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Priorities for Action on Alcohol in the 2018 Strategy



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1. Future of advertising and marketing

Suggested priority 1: Review of government policy on alcohol marketing, including independent market regulation as a replacement for the current industry self-regulatory system.

The evidence:

- There is an association between exposure to alcohol advertising or promotional activity and subsequent alcohol consumption in young people. Exposure to advertising has led to both earlier initiation into drinking and heavier drinking by children and young people so exposed [1].
- Evidence from seven studies of more than 13 000 young people aged 10-26 years has shown that each additional alcohol advertisement seen by youngsters increases their alcohol consumption by 1% [2].
- Children are more likely to drink beverages that have been heavily advertised unlike adults who consume a more diverse range of products [1].
- The current self-regulatory systems that govern marketing are not meeting their intended purpose of restricting children's exposure to marketing in the UK [1]. This is clearly analogous to the voluntary agreements with the tobacco industry which have been demonstrated to fail in protecting children from the harms of advertising [3].

Suggested priority 2: Implement bans or restrictions on price promotions for alcohol.

The evidence:

- Price promotions influence purchasing patterns of alcohol [1].

- The level of intoxication and the odds of drink-driving and being involved in physical altercations upon leaving an on-trade venue is doubled by the presence of price promotions such as 'happy hour' [1].
- Analysis of the impact of the multi-buy ban in Scotland demonstrated it was associated with a 3% decrease in off-trade alcohol sales, largely driven by wine sales [4].
- Modelling of a complete ban on off-trade discounting in England is estimated to reduce alcohol consumption by a similar amount (2.8%) [1].

2. Alcohol sales and licensing

Suggested priority 1: Reduce alcohol consumption through price with a combination of taxation and minimum unit pricing (MUP).

The evidence:

- There is strong evidence demonstrating that the price of alcohol is an important determinant in its consumption. A 10% increase in the price of alcohol would lead to a 5% decrease in its consumption [1, 5].
- Increasing tax is associated with a proportionate decrease in alcohol consumption and harms and is therefore a highly effective and cost-effective approach which offers the greatest benefits to heavy drinkers [1].
- MUP would affect high risk drinkers and off-trade the most; moderate drinkers and on-trade would be minimally affected at the usually proposed rates [1].
- Among different policy alternatives, a MUP is more effective in reducing consumption than specific taxation, especially for consumers in the lowest-income quintile. Policies that increase the cost of the cheapest alcohol can therefore be effective in reducing alcohol consumption and associated harms including health service use, without having substantial regressive effects [6].
- The combined impact of increases in taxation and MUP is greater than for either of these measures alone, both in terms of decreases in alcohol consumption and the associated harms to health, and in positive impacts to the Exchequer [1].
- Some good evidence emerging from Russia that recent state level alcohol harm reduction policies including duty rises, MUP for vodka and clampdowns on illegal production are already resulting in a significant reduction in the high levels of alcohol related mortality in Russia [7].

Suggested priority 2: Review the role of licensing in protecting children and young people from exposure to alcohol environments. Consider restrictions on where children and young people may be seated in licensed premises, times when they may be present, and supervision of children and young people in licensed premises as measures that reduce harm and promote wellbeing.

The evidence:

- The pro-alcohol culture in the UK has led to normalisation of drinking in a range of settings and has resulted in a cultural blindness to the impact of alcohol-related harm [8].
- Risks are increased where licensed premises have no restrictions on where families can sit (e.g. at the bar), the time that families can be present, where the focus is on drinking and where alcohol is advertised [1].
- Without appropriate restrictions the risks of initiation into alcohol consumption and heavier drinking by young people are considerably increased [1]. While a recently published report confirm that young peoples' drinking continues to decline [9], the underlying reasons for this remain uncertain, meaning that any complacency about this as a permanent trend may be misplaced.
- The UK government adopted the UN Convention of the Rights of the Child in 1989 [10]. This includes protection from use of psychotropic substances defined in international treaties.
- The licensing board has a duty to protect children and young people from harm. This duty encompasses protecting children from excessive exposure to alcohol environments, areas where alcohol is advertised, alcohol consumption is the main focus of activity and where excessive consumption may occur.
- Recently updated Home Office Guidance specifically stipulates that local authorities should pay particular attention to promoting the 'protection of children' objective in areas where there are 'high levels of alcohol-related harms in persons aged under 18 (section 2.29 of updated guidance [11]).

Suggested priority 3: Explore measures within the current licensing set-up that might better address the recent compelling evidence around the strong social gradient in both alcohol harms and alcohol availability. Consider the introduction of a fifth licensing objective to protect public health.

