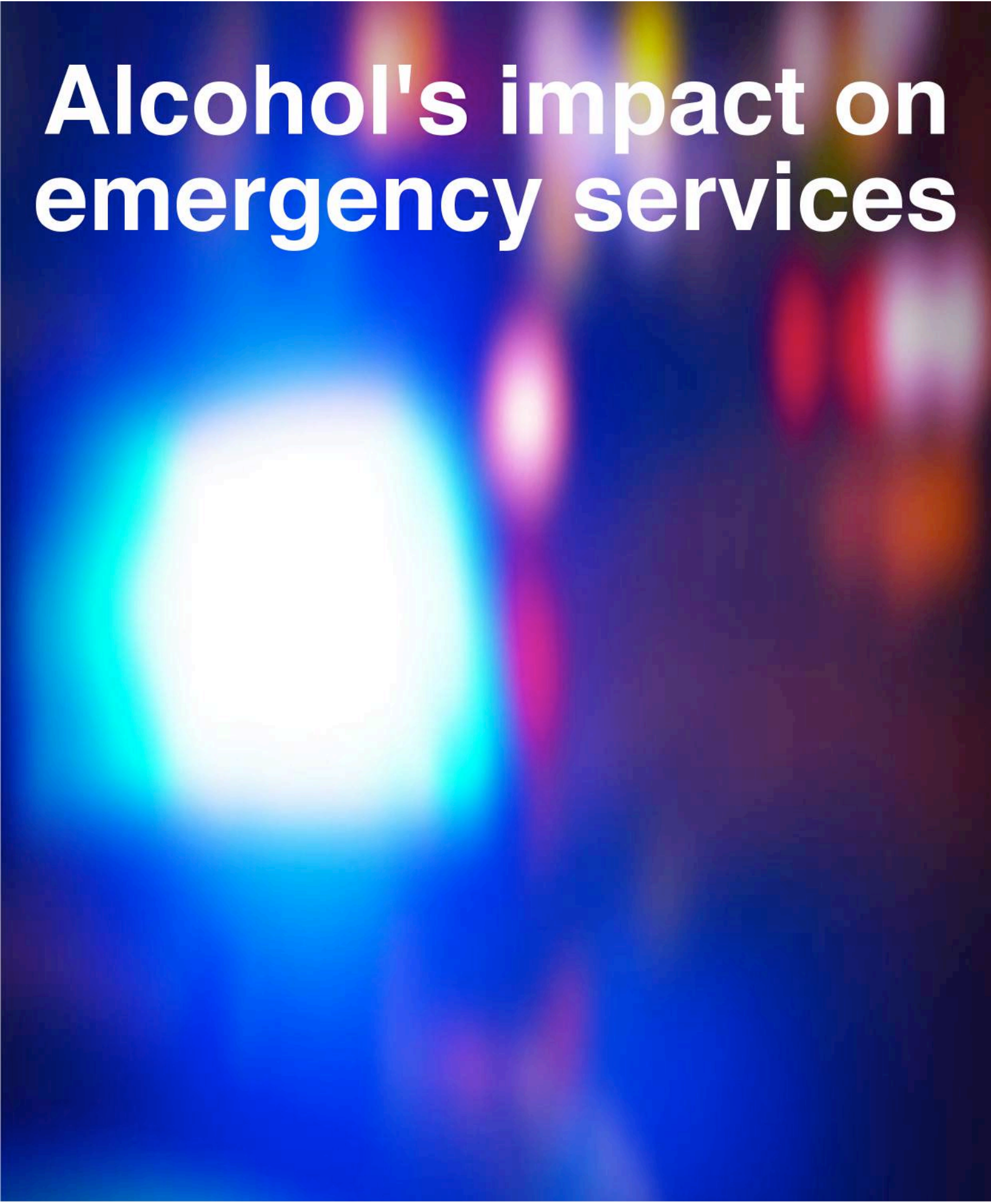
Alcohol's impact on emergency services



October 2015

Institute of Alcohol Studies

Alcohol's impact on emergency services

A report written and produced by the Institute of Alcohol Studies

About the Institute of Alcohol Studies

The core aim of the Institute is to serve the public interest on public policy issues linked to alcohol, by advocating for the use of scientific evidence in policy-making to reduce alcohol-related harm. The IAS is a company limited by guarantee, No 05661538 and registered charity, No 1112671. For more information visit www.ias.org.uk.

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Executive Summary

Key points

- Alcohol places a significant and unnecessary strain on emergency services
- Public drunkenness makes emergency servicepeople's lives and jobs harder
- All services want more day-to-day support in dealing with alcohol
- Frontline staff are calling for policy action to curb alcohol harm
- There are evidence-based interventions that can ease this burden

Alcohol places a significant and unnecessary strain on emergency services

A growing body of evidence is gradually revealing the extent of the burden that alcohol places upon our public services. Up to 80% of weekend arrests are alcohol-related[1], and just over half of violent crime is committed under the influence.[2] In 2009/10 there were 1.4 million alcohol-related ambulance journeys, which represents 35% of the overall total.[3] Estimates for the proportion of Emergency Department attendances attributable to alcohol vary, but figures of up to 40% have been reported, and it could be as much as 70% at peak times.[4] Alcohol is typically found to be involved in 10-30% of all fires.[5] Moreover, alcohol-caused fires are usually worse: 50% result in casualties, compared to 14% for other fires; and they cost five times more on average.[6]

Our survey of front line staff confirms the magnitude of the problem: alcohol takes up as much as half of their time. The issue is particularly acute for the police, for whom 53% of their workload, on average, is alcohol-related. However, even fire and rescue teams, who reported being the least affected of the emergency services by alcohol, typically spent one in five working hours dealing with the consequences of drinking.

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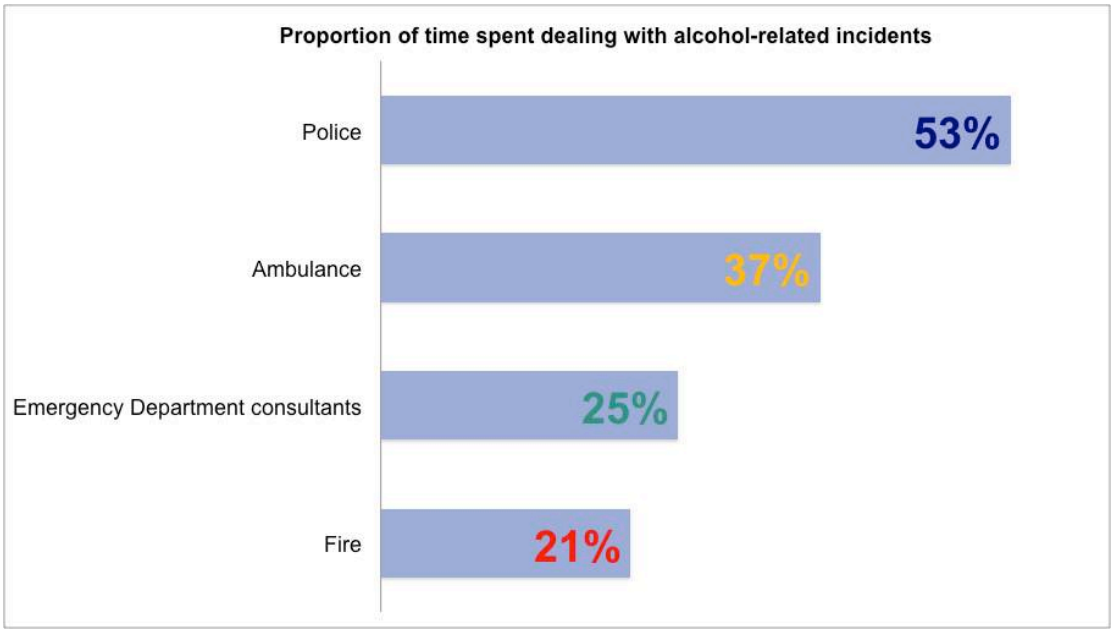
[1] Stoddart, J. (2011) *Alcohol's impact on policing*. Balance – The North East Alcohol Office. [Available: http://www.balancenortheast.co.uk/library/documents/The_Impact_of_Alcohol_on_Policing_Slideshow.pdf]. [Accessed: 15 October 2015].
[2] Office for National Statistics (2015), ONS Nature of Crime Tables, 2013-14 – Violence, Table 3.11.
[3] NHS (2012) The cost of alcohol harm to the NHS in England (2009/2010).
[4] York Health Economics Consortium (2010), The Societal Cost of Alcohol in Scotland for 2007, p28; Drummond, D., Phillips, T., Coulton, S., et al. (2005) National prevalance survey of alcohol-related attendances at accident and emergency departments in England, *Alcoholism: Clinical and Experimental Research* 29:5, pp36A:36A.
[5] Department for Communities and Local Government Arson Control Forum (2006) Learning lessons from real fires: findings from fire investigation reports. Research Bulletin No.9 [Available: http://www.stoparsonuk.org/documents/resources/fatal.pdf]. [Accessed: 15 October 2015].
[6] House of Commons Health Committee, *Government's Alcohol Strategy* (HC 132, 2012-13), Written evidence from the Department of Health (GAS 01).



This flood of alcohol-related incidents inevitably comes at a cost to the taxpayer: previous research has shown that the police and justice system spend £1.7bn every year responding to alcohol-related crime[7]; alcohol costs the health service £696m in Accident & Emergency costs, and a further £449m in ambulance services[8]; and the fire service spends £131m tackling fires caused by drinking each year.[9]

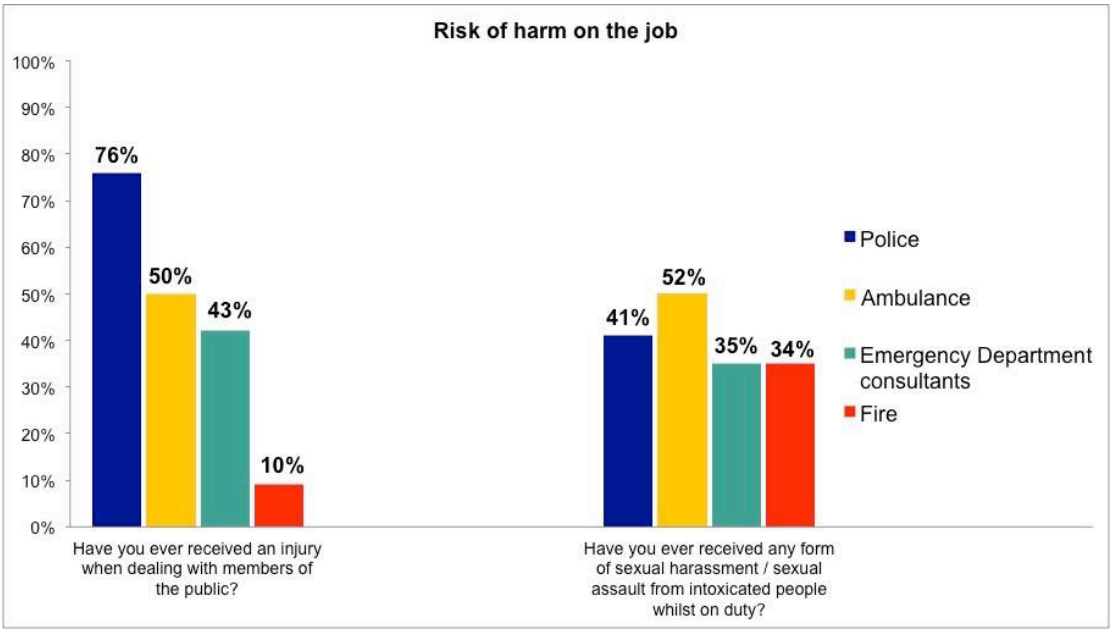
Public drunkenness makes emergency servicepeople's lives and jobs harder

Perhaps the most shocking finding of our survey was how widespread drunken physical, sexual and verbal abuse of emergency services staff is. Again, police and ambulance crews suffer the worst. Three quarters of police respondents, and half of ambulance respondents, had been injured in alcohol-related incidents. Between a third and a half of all servicepeople had suffered sexual harassment or abuse at the hands of intoxicated members of the public. Ambulance staff were particularly at risk, with 51% reporting sexually-related incidents, but the numbers were concerningly high across all services.

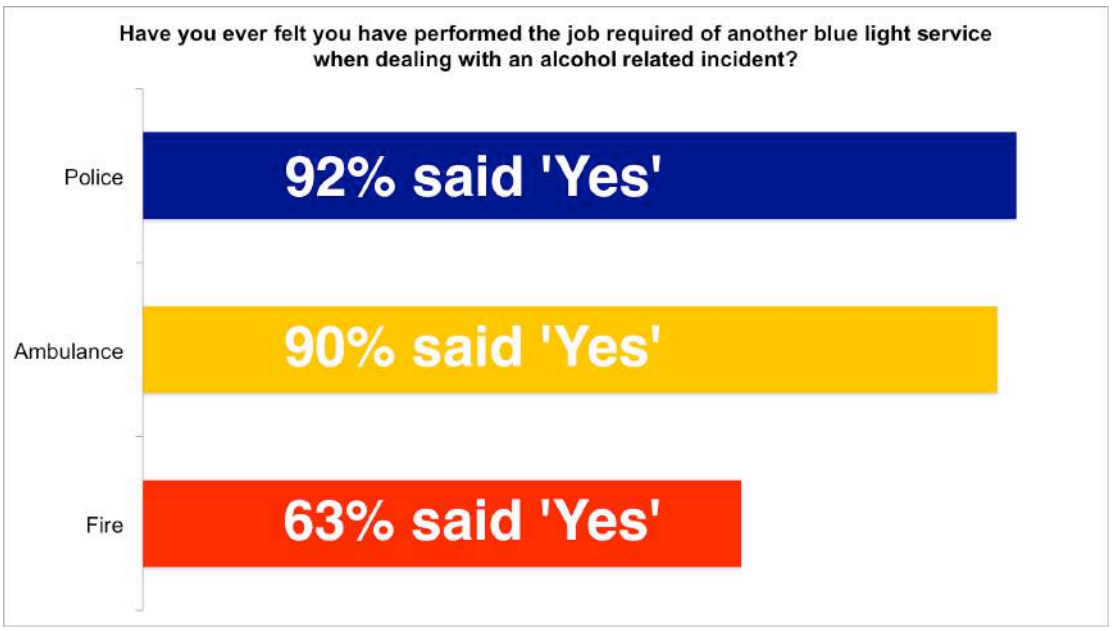
This has created a culture of fear in the emergency services, particularly for those out on the streets. 78% of police feel at risk of drunken assaults, compared to 65% of ambulance staff. But even Emergency Department Consultants within hospitals believe themselves to be in danger, with 35% concerned about the possibility of physical attack.

- *"I was assaulted by a patient who knows he convulses after alcohol. He tried to murder his mother."* (Paramedic)
- *"Solo responders should NOT be sent to drunken collapses. It is completely unsafe."* (Paramedic)

[7] Leontaridi, R. (2003) Alcohol misuse: how much does it cost?. London: United Kingdom Cabinet Office, p. 59
[8] NHS (2012), op. cit.
[9] House of Commons Health Committee, *Government's Alcohol Strategy* (HC 132, 2012-13), Written evidence from the Department of Health (GAS 01).



It was also clear from our study that many of the emergency services feel stretched by a combination of alcohol-related incidents and tightening budgets. As a result, it is increasingly common for different emergency services to have to plug the gaps and fill in for each other. Nearly all police (92%) and ambulance (90%) respondents recalled performing duties they felt belonged to another emergency service, as well as a majority of fire service respondents (63%).



Inevitably, this increased workload has consequences for the personal lives of servicepeople: 67% of police surveyed said that alcohol-related incidents negatively affect their work-life balance.

All services want more day-to-day support in dealing with alcohol

Another consistent theme in our results was the perception that frontline services need more help in dealing with alcohol, though the specific requirements and severity of the need varied by service. For the police, the major constraint seems to be manpower. A number of

respondents were concerned that there appears to be a vicious cycle emerging, whereby cuts to the number of officers puts those remaining at greater risk of assault, and so greater danger of missing service through injury:

- *"... as officer numbers reduce there seems to be a propensity by drunken and drugged people to assault officer's [sic] who are routinely single crewed now…**I fear as officer's [sic] get injured and are off work recuperating the thin blue line will break**."* (Police Sergeant, Response Team)

Training seems to be a greater issue for ambulance and fire staff. 53% of ambulance staff felt they were inadequately prepared for dealing with alcohol-related incidents, with 64% expressing the view that additional training would be helpful. For fire departments, 72% believed they lacked training, and 62% would like more.

ED Consultants were by far the most confident in dealing with drunken members of the public, with two-thirds claiming to have the necessary skills to do so. This may be a consequence of the relatively high investment in alcohol-specific services in hospitals: 55% of ED Consultants work in a department with an alcohol-specialist nurse.

Frontline staff are calling for policy action to curb alcohol harm

The emergency service staff we spoke to were full-throated in their call for policy action on alcohol harm. Overall, the impression was one of frustration and impatience with the status quo. However, though the desire for change was clear, respondents disagreed over how best to reform current practices.

The police were generally in favour of stronger control and regulation, particularly on licensing and alcohol prices. There was a clear sense that later opening hours have created a huge strain on police officers, with many calling for a return to earlier closing times for pubs, bars and nightclubs.

- "***The change in licensing hours changed policing forever**… **No longer are we able to patrol residential areas to catch burglars.**"* (Police Constable, Response Team)

Another measure that commanded impressive support from the police was levies on licensed premises to fund police activity – 89% were in favour. Moreover, they were insistent that this policy should not be focused solely on pubs and bars, but that supermarkets and off licenses should be targeted as well:

- *"I feel the off-sales should take more responsibility [sic] – it isnt [sic] just an issue for on-licensed premises to pay a late night levy. Off-sales contribute to pre-loading which in my experience (both operationally and academically) has a signifcant [sic] effect on the night time economy (and therefore policing)."* (Police staff member, Neighbourhood Policing Team)

Fire service respondents expressed similar views about the need to better control the night time economy by reducing availability and affordability.

Health service staff also emphasised the need for action, but were divided as to whether this should be focused on individuals or the population at large, and in particular on the question of user charges. 76% of ambulance staff believed that users should have to pay for callouts resulting from their own drunkenness. However, only half of ED Consultants favoured this move, and those opposed expressed strong objections, believing user charges to be against NHS values, and inadequate to tackle the root causes of harmful drinking.

- *"**I perceive the problem to be one of our relationship with alcohol on a wider scale, rather than attributable blame**. [User charges] would also*

represent ***a betrayal of the fundamental free-at-the-point-of-entry nature of the NHS****. I believe we need an enormous national public health campaign, and stronger minimum alcohol pricing."* (ED Junior Clinical Fellow)

There are evidence-based interventions that can ease this burden

These findings add up to a strong case for policy action. Alcohol takes up a disproportionate share of emergency service time, and costs taxpayers billions of pounds each year. It means that police, fire services, ambulance workers and ED Consultants cannot do their jobs without fearing attack, that many are stretched into roles they are not fully trained nor equipped to tackle, and that their personal lives must bear the brunt of longer working hours. Frontline staff are demanding policy change, though they are divided on what form of action is best.

Evidence suggests that there are a number of interventions that could improve the situation:

- Alcohol Treatment Centres (also known as 'Welfare Centres', 'Sobering Centres' and even 'Drunk Tanks') are special facilities designed to help people who are highly intoxicated by providing a safe place to sober up, whilst offering supervision and elements of clinical care, such as airway management and fluid infusion (a drip) to reverse dehydration. These have been shown to be a cost-effective way of relieving pressure on police and emergency departments.
- Delivering Identification and Brief Advice (IBA) (screening for risky drinking, and providing advice to encourage risky drinkers to reduce consumption) at 'teachable moments' could be a way of 'investing to save'. This measure has been shown in a range of settings to reduce harmful drinking, and so would, in turn, reduce future demand for emergency services.
- A lower drink drive limit of 50mg of alcohol per 100ml of blood would bring England and Wales in line with Scotland, Northern Ireland (which is currently passing legislation) and the rest of Europe, and could prevent hundreds of accidents each year.
- Improving information sharing between emergency departments, police services and local authorities has the potential to develop more targeted and effective strategies for tackling alcohol-related violence.
- A more assertive use of licensing powers by local authorities could reduce the burden on the emergency services by securing earlier closing times where necessary, addressing problematic areas with high concentrations of licensed venues, and ensuring that late night venues contribute to the cost of late night policing.
- Reducing the affordability of alcohol, for example through a minimum unit price, is widely agreed to be one of the most effective and targeted ways to tackle alcohol harm.

Alcohol's Impact on Emergency Services reveals the full extent of the toll of alcohol consumption on emergency services, and outlines the steps that can be taken to address this issue. This ought to serve as a wake up call to policymakers, the media and the general public. We cannot keep taking our emergency services for granted.

Introduction

This report investigates the relationship between alcohol and the emergency services. It is divided into two parts. Part one collates the latest evidence, including our original research, to shed light on the particular issues faced by the different services and to establish the scale of these problems. Part two draws on these findings to develop a set of policy recommendations that address the burden on the emergency services from alcohol.

In part one, we look at different branches of the emergency services in turn – police, ambulance, hospital emergency departments and fire and rescue – to collate and evaluate the evidence on how alcohol affects their staff and operations. For each service, we conduct a thorough review of existing evidence on the costs and burdens of alcohol, drawn from public statistics, NGO reports and academic research. This existing evidence base is then supplemented with four bespoke surveys of emergency service staff.

We collaborated with bodies representing each of the focus services to develop questionnaires for dissemination amongst their members. Each survey addressed similar themes, including how alcohol contributes to and shapes their workload, the personal consequences of dealing with intoxicated members of the public and views on different policy prescriptions. Each survey was, however, customised to focus on the issues we believed to be most relevant to the different services.

The police survey was designed with the support of the National Police Chiefs' Council (formerly the Association of Chief Police Officers), who distributed it to all police forces in England between June and August 2015. The Association of Ambulance Chief Executives and College of Paramedics supported us in developing the Ambulance survey, which was then disseminated to their members in July 2015. The Royal College of Emergency Medicine performed the same role for our survey of ED Consultants, circulated to their members in July 2015. We consulted Greater Manchester Fire and Rescue Service to design the fire service survey, which was then sent to the membership of the Chief Fire Officers' Association in July 2015.

