Institute of Alcohol Studies
Response to the Prevention Green Paper

Summary

1. The Institute of Alcohol Studies is an independent institute bringing together evidence, policy and practice from the UK and elsewhere to promote an informed debate on alcohol's impact on society.

2. We welcome the publication of the Prevention Green Paper, which provides a timely opportunity to address some of the biggest causes of preventable harm and re-focus society away from treating illness to supporting healthier, happier lives. It could help to reduce health inequalities and narrow the gap between the experience of the richest and the poorest citizens.

3. To achieve this prevention vision, it follows that all preventable causes of ill-health should be considered. This includes the harm caused by alcohol – one of the major drivers of premature mortality, health inequalities, physical and mental ill-health.

4. Alcohol has become the leading risk factor for death among 15-to-49-year-olds.[1] With more than 1.1 million alcohol-related hospital admissions every year, alcohol places undue strain on our health services.[2] Unless trends are reversed, it is projected to cost the NHS £17 billion over the next five years.[3] The government estimate for the social and economic costs of alcohol was £21 billion in England in 2012,[4] with PHE more recently highlighting estimates between £27 billion to £52 billion in 2016.[5]

5. The wider environment has an enormous influence on individuals' behaviour. Targeted interventions which create a healthier environment by reducing demand are essential to prevent alcohol harm and reduce health inequalities.

6. To make a real difference and address alcohol harm effectively, we need bold evidence-based policies on price, availability and promotion, as recommended by the World Health Organization. In addition, support for at-risk drinkers needs to be extended and improved. Our key recommendations are:

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[1] PHE (2016) The public health burden of alcohol and the effectiveness and cost-effectiveness of alcohol control policies
[2] Public Health England (2017) Health matters
[3] Foundation for Liver Research (2017) Financial case for action on liver disease
[4] Home Office (2012) A minimum unit price for alcohol – impact assessment
[5] PHE (2018) PHE Research 2016 to 2017: annual review

a. Affordability:
    i. **Introduce a minimum unit price for alcohol.**
    ii. **Increase alcohol excise duty by 2% above inflation every year.**

b. Availability:
    i. **Include public health as an additional licensing objective.**
    ii. **Introduce greater powers for local authorities to control when and where alcohol can be sold (for example, by reversing the presumption to approve a new license).**

c. Promotion and information:
    i. **Review and reform the current regulatory system for alcohol marketing, including the establishment of an independent regulator.**
    ii. **Restrict alcohol marketing to protect children from alcohol advertising and promotion, including a 9pm watershed for television and restricting alcohol advertising in cinemas to those films with an 18 certificate.**
    iii. **Adopt the CMOs Expert Advisory Group's recommendations that the low-risk drinking guidelines be communicated through the inclusion of health warnings on all alcohol advertising, products and sponsorship as well as through government-backed media campaigns. This should include both the weekly low-risk consumption guidelines and the guidelines around drinking in pregnancy.**

d. Better support for at-risk drinkers:
    i. **Improve access to treatment through an additional £170 million per year investment in specialist treatment.**
    ii. **Establish consultant-led seven-day Alcohol Care Teams in each district hospital, with an Assertive Outreach Treatment team targeting high need, high cost alcohol-related frequent attenders.**
    iii. **Develop an Alcohol Workforce Strategy, including at least 60 addiction psychiatry training posts.**

Introduction

1. We welcome the development of the Prevention Green Paper, which provides a timely opportunity to address some of the biggest causes of preventable harm and re-focus society away from treating illness to supporting healthier, happier lives. It could help to reduce health inequalities and narrow the gap between the experience of the richest and poorest citizens.

2. To achieve this prevention vision, it is paramount that all preventable causes of ill-health are considered. This includes the harm caused by alcohol – one of the

major drivers of premature mortality, health inequalities, physical and mental ill-health.

3. The impact of alcohol is, however, largely absent from the Green Paper, even though the paper notes that alcohol harms are rising. Indeed, alcohol harms are major preventable contributors to our nation's ill-health.

    a. Alcohol has become the leading risk factor for death among 15-to-49-year-olds.[6] According to NHS Digital, over 20% of adults are drinking at levels that increase the risk of a range of conditions, including heart disease, stroke, cancer, mental ill health and dementia.

