and play a role in designing enforcement strategies.

6.55 Current initiatives focus upon reducing the accessibility of alcohol for young people. Population-wide efforts to reduce alcohol availability will also reduce the availability of alcohol for young people. It is suggested that increasing targeted interventions, such as those which zone alcohol distribution or other urban planning initiatives, could render alcohol less available to youth.

6.56 At present, demand-side interventions are not considered in the strategy review. There is scope for intervention to strengthen the opportunities for taking personal responsibility with respect to alcohol consumption.

- One example demand-side strategy might be the development of competing demands for youth to "crowd out" demand for alcohol. Such strategies, building upon the *Designing Out Crime* paradigm, could focus on improving the availability and accessibility of other civic services and facilities for young people, such as coffee shops, bookstores, youth centres, theatres, and sports and recreational facilities. There is an unmet need for night-time youth provision that is not based around sale and consumption of alcohol.

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10 The HIA team has been informed that this suggestion has been accepted.

11 The HIA team have been informed that DCMS and DfES may want to consider this suggestion.
6.57 Although the focus of this policy area is that of policing and enforcement (of regulations or of voluntary codes), which requires manpower and expenditure, we suggest there is an opportunity for developing incentives and a greater number of self-regulated interventions.

6.58 We ask the Government to consider including indicators for ensuring enforcement activity is efficient and well-targeted. Benchmarks need to be devised to measure progress against what reductions are considered feasible within specific time frames. These benchmarks should take into account the long- and variable-lag times between alcohol consumption and alcohol-related morbidity and mortality.

6.59 Many schools now have a drug and alcohol policy in which is set out their approach to drug and alcohol education and other aspects of substance misuse. In the classroom, alcohol education is chiefly delivered through Personal, Social and Health Education (PSHE), and will also feature in the statutory Citizenship Curriculum. These aim to develop pupils’ knowledge, skills, attitudes and understanding about alcohol. Although such programmes are successful in imparting information, there is little evidence for the effectiveness in changing behaviour of alcohol education delivered in schools or any other alcohol prevention programme aimed at young people, especially in England. We ask the Government to consider including liaison with schools as part of the programme for the local partnerships on alcohol-related crime and disorder. In addition, we suggest one of the potentially important audience segments for the social marketing interventions is schoolchildren, with the school being a focus for some of the interventions devised and developed during the social marketing campaign.

6.60 We ask the Government to consider ways of ensuring that

**Responsible retailing and promotions**

Priority Action 13.

The Government will commission an independent national review of evidence on the relationship between alcohol price, promotion and harm, and, following public consultation, will consider the need for regulatory change in the future, if necessary.

**What will happen**

6.61 The Government will review the evidence on how and in what circumstances price — including discounting, advertising and other forms of promotion — drives overall consumption of alcohol and problem drinking in particular. As part of this, the Government will look for evidence on whether the current advertising restrictions are sufficient to protect children and young people, taking into account the work currently being done by the Advertising Standards Authority (ASA).

6.62 The Government will also consider the evidence that pricing structures may form an effective part of a harm reduction strategy for heavy drinkers, young people and people on low incomes. This review will be led by the Department of Health, in collaboration with other government departments, and will be carried out during 2008. The Government will seek the advice of the Alcohol Education and Research Council, as an independent and authoritative source of evidence-based advice, on the extent to which current research indicates to what extent, if any, the advertising and promotion of alcohol could result in increased levels of consumption and harm to health. The review will take into account work currently being done by the advertising regulators.

6.63 Price promotions

- Retailers of alcoholic products should continue to play their part in ensuring that their sale of discounted alcohol is not encouraging irresponsible drinking.
- One aspect of price promotion initiatives focuses on encouraging industry-led partnerships at local levels to improve adherence to socially responsible industry standards.

6.64 The other major aspect of these price promotion initiatives is to ensure that sales promotions are socially responsible, which means rooting out loss-leading, or ‘deep-discounting’, alcohol strategies.
6.65 Government believes that retailers of alcoholic products should continue to play their part in ensuring that their sale of discounted alcohol is not encouraging irresponsible drinking.

