# Health First

## An evidence-based alcohol strategy for the UK

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UNIVERSITY OF STIRLING

alcohol health alliance uk

BRITISH LIVER TRUST

# Health First: an evidence-based alcohol strategy for the UK

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# Foreword

The consumption of alcohol is an established part of life in the UK today. It is not ubiquitous – there are many people who choose not to drink – but, for the majority of adults in the UK, alcohol is accepted and enjoyed both in the routines of daily life and in the events that mark out the broader pattern of life: birthdays, weddings and celebrations of all kinds. The pleasure of alcohol, for those who choose to drink, is clear.

Yet alcohol also brings forth a whole world of harm. For the individual, regular drinking risks a future burdened by illnesses such as cancer, liver cirrhosis and heart disease, and a taste for alcohol can turn all too easily into dependence. For families, alcohol dependence can lead to relationship breakdown, domestic violence and impoverishment. For communities, alcohol can fuel crime and disorder and transform town centres into no-go areas. For society as a whole, the costs of alcohol consumption include both the direct costs to public services and the substantial impact of alcohol-related absenteeism on productivity and earnings.

In March 2012 the UK government launched a new alcohol strategy for England which promised to tackle the harms of alcohol 'from every angle'. We welcome this strategy which included many new measures including the important step of introducing a minimum unit price for all alcohol sales. However, other important steps remain to be taken. Elsewhere in the world, governments are acting with foresight and courage to reduce the harm from alcohol. In South Africa, for example, the Minister of Health has announced that he will be putting legislation before parliament to prohibit the advertising of all alcohol products. If the UK government is to be a world leader in tackling the harm from alcohol, as it is in tackling the harm from tobacco, it needs to take robust action and seize every opportunity for change.

This report has been produced by an independent group of experts with no involvement from the alcohol industry. It has been written for everyone with an interest in promoting public health and community safety, at both national and local levels. The time has come to acknowledge the extraordinary scale of the harm caused by alcohol in the UK, develop a genuinely proportionate, evidence-based response, and change society's relationship with alcohol for the better.

Professor Sir Ian Gilmore

Chair, Alcohol Health Alliance UK

# Supporters

This strategy was produced by an independent group of experts under the auspices of the Alcohol Health Alliance UK. The members of the strategy group are listed in the appendix. The strategy is supported by the following organisations:

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Alcohol Health Alliance UK
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Balance, the North East Alcohol Office
Breakthrough Breast Cancer
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Faculty of Occupational Medicine
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Health & Social Care Alliance Scotland
Institute of Alcohol Studies
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Liverpool John Moores University
Medical Council on Alcohol
Men's Action Network (Northern Ireland)
Men's Health Forum
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Mouth Cancer Foundation
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NECA
Newcastle City Council
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North East Clinical Liver Network
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# Summary

Alcohol is taken for granted in the UK today. It is easy to get hold of, increasingly affordable, advertised everywhere and accepted by many as an integral part of daily life.

Yet, despite this, the great majority of the population recognise the harm that alcohol causes. They believe that drinking damages health, drives antisocial behaviour, harms children and families and creates huge costs for the NHS and the Police.

They are right. Every year in the UK, there are thousands of deaths and over a million hospital admissions related to drinking. More than two in five (44%) violent crimes are committed under the influence of alcohol, as are 37% of domestic violence incidents. One fifth of all violent crime occurs in or near pubs and clubs and 45% of adults avoid town centres at night because of drunken behaviour. The personal, social and economic cost of alcohol has been estimated to be up to £55bn for England and £7.5bn for Scotland.

None of this should be taken for granted. The impact of drinking on public health and community safety is so great that radical steps are needed to change our relationship with alcohol. We need to imagine a society where low or no alcohol consumption is the norm, drunkenness is socially unacceptable and town centres are safe and welcoming places for everyone to use. Our vision is for a *safer, healthier and happier world where the harm caused by alcohol is minimised*.

This vision is achievable. But only if we tackle the primary drivers of alcohol consumption. The evidence is clear: the most effective way to reduce the harm from alcohol is to reduce the affordability, availability and attractiveness of alcohol products. It is not enough to limit the damage once people are drunk, dependent, ill or dying. We need to intervene earlier in order to reduce consumption across the entire population.

The tools are available. The 'four Ps' of the marketing mix – price, product, promotion and place – are used by alcohol producers and retailers to increase their sales of alcohol. They can also be used by government to reduce alcohol sales, alcohol consumption and alcohol-related harm.

Alcohol taxes are an effective public health measure as they raise prices and suppress demand. However, if they do not keep pace with both inflation and incomes, alcohol products will become more affordable over time. This has been the case in the UK. Deep discounting by retailers has also driven down the price of alcohol and encouraged heavy drinkers to maintain dangerous levels of consumption. These problems need to be tackled by a combination of more effective fiscal policy and controls on pricing and discounting.

Alcohol products are an extraordinary anomaly. Unlike most food products, they are both remarkably harmful and exceptionally lightly regulated. As with other toxic products, the product label ought to communicate the content of the product and the risks of its consumption. Regulation should drive out products that appeal to young people while also incentivising the development and sale of lower strength products.

The pervasive marketing of alcohol products in the UK is indefensible. Current restrictions are woefully inadequate: children and young people are regularly exposed to alcohol advertising in both old and new media. Only a complete ban on all alcohol advertising and sponsorship will make a lasting difference.

Licensing practice in the UK is out of date. The focus on pubs and bars has allowed shops and supermarkets to become the dominant players in alcohol sales. Consequently, alcohol is now more available than it has ever been. This has driven pre-loading: getting drunk on cheap, shop-bought alcohol before heading out to late-opening night life. Licensing must focus on public health and seek to control the overall availability of alcohol as well as the effects of drunkenness.

Beyond these population-level approaches, many more targeted measures are needed to reduce alcohol-related harm. Early intervention by health and social care professionals is an important and underexploited opportunity to prevent problems developing. Stronger drink driving measures are also required.

All these measures are needed. Together, they provide a template for an integrated and comprehensive strategy to tackle the harm from alcohol in the UK.

# Recommendations

## Top Ten Recommendations

- A minimum price of at least 50p per unit of alcohol should be introduced for all alcohol sales, together with a mechanism to regularly review and revise this price.
- At least one third of every alcohol product label should be given over to an evidence-based health warning specified by an independent regulatory body.
- The sale of alcohol in shops should be restricted to specific times of the day and designated areas. No alcohol promotion should occur outside these areas.
- The tax on every alcohol product should be proportionate to the volume of alcohol it contains. In order to incentivise the development and sale of lower strength products, the rate of taxation should increase with product strength.
- Licensing legislation should be comprehensively reviewed. Licensing authorities must be empowered to tackle alcohol-related harm by controlling the total availability of alcohol in their jurisdiction.
- All alcohol advertising and sponsorship should be prohibited. In the short term, alcohol advertising should only be permitted in newspapers and other adult press. Its content should be limited to factual information about brand, provenance and product strength.
- An independent body should be established to regulate alcohol promotion, including product and packaging design, in the interests of public health and community safety.
- The legal limit for blood alcohol concentration for drivers should be reduced to 50mg/100ml.
- All health and social care professionals should be trained to routinely provide early identification and brief alcohol advice to their clients.
- People who need support for alcohol problems should be routinely referred to specialist alcohol services for comprehensive assessment and appropriate treatment.

### The development of public policy

1. Public health and community safety should be given priority in all public policy-making about alcohol.
2. Drinks companies should contribute to the goal of reducing alcohol-related harm only as producers, distributors and marketers of alcohol. They should not be involved in alcohol policy development or health promotion.
3. The UK government and the devolved administrations should develop appropriate alcohol policy targets for each of the nations and regions of the UK.

### National taxation and price policy

4. A minimum price of at least 50p per unit of alcohol should be introduced for all alcohol sales, together with a mechanism to regularly review and revise this price.
5. Taxes should be used to raise the real price of alcohol products such that their affordability declines over time.
6. All bulk purchase discounting of alcohol including ‘happy hours’ should be prohibited.
7. The tax on every alcohol product should be proportionate to the volume of alcohol it contains. In order to incentivise the development and sale of

lower strength products, the rate of taxation should increase with product strength.

## Regulation of alcohol promotion and products

8. An independent body should be established to regulate alcohol promotion, including product and packaging design, in the interests of public health and community safety.
9. All alcohol advertising and sponsorship should be prohibited. In the short term, alcohol advertising should only be permitted in newspapers and other adult press. Its content should be limited to factual information about brand, provenance and product strength.
10. Alcohol producers should be required to declare their expenditure on marketing and the level of exposure of young people to their campaigns.
11. The sale of alcohol products that appeal more to children and young people than to adults should be prohibited.
12. At least one third of every alcohol product label should be given over to an evidence-based health warning specified by an independent regulatory body.
13. Every alcohol product label should describe, in legible type, the product's nutritional, calorie and alcohol content.

## Licensing and local authority powers

14. Public health should be a core objective and statutory obligation of licensing throughout the UK.
15. Licensing legislation should be comprehensively reviewed. Licensing authorities must be empowered to tackle alcohol-related harm by controlling the total availability of alcohol in their jurisdiction.
16. Local authorities should develop comprehensive alcohol strategies that prioritise public health and community safety.
17. Measures to deal with the consequences of drunkenness must be complemented by measures to reduce the prevalence of drunkenness, including forward planning of the number, density and opening hours of all licensed premises.
18. The sale of alcohol in shops should be restricted to specific times of the day and designated areas. No alcohol promotion should occur outside these areas.
19. The law prohibiting the sale of alcohol to people who are already drunk should be actively enforced.
20. Wherever alcohol is sold, a soft drink should be available that is cheaper than the cheapest alcoholic drink on sale.
21. Local authorities should use local byelaws to improve community safety by creating alcohol-free public spaces where alcohol consumption is prohibited.

## Drink driving measures

22. The legal limit for blood alcohol concentration for drivers should be reduced to 50mg/100ml.
23. Random breath-testing of drivers should be introduced.
24. Graduated driver licensing should be introduced, restricting the circumstances in which young and novice drivers can drive.

## Early intervention and treatment

25. All health and social care professionals should be trained to routinely provide early identification and brief alcohol advice to their clients.
26. People who need support for alcohol problems should be routinely referred to specialist alcohol services for comprehensive assessment and appropriate treatment.
27. Greater investment is needed in specialist community-based alcohol services to meet current and future alcohol treatment needs.
28. Every acute hospital should have a specialist, multi-disciplinary alcohol care team tasked with meeting the alcohol-related needs of those attending the hospital and preventing readmissions.

## Mass media

29. Mass media health promotion campaigns should be developed as part of broader strategies to reduce the harm from alcohol. Campaigns should be designed and run independently of the alcohol industry.
30. Guidelines for the portrayal of alcohol in television and film should be developed and promoted.

chapter 1

# Safer, healthier, happier


## Summary

The harm caused by alcohol is a problem for the whole of UK society. Every year, millions of individuals and families suffer the direct and indirect adverse effects of drinking. This needs to change: we need to imagine a future where low or no alcohol consumption is the norm, drunkenness is socially unacceptable and town centres are safe and welcoming places for everyone to use. Our vision is for a safer, healthier and happier world where the harm caused by alcohol is minimised.

This vision will only be achieved if the overall volume of alcohol consumed within the UK is significantly reduced. Alcohol-related harm is not confined to a small minority. Heavy drinkers may be most at risk of harm but alcohol has long-term health consequences for the large population of regular drinkers. A comprehensive approach to tackling alcohol must combine population measures to reduce the affordability and availability of alcohol for all drinkers with targeted measures to support those who are most vulnerable to harm.

A comprehensive agenda for change needs the involvement and support of the many national and local stakeholders who are committed to promoting public health and community safety. This does not include the alcohol industry which has a fundamental conflict of interest and no expertise in public health. The industry's contribution should go no further than what they can offer as producers, distributors and marketers of alcohol.

The tools used by industry can, however, be used by those committed to promoting public health and community safety. Just as the four Ps of the marketing mix – price, product, promotion and place – are used by the alcohol industry to maximise their sales, so they can be used by policy makers to reduce both sales and alcohol-related harm.

### Public health goals

- Reduce the overall level of alcohol consumption in the population
- Reduce the incidence of alcohol-related illness, injuries and deaths
- Reduce the incidence of alcohol-related disorder, anti-social behaviour, violence and crime

### Recommendations

- Public health and community safety should be given priority in all public policy-making about alcohol.
- Drinks companies should contribute to the goal of reducing alcohol-related harm only as producers, distributors and marketers of alcohol. They should not be involved in alcohol policy development or health promotion.

## Minimise harm

The harm created by alcohol is immense. Every year in the UK, there are thousands of deaths, hundreds of thousands of hospital admissions and over a million violent crimes linked to drinking alcohol. This is not a problem of a small minority. It is a problem that cuts across the entire population.

Given the scale of the problem, we need to ask ourselves: is the current policy response proportionate? Is it even adequate? A comparison with the response to tobacco is instructive: over the past thirty years, images of cigarettes have all but disappeared from public view and smoking has become increasingly socially unacceptable. Over the same time period, the opportunities for buying alcohol have multiplied and drinking and drunkenness have become ever more visible. Alcohol branding is commonplace and alcohol advertising penetrates all media, reaching new audiences every day.

Major changes are needed to reverse these trends and drive down the harm from alcohol in the UK. We cannot reduce this harm to zero, for any alcohol consumption carries some risk. As long as people drink, there will be adverse consequences of their drinking, yet outright prohibition would bring its own harms; illicit markets are never harm-free. The best we can do – and we are some way from this today – is to focus squarely on reducing the harm from alcohol in order that individuals, families and society can flourish.

Our vision is for a *safer, healthier and happier world where the harm caused by alcohol is minimised*.

The current place of alcohol in British culture is not immutable. It changes all the time. Over the past thirty years, drinking has changed from an activity pursued mainly by men, with beer, in the pub, to an activity pursued by most of the population in many different settings and with many different drinks. We must begin by imagining how the place of alcohol in British life could change again, for the better: a society where low or no alcohol consumption is the norm, drunkenness is socially unacceptable and town centres are safe and welcoming places for everyone to use.

Our vision is ambitious but achievable. It requires a comprehensive approach to tackling the harm from alcohol. In turn, this requires that we make use of the best available evidence, identify all the drivers of alcohol-related harm and prioritise the most effective ways of tackling them.

## Policy goals and approach

If we are to minimise the harm from alcohol in the UK, we must:

- reduce the overall level of alcohol consumption in the population;
- reduce the incidence of alcohol-related illness, injuries and deaths; and
- reduce the incidence of alcohol-related disorder, anti-social behaviour, violence and crime.

The first of these goals is critical: we will not reduce the harm from alcohol in the UK unless we significantly reduce the total volume of alcohol that the population consumes. Alcohol-related harm is not confined to a minority of very heavy drinkers who experience acute problems. The greatest harm overall is suffered by the large population of regular drinkers whose exposure to alcohol has long-term consequences for their health and well-being. This is why highly targeted interventions for those at greatest risk are necessary but not sufficient. Long-term success in minimising the harm from alcohol will only be achieved by population measures that reduce the affordability and availability of alcohol products for all drinkers. The research evidence is unequivocal: such population measures are the most effective in reducing alcohol consumption and alcohol-related harm[1,2,3].

This report sets out a strategy that combines population measures, such as controls on the pricing, advertising and sale of alcohol, with targeted measures such as drink driving restrictions and support for problem drinkers. This range of policy options is not a 'pick and mix' offer – every one of them is important. Long-term success in reducing the harm from alcohol in the UK will only be achieved if every opportunity for effective action is pursued, at every level of society.