The surveys were created online using Survey Monkey.[10] Participation was voluntary, with no incentive provided, and it was made clear that all data collected would remain anonymous. A copy of the survey questionnaires and full results can be found on the IAS website.[11]

We are aware of the limitations of this sort of self-selecting survey research, though it is a standard and accepted research methodology. For example, there is a possibility that our sample of respondents may be biased – perhaps those who are more concerned about alcohol-related problems are more likely to complete a survey on the issue. We acknowledge that our sample of respondents cannot be considered as wholly representative of the entire emergency services. Moreover, the questions typically ask about people's recollections or perceptions of alcohol-related harm – there is no guarantee that these accurately reflect the situation. Nevertheless, despite these limitations (to name just two), we believe this report contains some powerful findings. Even if in some cases, the methodology means that we cannot exactly quantify the magnitude of a trend or phenomenon, most of our results appear strong enough to provide a directional indication of the state of the emergency services. All the same, in the following pages, we have tried to present our results with the appropriate level of caution.

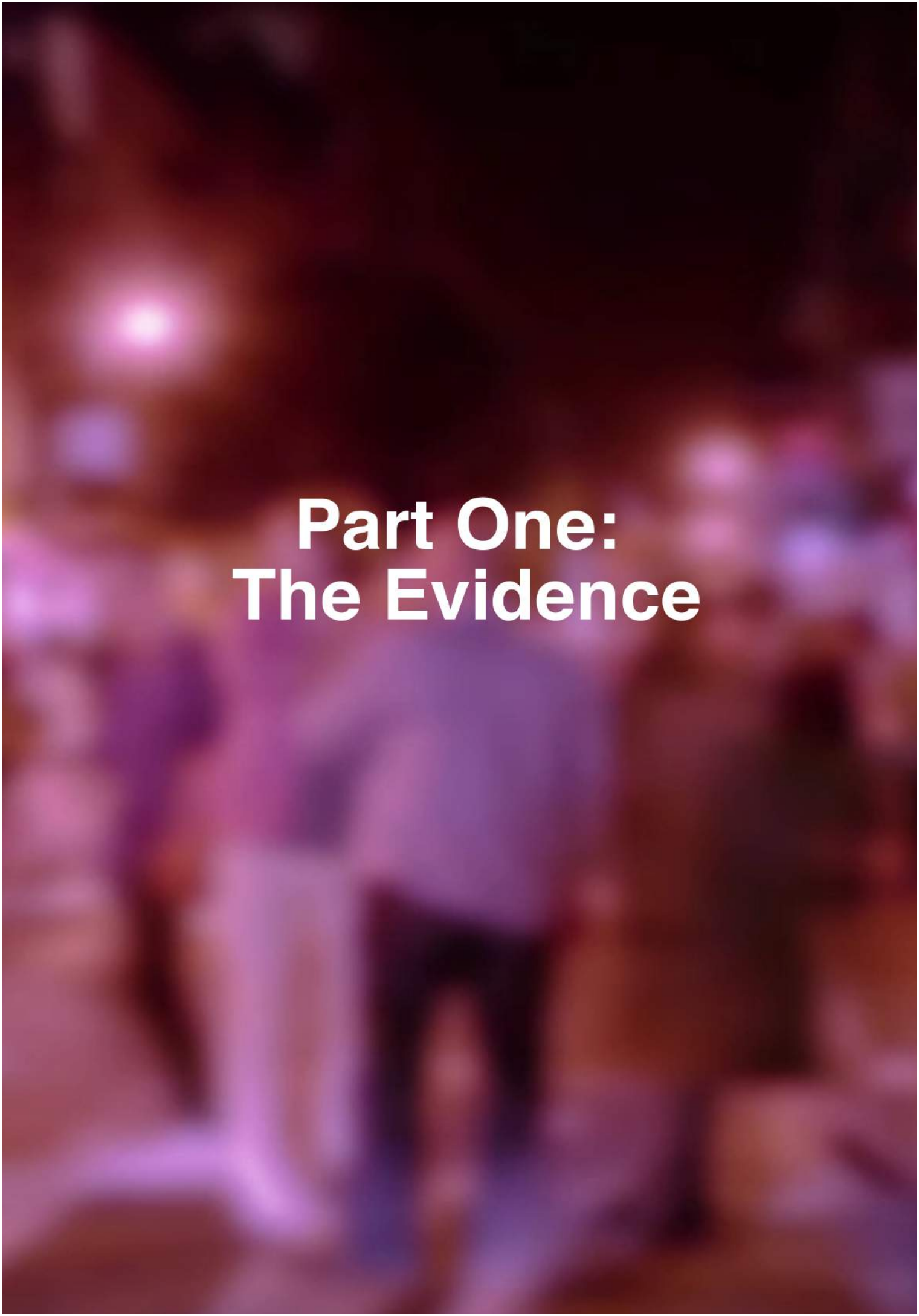
In part two, we draw on the latest research and practice to develop a set of evidence-based policy recommendations for action. We have identified five measures, eliciting broad-based support in the academic and public health community which we believe could address the issues outlined in part one. These are:

- Alcohol Treatment Centres

[10] https://www.surveymonkey.com
[11] http://www.ias.org.uk/What-we-do/IAS-reports.aspx

- Delivering Identification and Brief Advice (IBA)
- A lower drink drive limit of 50mg of alcohol per 100ml of blood
- Earlier closing times for licensed venues, and a greater contribution from these outlets to late night policing
- Reducing the affordability of alcohol

Over the course of part two, we discuss each of these measures in turn, synthesising the evidence on their effectiveness, particularly in emergency service contexts. We use this evidence to develop recommendations as to how these ought to be implemented and develop a plan for easing the burden of alcohol on the emergency services.



Part One:
The Evidence

Chapter 1: Alcohol and the Police Service

Key findings

I. Alcohol places a significant strain on the police force
- Over 50% of police workload is alcohol-related
- 90% of police believe violent crimes, such as assault and domestic violence, are significantly affected by alcohol

II. Alcohol makes policing a tougher and more dangerous job
- 76% of police have been injured by drunken perpetrators; 65% on multiple occasions
- 41% of police have been sexually harassed by drunken people

III. The police support stricter regulation of licensing and pricing to address these issues
- Nine in ten believe licensed establishments should be charged to fund additional late-night policing
- Many favour policies to reduce affordability, such as higher taxes or a minimum unit price

The Existing Evidence

The burden of alcohol-related crime

Police officers typically cite alcohol – and particularly cheap alcohol – as the biggest problem they face, implicated in crime in both the night time economy and domestic settings. The head of the Metropolitan Police has described it as a "multiplier in the volume of crime in the UK".[12]

The available data bears out the view that alcohol is a substantial contributor to criminal activity. Estimates from different parts of the country have found that between a third and a half of all arrests are alcohol-related, rising to over 80% on weekend evenings.[13] In 2013/14, just over half of all victims of violent crime believed their attacker to be under the influence of alcohol (around 704,000 incidents). This was the case in 64% of incidents of stranger violence and 36% of domestic violence incidents.[14] While overall crime levels have decreased, recent years have nevertheless seen a slight increase in recorded violent crime within pubs.[15]

It has been estimated that in a community of 100,000 people, each year 1,000 people will be a victim of alcohol-related violent crime.[16] Consequently, the 2010-15 Coalition Government

[12] Hogan-Howe, B. (2015), *2020 vision, public safety in a global city*, 13 March, Royal Society of Arts, London, p21.
[13] Stoddart, J. (2011) *Alcohol's impact on policing*. Balance – The North East Alcohol Office. [Available: http://www.balancenortheast.co.uk/library/documents/The_Impact_of_Alcohol_on_Policing_Slideshow.pdf]. [Accessed 15 October 2015].; Man, L.-H., Best, D., Marshall, J. et al (2002), *Dealing with alcohol-related detainees in the custody suite*. Home Office Research Findings 178.
[14] Office for National Statistics (2015), ONS Nature of Crime Tables, 2013-14 – Violence, Table 3.11.
[15] Gross, O., (2015) Exclusive: National rise in violent crime at pubs, *The Publican's Morning Advertiser*, 16 September 2015. [Available: http://www.morningadvertiser.co.uk/Legal/Health-safety/Exclusive-National-rise-in-violent-crime-at-pubs/?utm_source=newsletter_daily&utm_medium=email&utm_campaign=17-Sep-2015&c=mYarICZS%2BJ3NK%2FXMnfWCCceDMZnMfRgf&p2=]. [Accessed 12 October 2015].
[16] Home Office, (2012), The Government's Alcohol Strategy. London: Home Office, p6.

listed a reduction in alcohol-fuelled violent crime as a core priority in its Alcohol Strategy.

The Government estimates that alcohol-related crime and social disorder costs England £11bn per year, at 2010/11 prices.[17] The specific cost of binge drinking on police arrests has been estimated at £0.94 billion, with binge drinking increasing the average number of alcohol-related arrests by 45%, equivalent to 786 additional arrests per day nationally. In addition, the police have to increase the number of officers on duty by around 30% at weekends as a direct result of binge drinking, carrying an estimated cost of £31 million.[18]

Alcohol's role in criminal activity

There is a strong link between alcohol consumption and violent or aggressive behaviour, partly because of the way in which alcohol lowers inhibitions. However, intoxication on its own does not cause violence, and people who are drunk do not often become aggressive unless they feel threatened or provoked.[19] It is because of this that pedestrian density and the concentration of pubs and bars is strongly linked with violence and social disorder in an area, as a consistent body of research has demonstrated.[20] As the former Assistant Chief Constable of Greater Manchester Police observes, there is: *"A point at which the number of premises in an area precipitates violence no matter how well they are managed individually"*.[21]

Crowding and intoxication also have implications for individual licenced premises: 'vertical drinking establishments' which are often crowded, with poor bar access and little seating, are associated with increased amounts of alcohol-related violence.[22]

A further issue is 'pre-loading' – drinking at home before going out to drink. Those who pre-load tend to consume greater overall quantities of alcohol, and as a result pre-loading is associated with increased amounts of violence, including sexual assaults.[23] One study found that pre-loaders were 2.5 times more likely to have been in a fight.[24]

While price, specifically the difference between the on and off-trades, is widely considered to be a significant motivation for pre-loading, there are a number of other important factors.[25] These include sociability and the fact that many bars and venues are seen as too noisy and crowded,[26] very late opening times, which allow people more time to drink at home before heading out,[27] and cultures of 'determined drunkenness', where regular heavy drinking is now normative as opposed to subversive.[28]

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[17] House of Commons Health Committee, *Government's Alcohol Strategy* (HC 132, 2012-13), Written evidence from the Department of Health (GAS 01).
[18] James, J. & Francesconi, M. (2015), *The cost of binge drinking in the UK*. Bath: Institute for Policy Research, University of Bath.
[19] National Institute on Alcohol Abuse and Alcoholism (1997), Alcohol, Violence and Aggression, *Alcohol Alert No. 38*, Rockville, MD: National Institute on Alcohol Abuse and Alcoholism.
[20] Institute of Alcohol Studies (2013), Crime and social impacts of alcohol factsheet. London: Institute of Alcohol Studies. [Available: http://www.ias.org.uk/uploads/pdf/Crime and social impacts docs/Crime and social impacts factsheet May 2013.pdf]. [Accessed: 15 October 2015].
[21] Hadfield, P.M. (2005), *Bar Wars: Contesting the night in British cities*. Ph.D. thesis, Durham University, p67.
[22] Brennan, A., et al (2009), *Modelling the Potential Impact of Pricing and Promotion Policies for Alcohol in England: Results from the Sheffield Alcohol Policy Model Version 2008 (1-1), Independent review of the effect of Alcohol Pricing and Promotion: Part B*, Sheffield: ScHARR, University of Sheffield.
[23] Boyle, A., Wee, N., Harris et al (2010), *Preloading, where are the binge drinkers coming from?*. Cambridge University Hospitals NHS Foundation Trust.
[24] Hughes. K., Anderson. Z., Morleo. M. et al, (2008), Alcohol, nightlife and violence: the relative contributions of drinking before and during nights out to negative health and criminal justice outcomes, *Addiction* 103:1, pp60-5.
[25] Manton, E., Room, R., Giorgi, C. et al (2014), *Stemming the tide of alcohol: liquor licensing in the public interest*. Canberra: Foundation for Alcohol Research and Education, p216.
[26] Wells, S., Graham, K. & Purcell, J., (2009), Policy implication of the widespread practice of 'pre-drinking' or 'pre-gaming' before going to public drinking establishments – are current prevention strategies backfiring? *Addiction* 104:1, p5.
[27] Bancroft, A. (2012), Drinking with and Without Fun: Female Students' Accounts of Pre-Drinking and Club-Drinking'. *Sociological Research Online* 17:4.
[28] Wells, S., Graham, K. & Purcell, J., (2009), op. cit. p5.

The impact of alcohol goes far beyond the high street, and it is an important factor in domestic abuse, with cases involving severe violence twice as likely to involve alcohol.[29] Alcohol misuse is also estimated to be involved in between 25% and 33% of child abuse cases[30] and concern about parental drinking is the number one reason that children contact ChildLine.[31]

How alcohol affects the police

Policing the night time economy within built up city centres is often resource intensive and potentially dangerous for the police officers themselves. While in theory the police have strong powers to deal with people who are causing problems, these are not always very easy to use in practice. One officer we interviewed explained that:

> *"Making an arrest can tie up officers for a considerable amount of time, taking them off the streets. Of course, you have to arrest people sometimes and we do, but it can cause knock on problems. If the local police station is full, which happens fairly often, it might be a 20 or 30 mile trip to the next station with a free cell. So sometimes it's just not safe to do that and leave other officers out and about with less backup."*

For example, a medium to large city may have 14 police officers working in pairs on a Saturday night. Two officers transporting someone who is drunk to either a police cell or the ED therefore represents a 15% reduction in capacity.[32]

Dealing with people who are not violent but extremely drunk causes additional complications for police officers, similar to those faced by the other emergency services.

> *"In theory anyone appearing to be drunk and incapable should be treated as needing medical assistance, and either taken to hospital or have an ambulance called. Doing this prevents officers from dealing with other issues, and communication problems because of extreme drunkenness often slow things down considerably."*

Intoxicated people held in police cells can cause additional problems there too and often need to be checked every 15 minutes to ensure that they are safe.

While it is generally accepted that police work is risky, officers face considerable levels of alcohol-related violence. A 2013 survey of police officers in the North East of England found that 86% had ever been subjected to an alcohol-related assault whilst on duty, with 20% subjected to six or more alcohol-related assaults over their careers. The survey also found that new recruits are commonly warned to expect alcohol-related assault before the end of their first year in the force.[33]

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[29] McKinney, C., Caetano, R., Harris, T.R. et al (2008), Alcohol Availability and Intimate Partner Violence Among US Couples, *Alcoholism: Clinical and Experimental Research*. 33:1, pp169-176.
[30] Prime Minister's Strategy Unit (2004), *Alcohol Harm Reduction Strategy for England*, London: Cabinet Office.
[31] Belfast Telegraph (2014), Jump in child calls over parents, *Belfast Telegraph*, 16 May 2014. [Available: http://www.belfasttelegraph.co.uk/news/local-national/uk/jump-in-child-calls-over-parents-30279013.html]. [Accessed 12 October 2015].
[32] Moore S.C., Sivarajasingam, V. & Heikkinen, M. (2013), *An Evaluation of the Cardiff Alcohol Treatment Centre Pilot*, Cardiff: Cardiff University, p30.
[33] Balance – The North East Alcohol Office (2013), *The impact of alcohol on Policing in the North East*.

IAS Police Service Survey Results

The sample of respondents

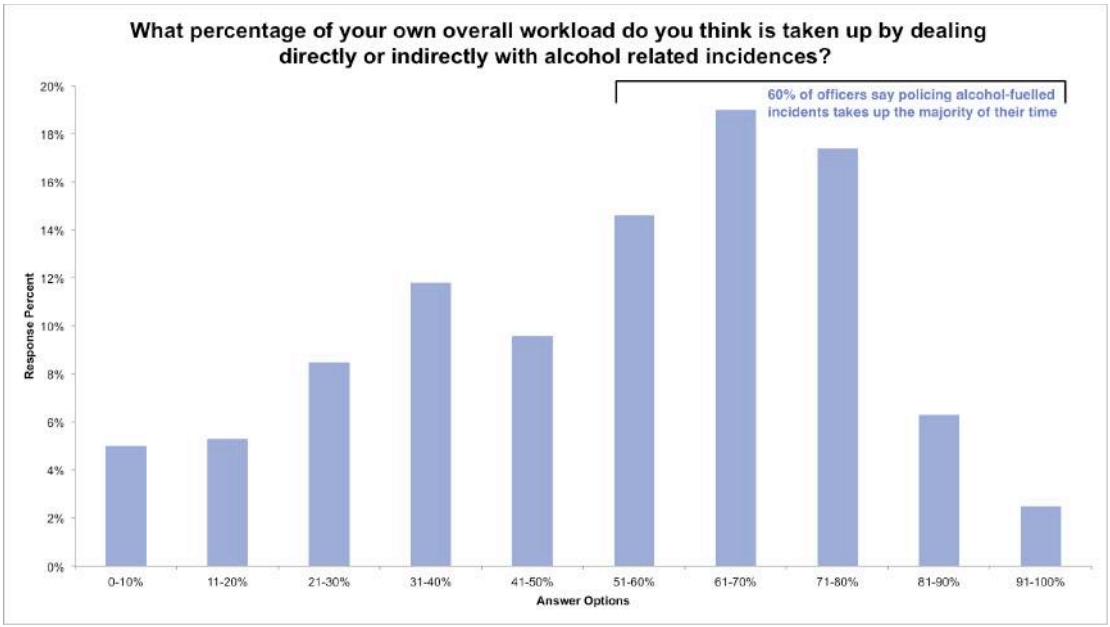
4,022 participants answered all of our mandatory survey questions. Of this sample, **73%** of respondents identified as male and **27%** as female. The vast majority of respondents (**96%**) were aged between 25-54 years, with **89%** having served at least five years in the police force. Just over three-fifths of respondents (**62%**) were of a police constable rank that worked in the response, neighbourhood, or the CID team.

Alongside the mandatory survey questions, we also offered respondents the opportunity to provide information and/or their own views in a free text box. A total of **1,382** responses were collected and analysed as part of this report and, where appropriate, relevant quotations are included below.

Findings

I. Alcohol places a significant strain on the police force

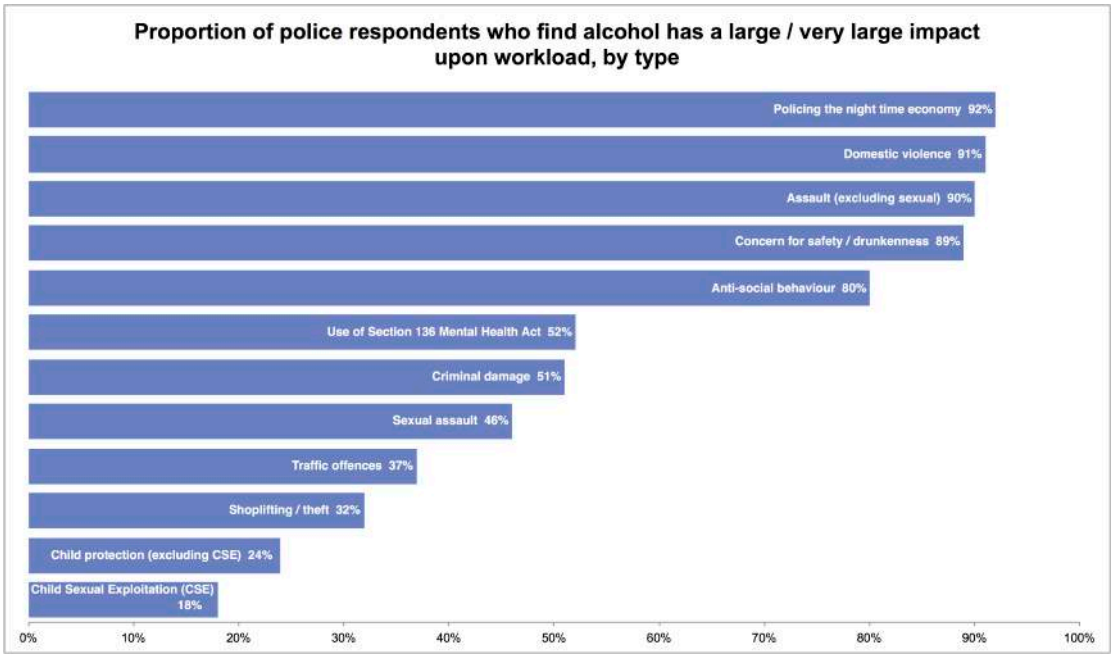
The survey corroborated the existing evidence of a substantial burden placed upon police time as a result of drinking. Our analysis indicates that on average **police respondents spend 53% of their time dealing with alcohol-related casework**.[34] Most respondents believe this to be a significant issue, with **60%** confirming that alcohol-fuelled incidents account for the majority of their time.



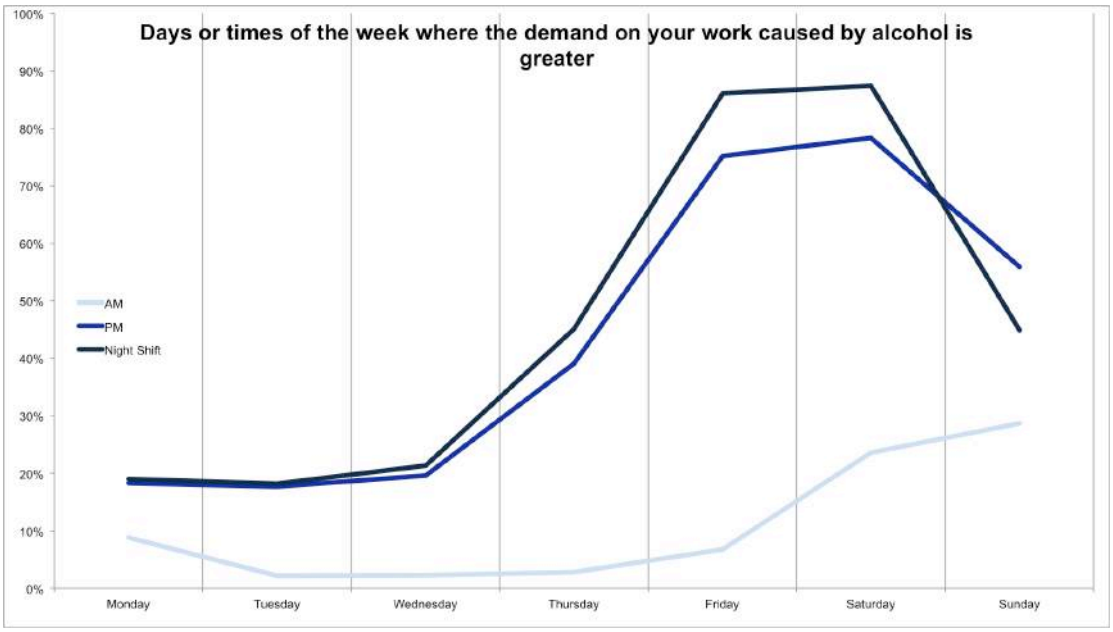
A number of areas of police work were identified as particularly affected by alcohol. Predictably, policing the night time economy and concern for safety and drunkenness were commonly cited. More notable is the fact that **90% of respondents believed domestic violence and assault to be significantly affected by alcohol**.[35] This demonstrates the clear connection, to the police at least, between drinking and violent crime.

