CAN SUCCESS EVER BE DEFINED?

THURSDAY, 6TH – FRIDAY, 6TH FEBRUARY 2014

Supported by the Portman Group

CONTENTS

As with all St George's House Reports, this report aims to reflect from an independent standpoint the main ideas and views put forward during the event, with the understanding that **not everybody involved in the discussions will have endorsed all of the ideas included**.

BACKGROUND

In October 2013 Irish Health Minister, Dr James Reilly, outlined his government's plans for a 'tobacco-free Ireland'. The aim was that by 2015 less than 5% of the population would smoke. Beyond this objective the government's 60 recommendations would aim to bring about the complete cessation of smoking. The minister has stated that, *"Smoking is the leading cause of preventable death in Ireland. Each year at least 5,200 people die from diseases caused by tobacco use. This represents almost one in five of all deaths."*

Looking beyond the rhetoric, a tobacco-free Ireland suggests far fewer deaths per year from smoking related illnesses. The implication is that something akin to an acceptable level of mortality from tobacco-induced illness can be achieved.

Turning the spotlight on alcohol, in the 1970s and 80s annual deaths from drink-driving in the UK regularly topped 1,400. Since then the figure has dropped sharply, to around 530-580 in the early 2000s, before dipping sharply between 2007-11. In 2011 an estimated 230 people died in such accidents, and while figures for 2012 show an increase of some 25% to 290, the figures are still substantially lower than those 30 years ago.

Of course drink-driving is illegal; the issue of civil liberties does not apply. Smoking is not illegal, therefore the matter of individual choice is very much to the fore. Yet in both instances, one hypothetical at the moment, the other backed up by hard statistics, can a reduction in deaths be defined as success? If we accept that even with an aim of reducing consumption to zero (as with tobacco) it is impossible to reach a completely death-free plateau in any such scenario, then can we acknowledge a point where there is an acceptable level of deaths, whether as a result of reducing consumption (smoking), or reducing over-consumption (alcohol abuse, poor diet etc.)? And if we can agree on such acceptable levels, can these, when achieved, be regarded as success stories?

What do we mean by success? And can it be measured only, or primarily, in terms of outcomes? The on-going and fractious debate about the over-consumption (and abuse) of alcohol in society is a case in point. All parties are agreed that abuse of alcohol can lead to increased pressure on our health system, more crime on our streets, loss of productivity at work, and familial dysfunction, all of which have social and economic implications. There is empirical evidence to substantiate such claims. But what about the economic, social and health benefits of alcohol to society?

The fractiousness arises when we consider how best to deal with such problems. The health lobby will attack the private sector on questions of pricing, special offers, increased availability of alcohol and advertising, to name a few areas of contention. The business community will counter that health lobby proposals aim for a reduction in absolute consumption as with tobacco (not a focus on over-consumption), and would punish responsible drinkers (the majority) and not necessarily solve the harms caused by those that abuse alcohol. There is little middle ground.

Perhaps we have reached the point where the debate needs to be taken to a different level. Is this the moment when the various interested parties might consider what realistic success might look like from their individual and organisational perspectives? Have we reached a point where an agreed target

can be set over the medium to long term, the attainment of which can be regarded as a shared success? If so, might this be a way to overcome stalemate?

CAN SUCCESS EVER BE DEFINED?

How could we define 'success' for levels of alcohol consumption in the UK? Given that 'we' includes groups and interests with some goals seemingly in tension or opposed, how can 'success' be defined to include as many shared interests and common aims as possible?

In the year just gone, the minimum price has been abandoned in England, the beer duty escalator scrapped, and 'Dry January' has publicised questions about our relationship with alcohol. Some community alcohol partnerships are working very well. Industry, through recent campaigns and the Portman Group, is increasingly engaged with the issues and Drinkaware continues to increase alcohol awareness. Overall volume of alcohol consumed is down (and has been declining since 2004).

However, harmful drinking remains at troubling levels, and some people, including some teens and young women, are consuming more alcohol than before. More needs to be done, but it has not been easy as yet to build broad agreement and partnerships between industry, public health, science, government, police, local authorities and others around alcohol consumption.

