Alcohol Change UK

Response to the Prevention Green Paper consultation

October 2019

Alcohol Change UK is a leading UK alcohol charity, formed from the merger of Alcohol Concern and Alcohol Research UK. With a vision of a society that is free from serious alcohol harm, we work towards five key changes: improved knowledge, better policies and regulation, shifted cultural norms, improved drinking behaviours, and more and better support and treatment.

Introduction

The Prevention Green Paper looks to prevent ill-health before it happens - but alcohol, a leading cause of health harm, is almost entirely absent. The prevention agenda is an exciting step forward, aiming to reduce the incidence of illnesses such as cancer, diabetes and heart disease, all of which can be caused or contributed to by the overconsumption of alcohol.

Alcohol is a cause of cancer, a grade 1 carcinogen in the same category as tobacco,[1] estimated to cause around 12,000 cases of cancer in the UK each year.[2] Alcoholic liver disease is one of the only preventable conditions for which deaths are increasing in the UK, while they fall across most of Europe. Alcohol intersects with many other issues addressed in the green paper, including obesity, mental health problems and smoking.

The absence of alcohol policies in the paper indicate there may be a denial about the scale of the problem. A recent study found that 1 in 10 hospital inpatients is alcohol dependent, while a huge 1 in 5 is drinking harmfully.[3] While 71% of drinkers in England do drink within the low risk drinking guidelines of 14 units a week,[4] the group of people experiencing serious alcohol harm is huge and growing. Alcohol harm happens on a spectrum, and millions of us are in the part of the spectrum at which there is real risk of cancer, alcohol-related brain damage, liver disease, heart disease and more. In England alone 1.9 million people drink at higher risk levels and 8.5 million at increasing risk levels. Even looking just at the most extreme end of this spectrum, there are around 590,000 dependent drinkers in England.[5]

The harm caused by alcohol is immense. If we want to reduce the prevalence of the diseases which the green paper seeks to tackle – diabetes, cancers, heart disease – we must address alcohol.

---

[1] International Agency for Research on Cancer. Consumption of alcoholic beverages. IARC Monogr Eval Carcinog Risks to Humans. 2012;100E. Available at: https://monographs.iarc.fr/wp-content/uploads/2018/06/mono100E-11.pdf

[2] Brown, K. et al. The fraction of cancer attributable to modifiable risk factors in England, Wales, Scotland, Northern Ireland and the United Kingdom in 2015. British Journal of Cancer 2018. Available at: https://www.nature.com/articles/s41416-018-0029-6

[3] Roberts, E. et al., 2019. The prevalence of wholly attributable alcohol conditions in the United Kingdom hospital system: a systematic review, meta-analysis and meta-regression. Addiction Journal, 114:10. Available at: https://onlinelibrary.wiley.com/doi/10.1111/add.14642

[4] PHE, 2016. The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An Evidence Review. p.21. Available at: https://www.gov.uk/government/publications/the-public-health-burden-of-alcohol-evidence-review

[5] Public Health England, 2018. Alcohol dependence prevalence in England. Available at: https://www.gov.uk/government/publications/alcohol-dependence-prevalence-in-england

Alcohol Change UK, 27 Swinton Street, London WC1X 9NW
020 3907 8480, info@alcoholchange.org.uk, www.alcoholchange.org.uk

Alcohol in the Green Paper

Included in the green paper are commitments to improve the availability of alcohol-free and low-alcohol products as well as to encourage innovation in the low/no sector by revising the alcohol-free descriptor. Alcohol-free and low alcohol products have a role to play for many individuals looking to cut down on their drinking, providing a stepping stone towards new habits. They aren't for everyone, but for some their improved availability means that a lifestyle with less alcohol becomes more achievable – and more fun. But on its own, this measure would barely scratch the surface of efforts to prevent alcohol harm.

Furthermore, this is not necessarily an area where government need focus its efforts as industry developments are already moving in this direction. There are far more impactful alcohol policies which could be implemented.

