Major conditions strategy call-for-evidence

Institute of Alcohol Studies response, June 2023

Would you like to answer questions about cardiovascular disease?	Yes	No
Would you like to answer questions about chronic respiratory diseases?	Yes	No
Would you like to answer questions about dementia?	Yes	No
Would you like to answer questions about musculoskeletal conditions?	Yes	No
Would you like to answer questions about cancer?	Yes	No
Would you like to answer questions about mental health?	Yes	No

[Questions on cardiovascular disease]

In your opinion, which of these areas would you like to see prioritised for CVD? (Select up to three)

- Preventing the onset of CVD through population-wide action on risk factors and wider influences on health (sometimes referred to as primary prevention)
- Stopping or delaying the progression of CVD through clinical interventions for individuals at high risk (sometimes referred to as secondary prevention)
- Getting more people diagnosed quicker
- Improving treatment provided by urgent and emergency care
- Improving non-urgent and long-term treatment and care to support the management of CVD

How can we successfully identify, engage and treat groups at high risk of developing CVD through delivery of services that target clinical risk factors (atrial fibrillation, high blood pressure and high cholesterol)?

N/A

[Questions on dementia]

In your opinion, which of these areas would you like to see prioritised for dementia? (Select up to 3)

- Preventing the onset of dementia through population-wide action on risk factors and wider influences on health (sometimes referred to as primary prevention)
- Delaying the progression of dementia through clinical interventions for individuals at high risk (sometimes referred to as secondary prevention)
- Getting more people diagnosed quicker
- Improving treatment provided by urgent and emergency care
- Improving non-urgent and long-term treatment and care to support the management of dementia

[Questions on tackling the risk factors for ill health]

Do you have any suggestions on how we can support people to tackle these risk factors?

- Yes
- No

How can we support people to tackle these risk factors? (Please do not exceed 500 words)

Alcohol is the leading risk factor for death, ill-health, and disability amongst those aged 15-49-year-olds in the UK.[1] Alcohol consumption is causally linked to over 200 diseases and injuries including alcohol-related brain damage, hypertension, stroke, and seven cancers.[2] The COVID-19 pandemic saw an increase in the number of higher risk drinkers, and the heaviest drinkers increasing their consumption the most. These changes will result in a significantly increased health and economic burden, but could be reduced with the below cost-effective alcohol control policies:[3]

Price

We welcome the move to a strength-based alcohol duty system but urge the government to go further by: increasing overall duty rates; setting the proposed cider rate at the same level as beer; and linking duty rates to automatically increase with inflation every year.

Evidence from Scotland and Wales has indicated that minimum unit pricing (MUP) has successfully reduced alcohol consumption and harm: household alcohol purchases have decreased by 7.7% and 8.6% respectively, in comparison to England,[4] and alcohol-specific deaths decreased by 13.4% in Scotland.[5] England should follow suit and introduce MUP to reduce hospitalisations and deaths.

Marketing

Exposure to alcohol marketing encourages children and young people to start drinking at an earlier age and engaging in riskier drinking habits,[6] and can trigger relapses for those with alcohol dependence. Including alcohol in the definition of 'unhealthy products' under the marketing regulations for products high in fat, sugar and salt would be a significant step forward.[7] The regulatory approach should be improved to reduce exposure and influence among the vulnerable.

Availability

Alcohol-related hospitalisations and deaths are directly linked to the density of licensed premises.[8] Making 'public health' a fifth licensing objective in England and Wales, as it is in Scotland, would ensure health was more broadly a part of local decision-making on alcohol availability.

Labelling

Over a third of alcohol labels still fail to provide the CMOs' low-risk guidelines.[9] A recent systematic review found that alcohol container labels with health messages, standard drink information and drink limit guidelines improve consumer knowledge, are well supported by the public, and have potential to decrease intentions to purchase or consume alcohol and actual alcohol consumption.[10]

Much of the public agrees that the government should be responsible for communicating alcohol-related health risks and harms.[11] The government should realise their 2020 commitment to consult on alcohol (calorie) labelling and expand the scope to include health warnings.

