

## *Researching & Developing Alcohol policy*

**Response from the Alcohol Education and Research Council to the National Alcohol  
Harm Reduction Strategy**

*The Alcohol Education and Research Council (AERC) is an independent, charitable organisation set up under the Licensing (Alcohol Education and Research) Act 1981 with a broad-based, multi-disciplinary membership. Council members are appointed by the Secretary of State for Culture under the rules governing public appointments. They are unpaid and their role is akin to that of charitable trustees. The AERC seeks to reduce the harm caused by alcohol abuse. It is committed to enabling better policy and services by improving their evidence base, and building research, educational and evaluative capacity. It seeks to promote collaborative working between those who are committed to the same aims but work in different settings.*

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## **Section 1: Comments on the Strategy**

Overall the Council believe that most of the important issues have been touched upon in the strategy. The following comments are not intended to suggest areas that have not been covered but simply give some indication of the priorities noted by Council members.

- In the very early stages it should be made clear which person in which government department is accountable for which components of the strategy. Contact details should be provided so that a body such as the Alcohol Education and Research Council could develop a communication network.
- It is important that the same model of alcohol misuse is shared by all, including the drinks industry. The alcohol problem covers hazardous drinking, harmful drinking and alcohol dependence. The problem is not just the smaller number of drinkers who are labelled alcoholics.
- Wherever possible similar projects should be encouraged to use the same instruments to measure change.
- Alcohol should be very high in the priorities of the “Choosing Health” initiative.
- There are many areas where the available evidence on effectiveness is relatively strong. These include brief interventions for the less severely affected, certain psychosocial treatments and multifaceted community interventions. The task in these areas is to spread good practice with continuous evaluation rather than starting from scratch.
- How to implement alcohol interventions is a crucial question but the first step is to convince the key players that reducing alcohol misuse is an important part of their role. These key players include GPs and Practice Nurses, social workers, health professionals within A&E departments, as well as bar managers and those serving beverages.
- There has been over 50 years of research on the treatment of alcohol abuse and dependence as well as many recent reviews. With this wealth of information resulting in a reasonable consensus the “Model of Care” document for alcohol services should be produced reasonably quickly, ideally within the next 9 months. It is important that the guidelines are not prescriptive but simply state the fundamental principles, based upon current evidence. Local judgement and local initiatives need to be maintained.
- There is an urgent need to protect alcohol services during the first year of the strategy. Many services rely upon soft funding often from local budgets for drug dependence. There is a threat that this funding could be withdrawn.
- Drug action teams should be dissolved and reconstituted in order to ensure that there is a balance between alcohol and drug workers on the new Drug & Alcohol Action Teams.
- The development of pilot projects should not be allowed to delay the implementation of the strategy. They should not cover ground where there is good evidence of effectiveness. For example, brief interventions for opportunistically newly identified problem drinkers have been shown to be effective. The issue to be explored by pilot projects is the best way of implementing them within a particular setting.
- The government should identify areas where a central steer or legislation could produce significant change. For example, the development of “Minimum Price Agreements” that could be agreed by the Office of Fair Trading.
- A manual could be published within the first year with 50 examples of good practice. This would provide clear descriptions of interventions that are working in practice, with contact details.
- Social Services have a very important role to play in the prevention of alcohol misuse as well as the care and support of individuals and families affected by an alcohol problem. There is little mention of the

role of Social Services in the strategy. This needs to be rectified and training programmes should be developed or expanded.

- The nursing profession will carry out much of the work that involves health services. The nurses involved are those working within Occupational Health, Psychiatric Hospitals, General Hospitals, Primary Care, Community Teams and the Prison Service. A major initiative will be required in collaboration with the Nursing Council on Alcohol.
- In line with a Harm Reduction Strategy it might be wiser and more acceptable to refer to safe drinking limits rather than sensible drinking. Young people in particular are not interested in sensible drinking messages.
- An area of immediate concern is the nighttime excessive drinking among young people linked to happy hours and other ways of providing cheap alcoholic drinks. The industry should be encouraged to focus upon this issue within the first few months of the strategy.
- Even though heavy drinking patterns should be the main concern of the strategy, per capita consumption is a useful proxy measure of cultural changes. The risk of becoming a hazardous drinker depends, *to some extent*, upon the "wetness" of the drinking culture to which the person belongs. The drinking habits of a person living in an environment where drink is cheap, freely available and where heavier drinking is the norm, will tend to be more hazardous than those of a person living in a relatively dry environment. Since mean alcohol consumption provides a proxy measure of the "wetness" of a society then one objective might be to ensure that per capita consumption does not increase further.
- The independent fund that will rely upon the support of the alcohol industry should be looking for strong evidence of effectiveness. A fund of £25 million will provide an enormous opportunity to research and develop effective approaches and then disseminate guidelines on good practice.