**Our vision is for a safer, healthier and happier world where the harm caused by alcohol is minimised**

This requires that public health and community safety are prioritised in all national and local decision-making about alcohol policy.

**Recommendation**

Public health and community safety should be given priority in all public policy-making about alcohol.

## Partners in change

As the emphasis of this report is firstly on population-level measures to tackle the harm from alcohol, many of our recommendations are addressed to government. However, local authorities, the NHS and the police also have major roles to play, as do schools and universities, youth agencies, sports bodies and many voluntary and community organisations. A comprehensive approach to tackling the harm from alcohol in the UK requires not only an extensive agenda for change but also broad support from all of those who are committed to promoting public health and community safety.

The British people are at the centre of this collective effort to transform our relationship with alcohol. It is their lives and their communities that suffer the consequences of harmful drinking. The vision described above will only be achieved with their support. It is increasingly clear that this support is forthcoming and tougher action is expected by the public (chapter 9).

In contrast, the alcohol industry is not a partner in change. We believe that the industry's conflict of interest is simply too great to allow it to take on a meaningful role in reducing the harm from alcohol. Long-term health improvement will only be achieved if the overall level of alcohol consumption in the population is significantly reduced. This is not an objective that the alcohol multinationals could ever endorse because they are required by law to prioritise shareholder returns over all other considerations. Likewise, the retail sector has no interest in reducing their sales. In fact, the discounting of supermarkets has become a key driver of alcohol-related harm. Turning a profit is also necessarily a primary concern of small businesses such as local pubs and shops.

The alcohol industry's overriding focus is on the successful marketing of alcoholic products, and it is only in this capacity that producers and retailers should be expected (indeed required) to make a contribution. For example, the industry has the expertise to produce and market low-alcohol products, to make pubs safer and less alcohol-centric, and to train staff appropriately. Such actions are valuable but they are secondary to the population-level measures described in this report. They should never delay or replace measures that are more effective in reducing the harm from alcohol.

The World Health Organisation has stated categorically that any public health interaction with commerce 'should be confined to discussion of the contribution the alcohol industry can make to the reduction of alcohol-related harm only in the context of their roles as producers, distributors and marketers of alcohol, and not in terms of alcohol policy development or health promotion'[4].

**Long term health improvement will only be achieved if the overall level of alcohol consumption in the population is significantly reduced**

**Recommendation**

Drinks companies should contribute to the goal of reducing alcohol-related harm only as producers, distributors and marketers of alcohol. They should not be involved in alcohol policy development or health promotion.

## Policy options: exploiting the marketing mix

Like most consumer products, the marketing of alcohol is typically based on the 'four Ps' of price, product, place and promotion. Alcohol marketing seeks to make the right alcoholic product available at the right price in the right place, backed up by effective promotion. This framework provides the alcohol industry and its marketing agencies with a powerful means of identifying and exploiting opportunities to expand sales. This in turn increases alcohol consumption and alcohol-related harm.

The 'four Ps' framework is potentially just as useful to those who want to reduce the harm of alcohol. Just as the alcohol industry uses the tools of price, product, place and promotion to increase sales and profits, so government can use them as social marketing tools to pursue the public health goals described above.

The policy options set out below are framed principally around the four Ps of the marketing framework. The options are informed by the best available evidence, either on alcohol or, where that evidence is lacking, from other directly relevant areas of public health. The questions addressed are:

- How can the price of alcohol be adjusted to reduce alcohol-related harm?
- How can alcoholic products be better designed to reduce alcohol-related harm?
- How can the promotion of alcohol be curtailed?
- How can the places in which alcohol is sold and consumed be better regulated and designed to reduce alcohol-related harm?

Beyond the 'four Ps' framework, this report also describes the important roles that health and social care professionals and others can play in helping drinkers to reduce their alcohol consumption before serious harm occurs and supporting those with existing alcohol problems (Chapter 7). Chapter 8 describes a range of additional measures to reduce alcohol related-harm including drink driving measures and information and education.

chapter 2

# The scale of the problem


## Summary

Alcohol is a major public health problem across the globe. Worldwide, over two million deaths every year are attributable to alcohol.

The direct effects of alcohol on individual drinkers include illness, injury, mental ill health and premature death. In the UK, a substantial proportion of the adult population is at risk: every week 26% of men and 17% of women drink at hazardous levels. The consequences of this level of population exposure in the UK include around 8,750 alcohol-related deaths per year, 1.2million alcohol-related hospital admissions (in England and Wales) and nearly 10,000 casualties of drink driving road traffic crashes.

The harms of alcohol extend to children, families, communities and society as a whole. Violence is the most common route to harm: in England and Wales, 44% of all violent incidents and 37% of domestic violence incidents are committed by people who have been drinking. For many people, town centres become no-go areas on Friday and Saturday nights because of the violence and disorder created by drinking. The personal, social and economic cost of alcohol has been estimated to be up to £55bn per year for England and £7.5bn for Scotland.

Alcohol also drives inequalities: people from more deprived groups suffer far greater harm from alcohol than people in higher socio-economic groups.


## The direct impacts of alcohol

Alcohol is one of the leading causes of illness, injury and death across the world. Globally, the deaths of over two million people every year are attributable to alcohol, more than the annual deaths from HIV/AIDS or tuberculosis. Among men aged between 15 and 59, alcohol is the leading risk factor for premature death[1].

In 2005, worldwide consumption of alcohol averaged 6.1 litres of pure alcohol per adult per year[2]. In the UK, the average was 11.4 litres per head[3]. Although consumption in the UK has declined since 2005, averaging 10.2 litres per head in 2010, the exposure of the British population to alcohol-related harm remains at a historically high level.

Alcohol harms health in many different ways. It is a risk factor for liver disease, cardiovascular disease and cancers of the head, mouth, neck, liver, breast and bowel. It is linked to poor mental health, depression and dependence. It can cause acute toxic poisoning. It increases the risk of accidents, violence and injuries. It can harm the unborn child and reduce birthweight[4]. These risks do not affect a small minority but a substantial proportion of the entire adult population: every week in Great Britain, 26% of men and 17% of women drink enough to risk suffering physical or psychological harm[5]. The consequences of this level of population exposure to alcohol-related harm are profound.

Alcohol kills thousands of men and women in the UK every year: the deaths of 5,792 men and 2,956 women in 2011 were related to alcohol[6]. In one generation, the number of alcohol-related deaths in the UK has doubled from 4,023 in 1992 to 8,748 in 2011. Although the death rate has stabilised in recent years, thousands more people die today from alcohol-related causes than in the early 1990s (Figure 2.1).

A majority of the deaths related directly to alcohol – around two thirds – are from liver disease. However, there are many more deaths that can be attributed in

part to alcohol consumption. In 2005, an estimated 15,000 people in England and Wales died from alcohol-attributable causes[7]. This included 27% of men, and 15% of women, aged 16-24 years[8].

We have a long way to go to get back to the lower level of harm experienced 20 years ago, let alone to the low and stable levels of alcohol-related deaths last seen in the 1950s. Between 1950-54 and 2000-02, deaths from liver disease among men increased by a factor of five in England and Wales and a factor of six in Scotland. In women rates increased four-fold in the same period[9].

The dramatic post-war increase in liver deaths is undoubtedly due, in part, to increasing alcohol consumption. Other diseases linked to lifestyle have declined over the same period. Taking 1970 as its index, Figure 2.2 compares the long-term changes in premature deaths (under the age of 65) from liver disease to changes in premature deaths from other major causes including circulatory diseases and cancer. Liver disease is clearly the exception to the general trend. Furthermore, as the Chief Medical Officer for England highlighted in her 2012 Annual Report, liver disease is the only major cause of deaths and illness which is increasing in England while decreasing among our European neighbours[10].

Beyond these mortality statistics there are many more people whose physical and mental health is damaged by drinking. For example, in 2011/12 there were an estimated 1.2million hospital admissions in England related to alcohol consumption, more than twice the number in 2002/03[11]. Here there has been no levelling off: admissions have continued to rise year-on-year for the last ten years (Figure 2.3). The majority of alcohol-related hospital admissions (75%) are due to chronic conditions such as cardiovascular disease, liver disease and cancer. However 16% are for mental and behavioural disorders resulting from alcohol use and 8% are for acute illnesses including injuries[12]. The more alcohol any drinker consumes, the more likely they are to be injured as a result of falls, violence or motor accidents[13].

In 2011, one in seven (15%) of the people killed on the UK's roads was the victim of a drink driving accident. Overall, an estimated 9,990 people were casualties of drink drive accidents in the UK in 2011 including 280 who were killed and 1,290 who suffered serious injury[14]. Following eight years of decline, the number of deaths and injuries from drink driving accidents rose in 2011.

Alcohol consumption and mental ill health are initimately linked: drinking is often a cause of mental health problems but mental ill health can also lead to problem drinking. Similarly, both alcohol use and poor mental health may be driven by, and exacerbate, wider personal, family and social problems. A 2002 study of substance misuse and mental illness found that 85% of users of alcohol services were experiencing mental health problems[15]. Alcohol dependence is itself a

Figure 2.1 Alcohol-related deaths per 100,000 population in the UK, 1992-2011 (ONS)

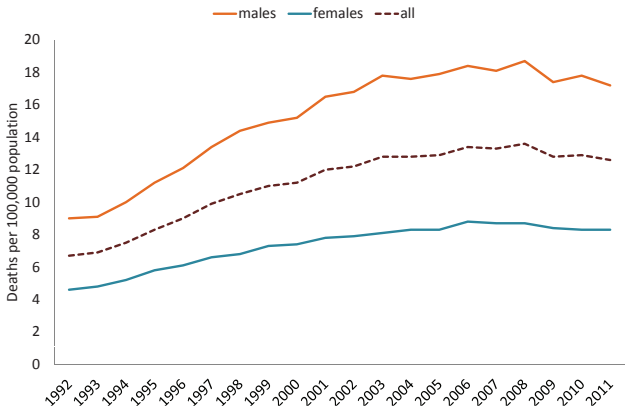



Figure 2.2 Deaths among people aged under 65 in the UK for major conditions, compared to 1970 (WHO)

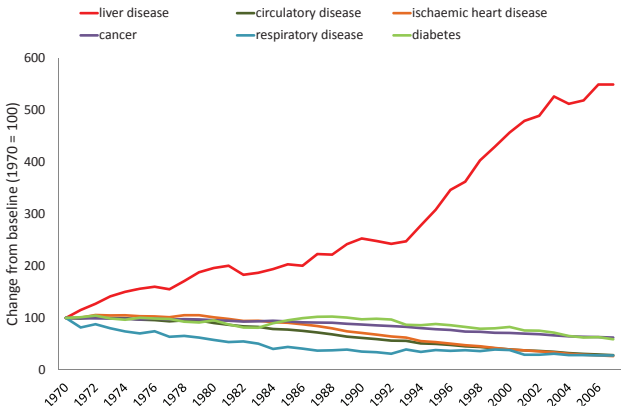
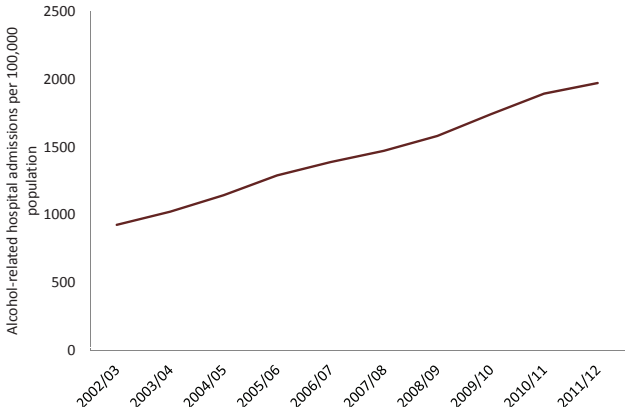



Figure 2.3 Alcohol-related hospital admissions per 100,000 population in England 2002-2012 (ONS)



significant mental health issue within the population, affecting 4% of people aged between 16 and 65 in England (6% of men and 2% of women)[16].

The physical and psychological risks of alcohol consumption are much greater for children and young people than they are for adults. In the UK, levels of drinking among 15-year-olds are significantly higher than the European average[17]. Currently early drinking uptake appears to be most common in Wales where high rates of drinking are already established among 13-year-olds (Figure 2.4).

The overall impact of alcohol on deaths, illness and disability is described by the number of lost 'disability-adjusted life years' in the population as a whole. According to the World Health Organisation, alcohol accounts for 9.2% of all the lost disability-adjusted life years in developed countries such as the UK, with most of these years lost due to mental health conditions and unintentional injuries such as road traffic accidents, burns, drowning and falls[18]. Whichever way the statistics are calculated, the conclusion is inescapable: the damage caused by alcohol to the health and wellbeing of individual drinkers is immense.

## Impacts on children, families and communities

Beyond the direct effects of alcohol on the health and wellbeing of individual drinkers, there are many adverse impacts of alcohol on children, families, households, communities and the national economy.

Within the home, domestic violence is all too often linked to drinking. In England and Wales in 2009/10, 37% of the victims of domestic violence perceived their attackers to have been under the influence of alcohol[19], and a Home Office study of male domestic violence offenders in England found that 49% had a history of alcohol abuse[20].

Children are especially vulnerable to violence and the wider effects of alcohol in the home. In 2008/09, a fifth (21%) of all young callers to Childline were worried about drinking by a parent or other significant person[21]. They described experiences of neglect, violence, isolation and fear.

Millions of children are at risk: in Britain, an estimated 3.4 million children live with at least one parent who binge drinks[22] and, in England, an estimated 79,291 babies under one year old live with a parent who is a problem drinker[23].

Recent research into the drinking behaviour of new parents found that, after the birth of their first child, 23% of parents continued to drink as much as before their baby was born and 17% increased the amount they consumed. Overall, around three in ten parents drank more than the recommended units per week[24]. Babies are at greater risk of dying suddenly and unexpectedly if their parents drink more than two units of alcohol before sleeping with them in a bed or on a sofa[25].

Both within and beyond the home, alcohol plays a central role in driving violence. In 2010/11, 44% of all violent incidents in England and Wales were committed by people who had been drinking[26]. That amounts to 928,000 alcohol-related violent incidents in a single year. Although the number of violent crimes in England and Wales has fallen over the last 15 years, the proportion committed under the influence of alcohol has not (Figure 2.5).

The economic cost of alcohol is difficult to quantify as no data are routinely collected. However each of the harms described above has a significant economic impact. Public services that bear the costs of alcohol include the NHS, local government, the police, the

Figure 2.4 Weekly drinking by 13-year-olds and 15-year-olds in Great Britain, 2009/10 (WHO)

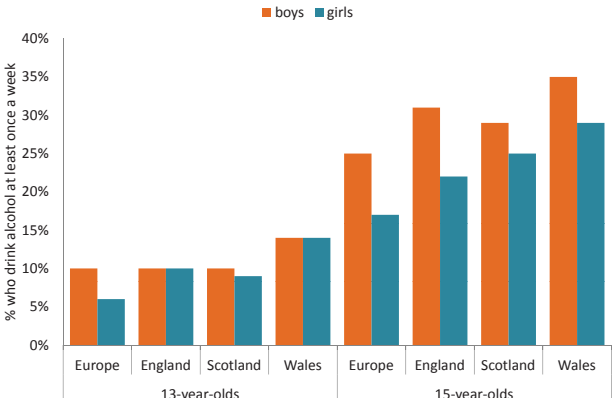
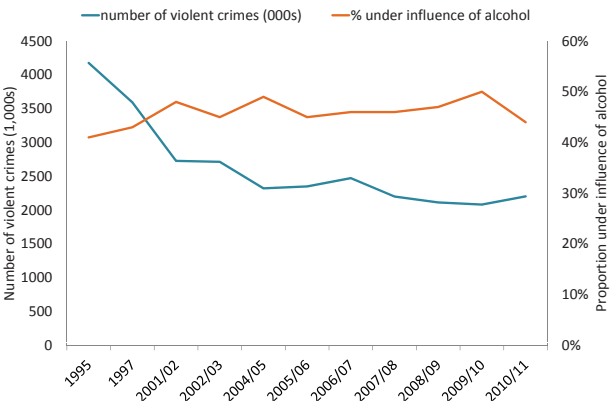



Figure 2.5 Violent crimes and the role of alcohol: England and Wales 2005 – 2011 (British Crime Survey)



justice system and schools. In addition, all sectors suffer from drinkers' absenteeism, illness and impaired performance. It is estimated that lost productivity accounts for at least half of the total social cost of alcohol[27]. One detailed estimate put the total personal, social and economic cost of alcohol in England at up to £55.1 billion per year[28]. Likewise a recent assessment for Scotland put the total annual cost to individuals and society at £7.5 billion per year[29].

