IAS response to Department for Transport consultation: Proposed changes to penalties for motoring offences

Drink and drug driving questions

5. In your view, should the legal alcohol limit for drink and drive offences in England and Wales:

Be lowered

6. What legal limit do you think is appropriate?

20mg of alcohol in 100ml of blood
9µg of alcohol in 100ml of breath
27mg of alcohol in 100ml of urine

7. Why do you think this legal limit is appropriate?

Despite a steady decline in the number of people killed and injured over the past 40 years from drink-drive collisions, since 2010 this decline has stalled, with fatalities plateauing and possibly slightly increasing.

We support a 20mg limit rather than a 50mg limit for several reasons. Evidence shows that impairment of critical driving functions begins at low blood alcohol concentrations (BAC), and that most people are significantly impaired at 50mg (Fell and Voas, 2009). The risk of death and serious injury does not increase linearly but exponentially, with drivers at 20-50mg at least three times more likely to die in a crash, those at 50-80mg six times more likely, and those at 80-100mg around eleven times more likely (NICE, 2010). One study suggests that crash risk increases very sharply from 30mg (Blomberg et al, 2009). Romano et al. (2014) supports this, finding a clear dose–response relationship between BAC and fatal crash risk, with drivers at 50mg approximately 3.5 times more likely to be killed in a crash if aged 35 or over, 4.8 times more likely if aged 21–34, and 6.5 times more likely if aged 16–20. This rises significantly at 80mg to around 7.5 times, 12 times, and nearly 20 times more likely, respectively, compared with sober drivers. Interestingly, the study also found that alcohol's contribution to fatal crash risk is much greater than for other drugs, including cocaine, cannabis, and opioids.

Crucially, this means a 50mg limit permits legal driving within a range where risk is already rising steeply. A 20mg limit captures drivers before they enter this high-risk zone, substantially reducing the likelihood of fatal and serious injury while still allowing for an enforceable and evidence-based threshold. This approach aligns with international best practice and reflects the clear dose-response relationship between alcohol and crash risk.

There is significant evidence from across the world that reducing the drink drive limit saves lives and reduces injuries. Sweden adopted a 20mg limit in 1990 – and the number of drink-driving accidents fell. A 1997 study on the change showed that a 20mg limit reduced fatal crashes by 9.7%, with a 7.5% reduction in all crashes. Crucially, crashes also fell among the most serious drink-driving offenders

(Nordström and Laurell, 1997). Japan reduced its limit from 50mg to 30mg in 2002, with traffic fatalities falling by 7.8% and fatalities involving drink driving falling by 26.7% (Nagata et al, 2006). Taiwan reduced its limit from 50mg to 30mg in 2013 and alcohol-impaired drivers who were patients in trauma units fell from 10.99% to 6.64% (Tsai et al. 2019).

Although we advocate for a lower limit, if effectively enforced, a reduction from 80mg to 50mg is still likely to reduce both deaths and injuries on the road. A high-quality European study found an 11.5% drop in alcohol-related deaths among 18–25-year-olds (NICE). In Australia when the limit was reduced from 80mg to 50mg, fatal accidents fell by 18% in Queensland and 8% in New South Wales.

Although studies have found that Scotland's reduction in the limit from 80mg to 50mg did not lead to reductions in fatalities, those studies also made it clear that this was likely due to a lack of enforcement and public awareness, which we will come to in a later answer (Lewsey et al. 2019; James and Francesconi, 2021).

Another crucial reason for lowering the limit to 20mg and not 50mg is the clear and easy to understand public message that people should never drink and drive. Currently (and if the limit was 50mg) there is a contradiction between much of the government communication around drink driving and the law itself. The government says people should not drink and drive, yet the law allows people to do so up to a particular BAC. Having effectively a "zero tolerance" level of 20mg would make it much easier for people to understand. A 2025 survey found that although 49% of people claim to understand the limit, when asked to identify them, 82% were wrong or said they didn't know (Direct Line 2025). It also found 25% of UK adults think the limits are measured by the quantity of alcohol consumed. This highlights that a zero tolerance limit would be much easier for people to understand, but that public awareness campaigns are also crucial so that people are aware of the new limit.

The drink-drive limit also lags behind public perception of what the limit should be. In all public polling over the past decade, a significant majority of people wanted a lower limit (YouGov, 2011: 56%; Brake, 2016: 78%; and AlcoSense, 2023: 69%).

