

Britain's Ruin?

Meeting Government objectives via a national alcohol strategy

Introduction

Statistics (see facing page) can give a flavour of the harm alcohol causes in Britain today. They do not, however, give the whole picture - some aspects are not measured or are hard to measure, for example:

- Alcohol as a factor in family break-up and the impact on children of problem drinkers
- The long-term health impact of binge drinking, including its role in heart attacks
- The longer-term effects of alcohol habits developed in teenage years
- The cost to business of presenteeism, employees present but not functioning productively
- The numbers of problem drinkers unable to access appropriate helping services.

The Government has identified a number of key priorities in the areas of health and social care, namely improving public health, reducing social exclusion (including addressing inequalities in health), and reducing crime and improving community safety.

This document explains where alcohol fits in with these identified challenges to improve the nation's health and well-being - where alcohol is a factor in disease, or a factor in violent behaviour; where prevention via quality services can assist in reducing the financial burden on the NHS and other public services, such as the police and social services; where addressing alcohol problems will help the Government to achieve its objectives.

To make a real impact on the Government's identified priorities and to improve the public health, the role of alcohol cannot be ignored. Alcohol crops up almost everywhere, either as a direct cause of ill-health and injury or as one significant factor among a number. The statistics outlined in this document demonstrate undisputed evidence of the harm alcohol causes. In turn, the existence of such a strong evidence base demonstrates the clear need for an effective strategy to reduce the harm.

The Government is committed to producing a strategy on alcohol misuse, which is a welcome step forward. *Britain's Ruin* shows how the implementation of a Government alcohol strategy will play an integral part in meeting the Government's objectives on public health, social exclusion, and crime and disorder.

The strategy needs to reflect the breadth and complexity of alcohol's impact (it's not all bad), and provide a planned and coherent set of policies aimed at tackling the wide range of alcohol-related harm.

An alcohol strategy is needed as a matter of urgency. Crucial to the success of the alcohol strategy will be the active support of the full range of Government departments with a stake in alcohol policy.

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Government priority: to save lives by preventing and treating diseases such as cancer, coronary heart disease and stroke

The relationship between heavy drinking and disease is complicated - it can directly cause some diseases (eg. liver disease), it is a major factor in other diseases (eg. high blood pressure, stroke, heart disease, oral and upper digestive cancers), and one factor among others in a large number of diseases (eg. other cancers). There are also cases where a strong link is suspected but has not yet been confirmed conclusively by research, for example the link between binge drinking and heart attacks. Alcohol also has a significant role in mental illness, including a strong link to depression, psychosis and suicides. Aside from disease, alcohol's contribution to accidental death is also well-established.

With 1 in 25 British adults dependent on alcohol (OPCS 1994), 1.7 million men and 0.6 million women drinking at very risky levels of above 50 units and 35 units a week respectively, and 37% of young men and 23% of young women regularly binge drinking (ONS 2000), the financial costs to the NHS of alcohol misuse are likely to be significant - however, no comprehensive review of the financial burden has yet been undertaken.

Alcohol's contribution to disease and hospital admissions, and its role in accidents, injuries and casualty admissions, is well-documented. A strategy which combines raising public awareness of harm and safe drinking levels with approaches aimed at identifying and addressing alcohol problems as a risk factor early on in the disease pathway would have a significant impact on improving public health and lessening the burden on the NHS.

Alcohol specific deaths

Debate surrounds the total number of alcohol-related deaths since only certain causes of death can be directly attributed to alcohol and recorded on the death certificate as being alcohol-related. In many more cases alcohol has played a major part in death but the cause of death will be recorded as, for example, heart disease.

The number of deaths from alcohol specific diseases (such as alcoholic psychosis, chronic liver disease and liver cirrhosis) has been rising steadily, with a 38% increase over a five year period from a total of 3,565 deaths in 1992 to 4,907 in 1997 (Department of Health 1999a). The number of deaths where alcohol is a significant contributory cause, rather than the sole cause, is far greater and has variously been estimated at between 25,000 and 40,000 a year (Royal College of Physicians 1987, Godfrey 1992, Royal College of General Practitioners 1986). The use of alcohol is second only to tobacco among substances as a cause of premature death.

Disease and hospital admissions

High alcohol consumption is closely linked with hypertension which is a major risk factor for vascular diseases including stroke and heart disease (MacMahon 1994). In 11% of cases, alcohol consumption is the main cause of men's high blood pressure (Vandongen 1994). Recent studies have indicated a connection between binge drinking and heart attacks. One ten year study in Scotland found an excess of deaths from coronary heart disease on Mondays (3% above daily averages) among people with no previous hospital admission for this disease, which the researchers suggest could be attributed to weekend binge drinking (Evans 2000).