- The alcohol industry's *Social Responsibility Standards for the Production and Sale of Alcoholic Drinks in the UK* include a commitment to "take all necessary steps to ensure that brands are not used as part of irresponsible promotions or promotions that 'appear to encourage excessive consumption." (1, p56)

### Optimal policy outcome

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Output</th>
<th>Intended effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent National Review of the relationship among alcohol price, promotion (discounting, advertising and other forms of promotion) and harm</td>
<td>Improved quantity and quality of information about the relationship between price, promotion and alcohol consumption. Assessment of appropriateness of advertising standards to protect children and young people.</td>
<td>Reduced incidence of problem drinking. Potential to improve management of problem drinking. Increased protection of children and young people from exposure to alcohol-related harm.</td>
</tr>
<tr>
<td>Government Review of potential for pricing structures to form part of an effective strategy for harm reduction</td>
<td>Improved quantity and quality of information about the relationship between pricing structures and alcohol-related harm, and pricing structure interventions to reduce alcohol-related harm.</td>
<td>Reduction in alcohol-related harm for: - Heavy drinkers - People on a low income - Young people.</td>
</tr>
</tbody>
</table>

### Threats to implementation

6.66 Specific actions to be taken by Government to forge industry partnerships are not specified, although aspirations relating to industry cooperation are expressed in the strategy review.

6.67 It is not made clear how Government will seek to improve regulation of alcohol sales through existing practices, or what the estimated cost of this improved regulation will be.

6.68 There are currently no indicators for monitoring improvement against industry standards or reducing the variation in adherence to them on the ground.

6.69 The priority action text states that prior to considering the need for regulatory change the Government will consult the public on the results of the national review. There is no mention of consultation in the supporting text and it is therefore not clear who will be consulted and by what mechanism.
6.70 Industry self-regulation tends to be less strict than NGO or public sector regulation. In the context of tobacco, industry codes, supported by industry-led science, have been used to counter pressure for more durable and health-promoting public sector regulation.

6.71 No empirical evidence is provided for the effectiveness of industry self-regulation for reducing alcohol harm in England. Most evidence suggests Corporate Social Responsibility (CSR), and other forms of voluntary industry regulation, have not worked for chronic disease control (including alcohol) as well as for infectious disease control. Of the CSR strategies that have shown some promise, those which are underpinned by rewards in the marketplace have been the most effective.

6.72 There is insufficient detail in the strategy review to identify the specific impacts that industry voluntary codes could have in relation to alcohol-related harm. Voluntary codes can inadvertently concentrate alcohol delivery and ownership, which may reduce the competitiveness of the alcohol market.

Suggestions

6.73 We ask the Government to consider establishing mechanisms to integrate and coordinate NGO involvement in the management of the potential harms associated with alcohol consumption. An alcohol coalition including the NGO and voluntary sector would enable the partnership objectives in the Alcohol Harm Reduction Strategy to be achieved.

6.74 Given the existence of a fundamental tension between profit incentives and reducing consumption, we ask the Government to consider the need to oversee industry self-regulation, and the potential role of NGOs in this respect. For example, selected industry-independent NGOs could be commissioned to monitor compliance and administer awards for adherence to industry standards or codes.

6.75 We ask the Government to consider whether there is a need for The Competition Commission to evaluate the effects of market structure changes on alcohol consumption and alcohol-related harm.

6.76 We ask the Government to consider liaising with industry to outline the groups at risk of alcohol-related harm who are meant to be protected by the industry’s Social Responsibility Standards. It is likely that those most at risk include children, and family members of people who consume alcohol at harmful levels (other people in marginalised and vulnerable groups affected by harmful levels of alcohol consumption are identified in the Equality Impact Assessment.) However, if there is clarity about the people who are at risk it is likely that the standards in place to protect those groups will be more appropriate and effective.

6.77 In the strategy review, it is suggested that loss-leading, or heavily discounting, promotions to encourage drinking, could result in harmful levels of alcohol consumption. Evidence is needed to assess whether this price promotion initiative is a major determinant of alcohol consumption because these price promotions are offered as important factors in alcohol-related harm. The logical inference is that price, at least below a certain threshold, is an important determinant of alcohol harm. We ask the Government to consider defining this operating threshold and making it transparent. It may provide important base information for reducing alcohol-related harm. This investigation could be incorporated into the Independent National Review.

6.78 We ask the Government to consider the issue of affordability of alcohol in relation to alcohol consumption and potential harm in the Independent National Review (see also paragraph 5.9 on page 20 where we note a difference between price and affordability).

6.79 As international and national evidence has consistently demonstrated that price, marketing and availability are key levers for reducing alcohol harm at a population level (2), we ask the Government to consider evaluating a range of economic instruments (including those proven to be effective or having been successfully implemented in EU countries) in terms of their health and economic impacts and suitability for application in England as part of the Government’s review of pricing structures.