Bringing the level to 50mg would still mean that we have the (joint) highest limit in Europe. There are at least 9 other European countries that have a lower limit than 50mg. Although the UK still has some of the safest roads in the world, the reduction in road deaths has been less than most other European countries' improvements. For example, between 2010 and 2020 the UK achieved only about a 20% reduction, whereas the EU average dropped much more – out of 32 countries, the UK had the 5th lowest reduction (PACTS, 2021). Reducing the limit to 20mg and combining that with improved enforcement and public awareness campaigns would make the UK world-leading in road safety once again.

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8. In your view, should the legal alcohol limit for drink and drive offences in England and Wales be lower for novice drivers than for other drivers?

Yes

9. What legal limit do you think is appropriate for novice drivers?

IAS believes the limit should be 20mg for all drivers. However, if the government reduces the limit to 30, 40, or 50mg, the limit should be lower for both novice and professional drivers, set at the following level:

20mg of alcohol in 100ml of blood
9µg of alcohol in 100ml of breath
27mg of alcohol in 100ml of urine

10. Why do you think this legal limit is appropriate?

People who have only recently passed their driving test, regardless of age, are at higher risk of road traffic harm than experienced drivers, with research showing that new drivers are three times more likely to be injured in a crash if they have been drinking alcohol (BMA, 2026). New drivers are far less experienced and are also more likely to be young. Adolescents and young people who drink drive, or allow themselves to be carried by a drink driver, are more likely to be involved in a car accident (Newbury-Birch et al, 2009). As the Department for Transport states: "Younger drivers are over-represented in drink-drive collisions compared to all injury collisions." And collisions among young people drink driving are more likely to be late at night. Younger people are also more likely to be harmed in a drink-drive collision.

Numerous European countries have lower limits for novice drivers, including Austria, Croatia, Cyprus, France, Germany, Ireland, Spain, and Switzerland. Many US and Canadian states also have lower limits. And Northern Ireland has plans to amend their legislation to have a lower limit for novice drivers.

Many also have graduated licencing, with restrictions on how many passengers new drivers can have, night-time restrictions, and a zero drink-drive limit, all of which could be considered. Evidence shows that graduated systems reduce crash rates among young/novice drivers – sometimes by 20-40%, depending on the jurisdiction and strength of the program (Aberystwyth University).

Many of the aforementioned countries also apply lower blood alcohol limits for commercial drivers, including Switzerland, Sweden, Portugal, Germany, and Belgium, which operate effectively zero-tolerance limits. The World Health Organization recommends a maximum blood alcohol concentration of 20mg/100ml for commercial drivers, reflecting the heightened risks associated with alcohol consumption in safety-critical driving roles (WHO SAFER initiative).

We support a lower drink-drive limit for commercial drivers for several reasons. First, commercial drivers frequently operate large and heavy vehicles, such as buses and lorries, which have greater stopping distances and can cause more severe harm in the event of a collision, even at relatively low speeds. Any level of alcohol-related impairment therefore carries a disproportionate risk. Second, commercial drivers are often responsible for carrying passengers or goods as part of their employment, placing them in a position of heightened duty of care. Third, lower or zero limits for commercial drivers are consistent with the standards applied in other safety-critical transport roles, such as aviation and rail, where alcohol consumption before or during duty is strictly prohibited. Aligning drink-drive limits for commercial drivers with international best practice would therefore strengthen road safety.

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11. In your view, if the legal alcohol limit for drink and drive offences in England and Wales is lowered, should the criteria for being considered a high-risk offender be lowered accordingly?

Yes

Why did you give this answer?

If the legal drink-drive limit in England and Wales is lowered on the basis of growing evidence that BAC levels between 50-80mg/100ml pose a significant risk to road safety, then it follows that there should also be recognition that lower BAC levels can constitute “high-risk” behaviour. Therefore it would be logical and proportionate to review and adjust the criteria for classification as a High Risk Offender (HRO) so that they remain aligned with the underlying evidence on impairment and crash risk, rather than anchored to a historic threshold.

However, any such change would need to be accompanied by very clear and sustained public awareness campaigns, explaining both the new legal limit and how HRO thresholds operate. Without clear communication, there is a risk that changes could be misunderstood, undermining deterrence and public confidence. Evidence from other jurisdictions suggests that the effectiveness of drink-drive policy changes depends not only on the legal framework, but also on visibility, understanding and enforcement.

