Call for evidence: Toxic Trio: Response from the Institute of Alcohol Studies

The Institute of Alcohol Studies (IAS) is an independent institute bringing together evidence, policy and practice from home and abroad 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. For more information, visit www.ias.org.uk.

A note on terminology: considering the stigma associated with substance use, mental health difficulties, and domestic violence, IAS are conscious that terminology such as 'toxic trio' can contribute to such stigma, refers instead to people experiencing multiple vulnerabilities, and encourages the London Assembly to adopt this language.

1. **Addressing the social, economic and political determinants of domestic violence, mental health difficulties, and alcohol use disorders**

Alcohol use is linked in multiple ways to both domestic violence and mental health difficulties.

Alcohol use can impact a person's mental health, and alcohol use disorders have been linked to a range of mental health difficulties including depression, bipolar disorder,[1] and antisocial personality disorder.[2] Indeed, more than 200,000 hospital admissions "for mental and behavioural disorders due to alcohol use" to English hospitals were made in 2014/15 – this represents almost a fifth (19%) of all alcohol-related hospital admissions here.[3] Alcohol use also may slow a person's recovery from co-occurring mental health difficulties.[4] Further, a person's relationship with alcohol may be impacted by their experiences of mental health difficulties; the University of Stirling note that "mental ill health can...lead to problem drinking."[5]

While alcohol is not a cause of domestic abuse, evidence suggests it is a compounding factor. The World Health Organisation suggest:

> "Alcohol consumption, especially at harmful and hazardous levels is a major contributor to the occurrence of intimate partner violence and links between the two are manifold."[6]

Indeed, repeated research has suggested that a substantial portion of domestic violence perpetrators have been drinking at the time of their assault – estimates range from 25% to 73%.[7, 8] Cases of severe violence have been found to be twice as likely as others to

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[1] Public Health England. 2016. The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An evidence review. pp. 53-54.
[2] Moeller, F.G., Dougherty, D.M. 2001. Antisocial Personality Disorder, Alcohol, and Aggression. National Institute on Alcohol Abuse and Alcoholism (NIAAA).
[3] Public Health England. 2016. The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An evidence review. p. 49.
[4] Greenfield, T.K. Individual Risk of Alcohol-Related Disease and Problems, Chapter 21 in Heather, N., Peter, T.J., Stockwell, T. (eds). 2001. International Handbook Alcohol Dependence and Problems, John Wiley & Sons Ltd, pp. 413–439.
[5] University of Stirling. 2013. Health First: an evidence-based alcohol strategy for the UK. p. 14.
[6] The World Health Organisation. 2006. Intimate partner violence and alcohol. https://www.who.int/violence_injury_prevention/violence/world_report/factsheets/fs_intimate.pdf. p. 1.
[7] Bennett L., and Bland P. Substance Abuse and Intimate Partner Violence. National online recourse centre on violence against women.
[8] Gilchrist E., Johnson R., Talriti R., Weston S., Beech A., and Kebbell M. 2003. Domestic Violence offenders: characteristics and offending related needs, Findings, 217. Home Office.

involve alcohol,[9] while the presence of an alcohol or substance use disorder in a relationship has been found to mean that domestic abuse is more likely than not to occur.[10]

Research examining alcohol-related health harms has revealed substantial inequalities in their distribution. Lower socioeconomic status has been found to be "associated with higher mortality for alcohol-attributable causes, despite lower socioeconomic groups often reporting lower average levels of alcohol consumption."[11] Indeed, as was noted in the 2010 Marmot Review of Health Inequalities in England, "Alcohol-related hospital admissions were 2.6 times higher amongst men and 2.4 times higher amongst women in the 20% most deprived areas compared to the 20% least deprived areas."[12] The London Assembly should consider that similar inequalities may be present regarding other alcohol-related harms, such as these discussed throughout this submission.

It is well established that population levels of alcohol-related harm are affected by a number of social, economic and political factors: in particular, the price, availability, and marketing of alcohol. These are also the levers the London Assembly ought to seriously consider to protect the health and wellbeing of London residents – particularly those experiencing multiple vulnerabilities.