An estimated 3% of cancer deaths are attributable to alcohol, largely cancers of the upper digestive tract (Doll 1996). Alcohol is one of a number of risk factors for breast cancer (Thun 1997, Smith-Warner 1998).

Alcohol-related hospital admissions place a significant burden on the NHS, with 15% (1 in 7) of acute hospital admissions misusing alcohol (Canning 1999). Another study considered all hospital admissions (acute and non-acute) and found that 1 in 16 of all hospital admissions was alcohol-related (Pirmohamed 2000). This study also found that 1 in 8 of Accident and Emergency (A&E) attendances was alcohol-related, and that alcohol-related admissions had a significant subsequent impact on outpatient clinics, particularly orthopaedics.

The burden on A&E departments has been borne out by another study which found that 1 in 6 people attending A&E departments for treatment had alcohol-related injuries or problems,

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rising to 8 out of 10 at peak times (Health Education Authority 1998a). Around half of seriously injured patients admitted via A&E and needing to stay in hospital had an alcohol-related injury (Dyehous 1995).

Accidental death and injury

Alcohol is a major contributor to accidental death - it is a factor in an estimated 20% to 30% of all accidents (Honkanen 1993); heavy drinking is associated with 15% of drownings (Royal Society for the Prevention of Accidents 1998) and with 39% of deaths in fires (Tether 1986). Deaths from drink-driving remain at more than ten a week (550 a year), with 2,940 serious casualties each year (DETR 1999). In addition, road casualty figures reveal that 37% of pedestrians killed on the roads had drunk over the legal limit for drink-driving (DETR 1999).

Mental health problems

As well as the physical impact of alcohol misuse, there is a close association between alcohol dependency and mental health problems. Looking at hospital admissions alone, during a 12 month period there were 72,500 hospital admissions with a diagnosis of mental and behavioural disorders due to alcohol, including 31,300 admissions for alcohol dependence syndrome (Department of Health 1999a).

Heavy drinking is closely linked with psychiatric morbidity including clinical depression (Health Education Authority 1997), with an estimated 65% of suicide attempts linked with excessive drinking (Department of Health 1993). Alcohol problems are a significant factor in male teenage suicides, and rises in suicide rates amongst older teenage men have been attributed to a rise in alcohol consumption (Royal College of Physicians 1995). The Government's Inquiry into Inequalities in Health identified a strong association between suicide and alcohol misuse, together with a link between people who deliberately self-harm and alcohol misuse (Acheson 1998).

Government priority: to improve health and reduce health inequalities, with a particular focus on local partnerships and issues such as drugs and teenage pregnancy

Local partnerships

The Government has identified local partnerships between the NHS, local authorities and other bodies as key to making the nation healthier, with local action agreed as part of the development of Health Improvement Programmes (HIMPs).

As alcohol is a key component of the many pressures facing health services at a local level, HIMPs should identify local action to reduce alcohol related harm. Primary Care Groups (PCGs) also have a role in addressing alcohol problems and this is the focus of an Alcohol Concern grants programme to develop the capacity of voluntary sector alcohol services and PCGs to work in partnership to respond to alcohol problems in primary care settings.

Other local partnerships which would benefit from addressing alcohol problems in their plans include Community Safety Partnerships and Youth Offender Teams (see pages 12 and 14).

Given the wide-ranging and complex nature of alcohol problems, there is an essential role for partnerships to be created at local level to develop action to identify and address the particular set of local problems. A number of Drug Action Teams have taken on a co-ordinating role in relation to alcohol misuse at local level, partly because no equivalent structure exists to address alcohol problems. Their role in relation to alcohol should be placed on a formal footing and underpinned by specific resources, including an expert Alcohol Reference Group. They should have a nationally agreed set of objectives originating from the national alcohol strategy, and they should link formally with HIMPs and Community Safety Partnerships.

Drugs and alcohol

Alcohol is often referred to as "our favourite drug". It is legally available and used by 89% of the adult population (ONS 1999a), often without problems, and yet is undisputedly the cause of a high level

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and wide range of harm. Parallels with illegal drugs are inevitably drawn, particularly in relation to the absence of an alcohol strategy to match the Government's drug strategy.

A significant number of those with drug problems are also misusing alcohol. The National Treatment Outcome Research Study (NTORS) into drug treatment found that almost half of those being treated in drug services were drinking at excessive levels (Gossop 1997). The study also found that the treatment they received, while effective for drug problems, did not impact on alcohol problems. Conversely, a census of alcohol services found that, of the 10,000 people receiving help for their drinking problems on any given day, the majority (85%) have problems solely with alcohol and do not use any illegal drugs (Alcohol Concern 1997).

It is, therefore, essential that an adequate range of specialist alcohol services is available to assist those with alcohol problems and that drug treatment services are able to recognise and respond to alcohol misuse.