We support the analysis and recommendations set out by PACTS, which emphasises that the scheme should be re-oriented towards long-term risk reduction rather than simply facilitating licence restoration. Given the strong association between high-BAC offending, repeat offending and alcohol dependence, assessment for alcohol problems or dependence should play a stronger and more consistent role within the scheme. In particular, we support the following recommendations:

- Greater use of evidence-based alcohol treatment and behaviour-change interventions for high-risk offenders
- Ensuring that medical and alcohol assessments are meaningful and linked to treatment, rather than operating as a procedural hurdle to licence reinstatement
- Stronger and more systematic links between the HRO scheme and health services, especially for repeat offenders and those with very high BAC readings
- Clearer national standards for assessment and decision-making, to reduce inconsistency in application
- Improved monitoring and evaluation of the scheme’s effectiveness, including reoffending outcomes
- Wider and more strategic use of alcohol interlocks, particularly for repeat and high-risk offenders, as a proven tool to reduce harm while supporting rehabilitation

Both NICE and PACTS recognise that a significant proportion of drink-driving offenders exhibit patterns of harmful drinking or alcohol dependence, and that punitive measures alone are unlikely to reduce long-term reoffending in these cases. Integrating enforcement with meaningful assessment, treatment and behaviour-change interventions is therefore essential to reducing repeat harm.

13. In your view, should a person suspected of committing a drink offence:

1. have their driving licence suspended until attendance at court
2. have their driving licence suspended until guilty plea
3. have their driving licence suspended until bailed pending forensic analysis being undertaken
4. not have their driving licence suspended

Why did you give this answer?

The period between a drink-driving incident and a suspect either pleading guilty or appearing in court presents a clear and avoidable risk to public safety, as individuals are often able to continue driving during this time. Evidence shows that reoffending is a serious and persistent problem: between 2013 and 2024, more than 27,000 people were convicted multiple times for drink-driving offences (DVLA, 2024).

At the same time, the government's own data show that the vast majority of those charged are subsequently convicted, with conviction rates of around 96%. This indicates that in most cases, suspects allowed to continue driving during this interim period are likely to be legitimately high-risk drivers. While the small minority who are not ultimately convicted underlines the importance of swift and fair proceedings, it does not outweigh the public safety risks posed during delays.

There is therefore a strong rationale for giving the police preventative powers to suspend driving licences, similar to powers used in other areas such as domestic abuse, to prevent suspected drink-drive offenders from driving before conviction and reduce the risk of further harm.

References

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14. In your view, should a person who is under investigation for a serious driving offence that leads to a:

1. fatality have their driving licence suspended: Yes
2. serious injury have their driving licence suspended: Yes

Why did you give this answer?

For the same reasons as our answers to question 13 and also due to fairness to the victim and victim's family.

15. Do you think the current minimum disqualification period for the offence causing death by careless driving while under the influence of:

drink of 5 years with compulsory extended retest is appropriate: Yes, No, Don't know

Why did you give this answer?

Causing death by careless driving while under the influence of drink is one of the most serious offences on the roads, with irreversible consequences for victims and their families. We do not consider a minimum disqualification period of five years to adequately reflect the seriousness of the offence or the irreversible harm caused.

The choice of five years appears largely arbitrary and is not clearly linked to evidence about long-term risk, behaviour change, or deterrence. Where a life has been lost, sanctions should be grounded in a clear, evidence-based rationale and should demonstrate that public protection is the overriding priority.

While compulsory retesting is an important safeguard, it does not on its own address concerns about reoffending risk or restore public confidence. A longer minimum disqualification period, combined with robust assessment before licence reinstatement, would better reflect the severity of the offence, respond to the concerns of victims' families, and strengthen deterrence.

In addition, any period of disqualification should begin only after a custodial sentence has been served, rather than running concurrently. Allowing both to run at the same time reduces the practical impact of the driving ban and weakens its intended purpose as a standalone road safety sanction.

16. Do you think the current minimum disqualification period for the offence:

1. driving a motor vehicle while under the influence of drink is appropriate: Yes, No, Don't know
2. being in charge of a motor vehicle while under the influence of drink is appropriate: Yes, No, Don't know

Why did you give this answer?