Firstly, according to NICE, making alcohol less affordable is "the most effective way of reducing alcohol related harm",[13] while the World Health Organisation recommends increasing taxes as a "best buy" policy to tackle alcohol harm.[14] Indeed, alcohol price increases have repeatedly been demonstrated to be associated with reductions in domestic violence and sexual assault levels.[15, 16, 17] It is concerning therefore that alcohol has become dramatically more affordable over the last 30 years[18] – off-trade beer and wine are 188% and 131% more affordable respectively than in 1987.[19] While the London Assembly is not involved in national taxation and alcohol pricing policy, there are still steps that can be taken. Regional initiatives can be powerful tools, such as the Reducing the Strength scheme deployed successfully in Suffolk targeting the most high-strength (often cheapest) products through a voluntary agreement with local license holders; this scheme saw a 25% decrease in the number of calls to the police concerning street drinking.[20] The scheme has also been deployed successfully elsewhere.[21]

Secondly, rates of violence have been linked with the physical and temporal availability of alcohol. Alcohol Focus Scotland and Centre for Research on Environment, Society and Health (CRESH) at the Universities of Edinburgh and Glasgow found crime rates, including violence and sexual offences, "were consistently and significantly higher in areas with more alcohol outlets. This relationship was found for total outlets, on-sales outlets and off-

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[9] McKinney, C.M., Caetano, R., Harris, T.R. and Ebama, M.S. 2009. Alcohol availability and intimate partner violence among US couples. Alcoholism: Clinical and Experimental Research, 33(1), pp.169-176.
[10] Galvani S. 2010. Supporting families affected by substance use and domestic violence. p. 5.
[11] Institute of Alcohol Studies. 2014. Alcohol, Health Inequalities and the Harm Paradox: why some groups face greater problems despite consuming less alcohol. p. 5.
[12] Marmot M. 2010. Fair Society, Healthy Lives. The Marmot Review. p. 57.
[13] NICE. 2010. Alcohol-use disorders: prevention. NICE Public Health Guidance 24.
[14] World Health Organisation. 2018. Alcohol.
[15] Patra, J., Giesbrecht, N., Rehm, J., Bekmuradov, D. and Popova, S. 2012. Are alcohol prices and taxes an evidence-based approach to reducing alcohol-related harm and promoting public health and safety? A literature review. Contemporary Drug Problems, 39(1), pp.7-48.
[16] Markowitz, S., 2000. The price of alcohol, wife abuse, and husband abuse. Southern Economic Journal, pp.279-303.
[17] Markowitz, S., 2000. Criminal violence and alcohol beverage control: evidence from an international study (No. w7481). National Bureau of Economic Research.
[18] NHS Digital. 2017. Statistics on Alcohol.
[19] Institute of Alcohol Studies. 2018. The rising affordability of alcohol.
[20] Local Government Association. 2016. Reducing the strength: Guidance for councils considering setting up a scheme. p. 16.
[21] Local Government Association. 2016. Reducing the strength: Guidance for councils considering setting up a scheme.

sales outlets."[22] Similarly, incidence of assault and serious facial injuries requiring surgery reduced (the latter by 60%) in the two years following the introduction of trading hours restrictions in New South Wales.[23] Despite such evidence, temporal and physical availability of alcohol has increased in recent years. Home Office data show an 8% increase in licensed premises between 2008 and 2017,[24] as well as a 16% increase in 24-hour licenses.[25] As such, the London Assembly may consider what support they can provide to local authority public health teams in their role as a responsible authority in the Licensing process, particularly in supporting measures such as Cumulative Impact Policies ("designed to prevent the proliferation of licensed premises concentrating in a designated area by making it harder to obtain an alcohol licence in areas where there are high levels of alcohol-related problems"[26]).