    b. Liver disease is the only major cause of death which is increasing: in England, liver disease deaths have increased 400% since 1970,[7] and liver disease now kills more people than diabetes and road deaths combined.[8] In 1999, liver disease surpassed lung cancer and breast cancer as a leading cause of years of working life lost and is set to overtake ischaemic heart disease within two-three years.[9]

    c. With more than 1.1 million alcohol-related hospital admissions every year, alcohol places undue strain on our health services.[10] Unless trends are reversed, it is projected to cost the NHS £17 billion over the next five years.[11]

    d. Alcohol causes harm disproportionately to poorer communities and excluded groups and exacerbates health inequalities: despite consuming less alcohol on average than more affluent groups, men in routine occupations are 3.5 times and women 5.7 times more likely to die of an alcohol-related ailment than those in higher and managerial occupations.[12] Similarly, there are significant regional differences within England on alcohol-related mortality and hospital admissions. The best alcohol health outcomes occur mainly in the south of England and the worst predominantly in the North East and North West.[13]

4. The negative effects of alcohol have an impact far beyond individual drinkers. The government estimate for the social and economic costs of alcohol was £21 billion in England in 2012,[14] with PHE more recently highlighting estimates between £27 billion to £52 billion in 2016.[15] PHE note that "the financial burden which alcohol-related harm places on society is not reflected in its market price,

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[6] PHE (2016) The public health burden of alcohol and the effectiveness and cost-effectiveness of alcohol control policies
[7] Department of Health, PHE (2017) Adult substance misuse statistics from the National Drug Treatment Monitoring System
[8] British Liver Trust, Facts about liver disease
[9] Office for National Statistics (2017) The 21st century mortality files - deaths dataset, England and Wales
[10] Public Health England (2017) Health matters
[11] Foundation for Liver Research (2017) Financial case for action on liver disease
[12] Siegler, V et al (2011) Social inequalities in alcohol-related mortality by National Statistics socio economic classification, England and Wales, 2001-2003, ONS Health Statistics Quarterly, 50.
[13] Public Health England (2018) Local Alcohol Profiles for England
[14] Home Office (2012) A minimum unit price for alcohol – impact assessment
[15] PHE (2018) PHE Research 2016 to 2017: annual review

with taxpayers picking up a larger amount of the overall cost of harm compared to individual drinkers".[16]

a. More working years of life are lost through alcohol than through the ten most common cancers combined.[17] The UK Government's official estimate suggests that alcohol costs the British economy £7.3 billion a year, through: (1) the loss of working age people from the labour force due to premature death, (2) higher unemployment among heavy drinkers and (3) higher rates of sickness absence due to alcohol consumption.[18] This does not include presenteeism: the cost to the economy of workers who make it in to work, but are less productive once they get there due to their drinking (either because they are intoxicated or hungover). A 2019 report by the Institute of Alcohol Studies estimated this cost to be between £1.2 billion and £1.4 billion a year.[19]

b. Drink-driving was estimated to be responsible for 230 deaths and 9,040 casualties in Great Britain in 2016, an increase on the previous year.[20] Alcohol is also a major driver in crime and anti-social behaviour, with 40% of violent crime and 28% of domestic violence linked to alcohol.[21]

5. Moreover, alcohol impacts negatively on children and families. Harm to children can begin with maternal alcohol consumption, resulting in Foetal Alcohol Spectrum Disorder, causing problems ranging from reduced intellectual ability and ADHD to heart problems.[22]

a. Data from Public Health England has shown that approximately 200,000 children under 16 live with a dependent drinker and a further 308,000 children nationally live with an increasing risk drinker.[23] Compared with other children, children of dependent drinkers are twice as likely to experience difficulties at school, three times more likely to consider suicide, and five times more likely to develop eating disorders.[24]

6. The wider environment has an enormous influence on individuals' behaviour. Targeted interventions which create a healthier environment by reducing demand are essential to prevent alcohol harm and reduce health inequalities.

7. The UK Government has supported a goal to reduce harmful alcohol consumption by 10% by 2025 as part of the WHO's global NCD targets following

[16] PHE (2016) The public health burden of alcohol and the effectiveness and cost-effectiveness of alcohol control policies
[17] PHE (2016) The public health burden of alcohol and the effectiveness and cost-effectiveness of alcohol control policies
[18] Home Office (2012) A Minimum Unit Price for Alcohol Impact Assessment. London: Home Office.
[19] Institute of Alcohol Studies (2019) Financial Headache, the cost of workplace hangovers and intoxication to the UK economy.
[20] Department for Transport (2018) Reported road casualties in Great Britain, final estimates involving illegal alcohol levels: 2016
[21] ONS (2018) Nature of crime tables, violence. Table 3.10
[22] National Organisation for Foetal Alcohol Syndrome UK, FASD Overview
[23] Pryce, R. et al (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
[24] APPG on Children of Alcoholics (2017) A manifesto for change

the Political Declaration on NCDs at the UN General Assembly in 2011. Bold evidence-based action is needed to achieve this ambition.

