Alcohol Change UK

Submission to the Commission on Alcohol Harm:

An Inquiry into the Effects of Alcohol on Society

February 2020

ALCOHOL CHANGE UK

Introduction

Alcohol is a part of many of our lives. We use it for celebration, for comfort, to socialise, to wind down, to cope. We treat it differently to other drugs; it's legal, socially acceptable, even encouraged. Yet in the UK 21 people every day die as a result of alcohol.[1] Alcohol harm – mental health problems, liver disease, seven forms of cancer, economic difficulties, and so much more – can affect any one of us, from any walk of life.

The harm doesn't end with the individual; each of us who drinks too much is part of a family and a community who feel the effects too, whether through frequent use of emergency services, drink driving, violence or neglect.

We see a future in which people drink as a conscious choice, not a default; where the issues which lead to alcohol problems – like poverty, mental health issues, homelessness – are addressed; where those of us who drink too much, and our loved ones, have access to high-quality support whenever we need it, without shame or stigma.

What impact does alcohol have on the NHS and other public services?

Our work on the Blue Light Project identifies a small group of people who place a large burden on public services because of their alcohol use.[2] These 'Blue Light clients' are people who have a long-term pattern of problem drinking or are alcohol-dependent, have a pattern of not engaging with or benefitting from alcohol treatment and frequently use public services as a result, including health, social care, criminal justice, domestic violence, children's services, police, housing and homelessness services. The project estimates there are 400-500 Blue Light clients in an average-sized local authority. All these people combined are estimated to cost £2.4bn each year to health, criminal justice, social care, housing and emergency services.[3]

Furthermore, in an analysis of Safeguarding Adult Reviews from 2017, we found that 25% of publicly available reviews featured alcohol as a significant factor in the person's life and/or death.[4]

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[1] Office for National Statistics (2019) Alcohol-specific deaths in the UK: registered in 2018

[2] Alcohol Change UK (2020) 'The Blue Light Project' webpage

[3] Alcohol Change UK (2014). The Blue Light Project Manual: Working with change-resistant drinkers.

[4] Alcohol Change UK (2019) Learning from tragedies: An analysis of alcohol-related Safeguarding Adult Reviews published in 2017

The main finding was that most of the people who died had multiple complex needs, including mental health problems, chronic physical health conditions, neurological conditions caused by alcohol, were self-neglecting, being exploited by others, had unfit living conditions, and had experiences of a past traumatic event such as bereavement or abuse. For many people, alcohol misuse is a coping mechanism for the myriad challenges they face, yet also exacerbates and worsens the very problems they are trying to manage.

The people featured in these reviews are an example of the Blue Light client. One review from the Teeswide Safeguarding Adult Board details how, in the three years prior to her death, 'Carol' had 1,000 direct contacts with mental health, alcohol, ambulance and hospital services, 472 reported incidents to the police and 175 offences.

In our role as secretariat to the All-Party Parliamentary Group on Alcohol Harm,[5] we ran an inquiry into the impact of alcohol on emergency services in 2016.[6] The inquiry found that:

- In one police force staff survey, "90% of officers expect to be assaulted on a Friday and Saturday night", and that for female officers, sexual assault is the norm.
- Alcohol-related cases overload emergency departments, impacting on wait times for non-alcohol-related patients.
- Fire officers reported that they now rescue more people from road traffic collisions than house fires, many due to drink-driving. Alcohol also makes house fires more "frequent and severe".

The London Ambulance Service responded to almost 64,000 alcohol-related incidents in 2018 and 6% of their callouts in December of that year were alcohol-related.[7] In the last three years the London Fire Brigade attended 1,120 accidental alcohol-related fires, equivalent to more than one incident every day. 39% of these fires were caused by cooking.

An estimated 35% of all A&E attendances are alcohol-related, with a majority of hospital bed days taken up by a minority of patients known as 'frequent attenders'. An Alcohol Change UK-funded report (formerly Alcohol Research UK) found that A&E staff do not have the "resources or training to provide the kind of personalised support" for alcohol problems which frequent attenders need. [8]

What challenges do alcohol treatment services currently face in supporting people impacted by alcohol harm?