## Health inequalities

Alcohol is also strongly linked to health inequalities with people from deprived groups suffering far greater harm from alcohol than those from higher socio-economic groups. Figure 2.6 illustrates the differences in alcohol-related death rates among working age adults across socio-economic groups in England and Wales. Deaths are far more common in lower socio-economic groups: there are nearly four times as many alcohol-related deaths among men in routine occupations than among men in higher managerial and professional roles (among women the ratio is nearly 5:1)[30].

Figure 2.7 illustrates a similar distribution for Scotland, though here all age groups and both sexes are described. The gradient is even more pronounced in this figure with over six times as many alcohol-related deaths in the lowest socio-economic quintile compared to the highest quintile[31]. The strength of the link between alcohol and inequalities is abundantly clear.

Figure 2.6 Alcohol-related mortality among adults aged 25-64 in England and Wales, 2001-03, by National Statistics socio-economic classification (ONS)

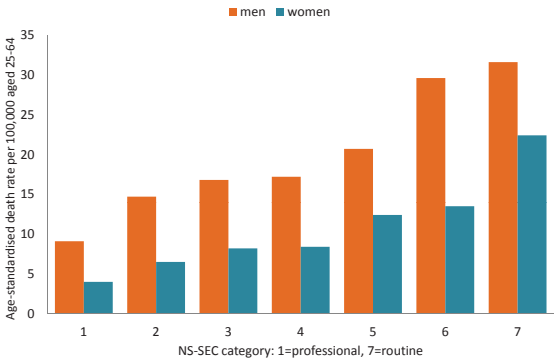
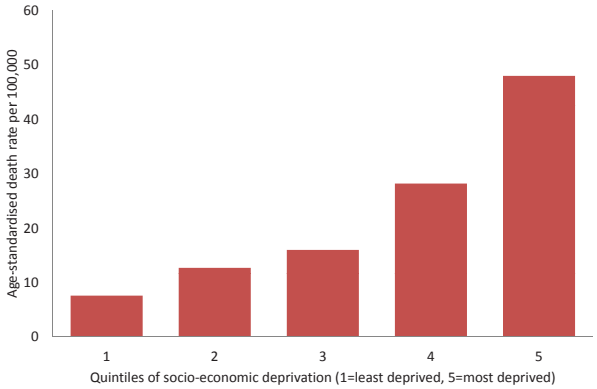



Figure 2.7 Alcohol-related mortality in Scotland, 2009, by quintile of socio-economic deprivation (ONS)



chapter 3

# The price of alcohol

## Summary

*Alcohol producers and retailers use pricing and discounting to sell more alcohol and increase their profits. In contrast, any government committed to improving the health of the public should use pricing policy to reduce the affordability of alcohol and so reduce the consumption of alcohol and its associated harms.*

The simplest way to reduce demand for alcohol is to put the price up. Like most consumer products, demand for alcohol is inversely related to its price. When demand for alcohol falls, so too does alcohol-related harm, ranging from liver disease to road traffic accidents. Consequently taxation remains an important and effective tool in reducing the harm of alcohol.

In the long term, however, it is the affordability rather than the price of alcohol that determines demand and in the UK the affordability of alcohol has increased despite rising taxes. In part, this is due to rising incomes. However the effect of a tax rise is immediately lost if retailers do not pass on the additional cost to their consumers. This is not unusual within the UK's highly competitive retail sector where discounting and special offers on alcohol products have become commonplace in order to attract people into stores.

A supply of very cheap alcohol enables the heaviest drinkers to maintain their consumption despite rising prices or falling incomes by switching to cheaper products and retailers. It also means that young people with limited money have access to cheap, strong drink. Of all the alcohol sold in the UK, very cheap alcohol products play the biggest part in driving alcohol-related harm.

An effective way of tackling this problem is to set a minimum price for every unit of alcohol sold, regardless of where it is sold. This raises the price of the cheapest products which has the greatest impact on the heaviest drinkers. This benefits the whole population: the introduction of a minimum price of 50p per unit of alcohol would save thousands of lives, prevent tens of thousands of crimes and cut work absenteeism by hundreds of thousands of days per year.

### Public health goal

- Reduce the affordability of alcohol in order to reduce alcohol consumption and its associated harms.

### Recommendations

- Taxes should be used to raise the real price of alcohol products such that their affordability declines over time.
- All bulk purchase discounting of alcohol including 'happy hours' should be prohibited.
- A minimum price of at least 50p per unit of alcohol should be introduced for all alcohol sales, together with a mechanism to regularly review and revise this price.

## Alcohol taxes

Consumers of alcohol in the UK are well aware that the money they spend on alcohol ends up in the Treasury as well as in the bank accounts of the alcohol producers. The taxation of alcohol has been an integral part of British fiscal policy since the seventeenth century, when it was introduced to help fund military campaigns. Today, alcohol taxes remain an important source of revenue for the government, raising around £10bn per year[1].

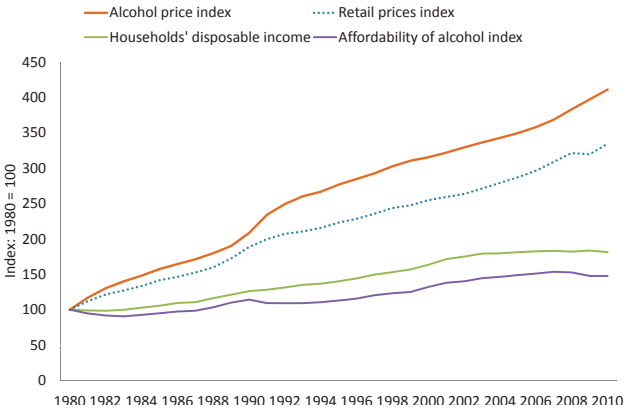
Alcohol taxes may not have been introduced as public health measures but they unquestionably contribute to public health today, regardless of how the government spends the money raised. Alcohol products are sensitive to the same supply-and-demand forces as other consumer products: if prices go up, demand will go down. There is overwhelming evidence that increasing the price of alcohol through taxation reduces average per-capita consumption[2].

There is also clear evidence that reductions in alcohol consumption achieved through price increases translate into reductions in alcohol-related harm[3]. Increases in the price of alcohol are associated with reductions in alcohol-related deaths and illness, traffic crash fatalities and drink driving, incidence of risky sexual behaviour and sexually transmitted infections, other drug use, violence and crime[4]. The reverse is also true: price cuts increase harm. For example, in 1999 a change in fiscal policy in Switzerland led to price reductions of between 30% and 50% on imported spirits. Following this change, consumption of spirits and alcohol-related harm both increased significantly[5].

As well as being demonstrably effective, taxation is attractive as a public health measure because alcohol taxes are relatively easy to implement and enforce. As the infrastructure for taxation and enforcement is long-established, the Chancellor of the Exchequer can raise alcohol taxes without difficulty. However, the relative simplicity of implementation does not necessarily mean that taxation is a blunt instrument. Alcohol taxes can be carefully calibrated to incentivise both the manufacture and purchase of lower strength drinks, promoting a shift in market share that delivers an overall reduction in alcohol consumption (see page 22).

In the long term, however, it is not the price but the affordability of alcohol that shapes consumer behaviour. Over the last thirty years the affordability of alcohol in the UK has increased despite rises in alcohol taxes. This has been a common outcome across

Figure 3.1 Increases in alcohol prices, household incomes and the affordability of alcohol in Britain, 1980 – 2010 (ONS)




Europe: between 1996 and 2004 alcohol became more affordable in 19 out of 20 European countries where the change was studied[6]. As long as alcohol taxes are set as fixed costs on top of the retail price, they will always be undermined by inflation unless they are regularly increased at rates at or above inflation. However, even if taxes keep pace with inflation, the affordability of alcohol will increase if personal incomes increase.

In the UK, between 1980 and 2010, alcohol prices increased faster than the rate of inflation but the affordability of alcohol nonetheless increased by 48% because of the expansion in households' disposable income (Figure 3.1). Over the same period, despite the rise in real alcohol prices, alcohol consumption per head of population increased by 8.5%[7].

The effect of taxes has not been to reduce harm but to contain the increase in harm caused by rising incomes and greater consumer purchasing power. A more robust approach to the taxation of alcohol would link tax increases not to retail prices but to the affordability of alcohol. In practice, however, the affordability of alcohol is also profoundly affected by the actions of retailers. On their own, tax rises are unlikely to stem the tide of very cheap alcohol.

**Recommendation**

Taxes should be used to raise the real price of alcohol products such that their affordability declines over time.

## The sale of cheap alcohol

Regardless of changes in taxation and wealth, if alcohol retailers radically cut the price of the products they sell, demand and consumption will increase. In Britain, the widespread use of discounting and price promotions in the retail sector has been a key driver of the rise in the affordability of alcohol, a rise that has been strongly correlated with increased consumption and alcohol-related harm[8]. Cheap alcohol is now a permanent feature on the supermarket shelves including an endless succession of special offers such as two-for-one deals on cartons of beer, half price bottles of wine and heavily discounted bottles of gin and vodka. Alcohol sales are a key focus of price competition between supermarkets, with the result that increases in alcohol taxes are not always passed on to consumers. Alcohol is routinely offered at less than cost price to entice people into the stores[9].

Discounting in all its forms, including happy hours in bars, distorts public attitudes to alcohol. Deals give consumers instant rewards by reassuring them that their money is well spent – and the more they spend, the bigger the reward. Alcohol ceases to be a potentially harmful product which consumers ought to purchase with care and becomes a bargain which consumers are encouraged to buy in bulk.

In Scotland, price promotions based on bulk purchasing have been prohibited since October 2011. This is a crucial first step in changing attitudes to alcohol and removing incentives for consumers to purchase more alcohol than they intend. It should be undertaken throughout the UK.

**Recommendation**

All bulk purchase discounting of alcohol including 'happy hours' should be prohibited.

Unfortunately, banning the volume discounting of alcohol does not prevent the sale of very cheap alcohol. Some products, such as high strength ciders, are consistently available at very low prices.

The offer of alcohol at very low prices sustains a culture of dangerous drinking. In particular, heavy drinkers who want to contain their costs in the face of rising prices but do not want to cut back their consumption have the opportunity to buy cheaper products from cheaper outlets. Similarly, young people with limited cash can still drink a lot of alcohol by turning to cheap, high-strength products. Cheap alcohol has been shown to be particularly attractive to harmful and dependent drinkers, binge drinkers and young drinkers[10].

**Of all the alcohol sold, very cheap alcohol products play the biggest part in driving alcohol-related harm**

Cheap alcohol is attractive not only to drinkers with limited means but also to drinkers of moderate and even high incomes. Anyone who drinks a lot of alcohol is likely to pay close attention to the price of the product. Of all the alcohol sold, very cheap alcohol products play the biggest part in driving alcohol-related harm.

This problem can be tackled effectively by setting a minimum price for all alcohol products based on their alcohol content. For example, a minimum price of 50p per unit of alcohol would ensure that a 700ml bottle of vodka with 40% alcohol content could not be sold for less than £14. The effect of such a policy is to selectively raise the price of the cheapest alcohol products while leaving the price of most drinks, including those served in bars and restaurants, unchanged. The Scottish Government has already approved a minimum unit price of 50p per unit of alcohol.

Setting a minimum unit price makes it very difficult for the heaviest drinkers to maintain their alcohol consumption without increasing their costs. It is therefore a highly targeted intervention, focussing on those who suffer the greatest harms from alcohol. There is good evidence that price increases at the cheapest end of the price spectrum are the most likely to result in reductions in alcohol consumption[11]. The benefits accrue not only to heavy drinkers but also to the many others – partners, children, friends – who are affected by their behaviour.

The evidence from areas where minimum pricing has been introduced is persuasive. In the Canadian province of Saskatchewan, a 10% increase in minimum unit prices reduced consumption of beer by 10.1%, spirits by 5.9% and wine by 4.6%. The biggest impact was on higher strength beer and wine: the consumption

of higher strength beer fell by 22.0% compared to an 8.2% decrease for lower strength beer[12]. Substantial reductions in alcohol consumption have also been reported following the introduction of minimum pricing policy in British Columbia[13]. Elsewhere, in the remoter communities of Australia, prohibition of the cheapest alcohol was followed by a 19% reduction in alcohol consumption and reductions in alcohol-related hospital admissions and crime. Two years in, most local people favoured retaining or even strengthening the pricing restrictions[14].

The case for minimum pricing is also supported by the substantial evidence of how individuals respond to alcohol prices across the price spectrum. The University of Sheffield has used this evidence to model the impact of minimum unit pricing in England and Scotland. The introduction of a minimum unit price of 50p in England is expected to result in a 6.7% reduction in average alcohol consumption per drinker, leading to the following benefits after ten years[15]:

- 3,100 lives saved every year;
- 41,000 fewer chronic illnesses and 14,000 fewer acute illnesses per year;
- 98,000 fewer hospital admissions per year;
- 43,000 fewer crimes per year including 11,000 fewer violent crimes; and
- 442,000 fewer days of absence from work per year.

Minimum unit pricing is a powerful policy because its effectiveness in targeting those who suffer the greatest harms from alcohol benefits not only these individuals but the whole of society. Reductions in deaths, illness and hospital admissions are complemented by reductions in crime and improvements in the safety and wellbeing of children, families and communities.

The impact of minimum unit pricing on moderate and light drinkers is likely to be relatively small precisely because they do not drink a lot of alcohol. A minimum price of 50p per unit of alcohol would increase moderate drinkers' costs, assuming their consumption remained the same, by an average of only 29p per week[16].

The impact of minimum unit pricing on low income households is highly targeted. These households consume the least alcohol overall and have the highest number of non-drinkers. However they also have high numbers of very heavy, harmful drinkers who will feel the effect of minimum unit pricing acutely. For example, in Scotland, 20% of men in the lowest income households do not drink compared to 4% of men in the highest income households. However, 9% of men in the lowest income households drink harmful amounts every week compared to 7% of men in high income households. The harmful drinkers also consume significantly more than their counterparts in high income households[17].

The long-term effectiveness of minimum unit pricing policy inevitably depends on how well it is calibrated to keep up with inflation and incomes. Policy should therefore include the specification of a transparent mechanism for the annual review of minimum unit prices in order to ensure their effect is not undermined by wider changes in the affordability of alcohol.

**Recommendation**

A minimum price of at least 50p per unit of alcohol should be introduced for all alcohol sales, together with a mechanism to regularly review and revise this price.

chapter 4

# Products and packaging

## Summary

*The alcohol industry increases its sales by creating appealing products for both existing and new, mainly young, drinkers. Any government committed to improving the health of the public should incentivise the development of lower strength products and prevent the development of products designed for young people. Packaging should communicate the content and harms of alcohol products to all consumers.*

Wherever alcohol is sold in the UK there is an opportunity to reduce alcohol consumption by encouraging drinkers to choose lower strength and non-alcoholic products. Because beers are taxed by the volume of their alcohol content, lower strength beers are widely available and are cheaper than higher strength beers. This tax regime, which offers an incentive to manufacturers to develop lower strength products, does not apply to ciders and wines; consequently lower strength wines and ciders are rare. Taxation should incentivise the development of lower strength products across all drinks.