Treatment and support

Funding and resources for alcohol treatment and support must be provided, over and above what is promised in the Drug Strategy, based not only on the recent increases in higher risk alcohol consumption, but also considering that only 1 in 5 dependent drinkers are currently accessing treatment.[12] Resources for primary and secondary prevention, such as screening and brief interventions, should also be provided.[13]

[1] VizHub - GBD Results. (2019). Global Health Data Exchange, Institute for Health Metrics and Evaluation, University of Washington.

[2] World Health Organization. (2018). Fact sheets: alcohol.

[3] Public Health England. (2016). The public health burden of alcohol: evidence review. World Health Organization. (2017). Tackling NCDs: 'best buys' and other recommended interventions for the prevention and control of noncommunicable diseases.

[4] Anderson, P. et al. (2021). Impact of minimum unit pricing on alcohol purchases in Scotland and Wales: controlled interrupted time series analyses.

[5] Public Health Scotland. (2023). Evaluating the impact of alcohol minimum unit pricing (MUP) on alcohol-attributable deaths and hospital admissions in Scotland.

[6] Jernigan, D. et al. (2017). Alcohol Marketing and Youth Consumption: A Systematic Review of Longitudinal Studies Published Since 2008. *Addiction*.

[7] Department of Health and Social Care. (2018). Childhood obesity: a plan for action, chapter 2.

[8] Alcohol Focus Scotland and Centre for Research on Environment, Society and Health (2018). Alcohol Outlet Availability and Harm in Scotland. Glasgow: Alcohol Focus Scotland.

[9] Alcohol Health Alliance UK. (2022). Contents unknown: How alcohol labelling still fails consumers.

[10] Hobin, E., et al. (2022). Enhanced alcohol container labels: A systematic review. *Canadian Centre on Substance Use and Addiction.*

[11] Alcohol Health Alliance UK (2018). How we drink, what we think: Public views on alcohol and alcohol policies in the UK.

[12] House of Commons Committee of Public Accounts. (2023). Alcohol treatment services (54th report of session 2022-23).

[13] Institute of Alcohol Studies and Health Lumen. (2022). The COVID hangover: Addressing long-term health impacts of changes in alcohol consumption during the pandemic.

[Questions on supporting those with conditions: can answer for multiple conditions; CVD: CRDs; MSK conditions; dementia]

Do you have any suggestions on how we can better support local areas to diagnose more people at an earlier stage?

- Yes
- No

Suggestions for dementia

Professionals should be better aware of the link between long-term heavy drinking and alcohol-related dementia. Current research suggests that alcohol-related brain damage (ARBD) accounts for 10-24% of all cases of dementia, and Wernicke-Korsakoff (a condition similar to dementia caused by alcohol) is seen in around 12% of all dependent drinkers.[1]

Unlike Alzheimer's, ARBD is not progressive, and with the right treatment, symptoms of ARBD can improve greatly. 75% of people with ARBD who receive treatment do make some recovery.[2]

Targeted screening and alcohol care teams in hospitals can support earlier diagnosis. Clinicians should also be made better aware of ARBD and the diagnosis process. The below categories and factors can help professionals decide if someone has ARBD:[3]

- Problem with long- and short-term memory
- Reasoning problems
- Problems with impulse control
- History of drinking at least 35 units of alcohol a week for women, or 50 units a week for men, for a period of at least 5 years
- Prolonged cognitive impairment – long-term difficulties with thinking and reasoning
- Vitamin B1 (thiamine) deficiency

[1] Alcohol Change UK (accessed June 2023). Alcohol-related brain damage.

[2] Alcohol Change UK (accessed June 2023). Alcohol-related brain damage – diagnosis and treatment.

[3] Alcohol Change UK (accessed June 2023). Alcohol-related brain damage – diagnosis and treatment.

Do you have any suggestions on how we can better support and provide treatment for people after a diagnosis?

- Yes
- No

Suggestions for multiple conditions:

Staff should also be aware of the link between alcohol consumption being used to cope with stress and aim to reduce the normalisation of alcohol as a form of self-medication for dealing with stress and distress.[1]

[1] Institute of Alcohol Studies and Centre for Mental Health (2018). Alcohol and mental health: Policy and practice in England.

Do you have any suggestions on how we can better enable health and social care teams to deliver person-centred and joined-up services?