Alcohol Change UK is called on the Government to create a comprehensive Alcohol Strategy at national level. Failing that, we urge the Government to adopt these most urgent, evidence-based prevention policies:

1. **Ensure that relevant health and social care professionals are trained to provide early identification and brief advice, particularly GPs, paramedics and A&E staff.**
2. **Bring England into line with Scotland and Wales by introducing Minimum Unit Pricing.**
3. **Develop statutory minimum requirements for labelling alcohol products. This should include health warnings, ingredients and nutritional information alongside existing advice.**

Alcohol policies elsewhere

There are many effective, workable policies which would help to achieve the green paper's prevention aims. Many of these are laid out in the Alcohol Charter,[6] endorsed by over 30 organisations across the drugs and alcohol sector, as well as MPs and peers from across political parties.

The green paper notes some great work already being done by Government to tackle alcohol harm, including the £6 million investment to support the 200,000 children in England with alcohol dependent parents and the commitment to rolling out alcohol care teams (ACTs) to the hospitals with the highest numbers of alcohol-related admissions over the next five years.

This is most welcome as the number of alcohol-related hospital admissions in England is 15% higher than it was 10 years ago.[7] However, the ACTs commitment includes no commitment to establish a certain number of ACTs. ACTs should be expanded to all 200 district general hospitals in England.[8] The NHS Long Term Plan does not define an 'Alcohol Care Team' and there is a danger that small 'teams' of one or two alcohol specialist nurses (ASNs) will be created, which would be insufficient to address the problem of high rates of alcohol-related hospital admissions. In 2016, 83% of UK hospitals had one or more ASNs, although many did not have the 3-4 ASNs required to provide a 7-day ASN service.[9] ACTs have 11 elements, including an alcohol assertive outreach team and consultant hepatologists.[10]

---

[6] The Alcohol Charter, 2018. Available at: https://s3.eu-west-2.amazonaws.com/files.alcoholchange.org.uk/documents/Full-Alcohol-Charter.pdf?mtime=20190320113141

[7] NHS Digital, 2019. Statistics on Alcohol, England 2019. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-alcohol/2019/part-1

[8] Alcohol Health Alliance UK, 2019. AHA comment on NHS long-term plan announcement on Alcohol Care Teams. Available at: http://ahauk.org/nhs-long-term-plan/

[9] Williams R, Alexander G, Aspinall R, et al. New metrics for the Lancet Standing Commission on Liver Disease in the UK. Lancet 2017; 389: 2053–80.

[10] Moriarty KJ. 2019. Alcohol care teams: where are we now? Frontline Gastroenterology Published Online First: 14 August 2019. doi:10.1136/flgastro-2019-101241 Available at: https://fg.bmj.com/content/early/2019/08/14/flgastro-2019-101241.info

Consultation questions

1) From life span to health span. Which health and social care policies should be reviewed to improve the health of people living in poorer communities, or excluded groups?

While the price of alcohol has increased by 31% over the last 10 years, it remains 64% more affordable than it was in 1987.[11] When the equivalent of 22 shots of vodka can be purchased for £3.59,[12] people in vulnerable and often excluded groups are at greater risk of alcohol harm. Introducing Minimum Unit Pricing in England, following the lead of Scotland and now Wales, would create a floor price below which a unit of alcohol cannot be sold, having the greatest impact on the heaviest drinkers.

Although on average, poorer people drink less than wealthier people,[13] those living in deprived areas are still more likely to suffer from health harms due to alcohol. For example, in Scotland, alcohol-related deaths are six times higher in the most deprived areas compared to the least deprived.[14] In England, half of the one million annual alcohol-related hospital admissions occur in the three lowest socioeconomic deciles.[15] For this reason, we need policies designed to address these health inequalities, such as Minimum Unit Pricing, and we need sustained effort to reach the most vulnerable groups, for example Alcohol Care Teams with assertive outreach services, and training non-alcohol specialist frontline staff across health, social care and criminal justice on how to work with people experiencing alcohol problems, such as the Blue Light Project.[16]

2) Intelligent health checks. Do you have any ideas for how the NHS Health Checks programme could be improved?

