ACMD

Advisory Council on the Misuse of Drugs

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Dear Ms Nicol,

The Advisory Council on the Misuse of Drugs (ACMD) are pleased to contribute to the Department of Health's consultation paper: Safe, Sensible, Social – consultation on further action.

The ACMD have addressed all of the questions individually but have also taken the opportunity to comment on its wider concerns around alcohol consumption in the UK. In particular, these concerns centre around alcohol use by young people and in combination with other substances.

Yours sincerely,

Professor Sir Michael Rawlins FMedSci
Chairman

The Advisory Council on the Misuse of Drugs

The Advisory Council on the Misuse of Drugs (ACMD) makes recommendations to Government on the control of dangerous or otherwise harmful drugs, including classification and scheduling under the Misuse of Drugs Act 1971 and its Regulations. It considers any substance which is being or appears to be misused and of which is having or appears to be capable of having harmful effects sufficient to cause a social problem. This therefore implicitly includes alcohol and tobacco.

The ACMD also carries out in-depth inquiries into aspects of drug use that are causing particular concern in the UK, with the aim of producing considered reports that will be helpful to policy makers and practitioners.

Safe, Sensible, Social – Consultation on further action

Overall comments

In 2006 the Advisory Council on the Misuse of Drugs (ACMD) published the report '*Pathways to Problems: Hazardous use of tobacco, alcohol and other drugs by young people in the UK and its implications for policy'*. The report concluded with a number of recommendations after reviewing a substantial body of evidence. Many of the recommendations are relevant to this consultation and the ACMD would encourage the Department of Health to revisit the ACMD's report.

It is apparent from our findings from *Pathways to Problems* and follow up work that young people in particular do not always draw a distinction between alcohol and illicit drugs. The ACMD therefore believes that the health and education messages should be well co-ordinated (between departments), consistent and be similar for both alcohol and illicit drugs.

In this respect, the use of the terms 'safe, sensible, social' are problematic, particularly when working with younger people. What is seen as 'normal', 'reasonable' or 'responsible' levels of drinking can be subjective and reflect the values or culture of a particular group or individual. The ACMD therefore believes that the term of 'less risky' – as used in the *Youth Alcohol Action Plan*– is more appropriate.

Given that significant numbers of people have concurrent alcohol and drug problems the ACMD welcomes the joint PSA introduced in April 2008 which set 'reducing the harms caused by alcohol and drugs as a key cross-Government priority'. The ACMD also welcomes the joined up approach by the Devolved Administrations, for example the new Welsh Assembly Government strategy *Working Together to Reduce Harm* explicitly covers 'alcohol, drugs and other substances'.

In this consultation the ACMD strongly supports the Government's indicated direction of travel, in their belief, that a new industry retailing code should be revised 'with a view to making it mandatory in retail premises that sell alcohol (on-licensed and off-licensed)'. We believe that a mandatory code will ensure that action from the industry will be taken - which to date has been severely lacking. The proposed actions will give a better platform upon which we can build to tackle alcohol misuse.

The ACMD therefore supports the implementation of policy option 4 in 'Safe, Sensible, Social - Consultation on further action Impact Assessments' so that the Government would:

> *Legislate to create a set of mandatory licensing conditions for **all** new or existing licenses to create a mandatory code for the alcohol industry, compliance with which is a mandatory condition of **all** licenses.*

Other key points to note are:

- There is a need for public health campaigns that spell out what the harms of risky drinking actually are (acute and chronic). For young people it would appear to be more effective to stress the short-term and immediate risks to health and status/self-esteem. The ACMD recognises the recent "Know Your Limits" television advertisement campaigns (sponsored by the Home Office). However, being less imaginative and complex may, for a target audience of young people, have greater impact on behaviour.

- There is a need to prevent off-licence outlets selling alcohol at lower than cost price; especially in supermarkets.

- It is important that all off-licences and licensed premises sell non-alcoholic and low alcohol beers/alternative drinks.