Both alcohol and drugs are a problem for a great many offenders before they enter the criminal justice system. Among male prisoners, 58% of remand and 63% of sentenced prisoners were drinking hazardously in the year before coming to prison, while 50% of remand and 43% of sentenced prisoners had a drug problem (ONS 1999b). However, treatment within prisons, which offers great opportunities for addressing alcohol and drug problems and therefore helping to prevent reoffending, is focused very much on drugs and not on alcohol - the amount spent addressing drug problems in prisons is greater than the amount spent on helping offenders with alcohol problems (Hansard 2000).

Funding dedicated via the Government's drug strategy to increase the number of drugs workers undertaking criminal justice interventions is having an adverse impact on specialist alcohol services. There is a lack of funding for similar posts working on alcohol issues, and at the same time alcohol workers are being attracted to the new posts due to the appropriateness and transferability of their skills.

Teenage pregnancy and unsafe sex

The way in which young people learn about alcohol is crucial to their ability to experiment without causing themselves harm. Alcohol is a risk factor in relation to sexual health - as a disinhibiting substance, alcohol can lead to young (and older) people doing things they later regret, including having sex in the first place or having unprotected sex. This can lead to fear of pregnancy and subsequent use of emergency contraception, unwanted pregnancies, or sexually transmitted diseases including HIV/AIDS.

Addressing levels of teenage pregnancy is a priority for Government in recognition of the fact that Britain has the worst record on teenage pregnancies in Europe, and the contribution of teenage parenthood to social exclusion.

In its report on teenage pregnancy, the Social Exclusion Unit highlights the importance of alcohol in teenage sex, pointing to research that shows that after drinking alcohol one in seven 16 to 24 year olds have had unsafe sex, one in five have had sex which they later regretted, one in ten have been unable to remember whether they had sex the night before, and 40% think they are more likely to have casual sex (Social Exclusion Unit 1999a, Health Education Authority 1998b).

Other research bears this out - a survey of 13 and 14 year olds found that 40% were "drunk or stoned" when they experienced first sexual intercourse (Wight 2000). Another survey looking at adults' behaviour highlights the role of alcohol in unsafe sex generally, with more than one in 5 men (22%) and 1 in 6 women (16%) admitting to having unsafe sex after drinking too much (Durex 1999).

In developing initiatives to reduce teenage parenthood, the role of alcohol in relation to sexual behaviour must not be ignored. By the same token, education and prevention activities aimed at teaching young people about how to handle alcohol with care should tie in with the teenage pregnancy agenda and cover ensuring safe sex and preventing regretted sex.

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Government priority: to provide fast, convenient and quality services for those in need, in the process reducing waiting lists and creating modern primary care

Waiting lists and times

As outlined earlier, alcohol misuse is associated with a range of physical health problems and a high number of acute and non-acute hospital admissions. Yet alcohol problems largely go unnoticed and/or untreated within the NHS. Consequently, opportunities are missed to treat the alcohol problem leading to continuing heavy alcohol use after patients have left hospital, and often readmission.

Research has shown that screening and brief interventions in hospital settings are effective in reducing alcohol consumption (Bien 1993). Supporting problem drinkers in this way before they develop damage to their health would contribute to reducing the numbers of people needing treatment. In addition, developing alcohol liaison services within general hospitals as part of a strategic approach to alcohol service development would provide opportunities for identifying large numbers of problem drinkers, and reducing their alcohol consumption and related harm. This would reduce readmissions and in turn reduce pressure on waiting lists and times.

The Government also wishes to modernise and improve Accident and Emergency (A&E) services. A&E departments have also been suggested as appropriate settings for offering help to reduce alcohol consumption (Green 1993), particularly important given the large number of attendances which are alcohol-related, as outlined earlier. Alcohol liaison services in A&E departments would therefore be an essential part of a joined up approach to health service provision which would identify problem drinkers when they present to the NHS, and ensure they are referred appropriately for help, thus reducing the burden on the NHS.

Modern primary care

Government priorities are focusing on developing Primary Care Groups and Trusts (PCGs/PCTs) to ensure appropriate prescribing and referrals, to deliver high quality care and to improve links with secondary and community

services. There are more than 600 specialist alcohol services around the country, to whom GPs are able to refer individuals with alcohol problems for expert assistance.

Primary care teams are ideally placed to identify many of those affected by problem drinking, since 98% of the UK population is registered with a GP and in any one year a GP will see 70% of the patients on their list (OPCS 1988). Problem drinkers are twice as likely to visit their GP than the average patient yet research suggests that the opportunity to identify them in primary care is often missed (Deehan 1998). There is great potential for GPs to influence positively an individual's drinking attitudes and behaviour via a brief intervention whereby a patient is assessed and advice on reducing consumption offered. This is supported by a strong evidence base indicating the effectiveness of such brief interventions (Bien 1993). However, it has been estimated that 42% of GPs feel inadequately trained to detect alcohol misuse (Deehan 1998)

There is a need, therefore, to develop partnerships between specialist alcohol treatment services and primary care services to identify and respond to the needs of problem drinkers and their families.

