The Alcohol Strategy

What is the focus of the alcohol strategy?
The Strategy has a particular, but not exclusive, focus on the problems associated with 'binge drinking' and the impact on town and city centres and hospital Accident and Emergency departments. It is estimated that there were nearly one million alcohol-related crimes and 1.2 million alcohol-related hospital admissions in 2010-11.

The Government estimates that in a community of 100,000, each year:

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

The effects of such 'excess', the strategy argues, ‘are clear’: alcohol-related harm is costing the country £21 billion every year, with consequences for crime and health, communities, and children and young people. The strategy identifies six outcomes that Government wants to see:

- A change in behaviour so that people think it is not acceptable to drink in ways that could cause harm to themselves or others;
- A reduction in alcohol-fuelled violent crime;
- A reduction in adults drinking above the NHS Guidelines;
- A reduction in ‘binge drinking’;
- A reduction in alcohol-related deaths;
- A sustained reduction in 11-15 year olds drinking alcohol and the amounts consumed.

What are the headline proposals from the strategy?
The Alcohol Strategy includes a foreword from the Prime Minister, and the Government has highlighted a number of key messages and proposals, which are developed in the Strategy:

- The introduction of a 'Minimum Unit Price' (MUP) for alcohol, with this price to be determined by further consultation, but with a 40 pence MUP discussed.
- Greater powers for local areas to tackle alcohol related issues, including:
  - Making it easier to act against and close down problem premises;
  - Stronger powers through licensing to control density of licensed premises;
  - Making health a licensing objective;
  - Extending existing powers to make ‘Early Morning Restriction Orders’ (EMROs), which enable local areas to restrict alcohol sales late at night where they cause problems;
  - Introducing a ‘late night levy’ so that businesses trading late contribute to policing costs.
- The development of ‘sobriety schemes’ and ‘sobriety orders’.
• Securing the support of the industry, including plans to build on the ‘Responsibility Deal’ and a welcome for the industry’s pledge to take one billion alcohol units out of the market by 2015.

• Greater support for individuals to make informed and healthy choices.

Does the alcohol strategy have anything to say about treatment for dependency?  
There is a section on ‘treatment and recovery’ near the end, but it is only three paragraphs (5.21, 5.22 and 5.23) – the first refers to the Drug Strategy 2010, the second is about adults in alcohol treatment with childcare responsibilities and partnership work with children’s services, and the third refers to the eight drug and alcohol recovery payment by results pilots that ‘went live’ on 2 April.

The Government would argue, however, that treatment for alcohol dependency is addressed by the Drug Strategy 2010 (see ‘The Alcohol Strategy in Context’ below).

The section on treatment is followed by discussions of mental health and offenders.

• A link is made to the mental health strategy, ‘No Health Without Mental Health’, and there is recognition (if not discussion) of the challenge of providing treatment for people with a ‘dual diagnosis’ of mental health and drug and alcohol problems;

• The importance of providing appropriate interventions for offenders with alcohol problems and the role of prisons is highlighted. The Government says it will:
  • produce a cost benefit analysis to support the case for local investment in alcohol interventions and treatment services for offenders;
  • look at the potential for payment by results approaches to alcohol treatment for offenders; and
  • develop ‘an alcohol interventions pathway and outcome framework in four prisons’ to inform the commissioning of interventions in all prisons.

While there are sections on mental health and offenders other issues are not dealt with in any detail; for example there is no real discussion of treatment and ‘poly-drug use’ or domestic violence.

What about other health interventions?  
Brief interventions, where GPs and other health professionals perform a short screening to assess levels of drinking, are given strong backing in the strategy. The Strategy notes that the National Institute for Health and Clinical Excellence (NICE) recommends that health professionals should routinely carry out alcohol screening.

Identification and Brief Advice (IBA) will focus on individuals who are ‘at risk through drinking above the guidelines, but not typically seeking help for an alcohol problem’. Local authorities are encouraged to examine the evidence for local investment in IBA carried out by primary care staff, with the case for IBA supported by the Screening and Intervention Programme for Sensible Drinking (SIPS) 2012 research. The strategy also commits the Department of Health to include IBA in the NHS Health Check for adults age 40 to 75 from April 2013.

The strategy ‘encourages’ hospitals to employ ‘Alcohol Liaison Nurses’, with responsibility for:

• Medical management of patients with alcohol problems in the hospital;

• Liaison with community alcohol and other specialist services;

• Education and support for other healthcare workers in the hospital; and

• Delivery of IBA in hospital with a focus on key groups, including pregnant women.

