



House of Commons
Health Committee

Alcohol

Written evidence

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Written evidence

Memorandum by the Department of Health (AL 01)

ALCOHOL

EXECUTIVE SUMMARY

1. The Government has a comprehensive strategy to tackle alcohol harms, including health harms, alcohol-related crime, and harms to children and young people from alcohol. This is based on:

- (i) **Informing and supporting people to make healthier and more responsible choices:** through national campaigns, providing better education and information for adults and young people; providing unit information; as well as targeted support for increasing-risk and higher risk drinkers.
- (ii) **Creating an environment in which the healthier and more responsible choice is the easier choice:** through the licensing and enforcement regimes, through a proposed mandatory code for alcohol retailing, and considering further restrictions on irresponsible ways of promoting alcohol and ensuring information on alcohol units and Government guidelines is widely available.
- (iii) **Providing advice and support for people most at risk:** through earlier identification of people whose consumption is damaging their health, and providing advice, intervention and, as needed, specialist NHS treatment.
- (iv) **A delivery system that effectively prioritises and delivers action on alcohol misuse:** through the **World Class Commissioning programme** to strengthen local commissioning of services, including alcohol services, and additional central and regional support, alongside local accountability.

Progress

2. We have published two alcohol strategy documents, the first in 2004 and a renewed strategy in 2007.¹ We are delivering the commitments we made in those publications and the latest data available (2007) show a small fall in the numbers of alcohol-related deaths in England. Total alcohol consumption may have plateaued since 2005, however alcohol-related hospital admissions continue to rise rapidly.

Government action

3. Our comprehensive action includes the following key elements:

Informing and supporting people to make healthier and more responsible choices

- public health education campaigns to improve understanding of alcohol units and health risks; and to challenge binge drinking and tolerance of drunkenness;
- planned campaigns from 2009 for children and their parents; and
- publication of The Chief Medical Officer's *Guidance on the Consumption of Alcohol by Children and Young People*.

Creating an environment in which the healthier and more responsible choice is the easier choice

- a review of the provisions of the Licensing Act published in March 2008;
- toughened enforcement to clamp down on alcohol fuelled crime and disorder and under-age sales;
- an independent review commissioned by the Home Office of the effectiveness of the alcohol industry's social responsibility standards published in July 2008;
- an independent review commissioned by the Department of Health on the effects of alcohol pricing and promotion, published in December 2008; and
- proposals in the Policing and Crime Bill for a mandatory code for alcohol retailing to tackle irresponsible promotions and reinforce industry good practice.

Providing advice and support for people most at risk:

- development of the evidence on effectiveness of brief advice and specialist alcohol treatment.

A delivery system that effectively prioritises and delivers action on alcohol misuse:

- a new Public Service Agreement (PSA) indicator from April 2008 to specifically address alcohol-related hospital admissions; and
- the Alcohol Improvement Programme, a programme of central and regional support for PCTs to help them commission and deliver improvements in prevention and treatment, linking to the World Class Commissioning programme.

¹ National Alcohol Strategy "Safe, Sensible, Social" 2007
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_075218

THE SCALE OF ILL HEALTH RELATED TO ALCOHOL MISUSE

Chronic ill health

4. Over a quarter of the population (10 million adults) drink above the Government's recommended daily limits for lower risk drinking of 2–3 units for women and 3–4 units for men, drinking $\frac{3}{4}$ of all alcohol consumed in the country.

5. People who regularly drink above the lower-risk levels recommended by Government increase their risk of ill health significantly. They are:

- 4.5 times more likely to get cancer of the mouth, neck and throat;
- 3.5 times more likely to get liver cancer;
- at 2–4 times the risk of high blood pressure;
- more than twice as likely to suffer from an irregular heartbeat;
- 13 times more at risk of liver cirrhosis;
- women are nearly 2.5 times more likely to get breast cancer; and
- other risks for both sexes include fatigue, depression, weight gain, memory loss, poor sleep and sexual difficulties.

6. 2.6 million adults (8% of men and 6% of women) regularly drink above the higher-risk levels, ie more than double the Government's guidelines (6 units for women, 8 units for men daily), drinking a third of all alcohol consumed in the country. They are particularly at risk of developing chronic ill health. Of these, 1.1 million adults are estimated to be dependent on alcohol.

7. While the number of under-age drinkers is decreasing, those who do drink are consuming more: nearly 13 units per week for 11–15 year olds who drink.

Harm from Binge Drinking

8. Binge drinking carries a risk of acute harm to individuals and their families and is associated with crime, nuisance and disorder.

- People who are drunk are much more likely to be involved in an accident or assault, be charged with a criminal offence, contract a sexually transmitted disease or have an unplanned pregnancy.
- The British Crime Survey shows that in 2007 46% of victims of violent incidents believed the offender to be under the influence of alcohol. 18 to 24 year-olds are most often associated with alcohol related offences.
- Binge drinking can bring people into contact with crime in several ways, as a victim or perpetrator. For example, 76,000 facial injuries in the UK each year are linked to drunken violence.

Mortality

9. Alcohol-related death statistics, published by the Office for National Statistics on 27 January 2009 show that:

- there were 8,724 alcohol-related deaths in 2007, lower than in 2006, but more than double the 4,144 recorded in 1991;
- for men, the number of deaths per million from liver disease has more than doubled from 76/million in 1991 to 162/million 2007; and
- the trend in the rate of alcohol-related deaths is now levelling out, following rapid increases from the early 1990s.

THE CONSEQUENCES FOR THE NHS

10. Alcohol misuse is estimated to cost the health service around £2.7 billion per annum.

- DH statistics show that, in England in 2006–07, there were estimated to be around 799,000 alcohol-related hospital admissions, that is 6% of all hospital admissions. This is an increase from 510,000 in 2002–03, and the figure is estimated to be rising by around 70,000 per year (though some of this increase will be due to background rises in admissions and coding changes). More than 60% of alcohol-related admissions are for chronic ill health.
- Up to 35% of all A&E attendance and ambulance costs may be alcohol-related.²

² Prime Minister's Strategy Unit, Alcohol Interim Analytical Report 2003.

 CENTRAL GOVERNMENT POLICY (I)

INFORMING AND SUPPORTING PEOPLE TO MAKE HEALTHIER AND MORE RESPONSIBLE CHOICES

GOVERNMENT APPROACH

11. The Government seeks to help people make healthier choices about alcohol through national advertising and social marketing campaigns. While the evidence is that education and information alone will not secure behaviour change, we believe they are essential support once individuals are motivated to change their behaviour.

12. The programme is jointly funded by the Department of Health and the Home Office, with an overall budget of £10 million in 2008–09.

- The programme comprises two central strands:
 - a “units” campaign, from May 2008, to raise general awareness of alcohol units and the risks to health of regularly exceeding recommended guidelines; and
 - a “binge drinking” campaign, starting in 2006 which, from June 2008, is challenging the public acceptability of drunkenness by highlighting the attendant personal and social consequences.

13. The Department for Children, Schools & Families (DCSF) is planning a new social marketing campaign from 2009, aimed at young people and their parents. This campaign is funded for the next three years with a total of £12.5 million. This campaign will take account of responses to the current *Young People and Alcohol Consultation*. The Chief Medical Officer’s *Guidance on the Consumption of Alcohol by Children and Young People*³ forms part of this consultation and will be reflected in DCSF’s plans for the campaign. Once the consultation has closed, and responses have been taken into consideration, the Chief Medical Officer’s guidance will be released for publication.

14. The industry funded, independently governed, Drinkaware Trust, plays a vital, complementary role in running campaigns, including those currently on the consequences of under age drinking and health risks from regular excessive consumption.

Labelling of alcohol with unit and health information

15. Labelling is an important support to the “units” campaigns. Labels with unit information can help people to assess their alcohol intake more easily against the Government’s guidelines.

16. The Government reached a voluntary agreement with the alcohol industry in May 2007, to introduce labels which include unit and health information, including guidelines for consumption and advice on alcohol and pregnancy. The Government hopes that the majority of labels by market share will have complied by the end of 2008.

17. Most respondents to the recent consultation⁴ supported the introduction of a legal requirement to include health and unit information on labels, if slow progress is made in implementing the voluntary agreement. Independent monitoring, to report by May 2009, will enable Government to decide the next steps.

Targeted support

18. In Autumn 2008, the Department of Health launched a new phase of its work to provide support targeting increasing-risk and higher-risk drinkers—mainly those drinking more than double the Government’s guidelines for regular drinking, who may wish to reduce their drinking.

19. We made a commitment in “Safe Sensible Social” in June 2007 to support the development of a range of new kinds of information and advice. This already includes web-based support and advice and an enhanced helpline available nationally.

20. The new phase includes a recently completed innovative pilot in the North West, where alcohol-related hospital admissions are at their highest, to target information to neighbourhoods, individuals and their families and encourage those most affected to seek advice and support, including help from health professionals locally. Initial results are promising and development work will continue in 2009. The aim is to develop an evidence base for effective local action by NHS bodies.

³ *Young People and Alcohol Consultation*, Chief Medical Officer’s *Guidance on the Consumption of Alcohol by Children and Young People*

<http://www.dcsf.gov.uk/consultations/index.cfm?action=consultationDetails&consultationId=1579&external=no&menu=1>

⁴ Consultation Report, *Safe, Sensible, Social—Consultation on Further Action*. DH December 2008 <http://www.dh.gov.uk/en/index.htm>

 CENTRAL GOVERNMENT POLICY (II)

CREATING AN ENVIRONMENT IN WHICH THE HEALTHIER AND MORE RESPONSIBLE CHOICE IS THE EASIER CHOICE

21. The Government recognises that the environment in which alcohol is purchased and consumed needs to support our strategic aim to promote a more responsible drinking culture in England. Government, local enforcement bodies, the police, trading standards, and licensing authorities, local NHS Primary Care Trusts, and local residents—along with the alcohol industry—all have responsibilities to ensure this happens.

Licensing

22. The Licensing Act 2003 sets out four main objectives:

- the prevention of crime and disorder;
- public safety;
- the prevention of public nuisance; and
- the protection of children from harm.

23. The Act also supports a number of other key aims and purposes, including:

- the protection of local residents from disturbance and anti-social behaviour;
- proportionate regulation to give business freedom to meet customers' expectations; and
- greater choice for consumers on where and how to spend their leisure time.

24. The Government's review of the Licensing Act 2003, published in March 2008, revealed that the overall volume of incidents of crime and disorder had remained stable and had not risen since implementation at the end of 2005, with some local variations. It found that licensing authorities and enforcement bodies were using the new **freedoms** conferred by the Act, but they were not sufficiently using the considerable **powers** granted by the Act to tackle problems. It concluded that there was a need to rebalance action towards **enforcement** and crack down on irresponsible behaviour.

25. The Government announced then that it would develop a toolkit of local powers for local authorities and police and take further steps to tackle wider anti-social behaviour associated with alcohol consumption.

26. Many of the key powers for tackling various forms of alcohol-related crime are now set out in the Home Office guidance on tools and powers.⁵ An update of this guidance will be available from Spring 2009.

27. The Policing and Crime Bill, recently introduced in Parliament, aims to add to the range of measures to tackle the misuse of alcohol including:

- removing the requirement to prove intent (to consume) before the police can confiscate alcohol from children;
- increasing the maximum fine for failure to comply with the directions of a constable to stop drinking in a designated public place;
- reducing the number of times alcohol can be sold to children before the licence holder can be prosecuted (from 3 strikes in three months to 2 in three months); and
- creating a new offence for under 18s who persistently possess alcohol in public places.

A mandatory code for alcohol retailing

28. The Home Office commissioned a review of the effectiveness of the alcohol industry's voluntary Social Responsibility Standards. This was carried out by KPMG and published in June 2008. The Government summarised the findings in *Safe, Sensible, Social—Consultation on Further Action*, published in July 2008. KPMG found that many alcohol retailers were not abiding by the industry's voluntary standards for responsible selling and marketing of alcohol. Those retailers who did operate good practice often expressed a view that this was not linked to the industry's Social Responsibility Standards. Numerous examples of poor practice, including irresponsible alcohol promotions, were found by KPMG.

29. Most of the responses to consultation expressed strong support for a mandatory code.

30. The Home Secretary and the Secretary of State for Health jointly announced in December 2008 the Government's intention to:

- put in place a new mandatory code of practice to target the most irresponsible retail practices; and
 - take powers:
 - to create new mandatory national licence condition; and
 - for local licence conditions applicable to groups of premises.
-

⁵ Home Office guidance on tools and powers
<http://drugs.homeoffice.gov.uk/publication-search/drug-strategy/alcoholguide?view=Binary>

31. Statutory guidance may in addition include advice on alcohol retailing good practice. Government continues to seek a positive partnership with the alcohol industry and will encourage industry to contribute to this guidance.

32. The mandatory national conditions will ban the most irresponsible practices and promotions, which encourage people to drink excessively, or promote a binge-drinking culture. This should not affect the majority of businesses, small or large, who behave responsibly.

33. The Government believes that implementing the new Code through Licensing Act enforcement mechanisms is consistent with the approach proposed by the review of the Licensing Act.

34. To reflect the fact that sometimes it is the collective impact of a number of premises which causes alcohol-related nuisance or disorder, the new powers will enable licensing authorities to attach licensing conditions to groups of premises in an area, rather than to individual premises. Details of these new conditions will be the subject of consultation.

35. The industry's voluntary Social Responsibility Standards included interventions to reduce health harms. The consultation sought views on whether proportionate and necessary actions to prevent health harms could (as a secondary objective) be part of mandatory licensing conditions, even though health is not a Licensing Act objective in England and Wales. There was general support for this.

The Effects of Alcohol Pricing and Promotion

36. The independent review by the School of Health and Related Studies, Sheffield University (ScHARR), published in December 2008,⁶ found that pricing policies can be effective in reducing health, crime and employment harms. The report found evidence that general price increases or minimum unit pricing could save substantial NHS, crime and employment costs.

37. The Government has made no decision to introduce a national minimum unit price at this stage for England and Wales.

38. We want to do further work to make sure that any policy would not be unfair to the majority of people who drink sensibly and responsibly. We want to ensure that pricing policies can be targeted, particularly at a time of household budget pressure from elsewhere, so that heavy drinkers, who incur the highest levels of harm, and young drinkers, are influenced the most.

39. We will announce later this Spring the details of further work, to make sure any future action is appropriate, fair and effective.

40. We will also take into account the ScHARR review findings for any proposed conditions within the new mandatory code, restricting irresponsible alcohol promotions, including those based on price.

CENTRAL GOVERNMENT POLICY (III)

PROVIDING ADVICE, SUPPORT AND TREATMENT FOR PEOPLE MOST AT RISK

41. The Government's goal is to ensure that we have in place high quality services to prevent, mitigate and treat effectively alcohol-related health harms. The NHS should move progressively from treating the consequences of alcohol misuse to preventing these.

42. The relevant services range from identification and brief advice to specialist services to treat dependent drinkers. Our approach is founded on strong evidence, not only that brief interventions and specialist alcohol treatment are effective for the people receiving them, but also that these services represent value for money in terms of NHS costs as they usually provide a net saving to the NHS. We seek to develop the evidence and to ensure that it is well known in the NHS.

43. International evidence shows strongly that, following a brief discussion with their GP, or nurse, one in eight higher-risk drinkers will reduce consumption to lower-risk levels.

44. The National Treatment Agency for Substance Misuse published a review of the effectiveness of alcohol treatment in 2006, which sets out the evidence that investment in treatment should yield net savings to the NHS.

45. Since November 2007, the Department has been running a £4 million "Trailblazer" programme. This comprises 52 projects, in GP practices, Accident & Emergency Departments, and probation settings. These are testing the most cost-effective ways in these settings of providing brief advice for those drinking at increasing-risk or higher-risk-levels. Initial findings are due in September 2009.

46. A new Directed Enhanced Service (DES) provides funding of £8 million for the development of identification and brief advice in primary care from 2008-09 for new registrants.

⁶ *The Effects of Alcohol Pricing and Promotion*. December 2008, School of Health and Related Research, Sheffield University. http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Alcoholmisuse/DH_4001740

47. We have also developed:

- Undergraduate medical training to help all new doctors identify and handle substance misuse problems, including alcohol.
- An E-learning programme available from February 2009 for those GPs who wish to develop “brief interventions”.

48. The Home Office has rolled out 13 **alcohol arrest referral pilots** across the country since October 2007. The aim of the pilots is to reduce re-offending among people arrested for alcohol-related offences by providing brief advice sessions on safer drinking and highlighting the link between alcohol and offending behaviour. These pilots will provide an opportunity to collect detailed evidence about how these interventions combat alcohol-related crime and disorder. At the same time, they will help establish a blueprint of best practice for others to follow.

CENTRAL GOVERNMENT POLICY (IV)

A DELIVERY SYSTEM THAT EFFECTIVELY PRIORITISES AND DELIVERS PREVENTION AND TREATMENT FOR ALCOHOL MISUSE

49. The Department aims to provide PCTs with the support, tools and incentives they need to provide services in their own areas effectively according to local needs.

50. In April 2008, the Department of Health put a new vital signs indicator for alcohol-related hospital admissions in place to enable NHS progress in dealing with alcohol harm to be monitored. The response has been encouraging. 99 PCTs have included this indicator in their plans as a local priority. The indicator also forms part of 73 Local Area Agreements.

51. This indicator is the first ever commitment to monitor how well the NHS is tackling alcohol related health harm. We expect the introduction of the indicator to result in a significant impact on the rising trend in hospital admissions over the coming years.

World Class Commissioning

52. All PCTs are now assessed on their progress against World Class Commissioning competencies and on the calibre of their governance.

- As part of the WCC commissioning assurance system, PCTs are required to demonstrate skills in prioritisation and strategic planning. As an element of this, all PCTs are assessed against up to 10 local health outcomes as an assurance of their commissioning capability.
- Two of these local health outcomes are mandatory (health inequalities and life expectancy) and tackling alcohol contributes to these.
- Feedback on the remaining eight local priorities that PCTs have chosen to include in their strategic plans as part of WCC shows that alcohol is featuring highly, and has been selected by 75 PCTs.
- The Department has provided extensive support to PCTs for this process and is now preparing alcohol specific commissioning guidance founded on WCC principles for issue during Spring 2009.
- The new guidance will complement and signpost the extensive support materials we have already made available to PCTs through the Alcohol Learning Centre.

Capacity and capability of delivery partners and collaborative working

53. A National Audit Office study, October 2008, of the NHS response to alcohol harm found that:

- The profile of alcohol within the NHS has risen, not least due to the vital signs indicator and the investment in data and support for commissioning.
- There is good evidence that brief interventions and specialist alcohol treatment should provide value for money in terms of NHS costs.
- Significant local variations exist in commissioning skills and practice.

The Alcohol Improvement Programme

54. This programme was launched on 5 November 2008 and includes:

- Data on local service provision and need. This includes the **National Alcohol Treatment Monitoring System**, which provides information for commissioners and providers on specialist alcohol treatment in each area including the length of time people have to wait.
- Advice on commissioning, through the NHS **World Class Commissioning** programme.
- Sharing best practice through the **Alcohol Learning Centre**.

- Direct support and funding to a group of 20 “**Early Implementer**” PCTs with high levels of alcohol-related hospital admissions in areas of high health inequalities. They will receive £11 million additional funding between 2008 and 2011.
- A **National Support Team for Alcohol** from September 2008, giving strategic support to areas with high rates of alcohol-related hospital admissions.
- The Department has provided £2.7 million new funding from 2008–09 for **Regional Alcohol Managers** to coordinate the Alcohol Improvement Programme in each region.

Background to the new alcohol-related hospital admissions data

55. Excessive drinking can result in a wide range of acute and chronic illnesses. Some are caused only by alcohol, like acute alcohol poisoning and alcohol related liver disease. These are known as **alcohol specific** illnesses. Other diseases or conditions, such as stroke, cancer and coronary heart disease may also be caused by other factors. These are described as **alcohol attributable** diseases.

56. We can accurately measure the number of alcohol specific hospital admissions based on the disease diagnosis, but we can only estimate the number of alcohol attributable admissions. Estimates are based on high quality epidemiological research into the proportion of each disease understood to be caused by alcohol.

57. **Alcohol related admissions data** is a wider definition (covering admissions for both alcohol-specific and alcohol attributable illnesses), developed to provide a better estimate of the total disease burden from alcohol consumption. Data are included on 45 conditions, of which 13 are wholly attributable to alcohol consumption and 32 conditions are partly attributable to alcohol consumption.

58. The use of partly attributable conditions allows national and local planning based upon the full range of conditions that are alcohol-related disease. The resulting figures remain estimates and we are continually working to refine them.

March 2009

Memorandum by Professor David Foxcroft (AL 02)

IN THE FACE OF SCIENTIFIC UNCERTAINTY: THE PRECAUTIONARY PRINCIPLE AS A BASIS FOR ALCOHOL MISUSE PREVENTION POLICY

This is an individual submission from Professor David Foxcroft. David Foxcroft is a Chartered Psychologist specializing in Prevention Science and holds a Chair at Oxford Brookes University. His major research interest is in the prevention of alcohol and drug misuse, especially in young people. He responsibilities include: Editor, International Cochrane Collaboration Drug and Alcohol Group; Editorial Board, *Drugs: Education, Prevention and Policy*; Trustee, Alcohol Education and Research Council; Trustee, the Drinkaware Trust; Honorary Visiting Scientist at the Addictive and Health Behaviours Research Institute, University of Florida. Previously he has been a specialist advisor to the World Health Organisation Substance Misuse Office (2001–02); was a member of the Home Office Blueprint drug prevention programme steering group (2002–05); and the Health Development Agency national drug misuse prevention advisory group (2002–04); provided a commissioned technical report to WHO Expert Committee on Problems Related to Alcohol Consumption (2006); and briefed the Cabinet Office for the development of the National Alcohol Strategy (2003) and has similarly advised the National Assembly for Wales (2007–08). He was awarded the Nan Tobler prize (2007) by the US Society for Prevention Research (SPR) for his work on alcohol misuse prevention.⁷

SUMMARY

Evidence on the effectiveness of alcohol misuse prevention programs is mixed, with some good evidence on the ineffectiveness of certain prevention programs, but scientific uncertainty regarding other interventions. In the challenging scenario of having to generate policy with an equivocal evidence base, extending the precautionary principle to incorporate the notion of beneficence alongside the primary notion of non-maleficence suggests interventions with the most support in high quality studies should be applied. In cases where interventions are predicated on inconclusive evidence, a program of evaluation is essential to promote future evidence based practice and to limit the opportunity cost associated with ineffective or relatively poorer preventive action.

⁷ www.snipurl.com/foxcroft

1. *Scientific Uncertainty*

1.1 Recent evidence and evidence reviews of the literature on the effectiveness of alcohol misuse prevention programs for young people give an uncertain picture.^{8, 9} On the one hand, there is pretty good evidence that some educational interventions, notably those that focus on increasing knowledge and awareness, or raising self-esteem, are ineffective. Yet these interventions persist in policy and practice because of a politicized decision making process.¹⁰ On the other hand, there is a fairly mixed bag of effectiveness evidence for social skills or family based prevention efforts, with some studies showing no effect whilst other studies show some positive effects. But much of the evidence is blighted by methodological weaknesses that make it difficult to draw out clear policy and practice recommendations.¹¹ For example, most single trials are too small and their results are not sufficiently robust against the effects of chance.¹²

1.2 This picture of scientific uncertainty clearly is not sufficient for strong evidence based prevention policy. There is a need for high quality replication studies in different settings to confirm or disconfirm provisional findings. But neither is this a conclusion that alcohol education and misuse prevention is ineffective, as some have argued.^{13, 14} This does, however, leave policy makers with an absence of strong evidence on which to make decisions and recommendations, and it is in this context that the precautionary principle might be put to good use.

2. *The Precautionary Principle*

2.1 The precautionary principle was initially developed to cover environmental hazards, for instance the United Nations 1992 Rio Declaration¹⁵ states that “Nations shall use the precautionary principle to protect the environment. Where there are threats of serious or irreversible damage, scientific uncertainty shall not be used to postpone cost-effective measures to prevent environmental degradation”. Similarly, the oft-quoted Wingspread Statement¹⁶ recommends that:

“where an activity raises threats of harm to the environment or human health, precautionary measures should be taken even if some cause and effect relationships are not fully established scientifically. In this context the proponent of an activity, rather than the public, bears the burden of proof”.

This means that those wishing to introduce a new product, for example a new pesticide, are required to provide convincing evidence for its safety otherwise regulatory bodies can exert the precautionary principle to limit the use of the product.

2.2 More recently there have been calls to extend the precautionary principle to other areas of public safety, for example public health actions¹⁷ including injury prevention¹⁸ where it is argued that the original focus of the precautionary principle on environmental hazards is “visionary but short sighted”.¹⁸ Accordingly, the principle can be extended to, for example, cell phone use in cars, or the use of bicycle helmets. In these examples there is still debate about what the evidence tells us, but under the extended precautionary principle the benefit of any doubt about harmfulness would prompt policy makers to take action to prevent cell phone use in cars (as many countries have now done through legislation), or to promote cycle helmet use (as many countries now do through health promotion activities).

2.3 This suggested development of the precautionary principle is more complex than it might at first seem, with not only an expansion into public safety, but also an extension into the area where there is overlap between the prevention of harm and the promotion of health. Simply stated, the original precautionary principle might be expressed as:

Prohibiting an activity where there is scientific uncertainty of potential harm from the activity is justified;

whereas the extended principle would also add the following:

Supporting an activity where there is scientific uncertainty of potential benefit from the activity may be justified.

⁸ Foxcroft D, Ireland D, Lister-Sharp D, Lowe G, Breen R. Longer-term primary prevention for alcohol misuse in young people: a systematic review. *Addiction* 2003;98:397–411.

⁹ National Research Council. *Informing America’s policy on illegal drugs: what we don’t know keeps hurting us*. Washington, DC: National Academy Press; 2001.

¹⁰ Rosenbaum DP. Just say No to D.A.R.E. *Criminology & Public Policy* 2007;6(4):815–824.

¹¹ Foxcroft DR, Lister-Sharp D, Lowe G. Alcohol misuse prevention for young people a systematic review reveals methodological concerns and lack of reliable evidence of effectiveness. *Addiction* 1997;92:531–537.

¹² Ioannidis JPA. Why most published research findings are false. *PLoS Medicine* 2005;2(8 (e124)):696–701.

¹³ Foxcroft DR. Alcohol education: absence of evidence or evidence of absence. *Addiction* 2006;101(7):1057–9.

¹⁴ Rehm J, Babor TF, Room R. Education, persuasion and the reduction of alcohol-related harm: a reply to Craplet (2006). *Addiction* 2006;101(3):452–453.

¹⁵ United Nations Environment Programme (UNEP). *Rio declaration on environment and development*. In: *Made at the United Nations Conference on Environment and Development, Rio de Janeiro, Brazil; 1992*.

¹⁶ Wingspread. *The precautionary principle*. *Jane’s Environment and Health Weekly* 1998;586.

¹⁷ Goldstein BD. The precautionary principle also applies to public health actions. *American Journal of Public Health* 2001;91:1358–1362.

¹⁸ Pless IB. Expanding the precautionary principle. *Injury prevention* 2003;9:1–2.

2.4 The original, or primary, form of the principle follows from the notion that one should do no harm, or non-maleficence, whereas the extended, or secondary, form is based on the notion of beneficence. Both are important notions for public health and specifically for alcohol policy and prevention. Extending the precautionary principle in this way it is possible to see how it might be applied in alcohol misuse prevention policy where there is provisional or equivocal evidence about the effectiveness of prevention programs, and where the potential for harm if an unknowingly effective program is not implemented is considered to be high.

3. *Qualifying Criteria for using the Precautionary Principle*

3.1 Given the picture of scientific uncertainty regarding the effectiveness of alcohol misuse prevention programs, coupled with the potential for disbenefit or harm if potentially effective programs are not implemented, policy makers arguably have a rationale for invoking the precautionary principle until such time as further evidence emerges which convincingly rejects the currently provisional or limited evidence of effectiveness. But, invoking the precautionary principle without considering the context of its use could be a problem.

3.2 Although the precautionary principle is arguably an important concept when applied to the field of alcohol and drug prevention, and therefore might be one of the explicit values held by policy makers, there is a danger that the principle might be loosely applied to support preventive actions where there is no or poor evidence for effectiveness or cost effectiveness or, worse still, if there was a risk that a prevention program might do more harm than good. The possibility of more harm than good has indeed been raised^{19, 20} although it is also possible that any iatrogenic effects from prevention programs are spurious statistical artefacts.^{21, 22} In any case, the primary form of the precautionary principle (non-maleficence) should generally be dominant over the secondary form of the principle (beneficence). Any loose or unclear application of the precautionary principle would be unfortunate as it would undermine the principle and essentially make it unworkable: the principle should not, in any circumstance, be applied so that just any preventive action can be justified. Rather, it is suggested that four qualifying criteria should be established:

- The costs and harms associated with a lack of effective action are considered to be high.
- There is some provisional high quality evidence of effectiveness for a specific preventive action, with no indication that the preventive action is in itself harmful, but further research is needed to provide convincing evidence either for or against the preventive action.
- Cost-effectiveness studies or models point to the potential of the preventive action to reduce costs and harms.
- Further high quality studies are fully resourced and planned or ongoing to establish convincing evidence for or against the specific preventive action so that the opportunity cost associated with a possibly ineffective preventive action can be minimised.

Providing the precautionary principle is only used when these four qualifying criteria are satisfied then we should have an important and workable principle.

3.3 One aspect where this formulation differs from earlier and narrower statements of the precautionary principle is responsibility for the burden of proof. According to the Wingspread Declaration,²³ the proponents of the activity should bear the burden of proof. But with alcohol misuse it is the general lack of activity which is potentially harmful, and it is difficult to see who the proponents for not undertaking a specific preventive action would be, other than those who think the opportunity cost is too high and that prevention resources would be better invested elsewhere. Because of this the burden of proof should, for practical reasons, rest with those who have responsibility for alcohol policy and for the best use of public funds, ie governments. The final criterion above is therefore important otherwise there is a danger that public money will continue, year after year, to be wasted on ineffective alcohol prevention programs.

4. *Making the implicit explicit*

4.1 Policy makers have probably, for many years, been using an implicit form of the precautionary principle in various policy arenas, including alcohol, drug, tobacco, sexual and mental health, where there is potential for harm if nothing is done. In fact, this approach characterises much of current preventive

¹⁹ Moos H. Iatrogenic effects of psychosocial interventions for substance use disorders: prevalence, predictors, prevention. *Addiction* 2005;100:595–604.

²⁰ Werch CE, Owen DM. Iatrogenic effects of alcohol and drug prevention programs. *Journal of Studies on Alcohol* 2002;63:581–590.

²¹ Foxcroft D, Ireland D, Lister-Sharp D, Lowe G, Breen R. Longer-term primary prevention for alcohol misuse in young people: a systematic review. *Addiction* 2003;98:397–411.

²² Foxcroft D, Ireland D, Lister-Sharp DJ, Lowe G, Breen R. Primary prevention for alcohol misuse in young people. *The Cochrane Database of Systematic Reviews* 2002, Issue 3. Art. No.: CD003024. DOI: 10.1002/14651858.CD003024. 2002.

²³ Wingspread. The precautionary principle. *Jane's Environment and Health Weekly* 1998;586.

health care policy, because there are many prevention programs supported that are not evidence based. And the proliferation of non-evidence based prevention programs is certainly a cause of concern for many scientists and policy makers in the context of the contemporary emphasis on evidence based policy and practice.

4.2 In preventive health and social care there are many cases where an explicit and developed form of the precautionary principle could be applied. Not only are there costs to health for not applying the available evidence, but there are economic costs in lost productivity due to illness if even small numbers of individuals are not prevented from, for example, starting to use drugs. A number of researchers have attempted to balance the costs saved by universal alcohol and drug prevention interventions on health-care costs and wider societal costs.²⁴ Even when prevention programs had only a small effect, the lifetime benefits for health and society of reducing alcohol, tobacco and drug use (US \$840 per participant) outweighed the costs of running the project (US \$150 per participant). But there are many alternative prevention programs that do, or might, have a small effect. Some might even have a bigger impact, but at greater cost. A key question, therefore, is which, if any, specific prevention program(s) should be supported in the face of limited, or equivocal, evidence about their effectiveness and compared with alternative techniques and policy options.

5. Conclusion

5.1 In the challenging scenario of having to generate policy with an equivocal evidence base, the precautionary principle suggests techniques with the most support in high quality studies should be applied. In cases where interventions are predicated on inconclusive evidence, a program of evaluation is essential to promote evidence based practice in the future. This will not only form the basis for preventive action in the face of scientific uncertainty, but will also form the basis for supporting further research to limit the opportunity cost associated with ineffective preventive action. In this way, prevention policy and prevention science policy are joined in pragmatism,²⁵ addressing concerns about the highly politicized nature of policy making which can lead to continuing and costly support for ineffective interventions.²⁶ Governments and other agencies may wish to consider incorporating this explicit statement of the precautionary principle, including the four qualifying criteria, as part of their prevention policy decision making framework.

March 2009

Memorandum by the Royal Pharmaceutical Society of Great Britain (AL 03)

We welcome the opportunity to make a submission to the Select Committee's inquiry on alcohol.

The RPSGB has responded to the Department of Health's *Safe sensible social consultation on further action*²⁷ and the National Institute of Health and Clinical Excellence (NICE) consultation on *Alcohol dependence and harmful alcohol use*.²⁸

We are a member of the Alcohol Health Alliance UK which is a groundbreaking coalition of 24 organisations whose mission is to reduce the damage caused to health by alcohol misuse and who are working together to:

- Highlight the rising levels of alcohol-related health harm;
- Propose evidence-based solutions to reduce this harm; and
- Influence decision makers to take positive action to address the damage caused by alcohol misuse.²⁹

This submission focuses on the contribution pharmacy can make to addressing alcohol misuse. We believe that pharmacists are trusted health professionals who can support government policy by supporting changes in public attitude and encouraging responsible drinking.

²⁴ Caulkins JP, Pacula RL, Paddock S, Chieas J. School-based drug prevention: what kind of drug use does it prevent? Santa Monica, CA: RAND; 2002.

²⁵ Dewey J. *The Public and its Problems*. New York: Holt; 1927.

²⁶ Rosenbaum DP. Just say No to D.A.R.E. *Criminology & Public Policy* 2007;6(4):815–824.

²⁷ Available at <http://www.rpsgb.org/pdfs/consdoc1639.pdf>

²⁸ Available at <http://www.rpsgb.org/pdfs/consdoc1758.pdf>

²⁹ For more information see the Alcohol Health Alliance UK webpage hosted by the Royal College of Physicians at <http://www.rcplondon.ac.uk/professional-Issues/Public-Health/Pages/Alcohol.aspx>

BACKGROUND—THE ROYAL PHARMACEUTICAL SOCIETY OF GREAT BRITAIN

The Royal Pharmaceutical Society of Great Britain (RPSGB) is the professional and regulatory body for pharmacists in England, Scotland and Wales. It also regulates pharmacy technicians on a voluntary basis, which is expected to become statutory under anticipated legislation.

The primary objectives of the RPSGB are to lead, regulate, develop and represent the profession of pharmacy.

The RPSGB leads and supports the development of the profession within the context of the public benefit. This includes the advancement of science, practice, education and knowledge in pharmacy. In addition, it promotes the profession's policies and views to a range of external stakeholders in a number of different forums.

Following the publication in 2007 of the Government White Paper *Trust, Assurance and Safety—The Regulation of Health Professionals in the 21st Century*, the Society is working towards the demerger of its regulatory and professional roles. This will see the establishment of a new General Pharmaceutical Council and a new professional body for pharmacy in 2010.

1. *The scale of ill-health related to alcohol misuse*

1.1 We believe that others are best placed to respond to this issue.

2. *The consequences for the NHS*

2.1 We believe that others are best placed to respond to this issue.

3. *Central government policy*

3.1 As we stated in our response to the Department of Health's Safe sensible social consultation we are heartened that the Government is demonstrably taking England's harmful drinking culture seriously and outlining a range of proposals which could have a positive impact on alcohol misuse and its impact on health and wellbeing. It is encouraging to see alcohol-related problems being discussed in a more holistic way which recognises that a whole population approach is needed to make the required cultural shift.

4. *The role of the NHS and other bodies including local government, the voluntary sector, police, the alcohol industry, and those responsible for the advertising and promotion of alcohol*

THE ROLE OF COMMUNITY PHARMACY

4.1 In 2005 *Choosing Health through pharmacy*³⁰ identified opportunistic advice, brief interventions and offering floor space to other health professionals as areas where community pharmacists can engage in reducing harm from alcohol, particularly as their public health role has been formalised in the contractual arrangements.

4.2 In England and Wales, pharmacies are required to participate in up to six public health campaigns each year, with topics decided by local primary care organisations (PCOs). One of these topics could appropriately involve alcohol intake. Pharmacists also have a contractual requirement to signpost patients to other services.

4.3 The 2008 pharmacy white paper *Pharmacy in England: building on strengths—delivering the future*³¹ refers to the scope for pharmacists to contribute to alcohol harm reduction in five areas:

- Healthy lifestyle advice;
- Brief interventions;
- Prescribing or Patient Group Directions (PGD)³² to enable the supply of medicines to reduce alcohol intake;
- Blood tests; and
- Supervised monitoring of medicines to treat alcohol withdrawal.

³⁰ DH (2005) *Choosing Health through pharmacy—A programme for pharmaceutical public health 2005–15*. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4107494

³¹ DH (2008) *Pharmacy in England: building on strengths—delivering the future*. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083815

³² Patient Group Directions are documents which make it legal for medicines to be given to groups of patients—for example in a mass casualty situation—without individual prescriptions having to be written for each patient.

4.4 To date community pharmacists have had little involvement in the provision of alcohol misuse services. However pharmacists have specialist expertise in working with addictions through their involvement in substance misuse (supervised methadone administration)³³ and smoking cessation services. These skills can be utilised in the context of a wide ranging approach in reducing harm from alcohol.

4.5 In 2008 we published *Community Pharmacy and Alcohol Misuse Services: a Review of Policy and Practice*.³⁴ This report found that:

- Community pharmacy could be an appropriate setting for alcohol misuse services;
- Brief interventions are appropriate and clinically useful tools for use in the community pharmacy setting; and,
- The expertise gained from providing pharmacy-based smoking-cessation services could be a good basis for developing alcohol-misuse services.

4.6 Some pharmacies are already delivering these services. For example in 2008, Wirral PCT commissioned over 50 local pharmacies to deliver brief interventions for alcohol misuse.³⁵

4.7 We are also aware that there is a pilot program of community pharmacists delivering brief alcohol interventions in the Forth Valley in Scotland.³⁶

4.8 The Guy's and St Thomas' Charity has awarded £258,000 to Lambeth PCT and researchers at King's College London to oversee an alcohol screening project involving community pharmacies in Lambeth.³⁷

4.9 Pharmacy alcohol misuse services will need to be integrated into wider services including referral pathways to specialist alcohol services. Pharmacists and their staff will need awareness of local services and referral mechanisms for patients with needs beyond the scope of the pharmacy service.

4.1.1 Community pharmacies can also play an important role in referring patients to self help and support groups.

4.1.2 Pharmacies are conveniently located in the vast majority of communities and they are very accessible as patients do not need to make appointments. They are a good place for information to be distributed to patients and the wider public.

PHARMACISTS IN PRISONS

4.1.3 Pharmacists have been at the forefront of the supervised methadone programme. There is an opportunity to expand these services into the related areas of alcohol, with treatment orders for supervised abstinence therapy in pharmacies which would allow suitable offenders to be treated in the community rather than in mental health units or prison facilities.

4.1.4 A significant proportion of prisoners are received into prison with a history of alcohol misuse and will undergo immediate detoxification. Pharmacists with direct contact with prisoners through clinics or providing prescription advice are well placed to provide health promotion advice relating to alcohol use to complement that given by other professionals within the prison. Prisoners "tend to have poorer physical and mental health than the population at large"³⁸ and can be a hard to reach target group following release into the community.

PHARMACISTS IN SECONDARY CARE

4.1.5 Alcohol misuse is linked to health inequalities and long term conditions and pharmacists are already involved in these areas. Pharmacists are able to utilise their clinical skills in brief interventions, treatment plans and patient screening. Pharmacists in primary and secondary care have extensive patient contact either in hospitals, during reviews in GP practices or in the community setting.

4.1.6 Pharmacists in secondary care also have important roles. These pharmacists can identify patients on acute medical and general psychiatric wards who are withdrawing from alcohol and advise ward staff about appropriate detoxification treatment and check referral systems to tier 2 and tier 3 alcohol services (provided that such services exist with sufficient capacity). Members of the Society are aware of situations where patients are started on a chlordiazepoxide withdrawal regimen but are discharged before the course

³³ This service involves the pharmacist supervising the consumption of prescribed medicines such as methadone and other medicines used for the management of opiate dependence, in the pharmacy. Pharmacists also offer patients non-judgemental and confidential advice and including referral to primary care or specialist centres where appropriate. Further information on the England and Wales Community Pharmacy Contract can be found at <http://www.psnc.org.uk/>

³⁴ <http://www.rpsgb.org/pdfs/commpharmacismisuseservices.pdf>

³⁵ Further information on the Wirral PCT scheme can be accessed at <http://www.wirral.nhs.uk/news.aspx?StoryId=2230>

³⁶ Further information on the Scottish Enhanced Services Programme for Primary and Secondary Care 2007-2009 can be accessed at <http://www.sehd.scot.nhs.uk/publications/DC20070907seps.pdf>

³⁷ Further information on the project can be accessed at the Charity's website <http://www.gsttcharity.org.uk/pdfs/brochure0708.pdf>

³⁸ DH (2003) A pharmacy service for prisoners. At page 9. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4007054

is completed and follow up support put in place. As the pharmacist dispensing the medication, the hospital pharmacist is in a position where they can check with ward staff that suitable referrals have been made and quantify the size of the problem across the hospital.

4.1.7 Pharmacists in secondary care also have an important medicine management role and can perform a variety of functions such as:

- Writing and developing Standard Operating Procedures for detoxification for both community and in-patient detoxification.
- Prescribing and managing detoxification as non-medical prescribers.
- Designing specialist in-patient and out-patient prescription cards to ensure the complex regimes are presented safely and efficiently for medical and nursing staff.
- Providing education and training to nursing and medical staff on the pharmacological aspects of detoxification.
- Writing and developing local patient information leaflets on drugs such as disulfira, acamprosate, chlordiazepoxide, vitamin B, parenteral vitamins, and naltrexone.
- Medicines management and supervision of drugs used in detoxification regimes.

5. Solutions, including whether the drinking culture in England should change, and if so, how?

5.1 The key messages of the Alcohol Health Alliance are:

- (a) Alcohol treatment and prevention programmes should be funded;
- (b) Alcohol taxation should be increased; and
- (c) There should be better regulation of the drinks industry.³⁹

5.2 Research has shown that “young people suffer disproportionately from high alcohol-related mortality”.⁴⁰ A much more holistic approach to tackling young people’s alcohol consumption is needed that brings together education, treatment and enforcement. There also needs to be greater public awareness of the potentially harmful long-term implications of heavy drinking during adolescence. This may encourage parents and carers to think about and eventually change their own drinking behaviour and could contribute to a process of cultural change which begins to de-normalise and change perceptions about excessive drinking in England.

5.3 In addition, we believe that the Government must take much stronger action on communicating the risks and effects of drinking alcohol during pregnancy to women of all ages. There is a need for the government to give clear and consistent advice to women regarding alcohol use while pregnant. Pharmacy would be ideally placed to help promote the right messages and provide advice to pregnant women.

5.4 Furthermore, we believe that the Government should consider and take advantage of community pharmacies:

- The regular contact pharmacists in the community have with wide sections of the population, including children and families of those with alcohol problems, giving increased access to specialist professional support and advice when required;
- The contact and interaction with at risk individuals and the ability to recognise those individuals through hospital admissions, prescription requirements, over the counter purchases and advice sought;
- Inclusion of alcohol awareness as part of public health campaigns using community pharmacies as a channel for health information and advice to help educate and raise awareness of alcohol units;
- The unique advantage community pharmacists have being the most accessible health professional in the community, available without appointments in the evenings and at weekends in an informal setting which can encourage otherwise reluctant individuals to seek advice and support;
- The parallels with smoking cessation and drug misuse services currently available in pharmacies; and
- Raising awareness with the general public of the pharmacist’s ability to provide advice as part of the healthcare team.

We hope that our comments will be of use to the Committee and look forward to seeing the final report.

February 2009

³⁹ For more information see the Alcohol Health Alliance UK webpage hosted by the Royal College of Physicians at <http://www.rcplondon.ac.uk/professional-Issues/Public-Health/Pages/Alcohol.aspx>

⁴⁰ Sheron, N, Olsen, N, & Gilmore, I (2008) An evidence-based alcohol policy. *Gut* October 2008;57;1341–1344; at pg 1342.

Memorandum by the Alcohol Education and Research Council (AL 04)

ALCOHOL RELATED PROBLEMS

1. EXECUTIVE SUMMARY

A great deal of evidence relating to alcohol policy can be found on the AERC website. These research findings support the following policy initiatives:

1.1 All districts should implement community programmes that focus upon mobilising the community, responsible sales, reduced availability of alcohol being sold to minors, as well as drink driving and media campaigns.

1.2 One component of a community approach should be a Safer Bars programme that attempts to curb aggression in bars.

1.3 Intensive implementation of test purchasing along with other community interventions is needed to have a major impact.

1.4 All A&E departments should have access to an Alcohol Health Worker who can be responsible for brief interventions.

1.5 There should be widespread use in all health settings of very brief screening instruments such as the Fast Alcohol Screening Test.

1.6 Young men are particularly at risk: A brief intervention programme within a maxillofacial service is an excellent method of reducing alcohol consumption in the 18 to 30 year old group.

1.7 Training in brief interventions should be widespread. Simply giving nurses intervention materials plus written guidelines alone is not sufficient. Skill-based training is the most effective and cost-effective approach.

1.8 A range of family interventions should be involved in treatment and prevention.

1.9 Pricing policies can be effective in reducing harm related to health, crime and unemployment. Minimum unit pricing and discount bans could save hundreds of millions of pounds every year in NHS, crime and unemployment costs.

2. ABOUT THE ALCOHOL EDUCATION AND RESEARCH COUNCIL

The Council funds research and development projects as well as a limited number of studentships. The Council was established by the Government in 1982 by an Act of Parliament, The Licensing (Alcohol Education and Research Act 1981), to administer the Alcohol Education and Research Fund. This Fund finances projects within the United Kingdom for education and research on alcohol related issues.

The Council's main aims are to:

- Generate and disseminate research based evidence to inform and influence policy and practice.
- Develop the capacity of people and organisations to address alcohol issues.

The Council's web site includes a large number of reports which have relevance to alcohol policy: <http://www.aerc.org.uk>.

3. ALCOHOL POLICY INITIATIVES

In the government publication entitled *Safe, Sensible & Social* it is estimated that the cost to the nation of excessive alcohol consumption is between £17.7 billion and £25.1 billion a year. Of this, the cost to the NHS is £2.7 billion per year. There were 811,000 alcohol-related hospital admissions in 2006–07, comprising 6% of all hospital admissions. More than 10 million adults are regularly drinking at levels that exceed government guidelines.

The massive harm resulting from excessive consumption is now clear and so we will focus on initiatives that can reduce or prevent this harm; most of the evidence outlined below has been commissioned or funded by the AERC.

3.1 *Community Interventions*

Community programmes move away from placing the responsibility solely on individuals and their families and promote community ownership of problems and solutions. In order to look more closely at community initiatives the AERC funded projects in Cardiff, Birmingham and Glasgow.

This investigation known as the United Kingdom Community Alcohol Prevention Project (UKCAPP) demonstrated that British communities can generate the kind of coordinated action which the USA and Sweden have shown can reduce alcohol-related violence and injury.

The AERC UKCAPP report⁴¹ documents how all three were able to generate activity of the kind they sought. An example is the impact in Birmingham, where in the targeted area (a transport corridor crossing three suburbs) the project started with a clean slate in terms of existing community organisation. Trading standards staff visited all the area's alcohol outlets, alerting staff to their responsibilities and warning of future "sting" operations to test whether outlets would sell to underage youngsters.

Police recorded reports of licensing infringements, followed up with an advice visit, and mounted highly visible operations similar to those used in relation to illicit drugs. Possibly as a result, offences such as vehicle crime, domestic burglary and robbery in the area fell by over a third compared to just 9% in a neighbouring area, and public place wounding fell by 30% compared to 17%, though the numbers involved were small. After the project was established few premises sold to underage test purchasers and most asked for proof of age.

The AERC Community Project in Glasgow was highlighted in the Scottish Executive's Update on Plan for Action on Alcohol Problems—Summary of Actions No 10⁴²—one of the targets is: "extending successful measures from the AERC funded culture change pilot to all areas of Scotland.

3.2 Server Training

An AERC systematic review of responsible server training in preventing injury indicated that the supportive evidence is meagre.⁴³

However one approach, the Safer Bars programme, attempted just to curb aggression in bars.⁴⁴ Managers worked through a checklist of the physical and social features of bars associated with aggression and selected relevant changes to implement. Additionally, a three-hour, group training session was offered to managers and to staff who interacted with customers. Rather than preventing intoxication through "responsible serving", the training focused on managing aggression—recognising and responding to warning signs, keeping cool and defusing incidents. The number of incidents involving aggression by customers fell in the intervention group but increased in the control premises.

3.3 Test purchasing

One AERC research project was labelled a landmark study by the Findings reports.⁴⁵ This study was based on test purchases by underage youngsters. It is suggested that many vendors' primary concern was not to avoid underage selling as such, but to avoid prosecution for selling to children who were clearly underage. The young people's self-reports were corroborated by test purchase data confirming that 16-year-old girls and boys, and girls as young as 13, have little difficulty in buying alcohol. "Findings" concluded that intensive implementation of test purchasing and other community interventions is needed to have a major impact. "Planning and licensing decisions which increase the density of drinking outlets, and competitive and financial pressures driving the policies of large club or pub chains, can counter the benefits. However, benefits remained and were probably enough to create substantial cost-savings for society".

3.4 Brief Interventions in A&E Departments

Accident and Emergency departments see a large number of patients who misuse alcohol. The AERC funded a study of A&E that has had a significant impact on practice and policy.⁴⁶ After screening, those who were referred on to an *alcohol health worker* were drinking less at follow up. At six months they were drinking 23 units of alcohol a week less than those given an information leaflet: at twelve months the difference was 14 units. Furthermore those referred to the alcohol health worker had on average fewer visits to the Accident and Emergency Department over the following 12 months. Attendance at an AED provides a "teachable moment" in which opportunistic identification of alcohol misuse can potentially help patients develop insight into the consequences of their drinking and promote improved health.

⁴¹ UKCAPP: an evaluation of 3 UK Community Alcohol Prevention Programs
http://www.aerc.org.uk/documents/pdfs/finalReports/AERC_FinalReport_0039.pdf

⁴² Scottish Executive's Update on Plan for Action on Alcohol Problems—Summary of Actions
<http://www.scotland.gov.uk/Publications/2007/02/19150222/3>

⁴³ The effectiveness of interventions in the alcohol server setting for preventing injuries: findings from a Cochrane Systematic Review: http://www.aerc.org.uk/documents/pdfs/insights/AERC_AlcoholInsight_0034.pdf

⁴⁴ The normalisation of binge drinking? An historical and cross cultural investigation with implications for action. http://www.aerc.org.uk/documents/pdfs/insights/AERC_AlcoholInsight_0049.pdf

⁴⁵ Internationally proven community alcohol crime and harm reduction programmes feasible in Britain:
http://findings.org.uk/docs/bulletins/Bull_07_11_08.htm

⁴⁶ FAST alcohol Screening Test Manual: http://www.aerc.org.uk/documents/pdfs/finalReports/AERC_FinalReport_0007.pdf

3.5 *Screening for risky drinking*

A very widely used screening test for alcohol misuse is the Alcohol Use Disorders

Identification Test (AUDIT), which was developed in a World Health Organisation collaborative project across six countries. Although AUDIT has been well validated and is turning out to be a very useful screening test, there are some situations, such as busy clinics as well as Accident and Emergency departments, where AUDIT takes too long to administer routinely. AERC funding led to the development of the Fast Alcohol Screening Test (FAST) which is now being used by many doctors' clinics and A&E departments.⁴⁷ It is the Screening Instrument of choice in a recently published book entitled: *Nursing Practice: Hospital and Home*. Compared to other tests it is quicker and very easy to incorporate into a medical interview. It works equally well in different medical settings including primary care, dental hospitals and fracture clinics and for different age and gender groups. The FAST is now one of the top rated screening instruments.

3.6 *Brief Interventions with young men*

Maxillo-facial surgeons see a regular stream of young male casualties with alcohol related facial injuries. The majority of them have been involved in a fight, usually on a Friday or Saturday night. They attend an A&E department, receive appropriate treatment and are given an appointment for a follow-up clinic within the next 10 days. This clinic provides an ideal opportunity to influence the drinking patterns of these young men. Can advice given at this point, when the young men are concerned about their good looks, influence future alcohol consumption? The AERC funded a brief intervention study to look at this possibility.⁴⁸ The motivational intervention lasted for less than twenty minutes and was given by the nurse as she removed stitches. Even though this intervention was very brief, it resulted in a significant change in alcohol consumption during the following year when compared to treatment as usual. There was a reduction of 55% in the number of young men drinking over the recommended limits compared to a drop of 8% in the comparison group. A brief dialogue between a nurse and a patient was clearly more effective than the natural processes associated with the passage of time. It is important to note that the dialogue with the nurse was completed as part of a routine service without the need for additional resources or additional time.

3.7 *Training*

A study completed with AERC funding looked at the best way to train nurses to carry out screening and brief interventions.⁴⁹ This training study evaluated the impact on implementation of providing nurses with (a) written guidelines, (b) guidelines plus practice-based training or (c) guidelines plus training and ongoing telephone support.

This study showed that primary care nurses are certainly interested in screening and brief alcohol interventions and many of them are willing to incorporate this approach into practice. Simply giving nurses intervention materials plus written guidelines alone was not sufficient. Skill-based training was the most effective and cost-effective approach.

TRAINING IN BRIEF INTERVENTIONS FOR ALCOHOL PROBLEMS SHOULD BE AS IMPORTANT IN MEDICAL AND NURSING COURSES AS INTERVENTIONS FOR DIABETES OR HIGH BLOOD PRESSURE

3.8 *Family Interventions*

The AERC has rated this as a priority area for both policy and research. The first project, carried out in collaboration with the World Health Organisation, was an analysis of what really works when it comes to preventing drug and alcohol misuse.⁵⁰ This systematic review of prevention approaches with young people supported the effectiveness of the "Strengthening Families Programme: For Parents and Young People 10–14" (SFP10–14) as an intervention for the primary prevention of alcohol misuse. <http://www.mystrongfamily.co.uk/index.html>.

Developed in the USA, the SFP10–14 is designed to reduce adolescent substance misuse and other behaviour problems by increasing parenting skills, building life skills in youth and strengthening family bonds. Parents and young people meet in separate groups for the first hour and together as families during the second hour to practise skills, play games and do family projects. The basic programme is over seven weeks, usually held in the evenings. Four booster sessions, three to 12 months after the basic sessions, are optional.

⁴⁷ FAST alcohol Screening Test Manual: http://www.aerc.org.uk/documents/pdfs/finalReports/AERC_FinalReport_0007.pdf

⁴⁸ AJ Smith, RJ Hodgson, K Bridgeman, JP Shepherd, *Addiction*: Volume 98(1) January 2003, p 43–52. A randomized controlled trial of a brief intervention after alcohol-related facial injury.

⁴⁹ A randomised controlled trial of training and support strategies to encourage screening and brief alcohol intervention by Primary Care Nurses. http://www.aerc.org.uk/documents/pdfs/insights/AERC_AlcoholInsight_0012.pdf

⁵⁰ Primary prevention for alcohol misuse in young people: results from a Cochrane Collaboration Systematic Review, http://www.aerc.org.uk/documents/pdfs/insights/AERC_AlcoholInsight_0017.pdf

One of the strong features of the SFP is that results actually improve over the four year follow-up period, while gains during the first year of conventional prevention programmes tend to decline in subsequent years.

The systematic review supported by the AERC was awarded the Nan Tobler Award by the American Society for Prevention Research (SPR).

Other approaches to family interventions include the Five Step approach⁵¹ and Option 2.⁵²

3.9 Pricing and Promotion

An AERC commissioned systematic review⁵³ concluded that there is an association between exposure to alcohol advertising or promotional activity and subsequent alcohol consumption in young people. However the effect is modest.

There is a much stronger relationship between pricing and consumption. The University of Sheffield report on Pricing and Promotion commissioned by the Department of Health confirms these findings and provides very clear information on pricing.⁵⁴ Amongst their conclusions are the following:

- Pricing policies can be effective in reducing harm related to health, crime and unemployment.
- Pricing policies can be targeted, so that those who drink within recommended limits are hardly affected whereas very heavy drinkers, who cause by far the most alcohol-related harm, pay the most.
- Minimum unit pricing and discount bans could save hundreds of millions of pounds every year in NHS, crime and unemployment costs.
- If policy makers wish to see the greatest impact in terms of crime and accident prevention, through reducing the consumption of 18–24 year old binge drinkers, they need to consider policies that increase the prices of cheaper drinks available in pubs and clubs as well as supermarkets.

Alcohol is certainly not an ordinary commodity. Unlike soap powder we cannot let market forces determine how it is priced and promoted.

4. DEVELOPING THE SCIENCE BASE

Although the AERC has contributed significantly to the knowledge base, there are still large gaps in the evidence which could be identified and articulated systematically and clearly, then fed through to research commissioners including the AERC, which in turn would support policy and practice developments. One neglected area of research is the historical view of culture and policy. Binge drinking, for example, can be placed in a long historical context.⁵⁵

March 2009

Memorandum by Sovio Wines (AL 05)

THE ROLE OF EXCISE DUTY RATES IN REDUCING EXCESS CONSUMPTION OF WINE

The Government policy of ensuring greater awareness of alcohol related ill health and promoting more moderate consumption patterns, has yet to demonstrate significant progress.

In discussions on the subject, we have been greatly encouraged by doctors involved in organisations such as Drinkaware and Alcohol Health Alliance, who believe we could play a major role in a really meaningful strategy in tackling alcohol issues.

Partly because of our command of unique technology which enables the creation of highly drinkable lighter style wines, and partly because we perceive other opportunities in regulatory and taxation areas, we would welcome the opportunity to discuss the issues with you.

We were recently invited by the All Party Parliamentary Wine Group investigating the effects of increased taxation on wine, to submit our thoughts in that area, and we're therefore including these deliberations in our submission.

⁵¹ The 5-Step family intervention in primary care: II. The views of primary healthcare professionals http://www.aerc.org.uk/documents/pdfs/finalReports/AERC_FinalReport_0036.pdf

⁵² Family interventions for alcohol problems, <http://alcalc.oxfordjournals.org/cgi/content/full/39/2/86>

⁵³ The effect of alcohol advertising, marketing and portrayal on drinking behaviour in young people: systematic review of prospective cohort studies. <http://www.aerc.org.uk/newsPages/homeNewsArticle0003.html>

⁵⁴ Sheffield report analyses effects of alcohol pricing and promotion policies, <http://www.sheffield.ac.uk/mediacentre/2008/1128.html>

⁵⁵ The normalisation of binge drinking? An historical and cross cultural investigation with implications for action. http://www.aerc.org.uk/documents/pdfs/insights/AERC_AlcoholInsight_0049.pdf

EXECUTIVE SUMMARY

Consumers tend not to change well established patterns of consumption without a strong incentive to do so, especially when the product consumed is generally recognised as pleasurable—in this case, wine.

The present rates of excise duty are identical for wines from 5.5% to 15% and there is no economic incentive for consumers to purchase wines lower in alcohol than the typical 13–14%.

The recommendation is that two additional excise breaks are introduced at 8% and 11%. This would encourage consumers to drink more moderately alcoholic wines at a lower price than the higher alcohol wines found on the shelves of supermarkets.

The effect should be to permit the continuation of wine consumption, yet reduce the levels of alcohol consumed, thus having a positive impact on consumer health.

POINTS OF ARGUMENT

- Increased tax plus recession has driven millions of consumers downmarket.
- Marked downgrading of consumer's quality aspirations and expectations.
- Consumers increasingly settle for "anything as long as it's cheap".
- Hugely increased discounting by powerful multiples driving independent merchants out of business.
- Government campaign for greater alcohol awareness/responsibility rendered irrelevant by economic factors.
- There is an opportunity to mitigate higher taxation and provide economic incentive to enhance awareness of alcohol levels in wine.
- The present wine excise system imposes an identical tax on wines above 5.5% alcohol, regardless of their quality or price.
- Two additional excise breaks are recommended to be introduced at 8% and 11%.
- The consequence would be that consumers would pay less for more moderately alcoholic wines.
- Superb quality at these levels is now possible and demonstrable.

DETAIL

1. The increased tax on wine, combined with recession, has helped drive consumers down to the bottom end of the retail price scale. There has been an identifiable increase in value lines and deep promotional offers, inevitably leading to a marked downgrading of quality aspirations and expectations. As the process continues, discernment and discrimination in wine choice are subordinated to a search simply for the greatest possible bargain (a bottle of anything so long as it's cheap).
2. At the retail level, the above phenomenon has driven wine consumers more than ever to the mass multiples whose discounting ability is enhanced by their purchasing power. This in turn has worked to the huge disadvantage of traditional wine stores, off licenses, etc, with consequent closures, loss of employment, and a reduction of consumer choice.
3. The Government's supposed campaign to inculcate greater awareness and responsibility in consumer behaviour with regard to choice and usage of wine (along with the rest of the alcoholic beverage category which wine now leads) has been increasingly submerged by economic factors. In any case, our own research suggests that attempts to educate wine consumers about the significance of different alcoholic strengths in a bottle of wine and different alcoholic contents in a glass have to date made only limited progress. Moreover, even if aware of these differences, most consumers still do not think much about their choices in this regard.
4. The Government has a golden opportunity to both mitigate the incidence of higher taxation AND to provide an economic incentive to enhanced awareness of choice related to alcohol levels in wine.
5. The present wine excise system imposes an identical tax on wines above 5.5% alcohol, regardless of their quality, price or alcohol content. Excise does drop significantly on wine below 5.5%, at which level reduced alcohol wines of unprecedented quality have recently been offered. Although appealing to some wine drinkers seeking a more moderate and refreshing version of wine, 5.5% alcohol is too low a level to capture the interest of the majority of wine drinkers on a regular basis.
6. However, quality wines that contain a lower level of alcohol than conventional wines eg 8% rather than 13% but offering consumers all the flavour and aroma they have come to expect, are becoming increasingly available. Under the existing tax regime, there is no financial incentive for consumers to purchase these lower alcohol wines as the duty is exactly the same as that for wines containing much higher levels of alcohol. Research undertaken by ourselves in collaboration with a major

retailer, indicates that many consumers are comfortable with wines in the range 8–10%, but expect to pay a little less for them (a perception that links price with alcohol content). These consumers should be encouraged to purchase via the introduction of lower tax rates.

7. In conclusion, it is strongly recommended the two other “steps” be introduced to the excise structure, whereby wines at 11% alcohol or below receive a significant tax break, and wines at 8% receive a further break—thus giving consumers the opportunity to pay less for more moderate versions of wine, and also a new and meaningful reason for awareness of the whole issue.

Sovio Wines Ltd is a small British company dedicated to the marketing of reduced alcohol wines.

Until recently the quality of lower alcohol wines was poor, relying on barely ripe early harvested grapes or unsatisfactory methods of alcohol reduction, often including dilution with water or fruit juice.

Sovio Wines, through its combination of classic winemaking skills and state of the art technology, has recently introduced a range of quality wines from 5.5%—11% which contain all the flavour and aroma of conventional wines but less alcohol.

Research shows a significant demand for these lighter style wines as consumers increasingly find high alcohol wines unattractive, yet are currently offered few real alternatives.

March 2008

Memorandum by the British Medical Association (AL 06)

The British Medical Association (BMA) welcomes the opportunity to submit evidence to the Committee’s inquiry on “Alcohol”.

The enclosed response focuses on alcohol, and in particular, alcohol misuse, as a major healthcare concern.

This evidence is supported by the BMA report *Alcohol misuse: tackling the UK epidemic* (2008) which leads the way in encouraging healthcare professionals to raise awareness of alcohol misuse and makes recommendations for tackling this epidemic.

EXECUTIVE SUMMARY

- Alcohol consumption represents an integral part of modern culture. Alcohol is a psychoactive substance and its consumption in moderation can lead to feelings of relaxation and euphoria. It is also an addictive drug and its misuse is associated with a wide range of dose-related adverse sequelae that can lead to significant harm to the individual and society.
- The relationship between alcohol consumption and health and social outcomes is complex and multifaceted. In the short term, the acute intoxicating effects of alcohol on cognitive and motor functioning impair an individual’s reactions, judgements, coordination, vigilance, vision, hearing and memory. This impairment is associated with many adverse outcomes for the individual and those around them as it can lead people to have accidents, misread situations and act aggressively. Excessive alcohol consumption is linked to long-term health and social consequences through three main causal pathways: intoxication, dependence, and toxic (and beneficial) direct biological effects.⁵⁶ These pathways are in turn affected by the volume of consumption and pattern of drinking. Alcohol misuse is also frequently associated with drug abuse and other harmful behaviours such as smoking.
- Alcohol consumption is commonplace; however, there is significant variation in the level and pattern of consumption between particular groups. Various estimates have been made for the number of individuals who misuse alcohol. While these estimates do not provide a definitive picture of consumption patterns, it is clear that a significant proportion of individuals misuse alcohol by drinking above recommended UK guidelines.
- The cost of alcohol misuse in the UK is substantial, both in terms of direct costs (eg costs to hospital services and the criminal justice service) and indirect costs (eg loss of productivity and the impact on family and social networks). There is substantial evidence demonstrating that targeted and population-wide alcohol control policies can reduce alcohol-related harm. Lessening the burden of alcohol misuse requires strong leadership and the implementation of effective alcohol control policies that reduce overall consumption levels and minimise the harm to the public and the individual. Developing comprehensive alcohol policy requires partnership between governmental agencies and organisations. Emphasis on partnership with the alcohol industry and self-regulation has at its heart a fundamental conflict of interest that does not adequately address individual and public health. The alcohol industry clearly has a vested interest in the development of alcohol

⁵⁶ Rehm J, Room R, Graham K *et al* (2003) The relationship of average volume of alcohol consumption and patterns of drinking to burden of disease: an overview. *Addiction* **98**: 1209–28.

control policies. It is essential that Government moves away from partnership with the alcohol industry and looks at effective alternatives to self-regulation that will ensure there is a transparent policy development process that is based on reducing the harm related to alcohol misuse.

- The BMA has produced comprehensive policy on alcohol and the 2008 Board of Science report *Alcohol misuse: tackling the UK epidemic* (enclosed) unifies this work and identifies effective, evidence based policies for reducing the burden of alcohol misuse in the UK. This document is accessible through the BMA website at www.bma.org.uk/health_promotion_ethics/alcohol/tacklingalcoholmisuse.jsp

ABOUT THE BMA

1. The BMA is an independent trade union and voluntary professional association which represents doctors from all branches of medicine all over the UK. It has a total membership of over 141,000.

2. The evidence for this Health Select Committee inquiry originates from the BMA report *Alcohol misuse: tackling the UK epidemic* (2008).⁵⁷

THE SCALE OF ILL-HEALTH RELATED TO ALCOHOL MISUSE

3. A large majority of the individuals in the UK who consume alcohol do so in moderation. Analysis of the patterns of alcohol consumption, however, reveals that a significant proportion misuse alcohol by drinking above the UK recommended guidelines. Of particular concern is the pattern of drinking among adolescents, and the high level of binge drinking and heavy drinking among men and women in the 16 to 24 and 25 to 44 age groups. UK teenagers are among the most likely in Europe to report heavy consumption of alcohol, being intoxicated and experiencing adverse effect from drinking.

4. The 2003 Prime Minister's Strategy Unit (PMSU) interim analytical report estimated that in Britain:

- 6.4 million people consume alcohol at moderate or heavy levels.
- 1.8 million consume alcohol at very heavy levels.
- 5.8 million people exceed recommended daily guidelines.
- 5.9 million people engage in binge drinking.
- 2.9 million of the adult population are alcohol dependent.⁵⁸

5. The 2004 Alcohol Needs Assessment Research Project (ANARP) estimated that, for adults in England aged 16 to 64:

- 26% have an alcohol misuse disorder (8.2 million);
- of the 26% with an alcohol use disorder, 23% (7.1 million) consume alcohol at hazardous or harmful, and 3.6% (1.1 million) are alcohol dependent; and
- 21% of men and 9% of women are binge drinkers.⁵⁹

6. Alcohol consumption has been shown to be causally related to over 60 different medical conditions and is a significant cause of morbidity and premature death worldwide. In the majority of cases there is a dose-response relationship, with risk increasing with the amount of alcohol consumed. Moderate alcohol consumption is not usually harmful to health. Indeed, consumption at moderate levels or below in older men and women is associated with a lower risk of coronary heart disease (CHD), ischaemic stroke and diabetes mellitus, compared to individuals who abstain from alcohol. While there are some beneficial direct biological effects linked to low-level alcohol intake, these are insignificant compared to the dangers of excessive intake. Drinking heavily, however, can result in significant health problems through either acute or chronic misuse. In the UK, the burden of alcohol-related morbidity and mortality is shifting to younger age groups in both men and women, and toward the most socially deprived groups. The pattern of consumption is important in determining the impact of alcohol misuse on health. Binge drinking is a particularly harmful form of alcohol consumption and significantly increases the risk of alcohol dependence in men and women. The frequency of heavy drinking by the pregnant mother is also associated with the occurrence of a range of preventable mental and physical birth defects, collectively known as fetal alcohol spectrum disorders (FASD).⁶⁰

⁵⁷ British Medical Association (2008) *Alcohol misuse: tackling the UK epidemic*. London: British Medical Association.

⁵⁸ Prime Minister's Strategy Unit (2003) *Interim analytical report for the national alcohol harm reduction strategy*. London: Prime Minister's Strategy Unit.

⁵⁹ Department of Health (2005) *Alcohol Needs Assessment Research Project (ANARP): the 2004 national alcohol needs assessment for England*. London: Department of Health.

⁶⁰ In 2007 the BMA Board of Science published *Fetal alcohol spectrum disorders*. This report focuses on the adverse health impacts of alcohol consumption during pregnancy and in particular the problem of FASD. This report is accessible at: www.bma.org.uk/health_promotion_ethics/alcohol/Fetalalcohol.jsp.

7. Alcohol misuse can lead to harmful consequences for the individual drinker, as well as their family and friends. It significantly impacts on family life and is also a significant contributory factor in domestic violence incidents in about 50% of cases. Parental alcohol misuse is also correlated with child abuse and impacts on a child's environment in many social, psychological and economic ways.

8. The levels of alcohol-related crime and disorder may vary with age and pattern of drinking, with alcohol related offences particularly common among binge drinkers in the 18 to 24 age group compared to other regular drinkers. Drinking alcohol, especially frequent drinking, is also a significant factor in criminal and disorderly behaviour in young people aged under 18.

9. Driving under the influence of alcohol is a significant cause of death and serious injury from road traffic crashes in the UK. In 2006, 6% of all road casualties and 17% of road deaths were due to alcohol intoxication. Alcohol consumption by other road users such as cyclists and pedestrians is also associated with fatalities and injuries. Driver impairment resulting from the use of alcohol with other drugs, both prescribed and illegal, is also an important factor in road traffic crashes.

10. The BMA recommends:

- The legal limit for the level of alcohol permitted while driving, attempting to drive, or being in charge of a vehicle should be reduced from 80mg/100ml to no more than 50 mg/100ml.
- Legislation permitting the use of random roadside testing without the need for prior suspicion of intoxication should be introduced. This requires appropriate resourcing and public awareness campaigns.

THE CONSEQUENCES FOR THE NHS

11. The National Social Marketing Centre estimated that the cost of alcohol misuse on public health and care services in the UK to be £2.8 billion.⁶¹ In 2004 the PMSU estimated that the overall annual cost of alcohol-related harm in England to be up to £1.7 billion.⁶² In 2002–03, it was estimated that NHS Scotland provided over £110 million worth of healthcare services.

EFFECTIVE POLICIES TO REDUCE ALCOHOL-RELATED HARM

12. There is a substantial body of evidence demonstrating that targeted and population-wide alcohol control policies can reduce alcohol related harm.

ACCESS TO ALCOHOL

13. This is an important determinant of alcohol use and misuse. This incorporates the implementation of policies that regulate the affordability of alcohol as well as the introduction and enforcement of strict controls on the availability of alcohol to adults and young people. There is strong consistent evidence that increases in price have the effect of reducing consumption levels, as well as rates of alcohol problems including alcohol related violence and crime, deaths from liver cirrhosis and drink driving deaths. Increases in the price of alcohol not only affect consumption at a population level, but there is evidence that particular types of consumers, such as heavy drinkers and young drinkers, are especially responsive to price.

14. Licensing interventions are one of the most influential methods for controlling alcohol consumption and misuse through regulation of where, when and to whom alcohol can be sold. There is strong evidence that increased opening hours are associated with increased alcohol consumption and alcohol related problems. Conversely, reductions in opening hours and particularly in the number of outlets are associated with reductions in alcohol use and related problems. A high density of alcohol outlets is associated with increased alcohol sales, drunkenness, violence and other alcohol related problems.

15. The BMA recommends:

- The availability of alcoholic products should be regulated through a reduction in licensing hours for on- and off-licensed trade.
- Town planning and licensing authorities should ensure they consider the local density of on-licensed premises and the surrounding infrastructure when evaluating any planning or licensing application. Legislative changes should be introduced where necessary to ensure these factors are considered in planning or licensing applications for licensed premises.

⁶¹ Lister G (2007) Evaluating social marketing for health—the need for consensus. Proceedings of the National Social Marketing Centre, 25–25 September, Oxford.

⁶² Prime Minister's Strategy Unit (2004) *Alcohol harm reduction strategy for England*. London: Prime Minister's Strategy Unit.

RESPONSIBLE RETAILING

16. Numerous factors contribute to the culture of drinking to excess and the rise in underage drinking and alcohol related harm. Key areas are the supply and promotion of alcohol to consumers. Active enforcement of laws regulating licensing hours, and prohibiting the sale of alcohol to individuals who are intoxicated or underage have been shown to be effective at increasing compliance with legislation. The layout, design and internal physical characteristics of licensed premises are also important considerations for strategies to reduce alcohol-related crime and disorder.

17. Irresponsible promotional activities are common in licensed premises and off licenses (including supermarkets and local convenience stores). It is essential that these forms of promotional activity are strictly regulated. This can be achieved through prohibiting price promotions on alcoholic beverages, and by establishing minimum price levels. Repeated exposure to high-level alcohol promotion influences young people's perceptions, encourages alcohol consumption and increases the likelihood of heavy drinking. Specific advertising strategies such as sponsorship of sporting and music events, as well as advertisements using celebrity endorsements all serve to reinforce the image of alcohol among young people and predispose them to drinking below the legal age to purchase alcohol. It is essential that there is statutory regulation of the marketing of alcoholic beverages. This includes prohibiting the broadcasting of alcohol advertising at any time that is likely to be viewed by young people, with specific provisions banning alcohol advertising prior to 9pm and in cinemas showing a film with a certificate below age 18. Consideration also must be given to prohibiting alcohol industry sponsorship of sporting and music events aimed mainly at young people.

18. *The BMA recommends:*

- Licensing legislation in the UK should be strictly and rigorously enforced. This includes the use of penalties for breach of licence, suspension or removal of licences, the use of test purchases to monitor underage sales, and restrictions on the sale of alcohol to individuals with a history of alcohol-related crime or disorder.
- Legislation should be introduced throughout the UK to:
 - prohibit irresponsible promotional activities in licensed premises and by off-licenses; and
 - set minimum price levels for the sale of alcoholic beverages.
- A statutory code of practice on the marketing of alcoholic beverages should be introduced and rigorously enforced. This should include a ban on:
 - broadcasting of alcohol advertising at any time that is likely to be viewed by young people, including specific provisions prohibiting advertising prior to 9.00 pm and in cinemas before films with a certificate below age 18;
 - alcohol industry sponsorship of sporting, music and other entertainment events aimed mainly at young people; and
 - marketing of alcoholic soft drinks to young people.

EDUCATION AND HEALTH PROMOTION

19. The use of information and educational programmes is a common theme for alcohol control policies. Such approaches are politically attractive but have been found to be largely ineffective at reducing heavy drinking or alcohol-related problems in a population. While education and health promotion may be effective at increasing knowledge and modifying attitudes, they have limited effect on drinking behaviour in the long term. It is essential that the disproportionate focus upon, and funding of, such measures is redressed.

20. *The BMA recommends:*

- Public and school based alcohol education programmes should only be used as part of a wider alcohol-related harm reduction strategy to support policies that have been shown to be effective at altering drinking behaviour, to raise awareness of the adverse effects of alcohol misuse, and to promote public support for comprehensive alcohol control measures.

21. Much of the strategy to reduce alcohol-related harm in the UK focuses on recommended drinking guidelines. While the majority of people are aware of the existence of these guidelines, few can accurately recall them, understand them or appreciate the relationship between units, glass sizes, and drink strengths. Labelling of alcoholic beverage containers would be a useful method for explaining recommended drinking guidelines and for supporting other alcohol control policies.

22. *The BMA recommends:*

It should be a legal requirement to:

- (a) prominently display a common standard label on all alcoholic products that clearly states:
 - alcohol content in units;
 - recommended daily UK guidelines for alcohol consumption; and
 - a warning message advising that exceeding these guidelines may cause the individual and others harm.

- (b) Include in all printed and electronic alcohol advertisements information on:
- recommended daily UK guidelines for alcohol consumption; and
 - a warning message advising that exceeding these guidelines may cause the individual and others harm.

It should be a legal requirement for retailers to prominently display at all points where alcoholic products are for sale:

- information on recommended daily UK guidelines for alcohol consumption; and
- a warning message advising that exceeding these guidelines may cause the individual and others harm.

EARLY INTERVENTION AND TREATMENT OF ALCOHOL MISUSE

23. Preventing alcohol-related harm requires the accurate identification of individuals who misuse alcohol and the implementation of evidence-based interventions to reduce alcohol consumption. At present there is no system for routine screening and management of alcohol misuse in primary or secondary care settings in the UK. Screening and management occur opportunistically and where clinically appropriate in both settings. Identification of alcohol misuse among people not seeking treatment for alcohol problems can be achieved via alcohol screening questionnaires, detection of biological markers, and detection of clinical indicators. The use of alcohol screening questionnaires is an efficient and cost effective method for detecting alcohol misuse. Biological markers can be used as adjuncts to questionnaires for the screening process. Primary care, general hospitals and accident and emergency (A&E) settings provide useful opportunities for screening for alcohol misuse and the delivery of brief interventions. It is essential that systems are developed in order to encourage this activity on a regular basis. Effective operation of such systems requires adequate funding and resources, and comprehensive training on the use of validated screening questionnaires as well as the provision of brief interventions. Routine screening in primary care could be facilitated by the introduction of a directed enhanced service (DES).

24. *The BMA recommends:*

The detection and management of alcohol misuse should be an adequately funded and resourced component of primary and secondary care in the UK to include:

- formal screening for alcohol misuse;
- referral for brief interventions and specialist alcohol treatment services as appropriate;
- follow-up care and assessment at regular intervals;
- a system for the detection and management of alcohol misuse in primary care should occur via the implementation of a direct enhanced service by the UK health departments. This must be adequately funded and resourced; and
- systems for the detection and management of alcohol misuse should be developed for A&E care and general hospital setting. These must be adequately funded and resourced.

25. Comprehensive training and guidance should be provided to all relevant healthcare professionals on the identification and management of alcohol misuse.

26. Brief interventions (behaviour modification techniques) provide prophylactic treatment and produce clinically significant effects on drinking behaviour and related problems in non-alcohol dependent individuals. For individuals with more severe alcohol problems and levels of dependence, specialised alcohol treatment services can effect significant reductions in alcohol use and related problems. It is essential that individuals identified as having severe alcohol problems or as being alcohol dependent are offered referral to specialist alcohol treatment services.

27. It is also essential that specialised alcohol treatment services are provided consistently, are adequately resourced and funded, and that this funding is ring-fenced. High-level commitment is also required to ensure that the alcohol treatment services are prioritised when commissioning services.

28. *The BMA recommends:*

Funding for specialist alcohol treatment services should be significantly increased and ring-fenced to ensure all individuals who are identified as having severe alcohol problems or who are alcohol dependent are offered referral to specialised alcohol treatment services at the earliest possible stage.

Memorandum by Professor Neil McIntosh (AL 07)

This submission is from an individual—Neil McIntosh, Emeritus Professor of Child Life and Health, Department of Child Life and Health, University of Edinburgh, and Past Vice President—Science, Research and Clinical Effectiveness, Royal College of Paediatrics and Child Health.