6.80 We ask the Government to reaffirm commitment to public consultation, and to specify the mechanism by which the public will be consulted, on the results of the independent national
We suggest that it is made explicit that the commitment to consultation means that the process will follow the Cabinet Office Code of Practice with all that that will entail.

**Review of the Social Responsibility Standards**

**Priority Action 14.**

A review and consultation will take place on the effectiveness of the industry's Social Responsibility Standards in contributing to a reduction in alcohol harm and, following public consultation, will consider the need for regulatory change in the future, if necessary.

**What will happen**

6.81 Voluntary codes

- The Government will encourage partnerships to work with the local licensed trade to promote good practice and compliance with existing voluntary codes.
- Government will work with industry, advertising and consumer bodies to ensure that existing voluntary codes are transparent and fully accessible to the public and are as effective as possible so that breaches of the industry's standards can be reported and acted upon by members of the public.
- All businesses that sell alcohol should seek ways to ensure that voluntary standards are being met on the ground, through local award schemes such as Best Bar None, through more formal self-regulation arrangements based on complaints from members of the public operated by e.g. Portman Group, or by using mystery shoppers to monitor compliance.

6.82 With respect to underage sales and to including information on sensible drinking and alcohol unit content on bottles and containers “the Government … believes that more can be done to ensure the visible and transparent implementation of these standards and that there are good arguments for independent monitoring to verify that standards have actually improved” (1, p56).

6.83 Depending on the result of a national review of the relationship between alcohol advertising and promotion and harm, the Government will consider the need for regulatory change in the future.

6.84 During 2008, the Government will commission a review and consult on the effectiveness of the industry's Social Responsibility Standards in contributing to a reduction in alcohol harm and the extent to which they have been implemented.

6.85 Based on the findings that emerge from this review, the Government will consider whether to seek legislative action for changing marketing practices.

6.86 Further steps by Government may include work with the industry to tighten standards and their monitoring and enforcement. If necessary, they may also include, legislative options in specific areas, such as advertising controls and promotions based on price that contribute to excessive consumption of alcohol.

**Optimal policy outcome**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Output</th>
<th>Intended effect</th>
</tr>
</thead>
</table>
| A review and consultation on the effectiveness of industry's Social Responsibility Standards in contributing to reducing the harm from alcohol | Information on the effectiveness of industry's Social Responsibility Standards and Potential areas for legislation, e.g. advertising controls and price promotions | Reduction in:  
  - access to alcohol for under-18s  
  - binge drinking  
  - harms through poor educational performance, truancy and exclusions  
  - alcohol-related disease  
  - ASB  
  - alcohol-related crime  
  - violence |
<table>
<thead>
<tr>
<th>Intervention</th>
<th>Output</th>
<th>Intended effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promote good practice and compliance with existing industry-designed voluntary codes</td>
<td>Transparency of voluntary codes to public</td>
<td>Reports by members of the public of breaches of voluntary codes</td>
</tr>
<tr>
<td></td>
<td>Accessibility of voluntary codes to public</td>
<td>Reduction in:</td>
</tr>
<tr>
<td></td>
<td>Effectiveness of voluntary codes, including facility to report breaches</td>
<td>• access to alcohol for under-18s</td>
</tr>
<tr>
<td></td>
<td>Compliance with voluntary industry regulatory standards ‘on the ground’</td>
<td>• binge drinking</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• harms through poor educational performance, truancy and exclusions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• alcohol-related disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reduction in:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• ASB</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• alcohol-related crime</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• violence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• noise</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• vandalism</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• accidents and injuries</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reduced burden on:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• NHS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Police</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Environmental services</td>
</tr>
</tbody>
</table>

**Threats to implementation**

6.87 Stakeholders for the review and consultation are not specified, neither is the mechanism for public consultation.

**Suggestions**

6.88 We ask the Government to consider including representatives from all stakeholder groups, including the NGO and voluntary sector, in the consultation for the review of the effectiveness of the industry’s Social Responsibility Standards. We also ask that

- the consultation process is made transparent (including the need for probity and the declaration of any conflicts of interest);
- independent literature reviews are commissioned; and
- any expert panels include representatives from academic institutions and NGOs.

6.89 With respect to the potential for legislation, we ask the Government to consider the potential for greater government intervention. We suggest that economic analysis of market failures should provide the case for whether government intervention is needed, or desirable, in the context of alcohol. This could follow the approach used in similar documents prepared for tobacco.