The evidence

- UK Population level studies have clearly demonstrated an elevated health burden attributable to alcohol in more disadvantaged groups, even though consumption levels are less [12].
- Otherwise known as ‘the alcohol harm paradox’ and recently confirmed for Scotland in a detailed nation-wide analysis [13], it is likely to be challenging to address given the higher densities of alcohol off-sales premises currently seen in more socially deprived areas throughout the UK [14, 15].
- Areas with more proactive licensing policies including greater use of policy instruments to restrict new licence applications, such as cumulative impact zones, are associated with a greater likelihood of reductions in both alcohol related hospital admissions and alcohol related harms [16-18]. Given the above-noted established excess harms in more socially deprived areas, there may be a case for encouraging local authorities to make greater uses of licensing restrictions in more socially disadvantaged areas.

3. Treatment

Suggested Priority 1: Address missed opportunities for identification and brief intervention or treatment through increased screening and Identification and Brief Advice (IBA) training in healthcare professionals.

The evidence:

- over 10 million people in England are drinking at increased risk levels or above [1]. Alcohol brief intervention for those drinking at increased risk and treatment for dependent drinkers is known to be effective [23] but this relies on identification of these individuals.
- There is evidence from modelling that the delivery of IBA in various settings could reduce alcohol-related harm [1]:

Delivery of IBA to every patient at their next registration with a new GP in England is estimated to result in

- Almost 2,400 fewer alcohol attributable deaths
- Almost 125,000 fewer hospital admissions
- Net savings to the NHS of £282 million
- People in the lowest socioeconomic groups experience the greatest absolute reduction in harm but the lowest relative reduction because they have a higher baseline level of alcohol-related harm.

Delivering IBA to all adults aged 40 – 74 who attend an NHS Health Check over the five-year cycle is estimated to result in:

- Almost 1,900 fewer alcohol-attributable deaths
 - Almost 86,000 fewer hospital admissions over 20 years
 - Net savings to the NHS estimated at £262 million
- The prevalence of drinking at increasing risk or above is highest for men aged 65-74 years old (39%) and for women 55-64 years old (21%) [1]. These age ranges are included in the NHS Health Check programme and would therefore offer opportunity for IBA in this setting.
 - Other settings where IBA has been shown to be effective include emergency departments and the criminal justice system and A&E [1]. At present, the evidence for delivery of IBA in sexual health clinics and pharmacies is limited [1].
 - Universal alcohol screening to all patients coming in to an acute medical unit of a large acute hospital has been shown to be feasible and identifies patients at increasing risk of alcohol harm as well as those with frequent A&E attendance, recurrent admissions, and elevated risk of alcohol-related liver disease [19].
 - Understanding of alcohol content is low by health professionals. A cross-sectional survey of 891 medical and nursing students found they were only able to correctly estimate the alcohol content in an average of 2.4 out of the 10 drinks. Wine and premium strength beers were underestimated by over 50% of students. Those who drank alcohol themselves, or who were further on in their clinical training, did better on the task, but overall the levels remained low [20]. Therefore, education around alcohol is needed at all stages of health professional training.

Suggested priority 2: Increasing access to cost-effective treatment for higher risk and dependent drinkers through increases in investment in specialist services and the expansion of the relevant workforce such as specialist alcohol care teams and addiction psychiatry. In a suggestion promoted by Alcohol Concern UK for example [21], increasing the tax on alcohol by 1% and ring fencing that amount for treatment services would provide £100 million each year, leading to estimated downstream savings of £300 million.

The evidence:

- There is evidence of pronounced regional disparities in the capacity of alcohol treatment services according to levels of need [21]: specifically, conservative estimates of the 1.4% of the population dependent on alcohol, 80% are not in any contact with treatment services. Furthermore, this varies geographically with many of the most deprived areas facing the highest levels of need, most acute gaps in provision, and poorest treatment outcomes.

- Given the estimate from Public Health England that for every £1 invested in effective alcohol treatment brings a social return of £3 [22], the under-investment and significant risk of further cuts in areas worst affected already after the removal of the public health ring fence in 2020, must be a significant cause for concern [21].
- A review by NICE (2010) [23], concludes that psychological and psychosocial therapies are effective in supporting recovery and recommended for alcohol dependence. These include:
 - Behavioural couples therapy
 - Cognitive behavioural therapy
 - Motivational enhancement therapy
 - Social behaviour and networks therapy
 - Behavioural therapies which apply principles of positive reinforcement
- There is evidence for the use of some pharmacological agents in the treatment of dependency, when used in conjunction with the psychosocial and psychological therapies [1].
- Scotland saw a doubling of the number of people in treatment from 2007 – 2012 following additional investment and national good practice guidance. One in four adults with possible alcohol dependence accessed alcohol services. Access is higher in Scotland than in England & Wales and is high by international standards [24].

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