COMMENT

1. Ingestion of alcohol is a traditional and significant problem in Scotland.
2. Binge drinking is now an adolescent ritual for both sexes across the UK.
3. Teenage pregnancy is common in the UK, and certainly is common in Scotland.
4. There is no data on the incidence of Fetal Alcohol Syndrome or Fetal Alcohol Spectrum in the UK.
5. The Scottish Paediatric Surveillance System run by the Scottish Paediatric Society is in a position to survey the current incidence of FAS, though not the Spectrum.
6. The surveillance would be optimised by a publicity campaign to all Scottish doctors particularly all paediatricians.
7. It is only when the extent of the problem is understood, that rational preventative measures can be put in place to safeguard future pregnancies in the mothers and management strategies developed to reduce the impact of the individual children born with FAS on the resources of the NHS.

Neil McIntosh DSc(Med)

March 2009

Memorandum by The College of Emergency Medicine (AL 08)

Thank you for asking the College of Emergency Medicine to contribute to this inquiry. College applauds the work that has been done, and the initiatives that are currently being undertaken, including by the opportunity of this submission.

However the College of Emergency Medicine is extremely concerned by the harms attributable to alcohol in our society, particularly those relating to short- and long-term health, crime and disorder. The brunt of the short-term health consequences of excess and irresponsible alcohol consumption falls on the ambulance service and the UK's already hard-pressed Emergency Departments, where care of sober patients may be delayed by the inebriated.

We subscribe to the Alcohol Health Alliance (chaired by Prof Ian Gilmore) being very supportive of its work focusing on reducing harms from alcohol misuse, especially by increasing price and reducing availability—the two processes of proven worth in reducing consumption. We have also been supportive of the Alcohol Clinical Experts Group (chaired by Sir George Alberti) and recent publications from the NAO, BMA and DOH.^{63, 64, 65}

THE SCALE OF THE PROBLEM AND THE CONSEQUENCES FOR THE NHS

The above demonstrate how significant numbers of adults and children attend Emergency Departments in the United Kingdom as a direct result of alcohol consumption. Short-term harms include serious accidents (some resulting in death and permanent disability, particularly road traffic collisions), assaults, domestic violence, collapse and psychiatric problems. Furthermore, all Emergency Departments also admit, on a daily basis, patients suffering from the longer-term health effects of sustained alcohol use, for example acute withdrawal fits secondary to alcohol dependence, pancreatitis and liver failure. Alcohol has a high attributable fraction to major medical problems such as stroke, heart disease and diabetes.

Estimates of the proportion of alcohol related emergency attendance vary. A national survey of most of the UK's Emergency Departments by Drummond found that 70% of night time attendances and 40% of daytime attendances were caused by alcohol. A study from Cambridge found the lowest proportion of alcohol related attendances was 24% at night and 4% during the day.

⁶³ National Audit Office, DOH. Reducing Alcohol Harm: health services in England for alcohol misuse, October 2008, http://www.nao.org.uk/publications/nao_reports/07-08/07081049.pdf

⁶⁴ BMA. Alcohol misuse: tackling the UK epidemic, February 2008, <http://www.bma.org.uk/ap.nsf/Content/tacklingalcoholmisuse>

⁶⁵ Review of the effectiveness of treatment for alcohol problems, November 2006, <http://www.nta.nhs.uk/publications/publications.aspx?CategoryID>

The proportion of alcohol related emergency department attendances is higher in more deprived areas, despite evidence from the General Household Survey that affluent men in the South-East of England are drinking the most. This indicates that alcohol affects people living in poorer areas disproportionately and widens health inequalities. We are also fully aware that young women and younger people are drinking more than ever before.

Fellows and Members of the College of Emergency Medicine are daily confronted with the health impacts of alcohol use, and also experience the effects of alcohol intoxication on behaviour, including social disorder and lawlessness which sometimes spills over into the hospital environment in general, and Emergency Departments in particular. Clearly the resource implications for all services involved are considerable. There have been only very modest reductions in alcohol related violence in recent years, and no decline in the other alcohol related presentations. Indeed, it is now common practice to attend to acutely intoxicated patients throughout every night of the week, and what was previously a weekend problem, confined mostly between the hours of 2200 and 0200, is now a 24 hour issue. During 2002 there were 1.2 million recorded cases of alcohol-related assault in England and Wales, but it is estimated that only 20% of such assaults are recorded by the police as a crime. Routine data systems, such as Hospital Episode Statistics, grossly underestimate the contribution of alcohol to hospital admissions, because this information is not routinely collected.

CENTRAL GOVERNMENT POLICY

1. The College of Emergency Medicine believes that self-regulation of the alcohol industry as a whole, and local licensed premises in particular, has proven ineffective in discouraging excessive and irresponsible alcohol consumption. Despite high levels of public concern and repeated attempts to achieve voluntary control, irresponsible behaviours by those who sell alcohol (for example promotional activities that encourage hazardous drinking) persist, and are a common and recurrent factor in excess alcohol consumption leading to significant harm. We would therefore urge the Government to introduce mandatory controls on all alcohol sales, to include both on-sales and off-sales. Such controls should include:

- (a) Mandatory labelling of all containers in which alcohol is sold.
- (b) Clear standards for all alcohol advertising. These standards should relate to both the target audience and intended message. Obligatory information regarding responsible drinking should be included with each advert, and under no circumstances should alcohol marketing target young people.
- (c) The implementation of further measures to promote responsible drinking, for example by banning the use of discount or time-based schemes to encourage the purchase of alcohol in both on-sales and off-sales licensed premises.
- (d) Mandatory door staff and server training to ensure that under-age or drunken persons are not able to purchase alcohol at licensed premises.

2. The College of Emergency Medicine believes that a national enforcement of the above four principles should be combined with local action to identify and intervene where specific circumstances are leading to alcohol harms in a particular community. This would allow an underpinning mandatory code to be supported by proportional and necessary actions to prevent health-related harms, crime and disorder in a defined local area.

3. The College of Emergency Medicine believes that a fully independent regulator of the alcohol industry is required to ensure that alcohol is sold responsibly, and that codes of conduct are effectively enforced. Such a regulator would be responsible for overseeing a consistent and sustained reduction in alcohol related harms in all areas.

4. We would like to draw further attention to the unequivocal evidence of the relationship between price and alcohol consumption. Whilst we believe that the elimination of irresponsible marketing through a mandatory code of practice will go some way to addressing this issue, we are also of the view that price regulation, which has been shown to be particularly effective in reducing consumption in those who drink the most, should be used as a means of improving public health. In particular, it is essential to ensure that off-sales are regulated as tightly as on-sales, so that the current trend towards “pre-drinking” (by purchasing supplies of alcohol from supermarkets and off licences before a night out) is not further encouraged. Likewise, test purchasing (to identify which off-licenses sell alcohol to underage people) should be supported.

SOLUTIONS

We believe that Fellows and Members of the College of Emergency Medicine and our nurses and managers can help the NHS make a positive impact on the effects of alcohol in the following ways:

1. The Royal College of Physicians (London) paper “Alcohol—can the NHS afford it?”, February 2001, highlighted the need for every acute hospital to have an Consultant/Senior Nurse Lead for Alcohol Misuse (to ensure early detection by any doctor/nurse) to work with Alcohol Nurse Specialists (to provide Intervention as well as education, audit, and liaison with the community . . .). We anticipate that NICE guidelines (2010–11) on alcohol misuse disorders will

give further support to this, advocating that brief psychological interventions supported by alcohol nurse specialists (providing alcohol health work) are clinically effective and cost effective in reducing unscheduled alcohol related Emergency Department re-attendance. There is good evidence that this form of intervention is particularly effective when the patient's Emergency Department attendance is linked to their harmful drinking (eg by the use of the Paddington Alcohol Test (PAT) to "make the connection"). We support the introduction of these services in and around our Emergency Departments with the creation Alcohol 'Leads' and the appointment of Alcohol Nurse Specialists.

We also support the work of the Medical Council on Alcohol (MCA), and of St George's Hospital Medical School (Professor Hamid Ghodse), in improving the education of undergraduates and the medical profession on Alcohol Misuse.

2. In parallel with this, Emergency Departments have a key role in collecting and collating information relating to harmful and hazardous drinking behaviour. Pioneering work by Professor Jonathan Shepherd in Cardiff, subsequently confirmed elsewhere, has demonstrated that Emergency Departments are capable of collecting valuable data on patients attending as a result of alcohol use and working in partnership with local organisations such as police, social services, public health, industry representatives and local authorities to develop effective strategies for local intervention. The sharing of data across services to develop a full picture of premises and factors that are contributing to alcohol harms in a community has been shown to promote the development of community-based interventions that target specific premises and areas. This approach is capable of reducing the number of patients attending an Emergency Department with alcohol related assaults by as much as 30%. This requires a very modest investment in IT infrastructure. Again this is not widespread: as present only three of the 18 acute hospitals in Eastern England have the required IT infrastructure. However the cost of this change in one hospital was under £5,000.

The College of Emergency Medicine is keen to engage with other services to achieve a co-ordinated response to alcohol harm, and to take a leading role in prevention through collaborative working and intervention in those persons and areas most at risk, tailored to the local community.

We would be pleased to provide any further information or evidence as required.

Mr John Heyworth

President, College of Emergency Medicine

Professor Jonathan Benger

Alcohol Co-Lead, College of Emergency Medicine

Professor Robin Touquet

Alcohol Co-Lead, College of Emergency Medicine

Dr Adrian Boyle

Consultant in Emergency Medicine, Addenbrookes Hospital

March 2009

Memorandum by the Royal College of Midwives (AL 09)

1. THE ROYAL COLLEGE OF MIDWIVES (RCM)

1.1 The RCM is the professional and trade union membership organisation that represents the vast majority of the UK's practising midwives. It is the only such organisation run by midwives and for midwives. The RCM is the voice of midwifery, providing excellence in professional leadership, education, influence and representation for and on behalf of midwives. We actively support and campaign for improvements to care services and provide professional leadership for one of the most established of all clinical disciplines.

1.2 The RCM welcomes the opportunity to contribute to the Committee's inquiry.

2. EXECUTIVE SUMMARY

2.1 Whilst the grave health risks to the foetus of heavy drinking during pregnancy are established, there is a lack of clarity on the impact of light drinking. While research needs to be commissioned into what is a safe level of drinking for pregnant women, it is also important to commission social studies into women's attitude to drinking in pregnancy—in order to make messages about the risks of drinking in pregnancy more meaningful.

2.2 A further area that requires additional research relates to arguments made about the health benefits of alcohol. It is important to understand if these perceived benefits are affected by being pregnant and by the different stages of pregnancy.

2.3 Whilst the RCM is content to adopt the precautionary principle and endorse the ideal of no alcohol consumption during pregnancy, we believe that this must be replaced as soon as possible with properly evidence-based advice.

2.4 If evidence on safe levels is established and advice flows from that, we believe that it should feature prominently in public awareness campaigns and be required by law to feature on alcoholic drink labels.

3. HEALTH RISKS OF DRINKING ALCOHOL DURING PREGNANCY

3.1 The evidence of the impact of heavy drinking during pregnancy is established.

3.2 Drinking during pregnancy is accepted to pose a serious health risk to the foetus. Indeed, particularly serious cases can lead to fetal alcohol syndrome (FAS);⁶⁶ symptoms can include serious birth defects. The National Organisation on Fetal Alcohol Syndrome estimates that more than 6,000 babies are born with FAS in the UK each year.

3.3 Further evidence was added to the existing body of evidence in January when results of an Australian study found that drinking heavily in the first third of pregnancy carried an almost 80% higher risk of premature delivery.⁶⁷

3.4 The risks, if any, posed by consuming small amounts of alcohol are less clear.

3.5 A large-scale study, conducted by University College London and reported last October, even reported that light drinking in pregnancy might even be linked to better behaviour amongst young boys.⁶⁸

3.6 It is important to establish clarity in this area as a majority of women do drink alcohol during pregnancy. In England in 2005, whilst 45% of women did not drink, 39% reported drinking an average of less than one unit per week, with 8% drinking one to two units;⁶⁹ this leaves a further 8% drinking more.

4. OFFICIAL GUIDANCE—LACKING AN EVIDENCE BASE AND CONFUSING

4.1 In March last year, the National Institute for Health and Clinical Excellence (NICE) issued guidance to pregnant women to avoid drinking any alcohol during pregnancy, but if they must drink then they could do so only after the first third of pregnancy and only one or two units once or twice per week.⁷⁰ It should be borne in mind, however, that as a form of measurement units are not always clearly understood or accepted by the population at large.

4.2 This advice was repeated during a short debate on this subject in the House of Lords on 2 February 2009.⁷¹

4.3 Not only is this message internally inconsistent (“do not drink but if you must then do not drink much”), but NICE conceded at the time of its release that it had no firm evidence to back it up.

5. RECOMMENDATIONS

5.1 The Royal College of Midwives endorses the NICE approach that women should adopt the precautionary principle and avoid drinking alcohol during pregnancy. This is only sustainable however whilst more research is commissioned and conducted into the pregnancy and behavioural outcomes for women who engage in light drinking. It cannot be considered settled.

5.2 Exercising the precautionary principle is an inferior option to following advice based on a solid evidence base. Such evidence must be actively sought as current advice is open to legitimate challenge.

5.3 Whilst the Government may wish to reduce alcohol consumption generally and pregnancy is a useful opportunity to convey that kind of positive public health message to women, it must not be afraid to discover that light drinking during pregnancy does not, in fact, pose any health risk to the foetus.

5.4 Once the advice is established, the RCM believes that it should be widely publicised and consistently publicised over time. We would argue that the effect of drinking on pregnancy should feature as a significant strand within wider alcohol awareness campaigning.

5.5 Again, once evidence on light drinking is properly established, we would support the establishment, in legislation, of requirements for the labelling of alcoholic drinks, including information on the effect on the foetus.

March 2009

⁶⁶ Information on FAS taken from “Q&A: Alcohol and pregnancy”, BBC News website, 31 October 2008.

⁶⁷ “Drink link” to premature birth, BBC News website, 21 January 2009.

⁶⁸ “Light drinking in pregnancy may be good for baby boys, says study”, Guardian, 31 October 2008.

⁶⁹ Statistics on Alcohol: England 2007, published by the NHS Information Centre on 26 June 2007.

⁷⁰ Alcohol ban advised for pregnancy, BBC News website, 26 March 2008.

⁷¹ House of Lords, Hansard, c468-70, 2 February 2009.

Memorandum by the National Association for the Children of Alcoholics (AL 10)

SUMMARY:

This document explains the role and function of the National Association for Children of Alcoholics (Nacoa) a charity that was founded to meet the needs of children of alcohol-dependent parents of all ages. It details the specific problems faced by these children and the consequences for them that can last throughout their lives. They are three times as likely to develop an addiction to alcohol or other drugs themselves and they are three times as likely to consider suicide both in childhood and later in adulthood.

1. There exists a stigma within society around alcoholism or any other form of addiction, especially in the home. Children will often conceal their difficulties and sense of inferiority. They therefore collude with their parent's secrecy and denial of problems. As a result these children are neither recognised nor properly supported. Without help, these children often repeat the cycle of alcoholism themselves.

NACOA IS COMMITTED TO BREAKING THIS DESTRUCTIVE CYCLE

2. Nacoa is a registered charity founded in 1990. It aims to address the problems of children growing up in homes where one or both parents suffer from alcoholism or a similar addictive problem. This includes children of alcohol-dependent parents of all ages, many of whose problems only become apparent in adulthood.

3. Research carried out on behalf of Nacoa indicates that there are 2.8 million adult children of alcohol-dependent parents in the United Kingdom and there are currently nearly a million children living with parental alcoholism.

4. Nacoa's services include a free, confidential, telephone, letter and email helpline providing information, advice and ongoing support for children of alcohol-dependent parents and people concerned for their welfare such as family members, friends, teachers and other professionals. Nacoa provides a valuable, non-judgemental service for callers some of whom are as young as seven years old. They can call as often as they like. Some develop a relationship with the charity over a number of months or even years.

5. Nacoa's service includes providing an empathic listening ear and reading stories to younger callers—something which many take for granted as a natural part of a loving childhood. Since 1990 Nacoa has responded to over 137 000 requests for help.

6. The Nacoa helpline service aims to identify a caller's motivations and symptoms whilst providing focussed listening and ongoing support. These children often have issues with trust. They are often looking for someone who understands the complexity of parental alcoholism. Using the "alcohol-dependent family system" as a tool to identify the role(s) adopted by children, Nacoa provides a safe way for callers to disclose their problems and fears. Success can be measured by the annual increase in calls—since 2000 calls have increased by 760%.

7. Nacoa's website www.nacoa.org.uk provides information, advice, personal experiences, training materials, factual and resource information, research and links to other organisations. In 2008 there were nearly 79,000 visits to the site.

8. Many children of alcohol-dependent parents grow up to be successful and productive members of society. However as the table at appendix 1 shows a number develop serious problems both as children and later as adults.

9. There are a number of common problems in these families. Lack of money occurs when a significant amount of the household budget is spent on alcohol. This may take priority over everything else leaving the rest of the family (sometimes this can be one of the children) to make sure that their basic needs such as food and clothing are met.

10. Growing up in a family where alcoholism is an issue can be very confusing. It can be difficult for children to predict what state of mind their parent(s) will be in when they get home from school. They might be in a good mood and want to do something fun, or they may become violent or irrational. What makes life even more confusing is when the family collude, tell lies to cover up the truth in order to keep their problems secret from outside society. Many children feel unable to take friends home, as they are embarrassed or fearful about their parent's behaviour.

11. Nacoa's research indicates that the learned habits of secrecy, manipulation and an inability to identify one's feelings are twice as likely to be prevalent in a family struggling with alcoholism. Irrational behaviour is five times more likely and 89% of adult children claimed that their childhood home was not a place to be proud of.

12. Many children may not suffer from obvious forms of abuse but they are often neglected or lack the little things, which are so crucial to our wellbeing. They may be exposed to rage, violence and abuse on a daily basis. This becomes part of the unpredictable and inconsistent environment in which they live.

13. Some children live in fear. Sometimes they are simply ignored, deprived of being loved unconditionally. They may lack care, clothing, food, warmth and being cherished for who they are. They often feel unwanted. Research indicates that 70% of these children successfully hide their problems from the outside world. They cannot ask for help—they remain isolated and alone.

14. Nacoa's research shows that aggression within the family environment is six times more common when one or both parents suffer from alcoholism. Social Services report that alcohol is a factor in:

- 40% domestic violence incidents.
- 40% child protection cases.
- 74% child mistreatment cases.
- In 50% of these cases, no action is taken to address the alcoholism of the parent(s).

15. These children may grow up feeling anxious, depressed, emotionally detached and socially isolated. Some may have taken on responsibilities within the family, which means that they do not have time to spend time with their friends, even if they wanted to. Children may have difficulties making friends, which can continue into adulthood. These children are frequently in a self-protective denial of the situation.

16. It is common for these children to feel they are the problem and that they are to blame. Nacoa's research indicates that they feel six times more responsible for conflict in the home and are seven times more likely to try to resolve arguments within the family.

17. In adulthood some children find themselves drawn to others who have grown up in similar environments. Research also identifies a family "trail" with respect to divorce, finding this is a more likely phenomenon amongst generations of families affected by alcoholism.

18. When alcoholism is the family secret, it can be very difficult to talk to anyone outside the home. Talking to someone is often seen as a betrayal of the parent. This may lead to the family becoming socially isolated and can have a negative effect on the way the family functions. There are three unspoken rules in families struggling with parental alcoholism. They are:

- Don't talk.
- Don't trust.
- Don't feel.

These rules help to preserve the illusion that the family is functioning well and that nothing is wrong.

19. As the family progressively adapts to alcoholism, a parallel path develops in family members. Thoughts, feelings and actions become prescribed and proscribed by the effects of alcoholism on the family. The family unconsciously adopts rigid roles as a coping strategy. The family members often become addicted to their roles—seeing them as essential to survival of the family unit.

20. These family roles occur in all troubled families and occasionally in healthy families in times of stress. However, in families coping with alcoholism (and the absolute need for secrecy from the outside world) the roles are more rigidly fixed and are played with greater intensity, compulsion and delusion. This work has been adapted from the family systems work of Virginia Satir, illustrated at Appendix 2.

RECOMMENDATIONS:

21. Nacoa exists to highlight the needs of children growing up in families where parental alcoholism is an issue. These children are often forgotten even when the addicted parent is provided with treatment and support. It recommends that the needs of these children must be addressed as a fundamental part of alcohol policy within the UK. Early intervention and support for all members of the family can make a crucial, perhaps life-saving difference and early intervention can help break the cycle of addiction.

22. We believe that teachers and other relevant professionals such as health visitors, early years and youth workers are trained to be alert to the signs of alcoholism within families such as:

- A child failing to get excited about an anticipated class trip or event.
- A child who acts very differently during alcohol and drugs education from the way he or she normally reacts.
- A child gets upset around birthdays and or holidays.
- A child wants time alone with the teacher or clings to a teacher or aide—this may represent an effort to secure the nurturing they lack at home.

23. Nacoa also believes that there should be a concerted effort by all sectors of society to treat alcohol addiction with the same seriousness as addiction to illegal drugs. Society's image of the stereotypical alcohol-dependant needs to be challenged. For instance the Christmas 2008 episode of "EastEnders" showed a group of alcohol-dependants as "Shakespearean rustics", functioning as light relief to the meatier drama of the rest of the programme. These images belie the fact that behind most alcohol-dependants there are often frightened, lonely and unhappy families.

24. Alcoholism is perceived by many as being less important than addiction to illegal drugs. Until there is clear recognition that alcohol is a substance with many of the same dangers and risks associated with illegal drugs, we believe that the problems in terms of ill health, anti-social behaviour and the negative impact on the family will fail to be adequately addressed.

March 2009

APPENDIX 1

NUMBERS OF PEOPLE AFFECTED BY SERIOUS PROBLEMS IN ADULTHOOD

<i>Eating Disorders</i>	<i>Children of alcohol dependent parents</i>	<i>Control group</i>
Children	15%	3%
Adults	20%	6%
Considered Suicide		
Children	29%	9%
Adults	42%	14%
In trouble with Police		
Children	20%	9%
Adults	11%	6%
Alcoholism		
Children	3%	2%
Adults	13%	4%
Drug addiction		
Children	4%	2%
Adults	12%	4%

APPENDIX 2

TYPICAL ROLES IN A FAMILY AFFECTED BY ALCOHOLISM

<i>Role</i>	<i>Motivating feeling</i>	<i>Identifying symptoms</i>	<i>Pay off for individual</i>	<i>Pay off for family</i>	<i>Possible price</i>
Alcohol dependant	Guilt Shame	Chemical use	Relief of pain	Known/familiar behaviour	Addiction
Spouse	Anger Despair	Powerlessness	Importance Self-righteousness	Responsibility	Illness "Martyrdom"
Child 1 "Hero"	Inadequacy Guilt	Over achievement	Attention (Positive)	Self-worth	Compulsive Drive
Child 2 "Scapegoat"	Hurt	Delinquency	Attention (Negative)	Focus away from Parental Alcoholism	Self-Destruction Addiction
Child 3 "Lost child"	Loneliness	Solitary Shy	Escape	Relief—no attention demanded	Social isolation
Child 4 "Mascot"	Fear	Clowning Hyperactivity	Attention (Amused)	Relief—fun	Immaturity; Emotional illness Addiction

Memorandum by the British Liver Trust (AL 11)

EXECUTIVE SUMMARY

1. As the UK's liver disease charity, the British Liver Trust is deeply concerned about the doubling in alcohol-related deaths since 1991 and ongoing high levels of alcohol consumption. We believe that this will lead to a further increase in the numbers of people dying from liver disease, which is now the fifth biggest killer and the only big killer disease where age-adjusted mortality is still increasing. Alcohol-related liver

disease is placing an increasing demand on liver services, and without further investment and capacity building in NHS diagnosis and treatment of liver disease, the patient experience and outcomes are likely to deteriorate.

2. The Trust believes a national liver strategy with a national clinical director for liver disease would provide the support to the NHS that is needed to tackle the complex causes of liver disease, support early diagnosis and referral to specialist centres, and management of the disease and its complications. This strategic approach has been effectively applied to other big killer diseases, whose mortality is now declining.

3. We support and welcome measures to inform people of safe drinking levels (through the Department of Health's units campaign) and to tackle irresponsible promotions (through the proposed mandatory code of practice on alcohol sales). However, we believe that an amendment to the 2003 Licensing Act to insert the protection and promotion of public health as a licensing objective is necessary. This will help integrated cross-Government efforts to curb alcohol-related harm that considers the health as well as the crime and disorder-related harms from excessive consumption. We also believe that a price floor of around 40p per unit is necessary to reduce the health threat posed by very cheap alcohol, affecting particularly young and heavy drinkers.

INTRODUCTION

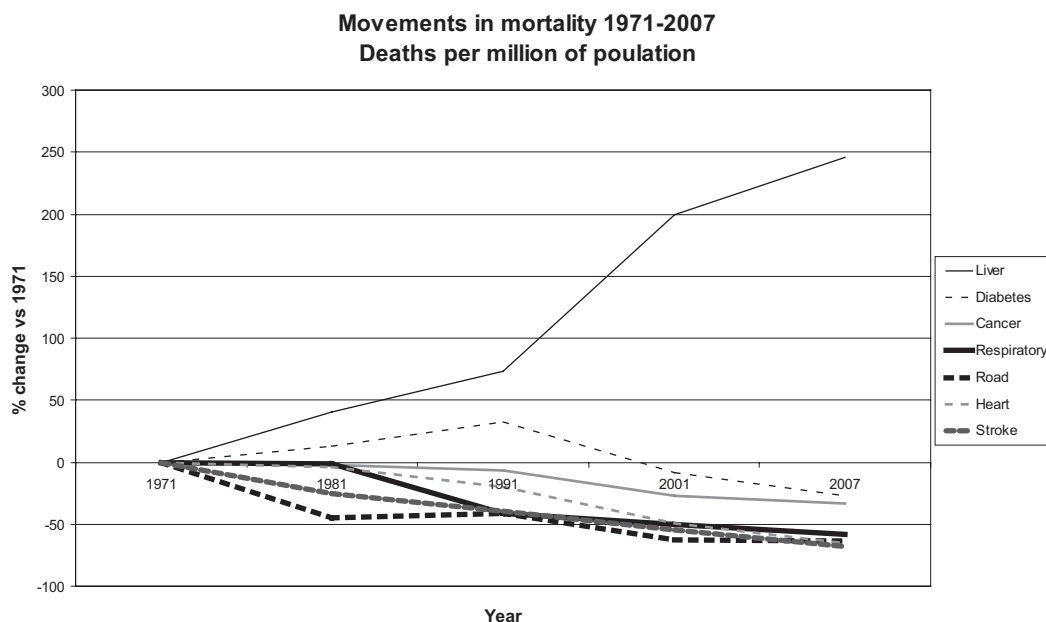
4. The British Liver Trust is the UK's national liver charity for adults, working to improve prevention, treatment and support for people with or at risk from all forms of liver disease. The Trust runs a medical information helpline, provides publications and a website, facilitates support groups and offers research grants into liver disease.

5. We welcome the Health Select Committee's inquiry into alcohol. The evidence of health harm from alcohol is significant and the Trust has been working with other clinical and campaign organisations as part of the Alcohol Health Alliance to draw attention to the issue and call for effective action to reduce the health impact of alcohol.

6. This submission will focus on the long-term impact of alcohol on health, specifically its impact on the liver and as a cause of alcoholic liver disease which can lead to cirrhosis and primary liver cancer.

7. Liver disease is now the fifth largest cause of death in the UK, killing 15,203 people a year, 13,126, in England and Wales.⁷² It is the only "big killer" that is still on the rise. On average, it results in death at a much younger age, killing people on average 19 years younger than cancer or heart disease.

8. The following table tracks changes in age-standardised mortality between 1971–2007 from a British Liver Trust analysis of Office for National Statistics mortality data. It demonstrates that while action on other major causes of death is resulting in declining mortality, there is a significant upward trend in deaths from liver disease.



⁷² British Liver Trust analysis of Office for National Statistics mortality statistics covering all deaths related to liver dysfunction covering ICD K70-76 and other codes including C22-24 (liver cancer), and B15-B19 (viral hepatitis), January 2009.

9. The liver breaks down alcohol and regular heavy drinking over a period of years (varying from 5–20 years) can cause liver damage. This can manifest itself first in fatty deposits (steatohepatitis), then in fibrous deposits (liver fibrosis) and in later stages, in scar tissue (cirrhosis). Cirrhosis can lead to complications that can be fatal, to liver failure, and also to primary liver cancer. In addition, large amounts of alcohol consumed in a shorter period of time can result in alcoholic hepatitis, which can be serious, although this is responsible for a smaller number of deaths than cirrhosis.

10. The risk of liver disease from heavy drinking varies from person to person, and there are genetic, gender, viral, immune system and environmental (exposure to drugs and toxins) factors involved. In many people, there are no symptoms of liver disease until irreversible liver damage has taken place. If it is diagnosed early, treatment and abstinence can be effective in allowing the liver to recover.

11. Liver damage from long-term alcohol use is referred to as alcoholic liver disease (ALD), whether or not the patient is alcohol-dependent. Alcoholic liver disease is one of the most serious medical consequences of long-term alcohol misuse, and is the single largest cause of serious liver disease.

12. The Trust is concerned about a “triple whammy” of pressures on liver health, from alcohol, increasing levels of obesity and viral hepatitis. People who are overweight, do not take enough exercise and particularly those with diabetes are at risk of liver damage from fatty deposits in liver tissue. Several hundred thousand people are thought to carry hepatitis B or C, many without knowing it. Alcohol consumption in these groups is more likely to lead to liver harm. Together, these factors are likely to lead to increasing levels of morbidity and mortality from liver disease.

THE IMPACT OF ALCOHOL-RELATED LIVER PROBLEMS

Alcohol consumption

13. The Trust is concerned about ongoing high levels of alcohol consumption and an increase in recent years. Due to the length of time liver disease can take to develop, we anticipate that this will lead to increasing levels of liver disease and corresponding increasing need for NHS liver services in the future. Data on alcohol consumption from the General Household Survey was released by the ONS on 22 January 2009. This showed that over a third of adults (37%) exceed the recommended maximum alcohol guidelines on their heaviest drinking day.

Alcohol deaths

14. 8,724 people died from alcohol-related causes in 2007 according to recent Office for National Statistics data. This has doubled since 1991, where 4,144 deaths were recorded. Overall, the alcohol-related death rate in the UK almost doubled from 6.9 to 13.3 per 100,000 population between 1991–2007.⁷³

15. Alcohol-related liver disease alone killed 7,251 people in 2007 in England and Wales,⁷⁴ approximately twice as many men as women. These figures have increased steadily in recent years, to 3,613 in 1996 and 5,061 in 2001.⁷⁵

Younger patients

16. The Trust is particularly concerned with the stark increase in deaths amongst younger people. While alcoholic liver disease peaks in the late 50s, there have been particular increases in the 35–54 age range. For men, this has increased from a 13.4 per 100,000 risk of death to 30.2.⁷⁶ During 2006, there was a 40% increase in the number of people in their late 20s dying of alcoholic liver disease. This indicates heavy drinking from a younger age that persists into adulthood.

International comparisons

17. The increase in alcohol-related liver deaths is not inevitable, and has not been replicated in other developed countries. Deaths from liver cirrhosis trebled between 1970 and 1998, while in the EU the number of deaths shrank by 30%.⁷⁷

⁷³ Office for National Statistics bulletin 27 January 2009.

⁷⁴ Office for National Statistics: Mortality Statistics, Deaths registered in 2007, DR_. ICD code K70.

⁷⁵ House of Commons Hansard 9.10.2006 column 623W.

⁷⁶ ONS bulletin 27 January 2009.

⁷⁷ Donaldson L (2001) *On the state of the public health: the annual report of the Chief Medical Officer of the Department of Health* 2001. London: 2001.

THE EXPERIENCE OF LIVER PATIENTS

Early symptoms

18. Many people with alcohol-related liver damage are not aware of their condition, and may not even be aware that they are drinking to excess. Liver disease usually develops silently, with no symptoms at all in the early stages. When symptoms appear, they tend to be vague and not distinctive (such as fatigue, weight loss, changes in sleep patterns, appetite etc), meaning that many people do not suspect that they have a liver problem.

Early diagnosis

19. This is essential in ALD, where early interventions, particularly to help the patient reduce or abstain from alcohol consumption, can be very effective. When patients do visit their GP for advice, the Trust has heard of patients' accounts suggesting opportunities for early diagnosis are missed. GPs may have preconceptions about their patients and their alcohol consumption, and ignore patients who do not fit the stereotype. Abnormal liver function test results are quite common and some GPs will ignore these rather than suspect a potentially serious liver problem and order further tests.

Referral

20. Where patients are referred for further investigation and treatment, it is usually to a local district general hospital (DGH). This may be appropriate for some patients but the Trust has concerns about the treatment of seriously ill patients with complications by general physicians or gastroenterologists who have not had hepatology training or extensive experience. Patients may miss opportunities for effective interventions, and the Trust is aware of individuals who once admitted to a DGH, have experienced difficulty being referred to a hospital with specialist liver services (those eligible for the payment by results tariff top-up for hepatology).

Quality of life

21. Liver disease has a profound impact on a patient's quality of life, although there may be no symptoms until significant and irreversible damage has occurred. Serious fatigue can prevent people undertaking everyday activities or regular work, and cause tiredness and lethargy. Symptoms can fluctuate, making it hard to hold down a job or plan a day. The build up of toxins from a failing liver causes hepatic encephalopathy, a distressing set of neurological symptoms that can range from drowsiness to confusion, paranoia, personality changes, inability to perform basic tasks and progress to coma. Swelling in the abdomen called ascites can prevent patients from eating or drinking adequately and hinder breathing and movement. Clinical outcomes are often poor, as there are only symptomatic treatments for cirrhosis rather than any clinical interventions to delay or reverse progression. One in four people die during their first hospital admission. Many are discharged as there is no effective treatment, and require full-time care at home by their families or friends.

Liver transplants

22. The number of patients treated with liver transplant for ALD has increased year-on-year over the last decade. This has increased from 94 in 1997–98 to 151 in 2007–08. ALD patients have increased as a percentage of the total transplanted patients, from 14% in 1997–98 to 23% in 2007–08.⁷⁸ The British Liver Trust believes that the true number of ALD related patients who could benefit from a transplant is much higher, and that most patients are not offered a place on the transplant list due to the shortage of organs and that with careful pre-transplant assessment, there are many more ALD patients who merit and could benefit from a transplant. Even so, the need for alcohol-related liver transplants is leaving fewer livers for non-ALD patients. These figures illustrate the increasing burden alcohol-related need is placing on NHS liver services.

Stigma

23. Patients with ALD suffer stigma and discrimination both in society and access to NHS services, including treatment for alcohol use disorders and the full range of services for liver disease that could be of benefit. The sense of blame attached to the minority of heavy drinkers who develop liver problems has also disadvantaged liver services and patients with other forms of liver disease. We believe that a national strategy to tackle the rising health burden from liver disease, covering prevention, early diagnosis and treatment, would be the most effective approach.

⁷⁸ House of Commons Hansard, 10 February 2009, Column 1924W.

RECOMMENDATIONS

24. A study to examine the implications of increasing alcohol-related liver disease on the need for specialist liver services and specialist clinicians would be highly beneficial. The Trust believes it is important to ensure there is sufficient capacity to respond to the rising health burden from alcohol related problems. Without this, services for other liver patients will suffer.

25. Continued funding of the Department of Health's "units" campaign raising awareness of guidelines on low-risk drinking allowances and the alcohol content of popular drinks. This has been very helpful in informing the public and enabling them to make informed choices.

26. An amendment to the Licensing Act 2003 to insert protection of public health as a licensing objective. This would enable licensing authorities to consider the public health implications of licensing decisions. It would also enable action to reduce health harm to be included in the mandatory code on alcohol sales, currently being prepared by the Home Office as part of the Policing and Crime Bill. This amendment to the Licensing Act could be made as part of the Bill currently being considered by Parliament.

27. The setting of a price floor that would prevent alcohol being sold for as little as 15p per unit in some outlets at present. There is evidence that very low priced alcohol increases consumption disproportionately amongst young drinkers and heavy drinkers, the two groups most at risk of health harm. The Sheffield Review produced thorough evidence on the impact of various pricing reforms, and "the results suggest that policies that increase the price of alcohol can bring significant health and social benefits and lead to considerable financial savings in the NHS".⁷⁹ A 40p per unit price floor would save 41,000 hospital admissions and the NHS £116 million each year according to Sheffield, whilst costing individuals on average 11p per week. The Trust believes a price floor around 40–50p per unit would remove the worst excesses whilst not imposing a financial penalty on the majority of the population.

28. Measures to improve earlier diagnosis of liver damage. The Trust is concerned about delays in diagnosis, and our own survey revealed patients wait on average 564 days before they are diagnosed and referred for treatment.⁸⁰ Measures to address this could be in the form of NICE guidelines to primary care practitioners. There is scope to add a liver function test (measured through analysis of a blood sample, which is already taken for a cholesterol test) to the vascular health checks being introduced for the over 40s.

29. Measures to improve earlier diagnosis of alcohol use disorders and prompt referral and easier access to treatment for alcohol use disorders. This could be incentivised through a measure in the Quality and Outcomes Framework for GPs, that screened a particularly high-risk group for alcohol-related harm for alcohol use disorders. Better resourcing of alcohol treatment services, to be comparable with drug treatment services, would also be necessary.

30. Early implementation of the mandatory code on alcohol sales and incorporation of effective measures to tackle health harm. This will include action on off-license as well as on-license sales. However, the Trust is disappointed the measures currently only aim to address crime and disorder rather than health harms.

31. A national liver strategy and national clinical director for liver disease, to cover the complex factors causing liver disease, examine strategies for early diagnosis and the framework for treatment services across England. This type of integrated approach has been effective in reducing mortality in the other "big killer" diseases and is urgently needed to curb rising mortality and incidence of liver disease.

March 2009

Memorandum by Professor Sir John Marsh (AL 12)

ALCOHOL

SUMMARY

This paper argues that there is relatively little that policies specifically concerned with alcohol can do about the major problems of alcoholism, "alcohol originated damage to work performance and health" or "binge drinking". All these issues are deeply related to cultural norms within society. Cultural patterns have changed to reduce the constraints on alcohol abuse. Incomes have risen allowing members of cultural groups where excess drinking is acceptable to consume more alcohol. Diminishing the damage to individuals and society requires changed attitudes and the encouragement of peer group behaviour that values achievement in other ways than drinking.

⁷⁹ School of Health and Related Research at the University of Sheffield (ScHARR) report, commissioned by the Department of Health, December 2008.

⁸⁰ British Liver Trust survey of support groups and other patients November 2007.

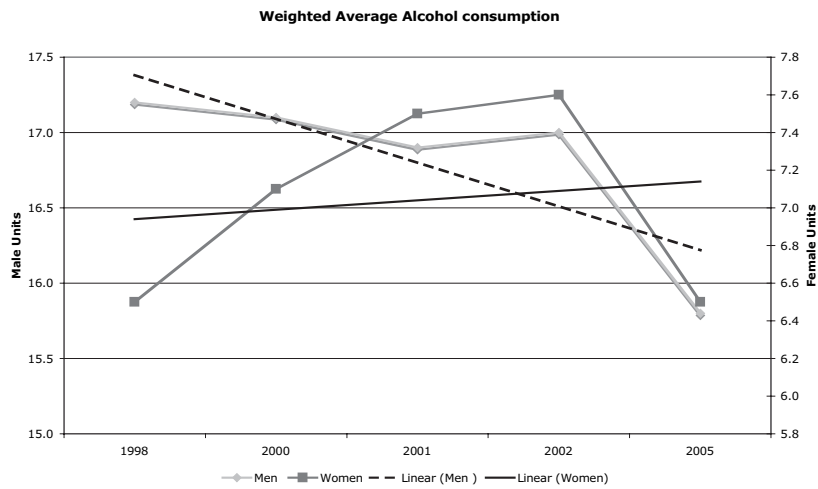
1. Average Alcohol Consumption changes relatively little. NHS data shows it to be much higher among men than women and that whilst among women consumption rose in the period 1998 to 2002 by 2006 it had reverted to the 1998 level. Trend lines suggest that whilst consumption among men is tending to decline amongst women it is rising.

Table 2.5

ALCOHOL CONSUMPTION (UNITS PER WEEK) AMONG ADULTS, BY GENDER, 1992 TO 2006

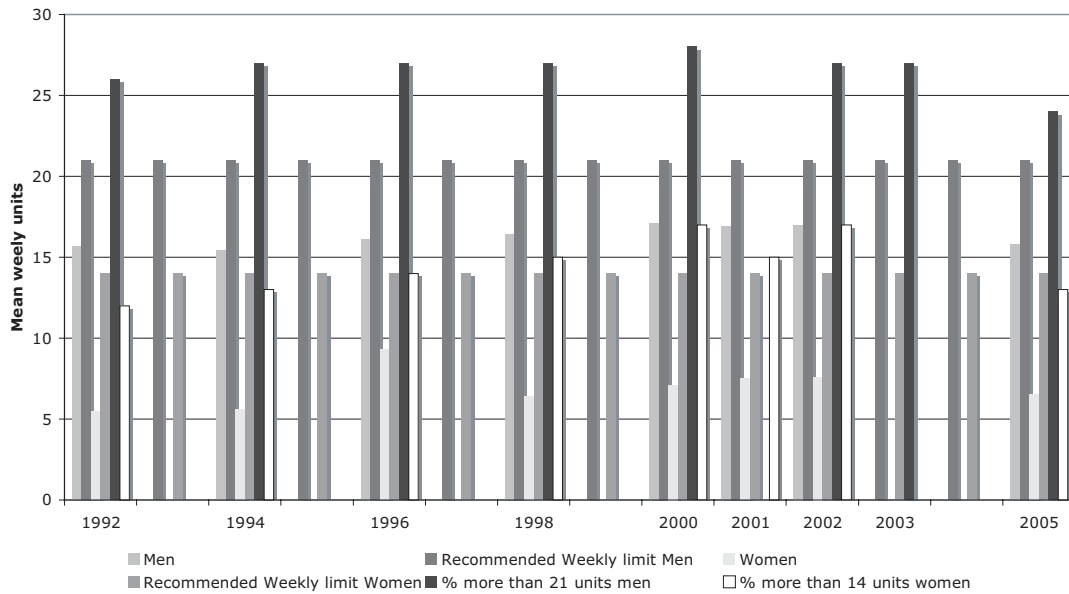
	1998	2000	2001	2002	2005
Men	17.2	17.1	16.9	17.0	15.8
Women	6.5	7.1	7.5	7.6	6.5

Statistics on Alcohol: England 2008 NS NHS Information Centre

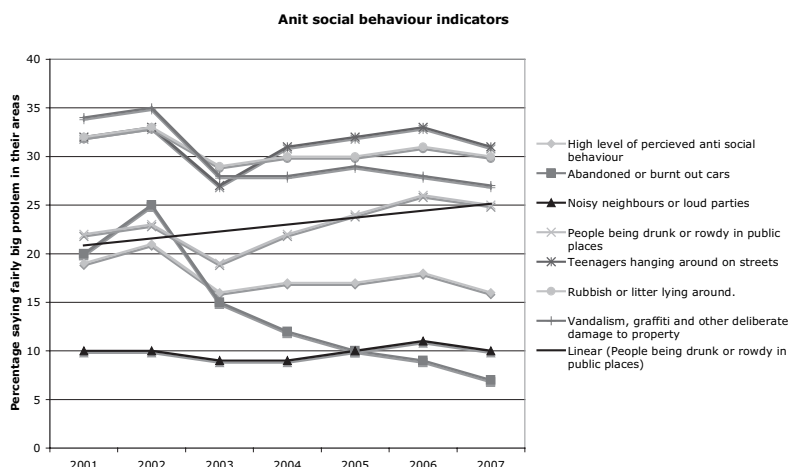


- (a) The data shows that average alcohol consumption is below the recommended maximum set by government at 21 units for men and 14 units for women. However a significant percentage of both men and women exceed these limits with corresponding hazards to their health.

Exceeding The Limit



- (b) Alcohol is seen as a major factor in anti-social behaviour both directly through drunkenness and through its ability to diminish inhibitions on other forms of unacceptable behaviour. The diagram below shows an increasing trend in numbers of people drunk or rowdy in public places.



- (c) Since many of the issues arise from cultural attitudes to drink, it is interesting to examine the social groups of those perceived seen to be responsible for anti-social behaviour. The table below looks at this in terms of the difference in share of specific social groups and the categories within that group that are responsible for the largest share of anti-social behaviour recorded.

DIFFERENCES IN THE PERCEPTION OF HIGH LEVELS OF ANTI-SOCIAL BEHAVIOUR BETWEEN THE LARGEST GROUP IN EACH CATEGORY AND AVERAGE FOR THE CATEGORY AS A WHOLE

<i>Socio Economic Category & peak group</i>	<i>% Difference from average for category</i>
Marital Status—Single Men	22
Employment—Unemployed	40
Occupation—Full time students	27
Highest Qualification O level/GCSE	18
Tenancy—Social rented sector	50
Accommodation Type—Flats and Maisonettes	67
Acorn Category—hard pressed	67

- (d) What stands out is that the perception of high levels of anti-social behaviour is greatest where there is unemployment, incomes are low, or people live in social housing or flats. A paradox for policy is that as incomes rise alcohol consumption increases but it is among the poorer members of the highest share of anti-social behaviour is disproportionately discovered. This poses a question about the direction of causality. Does a tendency to excess drinking result in people becoming unemployed, relatively poor and forced to reside in the cheapest housing, often in relatively deprived areas? Or does relative poverty encourage people to drink and indulge in antisocial behaviour as a form of release from their sense of relative powerlessness?

2. Policies directed at controlling alcohol abuse attempts to manipulate three variables:

- (a) The price of alcoholic drink.
- (b) Control of the places at which it can be supplied.
- (c) Punishment based on evidence that alcohol has been consumed in excessive quantities.

Whilst these policies may have some immediate success in discouraging consumption it is clear that they have failed to prevent a rising trend in alcoholism or in the social disorder associated with binge drinking.

3. This memorandum relates to the role of policy in relation to the management of three types of alcohol related problems. All three result in higher costs for the NHS.

- (a) Addiction affecting individuals whose work, health and family life are disrupted by excessive and uncontrolled consumption of alcohol.
- (b) Alcohol consumption by individuals that results in economic costs, some of which fall on the NHS but others include diminished capacity to perform demanding jobs, damage to property, accidents, including for example those caused by drink driving and unintended and teen age pregnancy.

- (c) Binge Drinking characterised by rowdy behaviour that imposes measurable costs on the police service, on hospitals and related medical activities and real and less measurable costs on members of the public who suffer fear and disrupted lives, deposits of litter and the vomit and excreta in inappropriate places.
4. Dependence upon alcohol can be traced to a mixture of personal and social characteristics.
- (a) The differences in individual reaction to alcohol mean that no single solution will be effective. Attempts to secure a solution by prohibition of high price levels not only penalise those who can regulate their consumption satisfactorily but also fails to deter addicts who seek supplies through covert means. It also creates situation in which they become victims of criminal groups who exploit them for gain, in much the same way that existing bans on drugs provide opportunities for criminals to make money.
- (b) The social characteristics that lead to dependence include many elements. They include:
- (i) Initiation into drinking as a sign of maturity.
 - (ii) The portrayal of alcohol as a means of coping with stress or of celebrating achievement. An image fortified in a very large number of TV programmes.
 - (iii) The psychological relief—at least until a hangover catches up with them—for individuals exposed to stress.
 - (iv) Peer group pressure where the capacity to consume large amounts of alcohol receives approval and refusal to participate leads to isolation.

For most people these characteristics do not lead to addiction but for the vulnerable they present real hazards.

5. The limits of policy:

- (a) There is little that policy can achieve to prevent individual alcohol dependence that is consistent with a free, market based society. Its immediate role must focus on diminishing consequential damage. In the longer term it can contribute to changing cultural norms.
- (i) Successful treatment can only happen when the addict wants a solution. Treatment requires a change in personal values that is enduring. There is no universally successful way of securing this and many attempts fail. Components of a solution are likely to require a clear confrontation with the damage that unrestrained drinking can do in terms of employment, family security, self-esteem and lifespan. They may also need some displacement activity that separates the individual from situations in which alcohol had become a key element.
 - (ii) Activities that make individuals aware that they can escape from addiction and achieve a life style that they really want are more likely to help. Once the wish to change is in place, support within the community, such as is provided by AA and medical treatment can aid the painful adjustment to a lifestyle free from alcohol. Since addicts can never be “cured” this is a long-term process that enables vulnerable people to live with themselves in ways that are less self-destructive.
 - (iii) At early stages punishment may play an important role in bringing an individual up short with the damage drinking can do. However, where punishment leads to social isolation and the labelling of people as “drunks” it is likely to have a negative effect.
 - (iv) Societal attitudes do not help. Vulnerable individuals are exposed to continuous hazard from a culture that tacitly approves excess consumption and tolerates drunken behaviour. Education has a role in making people aware of the facts of excessive drinking. However, formal teaching of young people will not make much impact against peer group pressure. Indeed it can be argued that, if moderation is seen to be demanded by “authority”, excess will become attractive as a means of asserting independence.
 - (v) A change in public attitudes similar to that resulting from the campaign to stop smoking is needed. However, the smoking model is an oversimplification. Alcohol in moderation has some very positive social and personal effects. It is not true that the only safe route for most people is total abstinence although that is what is required of alcoholics. To argue the benefits of moderation is much more complicated whilst communicating the danger of dependence for some individuals is difficult. There needs to be a clear message that bad behaviour resulting from excess drinking is both avoidable and unacceptable.

6. It is more straightforward to legislate against alcohol consumption that reduces competence in performing tasks that impinge on other people. This has been recognised in contexts such as driving, flying and in many professional areas such as medicine.

- (a) A legal basis for such regulation in relation to driving has been recognised as necessary in virtually all countries.
- (b) There may be a case for making public and enforceable limits in other areas where individual performance impacts on others. This could include, for example people using powered machinery, people responsible for the safety of others in public places and people required to give evidence in court.

- (c) Employers can play a critical role by disciplining staff that turn up for work in a condition that damages their output or the work of others. People who do this are damaging the business to at least as great an extent as those who steal from it.
- (d) There is a difficulty in fixing any specific level of alcohol as being dangerous. There is a worry that statistics are used to defend existing, or support more stringent, laws than reveal the complex truth. For example, road accidents where some involved are proved to have had a drink may be recorded as an alcohol related. However the cause of the accident may have been careless behaviour by someone who had drunk nothing. The Select Committee might usefully consider the statistical evidence base needed to justify and enforce legislation.

7. Binge drinking provides a classical case where a social problem is blamed on a product rather than on the society that uses it. Such an approach fosters bogus solutions.

- (a) It is clear that in many societies and among many groups within the UK community social drinking takes place without rowdiness or misbehaviour. A critical element in approaching the social problems has to be to identify the groups within society who do binge drink, to understand their motivation and seek to replace this behaviour by activities that have no damaging and possibly some positive benefits for the community.
- (b) Banning access to alcohol, or attempting to price it out of the market, will encourage the development of a criminal black market. In such a situation those who “beat the system” are likely to receive approval among their peers. The tacit approval that was often given to people who broke the prohibition laws in the United States illustrates what can happen.
- (c) Much of the problem arises from a minority of the population whose cultural background accepts indisciplined drunken behaviour. Such groups are often, but not always, ill educated, work in poorly paid jobs and may accept living on social benefits as normal. Within such groups consumption of alcohol to the point at which behaviour becomes uninhibited is seen as a mark of belonging. This creates pressure on young people, as they seek to establish recognition among their peers, to find partners or to separate themselves from the authority of parents and schools to drink to excess. Other groups that share similar behaviour patterns include city workers celebrating after a day of intense trading, rugby players joining to commiserate or relish a game and soccer fans.
- (d) Behaviour is strongly influenced by cultural norms. Given the damage to individuals and society the role of alcohol in television and other media seems incredibly irresponsible. In the popular media excess drinking is seen as acceptable for people celebrating or under stress. Drunkenness is seen as funny and is portrayed as a rite of maturity among normal young adults. Such implicit approval for consuming cocaine would lead to public outrage and demands for changed behaviour. Alcohol is no less destructive. It would be appropriate for the Committee to invite the Media to explain themselves.
- (e) We do not understand why it is that in this country such group behaviour should be more common than elsewhere but there are some pointers that are important for policy:
 - (i) People who drink responsibly at home may indulge in outrageous activities within a group. Binge drinking has no simple relationship to family drinking habits. Indeed controlled drinking at home may make individuals aware at an earlier stage of the unacceptability of drunken behaviour.
 - (ii) Because young people have more money, they are able to afford more drink. However, many young people with similar or greater financial resources do not become involved binge drinking. Raising prices may curtail consumption but to do so the increase has to amount to a reduction in real income for the drinker. This penalises the majority for the behaviour of a minority. It may also lead to cheaper and possibly black market sources of alcohol consumption.
 - (iii) Binge drinking fits within a pattern of social development within which traditional social constraints are not acknowledged or have been undermined. These include attitudes to sex, to religion and respect for authority. Many of the constraints that made it easier for an individual at the point of losing control to say “no”, have been removed.
 - (iv) The leisure profile of many young people is very limited. Apart from work, most partake in relatively few participative activities such as hobby clubs, church groups or games teams.
- (f) The problems of evolving a more acceptable cultural consensus are deep seated. Alcohol is only a part of the reason for bad behaviour. It also has some beneficial social and personal aspects. The starting point in seeking a more acceptable pattern of behaviour has to be an explanation of why the offending groups are formed and why they find rewards in disrupting the ordinary life of the community.
 - (i) It seems that many people define themselves by reference to peers. People discover who they are in relation to those with whom they work and meet in leisure activities ranging from discos and music festivals to sporting clubs, church and charitable groups. Alcohol helps to diminish diffidence and so eases entry into the group.

- (ii) Recognition within the group is a powerful dynamic; membership implies conformation to group norms. Since drinking provides an excuse to meet, to talk and to get to know people as well as reducing the shyness that often inhibits these activities it forms a natural part of such relationships. Although this poses perils for some addictive personalities in general it can be seen as serving a positive function as a social lubricant.
- (iii) Within any group there is an incentive to excel. In a criminal society status is achieved through being a successful—or even a notorious criminal. If we wish to divert the award of status from drinking to more socially constructive activities we have to understand and replace the concepts of excellence perceived by groups that tolerated binge drinking.
- (iv) In practice the incentives offered too many youngsters, especially those of limited education, from dysfunctional families or with poor employment records are few. Life seems to focus on the achievements of celebrities and since realistically only a few people achieve this status, for the majority the thing they can do more of, is what they already enjoy, drinking and making whoopee. For a moment they see themselves as celebrities. With inhibitions reduced, the inherent conflicts within any group of peers can quickly turn to violence.
- (v) Policy relevant to this cannot be conceived simply in terms of stopping binge drinking it has to evolve accepted alternatives that meet the individual and group needs. These must encourage a much wider range of ways in which people value themselves and other people. There are no short cuts but the existence of the problem is an indication of the failure of a society that does not value people as such but only their performance in economic goals.

8. If this analysis is correct then policies targeted only at alcohol are unlikely to have much effect. What is needed is an understanding of how government as a whole can influence and encourage constructive cultural norms. How, for example, policies designed to prevent discrimination may undermine traditional social values without providing constructive alternatives. Such a strategy must have at least four aspects.

- (i) Systematic research into the cultural impact of all policies including an automatic requirement to monitor new law for its impact on cultural groups.
- (ii) Seeking the evolution of accessible activities that are socially beneficial these include participation in sport and many hobby activities.
- (iii) Seeking consensus for enforceable regulations where alcohol abuse leads to danger to other people.
- (iv) Seeking to ensure that drunkenness and binge drinking are portrayed in the media as an unacceptable assault on a peaceful society. People who behave in this way should encounter social isolation rather than be regarded with amusement and receive social tolerance.

March 2009

Memorandum by Alcohol Concern (AL 13)

1. ABOUT ALCOHOL CONCERN

1.1 Alcohol Concern aims to reduce alcohol related harm. We campaign for effective alcohol policy and work to improve services for people whose lives are affected by alcohol misuse.

1.2 Alcohol Concern is a membership body working at a national level to influence alcohol policy and champion best practice locally. We support professionals and organisations by providing expertise, information and guidance.

2. EXECUTIVE SUMMARY

2.1 We welcome the opportunity to comment on the level of alcohol misuse and measures which could be taken to reduce alcohol related harm. Alcohol Concern urges the Select Committee to recommend evidence-based action to reduce the unnecessary costs associated with excessive drinking. In our view, this requires measures that more effectively regulate the sale, promotion and marketing of alcohol in order to encourage safer drinking; and that provide greater access to support for those whose consumption of alcohol has caused adverse consequences.

3. THE SCALE OF ILL-HEALTH RELATED TO ALCOHOL MISUSE

3.1 Alcohol misuse is a major public health issue. A recent World Health Organisation report identifies alcohol as the third highest risk to health in developed countries.⁸¹

3.2 Since 1991 the number of alcohol-related deaths has almost doubled.⁸² Analysis by the Cabinet Office in 2003 estimated that alcohol is implicated in 22,000 deaths annually.⁸³ This is greater than the combined number of people who die from breast cancer, cervical cancer and MRSA each year. The figure encompasses a wide range of individual circumstances including cirrhosis of the liver, cancer, accidents, suicide, cerebrovascular diseases and violent crime. Premature death, while catastrophic for the individuals concerned can also deeply affect their families, social networks and society at large. We cannot quantify this additional toll.

3.3 An important measure of alcohol-related deaths is the rate of mortality due to liver cirrhosis. In England, the rate of liver cirrhosis mortality approximately trebled between 1970 and 1998, while the rate in the EU decreased by 30%.⁸⁴ In the 35 to 44 years age group the death rate increased eight-fold in men and almost seven-fold in women, while there was a four-fold increase in 25 to 34 year-olds.⁸⁵

3.4 There is a high level of need across categories of drinkers. 38% of men and 16% of women (age 16–64) have an alcohol use disorder (26% overall), which is equivalent to approximately 8.2 million people in England.⁸⁶ The prevalence of alcohol dependence overall was 3.6%, with 6% of men and 2% of women meeting these criteria nationally. This equates to 1.1 million people with alcohol dependence nationally.⁸⁷

4. THE CONSEQUENCES FOR THE NHS

4.1 Alcohol misuse, whether it is direct or indirect, increases the burden on all aspects of health and social care—primary care services and most hospital services including Accident & Emergency, medical and surgical inpatient services, paediatric services, psychiatric services and outpatient departments. It may cause admission directly or contribute to admission with other causes. It may also adversely affect the course of illness once a patient has been admitted and interfere with their recovery. Additionally, the burden of alcohol misuse on general hospital workload results from damage not only to the harmful/problem drinker him or herself, but also to others affected by that person's drinking. In 2006–07, there were 811,000 alcohol-related hospital admissions, comprising 6% of all admissions. This figure is rising by 80,000 admissions per year.⁸⁸

4.2 It is estimated that the annual cost of alcohol harm to the NHS in England is £2.7 billion in 2006–07 prices.⁸⁹

4.3 NHS hospital admissions specifically related to alcohol doubled between 1995–2006 and 2006–07. Alcohol was either the primary or secondary cause of 207,800 NHS admissions in 2006–07, compared to 93,500 in 1995–96.⁹⁰

4.4 In 2007, there were 112,267 prescription items for drugs for the treatment of alcohol dependency prescribed in primary care settings in England. This is an increase of 20% since 2003, when there were 93,241 prescription items.⁹¹

4.5 Of Accident & Emergency staff polled by Alcohol Concern in 2003, 90% said that alcohol misuse is one of the most serious public health problems facing Britain today. Over 50% said that alcohol misuse accounted for a “very significant” proportion of the illness and injuries treated in their department.⁹² Common reasons for alcohol-related attendance at A&E Departments include violent assault, road traffic accidents, psychiatric emergencies and deliberate self harm.⁹³ Alcohol-related attendances at A&E account for up to 70% of all attendances at peak times of midnight to 5am, and 41% of attendees at all times were positive for alcohol consumption.⁹⁴

4.6 Research has shown that problem drinkers consult their GPs twice as often as the average patient.⁹⁵

4.7 The Alcohol Needs Assessment Research Project estimated that £217 million was spent in 2003–04 on alcohol treatment. The vast majority of this was provided by primary care trusts but some also comes from local authorities and charitable funds.⁹⁶

⁸¹ World Health Organisation (2002) “The world health report 2002: reducing risks, promoting healthy Life”

⁸² Office of National Statistics (2006) “Alcohol related death rates almost double since 1991”

⁸³ Cabinet Office Strategy Unit (2003) Interim Analytical Report, Cabinet Office, London

⁸⁴ Drug and Alcohol Research Unit Ireland (2008) Drugnet newsletter, Issue 27

⁸⁵ Department of Health (2001) On the state of the public health: the annual report of the Chief Medical Officer

⁸⁶ Department of Health (2004) Alcohol Needs Assessment Research Project (ANARP)

⁸⁷ Ibid.

⁸⁸ Department of Health (2008) Safe, Sensible, Social—Consultation on further action

⁸⁹ Department of Health (2008) “The cost of alcohol harm to the NHS in England—An update to the Cabinet Office 2003 study”

⁹⁰ NHS Information Centre for Health and Social Care (2008) Statistics on Alcohol: England 2008

⁹¹ Ibid.

⁹² Alcohol Concern (2003) “No Half Measures”

⁹³ Cabinet Office Strategy Unit (2003) Interim Analytical Report

⁹⁴ Prime Minister's Strategy Unit (2003) Alcohol Harm Reduction Report—Interim Analytical Report

⁹⁵ Heather N and Kaner E (2002) “Brief interventions Against Excessive Alcohol Consumption” in Warrell *et al* (eds) Oxford Textbook of Medicine (4th Edition) Oxford Medical Publications

⁹⁶ Department of Health (2004) Alcohol Needs Assessment Research Project (ANARP)

5. CENTRAL GOVERNMENT POLICY

5.1 Alcohol Concern believes that the Alcohol Harm Reduction Strategy for England, launched in 2004, mistakenly viewed alcohol misuse as the preserve of a small minority and particularly focused on chronic and binge drinkers. While rightly pointing out the large-scale harms associated with this, the strategy failed to acknowledge the relationship between price, public health and our heavy drinking culture, or the potential for government to achieve real behaviour change by using the levers available to them. Safe, Sensible, Social—The Next Steps in the Alcohol Strategy (SSS), which was published in 2007, has belatedly re-focused efforts to combat hazardous and harmful drinking, while the subsequent PSA target to reduce the rate of alcohol related hospital admissions was welcomed by health groups. However in the context of attempting to reduce the scale of alcohol harms, both strategies appear to have failed to provide the necessary levers addressing the affordability and availability of alcohol to adequately change the prevalence of heavy drinking or the resultant harms arising from it.

5.2 A lack of specific targets to reduce harm has hampered efforts to encourage Primary Care Trusts and local authorities to act on the guidance issued. In addition, the lack of ring-fenced funding; absence of alcohol from GP's Quality Outcome Framework and poor local performance and monitoring systems have allowed alcohol-related health conditions to spiral.

6. THE ROLE OF THE NHS AND OTHER BODIES INCLUDING LOCAL GOVERNMENT, THE VOLUNTARY SECTOR, POLICE, THE ALCOHOL INDUSTRY, AND THOSE RESPONSIBLE FOR THE ADVERTISING AND PROMOTION OF ALCOHOL

7.1 Local authorities and mainstream statutory bodies which deliver public services, such as PCTs, Police Authorities, Education services and Social Services have been issued with plentiful guidance on working together through partnership structures to identify need, develop strategies and monitor performance to reduce alcohol related harm⁹⁷. This should be led by senior officials and overseen by local Boards and Councils. In practice, this approach happens in some areas but not others, is often poorly resourced and is not usually scrutinised by central departments who have devolved decision making to local areas. In order to be effective, stronger levers are required to oblige local areas to address alcohol harms and to be answerable to Strategic Health Authorities and regional Government Offices.

7.2 Statutory teams in health, social care, education, housing and the criminal justice system should introduce widespread systems to identify problem drinking and provide brief advice. This process of screening and brief interventions has a vast body of evidence demonstrating effectiveness at low-cost⁹⁸.

7.3 The voluntary sector plays a key role in delivering social care and psycho-social interventions for treating alcohol problems. The vast majority of treatment provision is delivered by the voluntary sector and good links exist between voluntary and statutory health providers. However, the voluntary sector suffers from short-term funding, excessive competitive tendering and client case loads that are increasingly complex and multi-faceted. The sector urgently requires infrastructure support, stable commissioning for long-term (five-year) contracts and a place at the table when local alcohol planning takes place.

7.4 Understandably the drinks industry has tended to take a protectionist view whenever it has engaged en masse in debates about reducing alcohol harm. What is needed is a new approach, whereby the drinks industry acknowledges its contribution to alcohol harm as a starting point for debate. One solution to ensure corporate social responsibility for advertising alcohol is to mandate drinks producers to fund a proportion of sensible drinking promotions in relation to alcohol advertising. So, for example one-sixth of all adverts on alcohol would be Government sponsored responsible drinking adverts, funded by the industry.

8. SOLUTIONS, INCLUDING WHETHER THE DRINKING CULTURE IN ENGLAND SHOULD CHANGE

8.1 Any future strategy needs to explicitly acknowledge the link between excessive drinking and risks to health and ensure a strategic focus across all departments, linking public health to price, regulation, awareness and treatment. The primary aim of any future strategy should be to drive consumption down and change the culture of heavy drinking. Furthermore, alcohol misuse should be a public health issue with the same status as smoking and obesity.

8.2 Government should make explicit their intention to reduce overall consumption, as the Scottish Government have done, and to introduce measures to outlaw irresponsible price promotions.

⁹⁷ See Local Alcohol Strategies Implementation Toolkit (2008)—HO/DH/DCVS/Alcohol Concern

⁹⁸ Heather *et al* (2005) Review of Alcohol Treatment Effectiveness, NTA

Education

8.3 All young people should have access to good quality alcohol education in both formal and informal settings with the aim that young people make healthy, informed choices. Alcohol education should not only provide knowledge but also develop skills and explore attitudes around alcohol, and take into account the context of young people's needs, age and experience. Alcohol Concern is pleased that the status of Personal, Social and Health Education in schools in England is to change to statutory and believes that alcohol should form an important component of the syllabus.

8.4 The Chief Medical Officer's guidelines for parents on young people's drinking, published by the Department for Children, Schools and Families in January 2009, should be supported by an awareness campaign, targeted at both parents and young people.

8.5 More training and support for the children and young people's workforce is required, so that they can provide early identification and intervention or brief advice and, where appropriate, a referral for young people who may need support around their drinking.

Advertising and media

8.6 Alcohol Concern recommends that there should be no alcohol advertising (either branded or supermarket) from 6am through to 9pm, regardless of the predicted age of audience of a programme. In other words, there should be no alcohol advertising before the watershed. In our view this is the only way to protect the majority of children from alcohol advertising. In programmes which run after the watershed but are still likely to appeal to some children, eg sporting events, alcohol advertisements should not appear where more than 10% of the audience are likely to be children.

8.7 Alcohol Concern is in favour of an "end-frame" of alcohol health information comprising one sixth of air time or press space attached to all alcohol advertising. To have no mandatory warning or health messages within alcohol adverts is at odds with the harm alcohol could cause.

Retailing

8.8 While we believe that self-regulation by the industry has a role, voluntary regulation by the industry has failed to eliminate bad practice, despite repeated promises that this would happen. Alcohol Concern believes that the alcohol industry should be independently regulated, with proactive monitoring of compliance with relevant codes.

8.9 There should be a new mandatory code of practice for the alcohol industry, an enabling power for which has been included in the Policing and Crime Bill 2009. The mandatory code should be enforceable, transparently managed and encourage the spread of best practice through recognition of success. This mandatory code should ban irresponsible pricing promotions which encourage people to drink more than they otherwise would.

8.10 Alcohol Concern believes there should be a legal requirement for all bottles and cans to be labelled with a DH standard worded health message alongside unit information. Research shows that there are serious gaps in public knowledge about safe drinking levels and the consequences of misuse which should be addressed.

8.11 In order to tackle high levels of alcohol consumption and related health harms, it is crucial to consider the issue of price. Research shows that alcohol responds to price increases like most consumer goods on the market, ie when other factors remain constant an increase in the price of alcohol generally leads to a decrease in consumption.⁹⁹ In support of this principle, analysis of trends in alcohol price and consumption show that, as the price of alcohol has decreased in the UK, consumption has increased.¹⁰⁰ Alcohol Concern recommends a 60p per unit minimum price to be applied to all alcohol sold in both the on and off trades. Various studies have shown that increasing price decreases the health harms caused by alcohol. It has been estimated, for example, that a 10% increase in alcohol prices in the UK would lead to a 10% fall in consumption.¹⁰¹ A 2006 study found that increased beer prices would result in substantially fewer violent injuries and reduce demand on trauma services.¹⁰² Recently the report of the School of Health and Related Research at the University of Sheffield found that a 60p minimum price would lead to 168,800 fewer hospital admissions per year in England, with total healthcare cost savings of £122.3 million in the first year and £2.45 billion over 10 years.¹⁰³

⁹⁹ World Health Organisations (2007) Second Report of the Expert Committee on Problems related to Alcohol Consumption' Technical Report Series 944

¹⁰⁰ Scottish Health Action on Alcohol Problems (2008) "Alcohol: Price, Policy and Public Health"

¹⁰¹ British Academy of Medical Sciences (2004) "Calling Time—The nation's drinking as a major health issue"

¹⁰² Matthews, K; Shepherd, J & Sivarajasingham, V (2006) "Violence-related injury and the price of beer in England and Wales", Applied Economics 38

¹⁰³ Meier *et al*, ScHARR, University of Sheffield (2008) "Independent review of the effects of alcohol pricing and promotion: Part B—Modelling the potential impact of pricing and promotion policies for alcohol in England"

Information and public awareness

8.12 Public education and information is needed on the implications of alcohol misuse so that people can make informed choices about drinking, enabling them to weigh up their options from a position of knowledge and awareness. Alcohol Concern believes there must be ongoing education and targeted campaigns, especially aimed at young people.

Licensing

8.13 Alcohol Concern believes that the Licensing Act 2003 should be amended to include a public health objective that informs decisions about licensing applications, reviews and cumulative impact zones. Licensing authorities should have access to a nationally standardised collection of A&E, ambulance, hospital admissions and treatment data. This would allow local authorities the power to refuse additional licenses or extensions if local alcohol-related health harms were increasing or a matter of significant concern. Incorporating a public health objective into the Act, to protect the community's health, would bring a greater coherence to the government's programme to reduce alcohol-related harms.

Alcohol treatment service provision

8.14 The Department of Health should establish an optimal level of access for alcohol treatment for England and Wales. The current access level of one in 18 should be reduced to around one in seven (15%)—this would chime with moderate treatment access targets in the USA, as described in the Alcohol Needs Assessment Research Project. While access is poor in many areas, more than a few trusts are able to offer “high” numbers of treatment places. Establishing a national consensus on a realistic target would help trusts measure their performance against a credible baseline in the medium term.

8.15 Primary Care Trusts (PCTs) should be required to produce an Alcohol Needs Assessment of alcohol issues in their areas, measuring the level of need across at-risk groups. This should include a plan for how needs will be commissioned for all drinking groups across the four tiers based on Models of Care for Alcohol Misusers. Strategic Health Authorities should performance manage PCTs' needs assessments.

8.16 The Department of Health (DH) should consider demanding of local commissioners that waiting times for alcohol treatment match targets for drug treatment in the next NHS operating framework. This is now possible as service providers must report alcohol treatment and waiting time data to the National Drug Treatment Monitoring System (NTDMS).

8.17 All key healthcare professionals should be trained to recognise and provide brief interventions and alcohol should be built into the Quality and Outcomes Framework for GPs.

8.18 Every hospital ward and A&E Department should have access to an alcohol health liaison worker. Alcohol Concern is a member of the Alcohol Health Alliance

March 2009

Memorandum by the NSPCC (AL 14)

EXECUTIVE SUMMARY

The purpose of this evidence is to inform the Committee of the significant impact that alcohol misuse by parents or carers can have on the children and young people in their care.

First, we provide a brief background to the NSPCC and the expertise that informs our submission. Secondly, we present factual information about the impact of parental alcohol misuse on children and young people. Thirdly, we consider a model of child and family support the NSPCC has provided in partnership with the Alcohol Recovery Project, in Camden, London since 2002. We conclude with a set of recommendations for action.

We would be pleased to supplement this written evidence with oral evidence to the Committee. In addition, if members of the Committee would like to learn more about therapeutic support for children and families dealing with alcohol misuse we would be very pleased to host a visit to a suitable NSPCC project.

INTRODUCTION

- (i) The National Society for the Prevention of Cruelty to Children (NSPCC) is the UK's leading charity specialising in child protection and the prevention of cruelty to children. The NSPCC exists to end cruelty to children through a range of activities which aim to prevent child abuse, help children at risk of abuse and help abused children to overcome the effects of abuse.

- (ii) We have a range of services throughout England, Wales and Northern Ireland. Their work includes:
 - (a) Providing telephone support for children and young people via ChildLine.
 - (b) Providing telephone support for adults concerned about the welfare of a child.
 - (c) Providing support for vulnerable children, young people and their families to help keep these children and young people safe and well cared for.
 - (d) Providing services for children and young people who need help to overcome the impact of abuse.
- (iii) The NSPCC broadly welcomes the Government's focus on alcohol use and its impact on children and young people. However, we are concerned that the dominant feature of this work is the threat that children and young people present to themselves and others by inappropriate patterns of drinking, as opposed to the threat posed to young and vulnerable children by alcohol misuse by their parents or carers.
- (iv) The NSPCC is concerned to highlight the considerable impact of alcohol on the safety and well-being of children and young people living with alcohol misusing parents or carers. We therefore welcome this Inquiry and the opportunity it presents to highlight this issue which has been neglected for too long and barely features in the national policy framework governing alcohol issues.
- (v) The evidence we present is based on our extensive experience of child protection and in particular the knowledge and understanding of our practitioners providing services to children and young people affected by parental alcohol misuse. We also draw upon the testimony of children and young people using our helpline service, ChildLine, and other services dedicated to children and families experiencing alcohol-related dysfunction.

FACTUAL INFORMATION

Alcohol and maltreatment

(i) Child maltreatment is the outcome of a series of complex and inter-related factors of which parental alcohol misuse can be one. A significant proportion of child abuse involves parental alcohol misuse, and children and young people living in these circumstances are at increased risk of maltreatment. This does not mean that all children of alcohol misusing parents or carers will always, or even typically, experience maltreatment. However, a significant number of them will, and this is of particular concern to the NSPCC.

(ii) It is difficult to provide an exact figure for the numbers of children and young people who are living with parents or carers who misuse alcohol. Quantitative reports typically conflate drug misuse and alcohol misuse into a generic heading of "substance abuse". However, the Cabinet Office (2004) estimates that between 780,000 and 1.3 million children are affected by parental alcohol problems, a figure which broadly corroborates the estimate of 920,000 provided by Alcohol Concern (2000).

Recommendation 1

Data collection and published data, for example as produced by the Office for National Statistics or the annual Child & Adolescent Mental Health Mapping exercise, should routinely disaggregate drug misuse from alcohol misuse where this is possible. Many parents and carers will use alcohol alongside other substances. This information should be clearly recorded. The gender of the misusing parent/carer and the nature of the substance abuse(s) of each should also be recorded. This would enable:

- Appropriate research to be undertaken to uncover the forms of child maltreatment associated with alcohol abuse and whether these are significantly different to maltreatment associated with other forms of substance abuse.
- Whether there is a distinctly gendered element to different forms of substance abuse and associated forms of child maltreatment. This would be helpful for identifying primary causal factors and, therefore, the most effective forms of support and intervention.

(iii) In the year ending March 2008, ChildLine received more than 80 calls each week (a total of 4,176 calls) from children and young people where alcohol misuse by a "significant other" was the substantive reason for the call. We cite some anonymised ChildLine case examples below to illustrate the impact of parental alcohol misuse on children.

(iv) Alcohol misuse has a significant impact on the life and family experiences of children and young people, for example:

- (a) Conflict and particularly exposure to domestic violence, is commonly associated with alcohol misuse. Gilchrist *et al* (2003) found alcohol to be a feature in 62% of prosecuted cases of domestic violence, while 48% of offenders were alcohol dependent.

"Dad drinks a lot and gets drunk at weekends. My step-mum's pregnant, and he pushes her about when he's drunk. I keep telling her to leave him, but she always goes back and I'm worried about her children. Mum says he used to push her around too".

(ChildLine call 2007–08).

- (b) Physical abuse and neglect are often associated with parental drinking (Forrester *et al*, 2006).

“She [mum] gets violent with my little sister as well. She always goes out, and leaves me and my sister alone, when she gets back she smashes up the house, and takes it out on my little sister when she’s done nothing wrong. I’ve been to school with bruises and when they ask I have to lie and pretend I’ve done it myself”.

(ChildLine call 2007–08).

- (c) Relationships between children and their parents and carers or peers are likely to be affected. Children and young people typically feel ashamed and embarrassed by the behaviour of a drinking parent (Tunnard, 2002).

- (d) Parenting capacity may be compromised as a result of alcohol misuse, resulting in emotional unavailability, variable or volatile behaviour (Cleaver *et al*, 1999), and in some cases behaviour that is abusive or neglectful.

“I can’t live with mum as she does drugs and goes drinking every night . . . dad hit [my] sister once but she called the police and he never hit her again . . . dad hardly food shops . . .”

(ChildLine call 2007–2008).

- (e) Role reversal is a common feature in families affected by alcohol misuse, where children will accept responsibility for the care and well-being not only of siblings, but of the alcohol misusing parent(s) (Tunnard, 2002).

“. . . didn’t go to school today . . . had to look after the kids again . . .”

(ChildLine call, 2007–08)

- (f) Poverty: Limited family funds, if diverted into buying alcohol, can result in real deprivation and/or pressure on individuals within the family. A failure to pay household bills, the mortgage or rent, can, over time, have a dramatic and detrimental effect on a family’s security and relationships (Tunnard, 2002, Forrester *et al*, 2006).

(v) The experiences of children living in a family environment where alcohol misuse is a significant factor are wide-ranging and unpredictable. What is known is that children of alcohol misusing parents “...have higher levels of behavioural difficulty, school-related problems and emotional disturbance than children of non-problem drinking parents, and higher levels of dysfunction than children whose parents have other mental or physical problems”. (Alcohol Concern, 2009)

(vi) The outcomes for these children are equally diverse, and include in particular: anti-social behaviour; emotional problems; poor educational engagement and difficulty in developing or sustaining trusting relationships (*ibid*). Parental alcoholism is also a major predictor of alcohol use in adolescents. The children of alcohol misusing parents or carers are at greater risk of alcoholism than the children of non-abusing parents or carers (Chassin *et al*, 1999)

(vii) Parental misuse of drugs or alcohol is a common issue for child care social workers. In a qualitative examination of social work case files, Forrester *et al* (2006) found parental substance misuse emerged as a major feature in 34% of cases. These cases tended to be associated with more severe levels of concern, for example, they accounted for 62% of children subject to care proceedings and 40% of those placed on the child protection register. The study also highlights “the central importance of alcohol misuse”, for while drug misuse receives more attention than alcohol misuse, by researchers and the media, Forrester *et al*’s sample found more cases involving alcohol misuse overall. In addition, those cases involving alcohol found a higher incidence of violence and were less likely to involve a substance misuse professional. “It is therefore clear that alcohol misuse is a central issue for social workers”.

(viii) In the main, the children tended to be younger and part of a family where both parents were substance misusers, or to come from single parent families where the lone parent was a substance misuser (Forrester *et al*, 2006). Families were typically chaotic; characterised by violence, relationship breakdowns, housing difficulties and unemployment. The concerns surrounding children’s welfare were predominantly associated with neglect (*ibid*).

(ix) Notwithstanding the above, referrals from health visitors and general practitioners were the exception rather than the rule (*ibid*) suggesting that substance misuse issues are either not being identified or not being referred by community health professionals. Primary health care professionals play a crucial role in the early identification of alcohol misuse, and in the development of multi-agency assessment and support. The government’s plans to expand the health visiting workforce are warmly welcomed. However, it is important that this expansion is not confined to targeted interventions such as Family Nurse Partnerships. The universal service traditionally supplied by health visitors and widely welcomed by families is a resource in which the NSPCC would wish to see significant investment and growth.

Recommendation 2

We recommend increased investment in the home visiting universal health visiting service, in addition to government plans to expand Family Nurse Partnerships and to ensure the availability of a health visitor at children's centres.