6.90 We suggest that it is made explicit that the commitment to consultation means that the process will follow the Cabinet Office Code of Practice with all that that will entail.
Labelling alcohol products

Priority Action 15.

Consultation will take place in 2008 on the need for legislation in relation to alcohol labelling, depending on the implementation of the scheme to include information on sensible drinking and drinking while pregnant on alcohol bottles and containers.

What will happen

6.91 The Government will continue to seek agreement with the industry on the display of information at points of sale and on advertisements regarding sensible drinking and understanding of alcohol units and on the inclusion in advertisements of a reminder about sensible drinking.

6.92 In April 2007 additions to labelling to support sensible drinking were implemented. Consultation will take place in 2008 on the need for additional legislation in relation to alcohol labelling for the adverse effects of drinking while pregnant. The Government will consider consultation on possible legislative options if insufficient progress is made.

Optimal policy outcome

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Output</th>
<th>Intended effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Government will continue to seek agreement with the industry on the display of information at points of sale and on advertisements regarding sensible drinking and understanding of alcohol units.</td>
<td>Increased provision of information at strategic locations</td>
<td>Increased understanding of the risks associated with alcohol consumption</td>
</tr>
<tr>
<td>Consultation on the need for legislation in relation to alcohol labelling following the launch of the alcohol labelling scheme in 2007</td>
<td>Potential areas for legislation on alcohol labelling</td>
<td>Decreased consumption of alcohol during pregnancy Reduction in incidence of foetal alcohol syndrome Reduction in: binge drinking alcohol-related disease Reduction in: ASB alcohol-related crime violence noise vandalism accidents and injuries Reduced burden on: NHS Police Environmental services</td>
</tr>
</tbody>
</table>

Threats to implementation

6.93 The planned consultation on legislation will not have an effect in the short-term, but in the longer-term potential health effects are high.

6.94 No measures have been provided to monitor the successful implementation of the Government’s objectives on alcohol labelling.

Suggestions

6.95 We ask the Government to consider identifying measures to monitor the implementation by industry of Government objectives on alcohol labelling.\(^\text{12}\)

\(^{12}\) The HIA team has been informed that this suggestion could be considered early on in the consultation process.
6.96 We ask the Government to consider determining the thresholds for success that will signal whether industry has achieved satisfactory progress in implementing agreed product labelling and advertising controls.

**Promoting a culture of sensible drinking**

<table>
<thead>
<tr>
<th>Priority Action 16.</th>
<th>Sustained national campaigning will challenge public tolerance of drunkenness and drinking that causes harm to health.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority Action 17.</td>
<td>Sustained national campaigning will raise the public’s knowledge of units of alcohol and ensure that everyone has the information they need to estimate how much they really do drink.</td>
</tr>
<tr>
<td>Priority Action 18.</td>
<td>The Government through its communications campaigns, the NHS and local communities, will target information and advice towards people who drink at harmful levels, and their families and friends.</td>
</tr>
</tbody>
</table>

6.97 There is an editorial inconsistency between the text in the chapter and the summary table. The chapter provides a heading (in blue type) *Actions to raise awareness*. This corresponds to the objective cited in the summary table (p.78) *Increases in the public’s awareness of the risks associated with excessive consumption and how to get help*. In pages 57 to 58 of the full chapter there are five headings presented in the formatting normally used for the sub-objectives in Annex B

- promoting a culture of sensible drinking;
- Drinkaware;
- challenging binge-drinking culture;
- raising unit awareness; and
- raising awareness of the risks of harmful drinking.

6.98 Annex B groups priority actions 16 to 18 under one sub-objective: *Promoting a culture of sensible drinking*. The HIA has followed the layout for Annex B.

**What will happen**

6.99 Use labels alongside a mass media campaign and wider social marketing initiatives to help reinforce sensible drinking guidance.

6.100 Raising unit awareness

- Government will run a cross-government social marketing and advertising campaign targeted at different groups of drinkers and the public as a whole, building on the Know Your Limits Campaign.

6.101 Drinkaware

- The Government will look to the Drinkaware Trust to continue to develop the information and advice provided to the public through its website.
- The Government will seek the advice of Drinkaware on the development of its own advertising and social marketing campaign and how best to ensure that these have the greatest impact.
- The Government looks to the alcohol industry to increase its support for the Drinkaware Trust to a level that matches the increasing use of the website on alcohol labels and by their consumers seeing the site to obtain information about sensible drinking and the risks of harmful drinking.
- Industry investment will be closely monitored by Government and included within its consultation on legislation relating to sale and promotion of alcohol.