## Section 2: Future Role of the Alcohol Education and Research Council

The AERC is an independent, charitable organisation. Council members are selected, inter-alia, from public health and health economics, psychology, social science, medicine, social services, criminal justice, education and the alcohol industry. The Council administers its own capital fund, which provides independence. It employs a very small staff, preferring to spend its income on innovative people and projects. These are selected by peer review, but supported and monitored by Council members who act as 'godparents' as necessary to people or projects at formative stages.

The primary aims of the AERC are to improve the alcohol evidence base as well as the research and development capacity of individuals and organisations. The Council is open to a wide range of methodologies including qualitative and quantitative approaches, single studies and systematic reviews

The medical, social, environmental and economic costs of the harm caused by alcohol abuse are considerable, but only small amounts are spent researching better policies, services and educational interventions. A recent report '*100% Proof: Research for Action on Alcohol*'<sup>i</sup> provides an overview of the gaps in the evidence base. Research funding is hugely disproportionate in relation to the social importance of alcohol, the income from alcohol taxation to government, the employment and profitability generated by the industry, and the workload on welfare, criminal justice and health services.

The Council believes that policy and services can be improved by intellectually critical support. Large employing agencies, such as the NHS, and the Probation Service, have responsibility for expanding the volume of services and for improving their effectiveness, efficiency and accessibility. This should involve a co-ordinated programme of research. Shortage of funding for research into alcohol over many years, and the resultant poor career prospects have meant that innovative researchers and educators have

tended to move into other fields. Many practitioners dealing with the harmful effects of alcohol are relatively isolated and work under enormous pressure. They have had little recent opportunity to develop their evaluation skills, investigate hunches developed from long experience, or to encourage and help their younger colleagues undertake research to improve intellectual criticality and service delivery.

The Council would like to explore ways in which it can facilitate links, obtain advice on study design and method, and make intellectually critical support available. Service providers need to be enabled and enthused to evaluate their work and carry out pilot studies of innovations in their field. The Council would like to test whether services can be improved by providing small but timely grants and support for workshops, methodological help, and time out for research and evaluation. Quick, but methodologically sound pilot studies might lever in more substantial research and service development funds if preliminary results suggest the possibility of change for the better. In the absence of accessible funding resolvable questions go unanswered.

The AERC has recently reviewed its strategy. It recognises that its income cannot meet the need, and goes nowhere near the potential demands from researchers and educators. It recognises it is only one of many organisations focusing upon alcohol abuse. It is keen to collaborate to find better policies and improve services. It does not seek to become a dominant partner in alliances, but recognises that at marginal administrative cost and without further legislation its aims could be substantially and beneficially expanded if it could target key areas and lever and access more funds. It would like to explore with partners how this could be achieved. The AERC believes its statutory basis, independence, and the breadth and standing of its members within their professions is unusual and valuable and provides an excellent model. Many organisations in other fields would welcome the structure and the flexibility it brings; but opportunities for such legislation and funding are rare. The Council will seek to considerably expand its funding base without compromising its independence. For example, it believes it would be well placed to become a Lottery partner, and apply its infrastructure and expertise to acting on behalf of the Lottery in helping develop, prioritise, and support bids. It wants to collaborate with other funding bodies in order to improve the leverage of limited resources.

### **Current Priorities**

The AERC is unable to provide funding across the whole range of initiatives and gaps in research that have been identified in a number of publications. Instead the Council is currently focusing upon three priority areas. These are:

#### *Interventions for families*

Approaches designed to strengthen families have the potential to prevent alcohol misuse. There are several different and promising intervention models and evaluation methodologies but most of the research has been completed in the US. This area requires further research and development within the UK.

Families at risk may be those already experiencing an alcohol problem. There is some evidence that interventions with such families and children can be effective and also that generic health and social care workers can implement them. This area is also in need of further research and development

#### *A Sustainable Community Response*

Community programmes are becoming increasingly accepted as key health promotion initiatives to deal with alcohol related issues. They empower communities to promote their own well-being and to reduce distress caused to them by intoxicated and rowdy behaviour and by irresponsible selling of alcohol, which encourages such behaviour. They might focus upon community mobilisation, responsible beverage service in licensed premises to reduce the risk of having intoxicated and underage customers

in bars or restaurants, reduced availability of alcohol being sold to minors, as well as drink driving and media campaigns. Many communities are beginning to develop partnerships to reduce alcohol-related problems. They need to be rigorously evaluated.