To make progress, we could:

- keep doing what works, while recognising continuing need for change
- look at UK alcohol consumption and its interested parties *now* (not past or potential)
- recognise UK alcohol consumption as a multifaceted issue requiring many partial answers
- accept and understand different motivations, strengths, and constraints among the players
- recognise and acknowledge common ground and concerns
- develop public consultation about acceptable levels for UK drinking
- agree shared goals in the form of hard figures defining 'success'
- acknowledge that different groups will retain different *measures* towards 'success'
- create partnerships for working together towards shared goals
- recognise various target audiences requiring targeted messaging about alcohol in the UK
- bring in other interested parties: advertising agencies, local authorities, etc.
- build on best practice and what has worked already
- use good research well
- acknowledge partners' ongoing (necessarily partial) achievements towards shared goals

'Industry vs public health'
For retail, goals and targets derive from winning market share (i.e. not declining as fast as competitors), and working with the rest of industry and in partnerships to engage with society and promote responsible drinking.

There is not necessarily a fundamental tension between selling alcoholic products and trying to change the culture around drinking. Commercial success is not equal to volume sold (whisky, for example, offers value through restriction of volume). Alcohol content can be reduced for some drinks (lager can't keep its

taste at low-alcohol levels while strong-tasting ales, stouts, etc. can). Importantly, commerce is in the business of supplying a substance the public wants; the alcohol content of drinks can't be nudged to zero and moral officiousness is not a possible stance.

Public health, necessarily, focuses on harms. Excess alcohol damages relationships and individual health. There is a clear link between alcohol and violence. We know this. Deprivation, and the number of licensed premises, point to violence in the statistics. Fundamental questions such as 'why is cider sold more cheaply than water?' should not get mired in econometrics and detailed disagreements about the meaning of variables. Overall safety and harm reduction is the concern. Alcohol is different from salt, for example, because there are victims of alcohol abuse other than the drinker. Alcohol treatment services for dependent drinkers cost half a million pounds in one county to treat one tenth of the dependent drinkers, who themselves comprise only one-third of the hazardous drinkers in the county.

It is not entirely true that commercial interests and public health interests are so polarised they can never agree. However, they use different sets of metrics to define 'success'. Broadly, commercial interests view harms as marginal minority cases, and desire policy to take the form of light-touch regulation and low taxation, through methods such as voluntary partnership, self-regulation, persuasion and nudges. Public health sees harms on a continuum and, concerned to promote and protect everyone's health, views it as a state responsibility to reduce harms by reducing consumption, with legislation to increase prices, make alcohol less available, and control marketing.

When based on different metrics for success, views of policy effectiveness and fairness also differ, and may often be defined in terms of winning arguments or establishing the first thoughts someone will have about the subject of alcohol. There are some intractable issues. It is also hard to see how to find common ground between risk-averse and risk-comfortable attitudes.

Common ground
Some common interests and shared agenda:

- Lessening underage drinking towards zero
- Lessening alcohol-related violence towards zero
- Lowering mortality rates connected with consumption of alcohol
- Lessening drunk-driving towards zero

Some shared solutions:

- Local partnerships (despite some scepticism, they have a good record of working)
- Lower-alcohol alternatives, where commercially possible
- Improved server training (which needs better back-up)
- Education and prevention (some scepticism about effectiveness)

We can agree on measures such as Challenge 21 and Challenge 25 (asking for ID before sale of alcohol), not selling to drunks, and Best Bar None, and should not abandon these while recognising that there are opportunities for industry (for example) to support staff better re underage sales, and that the mechanisms between Trading Standards, local authorities, and RIPA need to be simpler.

Organisations should *use* Portman to report irresponsible distribution/sale of alcohol so it can enter the system and something done about it. Getting more complaints to Portman would be easier if anonymous complaints could be made.

How to work together
There *are* always areas of common ground which can enable us to keep the good while not protecting an unsatisfactory status quo. Alcohol is not a problem in isolation from other areas of life, so let's keep finding areas for success, and recognising valid efforts: the industry has pledged to remove one billion units of alcohol from the UK marketplace, and ACPO has enabled the Proof of Age Standards Scheme (PASS) to be renewed in a form that looks workable, both to be applauded.

Talking about the past and what has been done or not done doesn't help with where we want to go, and isn't relevant to newer faces. Success means winning for the general public, and building trust, which is often difficult, but necessary. Could we frame questions in terms of who we want to do what, using key performance indicators, as in business?

More agreements would be very useful. Mutually agreeable goals for alcohol consumption in the UK would allow for more trust, and research geared to a shared end point rather than an uneasy continuum between disagreeing extremes. So what numbers would mean success? What do we think is an acceptable level of drinking in a liberal democracy? Social contract theory means finding out how to deliver the greatest good, which needs wide consultation with the public.