Recommendation 3

We also recommend that qualitative research should be undertaken to establish why community health professionals are not identifying and/or referring parents/carers with problems associated with substance, and particularly alcohol, abuse.

(x) Forrester *et al* (2006) identify the legal status of alcohol and its prominent role within society as being a possible partial explanation for the challenges that arise when working in this area. They conclude this may be the reason why the inter-agency framework works less well in relation to alcohol misuse than to other substances.

(xi) The National Service Framework for Children Young People & Maternity Services (NSF) (2004) is clear that the children of substance and alcohol misusing parents/carers are likely to need particular support.

Recommendation 4

The abovementioned research might usefully be extended to include an examination of why the inter-agency framework works less well in relation to alcohol misuse than to other substances. This would inform the development of appropriate practice and procedures in a multi-agency environment.

xi. Finally, Forrester *et al* continue that social workers are ill-prepared for work with substance-misusing parents and lack appropriate training. This is compounded by the lack of involvement of substance misuse professionals in care plans.

Recommendation 5

All professionals working with children and families should be required to undertake appropriate multi-agency training concerning the impact of parental/carer drug and alcohol misuse on the children for in their care.

(xii) Anecdotal evidence from the NSPPCs services indicates a high level of substance misuse in cases of serious or fatal child abuse, and this is verified by studies into fatal child abuse which record the persistence of "substance abuse" as a risk factor: 60% of cases (Wilczynski, 1995); 57% (DCSF, 2008). Further interrogation shows a complex picture of co-morbidities, without any clear indication of a primary causal factor. For example: 66% of cases show incidence of domestic abuse and 55% of cases show incidence of mental health disorders. What is clear is that substance misuse, though rarely a causal factor when taken in isolation, is a high risk factor when associated with either or both domestic abuse and/or a mental health disorder (DCSF, 2008).

Recommendation 6

Detailed scoping for further research into co-morbidities should be undertaken as a matter of urgency. This should, in particular, consider how, where multiple factors are present, the primary cause might be identified, as this will shape the support offered to parents, carers and families.

(xiii) The link between alcohol misuse and non-fatal child abuse is also clear. Robinson & Hassle's study in Camden & Islington (2000) found that alcohol played a part in around 25% of known cases of child abuse and that domestic violence, drug misuse and alcohol misuse were found to be the highest contributory factors within the family unit affecting the welfare of the child. Of particular concern, particularly given the frequency with which it occurred, was the fact that substance misuse was not included in assessment (Robinson & Hassle, 2000). These findings bear out the current experiences of NSPCC teams working with substance misuse, including alcohol misuse, where adult and children's services do not typically plan jointly for children in need and children who are subject to a child protection plan.

Recommendation 7

The Department of Health and the Department for Children, Schools & Families should develop a stronger policy focus on the impact of parental alcohol misuse on children.

Recommendation 8

The Department of Health and the Department for Children, Schools and Families should develop joint guidance for all professionals working with children and families reinforcing the need to:

- Ensure that assessments explicitly include and record an assessment of need and risk in connection with alcohol and/or substance abuse.
- That this assessment should record alcohol misuse as a separate factor to other forms of drug abuse.
- That the gender of the substance/alcohol abusing parent/carer should be routinely recorded.
- That an appropriate record is made of plans for support, intervention and review.

Recommendation 9

This information should be aggregated within Local Authority Children's Services Department and used to inform Primary Care Trust (PCT) Joint Strategic Needs Assessments (JSNAs) and Local Authority Children & Young Persons' Plans (CYPPs).

Recommendation 10

The Department of Health and the Department for Children, Schools and Families should consider the development of a joint performance indicator concerning the identification of parental/carer alcohol misuse, the rate of referral and the impact of treatment in terms of the effect it has on family stability.

In addition, women experiencing domestic violence are 15 times more likely to misuse alcohol than the general female population and this affects their parenting capacity (Stark *et al*, 1996; Stephens *et al*, 2000; Humphreys *et al*, 2003)

Other research suggests that children are more likely to suffer physical abuse if the father is the drinker, and neglect if the mother is the drinker (Cleverly *et al*, 1999).

Recommendation 11

Further research should be commissioned to establish to what extent abuse associated with alcohol misuse is gendered. This will inform the nature of intervention and support provided.

xv. Alcohol misuse is typically conflated into a generic figure for "substance misuse". This is not helpful for developing social policy on alcohol-related harm and arguably serves to mask some of its negative effects. Alcohol is qualitatively different from other substances included in the term "substance misuse" in that it is a legal substance, is widely and easily available, relatively cheap and widely socially embraced across class, gender and many cultures (more so, arguably, than abstinence). It is the ease of access to alcohol, and the relative acceptability of its use, that inadvertently conceals the extent and severity of its impact on family life.

Recommendation 12

Substance abuse data should be disaggregated into component parts showing "alcohol misuse" and other substance misuse. This would:

- Provide a clear source of quantitative evidence to inform practice and policy in this area.
- Provide commissioners with high-quality information concerning the sorts of specialist services required.

xvi. Routine assessment of parental alcohol use is widely undertaken, and should form a part of all antenatal presentations (RCOG, 2006). This should include enquiries concerning alcohol use by partners.

xvii. Similarly, routine assessment of parental alcohol misuse should form a part of all post-natal enquiries and this should include enquiries concerning alcohol use by partners.

Recommendation 13

Alcohol (mis)use should form a routine and consistent element of post-natal assessment by health visitors and/or general practitioners.

THE NSPCC & ALCOHOL RECOVERY PROJECT FAMILY ALCOHOL SERVICE

“Children and young people and families receive high quality services which are coordinated around their individual and family needs and take account of their views”.

(National Service Framework for Children’s & Maternity Services, 2004, Core Standard 3)

“The stresses of parenthood can precipitate or exacerbate parents’ difficulties. In some cases, children may be at risk of harm as a result of their parents’ problems; substance or alcohol misuse, in particular, can lead to a chaotic lifestyle”.

(National Service Framework for Children’s & Maternity Services, 2004, p.79, para 9.2)

The Family Alcohol Service (FAS) started in May 2002, as a partnership project between the NSPCC and the Alcohol Recovery Project (ARP), to provide therapeutic and family support services to families in Camden and Islington where there are parental alcohol problems.

- (i) It is one of a number of NSPCC projects providing support services to children and families experiencing parental alcohol problems. Such services are relatively rare.
- (ii) The project aims to bridge the gap between services to adults and services to children by offering support to the whole family through one service, using a solution-focused approach which emphasises the values and strengths of family members, looking at their motivation to change their behaviour to concentrate on the needs of their children.

“Despite the evidence that many families and children are badly affected [by alcohol misuse], recognition of their experiences, alongside service provision for these families, has been limited. Traditionally services have focused on the needs of problem drinkers ...” (Velleman *et al*, 2003)

- (iii) Following a short assessment period, FAS offers a range of services, suited to the needs of each family. This may include family sessions, individual work with the drinking parent and the non-drinking partner, couple sessions, as well as individual play therapy sessions with children affected by their parents’ alcohol problems.

“I come here when Mummy is not well and it’s nice to have someone to talk to”.

“It’s great to come to this place—you can talk about difficult stuff”.

Feedback from service users: NSPCC Family Alcohol Service

- (iv) The aim is to increase children’s resilience and ability to cope with their situation, as well as helping parents + recognise the impact their drinking has on their children and make positive changes to benefit them.

“FAS listens to me when I talk about the things I do well for my family, not just the bad things”.

“Alcohol misuse affects all the family—the work you do with the whole family makes sense”.

Feedback from service users: NSPCC Family Alcohol Service

- (v) FAS work with families for about six to nine months on average in an intensive way, often seeing more than one family member for individual sessions. Referrals mostly come from Social Services but the project also works with other alcohol agencies as well as health services. Self-referrals are also encouraged and often these are more motivated to attend and make positive changes.
- (vi) An evaluation of the first 12 months of this project was published in 2003. It found, amongst other things that:
 - The FAS engaged with 74 families including 120 children in the first year of service.
 - Many of the children were on the child protection register, the subject of care proceedings, living with other family members or in care.
 - Family members were “enthusiastic in their praise for the service. Both referrers and FAS staff have reported significant success in engaging difficult-to-treat families in the change process”.
 - Children became less anxious and more able to express and resolve negative feelings about their home circumstances. School attendance and achievement improved.
 - Most importantly: the aspiration of the FAS was to be seen as an example of good practice. The evaluation found that “... FAS has made a good start on becoming just that, demonstrating some inspiring and innovative work in an extremely difficult area of practice”.

Safe, Sensible, Social: The next steps in the National Alcohol Strategy (HM Govt, 2007) acknowledges the risks parental alcohol misuse presents for children and young people, but does not include any recommendations in this context.

Recommendation 14

We recommend that the Department of Health and the Department for Children, Schools & Families develop a stronger joint focus on the issue of parental alcohol misuse and its impact on children and young people.

 Recommendation 15

We further recommend that consideration is given to the provision of more family-focused therapeutic work with alcohol misusing parents/carers and their children, such as that outlined above and in line with the requirements of the Department of Health, National Service Framework for Children's & Maternity Services, Core Standard 3.

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- March 2009
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Memorandum by the National Association of Cider Makers (AL 15)

NATIONAL ASSOCIATION OF CIDER MAKERS

The National Association of Cider Makers (NACM), which represents producers of cider and perry in England, Wales and Northern Ireland, welcomes the opportunity to offer comments to the Health Select Committee—Alcohol Enquiry.

THE INDUSTRY

The cider industry is characterised by its wide range of scale of production with two major producers, a handful of medium scale producers and a very long tail of very small scale with some perry and cider makers produce less than 70Hl per annum.

The principal raw material for making perry and cider is pears for perry and apples (both cider apples and dessert apples) for cider. The source of the pears and apples for making perry and cider is from a wide variety of orchards, varying in scale from two to three trees to large orchards in England and Wales.

Cider and perry is sold throughout the United Kingdom in a wide range of outlets from major national and regional pub chains, major multiple retailers to farm shops and local pubs and local supermarkets.

The share which cider and perry have of the total UK alcoholic drinks market is only very small at about 7%, compared to beer (41%), wine (25%), spirits (25%) and RTDs (alcopops) (1%). Of cider's 7% share of the alcoholic drinks market less than that 10% is strong white ciders > 7.5% ABV, accounting for only 0.7% of the total alcohol market. Furthermore this product is declining in sales volumes and is increasingly representing a reducing share of the alcoholic drinks market.

ALCOHOL MISUSE POLICY OVERVIEW

NACM appreciates the Government's desire to tackle alcohol misuse and believes that Government should take appropriate measures to address this issue and introduce policies that will contribute to the significant reduction in the harm which arises from misuse.

A review of published reports in the public domain produced by the UK Government and other bodies, quite clearly demonstrates that no one alcoholic drink is responsible for alcohol misuse—misuse is caused by certain drinkers who clearly misuse alcohol and by some under 18s who are clearly breaking the law. This therefore is not a problem about problem drinks but about problem drinkers.

CULTURAL CHANGE

For the Government to succeed in bringing about a cultural change in how alcohol is consumed by the irresponsible minority then as an urgent priority, it needs to identify and deal with the real causes of alcohol misuse (and indeed substance abuse in general). It is misplaced to focus on the availability and affordability (price and promotion) of alcohol as the sole and root cause of misuse. The real drivers behind harmful drinking, binge drinking behavior and under 18's alcohol misuse tend to get overlooked as a consequence. This means adopting or calling for a combination of long-term measures such as improving education, awareness campaigns, etc and short-term measures which can also be effective such as enforcing the legislation that already exists.

NACM acknowledges that Government has committed resources to initiatives in this area as indeed has industry. NACM is a supporter of the Drinkaware Trust and of "Project 10" a £100 million (over five years) industry education initiative.

POLICY CONSIDERATIONS

The Minister of State for Public Health, stated in the Ministerial Foreword to the "Safe, Sensible, Social—Consultation, on Further Action";

“ . . . retailers and consumers of alcohol act responsibly and it is the irresponsible minority on which our efforts should be focused. It is right to consider ways to tackle irresponsible practices but we must ensure that any measures do not unduly penalise those consumers who benefit from legitimate promotions responsibly.”

NACM fully endorses the position stated by the Minister. It is important to bear in mind that the distinction must be made and maintained to ensure that whatever means are introduced they are targeted at preventing harmful drinking without punishing the majority of people who drink responsibly. The industry is concerned that the introduction of measures that have a broader impact and go beyond targeting problem drinkers will bring with it unintended consequences.

To this end industry has a legitimate role to play in working with Government in reaching solutions.

NACM firmly believes that any policy considerations, by the Government, to address the specific misuse of alcohol by problem drinkers, should be:

1. Based on robust evidence (ensuring that studies are peer reviewed) that is relevant to equivalent environments, as opposed to deploying convenient data to fit an argument.
2. Given that the majority of the public drink sensibly and that alcohol is misused by a minority of drinkers, general population measures such as increasing taxes or other means of raising prices (curbing promotions, introducing minimum pricing etc.) are not the appropriate means for tackling misuse—it penalises the majority of sensible drinkers without necessarily dealing with alcohol misuse. People’s lives are already being negatively impacted by problem drinkers and it seems ironic that this negative impact should be doubly visited upon them by having to endure restrictions, inconvenience, and ultimately higher prices, as set out in the consultation document, to deal with the problem drinkers.
3. Dealt with, in the many instances of misuse, by better/more effective enforcement. No new legislation is required. NACM believes that the Government should focus on maximising the effective use of existing legislation to target problem drinkers and that it should avoid using one-size-fits-all measures that just punish everyone.
4. There is a need to ensure that measures proposed do not in fact work against the Government’s overarching objective of reducing alcohol related harm. (This point is elaborated further below but deals particularly with the area of advertising and promotions.)

Below, NACM would like to comment on some specific policy areas which have been discussed recently.

SHEFFIELD STUDY—PROMOTIONS

A key point that comes across in the School of Health and Related Research at Sheffield University (SchARR) Study on “Price, Promotion and Harm” is that very little research has been conducted in the UK that throws light on individual behaviour with regard promotional activity of alcoholic drinks and harms. A significant amount of the material SchARR draws on derives from the USA. A basic sociological critique of the SchARR report would immediately pick up on the “situational relevance” of those studies to the UK. The USA operates different laws regarding drinking which vary from State to State, there are different sales tax regimes, the socio-ethnic and psychosocial dynamic in the USA is not replicated in the UK, etc.

Notwithstanding these short-comings SchARR has failed to recognise that promotional activity provides a direct and more effective way to introduce consumers to new products and product variants. Restricting promotions will inhibit new product introductions.

The average strength of cider in the UK has reduced. There are also plans to introduce into the UK market significantly lower strength cider but before the product is put on sale more widely it is being trialed/promoted in a limited number of retail outlets. However, without the ability to promote such new products, producers will not be able to introduce them to the public at large. Of concern is that inevitably the market will stagnate and will become characterized by lower quality and cheaper products.

ADVERTISING

Advertising is already strictly regulated. NACM does not believe that any further restrictions on advertising will address any particular misuse issues. The consequences of further restrictions will be to shut down a further avenue for bringing to market newer and better quality products.

The Sheffield University review failed to provide compelling evidence that would warrant the Government to introduce controls on promotions and advertising. The review cited publications and references making causal links but some of these documents have not been peer reviewed. NACM reiterates its position that evidence should be robust.

REVIEWING SELF-REGULATORY COMMITMENTS BY THE ALCOHOL INDUSTRY

NACM is fully supportive of improved alcohol product labeling. The leading members of NACM, accounting for a significant volume of cider on the market, include on their cans and bottles:

- Unit information.
- Sensible drinking messaging.
- Promote “Drinkaware”.

- And by the year end one will start to see bottles and cans carrying the “pregnancy advice information/logo”.
- Company websites include the sensible drinking message and age restrictions to entry.

Monitoring the industry’s voluntary labelling agreement

Paragraphs 2.28 to 2.33 of “Safe, Sensible, Social—Consultation, on Further Action” address the uptake of the voluntary labelling agreement and disappointment is expressed in paragraph 2.31 that only 57% of products contained alcohol unit information and only 3% contained the labelling scheme information “in its entirety”.

It is greatly appreciated that the Department of Health, Campden and Chorleywood Food RA are working together with the industry to develop a robust and reliable set of data on this issue, compared to the misleading numbers reported. Although not part of the 1998 agreement to incorporate alcohol unit information on cans and bottles, over 65% of cider by volume is declaring its unit strength. This was in response to the commitment set out in the Social Responsibility Standards, published in November 2005, to which the NACM was a signatory.

As mentioned above members of the NACM are introducing the labelling scheme information on bottles and cans. However, this can only be done with planned label changes over a period of time to avoid writing off (and additionally creating its own waste issues) £ms of packaging materials.

It also has to be recognised that that not all cans and bottles are the same size and with the smaller containers there is a practical limitation to including all five components of the labelling scheme. It is the NACM’s understanding from the various versions of the Memorandum of Understanding, that have been in circulation that it was acceptable for these smaller containers to only include three components of the labelling scheme. This needs to be formally recognised in any follow up “uptake audit” that will be commissioned.

NACM is aware that the Government is holding legislation in reserve to secure a greater uptake of the labelling scheme information (suggested in paragraph 2.33). If this approach were to be actively pursued it would halt, in its tracks, any further voluntary introduction of the key components of the labelling scheme because it would introduce uncertainty as to what would be specifically required to be included on cans and bottles re exact wording, use or non use of the pregnancy logo, dimensions of characters, positioning of statements etc. The industry would not want to write off two sets of packaging. Furthermore legislation would recognise the industry’s legitimate request for a period of 12 to 18 months for transition period to permit existing non complying packaging to be sold through.

PORTMAN GROUP CODE OF PRACTICE

NACM was one of the first signatories to the Portman Group “Code of Practice on the Naming, Packaging and Promotion of Alcoholic Drinks” and its members fully subscribe to it. As others will also indicate the Portman Group is an excellent example of self regulation that demonstrably works which has been recognised by the Better Regulation Taskforce and the International Harm Reduction Association.

The Better Regulation Taskforce described The Portman Group Code as a good example of a Code that works well, demonstrating how effective self-regulation can be.

The International Harm Reduction Association included the latest edition of the Code in its “50 Best Collection on Alcohol Harm Reduction”, published in May 2008 (ref IHRA.) The Collection contains project reports, documents and research papers from around the world, chosen by an international panel of experts for their evidence-base, reasoning, justification and contribution to alcohol harm reduction.

NACM firmly believes that the Portman Group Code of Practice is fulfilling, effectively, a valuable self regulatory role with regard to the way producers package, name and market their products and as should be fully supported by Government agencies. This support should include promoting greater awareness amongst TSOs and Licensing Officers of their role with the code in ensuring compliance at local level when non-complying products are included in the Retailer Alert.

CONCLUSION

Penalising the industry and the general population is not an appropriate way forward in either seeking to bring about the desired changes in reducing alcohol harm or dealing with alcohol misuse (the problem drinkers).

Furthermore before any action is considered with regard to promotions and advertising it is vital that research is undertaken that is situationally relevant to the UK to avoid ill-considered policy proposals: proposals that could undermine efforts to promote a cultural change if new products are not provided a route to market.

To restate, there are no problem drinks, only problem drinkers and therefore measures need to be targeted at these misusers. Furthermore NACM believes that the panoply of powers available to the police and local authorities should be used much more effectively both against individuals who misuse alcohol and those who willfully seek to break the law in obtaining alcohol underage, as well as against those retailers who sell alcohol irresponsibly.

March 2009

Memorandum by the Socialist Health Association (AL 16)

The Socialist Health Association was founded in 1930 to campaign for a National Health Service and is affiliated to the Labour Party. We are a membership organisation with members who work in and use the NHS. This includes doctors and other clinicians, managers, board members and patients. We have held a number of seminars and discussions across the UK on public health topics, some specifically in respect of alcohol, and this submission is informed by those discussions and by contributions from some of our public health practitioners.

This submission is made on behalf of the Association.

1. The scale of ill-health related to alcohol misuse is immense. No doubt the committee will receive much evidence on this point, but we understand that alcohol misuse is associated with:

- 50% of street crime;
- 33% of burglaries;
- 30% of sexual offences;
- 33% of domestic violence offences;
- causing some 60 different diseases/conditions, including injuries and mental and behavioural disorders;
- between 15,000 and 22,000 deaths each year;
- 150,000 hospital admissions;
- up to 35% of A&E attendances and ambulance costs (rising to 70% between midnight and 5.00 am at weekends);
- 49% of attendances at A&E after an assault, in Merseyside;
- £2.4 billion annually lost to the economy due to premature death;
- 17 million days of absences from work each year;
- annual losses in productivity of £6.4 billion; and
- people of all ages, although it is young people who are often highlighted, are more likely to have unprotected and otherwise risky sex when alcohol has been consumed. This results in accelerated transmission of sexually transmitted infections, unplanned pregnancy and emotional distress.

2. All these figures are of course debatable, but in our submission the damage caused by alcohol appears to be similar in kind but much greater in quantity than that caused by the abuse of other addictive substances, but resources directed to alleviating the problems are not in proportion.

3. Evidence released by the Mental Health Foundation shows the impact of the poverty gap to both individual and collective mental health. Their report, “Mental Health, Resilience and Inequalities”, shows how the gap between rich and poor affects the mental health of individuals by causing psychological and physiological changes. Their report argues that mental health is the lynchpin between economic and social conditions. Poor mental health experienced by individuals is a significant cause of wider social and health problems, including:

- low levels of educational achievement and work productivity;
- higher levels of physical disease and mortality; and
- violence, relationship breakdown and poor community cohesion.

Mental ill health is closely linked to the abuse of alcohol and other drugs.

In contrast, good mental health leads to better physical health, healthier lifestyles, improved productivity and educational attainment and lower levels of crime and violence. This appears to be entirely consistent with the work of Prof Richard Wilkinson and Sir Michael Marmot which relates the excessive inequality in British (and US) society with high levels of all kinds of social pathology.

4. It appears to us that nobody wants to take charge of alcohol policy. Responsibilities at a national level are spread over a number of different departments and we don't see much evidence that they talk to each other. Culture Media and Sport deal with licensing hours, the Home Office and Department of Justice with policing, Customs and Excise and the Treasury have a major impact on the price; The NHS picks up the pieces; and the Dept for Business, Enterprise & Regulatory Reform presumably regards the increasing

consumption of alcohol as something to be celebrated. The Treasury appears to have very little interest in the problems caused by alcohol, or indeed the cost of dealing with them. They regard taxation of alcohol as merely a revenue raising exercise. Because there is no co-ordination between them over the last decade they have effectively decided to make alcohol cheaper in real terms than before, more widely available through supermarkets etc. and available for longer hours. Then just to add to the fun the industry has decided to make it stronger. Wines are now 12–14% instead of 10–12% and beers are often 5–8% rather than 3.5–5%. The impact has been to at least double the harm done. The strategy of relying on voluntary regulation by the alcohol industry is been shown to be ineffective. Budgets have repeatedly raised the duty on drinks with lower alcoholic content (beers, cider and wine) to a greater degree than the harder drug of spirits. Presumably this is to support the whisky industry but there could be more imaginative ways than increasing the accessibility of higher strength drugs both neat and as incorporated into mixers.

5. Two structural changes took place in the drinks industry during the 1990s that the drinks industry should take full responsibility for. One was the market segmentation of the pub trade and the other the introduction of alcopops. These are interlinked. Prior to this decade, drink had an unpleasant taste to most young palates and indeed was an acquired taste. Pubs tended to contain a mix of ages, it was the nightclubs that were the preserve of younger people. Young people were initiated into the use of alcohol in pubs with more experienced users and had to conform to the peer pressure around conduct and alcohol use of the established users. Use of alcohol tended to commence with high volume relatively low alcoholic content drinks such as beers and ciders, spirits being an older taste that was graduated to. Spirits were also expensive compared to beer and cider.

The pub market was segmented demographically with pubs targeted at young people only or being for food mostly or families. Alcopops were introduced. So we moved to a situation where drinks designed for a young palate are being promoted in establishments targeted at young people. Without the barriers of an unpleasant initial taste, social mores of more experienced users and with the encouragement of low price (the duty on the spirit base of an alcopop being pegged or increasing at a much lower rate than beer), it is unsurprising that as intended by the drinks industry, consumption of alcohol increased.

During the 1990s there were changes in the pattern of student drinking. There was a move from having a pint, having another pint and maybe a gradual escalation that from time to time resulted in extreme drunkenness to going out less frequently but with the advance intention of getting drunk and as fast and cheaply as possible.

6. Sadly central government presents an example of the weakness of a partnership approach, which enables all the partners to deny their responsibilities except for those who have to clear up the mess. Such performance by a local authority would be labelled as failing. The resultant costs falling on the NHS (and the criminal justice system) are rising so rapidly as to threaten its viability as a comprehensive service. The only cost effective approach to health problems is to devote resources to prevention.

7. At a local level various departments within local authorities have an interest, including planning, leisure, youth, trading standards, social services, environmental health, education and those concerned with community safety, crime and disorder and licensing. Outside the local authority there are more players:

- businesses including pubs and clubs and supermarkets;
- police;
- primary care trusts;
- alcohol industry;
- strategic health authorities; and
- sometimes two tiers of local government.

As with any partnership approach local effectiveness varies very considerably, but the impression we have is that in many places is that the police and the casualty department are left to pick up the pieces with the other partners hoping that the sale of alcohol will keep the local economy moving.

8. We need a strategy which covers:

- (a) prevention;
- (b) early interventions; and
- (c) proper services.

We must consider honestly why we use alcohol and be clear about what behaviour we actually want to change. There are many mixed messages. Alcohol is a drug that seems to meet a need in many of us, all users need to understand more about why and how they are using it and policy needs to consider whether there are alternatives with better outcomes for society. Like other behaviours that have risks—self-injury for example, alcohol use may well be a much needed coping strategy. There are many who consider moderate to high use a perfectly acceptable pleasure.

The current messages seem to be that we want to prevent violent and irritating behaviour that impacts on others and risky behaviour that exacerbates the situation of vulnerable people. In addition we want to make people aware that even at what many would consider low levels of use can cause health problems. These are very different messages not necessarily of relevance to the same person.

Thought should be given to the terms used and social norms. It is most unhelpful to label “binge drinking” a level of consumption that whilst causing health problems, is below what many consider low or average. This just alienates the user who then ignores the rest of the information.

9. Prevention has to cover price, and availability and possibly advertising. We do not think that social marketing approaches will be effective without an increase in the retail price of alcohol. Alcohol consumption is quite sensitive to levels of disposable income. The most price sensitive groups are the young and the very heaviest drinkers. Unlike most pathology abuse of alcohol is not confined to the poor and so our present economic situation is likely to lead to a reduction in consumption, just as increasing consumption over the past 10 years has been driven by increasing prosperity. Alcohol policy has tended to focus on the minority of the drinking population who are the heaviest drinkers. However, it is actually the much greater number of drinkers in a population who, on occasions, drink to excess, who account for most of the alcohol-related problems. A greater proportion of the overall burden of harm is associated with the acute effects of alcohol use and drinking to intoxication, rather than the chronic effects of sustained heavy drinking over a long period of time. There seems good reason to suppose that in an increasingly mobile world putting up prices could encourage smuggling unless this issue is tackled across the whole of the EU.

10. Alcohol is a public health problem that needs to be addressed within a social model of health promotion, rather than focusing on treatment. It is not possible to order the range of interventions into a hierarchy, with one being considered more effective than another. The evidence points to multi-component approaches, where attempts are made to make progress with each intervention, within available resources.

11. The problems of price relate primarily to supermarket sales. Wider availability of alcohol in supermarkets has coincided with the phenomenon of young people getting drunk before they go out for the night. It has also been accompanied by very severe economic pressure on public houses. In our view consumption of alcohol in the relatively supervised environment of the public house is safer for all concerned than the alternatives. We think serious consideration should be given to limiting the amount of alcohol people can buy from supermarkets or off licences at one time. This strategy seems to have been quite successful when applied to the sale of paracetamol. We would also like to see taxation much more closely related to alcohol strength and the removal of various measures designed to protect indigenous manufacturers of alcoholic drink.

We need to be wary however of the Scandinavian experience where the price barrier results in sporadic heavy drinking—true binge drinking with the attitude of “if I’m going to spend £10, I might as well spend £1,000”.

12. There are also problems associated with some clubs and vertical drinking establishments. Our impression is that police intervention in these establishments is very limited. Prosecutions under sections 141 and 142 of the licensing act (sale and supply of alcohol to people who are drunk) seem to be extremely rare, although the streets and hospitals are full of evidence of offences under these sections every week. We do not understand why the provisions enabling licensed premises to be charged for the cost of policing associated disorder have not been widely used.

We would like to see consultation on the possible raising of the age at which young people are allowed to buy alcohol, and particularly spirits (we understand in some European countries young people are only allowed to drink beer), although we should be mindful that a major source of alcohol for young people is parents and carers and that removing alcohol simply pushes young people towards other drugs that may be more harmful both from a health perspective (particularly as they are supplied in varying and unpredictable strengths) and incur increased risks of being drawn into criminality. We are in favour of lowering the driving blood/alcohol limit from 80 to 50, and Random Breath Tests for motorists.

13. Early intervention is about getting GPs (and other professionals) to recognise the problem at a time when fairly minimal intervention can be quite effective. That’s about training etc, but practitioners should only be regarded as qualified to give advice if they understand their own motivation around alcohol use, non use or abuse. Every polyclinic and casualty department should have an alcohol-adviser available.

14. Services for those with serious alcohol related problems **MUST** be properly funded and provided. At present, we have been told repeatedly that they are the poor relation of drug services. The tendering process is a disaster, bringing uncertainty to services especially as often the contracts are for shorter periods that a client will use a service. (Many clients are with a service for 5 years, from de-tox through dry houses, therapy and aftercare; this is impossible where the service provider is constantly having to tender, and may lose the service.) Also, funding is often only for new initiatives, but the on-going, high quality and much needed services are devilishly difficult to fund.

Memorandum by the Royal College of General Practitioners (AL 17)

1. The College welcomes the opportunity to contribute evidence to the Parliamentary Health Committee's inquiry into alcohol.

2. The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. It aims to encourage and maintain the highest standards of general medical practice and to act as the 'voice' of GPs on issues concerned with education, training, research, and clinical standards. Founded in 1952, the RCGP has over 36,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline.

3. The College recognised the impact of alcohol and we are committed to measures to reduce alcohol harm. As well as the increased risk of violence and anti-social behaviour, alcohol is a major contributing factor for many health disorders. Heavy drinking can lead to heart and liver problems, strokes, brain damage, memory loss and various forms of cancer. Research shows that GPs can be highly effective in helping people to cut down both their overall alcohol consumption and episodes of binge drinking. We have commented on each area of the terms of reference below:

The scale of ill-health related to alcohol misuse

4. There are estimated to be more than seven million hazardous and harmful drinkers (23% of the adult population) and more than one million moderately or severely dependent drinkers (4%) in England. There are different types of services for these groups, ranging from simple measures to provide information and raise awareness to acute clinical or mental health interventions for severe cases.

The consequences for the NHS

5. We recognise that alcohol has a significant impact on the NHS. However, to reduce alcohol harm it is necessary to target resources where they are needed, and to do this it is necessary to have appropriate information. Many Primary Care Trusts (PCTs) have not accurately assessed the alcohol problems in their area and a quarter of PCTs have not assessed need at all.¹⁰⁴ Without such assessments, PCTs cannot know what services they should be providing, nor assess whether what they do provide is sufficient or cost effective.

6. Many PCTs do not have a strategy for alcohol harm, or a clear picture of their spending on services designed for this purpose. This is slowly being addressed, but still too much responsibility lies with Drug and Alcohol Teams (DAATs), many of whom do not have the capacity or capability to respond. Many DAATs do not have the sufficient links with primary or acute (hospital) care to commission effective alcohol interventions in these areas. The links with acute trusts have been historically difficult to establish, and whilst the Public Service Agreement (PSA) should support partnership and alliances with acute health organisations, there are many competing priorities for hospital trusts can hamper progress. There is also much scope for better integration of hospital services with follow-on and support services. This would help improve recovery rates and prevent patients relapsing into their previous drinking patterns.

Central government policy

7. Until this year, neither the Department of Health nor the NHS had any specific objectives in relation to alcohol for which they were directly accountable. April 2008, however, the Department became jointly responsible, with the Home Office, for a new Public Service Agreement (PSA 25) on alcohol and illegal drugs. The PSA is to be monitored annually until 2011 and includes five indicators used to measure progress. One of these requires the Department to secure a reduction in the rate of increase of alcohol-related hospital admissions. The other indicators measure the effects of illegal drug use and of alcohol-related social disorder. Most PCTs in the country have elected to identify the reduction in alcohol related admissions as a key indicator.

8. However, Drug Action Team expenditure (DAT) expenditure far outweighs alcohol expenditure despite significant disparity in health need and social and economic impact. Models of Care for drugs have been rigorously implemented and performance managed as a process. However, this is not the case for alcohol, where service performance management is inconsistent nationally and there is not an equitable and coherent performance monitoring system as yet. Models of care for alcohol misusers (MoCAM) has not been benchmarked or measured since implementation.

¹⁰⁴ National Audit Office report: Reducing Alcohol Harm: Health Services in England for Alcohol Misuse (2008) http://www.nao.org.uk/publications/0708/reducing_alcohol_harm.aspx

The role of the NHS and other bodies including local government, the voluntary sector, police, the alcohol industry, and those responsible for the advertising and promotion of alcohol

9. The available evidence suggests that early intervention programmes such as screening and “brief advice” can bring substantial savings by reducing the need for later more intensive treatment. At present significant work is required at a local level to exploit opportunities to identify and advise people who are drinking above sensible levels. Alcohol screening questionnaires and the provision of “brief advice” offer a quick and effective means first to identify and then to engage with those who are drinking excessively but who may not realise the damage they are doing to their health. There is evidence indicating the cost-effectiveness of such early intervention programmes.

10. However, screening and brief advice is only sporadically provided by GPs and health workers, and rarely used in other parts of the health service, such as accident and emergency (A&E) departments. There is an urgent need for a competency framework for practitioners and accessible training for all health and social care professionals. This training should be mapped to the learning needs and competencies associated with Level 1 through to Level 3 provision.

11. The RCGP Substance Misuse Unit is working with the Department of Health to integrate workbook and face-to-face training up to, and including, competencies associated with those held by a Practitioner with Special Interest (PwSI) with the Department of Health alcohol virtual learning centre, which includes an e-modular programme.

12. Health professionals feel that improved pathways into specialist treatment will deliver reduced alcohol related hospital admission rates. There is a need to improve and integrate alcohol services into universal services in primary care, which would operate alongside community clinics.

13. We would support the provision of Identification and Brief Advice (IBA) training as a means to target high risk groups in a primary care setting. Similar training can be adapted and linked to the development of pathways between hospital and community. For example, IBA could be used in A & E units, possibly with the use of specialist alcohol nurses or alcohol health workers. It might also be possible to develop IBA in specialist settings including, for example, maxillofacial clinics, Hepatology wards, Gastro units or prison healthcare centres. There are also other settings where emergent work suggests that IBA could make a difference, including in custody suites and by ambulance services stationed in town centres in the evenings etc.

14. There is a role to play for Crime & Disorder Reduction Partnerships (CDRPs) and alcohol should be prioritised within Local Area Agreements.

15. Changed can be achieved through advocacy. On a local level, government should engage with local champions who publicise the harm caused by alcohol. There is also a need to involve local health promotion campaigns to disseminate and amplify the messages of the national social marketing campaign.

16. Much good work was undertaken as part of the regionally led Darzi reviews. For example, Yorkshire and Humber SHA, as part of the Darzi review, chose alcohol as one of the thematic areas in the staying healthy group. Their work took into account an individual’s lifecycle as well as both intrinsic and extrinsic influences on individuals in order to enhance thinking about what would be the most effective interventions in particular cases (such as during pregnancy) and how interventions can be targeted most effectively.

Solutions, including whether the drinking culture in England should change, and if so, how?

17. The majority of alcohol related harm is preventable. Specialist alcohol treatment delivers the greatest short-term impact on admissions and mortality because it targets the patients at greatest risk of death or serious disease. Identification and brief advice delivers medium and longer-term reductions in the kind of “everyday” drinking which leads to coronary heart disease, liver disease and other problems. Evidence shows that for every eight people who receive brief advice, one will change their drinking to within low-risk levels.

18. We should encourage greater service user involvement in the design and delivery of alcohol services. For alcohol services, user involvement is currently much less evolved than it is for drug services. There is a need to understand the barriers to involvement and how peer mentorship, support and training can be offered to facilitate user involvement. It might be possible to adapt the training offered to healthcare professionals for service users and carers.

19. The Department of Health has invested heavily in advertising campaigns to promote the Department’s current guidelines on sensible drinking. The RCGP supports the government’s Know Your Limits campaign as we consider it be way of empowering people to take responsibility for their own health and wellbeing. However, we are concerned that daily limits are not fully understood by patients who tend to underestimate the amount of alcohol that their drinks contain. These campaigns are costly, and although they have followed good practice guidance, there is some scepticism as to their impact.

20. In recent years, professional health alliances, such as the Alcohol Health Alliance, have predicted that advertising campaigns alone will prove ineffective and have argued that increasing taxation and reducing access to potent alcoholic drinks is the most effective way to reduce alcohol harm.

21. For PSA targets to be effective, there is a need for a consistent set of codes and the design of a minimum data set as a means of demonstrating improvement and positive change. Several PCTs are unsure as to the reliability of local coding and accuracy of baseline figures. This makes it difficult for PCTs to set local goals for reduction.

22. There is a need for a centrally funded national training programme linked to the commissioning of comprehensive range of evidence-based services.

23. I gratefully acknowledge the significant contribution of Dr Linda Harris, Director of the RCGP's Substance Misuse Unit, towards the above comments.

Dr Maureen Baker
Honorary Secretary of Council

March 2008

Memorandum by Diageo (AL 18)

1. EXECUTIVE SUMMARY

1.1 Diageo welcomes the opportunity to contribute to the Committee's inquiry into alcohol policy.

1.2 As a leading premium drinks producer, we recognise that responsible drinking is important both to our business interests and to society's interests, and that we have a role to play in raising awareness and seeking to influence attitudes and behaviour among consumers of our products.

1.3 While we believe that alcohol misuse is a problem, particularly for some specific groups (under-age drinkers, binge drinkers and harmful, private drinkers), it is wrong to paint Britain as a nation with an alcohol problem. As the Government's own statistics show, the vast majority of people in Britain drink responsibly, and within Government guidelines. Policy and actions should therefore be mainly targeted at the specific problem groups.

1.4 We believe that alcohol policy should be fair, effective, proportionate, consistent and evidence-based, and that it should not have unintended economic or social consequences. We do not believe that effective alcohol policy automatically or necessarily involves new legislation or regulation.

1.5 Diageo believes that the potential for harm is preventable and that a valuable and sustainable place in society exists for alcohol beverages. Diageo believes that better enforcement of existing laws and regulations and better partnership working can deliver a more responsible drinking culture. This requires the skills, experience and contributions of all stakeholders to be leveraged more effectively. Clarity on their sphere of influence and interaction is key.

1.6 A wide range of stakeholders have a role to play and include:

- individual consumers;
- parents, family and friends;
- national government;
- local government, including trading standards officers;
- the police;
- alcohol producers and retailers;
- the medical community;
- the education and academic research community;
- employers;
- NGOs and campaign groups; and
- the media.

1.7 Diageo has proposed to Government the creation of three important new initiatives:

- a new mandatory code on retail promotions, within a framework of co-regulation, under the auspices of The Portman Group;
- a co-regulatory approach on mandatory labelling of alcohol, also under the auspices of The Portman Group; and
- an industry-wide significant new social marketing partnership, aiming towards changes in attitudes and behaviour among certain target groups in the UK.

1.8 We hope that the Government will respond positively to these initiatives, and that other stakeholders will contribute effectively, so that we can have a positive, collective effort to raise awareness and shift attitudes and behaviours on alcohol and reduce alcohol misuse among the specific minority groups most at risk of alcohol-related harm.

2. ABOUT DIAGEO

2.1 Diageo is the world's leading producer of premium brands across spirits, wine and beer, including Smirnoff vodka, Johnnie Walker and J&B whiskies, Captain Morgan rum, Baileys liqueur, José Cuervo tequila, Tanqueray gin, Sterling Vineyard wines and Guinness, as well as a range of malt whiskies from our Scottish distilleries.

2.2 We produce more than 30 million cases of Scotch whisky and 12 million cases of white spirits every year, most of which is exported to 180 markets around the world, generating revenues worth more than £3 billion a year, and accounting for 20% of food and drink exports for Scotland alone.

2.3 We currently employ more than 20,000 people worldwide, in 80 markets, including 5,000 in the UK. Our brands feature in almost every bar, pub, club, restaurant, off-licence, supermarket and licensed corner shop in the country, contributing to the revenue, profits and employment of every one of these businesses.

3. DIAGEO'S INTEREST IN ALCOHOL POLICY

3.1 We believe that alcohol beverage producers, and on and off trade retailers, as well as a wide range of stakeholders outside it, are needed to tackle alcohol misuse and promote responsible drinking in the 21st century.

3.2 Responsible drinking is also at the heart of our business interests. Our reputation as a business and the reputation of our brands are damaged when our products are misused. We do not want to be targeted as a cause of anti-social behaviour, of drunkenness or of damage to our consumers' health. We understand that governments, regulators and society will rightly act to curtail alcohol misuse where it occurs, but that inappropriate or ineffective legislative and regulatory actions may cause disproportionate damage to our business interests.

4. EFFECTIVE ALCOHOL POLICY

4.1 We have a strong interest in helping to ensure that the UK has fair, effective, proportionate, consistent and evidence-based alcohol policy, which does not have unintended economic or social consequences.

4.2 However, we do not believe that to achieve effective alcohol policy necessarily means additional regulation or legislation. In many cases, the necessary changes in attitudes and behaviours can be effected by the better enforcement of existing regulations and laws –such as by cracking down more effectively on under-age alcohol sales, which are already illegal, but for which far too few retailers or individuals are ever prosecuted.

4.3 In many cases too, better information and awareness raising campaigns can help deliver attitudinal shifts among consumers, while local partnerships between enforcement agencies, alcohol off-licence retailers, bars, pubs and clubs, and community groups can also effect attitude and behavioural change. These represent effective alcohol policy in action, without the need for additional legislation.

5. THE SCALE OF ALCOHOL MISUSE

5.1 The UK's long history with alcohol is complex, rooted in tradition and long-established societal behaviours and our relationship with alcohol varies by our age, gender, income, education, occupation and even where we live. Yet our national relationship with alcohol is stereotyped, caricatured and portrayed in simplistic and inaccurate generalisations.

5.2 Media headlines imply that we are a nation of binge drinkers, under-age drinkers, and 24-hour drinkers. They imply that consumption is rising, that we start drinking younger, drink more and drink more often than continental Europeans. As a nation we are far from these simple caricatures, and in recent years the picture has improved in some respects.

5.3 The NHS Statistics on Alcohol reveals trends and patterns in drinking, collating information from a wide range of sources, including the General Household Survey. The method of calculating some of these statistics changed in 2006, to take account of stronger drinks and larger measures, which makes time-series comparisons difficult. In our summary below we show figures based on both the old methodology (for historic comparison) and the new methodology (for a current snapshot). Most statistics come from the 2007 General Household Survey, although the figures for average weekly consumption are derived from 2006, as this question was not asked in 2007.

5.4 An analysis of these published statistics clearly shows that excessive drinking is not the widespread problem that is often suggested, but is instead a minority issue, affecting some specific groups. We summarise the main findings as:

5.4.1 We drink less in total now than a few years ago

- Average alcohol consumption has fallen from 9.4 litres of pure alcohol per person in 2004 to 8.9 litres in 2006.
- The UK is ranked 13 out of 27 in the EU league table of per capita alcohol consumption.

5.4.2 Most of us drink every week

- 72% of men and 57% of women had at least one drink in the previous week, slightly fewer than the 1998 figures of 75% and 59%.

5.4.3 Most of us only drink once or twice a week or not at all, but a minority drinks five days a week or more

- 61% of men and 74% of women either did not drink, or had a drink just once or twice a week.
- 22% of men and 12% of women drank on five days or more.

5.4.4 We drink less today, on average, than we drank in the 1990s

- Government guidelines suggest that men should drink no more than 21 units in total in a week and women no more than 14 units a week:
- In 2006 men drank an average of 14.8 units a week, about 2.5 units less than they were drinking from 1998 to 2002 (new methodology = 18.7 units).
- Women drank an average of 6.2 units a week in 2006, about 1.5 units less than in 2002 (new methodology = 9 units).

5.4.5 Most of us drink at or below the daily guidelines of 3–4 units a day for men, and 2–3 units a day for women, though a significant minority drink above these guidelines at least once a week

- 59% of men and 66% of women drank below or up to the daily guidelines, and 41% of men and 34% of women drank above them.

5.4.6 It is not young people who drink most frequently; it is the middle-aged and elderly

- 76% of men and 84% of women aged 16-24 drink no more than twice a week and only 9% of men and 4% of women in this age group drink five times a week or more.
- 47% of men and 31% of women aged 45-64 drink at least three times a week and 27% of men and 15% of women in this age group drink at least five times a week.
- 29% of men and 15% of women aged 65 or over drink five times a week or more.

5.4.7 Middle-aged men and young women drink the most in a week, although their average drinking is still within the weekly guidelines

- Men aged 45 to 64 drink 20.8 units a week, versus 19.7 units for 25 to 44 year olds, 18.6 units for 16 to 24 year olds and 13.5 units for men aged 65 or over.
- Women aged 16 to 24 drink 10.8 units a week, versus 10.1 units for 25 to 44 year olds, 9.8 units for 45 to 64 year olds and 5.1 units for women aged 65 or over.
- In 2006, 7% of men and 5% of women aged 16–24 were chronic drinkers (drinking more than 50 units a week for men, and 35 units for women), the highest of any age group.

5.4.8 More younger people than middle-aged and older people drink too much in a single session

- 32% of men and 24% of women aged 16 to 24 drank at least twice the drinking guidelines on at least one day, as did 31% of men and 22% of women aged 25 to 44.
- 24% of men and 13% of women aged 45 to 64, and 8% of men and 3% of women aged 65 and over drank at least twice the drinking guidelines on at least one day.

5.5 In summary, these figures show that:

- as a nation, we are drinking less in total than we were a few years ago;
- most of us drink every week, but well within weekly drinking guidelines;
- most of us drink no more than twice a week, and keep within daily drinking guidelines when we do drink;
- a very small minority drinks substantially more than the weekly drinking guidelines—and they are most likely to be young;
- a larger minority drinks more than the daily drinking guidelines at least once a week—and they are likely to be young; and
- a minority drinks five times a week or more—and they are likely to be middle-aged and older.

5.6 Diageo therefore agrees with the Government that there are three specific types of drinkers that should be targeted:

- under-age drinkers, who should not be purchasing alcohol at all;
- 18 to 24 year-old binge drinkers—who drink more than the guidelines in a single session, some of whom may also be drinking more than the weekly guidelines; and
- middle-aged and older drinkers, who drink most frequently, and often in private.

6. LEVERAGING THE SKILLS, EXPERIENCE AND CONTRIBUTIONS OF STAKEHOLDERS MORE EFFECTIVELY

6.1 The relationship between individuals and alcohol is ultimately a personal one: individuals decide for themselves if, when, where, how much and how often they drink. But a wide range of stakeholders have a role in influencing that individual decision and enabling the consumer to make informed choices. Clarity on their sphere of influence and interaction is key:

- *individuals*: heed information and advice, and accept responsibility for their own drinking and for the impacts of that drinking on themselves and others;
- *parents, family and friends*: set an example by demonstrating responsible drinking behaviour, and confront and discuss alcohol issues with those individuals to whom they are close who misuse alcohol;
- *national government*: deliver a legislative and regulatory framework to help encourage a responsible drinking culture working with all relevant stakeholders, including the drinks industry;
- *local government, including trading standards officers*: ensure the effective funding for enforcement, the development of local partnerships, and promote a safe environment to protect people, including drinkers, from harm;
- *the police*: monitor sales of alcohol to under-age drinkers and to prosecute licensed premises and individuals breaking the law, maintain a visible presence, especially at night, and crack down on anti-social behaviour among people under the influence of alcohol;
- *alcohol producers and retailers*: comply with the law; market, advertise and promote products responsibly; ensure that consumers have adequate information from which to make informed choices; work with relevant stakeholders to raise awareness and seek to change attitudes and behaviours; participate in local community partnerships based on harm minimisation/reduction; and promote a national social marketing partnership;
- *the medical community*: research, collate and present unbiased information on alcohol consumption and its health impacts, to provide an informed platform for policymaking by all stakeholders; and implement screening and brief interventions nationally, in every hospital and GP surgery, in order to identify and offer support and advice to people who may be misusing alcohol;
- *the education and academic research community*: similarly, research, collate and present unbiased information on alcohol; and as custodians of pupils and students in schools and colleges support alcohol health and social education, awareness and social marketing campaigns;
- *employers*: develop and implement workplace alcohol policies, to promote alcohol awareness; and support screening and brief interventions, to tackle alcohol misuse among employees, and provide support and understanding to affected employees during their treatment and recovery;
- *NGOs and campaign groups*: raise issues of concern about alcohol with policymakers, raise general awareness about these issues and propose policies, initiatives and actions to tackle alcohol misuse, in partnership with other stakeholders; and
- *the media*: influence the tone of debate, by better informing the public about alcohol issues, so that there is a more accurate and balanced understanding about the extent of misuse in Britain; and actively educate the public about responsible drinking, to promote pro-social behaviours, rather than reinforce negative drinking patterns and anti-social behaviour.

7. DIAGEO AND RESPONSIBLE DRINKING

7.1 We have identified three key priorities for responsible drinking within Diageo:

- set world-class standards for responsible marketing and innovation;
- combat alcohol misuse, working with others on initiatives to reduce alcohol-related harm; and
- seek to promote a shared understanding of what it means to drink responsibly. This is underpinned by our use of our marketing insight and skills in an attempt to transform consumers' attitudes to alcohol.

7.2 These priorities dovetail with the framework for alcohol harm reduction devised by the International Centre for Alcohol Policies (ICAP). The ICAP framework states that it should ensure the well-being of societies and their members by maximising benefits and minimising potential for the harm that may be associated with drinking. The framework suggests that to be effective, alcohol policies should create a balance between the rights of individuals and those in society. It is based on three key elements:

- *evidence* on drinking patterns and their outcomes, as a sound scientific base for policy development;
- *targeted interventions* that address specific at-risk populations, potentially harmful contexts and drinking patterns; and
- *partnerships* that allow the inclusion of the public and private sectors, the community and civil society, all working towards a common goal.

7.3 We also believe that harm reduction efforts that seek to reduce the health, social and economic harms associated with alcohol misuse can work alongside efforts designed to encourage people to drink less and are a pragmatic and realistic response to the challenges of alcohol misuse.

7.4 Diageo is willing to provide leadership within our industry and step up to the challenges of promoting responsible drinking. In 2008, in our formal response to the Department of Health's consultation *Safe. Sensible. Social* we proposed to Government the creation of three important initiatives:

- a new mandatory code for alcohol within a framework of co-regulation on retail promotions under the auspices of The Portman Group;
- a co-regulatory approach on mandatory labelling of alcohol, again under the auspices of The Portman Group; and
- a significant new social marketing partnership, aiming to change attitudes and behaviour among certain target groups in the UK.

7.5 We hope that the Government will continue to consider co-regulation in delivering a mandatory code as well as respond positively to the other initiatives outlined in this submission, and that other stakeholders will also act, so that we can have a positive, collective effect in raising awareness and shifting attitudes and behaviours on alcohol and reducing alcohol misuse among the specific minority groups most at risk of alcohol-related harm.

March 2009

Memorandum by the Family Planning Association (fpa) (AL 19)

1. EXECUTIVE SUMMARY

1.1 fpa (Family Planning Association) is the UK's leading sexual health charity working to enable people to make informed choices about sex and to enjoy their sexual health free from exploitation, oppression or physical or emotional harm.

1.2 We have restricted the following comments to issues around alcohol and sexual risk taking and sexual assault.

1.3 There has long been concern about the links between alcohol use and poor sexual health and vulnerability to sexual assault. There is also evidence that some people actively use alcohol specifically to facilitate their sexual activity.

1.4 There is also some evidence of the role that alcohol can play in teenage conceptions. When the Independent Advisory Group on Sexual Health and HIV organised a seminar to consider the issues of sex, drugs, alcohol and young people, Professor Mark Bellis of Liverpool John Moores University reported that 40% of sexually active 13–14 year olds were drunk or stoned at first intercourse.¹⁰⁵

1.5 In addition, alcohol can make people more vulnerable to sexual assault and can affect people's perceptions of whether a sexual assault has taken place.

2. ALCOHOL AND SEXUAL RISK TAKING

2.1 Rates of sexually transmitted infections have been rising in the UK in recent years. For example, in 2007, there were 397,990 new sexually transmitted infection diagnoses at genito-urinary medicine (GUM) clinics in the UK, an increase of 63% on 1998.¹⁰⁶ Statistics show that rates of alcohol use have also been increasing. There appears to be a clear circumstantial link between high levels of alcohol use and poor sexual health.

¹⁰⁵ Independent Advisory Group on Sexual Health and HIV, *Sex, drugs, alcohol and young people: A review of the impact drugs and alcohol have on young people's sexual behaviour* (London: IAG, 2007).

¹⁰⁶ Health Protection Agency, "STIs annual data" <www.hpa.org.uk>, accessed 11 March 2009.

2.2 Research conducted in sexual health clinics in the UK appears to confirm the link between alcohol use and poor sexual health. In one study a questionnaire was carried out in a GUM clinic in 2006. This research found that 76% of respondents had had unprotected sex as a result of drinking and 77% of participants were usually/always or occasionally drunk before sex with a new partner.¹⁰⁷

2.3 The research also found that there was a correlation for women participants between the number of sexual partners and frequency of drinking, weekly intake and binge drinking. For men, those engaging in unprotected sex had a higher daily alcohol intake than those who did not.

2.4 Overall the research found that attenders at a typical STI clinic were binge drinking to a significant extent. Of the clinic attenders who took part in the questionnaire, 77% had been drinking before sex with a new partner and of those that did, 65% were usually or occasionally very drunk.

2.5 A similar piece of research was conducted with women aged 16–24 attending a clinic for chlamydia testing in the east of England in 2005.¹⁰⁸ In this research 74.5% of women showed a pattern of episodic binge-drinking, consuming five or more units on a “typical” night out. Those women who had been treated for chlamydia drank a median of 15 units on a heavy night compared to 12 units for those who had not been treated.

2.6 In this research 98 women reported using condoms regularly. However, when they were asked if they had used condoms “the last time they had sex after drinking alcohol” only 49 out of 98 (50%) said “yes”.

2.7 Literature reviews of existing evidence also appear to confirm the link between alcohol use and poor sexual health. One review of 42 eligible studies found that “[t]aken together, these results suggest that problem drinking is clearly associated with an increased risk of STDs across a wide variety of populations. The results from the studies with general measures of alcohol consumption were similar, with the majority finding a significant association with at least one STD”.¹⁰⁹

2.8 A further literature review reported that “[p]ost-drinking self-reported sexual behaviour attributes alcohol to lowered sexual inhibitions, enhanced sexual enjoyment, intercourse during adolescence and the expectancy that alcohol enhances or disinhibits sexual experiences”.¹¹⁰

2.9 There is research which suggests that some people use alcohol strategically for specific sexual purposes. A study carried out with young people in nine European cities found that 28.6% of alcohol users used it to facilitate sexual encounters.¹¹¹ In addition, the research found that participants who had been drunk in the past four weeks were more likely to have had five or more partners, to have had sex without a condom, and to have regretted sex after drink or drugs in the past 12 months. Frequent use of alcohol was also linked to having sex that was later regretted.

2.10 This research found a connection between use of alcohol and drugs before 16 and sexual initiation before that age. This was strongest for young women. The research found that alcohol use under 16 increased the odds of sex under 16 by 2.47 times in boys but by 5.70 times in girls.

2.11 There are particular concerns about young people’s use of alcohol and sexual activity. The Independent Advisory Group (IAG) on Sexual Health and HIV held a seminar on the issues of sex, drugs, alcohol and young people. The IAG found that the links between substance use and risky sexual behaviour were considerable. During his presentation to the IAG Professor Mark Bellis of Liverpool John Moores University highlighted that 40% of sexually active 13–14 year olds were drunk or stoned at first intercourse. In addition, 11% of 15–16 year olds had engaged in regretted sex after drinking alcohol and young people are three times as likely to have unprotected sex when they are drunk than when they are sober.¹¹²

2.12 In addition, a report into alcohol and teenage pregnancy by Alcohol Concern¹¹³ noted that three quarters of 16–20 year olds used contraception when sober compared to 59% when mildly intoxicated and 13% of those who are strongly intoxicated. In addition, of those 15–19 year olds who had had sex with someone they had known for less than one day, 61% of females and 48% of males gave alcohol or drugs as a reason.

2.13 Research with school aged young people (14–15 years old) conducted in Rochdale also found links between drinking alcohol and sexual activity.¹¹⁴ The majority of young people who took part in the research were not sexually active. However, there were significant variations in this picture according to gender,

¹⁰⁷ Standerwick K *et al*, “Binge drinking, sexual behaviour and sexually transmitted infection in the UK”, *International Journal of STD and AIDS*, no 18 (2007), 810–813.

¹⁰⁸ McMunn V A and Caan W, “Chlamydia infection, alcohol and sexual behaviour in women”, *British Journal of Midwifery*, vol 15, no 4 (2007), 221–224.

¹⁰⁹ Cook R L and Clark D B, “Is there an association between alcohol consumption and Sexually Transmitted Diseases? A systematic review”, *Sexually Transmitted Diseases* vol 32, no 3 (March 2005), 156–164.

¹¹⁰ Markos A R, “Alcohol and sexual behaviour”, *International Journal of STD and AIDS*, vol 16, no 2 (February 2005), 123–127.

¹¹¹ Bellis M A *et al* “Sexual uses of alcohol and drugs and the associated health risks: A cross sectional study of young people in nine European cities”, *BMC Public Health* vol 8 (May 2008) doi: 10.1186/1471-2458-8-155.

¹¹² *Op cit* no 105.

¹¹³ Alcohol Concern, *Alcohol and Teenage Pregnancy* (London: Alcohol Concern, 2002).

¹¹⁴ Redgrave K and Limmer M, “It makes you more up for it”: *School aged young people’s perspectives on alcohol and sexual health* (Rochdale: Rochdale Teenage Pregnancy Strategy, 2005).

ethnicity and aspirations. For example, the young people who reported sexual intercourse were more likely to be white, female and with low education aspirations. These young people were also the most likely to report binge drinking.

2.14 It is important to remember that using alcohol can not only affect use of contraception when drunk, for example failure to use condoms or inability to use condoms properly, but also can affect contraception afterwards. For example, women taking oral contraceptives who vomit the day after drinking alcohol may not have the full contraceptive cover they would expect.

3. ALCOHOL AND VULNERABILITY TO SEXUAL ASSAULT

3.1 Along with increasing the likelihood of sexual risk-taking, alcohol can have an impact on people's vulnerability to sexual assault and can also affect people's perceptions of whether a sexual assault has taken place.

3.2 A literature review reported that data collection from convicted rapists suggested that the offender was under the influence of alcohol in 40–63% of the studied cases. In addition, the review found that analysis of police records indicated that the alleged offender, the victim or both were under the influence of alcohol in up to 72% of the studied cases.¹¹⁵

3.3 Alcohol use appears to affect expectations of sexual behaviour. For example, the same review found that observers of rape scenes cast less blame on a drinking rapist than sober one but considered an intoxicated victim to be blame worthy more than a sober one.

3.4 Research has also shown that perceptions of risk are affected by alcohol use. Markos' literature review found that intoxicated women were less able to perceive risk, less able to escape dangerous situations, more likely to get involved in risk behaviours and less likely to use direct resistance than sober women.¹¹⁶

3.5 The research with women attending sexual health clinics included a small focus group in which women reported risk behaviours attributed to alcohol use such as getting into strangers' cars and walking home alone late at night.¹¹⁷

4. AREAS FOR ACTION

4.1 Given the clear link between alcohol use and sexual risk-taking and sexual assault, fpa recommends that a more joined up approach is taken to these issues at local and national levels.

4.2 There appears to be clear evidence that some people use alcohol as a way of facilitating sexual activity and in many cases the two issues are closely linked for people. However, the approach from professionals is usually only focused on one aspect and people who approach alcohol misuse services are not signposted to sexual health services and vice versa.

4.3 We recommend that at a national level clear links are made between strategies and initiatives to tackle sexual health and those directed at addressing alcohol use. This could include, for example providing links to organisations addressing alcohol use on the condom essential wear website and similarly including information about sources of information on sexual health on the Talk to FRANK website.

4.4 At a local level professionals need to be more aware of the links between alcohol and sexual health and how this can affect people's behaviour. The research cited above with women who were being tested for chlamydia noted that staff in the sexual health clinic were "surprised at the levels of [alcohol] consumption per drinking session and the associated risk behaviour reported".¹¹⁸ Professionals need high quality training and up to date information to ensure that they can recognise when people's alcohol use is affecting their sexual health and be able to signpost them to appropriate agencies for support.

March 2009

Memorandum by the British Society of Gastroenterology and the British Association for the Study of the Liver (AL 20)

1. INTRODUCTION

1.1 This paper is a joint response by the British Society of Gastroenterology (BSG) and the British Association for the Study of the Liver (BASL) to the Health Select Committee Inquiry on Alcohol. Specialist representatives from the BSG and BASL would welcome the opportunity to give oral evidence to the Committee.

¹¹⁵ *Op cit* no 110.

¹¹⁶ *Op cit* no 110.

¹¹⁷ *Op cit* no 108.

¹¹⁸ *Op cit* no 108.

1.2 The BSG exists to maintain and promote high standards of patient care in gastroenterology and hepatology and to enhance the capacity of its members to discover, disseminate and apply new knowledge to the benefit of patients with digestive and liver disorders. Founded in 1937, the BSG has over three thousand members drawn from the ranks of physicians, surgeons, pathologists, radiologists, scientists, nurses, dietitians, and others interested in the field.

1.3 BASL has been in existence for 40 years and has over 400 members. It has a focus on clinical and scientific aspects of liver disease and is dedicated to understanding of the biology and pathology of the liver. BASL complements the activities of BSG and together with the BSG, is the primary body representing the views of UK hepatologists. BASL membership also reflects the broad group of clinicians and scientists dedicated to advancement in liver disease.

2. EXECUTIVE SUMMARY

2.1 The scale of alcohol related ill health and mortality in the UK is rising in comparison with other European countries such as Spain, Italy and France. The costs to the NHS are estimated to be £2.7 billion. The Government's approach, through self regulation, has been largely ineffectual despite the weight of opinion pointing to price being the most effective driver of change.

2.2 The alcohol industry has been a dominant force in the debate over alcohol in recent years and has succeeded in pushing the Government towards education based approaches to alcohol harm. The effectiveness of such campaigns is debateable and there is a need to further restrict the marketing and promotion of alcohol.

2.3 The NHS must prioritise alcohol related illness through a National Liver Plan as quickly as possible to ensure specialist liver services are in place and early detection, intervention and treatment is prioritised.

2.4 The BSG and BASL are calling for a combined approach of an increase in alcohol duty and a minimum price per unit of alcohol to protect harmful drinkers and fund alcohol services.

3. THE SCALE OF THE PROBLEM

3.1 According to the most recent analysis published in July 2008¹¹⁹ liver disease is the most common cause of alcohol related death in men and women between the ages of 35 and 75 in England. Death certification data reveals that more than 80% of UK liver deaths are due to alcohol related cirrhosis.¹²⁰ Liver disease and liver deaths are the most reliable barometer of alcohol related ill health and mortality in the UK. While the wine drinking countries of Southern Europe always had historically very high levels of liver deaths from alcohol related cirrhosis (figure1); deaths in these countries have been dropping, whereas UK deaths are still increasing inexorably.

3.2 The UK finally overtook Spain, Italy and France for liver deaths in 2004—the year that the UK Government finally published the long awaited alcohol strategy. This strategy was criticised by health campaigners at the time because it appeared to put the interests of alcohol producers and retailers above the health of UK citizens. At the time of publication the Cabinet Office's Strategy Unit estimated the cost of alcohol misuse to the NHS in England at £1.4–1.7 billion. In 2008 the same team recalculated these costs to the NHS at £2.7 billion.

¹¹⁹ Jones, L, Bellis, M A, Dedman, D, Sumnall, H, and Tocque, K. Alcohol attributable fractions for England; alcohol attributable mortality and hospital admissions. North-West Public Health Observatory and Dept of Health; 2008. <http://www.nwph.net/nwpho/publications/forms/disform.aspx?ID=186>

¹²⁰ *Hansard* 9 October 2006. Column 629w.

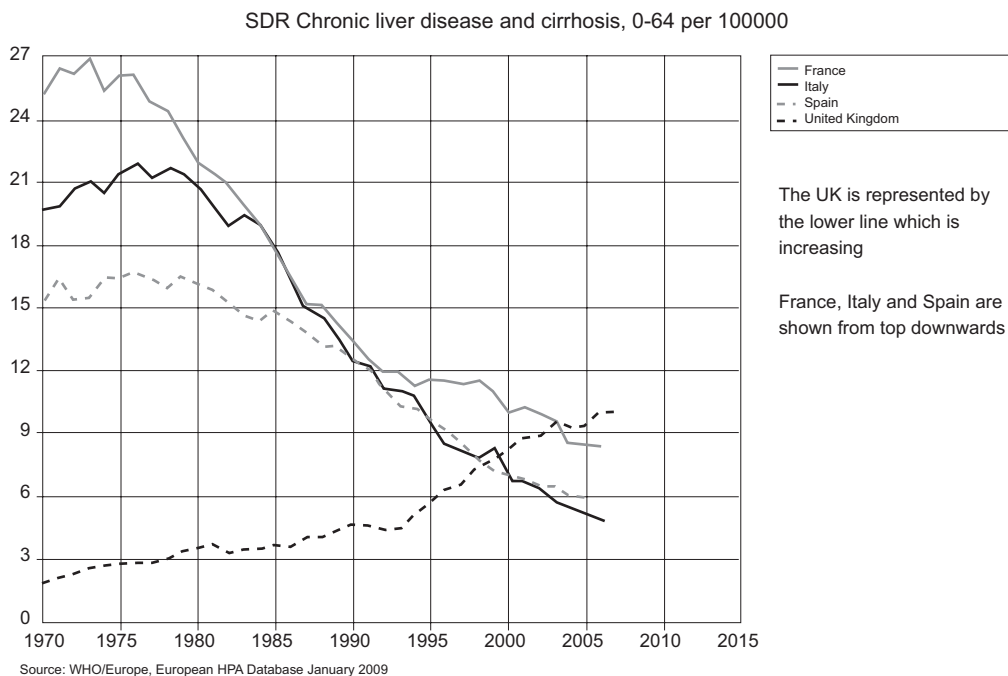


Figure 1
 Liver death rates in the UK compared to France, Spain and Italy—countries with historically extremely high liver death rates. Data from the WHO Health For All database.¹²¹

3.3 Much of the alcohol debate and media attention has since centred on the problems of binge drinking amongst young people, and in particular the link between alcohol use and anti-social behaviour. The degree of loss of life at all ages caused by alcohol has generally escaped the attention of the media, and in particular the fact that young people have the highest proportion loss of life from alcohol related causes—more than 26% of deaths in males aged 16 to 24 are due to alcohol (figure 2).¹²²

3.4 The most recent publication by the Office of National Statistics revealed that since 2004 deaths in males aged 15 to 34 increased by 2.5%, and in females of the same age by 24%—for all age groups figures showed an increase of 5% for males, and 7% for females.¹²³

¹²¹ European health for all database (HFA-DB) World Health Organization regional office for Europe
<http://data.euro.who.int/hfad/>

¹²² Jones, L, Bellis, M A, Dedman, D, Sumnall, H, and Tocque, K. Alcohol attributable fractions for England; alcohol attributable mortality and hospital admissions. North-West Public Health Observatory and Dept of Health; 2008.
<http://www.nwph.net/nwpho/publications/forms/dispform.aspx?ID=186>

¹²³ Alcohol Deaths; Rates stabilise in the UK Office of National Statistics <http://www.statistics.gov.uk/cci/nugget.asp?id=1091>

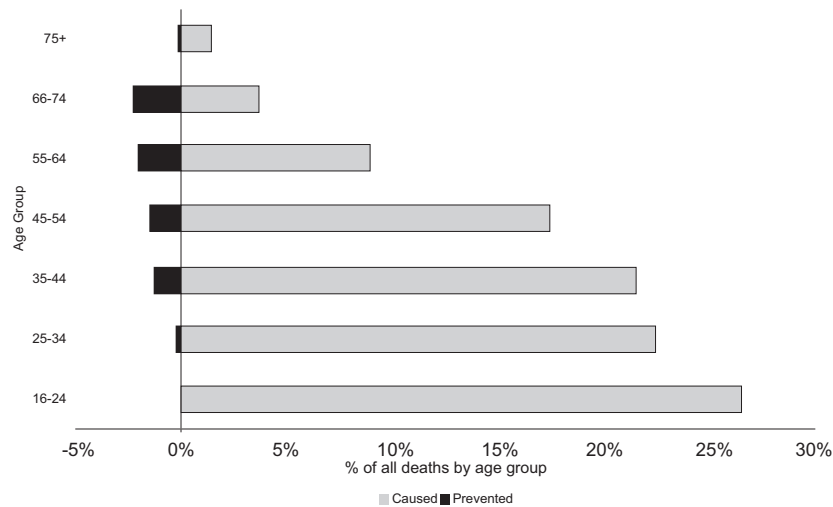


Figure 2

The proportion of all deaths that are due to alcohol at various ages, the levels of deaths in younger patients are staggeringly high. Data appears on the DH website.¹²⁴ Thus, between 17–27% of all deaths are due to alcohol between the ages of 16 to 54 years.

4. THE CURRENT APPROACH BY GOVERNMENT

4.1 There is no evidence that current Government approaches have worked so far in terms of reducing either alcohol related deaths or hospital admissions.

4.2 Alcohol policy has been intensely studied, and there is a large evidence base for the policies that work. The subject has been subjected to a number of independent expert reviews commissioned by; the World Health Organisation,¹²⁵ the European Commission¹²⁶ and the UK Academy of Medical Sciences.¹²⁷ The findings of these reviews are all entirely consistent and show universally that the key drivers to alcohol related harm are cheap alcohol, easy availability of alcohol, and the promotion and marketing of alcohol by industry. There are also underlying cultural differences in the patterns of alcohol related harm, which in many cases are centuries old.

4.3 More recently the UK Government have commissioned further expert reviews on self regulation by the alcohol industry,¹²⁸ the role of price and promotions¹²⁹ and the effectiveness of education based approaches to change harmful drinking behaviours.¹³⁰ The findings of these studies are also entirely consistent with the previous expert reviews. Self regulation does not work, and low prices and cheap promotions are the key reversible factor in the dramatic increases in alcohol related harm seen in the UK.

4.4 For liver disease—the evidence linking UK liver deaths to the affordability of alcohol is incontrovertible—the correlation between the two is 0.98—as can be seen in figure 3, the two are clearly linked. This direct link is the result of two factors in the clinical evolution of alcohol related liver disease.

4.5 First, one needs to drink a lot of alcohol, the equivalent of more than 4 bottles of wine a week, for more than 10 years to get liver disease.

4.6 Second, many liver deaths occur largely as a result of alcoholic hepatitis, and therefore a reduction in drinking has an immediate effect on mortality.

¹²⁴ Jones, L, Bellis, M A, Dedman, D, Sumnall, H, and Tocque, K. Alcohol attributable fractions for England; alcohol attributable mortality and hospital admissions. North-West Public Health Observatory and Dept of Health; 2008. <http://www.nwpho.net/nwpho/publications/forms/dispsform.aspx?ID=186>

¹²⁵ Babor TF, Caetano R, Casswell S, Edwards G, Giesbrecht N, Graham K *et al.* *Alcohol: No Ordinary Commodity/Research and Public Policy.* Oxford and London: Oxford University Press; 2003.

¹²⁶ Anderson, P and Baumberg, B. Alcohol in Europe: A public health perspective. EU Health and Consumer Protection Directorate General; 2007. http://ec.europa.eu/health-eu/doc/alcoholineu_content_en.pdf

¹²⁷ Academy of Medical Sciences. Calling time—The nation's drinking as a major health issue. Academy of Medical Sciences, London; 3 January 2004. www.acmedsci.ac.uk

¹²⁸ KPMG LLP. Review of the Social Responsibility Standards for the production and sale of Alcoholic Drinks. 2008.

¹²⁹ Meier, P and *et al.* The independent review of the effects of alcohol pricing and promotion. Summary of evidence to accompany report on phase 1: Systematic Reviews. School of Health and Related Research University of Sheffield, UK June 2008; 2008.

¹³⁰ NICE. School-based interventions on alcohol: Interventions delivered in primary and secondary schools to prevent and/or reduce alcohol use by young people under 18 years old (draft guidance). internet: NICE; 2007. <http://www.nice.org.uk>

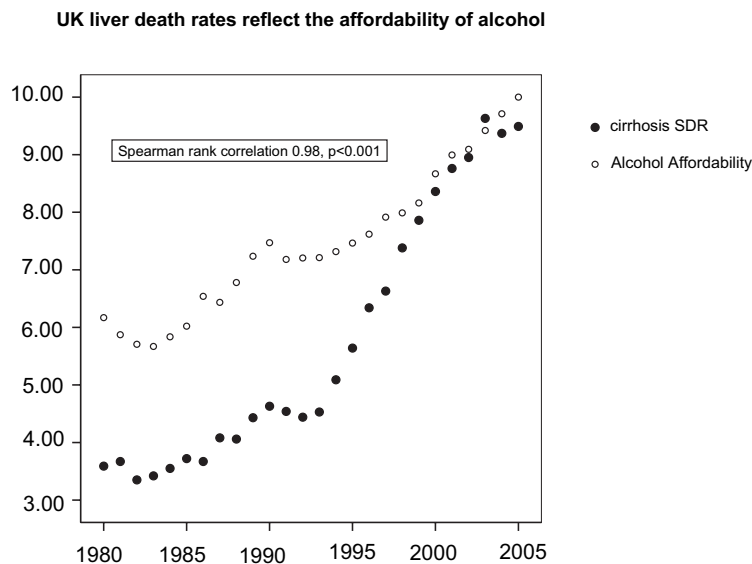


Figure 3
Changes in UK liver death rates are closely related to the affordability of alcohol.¹³¹

5. EDUCATION, SOCIAL MARKETING AND THE ROLE OF INDUSTRY

5.1 As reviewed most recently by NICE—there is very little evidence, even in young people, that education based approaches promoted by the alcohol industry and favoured by the Government reduce alcohol related harm.¹³² The somewhat cynical view being that this is the precise reason that they are so favoured by the alcohol production and retail industries. According to the DH, 25% of the UK population are hazardous or harmful drinkers, but this minority consumes 75% of alcohol sales. This phenomenon is well described in other countries,^{132, 131} and means that the alcohol production and retail industries rely on hazardous and harmful drinkers to supply three-quarters of their profitability. One therefore has to question the motivation of the alcohol industry to reduce alcohol related harm, and their central role in policy making so far.

5.2 The role of education and social marketing—namely the use of commercially derived marketing approaches to improve health related behaviours—is however somewhat paradoxical. On one side of the health debate, industry claims that education based approaches are effective, but that their own promotional activities do not increase the consumption of alcohol. Whereas the health lobby claims that education based approaches are completely ineffective, but that the promotional activity of industry has deleterious consequences in terms of alcohol, consumption, and in particular teenage drinking. It is likely that the truth lies between these two polarised positions, there is a mounting body of evidence that when used correctly, social marketing is an effective tool.¹³³ It is only recently that the government has tried to stigmatise drinking in the same way that smoking is now stigmatised with adverts showing the shameful and embarrassing effects of being drunk. Similarly a large body of evidence shows that alcohol marketing has a deleterious effect on the drinking behaviour of young people.^{134, 135} The independent Science Group of the EU Commission recently reviewed the impact of alcohol marketing communications on young people and the verdict was clear:¹³⁴ “it can be concluded from the studies reviewed that alcohol marketing increases the likelihood that adolescents will start to use alcohol and to drink more if they are already using alcohol”.

5.3 The largest fall in EU liver deaths has occurred in France which has tight restrictions on alcohol marketing—the “Loi Evin”. Alcohol advertising is banned on TV, in cinemas and at sporting events, print advertising is permitted but “messages and images should refer only to the qualities of the products such as origin, composition and means of production”.

¹³¹ Verril C, Markham H, Templeton A, Carr N, Sheron N. Alcohol related cirrhosis—early abstinence is a key factor in prognosis, even in the most severe cases. *Addiction* 2009; in press.

¹³² NICE. School-based interventions on alcohol: Interventions delivered in primary and secondary schools to prevent and/or reduce alcohol use by young people under 18 years old (draft guidance). internet: NICE; 2007. <http://www.nice.org.uk>

¹³³ Stead M, Hastings G, McDermott L. The meaning, effectiveness and future of social marketing. *Obes Rev* 2007 March; 8 Suppl 1:189–93.

¹³⁴ Science Group of the European Alcohol and Health Forum. Does marketing communication impact on the volume and patterns of consumption of alcoholic beverages, especially by young people?—a review of longitudinal studies. 2009.

¹³⁵ Chief Medical Officer. On the state of the public health. 2001.

6. THE ROLE OF THE NHS AND OTHER SERVICES

6.1 Services for patients with liver disease have developed in an unplanned manner as an offshoot of general gastroenterology, and many liver patients are managed at District General Hospital level by general gastroenterologists, many of whom have had no training in a specialised liver unit. The service structure developed at a time when liver disease and death from liver was relatively uncommon and the 10 fold increase in young liver deaths over the last 30 years¹³⁶ has not been matched by the development in services needed to cope. The DH is aware of the situation with regard to liver services and there appears to be agreement within the DH that a Liver Strategy is urgently needed. The BSG and BASL are currently drafting a National Plan for Liver Services which it is hoped will feed into this new strategy when commissioned.

6.2 As reviewed in the recent NAO report¹³⁷ health services for alcohol misuse are, if anything, in a worse state than liver services. This is largely the result of two factors. Firstly, subjects with substance misuse issues are not seen as coming under the remit of general mental health services—but are seen as needing specialist addiction services. Secondly, specialist addiction services under the control of the National Treatment Agency and the associated network of Drug Action Teams are all geared almost entirely to the treatment of drug misuse. The pooled treatment budget for these services in 2009–10 will be £406 million.¹³⁸ This has resulted in a bizarre situation in which the waiting time for treatment for drug offences is two to three weeks, whereas for patients with potentially fatal alcoholic liver disease the waiting time for an assessment is over six months. This effectively means that alcohol treatment services do not exist in many areas.

¹³⁶ Chief Medical Officer. On the state of the public health. 2001.