Increased alcohol consumption increases the risk of developing stroke, heart disease, type 2 diabetes and dementia, all of which are targets for NHS Health Checks. Although alcohol screening is included in Health Checks, they often don't take place. Health care professionals require more training and guidance on how to raise the topic of alcohol with patients. Health care professionals should be required to record patients' answers to the alcohol screening section, thereby ensuring it is always carried out. GP surgeries and pharmacies need strong links with community alcohol services and should feel confident in referring patients to treatment.

5) Support for individuals to achieve and maintain a healthy weight. How can we help people reach and stay at a healthier weight?

People in need of alcohol treatment are nine times more likely to have eating disordered behaviours than the general population, and vice versa.[17] It is essential that alcohol treatment services and services for disordered eating are providing adequate support for the other condition.

---

[11] NHS Digital, 2019. Statistics on Alcohol, England, 2019. Part 7: Expenditure and affordability. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-alcohol/2019/part-7

[12] Alcohol Health Alliance, 2016. Cheap Alcohol: the price we pay. Available at: http://ahauk.org/cheap-alcohol-price-pay-aha-report-october-2016/

[13] NHS Digital, 2019. Statistics on Alcohol, England 2019. Part 4: Drinking behaviours among adults. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-alcohol/2019/part-4

[14] Giles L. and Robinson M., 2017. Monitoring and Evaluating Scotland's Alcohol Strategy: Monitoring Report 2017. Available at: http://www.healthscotland.scot/media/1449/mesas-final-report_english1.pdf

[15] Public Health England, 2018. The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An evidence review. p.200. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/733108/alcohol_public_health_burden_evidence_review_update_2018.pdf

[16] Alcohol Change UK, 2019. The Blue Light project. Available at: https://alcoholchange.org.uk/help-and-support/get-help-now/for-practitioners/blue-light-training

[17] Tan, J. and Johns, G. 2019. Drinking and Eating. Available at: https://alcoholchange.org.uk/publication/drinking-and-eating

At the same time, for those without disordered eating behaviours, alcohol can still contribute to obesity. For users of the Try Dry (Dry January app), their average weekly alcohol consumption before starting Dry January is 2,200 calories. Yet over 80% of people do not know or underestimate the number of calories in a large glass of wine.[18] The government should introduce mandatory labelling of nutritional information, ingredients, number of units, CMO low risk drinking guidelines and health risk information on alcohol products to improve public knowledge.

7a) Taking care of our mental health. How can we support things that are good for mental health and prevent the things that are bad for mental health, in addition to the mental health actions in the green paper?

Alcohol is a depressant and can contribute to mental health problems. Equally, alcohol can be used by those with existing mental health problems to cope with their symptoms, yet further exacerbating them. 86% of people in alcohol treatment services have a co-occurring mental health condition[19] and 85% of alcohol and mental health professionals in a Centre for Mental Health and Institute of Alcohol Studies survey agreed that having an alcohol use disorder is a barrier to mental health support.[20] Recommendations from their report include:

- "The Department of Health and Social Care, NHS England and Public Health England should urgently review the funding of addiction services and the provision of support to people with co-occurring mental health conditions.
- Sustainability and Transformation Partnerships and emergent Integrated Care Systems should develop plans for improved support for people with co-occurring mental health and alcohol problems.
- Local suicide prevention plans should include action to address the links between alcohol misuse and deaths by suicide.
- Health Education England should ensure that all trainee psychiatrists receive training and undertake placements in addiction services (which could include those in the voluntary sector).
- Alcohol liaison services in general hospitals should seek to identify people who are misusing alcohol and refer them to appropriate support from local services.
- The Improving Access to Psychological Therapies (IAPT) programme nationally, and CCGs in local areas, should ensure that people with co-occurring alcohol difficulties are not excluded from psychological therapy services.
- The Department of Health and Social Care and Public Health England should commission a national anti-stigma campaign to dispel myths about people with co-occurring problems, including specific work to address professionals' attitudes."

