Psychiatric Bulletin (1993), **17**, 726

Expert opinion

'The development of alcohol strategies in England and Wales': a review

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The misuse of alcohol causes a range of health, legal, social and employment problems for the individual and the rest of society. Many agencies are involved in dealing with the consequences of alcohol misuse and providing services to those with problems. Sources of funds to finance interventions for drinkers whether from health authorities, social services, probation or other sources are very limited. Without some co-ordination there will be a tendency for each funder to shift responsibility and costs. These difficulties have been recognised and in 1989 a government health circular was issued emphasising the need for the development of local multi-agency alcohol misuse prevention strategies. Implementing policies such as community care and *Health of the Nation* also require multi-agency co-operation if they are to fulfil their aims. The survey of the development of local alcohol strategies reported in this paper (Wallace *et al*, 1993) is therefore of great interest.

The aim of the study was to assess how many health districts and regions had developed or were in the process of developing an alcohol strategy. The survey of all districts and regions in England and Wales, undertaken in November 1992, had a response rate of 89%. It may seem disappointing that only 27% of districts were found to have a strategy. However, given the major changes occurring in health and social services at the time of the study, it is perhaps a surprisingly high figure. More encouragingly 73% of those districts with no current strategy were planning a document. The range of agencies involved in developing a strategy would seem to vary with most involving health promotion, voluntary agencies, social services, public health, the police and psychiatrists/physicians. However, of the 49 districts who had involved other agencies in developing existing strategies only 32 had Family Health Service Authority involvement. Other agency involvement was also more mixed with only 14 districts using a contribution from occupational health, ten from magistrates and five from licensees.

The authors of this survey make four recommendations: to set a target that by 1995 all districts should have produced and implemented a strategy; that a set of criteria should be developed to judge the quality of a strategy; that Regional Alcohol Co-ordinators should have a role in both collating the information on the activity undertaken at a local level and reviewing these activities; and that by the end of 1994 all health districts and regions should have produced and implemented a workplace alcohol policy. This last recommendation could perhaps be extended to cover all statutory and non statutory agencies with which health authorities are contracting.

A strategy also needs to be implemented and for many areas recent changes in policy, particularly the separation of purchasers from providers, may change the nature of multi-agency working. One area not discussed by the authors of this report is the resources needed to produce and implement a strategy. Information about alcohol consumption and problems in a local area have to be collated from a number of sources and some skill is needed in analysing this data to identify the needs for services. Having a specific co-ordinator who can negotiate local initiatives across agencies may be necessary if plans are to be converted into action. Finally, if alcohol strategies are to thrive and prosper they will need the support of those who can influence purchasing decisions.

Reference

WALLACE, S. A., BENNET, J. & WARD, B. (1993) The development of alcohol strategies in England and Wales. *Journal of the Royal Society of Medicine*, **86**, 319–323.