Between 2016 and 2018 alone, over two-thirds of local authorities cut their alcohol treatment budgets, with 17 implementing cuts of more than 50%.[9] Local authorities with the most severe cuts to their spending also had the highest numbers of alcohol-dependent people as a proportion of

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[5] Alcohol Change UK (2019) 'The All-Party Parliamentary Group on Alcohol Harm' webpage
[6] All-Party Parliamentary Group on Alcohol Harm (2016) The Frontline Battle: An Inquiry into the Impact of Alcohol on Emergency Services by the All-Party Parliamentary Group on Alcohol Harm
[7] The City of London (2019) Eat. Pace. Plan. Christmas campaign toolkit
[8] Neale *et al.* (2016) Frequent attenders to accident and emergency departments: a qualitative study of individuals who repeatedly present with alcohol-related health conditions
[9] Alcohol Change UK (2018) The Alcohol Treatment Levy

their population, meaning those areas most in need of treatment have experienced the most dramatic change in their resources – a huge blow to their ability to mitigate the problem. The Alcohol Change UK report, The Hardest Hit, details how cuts in funding to treatment services have pushed commissioners to have shorter re-tendering cycles and has resulted in a loss of qualified staff.[10] Surveys and interviews of professionals from public health, criminal justice, commissioning, substance use services and clinical specialists found that 88% of respondents felt resources were insufficient in their area, citing an "assault on funding", "phenomenal workloads" and "paring back to a skeleton service".

An upcoming Alcohol Change UK-funded report, due to be published in March 2020, looks at the impact of reduced funding on commissioning practices. It found that commissioners from five local authorities, representing a diversity of areas, reported common challenges. These included the under-representation of alcohol clients in treatment compared to other substances, a lack of effective pathways into treatment, the existing system being too complicated and a need for minimum standards of service provision, among others.[11]

Alongside this crisis in service provision, not everyone makes it to the service in the first place. Since 2013/14, there has been a 20% decline in the number of people entering alcohol treatment,[12] while at the same time the number of people in need has remained stable. PHE's inquiry into this fall in treatment numbers found that reduced budgets were a major factor.[13]

People can submit their stories of their experiences of alcohol harm on the Alcohol Change UK website. Throughout this document these direct quotes are from this source and anonymised. The following story illustrates how properly funded treatment services are crucial.

"My Mum told us shortly after they split up after the business collapsed and his drinking started to escalate. I then saw my beloved daddy change into someone I didn't recognise. My mum repeatedly begged him to get help and even drove him to the hospital to get rehab - he refused and walked out. I remember saying to him on the phone in tears, " I do not want to go to a funeral, Daddy".

He received a letter from the hospital, diagnosing him with Alcoholic Liver Disease. Frightened, he did agree to attend a GP appointment to seek residential rehab. He was told that he could be on the NHS rehab waiting list for months and private rehab was expensive - nothing that my dad nor my teacher-in-training mum with two children could afford. After that he gave up. Counselling was not enough for him and it was too late. He died three months later. I did go to a funeral.

Residential rehab is difficult to access and in the case of severe alcoholics like my father it is the only treatment that will do enough to help. I hope that this changes one day so that someone else's daddy can be helped."
(Female, 18, Derbyshire)

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[10] Alcohol Change UK (2018) The Hardest Hit: Addressing the crisis in alcohol treatment services

[11] Buykx, Irving and Gavens (2020). Local alcohol treatment & recovery service commissioning practices & their perceived outcomes for service provision: An in-depth exploration [to be published March 2020]

[12] Public Health England National Drug Treatment Monitoring System (2019) Substance misuse treatment for adults: statistics 2018 to 2019

[13] Public Health England (2018) PHE inquiry into the fall in numbers of people in alcohol treatment: findings

What data exists to show alcohol's current impact on different demographic groups, including age, sex and social class?

With middle-aged and older people drinking more than in previous years, there is increasing demand for alcohol treatment for this age group. In fact, the average age of people entering alcohol treatment in England is 46, higher than for other substances. However, treatment services are not tailoring their provision to this client group. An Alcohol Change UK-funded study in 2017 found that three out of four residential alcohol treatment facilities are excluding older adults on the basis of arbitrary age limits and that rehabs tend not to take the needs of older adults specifically into account. [14]

What impact does alcohol have on economic productivity and is there evidence of this changing since 2012?

Alcohol Change UK provides services for workplaces to improve their alcohol policies and promote the health and wellbeing of their employees, including training for managers, coaching and advice, and alcohol awareness activities.[15] We have found that the key issues identified by corporate clients are:

- Brief sickness absences by known heavy drinkers which is usually tolerated but resented. Management don't feel they can intervene without evidence. HR find that employees with an alcohol problem take up a lot of time and resources. One example from our experience was of an executive with an alcohol problem. His colleagues made allowances in an attempt to be supportive and 'protected' him from the consequences of his drinking. After a few years, he was fired for gross misconduct due to a drunken incident with a client. This led him to threaten legal action, as he felt his drinking was condoned by management. This is a typical example where employers are unwilling to tackle problematic alcohol use if they can't see a direct impact on the workplace.
- Employees turning up at work under the influence, often due to personal circumstances such as a bereavement. Employers are keen to be supportive but don't know how to respond.
- Concerns that the drinking culture is part of the attraction to the job and that changing the culture will cause businesses to lose their talent. This is often the case in finance, insurance and surveying. However, employees often report they feel obliged to join in.