9) Prevention in the NHS. Have you got examples or ideas for services or advice that could be delivered by community pharmacies to promote health?

There is some evidence from feasibility studies to show that identification and brief advice (IBA) for alcohol can be delivered successfully in community pharmacy settings.[21] Community pharmacies can develop

[18] Royal Society for Public Health, 2014. Increasing awareness of 'invisible' calories from alcohol. Available at: https://www.rsph.org.uk/uploads/assets/uploaded/979245d2-7b5d-4693-a9b3fb1b98b68d76.pdf

[19] Public Health England, 2017. Better care for people with co-occurring mental health and alcohol/drug use conditions. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf

[20] Institute of Alcohol Studies and Centre for Mental Health, 2018. Alcohol and mental health: Policy and practice in England. Available at: http://www.ias.org.uk/uploads/pdf/IAS%20reports/rp31042018.pdf

[21] Thom, B., Herring, R., Bayley, M., Hafford-Letchfield, T. Luger, L., Annand, F. and Bristow, A. 2016. The role of training in delivering alcohol IBA in non-medical settings: Broadening the base of IBA delivery. Available at: https://alcoholchange.org.uk/publication/delivering-alcohol-iba-broadening-the-base-from-health-to-non-health-contexts

long-term relationships with patients and therefore be more attuned to changes in drinking behaviour that other primary health care settings where patients attend less frequently.

12) Creating healthy spaces. What could the government do to help people live more healthily in homes and neighbourhoods, when going somewhere, in workplaces and in communities?

Alcohol harm is a population level issue as well as an individual one. Harm can be found at all levels of society, from within our homes where alcohol can contribute to domestic abuse and violence, to causing disruptive behaviour when travelling, to posing a risk in the workplace environment, and to its ubiquity within our communities in its affordability, availability and marketing.

- **In homes and neighbourhoods:**

Often both victims and perpetrators of domestic abuse are in need of alcohol treatment. Those who experience domestic abuse may use alcohol to cope. Alcohol services should work together with domestic violence services to ensure that victims do not have to attend services where their abuser may be present. Less than half of local authorities in England and only one in five Welsh unitary authorities have women-only services.[22] Alcohol treatment services should be adequately funded to provide women-only services with support for those with children.

There are approximately 190,000 children in England[23] and 51,000 in Scotland living with an alcohol-dependent parent or carer[24] and parental alcohol use is the most common reason children call ChildLine.[25] With fewer than one in five dependent drinkers in England accessing alcohol treatment services, 17% fewer than six years ago,[26] more investment in treatment services is needed. Alcohol treatment *is* prevention, as it addresses the alcohol problem itself, before further ill effects occur, not only to the individual, such as alcoholic liver disease, but also to their affected children and family members.

'Millions of children live with parents who drink riskily but not yet at a dependent level and they are influenced by the drinking behaviours they see in the home. They can also suffer when such drinking impacts negatively on parenting.[27] When parents regularly drink with their children, it increases the risk that the children will develop risky drinking behaviours in the future.[28] Parents should enable their children to maintain an alcohol-free childhood until at least the age of 15. The earlier children start drinking, the more likely they will develop alcohol problems later in life.[29]

---

[22] AVA and Agenda, 2017. Mapping the maze: Services for women experiencing multiple disadvantage in England and Wales. Available at: https://www.mappingthemaze.org.uk/wp/wp-content/uploads/2017/09/Mapping-the-Maze-executive-summary-for-publication.pdf

[23] Pryce, R., Buykx, P., Gray, L., Stone, T., Drummond, C. and Brennan, A., 2017. Estimates of alcohol dependence in England based on APMS 2014, including estimates of children living in a household with an adult with alcohol dependence. Public Health England. p. ix. Available at: https://www.sheffield.ac.uk/polopoly_fs/1.693546!/file/Estimates_of_Alcohol_Dependence_in_England_based_on_APMS_2014.pdf

[24] Scottish Government. 2012. Final Business And Regulatory Impact Assessment For Minimum Price Per Unit Of Alcohol As Contained In Alcohol (Minimum Pricing) (Scotland) Bill.