Finally, not only has exposure to alcohol marketing been shown to increase consumption,[27] but regressive gendered stereotypes presented in alcohol advertising might harm mental wellbeing, perpetuate objectification of women, and normalise sexual harassment. An examination of internal alcohol industry marketing documents obtained by the Health Select Committee presents a concerning example of this:

> "…one of Carling's agencies goes as far as to develop a set of "Carling Commandments" for its male consumers…behaviours which are stereotypically associated with femininity are mocked ("Thou shalt never been [sic] seen at a 'musical'")…drunkenness is alluded to ("thou shalt never desert thy mates in drunken distress"), and, despite the CAP codes[28] clearly stating that "references to, or suggestions of, buying repeat rounds of drinks are not acceptable", these commandments state that "thou shalt never miss a round"."[29]

Further, a report from Scottish Health Action on Alcohol Problems and the Institute of Alcohol Studies suggested; "When marketing is targeted at women...the aim is to establish a link between alcohol and empowerment...Marketing targeted at men often depicts women as sexual objects...".[30] Alcohol marketing is currently governed through co-regulation and self-regulation, by the Advertising Standards Authority, Ofcom, and the Portman Group. However, the efficacy of this system has been questioned; Public Health England suggest that self-regulatory approaches like this fail to meet "their intended goal of protecting vulnerable populations"[31] and that tactics such as "promoting ineffective voluntary codes and non-regulatory initiatives…are similar to the strategies used by the tobacco industry"[32]. As such, the London Assembly may consider deployment of measures like alcohol advertising restrictions on public transport. This would fit with the strategies

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[22] Alcohol Focus Scotland and CRESH. 2018. Alcohol Outlet Availability and Harm in Scotland. p. 8
[23] 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
[24] Home Office and ONS. 2017. Alcohol and Late Night Refreshment Licensing England and Wales. Table 1.
[25] Home Office and ONS. 2017. Alcohol and Late Night Refreshment Licensing England and Wales. Table 1.
[26] The Institute of Alcohol Studies. 2018. Driving factors of alcohol-related crime. p. 3.
[27] Stead, M., Angus, K., Macdonald, L., and Bauld, L. 2014. Looking into the Glass: Glassware as an Alcohol Marketing Tool, and the Implications for Policy. Alcohol and Alcoholism, 49: 3, pp. 317–320; University of Sheffield. 2008. Modelling alcohol pricing and promotion effects on consumption and harm. Independent Review of the Effects of Alcohol Pricing and Promotion, Part B; Nakamuraa, R., Pecheya, R., Suhrckea, M., Jebba, S., Marteau, T. 2014. Sales impact of displaying alcoholic and non-alcoholic beverages in end-of-aisle locations: An observational study. Social Science and Medicine, 108, pp. 68–73; Brown, K. 2016. Association Between Alcohol Sports Sponsorship and Consumption: A Systematic Review. Alcohol and Alcoholism, 2016, pp. 1–9.
[28] Codes governing the marketing of alcohol.
[29] 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. 28.
[30] SHAAP and IAS. 2018. Women and Alcohol: Key Issues. p. 7.
[31] 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.
[32] Public Health England. 2016. op. cit. p. 109.

deployed and planned in many international settings, including Israel, Western Australia and New York.[33]

2. Ensuring equal access to support

There is reason to believe these individuals experiencing multiple vulnerabilities are highly likely to be excluded from support services, as evidence suggests alcohol use disorders can restrict a person's ability to access treatment for any mental health difficulties or refuge spaces in cases of domestic violence.

Co-occurring alcohol misuse and mental health difficulties have long been recognised as a barrier to effective help from statutory services in the UK. In 2018, the Institute of Alcohol Studies and Centre for Mental Health surveyed workers in both alcohol and mental health treatment fields, finding:

> "that most staff, in both alcohol and mental health services, felt that support for people with co-occurring conditions was poor…[and] that trust and understanding between alcohol and mental health services were weak..."[34]

Similarly, access to domestic violence refuges is limited for women with co-occurring alcohol use problems. Research from AVA and Solace Women's Aid found that 61% of London boroughs only 'sometimes accept' women who use alcohol or drugs into their refuges, while two boroughs exclude them entirely.[35]