Since 2012, we have found that more organisations have bespoke alcohol policies and there is more recognition and acknowledgement of alcohol harm, but still uncertainty about how to deal with it. In the past, employers were predominantly punitive but are now more sympathetic.

Where workplaces can improve:

- Nowhere has a recruitment policy around alcohol. Workplaces should strive to be a 'recovery-positive' employer.

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[14] Wadd and Dutton (2017) Accessibility and suitability of residential alcohol treatment for older adults

[15] Alcohol Change UK (2020) 'For workplaces' webpage

- Where employees are driving, nothing is being done to educate staff about the length of time alcohol stays in the body, putting them at risk of being over the limit.
- Leaders need to lead by example. Senior management often don't follow the rules other employees are expected to follow, for example, by drinking at lunchtime.
- Alcohol is still considered the default reward that everyone wants.

People's stories about alcohol and workplaces:

- "*I suppose I am a typical doctor: I will have a glass of wine (or two) most evenings to help me relax after work. As part of my job, I often encourage patients to cut down on alcohol so I decided to calculate my own intake. I must admit I was a bit surprised how much more I was drinking than recommended safe limits, and also that I could be described as a 'high risk' drinker.*" (Female, 37, Scotland)
- "*For approximately 15 years I've enjoyed a few Stellas after a long day on site. This started out as a social gathering after work but soon became a behind closed door at home drinking binge which became 10 pints a night! Late December 2019 I went to my GP for my annual MOT which unfortunately opened my eyes to see just what damage I am doing to my body, mainly my veins and liver.*" (Male, 44, Leeds)

What recent evidence is there of links between alcohol and other addictive behaviours (such as smoking, drug use and gambling)?

An Alcohol Change UK-commissioned report from the University of South Wales looked at gambling and drinking in the Welsh population.[16] In a survey of 263 Welsh adults, 24% of participants said they always drank alcohol when gambling. The researchers found that "gambling frequency is highly correlated with hazardous drinking patterns and indicators of alcohol dependence" and at the same time more frequent drinkers tend to gamble more often and more hazardously. Their findings indicate that "individuals with high risk gambling behaviour drink alcohol as a coping strategy, whilst high risk drinkers gamble for enhancement", i.e., increasing the excitement and fun of the situation.

For both drinking and gambling, changes in behaviour, technology and licensing are contributing to the problem. With more home drinking and the increase of online gambling, there is a 'dual harm' in "an environment away from public view".

What effect does the current approach to alcohol marketing and licensing have on alcohol harm?

The current self-regulation of alcohol marketing is not fit for purpose. The industry-funded corporate social responsibility body, the Portman Group, responds to reports of products which breach its Code of Practice. A 2018 Alcohol Change UK report analysed the 99 decisions the Portman Group had made in the preceding ten years and found inconsistencies in decision-

[16] John and Roderique-Davies (2018) An investigation into the comorbidity of harmful drinking and gambling behaviour in a general population

making, as well as a “lack of oversight and scrutiny”.[17] While it can impose sanctions on products or marketing campaigns which don’t meet the Code, these are often ruled on many months after the campaign has ended.

Similarly, the lack of regulation around alcohol labels means that consumers are not able to make informed choices about how much and what they drink.

Upcoming research (late-April 2020 publication) from the Alcohol Health Alliance has found that in a survey of 424 alcohol products, 71% of labels do not show the current low-risk drinking guidelines, four years after the guidelines were updated by the Chief Medical Officers. This is despite the Portman Group advising manufacturers to include this information on labels – a clear sign that self-regulation is failing consumers. Alcohol product labels also do not have to contain any nutritional or ingredient information, in stark contrast to every other food product including non-alcoholic drinks. This anomaly means that consumers are not provided with all the necessary information to understand the health implications of their purchases at the point of choice and purchase.

There is research to show that there is high public support[18] for including more information on alcohol product labels, and that considering the placement and design of information[19] can “positively influence drinking behaviour”.[20]

What policy changes would help to reduce the level of harm caused by alcohol? Are there policy responses from other governments (including within the UK) that have been successful in reducing harms caused by alcohol that could be implemented in the UK?