The current minimum disqualification periods of one year (or three years for repeat offences) do not sufficiently reflect the risks posed by drink-impaired driving, nor do they adequately deter reoffending. Driving while under the influence of drink presents a clear and well-evidenced danger to road safety. A one-year minimum risks underestimating the seriousness of the offence, particularly given its potential for fatal or life-changing consequences.

Although the offence of being "in charge" of a vehicle is distinct from driving, it still involves a significant risk, particularly where there is the potential for the individual to drive while impaired. The same concerns therefore apply, and the current minimum periods do not sufficiently discourage risky behaviour.

Driving is not a right, and for the most serious or persistent offenders, lifetime bans should be considered. Effective sanctions and prevention measures are essential to reducing deaths and serious injuries on our roads.

17. Do you think the current minimum disqualification period for the offence:

1. driving a motor vehicle with alcohol concentration above the prescribed limit is appropriate: Yes, No, Don't know
2. being in charge of a motor vehicle with an alcohol concentration above the prescribed limit is appropriate: Yes, No, Don't know

Why did you give this answer?

See previous answer

18. In your view, should new powers be created to allow the seizure of vehicles of a person arrested for drink and drug driving?

Yes, No, Don't know

19. Why did you give this answer?

Where there is sufficient evidence of drink driving, temporary vehicle seizure can act as an immediate public protection measure and a strong deterrent against reoffending while legal proceedings are ongoing. Crucially, it removes the means to reoffend — not just the licence — and helps address situations where individuals continue to drive despite licence suspension or bail conditions. This is particularly important given that more than 27,000 people were convicted multiple times for drink-driving between 2013 and 2024, demonstrating that existing sanctions do not always prevent reoffending.

Such a power would be most valuable where there are clear indicators of risk, such as a high alcohol reading, repeat offending, or non-compliance with previous sanctions. As with other enforcement measures, it should be proportionate, time-limited, clearly defined in law, and subject to judicial oversight and appropriate appeal safeguards — including consideration of cases where the vehicle is essential for employment or family responsibilities. Within those parameters, we believe this measure could save lives and strengthen public confidence that drink-driving is treated with the seriousness it warrants.

20. In your view, should alcohol ignition locks (alcolocks) be allowed to be used as part of a drink drive rehabilitation process?

Yes

21: Why did you give this answer?

Much like a lower drink-drive limit and different rules for novice drivers, many other countries are well ahead of the UK when it comes to the use of alcohol interlocks. Although it seems quite novel to UK drivers, many US states require ignition

interlocks for convicted drink-drivers, as do certain European countries such as Sweden, Finland, France, and Denmark.

There is strong international evidence that interlocks reduce reoffending. Coben and Larkin (1999) found across five studies that participants in interlock programs were 15%-69% less likely than controls to be re-arrested for drinking while intoxicated. A 2004 Cochrane Review found interlocks reduced reoffending but there was no long-term benefit after they were removed (Willis C, 2004). A 2011 systematic review looking at more recent studies also found a reduction only when interlocks were in place (Elder et al, 2011). A 2022 study had similar findings although found a modest reduction following the removal of interlocks (Rahman, 2022).

This evidence supports the use of alcohol interlocks, although there must be consideration regarding how to increase the chances of more long-term reductions in reoffending. As Elder et al. suggest, interlocks should be combined with effective alcohol treatment for people with alcohol problems, as well as alternative transportation options. The government could consider the use of interlocks for a longer time period than countries that have found a lack of reduction after interlocks are removed, or a tiered approach for how long they are fitted, depending on the BAC level of those convicted.

The independent sentencing review by the Right Honourable David Gauke highlights South Dakota's '24/7 Sobriety' programme – a similar programme to the UK's alcohol monitoring tags – being used for people arrested or convicted of drink driving. This led to a 12% drop in repeat drink-drive arrests.

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22: In your view, should oral fluid and other samples (such as saliva and sweat) be used in drug driving forensic analysis?

Don't know

Why did you give this answer?

23: In your view, could hospital procedures for drink and drug driving suspects be improved?

Yes

24: How do you think hospital procedures for drink and drug driving suspects could be improved?

