

Alcohol Charter

Drugs, Alcohol & Justice Cross-Party Parliamentary Group and
All-Party Parliamentary Group on Alcohol Harm

October 2018

A new national Alcohol Strategy must lead the way internationally in reducing the damage to society caused by alcohol misuse.

The strategy must:

- Be based on the evidence of what works to reduce alcohol harm as outlined in the PHE alcohol evidence review
- Tackle the increased availability of excessively cheap alcohol
- Empower the general public to make fully informed decisions about their drinking
- Provide adequate support for both dependent and non-dependent drinkers
- Set out the Government's intention to reduce harmful drinking, tackle health inequalities, improve family and community resilience and ensure the UK has a healthier, better informed relationship with alcohol. It will do this through evidence-based policy and targeted investment.

ALCOHOL HARM – THE CASE FOR GOVERNMENT ACTION

Alcohol harms our health, our communities, and our economy

Alcohol is harming the country's health. Every year, there are more than a million alcohol-related hospital admissions in England. Here, if you are aged 15 to 49, there is no greater risk factor to you for premature death, illness and disability than alcohol.¹ In the UK, alcohol is linked to 12,800 cancer cases every year,² and unless trends change, is expected to lead to 1.2 million cancer hospital admissions and 135,000 cancer deaths in the next 20 years.³ Indeed, in England there are now more years of working life lost to alcohol than to the 10 most common cancers combined,⁴ while liver disease deaths have increased by 400% since 1970⁵ – now the only major cause of death in the UK which is rising.⁶

It is not only our health, but our communities that suffer the effects of alcohol harm. Alcohol-related crime is ubiquitous, with more than 40% of all violence in England and Wales being alcohol-related.⁷ Our dedicated emergency services personnel suffer more than most; 3 of every 4 police officers have been injured in an alcohol-fuelled incident,⁸ and 52% of all ambulance staff have been sexually harassed or assaulted by an intoxicated individual.⁹ Families and children find themselves impacted. Indeed, there are almost 200,000 children living with at least one alcohol-dependent adult,¹⁰ and more children call Childline concerned about a parent's drinking than for any other reason.¹¹

This extensive harm comes at a cost. Unless consumption changes, alcohol is set to cost the NHS £17 billion in the next five years alone.¹² In England and Wales, alcohol-related crime costs up to £11 billion a year.¹³ It wastes resources, taking up as much as half of emergency services' time.¹⁴ The total societal cost of alcohol misuse in England and Wales has been estimated to fall between 1.3% and 2.7% of GDP¹⁵ (and possibly as high as £52 billion¹⁶) – a bill not covered by alcohol's tax take.¹⁷

¹ Public Health England. 2016. [The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An evidence review](#). p. 200.

² Parkin, D. M. 2011. [3. Cancers attributable to consumption of alcohol in the UK in 2010](#). *British Journal of Cancer*, 105(S2), p. S14.

³ Cancer Research UK. 2016. [Alcohol and cancer trends: intervention scenarios](#). p. 4.

⁴ Public Health England. 2016. [The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An evidence review](#). p. 200.

⁵ Public Health England. 2016. [The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An evidence review](#). p. 200.

⁶ Data sourced from the Lancet Liver Commission. Available at: [Addressing liver disease in the UK](#).

⁷ ONS. 2018. [The nature of violent crime in England and Wales: year ending March 2017](#). p. 24.

⁸ The Institute of Alcohol Studies. 2015. [Alcohol's impact on emergency services](#). p. 4.

⁹ The Institute of Alcohol Studies. 2015. [Alcohol's impact on emergency services](#). p. 24.

¹⁰ 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. vi.

¹¹ Mariathasan, J. and Hutchinson, D. 2010. Children talking to ChildLine about parental alcohol and drug misuse. NSPCC.

¹² Foundation for Liver Research. 2017. [Financial case for action on liver disease](#). p. 2.

¹³ Parliament.uk. 2013. [Written evidence from the Department of Health \(GAS 01\), in '3rd report – Government's Alcohol Strategy', Health Committee](#).

¹⁴ The Institute of Alcohol Studies. 2015. [Alcohol's impact on emergency services](#). p. 3.

¹⁵ Public Health England. 2016. [The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An evidence review](#). p. 201.

¹⁶ Foundation for Liver Research. 2017. [Financial case for action on liver disease](#). p. 2.

The more we drink, the more harm is done

As Public Health England recognised in their extensive alcohol policy evidence review of 2016, the more alcohol is drunk, the more harm is done;¹⁸ and alcohol consumption in the UK has doubled since the 1950s.¹⁹ In England today, “there are currently over 10 million people drinking at levels which increase their risk of health harm,”²⁰ and enough alcohol is sold for every drinker to drink more than 20 units every week – substantially more than the Chief Medical Officer's low risk guideline of 14 units a week.²¹

These increases in consumption, and consequent harm, are largely driven by alcohol's increasing affordability and availability. Since 1980, alcohol has become 60% more affordable.²² This trend has been even starker in the off-trade, with beer and wine here now 188% and 131% respectively more affordable than 30 years ago.²³ Today, alcohol products like high-strength white ciders and supermarket own brand vodkas are on sale across the country for pocket money prices. Changes to the licensing legislation in recent decades – the introduction of the Licensing Act 2003 – have also made alcohol more available, both physically and temporally. In the last ten years, both numbers of licensed premises and of those with 24-hour licences have increased, by 8% and 16% respectively.²⁴

As these trends continue unaddressed, harm will only worsen. This is concerning in itself, but more so because evidence suggests a wide range of alcohol harms disproportionately impact the most vulnerable, including children. Half of the 1 million annual alcohol-related hospital admissions occur in the three lowest socioeconomic deciles.²⁵

We call on the Government to take tangible steps that can both reduce existing harm to individuals and communities, and prevent people drinking in ways likely to create harms in the future. We call for the government to:

IMPROVE SUPPORT FOR THOSE IN NEED

- 1. Introduce a 1% ‘treatment levy’ by increasing alcohol duties to generate additional funding for alcohol treatment services to increase the proportion of dependent drinkers accessing treatment. Furthermore, set a target date for when treatment services will be available for all who need access.**
- 2. Mandate local authorities to provide and promote a ‘ring-fenced’ resource for alcohol treatment, early alcohol intervention provision, and prevention services.**

Public Health England estimates that there are 595,000 alcohol-dependent adults in the England – 1.4% of the population.²⁶ However, provision of treatment for these individuals is inadequate; only around 20% of these individuals accessed treatment in 2016-17.²⁷

This under provision also appears to be experienced more acutely by some than others. In their report mapping women's access to a range of services across England and Wales, AVA and Agenda found that “less than half (49.0%) of all local authorities in England and only five unitary authorities in Wales (22.7%) report substance misuse support specifically for women” and that where this was provided it was often either a weekly women's session within a mixed gender service, or a substance misuse midwife.²⁸

This situation is due, in part, to funding shortages. While alcohol treatment commissioning is “overseen by local authority Public Health teams, with support from Public Health England...[funded] through a ring-fenced local authority

¹⁷ Public Health England. 2016. [The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An evidence review](#). p. 201.

¹⁸ Public Health England. 2016. [The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An evidence review](#). p. 200.

¹⁹ British Beer and Pub Association. 2007. Statistical Handbook 2007.

²⁰ Public Health England. 2016. [The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An evidence review](#). p. 200.

²¹ Monitoring and Evaluating Scotland's Alcohol Strategy (MESAS). 2016. [MESAS alcohol sales and price update](#); and NHS Digital. 2015. [Health Survey for England 2014](#).

²² NHS Digital. 2017. [Statistics on Alcohol](#).

²³ Institute of Alcohol Studies. 2018. [The rising affordability of alcohol](#). p. 1.

²⁴ Home Office and ONS. 2017. [Alcohol and Late Night Refreshment Licensing England and Wales](#). Table 1.

²⁵ Public Health England. 2016. [The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An evidence review](#). p. 200.

²⁶ 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.

²⁷ Public Health England. 2017. [Adult substance misuse statistics from the National Drug Treatment Monitoring System: 1st April 2016 to 31st March 2017](#). p. 5.