Quality services

In order to reduce alcohol-related disease, injuries and hospital admissions, a wide range of quality support services needs to be available for people experiencing difficulty with their drinking, ranging from advice and counselling services to residential and home detoxification programmes to reflect the full range of need in every locality. Alcohol Concern, in partnership with Drugscope has produced, as part of its Quality in Alcohol and Drug Services (QuADS) project, organisational standards for alcohol and drug treatment services which aim to promote quality in specialist services.

As outlined above, evidence suggests that brief interventions targeted at drinkers in primary care and hospital settings can result in significant reductions in alcohol-related harm. Although there are some examples of good practice, many areas have no such interventions and there is a need to develop these services comprehensively. However, this should be alongside, not instead of, specialist community based and residential services.

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Availability of the full range of treatment services varies across the country. A consultation exercise by Alcohol Concern to collate the evidence base for proposals for a national alcohol strategy highlighted concern at the wide geographic differences in alcohol treatment services available with, in particular, many rural areas poorly served by specialist services (Alcohol Concern 1999). The shortage of detoxification and rehabilitation places across the country was highlighted as being of particular concern. This has major implications for the Government's commitment to addressing social exclusion where lack of services in deprived neighbourhoods has been identified as an important factor. Failure to access dependent drinkers into appropriate services leads to furthering problems of social exclusion, particularly given the high rates of alcohol problems among groups such as rough sleepers and those in the lower socio-economic groups. Access to alcohol services should be seen as one strand of an effective policy to reduce social exclusion, and improve core services in deprived areas.

Staff

The Government is committed to investing in staff in order to deliver high quality services. One element of this is to achieve a 20% reduction in incidents of violence against NHS staff. Given the high number of alcohol-related attendances in Accident and Emergency departments, a significant proportion of these incidents will be related to alcohol use. One study found that in 65% of violent incidents against Accident and Emergency staff the patient was intoxicated (Cembrowicz 1992). Providing alcohol liaison services in primary care and hospital settings will help to achieve this target, as will ensuring staff are appropriately trained to deal with drunk and aggressive patients.

Another element relates to increasing the number of health-related professional staff through recruitment and retention policies. There is considerable anecdotal evidence that existing services are under pressure with many problem drinkers not able to access support immediately and waiting lists building up. It is hoped that the implementation of a Government strategy on alcohol will create an expansion of existing alcohol services to meet the unmet need.

Responding to an identification of alcohol misuse as a priority by central Government, local and health authorities are likely to commit higher levels of funding to address alcohol problems.

However, many alcohol specialist services are currently experiencing difficulty recruiting and retaining staff due to the impact of a recent rapid increase in funding for drugs workers to undertake criminal justice interventions - this funding has been dedicated via the Government's drug strategy. The lack of drugs workers to take on the new roles, combined with the appropriateness and transferability of alcohol workers' skills, is leading to a "brain drain" away from specialist alcohol services, identified by an Alcohol Concern survey (Alcohol Concern 2000).

Government priority: to care for vulnerable groups, including children, older people and those with mental health problems

Children

Alcohol can be a problem for young people as a result of their own drinking, but also for many as a result of problem drinking by one or both parents.

Among 11 to 15 year olds, 21% drink on a weekly basis - among the drinkers, the average weekly consumption rose from 5.3 units in 1990 to 9.9 units in 1998 (ONS 1999c). These figures conceal wide variation in the amounts being drunk, with many drinking only modest amounts. However, at the other end of the scale, 4% of boys and 2% of girls drink 15 or more units a week. Problems among young children and teenagers are mostly as a result of intoxication (eg. accidents, getting into fights), with research showing a tenfold increase in admissions to Accident and Emergency departments between 1985 and 1996 among under-15s due to alcohol overdoses and other accident or violence-related injuries (Robson 1998). Another, often overlooked, problem relating to intoxication relates to having unsafe sex or being sexually abused (see Teenage Pregnancy section on page 6).

Little is known about the longer-term health impact of regular drinking on teenagers, or whether heavy drinking as a teenager increases the likelihood of developing problems in later life. However, it is known that 16 to 24 year olds are the heaviest drinking section of the population, with 50% of males and 41% of females drinking above safe levels, and 12% of male and 7% of female 16 to 19 year olds showing signs of alcohol dependence (OPCS 1994).