¹³⁷ National Audit Office. Reducing Alcohol Harm: Health services in England for alcohol misuse. National Audit Office; 2008 Oct 28. http://www.nao.org.uk/publications/0708/reducing_alcohol_harm.aspx

¹³⁸ 2009–10 Pooled Treatment Budget National Treatment Agency.
http://www.nta.nhs.uk/news_events/newsarticle.aspx?NewsarticleID=133

Survival Functions

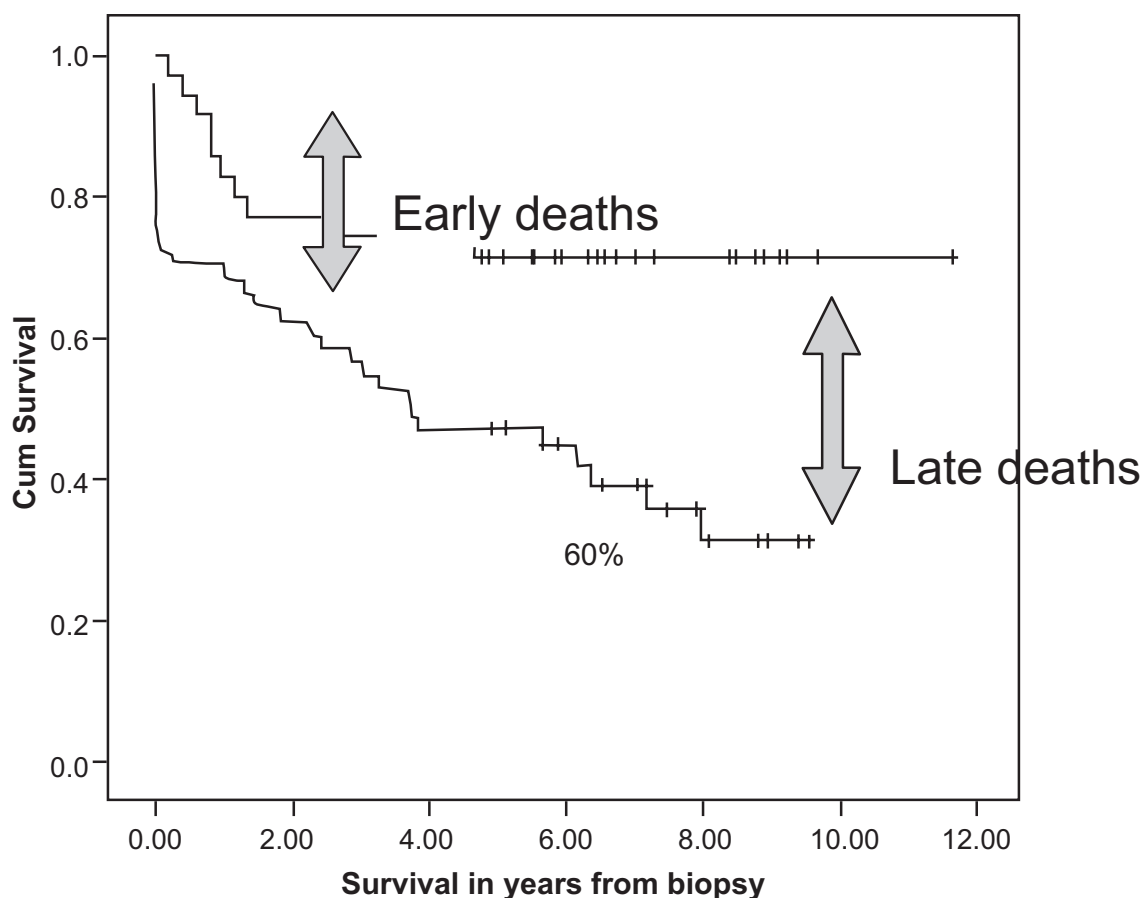


Figure 4

As can be seen from the survival curves in subjects with liver cirrhosis, there are two phases of liver deaths. Early deaths within the first few weeks can only be prevented by preventing liver disease from developing in the first place. Whereas late deaths after the first year are almost entirely related to continued drinking behaviour, and can be decreased by improved treatment of alcohol addiction.¹³⁹

7. THE EFFECTIVENESS OF DETECTION, INTERVENTION AND TREATMENT SERVICES

7.1 Figure 4 illustrates that many patients with liver disease die before they get the chance to stop drinking; if the DH are serious about decreasing the rising tide of liver deaths in the UK we need to prevent people from developing serious liver disease. There are two evidence based methodologies for doing so: making alcohol less affordable through increases in taxation, or early intervention in heavy drinkers before they develop problems.¹⁴⁰ The latter is the more expensive option, and combinations of the two options, together with restrictions on alcohol promotions/availability and increased measures against drink driving are the most effective on a global scale.

¹³⁹ Hatton J, Burton A, Nash H, Munn E, Burgoyne L, Sheron N. Drinking patterns, dependency and life-time drinking history in alcohol-related liver disease. *Addiction* 10 February 2009.

¹⁴⁰ Roberts SE, Goldacre MJ, Yeates D. Trends in mortality after hospital admission for liver cirrhosis in an English population from 1968 to 1999. *Gut* 2005 November; 54(11):1615–21.

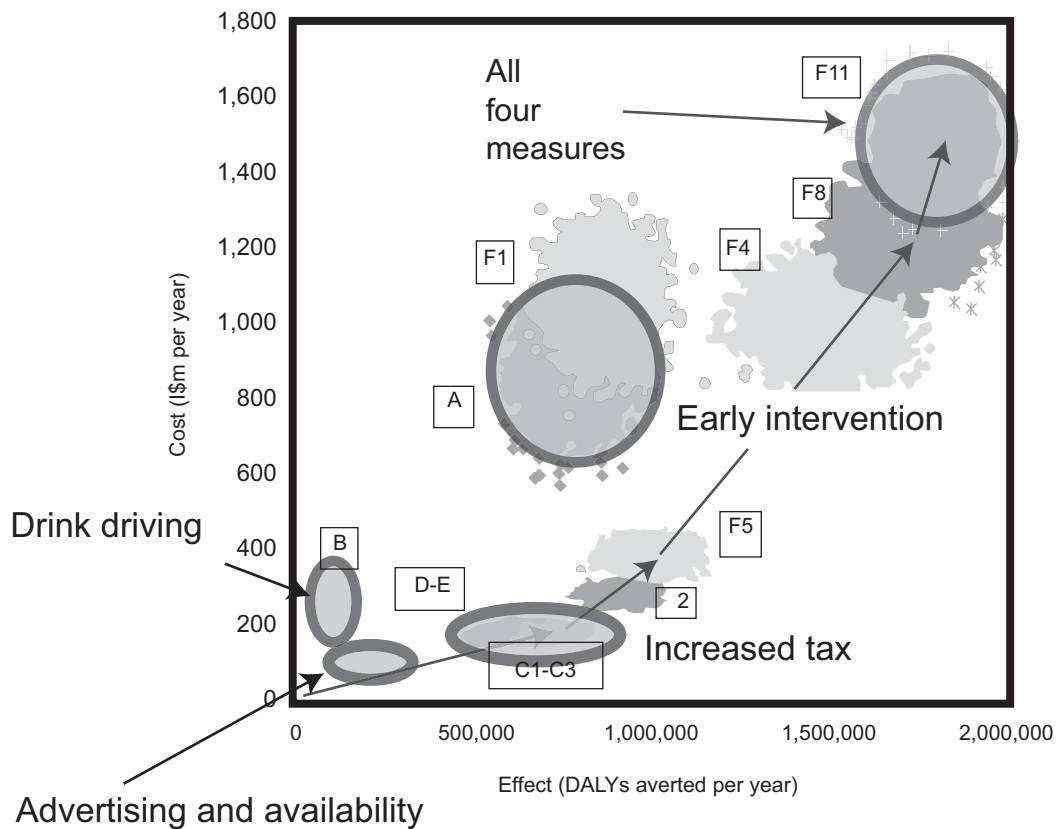


Figure 5
Modelling of effective alcohol policy by the World Health Organisation¹⁴¹

8. WHAT WOULD AN EFFECTIVE UK ALCOHOL STRATEGY LOOK LIKE?

8.1 The distinction between the Northern European culture of binge or feast drinking and the Southern European culture of regular heavy drinking with meals has been long recognised.^{142, 143} There is no precedent for actively changing the drinking culture of one nation into that of another, although in the UK at the present time we have superimposed a regular drinking Mediterranean culture on top of our underlying Anglo-Saxon binge drinking culture, and we are reaping the consequences in terms of liver deaths.

8.2 The recent increase in alcohol related problems in the UK can largely be explained by the reduction in the relative price of alcohol, combined with the massively increased marketing of alcohol—largely directed at young people—that occurred from the early 1990's onwards. The UK alcohol industry currently spends around £800 million on promotion—compared with tiny sums on social marketing. Much tighter regulation of promotion is urgently needed with serious consideration given to a UK version of the French “Loi Evin”.

8.3 The increased burden of alcohol related health issues has put an intolerable strain on the provision of alcohol services, and the increase in services that are required should be matched by additional funding either from general taxation, from a reduction in other NHS services, or from an increase in levels of duty on alcohol.

¹⁴¹ Chisholm D, Rehm J, Van OM, Monteiro M. Reducing the global burden of hazardous alcohol use: a comparative cost-effectiveness analysis. *J Stud Alcohol* 2004 November;65(6):782–93.

¹⁴² Engs RC. Do traditional western european drinking practices have origins in antiquity? *Addiction Research* 1995; 2(3): 227–39.

¹⁴³ Boniface St. *The Anglo-Saxon Missionaries in Germany: Being the Lives of S.S. Willibrord, Boniface, Strum, Leoba and Lebuin, together with the Hodoeporicon of St. Willibald and a Selection from the Correspondence of St. Boniface.* New York: Sheed and Ward; 1954.

9. RECOMMENDATIONS

9.1 *Increase in the duty on alcohol*

A gradual year on year increase in the duty on alcohol would solve both problems. As we have already seen, three quarters of the alcohol sold is drunk by hazardous and harmful drinkers, and so duty increases would fall predominantly on those at risk whose consumption in any case needs to be reduced. The impact of duty increases on truly moderate drinkers would be negligible—even more so when staged over a number of years.

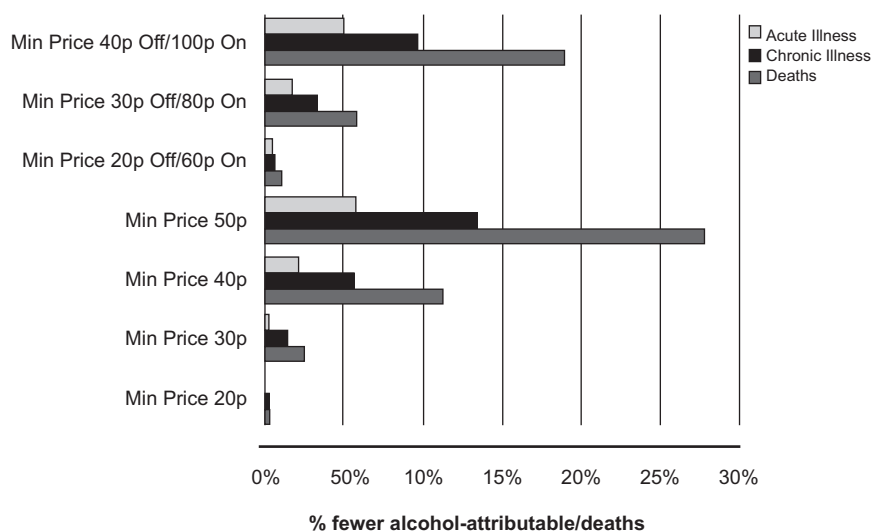


Figure 6
*Modelling of the reductions in illness and deaths that would result from various levels of minimal price/unit of alcohol.*¹⁴⁴

9.2 *Minimum price for a unit of alcohol*

Recent increases in alcohol duty have on the whole not been passed on to customers by the large retailers, including supermarkets—suppliers have been squeezed instead. Increasing duty on its own does not ensure that the problem of cheap booze will be remedied. The solution to this would be to introduce a minimum price for a unit of alcohol. This policy option has been extensively modelled for the Department of Health, and has also been proposed by the Scottish Government. It has the merit of protecting revenues of the alcohol industry, but the disadvantage of not raising the additional revenue for the NHS and other services. A combination of the two options, stepped duty increases and a minimum price, provides the most comprehensive solution to the UK alcohol problem, and restores a much needed level of control to the health consequences of the alcohol free-market. There is a delicate balance between the price of alcohol and the cost of alcohol to UK society—the balance simply needs to be redressed.

9.3 *National Plan for Liver Services*

BSG and BASL strongly support the decision to develop a National Liver Plan and urge that the management of patients with alcoholic liver disease is at its heart.

9.4 *Improved alcohol support services*

The time of first presentation is a period of opportunity for personal reform. There is a desperate need to invest in effective support services for alcoholics, particularly at a time of first diagnosis. Revenue from increased duty on alcohol should be used for this purpose, whether or not the tax is specifically hypothecated.

¹⁴⁴ Meier, P and *et al.* The independent review of the effects of alcohol pricing and promotion. Summary of evidence to accompany report on phase 1: Systematic Reviews. School of Health and Related Research University of Sheffield, UK June 2008; 2008.

This response was drafted on behalf of the British Society of Gastroenterology (liver section) and the British Association for the Study of the Liver. This response has been co-ordinated with the formal responses from the Royal College of Physicians, and the Alcohol Health Alliance. Specialist representatives from the BSG and BASL would welcome the opportunity to give oral evidence to the Committee.

March 2009

Memorandum by Sainsbury's (AL 21)

1. INTRODUCTION

1.1 We welcome the opportunity to respond to the Committee's inquiry into Alcohol. Please note that we have only responded to those sections/questions where we feel we can add value and insight, and in each case have provided a response based on our own first-hand experiences as a food and drink retailer.

1.2 For context, key statistics on Sainsbury's:

- 785 stores, of which 276 are convenience;
- 153,000 employees;
- Around 18 million customers a week; and
- 26,000 food/drink products (15,000 of which are own-brand).

1.3 We are committed to driving positive behaviour change, both within our company and with our customers. Our customer insights research and experience shows us that changing consumer behaviour is most successful when information and education, together with incentives, work better than when change is imposed by regulation or restriction.

1.4 Health is at the heart of our business. Our goal is to offer our customers high quality, healthy, affordable products and to allow them to make informed and healthier choices. One of our Corporate Responsibility principles is being the best for food and health. This includes the responsible retailing of alcohol. We have extensive experience of providing information and products to ensure our customers make healthier choices.

2. EXECUTIVE SUMMARY

2.1 We are fully committed to working with the Government and others to improve the cultural and educational aspects of drinking and enjoying alcohol, particularly with food. We have a strong record in helping to inform our customers about responsible drinking through alcohol unit labelling, wine style guides helping customers to demystify the buying of wine, and with local and national stakeholders in implementing Community Alcohol Partnerships in identifying and tackling hot spot groups and areas.

2.2 We would welcome further working with the Government on best practice on how to communicate to customers about responsible drinking. However, the Government needs to show a much greater commitment and emphasis to a long-term strategy on the demand-side of alcohol abuse, with a clear targeted educational approach to "at risk" and problem drinkers.

2.3 The vast majority of our customers consume alcohol responsibly and buy alcohol as part of their weekly shop for family occasions. A survey in 2007 by Ipsos Mori of our customers about their attitudes and buying behaviour towards promotions on beer found that 91% of customers said they would drink about the same in a month when purchasing beer in bulk. This supports our argument that our customers take advantage of promotions to stock up and then use this stock to sustain them for a period of time. We have very clear sales data, particularly on wine, which shows that customers' motivation is to trade up to higher cost brand or own-brand wines during a wine promotion period rather than just buying more alcohol *per se*.

2.4 There is too much emphasis on the supply-side, with not enough on the demand-side. There also seems to be an unrealistic expectation that perceived "easy wins" around a ban on promotions and the introduction of minimum pricing, which do not have sound evidence for their introduction, will produce easy and substantial public health returns. What is known is that a higher pricing regime will result in the unintended consequences of those on fixed incomes being hardest hit. It will be seen as an unfair and anti-consumer policy by customers, introduced at a time of financial hardship for many families.

2.5 For any business operating in the UK, a business friendly environment is imperative in order to continue to create jobs and prosperity in local communities. There is a need for a "better regulation" agenda to be encouraged to ensure a viable business environment. Additional regulation or rules which add cost to our business makes the ability to trade harder and could have a detrimental knock-on impact on the wider English/UK food and drink sector.

3. CENTRAL GOVERNMENT POLICY

3.1 As with all policy making, central government policy on alcohol should:

- Be based on sound evidence.
- Be targeted, with specific messaging and action, at specific “at risk” groups.
- Have clear objectives for how change will be effected and measure progress against these objectives.
- Have consideration for the Hampton Principles and the Better Regulation Executive’s five principles for good regulation.
- Not duplicate existing legislation or other government initiatives.

3.2 Recent proposals put forward by the Home Office for a Mandatory Code on alcohol appear confused owing to a lack of evidence for many of the measures. This has led to many of these measures being disproportionate and potentially adding considerable regulatory and cost burdens on businesses, with few tangible outcomes to tackle either alcohol abuse or disorder.

3.3 We also believe that the aim of the recently introduced Alcohol Disorder Zones overlaps with that of the Draft Mandatory Code, therefore creating an additional layer of confusion through the number of policy initiatives in the same space.

4. THE ROLE OF THE NHS AND OTHER BODIES INCLUDING LOCAL GOVERNMENT, THE VOLUNTARY SECTOR, POLICE, THE ALCOHOL INDUSTRY, AND THOSE RESPONSIBLE FOR THE ADVERTISING AND PROMOTION OF ALCOHOL

Promotions and marketing of alcohol

4.1 We do not believe that increased purchasing of alcohol directly impacts on increased excessive consumption. We believe that the issue is much more complex, and involves much more of an understanding and emphasis on the demand side of why people misuse alcohol in the first place. The limited evidence presented so far in favour of an off-trade ban on promotions shows only a very small public health gain.¹⁴⁵

4.2 As a food retailer, while our customers may buy alcohol on promotion, it is overwhelmingly part of their weekly shop. Customer transaction details show that just over 1% of weekly transaction sales are alcohol-only.

4.3 Our research also shows that the vast majority of our customers take advantage of promotions to either trade up to higher cost brands (particularly in the case of wine), or to stock up for special occasions such as family birthdays and summer barbeques.

4.4 A survey in 2007 by Ipsos Mori of our customers about their attitudes and buying behaviour towards promotions on beer found that:

- $\frac{1}{3}$ said they would buy a little more than usual, with nearly half saying they would buy “about the same”.
- 48% said they would check to see if the brand of beer they like is on promotion and if not, they would still buy their preferred brand.
- 91% of customers said they would drink about the same in a month when purchasing beer in bulk.
- Only 23% said they tend to choose a beer based on its strength.

4.5 We categorically do not run promotions to increase consumption of alcohol, but rather in a highly competitive branded and own-branded alcohol market, promotions are run to encourage customers to switch between brands and try different products. We do not offer Buy One Get One Free promotions on alcohol.

Minimum retail pricing

4.6 There has been much discussion recently about setting a minimum retail price for alcohol. While this is something that the Scottish Government is obviously considering, we believe that it could have unintended consequences and we would urge the Government to avoid this as a tactic to reduce alcohol consumption.

4.7 Minimum pricing will only affect disproportionately affect the vast majority of our customers who drink responsibly, but particularly those households with a lower disposable or fixed income, particularly at this time of economic difficulty, and may simply lead to a shift in product choice rather than lower consumption.

¹⁴⁵ Sheffield University Review into alcohol pricing and promotions policy. <http://www.sheffield.ac.uk/mediacentre/2008/1128.html>. “Sheffield report analyses effects of alcohol pricing and promotion policies”: 3 December 2008. “A total ban on off-trade discounting is estimated to reduce consumption by 2.8%”.

4.8 There is little or no credible and impartial economic modelling to show what an optimum reduction in alcohol-related deaths would look like from achieving a set minimum price. We would argue that major increases in price, even above our current prices, would be necessary to make even a small impact on overall consumption.

4.9 We are concerned as well that a policy of minimum pricing may lead to increased cross-border “white-van” type sales. In Northern Ireland, we have seen this cross-border shopping in practice. Our Newry store regularly sees shoppers “commute” from Dublin to Newry to do their weekly or monthly shop. As a result our Newry store has the highest alcohol sales in the whole of our UK estate.

4.10 Introducing any scheme of minimum pricing, would have a significant impact on our business and our customers. Therefore there must be a clear evidence base and cost-benefit analysis before the Government consider any policy based on this issue. Introducing minimum pricing without an evidence base would be disproportionate and unfair.

Education

4.11 As a responsible retailer we are wholly committed to educating our consumers about alcohol consumption. We run a number of different programmes and initiatives to achieve this.

4.12 We were on the first supermarkets to join The Drinkaware Trust, which brings together producer companies, retailers, health professionals, academics and NGOs. Its aim is to positively change public behaviour and reduce alcohol misuse. One of its key priorities is around under-18’s education. Our Head of Legal Services is a Trustee.

Product labelling:

4.13 With research showing that fewer than half of consumers are able to identify the recommended daily alcohol intake for men and women, we are also committed to educating our consumers about “unit” consumption.

4.14 In 2007, we became the first retailer to adopt the Department of Health’s Guidelines on Alcohol Labelling on our own-brand beers, wines and spirits.

4.15 The labels, which include recommended maximum daily intake information, are currently on 78% of our own-branded products. By the end of 2009, they will be rolled out across all our own-branded alcohol range. Please see example below:

Know your limits

This bottle contains
20 glasses

Units of alcohol
per 25ml glass
and 50cl bottle: **1.1**

**21.5
UK
UNIT**

Government guideline Do not regularly exceed:	
Women	2-3 units daily
Men	3-4 units daily

**Seek medical advice regarding
alcohol and pregnancy**
www.drinkaware.co.uk

Shelf-edge labelling:

4.16 We are also increasingly promoting the benefit of matching food with alcohol in an attempt to encourage customers to enjoy drinking responsibly as part of a meal. Last year in all of our stores we launched a “Wine Style Guide”. The Guide divides our wines into wine and red wine styles, such as “light & fruity” and “smooth & mellow”), with the description on the colour disc describing the character of the wines. The Guide is designed to demystify the buying and choosing of wine, which customers often find daunting. We feel that this will help customers to make more informed “cultural” choices about wine.

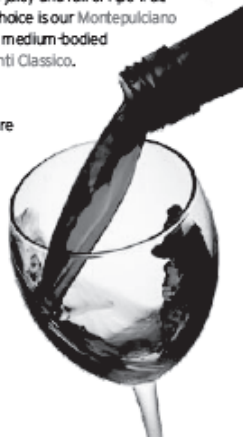


Choosing red wines

Light & fruity Easy-drinking, light-bodied reds fit into this category. If you enjoy the light berry flavours in our Beaujolais, then the juicy cherry notes in our Bardolino or the raspberry flavours in our Old Vines Tempranillo offer you some tantalising alternatives.

Smooth & mellow Wines in this category, such as our Rioja Reiente, are juicy and full of ripe fruit flavours. Another great choice is our Montepulciano d'Abruzzo or the elegant, medium-bodied Taste the difference Chianti Classico.

Rich & complex These are wines that are full bodied and intensely flavoured. If you like a powerful, rich red like our Barossa Shiraz, then try the Taste the difference Amarone for a new flavour sensation.

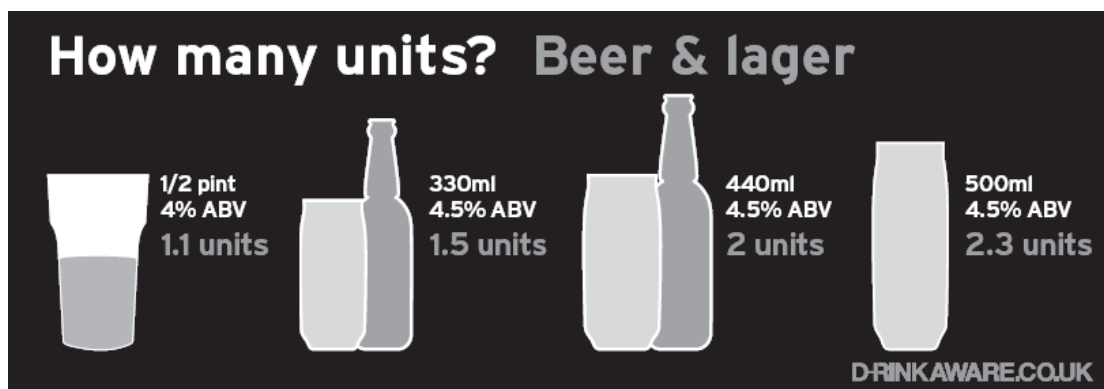


Enjoy with food

Our new wine-labelling system makes it even easier for you to match your wine with your meal. We've also added handy food-matching tips on the back label of each wine to help you. Here are some more quick ideas...

- **Crisp & delicate** These light, fragrant wines are the perfect match for fish, seafood, light salads or to give a refreshing lift to a rich cheese dish.
- **Soft & fruity** The ripe fruit and bold flavours in these whites work well with strongly flavoured dishes. Try them with smoked fish, buttery roast chicken or pork. For an exciting twist, pair with spicy Asian cuisine.
- **Complex & elegant** Cooking something special? These wines will add a little extra to the finest meal. Enjoy their complex flavours by matching with other delicately flavoured food such as seafood, creamy pasta dishes and risottos.
- **Sweet wine** Something so lusciously sweet deserves an equally decadent partner. Try with a tangy lemon tart or rich fruit cake for an indulgent finish to your meal.
- **Light & fruity** These easy-drinking reds are versatile when it comes to food matching. Perfect with a simple tomato pasta sauce, pizza or whole roast ham. These are all dishes that could be overpowered by heavier reds.
- **Smooth & mellow** These soft, silky reds make a great match for a hearty casserole or family favourites like spaghetti Bolognese, sausages and mash or lasagna.
- **Rich & complex** The bold and intense flavours of these reds require a powerful food combination. Try with rich beef stew or roast red meat. If you're feeling like a treat, their complex flavours will add excitement to a simple fillet steak.

4.17 In October 2008 we introduced a customer-friendly "alcohol education point of sale" in stores in Scotland and Northern Ireland. Shelf-edge labels are designed to help our customers easily understand how many units there are in different alcoholic drinks, by providing practical information and handy tips on units and measures. We will shortly be analysing how our customers have responded to the initiative, and pending any adaptations will be rolling them out across England.



Tackling Under age sales:

4.18 From September 2009 we will be introducing a Think 25 policy across all of our stores. This builds on the Think 21 policy we introduced in September 2005. All employees are trained to check the age of anyone buying alcohol if they look under 21. To coincide with the policy, we also introduced in-store signage to ensure customers are aware of the policy.

4.19 It is worth noting that an independent study by KPMG (sponsored by the Home Office), published in 2008, into the effectiveness of the alcoholic drinks industry's Social Responsibility Standards¹⁴⁶ in contributing to a reduction in alcohol harm in England, found good practice in the off trade, particularly in the supermarket sector. The report praised the sector in particular for its policies on restricting under age sales and in signage in highlighting and enforcing the Think 21 policy.

¹⁴⁶ Standards set in 2005 for alcohol retail covering sensible drinking messages, responsible marketing and ensuring that retailers don't sell to the underage or intoxicated customers.

4.20 *Working with stakeholders:* In September 2007, the Retail Alcohol Standard Group (which Sainsbury's Head of Legal Services chairs) and Cambridge Trading Standards began a new initiative—a Community Alcohol Partnership (CAP)—to reduce alcohol-related community problems. CAP brings together retailers, the police, local authorities, secondary schools, youth clubs and the local press to tackle under-age drinking through education, enforcement and public perception.

4.21 St Neots, a small market town in central Cambridgeshire with a history in anti-social behaviour and youth related disorder, was selected as the pilot project. We participated in the project which saw:

- 42% decrease in anti-social behaviour.
- 94% decrease in under-age people found in possession of alcohol.
- 92% decrease in alcohol-related litter.

The project has been rolled out to other areas including Nottingham, Cambridge and Kent and in 2008 won an award for best initiative at the Responsible Drinks Retailing Awards.

5. SOLUTIONS, INCLUDING WHETHER THE DRINKING CULTURE IN ENGLAND SHOULD CHANGE, AND IF SO, HOW

Encouraging cultural change

5.1 We strongly believe that the debate around alcohol needs to focus to a much greater extent on policies which drive and facilitate a cultural change, as opposed to the current over-emphasis on the supply-side, and the ban on high profile, but limited long-term public policy avenues such as promotions and minimum pricing.

5.2 We would particularly welcome further joint working with the Government on customer alcohol buying and behavioural trends, particularly helping to identify the best way to communicate to our customers the important message of responsible drinking.

5.3 We would encourage the Government as well to have a higher regard for voluntary, joint-working measures which help tackle long-term public health problems, and to acknowledge the leadership that the retail industry has taken to ban undertake age drinking. While we welcome the support that the Government has shown to measures such as our Think 21 and soon to be Think 25 policy, we would call on them to show a much greater awareness of the impact of these schemes when devising policy.

5.4 There needs to be a much clearer strategy of targeting problem drinkers and “at risk” groups, rather than adopting a disproportionate universal approach. This will mean a better use of public funds and resource and ensure an overall better overall public health outcome.

Working in partnership

5.5 The Government have previously shown an interest in the CAP partnership outlined in the section above (paragraph 4.20/4.21). We firmly believe that this is an excellent solution for not only tackling under-age drinking but driving more responsible consumption and behaviour. It also brings together a number of stakeholders to work collaboratively to tackle underage sales. We would urge the Government to:

- (a) Invest in the scheme and to roll it out more widely across the country, particularly in “hot spot” areas.
- (b) Encourage local authority Trading Standards and the police to positively engage with us and other supermarkets in adopting the CAP scheme.

Education and message

5.6 As a responsible retailer, we have devised and implemented a number of polices to educate our customers about alcohol at the point-of-sale. The Government needs to play a greater role, however, in educating children, parents and adult about the health effects and dangers of excessive drinking.

5.7 While we are happy to play our part in communicating to customers, the Government should also consider how it can use education in schools to reach children and parents and directly influence attitudes and behaviours towards alcohol.

Enforcement

5.8 We would urge the Government to ensure enforcement of current laws around under-age and proxy sales and to take appropriate action in law against those children or adults who buy alcohol and then pass in on to children. There are currently very few prosecutions. While this is a “law and order” issue, it is an important aspect in terms of establishing with young people a clear understanding about respecting alcohol and the knock on impacts in terms of child health/welfare/safety.

5.9 If the Government is serious about tackling under-age drinking then it needs to be working much closer with local authorities to ensure that there is not only a consistent message, but that the law is better enforced. We believe that this will act as a deterrent and lead to an immediate reduction in the number of underage and disorderly drinkers on the streets. The police must also play a role in following-up with parents of children who offend, or those offending parents, to reinforce the message that the purchasing of under-age/proxy sales is illegal.

Manufacturers

5.10 Sainsbury's has taken a pro-active and positive approach to the Department of Health's "Know Your Limits" alcohol health labelling for our own-label products. While some manufacturers have also implemented this initiative, we would encourage a quicker and greater take up by other manufacturers. Having uniformity and consistency in alcohol health labels will not only make things clearer for customers but help emphasise the recommended maximum daily intake, and number of units per beverage.

J Sainsbury plc

March 2009

Memorandum by ASDA (AL 22)

1. ASDA is the UK's second largest supermarket operating 346 food stores, employing 170,000 colleagues, and serving over 17 million customers every week.

2. We are grateful for the opportunity to submit evidence to the committee. We support measures which prevent the illegal sale of alcohol and target irresponsible drinkers. We do not, however, support blanket interventions that penalise all customers, including the majority who drink responsibly. In particular we would like to make observations around four policy areas currently under review:

- (1) Minimum pricing;
- (2) A ban on promotions;
- (3) Separate checkouts; and
- (4) The siting of alcohol.

EXECUTIVE SUMMARY

We have always been willing to work with Government to tackle alcohol misuse. However:

- We are against a minimum price for alcohol—either nationally set and nationally controlled or nationally set and locally controlled. A locally controlled minimum price makes it logistically impossible to operate a multiple retailer.
- Minimum Pricing and a ban on promotions disproportionately affects those on low incomes and is unfair. A severe economic recession combined with price controls make for a dangerous combination with real unintended consequences.
- Separate checkouts involve a huge cost burden for businesses large and small and are an inconvenience to customers. They do not decrease demand for alcohol, perversely they will make buying alcohol easier.
- Those affluent enough to access the Internet will be able to escape price controls and that cannot be fair to the customer or to a non-Internet business.

COMMENTS

3. We have devoted extensive resources to improve the way we sell alcohol and promote health issues with our customers. We recognise that the only way to change the UK's consumption of alcohol is for a cultural shift to take place. We have direct contact with 17 million customers, and can make this change by ensuring sales are legal and by helping customers to make healthy choices through clear labelling and supporting information.

4. We take the issue of alcohol misuse seriously and have already delivered eight key voluntary measures to ensure that we live up to our responsibilities on alcohol. Please see Appendix One for more detail.

5. We are ready to create a new way of selling alcohol that does not disadvantage the majority of drinkers who consume responsibly. We are however, deeply concerned at the unintended consequences that many of the new proposals being discussed would create, particularly proposals suggesting a system of minimum pricing and a ban on promotions with very considerable process difficulties for business. Actions such as those currently muted would seriously distort the market. The proposed mandatory code as it stands also makes no mention of the rewards given through loyalty cards and money off vouchers, these absolutely must be included if there is any possibility of a level playing field between retailers.

COMPETITION

6. We believe that both a proposal to introduce minimum pricing, and a proposal for a ban on promotions are incompatible with the Competition Act 1998 and the European Competition Treaty in that they will severely restrict the ability of businesses legitimately to compete with each other and provide genuine customer choice—they would, therefore, ultimately be detrimental to customers.

7. ASDA has represented value for over forty years and is opposed to lower income customers bearing the brunt of these proposed changes. In a time of recession, we do not think that hard-pressed, law-abiding customers should be asked to pay more for alcohol as a result of minimum pricing. We strongly believe that competition on price and on promotions is positive for customers. They have clearly told us that they would be concerned if Government initiatives were to put this at risk—please see Appendix Two to see our survey of 10,500 customers.

A BAN ON PROMOTIONS

8. We believe that a ban on promotions would punish the majority of responsible drinkers.

9. The Joseph Rowntree Foundation report A minimum income standard for Britain¹⁴⁷ sought to establish what the public considered was necessary to achieve an acceptable standard of living.

10. The report considers four different household types: single working age, pensioner couple, couple with two children, and lone parent with one child. Focus groups decided that for each household type some level of spending on alcohol was necessary to achieve an acceptable standard of living (p 18). In the case of a couple with two children, it was decided that only alcohol for consumption in the home was a necessity (p 33).

DO NOT PENALISE THE RESPONSIBLE MAJORITY

11. We are concerned that the most responsible, law-abiding customers are the ones who will lose out, and that individuals who create public order disturbances will continue to do so. In particular, it would be a severe unintended consequence for low income shoppers already hit by rising utility costs, rising fuel and food prices if new regulations were to hit responsible drinkers in lower income groups. The introduction of new price controls such as minimum pricing or a ban on promotions would further reduce their disposable income but, unlike with duty, would not deliver a single additional penny of revenue to the state. The benefit would effectively be privatised while the cost is socialised.

12. We are urging the Government to ensure that offers which deliver a reasonable amount of alcohol that a family may purchase at a discounted price are not put in jeopardy by any change to legislation. An example of what could clearly be considered a “reasonable amount of alcohol” would be ASDA’s current offer on wine delivering three bottles for £10. This cannot be classed as “binge drinking” when purchased as part of a full weekly shop. Three bottles of normal strength wine equals approximately 30 units of alcohol. The recommended safe level of alcohol according to the Department of Health for a couple over a week is 35 units.

LOCALLY SET PRICE CONTROLS AND MINIMUM PRICING

13. The draft mandatory code uses the phrase: “. . .the sale of very low priced alcohol to be prohibited or limited”. Significantly, we still have no clarification on the definition of “very low priced”. This is perhaps something for the committee to consider. This really is a subjective matter because to someone on benefits the current promotional offers at ASDA and many of our competitors will not be classed as “very low priced”. We look forward to understanding what is meant by this description and assume that the Government is referring to large pack offers. We believe from discussions with policy makers that it is primarily these very large packs of beer that are the focus of concern.

¹⁴⁷ Joseph Rowntree Foundation—A minimum income standard for Britain, July 2008.

14. We believe that currently policy makers are considering minimum pricing decided nationally and imposed locally. This is in serious risk of distorting the market. Councils already have considerable powers under the Licensing Act to impose conditions if they so choose. Such a system of pricing would raise many questions:

1. Do politicians really want to set the price of alcohol?
2. There will most certainly be legal appeals by manufacturers and retailers of own label products to the banning of their particular products when other competing products in the same category have not been banned. We question whether the financial resources of councils will be wisely used engaging the myriad legal challenges that will arise.
3. Are there any precedents for local authorities setting the price of goods in the private sector?

15. The concept of a locally administered minimum price is contrary to the principles of better regulation. How would local authorities ever be able to administer such a scheme—particularly if they had a “menu” of several different possible prices from which to choose? It is also possible that councils would have to consult before each change in price. They would also need clear guidance on how not to breach competition law.

16. If minimum pricing is controlled locally, there will clearly be an unfair and uncompetitive element for stores close to each other—where one store has minimum pricing imposed on it, and another store in the same vicinity doesn't. The implications for a distortion of competition in such circumstances are clear.

SEPARATE CHECKOUTS

17. We have picked up speculation, at odds with much of the Government's wider pro-customer, family friendly agenda about support for separate checkouts. Any decision to include separate checkouts in the mandatory or local codes would be challenged by us on better regulation grounds and because it is disproportionate. The premise behind this policy proposal is flawed and anti-customer in its practical day to day outcome. Separate checkouts do not result in lower alcohol sales, they only result in frustrated customers and a miserable shopping experience. All our stores in Northern Ireland have separate alcohol checkouts, yet our alcohol sales there remain very strong. BWS sales account for almost 12% of total sales in Northern Ireland compared with 10% for our North region as a whole.

18. There is a possibility that separate checkouts could actually make it easier to buy alcohol quickly, as shoppers would not have to join a conventional checkout queue behind customers paying for a full weekly shop. Perversely, customers who would be severely inconvenienced by the introduction of separate alcohol counters would be busy weekly shoppers who are purchasing a bottle of wine or a few cans of beer as part of their weekly family shop.

SITING OF ALCOHOL

19. Any considerations on the siting of alcohol, must allow a degree of flexibility so that sensible promotions, such as cheese and port at Christmas, are not included.

20. This flexibility must also take account of the different trading conditions at certain times of the year—for example the huge increase in demand over the Christmas period, and during the World Cup. It would be vital that any restrictions to siting allowed for derogations so that our colleagues and other shopworkers can serve customers in a safe and tolerable way. We support the concerns of USDAW on this matter.

SUMMARY

21. We believe that a mixture of education for customers, and a robust enforcement of current legislation in place to stop access to alcohol by those under 18, is the right way to tackle the issue of alcohol misuse. In particular, we would like to see real action taken against those who buy, or attempt to buy, alcohol for those under 18—action which currently is rarely taken.

22. We urge the committee to listen to all stakeholders before making recommendations on areas of alcohol policy which will have a real financial impact on the quality of life for millions of hard working families.

ASDA VOLUNTARY ALCOHOL MEASURES

We take the issue of alcohol misuse seriously and have already delivered eight key voluntary measures to ensure that we live up to our responsibilities on alcohol.

Our voluntary alcohol measures include:

- a universal roll-out of Challenge 25;
- stop selling alcohol at 100 of our town centre stores between midnight and 6.00 am (as highlighted in the recent Home Affairs Select Committee report);
- a fund to help educate young people on alcohol misuse;
- a doubling of 4,000 independent test purchases of our own people per year;
- the delisting of some products and reduction in alcohol content of others;
- introduction of the new UK Department of Health recommended wine label on our own brand wines;
- regularly providing information on responsible drinking through the ASDA Magazine which has a readership of five million throughout the UK; and
- the banning of “% extra free” alcohol packs.

Appendix Two

ASDA CUSTOMER SURVEY

We have commissioned an independent market research organisation to ask 10,000 of our customers their views on the key proposals. The results of that survey are shown below:

RESULTS OF ASDA CUSTOMER SURVEY

This survey consisted of 10,109 face-to-face interviews conducted with ASDA shoppers in 30 stores throughout Scotland. All interviews were conducted between 15 and 29 August 2008. The research was conducted by Market Research Society-trained interviewers from the Ace Fieldwork market research agency.

1. *The Scottish Government is concerned that alcohol is currently too cheap. The Government wants to set a fixed minimum price for alcohol to reduce the amount people drink. What do you think of this proposal, do you agree or disagree with it?*

1. Agree	3,385	33.5%
2. Disagree	6,170	61%
3. Don't Know	549	5.4%
4. No answer	5	0.0%

2. *The Government is also proposing to ban multi-product promotions (eg “3 for 2” and “Buy one Get one Free”) to reduce the amount people drink. What do you think of this proposal, do you agree or disagree with it?*

1. Agree	2,978	29.5%
2. Disagree	6,818	67.4%
3. Don't Know	309	3.1%
4. No answer	4	0.0%

3. *Of the two proposals outlined above (minimum pricing, and the banning of promotions), which do you think would be most effective in reducing alcohol consumption?*

1. Minimum Pricing	1,772	17.5%
2. Banning Promotions	1,997	19.8%
3. Neither	6,017	59.5%
4. Other	284	2.8%
5. Both	27	0.3%
6. No answer	12	0.1%

4. *The Scottish Government is considering that from September 2009, supermarkets would not be able to sell alcohol together with other items. This would mean customers would buy alcohol at a separate checkout and make two separate transactions. Do you agree with this proposal?*

1. Agree	2,190	21.7%
2. Disagree	7,405	73.3%
3. Don't Know	507	5.0%
4. No answer	7	0.1%

Memorandum by Professor Forrester Cockburn, Dr John McClure and Dr Margaret Watts (AL 23)

EXECUTIVE SUMMARY

Fetal alcohol spectrum syndrome and fetal alcohol spectrum disorders constitute a burden of harm associated with alcohol in the UK. In the absence of any structured surveillance or reporting systems the true nature and extent of this harm is unrecognised. As women's drinking in the UK increases, the potential for harm to the unborn generation also increases and action is needed to address this damage.

FETAL ALCOHOL SYNDROME IN SCOTLAND

1. Question: *In Scotland, what is the commonest known preventable cause of:*
 - *Microcephalus*
 - *Growth failure*
 - *Intellectual impairment*
 - *Speech and language disorders*
 - *Attention deficit hyperactivity disorders*
 - *Poor coordination*
 - *Violent behaviour?*
2. Answer: Fetal alcohol syndrome (FAS) and fetal alcohol spectrum disorders (FASD).
3. There are more embryos and fetuses damaged by maternal alcohol use in Scotland each year than the total number ever damaged by thalidomide.
4. There are more children with attention deficit hyperactivity disorder due to maternal alcohol ingestion during pregnancy than due to the exposure of children to food additives.
5. FASD is the umbrella term used to describe the range of permanent physical, mental and behavioural problems caused by maternal use of alcohol in pregnancy. Fetal alcohol syndrome (FAS) is the most readily recognised presentation of this condition.
6. The burden of alcohol-related harm in the next generation caused by drinking alcohol is largely unrecognised. There are no structured surveillance or recording systems in place for the screening, diagnosis, and estimation of incidence or prevalence of FAS or FASD in Scotland, or the wider UK. Estimates of incidence and prevalence are based on studies conducted elsewhere in the world, predominantly Canada and the United States of America.
7. In 2007, the British Medical Association Board of Science produced Fetal alcohol spectrum disorders a guide for healthcare professionals which uses such studies to indicate the potential burden of FASD in the UK.
8. We would like to urge the Inquiry to look specifically at FASD for the following reasons:
 - The condition is totally preventable; no mother who did not drink alcohol during pregnancy has ever had a child affected with FASD.
 - There is a lack of awareness of the effects of alcohol in pregnancy. This extends from professionals in health, social care and education services to women themselves and the wider public.
 - Awareness raising through bottle labelling, whilst of limited effect, does play a role in this and is used in the United States, Canada and France amongst other countries.
 - Whilst we have no accurate estimate of the size of the problem, small studies in Scotland indicate incidence of FAS as upward of 0.2/1,000 live births (Beattie *et al*, 1983; Watts, 2005). International data implies incidence greater than this—from 0.2–1.5/1,000 live births from surveillance (Bertrand *et al*, 2005) to rates of 55/1,000 identified through case finding. The incidence of FASD is considered to be five to ten times as great.

- There is no screening tool or other mechanism through which to identify the women whose babies will suffer damage in utero; evidence indicates that single binge drinking episodes can cause permanent harm although children born to heavy drinking women are more likely to be damaged. Since there is no identification possible of such women, public health principles must be applied to prevention and clear consistent advice given not to drink alcohol when pregnant or contemplating pregnancy.
- FAS and FASD are incurable, lifelong conditions and the neurological damage and behavioural consequences can be debilitating, resulting in inability to live independently. However, there is good evidence that early recognition and intervention, particularly before the age of six, will reduce the effects of FASD.
- In Scotland, and the UK, there is a lack of trained staff and of services for the identification, assessment and diagnosis, and subsequent management of affected individuals and their families at every life stage.
- Areas which are having success in treatment programmes (such as British Columbia) have established guidelines and dedicated expert resource services to support clinicians and practitioners in the field.

9. FAS and FASD form an area of harm caused by alcohol that has not been scrutinised in the UK. To continue to ignore these conditions at a time when women's drinking of alcohol continues to increase is detrimental to the future of the country and we would urge the Inquiry to address them in their review of alcohol related harm.

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March 2009

Memorandum by the British Retail Consortium (AL 24)

1. INTRODUCTION

1.1 The British Retail Consortium (BRC) is the trade association for retailers, including the majority of supermarkets, our members account for approximately 80% of all grocery sales.

1.2 Our members take their responsibility for the sale of alcohol extremely seriously, but it is only one part of their overall sales. Alcohol typically makes up 10% of the overall turnover of a supermarket. Consumers typically buy alcohol as part of their grocery shopping, our members estimate only 1% of sales from their stores are only for alcohol.

1.3 We have given details in the submission of how retailers sell alcohol and the role they are playing promoting responsible consumption. We are not, however, able in this submission or in oral evidence to give details on pricing and promotion that would fall foul of competition legislation.

2. EXECUTIVE SUMMARY

2.1 We believe major changes will only be achieved by changing our culture around alcohol, to do this will require all stakeholders to work together. Cultural change will not be achieved overnight.

2.2 BRC members have been at the forefront of measures to tackle illegal sales and promote responsible consumption.

2.3 We support measures which prevent illegal sales of alcohol and target irresponsible drinkers. We do not, however, support measures that penalise responsible sellers or blanket interventions that penalise all consumers, including the majority who are drinking responsibly.

3. BRC CONTRIBUTION TO RESPONSIBLE ALCOHOL CONSUMPTION

3.1 BRC members have devoted extensive resources to improve the way they sell alcohol and promote health issues with consumers.

3.2 BRC members recognise that the only way the UK will change its consumption of alcohol is for a cultural shift to take place and for that to happen, each stakeholder must contribute in their most effective way. For retailers, who have direct contact with millions of consumers that is by ensuring sales are legal and helping customers to make healthy choices through clear labelling and supporting information.

3.3 BRC members have led businesses in tackling under age sales. They were the core of businesses that created the Retail of Alcohol Standards Group (RASG) in 2005. RASG now covers the vast majority of the off-trade and has been extremely successful working in partnership. RASG pioneered the Challenge 21 principle, where all customers who appear to be 21 or under are challenged for recognised ID. If they do not have ID, then no sale takes place. Retailers are now further tightening this approach by introducing a challenge 25 principle.

3.4 RASG has also been successful through its partnership, both between retailers who have exchanged best practice on training and controls, and by working with stakeholders on the ground. The Community Alcohol Partnerships, created by RASG operate in local areas, bringing together retailers, local authorities, police and schools to reinforce the problems with underage sales. They have been extremely effective in tackling not only underage sales but also social problems associated with teenage drinking. There are currently a number of these being set up around the country.

3.5 Retailers have also been working with the Department of Health (DH) and customers to raise awareness of the unit content of alcohol. They have been changing all of their own brand labels to carry the official DH health label. By December 2008, our six largest members had changed 1,012 own brand lines (58% of the total) with more carrying the label every week.

3.6 Retailers are now engaged in campaigns to encourage customers to check the label as part of their consumption. Members are working with the Drinkaware Trust to put point of sale information in store raising awareness of the label and the need to check the unit content against recommended intake limits.

4. ALCOHOL PRICING AND PROMOTION

4.1 The price of alcohol has become an issue in recent years and we are keen to correct some myths. Firstly, we need to keep some perspective on the statement that alcohol is more affordable. Using figures from ONS, the BRC has tracked rises in average earnings, alcohol prices and RPI between 1990 and 2008. This shows that alcohol is more affordable, alcohol price rose by 85% in those 18 years and average incomes rose by 112%. However, food price rose by only 38% in that period and overall inflation by 60%. In other words, virtually everything retailers sell is more affordable, due to an increase in our earnings but alcohol prices have not come down in price quicker than food prices, which shows that grocers have not been over promoting alcohol compared to other products they sell.

4.2 The second myth is the suggestion that retailers routinely sell alcohol at below cost price. It would simply be unsustainable to do so, but we need to remember that grocers are extremely competitive in the UK with the average profit margin being 4%. Retailers are competitive at buying all their products and pass that on to consumers, a low profit margin means all products, including alcohol are offered at competitive prices, but that is different to below cost selling. There will be occasions where retailers, usually working with producers, may offer alcohol below cost, for example to encourage consumers to try a new product, but it isn't true to suggest retailers are routinely selling alcohol below cost.

5. CHANGING THE ALCOHOL CULTURE IN ENGLAND

5.1 We recognise that we need a change in the alcohol culture in the UK. Whilst we have supported measures to target irresponsible sales of alcohol, we believe real change will only be achieved by ensuring we all take responsibility for our own consumption.

5.2 We recognise that Government intervention is required as part of the solution. We have not objected to measures to tighten the responsibility of alcohol sellers to ensure they do not sell to young people and drunks. Irresponsible sellers should be targeted and stopped and BRC members have accepted their responsibility by improving practices and controls working with other retailers in RASG.

5.3 We do not believe, however, that intervention should be extended to the way legitimate retailers promote and sell alcohol. We believe intervention to outlaw promotion simply penalises the vast majority of consumers who drink responsibly. The Government's own figures have shown not only is alcohol consumption falling but so has the section of the population that is drinking irresponsibly. There is, undoubtedly a section of the population that drink harmfully but they are in the minority and it would be wrong to penalise the majority of consumers who drink responsibly. Measures need to be evidence based and targeted at those irresponsible drinkers, particularly as it is clear that major increases in price, even above our current prices, would be necessary to make a small impact on overall consumption.

5.4 We support the Government targeting three sections of the population, the young, the young binge drinkers and the older harmful drinker. Retailers are playing their role by using their resources to control sales and use their stores to promote responsible consumption.

5.5 In terms of the first group, retailers have led the way in preventing sales to underage persons, and it is no accident that the supermarkets consistently have the best record in test purchasing campaigns. We feel the Community Action Partnerships, co-ordinated by RASG demonstrate a great way to combat wider alcohol problems. Working at a local level, with police, local authorities and schools it means all are reminded of the legal controls in place as well as providing a forum to explain to young people their responsibilities in the way they approach alcohol. The results are improved control on sales, reduced disorder and education for young people at a crucial stage in their development.

5.6 We believe, however, more is needed to control young persons' access to alcohol. The supply from retailers has been reduced but it is clear young people are still obtaining alcohol, which means they must be getting it from older peers or parents. We have always supported more controls on proxy purchasing and have supported the measures in the Policing and Crime Bill to make it easier for police to confiscate alcohol from young people.

5.7 In terms of the binge and harmful drinkers, retailers are at the forefront of education to inform customers of the alcohol they are consuming and their total consumption against recommended limits. Retailers were the first to begin rolling out the DH label on products and are now supporting it through point of sale and in store information to support the new labels.

5.8 Retailers have a good record in labelling and helping consumers think about sensible consumption from their work in nutrition and health and have applied the same learnings to alcohol consumption.

5.9 We believe that whilst enforcement and intervention can play a part, we will only see real change through co-ordinated education and information campaigns. The Government campaigns on the dangers of binge drinking and raising unit awareness mean consumers are better informed to use the information on sensible drinking on the products they buy from our members.

5.10 In conclusion, we believe major change in the way we approach and consume alcohol and that will rely on an improvement in our understanding of the risks of excessive drinking. That will only be achieved by education and information provided by retailers, government, schools and parents. This will not provide the immediate change that some demand but is the only sustainable way to change alcohol culture.

British Retail Consortium

March 2009

Memorandum by the Institute of Alcohol Studies (AL 25)

EXECUTIVE SUMMARY

1. INTRODUCTION

1.1 The IAS welcomes this opportunity to present its views to the Health Select Committee on what is now widely recognised as a major public health issue and one that is likely to place an even greater burden on health services in the future than at present.

1.2 The IAS welcomes the considerable progress that has been made in tackling alcohol-related harm since the inception of the National Harm Reduction Strategy, published in 2004. Although universally criticised by the public health community for being largely preoccupied with issues of alcohol-related crime and disorder, there is now a general acceptance that "Safe. Sensible. Social. Next Steps in the National Alcohol Strategy" takes a much superior approach. The impact of alcohol consumption on health issues needs to remain at the forefront of policy.

1.3 The IAS welcomes, in particular, the introduction of Public Service Agreement 25 as part of a much improved framework at local level for commissioning health and social care, including Joint Strategic Needs Assessments and the national health indicators which now include alcohol-related hospital admissions.

Public Health

1.4 Given the known public health benefits of reduction in per capita consumption of alcohol, the Government should consider setting a clear target for ensuring that overall alcohol consumption does not increase further and should preferably set a target of a decrease in consumption over the next five years.

1.5 To reduce the impact and scale of ill health related to alcohol consumption, the IAS considers that the Government should prioritise the following areas:

- 1.5.1 changes to primary legislation to allow for the introduction of public health considerations as a new licensing objective.

Driving

- 1.5.2 the introduction of high visibility roadside checks with evidential roadside breath testing and a lowering of the Blood Alcohol Level to 50mg% in general and 20mg% for young and novice drivers.

Promotion and finance

- 1.5.3 the introduction of the amendments to the duties on alcohol as proposed in the Pre-Budget Report 2008 without concession to the current financial downturn;
- 1.5.4 the introduction of a mandatory code of practice for the promotion, advertising and sale of alcoholic beverages;
- 1.5.5 increasing the quality and range of alcohol intervention services for those who wish to reduce their alcohol intake or stop drinking altogether; and
- 1.5.6 carry out further investigation into the hidden harm caused by alcohol to third parties, including older people and adults as well as children and young people.

1.6 The IAS welcomes the shift in emphasis towards low risk guidelines and away from “sensible limits”. An appreciation of risk associated with alcohol consumption at all levels is required to change cultural attitudes and norms. The introduction of a “Less is Better” message would provide greater coherence to the public health approach to reducing alcohol related harm.

1.7 The IAS welcomes the emphasis on delaying the onset of drinking contained within the draft guidelines issued by the Chief Medical Officer on the Consumption of Alcohol by Children and Young People.

2. THE SCALE OF ILL-HEALTH RELATED TO ALCOHOL MISUSE

2.1 The IAS recognises the significant advances that have been achieved over this decade in improving information systems and in the collection and collation of alcohol-related data at global, European, national and local levels.

2.2 The scale of the known direct burden of ill health associated with alcohol is astounding and is responsible for 4.4% of the global burden of disease. Harmful use of alcohol is now the third leading risk factor to health in developed countries. (WHO A61/13, 20 March 2008)

2.3 The corresponding burden of ill health in Europe and in the UK is well documented and need not be repeated here. However, we would wish to draw attention to several key indicators that point to a longer term trend in alcohol-related harm and that emphasise the need for Government to adhere to a long-term strategic public health approach to deal with the harmful consumption of alcohol.

2.4 The World Health Organisation Regional Office for Europe HBSC International Report, “Inequalities in Young People’s Health” (2008) states that the “specific characteristics of the initiation into alcohol (such as drinking at family gatherings and feeling drunk) and early drinking styles (drunkenness-orientated consumption) are particularly predictive of later problems with alcohol.” (Section 4 p 127) English, Welsh and Scottish 15 year olds who report first drunkenness at age 13 or younger feature in the top eight of countries and in the top four (with Lithuania) for 13 year olds who report having been drunk at least twice.

2.5 The IAS considers that early initiation into harmful patterns of drinking and alcohol-related antisocial behaviour such as those highlighted in the Government’s Youth Alcohol Action Plan can lead to later problems with alcohol and welcomes the emphasis in the Chief Medical Officer’s guidelines on delaying the onset of drinking for under 15 year olds.

2.6 A key indicator of longer term damage is liver cirrhosis and the upward trend since the mid-90s to 2005–06 for both men and women highlights the need for long-term public health approaches to reduce per capita consumption. Figures for total alcohol-related hospital admissions show an increase from 147,659 in

2003–04 to 207,788 in 2006–07.¹⁴⁸ The sharp increase in levels of alcohol-related harm across all diagnoses for males and females aged 35 to 65 points to the need to take concerted and strategic action using all available means.

2.7 Although the scale of the known direct burden of ill-health associated with alcohol is high, the IAS considers that a significant additional burden of ill-health goes undetected. The impact of harmful alcohol use on third parties warrants further and systematic investigation.

3. THE CONSEQUENCES FOR THE NHS

3.1 The disease burden caused by the harmful use of alcohol is avoidable but the cost, in the main, is borne by health services. The ill health burden relates to volume of alcohol consumed over time, or frequent drinking episodes that lead to intoxication and to risk factors for neuropsychiatric disorders, alcohol use disorders and dependence and communicable and non-communicable diseases.

3.2 For this reason, the consequences for the NHS are both profound and far-reaching, impacting the whole spectrum of services from neonatal care to healthcare for the elderly.

3.3 Alcohol-related harm will also impact the NHS as a major employer and alcohol policies for the workforce will need to take into account the risks related to alcohol consumption on work performance and the opportunities that exist to offer helpful interventions in the workplace.

3.4 The demands placed upon the whole spectrum of health services by alcohol-related ill-health means that there is a requirement for increasing the availability and accessibility of training and awareness for staff at all grades and in all settings.

3.5 The IAS welcomed the publication of the Models of Care for Alcohol Misusers and the introduction of local planning and implementation structures. However, the Government should also ensure, through audit and inspection, that the needs of alcohol misusers and third parties are adequately met at all tiers of service.

3.6 In the current economic climate there is a real risk that local and national decisions will be made to disinvest in alcohol prevention and direct services. The IAS considers that, due to the present and likely future burden of demand on the NHS from alcohol-related ill-health, this is not the time for disinvestment but for greater investment in cost-effective interventions, particularly in partnership approaches with Local Authorities and the Police, to reduce the burden on acute services, identification and brief advice services in primary care, and integrated, multi-tiered services for those with complex needs and dependency.

3.7 Equally, the burden of evidence points to cost effectiveness of other policy options to reduce alcohol-related harm. These include a combination of measures that target the population at large, vulnerable groups, affected individuals and particular problems such as drinking-driving and alcohol-related violence. Reducing the public health impact will require the Government to regulate the availability, marketing and pricing of alcohol as well as supporting the NHS in its response to the consequences of alcohol consumption.

4. CENTRAL GOVERNMENT POLICY

4.1 Public health objectives should be paramount in defining responses and when defining objectives and targets for national policies, strategies and action plans.

4.2 The Government should review primary Licensing legislation and introduce public health as a new licensing objective.

4.3 The adjustments to duties on alcoholic beverages announced in the 2008 Budget and the Pre-Budget Report (November 2008) should be adhered to despite the changing economic climate. Addressing the affordability of alcohol is a key issue for the immediate and longer term reduction in the burden of alcohol-related ill-health as the Government itself has recognised. Tax increases will save thousands of lives and reduce the overall burden on the NHS over time.

4.4 Recent reports have confirmed the influence of alcohol marketing and promotion on consumption and harm:

1. Independent review of the effects of Alcohol pricing and promotion
ScHARR, University of Sheffield
Project report for the Department of Health—September 2008
2. Does marketing communication impact on the volume and patterns of consumption of alcoholic beverages, especially by young people?—a review of longitudinal studies
Scientific Opinion of the Science Group of the European Alcohol and Health Forum—February 2009

¹⁴⁸ “Total admissions to hospital in which the patient had a primary or secondary diagnosis which was alcohol-related at the start of his/her stay for 2003–04 to 2006–07” Statistics deposited in House of Commons Library in response to a parliamentary question from James Brokenshire on 13 October 2008

3. The affordability of alcoholic beverages in the European Union—Understanding the link between alcohol affordability, consumption and harms

Report prepared by RAND for the European Commission DG SANCO—February 2009

4.5 The Home Office has also recently reviewed the Social Responsibility Standards for the production and sale of Alcoholic Drinks. The IAS considers that a mandatory code of practice for producers, promoters and retailers should be introduced. Whilst such legislation may require primary enabling legislation, it may also be achieved by an amendment to the Licensing Act 2003. The Act already contains enabling sections to which a mandatory code could be added.

4.6 The IAS, in its response to the latest Department for Transport consultation on Road Safety, has supported the introduction of random breath testing at high visibility roadside checkpoints, together with the reduction to 50mg% of the legal blood alcohol level for driving and 20mg% for young and novice drivers. The combined effect of these countermeasures, together with other strategic responses referred to above, should result in the reduction of alcohol-related injury, death and ill-health.

4.7 Economic operators with a vested interest in the promotion, marketing and sale of alcoholic beverages should not decide public health policy and their contributions should be confined to the implementation of policy.

5. THE ROLE OF THE NHS AND OTHER BODIES INCLUDING LOCAL GOVERNMENT, THE VOLUNTARY SECTOR, POLICE, THE ALCOHOL INDUSTRY, AND THOSE RESPONSIBLE FOR THE ADVERTISING AND PROMOTION OF ALCOHOL

5.1 The NHS is a main stakeholder at local and national level and can effectively reduce the harmful use of alcohol by providing direct services, engaging in partnerships and advocating with Government for the introduction and implementation of effective public health policies.

5.2 In addition, the IAS considers that the NHS is in a critical position to develop adequate mechanisms for the assessment and reporting of alcohol-related harm to third parties, and that surveillance and information systems within the NHS and across partnerships need to be developed. The aim would be to capture the impact on health (including injuries), mental health, social well-being of third parties including children's health and older people's health.

5.3 The NHS and its workforce has a role in providing leadership around values, appropriate public health strategies and interventions aimed at reducing alcohol-related harm.

5.4 One of the roles of the voluntary sector is to support advocacy, research and capacity building.

5.5 Alliances can be formed across the voluntary sector to share information and good practice. Specialist alcohol voluntary sector organisations benefit from sharing knowledge and expertise with non-specialist but related organisations. These include voluntary organisations involved with older people, young people and children, medical research organisations, liver, heart and cancer charities and social and development charities.

5.6 The IAS welcomed the establishment of the Alcohol Health Alliance and is a participating member.

5.7 The voluntary sector can provide some capacity to evaluate programmes, and assess the impact of strategies and initiatives. It can also work in partnership to implement strategies and to develop innovative approaches and actions.

5.8 The voluntary sector also has the role of alerting the Government to areas of particular concern and of representing the voice of individuals and groups who are adversely affected by alcohol consumption directly or indirectly. The IAS is currently involved with Age Concern and others in examining the impact of alcohol use on the older population.

6. SOLUTIONS, INCLUDING WHETHER THE DRINKING CULTURE IN ENGLAND SHOULD CHANGE, AND IF SO, HOW

6.1 Knowledge alone will not affect the cultural shift required to significantly reduce the levels of harm currently being experienced in the UK.

6.2 Cultural expectations are currently centred around intoxication and regular frequent use and the combination of both is damaging in the short and long term.

6.3 Solutions will rely on a combination of formal and informal measures and Government will need to demonstrate leadership in introducing public health measures in order to support the efforts of the NHS and other partners in dealing with the consequences of harmful alcohol consumption. Raising prices, addressing availability and affordability, a mandatory code of practice for the industry and investment in health care will send out the right message and will create an environment for change.

6.4 The Government, together with relevant stakeholders, should also review informal measures and the content of educational/awareness messages. The IAS welcomed the introduction of the concept of "risk" as opposed to "sensible limits" and would support the change of emphasis to a message of "less is better" in order to provide coherence with public health policy.

6.5 Challenging existing values and norms is required to effect change.

The IAS is mindful of the five ethical principles and goals for alcohol policy set out in 1995 and adopted by the WHO at the Conference on Health, Society and Alcohol in Paris.

1. All people have the right to a family, community and working life protected from accidents, violence and other negative consequences of alcohol consumption.
2. All people have the right to valid impartial information and education, starting early in life, on the consequences of alcohol consumption on health, the family and society.
3. All children and adolescents have the right to grow up in an environment protected from the negative consequences of alcohol consumption and, to the extent possible, from the promotion of alcoholic beverages.
4. All people with hazardous or harmful alcohol consumption and members of their families have the right to accessible treatment and care.
5. All people who do not wish to consume alcohol, or who cannot do so for health or other reasons, have the right to be safeguarded from pressures to drink and be supported in their non-drinking behaviour.

March 2009

Memorandum by Scottish Health Action on Alcohol Problems (AL 26)

1. EXECUTIVE SUMMARY

- Problem alcohol use currently represents one of the biggest threats to public health in the UK. Whilst rates of heart disease and cancer have fallen, death rates and hospital admissions for alcohol-related causes have steadily and sometimes dramatically increased.
- The increase in alcohol-related health harm is putting severe pressure on the NHS. Evidence suggests that the capacity of health services to provide support and treatment for alcohol problems falls far short of demand.
- The increase in alcohol-related health harm is clearly linked to a rise in alcohol consumption in the UK over the past few decades. The main solution to lowering rates of alcohol health harm, and thus relieving pressure on NHS services, must lie in reducing *per capita* alcohol consumption in the UK.
- An overwhelming amount of evidence indicates that the most effective and cost-effective means of reducing the burden of alcohol harm are by implementing controls on the price and availability of alcohol.
- Alcohol is no an ordinary commodity. It is a dependence-inducing, psychoactive drug that is linked to around 60 different types of disease, disability and injury. Problem alcohol use harms individuals as well as our society as a whole. It is therefore entirely proper for government to regulate the availability of alcohol in the interests of public health and the wider public good.

2. ABOUT SCOTTISH HEALTH ACTION ON ALCOHOL PROBLEMS

2.1 Scottish Health Action on Alcohol Problems (SHAAP) was established in 2006 by the Scottish Medical Royal Colleges and Faculties to provide an authoritative medical voice on reducing the negative impact of alcohol on the health and well-being of the people of Scotland. Members of SHAAP include consultants in accident and emergency medicine, gastroenterologists, psychiatrists, public health specialists, general practitioners and nurses—all with first-hand experience of the adverse affect that alcohol can have on individuals and our health services. SHAAP is a member of the Alcohol Health Alliance UK, an alliance of medical bodies, patient representatives and alcohol health campaigners working together to highlight rising levels of alcohol health harm in the UK.

2.2 Political devolution in Scotland means the Scottish Parliament and Government can implement measures to address alcohol health harm independently of Westminster, and indeed the alcohol strategies adopted by the two countries reveal quite different approaches to tackling alcohol-related harm. However, not all aspects of alcohol policy fall under the remit of the devolved administration. Areas such as alcohol taxation, advertising, sponsorship and drink-drive limits are reserved powers. In addition, the close political, geographical and economic links between Scotland and England mean that policies developed in one country will have a bearing on the other, particularly when it comes to regulatory interventions such as price controls. It is for these reasons that SHAAP is making a submission to the House of Commons Health Committee Alcohol Inquiry.

3. THE SCALE OF ILL-HEALTH RELATED TO ALCOHOL USE

3.1 Alcohol-related health harm as measured by hospital admissions and death rates has increased markedly in the UK over the past decade. The number of alcohol-related deaths almost doubled between 1991 and 2004.¹⁴⁹ Although the latest figures on alcohol-related deaths in 2007 show a levelling-off following year on year increases during the 1990s, it is too early to say whether this change is going to be sustained.¹⁵⁰ Across the UK there is a clear link between alcohol health harm and deprivation, with people in poorer communities more likely to die an alcohol-related death than people in richer communities.¹⁵¹

3.2 Cirrhosis accounts for most alcohol-related deaths in the UK and evidence shows that the majority of chronic liver disease and cirrhosis deaths are alcohol-related. This makes chronic liver disease and cirrhosis rates an important indicator of the extent of alcohol-related health damage in a society. Over the past 30 years, UK liver cirrhosis mortality has risen over 450% across the population as well as peaking at a younger age.¹⁵² Death rates have increased across the UK at a time when rates in most of Western Europe are falling.¹⁵³ In parts of Scotland alcoholic liver disease has now overtaken heart attacks as the main cause of premature death amongst men.¹⁵⁴

3.3 The definition of alcohol-related deaths includes only those causes regarded as being directly due to alcohol consumption, whereas alcohol is known to be a contributory factor in many other illnesses such as cancer, stroke and heart disease, as well as being linked with brain disorders such as dementia. It is estimated that around 6% of UK cancer deaths could be avoided if people did not drink.¹⁵⁵

3.4 Alcohol-related health harm is not just restricted to chronic disease or physical illness. Alcohol is recognised as a contributory factor in accidents on the road, at home and in the workplace, as well as being strongly linked with acts of violence and social disorder. It is estimated that up to a third of all attendances at hospital Accident and Emergency departments are alcohol-related.¹⁵⁶ There is also a strong link between alcohol and mental health problems. The most common admissions to NHS hospitals in the UK where alcohol was specifically related to the primary diagnosis involved mental and behavioural disorders due to alcohol. In England, admissions for this reason have increased by nearly 40% over the past decade.¹⁵⁷

4. REASONS FOR INCREASED ALCOHOL-RELATED HEALTH HARM

4.1 Alcohol health harm in the UK has risen in line with an increase in alcohol consumption, which has more than doubled over the past 40 years.¹⁵⁸ For most health conditions in which alcohol is a significant factor, there is a dose-dependent relationship. That is, the more alcohol is consumed, the greater the risk of alcohol-related health harm. This relationship can be observed both at the individual and the population level. It is now well established that the average population consumption is directly related to the burden of alcohol-related harm: the higher the average *per capita* consumption, the greater the harm. Conversely, if the average population consumption is reduced, the overall burden will be reduced.

4.2 A number of economic, environmental and cultural factors may explain why alcohol consumption has increased in recent years:

- A liberalisation of licensing laws has led to alcohol being sold in more places and for longer periods of time, meaning that it is much more accessible and easy to obtain than in the past.
- More competition between alcohol retailers has driven down the real cost of alcohol, with alcohol presently being 69% more affordable than it was in 1980.¹⁵⁹ The cheaper alcohol has become, the more consumption has gone up.
- The UK alcohol market is multi-million pound industry dominated by big global alcohol producers who spend millions marketing specifically-designed products aimed at capturing new consumers, such as young people and women.¹⁶⁰
- Changing attitudes towards drinking, particularly amongst women, has contributed to increased overall consumption. In our society, drinking alcohol is now completely socially acceptable and occupies a central place in how we spend our leisure time. Everyday drinking and drinking to excess are viewed as entirely normal drinking behaviours to the extent that public reaction to government recommended drinking limits is very often one of utter incredulity.

¹⁴⁹ *Trends and geographical variations in alcohol-related deaths in the UK, 1991–2004*, ONS, Spring 2007.

¹⁵⁰ *Health Statistics Quarterly*, No 41, Spring 2009, ONS.

¹⁵¹ *Alcohol Statistics Scotland 2009*, ISD, 2009. *Indications of Public Health in the English Regions: Alcohol*, APHO, 2007.

¹⁵² *Calling Time: The Nation's drinking as a major health issue*, Academy of Medical Sciences, 2004.

¹⁵³ Leon D A & McCambridge J (2006) "Liver cirrhosis mortality rates in Britain from 1950 to 2002", *The Lancet*, Vol 367, 52–56.

¹⁵⁴ *Health in Scotland 2007: Annual Report of the Chief Medical Officer*, NHS Scotland, Dec 2008.

¹⁵⁵ *Alcohol and cancer risk*, Cancer Research UK, <http://www.cancerresearchuk.org/>

¹⁵⁶ *Alcohol Harm Reduction Strategy for England*, The Prime Ministers Strategy Unit, 2004.

¹⁵⁷ *Statistics on Alcohol: England 2007*, The Information Centre, 2007.

¹⁵⁸ Tighe A. (ed) *Statistical Handbook 2007*, Brewing Publications Ltd.

¹⁵⁹ *Alcohol Statistics Scotland 2009*, ISD, 2009.

¹⁶⁰ Hastings, G *et al.*, "Alcohol Marketing and Young People's Drinking: A review of the research", *Journal of Public Health Policy*, 2005 (26) 296–311.

5. CONSEQUENCES FOR THE NHS

5.1 As the statistics on alcohol-related health harm indicate, the impact of alcohol on the NHS extends across many services including accident and emergency, mental health, gastroenterology, and cancer treatment services. The annual cost to the NHS of treating alcohol-related conditions is estimated at £1.7 billion in England and £405 million in Scotland.¹⁶¹

5.2 Evidence suggests that the NHS is struggling to meet the growing demand for alcohol-related treatment services. Needs assessment work¹⁶² has revealed a lack of capacity in psychological therapies, specialist addiction services and a lack of implementation of prevention strategies, such as screening and brief interventions in primary health care, which is known to be effective (and cost-effective) in reducing hazardous and risky drinking. Alcohol Health Alliance UK has highlighted the absence of dedicated funding for alcohol treatment in contrast to drug treatment.

5.3 Evidence also suggests that unless measures are taken to significantly reduce the health harm caused by alcohol use, then the pressure on NHS services will mount. Currently, surveys of drinking behaviour reveal a high percentage of abstainers in the oldest age groups. However, this position is likely to change in the near future if generations of people who have grown up in a culture of regular and often excessive alcohol consumption continue to drink at the same rate as they age.¹⁶³ It has been recently reported that hospital admissions for alcohol-related causes in the over-65s have increased by two-thirds over the past four years.¹⁶⁴

6. SOLUTIONS

6.1 Increased alcohol-related health harm is linked to increased alcohol consumption and therefore the main solution to lowering the burden of harm from alcohol use lies in reducing the amount of alcohol consumed. The UK population needs to drink less and drink less often.

6.2 Whilst there is clearly a need to invest in the provision of adequate treatment and support services so that individuals can get the help they require to address problem alcohol use, the major focus of any health policy related to alcohol use should be on prevention. Most alcohol-related health harm is avoidable. If we can reduce the risk to individuals of experiencing alcohol harm then a large percentage of NHS resources that are currently invested in treating alcohol-related conditions and the victims of other people's alcohol misuse can be redirected to other uses.

6.3 A substantial body of evidence exists indicating which interventions are likely to be successful in reducing alcohol-related health harm.¹⁶⁵ The most effective interventions are increasing alcohol price (taxation and minimum pricing), restricting the availability of alcohol, enforcing a minimum legal purchase age, low BAC limits, random breath testing for drivers, and brief interventions for hazardous and harmful drinkers. Education and public awareness campaigns are costly to implement and as stand-alone measures are the least effective means of changing drinking behaviour.¹⁶⁶ If education approaches are used they should be implemented in conjunction with other more effective interventions. For example, mass media campaigns have been used to reinforce the ban on drink driving. The combination of regulatory intervention backed up by public awareness-raising has been effective in reducing the incidence of drink-driving which was once a widely accepted practice.

6.4 Effective interventions to reduce the burden of alcohol health are also likely to have an influence on changing our drinking culture. If the evidence suggests that environmental factors such as the pricing, promotion and marketing of alcohol and its increased availability has influenced population drinking patterns and behaviours over the past few decades, then it is highly likely that effective interventions that address these environmental factors will contribute to a changed, healthier drinking culture.

7. RECOMMENDATIONS

7.1 General

In Scotland, the government has published a framework for action for tackling alcohol misuse that proposes a set of robust policy measures to reduce harm, including a ban on irresponsible price promotions, the introduction of a minimum price for alcohol, and separate display areas for alcohol in retail outlets.¹⁶⁷ SHAAP believes that the Westminster Government should adopt the same measures so that the whole UK population can benefit from policies that are known to be the most effective in reducing harm. The Sheffield

¹⁶¹ *Costs of alcohol use and misuse in Scotland*, Scottish Government, 2008. *Indications of Public Health in the English Regions: Alcohol*, APHO, 2007.

¹⁶² *Alcohol Needs Assessment Research Project (ANARP): The 2004 national alcohol needs assessment for England*, Department of Health, 2005.

¹⁶³ See *Alcohol and Ageing*, Health Scotland, March 2006.

¹⁶⁴ "NHS treating more older drinkers", *BBC*, 5 March 2009.
<http://news.bbc.co.uk/1/hi/health/7922002.stm>

¹⁶⁵ Babor *et al*, *Alcohol: No ordinary commodity*, 2003.

¹⁶⁶ *A review of the effectiveness and cost-effectiveness of interventions delivered in primary and secondary schools to prevent and/or reduce alcohol use in under 18s*, NICE, June 2007.

¹⁶⁷ *Changing Scotland's relationship with alcohol: A framework for action*, The Scottish Government, March 2008.
<http://www.scotland.gov.uk/Publications/2009/03/04144703/0>

Study on alcohol pricing and promotion, commissioned by the Department of Health, found that policies which lead to price increases reduce consumption and can have significant effects on reducing alcohol-related harm. The results of the study showed that targeting price increases at cheaper types of alcohol would affect harmful and hazardous drinkers far more than moderate drinkers. There is strong evidence to suggest that young drinkers, binge drinkers and harmful drinkers tend to choose cheaper drinks, which underlines the importance from a public health perspective of introducing minimum pricing for alcohol.¹⁶⁸

7.2 *Mandatory retail code for alcohol industry*

The Department of Health has been consulting a new retailing code for the alcohol beverage industry following the findings by KPMG that voluntary self-regulation by the industry has failed in preventing many irresponsible and harmful practices in the sales of alcoholic drinks.¹⁶⁹ SHAAP believes that if a new retailing code is to be successful in preventing harmful retail practices then it must be made mandatory and enforceable by law. As well as addressing irresponsible pricing practices, a new code should ban drinking games, organised pub crawls, marketing and other forms of entertainment that encourage excessive drinking, such as inducements by DJs to consumers to drink greater quantities and encouragement to drink more and faster through shots and shooters being “downed in one”.

7.3 *Relating to reserved powers*

Advertising—SHAAP believes that the UK should follow France and introduce a complete ban on alcohol advertising and sponsorship. The UK system of advertising regulation has been viewed as ineffective by the WHO and other international bodies and SHAAP believes that policy on this needs to be re-examined in light of the emerging evidence base that alcohol marketing does have an effect on drinking behaviour. The most recently reported research indicates that people are more likely to drink alcohol whilst watching TV after seeing drinking portrayed in films or adverts.¹⁷⁰ The alcohol industry spends millions of pounds a year in advertising and cumulative exposure to these campaigns which suggest that drinking is socially desirable and attractive may reinforce negative drinking behaviours.

7.4 *Reduction of drink-drive limit*

SHAAP believes that the UK Government should reduce the drink-drive limit from 80mg per 100ml of blood to 50mg, in line with most other European countries. Research suggests that as many as 65 fatalities per year could be prevented by lowering the limit.¹⁷¹

7.5 *Alcohol taxation*

SHAAP welcomes the increase in alcohol taxation announced in last year’s budget and hopes that the above inflation increases over the next few years will be implemented as announced.

March 2009

Memorandum by Professor Eileen Kaner (AL 27)

BACKGROUND

Professor Kaner leads a programme of research on alcohol and public health at Newcastle University. Her research aims to understand the nature and extent of alcohol-related risk and harm across populations, and to promote evidence-based interventions to reduce these problems. To date, she has published over 70 peer reviewed papers and won over £12 million in research income from a range of competitive sources. She currently co-leads the three national SIPS (Trailblazer) trials which are evaluating screening and brief alcohol intervention approaches in primary care, accident and emergency departments and criminal justice settings. Her research programme also includes funded projects on substance use in pregnant women and in young people. Professor Kaner recently led a national review of liver disease epidemiology, treatment and service provision in England for the Department of Health and is currently leading a review of the risks and benefits of alcohol consumption in children and adolescents for the Department of Children, Families and Schools. The latter forms the scientific basis for recently announced guidance for parents on alcohol consumption in children and young people. Professor Kaner is a Trustee and board member of the Alcohol

¹⁶⁸ Independent Review Of The Effects Of Alcohol Pricing And Promotion: Part B Modelling the potential impact of pricing and Promotion policies for alcohol in England: Results from the Sheffield alcohol policy model, Department of Health, December 2008.

¹⁶⁹ *Review of the Social Responsibility Standards for the production and sale of Alcoholic Drinks*, KPMG for the Home Office, April 2008.

¹⁷⁰ “Alcohol on TV prompts drinking”, BBC, 4 March 2009.

¹⁷¹ *Changing Scotland’s relationship with alcohol: a discussion paper on our strategic approach*, The Scottish Government 2008.

Education and Research Council. She is also Chair of the National Institute for Health and Clinical Excellence (NICE) programme development group on the prevention of alcohol use disorders in adults and adolescents. In addition, she was recently appointed to the Science task-force of the European Forum on Alcohol and Public Health. Lastly, she is a member of a range of National and Regional Advisory bodies on alcohol and an expert advisor to BMJ Public Health, the World Health Organisation and numerous other public bodies.

1. EXECUTIVE SUMMARY

The problems of alcohol misuse extend far beyond “alcoholism” or even severe alcohol dependence. Excessive drinking is responsible for a wide range of health and social problems.¹⁷² Internationally, excessive drinking contributes 4% to the total global disease burden, as measured by disability-adjusted life years (DALYS).¹⁷³ This burden is more evident in developed countries (such as the UK), where alcohol ranks third after smoking and hypertension as the leading cause of morbidity and premature death.¹⁷⁴ Indeed, 3% of deaths worldwide are caused by excessive drinking.¹⁷⁵

Rates of mortality due to liver cirrhosis are an important indicator of population levels of alcohol harm. In Britain, cirrhosis mortality rates have steeply increased over the past 30 years, particularly in men in Scotland (104% increase) but also in men in England and Wales (69% increase).¹⁷⁵ The corresponding mortality increases in women were 46% in Scotland and 44% in England and Wales.¹⁷⁵ This rise in alcohol-related mortality is significant because European Union rates for liver cirrhosis have reduced by 30% over the same time period.¹⁷⁵

In England, the first national alcohol needs assessment in 2004 reported that 38% of men and 16% of women (aged 16–64 years) had an alcohol use disorder (see below), which is equivalent to 8.2 million people.¹⁷⁶ Of this total, just 1.1 million people were alcohol dependent. Thus, when those at risk of harm due to alcohol consumption are added to those who have already experienced harm, the proportion of people adversely affected by alcohol approaches one in four of the adult population.¹⁷⁷ This proportion is similar to the number of people whose health is directly affected by smoking.