a. The 2016 Public Health England (PHE) Evidence Review on the effectiveness and cost-effectiveness of alcohol control policies provides the most recent and solid evidence base to guide alcohol policy decisions. The review has been rigorously peer reviewed by international experts and published in the *Lancet*. Evidence outlined in the PHE Review is yet to be translated into formal recommendations for government action. We believe the Prevention Green Paper should draw upon the work of PHE.

b. The World Health Organisation (WHO) recommends three evidence-based 'best buy' policies as the most effective and cost-effective way for governments to reduce alcohol harm. These are policies to address the affordability, availability and promotion of alcohol.[25]

Improving health and wellbeing by tackling the affordability of alcohol

8. Alcohol has become increasingly affordable in recent years, especially in the off-trade. Beer in supermarkets and off-licences is now 188% more affordable in real terms than in 1987.[26]

9. The 2012 Alcohol Strategy recognised that "cheap alcohol is too readily available and industry needs and commercial advantages have too frequently been prioritised over community concerns".[27] Since that was published in 2012, off-trade beer has become 22% more affordable.

10. The 2012 Strategy went on to note that "there is strong and consistent evidence that an increase in the price of alcohol reduces the demand for alcohol".[28] Reducing the affordability of alcohol has been described by NICE as "the most effective way of reducing alcohol-related harm".[29] PHE notes that policies reducing affordability "are the most effective, and cost effective, approaches to prevention and health".[30]

11. One of the best ways to reduce the affordability of alcohol is by introducing minimum unit pricing (MUP). MUP sets a floor price based on the amount of alcohol a product contains, thus reducing the affordability of the cheapest products that are linked to the worst harms.

[25] WHO (2017) 'Best buys' and other recommended interventions for the prevention and control of noncommunicable diseases
[26] Institute of Alcohol Studies (2018) The rising affordability of alcohol
[27] HM Government (2012) The Government's alcohol strategy
[28] Ibid
[29] NICE (2010) Alcohol-use disorders: preventing the development of hazardous and harmful drinking Public health guidance 24
[30] PHE (2016) The public health burden of alcohol and the effectiveness and cost-effectiveness of alcohol control policies

a. In the first five years alone, a 50p MUP in England is estimated to save 1,148 lives, reduce hospital admissions by 74,471, and cut health care costs by £326 million.[31]

b. These benefits are targeted at those who suffer most from alcohol-related illness: routine or manual worker households, who account for around 41% of the population, would make up around 80% of reductions in deaths and hospital admissions resulting from the introduction of MUP.[32]

c. MUP is highly targeted to have the greatest impact on drinkers who drink at a harmful level, whilst having only a minimal impact on moderate drinkers. Harmful drinkers on low incomes are estimated to purchase, on average, more than 60 units per week below 50p per unit, compared to moderate drinkers of all incomes, who purchase fewer than two units per week below this level.[33]

d. MUP has been introduced in Scotland in May 2018 and will be implemented in Wales in early 2020. The initial figures from the Scottish official evaluation on the amount of alcohol sold per adult are encouraging and suggest the policy is having a real impact: average consumption of alcohol fell by 3% in 2018 in Scotland, to the lowest level in 25 years. At the same time, consumption increased by 1.5% in England and Wales, where MUP is not in place. The figures are particularly encouraging given that MUP was only introduced on 1 May, four months into the year, and the fact that the 2018 summer was an extraordinary one, which according to the trade press pushed up alcohol sales across the UK.[34]

e. A recent study published in the BMJ found that MUP appears to have been successful in reducing the amount of alcohol purchased and, by inference, consumed by households. The introduction of MUP was followed by a reduction of 1.2 UK units in weekly off-trade purchases of alcohol per adult per household.[35] The effects were greatest in households who bought the most alcohol, suggesting that the policy "has achieved its ambition to make relatively cheap and strong alcohol less affordable, which in turn should positively impact public health over time".[36]

12. PHE and the World Health Organisation also recommend increasing alcohol taxes as one of the most effective and cost-effective ways to reduce alcohol harm.

    a. The Alcohol Duty Escalator, which saw alcohol duty rise 2% above inflation each year from 2008-2013, contributed to reversing harmful