Ultimately, however, hospitals will be dependent on Clinical Commissioning Groups (potentially in partnership with public health) to provide the necessary funding for Alcohol Liaison Nurses.

The Strategy notes the role of alcohol in domestic violence, and references the Government’s ‘Call to end violence against women and girls’. It states that the Government expects all local areas to implement
NICE Guidelines (NICE published guidance on ‘Alcohol dependence and harmful alcohol use’ [CG115] in February 2011). It refers to the work of the Alcohol Learning Centre in providing information on trends and interventions, and, specifically, on promotion of effective partnerships to prevent alcohol-related harm.

What about young people – do they figure in the alcohol strategy?
Prevention and early intervention is a primary focus throughout the strategy - including regulation of advertising in new social media, support for parents to influence children to drink healthily, and tougher penalties for those who repeatedly sell alcohol to under-aged customers.

Particularly notable proposals on prevention, education and early intervention are:

- A £2.6 million youth marketing programme aimed at driving further reductions in regular smoking, drinking, drug use and risky sexual behaviour during teenage years; and

- A reference to the need to improve the quality of PSHE in schools.

The Government’s commitment to local decision making limits the reach of a national strategic approach. On PSHE, for example, it does not place requirements on schools, but refers to the need for ‘exploring how schools can better decide for themselves what pupils need to know, in consultation with parents and others locally’.

Localism also leaves decisions about investment in young people’s services to local decision-makers. The Alcohol Strategy observes that ‘assessment of local need through Joint Strategic Needs Assessment and integrated commissioning and cross-sector partnership will be critical in ensuring young people get early help and advice from practitioners and services they trust, such as youth organisations’, and that ‘young people’s involvement will be key in shaping effective local support’.

What about young people’s treatment?
Despite the high proportion of young people in treatment with alcohol issues, there is no direct reference to young people’s specialist treatment in the Alcohol Strategy (although the treatment and recovery section does discuss the impact of parental substance misuse on young people and the section on offenders refers to high levels of risky drinking among young offenders). Again, the Government would say that young people’s drug and alcohol treatment is dealt with in the Drug Strategy 2010 (see the section on ‘The Alcohol Strategy in Context’ below).

The Alcohol Strategy does include proposals to improve interventions for young people in the NHS. It notes that one-third of alcohol-related A & E attendances are for under 18s, and that there are significant local variations in responding to this group. It is stated that ‘the Department of Health will also work with practitioners, the Royal Colleges and the Association of Directors of Children’s Services to develop a model that ensures young people who attend A&E due to alcohol receive proper follow-up care, including parents being informed, where appropriate’. It highlights the opportunities for sexual health services to help to tackle alcohol misuse, with the DH currently piloting alcohol advice interventions in sexual health clinics.

Does the evidence support the Alcohol Strategy?
The Strategy provides strong evidence in support of key claims about alcohol-related harms and costs. It references a number of key resources for data, information and evidence, including:

- The National Treatment Agency’s National Alcohol Treatment Monitoring System (NATMS);

- NICE guidelines on addressing alcohol-related harm; and

- Resources produced by the Alcohol Learning Centre.

The Strategy rightly emphasises that levels of binge drinking among 15 to 16 year olds compare poorly with many European countries. However, more alarmist portrayals of current trends should be treated with caution, in reality:
• the public is drinking less than in 2005;¹
• there has been a fall in the numbers of young people drinking;²
• binge drinking is also on the decrease, particularly among 16-24 year olds.³

What about the evidence-base on alcohol-related health concerns?

While the total amount of alcohol consumed in England is on the decrease, drink dependency remains a significant problem. Alcohol Concern has reported that the number of moderate to severely dependent drinkers increased by 24 per cent between 2000 and 2007, while the number of alcohol-related hospital admissions rose by 100 per cent between 2002 and 2010. Deaths from alcohol-related liver disease rose by 36 per cent between 2001 and 2008, and accounted for 63 per cent of alcohol-related deaths in 2009. In all, there were 6,584 deaths directly attributable to alcohol in 2009, a 20 per cent increase since 2001.⁴

The Government is keen to encourage local investment in brief interventions. Is this supported by evidence?