[34] The question asked respondents to estimate the proportion of their workload relating to alcohol-related incidents, and asked to select from ranged intervals (e.g. 0-10%, 10-20%). The average was calculated by taking the sum of the mid-point of each interval multiplied by the respective percentages of each response (i.e. taking a weighted average).

[35] 'Significantly affected' is defined as having a rating of 4 (large impact) or 5 (very large impact).



Alcohol-related problems clearly peak around weekends, but are not limited to Fridays and Saturdays. **45%** of respondents cited Thursday and Sunday nights as times when alcohol places greater demand on the police service. Indeed, **more than half of respondents (53%) reported that local custody capacity was an issue during most or every shift in the night time economy**.



Furthermore, **92% police service respondents felt that they had performed the job required of another emergency service** when dealing with an alcohol-related incident. One respondent commented:

> *"We often spend hours waiting for ambulances to deal with drunk people and make sure they are safe. When we could spend this time dealing with crime."*

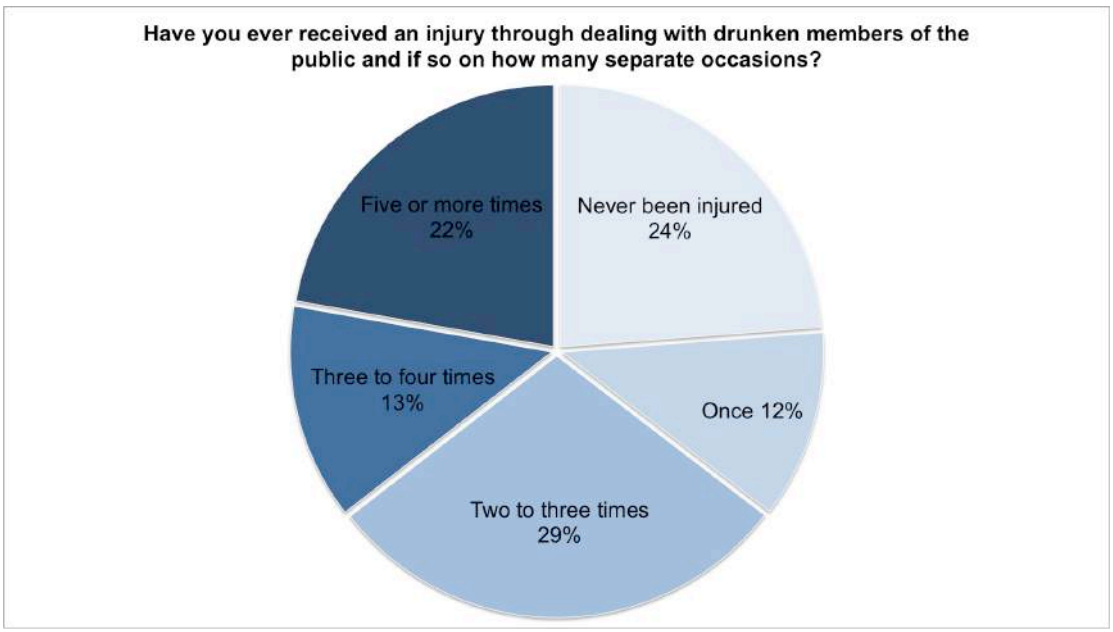
Numerous examples of police 'stepping up' to perform the role of paramedic/health care professionals were recounted, citing a lack of NHS resources as leaving intoxicated members of the public vulnerable to harm:

- *"Heavily intoxicated male in local town centre overnight had a fall while trying to impress group of friends, managed to dislocate both bones in right forearm at elbow, each in different direction. Nearest ambulance 45 minutes away. Role as police medic resulted in request for us to transport male to A+E in police PSU carrier."*

- *"When people are saying that they feel suicidal and are going to kill themselves, suffer with recorded mental ill health it is very hard to discern whether it is just the drink talking or they are likely to harm themselves. Officers are then having to sit with patients until they sober up before they can be assessed mentally, the risk being that if they are just left with ambulance or are left at the hospital that they will wander off and become potentially a high risk Misper [missing person] that then requires further amounts of resources. It is a huge drain on manpower. I don't think that I have had one set of shifts in for a long while where my colleagues and I have[n't] had to attend and then sit with drunken, mentally ill people. It doesn't seem to get any better."*

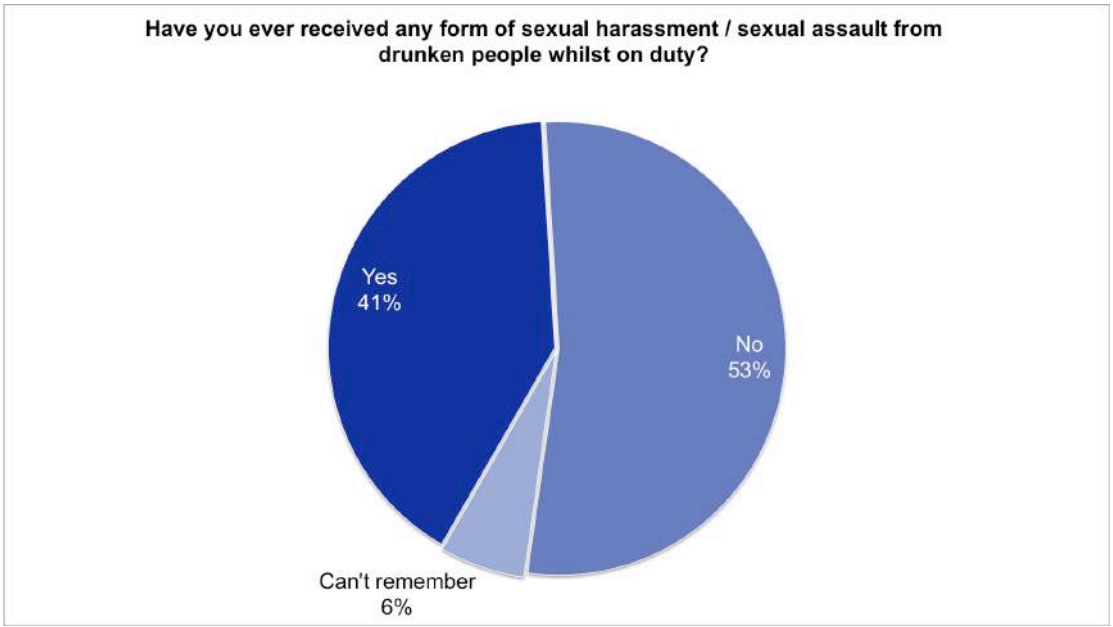
II. Alcohol makes policing a tougher and more dangerous job

When working in the night time economy, **78%** respondents stated they felt either 'at risk' or 'very at risk' of being physically assaulted by intoxicated members of the public. These feelings appear to be borne out by actual experiences – **more than three-quarters** (**76%**) **of police respondents had received an injury through dealing with drunken members of the public**, with **65% stating that they had been injured on multiple occasions**. This national figure is in line with high rates of assault previously reported in the North East.[36]



Just over a fifth (**22%**) reported that they had been injured five or more times. Furthermore, **41% police respondents reported being sexually harassed or assaulted by drunken people whilst on duty**.

[36] Balance – The North East Alcohol Office (2013), op. cit.



The survey indicated that the heightened risk of alcohol-related assaults and injuries experienced while on duty was often perceived to be linked to government policies, like budget cuts or the liberalisation of licensing hours:

- "*With **the reduction of policing budgets** there is now a large shortfall of officers policing the NTE. This **has the effect of putting officers at risk** and they are regularly becoming injured... last weekend 1 officer ended up in hospital having his head glued due to an injury he sustained and in the same incident another officer was bitten. This was due to over 100 youth who were drunk and very limited officer[s] to police this…"*

- *"Historically, with the old licensing hours police officer's [sic] were able to conduct proactive work to target offenders committing Burglary, Vehicle and Rural crimes after around 3am. However, responding to drunken fights is now a 24/7 issue, which, as more austerity cuts occur will have an even more dramatic effect on policing. I have noticed recently, **as officer numbers reduce there seems to be a propensity by drunken and drugged people to assault officer's [sic] who are routinely single crewed now**. In a four week period at one station 4 officer's [sic] were assaulted sustaining [a] dislocated finger, [a] broken ankle, [a] cut to the eye requiring stitches and bruising. **I fear as officer's [sic] get injured and are off work recuperating the thin blue line will break.**"*

- *"I am currently on restricted duties awaiting ill-health retirement following [an] injury sustained whilst arresting violent drunken offender during a NTE shift."*

The impact of policing alcohol-related crime and disorder was also found to affect the home life of more than two-thirds (**67%**) of respondents, who said it had an impact on their work-life balance. Almost a quarter (**23%**) of police respondents found themselves retained on duty for additional hours on most night time shifts and **65%** reported that changes to the night time economy in recent years had led to changes in their shift patterns.

III. The police support regulation of licensing and pricing to address these issues

- *"All night drinking and ubiquitous cheap available alcohol has changed the face of the UK for the worse."*

We asked police respondents for their views on the factors causing alcohol-related crime and disorder and the measures that could be taken to reduce alcohol-related offences. The top five contributing factors respondents listed as having either a 'large' or 'very large' impact on alcohol-related crime and disorder are detailed below:

i)	The current drinking culture	**90%**
ii)	The availability of alcohol	**74%**
iii)	Licensing hours	**68%**
iv)	Pre-loading	**65%**
v)	Irresponsible alcohol promotions	**58%**

The current drinking culture was widely seen as the underlying cause of alcohol-related crime and disorder in the night time economy, exacerbated by the increasing availability and affordability of alcohol in the off-trade. The open-ended responses also showed a general consensus amongst participants that the extension of licensing hours for licensed establishments under the *2003 Licensing Act* (e.g. 24-hour licensing) had contributed to increased levels of alcohol-related incidents in the early hours of the morning, crowding out other police work:

- "***The change in licensing hours changed policing forever**, with the majority of time being spent dealing with the fall out from the night time economy. **No longer are we able to patrol residential areas to catch burglars etc**."*

- *"The new licensing hours have created a huge problem for police and NHS services."*

Consequently, one of the most common solutions proposed was **reverting back to traditional licensing hours**, when pubs generally closed at 11am and clubs closed at 2-3am:

- *"... Review licensing hours. **We do not have the Eurpoean [sic] drinking culture that was so desired with the change in opening hours**. This is why I believe they should be reviewed and revoked back to the old system."*

- *"**A return to the old licensing hours would drastically improve drink related crime trends**, plus allowing consistency across all licensed premises which simplifies enforcement. At the moment every pub, club, and late night eatery has different serving times, making it a real challenge to complete well informed licensing checks and any on-the-spot action."*

- *"We need to go back to the old licensing hours, this would prevent the late night/early hours of the next day culture and as a consequence stop a lot of pre-loading. I work in Blackpool where clubs are open until 6am, **we haven't enough staff to deal [with them] and can be still locking drunk people (from the night before) up to 9am, sometimes even later**."*

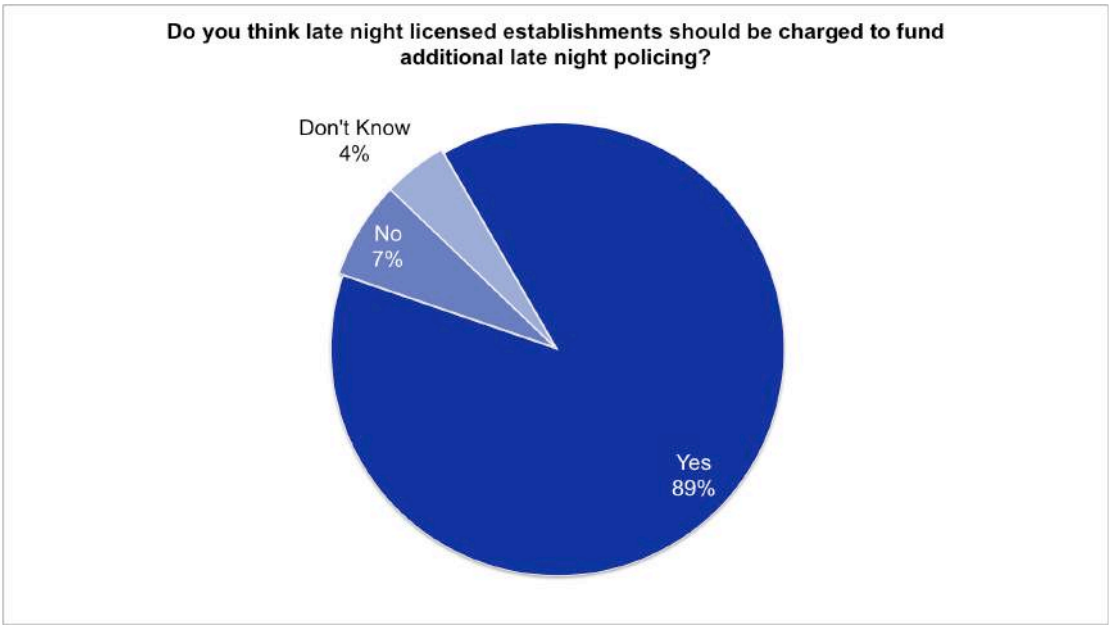
We asked police if they felt the disposal methods available to them for dealing with alcohol-related crime and disorder were effective in reducing reoffending. Charging alcohol-related offenders was seen as the most effective method, with just over half (**51%**) of respondents agreeing that they are effective. However, there was little enthusiasm for the other measures discussed. Cautions and Conditional Cautions were seen as the least effective tool, with just **15%** respondents agreeing they were effective (and **56%** of respondents claiming they were

ineffective). Moreover, **44%** respondents felt that fixed penalty notices do not work and **41%** respondents claimed that the use of Section 36 Dispersal Notices is ineffective.

Nine in ten respondents (**89%**) **believed that licensed establishments should be charged to fund additional late-night policing**, and many respondents expressed a strong desire for some form of 'polluter pays' scheme. Several references were made to the current system whereby football clubs contribute to policing costs, with calls to emulate this approach with late night pubs, bars and clubs:

- *"Pubs / Clubs to contribute to policing (like Football Clubs) Council to provide more assistance, enforcement of licencing [sic] violations. Councils get higher rates from Clubs / Pubs yet the police are left to do all the work."*

- *"If the licensing hours don't change then pubs and clubs should have to pay a levy which increases the later they stay open."*



It was also frequently suggested that supermarkets and off-licenses should take responsibility for their contribution to drunken behaviour in the night time economy, including a late night levy:

- *"Just regarding the late night establishments having to pay, this should be all licensed premises including supermarkets as a lot of people pre load with cheaper alcohol before going out so it shouldnt [sic] be just pubs and clubs who pay for the Policing."*

- *"I feel the off-sales should take more responsibility [sic] – it isnt [sic] just an issue for on-licensed premises to pay a late night levy. Off-sales contribute to pre-loading which in my experience (both operationally and academically) has a signifcant [sic] effect on the night time economy (and therefore policing)."*

Cheap alcohol sold in shops and supermarkets was referenced by many respondents who saw this as playing a major role in encouraging pre-loading and increasing the number of revellers entering into the night time economy intoxicated:

- *"Pre-loading has a major effect on alcohol-related issues especially surrounding the Night Time Economy. Even with the new pricing directives alcohol purcehased [sic] from supermarkets and off-licences is still considerably lower than on-licensed prices and encourages people to buy and drink more alcohol prior to going out to the NTE."*

- *"The main problem is large bottles of very strong alcohol on sale for extremely cheap prices e.g. 2litre bottle of cider for £1.99."*

Consequently, raising the price of the cheapest alcohol through taxation and minimum unit pricing were seen be many as necessary measures to reduce alcohol-related crime and disorder:

- *"Minimum pricing needs to be introduced along with a tax on off-sales – the tax then needs to go directly into operational policing of the night time economy."*

The provision of **welfare centres or 'drunk tanks'** in town and city centres was also suggested by many police respondents, who argued that **places of safety** were required for intoxicated members of the public who were vulnerable to risk:

- *"Drunk tanks on site in town centres to commit suspects to being taken off the street quickly rather than 2hr turnaround on route to custody, it would also mean we could deal with more proactive robust behaviour of drunks and the subsequent knock on issues presented."*

Chapter 2: Alcohol and the Ambulance Service

Key findings

I. Alcohol is a leading cause of ambulance call outs
- 37% of ambulance time is estimated to be spent on alcohol-related incidents

II. Most ambulance staff believe they are at risk of harm in the line of duty
- 96% have been threatened or verbally abused by drunken members of the public
- 50% have been injured in the field
- 54% feel unsafe in their own ambulances

III. Many feel ill-equipped to deal with intoxicated individuals
- 50% believe they lack the relevant training

IV. A significant proportion of ambulance service workers support tougher NHS policies on intoxication
- 76% favour charging users for callouts resulting from their own intoxication

The Existing Evidence

The burden of alcohol on ambulance services

Alcohol is a key contributor to ambulance callouts. Government figures estimate that in 2009/10 there were 1.4 million alcohol-related ambulance/paramedic journeys, which accounted for 35% of all emergency journeys.[37] The Scottish Ambulance Service has calculated it is called out to deal with an intoxicated patient once every 21 minutes.[38]

Common reasons for paramedics and ambulance staff to be called to alcohol-related incidents include assaults and injuries, drink drive accidents, domestic violence, people experiencing seizures or fits, unconsciousness, overdoses, self harm, as well as reports of people being 'generally unwell'.

Not all ambulance call outs result in a hospital attendance. Some patients with minor injuries are treated at the point of collection.[39] In order to quantify the impact that alcohol has on the ambulance service it is therefore necessary to consider the time and resources dedicated to attending to, transporting and referring on patients who present with alcohol-related problems.

[37] NHS (2012), The cost of alcohol harm to the NHS in England (2009/2010).
[38] Beatson, J. (2015), Drunk Scots call for ambulance every 21 minutes, *The Scotsman*, 10 April. [Available: http://www.scotsman.com/news/health/drunk-scots-call-for-ambulance-every-21-minutes-1-3742546#axzz3oLAAf7sQ] [Accessed 12 October 2015].
[39] Martin, N., Newbury-Birch, D., Duckett, J. et al (2012), A Retrospective Analysis of the Nature, Extent and Cost of Alcohol-Related Emergency Calls to the Ambulance Service in an English Region. *Alcohol and Alcoholism* 47:2, pp191-197.

While estimates vary, official government figures estimate that the average cost of an alcohol-related emergency ambulance/paramedic journey is £321.30. The total cost to the NHS in England in 2009/10 for alcohol-related emergency journeys was £449 million.[40]

Alcohol's impact on ambulance service staff

A study in the North East of England found that alcohol-related ambulance call outs were three times more likely to involve verbal or physical abuse of staff compared with general ambulance work.[41] Detailed figures are scarce, but information from the East Midlands shows that, locally, drugs and alcohol played a part in around 300 violent attacks on ambulance crews in 2013.[42] Some areas where violent incidents have occurred are routinely flagged and ambulance crews will only attend if accompanied by a police officer.

In addition to making the work of paramedics and ambulance crews more difficult and dangerous, attacks from intoxicated patients can take ambulance staff off the streets, as they need time to recover and speak to the police, slowing down the service and reducing its ability to respond to other incidents.

Paramedics and ambulance staff that attend alcohol-related emergencies are often required to deal with seriously – sometimes critically – ill patients. Drink driving accidents, overdoses and severe injuries due to assault are just some examples of when the rapid and professional response of an ambulance crew is of paramount importance in saving lives.

However, alcohol-related callouts can be time consuming and resource-intensive even if the medical situation is not especially severe. Speaking to the House of Commons Health Select Committee in 2010, Brian Hayes, a London Ambulance Paramedic, gave evidence on the impact treating intoxicated patients could have on an ambulance crew:

> *"The first thing most of them do as we leave the scene is vomit. That then renders the ambulance off the road for an hour once that call has been finished because it has to be deep cleaned because of infection and so on. Hopefully none of the vomit has gone over the ambulance crew because if that happened—shower, change your uniform. So you can be looking at that ambulance being unavailable to deal with anything else for two hours, two and a half hours because of alcohol. Then you will get the ones where the ambulance crews have been assaulted…We have had cases of paramedics being sliced with knives, punched, kicked, ambulances being nicked just as a prank through somebody being drunk and driving it into a row of cars".*[43]

IAS Ambulance Service Survey Results

The sample of respondents

A total of **398** members of the ambulance services in England completed all of the mandatory survey questions, and so were included in our analysis. The male to female ratio of respondents was **69:31**. Most (**84%**) were aged between 25-54 years, and nearly four-fifths (**79%**) had served in the ambulance service for more than five years. The majority (**71%**) were paramedics. Emergency medical technicians, emergency care support workers and managers comprised the majority of the remainder.

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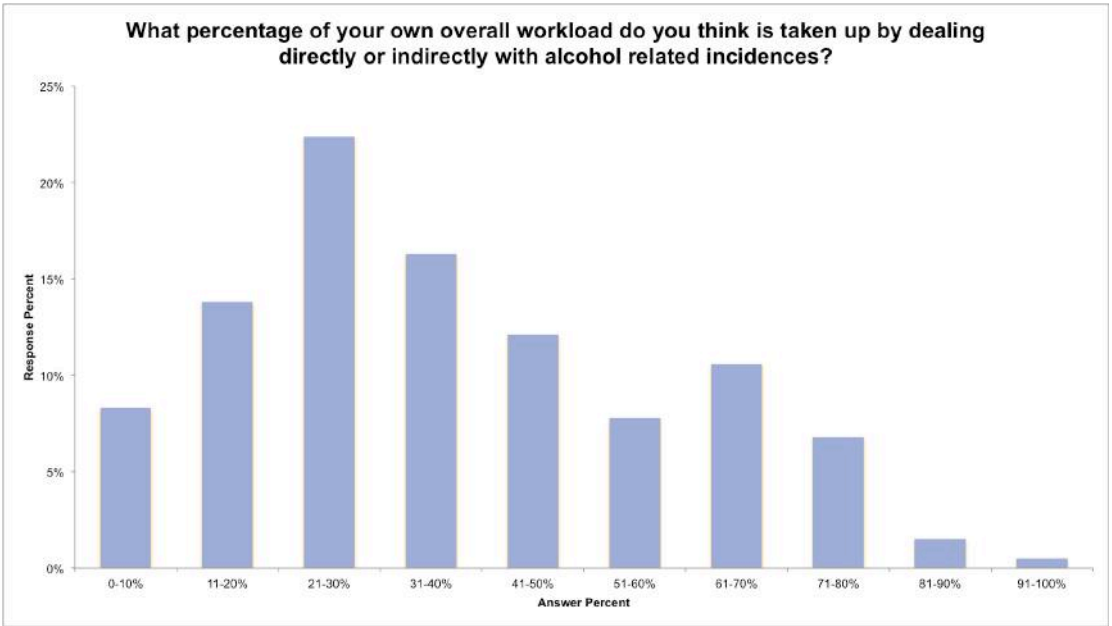
[40] NHS (2012), op. cit.
[41] Martin, N., Newbury-Birch, D., Duckett, J. et al (2012), op. cit.
[42] Jones C. (2013), Huge Surge in number of attacks on ambulance staff, *Derby Telegraph*, 7 September. [Available: http://www.derbytelegraph.co.uk/Huge-surge-number-attacks-ambulance-staff/story-19766907-detail/story.html]. [Accessed 12 October].
[43] House of Commons Health Committee, *Alcohol* (HC 2009-10, 151-I).