### *Key Components of The Alcohol Harm Reduction Strategy*

Core elements of the government's recently published strategy will need to be subjected to good research and evaluation. Whether the focus is the training of bar staff, educational initiatives or the treatment of dependence, there will be a need for rigorous evaluation. Policy initiatives on licensing, availability of alcohol and changes in price, will also need to be monitored. A comprehensive, research and development programme will be an important component of the national strategy.

### **Developing the evidence base**

The recent report '*100% Proof: Research for Action on Alcohol*' (1) provides an overview of the gaps in the evidence base. Several AERC members contributed to this study, convened by Alcohol Concern and the Council strongly supports the central conclusions that:

- the report's recommendations should form the basis of discussions with interested parties on the development of a coherent alcohol research programme; and
- mechanisms should be established to ensure the central collection and sharing of information on alcohol research. These included:
  - a. Standardising agreed data collection instruments of measurement and implementing their routine use in research practice.
  - b. Providing a clearinghouse for co-ordinated research projects in the UK.
  - c. Commissioning research; and
  - d. Promoting the development of a training and career structure for researchers and interested practitioners.

To develop such a programme we recommend the establishment of a working group to bring together representatives of institutions and organisations concerned with the conduct and funding of alcohol research.

The AERC would be happy to organise and fund such a group and if there were sufficient consensus accompanied by appropriate funding, the Council would be prepared to extend its remit to provide this central agency. We believe that, by its statutory base, infrastructure, independence, and well-established networks and peer-review system it is well placed to take on this role.

### **Influencing practice**

Crucially important is a focus upon dissemination as well as the initiation and management of change. There is a great deal of evidence indicating that research findings often do not influence practice. This concern is highlighted in the Research Governance agenda, which also quite sensibly suggests that public money should only be spent on research that is seen to benefit the public. The Council proposes that more attention and research funding focuses upon identifying ways in which research findings can be translated into policy and practice. More specifically, a meta-analysis of completed research studies on the best methods of translating policy into practice should be commissioned.

## **Taking a Lead on the National Research & Development Programme**

The AERC has a wealth of experience in funding all types of research and development, including randomised control trials, qualitative research and action research projects. Trustees have concluded that the AERC is in a strong position to lead the work on a National Research & Development strategy. Such a programme requires adequate funding, a supportive infrastructure and an advisory group from a broad range of backgrounds, but with expertise in the alcohol field.

The AERC is able to provide the following:

- Annual funding of £500,000.
- Trustees with a variety of backgrounds including a strong representation from public health, health promotion and social science, as well as probation, health and social services.
- Strong networks and links with key players within the field, including the alcohol industry.
- Tried and tested procedures for the rigorous assessment and peer review of research & development proposals.
- Independent judgement, free from vested interests or domination by other bodies and organisations.

The AERC is in a strong position to commission the best people and teams to carry out rigorous research and evaluation.

## **Appendix: Recently completed AERC R&D projects**

The following completed projects give some indication of the spread of topics funded by the Council. Details can be found under publications on [aerc.org.uk](http://aerc.org.uk).

1. Alcohol sales to underage adolescents
2. Controlling supply: the concept of need in liquor licensing
3. Reducing alcohol consumption in young men with alcohol-related facial injuries
4. Aiming for moderation rather than total abstinence
5. Fast screening for alcohol problems
6. The effect of alcohol on surgical dexterity
7. Drinking habits of 16 year olds: Secondary analysis of the 1970 British Cohort Study
8. Maternal alcohol consumption and the behaviour of the foetus
9. Improving methods of estimating alcohol consumption
10. The European School Survey Project on Alcohol & other Drugs (ESPAD)
11. A randomised controlled trial of training and support strategies to encourage screening and brief alcohol intervention
12. The Effects of Alcohol Consumption in People with Diabetes Mellitus
13. 'Optimal' Levels of Alcohol Consumption for People at Different Ages
14. Alcohol Education Materials for Secondary Schools
15. Primary Prevention for Alcohol Misuse in Young People
16. Down Your Drink: an online Treatment Plan for Problem Drinkers

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<sup>i</sup> Sir Alexander Macara Chairman, Alcohol Research Forum: *'100% Proof: Research for Action on Alcohol'* ISBN 1 869814 50 9 Published by Alcohol Concern, London, 2002.