A 2011 Department of Health report⁵ concluded that brief interventions using the Alcohol Use Disorders Identification Test (AUDIT) in primary care settings could achieve an average 12.3 per cent reduction in alcohol consumption per individual, with subsequent savings exceeding costs of £17.41 per head (2009/10 prices) by a factor of nearly 12 to 1 after seven years.⁶

There is evidence of the need for improved detection of alcohol abuse in health services. A 2009 Health Select Committee report concluded that the NHS was poor at detecting alcohol abuse. Only one in 67 male and one in 82 female hazardous drinkers were identified by GPs.⁷

The Committee expressed concern that clinicians lacked assessment skills, while noting that their job was made more difficult by a lack of specialist services and referral pathways.

Doesn’t the value of brief interventions depend on the ability to make referrals to more intensive interventions and services?

It does for those identified as needing specialist help. Over 70 per cent of GPs reported a shortage of rehabilitation and detoxification services, according to the same 2009 Health Select Committee report.⁸ It is estimated that only 6 per cent to 8 per cent of dependent drinkers were accessing specialist treatment. The Drug Strategy 2010 acknowledges that progress on alcohol treatment has lagged significantly behind drug treatment and identifies this as a priority.

A review by Her Majesty’s Inspectorate of Prisons - ‘Alcohol services in prison: an unmet need’ (2010) - concluded that, while 13 per cent of prisoners reported having an alcohol problem when they entered prison, ‘at every stage in prison, their needs are less likely to be either assessed or met than those with illicit drug problems’.

Is the cost-benefit analysis there to persuade local commissioners to make the investment?

A 2010 NHS Confederation report estimated that the cost of dealing with alcohol in the health system was £2.7 billion, a figure that was likely to rise to £3.7 billion over the next few years. This is in stark contrast to the amounts spent on treating alcohol dependency. In all, the annual spend is calculated at £217m, or £136 per dependent drinker.⁹ Alcohol Concern states that the average PCT expenditure is £600,000, or just 0.1 per cent of their annual budget. Doubling this investment, the charity calculates, would save the NHS £1.7 billion a year.¹⁰

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¹ According to the General Lifestyle Survey published by the Office of National Statistics the average adult drank 11.5 units per week in 2010 compared with 14.3 units in 2005.
² In 1996, 27 per cent of 11-15 year olds were reporting drinking in the last week compared to 13 per cent in 2010 (NHS Information Centre 2011, Smoking, drinking and drug use among young people in England 2010).
³ The proportion of young men drinking more than four units on their heaviest drinking day in the last week has fallen to 34 per cent from 44 per cent in 2005 (see General Lifestyle Survey 2010).
⁵ Mental Health Promotion and Mental Illness Prevention: The Economic Case, Department of Health, Knapp, McDaid and Parsonage (editors), 2011
⁶ The 2011 DH AUDIT Report states: ‘given the £17.41 cost of the intervention, the results demonstrate that savings after seven years exceed costs by a factor of nearly 12 to 1. Purely in terms of public expenditure, the intervention offers good value for money over the same period as combined savings in the NHS and criminal justice system exceed the costs of the intervention by a factor of more than 3 to 1. Estimated savings in the NHS alone exceed costs by more than 2 to 1.’
⁷ House of Commons Science and Technology Committee - Alcohol Guidelines 2010-12.
⁸ See also APPG on Alcohol Misuse (2009), The future of alcohol treatment services.
⁹ Making alcohol a health priority: opportunities to curb alcohol harms and reduce rising costs, Alcohol Concern, 2011
¹⁰ Ibid.
A report by Frontier Economics for the Department for Education (DfE) called ‘Specialist drug and alcohol services for young people – a cost benefit analysis’ (2011) concluded that a £1 investment brought a subsequent saving of between £5 and £8. \(^{11}\) This return on investment comprises both health and crime costs, as well as the impact on subsequent rates of adult dependency. As the report notes, around a third of young people accessing these specialist services identify alcohol misuse as their primary problem.

THE ALCOHOL STRATEGY IN CONTEXT: THE BIGGER PICTURE

The Alcohol Strategy 2012 needs to be placed in the context of other important developments, including:

- The emphasis on alcohol dependency in the Drug Strategy 2010;
- The abolition of the NTA in April 2013 and the transfer of its responsibilities to the public health service, which will bring drugs and alcohol provision together, along with other public health responsibilities;
- The discontinuation of the pooled drug treatment budget in April 2013 and its absorption into the new public health budget, along with alcohol budgets;
- The launch in April 2012 of eight ‘Drug and Alcohol Recovery Payment by Results’ pilots;
- The separate development of Alcohol Treatment PbR within the NHS;
- The introduction and development of ‘sobriety orders’;
- Changes in the profiles of people needing treatment services with a fall of 10,000 in new clients with heroin and crack cocaine problems\(^ {12}\) and concerns about alcohol dependency and poly-drug use.