Alongside the mandatory survey questions, we also offered respondents the opportunity to provide additional information concerning alcohol-related issues in their working environment. A total of **140** responses were collected and analysed as part of this report and, where appropriate, relevant quotations are included below.

Findings

I. Alcohol is a leading cause of ambulance call outs

Respondents were near unanimous that alcohol places a strain on ambulance services – **89% believed that dealing with alcohol-related ambulance callouts placed an unnecessary burden on their time and resources**. Our survey results suggest that on average **37% of ambulance service time is taken up dealing with alcohol-related incidents**.[44] Moreover, **27% of ambulance service workers** said **more than half of their own overall workload comes, directly or indirectly, from alcohol.**



One London-based paramedic said:

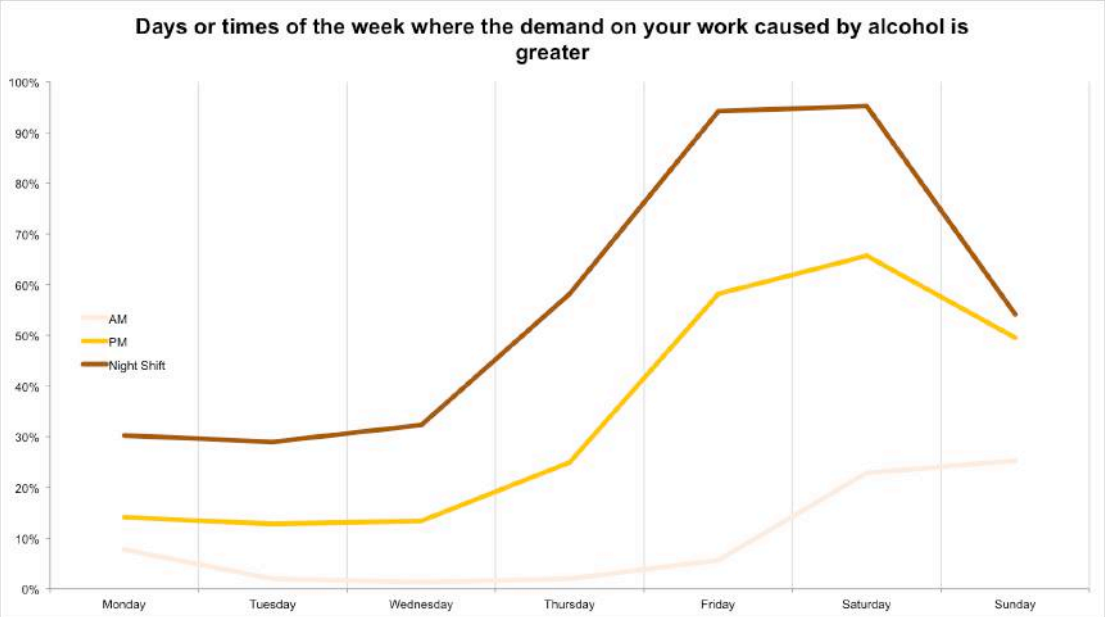
> *"Alcohol plays a far bigger part in our workload than what is reported. This is because it requires the clinician to use the code '62' on the paperwork. A classic drunk person who falls over and has a head injury will however be recorded by many clinicians as '03' (fall) and '75' (minor head injury) but they wont [sic] necessarily add '62' (alcohol-related) to the form. This is why the absurdly low figure of 6% of calls are alcohol-related, when in fact its more like 60% across the trust and 80% in the west end / central areas."*

Alcohol was seen as a key driver of certain types of illness and injury. **Almost every respondent agreed that alcohol has a large impact on assaults (95%)**. Alcohol was also perceived by a high proportion of respondents to be strongly connected to overdose/self-harm (**85%**) and domestic violence (**77%**).

Ambulance workers generally confirmed that there is a peak of alcohol-related activity around the weekend, with almost all respondents citing Friday (**94%**) and Saturday (**95%**) nights as problem times. One respondent went so far as to say that they no longer worked night shifts

[44] The question asked respondents to estimate the proportion of their workload relating to alcohol-related incidents, and asked to select from ranged intervals (e.g. 0-10%, 10-20%). The average was calculated by taking the sum of the mid-point of each interval multiplied by the respective percentages of each response (i.e. taking a weighted average).

"to primarily avoid the alcohol-related cases". However, it was clear from the responses that alcohol remains an issue throughout the week: **25% suggested that the demand on their work from alcohol is consistent throughout the week**.



Furthermore, **90% of ambulance service workers** felt that they had **performed the job required of another blue light service when dealing with an alcohol-related incident**.

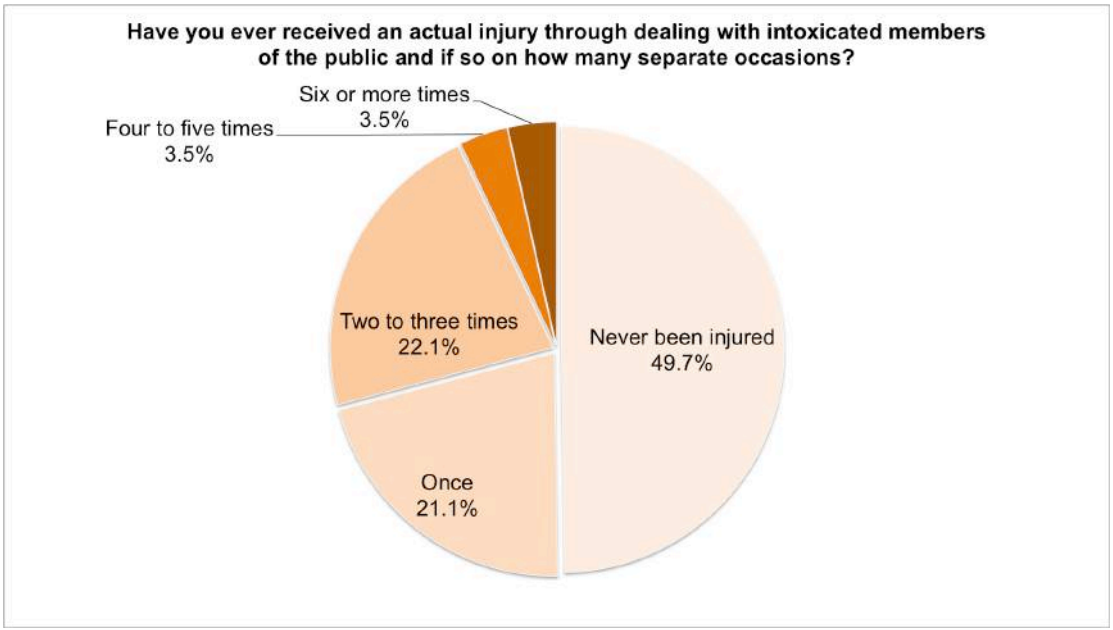
- *"Calls to police ref intoxicated persons in public places passed by police control to ambulance service as 'life status questionable' with police declining to attend."*

- *"Often when people are simply intoxicated the police will not arrest for drunk and incapable. Instead it falls to ambulance to take them somewhere (ED) to sleep it off."*

II. Most ambulance staff believe they are at risk of harm in the line of duty

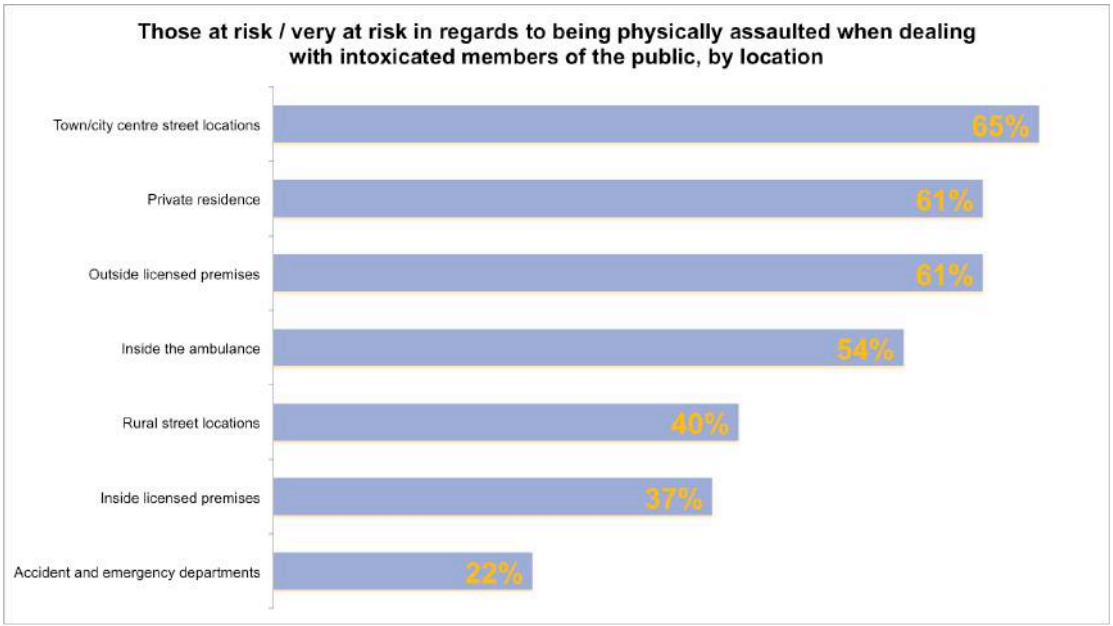
Our survey revealed that abuse of ambulance staff is ubiquitous. **96% of respondents have been threatened or verbally abused by someone who appears to be intoxicated whilst on duty**. Worse still, **half of respondents (50%) reported sustaining an actual injury at least once through dealing with intoxicated members of the public**, with **29%** suffering injuries on multiple occasions. Furthermore, just over half (**52%**) of ambulance service workers claimed to have been the victim of intoxicated sexual harassment or assault.

- *"I was assaulted by a patient who knows he convulses after alcohol. He tried to murder his mother, I stopped him, he didnt [sic] like it. The DPP wouldn't prosecute…"*



Ambulance service workers reported feeling at risk in a range of locations, with town and city centres, private residences and spaces outside licensed premises seen as particularly dangerous. Perhaps most shockingly, **a majority** (**54%**) **believed they faced significant risk of physical assault within their own ambulances**.

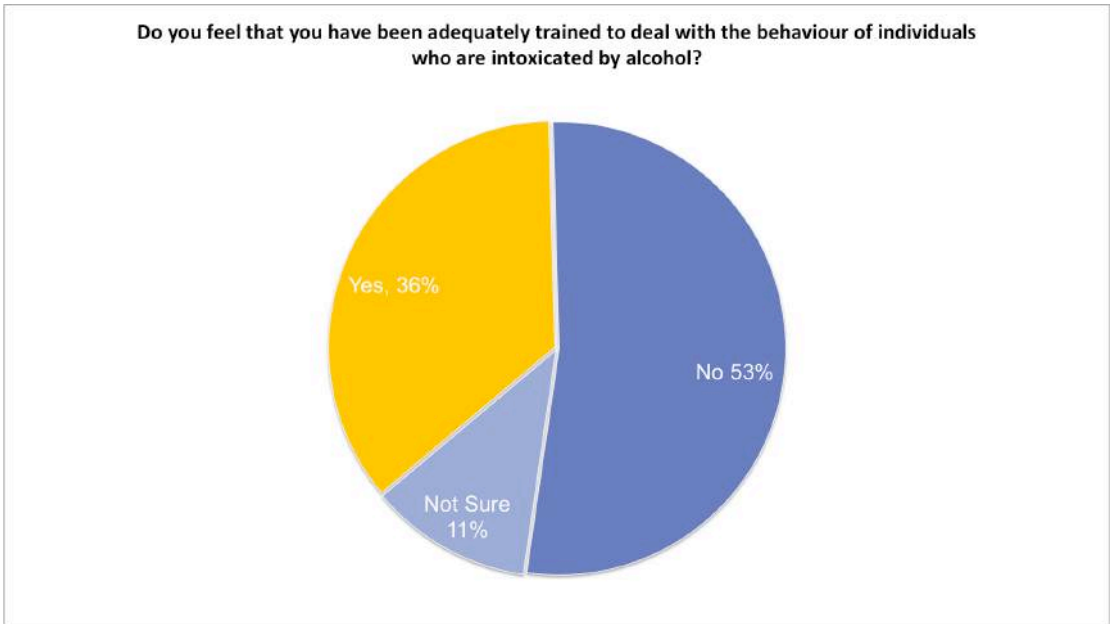
> *"It is infuriating when drunken collapses in the city centre at night time take priority and old folk are left lying on the floor at home with a broken hip for hours on end as they are a lower priority. Solo responders should NOT be sent to drunken collapses. It is completely unsafe."*



III. Many feel ill-equipped to deal with intoxicated individuals

We found significant anxiety amongst respondents regarding their ability to deal with intoxicated behaviour. **Over half of ambulance workers** (**53%**) **did not feel they had received adequate training** on how to respond in such situations. **64%** felt that additional training in alcohol awareness and advice would be useful in their day-to-day work.

Consequently, only half of respondents were confident that they possess the necessary skills to manage the potential conflict that can arise from public inebriation.



IV. A significant proportion of ambulance service workers support tougher NHS policies on intoxication

Most ambulance service workers believed that the NHS should be less tolerant of intoxicated patients. A majority (**56%**) expressed the view that paramedics and ambulance crews should not be responsible for dealing with the consequences of the excessive consumption of alcohol in patients that they are called out to treat. An even greater proportion of respondents (**76%**) **believe that those whose attendance was purely down to their own intoxication from alcohol should be charged personally for their visit to an ED**.

- *"Society needs to make excessive alcohol intake & consequent bad behaviour 'unacceptable'. If someone becomes incapable through drink they should be charged for the care it takes in getting then [sic] sober enough to 'self care'."*
- *"Introduce a consequence for alcohol excess, either finacial [sic] or through the courts. Automatic call out charge for alcohol-related ambulance events."*
- *"Charges made for intentional drunkeness [sic]. Fine pubs and clubs who are repeat offenders and expect the NHS to deal with the problem once money has been spent at their establishments. In repeat offenders remove their licences."*

Chapter 3: Alcohol and Emergency Departments

Key findings

I. Alcohol puts significant pressure on Emergency Departments
- Alcohol-related incidents account for 25% of ED caseload
- Around 90% of doctors believe alcohol has a large impact on assaults, domestic violence, overdose and self harm

II. Many consultants feel unsafe at work
- Over a third of consultants believe they are at high risk of assault
- 43% reported suffering an injury from drunken members of the public

III. Most Emergency Departments target resources specifically towards dealing with alcohol
- 55% of consultants work in a department with an alcohol nurse specialist

IV. Consultants are divided over whether the NHS should be tougher on excessive drinkers
- 54% believe patients whose admission is purely down to their own intoxication should be charged for their visit

The Existing Evidence

Burden of alcohol on Emergency Departments

Alcohol is a significant factor in a large number of Emergency Department (EDs) admissions. In 2009/10 the Government estimated that there were more than 7.1 million alcohol attributable A&E attendances, which cost the NHS £696 million.[45]

There is dispute over the exact proportion of ED admissions that are attributable to alcohol, with estimates ranging from 2% to 40%.[46] This has been found to rise to 70% at peak times.[47] Our own research suggests that the proportion of total consultant time dedicated to intoxicated patients is around 25% (see below). Government figures estimate that more than 600,000 patients were admitted to hospital in 2012/13 via Accident and Emergency departments for an alcohol-related condition.[48]

Common alcohol-related reasons for attending EDs include: road traffic accidents, assaults, fractured limbs, domestic violence, head injuries, unconsciousness, seizures, psychiatric problems, overdose and self-harm. Furthermore, EDs admit a significant number of patients to hospital that are suffering from the long-term health effects of sustained heavy drinking, such as chronic liver disease, pancreatitis, gastrointestinal bleeding, cardiac arrhythmia and cancer.

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[45] House of Commons Health Committee, *Government's Alcohol Strategy* (HC 2012-13, 132), Written evidence from the Department of Health (GAS 01).
[46] York Health Economics Consortium (2010), The Societal Cost of Alcohol in Scotland for 2007, p28.
[47] Drummond, D., Phillips, T., Coulton, S., et al. (2005) National prevalance survey of alcohol-related attendances at accident and emergency departments in England, *Alcoholism: Clinical and Experimental Research* 29:5, pp36A:36A.
[48] *Hansard* HC Deb. Vol. 584 col. 230W, 8 July 2014.

Effect of alcohol on Emergency Department staff

One of the many side effects of alcohol-related attendances at EDs is abuse, both verbal and physical, directed at staff. There were 17,900 recorded assaults on NHS staff working in acute settings in 2013/14,[49] though data is not available on the proportion of these assaults related to alcohol.

A 2010 report from the NHS Security Management Service found that **A&E nurses are more than twice as likely as other frontline NHS staff to experience verbal or physical abuse, and that tending to drunken patients was the main reason for this discrepancy**.[50] The same report found that A&E staff were more likely than any other NHS staff to report the presence of security officers in their workplace, demonstrating the additional resources allocated to Emergency Departments to cope with the impact of alcohol-related assaults and abuse.

When a patient is admitted to an ED the responding health care professionals need to manage the presenting acute health problem, plus any underlying physical and/or mental health problem. Intoxicated patients may present with symptoms that are similar to serious conditions. For example, unconsciousness, slurred speech or poor vision could be signs of brain damage, so many intoxicated patients that present with a head injury are given CT scans to check for bleeding on the brain.

ED staff work to ensure that other medical conditions are excluded from explaining the behaviour of a patient before establishing that their symptoms are due to intoxication. This process can be costly, as one ED Consultant we interviewed explained:

- *"When a patient presents who is intoxicated they can be very resource intensive and time consuming. A patient who is disruptive can take six hours to deal with. They or their relatives may be aggressive in the waiting room, or they may vomit over the floor or on other people… They may walk around the department or be unruly and rowdy in and around the cubicles. I have known of drunken patients that have smashed equipment and NHS property… Staff need to spend time managing the safety of these and all other patients in the department."*

- *"Diagnosing an intoxicated patient requires a number of tests to check their behaviour is related to alcohol and nothing else such as an infection, low blood sugars or low oxygen levels. Patients with a head injury often require a CT scan because symptoms of bleeding into the brain are similar to being drunk. Patients who vomit blood will often require an abdominal scan to look for liver disease… When we have established a patient's symptoms are due to alcohol we'll often give them fluids and, if they have a history of drinking, vitamin replacements to prevent the onset of brain damage or dementia… If patients are being very aggressive we might administer benzodiazepines."*

In June 2015 the Royal College of Emergency Medicine produced a toolkit for Emergency Department Staff, which aimed to promote best practice in the area of alcohol management and advise on approaches for caring for patients with alcohol-related conditions.[51] This recommended that every acute hospital should have a specialist, multi-disciplinary alcohol care team to help with alcohol-related patients and prevent readmissions. It suggested that ED Consultants are ideally placed to lead such teams.

The toolkit provides an example 'intoxicated patient pathway' and recommends Junior Doctors and Nurses are taught on the safe management of the intoxicated patient and the need for regular observations to be performed in a 'safe environment', such as the Clinical Decision Unit (CDU). It states that "patients should not be discharged to the waiting area of

[49] NHS Protect (2014), Tables showing the number of reported physical assaults on NHS staff in 2013/14.
[50] Ipsos MORI (2010), *Violence against frontline NHS staff.*
[51] Royal College of Emergency Medicine (2015), *Alcohol: A toolkit for improving care.*

the Department to 'sober up' as these are high risk patients". It recommends that patients can are clinically managed in the CDU, which is an ideal place for brief interventions and advice (IBA) to take place. This is discussed in further detail in chapter six.

IAS Emergency Department Consultants Survey Results

The sample of respondents

A total of **325** complete responses to our Emergency Department consultants' survey from across England were received and analysed. The ratio of male to female respondents was **57:43**. Most (**91%**) respondents were aged between 25-54. Two-thirds (**65%**) identified themselves as standard ED Consultants, with ED SPRs, ED Staff Grades and ED Associate Specialists accounting for most of the rest. Alongside the mandatory survey questions, we also offered respondents the opportunity to provide information and/or their own views in a free text box. A total of **123** responses were collected and, where appropriate, relevant quotations are included below.