- Yes
- No

Suggestions for multiple conditions

The latest data indicate that in 2021, almost 6% (980,000) of all hospital admissions in England were alcohol related. Of these, 45% were for cardiovascular disease, 23% were for mental and behavioural disorders due to alcohol, and 10% were for cancer.[1] Alcohol care teams (ACTs) can reduce readmissions and bridge the gap between secondary and community care.[2] ACTs are teams of specialists (including a lead clinician, co-ordinated prevention and treatment policies, alcohol specialist nurses, addiction and liaison psychiatry, outreach, and hepatology services) that reduce acute hospital admissions, readmissions and mortality, and improve the quality and efficiency of alcohol care.[3] They are cost-effective across all four elements of alcohol-related harm: crime and social disorder, families and family networks, the workplace, and health.[4] Alcohol liaison services in

general hospitals can identify people who are drinking at high-risk levels and refer them to appropriate support from local services.

NICE quality statements have reinforced two principles that would help to integrate care. Firstly, 'everyone's job' indicates that both commissioners and service providers should be responsible for providing services for people with a dual diagnosis or complex needs. Secondly, 'no wrong door' underlines that service providers should not turn away people with co-occurring conditions and that treatment for any of the conditions should be available at every point of contact, known as Making Every Contact Count.[5]

Integrated Care Systems (ICSs) can play a crucial role in reducing alcohol-related harm by coordinating regular intelligence amongst local stakeholders including hepatology departments, community treatment services, local authorities and mental health services, to get more people who are drinking at higher or increasing risk support to cut down or stop altogether. ICSs should make tackling alcohol related harm a priority, e.g., setting targets for reducing the number admitted to hospital due to alcohol consumption and the number of ambulance call-outs for related incidents, as is the case in West Yorkshire. ICSs should develop plans for improved support for people with co-occurring mental health and alcohol problems, bringing together the commissioners and providers of relevant services and those using them to agree plans for developing integrated support.

Finally, health and social care teams should be aware of the clustering of risk-factor behaviours, such as smoking and higher-risk drinking, and the impact this has on ill-health:[6] e.g., those who simultaneously drink and smoke have a higher risk of cancer than those who do just one.[7] Smoking cessation is especially unlikely for smokers who are also heavy drinkers or who have an alcohol use disorder.[8] It is, therefore, recommended for smokers who drink alcohol and who intend to quit smoking use an integrated approach, i.e., to stop or substantially reduce their alcohol consumption before and/or during their attempt to quit smoking. Efforts to reduce alcohol consumption could therefore not only limit health harms associated with alcohol but also support reduction in chronic respiratory conditions.

[1] NHS Digital (2021). Statistics on alcohol, England 2021.

[2] Moriarty, K. (2019). Alcohol care teams: where are we now. *Frontline Gastroenterology.*

[3] Moriarty, K. (2019). Alcohol care teams: where are we now? *Frontline Gastroenterology.*

[4] Moriarty, K. (2019). Alcohol care teams: where are we now? *Frontline Gastroenterology.*

[5] NICE. (2019). Coexisting severe mental illness and substance misuse.

[6] Meader, N. et al. (2016). A systematic review on the clustering and co-occurrence of multiple risk behaviours. *BMC Public Health.*

[7] Schütze M. et al. (2011). Alcohol attributable burden of incidence of cancer in eight European countries based on results from prospective cohort study. British Medical *Journal*.

[8] van Amsterdam, J. et al. (2023). The effect of alcohol use on smoking cessation: A systematic review. *Alcohol*

Do you have any suggestions on how we can make better use of research, data and digital technologies to improve outcomes for people with, or at risk of developing, the major conditions?

- Yes
- No

(multiple conditions)

Research has found that less than 10% of those who drink 'excessively' reported having received any advice on their alcohol consumption over a period of a year.[1] Out of 1.8 million registered adult patients, less than 10% had an Alcohol Use Disorders Identification Test (AUDIT) or Fast Alcohol Screening Test (FAST), and almost half had no recorded alcohol consumption data at all.[2] Systems to ensure the targeted and consistent use of IBAs can help to identify people drinking at high-risk levels and provide them with individualised information on their risk and advice on strategies to reduce their alcohol consumption.