²⁸ AVA and Agenda. 2017. [Mapping the maze: Services for women experiencing multiple disadvantage in England and Wales](#). p. 1.

public health grant", alcohol treatment is not ring-fenced itself within this grant.²⁹ As a result, many stretched local authorities have begun to cut funding to these services. Funding cuts of up to 58% have been reported in some areas, in what one clinical specialist described as an "assault on funding".³⁰ This situation looks only set to worsen as the ring-fencing of the public health grant is set to be removed altogether in 2020.³¹

Research has demonstrated the impact these funding shortages have had on services. In their 2018 survey of professional stakeholders and service users, Alcohol Concern / Alcohol Research UK found that "only 12% of respondents felt resources were sufficient in their area", damaging staff capacity and morale. Cuts have damaged workforces, "meaning fewer specialist addictions psychiatrists, clinical psychologists, and nurses, and a greater reliance on doctors without specialist training and volunteers with limited training."³² Indeed, there was a 60% drop in training posts in addiction psychiatry between 2006 and 2016.³³ Further, in an attempt to cut costs, the "payment by results" model has been implemented by some local authorities; however, this leaves patients with complex needs overlooked in favour of patients who represent quicker wins.³⁴

Alcohol dependence is a serious condition which affects the health and wellbeing not only of the individual but of others around them, such as family members who may be required to care for loved ones, or the estimated 200,000 children who live with an alcohol-dependent adult in England.³⁵ Not only is effective treatment demonstrated to bring a substantial return on investment (for every £1 spent, £3 of social return is generated,³⁶ a cost effectiveness recognised by Public Health England³⁷), but it can relieve this physical and emotional toll from some of the most vulnerable in society.

While Public Health England concluded in their 2016 evidence review of alcohol harm reduction policies, that the success of treatment interventions "depends on large-scale implementation and dedicated treatment staffing and funding streams,"³⁸ it appears the treatment landscape today is only moving further away from this ideal. Government has a duty to act now to ensure treatment services are accessible to all who need them.

- 3. Address the needs of older alcohol drinkers by enforcing action against age inequalities in existing services and developing a range of specialist services to support older adults who drink.**
- 4. Ensure local areas have adequate service provision for those with complex needs, especially those with both alcohol and mental health conditions. One way to achieve this is to ensure assertive outreach and multi-agency partnerships are in place.**

There are a number of intersecting needs a person may have that must be considered when providing accessible alcohol treatment services for all. It is essential the government considers this in all decisions on treatment they undertake.

Evidence suggests older people today "may be relatively heavier drinkers than previous generations."³⁹ Despite this, research has demonstrated that older drinkers are often failed by existing treatment services. In their report investigating the provision of services for older adults with alcohol problems, Drink Wise Age Well found evidence of "age discrimination in alcohol policy, practice and research... including arbitrary age limits which prevent older adults accessing alcohol rehabs, younger clients being prioritised over older adults in terms of alcohol treatment, older adults not being offered alcohol treatment because of their age and older adults being excluded without good reason from studies on alcohol."⁴⁰ One example of such discrimination the report noted was alcohol services not offering home visits for those restricted from visiting treatment centres due to limited mobility.⁴¹ While the report noted that this discrimination was rarely intentional,⁴² it is essential that the barriers this places to older people accessing alcohol treatment services are identified and addressed.

²⁹ Alcohol Concern / Alcohol Research UK. 2018. [The Hardest Hit: Addressing the crisis in alcohol treatment services](#). p. 6.

³⁰ Alcohol Concern / Alcohol Research UK. 2018. [The Hardest Hit: Addressing the crisis in alcohol treatment services](#). p. 7.

³¹ Alcohol Concern / Alcohol Research UK. 2018. [The Hardest Hit: Addressing the crisis in alcohol treatment services](#). p. 6.

³² Drummond, C. 2017. [Cuts to addiction services are a false economy](#).

³³ Drummond, C. 2017. [Cuts to addiction services are a false economy](#).

³⁴ Drummond, C. 2017. [Cuts to addiction services are a false economy](#).

³⁵ 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.

³⁶ Public Health England. n.d. [Alcohol and drugs prevention, treatment and recovery: why invest](#). p. 30.

³⁷ Public Health England. 2016. [The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An evidence review](#). p. 206.

³⁸ Public Health England. 2016. [The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An evidence review](#). p. 206.

³⁹ The Institute of Alcohol Studies. 2013. [Older people and alcohol factsheet](#). p. 3.

⁴⁰ Drink Wise Age Well. 2017. [Calling Time: Addressing ageism and age discrimination in alcohol policy, practice and research](#). p. 10.

⁴¹ Drink Wise Age Well. 2017. [Calling Time: Addressing ageism and age discrimination in alcohol policy, practice and research](#). p. 10.

⁴² Drink Wise Age Well. 2017. [Calling Time: Addressing ageism and age discrimination in alcohol policy, practice and research](#). p. 10.

It is also important to consider the needs women have, particularly those who may have experienced domestic abuse, in accessing appropriate alcohol dependency treatment. Those who experience domestic abuse may use alcohol to cope with this; research has found that women who had experienced this were twice as likely as their violent partner to drink after abuse.⁴³ These women may feel unable to attend mixed-gendered alcohol treatment services. As touched upon earlier, women's only alcohol treatment services are sparse in England and Wales; with less than half of English local authorities, and only one in five Welsh unitary authorities, providing this.⁴⁴ In their report discussing the findings from an expert seminar series examining issues relating to women and alcohol, Scottish Health Action on Alcohol Problems and the Institute of Alcohol Studies recommend that this needs improvement, suggesting benefits to increasing availability of and access to "residential treatment and recovery support for women with children", as well as increased availability of anonymous support services for women, such as online portals.⁴⁵

Despite it being common for those with alcohol dependency to also have a co-occurring mental health condition (86% in alcohol treatment services experience this⁴⁶), these individuals have also been shown to face multiple barriers to accessing appropriate treatment services. Joint research from the Institute of Alcohol Studies and Centre for Mental Health examining this, through a survey and seminar session held with professionals working in mental health and/or alcohol services across the country, found that co-morbidity is a barrier to treatment, and support for people with co-occurring alcohol and mental health problems is too often poor and fragmented.⁴⁷ Indeed, 84% of alcohol and mental health professionals agreed that having an alcohol use disorder is a barrier to getting any kind of mental health support.⁴⁸ Lack of understanding and join-up between services, funding and workforce shortages, and stigma facing those with co-morbidities were highlighted as major problems – indeed, more than 90% of respondents viewed funding shortages as a problem.⁴⁹ One activity that can be crucial in the treatment of these individuals is assertive outreach but these activities are suffering from the cuts discussed previously.⁵⁰

5. Develop a funded national programme of advice, guidance and support for those concerned about alcohol including families, carers and children of alcoholics.

It is not only drinkers themselves that may be harmed by alcohol. Families can also be affected.

As the Alcohol and Families Alliance – a cross sector alliance of almost 40 organisations including the NSPCC, the Children's Society, and Adfam – note, "the greatest impacts of familial drinking are often experienced by children."⁵¹ Public Health England estimates that there are 189,119 children living with at least one alcohol-dependent adult in the England, and between 14,390 and 32,887 living with two.⁵² 51,000 children live with an alcohol-dependent parent or carer in Scotland.⁵³ Living with a parent or carer misusing alcohol can have a wide range of negative impacts for children. Indeed, parental alcohol use is the most common reason children have for calling Childline.⁵⁴ In their review of this evidence, the Parliamentary Office of Science and Technology⁵⁵ found that parental alcohol misuse can lead to "inconsistent and unpredictable parenting, children having to care for their parent or younger siblings, impacts on school attendance and homework, and physical and mental health impacts."⁵⁶ Alcohol is also implicated in a substantial number of care proceedings; alcohol or substance misuse occurred in 61% of care applications in England⁵⁷ and parental substance misuse was cited in 39% of child protection conferences in Scotland.⁵⁸ Even low-level alcohol consumption has been demonstrated to impact on parenting, with a notable proportion of children reporting their parent's low level drinking made them worried (11%) or embarrassed (18%).⁵⁹

It is not only children that might be affected by a family member's alcohol use however. As the Alcohol and Families Alliance note, families may experience "financial problems, relationship issues, mental ill health, bereavement, and domestic abuse" through a relative's alcohol misuse.⁶⁰ For example, family members may be called on to care for an

⁴³ University of Bedfordshire & Alcohol Concern. 2010. [Grasping the Nettle: alcohol and domestic violence](#). p. 2

⁴⁴ AVA and Agenda. 2017. [Mapping the maze: Services for women experiencing multiple disadvantage in England and Wales](#). p. 1.

⁴⁵ SHAAP and IAS. 2018. [Women and Alcohol: Key Issues](#). p. 2.

⁴⁶ Public Health England. 2017. [Better care for people with co-occurring mental health and alcohol/drug use conditions](#). p. 8.

⁴⁷ The Institute of Alcohol Studies. 2018. [Alcohol and Mental Health: Policy and practice in England](#). p. 4.