The Alcohol Strategy 2012 says very little about treatment and recovery. Is it true that this is unnecessary as the issues are adequately dealt with in the Drug Strategy 2010?

From the opening line of the Home Secretary’s Foreword to the Drug Strategy 2010 it is made clear that it is concerned with both drugs and alcohol. The section on ‘Building Recovery in Communities’ highlights the need to make the same progress on treatment for severe alcohol dependency as has been ‘made in drug treatment over the past decade’. The first of eight best practice outcomes for recovery is ‘freedom from dependence on drugs and alcohol’. It also says that the NTA will ‘begin to build a role in helping to improve the provision of services for alcohol dependence’.\(^ {13}\)

However, there is little detailed discussion of specific issues and challenges in addressing alcohol dependency. For example, while it sets out the ambition for expanding alcohol treatment to match the expansion in drug services, it does not say where the investment to achieve this expansion will come from.

It would have been helpful for Government to have restated this commitment to treatment and recovery more forcefully in the Alcohol Strategy 2012, and set out its vision in more detail. There is no guarantee that local decision-makers will ‘read across’ to relevant sections in the drug strategy.

Finally, the Alcohol Strategy 2012 might be said to embody a different ‘paradigm’ to the Drug Strategy 2010, as it takes a ‘public health’ approach.

Drug policy has had a strong focus on treatment services for ‘problem drug users’ and ‘recovery-oriented treatment’. Public health has focussed on population-wide measures, such as reducing the numbers of people drinking above recommended levels. Public health has limited experience of commissioning interventions for people with chronic and acute health problems. This suggests that there a potential for the development of alcohol policy, guided by the Alcohol Strategy, to deviate from the ‘recovery’ focus at the heart of the drug strategy. How this plays out in practice will depend on the impact

\(^{11}\) Ibid.
\(^{12}\) In the two years up to 2010-11
\(^{13}\) By contrast, the 2008 Drug Strategy made no reference at all to alcohol in the section on ‘Delivering new approaches to drug treatment and social integration’. The New Labour approach in the 2008 strategy is summed up in the following quotation: ‘although the pooled treatment budget for adults will remain beyond use for the provision of primary alcohol misuse treatment, it may be right in some communities for plans to tackle drug use to be developed alongside action to tackle harmful drinking’ (emphasis added).
of the transfer of NTA staff into public health, and the way these issues are addressed – and the ‘paradigms’ balanced and integrated - locally (for example, by Health and Wellbeing Boards).

Any further details in more recent policy and strategy documents?

The only specific priorities identified in the Annual Review of the Drug Strategy 2010 (Home Office 2012) were:

- work to develop a measure of young people’s drug and alcohol use locally, to support planning and commissioning decisions by local authorities;
- supporting areas who choose to develop an integrated approach to alcohol and drug-related arrest referrals (for example, joint drug and alcohol workers in custody suites).

The ‘Action plan for the NTA 2012-13’ has commitments on alcohol, including:

- Implement improvements in the alcohol treatment system outlined in the Alcohol Strategy by working with DH to identify the support needed by local areas to secure improvements in alcohol treatment and begin implementation;
- Develop the National Alcohol Treatment Monitoring System (NATMS) and amend the ‘alcohol core dataset’;
- Work with the Department of Health to develop ‘an alcohol treatment capacity model’;
- Investigate links between alcohol treatment and crime reduction;
- Extend capacity to ‘match’ Department of Work and Pensions and NTA data to include alcohol;
- Work with the independent Substance Misuse Skills Consortium to develop its support for alcohol treatment and recovery; and
- Work with the Ministry of Justice, Offender Health and NOMS to ‘develop a strategy to offer treatment for an agreed cohort of alcohol-dependent prisoners’.

Currently, something called Local Alcohol Profiles England (or LAPE) is a key source of alcohol-related data for public health. There appears to be a lack of clarity about how LAPE and the NATMS will combine to inform service delivery and outcome monitoring.

How big a role is ‘payment by results’ likely to play in the development of alcohol services?