[31] Angus, C. et al. (2016) Alcohol and cancer trends: Intervention Studies..
[32] As reported in IAS, Alcohol health inequalities and harm paradox summary briefing
[33] Sheffield Alcohol Research Group, Frequently Asked Questions
[34] NHS Health Scotland (2019) MESAS Monitoring Report 2019
[35] O'Donell et al (2019) Immediate impact of minimum unit pricing on alcohol purchases in Scotland: controlled interrupted time series analysis for 2015-18. BMJ 366:l5274.
[36] O'Donell et al (2019) Immediate impact of minimum unit pricing on alcohol purchases in Scotland: controlled interrupted time series analysis for 2015-18. BMJ 366:l5274.

alcohol trends in the UK.[37] Under the duty escalator, affordability began to fall for the first time in years, as did the number of alcohol-related deaths. When it was scrapped, both measures began to rise again.

b. Modelling by the University of Sheffield found that cuts in alcohol duty since 2012 have led to 2,223 additional deaths and almost 66,000 additional hospital admissions in England and Scotland between 2012 and 2019. This has resulted in £341 million additional costs to the NHS.[38]

c. The same report also shows that above inflation increases in alcohol duty, starting from the forthcoming Budget could have dramatic benefits: Increasing alcohol duty by 2% above inflation every year between 2020 and 2032 would result in 5,120 fewer alcohol-attributable deaths in England and Scotland.[39]

Key recommendations:

- **Introduce a minimum unit price for alcohol.**
- **Increase alcohol excise duty by 2% above inflation every year.**

Improving health and wellbeing by addressing the availability of alcohol

13. Increased alcohol outlet density is associated with increased harm. Research from Scotland found that neighbourhoods with the most outlets had twice as many alcohol-related deaths and four times as much crime, compared to neighbourhoods with the fewest outlets.[40]

14. Extended hours of sale are also linked to increased rates of consumption and harm, particularly in the late-night hours. The introduction of 24-hour licensing in England and Wales has been associated with increases in hospital admissions in some areas and a shift in crime and disorder to later in the evening.[41] Emergency service workers also reported a strain on resources.[42]

    a. Conversely, restricting hours of sale has been linked to reductions in violence and assaults. In Australia, laws introduced in 2014 to restrict sales in parts of Sydney after 3am were associated with a 49% reduction in non-domestic assaults in those areas by 2016.[43]

15. Empowering local authorities to control alcohol availability, both through outlet density and hours of sale, can help to reduce harm. Introducing a fifth licensing objective in England, to address the health harms associated with the sale of alcohol (as exists in Scotland), would enable health bodies to make more effective representations in licensing decisions based on the health needs of their local communities.

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[37] Sheron, N. (2016) Alcohol-related liver disease: prevention and prediction.
[38] Angus, C & Henney, M (2019), Modelling the impact of alcohol duty policies since 2012 in England & Scotland.
[39] Angus, C & Henney, M (2019), Modelling the impact of alcohol duty policies since 2012 in England & Scotland.
[40] Alcohol Focus Scotland and CRESH (2018) Alcohol outlet availability and harm in Scotland
[41] PHE (2016) The public health burden of alcohol and the effectiveness and cost-effectiveness of alcohol control policies
[42] Institute of Alcohol Studies (2015) Alcohol's impact on emergency services
[43] New South Wales Bureau of Crime Statistics and Research (2016) 'Lock-outs, last drinks and alcohol related violence in Sydney'

Key recommendations:

- **Include public health as an additional licensing objective.**
- **Introduce greater powers for local authorities to control when and where alcohol can be sold (for example, by reversing the presumption to approve a new license).**

Improving health and wellbeing by reducing alcohol promotion and increasing Information

16. There is extensive evidence that exposure of children and young people to alcohol marketing leads them to drink at an earlier age and to drink more than they otherwise would.[44]

    a. Research shows that 10-15-year-olds see more alcohol advertising on television than adults aged 25 and over.[45] A survey of Scottish primary schools found that children as young as 10 could readily identify alcohol brands, logos, and characters from alcohol advertising on TV. Nine out of ten children recognised the beer brand 'Foster's', a higher recognition rate than for leading brands of crisps, biscuits and ice-cream.[46]

    b. The regulatory system and codes of conduct for alcohol advertising, overseen by the Advertising Standards Authority (ASA) and the Portman Group, have been criticised for failing to protect young people. 29% of participants in a study of UK alcohol TV adverts felt that at least one advert they saw breached the ASA rule that they 'must not appeal strongly to people under 18 … reflecting or associated with youth culture or showing adolescent or juvenile behaviour'.[47] The government should establish a thorough review of alcohol marketing regulation and establish an independent regulator, operating on a statutory basis.