With screening and brief advice estimated to save £1.23 for every £1 spent,[3] this intervention should be incorporated more systematically into primary medical and dental care, and with people eligible for breast cancer screening, due to the association with alcohol consumption. For breast cancer, relative risks of both illness and death increase by: 16% if drinking regularly at 2 units per day (equivalent to the CMO guidelines), and by 40% if drinking regularly at 5 units per day (more than double the guideline).[4]

At points of data collection, both in alcohol and mental health services, as well as in large-scale surveys, more granular data is needed on race and ethnicity.

[1] Brown, J. et al. (2015). Comparison of brief interventions in primary care on smoking and excessive alcohol consumption: a population survey in England. *British Journal of General Practice.*

[2] Mansfield, K. et al. (2019). Completeness and validity of alcohol recording in general practice within the UK: A cross-sectional study. *BMJ Open.*

[3] Drummond, C. et al. (2019). Assertive outreach for high-need, high-cost alcohol-related frequent NHS hospital attenders: The value-based case for investment. NIHR.

[4] Department of Health. (2016). Alcohol guidelines review – report from the guidelines development group to the UK Chief Medical Officers.

Do you have any suggestions of how we can improve access to palliative and end of life care?

- Yes
- No

[Questions on cancer]

How can we better support those with cancer? (Please do not exceed 500 words)

The changes in alcohol consumption seen during and after the COVID-19 pandemic could result in up to almost 20,000 additional cases of six types of cancer (breast, colorectal, liver, mouth, oesophageal, and throat) by 2035 if drinking does not return to pre-pandemic levels.[1]

Cancer risks start from any level of drinking and rise with the amount of alcohol consumed, as well as when combined with other common risk-factors.[2] Despite this, only 31% of people are aware of the link between cancer and alcohol. Likewise, awareness of the Chief Medical Officers' (CMOs) low

risk drinking guidelines is inadequate, with only one in five people able to correctly identify the weekly drinking guidelines of 14 units.[3]

Arming people with better information about the risks associated with alcohol would help to empower people to make healthier choices. Research by the Alcohol Health Alliance into alcohol labelling found that, out of 369 products, only one included a specific warning about the link between alcohol and cancer.[4]

As previously mentioned above, health warning labels can increase consumer awareness and reduce consumption of harmful products.[5] A Canadian real-world study found that health warnings on alcohol product labels led to increased recall, cognitive processing, and self-reported impact of drinking. Specifically, cancer labels increased knowledge of alcohol as a carcinogen,[6] which could prevent future cases and deaths. Over half (55%) of the public support a specific cancer warning on product labels.[7] Ireland have recently passed legislation mandating health information on alcoholic labels, including requiring a cancer warning.[8] We urge the government to fulfil their commitment to consult on the labelling of alcoholic drinks, expanding the scope to welcome views on mandatory health warnings.

[1] Institute of Alcohol Studies and Health Lumen. (2022). The COVID hangover: Addressing long-term health impacts of changes in alcohol consumption during the pandemic.

[2] Department of Health. (2016). UK Chief Medical Officers' Alcohol Guidelines Review. Schütze M. et al. (2011). Alcohol attributable burden of incidence of cancer in eight European countries based on results from prospective cohort study. *British Medical Journal*.

[3] Alcohol Health Alliance UK. (2018). How we drink, what we think: Public views on alcohol and alcohol policies in the UK.

[4] Alcohol Health Alliance UK. (2022). Contents unknown: How alcohol labelling still fails consumers.

[5] Kokole, D. et al. (2021). Nature and potential impact of alcohol health warning labels: a scoping review. Nutrients

[6] Hobin, E. et al. (2020). Testing Alcohol Labels as a Tool to Communicate Cancer Risk to Drinkers: A Real-World Quasi-Experimental Study. *Journal of the Study of Alcohol and Drugs.*

[7] Alcohol Health Alliance UK (2018). How we drink, what we think: Public views on alcohol and alcohol policies in the UK.

[8] Pogatchnik, S. (2023). Ireland signs law requiring cancer warnings on all alcoholic beverages. Politico.

