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▶ The government's alcohol strategy.

[UK] HM Government.
[UK] HM Government, 2012.

The UK government alcohol strategy for England and Wales claims to signal a radical change to turn the tide against irresponsible drinking. After resisting the policy, headline is the commitment to setting a minimum per unit price for alcohol.

In March 2012 the UK government released its strategy for dealing with alcohol-related problems, said to signal a radical change which "seeks to turn the tide against irresponsible drinking". Taxation proposals apply across the UK while provisions on crime and policing, alcohol licensing and pricing apply to England and Wales.

In his foreword, the prime minister highlighted crime and violence associated with "binge drinking", which "accounts for half of all alcohol consumed in this country". The strategy argues that in the past decade nuisance- and harm-creating public drunkenness has become acceptable. However, it also adopts a broader public health perspective in line with a diagnosis of the problem which argues that too many people drink alcohol to excess, making it one of the three biggest lifestyle risk factors for disease and death in the United Kingdom after smoking and obesity. The causes are said to include cheap and too readily available alcohol due to prioritising industry needs and commercial advantages over community concerns, the failures of previous governments, including the attempt to foster a continental-style 'café culture' (partly by more flexible and extended opening hours), and insufficient challenge to people whose drinking harms others and to businesses which tolerate and even encourage this behaviour.

Pricing, taxation and promotion

The single most important change in policy was the commitment to rapidly set a uniform minimum price per unit for alcohol across all drinks, the level of which will be subject to consultation. It meant the abandonment of the plan to set a minimum price for alcohol at the level of duty plus VAT which would vary with the drink. Research indicates that in public health terms the abandoned policy would have been of minor impact but that the new policy can make a substantial contribution. Possible windfall profits for alcohol producers and suppliers will not attract extra tax. Instead the intention is to work with

retailers to divert any additional revenue to provide better value on other purchases.

Consultations will examine a possible ban on multi-buy promotions in the off-trade. No further promotion regulations are envisaged but steps will be taken to heighten awareness of existing controls on targeting young people.

The strategy reminds readers that already the government has sought to tackle the availability of heavily discounted alcohol by annually raising alcohol duty by 2% above inflation, preventing high strength 'white ciders' qualifying for lower rates of duty applicable to cider, and a higher rate of duty for beer containing over 7.5% alcohol and a lower rate for beer at or below 2.8%.

Licensing and local action

Licensing policy and related parts of the strategy largely recap initiatives already put in place or signalled. However, one potentially far-reaching innovation will (as in Scotland) enable licensing authorities to consider health-related harms in taking their decisions. As announced, the policy would be limited to decisions over whether the concentration of licensed premises in an area is giving rise to serious problems (so-called 'cumulative impact') – problems previously limited to nuisance and disorder. Nevertheless, this opens the door to health as a licensing issue, a move seen as important by campaigners on alcohol-related ill health. Further down the road there is the potential for arguments to be made that not just the density of outlets, but also their hours and days of sale all have some health implications.

To further counter adverse effects associated with concentrations of drink outlets, statutory guidance on the Licensing Act 2003 is to be amended to make it clear that it applies both to the on-trade and the off-trade, and that licensing authorities can reflect the needs of their local area by using measures such as fixed or staggered closing times and zoning where they consider them to be appropriate.

Already in train and to be implemented in April 2012 is an amendment making licensing authorities and local health bodies responsible authorities under the Licensing Act 2003. It means licensing authorities will be able to be more proactive and themselves instigate a review of a premises' licence and submit representations against licence applications. Primary care trusts and local health boards will automatically be notified of an application for or review of a licence, and will be able to make representations and initiate review proceedings. However, except (once this change has been made) in respect of cumulative impact, health considerations cannot be the basis for their actions, which will have to fit under the existing licensing objectives of prevention of crime and disorder, public safety, prevention of public nuisance and protection of children.

These reforms will be made more effective by a change in the basis on which licensing authorities make their decisions; from having to show these were "necessary" for promoting licensing objectives, they will only to have show they were "appropriate". Other changes mean anybody who lives or operates a business in the licensing area – not just those in the affected vicinity – will be able to submit representations or participate in review proceedings. Extended powers will enable authorities to restrict alcohol sales between midnight and 6am and levy a charge on premises operating during those hours to contribute to the increased costs of late-night policing and wider local authority action.

The maximum fine for persistently selling alcohol to under-18s is to be doubled to £20,000 and it will be easier to close down persistent offenders. Police can also seize alcohol from under-18s and charge those persistently found with alcohol in public. Government wants action taken more often on these and other offences, including knowingly serving alcohol to a drunk customer, perhaps enforced by using 'stooges' to test premises' compliance.