Leadership is needed to take the group further than each could go alone – where will it come from?

UK drinking-culture norms
To any one person at any given moment, 'alcohol' is many different things, but it is a historical constant. Cultural norms, including factors such as class identity and religion, are important in shaping our relationship with alcohol. What are the actual values of UK society (as opposed to the commercial vs. health arguments)? Can we discuss how and why people drink? We might examine statistics in other cultures such as high-Muslim-majority countries as a point of reference. We tend to look down to understand social problems (what is one's reaction to the phrase 'the drinking classes'?). We could look up instead.

In the UK, drinking culture is geared round volume and normalising volume, and is governed by the environment, expectations and what one can get away with. The round, as a ritual, encourages more drinking. At beer festivals, there is little violence. Rugby fans are 'safe to drink', football fans are not. It's debatable whether we have a 'liberal' drinking culture. Someone without ID can be obliged to pour their drink away; there are bans for drinking games.

Cultural changes
There has been a shift from drinking pints of ale to pints of lager over the past fifty years. Alcohol in combination with other drugs is a relatively new thing. Old style drunks were sleepy (beer); the new are lively and aggressive on vodka with energy drinks. Success for the UK could look like a Saturday nightclub full of excited, lively people looking out for each other. Failure looks like our town centre high streets at 5 am, when it's busier than a Saturday afternoon but with unwholesome activity. Taking an unconscious 26-year-old home to his parents is

no fun. Magistrates and counsellors need to come out on a Saturday late and *see* it.

Drinking patterns are changing; for example, fewer teens are drinking, but some are drinking much more; and more people, including women, seem to be binge-drinking, or drinking to get drunk. People are more aware of what units are than they used to be, but still can't look at a drink and say how many units are in it. Trends such as 'neknomination' worry parents; where are the boundaries, and who sets them? Drunkenness, among other drug-taking, devours public resources. Society can't guarantee the safety of drunks or others around them, and we are too tolerant of drunkenness as a cause to enter (and complicate) A&E.

Making changes requires reduction of harms, not getting caught up in consumption statistics.

Making good use of good research
Research (or its evidence base, or model) is a big issue often of contention. It is frequently criticised for not being neutral, or for being based on small or unrepresentative samples. Equally, neutral results may be used, or be seen to be used, in biased ways. The same results may be used to support different conclusions because they are viewed according to a different context or different starting assumptions.

Research should be independent, robust and open:

- Demand-side issues (sociologies of drinking; prevention; parental influence; neuroscience)
- Supply-side issues (policy implementation studies; econometric analysis)
- Treatment and interventions
- Harm pathways

Responsibility for health
Who – among individual, family, community and state – is responsible, to what extent, and at what times, for the health of the individual? It's a topic that can be argued hotly.

There is an assumption in public health that we are all hyper-rational, self-monitoring individuals unbound by context. In fact, people rarely 'believe wrong things' and so damage themselves; as emotional beings (not rational) they become unhappy, or don't care, and so drink harmfully.

Public health's focus on individual rather than social health harms is new. But in the social context, alcohol consumption is all about pleasure. If pleasure (or diminishment of perceived pain) had a metric as quantifiable as hospitalisation, it would be easier to judge risks versus benefits. Some drinking comes from alcoholism as a disease, and is to be treated with compassion, but much is chosen drunkenness. Being drunk and disorderly, or incapable, is against the law but we haven't set an upper limit of 'this is no longer *socially* acceptable' – perhaps we need to.

Science can't say *why* people drink. Nor can the state answer whether getting drunk is moral or immoral. Is drunkenness *per se* bad, because it diminishes usual self-control and social inhibitions? – or is it only anti-social behaviour, when it occurs, which is objectionable? It's not policymakers' business to make us more

caring to each other. It's about setting an example of good behaviour whereby personal responsibility and choice are linked with social responsibility and choice. Perhaps putting the public health function back into local government would be a good thing.

Parenting input is important: warning children early about alcohol, and providing consistent discipline in teenage years and discussion with them at university age. Heavy-drinking parents set an example and the (un)availability of parents sends important messages to a child about alcohol.

It's better to tackle root causes rather than the symptoms of social problems. Hazardous drinking doesn't take place in isolation. Good relationships are crucial and should be taken seriously as influencing health outcomes in adults as well as being necessary for children.