The Alcohol Strategy itself includes only one reference to payment by results (PbR), where it states that the evaluation of the eight drug and alcohol recovery pilot areas will inform future PbR modelling for alcohol offending. But it is clear that Government attaches a high priority to these pilots as a key implementation mechanism for its vision of ‘recovery-oriented treatment’.

Initially, the eight PbR pilots were envisaged as covering drug treatment only, but as they developed they were extended to encompass alcohol services. Outcomes by clients with alcohol problems will be included across the three PbR outcome ‘domains’: free from drugs of dependency, offending and improved health and well-being. It is important to recognise that your local area may be affected by PbR initiatives even if you are outside the pilot areas, with the Government encouraging other local areas to develop PbR approaches to recovery (‘early adopters’).

The picture is complicated by the development of a separate Alcohol Treatment PbR project as an extension of PbR initiatives within the NHS. The NHS conducted four pilots for Alcohol Treatment PbR in 2011-2012 in Middlesborough, Rotherham, Wakefield and Nottingham.

The relationship between these two distinct PbR initiatives for alcohol is unclear, and there is limited information on future plans for developing the Alcohol Treatment PbR. The NHS-based pilot is focussed on clinical aspects of alcohol treatment in the context of NHS delivery, whereas the recovery pilots embody a broader conception of ‘treatment’ and ‘recovery’ (for example, covering offending and housing).

The models and approaches are markedly different, even contradictory. The Drug and Alcohol Recovery PbR pilots take a ‘black box’ approach – the idea is that where commissioners focus on outcomes this leaves

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14 Led by the Department of Health, they were launched at the beginning of April 2012 in Bracknell Forest, the London Borough of Enfield, Kent, Lincolnshire, Oxfordshire, Stockport, Wakefield and Wigan. The pilot areas will be periodically submitting updates for learning and evaluation which will be accessible on a drugs and alcohol recovery bulletin on the Department of Health website (at www.dh.gov.uk/health/2011/10/drugs-recovery).

15 Where alcohol misuse is a complicating factor for mental health problems – ‘dual diagnosis’ – it is included in other areas of mental health PbR).
service providers with more freedom to innovate in the delivery of interventions. By contrast, Alcohol Treatment PbR is about assigning service users to a set of ‘needs-based clusters’, to ensure that ‘they will receive defined packages of care that follow best practice guidelines and seek to reduce unacceptable variations in practice’.

What will be the significance of the transition to public health?

Directors of Public Health employed by local authorities, sitting on Health and Wellbeing Boards, and guided by joint strategic needs assessments and local health and well-being plans, will assume responsibility for drug and alcohol commissioning from April 2013, supported nationally by Public Health England.

Local decision-making will be constrained to some degree by the Department of Health’s ‘Public Health Outcomes Framework’ (PHOF) for 2013 to 2016. This includes ‘successful completion of drug treatment’, but with no comparable outcome for alcohol treatment. The one outcome that makes direct reference to alcohol is ‘reducing alcohol admissions to hospital’, although other key outcomes should drive investment in alcohol services (for example, reducing liver disease and violent crime). The Government has said, however, that the PHOF is not intended to pre-empt local decision-making. In addition, the Drug Strategy 2010 and the Alcohol Strategy 2012 will both have a potential role in shaping and informing local decisions.

How much impact is all this likely to have in practice?
The transition to public health and localism is potentially ‘game changing’.

First, it is widely accepted that alcohol treatment has been poorly funded in comparison with drug services. In part, this reflects the strong central push under the previous Government to improve treatment services for ‘problem drug users’, particularly because of the impact on crime and community safety. From April, drug and alcohol money will be brought together in the same pot, with the potential for a more even distribution of resources (although this will partly depend on the details of any arrangements for providing some protection for investment in drug treatment following the discontinuation of the pooled treatment budget and the transition to public health).

Second, the public health reforms provide opportunities to improve responsiveness to local need. There is a potential for localism to shift the focus of investment, raising the profile of alcohol interventions and services (with corresponding risks for current drug treatment provision). Even if this is the case, the form this takes will be dependent on local priorities – for example, in the allocation of resources between ‘whole population’ approaches and specialist services for severe alcohol dependency. (In 2010, the National Audit Office\(^\text{16}\) found that there was little correlation between Primary Care Trusts spending on alcohol services and the extent of alcohol problems in the local population.)