- One major reason for the increase in binge intoxication in the UK is the gradual increase in the alcohol content of alcohol in wines, beers and especially lagers. Twenty years ago the average alcohol content of beers and lagers was between 3.5 and 4%. Now the most popular drinks are in the 5–5.5% range and some strong lagers are up to 8%. Reducing alcohol content would be a simple approach to reducing intoxication. Differential taxing - according to alcohol content (e.g. per unit) - could be one such method employed to reduce the amount of alcohol consumed (in like for like consumption). Some countries e.g. Sweden, already use this approach to alcohol harm reduction by only allowing beers of less than 3.5% alcohol content to be made available in public places such as airports.

- There is a lack of alcohol treatment service provision - specifically for young people. The ACMD believes that treatment services for alcohol problems are seriously under-funded in the UK and there is a north-south divide. Furthermore, provision for young people is very patchy throughout the country. Even then, there are more likely to be services for drug rather than alcohol problems.

Addiction specialists are seeing increasing numbers of young people and especially young women, who present with severe alcohol addiction and require medically supervised detoxification because of the risk of a fatal outcome as a result of delirium tremens. The ACMD understands, from feedback from adolescent addiction psychiatry specialists, that it is difficult to find and arrange for admission to suitable inpatient provision for teenagers with this plight. The above issues and concerns were cited in the NTA report - *The role of CAMHS and addiction psychiatry in adolescent substance misuse services*.

- In addition, practitioners as well as young people and their parents are not aware that treatment may be effective nor where to go for treatment.

- There is a need for the provision of mainstream service education and training for identifying risky behaviours and harm e.g. at youth clubs.

Question 1.

How might a new code be made effective in stopping licensed premises from engaging in practices that encourage people to drink excessively and irresponsibly?

The ACMD believes that the alcoholic drinks industry and retail outlets are not fully engaging with their own regulatory code; *Social Responsibility Standards for the production and sale of Alcoholic Drinks*. The lack of consistent adoption of the code and its standards, by the industry, is reflected in the findings of the recent Home Office commissioned KPMG independent review. The ACMD believes that a more robust approach is required and strongly supports the Government in their belief that the code should be revised '**with a view to making it mandatory in retail premises that sell alcohol (on-licensed and off-licensed)'.**
Specifically we have issues in the following areas:

- **Labelling**
  - The ACMD welcomes and supports the proposal for the mandatory addition of labels indicating 'know your limits'. However, messages on the label should be clear on the harm caused. The ACMD considers that public health messages e.g. 'excessive consumption is harmful' – combined with standardised/consistent unit information – would be appropriate. In addition, labelling could include calorie content and possibly specific warnings e.g. increased risk of accidents. (see also the ACMD response to Question 8)

- **Point of retail**
  - The ACMD is particularly concerned with current pricing strategy - of deep discounting and bulk buys - of certain 'off licence' retail outlets (e.g. supermarkets). Such cheap availability encourages bulk purchase and consumption. Of specific concern is that the pricing puts alcohol more within the budgets of young people.
  - The often huge price differential between 'off-licence' and 'on-licence' premises encourages the practice of 'tanking up' at home, on cheaper alcohol, before visiting bars and clubs, thus exacerbating risks to health and anti-social behaviour.
  - The availability of cheaper alcohol to young people in off-license outlets is likely to lead to more young people drinking unsupervised.

- **Enforcement**
  - The ACMD concurs with the findings of the KPMG report that 'the Standards are not being consistently adopted and applied across the whole of the alcohol industry'. The ACMD believes that the Standards should be strengthened and enforced; the

    KPMG report concludes that ‘Standards should be strengthened and enforced more effectively by Government, industry and other agencies…’. However, adoption and application of the revised stand-alone mandatory code should be closely monitored – the ACMD considers that if after implementation there is still a lack of upholding the Standards by industry, consideration is given to the formulation of a regulatory body/agency with enforcement powers.
  - The ACMD encourages local authority and the police to be more active in the area of enforcement, particularly at on-licence establishments.