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Problem drinking among young people can have a whole range of psychological and behavioural effects, ranging from suicides, criminal behaviour, and exclusions from school (see pages 11 to 13).

A large number of children, estimated at 920,000, are currently living in a home where one or both parents misuse alcohol, with 6.2% of adults having grown up in a family where one or both of their parents drank excessively (NACOA 2000). Serious problems are experienced by children as a result of the drinking behaviour of their parents. An analysis of NSPCC helpline calls showed parental alcohol misuse to be a factor in 23% of child neglect cases, and parental alcohol misuse was also reported in 13% of calls about emotional abuse, 10% of calls about physical abuse, and 5% of calls about sexual abuse (NSPCC 1997). Heavy drinking by parents was identified as a factor in over 50% of child protection case conferences (Davidson 1994).

The psychological impact on children can be immense, often leading to the development of alcohol problems later in their own lives. By the age of 15 young people in families with a problem drinking parent have rates of psychiatric disorder between 2.2 and 3.9 times higher than other young people (Lynksey 1994). Higher rates of alcohol use among teenagers of problem drinking parents have been found than among other teenagers (Zeitlin 1994), and men have double the risk of becoming an alcoholic by the age of 30 if their parents drank heavily (NACOA 2000).

In order to minimise the negative impact of intoxication and to prevent problems of dependency from developing as young people get older, a focus on increasing awareness of potential harms and learning safe drinking techniques while still at school should form a crucial part of an alcohol strategy. In addition, appropriate support services need to be made available to young people experiencing problems because of their parents' drinking to be run alongside help and support for the problem drinkers themselves.

Older People

While older people do not constitute one of the heavier drinking groups within the population,

this is a vulnerable group since serious life changes, such as retirement, bereavement, or a move to residential care, can lead to increased drinking which is likely to go undetected. Older people are major consumers of prescribed and over-the-counter drugs, many of which do not mix well with alcohol, creating negative medical side-effects and, in some cases, resulting in an increased risk of falls. In addition, alcohol consumption can increase the risk of, and damage from, falls.

The proportion of the population over retirement age is increasing and there is likely to be a growing number of older people with alcohol problems. However, alcohol-related problems can be difficult to distinguish from those which are a natural consequence of ageing, and can present in non-specific ways such as falls, hypothermia, malnutrition and confusional states (Herring 1995). Under-recognition and under-reporting of alcohol problems by those in the caring professions tends to take place, compounded by a reluctance among older people to come forward for help, perhaps due to the social stigma attached to having an alcohol problem, and a tendency on the part of relatives to deny the possibility of alcohol misuse by the older person (Ward 1997).

Increasing detection of alcohol problems in older people would contribute significantly to reducing their morbidity and mortality, preventing accidents, and reducing associated health and social care costs. Few specialist services designed for older people are available, and some services for problem drinkers operate an upper age limit for referrals due to constraints on numbers and the difficulties associated with finding a place for an older person requiring residential care.

There is great potential for care workers to identify older people whose drinking has changed as a reaction to problems associated with ageing (rather than those with a longer-term alcohol problem) and offer a brief intervention (as described on page 7). However, training for carers to undertake such a role would be essential.

An imaginative approach to alcohol and older people is required which focuses on health education and promotion for this group, as well as identification and treatment of problems, and

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opportunities to address alcohol issues should be incorporated into the *National Service Framework for Older People* being developed by the Government.

Individuals with mental health problems

There is a close association between problem drinking and mental health problems ranging from behavioural disorders, clinical depression, and suicides, as outlined above (see page 5). Many people with severe mental health problems also develop problems with alcohol and/or drugs, and in other cases use of alcohol and/or drugs can trigger or exacerbate mental illness in vulnerable people. Individuals with these complex needs commonly experience difficulties in accessing appropriate services because specialist alcohol services are usually not equipped to deal with mental health problems, and psychiatric services can often overlook a contributory alcohol problem. New types of services to address both sets of problems, or new ways for alcohol and psychiatric services to work together, need to be developed so that individuals with complex needs are able to access appropriate help.

The Government has highlighted reducing suicides by at least one-fifth by 2010 as a target in the public health white paper, *Saving Lives: Our Healthier Nation* (Department of Health 1999b), and the *National Service Framework for Mental Health* has set reducing suicides as one of its five standards (Department of Health 1999c). Given the impact of alcohol problems on psychiatric morbidity, issues relating to problem drinking should be addressed as one strand of attempts to improve mental health overall. Specialist alcohol services have a key role and must be adequately resourced through a national alcohol strategy to enable them to work jointly with mental health services to ensure vulnerable people do not slip through gaps in service.