How to shift drinking culture towards perceived good
Establishing new norms is good: 'It's not cool to be drunk, to drink harmfully' and 'it's genuinely a shared problem'. Education is not predictably workable, but it helps, and multiple messages for greater awareness can lead to attitudinal change and lasting behavioural change over the next twenty to fifty years. It should be assumed that there is some personal responsibility involved. More shame could be invoked, through local employers, or local newspapers.

In the shorter term, cultural change can, perhaps, be underpinned with legislation – if the legislation is framed genuinely to drive change, and does not seek merely to remove a 'bad' from society. Legislation, however, is a blunt instrument, especially if not aimed at a clear outcome. In the case of seatbelts, it was culture that was shifted first; in the case of gay marriage, legislation made the running. Other laws, for example on dangerous dogs, have not worked (perhaps because they were not part of something bigger). Still, legislation could make the difference when the voluntary approach remains insufficient in sections of the market not playing the responsibility game.

Policy is often not based on conclusive evidence or research but is trying to answer questions of whether something is worthwhile on balance. Bringing in 'community safety' as a third term alongside commercial interests and health would help bring in new and different policy.

Short, sharp interventions are used in Amsterdam and Moscow; could these change our drinking culture? Should it be easier for the police to take drunks into custody, and for local authorities to generate more prosecutions for people who are clearly intoxicated? The police have to be able to use their discretion in deciding what to do: arrest, warning, fixed penalty, telling parents, etc. – but in serving the public they need to know what norm the public wants overall.

'Trigger events' can be an important catalyst for change: being arrested, or shown when sober a video of one's drunken behaviour when asked to leave the scene (Section 7), can be powerful indications to an individual that their drinking has gone too far. The idea of public 'drunktanks' (a £500 service to hold the inebriated safe) gets a positive public response on the basis that if someone chooses to get very drunk they should pay for the consequences. Breath-testing on the street is also possible. Sobriety bracelets can act as a later reminder not to drink. We need to pilot various such measures to test effectiveness.

Marketing

Marketing plays a huge role in how, what and when we drink by defining the image of a norm for people to agree with. There is, in principle, room to change alcohol consumption by marketing desired behavioural changes ('marketing brotherhood and rational thinking like soap'). One example is that plain packaging would disassociate alcoholic products from lifestyle and identity.

But putting pressure on people's lifestyles may have little effect in the context of who they are and where they are from. The hardest-to-reach populations are the ones you need to reach most, disproportionately located out of the socioeconomic reach of social marketing. Those who can make lifestyle changes do, so 'safe drinking' gets lower, but problem drinking stays much the same and inequality widens.

Nudging is an aligned theory, as is a form of libertarian paternalism whereby people are encouraged to make 'better' but still 'free' choices. But might we respond even better if appealed to as moral beings, rather than only in our (assumed) self-interests of longer life and better health at the expense of our desires?

Problem drinkers, problem drink

Some products are always drunk by problem drinkers: white cider, 7% lager. Reducing 6.5% drink to 4% gives an hour extra time in which to intervene for a problem drinker going through ten cans. What other ways could be used to extend that window of opportunity to intervene? Already-problem drinkers will find something else to drink, but if lowering alcohol availability prevents the not-yet-problem drinkers from becoming problem drinkers, it's a start.

Ten percent of people drink 44% of the alcohol consumed in the UK. To what extent will reducing *overall* consumption usefully affect that decile? The 'alcohol harm paradox' indicates that the quantity of alcohol consumed in itself is not a direct index of harm caused. The harms caused by a similar level of alcohol consumption are higher in multiple deprivation areas. Other experiences in the same category are heroin use and educational failure.

How do we calculate the amount of harm or violence that we can accept taking place?

Accessibility

Is the real problem people who drink too much, or alcohol in itself? Policy and pricing take place in a cultural context whereas intervention has to take place at an individual level. Ipswich's problem drinking culture was changed by reducing access *and* providing treatment. (It should be noted that removing high-strength beer and cider was reported to have been only one of thirty-six points in the overall plan originally devised to solve the problem of murder of street prostitutes.) Unarguably, if alcohol is cheap and available all day it's easier to abuse it. Long opening hours, early-morning restriction orders (EMROs) and late night levies are difficult topics, and local authorities and industry may wish to converse more openly about these.