The full impact of alcohol upon the health and well-being of individuals and the wider community is difficult to quantify because of many hidden effects resulting from its use. This includes increased levels of violence, accidents and suicide.¹⁷⁸ Many of the social problems arising from alcohol misuse affect individuals other than the drinker, such as family members including children and victims of alcohol-related crime and disorder who may not be known by the offender.

In 2004, excessive drinking cost the UK approximately £20 billion each year.¹⁷⁸ More recently, the cost has been estimated as closer to £25 billion. Much of this cost is incurred by health, social care and criminal justice services as they respond to the consequences of heavy drinking.

Since excessive drinking is responsive to even brief intervention in community-based settings,¹⁷⁹ it is imperative that the public health community acts to prevent alcohol-related risk and harm across the population.

2. TERMINOLOGY

When considering alcohol-related problems, it is helpful to disentangle a confusing terminology which involves both lay and technical language. In particular, it can be difficult to distinguish between terms such as alcohol use, misuse, hazardous and harmful drinking, excessive drinking, binge drinking and alcohol dependence.

¹⁷² Room R, Babor T, Rehm J. Alcohol and public health. *The Lancet* 2005;365:519-530.

¹⁷³ Rehm J, Room R, Monteiro M, Gmel G, Graham K, Rehn R, et al. Alcohol as a risk factor for global burden of disease. *European Addiction Research* 2003;9(4):157-164.

¹⁷⁴ Ezzati M, Rodgers A, Vander Hoorn S, Murray C. Selected major risk factors and global and regional burden of disease. *The Lancet* 2002;360:1347-1360.

¹⁷⁵ Leon D A, McCambridge J. Liver cirrhosis mortality rates in Britain from 1950 to 2002: an analysis of routine data. *Lancet* 2006;367(9504):52-6.

¹⁷⁶ Drummond C, Oyefeso A, Phillips T, Cheeta S, Deluca P, Perryman K, et al. Alcohol needs assessment research project (ANARP). The 2004 national needs assessment for England. Department of Health, 2004.

¹⁷⁷ Heather N, Kaner E. Brief interventions against excessive alcohol consumption. In: Warrell D, Cox T, Firth J, Benz E, editors. *Oxford Textbook of Medicine*. 7th ed: Oxford University Press, 2009.

¹⁷⁸ Prime Minister's Strategy Unit. Strategy Unit Alcohol Harm Reduction Project: Interim Analytical Report. London: Cabinet Office, 2003.

¹⁷⁹ Kaner EFS, Beyer F, Dickinson HO, Pienaar E, Campbell F, Schlesinger C, et al. Effectiveness of brief alcohol interventions in primary care populations. *Cochrane Database of Systematic Reviews* 2007(2):CD004148.

Alcohol use

Alcohol use refers to any ingestion of alcohol. Low-risk use of alcohol refers to drinking within legal and medical guidelines, which is not likely to result in alcohol-related problems.¹⁸⁰

Alcohol misuse

Alcohol misuse is a general term for any level of risk, ranging from hazardous drinking to alcohol dependence.¹⁸⁰

Hazardous drinking

Hazardous drinking is consumption at a level or in such a pattern that increases an individual's risk of physical or psychological consequences.¹⁸¹ Physical consequences of hazardous drinking could include accidents due to impaired judgement after drinking alcohol whilst psychological effects could relate to mood disturbance which may affect personal or social interactions. Hazardous and heavy drinking are more or less synonymous terms, and are often used interchangeably.

Harmful drinking

Harmful drinking is defined by the presence of adverse consequences related to alcohol.¹⁸² Adverse consequences can be physical (eg liver cirrhosis) or psychological (eg depression).

Excessive drinking

Hazardous and harmful drinking are referred together as “excessive drinking”. Excessive drinking can also be operationalised via drinking limits recommended by medical authorities in various countries, beginning with the level of consumption identified by epidemiological evidence as the point where the risk of harm begins to increase.

In the United Kingdom, for example, a joint working group of the Royal Colleges of Physicians, Psychiatrists, and General Practitioners in 1995¹⁸³ defined “low risk” through to “harmful” drinking in terms of standard drink units per week (one unit = 8g ethyl alcohol) see Table 1. At about the same time, a United Kingdom government report on sensible drinking advised that consistently drinking four or more units per day in men and three or more units per day in women carried progressive health risks.¹⁸⁴ These weekly and daily benchmarks provide the basis for current public health advice alcohol consumption.

Binge drinking

Binge drinking refers to high intensity drinking during a single drinking session.¹⁸⁵ It is strongly associated with intoxication or drunkenness. Binge drinking was defined in the 1995 UK government report as drinking twice the daily limit for alcohol consumption (ie 8+ units for men/6+ for women) in one day.¹⁸⁴

Table 1

<i>Category</i>	<i>Alcohol consumption in men</i>	<i>Alcohol consumption in women</i>
Low risk or “sensible”	21 units/week or up to 4 units per day	14 units/week or up to 3 units per day
Increasing risk or “hazardous”	22–50 units/week	15–35 units/week
High risk or “harmful”	> 50 units/week	> 35 units/week

¹⁸⁰ Babor T F, Higgins-Biddle J. Brief intervention for hazardous and harmful drinking: a manual for use in primary care. Geneva, Switzerland: W.H.O. Department of Mental Health and Substance Dependence., 2001.

¹⁸¹ Edwards G, Arif A, Hodgson R. Nomenclature and classification of drug and alcohol related problems: A WHO memorandum. *Bulletin of the World Health Organization* 1981;59:225–242.

¹⁸² World Health Organisation. *International classification of diseases, 10th revision*. 10th revision ed. Geneva, 1992.

¹⁸³ Royal College of Physicians, Royal College of Psychiatrists, Royal College of General Practitioners. Alcohol and the heart in perspective: sensible limits reaffirmed. London: Royal College of Physicians, 1995.

¹⁸⁴ Department of Health. Sensible Drinking: The report of an inter-departmental working group. London: Department of Health, 1995.

¹⁸⁵ Murgraff V, Parrott A, Bennett P. Risky single-occasion drinking amongst young people—definition, correlates, policy, and intervention: a board overview of research findings. *Alcohol & Alcoholism* 1999;34(1):3–14.

Alcohol dependence

Alcohol dependence (syndrome) is a psychobiological condition characterized by an inner drive to consume alcohol, continued drinking despite harm and commonly a withdrawal state upon stopping drinking.¹⁸⁶ There are two forms of diagnostic criteria for alcohol dependence: The World Health Organisation International Classification of Disease (ICD-10) has six criteria;¹⁸⁷ and the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) has seven criteria.¹⁸⁸ Both systems are based on a description of the Alcohol Dependence Syndrome by Edwards & Gross¹⁸⁹ and many of their criteria are similar, despite some differences in wording or emphases.¹⁹⁰ People with alcohol dependence who are assessed by a health professional usually have three or more of the criteria shown below during the previous year.¹⁹¹ A narrowing of the personal repertoire of patterns of alcohol use has also been described as a characteristic feature of dependence (eg a tendency to drink alcoholic drinks in the same way on weekdays and weekends, regardless of social constraints that determine appropriate drinking behaviour).¹⁸⁹

Alcohol Dependence Criteria

- a strong desire or compulsion to take alcohol;
- difficulty in controlling alcohol consumption in terms of onset, termination, or levels of use;
- physiological withdrawal when alcohol use has ceased or reduced, or use of the alcohol with the intention of relieving or avoiding withdrawal symptoms;
- evidence of tolerance, in which increased doses of alcohol are required in order to achieve effects originally produced by lower doses;
- progressive neglect of alternative pleasures or interests because of alcohol use; and
- continued use despite clear evidence of harm, such as liver damage.

Alcohol use disorder

An alcohol use disorder has been defined as hazardous, harmful or dependent drinking.¹⁹²

3. TRENDS IN INCIDENCE AND PREVALENCE

The level of alcohol consumption in the UK has risen steadily as the retail price of alcohol relative to personal disposable income has fallen over time (see Figure 2).¹⁹³ Indeed, in the last 50 years, alcohol consumption in the UK has more than doubled, with a 121% per capita increase since 1951.¹⁹⁴ Binge drinking is particularly prevalent in Britain, with Ireland and the UK coming first and third respectively in a European survey on alcohol.¹⁹⁵

The level of excessive drinking in the UK is higher than in most other countries of the world including culturally similar countries such as the USA, Canada and Australia.¹⁹⁶ thus unsurprisingly, age-specific alcohol-related death rates in England and Wales have risen sharply over the last decade and are peaking earlier in men.¹⁹⁷ In Scotland, alcohol was a contributory factor in 11% of all attendances in A&E, most were men (71%) and over half had sustained some form of injury.¹⁹⁸

¹⁸⁶ Saunders J B, Lee N K. Hazardous alcohol use: Its delineation as a subthreshold disorder, and approaches to its diagnosis and management. *Comprehensive Psychiatry* 2000;41(2):95–103.

¹⁸⁷ World Health Organisation. *International classification of diseases, 10th revision*. 10th revision ed. Geneva, 1992.

¹⁸⁸ American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. Fourth ed. Washington DC, 1994.

¹⁸⁹ Edwards G, Gross M M. Alcohol dependence: provisional description of a clinical syndrome. *British Medical Journal* 1976;1(6017):1058–61.

¹⁹⁰ Caetano R, Tam T W. Prevalence and correlates of DSM-IV and ICD-10 alcohol dependence: 1990 US National Alcohol Survey. *Alcohol & Alcoholism* 1995;30(2):177–86.

¹⁹¹ Babor T F, Higgins-Biddle J. Brief intervention for hazardous and harmful drinking: a manual for use in primary care. Geneva, Switzerland: W.H.O. Department of Mental Health and Substance Dependence., 2001.

¹⁹² Drummond C, Oyefeso A, Phillips T, Cheeta S, Deluca P, Perryman K, *et al.* Alcohol needs assessment research project (ANARP). The 2004 national needs assessment for England. Department of Health, 2004.

¹⁹³ Lehto J. The economics of alcohol. *Addiction* 1997;92(Suppl 1):55–9.

¹⁹⁴ Prime Minister's Strategy Unit. Strategy Unit Alcohol Harm Reduction Project: Interim Analytical Report. London: Cabinet Office, 2003.

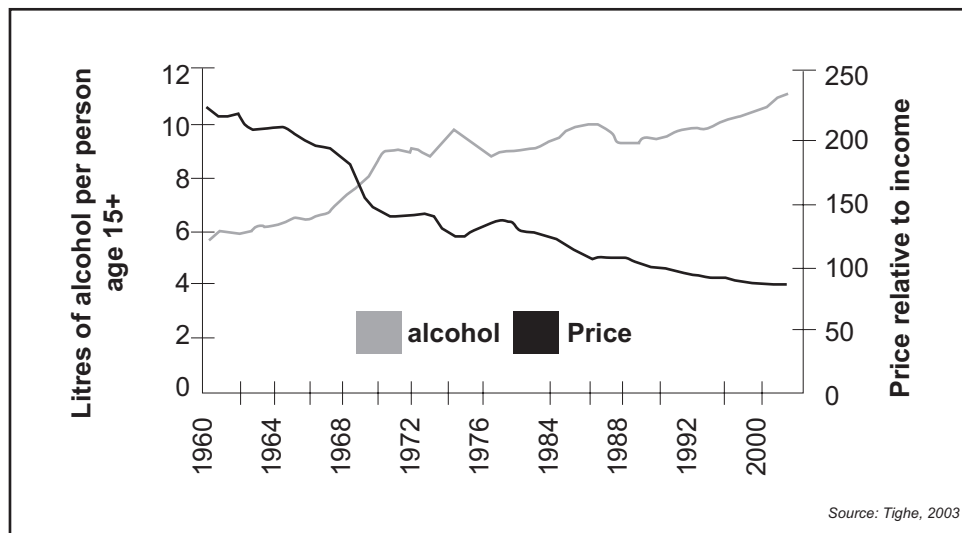
¹⁹⁵ European Commission. Attitudes towards alcohol. *Special Eurobarometer 272b/Wave 66.2—TNS Opinion & Social*, 2007.

¹⁹⁶ World Health Organisation. WHO Global Status Report on Alcohol. Geneva: World Health Organisation, Department of Mental Health and Substance Abuse, 2004:ISBN 924 156272 2.

¹⁹⁷ Academy of Medical Sciences. Calling time. The nation's drinking as a major health issue. London: Academy of Medical Sciences, 2004.

¹⁹⁸ NHS National Services Scotland/Information Services Division. Alcohol Statistics Scotland Common Services Agency/ Crown Copyright, 2007.

Figure 2

PRICE OF ALCOHOL AND CONSUMPTION—SOURCE¹⁹⁹

Gender

Men are much more likely to have an alcohol use disorder than women. An estimated 38% of men and 16% of women (aged 16–64 years) had an alcohol use disorder in England in 2004.²⁰⁰ This represented 8.2 million people (26% of the total population).²⁰⁰

Men are also much more likely to be hazardous or harmful drinkers than women. Out of the 8.2 million people in England who have an alcohol use disorder in 2004, 7.1 million individuals were hazardous or harmful drinkers: 32% were men and 15% women.²⁰⁰

Binge drinking

Men are twice as likely to be binge drink compared to women. In the 2004 national alcohol needs assessments, 21% men and 9% women in England were binge drinkers.²⁰⁰ Indeed binge drinking accounts for 40% of all drinking occasions among men and 22% among women—a rate far higher than reported in most other countries.²⁰¹ Although binge drinking is commonly associated with young people, it can persist into middle age.²⁰²

Alcohol dependence

Men are more likely to be dependent on alcohol than women. In 2004, 1.1 million people (4%) in England were found to be alcohol dependent, representing 6% men and 2% women.²⁰⁰ Indeed, alcohol dependence is considerably more prevalent than problem drug use in England, with adult population prevalence rates of 4% and 0.8% respectively.²⁰⁰

Age

Young people tend to drink more heavily than older people, and they generally cut down on their drinking as they get older. Nevertheless, young people in the UK have one of the highest rates for weekly drinking and episodes of drunkenness across 35 countries worldwide.^{203, 204} In a World Health Organisation survey of young people across 27 countries, 47% and 36% of English boys and girls, aged 11–15 years, drink alcohol weekly.²⁰³ Since young people typically do not drink as frequently as adults, this increased consumption often results from binge drinking.

¹⁹⁹ Academy of Medical Sciences. Calling time. The nation's drinking as a major health issue. London: Academy of Medical Sciences, 2004.

²⁰⁰ Drummond C, Oyefeso A, Phillips T, Cheeta S, Deluca P, Perryman K, *et al.* Alcohol needs assessment research project (ANARP). The 2004 national needs assessment for England. Department of Health, 2004.

²⁰¹ Office for National Statistics. General Household Survey 2003. London: Office for National Statistics, 2004.

²⁰² Jefferis BJMH, Power C, Manor O. Adolescent drinking level and adult binge drinking in a national birth cohort. *Addiction* 2005;100:543–549.

²⁰³ Currie C, Roberts C, Morgan A, Smith R, Settertobulte W, Samdal O, *et al.* Young people's health in context. Health Behaviour in School-aged Children (HBSC) Study: International reports from the 2001–02 survey. *Health Policy for Children and Adolescents, No 4*. Copenhagen: World Health Organisation Regional Office for Europe, 2004:ISBN 92 890 1372 g.

²⁰⁴ Settertobulte W, Bruun Jensen B, Hurrelmann K. Drinking among young Europeans. Copenhagen: World Health Organisation Regional Office for Europe, 2001:EUR/ICP/IVST 06 03 05 C.

Ethnic groups

Black and minority ethnic (BME) groups in England have a lower prevalence of hazardous/harmful alcohol use, but a similar prevalence of alcohol dependence compared to the white population.²⁰⁵ The prevalence of hazardous or harmful drinking in BME groups was approximately 14% compared to 23% in the general population.²⁰⁵ The prevalence of alcohol dependence in BME groups was 3% compared to 4% in the general population.²⁰⁵

Population effects

The majority of alcohol-related problems that occur in a population are not due to the heaviest drinkers, who are generally individuals with alcohol dependence, but are due to the much larger group of excessive drinkers. Excessive drinkers outnumber dependent drinkers by a ratio of 7:1.²⁰⁵ Thus the greatest impact in reducing alcohol-related problems in our population can be made by reducing alcohol consumption in excessive drinkers rather than focusing on the most extreme or heaviest drinkers only; this is sometimes known as the preventive paradox.²⁰⁶ The preventive paradox is more pronounced in populations where heavy episodic drinking or intoxication is a common part of the drinking pattern.^{207, 208} Thus the preventive paradox is particularly pertinent in the UK.

4. RISK FACTORS

The aetiology of alcohol misuse is multifactorial and genetic, psychological and social factors are all significant determinants.²⁰⁹ Earlier age of initiation is an important precursor to later alcohol misuse.²¹⁰ Other precursors of later misuse include parents' drinking, friends drinking, poor family management practices and favourable attitudes towards substance use.²¹¹ Individuals who begin using alcohol in the pre- and early adolescent years (ages 11–14) are most vulnerable to developing alcohol use disorders later in life.²¹² Indeed individuals who report drinking before the age of 14 are four times more likely to develop alcohol dependence than those who began drinking at age 20 or more.²¹³

Males are more likely to develop alcohol use disorders than females.²¹⁰ However, whilst heavy drinking in men occurs across all social classes, women from higher social classes are more likely to drink heavily than women from lower social classes.²¹⁴ Nevertheless, the problems arising from heavy drinking are experienced more severely by people from lower social classes.²¹⁴

Different alcohol-related problems are associated with average volume consumed and/or different patterns of drinking.²¹⁵ Frequent heavy drinking tends to result in chronic health conditions (eg hypertension or liver problems), whereas binge drinking tends to result in more acute health problems (accidents or trauma) and socio-legal consequences (antisocial or criminal behaviour).

Risks in adults

The risks of alcohol for adults include a wide range of chronic and acute health conditions, psychological disorders, social, financial, legal consequences.²¹⁶ Heavy drinking is a key risk factor for liver cirrhosis and cirrhosis mortality rates are an important indicator of alcohol-related harm in populations.²¹⁶ Chronic heavy drinking also contributes to the risk of both haemorrhagic and ischaemic stroke.²¹⁷ Deaths in the UK due to the association of alcohol and haemorrhagic stroke account for 1,200 deaths per year.²¹⁷

²⁰⁵ Drummond C, Oyefeso A, Phillips T, Cheeta S, Deluca P, Perryman K, *et al.* Alcohol needs assessment research project (ANARP). The 2004 national needs assessment for England. Department of Health, 2004.

²⁰⁶ Kreitman N. Alcohol consumption and the preventive paradox. *British Journal of Addictions*. 1986;81:353–363.

²⁰⁷ Poikolainen K, Paljarvi T, Makela P. Alcohol and the preventive paradox: serious harms and drinking patterns. *Addiction* 2007;102(4):571–8.

²⁰⁸ Rossow I, Romelsjo A. The extent of the “prevention paradox” in alcohol problems as a function of population drinking patterns. *Addiction* 2006;101(1):84–90.

²⁰⁹ Galea S, Nandi A, Vlahov D. The social epidemiology of substance use. *Epidemiologic Reviews* 2004;26:36–52.

²¹⁰ Hawkins JD, Graham JW, Maguin E, Abbott R, Hill KG, Catalano RF. Exploring the effects of age of alcohol use initiation and psychosocial risk factors on subsequent alcohol misuse. *J Stud Alcohol* 1997;58(3):280–290.

²¹¹ Newbury-Birch D, Gilvarry E, McArdle P, Ramesh V, Stewart S, Walker J, *et al.* Impact of Alcohol Consumption on Young People: Report for the Department of Children, Schools and Families: Newcastle University, 2009.

²¹² DeWit D J, Adlaf E M, Offord D R, Ogborne A C. Age at first alcohol use: a risk factor for the development of alcohol disorders. *American Journal of Psychiatry* 2000;157(5):745–50.

²¹³ Hingson R W, Heeren T, Winter M R. Age at drinking onset and alcohol dependence: age at onset, duration, and severity. *Archives of Pediatrics & Adolescent Medicine* 2006;160(7):739–46.

²¹⁴ Marmot M, Feeney A. Inequality, alcohol and alcohol-associated harm. In: Waller S, Crosier A, McVey D, editors. *Inequalities in Health*. London: Health Education Authority, 1999:ISBN 0 7521 1375 5.

²¹⁵ Rehm J, Room R, Graham K, Monteiro M, Gmel G, Sempos CT. The relationship of average volume of alcohol consumption and patterns of drinking to burden of disease: an overview. *Addiction* 2003;98(9):1209–28.

²¹⁶ Room R, Babor T, Rehm J. Alcohol and public health. *The Lancet* 2005;365:519–530.

²¹⁷ Leon D A, McCambridge J. Liver cirrhosis mortality rates in Britain from 1950 to 2002: an analysis of routine data. *Lancet* 2006;367(9504):52–6.

The incidence of hypertension is approximately double in patients who regularly drink more than six units a day.²¹⁸ In 11% of all cases, alcohol consumption is the main cause of men's hypertension and is second only to obesity as an acquired determinant. There is a consistent relationship between alcohol reduction and reduced blood pressure.²¹⁹

Excessive drinking, especially if combined with cigarette smoking, contributes to the risk of a range of cancers,²²⁰ particularly cancers of the gastrointestinal tract. There is generally a dose-response relationship between level of alcohol intake and an increased risk of developing cancer.²²⁰

Excessive drinking also has significant implications for mental health including a causal link with anxiety, depression²²¹ and suicidal behaviour.²²² About $\frac{1}{3}$ of psychiatric patients with serious mental illness in the UK have a substance misuse problem, mostly involving alcohol.²²³

Alcohol increases the risk of accidental death and may be associated with between 1/3 and 1/7 such deaths, amounting to up to 1,700 deaths per year in the UK.²²³ Alcohol has been linked to 38–45% of deaths in fires, 7–25% of deaths at work and 23–28% deaths by drowning.

Between 16 and 45% of suicides are thought to be linked to alcohol; 50% of those who present to hospital after deliberate self-harming are regular excessive drinkers and 23% are alcohol dependent.²²⁴

Benefits in adults

Individuals who do not drink alcohol have been found to experience an increased risk of coronary heart disease compared to those who drink at low to moderate levels.²²⁵ The majority of evidence relating to this coronary protective effect of alcohol has been found in older men and post-menopausal women.

Beyond a consumption level of about 1–2 standard drink units per day the risk of coronary heart disease rises in a dose-response fashion; the more alcohol consumed, the greater the risk. This pattern of risk where non-drinkers and heavy drinkers experience a greater risk of heart disease than low-to-moderate drinkers has been described as the J-shaped curve.²²⁰

Risks in children and young people

Heavy or frequent drinking by women during pregnancy can affect the pre- and post-natal development of their baby and lead to Fetal Alcohol Syndrome (FAS) or, its less severe form, Fetal Alcohol Spectrum disorders (FASD). Low level, infrequent consumption is unlikely to have an adverse effect on the fetus.²²⁶ It is estimated that the incidence of FAS in industrialized countries is between 0.4 and 2 live births per 1,000.²²⁷ Children born with fetal alcohol effects can experience a range of developmental problems and some consequences may be apparent throughout their lifetimes.²²⁸

A recent (detailed) report on the impact of alcohol on children and young people, which was commissioned by the Department of Children, Schools and Families.²²⁹ This work described a wide range of health and social problems for young people that are linked to alcohol use. In general, young people drink less frequently than adults but on each drinking occasion they tend to drink larger amounts (ie binge drink). Acute intoxication can result from binge drinking, refers to disturbances in levels of consciousness, cognition, perception, mood or in social behaviour. In the UK, acute intoxication was responsible for 23,000 hospital admissions in 2000–01.²²⁴ These admissions peak steeply in the under 20's and then attenuate.²²⁴ Given young people's tendency to engage in binge drinking, and their relative inexperience with alcohol, they are at greater risk from acute intoxication.²³⁰

²¹⁸ Hingson R W, Heeren T, Winter M R. Age at drinking onset and alcohol dependence: age at onset, duration, and severity. *Archives of Pediatrics & Adolescent Medicine* 2006;160(7):739–46.

²¹⁹ Xin X, He J, Frontini M G, Ogdan L G, Motsamai O I, Whelton P K. Effects of alcohol reduction on blood pressure: a meta-analysis of randomized controlled trials. *Hypertension* 2001;38(5):1112–7.

²²⁰ Anderson P, Cremona A, Paton A, Turner C, Wallace P. The risk of alcohol. *Addiction* 1993;88:1493–1508.

²²¹ Manninen L, Poikolainen K, Vartiainen E, Laatikainen T. Heavy drinking occasions and depression. *Alcohol & Alcoholism* 2006;41(3):293–9.

²²² Brady J. The association between alcohol misuse and suicidal behaviour. *Alcohol & Alcoholism* 2006;41(5):473–8.

²²³ Leon D A, McCambridge J. Liver cirrhosis mortality rates in Britain from 1950 to 2002: an analysis of routine data. *Lancet* 2006;367(9504):52–6.

²²⁴ Prime Minister's Strategy Unit. Strategy Unit Alcohol Harm Reduction Project: Interim Analytical Report. London: Cabinet Office, 2003.

²²⁵ Royal College of Physicians, Royal College of Psychiatrists, Royal College of General Practitioners. Alcohol and the heart in perspective: sensible limits reaffirmed. London: Royal College of Physicians, 1995.

²²⁶ Henderson J, Gray R, Brocklehurst P. Systematic review of effects of low-moderate prenatal alcohol exposure on pregnant outcome. *BJOG* 2007.

²²⁷ May P, Gossage J. Estimating the Prevalence of Fetal Alcohol Syndrome: A Summary. *Alcohol Research & Health* 2001;25(3):159–167.

²²⁸ Guerri C, Bazinet A, Riley E. Foetal alcohol spectrum disorders and alterations in brain and behaviour. *Alcohol & Alcoholism* 2009;44(2):108–114.

²²⁹ Newbury-Birch D, Gilvarry E, McArdle P, Ramesh V, Stewart S, Walker J, *et al*. Impact of Alcohol Consumption on Young People: Report for the Department of Children, Schools and Families: Newcastle University, 2009.

²³⁰ Murgaff V, Parrott A, Bennett P. Risky single-occasion drinking amongst young people—definition, correlates, policy, and intervention: a board overview of research findings. *Alcohol & Alcoholism* 1999;34(1):3–14.

5. HEALTH CONSEQUENCES

Alcohol is causally related to more than 60 medical outcomes, in most cases detrimentally.²³¹ In terms of alcohol-related mortality, almost half the global burden (46%) is related to acute causes, with 32% due to unintentional injuries and 14% to intentional injuries.²³² Malignant neoplasms account for 20% of global alcohol-related mortality, 15% is due to cardio-vascular disease and 13% to other non-communicable disease, mainly liver cirrhosis.²³²

Alcohol-related morbidity is generally measured in disability adjusted life years (DALYS) which take account of disability as well as disease.²³² World-wide, neuropsychiatric conditions are responsible for the largest proportion of alcohol-attributable DALYS (37%), followed by unintentional injuries (28%) and intentional injuries (12%).²³²

Essentially, virtually every system in the human body can be damaged by alcohol.²³³

In England rates of alcohol-related mortality from liver disease trebled between 1970 and 1998 while the European Union rate reduced by 30%.²³⁴ Indeed, Scotland now has one of the highest cirrhosis mortality rates in Western Europe.²³⁴ Between 1970 and 2000 there was a nine-fold increase in the number of deaths from chronic disease in English men and women between 25 and 44 years.²³⁵

Hypertension accounts for about 3,000 deaths per annum and about 300 of these may be specifically related to alcohol consumption. Thus alcohol consumption is the main cause of men's hypertension in 10% of cases. Moreover, the incidence of hypertension doubles in individuals who are drinking six or more standard drink units per day.²³⁶ Hypertension is also linked to the risk of haemorrhagic stroke. Indeed, chronic high alcohol intake increases the risk of both haemorrhagic and ischaemic stroke.²³⁷ Deaths from the former, linked to alcohol use may account for 12,000 deaths per year.²³⁸ One 10 year study in Scotland found an excess of deaths from coronary heart disease, particularly strokes, on Mondays (3% above average intake) among people with no previous hospital admission for such conditions; this spike in deaths has been ascribed to weekend binge drinking.²³⁹

In the UK, alcohol causes 150,000 hospital admissions and between 15,000 and 22,000 deaths each year associated with excessive drinking.²³⁷ Alcohol-related liver disease accounts for approximately 33,000 hospital admissions and over 4,500 deaths per year. Moreover, there are 30,000 hospital admissions for alcohol dependence syndrome. Age specific mortality rates from liver disease have risen by 90% over the last decade; although it is likely that an interaction with hepatitis C infections has contributed to this rise.²³⁴

Alcohol is second in importance, after smoking, as a proven cause of cancer²⁴⁰ and is responsible for 3.5% of UK cancer-related deaths²³⁷ or 5,000 deaths per annum.²³⁴ Alcohol-related cancer is particularly evident in the digestive system;²⁴¹ furthermore, there is an interaction with smoking in the development of cancer in the upper gastrointestinal tract.

Alcohol misuse is also linked to about 14% of accidental deaths per year in the UK which involves about 1,700 individuals.²³⁷ It has also been estimated that alcohol misuse is linked to 38–45% deaths in fires, 7–25% deaths at work and 23–38% of deaths due to drowning.²³⁴ In addition, it is thought that around 16–41% of suicides may be attributable to alcohol; among those presenting to hospital with self harm 50% were found to be regular drinkers and 23% were dependent.²³⁴

Most of the recorded mortality and morbidity relates to individual experience of harm due to personal alcohol consumption. However, a significant factor in alcohol misuse is that a wide array of other people (known and unknown) can be affected by each drinker.²⁴² This list of “affected others” is extensive and can include: the drinker's partner and/or children, other family members and friends; acquaintances met in social situations involving alcohol; and unknown individuals in the vicinity of public drinking venues.

²³¹ Room R, Babor T, Rehm J. Alcohol and public health. *The Lancet* 2005;365:519-530.

²³² Rehm J, Room R, Monteiro M, Gmel G, Graham K, Rehn R, et al. Alcohol as a risk factor for global burden of disease. *European Addiction Research* 2003;9(4):157-164.

²³³ Guerri C, Bazinet A, Riley E. Foetal alcohol spectrum disorders and alterations in brain and behaviour. *Alcohol & Alcoholism* 2009;44(2):108-114.

²³⁴ Leon D A, McCambridge J. Liver cirrhosis mortality rates in Britain from 1950 to 2002: an analysis of routine data. *Lancet* 2006;367(9504):52-6.

²³⁵ Academy of Medical Sciences. Calling time. The nation's drinking as a major health issue. London: Academy of Medical Sciences, 2004.

²³⁶ Xin X, He J, Frontini M G, Ogdan L G, Motsamai O I, Whelton P K. Effects of alcohol reduction on blood pressure: a meta-analysis of randomized controlled trials. *Hypertension* 2001;38(5):1112-7.

²³⁷ Prime Minister's Strategy Unit. Strategy Unit Alcohol Harm Reduction Project: Interim Analytical Report. London: Cabinet Office, 2003.

²³⁸ Royal College of Physicians. Alcohol—can the NHS afford it? London: Royal College of Physicians, 2001.

²³⁹ Evans C, Chalmers J, Capewell S, Redpath A, Finlayson A, Boyd J, et al. “I don't like Mondays”—day of the week of coronary heart disease deaths in Scotland: study of routinely collected data. *British Medical Journal* 2000;320:218-219.

²⁴⁰ Austoker J. Reducing alcohol intake. *British Medical Journal* 1994;308:1549-1552.

²⁴¹ Anderson P, Cremona A, Paton A, Turner C, Wallace P. The risk of alcohol. *Addiction* 1993;88:1493-1508.

²⁴² Alcohol Concern. Britain's Ruin? London: Alcohol Concern, 2000.

Consequences for young people

Young people may experience adverse effects from alcohol misuse either due to the drinking behaviour of other people (eg poor parenting due to parental drinking) or their own alcohol consumption.²⁴³ Although many young people can use alcohol without serious adverse effects, a significant minority can cause substantial damage both for themselves and also for other people.²⁴⁴

The relationship between alcohol and harm in young people is complex.²⁴⁵ Alcohol may increase a young person's probability of doing something that is potentially harmful (eg getting into fights); alcohol use in conjunction with an activity may increase the probability of harm (eg accidents related to drinking and driving); and alcohol use may itself lead to harm (eg physical illness, mortality).

Young people are more vulnerable than adults to the adverse effects of alcohol, for various reasons, including differences in body mass and metabolic handling of alcohol and experience in assessing alcohol-related risk situations.²⁴⁶ Young people's alcohol misuse is also known to have a deleterious impact on motivational and cognitive processes including mood disorders which influence school performance and risk of accidents, injury and death.²⁴⁷

6. COSTS OF ALCOHOL MISUSE

UK national cost-estimates relating to alcohol misuse were reported in detail in 2004²⁴⁸ and updated in 2008.²⁴⁹ The national cost estimate ranges from £20–25 billion each year. Costs to the NHS are in the order of £2–2.7 billion.²⁴⁹ The largest proportion of the health cost is spent on specialist services; in 2004 this was estimated as which cost £95 million each year.²⁴⁸ Of this total, £24 million was spent by NHS (statutory) services and £71 million by voluntary sector services.

Alcohol-related diseases are thought to take up 1 in 26 NHS bed days at a cost of approximately £2 million and a further 1 in 80 NHS day cases costing about £40,000. In surgical and general medical wards, estimates of excessive drinkers range up to 30% of all male admissions and 15% of female admissions.²⁵⁰

It has been estimated that 35% of A&E attendances and ambulance costs may be alcohol-related with a resultant cost of £0.5 billion each year. It is now well established that excessive drinkers are over-represented among patients of accident and emergency services, with an estimate in the UK of 40% of all admissions, rising to 70% at peak times.²⁵¹

In 2004, the primary care spend on alcohol-related care was thought to be around £0.5 billion annually. However, this figure is likely to be an under-estimate. Patients with alcohol problems consult their general practitioners twice as often as average patients, with a wide range of common complaints such as hypertension, gastrointestinal problems, psychiatric symptoms and accidents. The link between alcohol and the presenting complaint is often not made. In 1999, it was reported that 100 hazardous drinkers and a further 40 harmful drinkers were expected in every 2,000 patients in primary care, but that primary care physicians were unaware of the problem in more than half of these.²⁵²

Annual crime and public disorder costs have been estimated at £7.3 billion.²⁴⁸ The costs of alcohol specific offences are thought to be in the realm of £30 million and include crimes such as selling alcohol to underage drinkers, selling unlicensed alcohol, being drunk and disorderly, or driving under the influence of alcohol. However, the largest costs are from offences related to alcohol, which cost a further £1.7 billion each year and include criminal damage, breach of the peace and assault, often sexual assault and/or domestic violence. In addition, criminal justice services spend about £1.5 billion in activities geared toward preventing alcohol-related criminality eg increased policing at public events where alcohol is served.

Workplace costs of alcohol misuse have been estimated to be £6.4 billion each year.²⁴⁸ Within this figure, the costs due to working days lost because of alcohol-related sickness are thought to range from £11–17 million whilst the costs of sickness absence range from £1.2–1.7 billion each year. For those in work, alcohol

²⁴³ Newbury-Birch D, Gilvarry E, McArdle P, Ramesh V, Stewart S, Walker J, *et al*. Impact of Alcohol Consumption on Young People: *Report for the Department of Children, Schools and Families*: Newcastle University, 2009.

²⁴⁴ Perkins W. Surveying the damage: a review of research on consequences of alcohol misuse in college populations. *Journal of Studies on Alcohol Supplement* 2002;14:91–100.

²⁴⁵ Leigh B C. The risk of drinking among young adults. Peril, chance, adventure: concepts of risk, alcohol use and risky behavior in young adults. *Addiction* 1999;94(3):371–383.

²⁴⁶ Miller E T, Kilmer J R, Kim E L, Weingardt K R, Marlatt G A. Alcohol skills training for college students. In: Monti P M, Colby S M, O'Leary T A, editors. *Adolescents, alcohol, and substance abuse*. New York: The Guilford Press, 2001:183–215.

²⁴⁷ Hawkins J, Catalano R, Miller J. Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. *Psychological Bulletin* 1992;112(1):64–105.

²⁴⁸ Prime Minister's Strategy Unit. Strategy Unit Alcohol Harm Reduction Project: Interim Analytical Report. London: Cabinet Office, 2003.

²⁴⁹ National Audit Office. Reducing alcohol harm: health services in England for alcohol misuse. London: The Stationery Office, 2008.

²⁵⁰ Barrison I G, Viola L, Mumford J, Murray R M, Gordon M, Murray-Lyon I M. Detecting excessive drinking among admissions to a general hospital. *Health Trends* 1982;14:80–83.

²⁵¹ Academy of Medical Sciences. Calling time. The nation's drinking as a major health issue. London: Academy of Medical Sciences, 2004.

²⁵² Kaner E F S, Heather N, McAvooy B R, Lock C A, Gilvarry E. Intervention for excessive alcohol consumption in primary health care: attitudes and practices of English general practitioners. *Alcohol and Alcoholism* 1999;34(4):559–566.

misuse can lead to loss of motivation, energy and this productivity at work, estimated as costing £20 million. Lastly, the annual cost to industry from the premature deaths due to alcohol has been estimated as £2.4 billion.

Cost-effective responses

In countries with a high-prevalence of heavy drinking, it has been reported that the most cost-effective way of reducing excessive drinking at a population level is by raising taxation on alcoholic products. The second most cost-effective strategy to reduce alcohol-related risk and harm was reported to be screening and brief interventions by primary care clinicians.²⁵³ The latter strategy was recently endorsed by the British Medical Association.²⁵⁴ In order to assess the applicability of this evidence to England, the effectiveness and cost-effectiveness of a range of strategies aimed at preventing alcohol-related problems in adults and adolescents are currently being considered by the National Institute of Health and Clinical Excellence (NICE).

7. RECOMMENDATION

The NICE guidance on alcohol is due to be published in the autumn of 2009. Given the extensive evidence on the harms and costs of alcohol misuse in England, it is imperative that evidence-based preventive strategies must be implemented on a widespread basis by all relevant agencies. To achieve successful implementation, this preventive work must be endorsed and encouraged by future Government policy on alcohol.

March 2009

Memorandum by the Royal College of Nursing (AL 28)

1. EXECUTIVE SUMMARY

1.1 The Royal College of Nursing (RCN) has serious concerns around the rising levels of harm to public health which excessive alcohol consumption can cause.

1.2 A recent RCN/Royal College of Physicians (RCP) survey of nursing staff and physicians showed that the majority do not believe that current national alcohol strategies and public health campaigns have been effective in changing drinking behaviour.

1.3 The RCN believes that the Government needs to work with stakeholders from the health professions as well as the drinks industry to create a mandatory code applicable to all of the drinks industry. Enforcement agencies should also be given appropriate powers to implement this mandatory code to make it effective. The current self-regulatory, voluntary system is not providing a solution.

1.4 The RCN feels that a strict, standardised guideline for the labelling of alcoholic drinks must be established, which clearly show how many units of alcohol are contained in the drink. This will allow consumers to make an increasingly informed decision into how much alcohol they consume. By increasing awareness the RCN believes that a cultural shift toward safer drinking could occur.

1.5 The RCN/RCP survey illustrated a need for further staff training into early diagnosis of alcohol related illnesses and the RCN feels that a greater emphasis must be placed on teaching nurses about alcohol misuse in the pre-registration part of their education.

1.6 Underage drinking is a chronic problem in the UK. School nurses are ideally positioned to educate young people about the dangers of alcohol misuse as well as spotting its effects. However, currently there is a widespread shortfall in the numbers of school nurses and recruitment must increase dramatically if they are to fulfil this role.

1.7 The RCN recognises the seriousness of alcohol misuse and the benefit of early intervention. As such the RCN has produced a resource for nurses and healthcare assistants to assist in the early identification of a patient with alcohol abuse problems.

1.8 Half of those surveyed in the RCN/RCP Survey on Alcohol Treatment Services responded that NHS facilities for treating alcohol related disease or health problems are currently inadequate.

1.9 Nurse-led initiatives across the country have demonstrated the potential role of nurses in tackling alcohol misuse, whether this is alcohol abuse or underage drinking.

1.10 The RCN would like the government to consider increasing the legal drinking age from 18 to 21.

²⁵³ Chisholm D, Rehm J, Van Ommeren M, Monteiro M. Reducing the global burden of hazardous alcohol use: a comparative cost-effectiveness analysis. *Journal of Studies on Alcohol* 2004;65:782-793.

²⁵⁴ British Medical Association. Alcohol misuse: tackling the epidemic. London: BMA Board of Science, 2008:ISBN 978-1-905545-26-1.

1.11 It is important that alcohol misuse is identified at the point of sale, therefore, a responsibility must be placed upon vendors to identify both intoxicated and underage drinkers and refuse to supply them with alcohol.

1.12 The RCN would like to see alcohol being treated in the same manner as smoking, making it a public health priority to educate the public about its potential dangers.

1.13 The RCN believes that the Government should do more to tackle the issue of “loss leading” by major retailers who are, in some cases, supplying alcohol at less than cost price.

2. INTRODUCTION

2.1 With a membership of almost 400,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the RCN is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

2.2 The RCN welcomes the opportunity to respond to the Health Select Committee’s Inquiry into Alcohol.

2.3 Nurses work in diverse areas and are faced with the consequences of excessive alcohol consumption on a daily basis. This ranges from having to deal with violent and aggressive patients in A&E to caring for people and their families suffering from long term conditions as a direct result of drinking alcohol.

2.4 People living in deprived areas suffer the highest levels of disease and hospital admissions due to alcohol abuse.²⁵⁵ This contributes to the inequalities in health suffered by those living in deprived circumstances.

2.5 The following response contains the views of the RCN following direct consultation with our membership and through a joint RCN/RCP member’s survey on alcohol treatment services.²⁵⁶ It also contains additional information that we believe is relevant to the inquiry. A full analysis of the survey is yet to be completed but will be submitted at a later date. The RCN would also be happy to discuss the results of this survey in more depth if invited to give oral evidence on the topic.

3. THE SCALE OF ILL-HEALTH RELATED TO ALCOHOL MISUSE

3.1 Government figures show that the harm to health from alcohol is increasing. It is estimated that 38% of males and 16% of females have an alcohol use disorder, equating to 8.2 million people.²⁵⁷ Areas of deprivation have the highest levels of disease and hospital admissions due to alcohol. We are concerned that alcohol is further exacerbating health inequalities in poorer areas and amongst underprivileged groups.

3.2 Alcohol is also a significant cause of mortality. 3.1% of all mortalities in the UK can be attributed wholly or in part to alcohol consumption. Young people are at particular risk, with 26.6% of male deaths attributed wholly or in part to alcohol occurring within the 16–24 age group. The same figure for females is slightly lower at 14.7%.²⁵⁸ These figures show that younger people and particularly males are disproportionately susceptible to alcohol related mortality.

4. THE CONSEQUENCES FOR THE NHS

4.1 Hospital admissions directly attributable to alcohol are rising by 80,000 people a year according to Hospital Episode Statistics. The cost of alcohol consumption to the NHS is estimated to be £2.7 billion a year. However, this does not take into account the social costs that could be attributed to excess alcohol consumption such as crime and disorder, lost days at work and the detrimental effects it can have on family life.²⁵⁹

4.2 In 2006–07, 6% of all hospital admissions were directly attributable to the use of alcohol. This constitutes a significant threat to public health.

4.3 The Department of Health’s evaluation of the cost of alcohol use in 2008 highlighted that 35% of all ambulance journeys and A/E visits were as a result of alcohol use. This equates to over 1.2 million ambulance visits and over 6.6 million A/E attendances in 2006–07.

²⁵⁵ Review of the national harm reduction strategy for England. Health Impact assessment. DOH 2007.

²⁵⁶ Royal College of Physicians and Royal College of Nursing Survey on Alcohol Treatment Services, 2009.

²⁵⁷ Alcohol Needs Assessment Research Project, ANARP 2005, Department of Health.

²⁵⁸ *Alcohol-Attributable Fractions for England, Alcohol-Attributable Mortality and Hospital Admissions*, Centre for Public Health, Faculty of Health and Applied Social Sciences, Liverpool John Moores University North West Public Health Observatory, June 2008, p13, 14.

²⁵⁹ Alcohol Learning Centre—www.alcohollearningcentre.org.uk/About/LearningCentre/AIP/PSA25/

5. CENTRAL GOVERNMENT POLICY

5.1 *National Strategy*

5.1.1 Of those surveyed in the RCN/RCP Survey on Alcohol Treatment Services 88% responded that overall, current national alcohol strategies are not effective and 84% responded that public health campaigns have not been effective in changing drinking behaviour.²⁶⁰

5.1.2 Currently, there are a number of self regulatory codes in operation such as the Portman Group code, trade association codes and corporate codes. This fragmentation results in a systemic weakness which is exacerbated by the fact that no single code is monitored or enforced.

5.1.3 The Government should work with stakeholders, including healthcare professionals, in creating a mandatory code covering the whole industry. This uniform code should be clear, unambiguous and provide police, trading standards and licensing agencies with clear tools for enforcement.

5.1.4 The Government has a history of working closely with the drinks industry, particularly in relation to voluntary codes. However, there is a developing consensus that the effectiveness of an essentially voluntary approach is limited and that self regulation alone is not sufficient to protect society and individuals from the harms of unsafe and unscrupulous retailing practices.²⁶¹ This is echoed in a Home Office commissioned KPMG review of industry compliance.²⁶² The RCN strongly supports the introduction of a mandatory code.

5.2 *Underage Drinking*

5.2.1 Tackling underage drinking should be seen as a priority for the Government as binge drinking in young people is common in the UK. A study conducted in 2003 found that UK teenagers have some of the highest levels of lifetime drunkenness in Europe.²⁶³ The average amount of alcohol consumed per week by 11–15 year olds who drink regularly has doubled from 5.3 units in 1990 to 11.4 units in 2006.²⁶⁴ Unhealthy patterns of drinking in adolescence may lead to an increased level of addiction and dependence on alcohol in adulthood.²⁶⁵

5.2.2 In 2006 North West Trading Standards surveyed over 10,000 young people in the region regarding under aged drinking. The survey's findings highlighted the protective effects of parents educating their children about alcohol. Such education included controlled access to alcohol in a similar fashion to many European countries. The Government's strategy should assist parents to educate their children on the dangers of alcohol by providing educational materials that they can use.²⁶⁶

5.3 *Labelling*

5.3.1 There has been some success in implementing the voluntary labelling agreement between the government and the alcohol industry. According to an initial report approximately 57% of products contain information on alcohol unit content.²⁶⁷ It is disappointing to note that only 3% contained the label in its entirety in the agreed format which includes:

- (a) One of three pre-determined health messages:
 - (i) "Know your limits"
 - (ii) "Enjoy responsibly"
 - (iii) "Drink responsibly"
- (b) UK Unit information.
- (c) Maximum intake recommendations for men and women and a specific warning for women who are pregnant or trying to conceive.
- (d) The address of the Drink Aware website.

5.3.2 It is very difficult to evaluate the impact of labelling on harm reduction in a public health context without some form of standardisation. The fact that only 3% of products fully comply with the labelling agreement represents a lost opportunity to study the efficacy of such a labelling measure in reducing alcohol related harm in the UK. This is a strong incentive for a mandatory labelling requirement.

²⁶⁰ Royal College of Physicians and Royal College of Nursing Survey on Alcohol Treatment Services, 2009.

²⁶¹ *Safe, Sensible Social, Consultation on Further Action*, Department of Health, 2008.

²⁶² *Review of the Social Responsibility Standards for the production and sale of Alcoholic Drinks*, Home Office, KPMG, April 2008.

²⁶³ *Alcohol Concern. Unequal Partners*. <http://www.alcoholconcern.org.uk>.

²⁶⁴ *Parklife: Alcohol and Young People at risk*. Addaction.

²⁶⁵ *Alcohol misuse* BMA 2008.

²⁶⁶ *Risky drinking in North West schoolchildren and its consequences: A study of fifteen and sixteen year olds* www.cph.org.uk/showPublication.aspx?pubid=355

²⁶⁷ *Monitoring Implementation of Alcoholic Labelling Regime*, Department of Health, Campden & Chorleywood Food Research Association Group, June 2008.

5.3.3 At the request of the alcohol industry, in return for providing this type of information on labels, the government launched its own “Units Awareness” campaign to help consumers understand the information included on bottles. The RCN was pleased to be one of the organisations who were publicly named and signed up supporters of this campaign.

5.3.4 A study conducted in Australia before the introduction of mandatory unit labelling on all alcoholic products indicated that most consumers did not know the number of units contained in their standard drinks and when asked, often underestimated the number of units. To make consumers aware of the amount they can drink safely is of limited use if they are unaware of the amount they are actually drinking. There have been no controlled studies to determine the effect of the introduction of mandatory unit labelling in Australia but there has been a reduction in consumption and alcohol related deaths since its introduction.

5.3.4 Labelling is an efficient way of giving individuals clear and unambiguous information about how much they are drinking while they are drinking. 91% of those surveyed in the RCN/RCP Survey on Alcohol Treatment Services responded that alcohol products should be labelled with unit information and sensible drinking guidelines. A public that is better informed about the amount they are drinking and are aware of the consequences of unsafe drinking are more likely to drink responsibly. We believe that a culture of increased awareness will result in a shift towards safer drinking practices in much the same way that attitudes about smoking have changed as society has become more aware of its negative effect on health.

5.3.6 With a wide variety of alcoholic drinks now on offer it is increasingly difficult to know how alcoholic a drink may be. Through standardised labelling consumers should be able to make an informed decision as to how much they drink. Women who are pregnant or trying to conceive should be able to make an informed decision about drinking alcohol and the potential dangers this brings about. For these reason the RCN believes the current labelling agreement should be made mandatory.

6. THE ROLE OF THE NHS AND OTHER BODIES INCLUDING LOCAL GOVERNMENT, THE VOLUNTARY SECTOR, POLICE, THE ALCOHOL INDUSTRY, AND THOSE RESPONSIBLE FOR THE ADVERTISING AND PROMOTION OF ALCOHOL

6.1 53% of those surveyed in the RCN/RCP Survey on Alcohol Treatment Services responded that NHS facilities for treating alcohol related disease or health problems are currently inadequate.²⁶⁸

6.2 Nurses are well placed to work in partnership with other agencies to intervene in many settings in their work with families, schools and GP practices as well as the more traditional hospital settings. For this to be effective, alcohol related harm must be recognised as a public health priority and adequately resourced. 71% of those surveyed in the RCN/RCP Survey and Alcohol Treatment Services responded that the government should invest more in treatment services to tackle alcohol related health problems and 88% responded that investment in staff and services has either not kept up with demand or has been seriously under-invested.²⁶⁹

6.3 Nurses often have direct experience caring for individuals who have suffered injury as a result of excessive alcohol consumption, either as a consequence of harm caused by the effects of alcohol on the body or through injuries incurred as a result of intoxication.

6.4 60% of those surveyed in the RCN/RCP Survey on Alcohol Treatment Services responded that there should be more staff training on diagnosis and management of alcohol problems.²⁷⁰ Effort should be made to influence the development of pre-registration nurse education to reflect the issue of alcohol misuse.

6.5 Statistics show that underage drinking is a substantial problem in the UK and is a significant cause of morbidity and mortality. School nurses are ideally situated to educate younger people on the effects of alcohol. Any scheme seeking to use school nurses as educators in a school setting will be limited by the current shortage of school nurses. The RCN has called for the Government to ensure that it reaches its target of a school nurse for every secondary school and cluster group of primary schools by 2010.²⁷¹ Currently there is a substantial shortfall in this area which must be addressed. It is vital that young people are not overlooked in a strategy to educate the public. Nurses are also attached to the Youth Offending Service and also working with children “looked after” by Local Authorities. Such vulnerable children and young people are at greater risk of alcohol misuse.

6.6 Pilot studies in two Glasgow hospitals in partnership with the Strathclyde Police have Emergency Room nurses trained in alcohol counselling to provide brief interventions on alcohol intake to patients presenting with knife wounds. Patients are encouraged to think about the way drinking may be affecting their lives and the links between alcohol and violence. A preliminary evaluation suggests that these types of interventions have a positive effect on curtailing harmful drinking behaviours.

6.7 The RCN recognises the benefit of early intervention in cases involving alcohol and has produced a resource for nurses and healthcare assistants to identify and assist individuals who have problems with alcohol.

²⁶⁸ Royal College of Physicians and Royal College of Nursing Survey on Alcohol Treatment Services, 2009.

²⁶⁹ *Ibid.*

²⁷⁰ *Ibid.*

²⁷¹ Department of Health, *Choosing Health: making healthy choices easier*, 24 February 2005.

6.8 In Merseyside two PCTs have invested in nurse led primary care services that provide rapid access to assessment and treatment of patients identified as having harmful or hazardous patterns of alcohol use. Whilst this approach is to be applauded it also highlights the dearth of such services in the rest of the country as alcohol treatment has not received the level of investment that drug misuse has received in recent years.

6.9 Different sections of the community exhibit markedly different attitudes towards alcohol, its consumption and the problems it can cause. The best programmes engage with communities at a local level to help identify root causes and effective and suitable methods for education and harm prevention. Amongst some groups of young people excessive alcohol consumption may be seen as normal and linked to “street cred” or bravado whereas in other factions of society there may be some stigma attached to it and an element of shame. There is evidence to support the benefit of early interventions on alcohol consumption designed specifically for target groups. For example, there is a strong case for targeted interventions that reflect the different patterns of alcohol use, eg the practice of drinking large quantities of cheap alcohol before going out, in order to save money.

6.10 There are pockets of excellent practice in this area in a number of hospitals around the UK. To make best use of innovative techniques and partnerships in the community it is important that information is shared. The Department of Health could have a role to play in monitoring and recognising good local practice.

6.11 There are examples of nurse-led programmes that have been developed to target young people who have been found to be involved in street drinking. Police in Lancashire have been accompanied by a nurse on their evening patrols of areas used by young people. The nurse has been able to provide health advice to young drinkers and access to ongoing support.

6.12 In Merseyside the police and community wardens in the borough of Sefton have been issued with “litmus strips” in order to test whether young people have concealed alcohol in soft drinks such as Coke. The parents of any young person found to be drinking alcohol will receive a letter from the local Council’s Anti Social Behaviour Prevention Team. Initial evaluation suggest that this approach has reduced the number of young people involved in street drinking and has enabled persistent “offenders” to be identified and followed up for further assistance or treatment from the borough’s specialist Young People’s Substance Misuse Team.

7. SOLUTIONS, INCLUDING WHETHER THE DRINKING CULTURE IN ENGLAND SHOULD CHANGE, AND IF SO, HOW

7.1 In order to facilitate a positive change in public attitude away from harmful drinking practises and to foster an attitude of awareness about safe and unsafe levels of drinking the RCN advocates a number of measures:

- 7.1.1 Failing to make public health concerns part of licensing objectives is inconsistent with wider health and wellbeing policies and must be urgently addressed. Scotland and Northern Ireland already include the protection and improvement of public health in their licensing objectives. The RCN would like to see such objectives incorporated into English licensing objectives.
- 7.1.2 Young people are thought to be particularly susceptible to advertising and branding, therefore it should be clear within any new alcohol code that targeting young people either directly or indirectly in marketing or advertising campaigns is unacceptable. There are a number of possible measures to ensure that this is enforced, each requiring careful consideration and examination. The RCN advocates a strict approach to the regulation of alcohol advertising that directly or indirectly targets young people.
- 7.1.3 Young people often drink in unsupervised areas as they are unable to gain access to pubs and clubs to buy alcohol. This can lead to risk taking behaviour such as fights, accidents and unprotected sex. Legislation must be tightened to make it more difficult for young people to obtain alcohol. One option would be to increase the age alcohol can be legally purchased from 18 to 21.
- 7.1.4 There is evidence to suggest that alcohol is used as a loss leader in supermarkets.²⁷² £38.6 million of alcohol was sold below trade price in the 2006 World Cup from supermarkets. Within the limits of EU and local competition law a new code should include measures to prohibit or curtail deep discounting. 73% of those surveyed in the RCN/RCP Survey on Alcohol Treatment Services believe that the Government should take action on the sale of low priced alcohol.²⁷³
- 7.1.5 Staff working in retail premises selling alcohol should have training to enable them to identify both underage and intoxicated drinkers and deal with them appropriately.
- 7.1.6 An indisputable amount of evidence linking smoking to a number of diseases has seen it become a public health priority. Alcohol is a widely consumed substance that can have equally harmful consequences if consumed to excess and deserves a similar priority status

²⁷² *Alcohol as a Loss Leader*, Institute of Alcohol Studies, Russell Bennetts, 2008.

²⁷³ Royal College of Physicians and Royal College of Nursing Survey on Alcohol Treatment Services, 2009.

on the public health agenda. The RCN favours a multi-faceted approach to providing help and education to those who are at risk or who wish to cut down on their drinking that includes engagement with communities at a local level.

Royal College of Nursing

March 2009

Memorandum by Breakthrough Breast Cancer (AL 29)

Breakthrough Breast Cancer welcomes the Health Committee's inquiry into alcohol, particularly its consideration of the health consequences of alcohol consumption. This submission will specifically address the first term of reference, that of ill-health resulting from alcohol consumption. It will not address the other terms of reference for the inquiry.

Breakthrough Breast Cancer is the UK's leading charity committed to fighting breast cancer through research, campaigning and education. Breakthrough has established the UK's first dedicated breast cancer research centre, and three research units, in order to realise our vision: a future free from the fear of breast cancer. Breakthrough campaigns for policies that support breast cancer research and improved services, as well as promoting breast cancer education and awareness amongst the general public, policy makers, health professionals and the media.

Breast cancer is now the most common form of cancer in the UK, with nearly 46,000 new cases diagnosed each year. Breast cancer is thought to be caused by complex interactions between our genes, lifestyle and environment. Evidence from epidemiological research indicates that a variety of factors are linked to breast cancer risk, many of which, such as age and height, cannot be modified. However, there are a number of measures that women can take to reduce their risk of developing this disease. These include taking regular exercise, maintaining a healthy weight and reducing alcohol intake.

Epidemiological research has shown that regularly drinking alcohol increases the risk of developing breast cancer. According to a recent meta-analysis conducted by the World Cancer Research Fund,²⁷⁴ the risk of developing breast cancer increases by up to 10% for each 10g of ethanol (alcohol) consumed each day. There is a dose-response relationship between alcohol and breast cancer risk, which means that the risk of developing the disease increases with increasing amounts of alcohol consumed on a daily basis.

Breakthrough Breast Cancer has used this finding to estimate the effect of drinking alcohol on an average UK woman's lifetime risk of developing breast cancer. For example, over a lifetime of at least 85 years, we would expect to see one extra case of breast cancer diagnosed among 100 UK women who drink one unit of alcohol a day, compared to 100 UK women who don't drink alcohol at all. This information is used in our publication *Alcohol and breast cancer risk: The facts*, along with illustrations and graphs, to better inform women of the effect on breast cancer risk associated with drinking alcohol.²⁷⁵

Recently published research has suggested that alcohol consumption could account for between 11% and 22% of breast cancer cases in the UK.^{276, 277} Although these are estimates of the impact of alcohol on breast cancer rates in the UK they indicate that, at a population level, a reduction in the levels of alcohol consumed by women may lead to a decrease in the number of cases of breast cancer diagnosed.

Unlike many other breast cancer risk factors, women have influence over the amount of alcohol they consume. However, while the evidence highlights the increased risk of developing breast cancer in women who regularly drink, as stated above it is important that the Committee recognises that many other factors also have a significant role in determining breast cancer risk. At an individual level, women who reduce the amount of alcohol they drink (and take other lifestyle measures such as exercising regularly and maintaining a healthy weight) can reduce their risk of developing breast cancer, but they will not be able to definitely prevent the disease. For most women, getting older is their biggest breast cancer risk factor and 80% of UK cases are diagnosed in women aged over 50.

Breakthrough Breast Cancer is actively involved in research to determine the causes of breast cancer, including the Breakthrough Generations Study. This study, conducted in partnership with the Institute of Cancer Research, is the world's largest and most comprehensive study into the causes of breast cancer. It will follow 100,000 women for the next 40 years to pinpoint the causes of the disease.

Breakthrough Breast Cancer supports new initiatives to both improve awareness of the impacts of alcohol consumption on health and to reduce such impacts. In October 2009, Breakthrough worked with the Department of Health to highlight the increased risk of developing breast cancer as a result of alcohol consumption, through their Know Your Limits campaign.²⁷⁸

²⁷⁴ World Cancer Research Fund/American Institute for Cancer Research. Food Nutrition, Physical Activity, and the Prevention of Cancer: A Global Perspective. Washington DC: AICR, 2007

²⁷⁵ http://www.breakthrough.org.uk/what_we_do/breakthrough_publications/alcohol_and.html

²⁷⁶ World Cancer Research Fund/American Institute for Cancer Research. Policy and Action for Cancer Prevention. Food Nutrition and Physical Activity: A Global Perspective. Washington DC: AICR, 2009

²⁷⁷ Allen NE et al (2009) Moderate Alcohol Intake and Cancer Incidence in Women. *J Natl Cancer Inst.* 101(5):296-305.

²⁷⁸ <http://units.nhs.uk/downloads/Alcohol-and-breast-cancer-press-release.pdf>

We hope that this submission provides useful information to the Committee's inquiry. We would be happy to provide any additional information about breast cancer risk factors or the association of alcohol consumption with breast cancer risk.

March 2009

Memorandum by Children in Scotland (AL 30)

The Committee is encouraged to give priority attention to the prevention, identification and treatment of Foetal Alcohol Syndrome (and Foetal Alcohol Spectrum Disorder).

Children in Scotland is the intermediate agency for the children's sector, with over 450 members—from large children's charities to community groups, professional associations and local authorities.²⁷⁹

CONTEXT

1. A significant percentage of children throughout the United Kingdom are harmed in various ways and to varying degrees by alcohol. Sometimes the negative effects are caused by alcohol consumption among children and young people themselves. In addition, there is abuse and/or neglect of children resulting from the drinking problems of parents or the other adults in their lives.

2. Scotland has become keenly aware of the alcohol-fueled problems facing children and young people. The report *Hidden Harm* analysed the situation and made recommendations worthy of consideration by the Westminster Health Committee. At the moment, the Scottish Government is in the midst of a major policy initiative around how best to address alcohol-related problems. The efforts made thus far offer useful information and ideas for the House of Commons Health Committee's own alcohol inquiry.

3. In comparison with the attention accorded to parental dependence upon alcohol—and the misuse of alcohol by children and young people—relatively little attention (and even less action) has been focused on the extent to which children's lives and life chances have been compromised by exposure to alcohol while still *in utero*. This blindspot is counterproductive. Ignoring the problem of Foetal Alcohol Syndrome (FAS) and Foetal Alcohol Spectrum Disorder (FASD) has not reduced the life-long harm with which many children must live because of foetal alcohol exposure.

THE BASICS

4. Foetal Alcohol Syndrome (FAS) is the term used to describe the visible birth defects and the invisible organ/brain/nervous system damage that can result from exposure to alcohol during pregnancy. It is used to describe the most severe form of a wide range of permanent physical, mental and behavioural problems that begin before birth. From malformed faces and limbs to heart problems and diminished intellectual capacity, FAS can and does adversely affect children's lives across the United Kingdom.

5. It is not the case that a child either has full-blown FAS or has no damage from foetal alcohol exposure. When the impacts of alcohol on the development of a baby are real, but less immediately obvious, this medical condition is referred to as Foetal Alcohol Spectrum Disorder (FASD). It is akin to a child who is born with a degree of visual impairment rather than complete blindness. The extent of the impairment only becomes evident as the child grows older. Damage can range from minimal to severe.

6. In the case of FASD, it is common for the brain's "executive functions"—eg, a person's ability to plan, learn from experience and control impulses—to be significantly diminished by foetal alcohol exposure. This happens because alcohol is a *teratogenic agent* (meaning a chemical that interferes with the normal development of a foetus). Some of this teratogenic harm can occur during the first weeks following conception—ie even before the pregnancy has been realised and confirmed by the mother.

7. The seven key messages about foetal alcohol exposure are:

- *It is potentially 100% preventable.* The one indisputable medical fact is that no mother who abstained from drinking alcohol throughout pregnancy ever has given birth to a baby with FAS/FASD.
- *It is incurable.* Although regarded as a problem affecting babies and children, the simple fact is that no one outgrows or "gets over" the harm caused by foetal alcohol exposure. While treatment/support can improve the well-being of a child with FAS/FASD, the developmental damage is irreversible.

²⁷⁹ www.childreninscotland.org.uk

- *It is unpredictable.* There is no guarantee that a woman who drinks heavily during pregnancy will have a baby with FAS—or that one who drinks moderately will not have a baby harmed by alcohol. There are no tests that can determine in advance which pregnancies will result in these alcohol-fuelled problems. Little is known about exactly when or how much of what type of alcohol will harm a particular foetus. Thus, there is no guaranteed “safe” level of alcohol during pregnancy.
- *It can be difficult to diagnose.* Just as there is no test to predict which pregnancy will result in FAS/FASD, so too there is no simple test that proves its presence or absence (except in the small percentage of cases where notable facial/physical anomalies or organ damage are evident). This is true, in part, because this diagnosis is dependant upon accurate recall and reporting of alcohol consumption by the mother.
- *It is under-diagnosed (or misdiagnosed) and under-reported.* For example, based upon international data, a conservative estimate is that there are 900 children in Scotland (0–18) who have FAS—and many times more (ie thousands) of children and young people who were damaged in more subtle, but still serious, ways by foetal alcohol exposure. Given its far larger population, the numbers will be far higher in England.
- *It has wide-ranging, serious consequences for individuals, communities and society.* Because FAS/FASD is not a problem that fades over time, many problems of young people and adults have their roots in exposure to alcohol as a foetus. At the deep end (eg when manifested by heart or other organ damage), there are major, on-going medical and therapy expenses. All along the foetal alcohol spectrum, however, the diminished “executive functions” of the brain can lead to numerous problems. These include: learning difficulties and disorders (and failure in school); difficult or anti-social behaviours; inability to secure/maintain employment; and, substance misuse/addiction. Such problems translate into high costs in human and economic terms, as well as extra demands upon public expenditures and services in the health, justice, social work, education and benefits systems.
- *Its ill effects can be lessened by proper diagnosis and proper treatment/support.* There are promising therapies and methods of support being developed and refined internationally. Misdiagnosis—that is, mistaking FAS or FASD for other medical/developmental problems—can lead to interventions that waste time, effort and money (and may worsen the situation for the individual affected).

RECOMMENDATIONS

8. *The identification of children, young people and adults harmed by Foetal Alcohol Syndrome and FASD should be given a much higher priority throughout the United Kingdom than is the case today.* This process must begin with an accurate assessment of the incidence and prevalence of these medical conditions—a task that can be accomplished only once there is a critical mass of health practitioners around the UK able to correctly make this diagnosis. This, in turn, depends upon health professionals reaching a level of agreement and consistency that does not now exist.

9. *Identification of FAS/FASD should be accompanied by the availability of appropriate treatment and effective support for the people harmed by foetal alcohol exposure.* Planning for such provision must be in synch with the identification process, as there currently is neither widespread agreement on the range of assistance needed, nor an adequate workforce in place that is prepared to offer the help that is needed.

10. *However, top priority should be accorded to the prevention of FAS and FASD across the four nations.* Given the difficulties of diagnosis and the reality that there is no “cure”, the importance of “prevention” is greatly magnified. Established public health principles and practices leads to the conclusion that **abstinence** from alcohol is the best advice to give to women who are: (a) trying to conceive; (b) at high risk of an unplanned pregnancy; or, (c) already pregnant. The abstinence message needs to become far more consistent and prominent across the United Kingdom. Mixed messages don’t help.

11. *Prevention of FAS/FASD should become a priority not only within, but also well beyond, the health professions.* Because harm from foetal alcohol can occur before a pregnancy is even known, prevention efforts must be strong at the pre-conception level. Accordingly, it is as much a job for educators, youth workers, sexual health counsellors and family planning specialists, as it is for midwives or physicians.

Children in Scotland encourages the House of Commons Health Committee to accord FAS/ FASD priority in its recommendations for action by the UK Government. Although there are areas of action here that properly are regarded and treated as devolved matters for each of the four nations, FAS/FASD is a public health issue that would benefit from UK-wide cooperation and information sharing.

Dr Jonathan Sher
Director of Research, Policy and Programmes

March 2009

Memorandum by the Scotch Whisky Association and the Gin & Vodka Association (AL 31)

EXECUTIVE SUMMARY

The Scotch Whisky Association (SWA) and Gin & Vodka Association (GVA) are committed to working in partnership with Government and other stakeholders to tackle alcohol misuse. It is the minority that misuse alcohol. Adoption of a blanket “one-size” fits all approach does nothing to support the responsible majority—whether consumer or trader.

We have set out in our submission our approach to tackling alcohol misuse. We believe in a targeted approach aimed at “at risk” populations. We consider that working in partnership with all stakeholders is fundamental to tackling the issue and that education coupled with robust enforcement and responsible marketing and promotion are key elements to creating and underpinning a culture of responsible drinking.

A. INTRODUCTION

1. The Scotch Whisky Association (SWA) and the Gin & Vodka Association (GVA) welcome the opportunity to make this joint submission to the House of Commons Health Select Committee Inquiry into Alcohol. Our aim in this paper is to set out our approach to tackling alcohol misuse.

The Scotch Whisky Association (SWA)

2. The SWA is the representative organisation for the Scotch Whisky industry. Our aim is to protect, promote and grow Scotch Whisky worldwide.

3. Our 54 member companies include distillers, blenders, bottlers, and brokers of Scotch Whisky, representing around 90% of the industry. The industry supports some 65,000 jobs across the UK often in less economically advantaged urban areas or in remote rural communities where limited alternative job opportunities exist.

4. The industry is one of the UK’s top five manufacturing export earners and accounts for 25% of food and drink exports generating in excess of £2.8 billion towards the UK balance of payments. Over £1 billion is spent on local goods and services in the UK.

5. The UK market is the industry’s 4th largest market in terms of volume and is often viewed by Governments in key export markets as a guide to how they should regulate Scotch Whisky.

The Gin & Vodka Association (GVA)

6. GVA’s 34 members represent 90% of the UK trade. Gin and vodka are exported to some 200 countries. Over 70% of UK produced gin and more than 20% of our vodka is exported. Exports of UK-produced gin and vodka are up 50% compared to 1990 and were worth over £250 million in 2007. It is the largest sector by volume in the UK spirits market.

7. Our members are major employers with a direct workforce of 2000, and around 8000 indirectly employed. GVA members’ distilleries and bottling plants stretch across the UK from Plymouth in the South to Invergordon in the North. Gin and vodka production is of significant importance to the rural economy using 160,000 tonnes of UK grown wheat.

8. Over £2 billion is paid annually in excise and VAT from UK produced gin, vodka and RTDs. Receipts from corporation tax, business rates and income tax for employees push the Government’s yield even higher.

B. OUR APPROACH TO TACKLING ALCOHOL MISUSE

9. As producer organisations, our members do not sell their product directly to the final consumers other than through limited online sales and direct to visitors at distillery visitor centres.

10. We recognise and share the desire to tackle alcohol misuse. Indeed, the SWA and the GVA have been active in promoting responsible drinking for some 40 years. The alcohol industry—alongside other stakeholders—clearly has a role to play in encouraging and promoting the responsible consumption of its products to protect the long-term sustainability of the industry. We recognise also that there is an urgent need to challenge the idea among a minority of the population that drunken antisocial behaviour is acceptable.

11. The drinks industry has a long history in promoting responsible drinking. Whilst these actions are making an impact we know there is still a long journey to travel. Both Associations and our members are committed to helping foster a step change in cultural attitudes to the consumption of alcohol in the UK, which recognises that responsible, moderate consumption is part of a modern, healthy society and that alcohol misuse is unacceptable. The recent decline in alcohol-related road deaths and injuries caused by drink driving illustrates how success can be achieved in this area.

12. Tackling alcohol misuse and achieving cultural change in attitudes to alcohol requires a long-term commitment, close collaboration and a concerted effort by a wide range of public and private stakeholders. It requires tough enforcement of existing alcohol laws, a sound regulatory framework, as well as an innovative approach to social marketing which reaches the right sections of the population. We welcome the government's decision to consult on its alcohol strategy and look forward to responding to the forthcoming consultation on the Government's proposed mandatory code of practice on alcohol promotions.

13. A number of key principles underpin our approach to tackling alcohol misuse. Successful strategies:

Target specific problem groups

14. The majority of consumers do drink responsibly. We believe that an approach targeting "at risk" populations and potentially harmful contexts and drinking patterns will be most effective. The following statistics demonstrate the need for target interventions.^{280, 281, 282}

- HMRC/British Beer and Pub Association data show that per capita consumption has been falling since 2004.
- The majority of the population choose to drink. These figures have shown a small constant decline since 2003 (men 75% to 72%; women 60% to 57%).
- The average weekly consumption for men is 18 units and for women 7.7 units. These are well within the weekly guidelines of 21 units for men and 14 units for women.
- The percentage of men who drink on five or more days a week has been relatively constant since 1998 at 22%. This is also true for women at 12%. However, it is important to note these figures are much lower for men and women within the 16-24 age group (9% and 4% respectively).
- The proportion reporting heavy drinking (ie drinking more than double the daily benchmark (eight units for men, six units for women) on at least one day during the previous week) is 24% men and 15% women.
- This pattern of drinking is highest amongst the 16–24 age group (32% men, 24% women). However, since 2002 there has been a clear downward trend in the percentage of young women drinking more than double the daily benchmark in this age group. For young men the trend is not constant, but is in a general downward direction.
- The percentage of men drinking at harmful levels (51 units and more per week) is 9%; the figure for women is 4% (36 units and more per week).
- The number of 11–15 year olds who have never drunk alcohol is increasing—40% in 2000 to 46% in 2006. However, in contrast to recent decrease in drinking prevalence amongst this age group the minority that are drinking are drinking more.

15. An analysis of alcohol statistics clearly show that excessive drinking is a minority problem, while closer scrutiny reveals that within this minority are three subsets of drinker towards whom efforts should be targeted:

- underage purchasers, who should not be buying alcohol at all;
- 18–24 year-old binge drinkers who engage in anti-social behaviour; and
- middle-aged and older predominantly male drinkers, who cause harm to themselves.

Deliver in partnership

16. We embrace a partnership approach with Government and all stakeholders, focusing action on evidence-based measures. Such an approach breaks down barriers between the various stakeholders, fosters co-operation and allows the different stakeholder groups to share their experiences and build on best practice. Examples of the concrete action in this area include:

- The SWA was the only national association to sign up as a founding member of the EU Alcohol and Health Forum. The Forum is a cornerstone for implementation of the EU strategy to reduce alcohol-related harm. The overall objective is to provide a common platform for all interested stakeholders at EU level that pledge to step up actions relevant to reducing alcohol-related harm.
- Both the SWA and GVA are members of the Scottish Government Alcohol Industry Partnership to tackle alcohol misuse. Launched in February 2007 the Partnership has brought forward a number of concrete actions including: Alcohol Awareness Week (details below), Sponsorship Guidelines, a model employee alcohol policy suitable for use by organisations of all sizes and a detailed project within a specific geographical location assessing a multi-component approach to tackling alcohol misuse.

²⁸⁰ Smoking and Drinking Among Adults 2007. Office of National Statistics 2008.

²⁸¹ Drinking: adults' behaviours and knowledge in 2008. Office of National Statistics.

²⁸² Statistics on Alcohol: England, 2008. The Information Centre, NHS.

- The first ever Alcohol Awareness Week held in Scotland in October 2007, a joint campaign involving Government, industry and health stakeholders proposed initially by the Scotch Whisky Association. A second successful Alcohol Awareness Week was held in 2008 and Alcohol Awareness Week is now very much an established part of the calendar.

Educate

17. Education in its widest sense is fundamental to a better appreciation of the risks associated with the misuse of alcohol. It can be used to target a range of problem drinkers including:

(i) Underage drinkers

18. Alcohol education should be introduced in schools at an early and formative age and be a compulsory part of the curriculum and we welcome the DCSF's recent commitment to introduce this measure. Children should be given sufficient information about alcohol to be able to discuss with their parents issues around alcohol consumption (much as children have done in relation to smoking or recycling).

(ii) Young adult binge drinkers aged 18–24

19. As well as running individual social responsibility programmes and supporting the Drinkaware Trust, an independent charity set up to help consumers make informed decisions about alcohol, the alcohol industry has responded to the Government's call to use marketing expertise to develop a campaign to tackle alcohol-misuse—particularly among young people age 18–24.

20. Following on from the letter from the Prime Minister to industry leaders and trade associations in March 2008 in which he wrote:

“I am sure you will agree that Government and industry both face a challenge from the public to reduce the harm that alcohol does to our society. Recognising the importance of the contribution the industry already makes, but mindful of the ongoing challenges we jointly face, I should be grateful if, in discussion with Departments, the industry could work constructively together, using their considerable expertise in marketing to devise a way forward . . .”

The industry, including both the SWA and GVA, has been working hard on developing a campaign. Project 10—Campaign for Smarter Drinking is the name given to this Social Marketing campaign, which is being developed by a voluntary alliance of producers and on and off trade retailers who believe it is in the interests of both our society and our industry that we make a positive response. The proposed campaign predominantly targeting 18–24 year olds is being designed to work alongside and reinforce existing initiatives from both Government and industry, most notably “Know Your Limits” and the existing work of the Drinkaware Trust. Project 10 currently has the support in-principle of 46 major companies including virtually all the major on-trade & off-trade retailers and the major producers.

21. “Social Norming” is another method which has not been extensively used in the UK, but shows promise. Social norms are those beliefs and attitudes we all hold about what is normal, expected or appropriate in any social situation. A key influencer of individual behaviour is what we believe is normal behaviour in those around us, the majority. Problems start to arise when minority behaviour is misperceived as majority activity as in the case of alcohol and drug use among young people.

22. The “Social Norms” approach to preventing problem behaviour and promoting reinforcement of positive behaviour seeks to address the problem by dispelling myths about what is perceived as the norm among peers. Evidence has shown targeted populations respond to these initiatives with more realistic perceptions about their peers. Negative behaviour decreases and the norm of the positive behaviour grows stronger.

(iii) Older harmful drinkers

23. Alcohol education should be reinforced in adult life through effective Government multi-media campaigns, supported by the industry and other stakeholders. Better communication of responsible drinking messages to the adult drinking population through measures, such as on-label messaging and advertising can also contribute in this area.

24. Complementary to industry messaging and schools education, the delivery of Brief Interventions by doctors and others in healthcare/criminal justice settings must be a routine part of the life-long education approach. Brief Intervention is recognised as a cost effective policy tool for reducing alcohol misuse and is supported by health stakeholders. We do welcome the work being done giving training on Brief Interventions to GPs, nurses, A&E staff and alcohol workers in police stations as well as encouragement to deliver such interventions. We would encourage the Department of Health to mandate the delivery of Brief Interventions in a wide variety of healthcare settings and ensure adequate training and support for rolling out of Brief Interventions.

Ensure alcohol is marketed and promoted responsibly

25. A fundamental deliverable from producers is responsible marketing and promotion of their brands.

26. Advertising, promotions and sponsorship are a legitimate part of commercial activity in every industry. They play an important part in competition between brands, and are well governed by Codes of Practice/Conduct such as Broadcast Committee of Advertising Practice (BCAP)/Committee of Advertising Practice (CAP) and the Portman Group Code of Practice on the Naming, Packaging and Promotion of Alcohol Drinks. The Code of Practice, which is supported by over 140 companies, is strongly enforced through an independent robust complaints process which includes the power to enforce sanctions for breaches of the Code.

27. In addition, the Scotch Whisky Association has developed its own mandatory Code of Practice on the Responsible Marketing and Promotion of Scotch Whisky, drawn up by the industry in 2005. A condition of Association membership includes signing the SWA Code of Practice, an industry code that uniquely has an international reach and is backed by an Independent Complaints Panel with the power to enforce sanctions on members in event of a breach of the Code, including the ability to fine members.

28. The SWA actively monitors and audits members' compliance with its Code of Practice as part of its continual improvement process allowing the Code to be improved and developed. The second edition of the Code was launched in February 2009 following a detailed audit, which tighten a number of requirements of the Code in relation to sponsorships, the need to carry a responsibility message on all advertising as well as controls on access to websites.