⁴⁸ The Institute of Alcohol Studies. 2018. [Alcohol and Mental Health: Policy and practice in England](#). p. 8.

⁴⁹ The Institute of Alcohol Studies. 2018. [Alcohol and Mental Health: Policy and practice in England](#). p. 13.

⁵⁰ Alcohol Concern / Alcohol Research UK. 2018. [The Hardest Hit: Addressing the crisis in alcohol treatment services](#). p. 14.

⁵¹ Alcohol and Families Alliance. 2018. [Families First: An evidence-based approach to protecting UK families from alcohol-related harm](#). p. 4.

⁵² 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.

⁵³ Scottish Government. 2012. Final Business And Regulatory Impact Assessment For Minimum Price Per Unit Of Alcohol As Contained In Alcohol (Minimum Pricing) (Scotland) Bill.

⁵⁴ Mariathanan, J. and Hutchinson, D. 2010. Children talking to ChildLine about parental alcohol and drug misuse. NSPCC.

⁵⁵ Hedges, S. and Kenny, C. 2018. [Parental Alcohol Misuse and Children](#). Parliamentary Office of Science and Technology.

⁵⁶ Alcohol and Families Alliance. 2018. [Families First: An evidence-based approach to protecting UK families from alcohol-related harm](#). p. 5.

⁵⁷ Guy, J., Blessington, V. and Green, R. 2012. [Three weeks in November... Three years on: Cafcass care application study 2012](#). Cafcass. p. 21.

⁵⁸ NSPCC Scotland. 2017. [How safe are our children? 2017, Report Briefing: Scotland Context](#). NSPCC Scotland.

⁵⁹ Foster, J., Bryant, L. and Brown, K. 2017. ["Like sugar for adults" - The Effect of Non-Dependent Parental Drinking on Children and Families](#). Institute of Alcohol Studies, Alcohol and Families Alliance & Alcohol Focus Scotland. p. 58.

⁶⁰ Alcohol and Families Alliance. 2018. [Families First: An evidence-based approach to protecting UK families from alcohol-related harm](#). p. 13.

alcohol-dependent relative or their children; indeed 47% of grandparents caring for a grandchild reported they did so due to parental drug or alcohol use.⁶¹ Caring responsibilities might be both financially and emotionally draining. This financial burden might be further worsened, as research has found that having a family member with an alcohol misuse issue might impact a person's performance at work; 19% of people were found to have been fired or suspended from their jobs while their family member was in active addiction compared to 8% when they were not.⁶²

Families are not only a highly valuable tool in alcohol dependency treatment but are themselves individuals with rights and needs that should be respected. It is essential the Government's alcohol strategy recognises this. The Alcohol and Families Alliance have identified many areas in which families are failed by current alcohol policy, and make recommendations to address this, which this Cross-Party Group supports, including:

- "Evidence-based support for families affected by alcohol available according to local need, driven by a new national minimum standard."
 - "Better training for universal service practitioners to identify parental drinking problems and signpost families to specialist support where appropriate."
 - "Information for carers regarding their legal rights and benefits, an increase to the Carer's Allowance, and improved rights for kinship carers to bring these in line with the rights of foster carers."
 - "The Government should publish evidence-based guidance on parental and family member drinking and its effect on children, including at low levels" and "should support the effective communication of the Chief Medical Officers' alcohol guidelines, in particular the guidance on drinking in pregnancy and alcohol consumption by children."⁶³
- 6. Ensure that relevant health and social care professionals are trained to provide early identification and brief advice, in particular GPs, paramedics and A&E staff, and create apprenticeships based on nationally recognised qualifications for the specialist alcohol and drugs treatment workforce.**

Much of alcohol's burden on the NHS is caused by harmful and hazardous drinking, as opposed to alcohol dependence.⁶⁴ However, as these individuals do not meet the criteria for alcohol-dependence, they may not seek out alcohol-related services for their problem, and this hazardous or harmful consumption might go unnoticed.⁶⁵ As such, there is potential for alcohol's burden on the health service to be eased if hazardous drinking was identified before it develops into serious health complications. Early identification and brief advice, delivered by the other health and social care professionals these individuals are encountering, may achieve this.⁶⁶

During an early identification, a patient is given a quick questionnaire about their drinking habits, followed by "advice and information, appropriate to the drinker and the context."⁶⁷ The quick nature of these services means they can be delivered in a range of settings, including "primary care via GPs, community settings such as schools, job centres and pharmacies, via social care services, in accident and emergency settings, and in the workplace."⁶⁸ Evidence suggests such interventions to be effective at reducing consumption and consequent health harms,^{69, 70} and to be highly cost effective. Public Health England estimate that for every 5000 people screened through such interventions, 61 hospital admissions and 67 A&E visits may be avoided.⁷¹

Despite this proven effectiveness, the implementation of the early identification and brief advice has been patchy. Discussing the rollout of this, Dr Matthew Andrews from the Safe Sociable London Partnership noted that "in the last two national strategies IBA has been noted, but with little strategy for implementation."⁷²

It is essential that this is rectified. The training required is not extensive,⁷³ and should be extended to all relevant health and social care professionals, including social care and criminal justice professionals to maximise the public

⁶¹ Lawson, D. and Raine, J. 2013. *The Kinship Care Guide for England*. Second Edition. Grandparents Plus.

⁶² Andersson, C., Best, D., Irving, J., Edwards, M., Banks, J., Mama-Rudd, A. and Hamer, R. 2018. [Understanding recovery from a family perspective: A survey of life in recovery for families](#). Alcohol Research UK. p. 63.

⁶³ Alcohol and Families Alliance. 2018. [Families First: An evidence-based approach to protecting UK families from alcohol-related harm](#). p. 9.

⁶⁴ Kaner, E.F.S., Newbury-Birch, D., and Heather, N. 2009. Brief Intervention. In: Miller, P.M. (Ed.) *Evidence-Based Addiction Treatment*. Burlington, MA: Academic Press; pp 189-213.

⁶⁵ University of Stirling, Alcohol Health Alliance, and British Liver Trust. 2013. [Health First: An evidence-based alcohol strategy for the UK](#). p. 33.

⁶⁶ University of Stirling, Alcohol Health Alliance, and British Liver Trust. 2013. [Health First: An evidence-based alcohol strategy for the UK](#). p. 33.

⁶⁷ The Institute of Alcohol Studies. n.d. [Early identification and brief advice](#).

⁶⁸ The Institute of Alcohol Studies. n.d. [Early identification and brief advice](#).

⁶⁹ Kaner, E.F.S. et al. 2007. Effectiveness of brief alcohol interventions in primary care populations. *Cochrane Database of Systematic Reviews* Issue 2. Art. No. CD004148. doi: 10.1002/14651858.CD004148. pub3

⁷⁰ Jonas, D.E. et al. 2012. Screening, behavioral counseling, and referral in primary care to reduce alcohol misuse, *Comparative Effectiveness Review* Number 64. Rockville, MD: Agency for Healthcare Research and Quality (USA).

⁷¹ Public Health England. n.d. [Alcohol and drugs prevention, treatment and recovery: why invest](#). p. 26.

⁷² Alcohol IBA Blog. 2015. [IBA direct evaluation shows people welcome IBA in public](#).

⁷³ The Institute of Alcohol Studies. n.d. [Early identification and brief advice](#).

health benefits.⁷⁴ This can allow these professionals to advise patients to help them reduce their drinking⁷⁵ to lower their risks of one of the 200 disease and injury conditions to which alcohol is linked.⁷⁶ It also can identify patients who might benefit from treatment for alcohol dependence.⁷⁷

Indeed, this recommendation is echoed by NICE,⁷⁸ and by the British Liver Trust, the Alcohol Health Alliance, and the University of Stirling in their evidence-based report into alcohol policy in the UK, Health First.⁷⁹

PROTECTION OF PUBLIC HEALTH

- 7. Launch a comprehensive review of alcohol duties, in preparation for a post-Brexit taxation structure that better reflects alcohol strength across categories and addresses anomalies between categories.**
- 8. Introduce Minimum Unit Pricing in England following the lead of other home nations.**

Alcohol is becoming increasingly affordable in the UK: research at the beginning of 2018 showed it is 60% more affordable than it was in 1980.⁸⁰ This trend is especially notable in the off-trade where beer has become 188% more affordable than it was in 1987.⁸¹ This increasing affordability means that strong alcohol products are sold for pocket money prices: 3-litre bottles of 7.5% ABV cider, containing the same amount of alcohol as 22 shots of vodka, are on sale for just £3.59.⁸²

According to NICE, making alcohol less affordable is “the most effective way of reducing alcohol related harm”.⁸³ There are two policies that could help tackle the harm of cheap alcohol; minimum unit pricing and a reformed duty system.