Alcohol products are designed to be attractive to consumers. Products such as alcopops and ready-to-drink beverages may be ostensibly designed for the young adult market but they also appeal to children and teenagers and therefore encourage the early uptake of drinking. Far stronger controls are needed over product and packaging design to ensure that this does not happen.

The complete lack of health information on alcohol product labels is indefensible. In order to make better judgements about the risks of their drinking choices, consumers need both better information about how much they are drinking (the units of alcohol content per product is a basic minimum) and clear, evidence-based information about the effects of alcohol on their health.

### Public health goals

- Reduce alcohol consumption by increasing the choice of lower strength and non-alcoholic products.
- Prevent the early adoption of drinking by young people, and minimise the volume of their alcohol consumption, by prohibiting products designed to attract this market.
- Increase public understanding of the harms of alcohol through product labeling.

### Recommendations

- The tax on every alcohol product should be proportionate to the volume of alcohol it contains. In order to incentivise the development and sale of lower strength products, the rate of taxation should increase with product strength.
- Wherever alcohol is sold, a soft drink should be available that is cheaper than the cheapest alcoholic drink on sale.
- The sale of alcohol products that appeal more to children and young people than to adults should be prohibited.
- An independent body should be established to regulate alcohol promotion, including product and packaging design, in the interests of public health and community safety.
- At least one third of every alcohol product label should be given over to an evidence-based health warning specified by an independent regulatory body.
- Every alcohol product label should describe, in legible type, the product's nutritional, calorie and alcohol content.

## Product strength

Consumers today can choose from an exceptionally wide selection of alcoholic drinks ranging from beers with an alcohol content of only 1% to spirits with an alcohol content of 40% or more. There is, however, little evidence that, on its own, changing the strength of an alcoholic product will affect total alcohol consumption. Price differentials are also needed to incentivise the purchase of lower strength products. If lower strength products are cheaper, their market share increases, leading to reductions in the quantity of alcohol consumed and in alcohol-related harm[1].

Alcohol producers have shown themselves to be adept at changing the strength of their products in order to optimise their sales. As beers are taxed by volume of alcohol, brewers have introduced many lower strength beers in order to offer consumers cheaper products. In contrast, the taxation of wines and ciders is based on specific thresholds of alcohol content rather than the precise volume of alcohol. This gives the alcohol industry an incentive to sell products that have the highest possible alcohol strength below a particular tax threshold. The popularity of high strength ciders, designed with an alcohol content just below the 7.5% tax threshold, illustrates the problem.

The taxation of all alcoholic drinks by the volume of alcohol they contain would ensure that fiscal incentives consistently encouraged the development and sale of lower strength products. This would not eliminate high strength drinks as there will always be a market for them – brewers have increased the alcohol content of their high strength beers – but it would increase manufacturers' incentives to develop lower strength products and consumers' incentives to buy them. This requires a change in policy at EU level.

The effectiveness of this approach is enhanced if the rate of taxation rises as alcohol strength rises. The changes in UK beer duty introduced in 2011 are a good example: products with 2.8% alcohol are taxed at 50% of the general beer duty and products with over 7.5% alcohol are taxed at 125% of the general beer duty.

Perhaps the most perverse pricing incentive in the UK is the high cost of alcohol-free drinks in bars and pubs which discourages consumers from choosing soft drinks. This is unfair to those who do not drink alcohol and unhelpful for those who want to drink less.

**Recommendation**

The tax on every alcohol product should be proportionate to the volume of alcohol it contains. In order to incentivise the development and sale of lower strength products, the rate of taxation should increase with product strength.

**Recommendation**

Wherever alcohol is sold, a soft drink should be available that is cheaper than the cheapest alcoholic drink on sale.

## The design of alcohol products

Alcohol producers use product design and packaging to help customers find their favourite products on the shelves, to revive interest in established products and to attract new customers. In recent years there has been significant innovation in the design of alcohol products as producers seek both to respond to changing tastes and to increase the size of their market.

Alcopops, flavoured alcoholic beverages and ready-to-drink products are obvious examples of products designed to recruit new customers, especially young people. These highly palatable, easy to consume formulations, presented in bright, attractive packaging may be ostensibly designed and marketed for people in their 20s but their appeal extends to young people with little or no experience of drinking alcohol. There is good evidence that alcopops and other ready-to-drink products are appealing to teenagers both because the taste is pleasant and because the branding and packaging give attractive identities to spirit and mixer drinks. The brand values employed by producers of alcopops and designer drinks, such as mocking the older generation and getting away with bad behaviour, are also strikingly attuned to young people[2,3].

The development of alcohol products designed to be attractive to young people is indefensible. Yet the current regulatory framework demonstrably allows this to happen. The design of alcohol products should be regulated and assessed by an independent body which focuses clearly on the interests of young people. Where there is independent evidence that an alcoholic product appeals more to children and young people than to adults, that product should be prohibited.

**Recommendations**

The sale of alcohol products that appeal more to children and young people than to adults should be prohibited.

An independent body should be established to regulate alcohol promotion, including product and packaging design, in the interests of public health and community safety.

## Product labels

Health warnings are now a familiar and prominent feature on all tobacco products. Likewise, detailed nutritional labelling is ubiquitous on food products and soft drinks. Yet the consumer information on alcohol products usually extends no further than a figure describing the strength of the alcohol content. Despite their substantial impact on both health and nutrition, many alcohol products are labelled with minimal regard for either. The producer has a free hand to exploit the label to promote the brand.

From a consumer perspective, this is an extraordinary anomaly. The objective of food labelling is to support consumers in making informed decisions about what they eat and drink. The absence of meaningful information on alcohol products leaves consumers uninformed about one of the most harmful products they purchase.

There is evidence that the inclusion of health warnings on alcohol products increases consumers' knowledge and awareness of the adverse health impacts of alcohol[4,5]. Evidence of the impact of warnings on actual drinking behaviour is more equivocal: improvements in information and knowledge may not be sufficient to trigger action but they provide a necessary foundation for action. However, the evidence of the impact of tobacco product health warnings on smoking behaviour supports the case for change[6], as does the wider literature on the impact of product warnings[7].

In order to be effective in informing the consumer about his or her risk, the labelling of alcohol products ought to include salient health warnings and unit information alongside nutritional and calorie information. The inclusion of unit information would help to address the low level of understanding of alcohol units among drinkers[7]. Health warnings should be varied to address the many potential harms to health of drinking.

**Recommendations**

At least one third of every alcohol product label should be given over to an evidence-based health warning specified by an independent regulatory body.

Every alcohol product label should describe, in legible type, the product's nutritional, calorie and alcohol content.

There is also considerable scope to communicate unit information in other settings. In pubs and bars, unit information ought to be displayed prominently at the point of sale. Likewise when alcohol is sold in supermarkets, the till receipts ought to show the number of units of alcohol purchased. Customer loyalty card data could also be used to inform customers about how many units of alcohol they have bought.

Consumers need a framework of risk within which to make sense of information about how much alcohol they are consuming. Existing governmental guidelines are based on a report by the Royal College of Physicians in 1987[9], subsequently revised upwards in 1995 despite a lack of evidence for the change[10]. The revised guidelines have been criticised as promoting levels of alcohol consumption above a 'low risk' threshold[11]. The Chief Medical Officer's current review of these guidelines is a prerequisite for the introduction of health warnings and unit information on alcohol products.

**The absence of meaningful information on alcohol products leaves consumers uninformed about one of the most harmful products they purchase**

chapter 5

# The promotion of alcohol


## Summary

*The alcohol industry increases its sales by promoting alcohol products to both existing and new, mainly young, drinkers through traditional and new media. As rising consumption leads to rising harm, any government committed to improving the health of the public should seek to curtail the promotion of alcohol as far as possible and prevent any alcohol promotion that appeals to children or young people.*

Alcohol advertising is ubiquitous in Britain today, appearing everywhere from television and billboards to music festivals and the internet. Age is no protection: children and young people inevitably encounter alcohol advertising and are especially likely to be exposed to the many forms of brand promotion that social networking websites make possible. There is abundant evidence that advertising in all media encourages young people to drink and lowers the age at which they start drinking.

Alcohol promotion ought to be tightly regulated yet current restrictions on alcohol advertising in the UK are woefully inadequate. Their impact is limited because they only define what cannot be said within alcohol advertising, leaving advertisers with plenty of scope to promote their brands. Restrictions that prohibit associations with values such as sociability or masculinity have proved to be very open to interpretation. Current restrictions also do nothing to limit the total volume of alcohol advertising to which the public is exposed.

Partial bans and limited controls on alcohol advertising will always have a limited impact. We know from the experience of tobacco control that only a comprehensive ban is likely to affect consumption and uptake significantly. There is a strong case for the complete prohibition of all alcohol advertising and sponsorship in the UK.

In the short-term. the focus of alcohol advertising regulation needs to switch to defining what advertisers can say, rather than what they cannot say. This has been the approach in France where the Loi Evin limits alcohol advertising to basic factual information. Such an approach, supported by an effective, independent regulator, would be an appropriate stepping stone to a complete ban.

### Public health goal

- Reduce alcohol consumption and the uptake of drinking by curtailing the promotion of alcohol as far as possible.

### Recommendations

- All alcohol advertising and sponsorship should be prohibited
- In the short term, alcohol advertising should only be permitted in newspapers and other adult press. Its content should be limited to factual information about brand, provenance and product strength.
- An independent body should be established to regulate alcohol promotion, including product and packaging design, in the interests of public health and community safety.
- Alcohol producers should be required to declare their expenditure on marketing and the level of exposure of young people to their campaigns.

## Advertising and sponsorship

In the UK today, alcohol advertising is as commonplace as advertising for coffee or cornflakes. Images of drinks and drinking penetrate all forms of media, new and old: billboards, newspapers, magazines, television and increasingly the internet. Sponsorship deals ensure that the public experience of sporting events and music festivals includes regular exposure to alcohol brands.

Yet, in the words of the World Health Organisation, alcohol is 'no ordinary commodity'. Unlike coffee and cornflakes, alcohol regularly destroys lives. Why then do we allow alcohol producers to promote their products through so many different avenues? Advertising restrictions are accepted for other legal products that have health risks, such as cigarettes and many pharmaceuticals. A comparable approach is both necessary and appropriate for alcohol.

The alcohol industry argues that alcohol advertising targets people who choose to drink alcohol, informing their choices and helping them to identify the brands and products that are most suitable for their lifestyles. This may be true, but it is only half the story. There are two major issues that this argument ignores. Firstly, advertising helps to normalise drinking and reassure consumers by presenting alcohol as an unproblematic part of everyday life. The harms of alcohol are disguised by the constant reiteration of positive images of alcohol and drinking behaviour. Secondly, advertising influences not only the choices of existing drinkers but also the choices of non-drinkers, above all children and young people, and so drives the uptake of drinking.

There is overwhelming evidence that alcohol advertising influences the behaviour of young people. A wealth of studies have shown that alcohol advertising increases the likelihood that young people will start to consume alcohol and will drink more if they already do so[1,2]. Alcohol advertising of any kind encourages young people to drink, not only advertising that targets young audiences, which advertising codes in the UK are supposed to prohibit.

Young people are regularly exposed to alcohol advertising through a variety of media. One British study found that 96% of 13 year olds were not only aware of alcohol advertising but had encountered it in more than five different media[3]. There is evidence that young people are actually *more* exposed to alcohol advertising than adults: a European study found that young people in the UK aged 10-15 years viewed more alcohol advertisements on television than adults aged 25 years and older[4].

Young people have been a target within the alcohol industry's marketing strategies since the early 1990s. In recent years, alcohol advertising has proliferated on the internet, providing the industry with new ways of communicating with young people. Social networking websites such as Facebook enable young people to engage with alcohol brands through informal peer-to-peer communication, for example by joining brand fan clubs, forwarding viral videos, and alerting friends to special offers or branded events. The greater the exposure of young people to online advertising, the more likely they are to binge drink[5].

When the media and popular culture are saturated with images of alcohol and drinking, the specific effects of these images cannot be easily isolated. For example, studies of the relationship between spending on alcohol advertising and population consumption tend to show only a small positive relationship between the two[6]. Similarly, the introduction of partial bans on alcohol advertising has been found to have little effect on overall consumption levels[7] . This is not surprising as the marginal effect of an increase or decrease in advertising is likely to be small compared to the long-term normalising effect of permitting alcohol advertising across all media. Partial bans simply invite advertisers to shift their efforts from one mode of communication to another.

The only country in Europe with a comprehensive ban on alcohol advertising is Norway where advertising is not permitted in newspapers, magazines, radio and television. Although there has been no formal evaluation of this policy, Norwegians have one of the lowest rates of alcohol consumption in Europe: an

**Alcohol regularly destroys lives. Why then do we allow alcohol producers to promote their products through so many different avenues?**

adult average of 8.3 litres of pure alcohol per year, two thirds of the average consumption in the UK[8].

Although data about the impact of comprehensive bans on alcohol advertising is limited, the evidence from tobacco control demonstrates that comprehensive advertising bans are highly effective. Comprehensive bans have reduced tobacco consumption where limited bans have not[9,10]. In Europe, advertising bans have been the second most effective means of reducing smoking after taxation[11].

Overall, the evidence of the impact of advertising on young people and the evidence from tobacco control provide a strong case for a comprehensive ban on alcohol advertising and sponsorship. Public perceptions of alcohol as an ordinary consumer product will only change if images of alcohol and drinking are removed from everyday experience.

**Public perceptions of alcohol as an ordinary consumer product will only change if images of alcohol are removed from everyday experience**

**Recommendation**

All alcohol advertising and sponsorship should be prohibited.

## More than half way: the Loi Evin

If a comprehensive ban on alcohol advertising is too big a step to take at once, we must define a clear route map to this destination. Given the inherent weakness of partial bans, any action in this area must be substantial and wide-ranging, addressing both the content and all the settings where alcohol is advertised.

Currently, restrictions on the advertising of alcohol in the UK are woefully inadequate. They do little to curtail the content of advertising and do nothing to limit its volume. If restrictions on alcohol advertising are to have any meaningful effect, they must go beyond defining exclusions, which advertisers can work around or simply ignore[12,13]. For example, the current advertising code prohibits advertisements which suggest that alcohol can enhance social success, masculinity, or femininity. Yet there is good evidence, from company documents and from the advertisements themelves, that this is exactly what some drinks companies have set out to do[14]. To avoid these problems, alcohol advertising codes should specify both a limited range of settings where advertising is permitted and the precise scope of what can be said within advertisements. The best international model of such an approach is the French Loi Evin (Evin Law).

The Loi Evin, introduced in 1991, carefully defines the limits of alcohol advertising in France to minimise the exposure of children and young people to this advertising. The law defines a narrow range of settings where advertising is permitted: in the adult press, on billboards, on radio channels under precise conditions, and at events such as wine fairs. The content of the advertising is limited to information about the product's provenance, content, production and strength. Drinkers and drinking environments cannot be depicted and a health message must also be included on each advertisement. Consequently, the language of alcohol advertising in France has been reduced to basic communication about the product.

There has been no detailed evaluation of the impact of the advertising restrictions introduced by the Loi Evin. This is methodologically difficult because alcohol consumption in France was declining prior to the introduction of the law, therefore any effects may be masked by this long-term trend. However research has shown that advertisements that are devoid of lifestyle images or references are less attractive to young people[15].