29. As members of the European Spirits Organisation—CEPS, producer companies belonging to the SWA and GVA must adhere to the Charter of Responsible Alcohol Consumption. This commits companies to include responsible drinking messages in 75% of advertising (print including billboards, TV/cinema and website) by 2010.

30. Clearly and quite rightly there are concerns around irresponsible promotions. The Minister of State for Public Health in the introduction to "Safe, Sensible, Social—Consultation on further action" stated:

“... that most retailers and consumers of alcohol act responsibly and it is the irresponsible minority on which our efforts are focused. It is right to consider ways to tackle irresponsible practices, but we must also ensure that any measures do not unduly penalise those consumers who benefit from legitimate promotions responsibly”.

31. We welcome the recognition by Government that the majority of retailers and consumers do act responsibly, and that the responsible majority should not be penalised. We believe a clear definition of what is meant by “irresponsible promotion” within different retail environments would be beneficial. In the on-trade purchase usually means consumption there and then, whereas in the off-trade purchase does not relate to immediate consumption or possibly indeed any consumption by the actual purchaser.

32. It is important to recognise that promotions are a very important tool and take many forms (ie on pack promotions such as a free glass or opportunity to enter a competition/prize draw, or opportunity to receive a money off voucher on a new brand when purchasing a bottle). We do not believe such promotions are irresponsible or lead to irresponsible consumption. An issue which has been receiving much attention is price-based promotions. The SWA and GVA are not opposed to appropriate price-based promotions. They are important in contributing towards brand awareness and introducing new products to the market. Without such mechanisms, established brands have an advantage and this can lead to market stagnation.

33. The SWA and GVA would like to make clear our view that we oppose any sort of minimum pricing as a matter of principle, and question whether such a system would be legal under EU and international trade rules.

Robust enforcement

34. There is already in place a robust regulatory framework to tackle alcohol misuse. It should be used effectively. There must be strict and consistent enforcement of the law on the sale of alcohol to those under the legal purchase age and those who are intoxicated. Measures such as “no proof, no sale”, “Challenge 21/25” and “test purchasing” when combined are powerful drivers of cultural change. Test purchasing should be carried out regularly and consistently across the country to catch those selling in breach of the law. Equally, the police should step up action against anyone underage who tries to buy alcohol illegally.

35. To compliment this, we fully support the training of all servers of alcohol, including casual bar and retail staff. Server training is recognised as being an effective measure in tackling alcohol misuse especially when coupled with robust enforcement of the law on not serving underage or intoxicated consumers.

March 2009

Memorandum by Children in Northern Ireland (AL 32)

Children in Northern Ireland (CiNI) is the regional umbrella body for the children's sector in Northern Ireland. CiNI provides information, training, policy and participation support services to our 126 member organisations, a significant number of whom provide direct support and services to some of our most vulnerable and marginalised children and young people.

CiNI welcomes the Health Committee's Inquiry into Alcohol and would like to endorse the recommendations within Children in Scotland's written submission.

Their recommendations are:

- The identification of children, young people and adults harmed by Foetal Alcohol Syndrome and FASD should be given a much higher priority throughout the United Kingdom than is the case today.
- Identification of FAS/FASD should be accompanied by the availability of appropriate treatment and effective support for the people harmed by foetal alcohol exposure.
- Top priority should be accorded to the prevention of FAS and FASD across the four nations.
- Prevention of FAS/FASD should become a priority not only within, but also well beyond, the health professions.

In line with Article 12 of the UNCRC, we also would strongly advocate that the Committee takes appropriate steps to engage with children and young people in the ongoing development, implementation, monitoring and review of strategic policy to tackle alcohol abuse.

March 2009

Memorandum by the Local Government Association (AL 33)

EXECUTIVE SUMMARY

1. Alcohol misuse impacts directly on health services, but it also has consequences for crime and disorder, community wellbeing, and the environment in which we all live. It is recognised that alcohol-related problems cannot be tackled by one body alone. This submission argues that local government plays a vital role in tackling the negative impacts of alcohol misuse. Councils:

- licence and regulate the sale of alcohol according to the needs of their local communities; and
- lead local strategic partnerships which bring together local partners including PCTs and the police.

2. Councils and their partners are already addressing these issues through various innovative local initiatives. Examples are included in the body of this submission.

3. This submission argues for modest but important changes to the Licensing Act 2003 that would empower elected councillors and licensing authorities to use licensing law to lead local action in tackling the negative effects of alcohol.

LOCAL GOVERNMENT ASSOCIATION

4. The Local Government Association (LGA) represents 466 authorities in England and Wales; together these councils speak for over 50 million people and spend £113bn a year delivering services on their behalf.

CONTEXT

5. Tackling the effects of excessive alcohol consumption is a key local priority. Half of all Local Area Agreements, for example, have prioritised reducing hospital admissions from alcohol related harm.

6. There are currently 155,400 premises licensed for the sale of alcohol in England, of which 40,600 are off-licence only.²⁸³ Councils' powers to licence and attach conditions to the sale of alcohol are central to taking action locally on problem drinking, as is the regulation and enforcement of licences by responsible authorities such as Trading Standards.

²⁸³ DCMS Licensing Statistical Bulletin, 2007–08.

SCALE OF ILL-HEALTH RELATED TO ALCOHOL MISUSE

7. The National Alcohol Harm Reduction Strategy 2003 included a number of stark statistics:
 - 150,000 hospital admissions annually as a consequence of alcohol;
 - 30,000 admissions caused by alcohol dependence syndrome;
 - estimated 1.2 million alcohol-related violent incidents each year;
 - around 20,000 people die prematurely, about a fifth from acute problems; and
 - around 480 deaths caused by drink-driving.
8. The Strategy estimated the cost of alcohol misuse to:
 - health—up to £1.7 billion to NHS;
 - crime and disorder—up to £7.3 billion (plus up to further £4.7 billion in human and emotional costs of alcohol related crime); and
 - workplace/productivity—up to £ 6.4 billion.
9. In 2008 the Department of Health updated the figures, estimating the annual cost of alcohol harm to the NHS in England to be £2.7 billion in 2006–07 prices.

CONSEQUENCES FOR THE NHS

10. Health professionals are best placed to provide the Committee with detail on the consequences of alcohol misuse on the NHS. Recent LGA research produced interesting findings on the impact of the Licensing Act 2003 on the NHS.

11. In June 2008, we commissioned research to increase understanding of the effects of the Licensing Act 2003 on local authorities, primary care trusts, and police authorities in England and Wales.²⁸⁴ We found:

- 29% of surveyed PCTs said the Act has increased the number of alcohol related incidents in their area. Of these, 86% felt that there is more pressure on resources as a result.
- 73% of PCTs felt the Act has resulted in closer working with local authorities.

CENTRAL GOVERNMENT POLICY AND THE ROLE OF LOCAL GOVERNMENT

Licensing

12. The main power available to local authorities to make interventions to reduce alcohol misuse is licensing law. The Licensing Act 2003 introduced the current licensing regime which councils use to regulate the sale and supply of alcohol in their communities.

13. Licensing authorities are responsible for administering the local licensing system. The licensing authority cannot intervene in applications or initiate reviews in its own right, so the role of responsible authorities and the local community is key.

14. Other parts of a local authority including environmental health, trading standards, planning and social services departments, together with the local police authority, are “Responsible Authorities”. They can intervene in applications for new premises and applications to vary existing licences. They can call for a review of existing licences where they believe there are problems with the way a particular premise is operating.

15. Licensing committees work closely with the police on the regulation of premises. The police can make representations at licensing committee meetings. We note PCTs cannot currently make the same representations.

16. All licence applications are advertised at the premises and in the local press, and local residents are entitled to comment on or raise concerns about applications based on the licensing objectives. These representations trigger a hearing by the licensing sub-committee. Members of the local community (“Interested Parties”) can also call for a review of a premises licence, triggering a formal hearing at which the licence can be modified, suspended or even revoked by the licensing sub-committee.

17. The Licensing Act does not contain objectives relating to health. Its key objectives are:
 - (a) The prevention of crime and disorder.
 - (b) Public safety.
 - (c) The prevention of public nuisance.
 - (d) The protection of children from harm.

All conditions imposed or other measures taken under the Act must be linked to at least one of these four licensing objectives.

²⁸⁴ LGA Report, *Unfinished Business: a state-of-play report on alcohol and the Licensing Act 2003*, 2008.

18. The LGA proposes a set of modest legislative changes, presented in the solutions section of this submission, to explicitly empower elected Councillors and licensing authorities to lead local action in using the Licensing Act to tackle the negative effects of alcohol.

19. We recognise the vast majority of pubs, bars and restaurants are well run establishments where alcohol is consumed in a safe, public and well regulated environment.

Policing and Crime Bill

20. The Policing and Crime Bill contains provisions intended to reduce alcohol misuse by amending police powers to deal with young people drinking alcohol in public. It will also raise the maximum penalties for those premises that sell alcohol to underage people and those people who refuse to stop drinking in public when instructed by the police.

21. The LGA welcomes the Bill's aim to tighten regulations on the sale of alcohol and the power for local authorities to impose conditions on existing licences that cause problems in particular localities. Local licensing authorities are best placed to recognise the diversity of premises in each community and target problem premises.

22. We oppose provisions that allow the Secretary of State to impose blanket regulations across the board on premises licenses. Blanket regulation is not an effective weapon in targeting problem premises. We are concerned about further blanket regulation to an industry which is already rapidly losing premises. Local pubs provide a social and economic hub in many communities and councils are keen to support their survival in difficult economic times.

23. We are also concerned about the impact of further licensing regulation on an already under-funded licensing regime. We estimate there has been a £100 million funding deficit from the imbalance between the cost of implementing the licensing regime and the fees councils can charge.

Off Licenses and Supermarkets

24. The regulation of off licenses is key to any effort to tackle problem drinking. Off licenses and supermarkets consistently sell alcohol cheaply which means people are able to buy more alcohol, to be consumed off the premises in unregulated environments. Drinking at home has increased since the smoking ban in 2007.

25. Smaller off-licences can though be associated with a number of specific problems in the public realm, for which local authority interventions are central to tackling:

- sale of alcohol to street drinkers, who congregate in the area and cause public nuisance and crime and disorder;
- sale of alcohol to minors, either directly making underage sales, or by “proxy” sales via adult purchasers; and
- crime and disorder in terms of shoplifting (eg alcohol) and robbery at the premises, or other criminal and anti-social behaviour.

26. Reviews of off-licences are most commonly brought by the police or trading standards, either following sales to underage customers, or due to problems with anti-social behaviour, crime and disorder. The licensing sub-committee hears the evidence brought by the responsible authority, as well as evidence from the licensee and members of the local community who have made relevant representations, and decides whether to impose stricter conditions on the licence, suspend the licence, remove the premises supervisor, or even revoke the licence completely.

27. Conditions in the current draft code that is proposed in the Policing and Crime Bill are biased towards further regulation of the on-trade and do not sufficiently address the contribution of off-sales to problem drinking.

Multi-agency Working & Local Area Agreements

28. National policy implementation takes effect at a local level. It has long been recognised that alcohol-related problems cannot be tackled by one body alone. Local Area Agreements (LAAs) are the most recent formal framework to drive multi-agency working, but partnership working is not new. Many councils have established connections with their local NHS, police and other partners to deliver innovative local solutions. This partnership is demonstrated through the contribution of examples in this evidence from the UK Public Health Association's Special Interest Group on Alcohol and Violence.

CASE STUDY—BLACKPOOL

Blackpool Council has worked closely with the NHS and police for several years.

How

There are two formal structures to enable a joint strategic approach, at which co-operation and the sharing of intelligence are paramount.

- An Alcohol Strategy Group was set up in 2005 to agree and deliver a multi-agency response to alcohol harm. Chaired by the Director of Public Health its membership includes the PCT's public health specialist, drug commissioner and alcohol lead, the council's Community Safety Manager, an elected member from the licensing panel, the police Chief Inspector, Young People's Commissioner, Integrated Youth Services Manager, Head of Regulatory Affairs at Trading Standards and Head of Probation Services.
- The Night Time Economy Strategy Group meets bi-monthly. Its membership is: PCT Alcohol Lead, Head of Regulatory Affairs at Trading Standards, police inspector for licensing and violent crime, elected member for tourism, council business development manager, a bar manager, town centre night time manager and the council's licensing solicitor.

Outcome

- The Alcohol Strategy Group drove the appointment of a police officer and a public protection officer in the PCT. Managed by the alcohol lead, both roles raise awareness of alcohol harm with the public, employers, community groups and schools. The police officer reviews new licensing applications and mobilises colleagues if objections are needed. The inclusion of the licensing elected member means better collaboration between responsible authorities during the licensing process.
- The Night Time Economy Strategy Group created new campaign, Alternat8, which has led to publicans replacing their glasses with new polycarbonate glassware. This is branded with the approximate number of alcohol units in the glass and a message to consider making the next drink water. More than 20,000 glasses were distributed free to licensees during January.

Anticipated outcomes

- A reduction in alcohol related crime and disorder and hospital admissions as a result of Alternat8.
- The possibility of piloting the ability of a PCT to act as an interested party and to object to particular licensing applications.

CASE STUDY—LONDON BOROUGH OF BRENT*Why*

- Brent's problem with excessive drinking is not as severe as many other areas. Alcohol-related hospital admissions are below the norm, at 734 per 100,000 for men and 351 per 100,000 for women. But there are signs the situation is changing. The number of alcohol-related hospital admissions rose by 27% in 2007 alone.

How

- The council and PCT reacted in 2006 by producing an alcohol harm reduction strategy. An alcohol focus group, comprising representatives from all parts of the public sector, recommended residents should have access to treatment and advice at an earlier stage.
- Brent already had a well-established alcohol treatment programme for dependent drinkers. This includes community detox programmes and in-patient hospital care. But the group recognised something had to be done for the "hazardous drinkers"—those drinking above the recommended levels but not yet classed as addicted.
- The strategy suggested a screening programme should be set up to identify those at risk.

Outcome

- The partnership set up a brief interventions scheme at GP surgeries and the local A&E department. About 20 hospital staff, plus practice nurses and GPs from three local surgeries were trained ahead of the start of the pilot scheme in April 2008.

Anticipated Outcomes

- If the pilot proves successful it will be rolled out across the borough.

29. A LAA is an agreement between central government and the local authority and its partners (such as Police, the NHS or Jobcentre Plus) about the priorities for the local area. All public sector agencies in the area have a duty to cooperate with each other and work with local councils to agree the priorities and work together to achieve them. The agencies and councils come together to form Local Strategic Partnerships (LSPs).

30. Up to 35 priorities can be chosen from a list of 198 national indicators. The list includes a number of alcohol-related indicators. Specific indicators are:

- NI 39 alcohol-harm related hospital admission rates;
- NI 41 perceptions of drunk or rowdy behaviour as a problem; and
- NI 115 substance misuse by young people.

Other relevant safer stronger community indicators include:

- NI 15 serious violent crime rate;
- NI 17 perceptions of anti-social behaviour;
- NI 32 repeat incidents of domestic violence; and
- NI 47 people killed or seriously injured in road traffic accidents.

Other relevant health indicators include:

- NI 112 under 18 conception rates—alcohol is a significant feature for teenage conceptions and makes young people more vulnerable to STIs.

31. 75 of the 150 LAAs prioritise reducing the rate of hospital admission per 100,000 of the population for alcohol related harm. It is the 20th most popular indicator. This demonstrates both the importance placed on alcohol-related issues at a local level and LSPs' views that these issues need to be tackled by the partnership, not just the NHS.

32. There is some interesting regional variability amongst LSPs that have chosen to include the hospital admission indicator in their LAA:

- 100% in Merseyside;
- 82% in the North West;
- 78% in the East Midlands; and
- 63% in the South East.

33. Although many LAAs contain the same targets, exactly how the problems are tackled at local level varies widely. There are already a range of local responses taking place on the ground:

- improved enforcement measures—for example, improving policing of sales of alcohol to minors, introduction of “zero tolerance” and alcohol free public spaces;
- controlling and improving drinking venues—introduction of schemes such as “pubwatch”, designated driver, and server training;
- encouraging changes in the design of public houses, for instance, the provision of food, less crowding, lower noise levels;
- providing local support for educational efforts in schools, youth clubs and other youth venues. This includes awareness and diversionary activities, help lines and youth advisory and help services;
- supporting the role of primary care and general services—for example, probation, social work, prison, local businesses—in providing a response to alcohol problems in their clients or workers; and
- supporting the provision of a range of specialist prevention and treatment services.

SOLUTIONS

Amending the Licensing Act to allow councils to lead local action

34. The LGA Group strongly advocates changes to legislation to clearly and explicitly empower elected Councillors and licensing authorities to lead local action to tackle the negative effects of alcohol, in partnership with other agencies. A vehicle to introduce this exists in the Policing and Crime Reduction Bill currently before Parliament. This legislation should contain the following key powers:

- elected Councillors and licensing authorities need to be able to instigate a review of a premises licence. This is the first step to focusing interventions on those premises that are causing the problem, rather than burdening the whole industry;

- elected Councillors should be an interested party in licence reviews of premises in their ward, and able to act on their own initiative. This is a basic democratic principle; and
- licensing authorities and Environmental Health officers should be able to object to Temporary Events Notices where they believe an event would compromise public safety or create a public nuisance, such as that which accompanies widespread binge drinking. Requiring them to co-opt a Police intervention simply adds to the burden of bureaucracy.

35. The LGA would welcome the opportunity to give oral evidence to the Committee.

36. In preparing this submission, we consulted member authorities and licensing policy officers. We suggest the Committee also seek evidence from individual authorities that have taken a particular lead on alcohol issues. We are also aware of various practical ideas and measures that, though untested, may reduce problem drinking. We would be happy to direct the Committee to this information, without LGA endorsement.

March 2009

Memorandum by Our Life (North West) (AL 34)

EXECUTIVE SUMMARY

1. Our Life has gained a unique insight into the views of more than 30,000 people from across the North West in a Big Drink Debate. Respondents told us why they drink, where they buy their alcohol, the factors that would impact on people drinking less or more, as well as how alcohol impacts their communities.

2. The North West experiences some of the worst health inequalities in the country, in which alcohol plays a significant role. The impact to individuals and communities, to public sector organisations and the economy are costly and far-reaching.

A SNAPSHOT OF ALCOHOL HARM IN THE NORTH WEST

3. 1.33 million people drink at harmful and hazardous levels (one third of the population). Around 35% of the North West's population binge drink.

4. One person is admitted to hospital for an alcohol-related condition every seven minutes across the North West. More than 70,000 people were admitted to hospital in the North West last year for alcohol related disease which accounts for 6.8% of all admissions in the North West. Cities in the North West have the highest rates of alcohol-specific hospital admissions, alcohol-related crime and violent crime in England (NW Public Health Observatory, 2007). This costs the North West's NHS services at least £400 million a year.

5. 30% of 15–16-year-olds in the North West binge drink weekly, a total of 56,900 young people. Three in five drink to forget their problems.

6. More than 73,000 recorded crimes last year were alcohol related of which 50,000 were violent crimes.

WHY THE NORTH WEST MATTERS

7. The North West is home to almost seven million inhabitants living in cities, towns and rural communities. It is home to a diverse population from across the socio-economic spectrum including affluent celebrities and middle-class professionals to economically deprived communities and socially excluded people. It is home to 230,000 companies and is worth a remarkable £106 billion.

8. Despite this, the North West experiences some of the worst economic, social and health inequalities in the country. A boy born in the North West can expect to live 10 years less than a boy born in the South of the country.

9. Our Life believes that the North West provides an excellent learning ground for the whole country.

THE BIG DRINK DEBATE

10. Our Life, in Partnership with Government Office in the North West and the Department of Health, conducted the largest-ever survey of its kind into people's drinking habits. It was the first attempt to seek the views of millions of people as to why they think people around them drink, what impacts increased and decreased drinking, and what their perception of alcohol harm is on the safety and cohesion of their communities.

11. Months of media coverage in news items, features and opinion columns informed and engaged thousands of people in the Debate through live radio debate and on-line discussion forums. Senior leaders signed a pledge to prioritise changing our harmful alcohol culture at a region-wide Big Drink Debate summit in November 2008. The summit attracted local councillors, chief executives, chairs, and non-executive directors from health organisations, police, fire and rescue services and local authorities.

HIGHLIGHTS OF THE BIG DRINK DEBATE FINDINGS

12. 80% of respondents told us that low prices and discounts increase the amount that people drink.
13. Almost half (45%) of respondents told us that they avoid town centres at night because of the drunken behaviour of others.
14. 75% of respondents thought large measures increased consumption.
15. 68% of respondents thought that allowing street drinking increased consumption.
16. 56% of respondents thought that advertising increased consumption.
17. 54% of respondents thought extended drinking hours increased consumption.
18. There was overall agreement that stress and depression (86%) and work-related stress (87%) increased people's alcohol use.
19. 48% of respondents said that advice from a GP would decrease alcohol consumption.

CONCLUSIONS AND RECOMMENDATIONS

20. Our Life urges members of the Health Select Committee to take note of the Big Drink Debate, which provides unique evidence of the role and impact of alcohol harm on individuals and communities.
21. Our Life believes that the Big Drink Debate in the North West complements the plethora of data gathered by experts and strongly supports the need to take decisive action to tackle alcohol sold and promoted at discount prices.
22. The Big Drink Debate clearly points to clear causes of excessive drinking and in particular low prices, discounts, large measures and advertising.
23. The ScHARR review (2008) by the University of Sheffield presents powerful evidence that a minimum price per unit of alcohol would have a significant impact in reducing alcohol harm to those most at risk of all ages and young people in particular. A minimum price would create a level playing field between the on-and-off-trade.
24. A minimum price would have to be complemented by a strictly enforced mandatory code of practice for the on-and-off trade.

OUR LIFE (NORTH WEST) LTD—A SOCIAL ENTERPRISE SET UP BY NHS NORTH WEST TO ENGAGE THE PUBLIC TO ADVOCATE FOR BETTER HEALTH

Comments from the Big Drink Debate website discussion forum

“Extended licensing hours have not turned us into a polite wine drinking society nor will it. Anyone who thought it would must be nuts! Strong %ABV drinks should be banned. Happy hours, 2 for 1 deals etc. should be banned. Small shops should not have licence to sell alcohol. Hike up the price/tax on booze and reduce it on petrol instead”.

“The main reason for people drinking more is because it is so much cheaper, in real terms, than 10 years ago. Supermarkets always have offers on and drinking at home has become the norm for me as a 42 year old with a stressful job!”

“I wonder what we should think about the likes of Everton and Liverpool football clubs using children as a mass advertising campaign to advertise alcohol. Both teams sell tens of thousands of shirts to our kids every year with their alcohol sponsors emblazoned across their chests effectively using these children as advertising hoardings. Interesting that Barcelona football club advertise UNICEF on their shirts”.

“It is the society we live in. If people socialise they go to the pub. In my area I have wanted to go out and sit in a coffee house and socialise. There is not one that is open past 6 in the evening. My point being people do not know where else to go or how to socialise with out being drunk”.

1. *Alcohol and the North West: costs and health inequalities*

1.1 Our Life was set up because of the unacceptable levels of health inequalities and health challenges faced by the people of the North West and the strain this is putting on its otherwise successful economy.

1.2 The North West is a region significantly affected by alcohol harm. More than 70,000 people were admitted to hospital in the North West last year for alcohol related disease which accounts for 6.8% of all admissions in the North West. This equates to one person being admitted to hospital for an alcohol-related condition every seven minutes and costs the North West's NHS services £400 million a year.

1.3 The North West experiences significant social, economic and health inequalities. Alcohol harm causes an average of 5.8 months lost for every North West resident compared with 3.6 months for somebody in the East of England. In the North West a boy might expect to live 10 years less than a boy in the South of the country. Four percent of North West deaths are attributable to alcohol (Professor M Bellis).

1.4 Additional alcohol damage includes intimate partner violence, road traffic accidents, crimes (in the North West 73,000 per year of which 50,000 violent) and sexual assault, abuse, foetal alcohol syndrome and unwanted pregnancy. All of these are symptomatic of communities experiencing significant health inequalities as many of those in the North West do.

1.5 Children in the North West are not only impacted by the adult drinking behaviour around them—many are drinking themselves. 30% of 15–16-year-olds in the North West binge drink weekly, a total of 56,900 young people. Three in five drink to forget their problems.

1.6 Excessive use of alcohol also harms our North West economy—it currently has the highest rates of incapacity benefit claimants in the country with the main medical reason being alcoholism.

2. *Our Life and The Big Drink Debate*

2.1 Our Life—set up by NHS North West to lead innovative approaches to tackling key health and health inequalities challenges—organised and launched a Big Drink Debate in partnership with Government Office in the North West, the Department of Health and the North West Public Health Observatory. The Big Drink Debate was the first attempt to seek the views of millions of people to why they think people around them drink, what impacts increased and decreased drinking, and what their perception of alcohol harm is on the safety and cohesion of their communities.

2.2 The Big Drink Debate ran for three months between May and the end of August 2008. The debate comprised a self-selecting questionnaire of 17 questions, which was available in paper format and online.

2.3 More than 30,000 individual members of the public responded to the survey from across the region from the north of Cumbria to southern Cheshire, from Liverpool and from across Greater Manchester and across Lancashire. The Big Drink Debate engaged more than 300 organisations in partnership working across the public, voluntary and private sectors. A significant amount of time and energy was spent targeting hard copies of the questionnaire at hard-to-reach groups. In November 2008, a summit of leaders from across the region signed a pledge to prioritise changing the harmful alcohol culture across the North West.

2.4 The Big Drink Debate survey was accompanied by significant communications activity to encourage widespread debate and discussion across all social and geographical groups. This included a discussion forum on a dedicated Big Drink Debate website. Media coverage for the first stage of the debate has included 42 million opportunities to see and hear, six regional TV pieces, dozens of radio items and local media items including news, feature and commentary pieces.

3. *Big Drink Debate—where do people buy alcohol? Does income group impact this decision? Why do people drink?*

A total of 30,857 adult residents of the North West responded to the Big Drink Debate. Key statistics include:

3.1 63% of those who drink were classified as drinking within Government sensible limits; 22% had drunk at hazardous levels in the previous week; and 6.6% had drunk at harmful levels. This estimate concurs with other surveys of the North West population.

3.2 The supermarket was the most common location for buying alcohol for all categories of drinkers, from 71% of hazardous drinkers and 68% of harmful drinkers to 65% of sensible drinkers. 73% of those buying in a supermarket said that it helped them to relax and unwind. Higher income respondents were more likely to buy their alcohol in supermarkets—74% of those with an income of over £37,000 compared with 49% of those with an income of less than £4,000.

3.3 Of respondents who were drinkers, 45% bought alcohol from pubs. This rose to 53% of hazardous drinkers and 56% of harmful drinkers. The use of pubs decreased with increasing income from 59% in the lowest income category to 36% of those with the most income.

3.4 Of the locations used to obtain alcohol, off licences were most associated with elevated alcohol consumption.

3.5 Respondents' views on what is good about alcohol revealed: people who drink harmfully are six times more likely to say alcohol relieves boredom or that it helps to forget problems than sensible drinkers. Harmful drinkers are also 2.5 times more likely to say that alcohol gives them confidence than sensible drinkers.

3.6 The use of off-licenses was greatest amongst the poorest—30% compared with 15% of the most well off.

4. *The Big Drink Debate—what people told us about factors impacting increased or decreased drinking*

4.1 80% of respondents thought that low price and discounts increased consumption.

4.2 75% of respondents thought large measures increased consumption.

4.3 68% of respondents thought that allowing street drinking increased consumption.

4.4 56% of respondents thought that advertising increased consumption.

4.5 54% of respondents thought that extended drinking hours increased consumption.

4.6 There was overall agreement that stress and depression (86%) and work-related stress (87%) increased people's alcohol use.

4.7 Fewer than half of respondents felt that information on alcohol-related harm (36%) and advice from a GP (48%) would decrease alcohol consumption.

4.8 Negative experiences while drunk were seen to reduce intake by 48% of respondents.

5. *Conclusions and recommendations*

5.1 The harm caused by regular drinking at above the recommended Government guidelines is continuing to cause significant suffering and disease, in particular to our most vulnerable communities and individuals. In addition, the perceived culture around excessive drinking is driving many people away from their town centres.

5.2 Our Life believes that the Health Select Committee should consider the underlying environmental factors that encourage a culture in which drinking to excess is often celebrated and treated as trivial and amusing.

5.3 It is unacceptable that we live in a climate where half the population is afraid of going into their town centre at night. Our Life believes that this is fuelled by the continued irresponsible promotion of getting drunk through “all you can drink”, “happy hour” and other similar offers.

5.4 Our Life believes that the information from the Big Drink Debate in the North West complements the plethora of data gathered by experts in this field and strongly supports the need to take decisive action to tackle alcohol sold and promoted at discount prices.

5.5 The Big Drink Debate clearly points to clear causes of excessive drinking and in particular low prices, discounts, large measures and advertising.

5.6 The ScHARR review (2008) published by the University of Sheffield presents powerful evidence that a minimum price per unit of alcohol of at least 40 pence would have a significant impact in reducing alcohol harm to those most at risk of all ages and young people in particular. A minimum price per unit of alcohol of at least 40 pence would create a level playing field between the on-and-off-trade.

5.7 A minimum price would have to be accompanied by a strictly enforced mandatory code of practice for the on-and-off trade. This should include provisions to ensure that:

- Alcohol is always offered in smaller measures at a proportionate price (larger measures should not be offered at less than double the price of a smaller measure).
- A direct ban on irresponsible promotions or price promotions of alcohol such as “happy hours”, “all you can drink” and “women drink free” within the on-trade.

5.8 The Big Drink Debate revealed that 56.4% of respondents said that advertising increases drinking. Our Life urges Health Select Committee members to support a Select Committee inquiry into the impact of the cultural centrality of alcohol as a key part of leisure and arts activities. In particular to consider the role of advertising and sponsorship of television programmes, films, sporting and other cultural events.

5.9 In light of the Big Drink Debate findings in which respondents told us they avoid their town centres at night and are concerned about the drunken behaviour of others, Our Life urges the members of the Health Select Committee to consider support for the inclusion of Public Health as an objective in the Licensing Act 2003 to support healthy, safe town centres.

5.10 We urge the members of the Health Select Committee to take note of this unique evidence submitted by Our Life (North West) Ltd.

March 2009

Memorandum by the Portman Group (AL 35)

EXECUTIVE SUMMARY

- Levels of alcohol misuse in the UK are undoubtedly a cause for concern and had been increasing towards the end of the last century. There is nonetheless evidence to suggest that misuse among most groups may have peaked and to give hope that associated harms may be about to start declining.
- Policy approaches that seek to tackle the problems of alcohol misuse by making the population as a whole drink less are untargeted, unfair and unlikely to succeed. Instead, measures should focus on addressing the minority that drink irresponsibly.
- Drinks producers are bound by strict codes of practice in the way in which they package and promote their products. These codes are mostly voluntary in the sense that the industry has volunteered to put the restrictions in place but are mandatory in that all the industry must comply with them or face strong sanctions.
- In addition to marketing their products responsibly, drinks producers have implemented a number of proactive initiatives to educate consumers into drinking responsibly. These include the development and promotion of a dedicated educational website; the use of brand labelling to convey information; and the creation of an independent educational charity, the Drinkaware Trust, of which the Portman Group is the major financial supporter having provided £6.4million in total over the last three years.
- One single policy initiative alone will not be sufficient to change our drinking culture overnight. It requires a joined-up approach led by Government and involving a number of key players including medics, teachers, parents, producers and retailers.
- Success influencing social change in other areas of public concern, including drink-driving, demonstrates that better education and effective law enforcement are the most powerful levers of social change.

INTRODUCTION

1. The Portman Group (TPG) was set up in 1989 by the UK's leading alcohol producers.²⁸⁵ Its purpose was to promote sensible drinking; to help prevent alcohol misuse; to encourage responsible marketing; and to foster a balanced understanding of alcohol-related issues.

2. In 2006, the Portman Group's remit for consumer education transferred to the independent educational charity, the Drinkaware Trust, which is receiving over £6 million of funding from the Portman Group during its first three years. Since then, our revised role has involved:

- Encouraging and challenging the industry to promote its products responsibly, mainly through the operation of the Code of Practice on the Naming, Packaging and Promotion of Alcoholic Drinks.
- Demonstrating leadership on alcohol social responsibility through the actions of member companies.
- Speaking on behalf of our members on these issues to inform public opinion and policy.

RECENT TRENDS IN ALCOHOL CONSUMPTION, MISUSE AND HARM

3. According to HM Revenue and Customs data, UK per capita consumption rose by 27% between 1995 and 2004 but from then until 2007 (the latest figure available) has fallen by 3%.²⁸⁶

4. The proportion of the adult population drinking at harmful levels has steadily declined since 2001. 29 percent of the male population drank more than 21 units a week in 2000. This had fallen to 23% by 2006 (using the same basis of calculation); the proportion of the female population drinking more than 14 units per week over the same period decreased from 17% to 12%.²⁸⁷

5. These positive trends are being reflected among young adults, an age group which typically drinks the most. Young men (16–24) drinking more than four and more than eight units on at least one day fell in 2004 and again in 2005 and in 2006, although the figure rose slightly in 2007.²⁸⁸

6. There is also evidence that that the upward trend in heavy drinking among young women may have peaked. The proportion of 16–24 year old women who had drunk more than six units on at least one day in the previous week increased from 24% to 28% between 1998 and 2002 but has fallen every year since then.²⁸⁸

²⁸⁵ Current member companies are Bacardi-Martini, Beverage Brands, Brown-Forman Brands, Carlsberg, Coors, Diageo, Inbev, Pernod Ricard, Scottish & Newcastle; collectively, they account for the majority of the UK alcohol market.

²⁸⁶ *Statistical Handbook 2008*, British Beer and Pub Association.

²⁸⁷ *Smoking and drinking among adults 2006*, Office for National Statistics.

²⁸⁸ *Ibid.*

7. There are also positive trends with underage drinking. The proportion of 11-15 year olds in England which admits to drinking in the last week fell from 26% in 2001 to 21% in 2006. The average alcohol consumption among those that do drink, however, has increased over the same period from 9.8 units to 11.4 units.²⁸⁹

8. Levels of alcohol-related health harms, as measured by hospital admissions and deaths, increased steadily during the mid-1990s and into this century.²⁹⁰ Hospital admissions are continuing to rise. The latest data, however, shows that alcohol-related deaths fell in 2007.²⁹¹

APPROACHES TO ALCOHOL POLICY

9. A dilemma facing Governments is whether to use alcohol policies to reduce the amount of alcohol that all drinkers consume in order to impact upon harmful drinking even though, by its very design, this approach penalises all drinkers alike. We believe that attempting to tackle problems through reducing per capita consumption (eg through taxation or restrictions on availability) is untargeted and unfair.

10. It is comparable to attempting to cut the number of road traffic accidents by making driving more expensive through raising taxes on all motorists, thereby reducing overall driving hours. It is far more appropriate to educate drivers and identify and enforce the law against those who drive dangerously.

11. Furthermore, the overall alcohol consumption figure masks complex and sometimes contradictory drinking patterns and trends among subgroups. It is quite possible that while a nation's per capita consumption is falling, certain sections of society will be drinking more and vice versa. Measures to tackle alcohol misuse through reducing overall consumption are therefore likely to be ineffective. Indeed, such an approach has been widely discredited in research studies.^{292, 293, 294}

12. We strongly believe the focus should be on reducing alcohol misuse. It is possible, indeed very probable, that reducing alcohol misuse will actually result in a net decrease in the nation's alcohol consumption but that doesn't mean that reducing overall consumption is an appropriate goal in itself.

13. A focused approach aimed at identifying and helping the minority of harmful drinkers is more likely to attract wider public support and has generally been favoured by the UK Government.

14. There are signs, as outlined in the above section on trends, that the UK Government's approach is starting to bear fruit. We consider, however, that better education, providing early advice and support to problem drinkers, and a more robust approach to alcohol law enforcement across the UK would deliver further improvements.

ROLE OF THE ALCOHOL INDUSTRY

15. The industry has an obligation to market its products responsibly so as not to encourage their misuse. It has a further obligation to use its reasonable endeavours to educate consumers and proactively encourage responsible drinking.

RESPONSIBLE MARKETING

16. Drinks producers are comprehensively regulated by the BCAP/CAP Advertising Codes (overseen by the Advertising Standards Authority) and the Portman Group's Code of Practice on the Naming, Packaging and Promotion of Alcoholic Drinks.

17. These codes (except for the BCAP Advertising Code) are self-regulatory and are therefore sometimes referred to as "voluntary". This term needs to be clarified, however, as it is potentially misleading. The codes are voluntary in so far as the industry has volunteered to impose the restrictions on itself. As is explained below, however, compliance with the codes is mandatory; there is no opt-out for any drinks manufacturer.

Advertising

18. The Advertising Standards Authority (ASA) oversees the co-regulatory BCAP Code applying to broadcast advertising and self-regulatory CAP Code applying to non-broadcast advertising.

19. The regulations prevent television alcohol advertisements from appearing whenever the proportion of child viewers reaches 20% above the national average. This regulation applies 24 hours a day, seven days a week and means that TV alcohol adverts are never placed within programmes aimed at, or with particular

²⁸⁹ *Smoking, drinking and drug use among young people in England*, The Information Centre.

²⁹⁰ *Statistics on alcohol: England 2008*, The NHS Information Centre.

²⁹¹ *Alcohol-related death rates in the UK 1991–2007*, Office for National Statistics.

²⁹² Rose, G (1992) *The Strategy of preventive medicine*. Oxford University Press. Oxford.

²⁹³ Tuck, M (1980) *Alcoholism and Social Policy. Are we on the right lines?* Home Office Research Study No 65. HMSO. London.

²⁹⁴ Duffy, JC (1993) *Alcohol Consumption and Control Policy*. Journal of Royal Statistical Association. Series A (Statistics in Society), 156, (2).

appeal to, children. This system of audience profiling is a more targeted and reliable method of protecting under-18s than the imposition of a blanket 9.00 pm watershed, particularly in today's TV-on-demand media environment which allows viewers to record what they like and watch programmes at any time.

20. Restrictions also apply to the placement of non-broadcast advertising. This does not mean though that alcohol advertising cannot ever be placed in media where under-18s might see it, which would effectively prevent any print or poster advertising for alcohol. Instead, the rules adopt a standard that no more than 25% of the audience should be under-18. We believe that this provides an appropriate balance between protection of children and advertiser freedom.

21. The reason drinks companies advertise is to encourage brand switching. Studies have demonstrated that responsible advertising can have a powerful effect on the type of alcohol people prefer but does not encourage either the onset of drinking or potentially harmful drinking behaviour.

22. The University of Sheffield's report, commissioned by the Department of Health last year, into the relationship between alcohol price, promotion and harm concluded that "there is some uncertainty over the mechanisms linking advertising to consumption, and thus it is unclear whether advertising restrictions can be expected to have an immediate effect on consumption".²⁹⁵

Packaging and promotion

23. The Portman Group's Code of Practice applies to the naming and packaging of alcoholic drinks and the promotional activities of drinks producers, including press releases, websites and sponsorship. It ensures that such activities are carried out in a socially responsible way.

24. All complaints made under our Code are heard by an Independent Complaints Panel. This Panel is chaired by Sir Richard Tilt, former Director General of the Prison Service; none of the Panel works in the alcohol industry.

25. Since the Code was introduced in 1996, over 70 drinks have been found to be in breach of the Code. Failure to comply with our Code results in a drink being removed from sale.

26. Enforcement of the Independent Complaints Panel's decisions is provided by retailers who do not sell any drink found to be in breach of the Code until that drink's marketing has been altered to comply with the Code. This sanction provides a strong commercial threat to companies, encouraging them to ensure that their marketing is responsible.

27. We also take a pro-active approach to identifying potential drinks producer non-compliance with our Code. Our Code Advisory Service offers fast, free and confidential advice to marketers. Last year, this Service gave advice on 250 products or promotions.

28. Furthermore, last year we commissioned management consultants, PIPC, to conduct an independent audit of drinks producer compliance with the rules. PIPC devised a rigorous process to collect a random sample of 485 drinks before assessing their packaging against the Code. PIPC expressed concerns over the packaging of 32 brands. Most of these producers voluntarily amended their packaging. In the case of 10 products, the producer chose instead to allow their product to be referred to the Independent Complaints Panel for adjudication. Of these, the Panel decided that only two were actually in breach of the Code.

29. We are committed to regularly reviewing our Code rules through public consultation involving key stakeholders to ensure that the Code evolves and that it is indeed offering a proper balance between protecting the public from irresponsible drinks producer marketing while at the same time allowing companies reasonable commercial marketing freedoms.

30. The effectiveness of our regulatory work has been recognised by several respected and independent bodies. The Better Regulation Taskforce described our Code as a good example of a Code that works well, demonstrating how effective self-regulation can be.²⁹⁶ The International Harm Reduction Association (IHRA) included the latest edition of the Code in its "50 Best Collection on Alcohol Harm Reduction", published in May 2008.²⁹⁷ The Secretary of State commends it to licensing authorities in his Guidance on the Licensing Act.²⁹⁸

²⁹⁵ *Independent review of the effects of alcohol pricing and promotion*, ScHARR University of Sheffield 2008.

²⁹⁶ *Thinking for Better Regulation*, Better Regulation Taskforce 2003.

²⁹⁷ <http://www.ihra.net/AlcoholHarmReduction>

²⁹⁸ *Guidance issued under section 182 of the Licensing Act 2003*, Secretary of State for Culture, Media and Sport, July 2004.

Pricing

31. Some commentators claim that the problem of alcohol misuse in the UK is made worse by the price is manipulated to encourage sales. Pricing is, of course, controlled by retailers not producers. Producers are nonetheless interested in the way in which their products are priced and promoted by the retailer.

32. In general, we do not accept that price is the main contributory factor in harmful drinking. For example, in France, Spain and Italy countries where alcohol is cheaper than in the UK, they do not have our binge drinking culture. Price and total consumption are undoubtedly closely related in that price hikes will usually lead to a fall in a nation's consumption. But the effect of price rises on the behaviours of the heaviest drinkers is ambiguous.

33. There are nonetheless some specific pricing tactics by retailers, such as below-cost selling and volume-related discounts, which raise potential concerns. The Portman Group, however, is unable to offer any regulatory intervention to prevent such tactics or any other aspect of retailers' pricing structures. Furthermore, retailers themselves may find it difficult to self-regulate on pricing because of fears of breaching competition law.

34. Volume-related discounts offer incentives to consumers to purchase extra amounts of alcohol and have also been subject to criticism by some commentators. We see a possible distinction between the on-trade and off-trade in respect of such discounts because purchase in the former is always for immediate consumption whereas in the latter it is not.

35. Incentives to purchase extra volume in the on-trade therefore almost inevitably impact on drinking patterns and thus run a higher risk of encouraging alcohol misuse. Particular care is therefore needed in the devising and presentation of such offers.

36. In the off-trade, however, the purchase of extra volume does not necessarily impact on drinking patterns; instead, consumers may choose to store their purchase and consume it at their leisure over weeks or months. For this reason, we are not convinced that action is required to curb volume-related discounts in the off-trade.

37. Any restriction on volume-related discounts in the off-trade risks possible unintended side-effects. Retailers may compete instead by further reducing basic prices or there may be a move to larger-sized stock-keeping units (SKUs); either of these might undermine the intent of the restriction.

EDUCATIONAL INITIATIVES

38. The Portman Group and its member companies have pioneered a number of inspiring alcohol responsibility initiatives which include:

Drinkaware website

39. In 2004, the Portman Group established the website, www.drinkaware.co.uk and producers have promoted it across their brand marketing with the web address appearing on 3 billion drinks containers every year. This has made it the most popular source of reliable drinking information for consumers in the UK, attracting over 100,000 unique visitors per month.

Labelling

40. Portman Group member companies were the first to unit label their drinks to enable consumers to fully understand how many alcohol units each drink contains. All Portman Group companies also promote the Drinkaware website and a responsibility message, such as "Please drink responsibly", on their labels.

Drinkaware Trust

41. The Portman Group was also instrumental in setting up the Drinkaware Trust and remains its largest financial contributor. The Trust is receiving £6.4 million from the Portman Group during the first three years of its existence. This money is funding education campaigns aimed at positively changing our drinking culture.

SOLUTIONS

42. No single policy action would transform our drinking culture overnight. Instead, alcohol harm reduction success depends on strong leadership from Government and a properly co-ordinated approach involving the medical profession, teachers, those working in the criminal justice system, regulators, media, parents, retailers and producers.

43. The effect of pricing, advertising and availability are insignificant next to the effect of cultural stereotyping, peer influence and role modelling. Education and campaigning can successfully challenge potentially harmful perceptions surrounding drinking. This is why social marketing is of fundamental importance and explains why the Portman Group is such an ardent supporter of the Drinkaware Trust.

44. The Drinkaware Trust's campaigning, the Government's "Know Your Limits" initiative and the industry's own marketing platforms can continue to change attitudes and behaviour. This social marketing will continue to erode the public's acceptability of heavy drinking and drunkenness.

45. Inspiration can be drawn from success with other public policy campaigns such as road safety. The transformation in public attitudes and behaviour surrounding drink-driving is a particularly powerful comparison. Through sustained education and proper law enforcement the number of people killed annually in drink-drive accidents has fallen by over 60% over the last 30 years.

46. There is absolutely no reason why this success cannot translate to alcohol harm reduction. In fact, the reduction in the number of harmful drinkers and the recent reduction in alcohol-related deaths suggest that this approach is starting to have a positive effect.

47. Providing early advice and support to problem drinkers on a one-to-one basis through the medical profession and other public sector professionals can also act as a catalyst for behavioural change.

48. We strongly believe that, given accurate and full information, the vast majority of consumers will make healthier lifestyle choices. With others, we need to use more forceful powers of persuasion. In some areas of the UK, the alcohol laws could be enforced to better effect. In particular, the police should be more vigilant for cases of drunk and disorderly. While concern about alcohol-related disorder appears to have risen over the past five years,²⁹⁹ the actual numbers of people prosecuted in magistrates' courts for being drunk and disorderly has almost halved.³⁰⁰

49. Additionally, powers in the Licensing Act should be used more widely to deter underage consumers and remove licences from the minority of irresponsible retailers. Only 15 defendants were proceeded against at magistrates' courts for purchasing alcohol illegally in England and Wales during 2006.³⁰¹ Furthermore, only two people have been prosecuted (and one found guilty) for selling alcohol to a drunken person since the 2003 Licensing Act was introduced.³⁰²

March 2009

Memorandum by the Nuffield Council on Bioethics (AL 36)

We focus in this response on relevant findings from the Council's report *Public health: ethical issues*, published in November 2007. The report included a case study on alcohol consumption.³⁰³

The report was prepared by a Working Party established in February 2006, which was chaired by Lord Krebs and included members with expertise in health economics, law, philosophy, public health policy, health promotion and social science. To inform discussions, the group held a public consultation and met with representatives from relevant organisations.

INTRODUCTION

1. In its report *Public health: the ethical issues*, the Nuffield Council on Bioethics considers the responsibilities of governments, individuals and others in promoting the health of the population. It concluded that the state has a duty to help everyone lead a healthy life and reduce inequalities in health. Our "stewardship model" sets out guiding principles for making decisions about public health policies.

The stewardship model

Concerning goals, public health programmes should:

- aim to reduce the risks of ill health that people might impose on each other;
- aim to reduce causes of ill health by regulations that ensure environmental conditions that sustain good health, such as the provision of clean air and water, safe food and decent housing;
- pay special attention to the health of children and other vulnerable people;
- promote health not only by providing information and advice, but also with programmes to help people to overcome addictions and other unhealthy behaviours;

²⁹⁹ *Crime in England and Wales 2007–08*, Home Office Statistical Bulletin.

³⁰⁰ *Hansard* 17 July 2008, Column 589w.

³⁰¹ *Hansard* 17 July 2008, Column 594w.

³⁰² *Hansard* 19 March 2008, Column 1244w.

³⁰³ www.nuffieldbioethics.org/publichealth

- aim to ensure that it is easy for people to lead a healthy life, for example by providing convenient and safe opportunities for exercise;
- ensure that people have appropriate access to medical services; and
- aim to reduce unfair health inequalities.

In terms of constraints, such programmes should:

- not attempt to coerce adults to lead healthy lives;
- minimise interventions that are introduced without the individual consent of those affected, or without procedural justice arrangements (such as democratic decision-making procedures) which provide adequate mandate; and seek to minimise interventions that are perceived as unduly intrusive and in conflict with important personal values [para 2.44]

2. Complementary to the stewardship model, the Council has proposed an “intervention ladder” as a method of thinking about the acceptability and justification of different public health policies. In general, the higher the rung on the ladder at which the policy maker intervenes, the stronger the justification and the stronger the evidence has to be. A more intrusive policy initiative is likely to be publicly acceptable only if there is a clear indication that it will produce the desired effect, and that this can be weighed favourably against any loss of liberty that may result [para 3.37].

The intervention ladder

Eliminate choice. Regulate in such a way as to entirely eliminate choice, for example through compulsory isolation of patients with infectious diseases.

Restrict choice. Regulate in such a way as to restrict the options available to people with the aim of protecting them, for example removing unhealthy ingredients from foods, or unhealthy foods from shops or restaurants.

Guide choice through disincentives. Fiscal and other disincentives can be put in place to influence people not to pursue certain activities, for example through taxes on cigarettes, or by discouraging the use of cars in inner cities through charging schemes or limitations of parking spaces.

Guide choices through incentives. Regulations can be offered that guide choices by fiscal and other incentives, for example offering tax-breaks for the purchase of bicycles that are used as a means of travelling to work.

Guide choices through changing the default policy. For example, in a restaurant, instead of providing chips as a standard side dish (with healthier options available), menus could be changed to provide a more healthy option as standard (with chips as an option available).

Enable choice. Enable individuals to change their behaviours, for example by offering participation in a NHS “stop smoking” programme, building cycle lanes, or providing free fruit in schools.

Provide information. Inform and educate the public, for example as part of campaigns to encourage people to walk more or eat five portions of fruit and vegetables per day.

Do nothing or simply monitor the current situation

THE COUNCIL’S RECOMMENDATIONS ON ALCOHOL

3. The Council’s recommendations on alcohol policy are outlined below. The full text and references can be found in Chapter 6 of Public health: ethical issues.

Role of government

4. The use of alcohol and tobacco has implications for nearly every government department in the UK. In some cases departments may support the alcohol and tobacco industries despite concerns about population health. This may also be found in devolved administrations and regional and local government, for example where job losses might be caused in that area if sales of these products reduced.

5. In 2004 the Government published its *Alcohol Harm Reduction Strategy for England* followed in 2007 by *Safe, Sensible, Social: The next steps in the National Alcohol Strategy*. A comparison of the Government’s Strategy with the findings of the evidence-based study *Alcohol: No ordinary commodity*³⁰⁴ (sponsored by WHO) finds that there is little consensus. The latter emphasised the effectiveness of increasing taxes, restricting hours and days of sale and the density of outlets that sell alcohol, and possibly of banning advertising, whereas it found little evidence in support of the effectiveness of education about alcohol in schools, and evidence for a lack of effectiveness concerning public service messages and warning labels. The Government’s original Strategy, however, concentrated on education and communication, reviewing the advertising of alcohol, enforcement of legal restrictions on selling to under-18s, and voluntary measures for

³⁰⁴ Babor T, Caetano R, Casswell S *et al.* (2003) *Alcohol: No ordinary commodity—Research and public policy* (Oxford: Oxford University Press).

the alcohol industry about labelling and manufacturing. The second part of the Strategy included further measures on guidance and public information campaigns and measures to try to promote a “sensible drinking” culture. A review of the evidence and a consultation on the relationship between alcohol price, promotion and harm was also announced and the Government pledged to consider the need for regulatory change in the future. We draw attention to the fact that alcoholic drinks in the UK are now less expensive relative to disposable income than they were in the 1970s.

6. The areas where *No ordinary commodity* and the UK Government’s strategies are in agreement include support for at-risk drinkers and treatment of people with alcohol problems and implementing rules about serving intoxicated people. The evidence presented in *No ordinary commodity* on the effectiveness of restricting the availability of alcohol stands in contrast to the Government’s policy since November 2005 of allowing extended opening hours for pubs and bars. The evidence for the effectiveness of some of the interventions aiming to reduce the overall consumption of alcohol is strong. Thus, the Government’s failure to take up the most effective strategies cannot be due to lack of evidence.

7. The stewardship model provides justification for the UK Government to introduce measures that are more coercive than those which currently feature in the National Alcohol Strategy (2004 and 2007). We recommend that evidence-based measures judged effective in the WHO-sponsored analysis *Alcohol: No ordinary commodity* are implemented by the UK Government. These include coercive strategies to manage alcohol consumption, specifically in the areas of price, marketing and availability. For example, taxes on alcoholic beverages might be increased, which has been shown to be an effective strategy for reducing consumption. We also recommend that the Home Office, the UK health departments and the Department of Culture, Media and Sport analyse the effect of extended opening hours of licensed premises on levels of consumption, as well as on antisocial behaviour. [Paragraphs 6.28–6.31]

Entitlement to treatment and costs to the NHS

8. Alcohol- and tobacco-related illnesses lead to financial cost to the public healthcare system and questions arise about whether this should affect people’s access to treatment. We considered a similar situation in the case of obesity and concluded that treatment should generally not be denied because of reasons including the value of the community and risks of stigmatizing or penalising people (see paragraph 5.42). We also found, however, that personal behaviour might need to be considered when assessing the potential effectiveness of a treatment for a patient.

9. We note that current Department of Health guidelines on liver transplantation require patients to have abstained from alcohol for six months, and people who are considered likely to continue to consume excessive amounts of alcohol are not offered a transplant. We agree that, as in this example, it might be justified for doctors to appeal to patients to change their behaviour in relation to alcohol and tobacco before or subsequent to an intervention provided by the NHS, provided that the change would enhance the effectiveness of the intervention, and people were offered help to do this. For example, alcohol treatment programmes might be offered in advance of performing a liver transplant as the cessation of excessive drinking would be likely to increase its clinical effectiveness, or could even make the transplant unnecessary.

10. Generally, as in the case of obesity, we take the view that decisions about healthcare provision for people who smoke and/or drink alcohol excessively raise some valid considerations about the most efficient use of resources. In terms of public health policy, the focus of efforts should be on avoiding the need for treatment for alcohol- and tobacco-related conditions in the first place. This is a fairer approach, and also seems likely to be more effective in economic terms. The UK health departments should further liaise with employers about how best to offer assistance with behaviour change programmes, such as smoking cessation, which could benefit the employer as well as employees. [Paragraphs 6.16–6.17]

Protecting the vulnerable

11. Under our stewardship model, public health measures should pay special attention to the health of children (paragraphs 2.41–2.44). As both drinking alcohol and smoking are associated with dependence and harms, there has frequently been concern expressed about any use by children and adolescents. A considerable number of respondents to our consultation called for vigorous action; for example: “[T]he State should do everything in its power to prevent children and teenagers from becoming addicted to smoking” (Dr V Larcher). Young people often lack judgement about risk and are vulnerable to the influence of others. Additionally, if people start drinking alcohol and smoking as children and adolescents and continue into adulthood, they will have been exposed to these health harms over a longer period of time than if they had started as adults. Health and other harms (such as any effect on education) caused by misuse of these substances can be very serious for developing children and adolescents.

12. Producers, advertisers and vendors of alcohol and tobacco need to recognise more fully the vulnerability of children and young people, and take clearer responsibility for preventing harms to health. This would include refraining from understating risks, and from exploiting the apparent desirability of drinking alcohol and smoking, particularly in ways that appeal to children and young people. Furthermore, it would appear that whatever the legal position, these products are widely available to underage children, and existing law and policy need to be implemented more stringently. We welcome the raising of the

minimum age for the purchase of tobacco from 16 to 18 years that has taken place throughout the UK as part of a strategy to protect vulnerable people. Although thought needs to be given to the way in which this measure can be implemented most effectively, it is an appropriate initiative in the context of the stewardship model, as the market has largely failed to self-regulate in this area. [Paragraphs 6.32–6.33]

March 2009

Memorandum by Barnardo's UK (AL 37)

SUMMARY

Barnardo's would ask the House of Commons Health Committee to pay specific attention within its Alcohol Inquiry to the prevalence of Foetal Alcohol Syndrome within the UK (and Foetal Alcohol Spectrum Disorder) and by doing so help encourage a comprehensive improvement in the identification, treatment and prevention of this poorly understood condition.

As one of the UK's leading children's charities, Barnardo's works directly with over 100,000 children, young people and their families every year. We run 394 vital projects across the UK, including counselling for children who have been abused, fostering and adoption services, vocational training and disability inclusion groups. Every Barnardo's project is different but each believes in the potential in every child and young person, no matter who they are, what they have done or what they have been through.³⁰⁵

BACKGROUND

A significant percentage of children throughout the United Kingdom are harmed in various ways and to varying degrees by alcohol. Sometimes the negative effects are caused by alcohol consumption among children and young people themselves. In addition, there is abuse and/or neglect of children resulting from the drinking problems of parents or the other adults in their lives. However, relatively little attention has been focused on the extent to which children's lives and life chances have been compromised by exposure to alcohol while still *in utero*. Foetal Alcohol Syndrome (FAS) is the term used to describe the visible birth defects and the invisible organ/brain/nervous system damage that can result from exposure to alcohol during pregnancy.

FAS describes the most severe form of a wide range of permanent physical, mental and behavioural problems that begin before birth. From malformed faces and limbs to heart problems and diminished intellectual capacity, FAS can, and does, adversely affect children's lives across the United Kingdom.

When the impacts of alcohol on the development of a baby are less immediately apparent to the eye, but are nonetheless potentially damaging, this is referred to as Foetal Alcohol Spectrum Disorder (FASD). Such variation is akin to a child who is born with a degree of visual impairment rather than complete blindness. The extent of the impairment only becomes evident as the child grows older. Damage can range from minimal to severe.

Both FAS and FASD are potentially seriously damaging to a child's development and more so to its long term life chances.

KEY MESSAGES

There seven key messages on foetal alcohol exposure that Barnardo's would highlight to the Health Committee:

- *It is potentially 100% preventable.* The one indisputable medical fact is that no mother who abstained from drinking alcohol throughout pregnancy ever has given birth to a baby with FAS/FASD.
- *It is incurable.* Although regarded as a problem affecting babies and children, the simple fact is that no one outgrows or "gets over" the harm caused by foetal alcohol exposure. While treatment/support can improve the well-being of a child with FAS/FASD, the developmental damage is irreversible.
- *It is unpredictable.* There is no guarantee that a woman who drinks heavily during pregnancy will have a baby with FAS—or that one who drinks moderately will not have a baby harmed by alcohol. There are no tests that can determine in advance which pregnancies will result in these alcohol-fuelled problems. Little is known about exactly when or how much of what type of alcohol will harm a particular foetus. Thus, there is no guaranteed "safe" level of alcohol during pregnancy.

³⁰⁵ www.barnardos.org.uk

- *It can be difficult to diagnose.* Just as there is no test to predict which pregnancy will result in FAS/FASD, so too there is no simple test that proves its presence or absence (except in the small percentage of cases where notable facial/physical anomalies or organ damage are evident). This is true, in part, because this diagnosis is dependant upon accurate recall and reporting of alcohol consumption by the mother.
- *It is under-diagnosed (or misdiagnosed) and under-reported.* For example, based upon international data, a conservative estimate is that there are 900 children in Scotland (0–18) who have FAS—and many times more (ie thousands) of children and young people who were damaged in more subtle, but still serious, ways by foetal alcohol exposure. Given its far larger population, the numbers will be far higher in England.
- *It has wide-ranging, serious consequences for individuals, communities and society.* Because FAS/FASD is not a problem that fades over time, many problems of young people and adults have their roots in exposure to alcohol as a foetus. At the deep end (eg when manifested by heart or other organ damage), there are major, on-going medical and therapy expenses. All along the foetal alcohol spectrum, however, the diminished “executive functions” of the brain can lead to numerous problems. These include: learning difficulties and disorders (and failure in school); difficult or anti-social behaviours; inability to secure/maintain employment; and, substance misuse/addiction. Such problems translate into high costs in human and economic terms, as well as extra demands upon public expenditures and services in the health, justice, social work, and education and systems.
- *Its ill effects can be lessened by proper diagnosis and proper treatment/support.* There are promising therapies and methods of support being developed and refined internationally. Misdiagnosis—that is, mistaking FAS or FASD for other medical/developmental problems—can lead to interventions that waste time, effort and money (and may worsen the situation for the individual affected).

RECOMMENDATIONS

Barnardo’s ask the Westminster Health Committee to consider the following during its Inquiry:

- The identification of children, young people and adults harmed by Foetal Alcohol Syndrome should be given a much higher priority throughout the United Kingdom than is the case today. This process must begin with an accurate assessment of the incidence and prevalence of these medical conditions—a task that can be accomplished only once there is a critical mass of health practitioners around the UK able to correctly make this diagnosis. This, in turn, depends upon health professionals reaching a level of agreement and consistency that does not now exist.
- Identification of FAS/FASD should be accompanied by the availability of appropriate treatment and effective support for the people harmed by foetal alcohol exposure. Planning for such provision must be in synch with the identification process, as there currently is neither widespread agreement on the range of assistance needed, nor an adequate workforce in place that is prepared to offer the help that is needed.
- Top priority should be accorded to the prevention of FAS and FASD across the UK. Given the difficulties of diagnosis and the reality that there is no “pound of cure”, the importance of an “ounce of prevention” is greatly magnified. Established public health principles and practices leads to the conclusion that abstinence from alcohol is the best advice to give to women who are: (a) trying to conceive; (b) at high risk of an unplanned pregnancy; or, (c) already pregnant. The abstinence message needs to become far more consistent and prominent across the United Kingdom. Mixed messages are not helpful.

March 2009

Memorandum by Scottish & Newcastle UK (AL 38)

Scottish & Newcastle is the UK’s leading brewer and cider maker, headquartered in Edinburgh, employing 4,500 UK-wide. The brewing and pub sector as a whole contribute significantly to the economic and cultural wellbeing of our society.

We are absolutely committed to working together with the Government, the public health community and industry colleagues to tackle the abuse of alcohol in our society and to promote the responsible consumption of our products.

S&N UK believes the most effective alcohol strategies should concentrate on tackling alcohol misuse and not consumption per se. Any measures which focus on total consumption obscures differences in how people drink and the outcomes they are likely to experience. On the other hand, addressing potentially harmful drinking patterns paves the way to targeted and pragmatic solutions.

S&N UK wants to work towards a change in those behaviours which society deems socially unacceptable. This will require long-term commitment, but examples such as attitudes towards drink driving show it is possible. Through the levers of peer pressure and strong penalties, both of which are currently lacking in tackling alcohol misuse and associated disorder, society's attitude can be changed.

S&N UK does not believe that new laws or codes are the most effective way to bring about change. There is already a full range of laws in existence to tackle disorder and sales to those who are underage or drunk. We believe strong and consistent enforcement of these laws will be the most effective way forward.

We strongly believe that industry can be a valuable partner in tackling alcohol misuse, by marketing its products responsibly, providing consumers with information—demonstrated by our full compliance with the voluntary label—and delivering education and responsible drinking programmes.

However, integral to the success of the strategy is the role of individual responsibility. From Government, to industry to the individual, all parties have a role to play.

In response to the four specific areas highlighted by the inquiry, S&N UK makes the following comments:

THE SCALE OF ILL-HEALTH RELATED TO ALCOHOL MISUSE

S&N UK believes the focus should be on tackling alcohol misuse and not consumption per se. Any measures which focus on total consumption obscures differences in how people drink and the outcomes they are likely to experience. On the other hand, addressing potentially harmful drinking patterns paves the way to targeted and pragmatic solutions.

The effects of alcohol abuse are very much apparent in the UK, yet we do not consume any more alcohol per capita than the rest of the UK. On a total population basis, the UK ranks 14th out of 20 EU countries in the table of alcohol consumption per head.³⁰⁶ HM Revenue & Customs data shows total alcohol consumption falling, with a decline of 5% between 2004–06.³⁰⁷

THE CONSEQUENCES FOR THE NHS

S&N UK believes that moderate alcohol consumption can play a part in a healthy lifestyle. As the UK's largest brewer and cider maker we recognise we have an active role to play in encouraging awareness of alcohol responsibility.

We build strategic community partnerships with social care organisations. Our partnerships pilot new and innovative ways to encourage responsible alcohol consumption and reduce the harm caused by alcohol misuse.

One of our partnerships is with Turning Point, providing a new Hospital Alcohol Intervention Service in Queen Elizabeth Hospital in Gateshead. Turning Point is the UK's leading social care organisation providing services for people who are misusing alcohol. The service provides patients with access to relevant information and interventions and, where necessary, refers patients to general community based services and more specialist alcohol treatment services. This service has recently gained mainstream funding from Government.

We would wish to see the Government supporting projects such as brief interventions, which educate consumers about responsible consumption at a point when they are receptive to the information. We would also call for the Government and industry to be aligned on key messages to ensure consistent communication with consumers.

CENTRAL GOVERNMENT POLICY

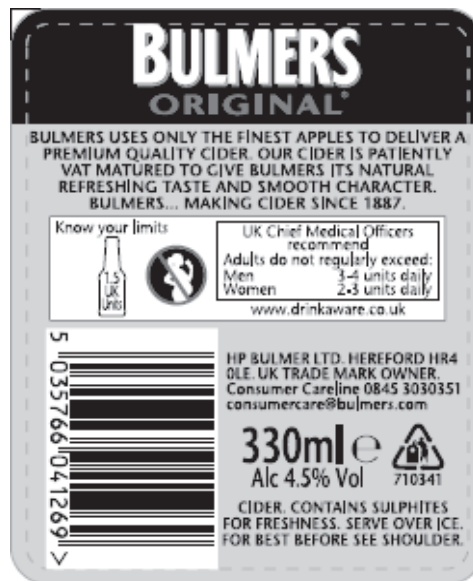
S&N is absolutely committed to working together with the Government, the public health community and industry colleagues to tackle the abuse of alcohol in our society and to promote the responsible consumption of our products.

S&N UK has led the industry on labelling and since 2005 has voluntarily included the UK Chief Medical Officer's responsible drinking guidelines and unit content on our labels. In 2007 we were part of discussions

³⁰⁶ Statistical Handbook 2007, British Beer and Pub Association.

³⁰⁷ HM Revenue and Customs.

with the Department of Health to establish a standard label. S&N UK introduced the new standard label in full, including the pregnancy advice, from October 2007. It appears on all of our packaged products accounting for 27% of the beer and cider market.



THE ROLE OF THE NHS AND OTHER BODIES INCLUDING LOCAL GOVERNMENT, THE VOLUNTARY SECTOR, POLICE, THE ALCOHOL INDUSTRY, AND THOSE RESPONSIBLE FOR THE ADVERTISING AND PROMOTION OF ALCOHOL

S&N UK strongly believes that industry can be a valuable partner in tackling alcohol misuse, by marketing its products responsibly, providing consumers with information—demonstrated by our full compliance with the voluntary label—and delivering education and responsible drinking programmes.

However, integral to the success of the strategy is the role of individual responsibility. From Government, to industry to the individual, all parties have a role to play.

We want to see the existing law applied strongly and consistently, along with effective partnership working between industry, Licensing Boards and the police. We do not believe that in such a diverse industry, a blanket approach such as a mandatory code would be appropriate or practical. We support targeted measures which focus on those premises which act irresponsibly and break the current law.

S&N UK believes that industry self-regulation can effectively ensure alcoholic drinks are advertised and promoted responsibly. We are a founding member of the Portman Group, a self-regulatory organisation that encourages and challenges the industry to promote its products responsibly. The recent KMPG report commissioned by the Department of Health recognised the Portman Group had delivered considerable improvement in alcohol marketing.

The Portman Group's Marketing Code of Practice was introduced in 1996 and is the basis of S&N UK's Responsible Marketing Policy. It provides guidance to everyone involved in marketing and selling our products to ensure our commercial communications do not contribute to excessive consumption or abuse. We always ensure that our policy goes beyond the requirements of industry voluntary codes.

We train employees and relevant external agencies annually on our Responsible Marketing Policy and its implementation.

We also use opportunities provided by major events to influence consumer behaviour and attitudes to alcohol consumption. We have included responsible drinking messages as part of major event sponsorships such as John Smith's Grand National, Edinburgh's Hogmanay and the Heineken Cup.

We encourage our employees to be ambassadors for alcohol responsibility and to take personal responsibility for their own alcohol use.

Alcohol responsibility information is part of our induction programme, and we have ongoing campaigns timed around events such as Scotland's Alcohol Awareness Week and the festive season. We provide counselling support to employees who request assistance with their alcohol use.

During 2009, S&N UK will introduce Cool@Work to all our employees. Heineken companies worldwide implement Cool@Work—a workplace alcohol information and prevention programme. It aims to improve safety and health at work, ensure responsible alcohol consumption and create awareness, commitment and ambassadorship among employees.

S&N UK has a leased pub division called Scottish & Newcastle Pub Enterprises. It operates over 2000 pubs in partnership with individual business people throughout the UK. Although our lessees are independent licence holders and business people, we work hard to educate them and promote best practice. For example, we heavily promote Challenge 21 in our communications with lessees, and area managers receive briefings on responsible drinking and irresponsible promotions.

Along with industry self-regulation and strong application of the existing laws, S&N UK would prefer to see better partnership working between the industry and local authorities. Local initiatives such as “Best Bar None” along with enforcement of the law on those premises acting irresponsibly, should come together to tackle irresponsible practices and associated disorder.

SOLUTIONS, INCLUDING WHETHER THE DRINKING CULTURE IN ENGLAND SHOULD CHANGE, AND IF SO, HOW

S&N UK wants to work towards a change in those behaviours which society deems socially unacceptable. This will require long-term commitment, but examples such as attitudes towards drink driving show it is possible. Through the levers of peer pressure and strong penalties, both of which are currently lacking in tackling alcohol misuse and associated disorder, society’s attitude can be changed.

However, S&N UK does not believe that new laws or codes are the most effective way to bring about change. There is already a full range of laws in existence to tackle disorder and sales to those who are underage and drunk. We believe strong and consistent enforcement of these laws will be the most effective way forward.

Conversely, those who retail in a responsible way should be encouraged, and shown as ambassadors of best practice.

S&N UK welcomes more investment in education and information on sensible drinking. We believe the industry has a vital role to play in providing consumers with relevant information about their products. Originally created by the Portman Group, the Drinkaware Trust is an educational charity that aims to positively change the UK drinking culture. It is a unique partnership between industry and the voluntary and public health sectors. The Trust receives its funding from voluntary donations by the drinks industry.

The Drinkaware Trust website: www.drinkaware.co.uk provides comprehensive advice on responsible drinking to the public. It is promoted by the industry, including S&N UK, on packaging and in advertising, making it the primary source of sensible drinking information for UK consumers.

The Drinkaware Trust also manages a site especially for Under 18s—www.truthaboutbooze.co.uk

Promotions in the off-trade are often blamed as contributing towards the binge drinking culture. Scottish & Newcastle has already stated in submissions to the Competition Commission that we believe deep discounting to drive footfall does not sit side by side with the promotion of responsible consumption. Unlike the on-trade, addressing pricing and promotions in the off-trade is more difficult through the Licensing Act as purchases are often not for immediate consumption. We would therefore welcome additional action to address discounting across all sectors of the alcohol industry.

In conclusion, S&N UK fully recognises the impacts of alcohol misuse on our communities and are fully committed to working in partnership to tackle these problems. We believe targeted, pragmatic solutions will be most effective way to forge a more responsible relationship with alcohol, rather than a focus on total consumption which obscures differences in how people drink and the outcomes they are likely to experience. Along with a focus on misuse rather than consumption per se, we want to see strong and consistent enforcement of existing legislation, along with improved partnership working at a local level, rather than the introduction of new or mandatory codes. There is a duty on the part of the industry to ensure it acts in a responsible manner, which goes hand in hand with a need for individual responsibility on the part of the consumer. We believe these actions will be the most effective approach to bringing about a long-term change in society’s attitudes towards excessive drinking and drunkenness.

March 2009

Memorandum by Wm Morrison Supermarkets plc (AL 39)

1. INTRODUCTION

1.1 Morrisons welcomes the opportunity to submit evidence to the Health Select Committee’s Inquiry into alcohol. This submission highlights some of the measures that Morrisons is taking to ensure that alcohol is sold responsibly; and comments on how the Government could target the irresponsible minority of people who misuse alcohol without penalising the majority of the people of England.

1.2 As a retailer, our business depends on understanding our customers and meeting their needs and aspirations. We are well placed to respond efficiently and effectively to changing customer preferences and to help manage responsible attitudes towards alcohol. Any intervention by the Government to how alcohol is currently retailed should work with the market, and in particular ensure that any distortions do not adversely affect the majority of people who do drink responsibly.

2. MORRISONS AND THE RETAILING OF ALCOHOL

2.1 Morrisons' vision is to be the "Food Specialist for Everyone". Our business model is different from other supermarket retailers. We focus on providing the freshest meat, fish and produce to our customers, sourcing directly from farms and preparing and processing ourselves. For example, cattle, lamb and pigs are bought by Morrisons and processed at our abattoirs in Colne and Spalding ready for our butchers to prepare for customers in store. We do not sell extensive ranges of non-food, eg clothing and electrical goods. We retail alcohol as a complement to our food specialism.

2.2 Morrisons approach to retailing alcohol is to enable our customers to make responsible choices. We are clear to our customers that alcohol is a product for adults. Our priority is to ensure that our customers have the information they need to drink responsibly and that sales are only made to those over the age of 18.

2.3 Our staff are trained to advise customers and verify the age of any customer who appears to be aged 25 or under seeking to purchase alcohol. Anyone who does not look over 25 will be asked to prove that they are above the legal age of 18 to purchase alcohol.

2.4 Stores work closely with local licensing authorities and the Police to ensure that all alcohol sales are not only within the law but consistent with responsible retailing. No Morrisons store is open 24 hours a day and we do not sell alcohol after 10.30 pm.

2.5 We ensure that our product range includes a good choice of "no-to-low" alcohol content products. We also do not stock products that could unduly appeal to people aged under 18.

3. THE SCALE OF ILL-HEALTH RELATED TO ALCOHOL MISUSE

3.1 Morrisons is not a provider of health services and is not in a position to comment specifically on the scale of ill-health related to alcohol misuse. However, Morrisons notes that there has been a decline in alcohol consumption in recent years.

3.2 Data from the HMRC demonstrates that across the UK alcohol consumption declined 2% in 2005 and 3.3% in 2006. A further decline is expected this year after a small increase in 2007.

3.3 A similar trend can be observed from consumption behaviour collated by TNS's Worldpanel. Data recording all food and drink consumption inside and outside the home is collected from diary entries from 11,000 individuals for a two week period twice a year. The sample is staggered throughout the year to guard against seasonal variation. The trend shows that alcohol total consumption has declined over the last three years. The driver of this decline is falling alcohol consumption in the home, down some 31% since 2005. Meanwhile, consumption outside the home has increased (up 14%).

3.4 This would suggest that measures to encourage reduced consumption should prioritise reversing the trend of increased drinking outside the home. (Morrisons acknowledges that diary data may underestimate the absolute number of servings consumed, but that does not negate from the strength of trend that the data shows).

4. MORRISONS VIEWS ON CENTRAL GOVERNMENT'S POLICY AND POTENTIAL SOLUTIONS

4.1 Morrisons shares the Government's aim to "... put in place a policy which will enable more people to drink sensibly ..." and "it is the irresponsible minority on which our efforts are focused ...". (*Safe, Sensible, Social: Ministerial Foreword, Page 5*). Morrisons wants to work with the Government to implement effective measures that target alcohol misuse. For example, there is much that the Government, producers and retailers can do together to tackle underage drinking (eg Community Alcohol Partnerships); and promote responsible drinking messages and improve information to consumers (eg Project 10).

4.2 Much of this should be achievable through voluntary action. Existing codes of best practice do provide a clear and consistent basis for major multiple off-trade retailers, like Morrisons, to prevent underage sales and ensure that irresponsible or excessive drinking is not condoned.

4.3 In our response to *Safe, Sensible and Social*, Morrisons gave conditional support to the introduction of a mandatory code if the proposed alternative model of co-regulation did not succeed. In doing so, Morrisons emphasised that inclusion of any measures on price and promotions, must be consistent with UK and EU competition law and not unduly penalise those consumers who benefit from legitimate promotions responsibly.

4.4 Morrisons recognises that different conditions, as set out in the early draft of the proposed mandatory Code, will apply to either the on-trade, or the off-trade or both. We have urged the Government to ensure that there is a consistent distinction of the measures in the Code that will apply to the on-trade and the off-trade. In particular, to remain consistent with why there are different licensing regimes—the off-trade being different as there is separation between the time and place of purchase, and the time and place of consumption.

4.5 Morrisons welcomes the tests for drawing up the conditions. In addition to meeting the four licensing objectives, Morrisons welcomes the statement in the early draft Code that Category A and B conditions must be in accordance with better regulation principles. The most important principle should be that the measures are proportionate. This should go hand in hand with targeting measures only at cases in which action is needed.

4.6 Therefore, before consulting formally on the mandatory code and including any measure that enables local licensing authorities to impose conditions on price and promotions, the Government must satisfy that doing so is consistent with UK and EU competition law. In addition, any measures should also be consistent with the Government's view that they: "do not unduly penalise those consumers who benefit from legitimate promotions responsibly". (*Safe, Sensible, Social: Ministerial Foreword, Page 5*).

4.7 Morrisons proposes that one possible way forward is that any measures in the mandatory code should be focussed on the potential problems associated with promotions aimed explicitly at encouraging excessive immediate consumption. This should help meet the test of not unduly penalising the beneficiaries of legitimate promotions, such as time limited "happy hours" for the on-trade or quantity discounts in the off-trade (eg purchasing a case of wine).

4.8 Consideration of a mandatory code should not negate the responsibility of Government to ensure that existing legislation is properly enforced. If all of the current regulations are consistently and fairly enforced this is likely to have a significant impact on the policy aims that the Government would like to achieve, eg the priorities set out in the Youth Alcohol Action Plan.

4.9 Morrisons therefore contests, for example, the Government's view in *Safe, Sensible and Social* that "enforcement alone will not bring about the desired reductions in alcohol related crime and disorder" (Paragraph 1.8). Morrisons' own position is consistent with the European Commission's "EU Strategy to help member states in reducing alcohol related harm". This sets out "good practice" to prevent alcohol related harm among adults:

"Experience gained in Member States tends to show that improved enforcement of current regulations, codes and standards, is essential to reduce the negative impact of harmful and hazardous alcohol consumption. Licence enforcement, server training, community- and workplace-based interventions, pricing policy (eg reducing "two-drinks-for-one" offers), coordination of public transport and closing times, advice by doctors or nurses in primary health care to people at risk, and treatment, are interventions that appear effective to prevent alcohol-related harm among adults and reduce the negative impact on the workplace. Education, information activities and campaigns promoting moderate consumption, or addressing drink-driving, alcohol during pregnancy and under-age drinking, can be used to mobilise public support for interventions."

COM(2006) 625 final, Paragraph 5.2.2

4.10 The EU appears to prioritise enforcement of current regulations, codes and standards as the most effective, indeed "essential", measure to reduce the effects of harmful consumption. Pricing policy is included but not in the context of population wide interventions such as bans on promotions offering discounts for multiple purchase (Morrisons, as part of our responsible approach to retailing, does not offer any "two-drinks-for-one offers"). Overall the Commission paper concludes that:

"Every measure has to be considered on a case-by-case basis; in all cases, they should be evidence-based, proportionate and implemented on a non-discriminatory basis".

COM(2006) 625 final, Paragraph 6.2.1

4.11 On this basis, Morrisons supports mandatory requirements in a Code, provided it is implemented in a way that is consistent with better regulation principles.

4.12 One additional policy solution where the Government could work more with industry is to communicate that the best way to consume alcohol is with food. TNS' Worldpanel collects data recording all food and drink consumption inside and outside the home from diary entries of 11,000 individuals for a two week period twice a year. The sample is staggered throughout the year to guard against seasonal variation. The data shows that the proportion of alcohol consumed with a main meal is now at 75% for the UK as a whole, but with market variation across the country. A combined Government and industry campaign to communicate that a good way to drink responsibly is to consume alcohol with a main meal could be an effective way of driving behavioural change and delivering health benefits.

Comments on the early draft mandatory Code

4.13 Morrisons contests the bald claim in Condition 4 that pricing promotions contribute to binge drinking. No evidence was presented in the consultation *Safe, Sensible and Social* to substantiate this claim, whether quantitative or qualitative (paragraph 3.9 set out an unsubstantiated claim of increased drinking of cheaper alcohol from supermarkets and off-licences before an evening in pubs and clubs).