Cost is another difficult issue. From a pubs' and producers' point of view, supermarkets sell too cheaply. But when tax is paid at the brewery rather than the retailer, it makes it hard to push for change. The law governing production of alcohol lacks nuance and does not take account of basic differences in means of production of, for example, beer, wine and spirits. Supporting a ban of low-cost

sales should take this into account. People who want alcohol will still buy it, possibly neglecting other more healthy purchases to make it possible. Do the possible health benefits arising from minimum pricing outweigh its costs and consequences?

Broad-brush policies

People genetically predisposed to addiction can't become addicted if not exposed; so, lowering the nation's exposure to alcohol will help them avoid alcohol addiction. One logical conclusion would be a blanket ban on drinking. Would this improve or protect the health of the population overall? Based on Prohibition records, it would lower the overall per capita consumption of alcohol which, based on post-war records in France, would decrease deaths by cirrhosis of the liver. Would that be a success?

Anti-smoking legislation was a blanket ban which, though widely supported, has not been entirely without cost in that it harmed some communities (social clubs, bingo halls) where social capital was a big protector of health. On the other hand, pubs now serve more food than restaurants, which is good for socialising, and good in terms of buffering and slowing alcohol consumed; and pubs build community – where else can young and old men talk together? There are different desires and problems at work in alcohol. Granted, a broad-brush policy will not touch problem drinkers, and may not be desired by the majority of the population. But this does not mean that any whole-population approach is one step towards legislating 'temperance'.

Identifying different audiences for targeted messages/interventions

Although there are different kinds of social drunks – ashamed next day, indifferent, or boastful – some rules are universal: look after your mates, don't drive, watch out for the vulnerabilities of sexual molestation, etc. These are hooks for public awareness campaigns. Drinkaware is a good example of a partial answer to alcohol's, which makes a positive difference by addressing the consumer in the voice of the consumer (not of government). Its website now gets 6 million hits per year whereas six years ago very few people sought information about alcohol online. Are such educational campaigns just about providing information – or is it realistic to expect they should demonstrate that they are driving changes in people's drinking behaviour?

Background messaging is also significant. Drunkenness is presented as entertainment on media. This should be looked at carefully regarding violence. Complicating simple messages is also problematic. Overall, the pubs' message is clear that drinking and driving is unacceptable; the public appreciates this; but an event such as the opening of a new Weatherspoon's pub on the M40 sends an unhelpful mixed message, as indeed do service stations selling alcohol. If the industry had said, we *could* open a pub but are not going to, it would have been a simpler (and better) communication.

Lowering middle-class drinking is a project with one particular target audience; helping addicts is another; giving accurate, nuanced, helpful information to pregnant women, tackling hazardous drinking among Armed Forces personnel, educating young people (and their parents) for resilience and self-worth, and informing harmful drinkers of consequences are others again. The right narrative has to be found for the target audiences.

Partnerships
Collective responsibility is key. No one answer (or group) can achieve what's needed for all, so we need to sacrifice extreme views for the sake of majority benefits. Partnerships can best succeed in areas we can agree on (even while there is disagreement elsewhere) and by concentrating on the areas we can control or influence – not where we can do nothing.

Without making the topic too big to deal with, alcohol consumption has to be opened up to wider partnerships, as obesity, housing associations, etc already have been – if not, the 'three-legged stool' of industry, public health and government is easily destabilised. Buy-in is needed from police, schools, health services, parents, local authorities, gangs, religious leaders etc. to get beyond transactions and get involved round a consensus. It's vital for everyone to play their part and understand others' parts (but not tell them what to do or do their jobs for them).

Suggested actions
Immediate actions which would help towards defining success and engendering positive changes in partnership could include:

- Agree about what good to aim for, especially for the young
- Find out from the public what is acceptable behaviour and desired or changing social norms
- Scale up some of the many local examples of partnerships that work well
- Communicate and roll out best practice more effectively, so wheels are not re-invented
- Segmented intervention (not using the same measures for cirrhosis as for binge-drinking)
- More conversations with media and the advertising industry
- More public and private conversations to communicate nuance which the media can't
- Home Office to re-establish a conversational group perhaps with more than one subgroup to bring together different sectors.