Social Exclusion

Government priority: to tackle the causes of social exclusion and to bring about neighbourhood renewal

Factors which contribute to social exclusion have been identified by the Government as poverty and low income, family break-up, unemployment, lack of education and training, housing and homelessness, crime and anti-social behaviour, inequalities in health, and mental health problems. The National Strategy for Neighbourhood Renewal will aim to address issues such as poverty and unemployment in order to reverse trends where many deprived areas have higher mortality rates, greater unemployment, and higher levels of crime (Social Exclusion Unit 2000a).

Alcohol can be identified as an exacerbating factor in many of these causes of social exclusion. Young people with alcohol problems are particularly vulnerable to social exclusion, as they have a high rate of mental health problems, are at risk of being excluded from school and further educational opportunities, and have a high rate of involvement in crime. In addition, alcohol dependency has been identified as a key barrier to young people's employment within the Government's New Deal for Young People programme. The role of alcohol in teenage pregnancies is outlined earlier (see page 6).

Alcohol issues should be addressed as one aspect of an overall strategy to reduce social exclusion and promote neighbourhood renewal, with a national alcohol strategy linking in closely with the wider social exclusion agenda.

Inequalities in health

Having reviewed available evidence, the Independent Inquiry into Health and Inequalities set up by the Department of Health identified reducing alcohol-related harm as one strand of an overall policy to reduce health inequalities. Problem drinking is twice as common in the poorest than in the most affluent of socioeconomic groups, and higher levels of consumption have been consistently observed in some deprived groups such as unemployed people and those who are homeless (Acheson 1998).

Looking at the harm arising from high consumption, a further study found a link between socioe-

conomic status and alcohol problems, particularly among men aged 25 to 39 in the unskilled manual class who are between 10 and 20 times more likely to die from alcohol-related causes than those in the professional class. Men aged 55 to 64 in the unskilled manual class are 2.5 to 4 times more likely to die from alcohol-related causes (Harrison 1999). The study found that for women in paid employment there is no consistent class gradient; younger women in the manual classes are more likely to die from alcohol-related causes, but for older women it is those in the professional class who suffer elevated mortality.

Equality of access to specialist alcohol services is a key issue in addressing social exclusion. There is inconsistent provision of support services across the country and, in particular, many rural areas are poorly served by specialist services (Alcohol Concern 1999). Groups with specific needs, such as women with young children requiring childcare facilities to enable them to participate in sessions, are under-catered for. Black and minority ethnic groups experience particular difficulty accessing appropriate alcohol services. Lack of specialist services leads to furthering problems of social exclusion, particularly given the high rates of alcohol problems among already excluded groups such as rough sleepers and young people not in education or employment.

Mental health problems

Special attention needs to be given to young people with alcohol problems who constitute a particularly vulnerable group at risk from social exclusion. Alcohol problems are a significant factor in male teenage suicides, and rises in suicide rates amongst older teenage men have been attributed to a rise in alcohol consumption (Royal College of Physicians 1995). The Inquiry into Inequalities and Health highlighted the link between alcohol misuse and suicides, recommending that policies to prevent suicide should include those aimed at the causes of social exclusion including the prevention of alcohol misuse (Acheson 1998).

For all age groups, alcohol dependency contributes considerably to hospital admissions for mental health problems, and heavy drinking is linked to psychiatric morbidity including clinical depression (see page 5). There exist important issues around access to appropriate services for those with both a mental health and an alcohol problem, since specialist alcohol services

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are usually not equipped to deal with mental health problems, and psychiatric services can often overlook a contributory alcohol problem (see page 10).

Truancy and school exclusions

The Government is concerned at the high levels of truancy and school exclusions, with each year over 100,000 children excluded temporarily and 13,000 excluded permanently, leading to lost years of education and, in many cases, involvement in crime (Social Exclusion Unit 1998b).

There are many factors contributing to truancy and exclusions, in particular family relationships and peer pressure. Where there is a problem drinking parent (see page 9) or a pupil is drinking heavily (see page 8), this can contribute significantly to the likelihood of truancy.

In addition, alcohol has been identified as a direct cause of exclusions with 20% of pupils suspended for drinking alcohol at school. An indirect link is also apparent, with 16% of excluded pupils drinking alcohol every day compared with 3% of non-excluded pupils, and 20% of excluded pupils drinking alcohol 3 to 4 times a week, compared with 3% of non-excluded pupils (Youth Justice Board 2000). In many cases, the fact that a pupil is not at school - with time on their hands, no adult supervision, and/or spending time with a heavy drinking peer group - could lead to increased levels of drinking. In many other cases, the high levels of drinking will have contributed to the exclusion since both heavy drinking and being drunk can bring about behavioural problems, such as violence, verbal abuse and vandalism.