Duty

Not only is alcohol more affordable than it's been in decades, but there are abnormalities in the current EU-led taxation system which create perverse incentives for some producers to produce higher strength products, or meaning certain products are able to be sold for substantially cheaper prices than others, despite being of equivalent strength. EU Directive 92/83/EEC requires EU Member States to tax beer and spirits according to alcohol content, but wine and cider according to their volume. A research paper by the IAS stated that, in the UK, “this has the perverse effect of incentivising wine and cider producers to formulate drinks with a higher alcohol content, as this results in a lower rate of duty per unit of alcohol”.⁸⁴

Brexit provides an opportunity for the UK Government to rationalise the alcohol duty system once we have left the EU and several public health groups including the Alcohol Health Alliance and the UK Health Forum have called for this. The Government has given its support to the principle that duty should be proportional to alcohol content. In a letter, former Health Minister Lord Prior stated “The UK Government believes alcohol duties should be directly proportional to alcohol, as is the case with beer”⁸⁵ In order to do this, the government must retain power to set a new duty structure in any future trade and investment agreements.

The duty system should also be reviewed as a mechanism to reduce alcohol's escalating affordability, and the accompanying harm this generates. Duty increases have been evidenced to save lives and reduce harm: the most recent analysis from the Sheffield Alcohol Policy Model shows that raising alcohol duty above inflation for five successive years would reduce alcohol-related deaths by 5% and hospitalisations by 4%, averting over 600 fatalities a year⁸⁶. Furthermore, additional revenues raised could provide vital funds to support a struggling NHS and specialist alcohol treatment services.

Minimum Unit Pricing

Minimum unit pricing (MUP) is an upstream intervention which compliments alcohol duty increases. Minimum Unit

⁷⁴ University of Stirling, Alcohol Health Alliance, and British Liver Trust. 2013. [Health First: An evidence-based alcohol strategy for the UK](#). p. 32.

⁷⁵ University of Stirling, Alcohol Health Alliance, and British Liver Trust. 2013. [Health First: An evidence-based alcohol strategy for the UK](#). p. 32.

⁷⁶ World Health Organization. 2014. [Global status report on alcohol and health 2014](#), p. xiii.

⁷⁷ University of Stirling, Alcohol Health Alliance, and British Liver Trust. 2013. [Health First: An evidence-based alcohol strategy for the UK](#). p. 32.

⁷⁸ NICE. 2010. [Alcohol-use disorders: prevention](#). NICE Public Health Guidance 24.

⁷⁹ University of Stirling, Alcohol Health Alliance, and British Liver Trust. 2013. [Health First: An evidence-based alcohol strategy for the UK](#). p. 32.

⁸⁰ NHS Digital. 2017. [Statistics on Alcohol](#).

⁸¹ Institute of Alcohol Studies. 2018. [The rising affordability of alcohol](#). p. 1.

⁸² Alcohol Health Alliance. 2016. [Cheap Alcohol: the price we pay](#). p. 9.

⁸³ NICE. 2010. [Alcohol-use disorders: prevention](#). NICE Public Health Guidance 24.

⁸⁴ The Institute of Alcohol Studies. 2018. [Brexit Battlegrounds](#). p. 7.

⁸⁵ (Lord Prior of Brampton. 2016. [Letter to Lord Brooke of Alverthorpe, 6 June](#).

⁸⁶ Angus, C., Holmes, J., Pryce, R., Meier, P. and Brennan, A. 2016. [Alcohol and cancer trends: Intervention Studies](#). University of Sheffield and Cancer Research UK.

Pricing (MUP) sets a floor price below which drinks cannot be sold, based on alcohol content. This has the effect of increasing the price of the cheapest, strongest products favoured by the heaviest drinkers whilst leaving the price of most drinks unchanged, including those sold in bars and restaurants. A 50p minimum unit price would mean that a drink with two units of alcohol could not be sold for under £1. A £3 pint of 4% beer or £4.50 bottle of 11% wine would be unchanged in price. Moderate drinkers will see little difference: spending an extra £2.25 a year on alcohol on average with a 50p MUP.⁸⁷

A 50p MUP in England is estimated save 1,148 lives in the first five years, as well as reduce hospital admissions by 74,471, cut health care costs by £326 million and lead to 36,400 fewer crimes per year.⁸⁸ The benefits of alcohol duty increases and MUP have been recognised by the World Health Organisation⁸⁹, the OECD⁹⁰ and PHE⁹¹. Pricing interventions have the support of leading medical and police organisations, some of the UK's largest charities, and the majority of the general public. Public support for MUP is high and only a quarter of the British public are opposed to it.⁹² Publicans also support MUP, with two publicans in favour for every one who is opposed.⁹³ They recognise that it would help to protect their businesses by stopping them being undercut by cheap alcohol from supermarkets and off-licences. In January 2018, 45 Parliamentarians, together with representatives of the health, homelessness, children's and religious sectors wrote an open letter to the Sunday Times calling for MUP to be introduced in England without delay. There were over 100 signatories in total.⁹⁴

MUP was implemented in Scotland on 1 May.⁹⁵ In Wales, the government passed legislation to implement MUP in June⁹⁶ and it is due to come in in 2019. The Northern Ireland government has the powers to introduce MUP, and the previous administration expressed its intention to do so.⁹⁷ MUP is also due to be introduced in the Republic of Ireland following the passage of the Irish Public Health (Alcohol) Bill.⁹⁸

- 9. Develop a government funded programme of health campaigns, without industry involvement and in line with the Chief Medical Officers guidelines to increase public knowledge of alcohol and its links to a wide range of physical and mental health conditions.**
- 10. Develop statutory minimum requirements for labelling alcohol products. This should include health warnings, ingredients, nutritional information alongside existing advice.**

Public knowledge of alcohol's links to a wide range of physical and mental health conditions in the UK is worryingly low. Only 1 in 10 are aware of the link between alcohol and cancer⁹⁹ and 82% do not know about the updated Chief Medical Officer's Low Risk Drinking guidelines.¹⁰⁰ 80% of adults in the UK do not know or underestimate the calorie content of a large glass of wine.¹⁰¹

The Chief Medical Officer's Low Risk Drinking guidelines were updated in 2016 to reflect, amongst other things, evidence which emerged since the previous guidelines were published linking any level of alcohol use to seven types of cancer.¹⁰² These guidelines were developed based on the principles that "people have a right to accurate information and clear advice about alcohol and its health risks" (a right supported by both the World Health Organization¹⁰³ and Public Health England¹⁰⁴) and that "government has a responsibility to ensure this information is provided for the public in a clear and open way, so they can make informed choices."¹⁰⁵ Despite this, since their publication there has been little government activity to promote the CMO guidelines to the general public. Further, the

⁸⁷ University of Sheffield. 2015. [FAQ – minimum unit pricing](#)

⁸⁸ University of Sheffield and Cancer Research UK. 2016. [Alcohol and cancer trends: Intervention Scenarios](#).

⁸⁹ World Health Organisation. 2017. [Best buys and other recommended interventions for the prevention and control of noncommunicable diseases](#). p. 9.

⁹⁰ OECD. 2011. [The prevention of harmful alcohol use](#). p. 15.

⁹¹ Public Health England. 2016. [The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An evidence review](#). p. 7.

⁹² NatCen Social Research. 2016. Attitudes to alcohol: Findings from the 2015 British Social Attitudes survey.

⁹³ Bhattacharya, A. 2017. [Pubs Quizzed: What publicans think about policy, public health and the changing trade](#). p. 39.

⁹⁴ AHA. 2018. [Minimum unit pricing must be implemented in England 'without delay'](#).

⁹⁵ Scottish Government. 2017. [Minimum Unit Pricing](#).

⁹⁶ Drink and Drug News. 2018. [Minimum pricing law passed in Wales](#).

⁹⁷ Institute of Alcohol Studies. 2015. [Northern Ireland to proceed with Alcohol Minimum Unit Pricing](#).

⁹⁸ Department of Health. n.d. [Alcohol](#).

⁹⁹ Buykx, P., et. al. 2015. [An investigation of public knowledge of the link between alcohol and cancer](#). University of Sheffield and Cancer Research UK. p. 9.

¹⁰⁰ Alcohol Health Alliance public opinion polling – November 2016. Cited in Alcohol Health Alliance. 2017. [Right to know: Are alcohol labels giving consumers the information they need?](#)

¹⁰¹ Royal Society for Public Health. 2014. [Increasing awareness of 'invisible' calories from alcohol](#). p. 2.