- **Penalties**
  - Penalties for not upholding the new code should be proportionate **and** effective.

Question 2.

If there continues to be slow progress in implementing a voluntary labelling scheme, should the Government take the steps to make it a legal requirement to include health and unit information on all bottles and cans?

The current messages on bottles and cans can be unclear and confusing. The ACMD notes the findings of a recent report that found only 57% of products had labels that contained information on alcohol unit content and only 3% followed the labelling scheme in its entirety. The ACMD would recommend that if there continues to be slow progress in implementing a voluntary labelling scheme the Government **should** make it a legal requirement to include health and unit information on all bottles and cans: **the ACMD welcomes mandatory, clear and prominent labelling.**

However, it should be noted that the ACMD has some concerns that the printing of alcohol units on bottles and cans may well have precisely the opposite effect to that which is intended; as it will aid some people, particularly young people, in their quest for the strongest alcohol i.e. drinking for effect (to get drunk). Nevertheless, the ACMD believes that labelling should be mandatory and that warnings should concentrate on the immediate risks to young people[1]. The ACMD recommends that research is undertaken to evaluate the impact of labelling on particular consumer groups.

The ACMD noted in their response to *Safe, Sensible Social* that there is still a lack of understanding of what constitutes a ‘unit’ of alcohol. The ACMD was made aware that the Department of Health definition of a “safe” number of

[1] It is noted that labels of unit information on bottles are likely to have more positive impact for adults than young people. The ACMD believes that efforts should be focussed on marketing and point of purchase for strategies that consider the harms to young people.

units differs from that of the Royal Colleges. We suggested that a definitive ruling needs to be made on this with an agreed metric. **The ACMD welcomes the guidance that 8g of pure alcohol constitutes a unit.**

Question 3.

What are the most important issues that need to be addressed in an alcohol retailing code?

The new code should:

Promote the Sensible Drinking Message

- It is imperative that the code's 'sensible drinking message' is revised and brought up to date. This has not been revised since 1995 and is of particular concern since it cites the 'health benefits' of drinking as its first bullet point.
- The new code should promote 'less risky drinking' – not 'safe' drinking - in line with the *Youth Alcohol Action Plan*.

Advertising

Recent research has provided evidence that the way certain types of alcohol are marketed particularly appeals to young people[2,3,4]. The Government commissioned an independent review of evidence on the relationship between alcohol price, promotion and harm and found 'evidence for a small but consistent effect of advertising on consumption of alcohol by young people at an individual level'. Furthermore, the research found that there was evidence to suggest that advertising (not including that on television) may 'increase the likelihood of young people starting to drink, the amount they drink, and the amount they drink on any one occasion'. Recent changes to the advertising standards in children's food (concept of healthy living) have demonstrated the level of change that can be achieved[5]. In addition:

- The ACMD recommends that the Department of Health carefully consider the impacts of alcohol related sponsorship – e.g. music festivals, sporting events and sports teams/clubs. Several EU member states have restrictions that go beyond the European directive e.g. prohibiting television advertisements for alcohol over a certain alcohol content.

- The ACMD supports the implementation of a policy, promoting 'less risky drinking' that would introduce 'a mandatory end frame with an average duration of one-sixth of total advertising minutes displayed on

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[2] Review of Pricing, promotion and harm – Safe, Sensible, Social – Consultation on further action Impact Assessments p.30.
[3] ELSA – Appealing Alcohol Beverages and Marketing Practices in Europe, May 2007
[4] Evidence collected by the ACMD's Pathways to Problems Working Group – to be published 2009.
[5] Changes in food and drink advertising and promotion to children. Department of Health, October 2008

broadcast and cinema advertising, with similar restriction for printed advertising'.