Hospital procedures for drink-driving suspects should do more than facilitate criminal justice processes: they should also ensure that underlying alcohol problems are identified and treated, which could reduce repeat drink-driving in the longer term. The new clinical guidelines for alcohol treatment (2025) recommend routine screening for alcohol use disorders using validated tools (e.g. AUDIT) on admission following an alcohol-related incident, with appropriate brief advice offered to increasing and higher risk drinkers. and referral to specialist assessment for those with probable dependence. Hospitals should also ensure that specialist Alcohol Care Teams are available to assess, manage, and link patients to ongoing treatment, including psychosocial intervention and community services, and that all clinical staff are trained in screening and referral procedures. These steps can reduce subsequent harm, readmissions, and repeat offending.

The Cardiff Model for violence prevention provides a good example of how linking hospital and police data can show patterns and inform public safety action and policymaking. Under the model, anonymised data is collected in hospital emergency departments - for instance the location, time, weapon used, number of assailants - and then shared with police and combined with their data to map where serious incidents occur. Evaluations show that this approach captures large proportions of data that police records miss, and action based on the findings has reduced hospital admissions for violent injury.

Although not specifically relating to drink-drive collisions, research commissioned by the RAC Foundation highlights the significant potential of linking routinely collected hospital data with police and transport datasets to improve road safety analysis (Yalamanchili, 2024). The study found that health data can identify serious injuries and contributory factors that are not always fully captured in police records, leading to a more accurate understanding of collision causes and outcomes. Strengthening systematic data linkage between hospitals and road safety agencies would therefore improve surveillance of alcohol-related harm, support better targeting of interventions, and enhance evaluation of drink-driving policies.

References

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25: Are there any other changes to current law and practice regarding drink and drug testing that you would like to suggest?

Yes

26: How do you think current law and practice regarding drink and drug testing could be improved?

We believe that, for a reduction in the drink drive limit to be effective, it must be combined with stronger and more visible enforcement, including enhanced police powers to conduct random breath testing, alongside high-profile public information campaigns.

Although there is strong evidence across the world that reducing the drink-drive limit leads to reductions in drink-drive collisions, deaths, and serious injuries, it is clear that this has to be done alongside strong enforcement, which the UK currently lacks. In fact, the numbers of breath tests in England and Wales have collapsed, with a 63% decrease from 2009 to 2023 (Home Office, 2024). As two studies in Scotland have shown, poor enforcement, limited media campaigns to increase public awareness of the reduced limit, and a lack of alternative transportation meant reducing the limit was not as successful as was hoped (Lewsey et al. 2019; James and Francesconi, 2021).

NICE is clear that the effectiveness of drink-driving policy depends far more on the perceived certainty and visibility of enforcement than on the severity of penalties alone. Increases in sanctions without corresponding improvements in enforcement and detection are therefore unlikely to deliver sustained reductions in harm.

Internationally, the evidence is compelling:

- In Queensland and New South Wales, when their limits were reduced from 80mg to 50mg, fatal accidents fell by 18% and 8% respectively, and crucially the researchers credited enhanced random breath testing as a major driver of this reduction (Henstridge et al. 1997).
- Random and selective breath testing (often referred to as sobriety checkpoints) have also been found to reduce drink-drive injuries and deaths, as found by Peek-Asa 1999 and Shults et al. 2001.
- In Brazil in 2008 a reduction in the limit from 60mg to 20mg led to significant reductions in injuries and deaths in Sao Paulo state and city, and larger effect in the capital likely due to enhanced police enforcement (Andreuccetti et al. 2011).
- Tippetts et al. (2005) found that the effects of reduced BAC limits were greater in US states that had greater enforcement measures.

Introducing random breath testing (RBT) in England and Wales would substantially strengthen drink-driving deterrence by increasing the perceived certainty of detection, which is central to behaviour change (Solomon and Chamberlain 2014). Unlike current selective testing approaches, RBT allows police to stop any driver at any time, removing drivers' ability to evade detection and maximising general deterrence. International evidence consistently shows RBT to be highly effective. Meta-analyses find that sobriety checkpoints, including RBT, reduce alcohol-involved crashes by at least 17%, with reductions of up to 22% in fatalities and 24% in high-BAC driving (Shults et al. 2001; Erke et al. 2009) – although their effectiveness depends on frequency, unpredictability, and public awareness of enforcement activity (NICE). Jurisdictions with intensive, highly visible, and well-publicised RBT programmes – particularly Australia and New Zealand – have seen large and

sustained reductions in serious and fatal crashes, including a 22% reduction in night-time serious or fatal crashes in New Zealand (Miller et al. 2004) and thousands of lives saved in Australia (Jiang et al. 2014). Evidence also shows RBT to be cost-effective (Ditsuwan et al. 2013). By contrast, selective testing misses a substantial proportion of impaired drivers and delivers weaker deterrence (McKnight and Voas 2001). Introducing RBT would align England and Wales with international best practice.