¹⁰² Department of Health. 2016. [UK Chief Medical Officers' Low Risk Drinking Guidelines](#). p. 2.

¹⁰³ World Health Organization. 2010. [Global strategy to reduce the harmful use of alcohol](#). p. 11.

¹⁰⁴ Public Health England. 2016. [The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An evidence review](#). p. 129.

¹⁰⁵ Department of Health. 2016. [UK Chief Medical Officers' Low Risk Drinking Guidelines](#). p. 3.

industry-funded¹⁰⁶ body responsible for the self-regulation of alcohol marketing, including packaging, no longer recommends that they are included on alcohol labels.¹⁰⁷

The lack of understanding of the physical and mental health impacts alcohol has might be addressed through a government-funded and run programme of health campaigns to communicate this information to the public, alongside statutory minimum requirements for labelling of alcohol products including health warnings, ingredients, nutritional information and existing advice.

It is essential that government develop a programme of health campaigns to communicate the physical and mental health impacts of alcohol to the public. Such a programme must be government-funded and government-run as research has demonstrated that industry-funded and industry-run health information campaigns are ineffective and may even distort evidence and present misinformation to the public. A 2018 analysis of alcohol industry websites and documents – including from DrinkAware (“funded by voluntary and unrestricted donations from major UK alcohol producers, pub operators, restaurants, major supermarkets and other retailers”)¹⁰⁸ – and found that the alcohol industry “appears to be engaged in the extensive misrepresentation of evidence about the alcohol-related risk of cancer”, activities which “have parallels with those of the tobacco industry.”¹⁰⁹ Further, research which assessed more than 200 alcohol industry corporate social responsibility schemes found that more than half (52%) were judged by public health experts as being likely to cause harm (for example, by increasing consumption).¹¹⁰ These findings were supported by Public Health England’s 2016 evidence review examining alcohol control policies and their effectiveness, which noted that the “delivery of education messages by the alcohol industry has no significant public health effects”.¹¹¹ Similarly, the OECD state that “the delivery of education messages by private sponsors [is found to] have no significant public health effects,”¹¹² a position supported by the British Medical Association, who note alcohol industry health education campaigns are of “questionable” public health value, and “likely to be counterproductive.”¹¹³

Similarly, statutory minimum requirements for labelling of alcohol products are required. Clear and understandable labels are one way in which awareness of information can be increased. For example, awareness of the dangers of drinking during pregnancy increased in France after the introduction of mandatory health labels.¹¹⁴

However, in the UK, currently only ABV is legally required to be displayed on products (under EU Law (Regulation (EU) No. 1169/2011)).¹¹⁵ There is no legal requirement for alcohol product labels to contain nutritional information (including calorie, fat, and sugar content), ingredients including allergens, or any kind of health warning – this means that alcohol-free alternatives need to provide more information than alcoholic beverages.¹¹⁶ The Portman Group – the industry-funded¹¹⁷ body responsible for the self-regulation of alcohol marketing, including packaging – recommend alcohol labels contain the 3 following aspects as a minimum: 1) units per container 2) references to the Drinkaware website for further information, 3) pregnancy warnings or logos. However, references to the 14-unit CMO guidelines are no longer a recommendation.¹¹⁸ Specific health warnings are not mentioned. As a result, very few alcohol products carry the current CMO guidelines – a recent audit from the Alcohol Health Alliance and Alcohol Focus Scotland found that only 1 of 315 labels reviewed included this, and none contained specific health warnings.¹¹⁹ Further, only 47% of product labels were found to meet the limited standard of the Portman Group’s code.¹²⁰

This lack of compliance with the voluntary measures in place, coupled with the evidence previously discussed demonstrating the limited effectiveness of such schemes, suggests mandatory regulation of labelling is necessary.

¹⁰⁶ Portman Group. 2017. [History and Mission](#).

¹⁰⁷ The Royal Society for Public Health. 2018. [Labelling the point: towards better alcohol health information](#) p. 10.

¹⁰⁸ Drinkaware. 2018. [About us](#).

¹⁰⁹ Petticrew, M., Maani Hessari, N., Knai, C. and Weiderpass, E. 2018. [How alcohol industry organisations mislead the public about alcohol and cancer](#). Drug and alcohol review, 37(3), p.293.

¹¹⁰ Robaina, K. et al. 2014. Effectiveness and Strength of Evidence of the Alcohol Industry’s ‘Industry Actions to Reduce Harmful Drinking’. American Public Health Association 142nd Annual Meeting & Expo.

¹¹¹ Public Health England. 2016. [The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An evidence review](#). p. 9.

¹¹² Organisation for Economic Co-operation and Development. 2015. [Tackling Harmful Alcohol Use](#). p. 110.

¹¹³ British Medical Association. 2009. [Under the influence. The damaging effect of alcohol marketing on young people](#). p. 40.

¹¹⁴ The Royal Society for Public Health. 2018. [Labelling the point: towards better alcohol health information](#) p. 10.

¹¹⁵ European Parliament, European Council. 2011. [Regulation \(EU\) No 1169/2011 of the European Parliament and of the Council of 25 October 2011](#).

¹¹⁶ The listing of common allergens is required on specific wine products, but the lack of ingredient lists on alcohol containers may make it hard to identify less common allergens, and those in non-wine products. Food Standards Agency. 2017. [Labelling wine](#).

¹¹⁷ Portman Group. 2017. [History and Mission](#).

¹¹⁸ The Royal Society for Public Health. 2018. [Labelling the point: towards better alcohol health information](#) p. 10.

¹¹⁹ Alcohol Health Alliance. [Right to know: are alcohol labels giving consumers the information they need?](#) p. 3.

¹²⁰ Keenan S. 2014. [Final Report on: audit of compliance of alcoholic beverage labels available from the off-trade with the Public Health Responsibility Deal Labelling Pledge](#). p. 23.

11. Introduce and enforce tighter alcohol marketing restrictions and regulation, without industry involvement, with a particular emphasis on protecting young people from exposure to alcohol marketing.

Marketing of alcohol in the UK is currently handled through a co- and self-regulatory system. The Advertising Standards Authority (funded by the advertising industry¹²¹), Ofcom, and the Portman Group (funded by the alcohol industry¹²²) lead this.

However, many have criticised this system as ineffective. Analysing this, the House of Commons Health Select Committee concluded that there are: “major shortcomings in the current self-regulatory codes covering alcohol advertising. Specifically, the codes do not...prevent the promotion of drunkenness and excess; or the linking of alcohol with social and sexual success...”¹²³ Further, an examination of the Portman Group’s rulings on alcohol advertising complaints from 2006-17 found that “decision-making has not been consistent over time” and that “decisions have often appeared subjective”.¹²⁴ Not only this, but these decisions have been found to emerge with a significant delay; Alcohol Concern / Alcohol Research UK note, this can often mean that “promotional activities that are found to have breached the Code will already have been active in the public domain for some time, and a campaign may even have been completed, before the judgement has been made.”¹²⁵

Particular concerns have been raised over the self-regulatory system’s inability to protect young people. Internal marketing communications from alcohol producers and their advertising agencies which came to light during a Health Select Committee inquiry into the industry’s conduct show that young people are a target of alcohol advertising – market research data from 15-16 year olds were shown to have been used to inform campaigns. Brands appeared to court the appeal of these audiences, with Carling hoping to “become the most respected youth brand...” and Lambrini suggesting TV spots hoped to be “a cross between Myspace and High School the Musical”.¹²⁶ More concerningly, one Carling executive was found to suggest “[Young men] think about 4 things, we brew 1 and sponsor 2 of them” – such outdated ideas targeted at young people may produce social harm, perpetuating harmful norms around gender inequity.¹²⁷

The failings of the current system mean that statutory regulation of this marketing is required. A model for this regulation are the statutory measures already in place in France; here, ‘Loi Evin’ regulation restricts placement and content of alcohol advertising, so that alcohol advertising is prohibited from targeting young people, and from employing ‘lifestyle’ messaging. This means content such as that encouraging excess consumption, or harmful gendered stereotypes, that the UK’s self-regulatory system fails to protect children from, is illegal.¹²⁸ This regulation ought to be overseen by an independent body, separate from alcohol industry influence.¹²⁹ As Alcohol Concern / Alcohol Research UK have stated, such a body would be free from any concern around conflict of interest.¹³⁰

Such marketing regulation is supported by many, including the World Health Organisation¹³¹ and the Alcohol Health Alliance.¹³² Indeed, Public Health England themselves have stated that such self-regulatory systems have been found time and again to fail to meet “their intended goal of protecting vulnerable populations”¹³³ and that the use of such self-regulatory codes as a route to influence policy “are similar to the strategies used by the tobacco industry”¹³⁴.