The strategy refers to the transfer of public health responsibilities to local authorities whose work is to be funded by ring-fenced grant for services, including those dealing with drug and alcohol problems such as treatment and screening and brief interventions. This work will be informed by health and wellbeing boards where councils, the NHS and local communities will assess local needs and develop a joint strategy. Directly elected police and crime commissioners will it is said ensure the public's priorities drive local police force activity and hold chief constables to account. The commissioners' remits will extend to preventing crime and antisocial behaviour, with implications for the commissioning of alcohol-related initiatives.

'Enforced sobriety schemes' using breathalysers and electronic tags which monitor alcohol levels will be trialled for offenders convicted of alcohol-related crimes. Hospitals will be encouraged to share non-confidential information on alcohol-related injuries with the police to enable problem premises to be identified and targeted.

Working with the alcohol industry

Voluntary 'Responsibility Deal' agreements with alcohol producers and suppliers commit them to "foster a culture of responsible drinking, which will help people to drink within guidelines". Further progress will be sought in respect of: informative labelling, smaller servings as the default, responsible promotions including linking decisions on drinking to positive and responsible behaviour, education and prevention programmes aimed at young people and in the workplace, training bar staff to reduce sales to people who are drunk, extending local agreements on responsible alcohol service, and increased scope and funding for the industry-funded Drinkaware charity.

Supporting individuals to change

A £2.6 million marketing programme will alert young people to the risks associated with alcohol as well as drug use and sexual behaviour. Personal, social, health and economic education will be reviewed to help schools decide what pupils need to know. Universities are expected to help students understand and act on the risks of excessive alcohol consumption and ensure that subsidised bars do not unduly promote drinking. Youth strategy will seek to ensure young people get help early and from practitioners and services they trust. Steps will be taken to make alcohol-related accident and emergency attendances by under-18s an opportunity to offer advice about their drinking and to ensure they receive proper follow-up and care, including (where appropriate) informing parents. Guidance will be made available for parents through a range of public and community outlets. £448 million is to be devoted to helping the 120,000 most troubled families in the country into education and employment and tackling their criminal and antisocial behaviour; many of these families suffer from drink-related problems.

If it proves effective and good value, the Change4Life media campaign on the health harms of excessive drinking will be extended. The Chief Medical Officer will be asked to

oversee a review of alcohol guidelines for adults and how best to communicate the risks of drinking.

The strategy calls for programmes to identify hazardous drinkers in NHS services. In primary care, alcohol identification and any subsequent brief advice in surgeries and pharmacies will from April 2013 be incorporated in the NHS Health Check for adults aged 40 to 75, adding to checks for heart disease, stroke, kidney disease and diabetes. Accident and emergency departments and hospitals in general are encouraged to also check for and offer brief advice about hazardous drinking, in the case of hospitals by employing alcohol liaison nurses who will also manage patients with alcohol problems, liaise with community alcohol and other specialist services, and support other healthcare workers in the hospital. In general, all areas are excepted to implement NICE guidance and the linked quality standard on the management of harmful drinking and alcohol dependence.

Treatment and recovery

The strategy considers it vital that we provide effective treatment and recovery from addiction and dependence. Recovery goes beyond medical or mental health issues to include dealing with the wider factors that reinforce dependence, such as childcare, housing needs, employability and involvement in crime. As set out in the government's drug strategy, eight pilot areas are developing approaches to paying for outcomes for recovery from drug or alcohol dependence, commissioning services from April 2012. The strategy also sets out how government is more generally raising the ambition to support full recovery from addiction, including to alcohol.

Around 31,000 (33% of the total) adults in alcohol treatment have parental childcare responsibilities and another 20% are parents whose children lives elsewhere. Treatment and children's and family services are increasingly working together to identify and respond to alcohol-related problems. Evidence shows that family intervention projects help tackle these families' entrenched problems.

Many offenders are risky drinkers and in need of support as well as punishment. Findings from the eight pilot areas will inform a potential 'payment by results' approach to alcohol treatment for offenders. By July 2012, an alcohol interventions pathway and outcome framework will be developed in four prisons to inform the commissioning of interventions in all types of prisons. From April 2013 the NHS Commissioning Board will commission health services and facilities in prisons and other places of prescribed detention, supporting work to prevent and reduce alcohol-related ill health and reoffending. [See these Findings analyses for alcohol services in prisons and for offenders on probation.]

Steps will be taken to increase the flexibility of the alcohol treatment requirement (which can be imposed by courts as part of a community sentence) so areas can tailor treatment to target more serious alcohol-related offending. In respect of antisocial behaviour, a new civil order may require individuals to undertake positive activities (including alcohol treatment) to address underlying issues driving their behaviour. Areas can use Drug Interventions Programme funding from the Home Office for both drug and alcohol arrest referral schemes, offering support to arrestees identified as having a substance use problem.

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