Crucially, people have to believe that they will be caught and punished if they drink drive. As Ross HL (1988) hypothesised, people initially think they will be caught but that this belief tails off over the long-term when people realise they are unlikely to be caught. Therefore, enforcement has to be extremely visible and rigorous to prevent that.

Alongside visible breath testing, any reduction in the drink-driving limit must be accompanied by sustained, highly visible public awareness and media campaigns explaining the new limit and penalties. Evidence from Scotland shows the consequences of failing to do so: following the reduction to 50mg, media spend was limited and short-lived, and public awareness of the new limit declined rapidly after the initial campaign (Lewsey, 2019).

Mass media campaigns are a standard component of drink-driving prevention and are essential to deterrence-based policies that rely on public knowledge to be effective (Williams, 2007). Evidence suggests that campaigns are most effective when they are well-designed, adequately funded, achieve high levels of exposure, and are delivered alongside effective enforcement. A review of high-quality evaluations found such campaigns were associated with a 13% reduction in alcohol-related crashes (Elder et al., 2004), while reduced funding for media publicity has been shown to weaken the effectiveness of sobriety checkpoints (Bergen et al., 2014). Media campaigns should be developed free of alcohol industry influence, as evidence shows that the industry uses drink-drive campaigns as part of corporate social responsibility activity that serve as brand recognition rather than harm reduction (Babor et al. 2018).

Other international evidence reinforces the importance of media attention at the point of policy change. In Taiwan, a new drink-driving law introduced in 1999 was accompanied by extensive media coverage and followed by a 73% reduction in fatal alcohol-related crashes over the subsequent 20 months (Chang and Yeh, 2004). However, as Babor et al. (2022) note, such effects tend to diminish over time unless reinforced through renewed enforcement and media activity, highlighting the need for sustained investment rather than one-off campaigns.

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27: In your view, should random breath testing (mirroring the powers in Northern Ireland) be introduced in England and Wales?

Yes

28: Why did you give this answer?

See answer to Question 25.

29: If you have any other evidence to provide or comments to make about the current penalty framework for drink and drug driving offences, please provide them here.

Despite advocating for a 20mg limit, we recognise a risk of doing so if it is accompanied by a weakening of penalties. There is a serious risk that introducing a very low limit alongside reduced sanctions between 20-80 mg, such as points or modest fines, would undermine deterrence and could even increase harm by signalling that lower-level drink-driving is less serious. A more effective and proportionate approach would be a graduated penalty framework, as used in countries such as Poland. In Poland, driving at 20-50 mg is treated as a lower-level offence, while 50mg and above attracts much stronger criminal penalties. Applied in England and Wales, this would allow a 20mg limit while ensuring that 50mg+ carries penalties equivalent to the current 80mg offence, aligning sanctions with risk and preserving public safety.

Finally, ambitions to reduce drink driving in England and Wales would have a greater chance of success if complemented by cross-government action to tackle record high rates of alcohol harm. The UK has not had a national alcohol strategy in place since 2012, and since the COVID-19 pandemic higher rates of heavy drinking have led to record alcohol-specific deaths, which increased 42% in England between 2019-2023 (ONS, 2025). International evidence shows that policies to tackle the affordability, availability and promotion of alcohol are the most effective and cost-effective interventions to reduce harm. This applies to road safety outcomes also, with a 10% increase in alcohol pricing linked to a 7% decrease in road deaths (Castillo-Manzano, J. I., 2017). IAS has worked with alcohol experts across the UK to develop a long-term vision for tackling alcohol harm, including ambitious but achievable targets for the next 10 years and a policy roadmap to meet them – which includes lowering the drink-drive limit. Please see here for more details: https://www.ias.org.uk/report/a-healthier-future-a-long-term-vision-to-tackle-alcohol-harm-in-the-uk/.

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