¹²¹ Advertising Standards Authority. 2018. [What we spend and how we spend it](#).

¹²² Portman Group. 2017. [History and Mission](#).

¹²³ 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.

¹²⁴ Alcohol Concern / Alcohol Research UK. 2018. [Fit for purpose? An analysis of the role of the Portman Group in alcohol industry self-regulation](#). p. 3.

¹²⁵ Alcohol Concern / Alcohol Research UK. 2018. [Fit for purpose? An analysis of the role of the Portman Group in alcohol industry self-regulation](#). p. 25.

¹²⁶ 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.

¹²⁷ 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.

¹²⁸ Institute of Alcohol Studies. 2017. [Policies to regulate alcohol marketing](#).

¹²⁹ Alcohol Health Alliance. 2018. [AHA letter to the Portman Group](#).

¹³⁰ Alcohol Concern / Alcohol Research UK. 2018. [Fit for purpose? An analysis of the role of the Portman Group in alcohol industry self-regulation](#). p. 3.

¹³¹ World Health Organisation. 2017. [Tackling NCDs](#). p. 8.

¹³² University of Stirling, Alcohol Health Alliance, and British Liver Trust. 2013. [Health First: An evidence-based alcohol strategy for the UK](#). p. 24.

¹³³ Public Health England. 2016. [The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An evidence review](#). p. 110.

¹³⁴ Public Health England. 2016. [The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An evidence review](#). p. 109.

It is heartening to see the government consider action to protect children from junk food advertising, with the announced consultation on a 9pm watershed for such content,¹³⁵ we are hopeful they will extend action to the highly harmful alcohol advertising viewed by children in the UK daily. It is essential that tighter alcohol marketing restrictions and regulation are introduced without industry involvement, without delay.

12. Improve alcohol licencing by:

- **Introducing a licensing objective to protect public health.**
- **Including a new mandatory licensing condition requiring alcohol retailers to have a written policy on how they will prevent illegal sales to intoxicated customers along with a specific requirement for authorities to enforce the existing law that makes such sales illegal.**
- **Carry out a comprehensive review of online sales and home deliveries, to prevent sales to underage, vulnerable or intoxicated customers.**

Licensing is a central tool in the prevention of alcohol-related harm. The physical and temporal availability of alcohol has been demonstrated to be related to levels of a wide range of alcohol harms; relaxation of alcohol sales in Finland in 1969, allowing sales of lower strength beer in grocery stores, was found to lead to a 50% increase in mortality rates for liver cirrhosis, and a 110% and 130% increase of hospital admissions for alcohol psychosis for men and women respectively, all within five years.¹³⁶ Crime rates have also been linked; the same Finnish study found an 80% and 160% increase in arrests for drunkenness for men and women respectively within five years of the legislation change, while Alcohol Focus Scotland and Centre for Research on Environment, Society and Health (CRESH) at the Universities of Edinburgh and Glasgow found rates of crime, including violence, "were consistently and significantly higher in areas with more alcohol outlets. This relationship was found for total outlets, on-sales outlets and off-sales outlets."¹³⁷ Further, trading hour restrictions in New South Wales introduced in 2014, were found to reduce rates of assault and of serious facial injury arising from this; there was a 60% drop in the need for surgery for such injuries in the two years following the restrictions' introduction.¹³⁸

This evidence is troubling when it is considered that alcohol has only become more physically and temporally available in the UK in recent years. Not only did the number of licensed premises in the UK double between the 1950s and the 21st century – a period when the population grew by only a fifth –¹³⁹ but the Licensing Act 2003, brought about in an attempt to create a more leisurely, café-culture of drinking,¹⁴⁰ also brought significant increases in both the temporal and physical availability of alcohol in England and Wales. Home Office data show there has been both an increase in premises licenses of 8% between 2008 and 2017, but also a 16% increase in premises with a 24-hour license.¹⁴¹ Indeed, in their evidence-based report analysing UK alcohol policy, the University of Stirling, Alcohol Health Alliance, and British Liver Trust note that "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."¹⁴²

Despite the strong evidence body suggesting alcohol availability is linked to harms, including health harms, public health remains excluded from the list of objectives that must be met in all in licensing decisions. While this has been implemented in Scotland, public health is not a licensing objective in England and Wales, meaning "current licensing legislation does not enable local authorities to take a strategic view of the total availability of alcohol when making decisions about specific proposals."¹⁴³ This must be rectified.

There are further emergent concerns that a review of licensing legislation ought to consider. The first is online sales. As an emerging market, there may be benefit to a comprehensive review of this and home deliveries, to prevent sales to underage, vulnerable or intoxicated customers. Online grocery shopping is a growing market, with £6.6 billion spent through this channel in 2017 – a rise of 4.6% since 2016.¹⁴⁴ If legislation hopes to keep pace with our increasingly online world, it may need to be reviewed to consider how to accommodate these types of sales.

¹³⁵ HM Government. 2018. [Childhood obesity: a plan for action. Chapter 2](#), p. 9.

¹³⁶ Poikolainen, K. 1980. [Increase in alcohol-related hospitalizations in Finland 1969-1975](#). British Journal of Addiction 75(3): pp 281-291. doi: 10.1111/j.1360-0443.1980.tb01381.x

¹³⁷ Alcohol Focus Scotland and CRESH. 2018. [Alcohol Outlet Availability and Harm in Scotland](#), p. 8

¹³⁸ The Foundation for Alcohol Research and Education and The Institute of Alcohol Studies. 2017.

[Anytime, anyplace, anywhere? Addressing physical availability of alcohol in Australia and the UK](#), p. 16

¹³⁹ British Medical Association Board of Science. 2008. Alcohol misuse: tackling the UK epidemic. London: British Medical Association. p. 50.

¹⁴⁰ The Institute of Alcohol Studies. n.d. [Licensing legislation and alcohol availability](#).

¹⁴¹ Home Office and ONS. 2017. [Alcohol and Late Night Refreshment Licensing England and Wales](#). Table 1.

¹⁴² University of Stirling, Alcohol Health Alliance, and British Liver Trust. 2013. [Health First: An evidence-based alcohol strategy for the UK](#), p. 29.

¹⁴³ University of Stirling, Alcohol Health Alliance, and British Liver Trust. 2013. [Health First: An evidence-based alcohol strategy for the UK](#), pp. 29-30.

¹⁴⁴ Retail Gazette. 2018. [Online grocery shopping's market share grew just 1% in 2017](#).

Drunken sales is an issue which ought to be considered within any updated alcohol strategy. As the affordability gap between alcohol in the off and on-trade increases (as it has done for the past 30 years),¹⁴⁵ the practice of pre-loading – drinking off-trade alcohol at home or another location before moving to the on-trade – seems unlikely to decrease. The practice has been linked to an increased likelihood of violence, with research surveying 18-35 year olds in North West England finding ‘pre-loaders’ were more than twice as likely to have gotten into a fight.¹⁴⁶ A new mandatory licensing condition requiring alcohol retailers to have a written policy on how they will prevent illegal sales to intoxicated customers, along with a specific requirement for authorities to enforce the existing law that makes such sales illegal, ought to be included in any updated alcohol strategy.

A FOCUS ON ALCOHOL-RELATED CRIME AND DISORDER

13. Expand the delivery of brief interventions in prisons, courts and custody suites ensuring support is provided post-release where required.