- The ACMD supports Alcohol Concern's recommendations that:
  - Drink adverts should be banned between 6am and 9pm to ensure that the majority of children are not able to see this form of alcohol advertising;
  - Drink adverts should be banned during programmes that run after the watershed but are still likely to appeal to children;
  - The regulations covering scheduling need to be made clearer and the sanctions for when these are contravened should be publicly promoted; and,
  - Broadcast codes should be brought into line with a clear definition of programming likely to appeal to children.

Retailing:
General
The ACMD recommends mandatory staff training and awareness for 'on-' and 'off-licence' where it is part of the premises core business.

Selling to under 18s
The ACMD advocates the discouragement of the sale of drinks that appear to be specifically targeting young people e.g. particular brands of: sweet wine, ciders, strong lager and shots which may appeal to under age drinkers[6].

Selling at a loss and other promotions
- The ACMD recommends that the code has measures that would curb the trend of supermarkets selling in bulk at a loss. As a consequence, 'on-licence' establishments (namely pubs) are being undercut by bulk-selling retail premises. Combined with the smoking ban in public places there is likely to be a significant number of people who are drinking more and unsupervised at home.

- The loss leader approach encourages bulk purchase and the likelihood of increased consumption. However, large price hikes across the board will impact disproportionately and unfairly on those on lower incomes and potentially encourage more unsupervised drinking. There is therefore a requirement for a more subtle, joined up and targeted approach. The ACMD suggests the exploration of a differential pricing approach (price based on alcohol content).

- For 'on-trade' premises, 'Happy Hours' and irresponsible promotions that encourage and facilitate irresponsible drinking practices (e.g. fees on the door for 'drink as much as you like' promotions, 2 for 1 promotions and triples the price of a single etc.) should be actively discouraged.

[6] ELSA – Appealing Alcohol Beverages and Marketing Practices in Europe, May 2007

Serving intoxicated customers
The ACMD recommends mandatory staff training and awareness. We support the Government in their consideration of a mandatory training certificate for, at certain premises, bar staff, **and,** additionally, off-licence staff.

The new code should note that outlets recognise a 'duty of care to the customer' by proactively preventing sales to those intoxicated.

Question 4.

Should the same restrictions be applied to:

- **All premises selling alcohol;**
- **All premises with some exemptions;**
- **Only certain types of premises (if so, how would you define these?);**
- **All premises within an area experiencing problems; or,**
- **A combination of these?**

The ACMD **strongly** supports the Government's belief that the code should be revised with a view to making it mandatory in retail premises that sell alcohol (on- and off-licensed).

Question 5.

Should an alcohol retailing code be made mandatory through further legislation? If so, how should it be applied?

The new code should be made mandatory.

The ACMD has already noted that the Standards are not being consistently adopted and applied across the whole of the alcohol industry'. The ACMD would be in favour of specific parts of 'option 3'[7] (policy option 4 in 'Safe, Sensible, Social - Consultation on further action Impact Assessments') considered by the government so that the government would:

> *Legislate to create a stand-alone mandatory code for **all** of those selling alcohol.*

Breach of the code would therefore be an offence which could lead to prosecution and licence review. Creating a set of minimum standards would ensure adherence to the code. The ACMD would particularly welcome the local authorities and the police to be more active in the area of enforcement, particularly at on-licence establishments.

Adoption and application of the revised mandatory standards should be closely monitored – the ACMD considers that if, after implementation of a new mandatory code, there is still a lack of upholding the Standards by industry then consideration is given to the formulation of a regulatory body/agency with enforcement powers. Whilst the ACMD recognises the Government's agenda

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[7] Safe Sensible, Social – Consultation on further action, Department of Health: pp24-25.

on better regulation this should not be to the detriment of enforcement of the new code. Should a code be made mandatory, as we propose, it needs to be **effectively** and appropriately enforced. The ACMD would see the potential role of a regulatory body being to monitor and enforce the code in matters of national/regional relevance (e.g., media advertising) and to monitor both compliance with the code and local enforcement.

Question 6.