Findings

I. Alcohol puts significant pressure on Emergency Departments

The survey found that, on average, **a quarter of consultants' workload is alcohol-related**.[52] As one respondent wrote:

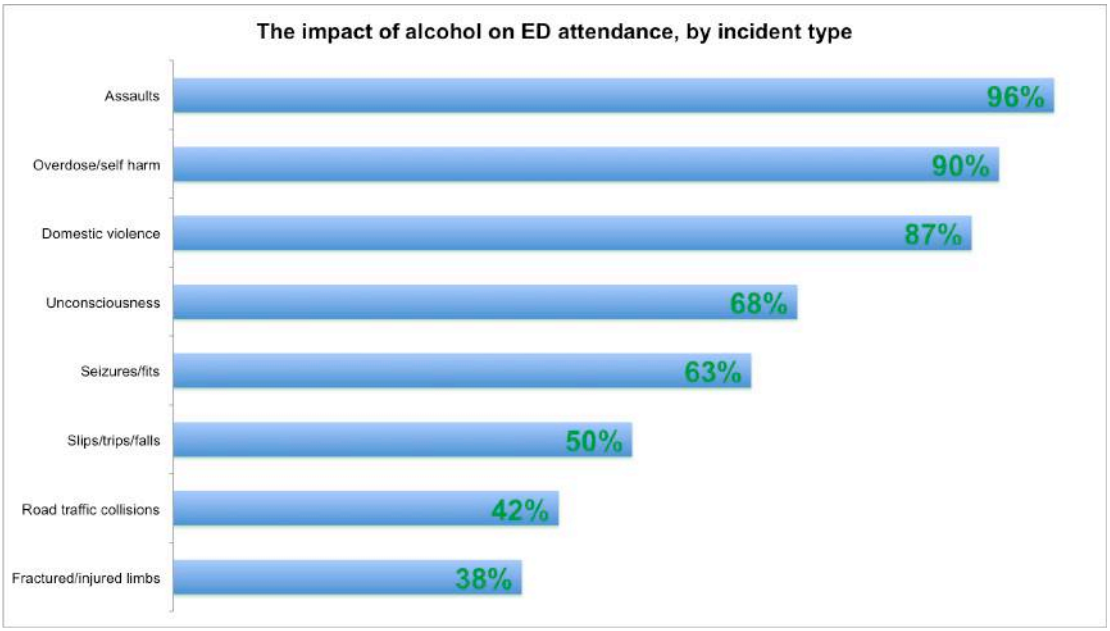
> *"The impact of alcohol related incidents on ED is HUGE! Although they only make up 10-15% of attendances, they take up VAST amounts of valuable time because they are either difficult to deal with or because they are requiring heavy nursing/doctor input such as airway support..."*

Alcohol is particularly closely associated with certain types of admission. A large majority of respondents said alcohol has a large or very large impact on violent incidents, in particular assaults (**96%**) and domestic violence (**87%**). In addition, **alcohol was also strongly connected with overdose and self-harm, with 90% of respondents linking them together**.

> *"Assaults equally due to people alcohol intoxicated and those in florid DTs [Delirium Tremens][53] as we try to treat... DT related assaults [include] human bite as treating a fracture dislocated ankle, kicks and blows, etc."*

[52] The question asked respondents to estimate the proportion of their workload relating to alcohol-related incidents, and asked to select from ranged intervals (e.g. 0-10%, 10-20%). The average was calculated by taking the sum of the mid-point of each interval multiplied by the respective percentages of each response (i.e. taking a weighted average).

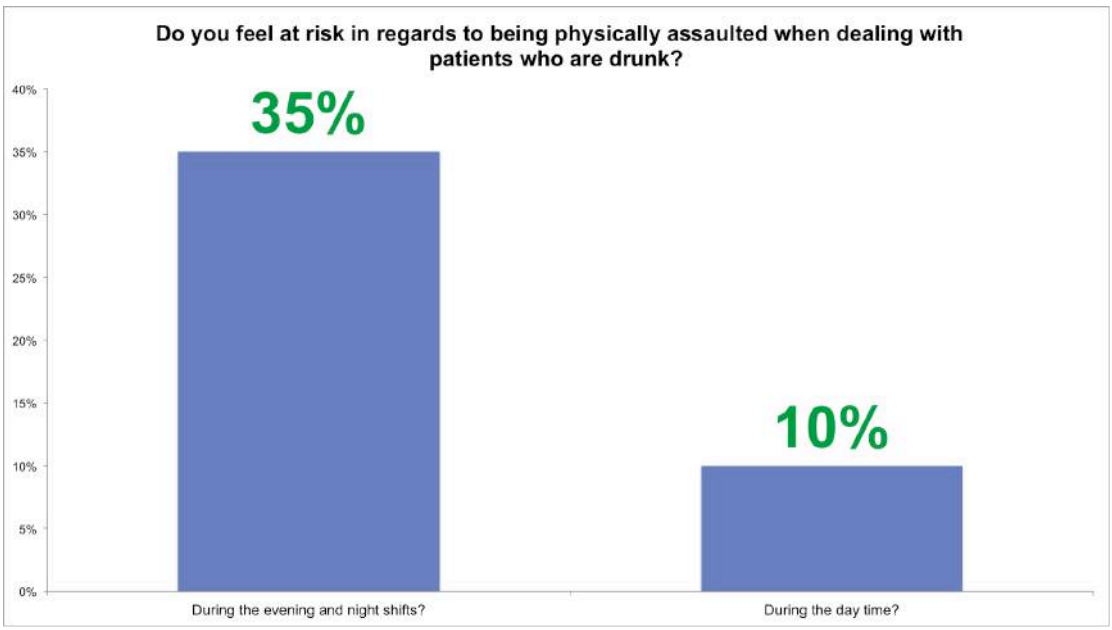
[53] Delirium Tremens is a state of confusion of rapid onset that is usually caused by withdrawal from alcohol.



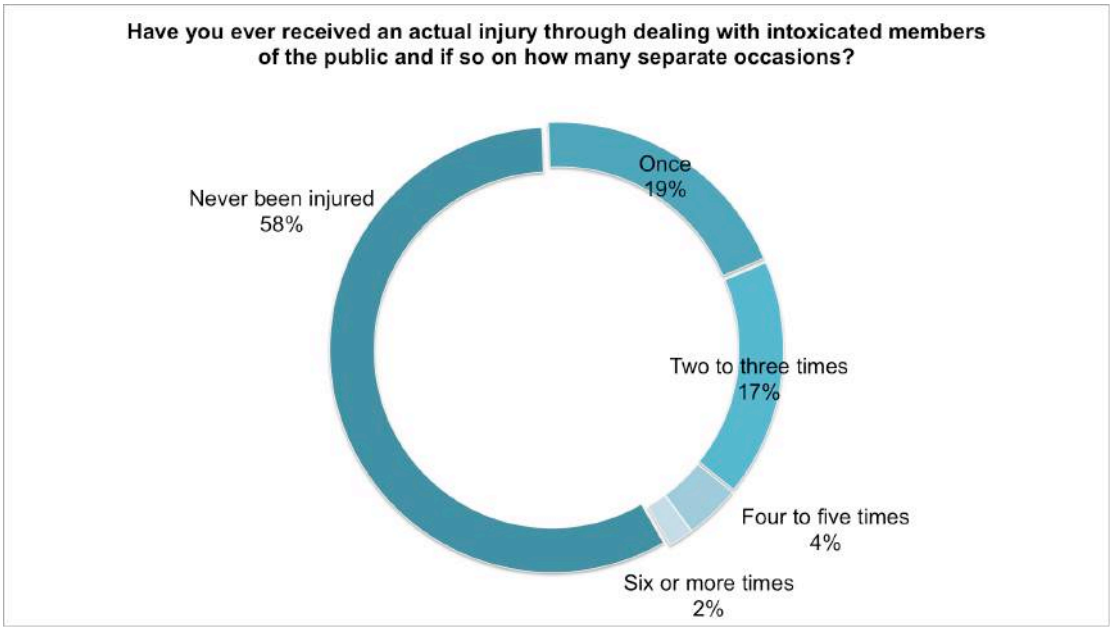
Consultants reported a significant spike in alcohol-related admissions around weekends, with **40% of weekend night admissions believed to involve alcohol**. Indeed, alcohol-related admissions were found to be as common during the day on weekends (**23%**) as on weekday nights (**25%**).

II. Many consultants feel unsafe at work

A third of respondents (35%) perceived a 'high risk' or 'very high risk' of being physically assaulted when dealing with patients who are drunk during evening and night shifts. One respondent wrote: *"there is a wrong perception that A&E is a place of safety who has to deal with all intoxicated patients, even when police seems to the better choice."*



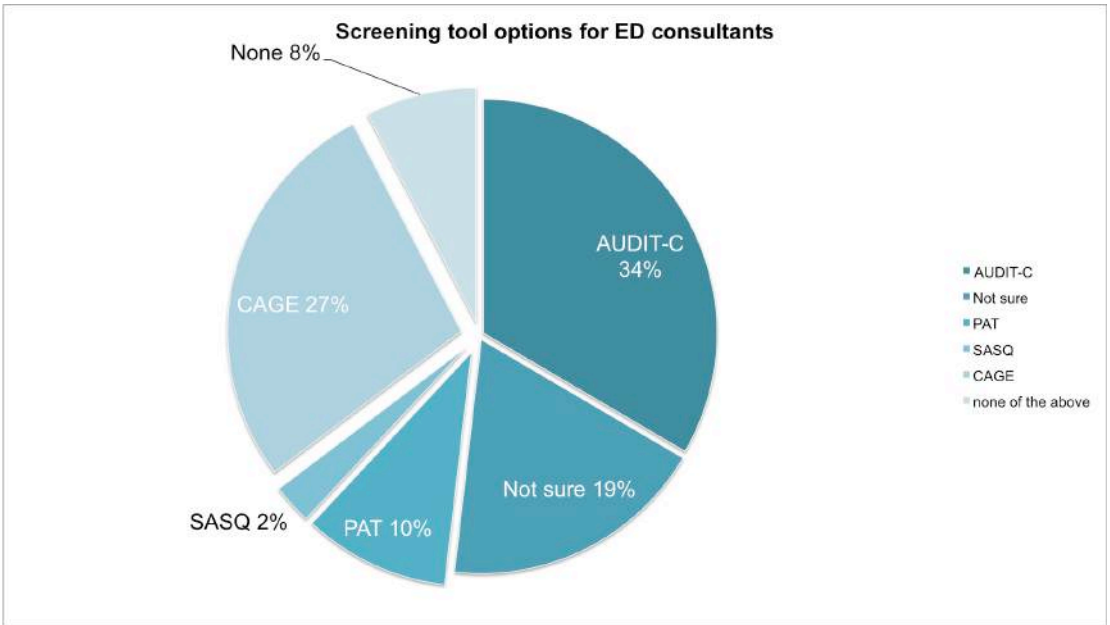
In many cases, this fear was clearly rooted in experience, with **43% suffering injuries from intoxicated members of the public**. Indeed, a quarter of respondents said they had been injured on multiple occasions. Furthermore, **35% ED Consultants reported being sexually harassed / assaulted** by drunken people whilst on duty.



Nevertheless, consultants were generally confident in their ability to handle drunken patients – two-thirds claimed to have the necessary skills to deal with verbal or physical abuse.

III. Most Emergency Departments target resources towards dealing with alcohol

Just over half of ED Consultants (**55%**) work in a department where there is an alcohol nurse specialist, in line with the Royal College of Emergency Medicine's recommendation. Moreover, **74%** of respondents reported using one of the common screening tools for hazardous drinking. Among these, AUDIT-C and CAGE were the most popular, with **34%** and **27%** claiming to use each, respectively.

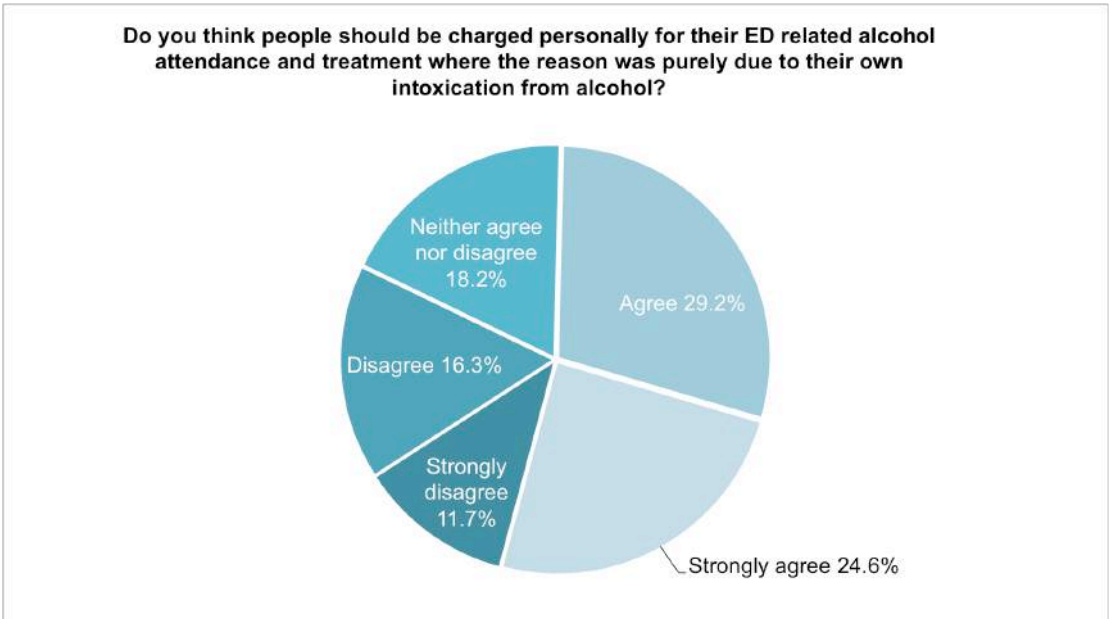


IV. Consultants are divided over whether the NHS should be tougher on excessive drinkers

As with ambulance staff, a large proportion of consultants surveyed favoured a tough approach to people who drink excessively. A third of ED Consultants (**35%**) did not believe

that paramedics and ambulance crews should be responsible for dealing with the consequences of the excessive consumption of alcohol in patients that they are called out to treat. **A majority (54%) believed that those whose attendance is purely down to their own intoxication from alcohol should be charged personally for their visit to an ED**.

- *"I think that people with alcohol intoxication or minor injuries due to alcohol misuse should be charged if they are brought in hospital (ambulance services & ED / hospital services) when they are discharged (to have the bill given to them)."*



However, these views were more controversial in the consultant community than among ambulance staff. **28% of respondents were against user charges, with many expressing strong disapproval of the measure**. Those opposed often believed that user charges are against the values of the NHS. A number rejected blaming individuals, arguing in favour of population-level measures, such as raising the price of the cheapest alcohol through taxation and minimum pricing:

- *"... the most problematic offenders have a genuine addiction and a lifestyle that deprives them of the wherewithal to pay a fine."*

- *"Alcohol intoxication can range from those patients with alcohol addiction which goes with severe comorbidities, high risk behaviour and high mortality, to irresponsible binge drinkers every weekend, to a dad who had one too many at his daughter's wedding. **you can't lump them all together**. Imposing charges would be the first step in a **slippery slope towards the end of the NHS** and would cost more to administer than it would raise."*

- *"Like most ED doctors I have seen a huge amount of alcohol-related admission[s], but **I perceive the problem to be one of our relationship with alcohol on a wider scale, rather than attributable blame**. I feel strongly that charging people for alcohol related admission would cause severe cases to be missed through non-presentation, and would also represent **a betrayal of the fundamental free-at-the-point-of-entry nature of the NHS**. I believe we need an enormous national public health campaign, and stronger minimum alcohol pricing."*

Chapter 4: Alcohol and the Fire Service

Key findings

I. Drinking alcohol greatly increases the risk of a fire, and is seen as more dangerous than smoking
- 88% of respondents said alcohol has a large or very large impact on the risk of fire, compared to 77% for smoking

II. Violent drunken abuse is less of an issue for fire and rescue staff than other emergency services, but sexual harassment is more common
- Although 34% of respondents reported sexual harassment or abuse…
- … rates of assault were much lower than in other services, with 10% suffering injuries

III. The fire service generally believe that alcohol's availability contributes to the risk of fire, alongside British drinking culture
- 51% believe that widespread availability is significantly related to the risk of fire

The Existing Evidence

Burden of alcohol on Fire & Rescue Services

Alcohol is typically found to be involved in 10-30% of all fires,[54] and these fires tend to be more serious, cause significantly more fatalities and cost more than other fires. Research by the Department for Communities and Local Government (DCLG) in 2011 found that where alcohol was a contributory factor, 49% of fire incidents resulted in casualties, compared to 14% for other fire incidents.[55]

Figures from London show that one in four people who die in a fire have alcohol in their system,[56] and as with the other emergency services it is binge drinking and acute intoxication is that is most problematic. Alcohol can also play a role in arson, as well as causing assaults and attacks on fire fighters, and fire authorities attend around 30,000 traffic accidents every year, where drink driving can be a factor.[57]

The DCLG research mentioned above reported that alcohol-related fires cost just under £131 million per year. On average an alcohol-related fire cost almost five times as much as other fires: £49,322 compared with £10,399.[58]

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[54] Department for Communities and Local Government Arson Control Forum (2006) Learning lessons from real fires: findings from fire investigation reports. Research Bulletin No.9 [Available: http://www.stoparsonuk.org/documents/resources/fatal.pdf]. [Accessed 15 October 2015].
[55] House of Commons Health Committee, *Government's Alcohol Strategy* (HC 132, 2012-13), Written evidence from the Department of Health (GAS 01).
[56] London Fire Brigade (2015), *Try a takeaway instead of cooking drunk during Rugby World Cup* [Press release]. [Available: http://www.london-fire.gov.uk/news/LatestNewsReleases_tryatakeawayduringrugbyworldcup.asp#.Vh0QfbS4mi5]. [Accessed 13 October 2015].
[57] Local Government Association (2015), *Lower the drink drive limit to cut road deaths*, say Fire and Rescue Authorities [Press release]. [Accessed 13 October 2015].
[58] House of Commons Health Committee, *Government's Alcohol Strategy* (HC 132, 2012-13), Written evidence from the Department of Health (GAS 01).

How alcohol contributes to fires

Alcohol-related fires tend to be more serious and more deadly because as well as being more likely to start a fire in the first place, people who are intoxicated have slower reaction times and so are less able to escape. The fact that around 63% of men and 48% of women who died in UK house fires have blood-alcohol levels above the legal drink-drive limit highlights this risk.[59]

In fact, falling asleep as a result of heavy drinking while smoking or cooking are key factors in alcohol-related fires. Figures from the London Fire Brigade show that three quarters of alcohol-related fires are caused by cooking while drunk, and over half of these fires happen because someone has fallen asleep. [60] By contrast, research from America found smoking to be a more prominent factor, involved in 42% of alcohol-related fire deaths, compared to 17% for heating equipment, and 13% for cooking equipment.[61] This difference may reflect cultural differences and the more common use of chip pans in the UK, which cause one fifth of all accidental home fires.[62]

> *"Even a small amount of alcohol affects people's awareness and alertness. Alcohol makes you fall asleep and you may sleep more deeply than normal. People might be smoking and fall asleep, and drop their cigarette while it's still lit. Or they come home from the pub or club and put the chip pan on. It's not unusual for people to put on a chip pan at 3am. Then they go to watch the television while it heats up and fall asleep on the sofa. They may wake up to find the pan on fire or sadly, they may not wake up at all".*[63] (Firefighter, Tayside Fire Brigade)

The link between alcohol, cooking and fire is so significant that the London Fire Brigade ran a campaign during the 2014 World Cup to encourage football fans to get a takeaway after watching matches instead of cooking under the influence of alcohol. An extra 2.2 billion pints were sold during the 2010 World Cup and the Brigade was concerned that there would be an increase in alcohol-related cooking fires. Statistics from the previous World Cup in 2010 showed that in London:

- There were 620 house fires during the month-long tournament – around 20 a day.
- Half of those were in the kitchen, with 40 per cent caused by cooking being left unattended.
- There were 65 fire related injuries, one for every game played. [64]

Alcohol is also known to play a role in arson, and figures from the Scottish Government estimate that alcohol is involved in around 1,200 cases of arson per year, which is about 2.6% of the total number of fires attended.[65]

Alcohol's impact on the Fire Brigade

Each year firefighters are subjected to assaults from members of the public in the line of duty. Attacks on firefighters are grouped into three categories:

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[59] Scottish Executive, *Fire Safety Scotland*. [Available: http://www.gov.scot/resource/doc/158926/0043178.pdf]. [Accessed 13 October 2015]
[60] London Fire Brigade (2014), *World Cup cooking is a fire hazard, warns brigade* [Press release]. [Available: http://www.london-fire.gov.uk/news/AC1B4F18D05A4D82B52979C6465BBFE5_WorldCupcooking.asp#.Vh0TKLS4mi4] [Accessed 13 October 2015].
[61] Evarts, B. (2011), *Possible Impairment by Alcohol or Drugs as a Contributing Factor in Home Fire Deaths*. National Fire Protection Association.
[62] UK Fire Service Resources, *Chip Pan Safety Advice*. [Online] [Available: http://www.fireservice.co.uk/safety/chip-pans]. [Accessed 13 October 2015].
[63] Scottish Executive, *Fire Safety Scotland*. [Available: http://www.gov.scot/resource/doc/158926/0043178.pdf]. [Accessed 13 October 2015]
[64] London Fire Brigade (2014), op. cit.
[65] The Scottish Government (2008), *Cost of Alcohol Use and Misuse in Scotland*.

- **Physical attacks from a distance** – including throwing stones or bricks
- **Close-up physical assault** – face to face attacks on personnel
- **Verbal abuse** – which covers not only front line staff but hoax calls to control room staff

National figures relating to the number of attacks on fire brigade staff are considered by the fire brigade union to be unreliable because of under-reporting and significant gaps in coverage.[66] As a result of this is it difficult to clearly identify the prevalence of alcohol-induced assaults. However, anecdotally, alcohol plays an important role in all three types of abuse fire brigade staff are subjected to.

Figures from Greater Manchester show that in 2010/11 there were 69 recorded attacks on firefighters, with alcohol playing a role in almost half of these. Incidents included groups of drunken youths throwing eggs and stones, aiming fireworks at firefighters, dropping objects from high-rise buildings, racial abuse and physically stopping firefighters from accessing fires and casualties.[67]

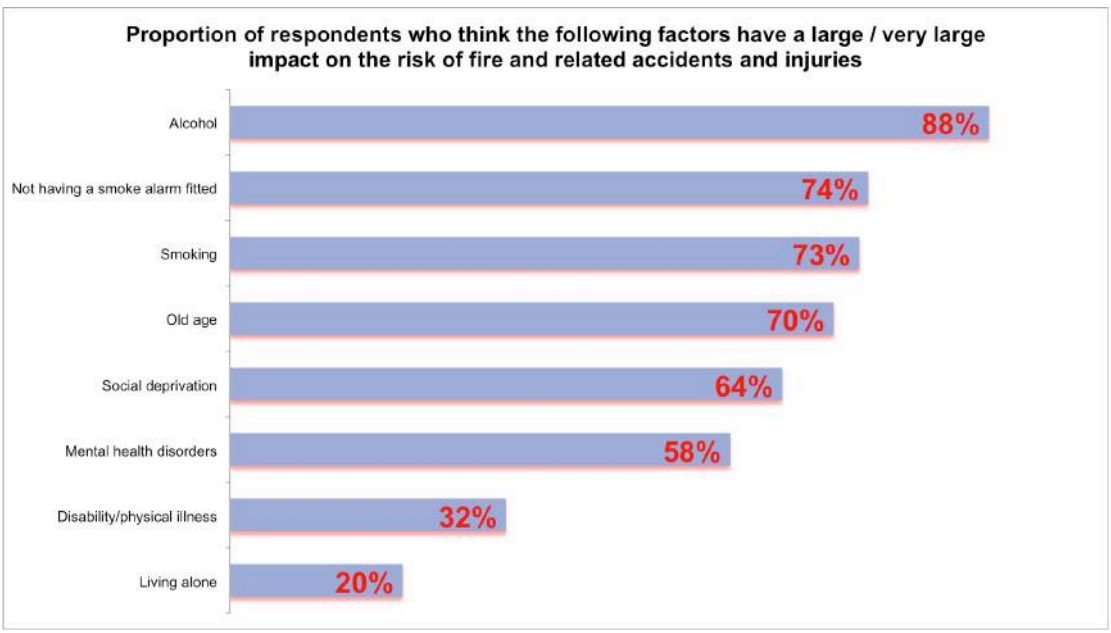
IAS Fire & Rescue Service Survey Results

The sample of respondents

169 respondents from fire and rescue departments in England completed our survey, and so were included in our analysis. **89%** of respondents identified as male, and **51%** were over the age of 45. Respondents had a range of roles, with firefighters (**30%**), watch managers (**30%**) and crew managers (**17%**) the most common. **46** people accepted the opportunity to add their own views in their own words via a free text box. Quotations from these qualitative responses are included alongside the analysis below.