A high proportion of those who come into contact with the criminal justice system in the UK have a problem with alcohol – three-quarters – while more than a third are dependent on alcohol.¹⁴⁷ Ministry of Justice data published in 2013 show “63% of prisoners who drank alcohol in the four weeks before custody would be classified as binge drinkers”.¹⁴⁸ Indeed, an evidence review analysing work examining the prevalence of alcohol use disorders in the criminal justice system found that estimates for the proportion of prisoners with an alcohol use disorder ranges from 13 to 86%, while equivalent figures for those in police custody range from 64 to 88%.¹⁴⁹ Survey research has also found that this may disproportionately affect women, finding that women are much more likely to report an alcohol use problem on arrival to prison; 30% of women compared to 16% of men.¹⁵⁰

Despite this high prevalence of alcohol use problems, the criminal justice system might be failing to adequately address the needs of these individuals. For example, the prison system has repeatedly been criticised for its inaction on this issue. The HM Inspectorate of Prisons, in their 2010 thematic review of the subject, “highlighted the failure of the Prison Service adequately to address the problems of alcohol misuse in prisons, despite repeated warnings by the Prison Reform Trust about its harmful effect on reoffending rates and the growing prevalence of alcohol-related crime.”¹⁵¹ They found that alcohol problems were not consistently identified, and that at all stages, a prisoner with an alcohol use problem was less likely to have his or her needs assessed, or acted upon, than those of a prisoner with a drug problem.¹⁵²

As has already been discussed, the delivery of brief interventions has the potential to decrease alcohol’s burden on the health service and to support those drinking at hazardous and harmful levels to access advice and support before this develops into serious health complications.¹⁵³ The criminal justice system is one setting where delivery of such brief interventions is essential. While the evidence on coercive treatment remains mixed,¹⁵⁴ it is essential individuals with alcohol misuse problems have the opportunity to undertake treatment voluntarily. Indeed, when the Ministry of Justice and Public Health England examined community-based treatment in 2017, it was found that “alcohol only clients showed the largest reductions in both re-offenders and re-offending (59% and 49%, respectively)”¹⁵⁵ while research from Public Health England examining brief interventions in prisons in the North East of England found that release and post-release both might be important times for the delivery of these interventions.¹⁵⁶

¹⁴⁵ Institute of Alcohol Studies. 2018. [The rising affordability of alcohol.](#)

¹⁴⁶ Hughes, K., Anderson, Z., Morleo, M. and Bellis, M. A. 2008. [Alcohol, nightlife and violence: the relative contributions of drinking before and during nights out to negative health and criminal justice outcomes.](#) *Addiction*, 103(1), p. 60.

¹⁴⁷ [www.parliament.uk](#). 2016. [Alcoholic Drinks: Misuse:Written question - 41699.](#)

¹⁴⁸ Hansard. November 2015. [Prisoners: Alcoholism: Written question – 17328.](#)

¹⁴⁹ Newbury-Birch, D., McGovern, R., Birch, J., O'Neill, G., Kaner, H., Sondhi, A. and Lynch, K. 2016. [A rapid systematic review of what we know about alcohol use disorders and brief interventions in the criminal justice system.](#) *International journal of prisoner health*, 12(1), p. 57.

¹⁵⁰ HM Chief Inspector of Prisons. 2016. [Annual Report 2015–16.](#) London: The Stationery Office. p. 55.

¹⁵¹ The Institute of Alcohol Studies. n.d. [Alcohol and the prison system.](#)

¹⁵² HM Inspectorate of Prisons. 2010. [Alcohol services in prisons: an unmet need.](#) p. 5.

¹⁵³ University of Stirling, Alcohol Health Alliance, and British Liver Trust. 2013. [Health First: An evidence-based alcohol strategy for the UK.](#) p. 33.

¹⁵⁴ An evidence review examining the use of legally coerced substance misuse treatment concluded that “three decades of research into the effectiveness of compulsory treatment have yielded a mixed, inconsistent, and inconclusive pattern of results, calling into question the evidence-based claims made by numerous researchers that compulsory treatment is effective in the rehabilitation of substance users” (Klag, S., O’Callaghan, F. and Creed, P. 2005. [The use of legal coercion in the treatment of substance abusers: An overview and critical analysis of thirty years of research.](#) *Substance use & misuse*, 40(12), p.1777).

¹⁵⁵ Ministry of Justice and Public Health England. 2017. [The impact of community-based drug and alcohol treatment on re-offending.](#) p. 5.

¹⁵⁶ Public Health England. 2017. [Brief interventions in prison: Review of the Gateways initiative.](#) p. 5.

It is essential to identify and support those within the criminal justice system with alcohol misuse treatment needs; not only because alcohol use may be linked to a variety of types of offending including murder and assault,¹⁵⁷ but because adequate access to treatment might relieve some of the physical and psychological impact alcohol misuse has on these individuals. The consistent roll out of these measures is a critical part of any alcohol strategy.

14. Reduce the drink-driving BAC limit to 50mg/100ml in line with Scotland and most of Europe.

The drink-drive BAC limit in England and Wales has remained unchanged since its introduction in 1965, but since 2010, we have seen no improvement in the number of drink-drive deaths.¹⁵⁸ Currently, there are around 240 drink-drive deaths and more than 8,000 drink-drive casualties reported in the UK every year.¹⁵⁹

At 80mg alcohol/100ml blood, England and Wales have the highest drink-drive limit in Europe,¹⁶⁰ and one of the highest in the world; all other EU nations have a limit of 50mg/100ml or lower, as do many commonwealth nations including Australia, South Africa and New Zealand.¹⁶¹

Evidence suggests drinking up to this 80mg alcohol/100ml blood limit leaves drivers six times as likely to die in an accident as those who have not drunk.¹⁶² If the limit in England and Wales were reduced to the 50mg/100ml level, research indicates that at least 25 lives would be saved every year, as well as preventing 95 casualties¹⁶³ and saving £800 million annually.¹⁶⁴

The devolved nations have already made this change. Indeed, when Scotland reduced its drink-drive limit to 50mg/100ml in December 2014, there was a 12.5% reduction in drink-drive offences in the first 9 months alone.¹⁶⁵

Research has found that the enforcement of the current drink-drive limit is also waning. Research from the Institute of Alcohol Studies using FOI data found that roads policing officer numbers, average roads policing budgets per force, and breath test numbers have all fallen between 2011/12 and 2015/16; by 27%, 17.9% and 25% respectively.¹⁶⁶ This makes the case for a reduction in the drink-drive limit only more compelling; the research suggests, at the same levels of enforcement, "a 50mg/100ml limit will save more lives and prevent more casualties than one of 80mg/100ml, with the same levels of enforcement."¹⁶⁷

Indeed, the Government themselves have noted: 'drink-driving deaths have fallen from 1,640 [in 1979] to 200 per year – but that's still 200 too many.'¹⁶⁸

A reduction in the drink-drive limit has wide public, political, emergency service and civil society support. Indeed, 77% of the British public support lowering the drink-drive limit,¹⁶⁹ while the British Medical Association, the Alcohol Health Alliance, the Fire Brigades Union, the Police Federation, Brake, and many more, all have pledged their support to the measure.¹⁷⁰ Lord Brooke of Alverthorpe also sponsored a Private Member's Bill to lower the limit in 2016, which passed through the House of Lords, but ran out of parliamentary time to pass the Commons.¹⁷¹

15. Continue to invest in family drug and alcohol courts.

Family Drug and Alcohol Court (FDAC) is "a problem-solving court approach to improving outcomes for children involved in care proceedings. It offers an alternative – and more successful – way of supporting parents to overcome the substance misuse, mental health and domestic abuse problems that have put their children at risk of serious harm. It offers parents optimism about recovery and change, combined with a realistic understanding of the immense challenge they face."¹⁷²

¹⁵⁷ Interventions & Substance Misuse Group: National Offender Management Service, Alcohol Concern, and MP Consultancy. 2008. [Alcohol Information Pack for Offenders Under Probation Supervision](#), in Alcohol Information Pack Offenders' Guide. Alcohol Learning Centre. p. 41.

¹⁵⁸ Tunbridge, R. and Harrison, K. 2017. [Fifty years of the breathalyser – where now for drink driving?](#) p. 3.

¹⁵⁹ Alcohol Policy UK. 2017. [Drink drive figures: cause for concern in 2017?](#)

¹⁶⁰ Malta have recently announced plans to reduce their limit to 50mg/100ml, however they still officially have a limit of 80mg/100ml (Institute of Alcohol Studies, [Save lives, safer roads, lower the drink drive limit](#)).

¹⁶¹ The Institute of Alcohol Studies. n.d. [Briefing: Lowering the drink driving limit in England and Wales](#). p. 1.

¹⁶² The Institute of Alcohol Studies. n.d. [Briefing: Lowering the drink driving limit in England and Wales](#). p. 1.

¹⁶³ Allsop, R. 2015. [Saving Lives by Lowering the Legal Drink-Drive Limit](#). Parliamentary Advisory Council for Transport Safety (PACTS). p. vii.

¹⁶⁴ The Institute of Alcohol Studies. n.d. [Briefing: Lowering the drink driving limit in England and Wales](#). p. 1.

¹⁶⁵ BBC News. 2015. [Drink-drive offences fall after lower limit introduced](#).

¹⁶⁶ The Institute of Alcohol Studies. 2017. [Running on Empty: Drink-driving law enforcement in England](#). p. 5.

¹⁶⁷ The Institute of Alcohol Studies. 2017. [Running on Empty: Drink-driving law enforcement in England](#). p. 5.

¹⁶⁸ Gov.uk (October 2017), [Life-saving drink drive law turns 50](#). Department for Transport.