**Recommendation**

In the short term, alcohol advertising should only be permitted in newspapers and other adult press. Its content should be limited to factual information about brand, provenance and product strength.

## A new approach to regulation

A UK version of the Loi Evin would be an appropriate stepping stone to full prohibition of alcohol advertising and sponsorship. Whatever route is taken to this policy destination, there is a need for a new, robust approach to the regulation of alcohol marketing that tackles not only advertising and sponsorship but also product design, packaging, branding, distribution, presentation at point of sale and price promotions. To be effective, regulation must be independent of the alcohol industry with a clear focus on promoting public health and community safety.

Regulation should also actively engage the public – especially young people – in the regulatory process. Digital media, sometimes referred to as participatory media, are changing the ways in which business markets its products: increasingly the emphasis is on co-production and the joint creation of value. Regulation needs to develop in an equally inclusive manner. A new regulatory body focussed on public involvement would provide an opportunity to go beyond traditional consumer protection to engage with the public about the scope and deployment of alcohol regulation.

An immediate regulatory need is access to data on the impact of alcohol marketing. Alcohol producers regularly obtain data about the reach and impact of their alcohol campaigns, including the exposure of children and young people to their advertising, but this intelligence is rarely scrutinised in the public interest as it remains commercially confidential. This public interest needs to be put first.

**Recommendations**

An independent body should be established to regulate alcohol promotion, including product and packaging design, in the interests of public health and community safety.

Alcohol producers should be required to declare their expenditure on marketing and the level of exposure of young people to their campaigns.

chapter 6

# The place of sale


## Summary

*Alcohol producers and retailers seek to increase their sales by increasing the number of shops and bars selling alcohol and maximising the hours of sale. Any local authority committed to improving the health of the public should seek to reduce alcohol consumption by restricting the overall availability of alcohol across all places of sale.*

The liberalisation of licensing in the post-war era has resulted in a substantial increase in the availability of alcohol in the UK. For most adults, and for many young people, alcohol is now incredibly easy to obtain. Today, most alcohol is sold through shops and supermarkets and most drinking takes place at home, so licensing that focuses on pubs and bars fails to address the major driver of alcohol-related harm. Licensing authorities must be given the powers to tackle this harm by controlling the total availability of alcohol in their jurisdiction, from all types of licensed premises.

The removal of restrictions on the hours of sale of alcohol in shops and supermarkets has eroded the distinction between alcohol and other food products. Alcohol is an exceptional, harmful product yet retailers treat it as an everyday grocery. Action is needed to reverse this trend.

Drunkenness within the night-time economy is commonplace in many British towns and cities. This is driven increasingly by 'preloading' – drinking cheap shop-bought alcohol before heading out to the bars – and sustained by very late opening hours. Although a great deal has been done to address alcohol-related violence and disorder in town centres, broader strategies are needed that look beyond dealing with the disorder and tackle the culture of drunkenness that drives it. Local partnerships need to prioritise public health in their licensing decisions, reduce the availability of alcohol and enforce legislation preventing the sale of alcohol to people who are already drunk.

### Public health goals

- Reduce alcohol consumption and its associated harms by restricting the availability of alcohol.
- Reduce the harms associated with drunkenness in the night-time economy by promoting good practice and tackling the causes of drunkenness.

### Recommendations

- Public health should be a core objective and statutory obligation of licensing throughout the UK.
- Licensing legislation should be comprehensively reviewed. Licensing authorities must be empowered to tackle alcohol-related harm by controlling the total availability of alcohol in their jurisdiction.
- The sale of alcohol in shops should be restricted to specific times of the day and designated areas. No alcohol promotion should occur outside these areas.
- The law prohibiting the sale of alcohol to people who are already drunk should be actively enforced.
- Local authorities should develop comprehensive alcohol strategies that prioritise public health and community safety.
- Measures to deal with the consequences of drunkenness must be complemented by measures to reduce the prevalence of drunkenness, including forward planning of the number, density and opening hours of all licensed premises.

## Controlling availability

There is no shortage of opportunities to buy alcohol in the UK today. Alcohol appears to be everywhere: stacked high at the entrances to supermarkets, lining the shelves of corner shops, delivered to domestic front doors at the touch of a button and available in pubs, bars and clubs throughout the night. The number of premises licensed to sell alcohol in the UK doubled between the 1950s and the beginning of the 21st century[1]; over the same period, the British population grew by only a fifth.

Any increase in the availability of alcohol leads to an increase in alcohol consumption and subsequent increases in alcohol-related harm. Conversely, when the availability of alcohol is restricted, consumption and its associated harms decrease[2]. The evidence is compelling. For example, in Finland a loosening of the state monopoly of alcohol sales in 1969 allowed beer of up to 4.7% alcohol to be sold in grocery stores. In the following year, overall alcohol consumption increased by 46%. In the five years following this change in legislation, liver cirrhosis mortality rates rose by 50%, hospital admissions for alcohol psychosis rose by 110% for men and 130% for women, and arrests for drunkenness increased by 80% for men and 160% for women[3].

In the UK, licensing laws have been the state's primary means of controlling alcohol sales since 1552 in England and Wales (later in Scotland and Northern Ireland). However market liberalisation has resulted in the steady loosening of these laws in the post-war era. Law makers have focused on regulating consumption of alcohol served in bars and restaurants, but their actions have given shops, and especially supermarkets, opportunities which they have not been slow to exploit. The result has been a critical shift of drinking behaviour: most alcohol is now bought from shops and drunk at home.

In 1974, 90% of all the beer consumed in Britain was sold in pubs and other 'on' trade premises[4]. By 2011, this had fallen to 52% (Figure 6.1). Shops and supermarkets (the 'off' trade) may soon capture a majority of the market share of beer, a position they already enjoy for all other alcoholic drinks. In 2010, 81% of wine, 80% of spirits, 63% of cider and 59% of flavoured alcoholic beverages (FABs) were sold through shops and supermarkets (Figure 6.2).

The implications of this shift in behaviour are profound. Most of the harm from alcohol is now driven by low cost 'off' sales, not by sales in pubs and clubs. The round-the-clock availability of alcohol ensures that anyone who wants to get drunk, and has the money, can do so with ease in private. However, the more visible harms created by drunk and disorderly behaviour in the night-time economy are also increasingly driven by cheap alcohol sales in shops and supermarkets (see below). Consequently, licensing decisions that focus on alcohol sales in pubs and bars and do not address the wider availability of alcohol are failing to tackle the major driver of alcohol-related harm.

In order to reduce the harm from alcohol in the UK, we have to reduce its availability. This public health challenge requires a proactive approach to licensing that takes into consideration the total number of premises selling alcohol, of all kinds, and the impact of this provision on the health and wellbeing of the local population.

Unfortunately public health is rarely a core concern of licensing authorities (though it is now a licensing objective in Scotland) and current licensing legislation does not enable local authorities to take a strategic view of the total availability of alcohol when making

Figure 6.1 Beer sales in Britain, 1974-2011 by sector market share (BBPA)

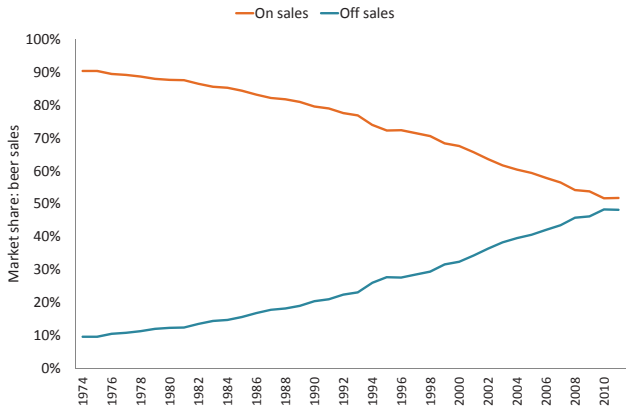
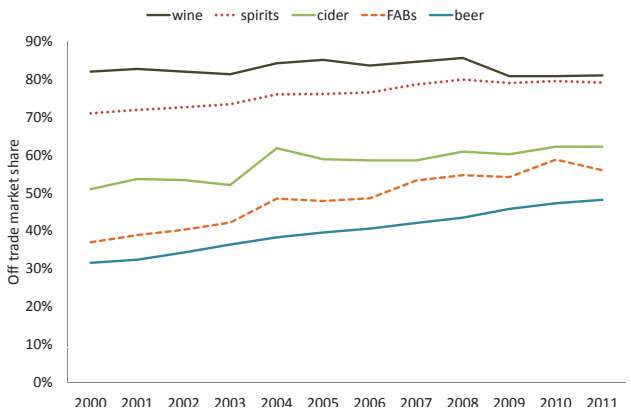



Figure 6.2 Off trade market share of alcohol sales in Britain 2000-2011 by drink type (BBPA)



decisions about specific proposals. A fundamental review of licensing law is required which focuses on controlling the availability of alcohol and reducing alcohol-related harm.

**Recommendations**

Public health should be a core objective and statutory obligation of licensing throughout the UK.

Licensing legislation should be comprehensively reviewed. Licensing authorities must be empowered to tackle alcohol-related harm by controlling the total availability of alcohol in their jurisdiction.

## Everyday groceries?

One of the key changes in licensing practice in recent years has been the removal of the distinctions in opening hours between the sale of alcohol and the sale of other food and drink products. This has allowed supermarkets not only to sell alcohol at all times of the day but also to break down the physical barriers between drink and other products within stores. Alcoholic products are routinely scattered across supermarkets, at the ends of aisles and at the centre of special front-of-house promotions as well as in the traditional drinks aisle.

These changes have helped to turn alcohol into an everyday product like any other. Alcoholic drinks are no longer bought in specific places and at specific times for specific drinking routines. They can be bought anywhere, at any time, as part of the routine of daily life. This has eroded the public perception that these are distinctive, and above all harmful, products.

In Scotland, new restrictions on the sale of alcohol in shops are a first step in re-establishing a distinction between alcohol and other food and drink products: alcoholic products must be located in one place and all price promotions are prohibited. Such measures need to be adopted throughout the UK.

Alcohol should be put back in its traditional place, as an exceptional product to be bought with care. This requires both that alcohol products and any related promotional materials are isolated from other groceries within supermarkets and that all retail alcohol sales are restricted to specific times of the day and week.

**Recommendation**

The sale of alcohol in shops should be restricted to specific times of the day and designated areas. No alcohol promotion should occur outside these areas.

## Drunkenness is back in fashion

In 1931, following a fifteen year decline in alcohol consumption in the UK, a Royal Commission on licensing stated that 'drunkenness has gone out of fashion'[5]. In 2013, the opposite case can be stated with some confidence: drunkenness is well and truly back in fashion and highly visible on the streets of British towns and cities every Friday and Saturday night. Less visibly, the modern culture of drunkenness extends to young people who may not participate in night-life but have little difficulty in obtaining alcohol from shops[6].

**Drunkenness is now commonplace at the beginning of a night out as well as at its end**

Drunkenness is now commonplace at the beginning of a night out, as well as at its end. This is thanks to the increasingly popular practice of preloading: drinking shop-bought alcohol at home before heading out to the bars and clubs where the drinks are more expensive[7]. Many young people start the night drunk and expect to drink more as the evening proceeds. Changes to licensing laws in 2005 that permitted much longer opening hours were supposed to reduce the incentives to drink heavily before closing time. But by extending closing times well beyond the early hours of the morning, these changes made new patterns of heavy drinking possible. People who want to enjoy urban night life can now go out much later and take more time at home to get drunk on cheaper alcohol.

A recent study of night-life drinking in four European cities – Liverpool, Ljubljana, Palma de Mallorca and Utrecht – found that the highest rates of pre-loading were in Liverpool: 61.4% of those surveyed had drunk alcohol at home, or in a friend's home, before heading for the bars and clubs. Most of these drinkers expected to binge drink that night: 82.5% of women and 96.0% of men anticipated drinking more than the binge-drinking thresholds (6 units of alcohol for women and 8 units for men) and a majority had already done so at the time of interview[8].

Although it is illegal to serve alcohol to someone who is already drunk, prosecutions are rare: in 2008 there were only seven successful prosecutions in England and Wales[9]. Although many bar staff and door staff are trained to deal with problem behaviour, there is little evidence that this training results in more frequent refusals to serve drunken people[10]. The law needs to be actively enforced.

**Recommendation**

The law prohibiting the sale of alcohol to people who are already drunk should be actively enforced.

The consequences of all this drunkenness are all too familiar, especially in areas where there are many bars in close proximity: noise, disorder and violence[11]. One fifth of all violent crime occurs in or near pubs and clubs[12] and 45% of adults avoid town centres at night because of drunken behaviour[13]. There are also serious consequences for partners, children and older relatives of people arriving home drunk after a night out. Over one in ten incidents of alcohol-related violence are domestic assaults[14].

In recent years, a great deal of effort has been invested in tackling alcohol-related violence and disorder in town centres, with some success. The focus of these efforts has been on higher profile policing supported by strong local public health partnerships. Intelligence-sharing between local authorities, the police and the NHS has helped to target problem areas, enforce licence requirements and exclude problem individuals. For example, the Cardiff Violence Prevention Programme brought together the local council, police and the local Accident and Emergency Department to develop a common strategy on tackling alcohol-related violence in the city. A key feature of the partnership was the sharing of information collected from patients treated in A&E departments about the circumstances of the violence they experienced. This enabled the police to target violence 'hot spots' with prevention strategies.

Bars and clubs have also played a part in reducing the risk of violence and disorder in and around their premises. A well-designed, well-managed bar, run by staff who are able to deal with aggressive individuals, can offer an attractive environment where drunkenness and violence are not perceived to be acceptable. This requires attention to many details including the quality of the physical environment, the provision of food and soft drinks, control of noise levels and air quality, management of the number of customers entering the premises, secure transport nearby and staggered closing times[15]. Such measures are at the heart of programmes such as Best Bar None, a collaboration between the Home Office and the alcohol industry, that encourages partnership between bar owners, the police and local authorities to reduce alcohol-related crime and disorder in a town centres.

These measures to reduce alcohol-related violence and disorder within the night-time economy are welcome but their impact on the underlying drivers of violence and disorder has been limited. The fundamental problem remains: a culture of drunkenness driven by cheap shop-bought alcohol and sustained by round-the-clock opening of licensed premises.

Minimum unit pricing of alcohol will help by removing the cheapest products from the supermarket shelves. However, local authorities need to address these deeper problems which undermine public safety and drive long-term harms for individuals, children, families and society. Public-health-focused licensing requires that all those involved – local authorities, police and magistrates – take seriously the aggregate population-level harms of their individual licensing decisions.

**Recommendations**

Local authorities should develop comprehensive alcohol strategies that prioritise public health and community safety.

Measures to deal with the consequences of drunkenness must be complemented by measures to reduce the prevalence of drunkenness, including forward planning of the number, density and opening hours of all licensed premises.

chapter 7

# Early intervention and treatment


## Summary

*Health and social care professionals have a vital role to play in helping people to drink less and so prevent the onset of illness, as well as providing treatment and support to people with alcohol dependence.*

The size of the harm created by alcohol in Britain reflects the high prevalence of hazardous and harmful drinking in the population. Health and social care professionals could potentially play a much greater role in reducing this harm through the early identification of hazardous drinkers and the provision of brief advice to help them to reduce their alcohol consumption. There is good evidence of the effectiveness and cost effectiveness of opportunistic early identification and brief advice delivered by general practitioners and other health and social care professionals. More widespread implementation within health, social care and criminal justice services would have a significant impact on reducing the costs of alcohol to the NHS and wider society.

Opportunities are also being missed to identify and treat alcohol dependence as early as possible. The resourcing of alcohol treatment services is inadequate and many of those in need do not gain access to specialist services. Improvements in both the identification and treatment of alcohol dependence are needed to maximise public health gains.