Should a mandatory code, if introduced, cover proportionate and necessary actions to prevent health harm as well as crime and disorder?

This question is based upon the presumption that crime and disorder are the primary objectives of the new code. The ACMD is of the belief that the health harms should be as much of an objective as that of preventing crime and disorder.

Question 7.

Do you think there is enough advice available for those who want to drink less? What other kinds of help are needed and who should provide them?

The ACMD believes that, currently, there is not enough advice for those who want to drink less. In particular, the quality of advice and mechanisms by which young people and their families can be informed about alcohol and its misuse needs to be enhanced. Increased use of the internet is one such possibility. Whilst the ACMD commends the Government's Drink Check website we consider it should be better promoted to raise its profile.

To reduce the prevalence of unsupervised and harmful drinking by young people the ACMD believe there should be greater provision of alternative, accessible and attractive activities.

The ACMD supports the actions that the DH will explore – such as: '…exploring commercial and public sector partnership, with the likes of pharmacies and retailers, to raise awareness of the risks associated with harmful drinking and make advice and support as widely available as possible'.

Alcohol awareness training

Training in alcohol awareness should start at the undergraduate level and continue through to postgraduate and continuing professional education in all health and social care professionals. However, the ACMD believe that currently there are not enough trained health professionals to provide advice - in A&E and GP surgeries, new polyclinics, assessment centres also in children's services such as child and adolescent mental health services, paediatrics, obstetrics. Such training should also be extended to school nurses and police stations. There is some evidence that brief and early interventions given by a health professional are effective.

In schools the ACMD advocate the provision, for all pupils, of accurate, credible and consistent information regarding drug misuse prevention – this should include information about the hazards of alcohol misuse.

In addition there should be more interactive, and inventive ways of promoting health and awareness of harms; for example, these should make the link between the hazardous use of alcohol and sexual health (e.g. unwanted pregnancies and infections).

Question 8.

Should alcohol advertising include health and unit information? How could this be achieved?

The ACMD believes that alcohol advertising should include health and unit information.

Following the *Youth Alcohol Action Plan*, the notion of "safe" drinking appears to have been dropped – safe drinking is a message that compromises any campaign. It is noteworthy that this has been replaced with "lower risk" drinking. It is of the utmost importance that this semantic is maintained and generalised.

The recent NHS/Home Office guide “Drinking, you and your mates - How much is too much?” attaches a calorific as well as unit value to specific drinks and then equates it to a food stuff e.g. a pint of lager = 2.3 units =170 calories = a sausage roll. Other types of “comparison” could be worth exploring along with further research to understand their potential impact and value.

The ACMD recommends that the Department of Health explore the policy of Government implementing an alcohol duty levy to fund promotion of health awareness.

Question 9.

In addition to providing alcohol treatment for the small number of drinkers with a serious dependency problem, what else could be done, and by whom, to support people who find it difficult to cut down on their drinking?

The ACMD would recommend that there is greater take up of schemes to provide people with appropriate training in providing early interventions at accident and emergency departments and at Police stations. This also applies to the all the services referenced in our response to Question 7.

It is clear that funding for alcohol treatment is disproportionate to the problem; currently, even for severely dependent people, treatment is lacking.
Funding should be more in line with that provided in drug services - where there has been significant investment. The ACMD notes the good examples amongst some DAAT’s and PCT’s (e.g. Westminster) where there has been investment from local health resources to increase, improve and better develop local treatment provision.

The ACMD welcomes the Department of Health's approach in providing funding for programmes for giving specialist training to all new doctors for identifying high-risk drinkers. However, the ACMD is concerned that resources have not yet been sighted and that currently training is patchy, in some areas at least, and absent for many midwives for example.

Even though the numbers of severely alcohol dependent young people in the UK might be relatively small, they are a very compromised group. They are very likely to have a number of major risk factors and complications as a result of many years (sometimes as many as 10) of heavy drinking. They require long term health and social support over many years if they are to live healthy, happy lives. The impact on families and on their communities and wider society are far reaching and costly.