¹⁶⁹ 2015 British Social Attitudes Survey. 2016. Attitudes to Alcohol: Findings from the 2015 British Social Attitudes Survey.

¹⁷⁰ The Institute of Alcohol Studies. n.d. [Briefing: Lowering the drink driving limit in England and Wales](#). p. 2.

¹⁷¹ The Institute of Alcohol Studies. n.d. [Briefing: Lowering the drink driving limit in England and Wales](#). p. 2.

¹⁷² National Unit FDAC. 2015. [Welcome to the National Unit](#).

In 2015, the FDAC National Unit was set up, funded by the Department for Education, to support the role out of this model to courts across the country. There are now 10 FDACs running in 23 local authorities. However, this National Unit is now facing closure due to lack of funds.¹⁷³ While individual FDACs are not closing, the FDAC National Unit note that they "hope the closure of the FDAC National Unit will not jeopardise the continuing viability of existing FDACs and the important work teams do to support some of the most vulnerable and marginalised parents and children in our society."¹⁷⁴

This is concerning when it is considered that evidence suggests that not only do FDACs improve outcomes for families, but that the National Unit has been shown to have contributed to their growth. Both 2016 and 2014 evaluations of the project suggest this, finding that significantly more families were reunited through FDACs (37% compared to 25% of families not using the FDAC system),¹⁷⁵ significantly more mothers were no longer experiencing substance misuse problems by the end of FDAC proceedings (46% compared with 30% not using the FDAC system)¹⁷⁶ and that "a year or more after proceedings had finished, there was further neglect or abuse of children in 25% of FDAC families, compared with 56% of families in normal care proceedings."¹⁷⁷ The government's own evaluation of the National Unit found that "the research indicates that the National Unit was perceived to have played a critical role in the set-up of new FDACs"¹⁷⁸ and that "the National Unit was seen as having an important ongoing role in relation to sustainability [of FDAC]..."¹⁷⁹ Continued investment in this service appears important in securing better outcomes for children and families.

16. Increase access to Alcohol Diversion Schemes for those involved in alcohol related crime and disorder.

Many parts of the UK now run Alcohol Diversion Schemes where drinkers who commit less serious offences are given a choice between a fine, possible court appearance and a criminal record; or a reduced fine and no criminal sanctions if they complete an alcohol awareness course. The course emphasis the dangers of extreme intoxication and focus particularly on the dangers of drinking at home before going out for the night and mixing drugs with alcohol.^{180, 181, 182, 183}

Diversory schemes have also been put in place in some locations to react to the alcohol-driven disorder and crime of the night time economy, and the impact this has on emergency service workers. Alcohol accounts for up 53% of police workload,¹⁸⁴ and this may be even more acute at weekends, where more than 80% of arrests are alcohol-related.¹⁸⁵ A great deal of this disorder is driven by cheap, readily available alcohol. The substantial affordability gap between the off and on-trade which has emerged over the last 30 years¹⁸⁶ has contributed to the practice of pre-loading, which has in turn been linked with increased likelihood of violence for those who engage in this.¹⁸⁷ Indeed, in their report, The Frontline Battle, Alcohol Concern present evidence given by police officers to the APPG on Alcohol Harm, in which police respondents called for action on cheap alcohol.¹⁸⁸ This disorder is not only a time and resource strain on police, but on the health service also, with the APPG on Alcohol Harm reporting; "the mean cost per alcohol related attendance was estimated at £249; and the cost to those admitted to hospital was £851."¹⁸⁹

There are a wide range of diversory schemes in place to attempt to relieve some of this strain, not only on police but emergency services more broadly.¹⁹⁰ They provide a place of safety, medical assessment, basic medical treatment, first aid, and supervised recovery. They treat people who have been injured, are intoxicated with alcohol or

¹⁷³ National Unit FDAC. 2015. [About the National Unit](#).

¹⁷⁴ National Unit FDAC. 2015. [About the National Unit](#).

¹⁷⁵ Harwin J., Alrouh B., Ryan M., McQuarrie T., Golding L., Broadhurst K., Tunnard J. and Swift S. 2016. [After FDAC: outcomes 5 years later. Final Report](#). Lancaster University. p. 20.

¹⁷⁶ Harwin J., Alrouh B., Ryan M., McQuarrie T., Golding L., Broadhurst K., Tunnard J. and Swift S. 2016. [After FDAC: outcomes 5 years later. Final Report](#). Lancaster University. p. 19.

¹⁷⁷ National Unit FDAC. 2016. [Better outcomes for parents and children](#).

¹⁷⁸ Department for Education. 2017. [Family Drug and Alcohol Court National Unit: independent evaluation](#). p. 6.

¹⁷⁹ Department for Education. 2017. [Family Drug and Alcohol Court National Unit: independent evaluation](#). p. 7.

¹⁸⁰ Alcohol Policy UK. 2011. [Findings offender-related alcohol research: need for offender services; alcohol diversion schemes](#).

¹⁸¹ CAIS. 2018. ['Opportunity' of new alcohol diversion scheme](#).

¹⁸² Framework. 2012. [Total success for pioneering alcohol education scheme](#).

¹⁸³ Surrey Police. 2017. [Penalty Notices for Disorder \(PND\) - Alcohol and Cannabis Diversion Scheme Procedure](#).

¹⁸⁴ The Institute of Alcohol Studies. 2015. [Alcohol's impact on emergency services](#). p. 3.

¹⁸⁵ Stoddart, J. 2011. [Alcohol's impact on policing](#). Balance – The North East Alcohol Office. p. 19.

¹⁸⁶ Institute of Alcohol Studies. 2018. [The rising affordability of alcohol](#).

¹⁸⁷ Hughes, K., Anderson, Z., Morleo, M. and Bellis, M. A. 2008. [Alcohol, nightlife and violence: the relative contributions of drinking before and during nights out to negative health and criminal justice outcomes](#). *Addiction*, 103(1), p. 60.

¹⁸⁸ Alcohol Concern. 2016. [The Frontline Battle: An Inquiry into the Impact of Alcohol on Emergency Services by the All-Party Parliamentary Group on Alcohol Harm](#). p. 35.

¹⁸⁹ Alcohol Concern. 2016. [The Frontline Battle: An Inquiry into the Impact of Alcohol on Emergency Services by the All-Party Parliamentary Group on Alcohol Harm](#). p. 14.

¹⁹⁰ Alcohol Concern. 2016. [The Frontline Battle: An Inquiry into the Impact of Alcohol on Emergency Services by the All-Party Parliamentary Group on Alcohol Harm](#). p. 38.

illegal drugs or are vulnerable for other reasons. These schemes range from volunteer groups such as Street Pastors, to more formal field hospitals and Alcohol Intoxication Management Services (AIMS), which "provide public facilities in and amongst night-time economy areas, staffed by medically qualified personnel [as] an alternative to A&E departments and ambulance assistance for patients who have had too much to drink...". These AIMS have been recommended to address the strain on services by the APPG on Alcohol Harm, alongside pricing and licensing interventions.¹⁹¹ These may be appropriate sites for delivery of brief intervention and advice.

It is essential these schemes are complimented by population wide actions, such as the measures on pricing and licensing discussed elsewhere in this charter. While these centres may be effective where they are in place, since "establishing and sustaining a scheme requires significant investment and on-going commitment, including for the evaluation and measurement of local impacts arising from a scheme's implementation,"¹⁹² their implementation nationwide may be difficult to achieve, and where they are successful, they will only be in a position to assist those individuals they have direct contact with. Evidence suggests the population-wide measures already discussed such as price increases and physical and temporal restrictions on sales of alcohol are necessary to make headway into this issue and relieve the strain on our emergency services.

¹⁹¹ Alcohol Concern. 2016. [The Frontline Battle: An Inquiry into the Impact of Alcohol on Emergency Services by the All-Party Parliamentary Group on Alcohol Harm](#). p. 7.

¹⁹² The Institute of Alcohol Studies. 2018. [IAS response to Night Time Commission Consultation Submission](#). p. 8.

The Drugs, Alcohol & Justice Cross-Party Parliamentary Group provides an interface for professional providers of drug and alcohol treatment with Parliamentarians who share an interest in these issues. It has established a considerable reputation in Parliament over a number of years, meeting with Government and frontbench representatives from all political parties and campaigning on numerous issues across the sector. Co-Chaired by Mary Glendon MP and Lord Ramsbotham, its programme of work is taken forward by Solidarity Consulting.

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The All-Party Parliamentary Group on Alcohol Harm exists to promote discussion of alcohol related issues and to raise issues of concern and make recommendations to government and other policy makers.

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