Failure to tackle hazardous drinking and dependence early enough results in high costs for secondary care services. Yet despite the role that alcohol plays in driving admissions, many hospitals do not have specialist alcohol support services. Both admissions and readmissions can be reduced by alcohol care teams within hospitals. These teams should be supported by a comprehensive range of specialist community alcohol services to provide ongoing treatment and support for people with alcohol dependence after they leave hospital.

### Recommendations

- All health and social care professionals should be trained to routinely provide early identification and brief alcohol advice to their clients.
- People who need intensive interventions should be routinely referred to specialist alcohol services for comprehensive assessment and appropriate treatment.
- Greater investment is needed in specialist community-based alcohol services to meet current and future alcohol treatment needs.
- Every acute hospital should have a specialist, multi-disciplinary alcohol care team tasked with meeting the alcohol-related needs of those attending the hospital and preventing readmissions.

## Interventions for the spectrum of alcohol problems

Alcohol can affect personal health and wellbeing in numerous ways ranging from anxiety and depression to severe and potentially life-threatening conditions such as liver disease, cardiovascular disease, cancer and neurological disease. It is not unusual for alcohol to cause multiple problems in the same individual, affecting both mental health and physical health.

The emphasis of this report is on preventing the harm from alcohol by intervening as early as possible in the chain of causes and effects that starts with cheap, attractive products and ends with chronic illness and premature deaths. Health and social care professionals have a key role to play in the prevention of alcohol misuse through early identification and brief advice for hazardous and harmful drinkers and, where necessary, prompt referral to specialist alcohol services for people with alcohol dependence. Such interventions are supported by a solid evidence base and are cost effective. However, when hospital treatment is necessary, the right team of staff needs to be in place to provide appropriate and effective support.

## Early identification and brief advice

At a population level, most alcohol-related problems are attributable to hazardous and harmful drinking rather than to alcohol dependence[1]. Yet few people who drink more than the recommended low risk levels of alcohol consumption seek professional help for their drinking. Often people are unaware of the long-term dangers to their health of their drinking and, when they develop alcohol dependence, they may take a long time to seek help. However, many will still encounter doctors or other health and social care professionals either because of acute alcohol-related problems or for reasons unrelated to their alcohol consumption. Such encounters provide an opportunity for professionals to identify risky drinking and respond appropriately.

The time available within any professional-client encounter for discussion of lifestyle issues such as drinking is always limited. Nonetheless there is strong evidence that opportunistic early identification and brief advice provided by general practitioners and other health professionals is effective in reducing alcohol consumption and related problems[2,3]. Such interventions have been designed specifically for professionals working in busy healthcare settings who do not have specialist training in alcohol disorders.

Early identification involves the administration of a short questionnaire about current drinking behaviour. This is followed by advice and information, appropriate to the client and the context. This does not require extensive training to deliver effectively. Patients who do not respond to brief advice or who experience alcohol dependence should be referred to alcohol specialists for more intensive interventions. Given both the size of the population who drink in a manner that is potentially or actually harmful to their health (in England, a quarter of the population) and the effectiveness of the intervention, the wider use of such brief interventions would significantly reduce the overall burden of disease caused by drinking.

Early identification and brief advice should be delivered and supported in both primary and secondary care to achieve maximum health gain. The potential cost savings to the NHS and wider society from widespread implementation are considerable.

Most of the work on brief interventions to date has been in primary care but there is increasing evidence of effectiveness in other settings including emergency care, pharmacies, schools, social care and the criminal justice system. NICE has recommended widespread implementation of early identification and brief advice in a range of health and social care settings, given the strength of the international evidence of its effectiveness[4]. The population living with, or at risk of, mental health problems is a particularly important target for these interventions.

**Recommendation**

All health and social care professionals should be trained to routinely provide early identification and brief alcohol advice to their clients.

## Treatment for alcohol dependence

People with alcohol dependence usually require more intensive interventions delivered by specialist alcohol services. Health and social care practitioners also have an important role in the early identification

of people with alcohol dependence and referral to specialist alcohol services. NICE has recommended more widespread implementation of a range of behavioural, psychological or pharmacological interventions delivered by specialist alcohol services[5]. The goals of these interventions will vary depending on the needs of the individual patient: abstinence may be appropriate for many with alcohol dependence and more complex needs, but a reduction in consumption may be a realistic goal for some people.

Unfortunately, treatment for alcohol dependence is currently reaching only a minority of those who could benefit from it and has not kept pace with the increased prevalence of alcohol dependence. For example, of the one million people aged between 16 and 65 who are alcohol dependent in England, only about 6% per year receive treatment. This reflects not only a low level of early identification and referral of people with alcohol-dependence but also the limited availability of specialised alcohol treatment services. In England, average spending on alcohol treatment services in 2008 was £197 per dependent drinker compared to £1,744 per head for the treatment of problem drug use[6].

NICE has published detailed guidelines on the identification, assessment and management of harmful drinking and alcohol dependence[7]. These guidelines recommend improved identification of alcohol misuse by health and social care professionals and improved access to effective interventions delivered by specialist services. These include psychological interventions and community-based assisted withdrawal programmes.

As patients with alcohol dependence place heavy demands on health and social care services and the criminal justice system, there is substantial scope to reduce the costs to the NHS and wider society by more comprehensive provision of evidence-based specialist alcohol treatment services.

**Recommendations**

People who need intensive interventions should be routinely referred to specialist alcohol services for comprehensive assessment and appropriate treatment.

Greater investment is needed in specialist community-based alcohol services to meet current and future alcohol treatment needs.

## Secondary care services

The cost of current failures to tackle hazardous drinking and dependence early enough are borne by many public services but especially by secondary care services. Nationally, 13-20% of all hospital admissions are alcohol-related. Alcohol-related hospital admissions have increased from 510,000 to over 1.2 million per annum in the past 9 years[8]. As patients with alcohol-related problems often have complex needs and many are repeatedly readmitted to hospital, they constitute at least 20% of the overall consultant direct clinical care workload[9]. The effect of alcohol on attendances in Emergency Departments is considerable with approximately 35% of all attendances being alcohol-related, rising to 70-80% at the weekends[10].

**Hospitals need to take a more proactive approach to identifying, addressing and preventing alcohol-related problems**

Given the size of the impact of drinking on hospital services, it is surprising that a majority (58%) of acute medical units in hospitals in the UK have no formal alcohol-related support services[11] . Where such services do exist, only 25% are available outside office hours. Inevitably, these service shortcomings mean that alcohol dependence is not consistently diagnosed and treatment for alcohol dependence and related disorders is often inadequate. This results in a higher cost to the service due to the effects of untreated alcohol dependence including hospital re-attendances.

Hospitals need to take a more proactive approach to identifying, addressing and preventing alcohol-

related problems. This requires leadership, cross-departmental collaboration and partnership with primary care, specialist community alcohol services and patient groups. There is good evidence that this can be achieved by the establishment of multi-disciplinary alcohol care teams[12]. Alcohol care teams aim to reduce acute alcohol-related hospital admissions and readmissions not only by providing high quality support to those who present with alcohol-related illness but also by developing broad-based strategy to prevent the development of such illness. Interventions initiated by alcohol care teams include[13]:

- 7-day hospital-based alcohol specialist nurses;
- psychiatry services specialising in alcohol;
- multi-agency assertive outreach alcohol services;
- integrated alcohol treatment pathways between primary and secondary care; and
- training in alcohol and addiction for alcohol specialist nurses and trainees in gastroenterology and hepatology, acute medicine, accident and emergency medicine and psychiatry

For example, the Royal Bolton Hospital has an alcohol care team that includes consultant gastroenterologists, a liaison psychiatrist, a psychiatric liaison nurse, a liver nurse practitioner and a dedicated social worker. The team initiated a hospital-based alcohol specialist nurse service which provides 7-day support for patients with any level of alcohol-related problem. The alcohol specialist nurses assess all alcohol-related admissions, provide brief interventions and initiate care plans which may include rapid outpatient appointments with the community alcohol team and/or detoxification starting in the hospital. The nurses also run their own liver disease course for staff and seek to improve alcohol-related risk management across the hospital. Outcomes include improvements in the quality of care received by patients with alcohol-related problems, substantial cost-savings due to reduced admissions and readmissions and fewer clinical incidents and assaults on other patients and nursing staff[14].

The British Society of Gastroenterology, Alcohol Health Alliance UK and the British Association for Study of the Liver have published a detailed set of recommendations for British district general hospitals serving a population of 250,000 focussing on the creation of consultant-led alcohol care teams[15]. These recommendations provide a framework for the improvement of alcohol services in hospitals and the development of more effective collaboration between hospital and community services to reduce alcohol-related harm.

In the hospital setting, specialist alcohol care teams have a crucial role to play in the early identification and management of patients with alcohol-related problems. However such services must be supported by adequately resourced specialist community alcohol services to provide on-going treatment and rehabilitation of people with alcohol dependence after they leave hospital. A comprehensive range of hospital-based and community alcohol services are needed in each locality based on the level of identified alcohol-related need.

This diversity of services must deliver for everyone with alcohol-related problems. Commissioners and providers should undertake regular health equity audits to identify and address the range of potential obstacles faced by local people in accessing specialist alcohol services. It is crucial that inequalities in alcohol-related harm (see page 16) are not exacerbated by inequalities in access to services. As attendance at specialist alcohol services can be stigmatising, great care is needed in the design of these services to ensure that they are welcoming to all. Here the voluntary and community sector plays an important role in building links with communities, promoting specialist alcohol services and supporting individuals to access the services they need.

**Recommendation**

Every acute hospital should have a specialist, multi-disciplinary alcohol care team tasked with meeting the alcohol-related needs of those attending the hospital and preventing readmissions.

chapter 8

# Additional measures


## Summary

This report focuses primarily on the population-level drivers of alcohol-related harm: significant reductions in harm will only be achieved by changing the price of alcohol, the range of products available, the promotion of alcohol and the availability of alcohol through all places of sale (the focus of chapters 3 to 6). However, there are other more targeted interventions which should also form part of a comprehensive alcohol strategy. This chapter considers the importance of the following:

*Measures to prevent drink driving*: a reduction in the legal blood alcohol limit for drivers is crucial if we are to further reduce alcohol-related deaths and injuries on the roads. A graduated approach to driver licensing would also help to reduce the risks for the most vulnerable.

*Information and education about the risks of drinking*: information and education interventions are unlikely to change drinking behaviour on their own but are important components of comprehensive strategies to reduce the harm from alcohol.

*Shaping media images of alcohol*: although the media presents negative as well as positive images of alcohol, most media images help to normalise drinking and rarely communicate the long-term risks of alcohol. There is scope to improve media practice in how alcohol and drinking are portrayed.

*Creating alcohol-free public spaces*: currently, very few public spaces in the UK are totally alcohol-free; there are potentially many opportunities to improve public safety by creating of such spaces.

### Recommendations

- The legal limit for blood alcohol concentration for drivers should be reduced to 50mg/100ml.
- Random breath-testing of drivers should be introduced.
- Graduated driver licensing should be introduced, restricting the circumstances in which young and novice drivers can drive.
- Mass media health promotion campaigns should be developed as part of broader strategies to reduce the harm from alcohol. Campaigns should be designed and run independently of the alcohol industry.
- Guidelines for the portrayal of alcohol in television and film should be developed and promoted.
- Local authorities should use local byelaws to improve community safety by creating alcohol-free public spaces where alcohol consumption is prohibited.

## Drink driving: the legal blood alcohol limit

Drink driving remains a major cause of injury and death in the UK. In 2011, drink driving resulted in 9,990 casualties including 280 deaths on British roads[1]. Analysis of road traffic deaths reveals the extent to which alcohol is implicated: over half (54%) of the cases examined by coroners involve drugs and/or alcohol with 42% involving alcohol only[2]. In England, the cost of drink driving is estimated to be £500million per year[3].

These harms are best tackled through population measures to reduce alcohol consumption, i.e. the measures described in chapters 3 to 6 to make alcohol less affordable, less attractive, less visible and less available. However, targeted driver-specific interventions are also needed to reduce the incidence of alcohol-related road accidents.

The legal blood alcohol concentration limit for drink driving is currently set at 80mg/100ml in the UK, the highest – and thus least stringent – limit in Europe with the exception of Malta. Although the introduction of this limit in 1967 reduced the number of alcohol-related deaths on the roads[4], there is clearly scope to go further. A review for NICE indicated that lowering the limit to 50mg/100ml would reduce fatalities by 6.4% and injuries by 1.4% in the first year after its implementation[5]. The Scottish government has recently indicated that it intends to lower the blood alcohol concentration limit for drink driving to 50g/100ml and the Northern Ireland government is consulting on a similar reduction.

NICE's recommendation[6] to reduce the blood alcohol concentration limit to 50mg/100ml is supported by the North Review of the Drink and Drug Driving Law[7] which noted that, although any alcohol consumption impairs driving, a driver with a blood alcohol concentration of between 50 and 80mg/100ml has at least six times the risk of dying in a crash than a driver who has drunk no alcohol. Reducing the blood alcohol concentration to between 20 and 50mg/100ml reduces this risk to around three times that of the completely sober driver. Crucially, there is convincing evidence that lowering the legal blood alcohol limit would affect the behaviour of drivers at all blood alcohol levels, including those drivers who drink heavily and in excess of the current 80mg/100 ml limit[8].

The impact of any change in the limit will be constrained by the effort put into its enforcement. In fact, improving enforcement would itself have a dramatic impact on drink driving harms. In Australia, for example, the introduction of random breath-testing reduced alcohol-related fatalities by 33% and injuries by 17%[9]. The NICE guidelines recommend the introduction of both random breath-testing and selective testing at 'sobriety checkpoints'. Such measures have a potentially powerful deterrent effect.

**Lowering the legal blood alcohol limit would affect the behaviour of drivers at all blood alcohol levels, including those drivers who drink heavily**

Such changes in policy must be communicated to the public through mass media campaigns which both reiterate the dangers of drink driving and make drivers aware of the changes to the legal blood alcohol limit.

**Recommendations**

The legal limit for blood alcohol concentration for drivers should be reduced to 50mg/100ml.

Random breath-testing of drivers should be introduced.

## Drink driving: graduated driver licensing

Younger drivers are particularly at risk of crashing when they have been drinking because they are less experienced drivers, less mature and have a lower tolerance of the effects of alcohol than older people. Younger drivers may also be predisposed to risk-taking. Drivers between the ages of 17 and 24 are far more

likely than others to be involved in a fatal collision after drinking alcohol[10].

There is a case for setting a lower blood alcohol limit for young drivers. However, a more effective alternative is graduated driver licensing which places restrictions on all young and novice drivers. Typically, these restrictions include a requirement to have an adult in the car when driving or prohibitions on night-time driving and driving with other young people in the car.

There is good evidence that graduated licensing reduces accidents. A review of studies from the USA, Canada, New Zealand and Australia found that the implementation of graduated driver licensing consistently resulted in reductions in crashes involving young people in all these jurisdictions[11]. The NICE guidelines concur that, in conjunction with zero tolerance laws, graduated licensing schemes can help reduce alcohol-related injuries and deaths.

**Recommendation**

Graduated driver licensing should be introduced, restricting the circumstances in which young and novice drivers can drive.

## Information and education

Information and education are necessary components of a comprehensive approach to reducing the harm from alcohol. Anyone who drinks alcohol, or who is considering starting drinking, ought to be fully informed of the risks of alcohol consumption. Interventions such as media campaigns and school education programmes are important both in increasing knowledge and in changing attitudes to alcohol. However the evidence suggests that information and education initiatives are unlikely, on their own, to deliver sustained changes in drinking behaviour[12]. They will only help to change behaviour if they support population-level measures that affect drinkers' choices (i.e. the measures described in chapters 3 to 6).