Youth offending

There is a strong link between alcohol and youth offending, with 18 the peak age for arrests for drunkenness (Home Office 1995). In one study of the associations between alcohol and deviancy in young people, 25% of weekly drinkers had a criminal record compared with 6 to 7% of occasional drinkers and non-drinkers, with criminal damage, disorderly behaviour and shoplifting being the commonest offences (Newcombe 1995). A report by the Chief Inspector of Prisons found that a quarter of young prisoners had been drinking when they committed their crime (Ramsbottom 1997).

The Government has issued guidance to Youth

Offending Teams on tackling drug problems. While the guidance recognises the role of alcohol in youth offending, it does not adequately deal with alcohol issues. Some initiatives have been successful in creating overlapping responses to young people's alcohol and drug use and misuse, but it is essential that the differences in legal status of, as well as societal attitudes to, the different substances are directly addressed in developing appropriate approaches.

Crime and anti-social behaviour

Crime and anti-social behaviour both contribute to, and arise as a result of, social exclusion. The links between alcohol and crime are well-established, with a large proportion of those entering the criminal justice system having a serious problem with alcohol (see page 15).

The report of the Government's Policy Action Team on Anti-Social Behaviour has identified alcohol misuse as a significant contributory factor to the incidence of anti-social behaviour in certain areas, highlighting the fact that poor neighbourhoods have a disproportionate number of problems of alcohol-fuelled anti-social behaviour, and that very young frequent drinkers are more likely to damage property and to be poorly supervised by their parents (Social Exclusion Unit 2000b). The Policy Action Team report does not make any recommendations on alcohol misuse in anticipation that the Government's alcohol strategy will include measures to protect communities from anti-social behaviour related to alcohol misuse.

Unemployment

Problem drinking inevitably impacts on an individual's ability to work productively and to hold down a job. With 1 in 25 adults dependent on alcohol (OPCS 1994) and 1.7 million men and 0.6 million women drinking at very risky levels (ONS 2000), alcohol problems contribute to problems at work and levels of unemployment. A census of alcohol services found that, of the 10,000 people receiving help for their drinking problems each day, 36% were unemployed (Alcohol Concern 1997).

Among young people, alcohol misuse has been specifically identified by the Government as a barrier to working within the New Deal for Young People programme, with attempts made to direct those with alcohol problems towards specialist support. The Government's report, *New*

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Opportunities for 16-18 Year Olds Not in Education, Employment or Training, has identified among the groups of young people particularly at risk from non-participation in education and employment those misusing alcohol, and draws on evidence that 13% of 16 to 18 year old non-participants in education and employment are dependent on alcohol, compared with 5% of participants (Social Exclusion Unit 1999b).

Rough sleepers

The Government's Rough Sleepers Unit has highlighted the fact that 50% of the rough sleeper population are alcohol reliant (as opposed to 20% who are drug users), and that between 30% and 50% of rough sleepers have a serious mental health problem (Rough Sleepers Unit 1999). A high proportion, around a third, are estimated to have multiple needs, where a mental health problem is combined with an alcohol or drug problem (Social Exclusion Unit 1998a). In order to meet the complex mental and physical health needs of those on the streets, considered central to helping them to come inside, the Rough Sleepers Unit is focusing on the provision of specialist workers to help rough sleepers at all stages during their move off the streets, and recommending the creation of "wet centres" where people can drink inside, as well as greater provision of "home" detox in hostels delivered by GPs.

Family problems

The adverse impact of alcohol misuse on families, and its role in family break-up, are additional factors when considering the contribution of alcohol to social exclusion. Heavy drinking is a common factor in family break-up, and marriages where one or both partners have an alcohol problem are twice as likely to end in divorce as marriages where alcohol problems are absent (Velleman 1993). As outlined earlier, large numbers of children are living in a home where one or both parents misuse alcohol, and alcohol misuse features heavily in cases of child protection (see page 9).

Children of problem drinkers have higher levels of behavioural difficulty, school-related problems and emotional disturbance than children of non-problem drinking parents, and higher levels of dysfunction than children whose parents have other mental or physical problems (Barber 1994, Simpson 1993, Zeitlin 1994). These adverse consequences of parental alcohol misuse are all factors which contribute towards social exclusion.

Crime & Disorder

Government priority: to reduce crime and improve community safety

The Government has stated that alcohol-related crime is a significant problem in society that requires joined-up action from key agencies, including government, law enforcement bodies, voluntary agencies and the licensed trade (Home Office 1999a). The financial burden on criminal justice agencies of alcohol-related crime, particularly the police, is large but no comprehensive analysis of the costs has yet been made. One survey of police officers found that alcohol causes more problems for the police than drugs, with 68% of officers reporting that they encountered alcohol-related crime or disorder on a daily basis (Police Review 1999).