Findings

I. Drinking alcohol greatly increases the risk of a fire, and is seen as more dangerous than smoking



[66] The Fire Brigades Union (2008), *Easy Target: Tacking attacks on fire crews in the UK*.
[67] The Guardian (2011), Attacks on Manchester firefighters detailed in data release, *The Guardian*, 25 March. [Available: http://www.theguardian.com/news/datablog/2011/mar/25/firefighters-attacks-manchester-data] [Accessed 13 October].

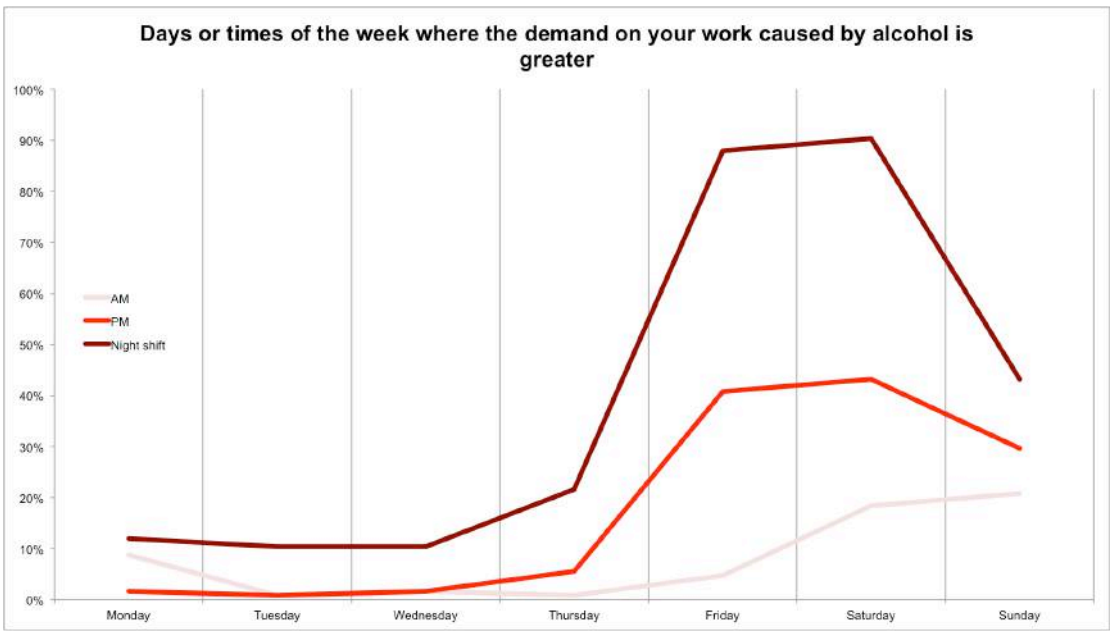
Alcohol was rated as the most significant risk factor for fire and related accidents, even above smoking, by our respondents. **88% believed that alcohol has a large or very large impact on the risk of fire**, compared with **73%** for smoking.

Drinking and smoking together was seen as especially risky, with **75% claiming that alcohol makes smoking-related fire significantly more likely**. A similar proportion identified road traffic accidents as a danger for drinkers (**78%**). However, drinking was most closely associated with cooking-related fires: **85% of respondents believed that alcohol has a substantial effect on the probability of kitchen fires**. One respondent working for West Yorkshire Fire Service said:

> *"A few Years ago we had a 'Don't Drink & Fry' Campaign in West Yorkshire due to the amount of Chip pan related Fire deaths & injuries caused by drinking then coming home putting on chip pans for food and falling asleep waiting for them to heat up."*

Our results suggest that, on average, **22% of fire service time involves dealing with incidents caused directly or indirectly by alcohol**.[68] This is consistent with our finding that **44%** of those surveyed estimated that they spent more than **20%** of their time on alcohol-related issues. Consequently, **47%** agreed with the proposition that alcohol places an unnecessary burden on their time and resources.

This extra burden on the fire service was clearly concentrated around the weekend, with Friday (**88%**) and Saturday nights (**90%**) by far the most commonly cited busy periods. Sunday night was the next busiest period, with **43%** identifying it as a time of high demand for fire services.



II. Violent drunken abuse is less of an issue for fire and rescue staff than other emergency services, but sexual harassment is more common

Over a third (**34%**) of respondents reported drunken sexual harassment or abuse whilst on duty, in line with other services. However, rates of violence were much lower than in other services, with **27%** of respondents having been the victim of an assault, and **10%** suffering injuries in the line of duty.

[68] The question asked respondents to estimate the proportion of their workload relating to alcohol-related incidents, and asked to select from ranged intervals (e.g. 0-10%, 10-20%). The average was calculated by taking the sum of the mid-point of each interval multiplied by the respective percentages of each response (i.e. taking a weighted average).

The fire service also suffered less in terms of their personal lives than other blue light respondents: **9%** were of the view that alcohol-related incidents affect their work life balance. Nevertheless, there is evidence to suggest that the difficulties of other services are spilling over and affecting fire as well: **63% had been required to perform the job of another blue light service because of an alcohol-related incident**.

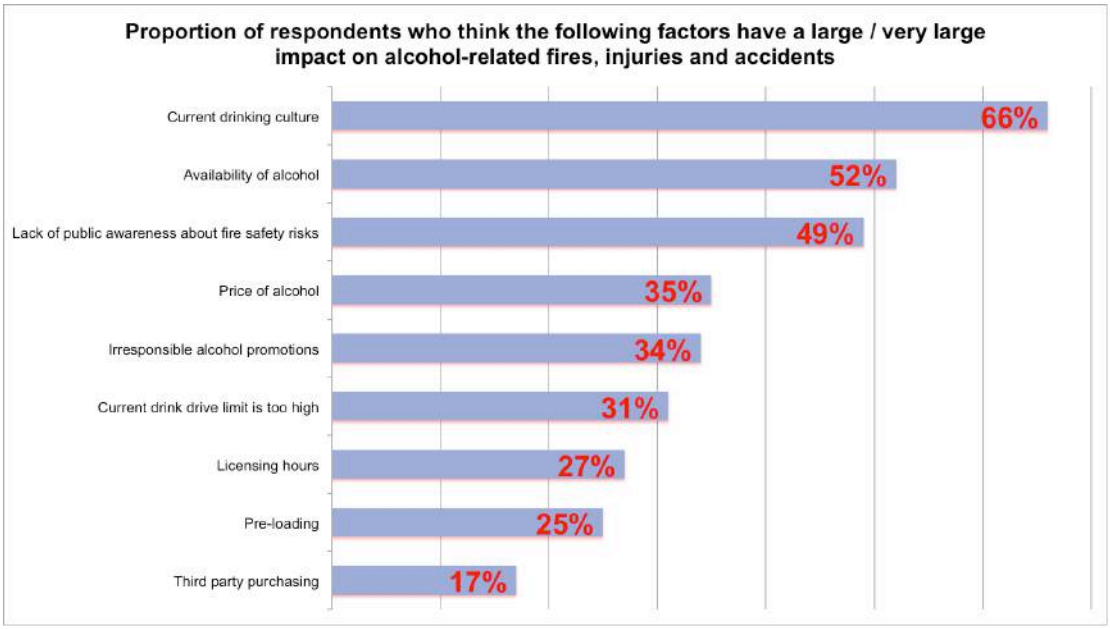
Despite the relatively low rates of harm, the majority (**72%**) of respondents felt they were inadequately trained to deal with the behaviour of those under the influence of alcohol, and **62%** believed that additional training in alcohol awareness and advice would be useful in dealing with their workload. Moreover, **46%** were in favour of being able to refer members of the public to alcohol services.

III. The fire service generally believe that alcohol's availability contributes to the risk of fire, alongside British drinking culture

Most respondents (**66%**) cited the current drinking culture was the biggest contributing factor to the risk of alcohol-related fires, injuries and accidents. The availability of alcohol was seen as the second most significant factor, with **52%** of respondents believing that it had either a large or a very large impact. There was also concern about public awareness of fire safety, with **49%** seeing this as making a substantial contribution to alcohol-related fires.

- *"… Culture amongst young people needs to change [as] regards alchol [sic] but this is endorsed on TV and Radio, the "lets get on it/get smashed" culture is advertised to young people everyday via TV/radio and there needs to be a government led open look and imposed restriction on this, celebs need to take responsibility and overall parents attitude with their young adults…"*

- *"**Prevent supermarkets/shops from selling cheap alcohol** without having any responsibility on what happens after people leave the premises. controlled areas like pubs are a more suitable place for alcohol."*



Part Two: Policy Recommendations

Chapter 5: Alcohol Treatment Centres

Alcohol treatment centres (ATCs), sometimes known as 'alcohol welfare centres', 'sobering centres' or even 'drunk tanks', are special facilities designed to help people who are highly intoxicated, in the process relieving pressure on local emergency departments and the police. There are a number of different models in use, aimed at different types of drinker; some areas run mobile units, while others use fixed facilities. At present there are few such centres in the UK, including schemes in Cardiff, Bristol, London and Norwich. Various types of ATC are also used in Australia, Poland and some US states.

As detailed in previous chapters, people who are acutely intoxicated put significant pressure on all of the emergency services. ATCs have been shown to relieve this, freeing up A&Es/EDs, improving ambulance turnaround times and helping to keep police officers on the street. They also provide an opportunity to deliver IBA once people have sobered up, potentially referring those who need help to specialist drinking services.

However, it should be remembered that while ATCs may be successful in reducing alcohol-related demand on the emergency services, they only deal with the symptoms of excessive drinking, and not the key drivers beneath this. As such there is a real need for wider policies which impact upon the related environmental factors, discouraging excessive drunkenness in the first place.

As a report into a 'sobering up centre' in Australia concluded, ATCs can be effective in dealing with short-term problems, ***"but in terms of dealing with the long-term problems of public drunkenness, you mop the floor endlessly but never turn off the tap"***.[69]

Who do 'sobering centres' help?

People who are a danger to themselves

ATCs seem to be most effective when they take over the care of those who are unable to take care of themselves because of acute intoxication. Many people in this position are so drunk that they are a danger to themselves, but may simply require a safe environment while they sober up, with supervision and elements of clinical care such as airway management and perhaps fluid infusion (a drip) to reverse dehydration. Others will have injuries as a result of their intoxication, such as cuts or head injuries from falls or assaults. Many of these can be dealt with by experienced clinical staff at the ATC, and in the process keep these people out of busy EDs.

People who are a danger to others

This group includes people who are drunk and aggressive, but would not be appropriate for someone who has committed a serious offence. For example, the sobering up centres in Santa Barbara, California, accommodate people who have committed petty intoxication related offences and need additional care while they sober up. Staff are specially trained to deal with aggressive behaviour and these individuals are given an IBA in order to try and address their problematic drinking, while escaping arrest or a criminal conviction.[70] It is reported that using the sobering up centre in Santa Barbara rather than the local jail saves around $200 for each individual.[71] This does not seem to be an approach used by any ATCs in the UK currently, and would require more extensive facilities to detain those who are intoxicated and aggressive.

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[69] Griesbach, D., Russell, P. & Lardner, C. (2009), *Services that manage the care needs of drunk and incapable people: a review of the literature.* Scottish Government Social Research, p22.

[70] McLeod, C. (2013), How drunk tanks – or 'Sobering Centres' – could help the police and our NHS, 10 October. *Policy Exchange* [Online]. [Available: http://www.policyexchange.org.uk/media-centre/blogs/category/item/how-drunk-tanks-or-sobering-centres-could-help-the-police-and-the-nhs]. [Accessed 13 October 2015].

[71] Wagstaff, E. (2008), Santa Barbara Sobriety Center Provides an Alternative to Jail, *The Daily Nexus*, 24 April. [Available: http://dailynexus.com/2008-04-24/santa-barbara-sobriety-center-provides-an-alternative-to-jail/]. [Accessed 13 October 2015].

Case study: Cardiff's Alcohol Treatment Centre

Cardiff's ATC, which is run in a church, offers treatment space for 15 patients on Friday and Saturday nights. It has been running since the end of 2012 and the pilot stage was formally evaluated by Cardiff University, producing useful information on the ATC's ability to reduce demand on the emergency services.

Reproduced with permission from Dragon News

It was concluded that the ATC pilot "resulted in a net benefit to Health, Ambulance and Police services as well as patients, their families and the community generally".[71] The ATC was found to have significantly reduced alcohol-related attendances at the local ED, significantly reduced ambulance referrals to the ED, and to have greatly reduced ambulance handover times.

As the police do not record the specific amount of time that they spend dealing with people who are dangerously intoxicated, it was not possible to quantify exactly how the ATC impacted on police activity. However it was believed to have reduced the amount of time taken for police who need to escort intoxicated people to medical treatment, because of the fact that the ATC was very close to Cardiff's night time entertainment area.

Overall the ATC was thought to be cost effective, thought the project was still bedding-in during the evaluation and a number of issues complicated the evaluation. As well as reducing costs, a number of intangible benefits were identified, including a better environment in the ED, allowing staff to better treat the patients there, and a reduced level of risk in the local night time economy.

Charging for care?

At present the various types of ATCs in the UK tend to work on a cost recovery approach, with services paid for out of public money, and the available evidence from the UK and Australia suggests that ATCs are probably cost effective if designed appropriately.[73]

However, some emergency service respondents to our survey suggested that people who are drunk and unable to look after themselves should be charged for their care in an ATC, and that private companies could be allowed to provide such services.[74] This is a controversial view, and would probably require primary legislation. Perhaps more importantly, as referenced by respondents to our Emergency Department Consultant survey, charging for

[72] Moore S.C., Sivarajasingam, V. & Heikkinen, M. (2013), *An Evaluation of the Cardiff Alcohol Treatment Centre Pilot*, Cardiff: Cardiff University, p2.
[73] Griesbach, D., Russell, P. & Lardner, C. (2009), op. cit.
[74] Evans, M. & Whitehead, T. (2013), Sober up in drunk tank and pay £400 to leave, *The Telegraph*, 18 September. [Available: http://www.telegraph.co.uk/news/uknews/law-and-order/10316456/Sober-up-in-drunk-tank-and-pay-400-to-leave.html]. [Accessed 13 October 2015].

medical attention would undermine the overarching principal that the NHS should provide universal free medical care at the point of entry.

Disadvantages and problems

As discussed in chapter 3, difficulties arise when people present with problems such as head injuries whilst also being very drunk, as it is difficult to determine whether their symptoms stem from their intoxication or the head injury itself. Typically staff within EDs will play it safe and run more complicated tests to investigate things further and ensure a correct diagnosis and speedy treatment, but this may not be possible within a sobering centre. It was for this reason that the Coalition Government did not proceed with ATCs, despite showing an interest in the idea.[75]

While this is a key issue, existing ATCs seem to have been able to triage patients successfully, aided by having well-qualified and experienced staff. For example, in Cardiff it was found that people arriving at the ATC who either needed treatment at the ED, or who needed to be arrested and taken into custody, were effectively triaged and transported to the most suitable location.

Case study: Bristol Alcohol Recovery Centre

Started in 2014, Bristol's Alcohol Recovery Centre (ARC) is provided by a partnership which includes the Police, Local Authority and Bristol CCG, with additional funding from the National Licenced Traders Association. The fact that alcohol attributable admissions cost the NHS in Bristol £16.7 million in 2009/10, and that this is expected to increase to £22-33 million by 2019/20, provided a clear rationale for attempts to rearrange services and reduce costs.

The ARC is staffed and run by the South Western Ambulance Services, and housed within a specially fitted lorry, which includes a fully fitted resuscitation cubicle, six observation beds and an assessment room, as well as a toilet, shower and kitchen. When in use it is located in a car park just outside Bristol city centre, and aims to increase ambulance availability and reduce pressures on the local ED.

The ATC currently treats an average of 17 patients every night that it is deployed, which comes to around 1800 per year. All patients are triaged by a clinician on arrival to ensure their suitability for the ATC, and where needed patents are transferred to the local ED. To date there have been no adverse incidents relating to patient safety, and relatively low referral rates to the ED.

Initial evaluations found it to be cost effective, and to provide additional productivity benefits for the local ED unit, as well as the police.

Recommendations

- More widespread trialling of Alcohol Treatment Centres, and further evaluation of their effectiveness

[75] *Hansard*, HC Deb. Vol. 582 col. 1269, 19 June 2014.

Chapter 6: Identification and Brief Advice

What is IBA?

IBA stands for 'Identification and Brief Advice.' While there are numerous variations, an IBA intervention typically lasts 5-10 minutes and involves two stages:

- The use of a screening tool to **identify** 'risky' drinking
- Delivery of short, structured '**brief advice**' to encourage a risky drinker to reduce their consumption

There are many different identification and brief advice tools, as well as different names for what is more or less the same process of alcohol brief intervention (ABI). IBA has come to be the most common form of ABI: a one-off intervention lasting roughly 5-10 minutes. Other variations include Screening and Brief Intervention (SBI) or in the US, Screening and Brief Intervention and Referral to Treatment (SBIRT).

The AUDIT (Alcohol Use Disorders Identification Test) tool is widely recognised as the best available screening tool, and is recommended by the National Institute for Health and Clinical Excellence (NICE).[76] It consists of ten multiple choice questions, and participants' scores are used to classify their drinking as no or low risk, increasing risk, higher risk, or possible alcohol dependence.

In some situations the full AUDIT tool may be too time consuming, and so a number of abbreviated tools have been developed. These often save time by eliminating further questions for those likely to be low risk drinkers, though further questions should be asked for participants who indicate as high or increasing risk. In time constrained contexts such as busy EDs, NICE recommends the use of AUDIT-C, The Fast Alcohol Screening Test (FAST), the Paddington Alcohol Test (PAT) or the Single Alcohol Screening Questionnaire (SASQ).

NICE guidance recommends that once a screening tool has been used, patients who are identified as possibly alcohol dependent should be referred for specialist treatment. For those drinkers who are identified as drinking at hazardous or harmful levels but are not alcohol dependent, it is recommended that feedback and brief advice be offered.

Where accepted, advice can take the form of a short sentence or two based on the person's questionnaire responses, sometimes accompanied by an information leaflet, or a longer discussion based on the FRAMES structure (which consists of Feedback, Responsibility, Advice, Menu of options, Empathy, Self-efficacy). Providing too much advice can make people defensive and actually be counterproductive, and participants should be encouraged to make their own decisions. There is evidence that in many cases simply providing feedback to a risky drinker may be as effective as additional forms of advice.[77] Feedback involves informing a person of the level of risk which should be the minimum offered following identification.

The effectiveness of IBA

NICE has suggested that IBA can contribute to the reduction of alcohol-related harm and alcohol-related hospital admissions. It recommends that all health professionals who have contact with those aged 16 and over should prioritise alcohol-use disorder prevention as an 'invest to save' measure. [78]

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[76] National Institute for Health and Care Excellence (2010), *Alcohol-use disorders: preventing harmful drinking* [PH24]. London: National Institute for Health and Care Excellence.
[77] Alcohol IBA Blog, About IBA. [Online]. [Available: http://alcoholiba.com/about/]. [Accessed 13 October 2015].
[78] National Institute for Health and Care Excellence (2010), op. cit.

Moreover, IBA is typically relatively cheap because it can be delivered alongside other interventions (e.g. by a nurse who is also removing stitches). Evidence supporting the effectiveness of IBA includes the findings that:

- Long-term reductions in alcohol consumption to lower risk levels are found in 1 in 8 increasing or higher risk recipients of IBA, though this figure may underestimate the impact. This compares with 1 in 20 smokers who benefit from stop smoking advice. On average individuals reduce their alcohol consumption by 15% after an intervention.[79]
- The Department of Health has estimated that spending £21.5 million on IBA in the UK would generate savings of £35 million to the NHS. This does not include other wider savings that would be generated for other public services, such as those to the criminal justice system.[80]

The evidence is strongest for the use of IBA within primary care, but there is also support for their use within EDs and the criminal justice system. At present there is limited evidence about the efficacy of IBA within the other emergency services, although logically the ambulance service ought to provide a reasonable opportunity to expand the programmes.

Emergency Departments and IBA

The firmest evidence of the effectiveness and cost effectiveness of IBA in reducing levels of alcohol consumption and associated harms comes from primary care settings.[81] [82] However, due to the time constraints often found within busy EDs, alternative screening tools such as SASQ, AUDIT-C, FAST or Paddington Alcohol Test (PAT) are commonly used, in line with the recommendations of NICE and The Royal College of Emergency Medicine.