6.102 The Government will undertake a major programme of social marketing research.

6.103 The Government will also link with programmes that already exist in schools and healthcare settings, and improved incentives will ensure that local providers develop tailored approaches to fit the needs of their communities:
• to understand better how different audiences respond to information about alcohol and what influences their drinking behaviour – looking at how people live their lives and identify ways to help them choose healthier lifestyles;
• to look at the most effective social marketing approach to reach the groups most at risk.

**Optimal policy outcome**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Output</th>
<th>Intended effect</th>
</tr>
</thead>
</table>
| Cross-governmental social marketing and advertising campaign | Increased awareness of risks associated with harmful drinking | Reduction in:  
- binge drinking  
- harms through poor educational performance, truancy and exclusions  
- alcohol-related disease |
|  | Increased knowledge of units of alcohol | Reduction in:  
- ASB  
- alcohol-related crime  
- violence  
- noise  
- vandalism  
- accidents and injuries |
|  | Increased knowledge of how to estimate units of alcohol | Reduced burden on:  
- NHS  
- Police  
- Environmental services |

| DH will work with FSA and Drinkaware Trust to better communicate calorific value of alcohol | Increased knowledge of calorific value of alcohol | Reduced calorie intake from alcohol  
Increased weight loss  
Reduced levels of obesity  
Reduced incidence of:  
- diabetes  
- cardiovascular disease  
- hypertension |

| Drinkaware Trust to provide information and advice to public (through website) and to Government for campaigns | Increased information available to public and Government | Increased awareness of risks associated with harmful drinking |

| Social marketing research to target individuals who drink at harmful levels | Information about what influences drinking behaviour  
Information on effective social marketing approaches to reduce alcohol-related harm for at-risk groups | Reduction in:  
- alcohol consumption in at-risk groups  
- binge drinking  
- harms through poor educational performance, truancy and exclusions  
- alcohol-related disease |

|  |  | Reduction in:  
- ASB  
- alcohol-related crime  
- violence  
- noise  
- vandalism  
- accidents and injuries |
|  |  | Reduced burden on:  
- NHS  
- Police  
- Environmental services |

**Threats to implementation**

6.104 The frame of reference for Priority Action 16 is unclear: it is prefaced by the sub-title *Challenging binge-drinking culture*. However the wording of this priority action focuses on *drunkenness and drinking*. The reference to *binge drinking*, and an implied focus on young
people, is misleading as the priority action appears to be more concerned with the social acceptance of alcohol as part of daily life.

6.105 Social marketing campaigns, especially on a national level, can be complex, and complicated to devise and develop. They can also be very resource-intensive.

**Figure 4: Individual choice and behaviour change**

| Individuals make choices about how much and how often they drink. Individuals are responsible for these choices, but they both influence and are driven by their peers and the wider culture of society. Accurate information is needed if individuals are to make informed choices about alcohol. |
| In particular, young people need to receive adequate education on the issues. Anyone who drinks alcohol needs to understand how sensible drinking guidelines apply to the kind of drinks they consume: and those who may be experiencing problems, along with their families and friends, need to know where to get help and advice. But information is only one factor influencing behaviour. The availability of alcohol, its role in our culture and the drinking behaviour by some groups in our society - particularly young people - all affect attitudes, which in turn shape and are shaped by culture. If individuals are to make responsible choices it is just as important to consider how to create social environments which discourage attitudes and behaviours which lead to the risk of harm. |
| Interventions to change personal behaviour can be far more cost-effective than medical interventions (5). The Wanless review cites the example of ‘statins’ - drugs that are used to control cholesterol - compared with investment in smoking cessation. A behavioural change approach can not only achieve the non-financial outcome more cost-effectively, but that it can substitute for direct financial expenditures. |
| The Strategy Unit Interim Analytical report (17) states that some drinkers - and especially young people - receive conflicting messages about drinking: |
| • those about the positive impact of alcohol are promoted far more heavily than those focussing on risks; and |
| • there is a perception that the content and target of advertising go beyond the spirit of existing self-regulation. |
| • Education is successful at imparting information about alcohol intake: this is essential if consumers are to make informed choices about their drinking; and it is particularly important for young people to have factual information, opportunities to develop attitudes and skills and to know where to go for further information on alcohol. |
| • But education is less successful in changing behaviour: it can be difficult to relate to everyday behaviour and experience: for example 100ml glasses are no longer widely used and wine strength has risen, making it hard for the consumer to calculate what a unit is in real terms; and long-term risks lack immediacy, and the effects of alcohol cloud perception of short-term risks. |
| • So to be effective education must work in tandem with other policies: the long-running drink-drive campaign has been successful because it has worked in tandem with policies on identification of offenders, tough enforcement and penalties which focus on preventing re-offending. |

**Suggestions**

6.106 We ask the Government to consider including the information in Figure 4 in the process of developing the social marketing campaign.