[25] Mariathasan, J. and Hutchinson, D. 2010. Children talking to ChildLine about parental alcohol and drug misuse. NSPCC.

[26] Public Health England, 2018. Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS). Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/752993/AdultSubstanceMisuseStatisticsfromNDTMS2017-18.pdf

[27] Parliamentary Office of Science and Technology, 2018. Parental alcohol misuse and children. Available at: https://researchbriefings.parliament.uk/ResearchBriefing/Summary/POST-PN-0570

[28] Degenhardt, L., 2015. Does the social context of early alcohol use affect risky drinking in adolescents: prospective cohort study. BMC Public Health 15:1137. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4647618/

[29] Rossow, I. et al., 2015. Does parental drinking influence children's drinking: a systematic review of prospective cohort studies. Addiction 111.2. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4832292/

- **When going somewhere:**

In Great Britain there are 8,600 casualties and 5,700 accidents due to drink-driving every year.[30] England and Wales have a drink-drive limit of 80mg alcohol/100ml blood, which is the highest limit in Europe. The government should reduce the drink-drive limit to 50mg/100ml in line with Scotland and the rest Europe. This would save an estimated 25 lives and prevent 95 casualties each year.[31]

Airports are an anomaly in that standard licensing laws do not apply. This means that airside outlets serving alcohol can do so at all hours of the day and night, which can lead to disruptive behaviour both in the airport and on the plane, posing a safety risk to other passengers. A 2018 survey found that three in five adults have encountered drunk passengers on their flight. The same licensing laws should apply in airports as in every other place in the country.

- **In workplaces:**

Lost productivity due to alcohol use costs the UK economy more than £7 billion annually and an estimated 167,000 working years are lost to alcohol each year.[32] There is evidence that employees in certain industries (such as mining and construction, hospitality, wholesale and those doing shift work[33]) are more likely to drink heavily. The government should consider targeting these employers to support interventions to reduce the effect of alcohol in the workplace, such as having an organisational alcohol policy.

- **In communities:**

At the community level, three main things can influence the likelihood that people can access and will want to access alcohol, and therefore the chance of alcohol harm.

Firstly, if alcohol is more available in the community, for example where there is high alcohol outlet density and long opening hours, it is easier for people to access alcohol and drink heavily. Indeed, since 2008 there has been a 16% increase in premises with a 24-hour license.[34] The government should consider introducing a public health licensing objective for England and Wales, as has been done in Scotland, which would require consideration of potential over-availability of alcohol in an area and its effects on public health.

If stronger alcohol is more affordable, the likelihood of health harms increases. The current duty system for alcohol does not link strength with price for all types of alcohol, meaning some producers are incentivised to produce higher strength alcohol which will have less duty and can be sold at a lower price. Rationalising the duty system to apply a higher duty to alcohol with a higher alcohol content would prevent super-cheap high-strength alcohol from being sold.

Finally, the government should enforce tighter alcohol marketing restrictions and regulation and consider abolishing the current self-regulatory system for an independently regulated one. The House of Commons

[30] Department for Transport, 2019. Estimated number of reported drink drive accidents and casualties in Great Britain: 1979-2017. Available at: https://www.gov.uk/government/statistical-data-sets/reported-drinking-and-driving-ras51#drink-drive-accidents-and-casualties

[31] Allsop, R. 2015. Saving Lives by Lowering the Legal Drink-Drive Limit. Parliamentary Advisory Council for Transport Safety (PACTS). p.vii. Available at: http://www.pacts.org.uk/2015/12/saving-lives-by-lowering-the-legal-drink-drive-limit/

