Making alcohol part of wider agendas is an opportunity that can't be missed, says **James Morris**

COME TOGETHER

It's easy to be cynical when we hear about how hard times can inspire change and innovation, when we know the bottom line is disinvestment. But there is also a real chance that the storm heading the way of public services could create a few genuine winners, and alcohol could be one.

Historically, a political rhetoric and funding bias towards (illicit) drugs has obstructed overall progress on reducing alcohol harm. In recent years, however, a focus on alcohol as a separate policy issue has been important in improving the evidence base and overall recognition of the need to act, but in terms of local commissioning, ring-fenced drugs budgets with strict targets have not helped when it came to investment in cost-saving approaches for alcohol. Areas that have made the biggest strides in alcohol harm reduction are those where champions and local partnerships have fought for its cause most resolutely, despite going somewhat against the grain.

But within the changing landscape there appear to be opportunities to lay down solid paths for improved alcohol treatment and prevention. Alcohol appears to be a key issue within the new public health agenda and dedicated national Public Health Service (PHS). The PHS will also take on the scope of the NTA, which should allow for better integration of the alcohol and public health principles it formally had no obligation to.

The real opportunity therefore is the chance to make alcohol a core part of wider substance misuse and public health frameworks. The alcohol agenda may lose some identity as a result but it can still be a net winner by joining the bigger team, and this will suit the expectation to better meet local needs within substance misuse budgets. Alcohol will still have to make its voice heard – for instance, making the case that more focus is needed on preventing people getting to later-stage alcohol dependency through increasing community-based intervention and support options. Helping people to address alcohol problems at an earlier stage, before losing vital recovery capital like jobs, homes, friends or family is a no-brainer.

Of course many obstacles will remain, particularly that real invest-to-save wins often mean spending on things that deliver no short-term gains. Prevention agendas do not fare well in tough times, so genuinely effective longer-term approaches will be pitted against disappearing budgets and the desire for apparent quick wins. The temptation has previously been to invest more in reacting to alcohol harms as crime and disorder problems, rather than to prevent and address them as wider health and social issues. In principle, integrating public health within local authority responsibilities offers real opportunities to shift this – for instance in considering possible health and social harms within licensing and planning decisions.

On a national level, minimum pricing is unlikely to advance any further given the new government's position and the apparent faltering of Scotland's bold effort at the last hurdle (see news story page 4). Nonetheless the prime minister's recent backing of local pricing approaches may offer other options. The government's decision to ban the sale of below-cost alcohol is also a welcome step in recognising the role price plays in consumption, but concerns that it may not translate into an effective approach seem valid. If the definition of 'below cost' is determined simply as duty plus VAT it will make little difference to prices. And if it's determined as the invoiced cost, how will compliance be ensured?

Another opportunity may exist in the Treasury's current review of alcohol taxation, which will target cheap and strong drinks like white cider – again welcome recognition that price plays an important role in consumption. However tax tweaks will be unlikely to satisfy the on-trade whose calls for a 'rebalancing of the system' seem just given that nearly 70 per cent of alcohol is now reportedly sold by supermarkets.

Other concerns, such as people simply switching to whatever is cheapest or the impact on those with existing dependency, raise further questions. In the likely case that supermarkets continue to stack it high and sell it cheap, health interests will continue to call for minimum pricing. In the meantime, the less convincing but more palatable approaches of social marketing and self-regulation will remain the choice of a population-level strategy focused on achieving more 'personal responsibility'.

Nonetheless the momentum that has built up around the alcohol agenda will be crucial in trying to avoid taking two steps back during very hard times. At the time of the first national alcohol strategy, in 2004, the drugs and criminal justice agenda was standing firmly in the limelight and there were few cohesive strategic approaches to alcohol prevention and treatment. The evidence base was smaller, with no real supporting frameworks for commissioning, learning and development. Since then there has been a significant amount of attention and investment in these areas and, in some cases, the services themselves.

To give some examples, the brief interventions agenda has really caught on and a national Alcohol Improvement Programme has delivered leadership and resources, such as the online Alcohol Learning Centre and increased PCT support. Some excellent research and reports have come out, including some important NICE guidance and the Health Select Committee's candid 2009 alcohol report. Alcohol has also been taken more seriously by crime and disorder partnerships and overall public awareness of alcohol harm has risen, reflected by ongoing media attention.

But if it's not a fatal blow, the financial crisis will be a real flesh wound to further progress on the ground. The reality is that local alcohol strategy posts pulling these elements together for local authorities and PCTs are already easy targets for public sector job losses. Continuing to gather information and data that helps us to understand and respond to local needs is essential in ensuring limited resources are targeted most effectively. Many other issues also need further recognition, research and local development – a rapidly growing older population is adversely affected by alcohol, often isolated and without access to services, while young binge drinkers have been increasingly mixing alcohol, cocaine and new drugs without knowing the effects. Responding to the big shift towards home drinking also requires new and innovative approaches.

Some of my concerns therefore mirror the wider 'big society' debate – people support the rhetoric of personal responsibility and addressing inequalities but communities don't always have the expertise or time to pull together learning, apply strategic approaches and deliver interventions. Alcohol harm is complex and a fundamental objective remains a more responsible idea of alcohol use. Certainly this can be regarded as a cultural issue, but the evidence is clear that change will not be achieved with 'education' alone.

Much still needs to be done to address the common misconception that alcohol problems are limited to those with severe dependency, instead of a spectrum of misuse. Getting the message to over 7m 'risky' drinkers that it's

worth it to cut down can be regarded as an issue of personal responsibility because individuals must make their own choices, but to reach and support them in behaviour change we need more trained health, social care and other professionals on board.

Investing more in early intervention and early stage treatment allows simpler preventative approaches a chance to nip problems in the bud. Opportunities within other generic practices such as community pharmacists and sexual health services must continue to be realised, and the same applies to other services where alcohol use underlies many issues – social services, workplace, housing and criminal justice settings to name but a few.

To support this, continued improvement in community-based treatment is necessary as more alcohol dependency is unearthed. Primary care is obviously the bedrock of delivering brief interventions or appropriate referral for treatment, so with the huge shift of responsibility for commissioning to GPs the opportunity is there to get alcohol and lifestyle prevention approaches within routine practice. This was recently advocated by lead GP Steven Field and the requirements are now clearly set out in the NICE alcohol prevention guidance.

While some practices recognise the importance of addressing alcohol within primary care – the huge but oft-missed linked to depression and anxiety for instance – there is still a significant way to go to ensure consistent and proper screening, interventions and referral. The varied application of primary care alcohol incentives (such as the Direct Enhanced Service) has demonstrated the very mixed picture on the ground. In this respect, my fear for the new commissioning agenda is that it will not help address the postcode lottery problem. The scale and pace of change set out with the abolition of the PCTs and SHAs even has centre-right think tanks such a Civitas feeling anxious about the implications. So, as the changes happen, robust needs assessments must be presented to GP consortia with invest-to-save cases for implementing NICE and 'signs for improvement' alcohol commissioning guidance.

Some areas have already been recommissioning drug and alcohol services with a strong focus on primary care and shared substance misuse resources. So while some shifts in commissioning practice will create opportunities at a local level, securing the necessary wider buy-in will present new challenges as the landscape changes. We will need to strive harder in persuading wider health and social care, criminal justice and local authority leads that addressing alcohol issues is in everyone's interest. Progress through a separate alcohol strategy has been all important to identify and promote what works, but to progress further we now need all relevant agendas take ownership and push the case forward.

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