PARTICIPANTS

Mr Simon Antrobus
Chief Executive
Addaction

Mr Henry Ashworth
Chief Executive
Portman Group

Mr Miles Beale
Chief Executive
The Wine and Spirit Trade Association

Mr David Bowden
Press and Editorial Manager
Institute of Ideas

Dr Samantha Callan
Associate Director, Families and Mental Health
Centre for Social Justice

Professor Jonathan Chick
Medical Director
Queen Margaret University,
Edinburgh and Castle Craig Hospital

Dr Paul Crawshaw
Assistant Dean
Teesside University

Ms Allison Dowling
Corporate Relations Director, GB
Diageo

Mr David Goodhart
Director
DEMOS

Ms Sarah Hanratty
Deputy Chief Executive & Head of Corporate
Affairs
Portman Group

Baroness Dianne Hayter
Shadow Minister and Vice Chair
All Party Parliamentary Group on Alcohol Abuse
House of Lords

Dr Paul Hegarty
Stakeholder Relationship Manager
Drinkaware

Mr Adrian Lee
Chief Constable
Northamptonshire Police

Mr Gary McKeone
Programme Director
St George's House

Dr Fiona Measham
Professor of Criminology
School of Applied Social Sciences
Durham University

Sir Martin Narey
Chairman
Portman Group

Dr James Nicholls	Research Manager Alcohol Research UK
Mr Rupert Oldham-Reid	Researcher Centre for Social Justice
Ms Katharine Scarfe-Beckett	Rapporteur
Mrs Brigid Simmonds, OBE	Chief Executive British Beer & Pub Association
Mr Benet Slay	Ex-Chief Executive UK Ex Carlsberg
Mr Jason Smith	Battle of Ideas Festival Committee Member Institute of Ideas
Mr Christopher Snowdon	Director of Lifestyle Economics Institute of Economic Affairs

ABOUT ST GEORGE'S HOUSE

The House was founded in 1966 by H.R.H The Duke of Edinburgh and the then Dean, Robin Woods, as a place where people of influence and responsibility in every area of society can come together to explore and communicate their views and analysis of contemporary issues.

The House is located within Windsor Castle and forms part of the fourteenth century foundations of the College of St George. The heart of the College is St George's Chapel, where three times a day, every day, prayer is offered for the nation. That tradition of prayer, established in 1348 by King Edward III, has extended for more than six hundred years. It is precisely this tradition that gives the House its impetus and its wider theological context. The offering of prayer in the Chapel finds a practical expression in Consultations, where the House offers space for nurturing Wisdom.

Today our Consultation programme focuses on three distinct areas: contemporary issues, service to the Church, and hospitality for groups who, understanding the ethos and core objectives of the House, bring to us their own Consultations. Taken together our annual programme is varied, rich, and intellectually challenging.

The Duke of Edinburgh believes that, as the College is hidden away within the Castle walls, it is particularly attractive to people in positions of leadership within government, industry, commerce and the churches as a venue for discreet discussions of mutual and national interest.

Our aim is to effect change for the better in our society by nurturing Wisdom through dialogue.

The values of the House are openness, honesty, trust and respect. People from all areas of society, holding diverse views, opinions and beliefs come here to debate freely. The art of Consultation seeks to nurture Wisdom and open up the possibility of a different and better world.

The Wisdom we seek to nurture affirms and encourages, questions and surprises. It searches out new possibilities and desires the best for all our people and our planet. It is forward-looking and free from contemporary idols. It fosters personal and community transformation. The practical result of such Wisdom is trust, justice, equality and peace.
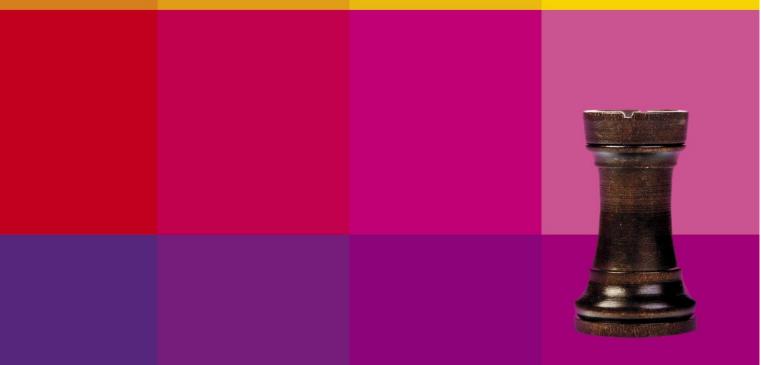
It is Wisdom based on knowledge, understanding, good judgement and far-sighted decision-making. It is Wisdom for our time.

ST GEORGE'S HOUSE

WINDSOR CASTLE
COLLEGE OF ST GEORGE
· HONI · SOIT · QUI · MAL · Y · PENSE ·

For more information about
Consultations at St George's House
visit www.stgeorgeshouse.org