A wide range of alcohol education programmes has been tried and tested. School-based programmes that have shown positive results include both normative education and resistance skills training. These aim to correct adolescents' overestimation of the normality and acceptability of drinking among their peers and provide training in ways to resist peer pressure to drink. Family and community initiatives have also shown promising results in raising awareness and changing attitudes, although any reductions in drinking by participants tend not to be sustained beyond the programme[13].

Mass media campaigns that inform the public about the risks of harmful alcohol consumption can also help to raise awareness but do not, in themselves, reduce alcohol-related harm[14]. Such health promotion messages have to compete against the sophisticated pro-drinking messages presented by alcohol advertising which appear much more frequently. However, evidence does suggest that high profile media campaigns that aim to prevent drink driving can be effective when combined with enforcement of strong drink-driving policies.

In the UK the most common mass media messages about 'responsible drinking' are delivered by the alcohol industry as components of their advertising campaigns. However these highly compressed messages provide little or no meaningful information about the risks and health consequences of drinking. There is some evidence to suggest that such industry-driven messages benefit the reputation of the sponsor more than public health[15]. Given the obvious conflict of interest, such campaigns ought to be developed and designed independently.

Overall, there is limited evidence of the effectiveness of information and education initiatives in changing drinking behaviour and reducing alcohol-related harm. However, as in tobacco control, they are an important part of wider strategies to change public attitudes and build support for the most effective measures.

**Recommendation**

Mass media health promotion campaigns should be developed as part of broader strategies to reduce the harm from alcohol. Campaigns should be designed and run independently of the alcohol industry.

## Media portrayals of drinking

Images of alcohol surround us not only through advertising but also through the portrayals of drinking in the media. For example, alcohol features in 86% of the popular films screened in the UK[16]. Although

these images include negative images of the harms of alcohol, such as drunkenness and addiction, positive and normalising images dominate. Examples include magazine photographs of celebrities, where drinking is portrayed as a component of a glamorous lifestyle, and the long-established use of pubs as settings for television soaps.

Such images do not necessarily have a direct effect on behaviour as consumers of the media are not uncritical of what they watch and read. However, they contribute to the normalisation of alcohol use. This is a particularly important issue for young people who are likely to be both keen consumers of many media and inexperienced consumers of alcohol. They tend to perceive media images of alcohol as representing normal social activity, with different drinks supporting different masculine and feminine identities[17].

Currently there is little media content that counters these normalising effects. Portrayals of the harms of alcohol tend to focus on the immediate effects of intoxication rather than the long-term effects of regular drinking. There is scope to improve current practice through the development of guidelines for the television and film industries about the portrayal of alcohol consumption and its effects.

**Recommendation**

Guidelines for the portrayal of alcohol in television and film should be developed and promoted.

## Alcohol-free public spaces

There are remarkably few public spaces in the UK where drinking is not permitted. Controlled Drinking Zones (created by Designated Public Place Orders) have been widely used by local authorities to reduce drinking and drunkenness in public places by giving the police more powers to intervene where alcohol use is creating problems. However they do not prohibit drinking. There is scope to go further and use local bye-laws to designate specific public places as being alcohol-free. Such measures do not necessarily reduce the overall level of drinking but they have the potential to improve the safety of key public environments such as transport facilities, sports venues and parks. They may also reduce the public acceptability of alcohol, especially for young people.

**Transport is an obvious target for alcohol prohibition due to the close proximity and potential vulnerability of multiple passengers**

Transport is an obvious target for alcohol prohibition due to the close proximity and potential vulnerability of multiple passengers. In 2008 a ban on drinking alcohol on public transport was introduced in London which contributed to an estimated 15% fall in the number of assaults on Underground staff between 2008 and 2011[18]. Since July 2012 alcohol has also been banned on Scottish trains between the hours of 9pm and 10am in order to reduce anti-social behaviour, drink-related violence and disruptions to train services.

There is a good case for prohibiting the sale and consumption of alcohol at sports venues such as football grounds in order to reduce the risk of violence and disorder between fans. It was the perceived role of alcohol in inflaming a riot at a Scottish Cup final between Celtic and Rangers that led to the 1980 ban on alcohol at most Scottish football matches. In the USA research has shown the benefits of such prohibitions: a study of an alcohol ban in a sports stadium in Colorado found a sharp decline in arrests, assaults and ejections[19].

Alcohol-free family zones should also be a routine feature of festivals and public events where alcohol is available.

**Recommendation**

Local authorities should use local byelaws to improve community safety by creating alcohol-free public spaces where alcohol consumption is prohibited.

chapter 9

# Public support for change


## Summary

There is increasing public support for a more robust approach to tackling the harm from alcohol in the UK. This chapter reports the findings of a national survey which examined the attitudes of the British people to alcohol and to different ways of reducing the harm it causes.

The respondents to the survey were well aware that alcohol is not benign. In fact, even although most people in the UK drink alcohol, a majority of the respondents thought that the British people's relationship with alcohol is unhealthy. To most respondents, the consequences of the nation's drinking habits were obvious: the effects on health and social disorder, the costs to the NHS and the police, and the harm to children and families.

Cheap alcohol is perceived to be a particular problem in creating harm. Consequently there is growing support for policies that selectively raise the prices of the cheapest products. The principle of minimum unit pricing is widely understood and more respondents actively supported the introduction of minimum unit prices for common alcohol products than actively opposed the policy.

The importance of communicating the harm from alcohol to drinkers is widely recognised. A majority of respondents wanted to see proper warning labels on alcohol products, as well as mass media health promotion campaigns.

Alcohol promotion is also seen as a problem by many people, especially when children are exposed to it. Three in five respondents felt that the exposure of children to alcohol advertisements is unacceptable.

Attitudes to how alcohol is currently sold are more ambivalent, although many more respondents wanted to see an increase, rather than a decrease, in restrictions on where and when alcohol is sold.


## Findings from a national survey

The British public are well aware of the harm that alcohol causes and support stronger measures to try to reduce this harm. This is the core finding of a major survey of the UK population that was undertaken to test the ideas in this report. There is of course disagreement – there are many people who do not want change – but overall the results of the survey suggest that public opinion is ahead of current government policy on alcohol. The findings described below provide a foundation for a much more ambitious national strategy to reduce the harm from alcohol in the UK.

The survey was undertaken by YouGov in June 2012 using a sample of 2,075 adults recruited from a UK panel of over 350,000 individuals. The survey was completed online. The results were weighted to ensure representation of the entire adult population of the UK.

### Perceptions of the harm from alcohol

The British people may have a long-standing relationship with alcohol but this does not blind them to the harms that it causes: 61% of respondents said that they thought this relationship is unhealthy. Only 9% said they thought that our relationship with alcohol is healthy.

More women (63%) than men (58%) thought that

our relationship with alcohol is unhealthy. There were also large regional and national differences: respondents in Northern Ireland and Scotland (where alcohol consumption per capita is relatively high) were particularly likely to perceive the public's relationship with alcohol to be unhealthy (Figure 9.1).

Alcohol is widely perceived to have significant effects on health and public disorder: 88% of respondents thought that alcohol affected health 'a great deal' or 'a fair amount' and 92% thought alcohol had a similar impact on disorderly and anti-social behaviour. Likewise, the great majority of respondents felt that alcohol affects NHS costs (91%) and policing costs (89%). Four in five respondents (79%) thought that alcohol harms children and families a great deal or a fair amount (Figure 9.2).

## Four in five respondents thought that alcohol harms children and families a great deal or a fair amount

### Raising the price of the cheapest alcohol

Raising the price of alcohol may be contentious but there appears to be support for pricing strategies that focus on the cheapest products: just over half of respondents (51%) thought that the availability of cheap alcohol is harmful to society. This compares to only 19% who thought that cheap alcohol is not harmful to society (the remainder were neutral on the issue).

When respondents were asked if alcoholic drinks (in general) ought to be made more expensive or cheaper, 35% said they should be more expensive compared to 22% who thought they should be cheaper. However, many more respondents expressed support for higher prices when the focus of the question was on setting minimum prices.

The principle of minimum unit pricing was explained to respondents (80% said they had already heard of the idea). They were then asked whether they supported the specific prices that a 50p minimum unit price per unit of alcohol would define for common alcohol products. Figure 9.3 illustrates the results. Across all six products, support for the minimum price outweighed objections by some margin.

Supermarkets were perceived to be the primary source of cheap alcohol: 37% of respondents thought that the price of alcohol in supermarkets was too cheap,

Figure 9.1 Respondents' assessment of the British people's relationship with alcohol

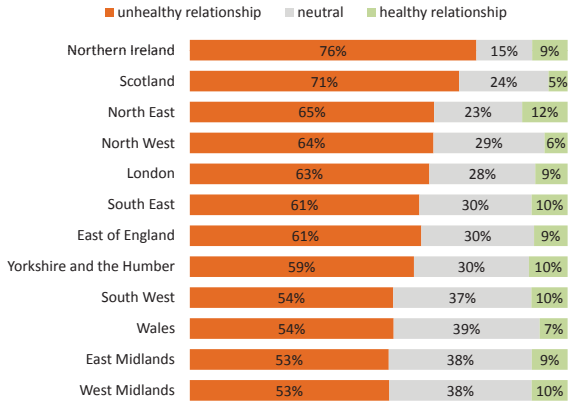



Figure 9.2 Respondents' views of the effects of alcohol

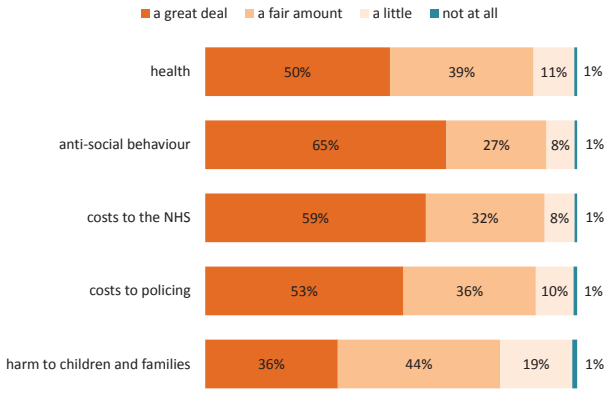
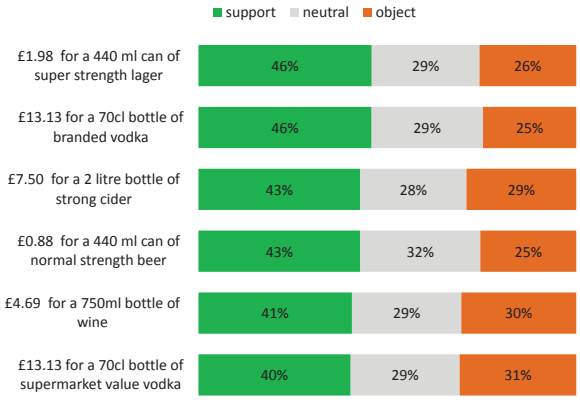



Figure 9.3 Respondents' support for specific minimum prices for alcohol products based on a minimum unit price of 50p per unit of alcohol.



whereas only 10% thought it was too expensive. In contrast, alcohol prices in pubs and nightclubs were perceived more often as being too expensive than too cheap.

One possible restriction on advertising is to prohibit alcohol advertisements on television before 9pm. This was supported by a majority of respondents: 60% agreed with this proposal compared to 17% who opposed it. This reflects a common concern about the exposure of children to alcohol advertising: 62% felt that it is not acceptable for children to be exposed to alcohol advertisements, compared to only 11% who said this was acceptable.

**62% said it was not acceptable for children to be exposed to alcohol advertisements**

There was also support for the principle that the price of drinks should be based on the alcohol strength of the drink: half of respondents (49%) agreed with this compared to 21% who disagreed.

### Communicating the harm from alcohol

The lack of information on shop-bought drinks about the harm from drinking alcohol was recognised by many respondents. A majority of survey respondents (57%) said they thought alcohol products ought to have labels on them in order to warn people about the potential harms of drinking. This is four times the number who thought warning labels ought not to be included (14%).

Two thirds of respondents (67%) agreed that it was important to run media health promotion campaigns to raise awareness of the harms of alcohol.

### Tightening the restrictions on the promotion of alcohol

The advertising of alcohol was widely perceived to be a problem: half (49%) of the respondents said there ought to be more restrictions on the way alcohol is advertised. Only 13% felt there should be fewer restrictions.

### Tightening the restrictions on the sale of alcohol

The ready availability of alcohol was of concern to a significant minority of survey respondents: 42% considered that there are insufficient restrictions on where alcohol can be sold, compared to 15% who felt there are too many restrictions (43% were neutral on the issue). Similarly, 41% said they thought the opening hours of pubs and bars should be reduced compared to only 15% who thought they should be extended.

### Treatment for addiction

The seriousness of alcohol addiction was recognised by survey respondents, most of whom supported the provision of appropriate treatment to those who suffer from addiction. Overall, 63% of respondents said that they thought it is important to provide treatment and support for people who are addicted to alcohol. Only 11% said that this is not important.

chapter 10

# Building on progress


## Summary

Real progress is being made throughout the UK in tackling alcohol-related harm. However much remains to be done. There is a need for a comprehensive approach which combines progressive action on price with stronger regulation of alcohol products, elimination of alcohol promotion, reform of licensing and greater investment in early intervention and treatment.

Ambitious targets are needed to drive and monitor progress. For the UK as a whole, the following targets are proposed:

- To reduce alcohol sales in the UK from 10.2 to 8 litres of pure alcohol per adult per year by 2020
- To reduce the rate of liver deaths from 11.4 to 4 per 100,000 population by 2020

Further targets are needed including specific targets for the nations and regions of the UK.

### Recommendation

- The UK government and the devolved administrations should develop appropriate alcohol policy targets for each of the nations and regions of the UK.


## National strategy

Across the UK, a great deal of progress has already been made in taking forward the recommendations of this report. Table 10.1 describes this progress in detail for each of the nations and regions of the UK. Scotland is leading the way but there has been real progress throughout the country.

This progress must be built on. This report has set out the scale of the harm from alcohol, the strength of the evidence for effective intervention and the increasing public support for tougher measures. The way forward should be to bring these together in a comprehensive strategy to tackle the harm from alcohol across the UK. We need to be ambitious not only in tackling the price of alcohol but also in regulating alcohol products, eliminating alcohol promotion and controlling the overall availability of alcohol in our communities. Greater investment in treatment and early intervention is also vital. Significant long-term reductions in the harm from alcohol will only be achieved through a genuinely comprehensive strategy.

## Targets

In order to assess progress in reducing the harm from alcohol in the UK, we propose two broad targets. They are:

- To reduce alcohol sales in the UK from 10.2 to 8 litres of pure alcohol per adult per year by 2020
- To reduce the rate of liver deaths from 11.4 to 4 per 100,000 population by 2020

These targets are ambitious; they are also measurable. Population-level indicators of alcohol-related harm for the UK are hard to come by because of the differences in how data are sourced between the regions and nations of the UK. Furthermore, subjective indicators, such as individuals' own assessments of how much they drink, are unreliable as national indicators.

The first target focuses on the overall level of alcohol consumption in the UK population, using sales as a proxy indicator. In order to reduce the harm from

alcohol experienced by individuals and communities, the people of Britain need to drink less. Clearly there are many people who do not need to reduce their consumption because they do not drink at all or they drink very little. However, they are the exceptions. We will only see significant reductions in harm at the population level if there is a population-level decline in alcohol consumption.

Data to inform progress against this target are available from HMRC, which annually reports alcohol sales per adult. A reduction to an average of 8 litres per adult would mean that those adults who do consume alcohol would, on average, be consuming no more than 21 units per week for men and 14 units per week for women (the current recommended low risk limits).