Early intervention – providing advice and other brief interventions – is key in providing support to harmful drinkers. The style of engagement called motivational enhancement therapy is a useful start to try to work with people to appreciate on their own terms what the pros and cons of substance use are in their lives and whether they want change and if so how to negotiate this change. It is important to recognise that there are a number of different 'groups' of people for whom such interventions would be beneficial. However, while this type of approach is undoubtedly a good method to involve people, we have to be careful not to exaggerate its benefit for those young people who need longer term help even if they are not yet dependent on substances.

It is vitally important that there is specific provision for young people to receive treatment. Young people have many different treatment needs which take account of their developmental stage (often delayed in young substance misusers), their complex, sometime chaotic circumstances (e.g. history of abuse and bereavement, school exclusion, family dysfunction, health problems, criminality), homelessness and reticence to engage with therapists. Young people are not mini-adults and treatment needs to be skilfully tailored to their specific needs. Practitioners need to be aware, trained and supervised (most importantly) in provision for this group for whom there are no easy solutions and well established protocols. One line of treatment that needs to be considered is the involvement of the family - where appropriate.

It is also important to consider the hidden problem for older adults who are drinking at higher risk levels whilst at home. For such people who are unlikely to access mainstream services there should be increased provision of advice and support for relatives and friends of dependent drinkers.

As far as the ACMD is aware there are currently no designated services for older substance misusers at all in the UK. Mainstream services do not cater for this group very well for the same reasons as with young people – it is not a question of those who will not access services – they are often not detected or if they are the services do not have the training and expertise to treat them.

The ACMD believes there is a great deal more that can be offered to the patients themselves which is not currently happening.

The ACMD would like to see better comorbidity services covering combinations of substances, mental health needs and physical problems.

Mental health needs

In inpatient adolescent addiction services it is estimated that about 75% of teenagers with substance problems have a comorbid mental health problem. This is itself indicates that comorbid conditions are integrally linked and need to be assessed and treated concurrently. Child and Adolescent Mental Health Services (CAMHS) are very reluctant to admit young people with substance problems although it is very likely that those patients they do admit have some degree of a substance problem that goes largely undetected. Thus it is a major issue. In addition, in order to assess whether the mental health issue is underlying the substance use or as a result of it or both, inpatient admission is the only practical way in which to make this assessment. The current paucity of CAMHS beds and adolescent addiction beds makes this almost impossible. Inpatient units are required not just for detoxification but for assessment, observation and treatment as well as continuity and very crucial aftercare - sometimes for years.

Similarly for adults and older adults – comorbid conditions are the norm rather than the exception. The same principles apply as for younger people.

Combined substance use/misuse and dependence

Furthermore drug misusers do mis/use alcohol and alcohol misusers mis/use drugs so substance comorbidities are a legitimate cause for concern. Often if patients are treated for one substance problem they substitute with another e.g. patients on methadone for heroin dependence drink heavily – this is very relevant to this document. Almost 90% will be smoking cigarettes.

Medical problems

There is a strong need to assess the physical health problems of dependent drinkers. Substance misusers have a panoply of physical health needs (including pain, cardiovascular (in older people), respiratory problems, infections and poor sleep and appetite). It is important that these are recognised and treated as part of the treatment process.

Long term dependency

For those drinkers that find it difficult to cut down on their drinking and for those that are drinking at higher risk levels there are options identified in the Department of Health's consultation document. However, there are also a significant minority who, even with expert help, may not reduce or abstain from drinking. In these cases the ACMD notes the following support that can be provided:

- provision of wet or damp houses, places to sleep it off;
- programmes which are not geared to abstinence;
- dietary advice and provision;

- harm minimisation e.g. monthly pabrinex (multi-vitamin), more use of medication (possibly - since do need to be motivated, so not suitable for those that are not) e.g. naltrexone, acamprosate, baclofen.