[Questions on mental health]

How can we better support those with mental ill health? (Please do not exceed 500 words)

Alcohol consumption and poor mental health have a strong bidirectional relationship: as well as increasing the risk of mental disorder, alcohol use disorders (AUD) can also develop as a consequence of mental health problems.[1] There are also common risk factors, e.g., exposure to traumatic events or adverse childhood experiences, and co-occurrence of poor mental health and AUD is very common: 44% of people in Community Mental Health Treatment and 85% of people in alcohol treatment have a dual diagnosis.[2] Despite this prevalence, treatment for each condition is often

dependent on a patient recovering from one condition first,[3] and awareness of the link is low in the mental health sector. Using alcohol as a coping mechanism can prevent people from seeking help for their mental health, and 84% of alcohol and mental health practitioners consider having an AUD to be a barrier to getting mental health support.[4]

A survey commissioned by Alcohol Change UK found that respondents from Black and ethnic minority backgrounds were more likely to use alcohol to cope with poor mental health (68%) compared to white British respondents (41%).[5] Racial and ethnic minority groups may be more likely to experience mental health and alcohol harms compared to White British groups drinking at the same level because those drinking harmfully are less likely to seek treatment, and experience poorer treatment outcomes.[6] Research has also demonstrated that LGBTQ+ communities tend to experience disproportionate mental health and alcohol harm.[7]

The below actions could better enable health and social care teams to deliver person-centred and joined-up treatment for mental ill health:

- ICSs should ensure that people with co-occurring alcohol difficulties are not excluded from psychological therapy services.
- Better training for healthcare professionals on the relationship between alcohol and poor mental health (including for GPs) and compulsory placements for all trainee psychiatrists in addiction services to help counter a lack of awareness that presents a significant barrier to integrating alcohol and mental health services.[8]
- Campaigns for both public and practitioner audiences to reduce the normalisation of alcohol as a form of self-medication for dealing with stress and distress and tackle stigma associated with alcohol problems.[9]
- Including actions to address the link between alcohol use and deliberate self-harm in local suicide prevention plans,[10] as those who are dependent on alcohol are approximately 2.5 times more likely to die by suicide than the general population,[11] and over half of hospital presentations for self-harm involve alcohol use.[12]
- Screening for alcohol use when patients present with common mental health problems, taking into account a typical under-reporting of alcohol consumption by 40-45%.[13]
- A greater focus on needs-based treatment rather than diagnosis-led services, proven to be successful for those experiencing both self-harming behaviours and alcohol use.[14]
- Extra attention to ensure services are accessible and effective across diverse populations.
- A workforce strategy is needed to address a shortage of specialist addictions psychiatrists, clinical psychologists, and nurses.[15]

[1] Boden, J. et al (2011). Alcohol and depression. *Addiction.* Campion, J. (2019). Public mental health: Evidence, practice and commissioning.

[2] Weaver T, et al. (2003). Comorbidity of substance misuse and mental illness in community mental health and substance misuse services. *The British Journal of Psychiatry*

[3] Care Quality Commission (2015) Right here, right now: People's experiences of help, care and support during a mental health crisis.

[4] Institute of Alcohol Studies and Centre for Mental Health (2018). Alcohol and mental health: Policy and practice in England.

[5] Alcohol Change UK. (2020). Over half of UK drinkers have turned to alcohol for mental health reasons during pandemic.

[6] Gleeson et al. (2019). Rapid evidence review: Drinking problems and interventions in black and minority ethnic communities. Bayley, M. et al. (2010). Drinking patterns and alcohol service provision for different ethnic groups in the UK; a review of the literature.

[7] Dimova, E. et al. (2022). What are LGBTQ+ people's experiences of alcohol services in Scotland? A qualitative study of service users and service providers.

[8] Alcohol Change UK. (Accessed June 2023). Alcohol and mental health: how can we support those with co-occurring problems?. Institute of Alcohol Studies and Centre for Mental Health (2018). Alcohol and mental health: Policy and practice in England.

[9] Institute of Alcohol Studies and Centre for Mental Health (2018). Alcohol and mental health: Policy and practice in England.

[10] Institute of Alcohol Studies and Centre for Mental Health (2018). Alcohol and mental health: Policy and practice in England.

[11] Samaritans. (2022). Insights from experience: alcohol and suicide.

[12] Ness, J. et al. (2015). Alcohol use and misuse, self-harm and subsequent mortality: an epidemiological and longitudinal study from the multicentre study of self-harm in England. *Emergency Medicine Journal.*

[13] Public Health England (2018). The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An evidence review.

[14] Alcohol Change UK. (2021). Alcohol and self-harm: A qualitative study.

[15] Dame Carol Black (2020) Review of Drugs: Executive Summary.