    c. According to the WHO, the best and most cost-effective way to protect children and young people from marketing is a ban on alcohol advertising across multiple media.[48] There are international examples of good practice, such as in France, where alcohol advertising and sponsorship is banned on TV and radio. Alcohol advertising is only permitted in adult print media and limited to descriptive qualities of the product, such as strength and provenance, accompanied by a health warning.[49]

    d. If the government will not consider a complete ban, it should put in safeguards to reduce the exposure of young people to alcohol marketing. This should include a 9pm watershed for TV advertising and restricting

[44] PHE (2016) The public health burden of alcohol and the effectiveness and cost-effectiveness of alcohol control policies
[45] Patil S et al. (2014) Youth exposure to alcohol advertising on television in the UK, the Netherlands and Germany
[46] Alcohol Focus Scotland (2017), Promoting good health from childhood. Reducing the impact of alcohol marketing on children in Scotland.
[47] Searle, R. et al. (2014) Do UK television alcohol advertisements abide by the code of broadcast advertising rules regarding the portrayal of alcohol?, Alcohol and Alcoholism, 49: 4, pp. 472–478
[48] WHO (2017) 'Best buys' and other recommended interventions for the prevention and control of noncommunicable diseases'
[49] Institute of Alcohol Studies Marketing factsheet

alcohol advertising in cinemas to films with an 18 certificate. There is already a comprehensive ban on tobacco advertising, and the government has consulted on new TV and online advertising restrictions on high fat, salt and sugar foods including a 9pm watershed. To fulfil the government's ambition of healthier homes and children being able to live happier, healthier lives, young people also need to be able to live lives free from alcohol marketing.

17. The Chief Medical Officers' (CMOs') guidelines recommend not to regularly consume more than 14 units of alcohol a week to keep risks low. The guidelines were based on two principles: (1) People have a right to accurate information and clear advice about alcohol and its health risks; (2) 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.

    a. However, awareness of the guidelines and health risks associated with alcohol remains low: only 19% of people are able to correctly identify the guidelines.[50] People of lower socio-economic status are less able to identify the guidelines, suggesting that insufficient communication of the guidelines could exacerbate health inequalities. The research also found insufficient knowledge of the health impacts of alcohol amongst the public, with only three in ten people linking alcohol and cancer without prompting.[51]

    b. The CMOs Expert Advisory Group suggested the guidelines should be communicated by government-backed media campaigns and through the inclusion of health warnings and consistent messaging on all alcohol advertising, products and sponsorship.[52] Currently, there is no legal requirement in the UK for alcohol products to carry the CMOs' guidelines. Evaluation of existing voluntary product labelling schemes shows that they are inadequate at informing consumers.[53]

    c. The PHE evidence review found that "labels increase knowledge and awareness" and that the "evidence supports a statutory approach".[54] This makes a strong case for the government to adopt the CMOs Expert Advisory Group's recommendations that the guidelines be communicated through the inclusion of health warnings on all alcohol advertising, products and sponsorship as well as through government-backed media campaigns.

18. Alcohol is also an important contributor to calorie consumption, and obesity: Alcoholic drinks can have a high calorie and sugar content: a unit of pure alcohol alone is 56 calories.[55] Additional ingredients can further increase calorie content:

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[50] AHA UK (2018) How we drink, what we think
[51] AHA UK (2018) How we drink, what we think
[52] Department of Health (2016) Alcohol guidelines review – report from the guidelines development group to the UK Chief Medical Officers
[53] AHA UK (2018) Our right to know: how alcohol labelling is failing consumers
[54] PHE (2016) The public health burden of alcohol and the effectiveness and cost-effectiveness of alcohol control policies
[55] Royal Society of Public Health (2014) Increasing awareness of 'invisible' calories from alcohol

a unit of an alcopop, for example, can be 144 calories.[56] To put this into context, a glass of wine can have the equivalent calories as a Cadbury's mini roll and a pint of beer can have the equivalent calories as a packet of crisps.[57]

a. Data from individuals taking part in Dry January indicates that their previous weekly consumption from alcohol is approximately 2,200 calories – about the equivalent of an adult's total daily recommended calorie intake.

b. At the same time, the large majority of UK adults are not aware of the calorie content of alcohol: 80% of people do not know or underestimated the number of calories in a large glass of wine.[58]

c. Despite this, the requirements for alcoholic drinks to carry adequate information on product labels are far less than for other products: there are no requirements to show nutritional information, nor any information about health risks such as cancer. To ensure people can make informed choices about how much they drink, information about calorie and nutrition information should appear on the labels of alcohol products. Consumers should not have to seek out this information, for example by scanning on-product barcodes or consulting websites or apps.