[32] Public Health England, 2016. Health matters: harmful drinking and alcohol dependence. Available at: https://www.gov.uk/government/publications/health-matters-harmful-drinking-and-alcohol-dependence/health-matters-harmful-drinking-and-alcohol-dependence

[33] World Health Organisation Europe, 2013. Status report on alcohol and health in 35 European countries. Available at: http://www.euro.who.int/en/publications/abstracts/status-report-on-alcohol-and-health-in-35-european-countries-2013

[34] Home Office and ONS, 2017. Alcohol and Late Night Refreshment Licensing England and Wales. Table 1. Available at: https://www.gov.uk/government/publications/alcohol-and-late-night-refreshment-licensing-england-and-wales-31-march-2017/alcohol-and-late-night-refreshment-licensing-england-and-wales-31-march-2017

Select Committee have found that the current system does not "prevent the promotion of drunkenness and excess; or the linking of alcohol with social and sexual success".[35]

13) Active ageing. What is your priority for making England the best country in the world to grow old in, alongside the work of Public Health England and national partner organisations?

The rate of older people over the age of 65 admitted to hospitals in England for alcohol-related conditions has risen by 14% since 2008/09.[36] However, this age group is under-represented in treatment services. Drink Wise, Age Well found evidence of age discrimination in services where younger clients are prioritised and a lack of tailored support for older drinkers, such as home visits for those with less mobility.[37] Older people with lived experience, alongside experts in alcohol and ageing co-created the Calling Time for Change charters for each of the four nations, which lay out in detail the policies needed to address the issue of alcohol misuse in older people. These included adequate funding for treatment services and inclusive commissioning.[38]

14) Prevention in wider policies. What government policies (outside of health and social care) do you think have the biggest impact on people's mental and physical health?

Many of the policies outlined so far would be the responsibility of multiple departments, with an impact for health and social care. For example, the effect of addressing affordability, availability and marketing of alcohol would in turn decrease population-level consumption and reduce alcohol-related mental and physical health harms. A cross-departmental government alcohol strategy is needed to coordinate policies on this multi-disciplinary topic.

16) Local action. What more can we do to help local authorities and NHS bodies work together?

As has been outlined, alcohol treatment should be seen as preventative. Addressing an individual's problematic alcohol use will go on to have positive effects on their relationships with family members, their mental health and physical health.

Local authorities and NHS bodies need to work together to ensure that people with multiple complex needs can receive the care they need, when they need it.

18) Next steps. What other areas would you like future government policy on prevention to cover?

Ultimately, we need a cross-departmental strategy on alcohol harm, jointly developed, supported and implemented by the Department of Health and Social Care, the Home Office, the Ministry of Justice, the Treasury and the Ministry of Housing, Communities and Local Government. This strategy should address alcohol in all its complexity, including its intersections with other causes of harm like poverty, social isolation and homelessness, which the existing small pockets of money and piloting do not provide.

Alcohol Change UK

11 October 2019

---

[35] Memorandum by Professor Gerard Hastings, 2010. '"They'll Drink Bucket Loads of the Stuff": An Analysis of Internal Alcohol Industry Advertising Documents' to the House of Commons Health Select Committee Inquiry. p.1&3.

[36] Public Health England, 2018. Local Alcohol Profiles for England. Hospital admissions by age-group. Available at: https://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/4/gid/1938132982/pat/6/par/E12000006/ati/102/are/E10000015/iid/92321/age/27/sex/4

[37] Drink Wise, Age Well, 2017. Calling TIme: Addressing ageism and age discrimination in alcohol policy, practice and research. Available at: https://drinkwiseagewell.org.uk/wp-content/uploads/2017/11/DWAW_Yr3_Report-FOR-WEB4.pdf

[38] Drink Wise, Age Well, 2019. Calling Time for Change Charters for Scotland, Northern Ireland, England and Wales. Available at: https://drinkwiseagewell.org.uk/research/