There is also a risk that both drug and alcohol budgets will be diverted to fund other public health priorities. Though the overall public health budget for local authorities is ring-fenced, there is no guarantee that the drug and alcohol spend, which amounts to around a billion overall, will not be eroded (although the Department of Health has introduced some protections).

Finally, as discussed earlier, there is the question of the impact of what could be described as ‘the public health paradigm’ on drug and alcohol commissioning – could we see a significant shift in resources from services addressing dependency towards ‘whole population’ approaches targeting other kinds of harmful drug and alcohol use?

Will Directors of Public Health have lead responsibility for commissioning all alcohol services?

No. In the first place, the responsibility for commissioning drug and alcohol services in prisons will rest with offender health services working under the aegis of the NHS Commissioning Board. In addition, elected Police and Crime Commissioners could have a role in commissioning some alcohol interventions (see below).

Secondly, the Alcohol Strategy envisages a significant expansion in the availability of alcohol advice and interventions within the NHS, and NHS commissioning will be the responsibility of the new Clinical Commissioning Groups, which are represented on local Health and Wellbeing Boards.

The Alcohol Strategy emphasises the need for Local Authorities and Clinical Commissioning Groups to work together, guided by the Joint Strategic Needs

Assessment and joint Health and Wellbeing Strategy. It envisages IBA being commissioned by local authorities from the Public Health Grant. It says Alcohol Liaison Nurses could be co-funded by Clinical Commissioning Groups and local authorities.

What about Police and Crime Commissioners (PCCs)?
The Alcohol Strategy acknowledges the potential role of PCCs given the high levels of alcohol-related crime and anti-social behaviour in many local areas.

From April 2013 PCCs will control the Community Safety Fund which has been significantly cut over the last two financial years, and now stands at £28.8 million. They will also control around £35 million of current Drug Interventions Programme (DIP) spending, but with ‘ring-fencing’ removed.

While PCCs are not statutorily required to sit on Health and Wellbeing Boards, there is an expectation that they will work with Directors of Public Health and Clinical Commissioning Groups. The 2010 Drug Strategy states that ‘Directors of Public Health will see commissioning and oversight of drug and alcohol treatment services as a core part of their work … and will work with local partnerships – including Police and Crime Commissioners (PCCs), employment and housing services, and prison and probation services – to increase the ambition for recovery’.

There seems to be a lot of political and media interest in sobriety orders – how significant are these?
There is certainly a lot of interest about the potential for sobriety orders to tackle alcohol-related crime. This has been particularly true in London, where this agenda has been championed by the Mayor, Boris Johnson, and the former Deputy Mayor with responsibility for policing and crime, Kit Malthouse.

It is important to distinguish between two different forms of ‘sobriety order’, both of which are now being piloted.

First, sobriety orders can be imposed as part of a ‘conditional caution’. This kind of order makes use of existing legal powers, and targets offenders convicted of lower level offences such as being drunk and disorderly, criminal damage and public disorder. The pilots are in Westminster, St Helens, Hull, Plymouth and Cardiff. As a condition of receiving a caution, the offender is required to abstain from drinking on the days they are most likely to commit alcohol-related offences (normally Friday, Saturday and Sunday). On those days they are required to attend a police station and be tested by breathalyser.

Second, the Legal Aid, Sentencing and Punishment of Offenders Act 2012 introduced new powers for the courts to impose an ‘Alcohol Abstinence and Monitoring Requirement’. This is not restricted to particular days of the week, but effectively imposes a compulsory sobriety requirement for a period of up to 120 days. The offender is either required to attend a police station for a breathalyser test or to wear an ‘alcohol tag’ on their ankle. It is initially being piloted in Westminster, London for more serious offences where alcohol is a factor, such as common assault and actual bodily harm.

In its response to the Ministry of Justice’s consultation on Effective Community Sentences (June 2012), DrugScope did not object in principle to the piloting of sobriety orders, and we welcomed the provision in the Legal Aid, Sentencing and Punishment of Offenders Act 2012 that sobriety orders may not be imposed on offenders who are alcohol dependent (while noting that this raises questions about the definition of ‘dependency’). Our response questioned the profile being given to sobriety orders, and highlighted other priorities, including more effective use of Alcohol Treatment Requirements as an alternative to custody.

There are particular concerns about any plans to extend ‘sobriety orders’ to perpetrators of domestic violence, which is raised as an option in the Effective Community Sentences consultation. Key organisations supporting victims of domestic violence have objected that this involves simplistic understandings of the relationship between alcohol and domestic abuse, and fear that the imposition of sobriety orders could put victims of domestic abuse at risk.