6.107 The Government needs more evidence about perceptions of drinking and drunkenness and this must not just be founded on young people’s perception but take the views of different population groups into account.

6.108 There needs to be clarification about the focus of Priority Action 16 and this needs to be reflected in any social marketing campaigns, particularly when considering audience segmentation especially during the scoping phases.

6.109 We also ask the Government to consider linking the local partnerships responsible for tackling alcohol-related crime and disorder into the social marketing campaign.

6.110 As the use of information, support and social marketing is vital in tackling low aspirations (24), we also ask the Government to consider linking the social marketing campaign with
programmes that already exist such as choice advisers for schools and healthcare. Improved incentives will ensure that local providers develop tailored approaches to fit the needs of their communities.

6.111 We ask the Government to consider the use of a ‘challenge fund’ approach to the social marketing campaign, whereby social marketing providers are rewarded on the basis of measurable changes in targeted behaviour. Within the strategy social marketing will influence awareness of alcohol-related harms at the societal level as well as at the individual level

- Awareness of strategies to avoid alcohol-related harms
- Awareness of the role of policies to reduce alcohol-related harms
- Attitudes regarding the social acceptability of excessive drinking
- Awareness and activation amongst parents/caregivers in their role in preventing/reducing alcohol-related harms
- Supportive prevention strategies in schools and community settings
- The effects of alcohol advertising and promotion
- Alcohol consumption behaviours

**Alcohol and pregnancy**

**Priority Action 19**

The Government, through its communications campaigns and NHS maternity care, will ensure that the reworded pregnancy advice is communicated to women who are pregnant or trying to conceive.

**What will happen**

6.112 Government will raise awareness of government advice of alcohol consumption for women who are pregnant or trying to conceive.

6.113 Alcohol, diet and nutrition (this initiative is listed under Priority Action 19).

- The Food Standards Agency is consulting until June 2007 on a Saturated Fat and Energy Intake Programme.
- DH will work with the Food Standards Agency and the Drinkaware Trust to explore means by which the calorific value of alcoholic drinks can be better communicated to consumers in ways that complement the Government's sensible drinking message.

**Optimal policy outcome**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Output</th>
<th>Intended effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dissemination of re-worded advice on alcohol consumption for women who are pregnant or trying to conceive</td>
<td>Increased awareness of risks associated with alcohol consumption during pregnancy</td>
<td>Decreased consumption of alcohol during pregnancy Reduction in incidence of foetal alcohol syndrome</td>
</tr>
<tr>
<td>DH will work with the Food Standards Agency and the Drinkaware Trust</td>
<td>Better communication of the calorific value of alcoholic drinks to consumers</td>
<td>Decreased consumption of alcohol among all population groups</td>
</tr>
</tbody>
</table>

**Threats to implementation**

6.114 This priority action is focussed on the provision of information and the Government's communications campaigns but it should be noted that providing information does not always lead to sustainable behaviour change (see Figure 4).

**Suggestions**

6.115 We ask the Government to consider the role of information in changing individual behaviour. Women who are pregnant or trying to conceive and consumers who are the target of the better communication of the calorific value of alcoholic drinks need social environments where there are viable alternatives to alcoholic drinks.
Support for harmful drinkers

Priority Action 20.
The Government will support the development of a range of new kinds of information and advice aimed at people who drink at harmful levels and their families and friends. These will run alongside other kinds of support and advice from the NHS.

What will happen

6.116 Overall
- The Government will expand the provision of information and advice (outlined on page 58).

6.117 Self-assessment of consumption
- Advice on how to use the alcohol industry’s new labelling scheme to estimate how much you drink would be an important part of the new Government TV advertising and social marketing campaign.
- Government will work with the voluntary sector, pharmacies, healthcare organisations and the media to explore ways in which a wider range of support can be made available to people who wish to reduce their drinking.