More than half of the 400 local Community Safety Partnerships have included alcohol-related crime as a specific strategic aim (Home Office 1999a). Involving key partners, including specialist alcohol services and the licensed trade, to develop approaches to address local problems will be key to success in this area. This should be backed up by specific national guidance to Community Safety Partnerships on preventing and reducing alcohol-related crime, as well as fear of crime.

The Government's Crime Reduction Strategy focuses on a number of key themes, including: working with families, children and schools to prevent young people becoming offenders of the future; tackling crime in communities; more effective sentencing practices; and working with offenders to ensure that they do not reoffend. Alcohol is significant within all of these themes.

Tackling alcohol-related crime, and ensuring appropriate treatment for offenders with an alcohol problem, should form a crucial part of the Government's drive to reduce crime. At the same time, a Government strategy on alcohol is important for drawing together public health, education and enforcement issues into one planned strategy to reduce the physical, psychological and social harms related to alcohol consumption.

Preventing young people becoming offenders

An understanding of young people's use and misuse of alcohol is crucial to the alcohol and crime debate, particularly as early use of alcohol can be predictive of deviant behaviour (Home Office 1999b). Tackling school exclusions has been identified as an important factor in preventing children from future offending. The role of alcohol as both a direct and indirect cause of exclusions is outlined in the Social Exclusion section above, as are the links between alcohol misuse and youth offending (see page 12).

Tackling crime in communities

One of the main social implications of alcohol misuse relates to its effect on people's behaviour towards others, and there is well-established recognition of the association between alcohol and crime. The relationship is complex: while alcohol does not always directly cause crime, it can be a significant factor. Alcohol's role in anti-social behaviour has already been outlined (see page 12): behaviour ranging from drunkenness, noise and public nuisance to vandalism can contribute significantly to fear of crime with, for example, residents avoiding town and city centres at pub closing times due to feelings of intimidation.

Alcohol's link to aggression and violent crime is of particular concern. Around 13,000 violent incidents take place in or near licensed premises each week (Home Office 1999a). In 41% of contact crime, including assaults and muggings, the offender has been drinking (Home Office 1996). A total of 125,000 facial injuries are sustained each year in violent circumstances, and in 61% of cases either assailant or victim has been drinking (Home Office 1999b).

Hidden crime within families

Certain crimes take place within communities, and impact on that community, but are hidden from view and often unreported because they occur within the family unit. Where there is a parent or partner within a family with an alcohol problem, the impact can be immense.

An outline of the numbers of children affected by parental alcohol misuse has already been given (see page 9), with the harm experienced ranging from child neglect, physical abuse and emotional abuse to sexual abuse (NSPCC 1997). In the child, these experiences can lead to psychiatric disorder, emotional disturbance, behavioural problems, the development of alco-

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hol and/or drug problems later in life, as well as deviancy and crime.

Alcohol has a significant role in the occurrence of domestic violence against partners. A comprehensive review of the research found that 60 to 70% of men who assault their partners do so when under the influence of alcohol (Jacobs 1998). Despite this, the role of alcohol is rarely highlighted in discussions on addressing domestic abuse, partly because of the difficulty in proving a causal link between domestic violence and alcohol misuse, and in understanding the ways in which the two are connected. The role of alcohol, however, should not be ignored when developing effective interventions. Co-ordinated responses are required that address both the violent behaviour and, where relevant, the alcohol problem.

Effective sentencing and preventing reoffending

A large proportion of those within the criminal justice system have an alcohol problem. A survey of probation officers found that nearly 30% of their clients and 58% of remand and sentenced prisoners had severe alcohol problems (NAPO 1994). A more recent study found that among male prisoners, 58% of remand and 63% of sentenced prisoners were drinking haz- ardously in the year before coming to prison (ONS 1999b).

Entering the criminal justice system offers impor- tant opportunities for addressing an alcohol prob- lem, but these opportunities are being missed due to the lack of appropriate assessment to identify alcohol problems, together with a lack of access to specialist services within prison.

Effective sentencing of offenders with alcohol problems should include automatic assessment of their problem together with referral, through sentencing requirements, for appropriate support and treatment. It has been suggested that Drug Treatment and Testing Orders, available to courts, should be extended to include alcohol. A particular target group would be offenders with alcohol problems who present a serious risk of reoffending and are in need of urgent access to treatment. Similarly, the concept of designated drug courts, with specially trained magistrates and support staff, could be expanded to cater for offenders with serious alcohol problems. Specialist alcohol services, providing a range of

interventions to meet individual needs, are not consistently available across the prison service. This results in missed opportunities for changing attitudes towards alcohol use before offenders return to the community and resume former pat- terns of behaviour, including reoffending. A spe- cific objective within the Government's alcohol strategy is required, parallel to the key objective within the drug strategy to increase participation of problem misusers, including prisoners, in treatment programmes which have a positive impact on health and crime.

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