Exclusion is made more likely still by the sustained funding shortages experienced by alcohol treatment services. While alcohol treatment services have been underfunded and unable to meet need for many years,[36] the recent removal of the ring fence for alcohol treatment service funds within local authority public health grants has only served to worsen this. A 2018 survey of service users and professional stakeholders found that "only 12% of respondents felt resources were sufficient in their area."[37] This has 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." [38] Those experiencing multiple vulnerabilities are likely to feel these cuts sharply as attempts to cut costs through "payment by results" models in some local authorities leaves those with complex needs overlooked in favour of patients who represent quicker wins.[39]

Other groups have been highlighted as having restricted access to alcohol treatment services:

- Particularly relevant to this inquiry are the experiences of women with multiple and complex needs. Research has found that only 19 of 173 areas in England and Wales have "services for women that address all of the following issues: substance misuse, mental health, homelessness, offending and complex needs" and that in more than a quarter of all cases where such support does exist, it is provided for pregnant women or new mothers only. Further to this, there are very few specific

[33] Ynetnews. 2012. Alcohol advertising on billboards, buses banned; New York Times. 2017. M.T.A. Will Ban Alcohol Advertising on Buses and Subways; Australian Associated Press. 2018. WA to ban alcohol ads on public transport.
[34] Institute of Alcohol Studies and Centre for Mental Health. 2018. Alcohol and Mental Health: Policy and practice in England. p. 4.
[35] Against Violence and Abuse. 2014. Case by Case: Refuge provision in London for survivors of domestic violence who use alcohol and other drugs or have mental health problems.
[36] Alcohol Policy UK. 2010. 'Investing in alcohol treatment': Alcohol Concern calls for more support for dependent drinkers.
[37] Alcohol Concern / Alcohol Research UK. 2018. The Hardest Hit: Addressing the crisis in alcohol treatment services. p. 7.
[38] Drummond, C. 2017. Cuts to addiction services are a false economy.
[39] Drummond, C. 2017. Cuts to addiction services are a false economy.

services for addressing these multiple needs for Black and Minority Ethnic women, and "none identified specifically for LBTQI, those with disabilities, or for refugees and asylum seekers."[40]

- Recent research examining "how LGBT people experience and understand alcohol consumption in Scotland"[41] emphasised "a range of barriers for LGBT people who needed to access alcohol services…[including] service providers assuming that all patients were heterosexual, and the perception that alcohol services and peer support groups would not provide a safe or welcoming space for LGBT people because they were 'macho' and 'intimidating'."[42] This is particularly concerning when it is considered that these communities have been highlighted as a target for alcohol marketing.[43]
- Similarly, older people also might experience barriers in accessing alcohol treatment services; Drink Wise Age Well found evidence of "age discrimination...including arbitrary age limits which prevent older adults accessing alcohol rehabs, younger clients being prioritised over older adults in terms of alcohol treatment, [and] older adults not being offered alcohol treatment because of their age…"[44] It is essential such barriers are identified and addressed.
- Research from Nacoa suggests that as many as "70% of [children of parents who drink too much] will try to hide their family's problems from the outside world"[45] – this leaves their parents' engagement in treatment services as one of few avenues through which these children can be identified for the support they need. If parents are excluded from treatment and support due to multiple vulnerabilities, these children are less likely to be identified as needing support themselves. The dual-diagnosis blind-spot therefore acts as a barrier to identification and intervention for children and families affected by these multiple vulnerabilities.

3. Improving quality and outcomes from support

Some policy interventions have been suggested to address the barriers to treatment already discussed. In particular, there have been repeated calls for funding[46, 47] for alcohol and mental health treatment services, as well as refuge spaces, which are properly equipped and trained to support patients experiencing these co-occurring difficulties, and to welcome and support those from previously underserved backgrounds.

Further to this however, it is also necessary to consider the families – children and adults – of these individuals and the support they require.