4.14 To understand customer behaviour once alcohol has been purchased from the off-trade, patterns of consumption need to be recorded. Sales of alcohol on promotion do not necessarily lead to ready consumption. Some alcohol may be stored and consumed over several months (this is particularly prevalent amongst spirits). Some alcohol sold will never be consumed (eg wasted when it's "best before" date has passed).

4.15 Overall, consumption of alcohol by people at home is falling. TNS Worldpanel data shows that the total consumption of alcohol in the home has declined by 13% since 2005. The fall is most marked across East Anglia and the South (26%) and slowest in the Midlands, but still a decline at (6%).

4.16 Moreover, when people are buying alcohol on promotion this is principally for consumption over time. In August 2008, Morrisons surveyed 1,000 of our Scottish customers. This showed that when buying alcohol on promotion 86% bought to stock up or have on hand to drink later; and 68% said that the alcohol was for a social occasion or party when the alcohol would be shared with other people. This evidence from the survey of Scottish customers should corroborate the Government's view that "measures do not unduly penalise those consumers who benefit from legitimate promotions responsibly". (*Ministerial Foreword, Safe, Sensible and Social Page 5*).

4.17 To intervene on price promotions at a local licensing authority level would be a blunt instrument that may not have the desired outcome that the Government would like to have of targeting binge drinking that leads to anti-social behaviour. Intervention on off-trade promotions would penalise the majority of people who drink responsibly. A blanket ban would not only be discriminatory and disproportionate, and therefore inconsistent with test 7 for better regulation, it is unlikely to have the intended impact or reducing incidences of alcohol-related harm.

4.18 If people have already consumed too much alcohol before an evening in pubs and clubs, then existing legislation should prevent them from being served further alcohol either in the on-trade or off-trade.

4.19 Morrisons contests that Condition 12 will be neither enforceable or effective. The condition will not be enforceable as no definition exists of "very low priced alcohol" that will be consistent with the application of UK and EU competition law. Not least, the pricing of alcohol in the on and off trade will vary depending on the scale of sales and the nature of the supplier relationship.

4.20 The condition is also unlikely to be effective. If low priced products are prohibited from a small number of outlets in one licensing authority, many consumers are likely to transfer their purchase and consumption to neighbouring retailers of alcohol (or indeed to internet purchasing).

4.21 The only certainty that prohibiting the sale of lower priced alcohol would bring is imposed higher costs to customers. This is neither proportionate nor fair. Moreover, if alcohol can still be purchased from nearby locations or on-line, it would be discriminatory.

4.22 For retailers, like Morrisons, that operate national pricing in our stores across the country to offer certainty to our customers, introducing such variable pricing would undermine price integrity. It would also be very difficult to implement, eg our Electronic Point Of Sale system is not designed to changed prices for one specific store on thousands of product lines.

4.23 Some retailers may also seek to reward their customers for alcohol purchases through loyalty schemes that give cash back on other purchases—effectively circumventing the impact of any minimum pricing or changes to promotions.

4.24 No evidence has been presented to substantiate the aim of Condition 21 that displaying alcohol in separate areas, or potentially requiring sales through designated purchase points, will reduce incidents of alcohol related harm.

4.25 If the Government's intention from this proposal is to potentially reduce the volume of alcohol sold on some outlets that have the condition imposed by licensing authorities, this is unlikely to be the outcome. Morrisons has 12 stores that for historical reasons have designated areas for the sale of alcohol with separate checkouts. The sale of beers, wines and spirits at these 12 stores is 4% higher than sales across all of our UK stores.

March 2009

Memorandum by the Association of Convenience Stores (AL 40)

1. ACS, the Association of Convenience Stores,³⁰⁸ welcomes the opportunity to respond to the Health Select Committee's inquiry into alcohol. Alcohol is sold in almost all of our members' shops and is an important category for convenience retailers.

2. However alcohol is an age restricted product and our members understand that there must be regulations as to how it is sold. ACS supports its members to ensure that alcohol is sold responsibly. We are committed to working with Government on delivering the objectives of the National Alcohol Strategy and we accept fully the role retailers can play in a partnership approach in tackling alcohol harm. ACS is a member of the Retail Alcohol Standards Group (RASG), which created the Challenge 25 initiative and is a founding board member of the Proof of Age Standard Scheme (PASS). We also helped found and are on the board of CitizenCard which has distributed more than 1.8 million proof of age cards and we support the No ID No Sale campaign.

3. In this submission we will address the issue relevant to ACS members in the current policy debates involving alcohol.

FURTHER LEGISLATION

4. Current measures being debated as part of the Police and Crime Bill will introduce further legislation in an attempt to mitigate crime and disorder issues relating to alcohol. ACS does not support that these measures, as we believe that they will not be effective in tackling alcohol related disorder.

5. Central Government policy on alcohol has been an area of much activity and change since the introduction of the new Licensing Act 2003. The new Act gave local authorities more powers to deal with premises they felt were contributing to alcohol harm in their area. Below is a list of actions that relevant authorities can take against problem premises:

- (a) Fines—A range of penalties are available:
 - (i) A Fixed Penalty Notice can be issued for selling to someone underage.
 - (ii) A fine of up to £5,000 can be issued to selling to someone underage.
 - (iii) £10, 000 fine if a retailer is found guilty of persistently selling alcohol to children.
- (b) Reviews—The licensing board can review a licence and take the following action:
 - (i) Add additional conditions.
 - (ii) Suspension.
 - (iii) Revocation.
- (c) Closure Notice—If a retailer is found guilty of persistently selling alcohol to children (on three occasions in a three month period), a 48 hours closure notice can be issued under the Violent Crime Reduction Act 2006.

6. There are now sufficient powers in legislation to allow relevant authorities to take action against premises that they believe could do more to prevent alcohol harms. These laws should be rigorously enforced, ensuring that where negligent practices take place they are ended or the premise is shut down. Though there is evidence that these powers are not being fully utilised the Home Office has undertaken a programme to raise awareness among practitioners, including regional seminars and the publication of a toolkit. We question whether making significant changes to the Licensing Act 2003 is necessary and instead would advocate a focus on enforcement of existing laws.

7. ACS' concern is that further regulations will unnecessarily burden responsible retailers, while issues regarding enforcement against problem premises will still remain. The Government's Regulatory Impact Assessment (RIA) accompanying the Policing and Crime Bill states that the cost impact of just some of the mandatory elements will be more than £300 million in the first year alone. What is equally alarming, with UK unemployment approached two million, is that the Government's RIA states in respect of the mandatory code proposals: "... we recognise that in the short run, there is the potential for significant transitional costs including job losses and the closure of small businesses". This is simply unacceptable rhetoric from Government, particularly at this time of economic downturn.

PROMOTIONS

8. There has been much discussion about whether Government should adopt a policy to restrict promotions. We note that currently "protecting public health" is not a licensing objective in England and Wales as it is in Scotland. Therefore the focus of the mandatory code announced by the Home Secretary and Secretary of State for Health in December 2008 was to reduce alcohol fuelled crime and disorder.

9. Promotions were covered under this remit by looking at how price and promotions have towards fuelling alcohol disorder and particularly among binge drinking 18–25 year olds.

³⁰⁸ See Annex.

10. The Government are currently consulting on whether there is a mandatory condition in the new Code of Practice which will restrict promotions in the off-trade. Current indication is that Government is looking to restrict “very large quantities” of cheap alcohol from supermarkets in an attempt to prevent “frontloading”, when young people drink before going out. However as the Home Office Minister Alan Campbell said “The whole point is to attack the binge drinking culture, not to attack responsible drinkers”.

11. ACS supports the approach of targeted measures. However we do not believe that there is a mechanism which would only tackle large supermarket promotions. Instead any tool used will be a blunt instrument which will affect all responsible businesses and as well as all responsible consumers.

12. We would also question the effectiveness of banning certain promotions. Supermarkets will always be able to buy products cheaper in all categories. Our members have well documented competition concern on below cost selling on all products, including alcohol. Even if promotions were banned it is likely that larger retailers would still be able to offer an incentive for shoppers through low product price.

13. Indeed it would be smaller retailers who could suffer the most from any restrictions on promotions. Currently multi-buys of small quantities are used as footfall drivers into store. In fact alcohol is the category most brought on promotion in convenience stores, which means it is a significant footfall driver.

14. We also have concerns about whether restrictions in price and promotions would be effective in achieving health objectives. The ScHaRR (School of Health and Related Research—University of Sheffield) review released by Government last year investigated the link between price, promotion and harm for moderate, underage, binge and hazardous drinkers. The review found:

- Bans of off-trade “buy one get one free” offers have small impacts as these affect only a small proportion of total sales.
- Restricting Off-Trade discounting via priced based promotion to no greater than 20% (5 for the price of 4) means overall weekly consumption reduces by -0.8% , on average 6.5 units per person per year.
- A total ban on all off-trade discounting reduces consumption by 23 units per year. This would give an estimated change in consumption of -2.8% , which is of a similar order of magnitude to a 40p minimum price policy.

15. ACS does not believe that these figures conclusively show that restricting price and promotions would significantly affect alcohol consumption for problem drinkers. We would argue that the Government needs more time to evaluate to undertake further work based on the ScHARR review’s findings to better understand the impact of policies affecting the price of alcohol before further policies are developed.

SUPPLY

16. While there has been much Government attention on new legislation and enforcement against retailers, ACS believes that there needs to be further action against other routes of alcohol supply for young people.

17. Not only is it currently an offence to sell alcohol to someone under 18 but it is also an offence to proxy purchase alcohol on behalf of a young person. It is also an offence for someone under 18 to attempt to buy alcohol. However as you can see from the 2007 figures for the issuing of Penalty Notices for Disorder (PND) below these laws are not equally enforced:

- 3,583 PNDs issued for selling alcohol to someone under 18.
- 555 PNDs issued for purchasing alcohol for someone under 18.
- 158 PNDs issued to young people attempting to buy underage.

18. The lower number of issued PNDs, particularly in relation to proxy purchasing, does not indicate a lesser problem. Indeed, in the latest alcohol figures from Scotland demonstrate that among both 13 and 15 year olds the most common way to have bought alcohol was from a friend or relative. In fact since 2004, there has been a notable increase in the proportion of young people who have bought alcohol from friends and relatives (a rise from 13% to 22% for 13 year olds and 19% to 29% for 15 year olds). This has coincided with a programme of voluntary off-trade actions such as the introduction of Challenge 21, which has made it harder for young people to purchase alcohol from shops.

19. It is clear that alongside successful action against irresponsible businesses there needs to be action against proxy purchasing to prevent displacing the problem. There can be successful enforcement against proxy purchasers as shown by the RASG Community Action Plan which ACS is heavily involved with.

20. It is also clear that young people are not just buying alcohol from adults but that on many cases they are given alcohol, often by their parents. The National Health Statistics from Scotland show that 80% of children spend no money at all on alcohol which suggests that in many cases they are being given it. More work needs to be done educating and advising parents on how to introduce their children to alcohol. ACS welcomes the current work on alcohol guidance being led by Department for Children, Schools and Families, but are keen to see further progress in this area.

21. However while further education and proxy enforcement is vital in tackling underage drinkers there also needs to be recognition that a degree of culpability for lies with the young people themselves. This can be achieved through a mix of education and enforcing the fines for attempting to purchase while underage. We believe that this is the most effective way to bring about significant cultural change.

March 2009

Annex

THE ASSOCIATION OF CONVENIENCE STORES

ACS is the trade body representing the interests of over 33,000 convenience stores operating in city centres as well as rural and suburban areas. Members include familiar names such as Costcutter, BP and Thresher, as well as independent stores operating under their own fascia. Our members operate small grocers, off-licence or petrol forecourt shops with between 500 and 3,000 square feet of selling space.

Memorandum by the NHS Confederation (AL 41)

The NHS Confederation is the only independent membership body for the full range of organisations that make up today's NHS. We represent over 95% of NHS organisations. We have a number of Networks which represent sector-specific organisations including the Foundation Trust Network, Primary Care Trust Network, Mental Health Network, Ambulance Services Network and the NHS Partners Network, which represents independent (commercial and not-for-profit) healthcare providers of NHS care.

The NHS Confederation welcomes the opportunity to give evidence to the Health Select Committee on alcohol. This memorandum sets out our views, based on feedback from our members and our ongoing work programme.

KEY POINTS

- There have been significant increases in alcohol based admissions in the last 10 years.
- Services for alcohol dependence need to be delivered in the appropriate settings. This may mean increasing community support services.
- There are issues for public health, ambulance resources and staff safety.
- NHS organisations are undertaking a number of local initiatives to deal with the consequences of alcohol.
- Many PCTs are commissioning alcohol services, but this could be more widespread.

Impacts of alcohol—acute care

1. Acute members have reported increases in the number of patients admitted with alcohol related liver disease in the past 10 years. According to the Institute of Alcohol Studies, there are now almost 240 admissions to hospital per day—or (87,000 in 2006–07) where alcohol was the primary cause. Admissions where alcohol was a secondary factor are additional to these figures.³⁰⁹ Admissions per 100,000 population have roughly doubled for men and women since 1995.

2. In addition, there are well-documented burdens from alcohol-related violence and accidents.

3. Costs to hospitals are rising concurrently. These include: higher bed occupancy, increased alcohol related medical complications, liver disease, nutritional failure, neurological disease, as well as increasing nursing, medical, physiotherapy and social work time caring for these patients (knowing that on discharge, community support may be suboptimal).

4. The identification of people with alcohol problems and the provision of community support for alcohol dependence is variable. This leads to hospitals being increasingly used as detox centres whilst community detox could lead to better outcomes.

5. The NHS Confederation would like to see a national initiative to improve detection and increase the availability of alcohol dependence services in the community. This could be supported by initiatives to decrease the amount of alcohol consumption in the population. It would, however, take time to put such a programme in place and to see the results.

6. Any new strategy needs to take into account the costs for hospitals providing services for people with alcohol problems.

7. Implementation of screening for alcohol problems in emergency departments is inconsistent and could be improved.³¹⁰

³⁰⁹ Alcohol Alert, 2008—http://www.ias.org.uk/resources/publications/alcoholalert/alert200801/al200801_p21.html

³¹⁰ *Emerging Medicine Journal* 2007;24:529–531.

Impacts of alcohol—ambulance services

8. Ambulance services have a substantial role in dealing with the consequences of excessive alcohol consumption.

9. Ambulances spend a lot of time transporting people who have had too much alcohol. This is a particular problem during the festive period and can be a serious strain on resources requiring extra measures to be taken.

10. Ambulance personnel are at the frontline of dealing with alcohol incidents and the consequences of excessive alcohol consumption. Ambulance services in particular have had to put resources into tackling alcohol incidents when ideally their resources should be directed to addressing incidents with the most critical, serious conditions such as stroke, trauma and coronary heart disease.

11. Ambulance services are taking action to protect violence against staff and a number of initiatives are currently being undertaken by the services which highlight the important role ambulance services play in tackling alcohol incidents. This includes the importance of engaging with the rest of the NHS in addressing the issue of excessive alcohol consumption.

CASE STUDY—CARS

- In South Central Ambulance Service, patient report forms that are completed by paramedics after each emergency response are scanned into the CARS (Clinical Auditing Reporting System) system. The data from these forms is used to audit and improve clinical performance within the trust.
- The system can also be used by primary care trusts (PCTs) and other commissioners to identify gaps in provision and unmet patient need.
- CARS can be used to pinpoint patients who frequently call 999, but whose health could be improved if they had access to alternative services in the community.
- CARS also shows where emergency responses take place, which could be the address of an individual patient or a particular area or building.
- One recent example identified in the South Central area:
- Night club: 60 responses to assaults and alcohol induced emergencies in 12 months. Evidence from ambulance service put into court. Conditions put on license, plus new management at club. Emergency responses reduced by 90% to just six incidents in following 12 months.

CASE STUDY—YORKSHIRE AMBULANCE SERVICE

Yorkshire Ambulance Service has seconded a public health specialist in for a 12 month period to develop a public health focus.

Alcohol forms a key part of this development and initiatives include:

- Partnership working with the Police to develop an alcohol model.
- Development of screening tools for use by operational staff to identify individuals with alcohol dependence.
- Referral pathways for clinically stable callers whose primary condition is alcohol related.
- Sign posting to services.
- Brief interventions using the three minute pharmacy model.
- Referral to Primary Care Trusts for frequent caller case management.
- Police and Paramedic co-responder schemes.
- Working with Government Office including the Department of Health and Home Office to scope involvement in the Multi Agency Risk Assessment model.

Commissioning for alcohol services in the NHS

12. All PCTs should already be members of alcohol harm reduction partnerships. Approaches to dealing with the consequences of alcohol misuse, and to reducing alcohol-related harm, involve agencies beyond the NHS, including bodies responsible for education, employment, leisure and criminal justice services.

13. Therefore, while PCTs may be the main commissioners of (for example) more community-based detox, alcohol dependence and screening services, responsibility for planning and funding such services should not fall solely on the NHS.

14. The NHS Confederation's PCT Network undertook a survey in November 2008, to get a picture of PCT needs assessments and plans for alcohol services.

15. We received 36 responses from PCTs across the country, and the results illustrate a range of pro-active approaches to planning alcohol services. All those who responded to the survey have a strategy for alcohol related harm in their five year strategies for health gain. 92% felt that they had accurately assessed the alcohol problems in their area.

16. Initiatives being undertaken by PCTs include:

- 16.1 Health trainers.
- 16.2 Social marketing campaigns.
- 16.3 Development of improving access to psychological therapies to include drug and alcohol services.
- 16.4 Interventions within primary care.
- 16.5 Linking public health education strategies and crime and disorder strategies for those involved in binge drinking.
- 16.6 Supporting PBC clusters to identify and commission alcohol services, working within community safety partnerships.
- 16.7 Partnerships with local councils to produce joint alcohol harm reduction strategies, employing a coordinator for implementation.

17. There is scope for learning from this best practice and ensuring that it is spread across the service.

March 2009

Memorandum by BII (AL 42)

SUMMARY

1. BII welcomes the opportunity to submit evidence to the Health Select Committee requesting solutions to address alcohol issues in the UK. BII has a number of ideas and suggestions for improving the health of people in the UK in general and how best to enable and encourage people to drink sensibly and responsibly in particular.

2. BII will be presenting a number of examples of practicable and measurable programmes which serve to encourage responsible drinking in educational and community settings.

3. BII believes that a multifaceted approach is critical in tackling these issues. Firstly, education at an early age in a child's life is crucial. Children are impressionable at this stage so teaching and qualifying them in alcohol awareness is a good start.

4. Secondly, training and development as a whole are key. If staff working in the hospitality environment are highly educated in alcohol issues and awareness, this will have a strong effect on responsible drinking as a whole.

5. Thirdly, responsible retailing is essential in any effective strategy. Consensual local partnerships, effective incentives and practical implementation are key to delivering results at a local level.

A BRIEF INTRODUCTION TO BII

6. BII is the professional body for the licensed retail sector, supporting over 15,000 permanent members, including managers, staff, lessees and tenants from both the on and off licence sectors. BII is also supported by 60 corporate patrons, members and supporters.

7. Members and supporters contribute to furthering the mission of the organisation which is to:

Promote high standards of professionalism throughout the licensed retail sector, to encourage new entrants into the industry and to help them develop long term careers. To provide all members with high quality information, skills and qualifications to help them succeed in their business activities.

8. BII helps to set and maintain standards through its wholly-owned awarding body BIIAB, which develops and certifies a wide range of nationally-recognised qualifications specific to the licensed trade. These include training courses for bar staff, kitchen staff, premises managers, licensees, door supervisors and many more. All courses are delivered through a UK-wide network of 660 training centres.

9. BIIAB is accredited by Ofqual and is the UK's 6th largest vocational qualification awarding body.

ALCOHOL MISUSE

10. The Government is imposing new and tighter regulations on the already heavily regulated licensed retail sector in what it sees as tactics to help to curb “binge-drinking” and reduce alcohol harm.

11. BII agrees that the licensed retail industry has an important role to play in the matter of alcohol harm and that, indeed, it has a duty to ensure retailers operate responsibly and in line with the law. However, BII also believes there is an element of individual accountability at play in every interaction with alcohol and that the decision to enjoy a drink or two is a basic human right in a free society.

12. BII believes that the pub is the safest and most socially responsible place to drink alcohol. The organisation exists to support its members in ensuring this is the case. BII’s mission to deliver consistently high standards of employment practice and social responsibility within the licensed retail sector is conveyed through its members who each sign up to a code of conduct which reinforces this professional message.

13. BII doesn’t support the use of happy hours or “all you can drink” and “buy one get one free” type drinks promotions. We also condemn any implication of sexual success or prowess associated with alcohol and we believe that competitive drinking games should be avoided at all times.

ENCOURAGING RESPONSIBLE DRINKING: EDUCATION

14. Underpinning BII’s position on alcohol harm reduction is a firm belief in the need for education and training. BII feels that we need to talk to drinkers at a young age, often before they’ve started drinking, and explain the downsides as well as the upsides to drinking. In doing this, we will help to ensure that the next generation and generations to come are better informed to make a choice as to their drinking habits.

The BII Schools Project

15. Research shows that in 2005 around 22% of 11–15 year olds in England had drunk alcohol in the previous week. They consumed an average of 10.5 units—an increase from 5.3 units in 1990.³¹¹ Through the *BII Schools Alcohol Awareness Project*, BII is committed to informing young individuals of the risks connected with alcohol misuse.

16. The BII Schools Project is a partnership framework that brings together the licensed retail industry and schools, in order to raise awareness of the importance of responsible drinks retailing and personal responsibility, through education.

17. The key aim of the project is encourage young people to develop responsible attitudes towards alcohol and be empowered to make informed personal choices regarding alcohol consumption.

18. The main academic aspect of the BII Schools Project is the BIIAB Level 1 Certificate in Alcohol Awareness (CAA) qualification. This Ofqual accredited qualification covers key subject areas, including: how the licensed retail sector promotes responsible drinking and contributes to the local and national economy; the nature of alcohol and strengths of different alcoholic drinks; how alcohol affects the body and the dangers of drinking too much. Although the qualification is essentially aimed at the 13–16 age group, many older young people and adults are benefiting from the learning involved.

19. The BIIAB CAA maps primarily to the Personal and Social Health Education aspect of the National Curriculum, with some mapping also to Citizenship and Science.

20. The Schools Project uses a number of resources to connect key stakeholders, which are coordinated through the www.schoolsproject.co.uk website. The website contains teaching support materials, such as on-line quizzes and case studies that can be used by anyone tutoring alcohol education in any environment. In addition to the quizzes, there are fun and colourful quiz sheets that highlight the importance of the hospitality sector in modern Britain, as well as the range of interesting and rewarding career opportunities it offers. The quizzes also draw attention to the impact that irresponsible or illegal sales of alcohol may have on both the retailer and the purchaser.

21. The project is evolving all the time, keeping pace with the educational needs of learners and industry best practice. It also recognises the social and political imperatives driven by the current climate, which are often fuelled by both local and national negative media coverage of the industry.

22. In addition, the CAA qualification is the first step on the ladder to a career in hospitality and a positive sign to prospective employers that the certificate holder understands the personal, social and physical effects of alcohol and what it means to be both socially and personally responsible.

23. To date, the project has attracted 48 sponsors, ranging from large corporations to individual licensees. These sponsors have nominated over 100 schools across the UK, meaning that the project has reached more than 20,000 young people.

24. At this time, the CAA qualification itself is offered in over 130 training venues, 52 of which are schools and colleges. By the end of 2008, over 6,000 people had been through the learning programme and awarded the qualification and this number is expected to treble by the end of 2009.

³¹¹ Public Health Intervention Guidance printed by the National Institute for Health and Clinical Excellence 4 December 2006.

25. Each school that receives a sponsored project pack is asked to give feedback on the materials it contains and this is used to review and update both the materials included and the project as a whole. Due to the evolving nature of the project, evaluation is ongoing, with regular project board meetings taking place to ensure that the aims of the project are being met, along with the needs of the learners taking part.

26. A full, independent, evaluation of the BIIAB Level 1 Certificate in Alcohol Awareness is in the planning stages, now that the qualification has reached a critical mass of learners. Initial feedback shows that the qualification has been instrumental in influencing the attitude and behaviour of young people towards alcohol, with regard to both retail and consumption.

27. Further study is also being carried out with the Licensed Victuallers' School in Ascot. This involves analysis of an "attitude survey" completed by learners directly after they finished the training, which will be followed up with interviews and focus groups approximately four months later. This will highlight post course behaviour and attitude changes that may not have been apparent directly following their learning.

ENCOURAGING RESPONSIBLE DRINKING: TRAINING AND QUALIFICATIONS

28. If staff working in the hospitality environment are highly educated in alcohol issues and awareness, this will have a strong effect on responsible drinking as a whole.

29. BII believes that training without assessment is problematic in the context of ensuring staff members have sufficient knowledge of legal and social responsibility issues to carry out their roles.

30. A training course can be of little use and effect if the input is not a valid educational experience. This is difficult to determine unless assessment of the trainee's knowledge has been made through an examination or other methodology. BII would therefore recommend that, if training staff at point of sale becomes a mandatory requirement, consideration should be given to staff being "qualified" through assessed and accredited programmes.

31. BIIAB's qualifications provide essential knowledge and understanding of the responsibilities of alcohol retailers authorised by a personal licence holder to sell alcohol. They enable those who complete qualifications to act within the law and support the designated premises supervisor in retailing alcohol responsibly in their licensed outlet.

32. BIIAB offers a number of qualifications to support licence holders in operating their premises in a socially responsible manner. The BIIAB Level 2 National Certificate for Personal Licence Holders (NCPLH) and Level 1 Award in Responsible Alcohol Retailing (ARAR) plus the Scottish Certificate for Personal Licence Holders (SCPLH) and the Scottish Certificate for Licensed Premises Staff (SCLPS) all cover aspects of social responsibility and the latter two meet the statutory requirements of the Licensing (Scotland) Act 2005.

33. The widely-used BIIAB Level 1 ARAR provides essential knowledge and understanding of the responsibilities of alcohol retailers authorised by a personal licence holder to sell alcohol. The ARAR provides additional protection to licensed premises operators and candidates alike as it contains three mandatory questions that ensure every candidate fully understands the legislation concerning underage sales, serving persons who are drunk and the licensing objectives.

ENCOURAGING RESPONSIBLE DRINKING: RESPONSIBLE RETAILING

34. BII believes that for progress to be made, a multi-faceted approach to encouraging responsible drinking is key and that responsible retailing and effective education are inextricably linked.

Best Bar None

35. The Best Bar None scheme was developed by the Manchester City Centre Safe project as part of its remit to address alcohol related crime. Work in this area began following findings which indicated that a significantly high proportion of crime (both violent and acquisitive) was directly or indirectly attached to licensed premises with poor management standards.

36. It was felt that in order for progress to be made in delivering a safer night time economy, a new consensual approach was required to enhance and complement traditional law enforcement activity. The objective of this approach was to provide an incentive for the operators of licensed premises to improve their standards of operation to the level of a commonly agreed national benchmark.

37. Best Bar None is a recognised award scheme supported by the Home Office and aimed at promoting responsible management and operation of alcohol-licensed premises. It was developed and piloted in Manchester in 2003 and found to be a huge success, with premises now competing to participate—improving the night time experience in their town centres. It has since been adopted by many towns and cities across the UK and is even now being taken up in parts of Europe, the USA, New Zealand and Australia.

38. The aim of launching a Best Bar None scheme is to reduce alcohol related crime and disorder in a town centre by building a positive relationship between the licensed retailer, the local authority and the police. The scheme also reduces the harmful effects of binge drinking as well as improving the knowledge and skills of enforcement and regulation agencies, licensees and bar staff in order to deal effectively with issues relating to the responsible management of licensed premises.

39. The scheme establishes a benchmark of good practice in off and on trade licensed premises thus creating consistency of standards throughout the UK with which to underpin the national Alcohol Strategy and the 2003 Licensing Act. There are currently over 80 schemes running across the country.

40. There are also some key economic drivers for businesses to adopt the scheme. Not only is there the opportunity to be formally and publicly recognised, there are opportunities for self-promotion, publicity, tourism and marketing.

41. Premises that are accredited can qualify for cheaper insurance—a real tangible business benefit for seeking Best Bar None accreditation beyond merely seeking to avoid official sanctions. This is central to the “win win” ethos underpinning the scheme as an incentive for premises to operate responsibly.

42. Furthermore, Best Bar None can act as a catalyst to ongoing dialogue between local police and partnership groups such as Local Area Partnerships, Crime and Disorder Reduction Partnerships and Pub & Club Watch. The standards outlined by Best Bar None also provide a common reference point for community police officers to work with their local pubs and clubs in tackling crime and disorder issues on an ongoing basis.

RECOMMENDATIONS

BII recommends that the Health Select Committee:

43. Considers making the BIIAB Level 1 Certificate in Alcohol Awareness (CAA) qualification a compulsory part of the National Curriculum; educating children and young people at an impressionable time in their lives about alcohol and its potential dangers.

44. Considers the importance of quality professional training and development for front line staff in the alcohol retail industry.

45. Looks to establish community partnerships at a local level which encourage consensual approaches to responsible retailing.

BII is keen to discuss these issues and recommendations further and offers its considerable experience and knowledge to assist the Health Select Committee take these matters forward.

March 2009

Memorandum by the Advertising Standards Authority (AL 43)

SECTION 1: INTRODUCTION AND OVERVIEW

1. *Introduction*

1.1 This evidence is provided on behalf of the Advertising Standards Authority (ASA). The ASA is content for this evidence to be published.

1.2 The ASA is the UK self-regulatory body for maintaining standards in advertising. The Committee of Advertising Practice (CAP) and the Broadcast Committee of Advertising Practice (BCAP) are the industry bodies responsible for writing and maintaining the Advertising Codes.

1.3 The ASA would be prepared to give oral evidence to the Committee or provide further written information on request.

2. *Executive Summary*

2.1 The advertising regulatory system is committed to upholding high standards in alcohol advertising.

2.2 The Codes contain special rules for alcohol, which sit on top of the general Code provisions that all ads must not mislead, harm or offend.

2.3 The rules for alcohol advertisements were strengthened significantly in 2005 to ensure that they remain relevant and evidence-based. These are actively promoted and enforced.

2.4 The updated rules are designed to protect young people and vulnerable groups. In particular, the rules ensure that alcohol ads do not reflect or encourage any antisocial or undesirable behaviours associated with alcohol misuse. There are also scheduling restrictions to protect young people.

2.5 The advertising regulatory system takes a 360° approach to regulation. This approach incorporates training and guidance; pre-publication advice and clearance; proactive monitoring of advertisements and, of course, an effective complaints and investigations procedure.

2.6 Recent ASA research shows that alcohol advertisements are mostly compliant with the rules. However, the ASA has not hesitated to take action against problematic ads, either those we have received a complaint about or those we have picked up ourselves. We will continue to monitor the sector closely. All ASA rulings and compliance surveys can be found on our website.

2.7 The ASA, CAP and BCAP are responsive to new evidence, which we will consider in light of Government Better Regulation principles. New evidence can be used to inform the application or effectiveness of existing rules.

2.8 We do not have any recommendations for the Health Select Committee to propose in the area of advertising because the UK advertising self-regulatory system is already effective and comprehensive. However, the system is open to considering any new evidence that comes to light through the Committee's work.

3. *A brief overview of the Advertising Regulatory System*

3.1 More comprehensive information about the ASA one-stop-shop is detailed at Annex A and on our website at www.asa.org.uk.

3.2 The ASA is the UK body responsible for regulating advertising in all media. It does this by enforcing the Advertising Codes. It accepts complaints from the public and industry about ads that seem to have breached those Codes. It also conducts other activities such as providing training and advice, and proactively monitoring ads in order to keep advertising standards high.

3.3 The Advertising Codes are written and maintained by CAP and BCAP. CAP is responsible for the Code that covers non-broadcast advertising (print, outdoor, cinema, online, SMS direct mail etc) and BCAP is responsible for the TV and Radio Advertising Codes.³¹²

3.4 The system is both self-regulatory (for non-broadcast advertising) and co-regulatory (there is a co-regulatory partnership with Ofcom for TV and radio advertising). Compliance with the Advertising Codes is not voluntary and all upheld adjudications are strictly enforced.

3.5 The system is widely recognised by Government, industry, consumers, the Courts and partner regulators, for example the OFT and Ofcom, as the means for providing consumer protection against misleading, offensive or harmful advertising.

3.6 The ASA is independent of both Government and industry. The system has consistently proven that it is prepared to take action against those advertisers that breach the Codes. In 2008, 2,475 ads were changed or withdrawn following ASA action.

3.7 The advertising regulatory system is an integral part of the alcohol regulatory system. Our role is distinctly different from that of The Portman Group, which regulates the naming, packaging and promotion of alcoholic drinks. The Portman Group code does not regulate any alcohol advertising that is covered by our Codes. The ASA has not seen any evidence of confusion about our respective roles.

SECTION 2: REGULATING ALCOHOL ADVERTISING

4. *The Rules*

4.1 The full alcohol advertising code rules are attached at Annex B.

4.2 The system recognises the social imperative of ensuring that alcohol advertising is responsible. For that reason, the Codes contain special rules for alcohol, which sit on top of the general Code provisions that all ads must not mislead, harm or offend.

4.3 The rules were developed in line with Government's better regulation principles, which state that regulation must be transparent, accountable, proportionate, consistent and targeted. The rules were drafted in light of the best available evidence about the impact of alcohol advertising on society.

4.4 The alcohol ad rules are exceptionally robust, especially in relation to the protection of young people and vulnerable groups. They were tightened significantly in October 2005, in response to the 2004 Alcohol Harm Reduction Strategy, which suggested a possible link between young people's awareness and appreciation of alcohol advertising and their propensity to drink.

4.5 The rules cover both the content and scheduling of alcohol advertisements.

4.6 The updated content rules ensure alcohol ads do not reflect or encourage any antisocial or undesirable behaviours associated with alcohol misuse. In summary, the rules state that alcohol ads must not:

- link alcohol with daring, antisocial, aggressive or irresponsible behaviour;

³¹² The CAP & BCAP Codes can be found at: <http://www.cap.org.uk/cap/codes/>, those Codes describe the remit in full.

- link alcohol with seduction, sex or social success;
- show alcohol being handled or served irresponsibly;
- show people drinking or behaving in an adolescent or juvenile way or reflecting the culture of people under 18 years of age; and
- depict people who are, or appear to be, under the age of 25.

4.7 In television, alcohol advertisements are subject to tough scheduling restrictions. The rules prevent alcohol ads from being placed during any programme that is made for or aimed at children³¹³ or is likely to appeal particularly to audiences below the age of 18, regardless of the time of day. This is done by audience indexing, which is explained at Annex B.

4.8 The rules mean alcohol ads cannot be shown around programmes popular with young people, such as “The Simpsons” and “Ugly Betty”, even if those programmes appear after 9.00 pm.

4.9 In non-broadcast advertising, alcohol advertisements should not be directed at people under 18 through the selection of media, style of presentation, content or context in which they appear. No medium should be used to advertise alcohol if more than 25% of its audience is under 18 years of age.

5. How are the rules enforced?

5.1 The alcohol advertising rules are comprehensively enforced. The ASA is aware of the importance not just of robust rules but of active enforcement. This means that we take a 360° approach to regulation: the industry receives training and pre-publication advice and, once the ads have been placed, the ASA considers complaints and proactively monitors the sector to remove problematic ads.

5.2 Training and Guidance

5.2.1 CAP and BCAP have produced guidance explaining the alcohol advertising rules, which is available online at the CAP website.³¹⁴

5.2.2 CAP and BCAP also provide regular training for the industry, via seminars, presentations and visits by our Code experts to companies and agencies. In 2008, CAP provided 13 training sessions for alcohol advertisers.³¹⁵

5.3 Pre-publication Advice and Pre-clearance

5.3.1 CAP provides a free pre-publication advice service for advertisers, agencies and media, called Copy Advice. The team dealt with some 225 alcohol ad queries in 2008.

5.3.2 TV and radio advertisements are centrally pre-cleared by Clearcast and the Radio Advertising Clearance Centre (RACC) respectively. These bodies have been set up and funded by the broadcasters to help ensure compliance with the Codes. This means that the vast majority of alcohol advertisements are compliant with Codes before they are aired. Clearcast and RACC approval does not prevent the ASA from acting on ads that seem to be problematic. More information about Clearcast and the RACC can be found at www.clearcast.co.uk and www.racc.co.uk.

5.3.3 It is worth mentioning that cinema also has a pre-clearance mechanism, which is provided by the Cinema Advertising Association (CAA). The CAA clears ads for every cinema in the UK. Their pre-clearance procedures are designed to ensure alcohol ads comply with the CAP Code and are scheduled around films with “U”, “PG”, “12A” and “15” certificates only if 75% of the average audience is likely to be 18 or older.

5.3.4 The BBFC rating is not a suitable mechanism for predicting the age make-up of audiences, for example, the current film “The Young Victoria” is certified PG but is highly unlikely to attract a youth audience; conversely the film “Sex Drive”, which carries a 15 certificate, is expected to have a high youth audience.

5.4 Complaints and Investigations

5.4.1 The ASA is able to accept complaints from both industry and consumers. One complaint is enough to trigger an investigation, which could lead to the withdrawal of an ad campaign.

5.4.2 All complaints are considered fully and those that bring to light possible Code breaches will be sent for thorough investigation.

5.4.3 All decisions on investigated ads are made by the independent ASA Council. The Council is two-thirds lay and is chaired by the Rt Hon Lord (Chris) Smith of Finsbury.

5.4.4 The investigation process is transparent and all adjudications are published weekly on the ASA website and attract significant media attention.

5.4.5 When it upholds a complaint against an advertisement, the ASA can ban the ad or require the advertiser or broadcaster to amend or schedule the advertisement appropriately.

³¹³ A child is defined as under 16 for the purposes of the Code.

³¹⁴ The CAP website is www.cap.org.uk

³¹⁵ 11 of these were co-presentations with The Portman Group.

5.4.6 In 2008, the ASA resolved 392 complaints about alcohol ads. To put this in context, the ASA deals with around 26,422 complaints during the year.

5.4.7 Complaint levels about alcohol are not particularly high but the ASA has banned 18 ad campaigns under the new alcohol rules since they were introduced. That figure does not include those alcohol advertisers that have breached the general Code provisions, for misleading, harmful or offensive ads.

5.4.8 To give the Committee a clearer idea of the enforcement approach taken by the ASA, below are examples of three ads that we have recently taken action against on three different aspects of the Codes.

5.4.9 *Linking Alcohol to Social Success and Enhanced Confidence (Wm Magners Ltd, February 2009)*³¹⁶

The ASA banned this TV ad for using the words “It’s the perfect ice breaker” and “Making sure the conversation flows” in a voiceover for Magners Draught Cider. The ASA felt the use of these words broke the rules that state that alcohol ads cannot imply that alcohol can boost a person’s confidence or be a reason for the success of a social situation.

5.4.10 *Linking Alcohol with Sexual Success (Moët Hennessy UK Ltd, December 2008)*³¹⁷

This press ad, for Belvedere vodka, showed a man sitting on a couch with a woman on either side of him, looking at his face. One woman had her arm around his neck. On a table in front of them were glasses and a half full bottle of Belvedere vodka. Text stated “Luxury Reborn”.

The ASA felt that the overall effect of the image implied that Belvedere had enhanced the attractiveness of the man; we concluded that the ad linked Belvedere with sexual success and therefore breached the Code.

5.4.11 *Linking Alcohol to Youth Culture (Coors Brewers, October 2008)*³¹⁸

The ASA acted against this TV ad because it used themes including exaggerated dance moves, a bear impression, props such as a fake moose and plastic keyboard and a woman hitting men with a pillow.

The ASA found that the characters’ silly behaviour would appeal strongly to young people’s sense of humour and concluded that the ad breached the Code for linking alcohol with youth culture.

5.5 Monitoring and Compliance Surveys

5.5.1 The ASA does not just wait for complaints to come in, but pro-actively monitors ads on a daily basis across all media for compliance with the Codes. It concentrates its activities on high-profile sectors (such as alcohol) or sectors with low compliance.

5.5.2 The monitoring team can ask advertisers to remove or amend their ads voluntarily but sometimes it is necessary to launch a formal investigation and take the advertisements to the ASA Council. A good example of monitoring enforcement was for a series of ads for “Smirnoff Ice”, which we banned for associating alcohol with youth culture.³¹⁹

5.5.3 The team conducts compliance surveys. Surveys involve assessing all ads from a particular sector that have appeared during a defined period. Ads are assessed against the Codes and unacceptable ads are either amended or removed.

5.5.4 We have conducted three surveys on alcohol ads since the rules changed. The 2006 survey revealed a compliance rate of 94%. The 2007 survey revealed a significantly higher proportion of alcohol ads (97%) were complied with the Codes.³²⁰ The 2008 survey will be published later this year; early indications are that the survey will reveal a similar level of high compliance.

5.5.5 Although the alcohol surveys have shown an acceptable level of compliance, we continually strive to improve it, as evidenced by the high number of training sessions held for alcohol advertisers in 2008.

5.6 Sanctions

5.6.1 Advertisers that breach the Codes face financial loss from having an ad campaign pulled and damage to reputation through the publication of upheld adjudications, which attract media attention.

5.6.2 Compliance with ASA adjudications is extremely high. For those few advertisers who refuse to comply, industry and other pressures can be brought to bear. For example, poster pre-vetting can be imposed and direct marketing companies can have benefits such as Royal Mail bulk mailing discounts removed. Although very rare, in serious cases of non-compliance, advertisers can be referred to the statutory authorities, for example to the OFT for action for unfair or misleading advertising, or to Ofcom for action against broadcasters.

³¹⁶ The full adjudication can be found at: http://www.asa.org.uk/asa/adjudications/Public/TF_ADJ_45841.htm

³¹⁷ The full adjudication can be found at: http://www.asa.org.uk/asa/adjudications/Public/TF_ADJ_45068.htm

³¹⁸ The full adjudication can be found at: http://www.asa.org.uk/asa/adjudications/Public/TF_ADJ_45145.htm

³¹⁹ The adjudication can be found at http://www.asa.org.uk/asa/adjudications/Public/TF_ADJ_41791.htm

³²⁰ Both reviews can be found on the ASA website at <http://www.asa.org.uk/asa/research/>

5.7 Consumer and Market Research

5.7.1 The ASA, jointly with Ofcom, commissioned a major two-stage research project to assess the impact of the strengthened alcohol advertising rules on young peoples' attitudes to alcohol ads.

5.7.2 The first wave (December 2005) established a measure of the appeal of alcohol advertising to young people. It was created as a benchmark against which the impact of the new rules could be assessed.³²¹

5.7.3 The second wave (November 2007) evaluated the impact of the tightened Codes and the changes to the alcohol advertising market over the previous two years.³²²

5.7.4 Both waves of the research used ads that seemed to be aimed at the younger end of the legitimate market: The research findings are not representative of all alcohol ads. Significantly it was more difficult to find suitable ads for the 2007 survey, perhaps indicating a shift in marketing focus away from the younger end of the legitimate market.

5.7.5 Findings from the second wave showed:

- Alcoholic drink suppliers had shifted their advertising spend away from television with a reduction of 26% on TV compared to a 3% fall for all media from 2005–07.
- Children and young adults were exposed to fewer alcohol advertisements on television.
- A significant decline in the proportion of young people saying they felt alcohol ads were aimed at them.
- A significant decline in young people's recall of alcohol ads, with unprompted mentions of alcohol ads down from an average of 3.9 ads remembered to 3.3.
- Young people also felt some of the "edgier" ads made the drink look appealing and would encourage people to drink, with 34% believing that in 2007 compared with 25% in 2005.
- 5.7.6 The results were positive but the ASA was concerned that some alcohol ads were still of strong appeal to under-18s. The ASA has taken the findings into account when interpreting the rules about youth appeal.

SECTION 3: THE FUTURE OF ALCOHOL ADVERTISING REGULATION

6. *Online Regulation*

6.1 Although it covers online sales promotions and online ads in paid-for space, the CAP Code does not currently cover other parts of companies' own websites, which are classified as editorial content.

6.2 The ASA and the advertising industry are aware of the need to future-proof advertising self-regulation so that online marketing material is regulated with the same sense of social responsibility as in traditional media.

6.3 Any extension to the ASA's remit is a decision for the advertising industry, not the ASA. The advertising industry, led by the Advertising Association, is presently considering whether and how the scope of the CAP Code might extend to promotional material on websites. The ASA, CAP and BCAP await the outcome of that work.

7. *Code Review*

7.1 In 2007, CAP and BCAP started work on a joint review of their Codes to ensure that they are more accessible and, importantly, in good shape for regulating advertising in the coming years.

7.2 Having completed the internal review process, CAP and BCAP are scheduled to launch a 12-week public consultation on the amended Codes before the end of March.

7.3 We are not a position to share any aspect of the consultation with the Health Committee at this stage but we will contact the Committee once it is launched.

8. *Price, Promotion and Harm Review*

8.1 The advertising regulatory system has consistently maintained an open relationship with Government on alcohol advertising.

8.2 Since the publication of Department of Health's review of the relationship between price, promotion and harm, the Culture Secretary has asked CAP and BCAP to assess the findings of that review.

³²¹ First stage research results at:

http://www.asa.org.uk/NR/rdonlyres/CC8127C7-D1AE-4092-99B0-335FE2F2A221/0/alcohol_research_2005.pdf

³²² The second stage research results can be accessed at:

http://www.asa.org.uk/NR/rdonlyres/D311E8A2-C7CD-44B5-BECD-D87BC3812F04/0/Youngpeoplealcoholadvertising_20071116.pdf

8.3 CAP and BCAP are evidence-based regulators and have committed to undertake the Culture Secretary's request. If the review presents new evidence that brings into question the effectiveness of the current rules, CAP and BCAP will consider whether to revise the Codes.

SECTION 4: CONCLUSION

9. Conclusion

9.1 We do not have any recommendations for the Health Select Committee to propose, because there are already strict, evidence based rules in place to control alcohol advertising in the UK, which are comprehensively enforced by the ASA.

9.2 The ASA, CAP and BCAP are responsive to new evidence. New evidence can be used to inform the application of existing rules or the effectiveness of the rules. The system is open to considering any new evidence that comes to light through the Select Committee's work. We are committed to keeping advertising standards high.

March 2009

Annex A

ABOUT THE ASA ONE-STOP SHOP

1. The ASA has been responsible for policing non-broadcast advertising standards since 1962, when the industry established the ASA as an independent complaints body to administer the new CAP Code.

2. The self-regulatory system is based on a concordat between advertisers, agencies and the media that each will act in support of the highest standards in advertising. It is not a voluntary system.

3. The success of the self-regulatory system led to the contracting-out of broadcast regulation (TV and radio) by Ofcom in 2004. Approved by Parliament, it created a "one-stop shop" for all advertising complaints.³²³

4. Two industry bodies, the Committee of Advertising Practice (CAP) and the Broadcast Committee of Advertising Practice (BCAP) are responsible for writing and maintaining the Advertising Codes. CAP maintains the non-broadcast Code and BCAP is responsible for the TV and radio Codes.³²⁴

5. The system is entirely funded by industry, through a levy of 0.1% on display advertising space and airtime and 0.2% on Royal Mail Mailsort contracts. The levies are collected by two arm-length funding bodies, the Advertising Standards Board of Finance (Asbof) and the Broadcast Advertising Standards Board of Finance (Basbof).³²⁵ Last year the ASA was awarded £8 million to run the system.

6. The ASA "one-stop shop" advertising regulatory system brings great benefits for consumers and for business:

- *Easier for consumers*—The establishment of a single complaints body has made it easier for consumers to complain.
- *Free to the taxpayer*—Because it is funded by industry.
- *Simpler regulatory structure for advertisers*—and cheaper for business than seeking resolution through the courts.
- *Harmonious decision making*—Cross media adjudications are made by a single organisation.
- *Corporate Social Responsibility*—Effective self-regulation works because the advertising industry has a strong interest in maintaining a level playing field for business and consumer trust in advertising.

7. Further information about the ASA and the work we do can be found at www.asa.org.uk. The website also contains a searchable database of all our adjudications from the past five years.

Annex B

ALCOHOL ADVERTISING RULES

To note: As well as adhering to the alcohol specific rules, alcohol advertisers must also adhere to the general Code provisions, that all ads must not mislead, harm or offend. The full Advertising Codes can be accessed on the CAP webstie at www.cap.org.uk

³²³ Agreed through a formal Memorandum of Understanding (MOU), with the Deregulation and Contracting Out Act 1994 (DCOA) as the legal function that enables the partnership.

³²⁴ The Advertising Codes can be found at: <http://www.cap.org.uk/cap/codes/>

³²⁵ www.asbof.co.uk

THE BRITISH CODE OF ADVERTISING, SALES PROMOTION AND DIRECT MARKETING (NON-BROADCAST CODE)

Alcoholic Drinks

(See the CAP Help Note on Health, Diet and Nutritional Claims in Marketing Communications for Alcoholic Drinks)

On 1 July 2007, a new and important regulation governing nutrition and health claims for foods (including alcoholic drinks) came into force. The regulation is complex and mandatory. CAP encourages advertising industry stakeholders to take advice on the effect of the regulation and to consult the Food Standards Agency's Guidance to Compliance with Regulation (EC) 1924/2006 on Nutrition and Health Claims on Foods, which is available at <http://www.food.gov.uk>

RADIO ADVERTISING STANDARDS CODE

11 *Alcoholic Drinks*

On 1 July 2007, a new and important regulation governing nutrition and health claims for foods (including alcoholic drinks) came into force. The regulation is complex and mandatory. BCAP encourages broadcasters to take advice on the effect of the regulation and to consult the Food Standards Agency's Guidance to Compliance with Regulation (EC) 1924/2006 on Nutrition and Health Claims on Foods, which is available at <http://www.food.gov.uk>.

Central copy clearance is required. Alcoholic drink advertisements must comply with the minimum standards set out here. These Rules also apply to low alcoholic drinks, except where otherwise stated.

These Rules apply principally to advertisements for alcoholic drinks and low alcoholic drinks. However, incidental portrayals of alcohol consumption in advertisements for other products and services must always be carefully considered to ensure that they do not contradict the spirit of these Rules.

TV ADVERTISING STANDARDS CODE

11.8 *Alcoholic Drinks*

On 1 July 2007, a new and important regulation governing nutrition and health claims for foods (including alcoholic drinks) came into force. The regulation is complex and mandatory. BCAP encourages broadcasters to take advice on the effect of the regulation and to consult the Food Standards Agency's Guidance to Compliance with Regulation (EC) 1924/2006 on Nutrition and Health Claims on Foods, which is available at <http://www.food.gov.uk>

The spirit as well as the letter of the rules in this section apply whether or not a product is shown, referred to or seen being consumed. (See also rule 1.2).

Rule 11.8.1 applies to all advertising. 11.8.2 applies only to advertising for alcoholic drinks. Where soft drinks are promoted as mixers, rules 11.8.1 and 11.8.2 apply in full.

RULES ON THE SCHEDULING OF TELEVISION ADS

Children and young people 4.2.1

(a) The following may not be advertised in or adjacent to children's programmes or programmes commissioned for, principally directed at or likely to appeal particularly to audiences below the age of 18:

(i) alcoholic drinks containing 1.2% alcohol or more by volume; (See also 4.2.5 below) (See note (iii) below on identification of programmes of particular appeal).

Religious programmes 4.2.5

The following may not be advertised in or between religious programmes:

(i) Alcoholic drinks containing 1.2 per cent alcohol or more by volume.

Audience Indexing

How does Ofcom define "of particular appeal to under-16s"?

The term "of particular appeal" is an approach that has been used for many years to ensure broadcasting regulation is appropriately targeted. This is the same approach used in restricting the scheduling of alcohol advertising.

Whether a programme is "of particular appeal" to the under 16s is assessed using a statistical approach called indexing and the end result is what is often referred to as a programme's Conversion Index.

If the proportion of children aged 4–15 watching a programme is more than 20% higher than the proportion of the UK television population watching the programme (or in other words, a programme achieves a Conversion Index of 120 or higher), the programme is defined as one which attracts a significantly higher than average proportion of viewers in that age group.

Calculation

A Conversion Index is based on audience viewing figures measured by BARB (Broadcasters' Audience Research Board Ltd).

Each programme achieves a TVR (Television Rating). The TVR measures the popularity of a programme by comparing its audience to the TV population as a whole.³²⁶

One TVR is numerically equivalent to one per cent of a target audience. So for example, if Programme X achieves a rating of 10TVRs based on children aged 4–15, this would mean the average child audience of the programme is equal to 10% of all children aged 4–15 in television households.

A Conversion Index is calculated by comparing a programme's TVR based on one audience (in this case children aged 4–15 years) with that of the base audience (all viewers).³²⁷ This comparison demonstrates the extent to which children aged 4–15 are attracted to a particular programme.

Example 1

Programme A achieves a Child (aged 4–15) rating of 5TVRs and an All Viewer rating of 3TVR. The following calculation would provide us with the Conversion Index:

$$\text{Conversion Index of Programme A} = \frac{\text{Child TVR}}{\text{All Viewer TVR}} \times 100 = \text{Conversion Index}$$

Formula:

$$\text{Example: } \frac{5 \text{ TVRs}}{3 \text{ TVRs}} \times 100 = 167$$

The proportion of Children aged 4–15 watching Programme A is 67% higher than the proportion of the UK television population watching the programme (a Conversion Index of 167). This programme is therefore defined as one which is of particular appeal to Child viewers.

Example 2

Programme B achieves a Child (aged 4–15) rating of 10TVRs and an All Viewer rating of 14TVRs. The following calculation would provide us with the Conversion Index:

$$\text{Conversion Index of Programme B} = \frac{\text{Child TVR}}{\text{All Viewer TVR}} \times 100 = \text{Conversion Index}$$

Formula:

$$\text{Example: } \frac{10 \text{ TVRs}}{14 \text{ TVRs}} \times 100 = 71$$

The proportion of Children aged 4–15 watching Programme B is 29% lower than the proportion of the UK television population watching the programme (a Conversion Index of 71). This programme does not attract a significantly higher than average proportion of child viewers, and therefore is not said to be of particular appeal to this audience.

³²⁶ BARB figures are based on TV homes. If the programme in question is broadcast on the terrestrial channels, the TVR would be based on the Network, or the number of viewers living in TV households in the UK. If the programme is broadcast on a non-terrestrial channel, the TVR would be calculated based on the Multichannel Network, or the number of viewers living in multichannel television households in the UK.

³²⁷ The BARB definition of all viewers is Individuals aged 4 or over. As per footnote 326, if the programme is broadcast on the terrestrial channel, the index would be based on the TVR figures for Children and All Viewers living in TV households in the UK. If the programme is broadcast on a non-terrestrial channel, the index would be based on the TVR figures for Children and All Viewers living in multichannel TV households in the UK.

Memorandum by the National Organisation for Fetal Alcohol Syndrome-UK (AL 44)

Submission from the National Organisation for Fetal Alcohol Syndrome-UK (NOFAS-UK) to encourage the Committee to recognise Foetal Alcohol Spectrum Disorder (FASD) as a widespread, under-diagnosed, costly preventable health issue.

NOFAS-UK is a national charity dedicated to eliminating birth defects as a result of alcohol consumption during pregnancy as well as improving the quality of life for children, families, carers and communities affected by FASD.

THE ISSUE

The issue of alcohol harm is well documented and well recognised. However, Foetal Alcohol Spectrum Disorder (FASD) has barely been detected on the Government's radar.

Foetal Alcohol Spectrum Disorder, alcohol related brain damage as the result of alcohol exposure in pregnancy though widespread is under recognised. International studies state that 1 in 100 children are born with FASD resulting in lifelong physical and mental disabilities. There is no cure for FASD, it's damage is irreversible.

However, if the public is educated and women do not drink alcohol during pregnancy, FASD is totally preventable.

At present women continue to drink during pregnancy because they are not being given consistent information. Doctors and midwives do not have consistent information. Women with drinking problems are not being given support to avoid drinking alcohol during pregnancy.

FASD is becoming a hidden epidemic. The rise in binge drinking will result in more children born with FASD brain damage, learning difficulties, attention deficit disorder. They may develop violent anti-social behaviour, alcohol and drug addiction. They may become suicidal and have problems with the law.

FASD does not only damage the lives of people born with these lifetime disabilities, it also affects their families, their schools and their communities. FASD adds to the burden of social services, foster care, special education, the criminal justice system and health and hospital services. The Government and the taxpayer pay the high price for FASD.

WHAT IS NEEDED

1. *UK based research*

Though there have been over 6,000 international studies on prenatal alcohol related brain damage, known as Foetal Alcohol Syndrome (FAS) and Foetal Alcohol Spectrum Disorder (FASD), there have been only three studies in the UK in the 1980's. At present there are three studies in progress. Before the UK can tackle the hidden epidemic of FASD, the route of the problem must be understood and assessed through research.

2. *Education, Education, Educatio*

(a) Public Education

It is well known that alcohol contributes to liver disease, health problems and anti-social behaviour. The public is not educated about the risks of drinking in pregnancy and the harm it inflicts on future generations.

FASD education is for everyone, men and women. It takes two to create a baby. Men too need information to support pregnant women, to prevent disabilities and to insure better health for their children.

Support for Lord Mitchell's Alcohol Labelling Bill, requiring warning labels on alcohol containers, will increase public awareness about the risks of drinking during pregnancy.

(b) Medical Education

The majority of medical schools in the UK do not include Foetal Alcohol Spectrum Disorder (FASD) on their medical curriculum.

I. Diagnosis

There are very few doctors in the UK who have been trained to diagnose Foetal Alcohol Spectrum Disorder (The whole spectrum of prenatal alcohol related disorders). Only geneticists in the UK are trained to recognise Foetal Alcohol Syndrome (FAS), just one condition of the full spectrum. Though FAS is not a genetic disorder, only geneticists are trained to recognise the dysmorphic facial and physical features of FAS. Medical training to diagnose the full spectrum of the psychological and behavioural disorders of FASD is needed and not offered in UK medical schools.

(c) Special Education

Children with FASD have a spectrum of learning difficulties that will require support, special education and transport for the vulnerable students.

(d) Mainstream Education

Sex education is a part of the school curriculum. Mainstream students should have FASD education as well before they start drinking and become sexually active. It is well known that alcohol reduces inhibitions and may encourage unprotected sex and unplanned pregnancies. Younger teens are becoming more sexually active and drinking which could result in children producing more children with lifelong FASD disabilities.

3. Support and Treatment Programmes

A large proportion of people with FASD are not able to sustain employment or live independently. They need special education, supported housing and supported transport. Without appropriate treatment and support people with FASD have adverse life outcomes.

It is estimated that Foetal Alcohol Spectrum Disorder may affect more than 1% of the UK population. We are asking the Government to make RESEARCH, EDUCATION AND TREATMENT of FASD a priority.

Reducing the number of children born with FASD will reduce the number of people in our population who, over their lifetime will be contributing to anti-social behaviour and draining our social services and health and education systems. Studies in other countries estimate the cost of services for a person with FASD to be as high as \$2,000,000 over their lifetime.

Children in the womb do not ask to drink alcohol. Should we not wait to introduce them to alcohol when they are older, educated and hopefully better able to make decisions about alcohol for themselves?

It is a rare disability that can be prevented. This one can.

NOFAS-UK has expertise and successful education programmes that can assist the Government in public, medical and school education.

NOFAS-UK Chairs the International FASD Medical Advisory Panel, is a member of the Alcohol Health Alliance, Royal College of Physicians, Chairs the Fetal Alcohol Forum, was a member of the Department of Health Advisory Group for the "Systematic Review of the Fetal Effects of Alcohol", was a Contributor to the British Medical Association "Fetal Alcohol Spectrum Disorders Guide for Medical Professionals", Consultant to the Canadian 2009 International Conference on Fetal Alcohol Spectrum Disorder. Susan Fleisher, the Executive Director, is a former teacher and adoptive mother of a child with Fetal Alcohol Syndrome.

March 2009

Memorandum by Business In Sport and Leisure (AL 45)

1. Business In Sport and Leisure (BISL) is an umbrella organisation for over 100 companies in the private sector sport, leisure, hospitality and tourism industry and many consultants who specialise in this field. Members of BISL listed on the London Stock Exchange and in private equity ownership have a combined value in excess of £40 billion. BISL has a long established working group on liquor licensing and published its first paper on licensing law reform in 2003. Today, BISL represents members in the sport, leisure, hospitality and tourism industry for whom the sale of liquor is a key part of their leisure offer, but is not the primary purpose of their facility.

2. SUMMARY

2.1 BISL acknowledges that there remains a culture amongst some people in the UK of binge drinking or drinking to dangerous levels. This clearly has a significant impact on health issues. However, we understand that consumption per head in the UK is not as high compared to other European countries and that it has actually been falling for several years. The problem of excessive alcohol consumption therefore belongs to a significant minority rather than the majority, who consume alcohol sensibly and responsibly.

2.2 BISL believes that sufficient powers already exist to crack down on irresponsible practices in the licensed trade and we would welcome better application of those powers.

2.3 We believe that the focus on curbing the ill-health effects of excessive alcohol consumption should be on promoting positive behaviour change in individuals through education.

3. GOVERNMENT POLICY

3.1 The Licensing Act 2003 defines the four licensing objectives that need to be promoted—the prevention of crime and disorder, public safety, the prevention of public nuisance and the protection of children from harm. BISL believes very firmly that it is right that there is no reference to public health issues in these objectives as such issues must be a matter for the Government rather than individual licensees to address. We are concerned that many of the current proposals emanating from Government seek to muddy the waters between the licensing objectives and public health goals, leading to the imposition of excessive and misdirected regulation.

3.2 The Licensing Act itself, particularly with the addition of subsequent legislation, for example in the Violent Crime Reduction Act 2006, provides ample powers for licensing authorities and the police to deal with licensed premises operating irresponsibly. However, we believe that these powers are not yet being used to good effect and adding additional powers will not help this.

3.3 Moreover, particularly in the case of young people under the age of 18, prosecution too often focuses on the licence holder or the person who bought the drink, rather than the young person themselves. We are aware of only a tiny number of young people being prosecuted for drinking in licensed premises and this is therefore not acting as a deterrent to under-18s seeking to do so.

3.4 Although it is the Home Office that is now seeking to impose a mandatory code of conditions on licensed premises through the Policing and Crime Bill this was first mooted in the National Alcohol Strategy document, *Safe, Sensible, Social*, which is co-owned by Home Office and Department of Health and clearly intended to tackle some of the health effects of alcohol. Such impositions are excessive, in particular requirements around mandatory training of staff, which would be immensely costly, particularly with regard to part time or seasonal workers in the tourism industry, and unlikely to result in any reduction in harmful drinking.

3.5 BISL believes that there is a danger in current Government policy making with relation to alcohol that the providers of alcoholic drinks are demonised for the health impact that those drinks generate when individuals choose to consume them to excess. In terms of combating the health impact of alcohol there needs to be equal if not greater attention thrown on the individual and trying to influence behaviour change as on the licensed trade.

3.6 Moreover, impositions on the licensed trade need to remain proportionate, for example recognising that not all “promotions” are necessarily likely to encourage irresponsible drinking. Free food and drink offers in casinos or a free glass of champagne on Valentine’s evening would seem to be sensible promotions.

3.7 Requirements to advertise the number of units in an alcoholic drink needs to take into account the fact that most people do not understand what units actually mean. There is also no scientific basis for the number of units of alcohol which DH maintain can be safely consumed by men and women.

4. THE ROLE OF THE ALCOHOL INDUSTRY

4.1 The main role of the alcohol industry in combating the problems associated with excessive alcohol consumption is one of responsible practice, partnership with local agencies and adherence to the conditions on their licence. The trade, particularly the on-trade, should not be indiscriminately blamed for a culture of irresponsible drinking, as the majority of premises are operating responsibly.

4.2 We acknowledge that there have been irresponsible practices within the licensed trade. However, these are perpetrated by the minority and the responsible majority would welcome more effective use of existing police and licensing authority powers to prevent such practices occurring.

4.3 In terms of advertising, responsibility initiatives such as “drinkaware” and sensible drinking messages are the right approach rather than draconian bans, particularly those that would adversely affect the sponsorship from the alcohol industry that many sports rely on.

4.4 The alcohol industry has also made efforts on education through the work of the British Institute of Innkeeping in schools and the Alcohol Awareness Certificate. Such work should be encouraged and supported.

5. SOLUTIONS

5.1 At the heart of the solution to the binge-drinking culture of the minority is education rather than regulation. BISL firmly believes that it is not possible to tax or regulate binge drinking behaviour out of existence. Having worked closely with Government over a number of years on obesity and physical activity issues, we are painfully aware of the difficulty of achieving behaviour change, but this has to be the right approach.

5.2 The only area where we feel there may be some benefit in regulating is with regard to minimum price in order to prevent off-trade retailers from irresponsibly selling alcohol at below cost-price. For BISL the issue remains not the consumption of alcohol within the well-regulated environment of a licensed premises but the consumption of alcohol bought cheaply in supermarkets in the home and on the street. We also support the banning of irresponsible promotions, although these need to be clearly defined.

5.3 Government needs to develop and promote a series of clear messages about alcohol that people understand. We welcomed the DH pilot in the North West of England focusing on adults over 45 who fall into nine drinking categories.

5.4 At the heart of the information campaign need to be GP surgeries, making the public aware of how much is too much and the dangers of excessive consumption.

BISL is very concerned that the Mandatory Code as written will cost businesses a great deal and achieve very little. It is likely to drive responsible, well run bars, pubs and nightclubs out of business and have far too great an effect on many members of BISL for whom the sale of alcohol is secondary to their main product and where customers do not visit to binge drink.

March 2009

Memorandum by the Royal College of Physicians (AL 46)

The Royal College of Physicians (RCP) plays a leading role in the delivery of high quality patient care by setting standards of medical practice and promoting clinical excellence. We provide physicians in the United Kingdom and overseas with education, training and support throughout their careers. As an independent body representing over 20,000 Fellows and Members worldwide, we advise and work with government, the public, patients and other professions to improve health and healthcare.

1. EXECUTIVE SUMMARY

1.1 We welcome the opportunity to comment on the scale of alcohol related health harm and the measures which could be taken to reduce it. The RCP believes that in the same way that doctors use evidence-based medicine to treat individual patients, the Government must implement a strong evidence-based approach that is aimed at reducing overall alcohol consumption and alcohol-related health harm. The cornerstones of this approach must be strong public policy measures on price and the availability of alcohol, better commissioning of treatment services, underpinned with greater investment in prevention.

1.2 To support our submission we carried out a survey together with the Royal College of Nursing of over 200 doctors and nurses asking their views on what public policy measures they felt would be effective in tackling alcohol related harm, reference is made to the survey throughout our submission.³²⁸

2. SCALE OF THE PROBLEM

2.1 In the UK the health harms caused by alcohol misuse are underestimated and continue to spiral:

- 8,724 people died from alcohol-related causes in 2007. This has doubled since 1991, where 4,144 deaths were recorded.³²⁹
- 13 children a day are hospitalised as a result of alcohol misuse.³³⁰
- More people die from alcohol related causes than from breast cancer, cervical cancer and MRSA combined.³³¹
- Over a third of adults (37%) exceed the recommended maximum alcohol guidelines on their heaviest drinking day.³³²
- 6.4 million people consume alcohol at moderate to heavy levels (between 14 and 35 units per week for women and 21 and 50 units per week for men).³³³
- 2.9 million (7%) of the adult population are alcohol dependent.³³⁴
- The “passive effects” of alcohol misuse are catastrophic—rape, sexual assault, domestic and other violence, drunk driving and street disorder—alcohol affects thousands more innocent victims than passive smoking.³³⁵

³²⁸ Royal College of Physicians and Royal College of Nursing Survey on Alcohol Treatment Services, March, 2009, www.rcplondon.ac.uk

³²⁹ Office for National Statistics bulletin 27 January, 2009.

³³⁰ Liver disease: alcoholic drinks, 13 March, 2007. *Hansard* Column 312w.

³³¹ Cancer Research UK: Cancer mortality statistics, 2004.

³³² Office for National Statistics bulletin 27 January, 2009.

³³³ *Ibid.*

³³⁴ *Ibid.*

³³⁵ Prime Ministers Strategy Unit, Interim Analytical Report, 2003.

2.2 One of the clearest barometers of alcohol related ill health is the change in patterns of liver disease. The Chief Medical Officers' annual report in 2001 highlighted this very starkly, "In the last 30 years of the 20th century deaths from liver cirrhosis steadily increased, in people aged 35 to 44 years the death rate went up 8-fold in men and almost 7-fold in women, in 25–34 year olds a 4-fold increase was seen over the 30 year period".³³⁶ The most recent analysis published in July 2008 showed that liver disease is the commonest cause of alcohol related death in men and women between the ages of 35 and 75 in England.³³⁷

2.3 Much of the alcohol debate and media attention since then has centred on the problems of binge drinking amongst young people, and in particular the link between alcohol use and anti-social behaviour. The degree of health harm at all ages caused by alcohol has generally escaped the attention of the media. There are potentially a large number of people who are unknowingly consuming well over the recommended limits in their own homes, and storing up problems for the future.

2.4 There are also a number of groups in society where the extent of alcohol related harm is only just beginning to emerge, for example amongst older people and ethnic minorities. Alcohol related hospital admissions in England for the over 65 showed a huge increase from 197,584 in 2002 to 323,595 in 2007.³³⁸

2.5 In the UK there is a link between alcohol-related mortality and areas of social deprivation. Self-reported average consumption differs little across socioeconomic groups, however in the General Household Survey, for men there are five-fold higher age-standardised alcohol-related deaths in the most deprived areas as compared to the least deprived, using the Carstairs deprivation categories. The same trend applies to women.³³⁹

3. THE CONSEQUENCES FOR THE NHS

3.1 It is estimated that the annual financial cost of alcohol harm to the NHS in England is £2.7 billion in 2006–07 prices.³⁴⁰

3.2 In 2006–07, there were 57,142 NHS hospital admissions in England with a primary diagnosis specifically related to alcohol. This number has risen by 52% since 1995–96. Of these admissions 4,888 (9%) involved patients under 18 years of age.³⁴¹

3.3 The burden of alcohol misuse affects all parts of the NHS: primary care services and most hospital services including Accident and Emergency, medical and surgical inpatient services, paediatric services, psychiatric services and outpatient services.³⁴² In many cases these services are not geared up to cope with this vast increase putting them under severe strain. Over 75% of respondents to our survey stated that current NHS facilities for treating patients with alcohol related health problems were inadequate or very inadequate.³⁴³

3.4 Access to alcohol services in both primary and secondary care across England is still unequal and patchy even though there is good awareness of the services. The main gaps in service provision that were identified include:

- A lack of screening in primary care and active intervention when problems are apparent.
- Incorrect early identification leading to referral to already overcrowded services.
- Poor liaison or integration between acute services and follow on and support services in the community.
- Huge gaps between acute detoxification and community addiction services, in addition to long waiting times between treatment for alcohol withdrawal symptoms and addiction services input.³⁴⁴

3.3 In 2006 the Department of Health and the National Treatment Agency issued guidance on alcohol treatment commissioning "Models of Care for Alcohol Misusers" to help commissioners develop more integrated and effective services. In 2008 Alcohol Concern's report "The Poor Relation" showed that the MoCAM guidance was having a limited impact.³⁴⁵ The recent National Audit Office report highlighted that commissioning of alcohol services is still poor, and that many PCTs were yet to develop more consistent and effective commissioning strategies based on local demographics despite the fact that the data to enable them to do this is available in Local Alcohol Profiles for England. A further complicating factor which hampers good commissioning is that PCTs often look to Drug and Alcohol Action Teams to take the lead in commissioning. However these teams are almost entirely to focus on the treatment of dependent users of alcohol and drugs.³⁴⁶

³³⁶ Department of Health, on the state of the public health: the annual report of the Chief Medical Officer, 2001.

³³⁷ Jones, L, *et al.*, "Alcohol attributable fractions for England; alcohol attributable mortality and hospital admissions". North-West Public Health Observatory and Dept of Health 2008:
<http://www.nwph.net/nwpho/publications/forms/disppform.aspx?ID=186>

³³⁸ Alcoholic Drinks: Elderly, *Hansard* 26 February, 2009, Column 1016w.

³³⁹ Office for National Statistics, General Household Survey, 2008.

³⁴⁰ Department of Health, "The cost of alcohol harm to the NHS in England—An update to the Cabinet", 2008.

³⁴¹ NHS Information Centre for Health and Social Care, Statistics on Alcohol: England, 2008.

³⁴² Royal College of Physicians, "Alcohol can the NHS afford it", 2001.

³⁴³ *Ibid* 328.

³⁴⁴ *Ibid* 328.

³⁴⁵ Alcohol Concern, "The Poor Relation—has the emphasis on 'localism' really improved alcohol commissioning", 2008.

³⁴⁶ National Audit Office, Reducing Alcohol Harm: Health services in England for alcohol misuse, National Audit Office, 2008.

4. THE ROLE OF THE NHS

4.1 The role of the NHS to date has focused very much on treating the consequences of alcohol related-harm rather than active prevention. However it is now widely acknowledged that the factors which influence alcohol misuse are complex and that a multi-stranded and holistic approach which brings together early detection and intervention, education and treatment may be more effective in tackling health harm. Therefore the NHS must think about refocusing its role on prevention and early intervention and work in partnership with services in local communities to raise awareness of alcohol related harm.

5. CENTRAL GOVERNMENT POLICY

5.1 Central government policy has only just started to seriously address issues of alcohol related harm. The National Alcohol Harm Reduction Strategy for England in 2004 was a positive step but it relied heavily on voluntary partnerships with drinks producers and retailers and emphasised the importance of information and education for the public while failing to address the association between price, availability and heavy consumption. In 2007 the Government published *Safe, Sensible, Social—The Next Steps in the Alcohol Strategy (SSS)*, which moved policy forward by addressing the needs of harmful and hazardous drinkers but still failed to address the links between price, availability and consumption. What has also been lacking to date is a coherent cross-Departmental approach required to reduce the scale and impact of alcohol related health harm. In our survey 88% responded that overall, current national alcohol strategies are not effective and 84% responded that public health campaigns have not been effective in changing drinking behaviour.³⁴⁷

6. RECOMMENDATIONS

Alcohol related health harm is a complex issue involving a range of determinants which are socio-economic, cultural and educational as well as health related. A future alcohol strategy must therefore take account of this complexity by being integrated and overarching, bringing together education, treatment and enforcement. What is also needed is large scale and lasting social and cultural change, to engrain sensible and healthy attitudes to alcohol consumption in the population that must be instigated by a comprehensive package of public policy measures.

6.1 Retailing

In order to reduce overall consumption and the resulting health harms the issue of price must be addressed. Alcohol can currently be bought in the off trade at a very low price. The latest review of alcohol price, promotion and harm conducted by Sheffield University showed that there is strong relationship between pricing and consumption and that pricing policies can be effective in reducing harm related to health, crime and unemployment. It also demonstrated that pricing policies can be targeted, so that people who drink within recommended limits are hardly affected whereas very heavy drinkers, who cause by far the most alcohol-related harm, pay the most. One way of achieving this would be to set a minimum price for a unit of alcohol to reduce alcohol consumption and related harm.³⁴⁸ In our survey over 70% of respondents felt that action on the sale of low priced alcohol would be effective in tackling alcohol related health problems.³⁴⁹

Other evidence suggests that increasing tax on alcohol by only 10% could decrease alcohol related deaths of various forms by 10–30%, yet alcohol has become over 50% more affordable in the last 25 years.³⁵⁰ Increases in overall alcohol related taxation would fall predominantly on those at risk whose consumption in any case needs to be reduced. The impact of duty increases on truly moderate drinkers would be negligible even more so when staged over a number of years. The revenue from increased duty could also provide more than enough funding for the exchequer, to bring alcohol treatment and prevention services up to the level of services provided for users of illegal drugs. A combination of the two options, a minimum price and stepped duty increases provides the single most effective solution to the UK alcohol problem.

6.2 Regulation

The review of alcohol industry standards by KPMG found that “the standards are not operating as the Government originally hoped. They are not a catalyst for self-regulation, self-improvement and social responsibility”.³⁵¹ This has shown that the voluntary self-regulation approach adopted by Government towards the industry had failed. The College therefore believes that a mandatory code is necessary. The

³⁴⁷ Ibid 328.

³⁴⁸ Meier *et al*, SCHARR, University of Sheffield—“Independent review of the effects of alcohol pricing and promotion: Part B—Modelling the potential impact of pricing and promotion policies for alcohol in England”, 2008.

³⁴⁹ Ibid 328.

³⁵⁰ Academy of Medical Sciences, “Calling Time on the Nation’s Drinking”, Academy of Medical Sciences, 2004.

³⁵¹ Home Office & KPMG, “Review of the Social Responsibility Standards for the production and sale of Alcoholic Drinks Volume 1”, 2008.

ground for the code has been laid by the enabling power included in the Policing and Crime Bill 2009. A mandatory retailing code should be accompanied by appropriate sanctions, as this the only way to ensure that the safe sensible drinking message is taken seriously and promoted by the industry. The College believes that the best way of doing this would be to set up an independent central agency to regulate the industry. This body could have enforcement powers and a range of sanctions to oversee and monitor practice within the industry.

6.3 *Investment in services*

In our survey 87% of respondents felt that investment in NHS staff and services for treating alcohol related health problems had either not kept up with demand or had been seriously under-invested.³⁵² Currently there is no ring fenced funding for alcohol treatment services. The funding which exists is often part of the pooled treatment budget for drugs and alcohol. The budget for these services in 2009–10 will be £406 million.³⁵³ Within these budgets most of the funding is dedicated to drug treatment. The NAO report showed that on average PCTs were only spending 0.1% of their money on alcohol services every year working out at £197 per dependent drinker where as the amount spent on dependent drug users every year equated to £1,744 per dependent person.

6.4 *Access to alcohol treatment services*

6.4.1 More needs to be done to improve earlier diagnosis of alcohol use disorders and ensure prompt referral. This could be incentivised through including a measure in the Quality and Outcomes Framework for GPs that screened in groups that are high-risk for alcohol-related harm and for alcohol use disorders.

6.4.2 The qualitative findings from our survey suggest there are huge regional variations in access to services and very poor integration and links across and between services. More must be done to convince PCTs that commissioning integrated care pathways based on the needs of the local demographic will result in cost savings across its primary and secondary care operations.

6.4.3 The waiting times for alcohol treatment are often far longer than for drug treatment. The Department of Health should consider demanding of local commissioners that waiting times for alcohol treatment match targets for drug treatment in the next NHS operating framework.

6.4.4 Every acute hospital should have a Consultant/Senior Nurse Lead for Alcohol Misuse to ensure early detection by any doctor/nurse and to work with Alcohol Nurse Specialists to provide intervention as well as education, audit, and liaison with the community.³⁵⁴

6.4.5 There is an urgent need to train clinicians working across primary and secondary care how to use early identification toolkits such as the Paddington Alcohol Test (PAT)³⁵⁵ to assess levels of consumption and harm and utilize brief interventions which are a quick and effective means of engaging with large numbers of drinkers who are not dependent, but are still harming their health. Our survey showed that 60% of respondents had received no specific training in this area. Alcohol screening and brief psychological interventions supported by alcohol nurse specialists have also been shown to be clinically effective and cost effective in reducing unscheduled alcohol related re-attendance in A&E.

6.5 *Health information*

Many people underestimate the amount of units they are drinking. A YouGov survey of 1,429 drinkers in England found more than a third did not know their recommended daily limit—2–3 units for women and 3–4 for men.³⁵⁶ The public must have the knowledge and information to enable them to make sensible choices about what they are drinking and this can only be achieved by making it mandatory for all promotional material and labelling to carry health and unit information, 91% of respondents to our survey believe that this would make a difference to attitudes towards alcohol. In the USA tobacco product labelling was shown to lead to a change in behaviour. Warning labels on tobacco products are large and we believe that there should be a mandatory requirement for alcohol warning labels to occupy at least 10% of the printed area. A label of this size would be about twice the size of the bar code on cans and bottles which currently occupies approximately 4% of the printed surface.

³⁵² Ibid 328.

³⁵³ National Audit Office, *Reducing Alcohol Harm: Health services in England for alcohol misuse*, National Audit Office, 2008.

³⁵⁴ Royal College of Physicians, "Alcohol can the NHS afford it", 2001.

³⁵⁵ Huntley, J.S., Blain, C., Hood, S and Touquet, R "Improving detection of alcohol misuse in patients presenting to an accident and emergency department", *Emergency Medicine Journal* **18**, 2001 99–104.

³⁵⁶ <http://news.bbc.co.uk/1/hi/health/7399192.stm>

6.7 *Tougher licensing conditions, considering health implications*

The RCP recommends amending the Licensing Act 2003 to insert a fifth licensing objective “protecting and improving public health” which would enable licensing authorities to consider public health matters when making decisions about licensing the sale of alcohol. It would also enable local authorities to take steps to restrict sales where there are particular public health problems, and so help address some of the worst regional health inequalities in liver disease and in the other health-related problems relating to alcohol. This type of provision is already in operation in Scotland, where the Licensing (Scotland) Act 2005 includes the protection and promotion of public health as a primary objective. In our survey 65% of respondents felt that this would help to tackle alcohol related health problems.³⁵⁷

6.8 *Advertising*

The recent increase in alcohol related problems in the UK can be explained in part by increased marketing and promotion of alcohol that occurred from the early 1990’s onwards. The UK alcohol industry currently spends a huge amount on promotion—compared with tiny sums of social marketing. Much tighter regulation of promotion is urgently needed. The RCP firmly believes that a starting point for this would be to ban alcohol advertising on TV before 9.00 pm and in cinemas unless films are 18 rated in a move towards total ban on broadcast advertising.