The successful implementation of IBA in EDs is tricky. Key challenges include a lack of time and problems with cognition and receptivity on the part of intoxicated people, issues recognized by the NICE guidance:

> *"Implementation of alcohol screening and brief interventions in emergency care settings is not as consistent as in primary care. The setting differs from primary care in terms of patient population and types of presenting cases, and as such, account needs to be taken of barriers and facilitators to implementation that are specific to the emergency care context, where attendance is brief and often traumatic, patients are more likely to be injured, traumatised, or intoxicated, and staff may feel less prepared to give advice".*[83]

A recent trial in England also concluded that the implementation of IBA in EDs was challenging, and that the success of such interventions was largely dependent on support from, and the effective management of, external alcohol specialist staff.[84] The Royal College of Emergency Medicine Alcohol Toolkit recommends that there is at least one Alcohol and Drug Nurse Specialist within each ED, as does NHS England.[85] A 2013 report suggests there are signs of improvement in terms of the number of Emergency Departments that performed

[79] Ward, M., Holmes, M., Booker, L. et al (2015), *The evidence of Effectiveness & Minimum Standards for the Provision of Alcohol Identification and Brief Advice in Adult Criminal Justice Settings (excluding prison)*. London: Safe Sociable London Partnership.
[80] Department of Health (2010), *Case for Change – Commissioning Identification and Brief Advice to improve health and justice outcomes in offender populations*.
[81] Kaner, E., Bland, M., Cassidy, P. et al (2013), Effectiveness of screening and brief alcohol intervention in primary care (SIPS trial): pragmatic cluster randomised controlled trial, *BMJ*. 346:e8501.
[82] D'Onofrio, G. & Degutis, L. (2002), Preventive care in the emergency department: screening and brief intervention for alcohol problems in the emergency department: a systematic review. *Academic Emergency Medicine* 2002, 9:6, pp627-38.
[83] National Institute for Health and Care Excellence (2010), op. cit.
[84] Drummond, C., Deluca, P., Coulton, S. et al. (2014) The Effectiveness of Alcohol Screening and Brief Intervention in Emergency Departments: A Multicentre Pragmatic Cluster Randomized Controlled Trial. *PLoS ONE* 9:6, e99463.
[85] Moriarty, K.J., (2011), *Alcohol Care Teams: to reduce acute hospital admissions and improve quality of care*. British Society of Gastroenterology.

IBA and have access to specialist staff: Of 189 English EDs surveyed, 71% had access to an alcohol care worker in 2011, compared to 16.9% in 2006.[86]

IBA in criminal justice settings

Criminal justice settings include the police, courts, prisons and probation services, and there is growing evidence that IBA is effective here, having been found to reduce reoffending rates.[87] Across these areas there are three times as many people with an alcohol use disorders than within the general population. Studies have found that detainees with a positive AUDIT score were more frequent A&E attendees and had worse overall health than negative AUDIT scorers. They were more likely to be violent offenders than other offenders and had more arrests, more days in court and more use of social services.[88]

In addition to the NICE guidance there is a range of specific guidance on the use of IBA within a criminal justice setting, including:

- **Working with Alcohol Misusing Offenders:** an offenders' alcohol use should be addressed at an early stage, regardless of whether their offence was alcohol-related or not.
- **Alcohol Information Pack for offenders under Probation Supervision, Offender Managers Guide:** recommends universal IBA for offenders, and identifies the pre-sentence report stage as particularly suitable for this.[89]
- **The NOMS Alcohol Interventions Guidance:** recommends the use of IBA to reduce the risk of self-harm and offender deaths following release.[90]

Studies suggest that the police, custody, probation and prisons all have a role to play in the delivery of IBA, although some are more effective than others.

- **Police:** In general, time constraints make it difficult for front line police officers to deliver IBA, and individuals who are drunk are far less likely to respond well. A 2012 review did find that though the police were interested in IBA, there was a need for a clear business plan to better support this.[91]
- **Custody:** Research into IBA within police custody is mixed. Some found this setting too chaotic for IBA, with detainees frequently intoxicated, while other studies have concluded that this was a feasible setting, although good staff cooperation was needed, and using existing drug intervention staff increased value for money. [92]
- **Probation and prisons:** Research comparing police stations, probation offices and prisons found that probation was the most suitable for IBA, with clients more receptive at this stage. Extended Brief Interventions (EBI) in prison settings were seen to be more appropriate for high risk and dependent drinkers who were in need of more intensive support.[93]

A recent review of IBA within a criminal justice setting by Safe Sociable London Partnership and Public Health England has pulled these findings together to identify a number of minimum standards in this area.[94]

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[86] Patton, R. & O'Hara, P. (2013), Alcohol: signs of improvement. The 2nd national Emergency Department survey of alcohol identification and intervention activity. *Emergency Medicine Journal* 30:6, pp492-495.
[87] Newbury-Birch, D., Coulton, S., Bland, M., et al. (2014), Alcohol Screening and Brief Interventions for Offenders in the Probation Setting (SIPS Trial): a Pragmatic Multicentre Cluster Randomized Controlled Trial. *Alcohol and Alcoholism* 49:5, pp540–8.
[88] Thom. B., Herring. R., Luger. L., et al (2014) *Delivering Alcohol IBA: Broadening the base from health to non-health contexts: Review of the literature and scoping*. London: Alcohol Research UK.
[89] National Probation Service (2008), *Alcohol Information Pack for Offenders under Probation Supervision: Offender Managers Guide*.
[90] Ministry of Justice National Offender Management Service (2010), *NOMS Alcohol Interventions Guidance including revised guidance on* Managing the Alcohol Treatment Requirement (ATR) – *Update of Annex B to Probabtion Circular 57/2005*.
[91] Ibid.
[92] Ibid.
[93] Ibid.
[94] Ward, M., Holmes, M., Booker, L. et al (2015), op. cit.

Ambulance Services and IBA

The use of IBA by ambulance and paramedic crews is less common and there is no strong research evidence in this area. The fast paced and acute workload, as well as the fact that patients are often very intoxicated, can make IBA difficult to administer. As a result, most people ambulance and paramedic crews come into contact with may be unsuitable for an IBA, and so the intervention is not part of core ambulance or paramedic training.

Currently there is no specific guidance covering IBA for ambulance and paramedic crews, although NICE Guideline Quality Standard 11 dealing with the use of IBA covers all NHS staff. The use of IBA is not part of core training for ambulance and paramedic crews, and as such has no funding attached to it. Ambulance staff who have received IBA training appear to respond positively as do most front line roles, but follow up implementation is unknown.

Yorkshire Ambulance Service has found a way of effectively incorporating IBA into their work and is the only service in the country to have a specific alcohol referral pathway. If there is an opportune moment after dealing with a patent's clinical needs, ambulance crew use the Modified Single Alcohol Screening Question (MSASQ) to identify those who might benefit from a referral to alcohol misuse services. Consent is obtained before referral, and there is a single referral point available 24 hours a day, 7 days a week, in order to make the process as straight forward as possible.

At present Yorkshire Ambulance Service makes around 20–30 referrals a month, and while the wider impact of this pathway is difficult to quantify it is believed to have a positive impact.

The Fire Service and IBA

There are some locally based initiatives where firefighters have been trained in delivering IBA. For example, firefighters in Wigan have received specialist training to be 'health champions' in their area.[95] This allows them to deliver health advice, including IBA, alongside the service's wider fire safety checks, which involve visits to 6,500 homes per year. If, in the course of these interactions, firefighters notice alcohol problems, they can offer brief advice.

However, there is no national guidance in this area, and IBA is not part of standard fire fighter training. There is, moreover, no research into the use of IBA by fire crews and other emergency services may be in a better position to delivery them effectively.

Barriers to IBA

The take up of IBA on a sustainable basis is the biggest challenge to its effective implementation in settings where there is convincing evidence for its use. Various schemes have been developed in order to address this problem, including the Have a Word programme, which has recently been adopted by Public Health England.[96]

A recent review into the effective delivery of IBA found that key barriers included workload and time pressures, a lack of organisational commitment, and staff needing to be convinced of the value of IBA in order to incorporate it effectively into their usual practice. As such successful implementation depends on local clinical and managerial champions working well with staff to embed the practice.[97]

Within the busy emergency services, barriers seem likely to be identifying a suitable 'teachable moment', as well as the tension between the often immediate and acute pressures that they deal with and IBA, which follow a prevention approach with longer-term benefits.

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[95] Local Government Association (2015*), Beyond fighting fires: The role of the fire and rescue services in improving public health*. London: Local Government Association.
[96] Have A Word [Online]. [Available: http://www.haveaword.org.uk/Home.aspx]. [Accessed 13 October 2015].
[97] Ward, M., Holmes, M., Booker, L. et al (2015), op. cit.

Recommendations

- Full implementation of the Royal College for Emergency Medicine guidelines in Emergency Departments, including delivery of IBA and specialist alcohol teams on site
- Greater use of IBA within the criminal justice system, administered in line with expert recommendations. These include a focus on parole, and addressing all offenders' alcohol problems, regardless of whether their offence is alcohol-related
- Specific guidance and the incorporation of IBA within core training for ambulance and paramedic crews
- Further trialling of fire service public health community outreach initiatives, such as the one in Wigan, and rigorous evaluation of the effectiveness of such interventions

Chapter 7: Reducing the drink drive limit

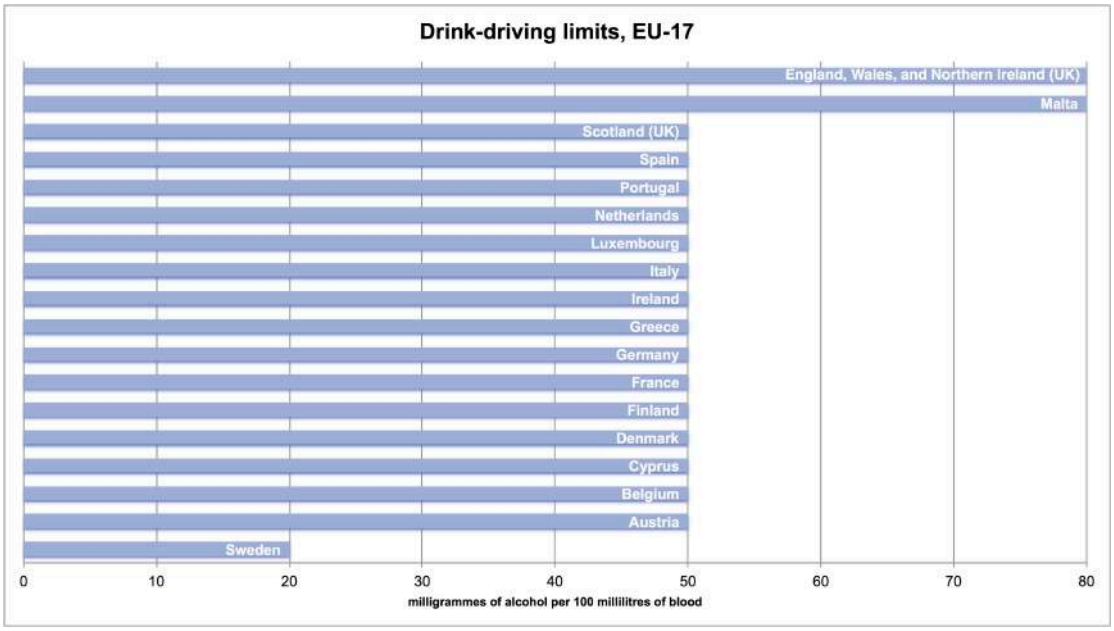
The scale of the problem

Drink driving is a significant source of pressure upon the emergency services, responsible for thousands of road traffic accidents and casualties every year, which have to be addressed by police, fire, paramedics and emergency departments. The Department for Transport estimates that there were 5,690 road traffic accidents caused by alcohol in 2013, resulting in 8,270 casualties. Around 240 people were killed by drink driving in the same year.[98]

Though these numbers have declined in recent years, with the number of accidents falling by 14% between 2010 and 2013 (following a substantial decline in 2010), there is worrying evidence that progress on some indicators is stalling. The number of drink drive fatalities has been unchanged since 2010, and provisional numbers suggest no improvement in the number of accidents or casualties in 2014. Moreover, the number of women convicted for drink driving has increased, from 9% in 2008 to 17% in 2012.[99]

Binge drinking has been calculated to increase road accidents by 17%, which is equivalent to 82 additional accidents per day nationally, costing an estimated at £2.04 billion at 2014 prices. This cost is spread across all the emergency services and the wider public sector, including the NHS.[100]

The evidence for reducing the blood alcohol limit



England and Wales have one of the most lenient drink drive limits in Europe, set at 80mg of alcohol in every 100ml of blood. Only Northern Ireland and Malta have drink drive limits this high (although Northern Ireland is currently legislating to lower this level), with most European countries setting their limit at 50mg or lower, and some at zero. Scotland has recently reduced its drink drive limit from 80mg to 50mg in order to reduce drink driving. This resulted

[98] Department for Transport Statistics (2015), Table RAS510001: Estimated number of reported drink drive accidents and casualties in Great Britain: 1979-2014.
[99] Beuret, K., Corbett, C. & Ward, H. (2014), *Drinking among British Women and its impact on their pedestrian and driving activities*. Social Research Associates.
[100] James, J. & Francesconi, M. (2015), op. cit.

in a 19% reduction in drink drive offences over the Christmas and New Year period 2014/15.[101]

Numerous bodies and reviews have found that the evidence supports reducing the legal blood alcohol limit to 50mg/100ml to bring England and Wales in line with the rest of Europe. In 2001, the European Commission endorsed this limit for all member states[102]; a call renewed by the European Parliament in 2011, which proposed harmonisation of drink drive regulations across the EU.[103] The independent North Review of Drink and Drug Driving Law, commissioned in 2010 by the then Transport Secretary, concluded that 50mg/100ml is the optimal level, finding that "a reduction to 50mg/100ml would undoubtedly save a significant number of lives".[104]

The Police Federation has recently called for this change, as have the Local Government Association (LGA), which speaks for Fire and Rescue Authorities (FRAs), and reductions in the drink drive limit are also supported by organisations such as BREAK, the road safety charity, and the Alcohol Health Alliance UK. The Association of Chief Police Constables has stated that a reduction in the drink drive limit to 50mg would save around 64 lives a year, while the LGA has estimated that it could save as many as 170 lives a year.[105]

According to NICE, which also supports reducing the limit, a driver with a blood alcohol concentration between 50 and 80mg/100ml is six times more likely to die in a car crash than a sober driver. Reducing the blood alcohol concentration to 20-50mg/100ml halves this risk.[106] Moreover, evidence from Australia suggests that reducing the blood alcohol limit to 50mg there reduced drinking at all levels, including those far above the previous limit: there was a 41% fall in the number of people driving with blood alcohol concentrations over 150mg/100ml.[107]

As the North Review found, "There is very considerable public support for a reduction in the current drink drive limit".[108] An RAC survey of over 2,600 motorists found that almost 80% of Scottish motorists supported their tougher drink drive limit, and that over 60% of motorists outside of Scotland supported similarly tough laws across the rest of the UK. 38% wanted the same limit as Scotland, while 23% would have preferred a total ban on alcohol while driving.[109]

Reducing the drink drive limit to 50mg/100ml is a policy that would ease the impact on emergency services from road traffic accidents. Perhaps more importantly, it would save lives and prevent hundreds of injuries.

Recommendations

- **Reduction of the drink drive limit in England and Wales to 50mg/100ml and appropriate investment in its enforcement**

[101] O'Hare, P. (2015), Lower drink drive limit in Scotland sees a 19 per cent reduction in offenders. *Daily Record*, 8 June 2015. [Available: http://www.dailyrecord.co.uk/news/scottish-news/lower-drink-drive-limit-scotland-4941693]. [Accessed 13 October 2015].
[102] Official Journal of the European Communities (2001), 'Commission Recommendation of 17 January 2001 on the maximum permitted blood alcohol content (BAC) for drivers of motorised vehicles', L 43/32.
[103] Podda, F. (2012), *Drink Driving: Towards Zero Tolerance*. European Transport Safety Council, p12.
[104] North, P. (2010), *Report of the Review of Drink Driving Law*. Department for Transport, p6.
[105] Local Government Association (2015), *Lower the drink drive limit to cut road deaths*, say Fire and Rescue Authorities [Press release]. [Accessed 13 October 2015].
[106] Killoran, A., Canning, U., Doyle, N. et al (2010), *Review of effectiveness of laws limiting blood alcohol concentration levels to reduce alcohol-related road injuries and deaths*. Centre for Public Health Excellence NICE, p3.
[107] Brooks, C. & Zaal, D. (1993), *Effects of a reduced alcohol limit for drivin*g. Australia: Federal Office of Road safety
[108] North, P. (2010), op. cit.
[109] RAC (2014), Scottish drink-drive limit lowered [Press release]. [Available: http://www.rac.co.uk/advice/motoring-news/scottish-drink-drive-limit-lowered]. [Accessed 13 October 2015].

Chapter 8: Information sharing between emergency services

The 'Cardiff Model'

Effective sharing of information between different emergency services has been shown to help reduce social problems, and particularly crime and violent incidents. The 'gold standard' of procedures for data sharing is sometimes referred to as the 'Cardiff model', because of the pioneering collaboration and processes introduced in the Cardiff area.

Prior to the introduction of the Cardiff model, two-thirds of assaults treated in emergency departments went unreported to the police.[110] The Cardiff model established common standards for data reporting, and encouraged the local emergency department to make this anonymised data available to police and local authorities to help inform prevention strategy and tactics.

Based on the experiences of Cardiff and other areas that have introduced the Cardiff model, the NHS have developed a set of national guidelines on how data should be collected and shared[111]:

- ED receptionists should collect the relevant data at registration
- There are three critical pieces of information to determine:
    1. Date and time of assault
    2. Means of assault (weapon or body part used)
    3. Assault location
- This anonymised data should be shared on a monthly basis with the local Community Safety Partnership[112] (CSP)
- There is no need for a formal information sharing agreement, as the data is anonymised

This information can then be used by police and local authorities to develop a fuller and more detailed picture of patterns of violence. This will help them to develop a more targeted response to these issues, and support a number of measures for reducing crime and violence in specific areas. For example, police can focus their patrols on high risk areas, conduct overt or covert interventions in particular licensed premises, or can pedestrianise risky areas. Local authorities can use the data to inform their licensing decisions, both in terms of specifically addressing problem outlets, and controlling the supply of alcohol in assault 'hotspots'. The data collected is also an invaluable resource for monitoring performance, and the success of specific interventions.

The effectiveness of Information Sharing

A number of evaluations have demonstrated that information sharing between services can be effective at reducing violent incidents and crime, and thus reducing pressure on the emergency services. In Cardiff itself, implementing the model reduced the number of assault patients seeking ED treatment by 35% within five years (compared with an overall 18% rise in England and Wales). Assaults in licensed premises in Cardiff fell by a third. Cardiff shot up Home Office rankings for safety and by 2005 had the fifth lowest level of violence of all towns larger than 100,000 people in England and Wales. Within its Home Office 'family' of fifteen comparable cities (based on socio-economic and demographic statistics), Cardiff rose from

[110] Sutherland, I., Sivarajasingam, V., Shepherd, J.P. (2002), Recording of community violence by medical and police services, *Injury Prevention* 8, pp246-7.
[111] Jordan, M. (2014), *Information Sharing to Tackle Violence (ISTV): Initial Standard Implementation Guidance*. Leeds: Health and Social Care Information Centre.
[112] Community Safety partnerships are statutory bodies comprised of councilors and independent members of the community who act as a liaison between community and police.

bottom to top by 2006.[113] An economic cost-benefit analysis estimated that the intervention reduced the economic and social costs of violence in Cardiff by £7m in 2007, including £1.62m of savings to criminal justice system, and £1.25m of savings to the health service. This represents £82 of benefit for every pound invested in the programme.[114]

Implementation of the Cardiff Model

The previous Coalition Government's 2010 Programme for Government included a commitment for all hospitals to share relevant information with the police, and this requirement has since been written into the NHS contract and made mandatory for all A&Es.[115] However, implementation of these guidelines has been patchy and inconsistent. A 2012 audit found issues with data quality, timeliness and usage. Only 36% of A&E/CSP partnerships were sharing information that meets the College's guidelines. In particular, location data – one of the most important elements of the programme – was often missing. Only 50% were receiving data on a monthly basis, as recommended. Unsurprisingly, this led to concerns from CSPs about the quality and usability of data, and so only 37% of CSPs were found to be using the data provided.[116] The results of a 2014 follow-up audit are yet to be released, but unofficial early indications have suggested that compliance will rise to around 60%.[117] This represents clear progress, though there is still scope to improve uptake and implementation of information sharing.

To some extent, the slow national implementation of the Cardiff model may be due to a lack of investment of resources, as well as the inertia of established institutions and ways of working. However, there is reason to suspect that some of the barriers may result from insurmountable structural issues. In particular, areas with multiple hospitals serving the same night time economy have reported greater difficulty in collating accurate and consistent data, due to the number of institutions involved and required to coordinate their actions.[118] Therefore, expectations for the Cardiff model ought to be restrained by awareness of the practical difficulties of implementing it in practice.

Recommendations

- Greater investment and effort towards data sharing between emergency services

[113] Shepherd, J. (2007), *Effective NHS Contributions to Violence Prevention: The Cardiff Model.* Cardiff: University of Cardiff; see also Florence, C., Shepherd, J. & Brennan, I. (2011), Effectiveness of anonymised information sharing and use in health service, police, and local government partnership for preventing violence related injury: experimental study and time series analysis, *BMJ* 342.
[114] Florence, C., Shepherd, J., Brennan, I. et al (2013), An economic evaluation of anonymised information sharing in a partnership between health services, police and local government for preventing violence-related injury. *Injury Prevention* 20, pp108-14.
[115] Home Office, (2012), The Government's Alcohol Strategy. London: Home Office, p15.; NHS Standard Contract Team (2015), *NHS Standard Contract 2015/16 Particulars*. Leeds: NHS England, pp68-9.
[116] Centre for Public Innovation (2012), *Information Sharing to tackle violence: Audit of progress on delivering the Coalition Commitment 2012*.
[117] Boyle, A. (2015), Information sharing to prevent community violence. *EMJ Supplement*, p3.
[118] Foster, J. (Forthcoming), Institute of Alcohol Studies.

Chapter 9: Licensing

Alcohol licensing in England and Wales is governed by the 2003 Licensing Act (the Act). While this hit the headlines for the introduction of 24-hour licences, it brought about a wide range of other changes, including transferring responsibility for licensing to local authorities, simplifying day-to-day administration and introducing four clear licensing objectives. These are:

1. Prevention of crime and disorder
2. Public safety
3. Prevention of public nuisance
4. Protection of children from harm

Under the Act, these objectives should be promoted within all licensing decisions. However, the Act also has wider aims, including enabling local authorities to set out suitable licensing strategies in their area and encouraging community involvement in licensing decisions.