There are an estimated 189,119 children living with at least one alcohol-dependent adult in England, while 14,390 to 32,887 live with two.[48] This can have a substantial impact on children's wellbeing. Indeed, as the Alcohol and Families Alliance – a cross sector alliance of almost 40 organisations including the NSPCC, the Children's Society, and Adfam –

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[40] Agenda and AVA. 2017. Mapping the Maze: Executive Summary. p. 1.
[41] Emslie, C., Lennox, J.C. and Ireland, L., 2015. The social context of LGBT people's drinking in Scotland. Glasgow Caledonian University/Scottish Health Action on Alcohol Problems: Glasgow, UK. p. 7
[42] Ibid. p. 5
[43] Drabble, L., 2000. Alcohol, tobacco, and pharmaceutical industry funding: Considerations for organizations serving lesbian, gay, bisexual, and transgender communities. Journal of Gay & Lesbian Social Services, 11(1), p. 2.
[44] Drink Wise Age Well. 2017. Calling Time: Addressing ageism and age discrimination in alcohol policy, practice and research. p. 10.
[45] Nacao. n.d. Information for Professionals. p. 4.
[46] Institute of Alcohol Studies and Centre for Mental Health. 2018. Alcohol and Mental Health: Policy and practice in England. p. 4.
[47] Against Violence and Abuse. 2014.
Case by Case: Refuge provision in London for survivors of domestic violence who use alcohol and other drugs or have mental health problems.
[48] 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.

note, “the greatest impacts of familial drinking are often experienced by children.”[49] The Parliamentary Office of Science and Technology[50] report that parental alcohol misuse can cause "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"[51], while alcohol or substance misuse was implicated in almost two-thirds (61%) of care applications in England.[52] Further to this, the most common reason for calling Childline is parental alcohol use.[53] Even at low levels, consumption can affect parenting, seeing some children report their parent's low level drinking made them worried (11%) or embarrassed (18%).[54] Such embarrassment and stigma are barriers to these parents or children disclosing their situation and accessing support.[55] The Alcohol and Families Alliance have also highlighted the impact that another relative’s alcohol use disorder can have on other family members, including "financial problems, relationship issues, mental ill health, bereavement, and domestic abuse".[56] For example, almost half (47%) of grandparents caring for grandchildren have reported that this was because of parental drug or alcohol use;[57] these family members may not recognise themselves as carers and the rights this affords them, and so they and the children in their care are often not in receipt of the support they are entitled to.[58]

Considering this, the Alcohol and Families Alliance have suggested that the following interventions which may be relevant to the London Assembly are required:

- "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...”
- "Evidence-based support for families affected by alcohol available according to local need..."
- Further, they highlight the need for "evidence-based guidance on parental and family member drinking and its effect on children, including at low levels" as well as "the effective communication of the Chief Medical Officers’ alcohol guidelines, in particular the guidance on drinking in pregnancy and alcohol consumption by children."[59]

The IAS would similarly welcome these interventions.

[49] Alcohol and Families Alliance. 2018. Families First: An evidence-based approach to protecting UK families from alcohol-related harm. p. 4.
[50] Hedges, S. and Kenny, C. 2018. Parental Alcohol Misuse and Children. Parliamentary Office of Science and Technology.
[51] Alcohol and Families Alliance. 2018. Families First: An evidence-based approach to protecting UK families from alcohol-related harm. p. 5.
[52] Guy, J., Blessington, V. and Green, R. 2012. Three weeks in November... Three years on: Cafcass care application study 2012. Cafcass. p. 21.
[53] Mariathasan, J. and Hutchinson, D. 2010. Children talking to ChildLine about parental alcohol and drug misuse. NSPCC.
[54] 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.
[55] Adfam. 2012. Challenging Stigma: Tackling the prejudice experienced by the families of drug and alcohol users.
[56] Alcohol and Families Alliance. 2018. Families First: An evidence-based approach to protecting UK families from alcohol-related harm. p. 13.
[57] Lawson, D. and Raine, J. 2013. The Kinship Care Guide for England. Second Edition. Grandparents Plus.
[58] Adfam. 2017. “No-one judges you here” Voices of older people affected by a loved one’s substance use.
[59] Alcohol and Families Alliance. 2018. Families First: An evidence-based approach to protecting UK families from alcohol-related harm. p. 9.