19. The CMO guidelines advise that the safest approach is not to drink any alcohol when pregnant or trying to conceive. However, more than 40% of women in the UK continue to drink during pregnancy and four times more children suffer alcohol-related birth defects than the global average.[59] The Royal College of Midwives also advises abstinence from alcohol in pregnancy and during breastfeeding.

    a. Recent research indicates that there are a number of barriers midwives encounter when providing the CMOs' advice. These include social influences, beliefs about the midwife's ability to provide advice, or an individual midwife not feeling that the advice will have any impact.[60]

    b. We recommend the development of best practice for midwives to give routine advice and guidance in a way most likely to change behaviour. Midwives should receive mandatory annual updates on best practice and CMO recommendations.

    c. Pregnant women and breastfeeding mothers receive advice from many sources, including from friends and family. Not all of this advice will be accurate. It is therefore important that advice from health professionals is consistent. Other groups (obstetricians, health visitors, GPs etc) should

[56] NHS, Alcohol support, calories in alcohol.
[57] NHS, Alcohol support, calories in alcohol.
[58] Royal Society of Public Health (2014) Increasing awareness of 'invisible' calories form alcohol
[59] Popova S et al (2017). Estimation of national, regional, and global prevalence of alcohol use during pregnancy and fetal alcohol syndrome: a systematic review and meta-analysis
[60] Institute of Alcohol Studies (2019) Alcohol Guidelines for pregnant women, barriers and enablers for midwives to deliver advice.

also be brought into this work, so that women receive a coherent message from all HCPs.

20. Even relatively low levels of parental alcohol consumption (less than the CMOs' low risk drinking guidelines) can lead to problematic parenting: disruptive home and school routines, poor social relationships and inconsistent parenting. A child who has seen their parent tipsy or drunk can be less likely to think that their parent is a positive role model.[61]

    a. It is therefore important that parents understand the importance of the negative impact that lower levels of alcohol consumption can have on children and families. The government should produce up-to-date information and advice for parents about parental drinking and this should be provided routinely by service providers and universal services including schools.

Key recommendations:

- **Review and reform the current regulatory system for alcohol marketing and establish an independent regulator.**
- **Restrict marketing practices to better protect children from alcohol advertising and promotion, including a 9pm watershed for television and restricting alcohol advertising in cinemas to those films with an 18 certificate.**
- **Adopt the CMOs Expert Advisory Group's recommendations that the low-risk drinking guidelines be communicated through the inclusion of health warnings on all alcohol advertising, products and sponsorship as well as through government-backed media campaigns.**

Improve health and wellbeing through better support for at-risk drinkers

21. The value of treatment in reducing alcohol harm is clearly acknowledged and successive government alcohol strategies have set out the clear need for effective alcohol treatment. According to PHE, every additional £1 invested in effective alcohol treatment brings an annual return of £3, which rises to £26 over 10 years.[62]

22. However, effective alcohol treatment for dependent drinkers has become increasingly difficult to access: PHE estimates that four in five of the 595,000 alcohol dependent people in England are not receiving treatment.[63]

    a. This lack of access to treatment is linked to funding issues. Since 2013, local authorities in England commission alcohol treatment from the public health grant. A Health Select Committee report showed that public health

[61] Institute of Alcohol Studies, Alcohol Focus Scotland, Alcohol and Families Alliance (2017) "Like sugar for adults" The effects of non-dependent drinking on children and families.
[62] Public Health England (2018) Public health matters blog: What we've learned from the latest alcohol and drug treatment statistics
[63] PHE (2017) Estimates of alcohol dependent adults and alcohol dependent adults living with children; Department of Health, PHE (2017) Adult substance misuse statistics from the National Drug Treatment Monitoring System

budgets have been cut every year since 2013, with alcohol and other drug services facing the biggest cuts; 72% of local authorities planned cuts to alcohol and other drug treatment services in 2016-17.[64] Across England, expenditure on treatment has fallen by 18% (£162 million) between 2013/14 and 2016/17.[65]

b. Research carried out for the fifth Lancet Standing Commission on Liver Disease found that the level of access to treatment for alcohol dependence compared to those who need it in England is half that in Scotland and Wales.[66]

c. Responding to this currently unmet need will require a significant increase in treatment capacity: the government should aim to have the same proportion of access to treatment as in Scotland, which would require an additional £170 million annually.

d. Measures should be put in place, including consideration of allocating these funds to NHS commissioners, to ensure that local authorities do not use the additional funding to plug spending gaps elsewhere. Moreover, the funding must address health inequalities, through allocation according to need, which is largely in the areas with greatest deprivation.