Licensing regulation can be used to manage the night time economy, by influencing the type of outlet in an area, although this is not always easy to do. Premises with favourable attributes might be more likely to be approved, or these attributes might be made conditions of the license. The Home Office has developed a list of features of licensed premises which are likely to reduce violence[119]:

Figure 1: Summary of strategies for reducing violence in and around licensed premises

Nature of intervention	Examples
Manipulation of the physical environment of pubs/clubs	• No 'hidden' alcoves that prevent the easy monitoring of behaviour • Attention to the spacing of furniture, including, tables, chairs, stools and pool tables to avoid customer crowding • Raised bar-areas to permit staff monitoring of customer behaviour
Controlling the social atmosphere	• Attractive, well-maintained premises • Registered door-staff schemes and employment of well-trained staff who discourage anti-social behaviour in a manner that does not escalate violence • The reduction of excessively loud music
Alcohol control	• No 'happy hours'/drinks promotions • Serving of food and soft beverages
Control of drinkers	• Well ventilated premises with controls over the number of customers entering • Well trained and socially skilled door staff and bar staff experienced at dealing with aggressive or violent individuals (see also above) • Refusal of alcohol to already intoxicated customers • 'Pubwatch' schemes • The use of CCTV to monitor disorder and violence • Staggered closing times to avoid large numbers of individuals gathering in the same area together • Regular and reliable transportation away from pubs and clubs
Injury reduction	• Use of toughened glass • Use of plastic cups • The banning of bottle-served alcohol • Swift removal of any glassware used • Weapons searches on entry to public houses and clubs
Criminal justice policy	• Heavier penalties for breaches of licensing laws such as serving to underage drinkers (relevant to both 'on' and 'off' licences) • Courts to divert alcohol-offenders to treatment and education programmes • Monitoring of 'problem/violent' premises • Alcohol education schemes

[119] Brookman, F. & Maguire, M. (2003), *Reducing homicide: Summary of a review of the possibilities*, RDS Occasional Paper 84. London: Home Office.

The impact of the Act

It is hard to clearly identify the specific impact of the Act on many alcohol related problems because of the wide range of confounding factors. In the ten years since the Act came in, alcohol consumption, binge drinking and overall crime have declined, but these trends are mirrored internationally and pre-date the Act, and so cannot be directly attributed to the Act.

It is, however, clear that the Act, and specifically early morning closing times, has caused logistical problems for the police. Two separate academic studies established that extended opening times have spread crime back into the night. One found a 25% increase in offences between 3am and 6am,[120] while the other found a 36% increase in violence for the same time period.[121] This spreading of harm has also occurred in Emergency Departments, with reports that alcohol related admissions, which previously peaked around 11pm until 2am, now continue until 4am or 5am.[122]

As a direct response to this many police forces rearranged their shift patterns, effectively 'doubling-up' shifts on Friday and Saturday nights. In some services the late shift runs from 6pm to 5am, while the night shift spans 8pm to 7am, meaning that there is significant overlap between the two. Moreover, as our survey uncovered, and other IAS research has found, police are often required to work beyond their scheduled shift, causing significant issues for those working on successive days.[123]

The effectiveness of the Act

While the Act helped to simplify day-to-day administration and introduced clear licensing objectives, questions remain around its effectiveness. In particular, many believe it is overly lenient on the licenced trade. These problems may not be entirely with the Act itself, however, but with the way in which local authorities use it, and the influence of the licenced trade in using legal support to shape the application of the Act in their favour.

Since its implementation in November 2005 the Act has been amended and 'rebalanced' in order to strengthen police powers. Some commentators have seen this as an unfortunate shift towards the "management of drunkenness"[124] and criticised the "general inability of area- and person-specific powers to address many of the underlying causes of drink-related crime and disorder".[125] It has also been suggested that new laws were passed unnecessarily when more should have been done to ensure that existing laws were enforced properly.[126]

As part of the 'rebalancing' process two new powers were granted to local authorities and the police: Early Morning Restriction Orders (EMROs) and Late Night Levy's (LNLs). While these are useful options in theory, they have proved to be either difficult or impossible to actually use in practice.

EMROs give local authorities and the police the option of enforcing a set closing time in problematic areas. However, while Blackpool did attempt this, at present no EMROs have been implemented and this potentially important option has been described as an 'invisible tool' which cannot be used. After investigating an EMRO in Lambeth, councillors were reported in the media describing the powers as poorly drafted and not fit-for-purpose.[127]

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[120] Hough. M., Hunter. G., Jacobson. J. et al (2008) *The impact of the Licensing Act 2003 on levels of crime and disorder: and evaluation*. Home Office, p9.
[121] Humphreys. D., Eisner. M., & Wiebe. D. (2013) Evaluating the impact of flexible alcohol trading hours on violence: an interrupted time series analysis. PLoS ONE 8:2, p2.
[122] Johnston, P., (2006), *24-hour laws haven't cured binge drinking*, *The Telegraph*, 25 November. [Available: http://www.telegraph.co.uk/news/uknews/1535010/24-hour-laws-havent-cured-binge-drinking.html?mobile=basic]. [Accessed 13 October].
[123] Foster, J. (Forthcoming), Institute of Alcohol Studies.
[124] Hadfield. P. & Measham. F. (2011), *Lost Orders? Law enforcement and alcohol in England and Wales: Final report to the Portman Group*. London: The Portman Group, p8.
[125] Hadfield. P & Measham. F., (2014) The outsourcing of control: Alcohol law enforcement, private-sector governance and the evening and night-time economy. *Urban Studies* 52:3, p525.
[126] Ibid.
[127] Ibid.

LNLs involve raising funds from late night venues in order to pay for policies that might combat alcohol related problems. As our survey found, these are an extremely popular measure with the police (see chapter 1). They are, however, very inflexible, having proved unsuitable for many areas because they cannot be focused on city centres, and so would have to be applied to rural pubs as well. Some areas with relatively concentrated night time economies, such as Newcastle, have managed to successfully implement LNLs, although their actual effectiveness in reducing problems is still unclear.

The limitations of the Act

The scope of the licensing objectives

In addition to problems around EMROs and LNLs, a number of licensing bodies have criticised the narrow scope of the licensing objectives, calling for the introduction of a fifth public health objective (as exists in Scotland) in order to help include a wider range of issues. Those in favour of this change include the Local Government Association (LGA),[128] the Greater Manchester Alcohol Strategy Group,[129] Public Health England and the Police and Crime Commissioners alcohol lead, Tony Hogg.[130]

While public health concerns may seem very different to existing licensing objectives, widening the scope of the Act in this way could help prevent crime and disorder. Forthcoming IAS research found considerable support from police officers for a public health objective.[131] However, public health bodies may need to lower their expectations about the impact of such an objective; while it would be a useful addition, the legal mechanisms within the Act would make it unlikely that chronic alcohol related problems could be effectively addressed via licensing.

High concentrations of licenced venues

High concentrations of premises within an area are known to be associated with additional crime and disorder.[132] However, the Act gives local authorities and the police few tools to address this problem. Cumulative Impact Policies (CIPs), also known as special policies, can be introduced in areas where the number of premises can be shown to cause additional problems. However, at best these only tend to contain the problem once it has arisen and slow down the growth of new premises. It is very rare for them to be effective in reducing the number of licenced premises.

Benedict Hogan-Howe, Head of the Metropolitan Police Service, recently called for more measures to address this issue as part of a 'prevention first' approach to policing:

> *"We need to make sure there is good control of the supply of alcohol. This means licence numbers, density and licensee-regulation being a priority for local authorities, however much they would like to develop local economies… do we really need as many licensed premises chasing limited business? The system needs reform and we have to police it better".*[133]

[128] Local Government Association & Alcohol Research UK (2013) *Public health and alcohol licensing in England: LGA and Alcohol Research UK briefing*. London: Local Government Association.
[129] Smith. S. & Gregory. J. (2015), *Greater Manchester LAAA and the Development of a GM Alcohol Strategy*, 15 January, LGA National Licensing Conference.
[130] Greenwood. W. (2014), Crime commissioner backs licensing reforms, *Western Morning News*, 15 February 2014 [Available: http://www.westernmorningnews.co.uk/Crime-commissioner-backs-licensing-reforms/story-20630964-detail/story.html]. [Accessed 13 October 2015].
[131] Foster, J. (Forthcoming), Institute of Alcohol Studies.
[132] Zhu, L., Gorman D.M. & Horel S. (2004), Alcohol Outlet Density and Violence: A Geospacial Analysis. *Alcohol & Alcoholism* 39:4, pp369-75.
[133] Hogan-Howe, B. (2015), op. cit., p22.

Funding

In theory licensing should pay for itself, but in many areas fees are inadequate to cover costs.[134] In fact, licensing fees have not risen since the Act was implemented in 2005, despite increases being recommended by an independent review.[135] The LGA estimate that alcohol licensing has cost local authorities approximately £183 million in the 10 years since the Act was introduced, which works out at £1.5 million of taxpayers' money per month being used to subsidise the licensed trade.[136]

As our survey uncovered, many people feel deep unease about the impact of funding cuts on the police's ability to manage the night time economy.[137] Alongside police cuts, many local authorities have also faced cuts in central government grants, which have been passed through to licensing and trading standards teams.

These funding crises have led to a more reactive and short-termist approach to the night time economy, with less effective and rigorous oversight. Without adequate resources to implement the Act properly, unsuitable venues are more likely to open, and problematic ones are less likely to be closed, creating greater problems for the police and other emergency services. Members of the licenced trade have recognised this too: Steve Thomas, head of Luminar, has claimed that more late night venues would have closed if local authorities had been able to enforce the Act properly.[138]

Implementation and training

There is a significant difference between the written detail of the Act, guidance and case law and the way in which licensing is often implemented by local authorities. Court of Appeal case law suggests that many local authorities could:

- Use greater discretion in reaching evaluative judgments
- Make fuller use of their right to ask questions of all parties
- Take a more strategic approach to licensing through Statements of Licensing Policy

As a result, a number of misinterpretations and myths have developed within day-to-day licensing decisions, reducing the ability of local authorities to use the Act assertively. Many local authorities could equip themselves better by using specialist legal advice more often, particularly in developing their Statement of Licensing Policy, and by investing in better training for the licensing committee. Licensing committees often make 'soft' and lenient decisions because of the fear of being taken to an expensive appeal hearing. While this is understandable, the best remedy is to make good, clear, rigorous decisions in the first place. Achieving this more regularly would help local authorities and many of the emergency services. This advice is developed more fully in a forthcoming IAS report.[139]

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[134] Roberts, M. (2014) A helping hand? The contribution of the night-time economy to the evolving high street. In: Wrigley, N & Brookes, E. (eds.) *Evolving high streets: resilience and reinvention. Perspectives from social science*. Southampton: University of Southampton, p.27

[135] Elton. L., (2006) The Licensing Act 2003: Report of the independent fees review panel.

[136] Local Government Association (2015), LGA responds to Government decision to reject locally-set licensing fees [Press release]. [Available: http://www.local.gov.uk/web/guest/media-releases/-/journal_content/56/10180/7048782/NEWS#sthash.BVcZZjIX.dpuf] [Accessed 13 October 2015].

[137] Syal. R. (2015), Home Office making police cuts without understanding, report says, *The Guardian*, 4th June [Available: http://www.theguardian.com/uk-news/2015/jun/04/home-office-making-police-cuts-without-understanding-report-says]. [Accessed 13 October 2015]; Shaw, D. (2015) Police forces all face major budget cuts, BBC News, 7 March [Available: http://www.bbc.co.uk/news/uk-31771456]. [Accessed 13 October 2015].

[138] Harrington. J. (2009) Luminar Boss: half of UK nightclubs could close, *The Publican's Morning* Advertiser, 18 March. [Available: http://www.morningadvertiser.co.uk/Operators/MA300-Business-Club/Luminar-boss-Half-of-UK-nightclubs-could-close]. [Accessed 13 October 2015].

[139] Foster, J. (Forthcoming), Institute of Alcohol Studies.

Recommendations

- Better application of the Act and subsequent legal guidance in practice
- Improved training and legal clarity within licensing committees
- The introduction of locally set fees so that licensing authorities can properly recover their costs
- The addition of a health impacts licensing objective: The 'prevention of adverse impacts on health and wellbeing'
- A flexible Late Night Levy targeted at specific geographic locations
- Clarified guidance for Early Morning Restriction Orders, particularly on the collection and presentation of evidence

Chapter 10: Reducing Affordability

The rising affordability of alcohol

A number of respondents mentioned the increasing affordability of alcohol as an underlying cause of their service's problems with drink:

- *"Alcohol has played a significant role in my 15 years of policing. Cheap accessable [sic] drink that is marketed towards certain groups of young people plays a significant role."* (Police Constable)
- *"The main problem is large bottles of very strong alcohol on sale for extremely cheap prices eg. 2litre bottle of cider for £1.99."* (Police Constable)
- *"Alcohol is readily available at extremely cheap prices in off licence shops. In my experience, the overwhelming majority of incidents where alcohol is a factor has stemmed from people purchasing high strength alcohol from such establishments."* (Police Constable)

As with most consumer goods, alcohol has become more affordable over time, with price inflation failing to keep up with growth in incomes. In 2014, alcohol was 54% more affordable than it was in 1980, with a dramatic increase in affordability from the late 1990s up to the recession.[140]

Sources: Alcohol Price and Retail Prices (all items) Indices: derived from Focus on Consumer Price Indices (Codes: CBAA, CBAB, CHBD, CHAW). Office for National Statistics. Real Households Disposable Income from the UK Economic Accounts (Code NRJR). Office for National Statistics.
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This is problematic, because more affordable alcohol leads to higher consumption, which in turn leads to numerous health and social harms, including those outlined in the report. Increases in the affordability of alcohol is associated with more alcohol-related deaths and illnesses, road traffic fatalities, violence, crime, drug use and risky sexual behaviour.[141]

[140] Health and Social Care Information Centre (2015), Statistics on Alcohol: England, 2015, pp11-12.
[141] Wagenaar, A.C., Salois, M.J. & Komro, K.A. (2009), Effects of beverage alcohol price and tax levels on drinking: a meta-analysis of 1003 estimates from 112 studies. *Addiction* 104:2, pp179-90.

The issue of cheap alcohol

Attempts to respond to the problem of increasingly affordable alcohol have focused in recent years on alcohol at the very lowest price points. Some products, such as high strength ciders, are consistently available at very low prices. These items therefore insulate heavier drinkers from the effects of general price rises. Moreover, they are especially appealing to young people with limited money. Research has demonstrated that cheap alcohol is popular with dependent drinkers, binge drinkers and young drinkers.[142]

Alcohol taxes can reduce affordability

- *"Increase alcohol excise duty to raise the unit price of alcohol."* (ED Associate Specialist)

- *"Raise the price of Alcohol. People would be able to afford less and would not drink beyond their limits."* (Special Constable)

Taxes have conventionally been the most common tool to control the affordability of alcohol. It is well established that changes in alcohol duty influence consumption levels, and so levels of alcohol harm. For example, cuts to alcohol taxes in Finland in 2004 led to a 10% increase in consumption, and a 46% increase in deaths from liver disease.[143] Conversely, a meta-analysis of 50 studies found that doubling alcohol tax would be associated with a 3% reduction in alcohol-related mortality, an 11% reduction in traffic accidents and a 2% reduction in violence.[144]

Recent policy changes have limited the effectiveness of UK alcohol duty in curbing drinking. From 2008 to 2013, the 'duty escalator' on alcohol ensured that excise taxes rose at 2% above inflation each year. This was due to expire in 2015, but was scrapped for beer in 2013, and for all alcohol in 2014.[145] Moreover, beer duty has been cut by 1p per pint in each of the last three budgets, and duty on cider and spirits was cut by 2% in 2015.[146] These changes mean that in future years, alcohol is likely to become more affordable as price rises fall further behind income growth.

A further issue with the alcohol tax system is that it incentivises the production and sale of certain high strength drinks at relatively low prices. **Cider duty is set at a considerably lower level than for other drinks. For example, a 440ml can of cider at 5% ABV attracts just 8p per unit of duty, less than a third of the rate for a comparable can of beer** (18p per unit on a 4% ABV 440ml can).[147] Moreover, the lower duty rate band for cider is relatively wide – drinks between 1.2% and 7.5% ABV attract the same rate of duty. As duty paid on cider does not increase by product strength within this range, there is no incentive for cider producers to reduce the strength of their drinks within these limits. This is in stark contrast to the duty regime for beer, where tax increases in line with the strength of the product. Moreover, since 2011, beer has had an additional band of excise duty (beyond the two applied to cider) applied at a lower rate to lower alcohol beers (below 2.8% ABV).[148] This effectively cut duty on lower strength beers by 50%, and within a year of the change, sales of lower strength beer had risen by over 40%.[149] Similarly, increasing the duty rate on higher strength ciders (over 7.5%) in 1996 significantly shrank the market for such products.

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[142] Jackson, R., Johnson, M., Campbell, F. et al (2010), *Interventions on Control of Alcohol Price, Promotion and Availability for Prevention of Alcohol Use Disorders in Adults and Young People*. Sheffield: ScHARR, University of Sheffield.

[143] Mäkelä, P. & Österberg, P. (2009) Weakening of one more alcohol control pillar: a review of the effects of the alcohol tax cuts in Finland in 2004. *Society for the Study of Addiction* 104, pp554-563.

[144] Wagenaar, A.C., Tobler, A.L. & Komro K.A. (2010) Effects of alcohol tax and price policies on morbidity and mortality: A systematic review, *American Journal of Public Health* 100:11, pp2270-8.

[145] BBC (2014), Budget 2014: Beer duty cut by 1p, *BBC News*, 19 Match. [Available: http://www.bbc.co.uk/news/business-26644768]. Accessed: 15 October].

[146] BBC (2015), Budget 2015: Beer duty cut by 1p a pint for third year, BBC News, 19 Match. [Available: http://www.bbc.co.uk/news/business-31940987]. [Accessed: 15 October].

[147] Calculations from Dr John Holmes, University of Sheffield.

[148] HM Treasury (2011), *Budget 2011*. (HC 836, 2010-11). London: The Stationery Office.

[149] Roberts, G. (2012), *Low-alcohol beers show their calibre*, *The Independent*, 18 March. [Accessed 13 October].

According to industry data, stronger ciders had constituted 20% of the total cider market, but within four years had fallen to less than 2%.[150]

A minimum unit price is a targeted solution to the problem of cheap alcohol

- *"Alcohol price needs to be regulated to be price per unit across the board it would lead to less people drinking at home. At present alcohol is so cheap in supermarkets it is causing a real big issue."* (Police Constable)

- *"The failure of government to implement minimum unit pricing was an incredible missed opportunity to tackle problem drinking without punishing responsible alcohol use."* (ED Consultant)

Increasing and reforming excise duty can help to address the issue of the general affordability of alcohol. A minimum unit price for alcohol, which was cited approvingly by a number of our survey respondents, can work alongside duty increases to help tackle the problem of cheap alcohol. A minimum unit price would regulate the pricing of alcohol, ensuring that, at the cheaper end of the market, stronger drinks are more expensive than weaker ones. The policy sets a floor price per unit of alcohol below which vendors cannot sell their products. For example, if a minimum unit price were set at 50p per unit of alcohol, then a 700ml bottle of vodka containing 28 units could not be sold for less than £14 (50p x 28 = £14).

A minimum unit price specifically targets the cheapest, strongest drinks that are mostly likely to be consumed by harmful, underage and binge drinkers. Its effect is greatest on the off-trade, and could address, to some extent, the culture of 'pre-loading', which many of our respondents cited as particularly harmful and dangerous.

There is persuasive evidence that minimum pricing can be an effective tool to ease the burden of alcohol on public services from its implementation in Canada. In Saskatchewan province, it was estimated based on previous minimum price increases that a 10% increase in minimum prices reduces alcohol consumption by 8%, with a particularly strong effect on high alcohol beer.[151] Research into the impact of the policy in British Columbia similarly found that that increasing minimum prices by 10% would be associated with a 19% reduction in road traffic violations, a 9% reduction in overall crime and a 9% reduction in alcohol-attributable hospital admissions within two years.[152]

In the British context, researchers at the University of Sheffield have modelled the health and economic consequences of a minimum unit price. Based on a minimum unit price of 45p per unit (in 2014/15 prices), they forecast that within ten years the policy could prevent 860 deaths a year, 29,900 hospital admissions and save the health service £0.6bn annually.[153] Moreover, such a policy is estimated to lead to 34,200 fewer crimes each year.[154]

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[150] National Association of Cidermakers (2010) A Response to the Alcohol Taxation Review, August 2010. [Online]. [Available: http://cideruk.com/files/PDF/NCGBRE.PDF]. [Accessed 13 October].

[151] Stockwell, T., Zhao, J., Giesbrecht N. et al (2012), The Raising of Minimum Alcohol Prices in Saskatchewan, Canada: Impacts on Consumption and Implications for Public Health. *American Journal of Public Health* 102:12, e103-110.

[152] Stockwell, T., Zhao, J., Marzell, M. et al (2015), Relationship between minimum alcohol pricing and crime during the partial privatization of a Canadian alcohol monopoly. *Journal of Studies on Alcohol and Drugs* 76:4, pp628-34; Stockwell, T., Zhao, J., Martin, G. et al (2013), Minimum Alcohol Prices and Outlet Densities in British Columbia, Canada: Estimated Impacts on Alcohol-Attributable Hospital Admissions. *American Journal of Public Health* 103: 11, pp2014-20.

[153] Holmes, J, et al (2014), Effects of minimum unit pricing for alcohol on different income and socioeconomic groups: a modelling study, *Lancet* 383, pp1655-64.

[154] Meng, Y., Brennan, A., Holmes, J. et al (2013), Modelled income group-specific impacts of alcohol minimum unit pricing in England 2014/15: Policy appraisals using new developments to the Sheffield Alcohol Policy Model (v2.5). , Sheffield: ScHARR, University of Sheffield, p81.

Recommendations

- Reintroduction of the duty escalator, ensuring that the excise duty system appropriately addresses alcohol harm, for example, by incentivising producers to promote lower strength drinks
- Introduction of a minimum unit price for alcohol

Summary Recommendations

Alcohol Treatment Centres

- More widespread trialling of Alcohol Treatment Centres, and further evaluation of their effectiveness

IBA

- Full implementation of the Royal College for Emergency Medicine guidelines in Emergency Departments, including delivery of IBA and specialist alcohol teams on site
- Greater use of IBA within the criminal justice system, administered in line with expert recommendations. These include a focus on parole, and addressing all offenders' alcohol problems, regardless of whether their offence is alcohol-related
- Specific guidance and the incorporation of IBA within core training for ambulance and paramedic crews
- Further trialling of fire service public health community outreach initiatives, such as the one in Wigan, and rigorous evaluation of the effectiveness of such interventions.

Drink drive limit

- Reduction of the drink drive limit in England and Wales to 50mg/100ml and appropriate investment in its enforcement

Information Sharing between Emergency Services

- Greater investment and effort towards data sharing between emergency services

Licensing

- Better application of the Act and subsequent legal guidance in practice
- Improved training and legal clarity within licensing committees
- The introduction of locally set fees so that licensing authorities can properly recover their costs
- The addition of a health impacts licensing objective: The 'prevention of adverse impacts on health and wellbeing'
- A flexible Late Night Levy targeted at specific geographic locations
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Alcohol affordability

- Reintroduction of the duty escalator, ensuring that the excise duty system appropriately addresses alcohol harm, for example, by incentivising producers to promote lower strength drinks
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