Policy solutions alone will not address all aspects of alcohol harm. Drinking cultures, narratives of drinking and the influence of friends and family create strong social norms. On the one hand, this normalises drinking to the extent that people do not realise they have a problem, or they are ostracised for choosing not to drink, as illustrated by the following quotes:

- “*I’m 49, not a big drinker, but this [Dry January] is the first time since I was 17 that I’ve been a week without alcohol.*” (Male, 49, Ireland)
- “*I started drinking at 14 and very heavily in my early 20s. I realised then that there was a problem but no one was interested as alcohol is so normalised and I didn't drink in the morning so I couldn't have a problem. With children, drinking became less social and more at home.*” (Female, 37, Nottingham)
- “*When I said I did not drink people, especially at work, found it difficult to understand as drinking is so ingrained in society, people want you to be like them.*” (Male, 36, Brighton)

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[17] Alcohol Change UK (2018) Fit for Purpose? An analysis of the role of the Portman Group in alcohol industry self-regulation

[18] Maynard *et al.* (2018) Know your limits: Labelling interventions to reduce alcohol consumption

[19] Royal Society for Public Health (2018) Labelling the Point: Towards better alcohol health information

[20] Roderique-Davies *et al.* (2018) Investigating the potential impact of changing health messages on alcohol products

On the other hand, there are still high levels of stigma around people with alcohol dependence, which also prevents people from accessing help.

> "*I am utterly exhausted trying to almost live two lives; a drunk one and an outwardly respectable normal one. I've held down a job for 23 years and no one knows I'm leading a double life.*" (Female, 42, Manchester)

Furthermore, no one policy option is a 'silver bullet'. Since the coalition government's alcohol strategy in 2012 [21] we have only seen isolated and disconnected policies and pilot schemes from Westminster, sitting within departmental silos. The pervasiveness of alcohol harm in all aspects of society - including chronic health harms such as liver disease and cancer, acute harms such as injuries, crime, domestic violence, the need for treatment for dependence, the effects of price, availability and marketing, as well as in other areas such as homelessness, mental health and gambling – necessitates an interdisciplinary approach to government policy on alcohol. The most effective strategy would be for a package of measures to be introduced which address the full spectrum of alcohol harms.

In contrast to England, the devolved governments have introduced comprehensive strategies to tackle alcohol harm.[22] The Welsh Government increased funding for substance misuse by 10% in their 2019-2020 budget. Most recently, in their 2020-21 budget, the Scottish Government announced an additional £12.7 million of funding for alcohol and drug harms.[23] At the same time, local authorities in England have seen their expenditure on alcohol treatment services fall by 10% in just two years between 2016/17 and 2018/19. During this time, total spending on public health fell by only 6%.[24] However, Scotland, Wales and Northern Ireland are limited by the extent of their devolved powers. Policies are needed at the UK-level, not just to allow these home nations to implement much-needed policies for their own areas, but for England to be able to 'catch-up' with the rest of the UK in terms of alcohol harm reduction.

In our role as secretariat to the All-Party Parliamentary Group on Alcohol Harm, we supported the development of the Alcohol Charter [25] – a blueprint for a government alcohol strategy across three main areas of public health, support and treatment, and criminal justice. The 16 asks in the Charter are endorsed by over 30 third sector organisations and Parliamentarians.[26] These policies should be introduced by the UK Government in order to reduce alcohol harms. The Alcohol Charter's asks are the following:

1. Increase alcohol duties by 2% above inflation to address the increasing affordability of alcohol.

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[21] HM Government (2012) The Government's Alcohol Strategy
[22] Scottish Government (2018) Alcohol Framework 2018
Welsh Government (2019) Substance Misuse Delivery Plan 2019-2022
[23] Scottish Drugs Forum (2020) 'Additional £12.7 million funding in Scottish Budget to address harm associated with drug or alcohol use'
[24] Ministry of Housing, Communities and Local Government (2019) Local authority revenue expenditure and financing: Revenue outturn social care and public health services (RO3)
[25] Alcohol Change UK (2020) 'The Alcohol Charter' webpage
[26] Alcohol Change UK (2020) 'Support for the Charter' webpage

2. Mandate local authorities to provide and promote a ‘ring-fenced’ resource for alcohol treatment, early alcohol intervention provision, and prevention services, increase the proportion of dependent drinkers accessing treatment, and set a target date for when treatment services will be available for all who need access.

3. Address the needs of older 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.

5. Develop a funded national programme of support for families, carers and children of alcohol-dependent parents.

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 treatment workforce.

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.

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’s 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 and nutritional information alongside existing advice.

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.

12. Improve alcohol licensing 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, and carry out a comprehensive review of online sales and home deliveries, to prevent sales to underage, vulnerable or intoxicated customers.

13. Expand the delivery of alcohol treatment and support in prisons, courts and custody suites and post-release.

14. Reduce the drink-driving Blood Alcohol Content (BAC) limit in England and Wales to 50mg/100ml in line with Scotland and the rest of Europe.

15. Invest in Family Drug and Alcohol Courts and support their national rollout.

16. Increase access to Alcohol Diversion Schemes at all possible points of diversion for those involved in alcohol-related crime and disorder.

Alcohol Change UK

17 February 2020