6.118 Screening and identification
- Government plans to expand the availability of screening and identification of risky alcohol consumption.

Optimal policy outcome

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Output</th>
<th>Intended effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Government will expand the provision of information and advice</td>
<td>People will be able to make an informed choice about the amount they drink.</td>
<td>Better informed public drinking more wisely.</td>
</tr>
<tr>
<td>Explore ways in which a wider range of support can be made available to people who wish to reduce their drinking</td>
<td>People will be able to make an informed choice about the amount they drink.</td>
<td>Better informed public drinking more wisely, with increased focus on all sectors of the community (including people with poor literacy skills and those whose first language is not English).</td>
</tr>
</tbody>
</table>

Threats to implementation

6.119 From the reference to information and advice outlined on page 58 it is not immediately clear what the Government plans to expand.

Suggestions

6.120 None

Preventing harm to those under 18 years of age

Priority Action 21
To help young people and their parents make informed decisions about drinking, the Government will provide authoritative, accessible guidance about what is and what is not safe and sensible in the light of the latest available evidence from the UK and abroad.

Priority Action 22.
Government will convene a panel of paediatricians, psychologists and epidemiologists to compile and discuss the effects of alcohol on young people’s physical and emotional health, cognitive development and brain functioning.

Priority Action 23.
The Government will raise awareness of the issues and will – through a social
marketing campaign – work to create a culture where it is socially acceptable for young people to choose not to drink and, if they do start drinking, do so later and more safely.

6.121 The Government will provide new guidance and advice to young people, parents, teachers and health professionals on preventing the harm associated with alcohol consumption by those under 18 years of age. The guidance will be based on the advice of a panel of people with expertise in youth alcohol use, as well as on consultation with young people and parents.

6.122 Government will develop a consistent age-based message for young people and parents that presents clear information on the effects of alcohol on young people's social, emotional and physical health and cognitive functioning, and offers recommendations on how best to prevent the harms to young people associated with alcohol consumption.

6.123 Government will seek the views of parents, young people and other key stakeholders when developing, distilling and distributing any information and guidance - which young people are drinking at the most harmful levels, what interventions will work with young people who are frequent drinkers and how the Government could be most helpful in supporting young people and their parents to make decisions around youth alcohol use.

6.124 Government will also consider a range of more targeted preventative measures, including identification and brief advice for use within the targeted youth support system. Government will take into account two recent reviews by the National Institute for Health and Clinical Excellence (NICE), the first of which looked at community based substance misuse interventions and the second of which reviewed alcohol education in schools.

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Output</th>
<th>Intended effect</th>
</tr>
</thead>
</table>
| Provision of advice about use of industry's labelling scheme to estimate units of alcohol consumption | Increased knowledge of how to estimate units of alcohol | Reduction in:  
- harmful levels of drinking  
- alcohol-related disease  
Reduction in:  
- ASB  
- alcohol-related crime  
- violence  
- noise  
- vandalism  
- accidents and injuries  
Reduced burden on:  
- NHS  
- Police  
- Environmental services |
| Wider range of support for people who wish to reduce alcohol consumption from voluntary sector, pharmacies and healthcare organisations | Increased availability and accessibility of interventions to reduce alcohol consumption | Reduction in:  
- alcohol consumption  
- alcohol-related disease |
| Plans to expand the availability of screening and identification of risky alcohol consumption | Earlier identification of risky alcohol consumption | Reduction in alcohol-related disease |
| Guidance for young people, parents, teachers and healthcare professionals on preventing harms to young people of alcohol consumption | Increased awareness among young people, parents, teachers and healthcare professionals of risks associated with alcohol consumption in young people | Reduction in:  
- alcohol consumption for under-18s  
- binge drinking  
- harms through poor educational performance, truancy and exclusions  
- alcohol-related disease  
Reduction in:  
- ASB  
- alcohol-related crime  
- violence  
- noise |
<table>
<thead>
<tr>
<th>Intervention</th>
<th>Output</th>
<th>Intended effect</th>
</tr>
</thead>
</table>
| Social marketing campaign to create a culture     | Reduced peer pressure: to start drinking at a young  | • alcohol consumption for under-18s  
| where it is socially acceptable for young          | age and at safer levels                             | • binge drinking  
| people to choose not to drink or to choose to     |                                                       | • harms through poor educational performance, truancy and exclusions  
| start drinking later                              |                                                       | • alcohol-related disease  
| and at safer levels                                |                                                       | • ASB  
|                                                 |                                                       | • alcohol-related crime  
|                                                 |                                                       | • violence  
|                                                 |                                                       | • noise  
|                                                 |                                                       | • vandalism  
|                                                 |                                                       | • accidents and injuries  
|                                                 |                                                       | Reduced burden on:  
|                                                 |                                                       | • NHS  
|                                                 |                                                       | • Police  
|                                                 |                                                       | • Environmental services  
| Introduction of a range of targeted preventative  | Increased prevention of harmful drinking in young    | • alcohol consumption for under-18s  
| measures in the youth support system              | people                                               | • binge drinking  
|                                                 |                                                       | • harms through poor educational performance, truancy and exclusions  
|                                                 |                                                       | • alcohol-related disease  
|                                                 |                                                       | • ASB  
|                                                 |                                                       | • alcohol-related crime  
|                                                 |                                                       | • violence  
|                                                 |                                                       | • noise  
|                                                 |                                                       | • vandalism  
|                                                 |                                                       | • accidents and injuries  
|                                                 |                                                       | Reduced burden on:  
|                                                 |                                                       | • NHS  
|                                                 |                                                       | • Police  
|                                                 |                                                       | • Environmental services  