Are there any other London-specific developments?
The new London Health Improvement Board (LHIB) has identified alcohol as one of three priorities for pan-London action on public health, alongside childhood obesity and prevention and early diagnosis of cancers. The LHIB will advise and support the Mayor in the discharge of his duties to improve the health of Londoners and to reduce inequalities in health outcomes across the capital. Its work will be funded by ‘top-slicing’ 3 per cent from the public health budgets of London Boroughs from April 2013, with the potential to transfer a further 3 per cent from local authorities subject to a two thirds veto from London Councils.
LHIB has produced a briefing on the alcohol priority and is developing an action plan to reduce alcohol-related harm in London, with a focus on:

- reducing alcohol-related crime and disorder;
- increasing and improving IBA provision;
- improving the numbers who take up treatment following an assessment of high risk;
- reducing alcohol-related A&E attendances; and
- reducing alcohol-related domestic violence incidents.

These objectives are to be achieved through three LHIB workstrands:

- developing a London vision for alcohol by leading a high profile engagement strategy;
- ensuring alcohol is supplied responsibly by using licensing powers;
- ensuring interventions are in place to support those most at risk by improving the use of IBA.

And outside London?

Shadow Health and Wellbeing Boards (HWB) may already be considering local priorities, including approaches to alcohol. It would be worthwhile to find out what discussions may have occurred and to start to influence and engage your local HWB around this agenda. The Kings Fund has a website that provides information about – including contact details for – shadow HWBs (see links below). Many HWBs have their own websites.

You could also consider how to engage with elected Police and Crime Commissioners from November – and with PCC Transition Boards, which are already meeting and may be discussing local community safety priorities. DrugScope is part of the Safer Future Communities (SFC) initiative to engage the voluntary and community sector and PCCs. You can find resources and information about your local SFC network at www.clinks.org.uk/sfc. Some local Transition Boards will have their own websites.

This briefing was prepared by Marcus Roberts (Director of Policy and Membership, DrugScope) and Michael Simpson (Policy Officer, DrugScope)

DrugScope is a leading independent centre of expertise on drugs and drug use and the national membership organisation for the drugs field, with around 400 members. We are committed to:

- promoting rational drug policy debate that is informed by evidence;
- involving our membership in all our policy work;
- supporting our membership to adapt to a changing policy and funding environment;
- ensuring our policy interventions are informed by front-line experience;
- speaking independently, and free from any particular sectoral interests;
- highlighting the unique contribution of the voluntary and community sector.


DrugScope membership is open to individuals and organisations with a shared interest and commitment to reducing drug and alcohol-related harms. Find out more at www.drugscope.org.uk/membership

DrugScope website is at www.drugscope.org.uk
LDAN website is at www.ldan.org.uk
Contact: info@drugscope.org.uk.
The Alcohol Glossary of Terms

Alcohol units – A unit is equivalent to 10ml of pure alcohol, which is the amount found in roughly half a pint of normal strength lager, a small glass of wine or a single 25ml measure of spirits.

Alcohol guidelines – The recommended weekly limit for alcohol consumption is 21 units for men and 14 for women. The recommended daily limit is three to four units for men and two to three units for women, but it is also recommended to have some completely alcohol-free days each week.

Binge drinking – Drinking a large amount in a short space of time – typically eight units in a day for men and six units in a day for women.

Hazardous drinking – Hazardous drinking is when a person drinks over the recommended weekly limit, which increases the risk of having health problems as a result of your alcohol consumption. It is also possible to be drinking to a hazardous level by binge drinking, even if total consumption is below the weekly limit.

Harmful drinking - Harmful drinking is when a person drinks over the recommended weekly limit, and is already experiencing health problems as a result of their alcohol consumption.

Dependent drinkers – If a person is a dependent drinker, this means they will feel like they are unable to function without alcohol, and drinking alcohol is an important or even the most important part of their life. Severely dependent drinkers usually experience severe withdrawal symptoms, which can be physical and/or psychological.

Identification and Brief Advice (IBA) – IBA is a simple intervention aimed at people who are drinking to hazardous or harmful levels, but are not dependent on alcohol. IBA has been proven to significantly reduce drinking among this group of people, and has a robust evidence-base.

Full definitions of key terms are available at www.nhs.uk/conditions/alcohol-misuse