The second target focuses on a specific harm from alcohol: liver deaths. Alcohol causes around 80% of deaths from liver disease and patterns of liver mortality reflect trends in overall alcohol-related harm. Liver death rates are therefore a good measure of the damage caused to society by alcohol[1]. The target rate of 4 deaths per 100,000 population is comparable to current rates in Sweden, Norway, Australia and New Zealand, which have broadly similar cultures and genetic backgrounds to the UK. Britain last experienced liver deaths at this rate in 1986. Data to inform progress against this target are available from the World Health Organisation which regularly reports liver deaths by country.

There is scope to define further targets and indicators for the nations and regions of the UK where methodological differences between the regions are not an issue.

**Recommendation**

The UK government and the devolved administrations should develop appropriate alcohol policy targets for each of the nations and regions of the UK.

Table 10.1. Recommendations: progress in each of the nations and regions of the United Kingdom

| Recommendation | Progress |
|---|---|
| **National taxation and price policy** | |
| A minimum price of at least 50p per unit of alcohol should be introduced for all alcohol sales, together with a mechanism to regularly review and revise this price. | Scotland passed legislation in May 2012 to introduce a minimum retail price per unit of alcohol. A proposed minimum price of 50p is due to come into force in 2013. However, the legislation is currently subject to legal challenges from the alcohol industry and the European Commission. This is likely to delay implementation.<br>A public consultation on a minimum unit price of 45p was launched in England and Wales in November 2012. The Welsh Government has stated its support for a price of 50p per unit but cannot legislate on this issue for Wales alone.<br>In Northern Ireland, the Department of Health, Social Services and Public Safety and Department for Social Development consulted in 2011 on the principle of introducing a minimum unit price for alcohol sales. Research is being commissioned to model the likely impact of this policy in Northern Ireland. |
| Taxes should be used to raise the real price of alcohol products such that their affordability declines over time. | A tax escalator was introduced in March 2008 to increase the duty on all alcoholic drinks by 2% above the rate of inflation. This policy has been maintained by the current UK government. |
| All bulk purchase discounting of alcohol including 'happy hours' should be prohibited. | In Scotland, irresponsible alcohol promotions in on-licensed premises are prohibited by the Licensing (Scotland) Act 2005, in force since September 2009. Irresponsible promotions include 'happy hours' and the sale of unlimited amounts of alcohol for a fixed price. A ban on discounted multi-buys in the off-trade was introduced in the Alcohol etc. (Scotland) Act 2010. This came into effect in October 2011.<br>In England and Wales, the Licensing Act 2003 restricts irresponsible promotions in on-licensed premises including offering large quantities of alcohol for a fixed price. A ban on multi-buys in the off-trade is currently subject to public consultation.<br>In Northern Ireland, the Social Development Minister announced that a ban on fixed price drinks promotions in on-licensed premises will come into force in 2013. |

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| The tax on every alcohol product should be proportionate to the volume of alcohol it contains. In order to incentivise the development and sale of lower strength products, the rate of taxation should increase with product strength. | Throughout the UK duty on beer and spirits is proportionate to the volume of their alcohol content but duty on wine and cider is not. Instead it is applied in bands. For example, for sparkling wine, one rate is applied for wines of 5.5-8.5% strength and another for wines of 8.5-15% strength. EU rules currently preclude a change in policy for wine and cider. |
| **Regulation of alcohol promotion and products** | |
| An independent body should be established to regulate alcohol promotion, including product and packaging design, in the interests of public health and community safety. | No body of this kind currently exists.<br><br>A voluntary code of practice on the Naming, Packaging and Promotion of Alcoholic Drinks was introduced by the alcohol industry's Portman Group in 1996. The code is supported by the industry and is adjudicated by an independent complaints panel.<br><br>The current UK regulatory system for alcohol advertising is a mixture of self-regulation for non-broadcast advertising and co-regulation for broadcast advertising. This regulatory system is maintained and paid for by the alcohol industry and enforced by the Advertising Standards Authority (ASA). The ASA is the independent regulator for advertising, and is funded by a levy on advertising space. For TV and radio advertising, the ASA regulates under a contract from Ofcom, which operates under the Communications Act 2003 and is accountable to the UK Parliament. |
| All alcohol advertising and sponsorship should be prohibited. In the short term, alcohol advertising should only be permitted in newspapers and other adult press. Its content should be limited to factual information about brand, provenance and product strength. | Current alcohol advertising regulation arrangements are described above. For sponsorship, the alcohol industry has a code of practice (the Portman Group's) that stipulates that people aged under 18 years should not comprise more than 25% of the participants, audience or spectators at events sponsored by the alcohol industry. In addition, alcohol producers are unable to display their company's branding on children's replica sports shirts under sponsorship agreements signed after 1 January 2008.<br><br>In Northern Ireland, a consultation launched by the Minister for Social Development addresses restrictions on the advertising of alcohol in supermarkets and off-sales premises, or within 200m of these premises. |
| Alcohol producers should be required to declare their expenditure on marketing and the level of exposure of young people to their campaigns. | No arrangements for this type of declaration are currently in place. |
| The sale of alcohol products that appeal more to children and young people than to adults should be prohibited. | The alcohol industry's own code of practice (from the Portman Group) states that products should not have 'particular appeal' to under 18s. In addition, product packaging should not incorporate images of individuals who are, or look as if they are, under 25 years of age. |
| At least one third of every alcohol product label should be given over to an evidence-based health warning specified by an independent regulatory body. | It is not currently compulsory for alcohol product packaging to state the alcohol unit content of the product or carry a health warning.<br><br>At UK level, the alcohol industry pledged through the 'Responsibility Deal' that, by December 2013, 80% of products would have at least some labelling and that this would contain a minimum of three elements: unit content, sensible drinking guidelines and a warning on alcohol consumption in pregnancy. No commitments to size or prominence of this labelling have been made. |
| Every alcohol product label should describe, in legible type, the product's nutritional, calorie and alcohol content. | These requirements are not currently in place. The terms 'non-alcoholic' and 'low alcohol' are defined in law but from 13 December 2014 this will no longer be the case. |

| Licensing and local authority powers | |
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| Public health should be a core objective and statutory obligation of licensing throughout the UK. | In Scotland, licensing legislation already includes the protection and improvement of public health as one of five licensing objectives.<br><br>In England and Wales, there is no reference to public health in the statutory licensing objectives. However a proposal to introduce a public health objective based on cumulative impact is currently subject to consultation. The Police Reform and Social Responsibility Act 2011 added primary care trusts in England and health boards in Wales to the list of responsible authorities under the Licensing Act 2003 which are entitled to make representations on new licence applications. The revised Home Office guidance suggests that these bodies may be able to link hospital admissions and casualty figures with certain premises or areas where alcohol is sold.<br><br>In Northern Ireland, a consultation launched by the Minister for Social Development aims to strike a balance between facilitating the sale of alcohol on the one hand, and public safety and the public interest on the other. He acknowledges the significant contribution made by the licensed trade to Northern Ireland's tourist experience and notes that the consultation should 'bring forward measures which aim to contribute towards a reduction in alcohol-related harms and help make the licensed trade more sustainable and attractive to tourists'. |
| Licensing legislation should be comprehensively reviewed. Licensing authorities must be empowered to tackle alcohol-related harm by controlling the total availability of alcohol in their jurisdiction. | Scottish licensing legislation requires licensing boards to assess overprovision of licensed premises in their area. Licensing boards can refuse applications for licences for new premises on the grounds that the area is overprovided.<br><br>In England and Wales, the principle of the Licensing Act 2003 is that each application for a licence should be considered on its own merits and granted unless there are reasons not to grant it according to the four criteria specified in the Act.<br><br>In Northern Ireland, the Licensing and Registration of Clubs (Amendment) Act (NI) 2011 (the 2011 Act) became law in March 2011. A number of changes are already in force, including a penalty point system for licensed premises when found to be in breach of the law and a new proof-of-age scheme for pubs and clubs. The 2011 Act is not entirely in force and among the outstanding provisions is the power under section 4 for the Department of Social Development to make regulations in relation to irresponsible drinks promotions held on or in connection with licensed premises. |
| Local authorities should develop comprehensive alcohol strategies that prioritise public health and community safety. | In England and Wales, local authorities are now the licensing authorities and as such are required to produce local licensing policies. Many local alcohol strategies in England are now out of date, being produced around 2005, as an outcome of the then Labour government's national alcohol strategy 'Alcohol Misuse Interventions—Guidance on developing a local programme of improvement'. Alcohol specific commissioning guidance for local healthcare organisations was subject to consultation in 2007.<br><br>In England, local authorities' new role in leading Health and Wellbeing Boards offers an important opportunity to link licensing policy with wider local strategies to reduce the harm from alcohol. |
| Measures to deal with the consequences of drunkenness must be complemented by measures to reduce the prevalence of drunkenness, including forward planning of the number, density and opening hours of all licensed premises. | The connection between these measures is currently weak at both local and national level in the UK.<br><br>In Northern Ireland, a consultation launched by the Minister for Social Development poposes restricting late opening hours to a limited number of occasions throughout the year, subject to certain conditions such as mandatory door supervisors, CCTV and the payment of a 'late-night levy'. Further proposals include extending the current 'drinking up' time from 30 minutes to 1 hour and preventing the removal of alcohol (carry outs) from pubs after normal opening hours. |

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| The sale of alcohol in shops should be restricted to specific times of the day and designated areas. No alcohol promotion should occur outside these areas. | In Scotland, shops can be licensed to sell alcohol for a maximum of 12 hours, from 10am to 10pm. There is a presumption against 24-hour alcohol sales. Off-sales alcohol can only be displayed in a single area of a premises and drink promotions can only take place within the alcohol display area.<br><br>In Northern Ireland, a consultation launched by the Minister for Social Development proposes restrictions on the availability of alcohol in supermarkets, increased separation between alcoholic and other goods in supermarkets and a prohibition on children under 18 years of age entering any area where alcohol is displayed.<br><br>In England and Wales, no restrictions of this kind exist. |
| The law prohibiting the sale of alcohol to people who are already drunk should be actively enforced. | Existing UK laws prohibiting the sale of alcohol to people who are drunk (such as s141 of the Licensing Act 2003) are inadequately enforced. |
| Wherever alcohol is sold, a soft drink should be available that is cheaper than the cheapest alcoholic drink on sale. | The mandatory code of the Licensing Act 2003 requires on-licensed premises to provide free tap water on request but there are no requirements regarding the price or availability of soft drinks. |
| Local authorities should use local byelaws to improve community safety by creating alcohol-free public spaces where alcohol consumption is prohibited. | Designated areas where alcohol consumption is controlled or prohibited have a long history across the UK. The Criminal Justice and Police Act 2001 provided a national framework for 'controlled drinking zones' (CDZs) and over 700 CDZs have been introduced since 2003 in England. These have been used most effectively in relation to problematic street-drinking rather than to address problems in the town centres and the night-time economy. A range of other powers, such as Dispersal Zones, Penalty Notices for Disorder and Drinking Banning Orders, are also available to police and councils, but these are not applied consistently. |
| **Drink driving measures** | |
| The legal limit for blood alcohol concentration for drivers should be reduced to 50mg/100ml. | Scotland consulted in the autumn of 2012 on lowering the drink-drive limits from 80mg/100ml to 50mg/100ml. The measure has cross-party support. The power to prescribe the drink-driving limits in Scotland was devolved to the Scottish Parliament in the Scotland Act 2012.<br><br>In Northern Ireland, a consultation to lower the drink driving limit to 50mg/100ml for drivers and 20mg/100ml for novice, learner and professional drivers closed in late 2012 and the outcome is awaited. |
| Random breath-testing of drivers should be introduced. | The Scottish Government is currently seeking the power from Westminster to introduce random breath testing.<br><br>In Northern Ireland, the consultation on drink driving limits also includes proposals to introduce random breath testing. |
| **Early intervention and treatment** | |
| All health and social care professionals should be trained to routinely provide early identification and brief alcohol advice to their clients. | In Scotland, a national health improvement target has been in place since 2008 for the delivery of alcohol brief interventions (ABIs). Since then over 272,000 ABIs have been delivered in primary care, A&E and antenatal care. Further targets for 2012-2013 are in place to sustain and embed the delivery of ABIs in Scotland.<br><br>The Welsh Government has commissioned Public Health Wales to train professionals in ABI. Since 2010, 550 GPs and 1,500 other professionals have been trained.<br><br>There is no comparable initiative to support the wider use of ABIs in England. In 2012, the government's Alcohol Strategy signalled that an alcohol check would be introduced into the NHS Health Check for adults aged 40-75 from April 2013. The Department of Health is considering whether the Quality and Outcomes Framework can support GPs to carry out ABIs. Local authorities will be encouraged 'to examine the strong case for further local investment' in ABIs in primary care.<br><br>In Northern Ireland, the Health and Social Care Board launched a regional enhanced service in 2012 for alcohol screening and brief interventions within primary care. |

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| People who need support for alcohol problems should be routinely referred to specialist alcohol services for comprehensive assessment and appropriate treatment. | In Scotland there is a national performance access target which states that, by March 2013, 90% of clients will wait no longer than 3 weeks from referral to appropriate drug or alcohol treatment. Based on the most recent data available, from April-June 2012, of the 10,942 people who started their first drug and/or alcohol treatment, 90.0% had waited 3 weeks or less, compared to 87.7% in the previous quarter.<br><br>The Welsh Government measures and records waiting times for referrals to specialist services, and reported in October 2012 that 70% of substance misuse clients were being assessed within 10 working days of referral, an improvement on the 2011 reported figure of 67%. Furthermore, 91% of clients were beginning treatment within 10 days of their assessment, a slight improvement on the 90% reported in 2011.<br><br>In England there are no specific national targets for referral to specialist alcohol treatment although there are some examples of local initiatives. |
| Greater investment is needed in specialist community-based alcohol services to meet current and future alcohol treatment needs. | In Scotland there have been recent increases in expenditure on both alcohol prevention and treatment with an investment of £196m over the four years since 2008. The bulk of this funding has been invested in local prevention, treatment and support services, in line with the priorities determined by local alcohol and drug partnerships.<br><br>The Welsh Government's Substance Misuse Action Fund budget for 2012-13 is £33m, with a further £17m ring-fenced within health board budgets for substance misuse services.<br><br>The UK Government's Drug Strategy in England mentions alcohol treatment but is not specific about what improvements in services are needed. No new national investment in treatment has been proposed. However pilot schemes are under way to examine the potential for alcohol treatment to be delivered under the Payment by Results approach based on local commissioning. |
| Every acute hospital should have a specialist, multi - disciplinary alcohol care team tasked with meeting the alcohol-related needs of those attending the hospital and preventing readmissions. | The UK Government's Alcohol Strategy in England encourages all hospitals to employ alcohol liaison nurses. However this has not been matched by specific national investment. A recent national survey of A&E departments in England showed that 72% had access to an alcohol health worker or clinical nurse specialist in 2011[2]. The Department of Health plans to develop a model of intervention for people aged under 18 attending A&E for alcohol-related reasons. |
| **Mass media** | |
| Mass media health promotion campaigns should be developed as part of broader strategies to reduce the harm from alcohol. Campaigns should be designed and run independently of the alcohol industry. | No substantive alcohol campaigns are currently in place, although advice on drinking alcohol is included in the Change4Life programme. Some key sources of advice and information, such as Drinkaware UK, are funded by the alcohol industry. |
| Guidelines for the portrayal of alcohol in television and film should be developed and promoted. | These guidelines do not currently exist, with the exception that alcoholic drinks cannot be product placed in UK television programmes. |

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