**Threats to implementation**

6.125 Many of the priority actions will have no noticeable effect on health in the short term. The major health effects associated with alcohol consumption for the majority of the population display lagged exposure outcome epidemiologies. This makes educating people about the health risks associated with alcohol extremely difficult because people will not experience any noticeable effects or more specifically personal physical and psychological ‘harm’ for almost half their adult lives. Short-term impacts will occur only indirectly via such factors as increased rates of alcohol-related violence, and absenteeism, which may lead to unemployment and poverty.

6.126 Social marketing campaigns, especially on a national level, can be complex, and complicated to devise and develop. They can also be very resource-intensive.
**Suggestions**

6.127 We ask the Government to consider including the information in Figure 4 in the process of developing the social marketing campaign targeted at reducing alcohol consumption in young people.

6.128 We also ask the Government to consider linking the local partnerships responsible for tackling alcohol-related crime and disorder into the social marketing campaign targeted at reducing alcohol consumption in young people.
7. Reference list


8. Appendices

Appendix 1: Models of priority actions

8.1 X's are used to denote whether the intervention is preventative or palliative in nature. X's that precede the population group(s) are preventative, while X's that follow the population group(s) are palliative or treatment-oriented.

Figure A1: Model of the effect of improving law enforcement for drink-driving and underage sales

Note: Key pathways of alcohol harm reduction are highlighted. X's denote main area of intervention.

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drink-Driving</td>
<td></td>
</tr>
<tr>
<td>Civil Society</td>
<td>Public will be consulted in 2007 to explore ways of improving police enforcement</td>
</tr>
<tr>
<td>Underage Sales</td>
<td></td>
</tr>
<tr>
<td>Retailers</td>
<td>Ensure introduction of effective monitoring and comprehensive training for employees</td>
</tr>
<tr>
<td>Alcohol Industry</td>
<td>Alcohol industry needs to encourage universal adoption of the Challenge 21 scheme (1, pg. 56); Trading standards can designate underage sales as a local priority based on recommendations from the Rogers review (1, pg. 56).</td>
</tr>
<tr>
<td>Association of Chief Police Officers</td>
<td>Establish reliable and transparent system of data collection</td>
</tr>
<tr>
<td>Local Authorities Coordinators</td>
<td>Establish reliable and transparent system of data collection</td>
</tr>
</tbody>
</table>
Figure A2: Model of effect of improving adherence to industry-led social responsibility standards

Note: Key pathways of alcohol harm are highlighted. X’s denote main area of intervention.

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locally Licensed Trade</td>
<td>Promote good practice and compliance with existing industry-designed voluntary codes</td>
</tr>
<tr>
<td>Alcohol Industry</td>
<td>Ensure existing codes are transparent and fully accessible to the public; Ensure that existing codes are as effective as possible; Ensure channels are in place for the public to report to industry in cases of breaches of industry standards</td>
</tr>
<tr>
<td>Advertising Bodies</td>
<td>Same as above</td>
</tr>
<tr>
<td>Consumer Bodies</td>
<td>Same as above</td>
</tr>
</tbody>
</table>

Note: Stakeholder groups identified from A Plan For Action: New Priorities for Delivering Change, Ch. 6 in National Alcohol Harm Reduction Strategy 2007, Version 2.F