23. We welcome the announcement made as part of the NHS Long Term Plan to invest in Alcohol Care Teams (ACTs) in the 50 most-affected hospitals. ACTs have been shown to be effective in improving health outcomes, reducing hospital admissions and saving money.[67] Once ACTs have been established in the most-affected hospitals, the rollout should continue to all district hospitals to ensure people everywhere have the same access to services.

    a. In order to be truly effective, an Alcohol Care Team should comprise the following seven elements:
        i. Consultant-led, multidisciplinary, patient-centred care, integrated across primary and secondary care;
        ii. A seven-day Alcohol Specialist Nurse Service;
        iii. Coordinated policies for the Emergency Department and Acute Medical Units
        iv. Addiction and Liaison Psychiatry Services;
        v. An Alcohol Assertive Outreach Service for frequent attenders to hospital;
        vi. Consultant hepatologists and gastroenterologists with expertise in liver disease;
        vii. Formal links with Local Authority, Clinical Commissioning Groups, Public Health, Patient Groups and other stakeholders.

[64] Health Select Committee (2016) Public health post 2013
[65] BBC News (2018) Drug and alcohol services cut by £162m as deaths increase.
[66] Williams R et al (2018) Gathering momentum for the way ahead: fifth report of the Lancet Standing Commission on Liver Disease in the UK. Lancet, in press.
[67] NICE (2016) Quality and Productivity Case Study: Alcohol Care Teams: reducing acute hospital admissions and improving quality of care British Society of Gastroenterology, Bolton NHS Foundation Trust

b. To provide a seven-day service, trusts should ideally have a minimum of four nurses, with liver and mental health expertise. A seven-day alcohol specialist nurse service is estimated to save £179,000 per annum per 100,000 population.[68] Implementation of an alcohol specialist nurse service in Nottingham improved the health outcomes and quality of care for detoxification and alcohol-related cirrhosis patients, resulting in a saving of 36.4 bed days per month in detoxification patients and a reduction in bed days used in the cirrhotic group from 6.3 to 3.2 days per month.[69]

24. The importance of a qualified workforce is often highlighted by service users as an essential aspect of recovery.[70] The PHE evidence review states that "the skills and personal quality of the person delivering the treatment can be an important predictor of treatment success".[71]

    a. Yet, the Advisory Council on the Misuse of Drugs found that the current workforce is "not fit for purpose" and that this was "one of the most significant barriers to recovery". The report identified an erosion of clinical expertise and an over-reliance on volunteers and peer mentors, and recommended a national review of the treatment workforce.[72]

    b. A survey of training in addiction psychiatry by the Royal College of Psychiatrists similarly found that there had been a 60% reduction in trainees between 2006 and 2016. Whilst there were 52 senior trainees in England in 2006, by 2016, there were just 21 such posts.[73]

    c. We recommend that Health Education England, Public Health England and the Department for Health and Social Care develop an Alcohol Workforce Strategy. The Royal College of Psychiatrists has called for at least 60 addiction psychiatry training posts in England.[74] Similar targets need to be defined for other professions, including nursing and clinical psychology.

25. There are strong links between harmful alcohol consumption and poor mental health. Alcohol is a depressant and can lead to long-term mental health issues, and mental health issues can also lead to heavy drinking to cope with symptoms. The links between alcohol and mental health have repercussion outside treatment – for example, for the police and justice system and in A&E.

    a. Dual diagnosis can leave harmful drinkers caught in the system without any support at all. Tackling alcohol harms and mental health problems in a

[68] NICE (2016) Quality and Productivity Case Study: Alcohol Care Teams: reducing acute hospital admissions and improving quality of care. Provided by the British Society of Gastroenterology and Bolton NHS Foundation Trust
[69] Ryder SD, Aithal GP, Holmes M et al. Effectiveness of a nurse-led alcohol liaison service in a secondary care medical unit. Clinical Medicine 2010; 10 (9): 435–40.
[70] PHE (2018) Public Health England inquiry into the fall in numbers of people in alcohol treatment: findings
[71] Martin G, Rehm J. The effectiveness of psychosocial modalities in the treatment of alcohol problems in adults. Can J Psychiatry. 2012;57(6):350-8, cited in PHE (2016) The Public Health Burden of Alcohol
[72] ACMD (2017) Commissioning impact on drug treatment p.26
[73] Drummond, C. (2017) Cuts to addiction services are a false economy. British Medical Journal, 357:j2704
[74] Drummond, C. (2017) Cuts to addiction services are a false economy. British Medical Journal, 357:j2704

way that recognises their mutually reinforcing relationship can help address health inequalities.

b. Specific recommendations as outlined by the Institute of Alcohol Studies and Centre for Mental Health in their 2018 report, 'Alcohol and Mental Health', include[75]:
    i. DHSC, NHS England and Public Health England to review funding of addiction services and support provision to people with co-occuring mental health conditions.
    ii. STPs and emergent Integrated Care Systems to develop plans to improve support for people with co-occurring mental health and alcohol problems.
    iii. Local suicide prevention plans to include action to address links between alcohol misuse, deliberate self-harm and deaths by suicide.
    iv. Trainee psychiatrists to receive training and undertake placements in addiction services.
    v. Alcohol liaison services in general hospitals to identify harmful drinkers and refer them to appropriate support.
    vi. Improving Access to Psychological Therapies programme/CCGs to ensure that people with co-occurring harms are not excluded from psychological therapy services.
    vii. DHSC/PHE to commission anti-stigma campaign
    viii. Funding for economic analysis of the costs of comorbidity of alcohol and mental health difficulties.

26. Local pharmacies can be ideally placed to make interventions that affect health inequalities. Specifically, pharmacies can develop a long-term relationship with people who might not otherwise be reached by technology-based campaigning. Decisions that may affect the size and shape of the pharmacy network should take into account its potential as a strategic asset.

    a. Local pharmacists know their customers and may be able to identify changes in behaviour implying more risky alcohol consumption (for example, following a bereavement). However, not all pharmacies have a layout conducive to confidential conversations.

    b. The public health campaigns that are agreed by the Pharmaceutical Services Negotiating Committee (PSNC) and NHS England should include an alcohol-related campaign no less frequently than annually (we note that there will be a campaign in January 2020).

    c. The evidence base to support the delivery of alcohol identification and brief advice (IBA) in pharmacies is under-developed, although individual projects have had promising results. Community pharmacies could be encouraged to deliver IBA to certain groups, such as people with hypertension.

[75] Institute of Alcohol Studies, Centre for Mental Health (2018), Alcohol and Mental Health. Policy and Practice in England

27. Additional targeted interventions which can support harmful and at-risk drinkers, include
    a. Alcohol Intoxication Management Services (booze buses, drunk tanks, safe havens) that are evidence-based and divert alcohol-related demand from A&E.

    b. Updated guidance within the Mental Capacity Act so that definitions can be applied to heavy/alcohol dependent drinkers where appropriate.

    c. 'Blue light' training for change-resistant drinkers aimed at staff in non-alcohol specialist front line services.

    d. Ensuring that alcohol is mentioned in every Health Check conversation. Alcohol consumption increases the risk for developing stroke, heart disease, type 2 diabetes and dementia; all conditions the NHS Health Check aims to prevent. However, currently Health Care Professionals (HCPs) often do not have adequate training in raising alcohol consistently. There is evidence that the topic is not always addressed, especially where the HCP feels embarrassment.[76] Moreover, the CMOs' advice is not always communicated to or understood by HCPs. We propose that clearer guidance is issued, together with a new requirement to record patients' responses to this part of the Health Check conversation. The latter would ensure that HCPs will have to raise the issue with every patient.

    e. Extending Alcohol Identification and Brief Advice (IBA) opportunities, including, where appropriate, in pharmacies.

    f. Alcohol-related deaths are highest among those aged 55-69 and alcohol-related admissions to hospital for those over-65s have risen by 14% in the last 10 years. Despite this, there is evidence of age discrimination in alcohol treatment services: Many alcohol rehabs have arbitrary age cut-offs and support services do not take into account the needs of older people. We need action against such age inequalities in existing services and develop a range of specialist services to support older adults who drink. This can include offering home visits for those who are unable to travel to the treatment centre.

Key recommendations:

- **Improve access to treatment through an additional £170 million per year investment in specialist treatment.**
- **Establish consultant-led seven-day Alcohol Care Teams in each district hospital, with an Assertive Outreach Treatment team targeting high need, high cost alcohol-related frequent attenders.**
- **Develop an Alcohol Workforce Strategy, including at least 60 addiction psychiatry training posts.**

[76] PHE commissioned research

About the Institute of Alcohol Studies

The Institute of Alcohol Studies is an independent institute bringing together evidence, policy and practice from the UK and elsewhere to promote an informed debate on alcohol's impact on society. Our purpose is to advance the use of the best available evidence in public policy decisions on alcohol.

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