The Royal College of Physicians is a member of the Alcohol Health Alliance.

March 2009

Memorandum by the Wine and Spirit Trade Association (AL 47)

INTRODUCTION

The WSTA represents the whole of the wine and spirit supply chain including producers, importers, wholesalers, bottlers, warehouse keepers, logistics specialists, brand owners, licensed retailers and consultants. The WSTA has over 330 members and works with them to promote the responsible production, marketing and sale of alcohol and to share best practice with the entire trade. The WSTA provides the support to the Retail of Alcohol Standards Group.

We welcome the opportunity to respond the Health Select Committee’s inquiry into alcohol.

EXECUTIVE SUMMARY

- The Department of Health estimates that 7% of people are drinking 33% of the alcohol consumed in the United Kingdom. Interventions need to be targeted at this minority of problem drinkers. The majority of consumers drink sensibly and general population measures such as raising taxes or increasing prices in other ways will penalise these consumers without necessarily dealing with alcohol misuse.
- Evidence also shows that people who misuse alcohol often suffer a range of other health and social problems related to deprivation and it is essential that the underlying causes of this are addressed alongside problems with alcohol.
- There are certain issues in UK drinking culture that need to be tackled. However, consumption of alcohol is actually falling and media portrayal of epidemic problems of drinking does not help to address these problems in an effective and targeted way. In fact it can go a long way to normalising unacceptable behaviour.
- The most effective way to bring about culture change is to encourage personal responsibility through robust enforcement of the laws that already exist around alcohol and to promote responsible attitudes to alcohol through educational and information campaigns including the use of social marketing techniques to communicate effectively with consumers.
- Industry recognises its responsibilities and is involved in a wide range of voluntary action to inform consumers of the dangers of alcohol misuse and ensure responsible retail and marketing of its products. Industry is keen to continue to work with Government and be part of the solution.
- The production and retail of alcohol is highly regulated in the United Kingdom and industry complies with a number of regulatory regimes in order to market and sell alcoholic products. The level of taxation on alcohol is also high in the United Kingdom when compared to other European countries, many of whom do not experience the same problems with alcohol as the UK does.

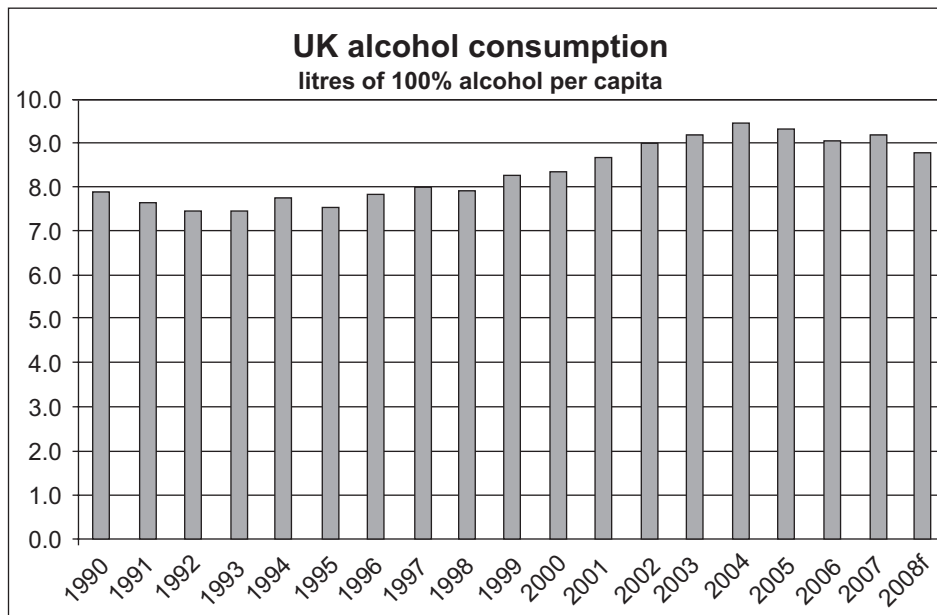
³⁵⁷ Ibid 328.

- Tackling problem alcohol consumption and changing public behaviour is a complex and long term project. A joined up, partnership approach involving national and local Government, health professionals, the police and the industry is needed and industry is willing and able to play a role in this.

KEY FACTS

Average alcohol consumption in the UK is falling

- Per capita alcohol consumption has been falling since 2004.
- The UK ranks 13th out of 27 in the EU league table of per capita alcohol consumption.
- On average, Britons drink 17% less than the French, and 19% less than the Germans.



[Source: HMRC/Nielsen/BBPA]

The 2008 forecast figure is based on the decline in H1 2008 compared to H1 2007—4.1%

The majority of people drink responsibly

- The numbers drinking over the recommended weekly guidelines fell between 2000 and 2006:
 - Men down from 29% to 23%.
 - Women down from 17% to 12%.
- In the UK 7% of the population drink 33% of the alcohol.

Underage drinking is declining but those who drink consume more

- Underage drinking is down from 26% of 11–15 year olds in 2001 to 21% in 2006.
- The numbers of 11–15 year olds who have never drunk alcohol are increasing:
 - 40% in 2000 to 46% in 2006.
- Weekly alcohol consumption among those 11–15 year olds who drink is up from an average of 10 units in the last decade to 11.4 units in 2006

Binge drinking is declining but is more common among 16–24 year olds

- Number of people reporting binge drinking (over eight units) on at least one day in previous week is down:
 - Men from 23% in 2003–04 to 18% to 2006.
 - Women from 9% in 2003–04 to 8% in 2006.
- Among 16–24 year olds, 27% of men and 21% of women reported binge-drinking in 2006, down from 36% and 26% in 2001.

The laws we have to tackle alcohol misuse are not being enforced

- Just two people have been prosecuted and one found guilty of selling alcohol to a drunken person since the 2003 Licensing Act was introduced (Parliamentary Written Answer 180410 19/03/08).
- Only six people in England and Wales were found guilty of supplying alcohol to under-18s in 2006.

The current picture; trends in alcohol consumption

Alcohol misuse is an area that has attracted a significant level of scrutiny in the media in recent years. Some coverage of the alcohol debate has likened the UK's problems to an epidemic. We believe that this assertion distorts the reality that the majority of consumers who drink do so moderately and responsibly and that alcohol consumption is actually falling— both by HMRC clearance figures and self reported consumption. The General Household Survey recorded alcohol consumption declining by 15% between 2000 and 2006 [*General Household Survey, ONS*] and UK consumption decline 8% between 2004 and 2008, based on clearance data for the first nine months of 2008 [*HMRC, BBPA*].

It is sometimes argued that although alcohol consumption has been falling since 2004, it is at a “historic” high compared to, for example, per capita consumption of 5.12 litres in 1957. In this context it is important to note the even longer term context of alcohol consumption having been at a historic low from around 1915 to 1965. In 1900, alcohol consumption was 11 litres per capita, compared to 11.2 in 2007.

The proportion of the adult population drinking at harmful levels has steadily declined since 2001. Twenty-nine per cent of the male population drank more than 21 units a week in 2000. This had fallen to 23% by 2006 (using the same basis of calculation); the proportion of the female population drinking more than 14 units per week over the same period decreased from 17% to 12% [*Smoking and drinking among adults 2006, Office for National Statistics*].

These positive trends are being reflected among young adults, an age group which typically drinks the most. Young men (16–24) drinking more than four and more than eight units on at least one day fell in 2004 and again in 2005 and in 2006, although the figure rose slightly in 2007 [*Smoking and drinking among adults 2006, Office for National Statistics*].

Alcohol misuse and harm; concentrated in a minority of the population who frequently experience other social problems

Firstly, it should not be overlooked that there is a significant body of evidence from many global studies that show that moderate alcohol consumption can bring a range of health benefits and therefore tackling alcohol misuse should not be to the detriment of moderate consumers.

Though alcohol consumption overall is in decline, it is clear that some sections of the population in the UK misuse alcohol. The estimate by the Department of Health that 7% of the population drink 33% of the alcohol consumed in the UK [*Safe, Sensible, Social—consultation on further action, DH, July 2008*] serves to illustrate this point. These are often hard to reach groups suffering problems related to deprivation, unemployment and education, a number of interrelated factors in which causation is difficult to establish. While alcohol misuse will exacerbate other problems, it should be recognised that this behaviour is often a result of other issues rather than the root.

The way alcohol misuse coincides with other health and social problems is illustrated when regional breakdowns of data are considered. According to the Department of Health UK Health Profile for 2008, the rate of admissions to hospital for alcohol specific conditions is almost two and a half times higher in the North West than in the East of England. The regional indicators used by the Department of Health show a number of other health indicators are disproportionately bad in many of the same areas.

HEALTH PROFILE OF ENGLAND												
Summary of Indicators - Regions (using Local Health Profile data)												
INDICATOR	Period	Unit ¹	England	North East	North West	Yorkshire and the Humber	East Midlands	West Midlands	East of England	London	South East	South West
Our communities												
1 Deprivation	2005	%	19.9	33.6	31.7	27.2	16.6	27.4	6.2	28.5	5.9	9.2
2 Children in poverty	2005	%	22.4	26.0	25.0	23.0	19.5	24.8	16.9	33.9	15.4	16.9
3 Statutory homelessness	2005-06	cr per 1000	4.4	5.2	4.1	4.2	3.7	5.8	3.5	6.8	2.3	3.6
4 GCSE achievement (5 A*-C)	2006-07	%	60.1	60.5	60.3	57.8	57.9	59.3	61.2	60.9	62.0	59.5
5 Violent crime	2006/07	cr per 1000	19.3	18.8	19.7	20.8	18.3	19.7	14.6	24.3	18.6	17.2
6 Carbon emissions	2005	t CO2 per ²	7.6	9.0	7.6	8.3	8.3	7.4	7.8	6.8	7.3	7.7
Children's and young people's health												
7 Smoking in pregnancy	2006-07	%	16.1	23.6	20.8	19.6	18.3	16.3	14.4	8.9	15.2	16.8
8 Breast feeding initiation	2006-07	%	69.3	49.8	59.8	62.5	70.3	60.3	69.7	81.9	75.6	75.8
9 Physically active children	2006-07	%	85.7	87.0	85.8	84.1	85.9	85.1	86.6	84.9	85.0	88.6
10 Obese children	2006-07	%	9.9	10.9	10.2	9.7	9.7	10.4	9.1	11.3	8.7	9.0
11 Children's tooth decay (at age 5)	2005-06	mean	1.5	2.0	2.0	1.8	1.3	1.0	1.1	1.7	1.1	1.6
12 Teenage pregnancy (under 18)	2004-06	cr per 1000	41.1	49.7	45.4	47.2	40.2	45.7	32.8	46.9	33.4	33.7
Adults health and lifestyle												
13 Adults who smoke	2003-05	%	24.1	29.1	26.0	25.5	24.9	24.0	23.9	23.3	21.8	21.8
14 Binge drinking adults	2003-05	%	18.0	26.5	23.0	22.0	17.7	17.9	15.2	12.7	16.2	15.3
15 Healthy eating adults	2003-05	%	26.3	18.5	23.6	24.7	25.9	25.1	27.0	29.7	30.4	25.9
16 Physically active adults	2005-06	%	11.6	11.4	11.1	11.1	11.6	10.5	11.3	11.6	12.5	12.6
17 Obese adults	2003-05	%	23.6	25.2	24.5	24.1	25.6	26.5	24.8	18.4	22.0	23.2
Disease and poor health												
18 Under-15s not in good health	2001	%	11.6	13.4	12.4	11.8	10.4	12.1	10.4	13.1	10.4	10.7
19 Incapacity benefits for mental illness	2006	cr per 1000	27.5	40.8	40.5	28.3	24.1	28.5	20.0	26.9	19.4	26.3
20 Hospital stays related to alcohol	2006-07	r per 100,000	260.3	422.9	424.2	250.9	238.0	252.5	170.0	239.7	201.9	247.3
21 Drug misuse	2004-05	cr per 1000	9.9	9.5	11.4	11.7	8.2	10.6	6.5	14.4	6.4	9.4
22 People diagnosed with diabetes	2005-06	%	3.7	3.8	3.9	3.7	3.9	4.0	3.4	4.0	3.3	3.5
23 Sexually transmitted infections	2003-05	%	23.3	23.3	23.3	23.3	23.3	23.3	23.3	23.3	23.3	23.3
24 New cases of tuberculosis	2004-06	cr per 100,000	15.0	5.0	9.0	11.0	12.0	17.0	7.0	44.0	8.0	5.0
25 Hip fractures in over-65s	2006-07	r per 100,000	479.8	552.3	493.9	484.0	480.1	499.0	467.6	454.4	467.5	462.7
Life expectancy and causes of death												
26 Life expectancy - male ⁴	2004-06	years	77.3	75.8	75.8	76.6	77.3	76.6	78.3	77.4	78.5	78.5
27 Life expectancy - female ⁴	2004-06	years	81.6	80.1	80.3	81.0	81.3	81.1	82.3	82.0	82.4	82.7
28 Infant deaths	2004-06	cr per 1000	5.0	4.9	5.6	5.6	5.1	6.5	4.1	5.0	4.0	4.4
29 Deaths from smoking ²	2004-06	r per 100,000	225.4	285.8	270.0	249.2	218.2	228.8	199.3	226.1	197.9	192.3
30 Early deaths: heart disease & stroke	2004-06	r per 100,000	84.2	99.8	102.2	90.5	84.6	90.7	72.9	89.0	70.2	69.5
31 Early deaths: cancer	2004-06	r per 100,000	117.1	136.0	131.0	122.3	115.1	119.2	108.3	114.6	109.8	108.1
32 Road injuries and deaths	2004-06	cr per 100,000	56.3	44.6	57.5	65.1	63.7	50.5	64.4	52.6	55.3	49.8

Key
GREEN = significantly better than national average
AMBER = not significantly different from national average
RED = significantly worse than national average
NO SHADE = significance not calculated, or data unavailable

¹ See appendices for fuller description of indicators. See column 'LHP Definition' in annex A for definition of unit.

² Rates differ from those shown in subsequent tables as the method used to calculate smoking attributable mortality for the Health Profile of England differs from the method used for the Local Health Profiles. See page 15 for a fuller explanation.

³ Tonnes CO2 per resident

⁴ The method applied to calculate expectation of life for England to compare against sub-national estimates differs from that used in the production of interim life tables: firstly sub-national estimates use abridged life tables to take account of the smaller number of deaths available at local authority level; secondly sub-national estimates exclude deaths to non-residents. For this reason the expectations of life quoted above will differ slightly from those sourced from interim life tables quoted in subsequent tables.
 cr = Crude rate of reference population (varies by indicator)

Health Profile England 2008, Jan 2009, DH

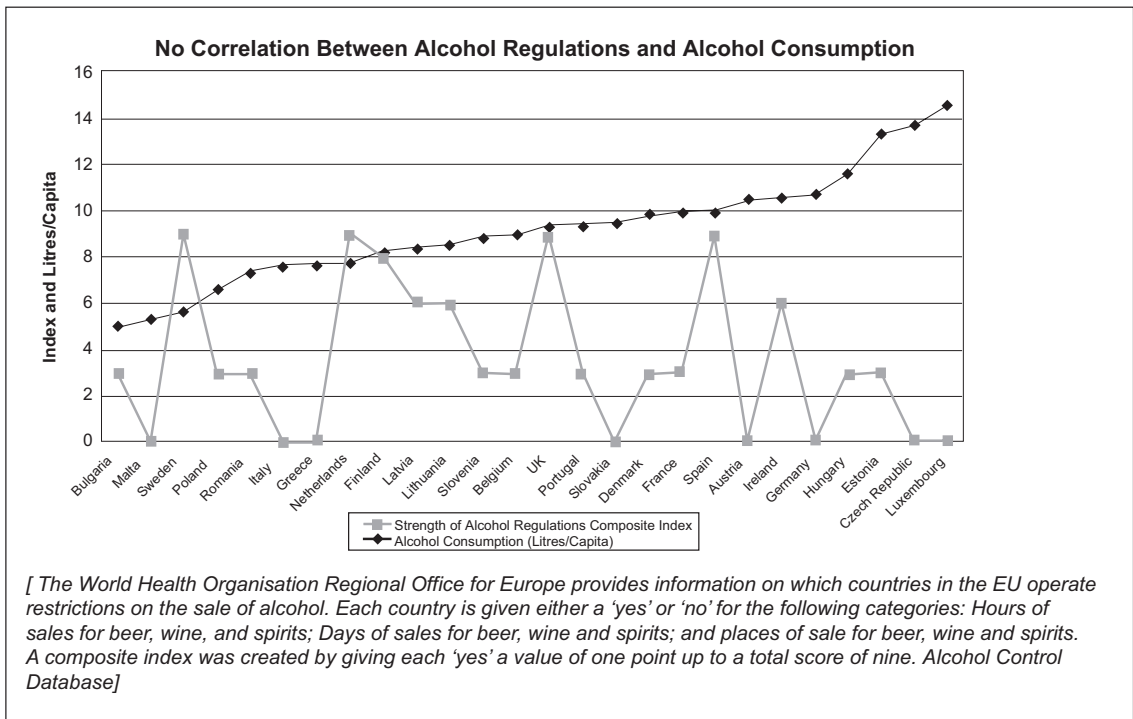
There are difficult problems that link alcohol abuse with social deprivation, unemployment, poor education, poor housing, poor nutrition and other major social issues. As the availability and price of alcohol is the same through the UK, these problems clearly have more complex causes than the freedom with which alcohol can be accessed. It is essential that the underlying causes of these problems be addressed and not solely the regulation of the alcohol industry.

When considering health statistics related to alcohol, it is worth noting that alcohol related ill health develops over many years and figures for rates of long term disease can reflect problems in the past. Although alcohol related deaths have been increasing since the 1990s, the latest figures show alcohol-related deaths in 2007 are down on 2006. [Office for National Statistics, Jan 2009]. It is to be hoped that the progress of the last few years will start to be reflected in health measures in the future.

Current policy on alcohol

The National Alcohol Harm Reduction Strategy was the first cross governmental strategy on alcohol when it was released in 2004. The strategy particularly targets young people under 18 who drink alcohol, 18–24-year-old binge drinkers, and individuals of any age who drink more than the recommended limit on a regular basis, which industry has welcomed.

It is essential that policy be based upon robust evidence of what works, and that is situationally relevant to the culture and circumstances of the United Kingdom. A targeted approach such is necessary to address the minority that are misusing alcohol without penalising moderate consumers. Whole population approaches to alcohol that concentrate on restricting supply across the board may reduce overall alcohol consumption, but these reductions tend to take place among the wider population rather than the problem drinkers whose consumption puts them at risk of harm. It should be noted that the UK has a high level of regulation on the sale of alcohol that accompanies a very high tax rate. As the WHO graph below shows, there is no discernible relationship between the level of regulation and level of harm/consumption.

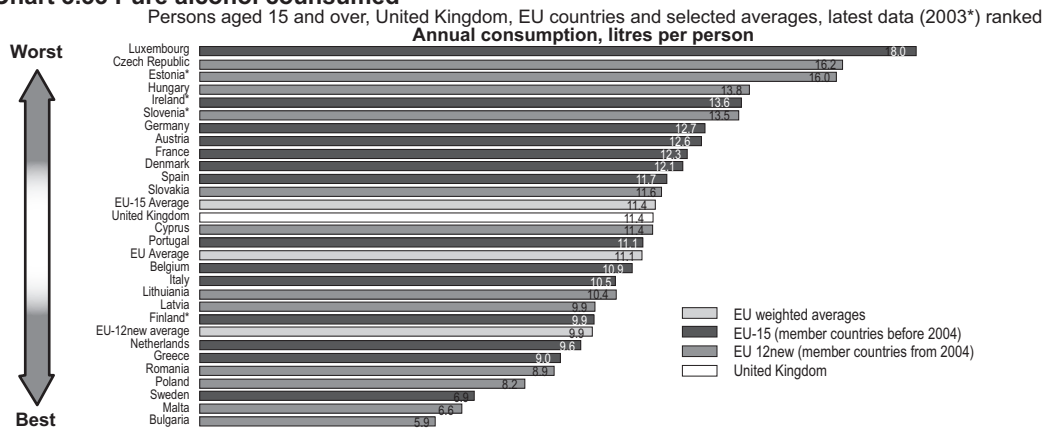


A central tenet of the Government’s alcohol policy has been its targeted approach to problem groups, the use of public information campaigns and openness to including industry in work to promote sensible drinking and tackled harmful drinking. We would encourage the Government to continue with this approach. No one policy can provide a solution to alcohol misuse and a long term commitment is needed to achieve permanent change amongst the population. The effects of such policy are not felt immediately, but we believe that the data shows that the benefits of this approach are beginning to show through.

Cultural change in drinking behaviour and how it can be achieved

As can be seen in the chart below, in 2003 the UK was broadly average among European countries in alcohol consumption, with both Germany and France drinking more pure alcohol per capita in the population over 15.

Chart 3.33 Pure alcohol consumed



Health Profile England 2008, Jan 2009, DH

Though the UK is at an average level of consumption, there is a difference in attitude to drinking in Britain from some other European countries which can result in drinking to get drunk and binge drinking patterns. While there is an element of sensationalism in media coverage of the issue, we do believe that there unhealthy aspects to English drinking culture that need to be tackled. These are a mixture of historical and current societal factors and a change of culture is likely to be a complex and long-term project. Experience in other

countries that have taken supply side approach to misuse of alcohol have shown that limiting access without sufficiently addressing demand leads to large increases in illicit trade and exacerbates risky behaviour when individuals do have freer access to alcohol.

Personal responsibility is clearly a key principle when tackling alcohol misuse and one notoriously difficult to foster. We believe that this is best done by greater enforcement of the laws relating to alcohol, quality school education and public health campaigns to promote a responsible attitude to drinking.

The WSTA White Paper on Enforcement published in 2008, clearly demonstrated many powers to prevent alcohol related problems are not being utilised. If drunk and disorderly behaviour were challenged by the law more routinely and the offences of proxy purchasing and attempting to purchase alcohol when underage were publicised and more often enforced, it would send a powerful message that such conduct is no longer considered normal or acceptable.

Studies have shown the importance of education from a young age and from a variety of sources. Positive messages must not only come from teachers and public health campaigns but from friends and family. Family attitudes have also been shown to be important in prevalence of drinking. Compared with pupils whose families did not like them to drink alcohol, pupils whose families didn't mind were more likely to have drunk in the last seven days. It is also significant that of the 11–15 year olds who had drunk 14 or more units of alcohol in the previous week, 48% claim to have been given the alcohol by their parents [*Youth Alcohol Action Plan, 2008*]. Given the importance of supporting parents in imparting a positive message to their children we warmly welcome the Government and Chief Medical Officer's action in seeking to provide advice on alcohol and young people.

Challenging the perceived norm of binge drinking is essential in changing behaviour; studies have shown that pupils were more likely to think that drinking alcohol was acceptable behaviour for someone of their own age than to think the same about smoking or drug use and tended to overestimate how many people their own age drank [*Drug use, smoking and drinking among young people in England in 2007*]. The impression created by the media that all young people go out and drink to excess can have a perverse effect on young people who don't, making them feel as though this are missing out on a normal part of teenage life. In reality, the number of young people who have never been drunk has been increasing in recent years. Social influence has been shown to be an important determinant in heavy drinking among young adults; among 18–25 year olds surveyed, of those who described themselves as binge drinkers, 85% said most or all of their friends binge drink. In contrast, 45% of non-binge drinkers said most or all of their friends binge drink [*Advertising and the misuse of alcohol; Prepared by FDS International and Volterra Consulting; Commissioned by The Advertising Association; June 2008*].

Lessons need to be learned from successful public awareness campaigns on issues such as seatbelt wearing and drink driving, sophisticated campaigns based on the principles of advertising. A recent study by the Department of Health found that 33% of the total mentions of alcohol on radio shows included in the study were found to be radio advertising warning of excessive drinking [*University of the West of England, Alcohol and the Media, July 2008*]. However, this message can be lost if alcohol is portrayed in an irresponsible manner by the media itself; the same report found that 73% of alcohol related comments made by radio presenters encouraged drinking. Though we by no means advocate censorship, we believe that Ofcom need to seriously consider the treatment of alcohol in media content and how this works to derail sensible drinking messages.

Increasing consumers' knowledge and appreciation of alcoholic products, through tastings and education courses also plays an important role in ensuring people drinks for the right reasons and do so in a healthy way. Wines and spirits can be a fascinating area of interest and teaching consumers to appreciate this is a more effective way of encouraging mature attitudes to alcohol than by demonising it through measures such as separate checkouts and tobacco style health warnings.

Cultural change is a long term project without simple solutions and it requires a long-term commitment from Government. Information campaigns are helpful but are yet more effective when backed up with interventions on a personal level [*King's Fund, Kicking Bad Habits, 2007*]. They also need to be tightly targeted based on local profiling and make full use of social marketing techniques. These methods are not easy and do not immediately show success but they have been shown to be effective. There are opportunities for industry to support Government in its work though it's knowledge of its consumers and how to communicate with them.

Though there are aspects of UK drinking culture that need to be tackled, there is cause for optimism in the attitudes of 11–15 year olds, who clearly see a distinction between drinking and getting drunk; less than half of those who thought drinking was OK also thought it was OK for someone of their age to get drunk [*Drug use, smoking and drinking among young people in England in 2007*]. The potential exists for well targeted education to build on this perception.

The part that industry is playing

The National Alcohol Strategy made a point of working in partnership with a range of stakeholders including industry and we welcome this approach and encourage the Government to make further use of the industry's expertise in communicating with consumers by supporting proposed social marketing initiatives. Industry has often shown that its initiatives are able to outpace legislation, as has recently been seen with the implementation of Challenge 21 and Challenge 25 policies, and we believe the Government can secure its policy objective in a more timely and cost-effective way by working with industry rather than against it. Government can support and encourage these voluntary initiatives by avoiding placing additional burdens on industry.

One example of the benefits of this approach is the success of Community Alcohol Partnerships. The offence of proxy purchasing is very difficult for police to detect, an area where industry can play a part by using the front-line position of retailers to gather intelligence and dispense information. The Community Alcohol Partnerships model developed by the Retail of Alcohol Standards Group (RASG)—whose secretariat is provided by the WSTA—can help by building up the relationship between police and retailers. This means that retailers can contact the police for support without fear of it leading to an investigation against their premises and police can use this intelligence to direct their enforcement operations against anti-social behaviour. The CAP model is also significant as it brings in all stakeholders in the local community to tackle problems with underage alcohol use, this encompasses residents' groups, schools and local health services as well as local business. This holistic approach achieved significant successes in its pilot in the Cambridgeshire town of St. Neots:

- In the last four months of the pilot, January to April 2008 inclusive, incidents of ASB dropped by two per cent over the pilot area and by 45.8% in one of the main hotspot areas.
- A 94% decrease in under-age people found in possession of alcohol. This was significantly lower than expected or in comparison with similar locations in the county.
- A 92% decrease in alcohol-related litter at a key hotspot area.

RASG are currently working with local authorities in several areas around the country, including Kent, Reading and North Yorkshire, to roll the model out in their communities.

Providing information to the consumer is a key part of changing culture and to this end, the drinks industry fund the Drinkaware Trust, a registered charity steered by an independent board, who provide grants for local charities working on alcohol related issues and provide comprehensive sensible drinking advice and an innovative "drinks diary" on www.drinkaware.co.uk. The WSTA recently collaborated with the Drinkaware Trust to design a set of point of sale message on sensible drinking. These are freely available to all retailers on the WSTA website.

A further example of an effective educational project that industry has been involved in is Fundación Alcohol y Sociedad in Spain. This comprises a non branded organisation funded by industry with Spanish doctors and sociologists making up its Board of Trustees. With the help of industry funding, tutors were trained and sent out to work in schools and over five years one million children in over 2000 schools have received instruction on the dangers of alcohol abuse. This is one of the few school programs in Europe where impact on behaviour can be tracked across a number of years. There have been two main results; the age of initiation to alcohol has gone down by just under a year among people who attended the classes and the number of drinks consumed per month decreased by 40%. Industry is currently looking at how the lessons from this project can be put to use in the UK.

While industry is involved in a large number of voluntary schemes to reduce the harms caused by alcohol misuse and promote its responsible consumption, it also take seriously the responsibility of marketing its products in a way that does not encourage their misuse. Drinks producers are comprehensively regulated by the BCAP/CAP Advertising Codes (overseen by the Advertising Standards Authority) and the Portman Group's Code of Practice on the Naming, Packaging and Promotion of Alcoholic Drinks.

The regulations prevent television alcohol advertisements from appearing whenever the proportion of child viewers reaches 20% above the national average. This regulation applies 24 hours a day, seven days a week and means that TV alcohol adverts are never placed within programmes aimed at, or with particular appeal to, children. This system of audience profiling is a targeted and reliable method of protecting under-18s.

The Portman Group's Code of Practice applies to the naming and packaging of alcoholic drinks and the promotional activities of drinks producers, including press releases, websites and sponsorship. It ensures that such activities are carried out in a socially responsible way. Enforcement of the Independent Complaints Panel's decisions is provided by retailers who do not sell any drink found to be in breach of the Code until that drink's marketing has been altered to comply with the Code. This sanction provides a strong commercial threat to companies, encouraging them to ensure that their marketing is responsible.

 CONCLUSION

Changing the culture of alcohol consumption in the UK is a complex task that requires the partnership of a range of stakeholders. There is no silver bullet that will solve the problems of alcohol misuse, but by pursuing evidence based policies that target harmful drinkers, addressing problems through better use of the legislation that already exists and by promoting responsible use of alcohol in the population through education, the Government, in partnership with industry and other stakeholders, will be able to make a impact.

March 2009

Memorandum by Alcohol Focus Scotland (AL 48)

ALCOHOL AND PREGNANCY

Alcohol Focus Scotland ran a campaign during November 2008 to highlight to workers and the general public that the only way to ensure that a baby does not suffer from any of the effects as a result of a mother drinking during pregnancy, was a “no alcohol” message.

It is unclear how many babies are born in Scotland each year with FAS and this in part could be attributed to a lack of understanding or recognition by health professionals. However, less obvious forms of damage are thought to be much more common with babies showing signs of other birth defects (alcohol-related birth defects and alcohol related neuro developmental delay, collectively known as fetal alcohol spectrum disorder—FASD). As they get older, these children will display behaviour and memory problems.

Current advice to women—For the past 25 years, advice to pregnant women has been to limit drinking of alcohol to “one or two units, once or twice a week”. In December 2006 the UK Chief Medical Officers agreed that the message across the UK should be: “Pregnant women or women trying to conceive should avoid drinking alcohol. If they do choose to drink, to minimise the risk to the baby, they should not drink more than one to two units of alcohol once or twice a week and should not get drunk.” They also agreed a shorter message: “Avoid alcohol if pregnant or trying to conceive.” Guidelines from other medical or health bodies offer variations on this advice which can be confusing for the public as to which one to follow.

Understanding units—In the UK we currently use the “unit” system to count how much we drink and gauge whether this is within recommended limits. Units are calculated on the alcohol content (abv) and volume contained in the drink. However, we know that many people struggle with the unit calculation because both strengths of drinks and the size of the glasses vary, so it is understandable that the message gets confusing.

We also know that there has been a substantial increase in consumption—one in four women are drinking more than the weekly recommended limits—and in alcohol-related health and social harm. Many people, including young women are unaware that they are drinking hazardously.

Alcohol Focus Scotland takes the view that the only message to the public should be: *Avoid alcohol while pregnant or trying to conceive.*

We believe this advice is the clearest because:

- it is the only way to be sure that women are giving their unborn baby the best chance as fetal alcohol spectrum disorders are entirely preventable;
- it is the safest advice given that research to-date has been unable to identify the threshold for risky consumption;
- many people don’t understand units and the strength of drinks—some people consume three to four units in a glass of wine mistaking it for one unit; and
- women who are trying to conceive will (1) increase their chances of becoming pregnant and having a viable pregnancy and (2) reduce any worry about alcohol-related damage during the time of trying to conceive and confirmation of pregnancy 3) females who are high risk of unintentional pregnancy.

* this advice is aimed at the general population. There will always be individual women—harmful drinkers/alcohol dependent—who will require individual advice about controlling their drinking during pregnancy. Controlling their drinking rather than stopping altogether may be all they can do. They should be advised to seek professional help.

Alcohol Focus Scotland advocates screening for all ante natal women with brief interventions for women whose drinking is at risky levels. Some women may need more intensive support to reduce or stop their drinking during this time and should be referred to appropriate services, such as local alcohol services.

Finally, taking account of FAS & FASD, we support any action to highlight the dangers of drinking when pregnant. Labelling should be mandatory and we recommend that any labelling or campaigns need to focus on the “avoiding” alcohol rather than adding to confusion by setting limits.

Currently, it is only babies with FAS who tend to be diagnosed and recorded by doctors in the UK. We need the means of diagnosing the whole spectrum of disorders (FASD) caused by fetal alcohol absorption.

March 2008

Memorandum by the Royal College of Psychiatrists (AL 49)

The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

We are pleased to respond to this consultation which was prepared by faculties in the Royal College of Psychiatrists.

EXECUTIVE SUMMARY

- The policy approach has been to favour public education approaches ahead of regulation of price, promotion and availability. There has been a reluctance to adopt whole population measures and a preference to attempt to target particular groups of the population.
- The provision of alcohol services has been a neglected area with little targeted investment.
- Considerable high quality work in England has reviewed the effectiveness of early intervention in risky and problem drinkers, especially in Primary Health Care and for more intensive interventions for those with more severe problems, including dependence, but the findings have not been implemented.
- A co-ordinated approach, backed by targeted investment to improve both early and intensive treatment for alcohol problems, including dependence, is required.
- The Health Committee should review alcohol developments in Scotland, Wales and Northern Ireland. The different approaches in these countries offer learning opportunities. There are also issues determined by the UK Government, such as excise duties, which have a major effect on alcohol issues in the devolved administrations.
- Alcohol dependence is a major risk factor in suicide it is one of the most common reasons for accessing psychiatric care, including hospital admission and is strongly associated with a range of other psychiatric disorders such as depression and dementia.

GENERAL COMMENTS

The Royal College of Psychiatrists strongly welcomes the House of Commons Health Committee's enquiry into alcohol.

We are concerned with the assessment and treatment of people with needs arising out of addictions and addictive behaviours. Raising awareness and prevention is an important role in the work of Addiction Psychiatrists. The Addictions faculty is involved with a wide range of activities with government and other agencies whose work and policies have an impact on the harm caused by addiction and substance use and misuse for individuals and communities.

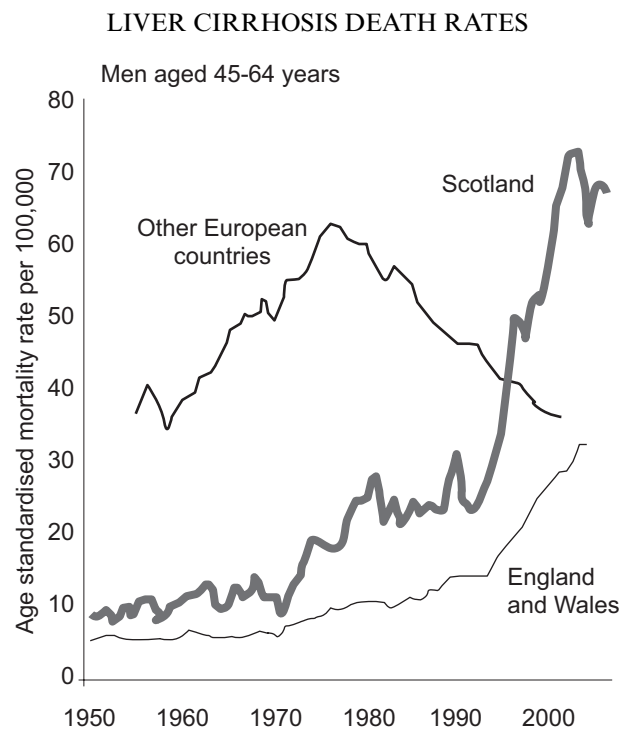
On a daily basis our members are engaged in responding to the harm caused by alcohol to people's health, relationships, and social functioning and to the harm caused to others. Alcohol dependence is a major risk factor in suicide, is one of the most common reasons for accessing psychiatric care, including hospital admission and is strongly associated with a range of other psychiatric disorders such as depression and dementia.

We have considerable expertise and experience in treatment and in effective approaches to prevention of alcohol related harm. The Addictions faculty therefore welcomes the Health Committee's enquiry into alcohol and the increasing harm which is being caused to individuals and communities in England and the rest of the UK. We are keen to offer any assistance we can to the Committee in this vitally important enquiry.

1. The scale of harm related to alcohol misuse

1.1 Alcohol is a major cause of ill health throughout much of the world. The World Health Organisation (WHO 2001) assess alcohol to be the 3rd most significant risk factor in the global burden of disease in developed countries, following tobacco and high blood pressure.

1.2 In the UK, indicators of alcohol related harm such as hospital admissions, rates of liver disease and alcohol related deaths have been steadily increasing in recent years. Alcohol related hospital admissions, for example, doubled in the 11 years up to 2007. Alcohol related deaths have also doubled in 15 years to 2006 (National Audit Office 2008). The UK is unusual among Western European countries in having a steep increase in indicators of alcohol related health such as liver disease, where the majority of other countries show a reduction (Leon and McCambridge 2006).



1.3 More than 10 million people in England drink above the government's recommended low risk levels for alcohol consumption. The estimated financial cost of alcohol related illness to the NHS is £2.7 billion per annum.

There are substantial costs in other sectors, such as criminal justice, the economy; social care with an estimated total cost of £25.1 billion. (National Audit Office, 2008). The increase in alcohol related harm is also against the trend for most other areas of public health in the UK. Rates of heart disease and cancer, for instance, are falling.

1.4 In Scotland, where there have a number of important developments in alcohol policy, the Chief Medical Officer describes alcohol as the country's most important public health challenge. In England, it is therefore time to look beyond the visible public aspects of alcohol misuse, such as anti-social behaviour, recognise the considerable, often hidden, health impact and put alcohol policy at the centre of health improvement.

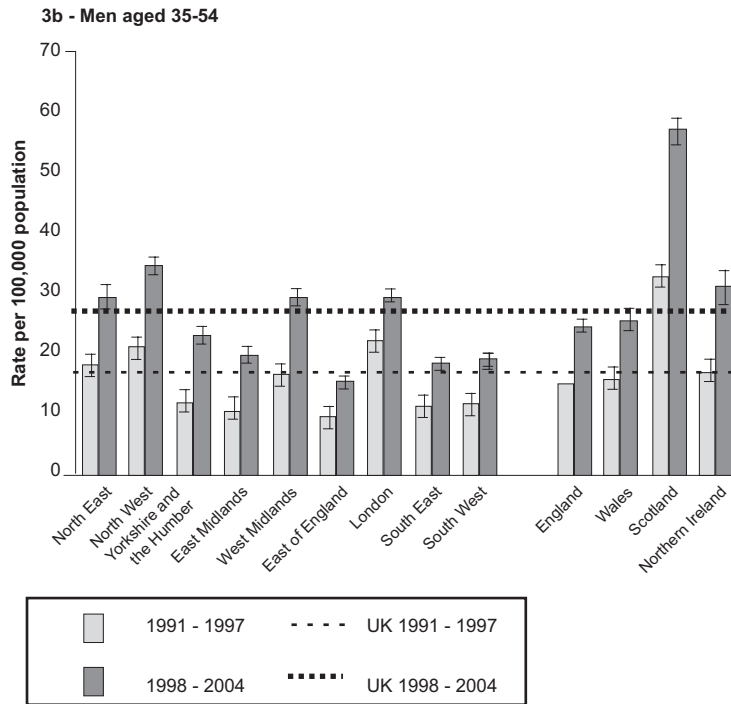
2. The consequences for the NHS

2.1 The impact of alcohol on NHS services is across many sectors including Mental Health, Accident and Emergency, Liver Medicine, Cancer Services, Child Health and Substance Misuse Treatment Services.

Mortality Trends

2.2 Alcohol related deaths doubled from 1991–2006. The contribution of alcohol to early mortality has considerably increased. In 1991 0.6% of deaths (estimated conservatively) were alcohol related. In 2006 the percentage was 1.5% (National Audit Office 2008). There is a considerable health inequality effect on alcohol related mortality. In the most deprived areas, men are five times more likely and women three times more likely to die an alcohol related death than those in the least deprived areas. Deaths increased in both genders, but more in men than women. Deaths increased in all parts of England with no consistent geographical trend, other than those related to deprivation (ONS 2007).

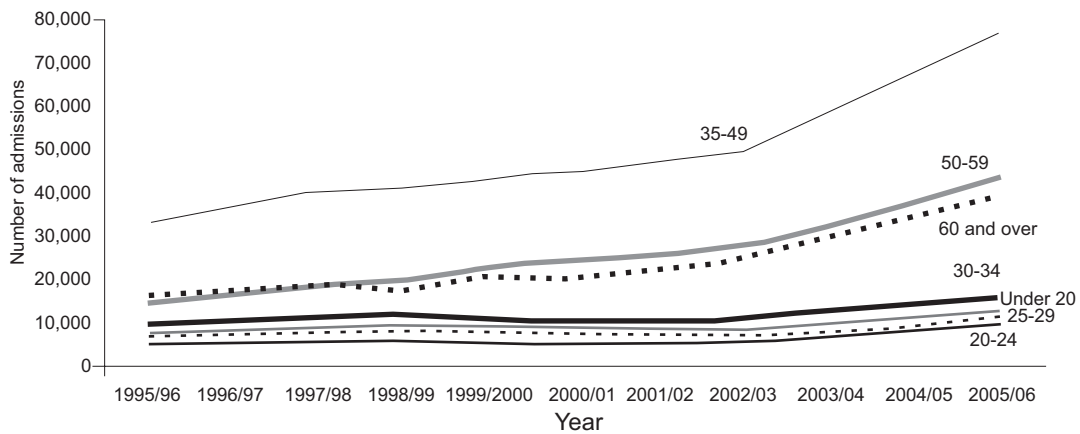
ALCOHOL RELATED DEATHS



Hospital Admission Trends

2.3 Alcohol Admissions doubled from 1995–2006. Admissions for liver disease trebled over the same period. Two thirds of admissions were males and the rate of increase is similar in both genders. Alcohol related admissions are increasing in all age groups, with the greatest increases in the over 35s, including the over 60s.

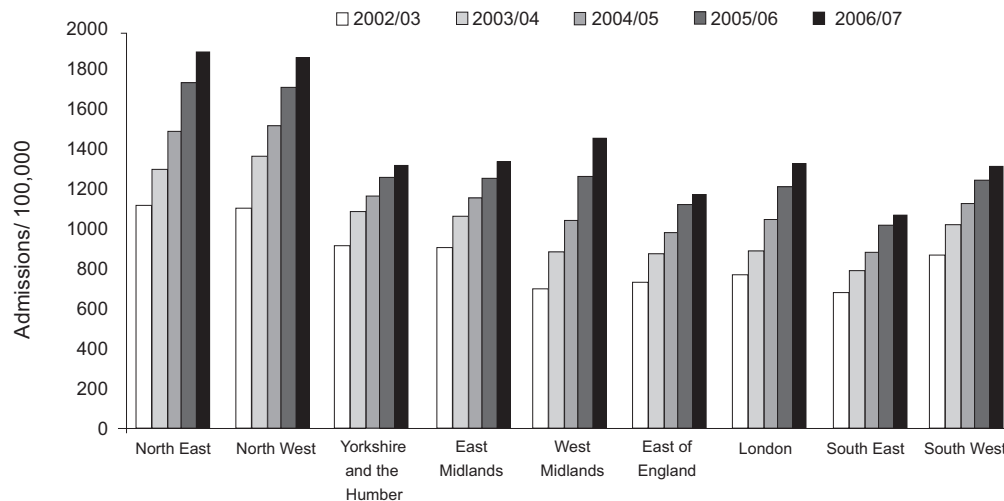
NUMBER OF NHS ADMISSIONS WHERE THERE WAS A PRIMARY OR SECONDARY DIAGNOSIS OF SELECTED ALCOHOL-RELATED CONDITIONS BY AGE: ENGLAND 1995–96 TO 2005–06



Source: The Information Centre (2006) Hospital Episode Statistics (HES). www.hesonline.org.uk

2.4 There are geographical differences in admission rates with rates in North being higher those in the South of England. All areas show an increase. While much of the public attention is focussed on particular groups, such as women and young people, or in areas of social deprivation, the upward trends in alcohol related harm are seen in all age groups, both genders and in all parts of England. (National Audit Office, 2008) (HM Government 2007).

RATE OF ADMISSIONS BY REGION



Source: Hospital admissions for alcohol-related harm, NWPHO, July 2008

3. CENTRAL GOVERNMENT POLICY

3.1 The UK has shown a considerable change in its alcohol policies in the post war years. A review of alcohol policies among the 15 pre 2004 EU member states and Norway showed that in 1950, the UK had an alcohol policy defined as strict, exceeded only by three Scandinavian countries. By 2006, the UK had one of the least restrictive policy approaches of this group of countries (Anderson and Baumberg 2006). These changes in English alcohol policy has been the subject of comment and criticism by from the perspective of international public health (Room 2004) the medical profession (Drummond 2004) and social policy academics (Plant 2004).

3.2 The World Health Organisation reviewed the effectiveness of a range of alcohol policy approaches in 2003 (Babor et al 2003). A mapping of the Alcohol Harm Reduction Strategy for England (AHRSE) proposal against the WHO findings showed that the AHRSE eschewed the most effective policies and adopted the least effective.

THE ALCOHOL HARM REDUCTION STRATEGY MAPPED AGAINST BABOR ET AL. (2003) ANALYSIS OF EFFECTIVE ALCOHOL STRATEGIES

<i>Strategy</i>	<i>Impact</i>	<i>Alcohol Harm Reduction Strategy and Licensing Act</i>
Taxation and Pricing	High	“More complex than price”
Restricting availability	High	24 hour availability
Limiting density of outlets	High	“Local planning”
Lower BAC driving limits	High	No change
Graduated licensing for young drivers	High	No
Minimum drinking age	High	No
Brief interventions/treatment	Medium	“Lack of evidence”—needs assessment; evidence review, Alcohol service framework
Safer drinking environment	Medium	Voluntary codes: safer framework
Heavier policing	Medium	Antisocial behaviour orders, on the spot fines
Public education campaigns	Low	Change safe drinking message, unit labelling
School based education	Low	More education
Voluntary advertising restrictions	Low	Yes

From Drummond and Chengappa 2006

3.3 International trends in alcohol consumption and harm have not been uniform over the past 20 years. The UK has done much worse than a number of other countries, including those countries with similar drinking patterns and attitudes such as Australia, New Zealand, the Netherlands and Canada. This is a powerful indication that our policy approach has not been effective and requires radical revision.

3.4 At the heart of this problem is the failure by government to implement effective, evidence based strategies to combat alcohol related harm. If the recent rising alcohol related harm statistics applied to cancer or heart disease or infectious diseases such a lack of effective policy action would be inconceivable.

4. *The role of the NHS and other bodies*

4.1 Most alcohol related harm is preventable and many of the key influences are within the control of central and local government, such as taxation and licensing policy. The NHS has a role in informing Government of trends in alcohol related harm and in conveying health promotion messages, though these, of themselves, are not powerful influences in affecting drinking behaviour.

4.2 More specific targeted interventions with those whose drinking is risky or harmful has been consistently shown to be effective (Heather, Raistrick and Godfrey 2006). The best evidence for the effectiveness of this screening and brief intervention is in Primary Health Care. This should be a routine part of Primary Health Care practice in the UK. There is also evidence for the benefits of this approach in the General Hospital setting.

4.3 Those with more severe alcohol problems, including Alcohol Dependence will generally require more intensive help than a brief intervention and the effectiveness of treatment interventions for this group has been reviewed (Heather Raistrick and Godfrey 2006). An effective treatment system requires interventions of varying intensity in a range of settings. The National Treatment Agency (NTA 2006) advocates a Stepped Care approach ranging from psychological help in the community settings to specialist NHS in-patient care for those with the most severe and complex problems.

4.4 However, needs assessment work has shown that the capacity of such services in England falls far short of the demand. In many parts of England, key elements of service such as psychological therapies, community detoxification and specialist in patient care is not available. It is estimated that there is capacity in specialist services for one in 18 people with alcohol dependence. In some parts of England, the picture is even gloomier, with specialist help available for around one in 100 people (Department of Health 2005).

4.5 There has been concern about the lack of alcohol treatment provision for certain groups such as older people, offenders, those with drug problems and those with psychiatric disorder. In general, this lack of provision reflects the shortage of treatment facilities across the whole population. The NHS should also provide increased capacity for treatment of specific alcohol related illnesses. There is a particular need to plan for a considerable growth in numbers of those with severe liver disease, who will often require extended stays in hospital with intensive treatment.

4.6 The NTA's Models of Care advocates an integrated local treatment system involving the voluntary sector and local authorities guided by informed local commissioning structures. As a service provider, the NHS has a key role in this system, providing many of the clinical elements which other services cannot.

Alcohol Industry

4.7 The committee has asked for views on the contribution of the alcohol industry. There is a widespread international view that England is a country where the alcohol industry has been the major policy influence for many years (Room 2004). The alcohol industry is diverse, and the interests most actively promoted have been those of the major producers and off sales retailers, in particular the major supermarkets.

4.8 In Scotland, the owner operated pubs have often allied with health groups regarding concerns about cheap alcohol and promotions in the off sales sector. No part of the alcohol industry should have a lead role in policy development. The conflict of interest of companies whose primary legal responsibility is to make profit for shareholders is too great to expect the industry to be a champion for public health.

4.9 One important role the industry can play is in the provision of sales data. The data held by retailers should be used to inform Government on alcohol sales trends. The speed with which the industry can access this data and the opportunity to link this with customer demographics would be of considerable value in understanding consumption trends.

5. *Solutions*

There is considerable information of effective prevention and interventions for alcohol related harm and the WHO evidence review should be the starting point for effective prevention approaches.

Price and Availability

5.1 Evidence demonstrates that the most important measures are those affecting price and availability. This review informed the Scottish Government's strategy (March 2009) which includes action to increase the cost of the cheapest alcohol and reducing access by:

- Establishing a minimum price for alcoholic drinks in line their alcohol content. The same price will apply in on and off sales.
- End the practice of discount for multiple purchase, such as three for two, or 20 cans of beer for the price of 12.
- Restrict alcohol displays to a designated area in stores in line with a philosophy that alcohol is not an ordinary commodity.

5.2 For young people, action on the cheapness of alcohol will have a major impact on access to alcohol. The enforcement of the current purchase age will be important, but much the alcohol consumed by under 15s is legally purchased by older friends or by parents. Young people on limited budgets are strongly influenced by the price of alcohol and they are also influenced by adult, including parental, attitudes and behaviour. The drinking of young people is therefore closely linked to that of the rest of the population, and should not be seen as taking place in separate sub-culture.

Service Provision

5.3 Alcohol Screening and Brief Intervention should become a routine part of NHS Primary Care, with performance management and reimbursement systems to ensure this. SBI should also become routine in the acute hospital sector.

5.4 Treatment services should expand to deliver interventions which are known to be effective, and highly cost effective, on a considerably wider scale than is currently available. This will require high quality commissioning focussed on alcohol misuse and the NHS taking a prominent role as a treatment provider along with partner agencies in other sectors.

5.5 However, without investment by central government in providing ring fenced funding to support the development of services for alcohol misusers, from screening and brief interventions in primary health care through to more intensive specialist treatments, this is unlikely to happen. So far only small amounts of funding have been directed towards improving care for alcohol misusers, and a significant proportion of this was not spent on alcohol misuse (National Audit Office, 2008).

5.6 In contrast the significant investment in services for drug misusers has greatly increased engagement in treatment, with benefits to drug misusers, their families and the wider community. If government is serious about tackling alcohol misuse as purported in the Alcohol Harm Reduction Strategy and subsequent updates, it will need to make a similar investment in treatment of alcohol misuse as it has done in the case of drug misuse. Alcohol dependence affects 4% of the population and alcohol misuse considerably more, whereas problem drug use rates are closer to 0.5%. Access to treatment is considerably better for drug misusers (one in two gains access to treatment per annum) than for alcohol misusers (one in 18 gains access to treatment per annum).

Changing Culture

5.7 The committee wishes to change the drinking culture in England. Culture is a result of a complex and dynamic interaction of legislation, formal and informal controls, general and specific environmental influence and personal belief systems. The presence of large stacks of deeply discounted alcohol in our major retail outlets has a major impact on public attitudes and expectations.

5.8 Discussions on changing alcohol culture often focus on exhortations to individuals to change personal attitudes and neglect the impact which other factors have on those attitudes. A strong emphasis has been placed on education, but education is not, in itself, a powerful factor in changing culture and behaviour. Education can, however, prepare the ground for other measures which lead to change.

5.9 Examples of areas for education include drink driving and seat belt use, as well as making improvements in smoke free public places. All of these initiatives were initially unpopular, but became accepted following the introduction of effective regulation. Change in alcohol culture is likely to require the same type of leadership.

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March 2009

Memorandum by Dr Noel Olsen (AL 50)

At present the Exchequer de facto contributes 28% of the cost of all alcoholic loss leaders such as supermarket lager offers. It also indirectly funds 28% of the cost of alcohol advertising and marketing.

This is because alcohol advertising (and junk food and sweet advertising) is still an allowable business expense. The cost can therefore be set against other profit and deductions of corporation tax made. It would probably be easier to achieve an end to this rather than a complete ban on alcohol advertising. (Although a powerful precedent on the latter has been set with considerable effect in France and Norway and substantial controls achieved in Australia) Disallowing the loss on alcoholic loss leaders would send a powerful message to the alcohol industry and to supermarkets. It also provides a potential public health half-way house for MPs who are not yet ready for an outright ban on advertising (eg junk food and sweet advertising) but would be pleased to end the Exchequer contribution. It would raise industry costs in these limited markets, reduce marketing and therefore probably reduce abuse and is likely to be enormously politically popular except to the supply end. I believe most voters would intuitively object to the idea that they are indirectly contributing substantially to products that damage public health.

Dr Noel Olsen, FRCP, FFPHM.

Independent Public Health Physician and immediate past Chair of the Alcohol Education and Research Council of the UK (a Dept of Health non departmental public body)

15 March 2009

Memorandum by the Alcohol Health Alliance (AL 51)

The Alcohol Health Alliance UK is a group of 24 organisations whose mission is to reduce the damage caused to health by alcohol misuse and who are working together to:

- Highlight the rising levels of alcohol-related health harm.
- Propose evidence-based solutions to reduce this harm.
- Influence decision makers to take positive action to address the damage caused by alcohol misuse.

While coalitions have previously been formed on specific topics in the medical field, notably tobacco control, this is the first time that a group has existed specifically to co-ordinate campaigning on alcohol, bringing together medical bodies, patient representatives and alcohol health campaigners.

1. EXECUTIVE SUMMARY

We welcome the opportunity to comment to respond to the Health Select Committee's Inquiry into alcohol and the scale of alcohol related health harm and the measures which could be taken to reduce it. The AHA believes that the Government must implement a strong evidence-based approach aimed at reducing overall alcohol consumption and alcohol-related health harm. The basis of this approach must be robust measures to tackle the low price and the easy availability of alcohol, greater investment in prevention and early intervention, supported by more effective commissioning of treatment services.

2. SCALE OF THE PROBLEM

2.1 In the UK the health harms caused by alcohol misuse are underestimated and continue to spiral. A recent World Health Organisation report identifies alcohol as the third highest risk to health in developed countries.³⁵⁸

2.2 An important measure of alcohol-related deaths is the rate of mortality due to liver cirrhosis. In England, the rate of liver cirrhosis mortality approximately trebled between 1970 and 1998, while the rate in the EU decreased by 30%. In the 35 to 44 years age group the death rate increased eight-fold in men and almost seven-fold in women, while there was a four-fold increase in 25 to 34 year-olds.³⁵⁹

2.3 Much of the alcohol debate and media attention since then has centred on the problems of binge drinking amongst young people, and in particular the link between alcohol use and anti-social behaviour. The degree of health harm at all ages caused by alcohol has generally escaped the attention of the media. Alcohol related hospital admissions in England for the over 65 showed a huge increase from 197,584 in 2002 to 323,595 in 2007.³⁶⁰

3. THE CONSEQUENCES FOR THE NHS

3.1 Hospital admissions directly attributable to alcohol are rising by 80,000 people a year according to Hospital Episode Statistics. The cost of alcohol consumption to the NHS is estimated to be £2.7 billion a year. However, this does not take into account the social costs that could be attributed to excess alcohol consumption such as crime and disorder, lost days at work and the detrimental effects it can have on family life.³⁶¹

3.2 In 2006–07, there were 57,142 NHS hospital admissions in England with a primary diagnosis specifically related to alcohol. This number has risen by 52% since 1995–96. Of these admissions 4,888 (9%) involved patients under 18 years of age.³⁶²

3.3 In Department of Health's evaluation of the cost of alcohol use in 2008 highlighted that 35% of all ambulance journeys and A/E visits were as a result of alcohol use. This equates to over 1.2 million ambulance visits and over 6.6 million A/E attendances in 2006–07.

3.4 To reduce alcohol harm it is necessary to target resources where they are needed, and to do this it is necessary to have appropriate information. Many Primary Care Trusts (PCTs) have not accurately assessed the alcohol problems in their area and a quarter of PCTs have not assessed need at all.³⁶³ Without such assessments, PCTs cannot know what services they should be providing, nor assess whether what they do provide is sufficient or cost effective.

3.5 At present many PCTs do not have a strategy for alcohol harm, or a clear picture of their spending on services designed for this purpose. This is slowly being addressed, but still too much responsibility lies with Drug and Alcohol Teams (DAATs), many of whom do not have the capacity or capability to respond. Many DAATs do not have the sufficient links with primary or acute (hospital) care to commission effective alcohol interventions in these areas.

4. THE ROLE OF THE NHS

4.1 Historically the role of the NHS has focused on treating the consequences of alcohol related-harm rather than active prevention. However, it is now widely acknowledged that the factors which influence alcohol misuse are complex and that a multi-stranded and holistic approach which brings together early detection and intervention, education and treatment may be more effective in tackling health harm. Therefore the NHS must think about refocusing its role on prevention and early intervention and work in partnership with services in local communities to raise awareness of alcohol related harm.

5. CENTRAL GOVERNMENT POLICY

5.1 Central government policy has only begun to address issues of alcohol related harm. The National Alcohol Harm Reduction Strategy for England launched in 2004 was a positive step but it relied too heavily on voluntary partnerships with drinks producers and retailers and emphasised the importance of information and education for the public while failing to address the association between price, availability and heavy consumption. In 2007 the Government published Safe, Sensible, Social—The Next Steps in the Alcohol Strategy (SSS), which moved policy forward by addressing the needs of harmful and hazardous

³⁵⁸ World Health Organisation (2002) "The world health report 2002: reducing risks, promoting healthy Life"

³⁵⁹ Department of Health (2001) On the state of the public health: the annual report of the Chief Medical Officer

³⁶⁰ *Ibid* 338.

³⁶¹ Alcohol Learning Centre—www.alcohollearningcentre.org.uk/About/LearningCentre/AIP/PSA25/

³⁶² NHS Information Centre for Health and Social Care, Statistics on Alcohol: England, 2008.

³⁶³ National Audit Office report: Reducing Alcohol Harm: Health Services in England for Alcohol Misuse (2008) http://www.nao.org.uk/publications/0708/reducing_alcohol_harm.aspx

drinkers but still failed to address the links between price, availability and consumption. What has also been lacking to date is a coherent cross-Departmental approach required to reduce the scale and impact of alcohol related health harm.

6. RECOMMENDATIONS

6.1 The central aim of a future strategy should be to drive down consumption and change the culture of heavy drinking in England, for this to happen alcohol misuse should be seen as a public health issue on a par with smoking and obesity. A future strategy must also be overarching and integrated, bringing together education, treatment and enforcement.

6.2 Retailing

6.2.1 In order to reduce overall consumption and the resulting health harms the issue of price must be addressed. The latest review of alcohol price, promotion and harm conducted by Sheffield University clearly demonstrated that there is strong relationship between pricing and consumption and that pricing policies can be effective in reducing harm related to health, crime and unemployment.³⁶⁴ It also showed that pricing policies can be targeted, so that people who drink within recommended limits are hardly affected whereas very heavy drinkers, who cause by far the most alcohol-related harm, pay the most. One way of achieving this would be to set a minimum price for a unit of alcohol to reduce alcohol consumption and related harm.

6.2.2 It has been shown that increasing tax on alcohol by only 10% could decrease alcohol related deaths of various forms by 10–30%, yet alcohol has become over 50% more affordable in the last 25 years.³⁶⁵ The revenue from increased duty could provide more than enough funding to bring alcohol treatment and prevention services up to the level of services provided for users of illegal drugs.

6.2.3 The review of alcohol industry standards by KPMG found that “the standards are not operating as the Government originally hoped. They are not a catalyst for self-regulation, self-improvement and social responsibility”.³⁶⁶ This shows that the voluntary self-regulation approach adopted by Government towards the industry has clearly failed. The Government must now introduce a mandatory code of practice for the promotion, advertising and sale of alcoholic beverages as proposed in the Policing and Crime Bill 2009. A mandatory code should be accompanied by appropriate sanctions, as this the only way to ensure that the sensible drinking message is taken seriously and promoted by the industry.

6.3 Investment in services

There is an urgent need for greater targeted investment in alcohol treatment services. The funding which currently exists is often part of the pooled treatment budget for drugs and alcohol. The budget for these services in 2009–10 will be £406 million.³⁶⁷ Within these budgets most of the funding is dedicated to drug treatment. The NAO report showed that on average PCTs were only spending 0.1% of their money on alcohol services every year working out at £197 per dependent drinker where as the amount spent on dependent drug users every year equated to £1,744 per dependent person.

6.4 Access to alcohol treatment services

6.4.1 More needs to be done to improve earlier diagnosis of alcohol use disorders and ensure prompt referral. This could be incentivised through including a measure in the Quality and Outcomes Framework for GPs that screened in groups that are high-risk for alcohol-related harm and for alcohol use disorders.

6.4.2 Increasing the quality and range of alcohol intervention services for those who wish to reduce their alcohol intake or stop drinking altogether is vital, there is growing evidence to show that early intervention with a provision of relevant health information can play a part in reducing alcohol-related health harms. There is also much scope for better integration of hospital services with follow-on and support services. This would help improve recovery rates and prevent patients relapsing into their previous drinking patterns.

6.4.3 The Department of Health (DH) should encourage local commissioners to ensure that waiting times for alcohol treatment match targets for drug treatment in the next NHS operating framework. This is now possible as service providers must report alcohol treatment and waiting time data to the National Drug Treatment Monitoring System (NTDMS).

6.4.4 Every acute hospital should have a Consultant/Senior Nurse Lead for Alcohol Misuse to ensure early detection by any doctor/nurse and to work with Alcohol Nurse Specialists to provide intervention as well as education, audit, and liaison with the community.³⁶⁸

³⁶⁴ Meier et al, ScHARR, University of Sheffield—“Independent review of the effects of alcohol pricing and promotion: Part B—Modelling the potential impact of pricing and promotion policies for alcohol in England”, 2008.

³⁶⁵ Academy of Medical Sciences, “Calling Time on the Nation’s Drinking”, Academy of Medical Sciences, 2004.

³⁶⁶ Home Office & KPMG, “Review of the Social Responsibility Standards for the production and sale of Alcoholic Drinks Volume 1”, 2008.

³⁶⁷ National Audit Office, Reducing Alcohol Harm: Health services in England for alcohol misuse, National Audit Office, 2008.

³⁶⁸ Royal College of Physicians, “Alcohol can the NHS afford it”, 2001.

6.4.5 Clinicians working across primary and secondary care must be trained in how to use early identification toolkits such as the Paddington Alcohol Test (PAT)³⁶⁹ to assess levels of consumption and harm and utilize brief interventions which are a quick and effective means of engaging with large numbers of drinkers who are not dependent, but are still harming their health. Alcohol screening and brief psychological interventions supported by alcohol nurse specialists have also been shown to be clinically effective and cost effective in reducing unscheduled alcohol related re-attendance in A&E.

6.5 Health information

6.5.1 The Department of Health has invested heavily in advertising campaigns to promote the Department's current guidelines on sensible drinking. The Alliance supports the government's Know Your Limits campaign as we consider it be way of encouraging people to take responsibility for their own health and wellbeing.

6.5.2 To allow people to make sensible and informed choices about how much they drink the Alliance believes that it must be mandatory for all promotional material and labelling to carry health and unit information. The success of health warning labelling can be seen in tobacco products where it has contributed to a reduction in cigarettes sales.

6.6 Tougher licensing conditions, considering health implications

The Alliance believes that the fact that the 2003 Licensing did not adopt a public health approach was a huge oversight. Incorporating a public health objective into the Act would provide greater consistency to the government's strategy to reduce the harm caused by excessive drinking. It would enable licensing authorities to consider public health matters when making decisions about licensing the sale of alcohol. It would also enable local authorities to take steps to restrict sales where there are particular public health problems, and so help address some of the worst regional health inequalities in liver disease and in the other health-related problems relating to alcohol. This type of provision is already in operation in Scotland, where the Licensing (Scotland) Act 2005 includes the protection and promotion of public health as a primary objective.

6.7 Advertising

The recent increase in alcohol related problems in the UK can be explained in part by increased marketing and promotion of alcohol that occurred from the early 1990's onwards. The UK alcohol industry currently spends a huge amount on promotion—compared with tiny sums of social marketing. Much tighter regulation of promotion is urgently needed. The Alliance firmly believes that a starting point for this would be to ban alcohol advertising on TV before 9 pm and in cinemas unless films are 18 rated in a move towards total ban on broadcast advertising.

MEMBERS OF THE ALCOHOL HEALTH ALLIANCE

Academy of Medical Royal Colleges
 Action on Addiction
 Alcohol and Health Research Trust
 Alcohol Concern
 Alcohol Focus Scotland
 British Association for the Study of the Liver
 British Liver Trust
 British Society of Gastroenterology
 College of Emergency Medicine
 Faculty of Occupational Medicine
 Faculty of Dental Surgery
 Faculty of Public Health
 Institute of Alcohol Studies
 Medical Council on Alcohol
 National Addiction Centre
 Royal College of General Practitioners

³⁶⁹ Huntley, J S, Blain, C, Hood, S and Touquet, R "Improving detection of alcohol misuse in patients presenting to an accident and emergency department". *Emergency Medicine Journal* 18, 2001 99–104.

Royal College of Nursing
Royal College of Physicians Edinburgh
Royal College of Physicians London
Royal College of Physicians and Surgeons, Glasgow
Royal College of Psychiatrists
Royal College of Surgeons London
Royal Pharmaceutical Society
Scottish Intercollegiate Group on Alcohol

March 2009

Memorandum by SABMiller (AL 52)

EXECUTIVE SUMMARY

- Our beer adds to the enjoyment of life for the overwhelming majority of our consumers; however we recognise that alcohol is associated with certain diseases, health conditions, and negative social consequences, especially when consumed excessively or irresponsibly.
- The alcohol industry's role includes providing consumers with accurate and accessible information about its products and ensuring that they are marketed in a way that does not encourage irresponsible drinking.
- As the link between producer and consumer, retailers, large and small, also have a big role in preventing irresponsible consumption and have a great deal of influence over the purchase of alcohol.
- The actions of the Government in its annual budget over the past ten years have in our view supported the increased consumption of higher strength drinks through above inflation rises in beer duty, while introducing lower rises and even freezes on duty for stronger alcohol products such as wine and spirits.
- There should be a downward adjustment to the excise duty rate for beer and the removal of the beer duty escalator at the earliest opportunity. This will aid the Government's objective of reducing alcohol misuse by providing a financial incentive for consumers to choose lower strength alcohol products.
- The initial findings of the University of Sheffield's *SCHARR Review of the Effects of Alcohol, Price and Promotion* raised the concept of "floor prices". We consider this proposal to be both disproportionate and unnecessary; minimum pricing is an incredibly blunt instrument which imposes significant costs across large sections of society, whilst having very limited benefits in terms of curbing the excesses of the minority.
- Instead of seeking to tackle alcohol misuse through blanket measures such as high prices that unfairly penalise the vast majority of adult drinkers who consume alcohol sensibly and legally, the UK should target the small minority who harm themselves or others when drinking alcohol.
- Existing laws governing the sale and consumption of alcohol already provide the police and other enforcement agencies with the power to prevent much alcohol misuse and crime—these laws need to be fully enforced.
- Tackling harmful drinking patterns will only be effective if people accept their individual responsibility. Increased pricing and restrictions on retailing are a small part of a wider issue which has individual judgement and accountability at its heart.

ABOUT SABMILLER PLC

1. SABMiller welcomes this opportunity to respond to the House of Commons Health Select Committee inquiry on alcohol.
2. Our response focuses on the Committee's request for evidence on the role of the alcohol industry, central government policy and solutions to tackling alcohol misuse.
3. One of the world's largest brewers, SABMiller has brewing interests and distribution agreements in over 60 countries across six continents. Our wide portfolio of brands includes premium international beers such as Miller Genuine Draft (MGD), Pilsner Urquell and Peroni Nastro Azzurro along with market-leading local brands such as Aguila, Castle, Miller Lite, Snow and Tyskie. Six of our brands are among the top 50 in the world. We are also one of the world's largest bottlers of Coca-Cola products.

4. Peroni Nastro Azzurro is the leading premium packaged lager sold in restaurants across the United Kingdom.
5. Originating from South Africa and now headquartered in London we are listed on the London Stock Exchange falling within the FTSE 20. Our annual turnover in the previous financial year was \$21.4 billion.
6. SABMiller Core Principles:
 - Our beer adds to the enjoyment of life for the overwhelming majority of our consumers.
 - We care about the harmful effects of irresponsible alcohol consumption.
 - We engage stakeholders and work collectively with them to address irresponsible consumption.
 - Alcohol consumption is for adults and is a matter of individual judgement and accountability.
 - Information provided to consumers about alcohol consumption should be accurate and balanced.
 - We expect our employees to aspire to high levels of conduct in relation to alcohol consumption.

ALCOHOL AND HEALTH

1. Our beer adds to the enjoyment of life for the overwhelming majority of our consumers; however we recognise that alcohol is associated with certain diseases, health conditions, and negative social consequences, especially when consumed excessively or irresponsibly.
2. In general terms, moderate drinking is associated with a number of health benefits in some people.³⁷⁰ The evidence also shows that moderate drinkers may experience health benefits in comparison to abstainers. These include lower overall mortality from all health causes.³⁷¹ Some people who are regular, moderate consumers of alcohol, including some daily drinkers, have lower risks for some diseases than individuals who drink less frequently.³⁷² The risk may be lower especially if drinking accompanies meals.³⁷³
3. Harmful outcomes, on the other hand, are generally associated with heavy drinking patterns and alcohol abuse. Harmful drinking patterns include both heavy long-term drinking and heavy drinking episodes, often referred to as “binge” drinking. The outcomes of these drinking patterns may manifest themselves as harm to health or as accidents and injuries.³⁷⁴
4. But it is important to note that some researchers associate health risks for some people with even moderate levels of consumption.

THE ROLE OF THE ALCOHOL INDUSTRY

5. The alcohol producer’s role includes providing consumers with accurate and balanced reminders about its products, and ensuring that these products are marketed in a way that does not condone or promote irresponsible drinking.
6. As the link between producer and consumer, retailers, large and small, also have a big role in preventing irresponsible consumption and have a great deal of influence over the purchase of alcohol.
7. Government’s role, both local and central, includes ensuring the laws on the sale and consumption of alcohol are fully enforced and placing restrictions only when targeted at problem groups not the majority who drink responsibly and cause no harm to themselves or others.
8. Producers, retailers and government also need to accept that tackling harmful drinking patterns will only be effective if people accept their individual responsibility towards their own alcohol consumption.

³⁷⁰ Gunzerath, L, Faden, V, Zakhari, S, & Warren, K (2004). National Institute on Alcohol Abuse and Alcoholism report on moderate drinking. *Alcoholism: Clinical and Experimental Research*, 28:829–847; Ellison, R C (Ed) (2007). Health risks and benefits of moderate alcohol consumption: proceedings of an international symposium. *Annals of Epidemiology (Suppl)*, 17(S5).

³⁷¹ Doll, R, & Peto, R (195). Mortality and alcohol consumption. *British Medical Journal*, 310, 470; Holman, C D, & English, D R (196). Ought low alcohol intake to be promoted for health reasons? *Journal of the Royal Society of Medicine*, 89, 123–129; Holman, C D, English, D R, Milne, E, & Winter, M G (196). Meta-analysis of alcohol and all-cause mortality: A validation of NHMRC recommendations. *Medical Journal of Australia*, 164, 141–145; Trevisan, M, Schisterman, E, Mennotti, A, Farchi, G, & Conti, S (2001). Drinking pattern and mortality: The Italian risk factor and life expectancy pooling project. *Annals of Epidemiology*, 11, 312–319.

³⁷² Mukamal, K J, Conigrave, K M, Mittleman, M A, Camargo, C A, Jr, Stampfer, M J, Willett, W C *et al.* (2003). Roles of drinking pattern and type of alcohol consumed in coronary heart disease in men. *New England Journal of Medicine*, 348:109–18; Tolstrup, J S, Jensen, M K, Tjonneland, A, Overvad, K, & Gronbaek, M (2004). Drinking pattern and mortality in middle-aged men and women. *Addiction*, 99:323–30; Tolstrup, J.S., Heitmann, B L, Tjonneland, A M, Overvad, O.K., Sorensen, T I, & Gronbaek, M N (2005). The relation between drinking pattern and body mass index and waist and hip circumference. *International Journal of Obesity (London)*, 29:490–497.

³⁷³ Trevisan, M, Ram, M, Hovey, K, Russell, M, Freudenheim, J, Muti, P, *et al.* (2001). Alcohol drinking patterns and myocardial infarction. *American Journal of Epidemiology*, 153, S97; Trevisan, M, Schisterman, E, Mennotti, A, Farchi, G, & Conti, S (2001). Drinking pattern and mortality: The Italian risk factor and life expectancy pooling project. *Annals of Epidemiology*, 11, 312–319.

³⁷⁴ Cunningham, R, Walton, M A, Maio, R F, Blow, F C, Weber, J E, & Mirel, L (2003). Violence and substance use among an injured emergency department population. *Academic Emergency Medicine*, 10, 764–775; Gutjahr, E, Gmel, G, & Rehm, J (2001). Relation between average alcohol consumption and disease: An overview. *European Addiction Research*, 7, 117–127.

Provision of information

9. SABMiller is proactive in providing consumers with accurate and balanced information about alcohol through our innovative website, www.TalkingAlcohol.com. This award-winning website, the first of its kind from a major alcohol producer, describes in detail the health and social considerations of drinking alcohol such as cancer, liver disease, and stroke among others are all discussed in a factual, balanced manner.

10. In addition to the health and social considerations of alcohol consumption, TalkingAlcohol.com provides our consumers with nutritional facts of more than 100 of our most popular brands of beer; such as alcohol content, calories, and cereal grains. There is also a detailed explanation of the brewing process so that consumers can better understand how beer is made, the ingredients that are used, and how the alcohol contained in beer is derived.

11. TalkingAlcohol.com is available in English, Spanish, Polish and Czech, with the Russian and Italian versions coming soon.

12. Elsewhere, industry has worked to provide relevant and factual information to consumers in accessible means such as through initiatives undertaken by the Drinkaware Trust of which SABMiller was the first corporate member.

13. The Drinkaware Trust is an independent charity set up with donations from the drinks industry to equip people with the knowledge they need to make decisions about how much they drink. The Trust promotes responsible drinking and seeks to find innovative ways to challenge the national drinking culture and tackle alcohol misuse.

Labelling

14. SABMiller supports the Government's voluntary labelling code and was the first alcohol producer to commit to fully implement the Government's voluntary code on labelling. Our premium brand, Miller Genuine Draft, was the first product to have the proposed labels in its entirety.

15. We agree with the Department of Health that there should be a debate on the merits of making the current voluntary agreement statutory as labels have been shown to be useful reminders to drinkers. However we do not believe that the use of such labels is in itself a suitable means for individuals to make fully informed choices about alcohol consumption.

16. Labelling should be a reminder about levels of unit consumption and key health messages, reinforcing the consumer's existing understanding of responsible alcohol consumption developed from the full provision of accurate, factual information.

Responsible marketing

17. Though we recognise that consumers are ultimately responsible for their own drinking decisions, our advertising will not present refusal, abstinence or moderate consumption in a negative light, suggest that alcohol has curative qualities, depict pregnant women, or be targeted to underage people.

18. In addition to compliance with the legislative codes, SABMiller adheres to the Code on Non Broadcast Advertising, Portman Group Code and the SABMiller Policy on Commercial Communications. When combined with the legislative codes, these voluntary codes help strike the balance between society's expectation for responsible advertising, our right to advertise a legal product in a free and competitive market, and the adult consumer's right to have information about our brands.

19. Currently our advertising in the UK is based on audience demographics, as directed by Ofcom. This is the case for all alcohol advertising in the UK. This approach states that at least 70% of the audience for a particular programme must be over 18 for alcohol advertisements to appear irrespective of the time of day.

The role of retailers

20. As well as ensuring our products are brewed and marketed responsibly, we also expect them to be sold and purchased legally and responsibly.

21. One of SABMiller's signature programmes conducted in the United States and under consideration for adaptation to the UK is the Responsible Retailing Programme. This programme is evidence-based, having been designed and researched over many years by Dr. Brad Krevor of the Responsible Retailing Forum at Brandeis University—with proven results.

22. The programme brings together local police, retailers, and the local authorities and community in an intensified programme to reduce sales to underage people. The programme brings tested training tools to retailers and their employees, and measures implementation of the tools through a mystery shopper programme.

23. To take an example from the UK, a scheme led by Trading Standards officials in St. Neots, Cambridgeshire has seen impressive initial results through the effective and coordinated enforcement of existing laws.

24. The Community Alcohol Partnership led to a fall in antisocial behaviour of 42% and a decrease in alcohol related litter by 92%.³⁷⁵ This involved no additional resources, no increased purchasing age and did not shift the problem on to another area. Its success came from effective enforcement and education through a partnership approach and demonstrates that coordination of responsible business and other stakeholders can be highly effective.

GOVERNMENT POLICY

Beer duty escalator

25. The Government's consultation document, *Safe, Sensible, Social*, notes that the increasing consumer preference towards wine and spirits has been one of the drivers behind increased hospital admissions.

26. The actions of the Government in its annual budget over the past ten years have in our view supported this trend through above inflation rises in beer duty, while introducing lower rises and even freezes on duty for stronger alcohol products such as spirits.

27. This was best highlighted in the 2008 pre-budget report, which increased the duty on beer by 8% and the duty on spirits, following lobbying by distillers, by only 4%.

28. This shift to the consumption of higher strength alcohol will be exacerbated by the ongoing duty escalator for alcoholic drinks which, combined with the restoration of the 17.5% rate of VAT in January 2010, will see prices rise further. Again, beer will be the hardest hit by these increases and the duty on beer will rise a further 40% by 2012. This reduces the financial incentive for consumers to choose lower strength alcohol products.

Minimum pricing

29. The initial findings of the University of Sheffield's SchARR *Review of the Effects of Alcohol, Price and Promotion* raised the concept of "floor prices".³⁷⁶ These have also been proposed by the Scottish Government in their report *Changing Scotland's Relationship with Alcohol*. We consider these to be both disproportionate and unnecessary.

30. Minimum prices interfere with the underlying principles of a free market economy. The process of setting minimum prices is arbitrary to which there is no end, and it is predicated on the improbable assumption that raising the price of alcohol will make the minority of drinkers who misuse alcohol and/or engage in anti-social behaviour act differently.

31. Minimum prices are most likely to impact the drinking behaviour of those adults who enjoy drinking alcohol and who do so in a legal, moderate, and socially-acceptable way. In much of continental Europe, the price of alcohol is far cheaper than in the UK but there are not the same problems; societal tolerance (or intolerance) of those who drink irresponsibly or illegally appears to be a greater determinant of the extent to which a country will experience alcohol harm than the price of alcohol.

32. SABMiller recently commissioned Centre for Economics and Business Research (CEBR) to evaluate the SchARR review of alcohol pricing and promotion effects on consumption and harm. The CEBR research found that:

"According to the UK Government's own research (Meier et al, University of Sheffield, 2008) those deemed to be hazardous or harmful drinkers are much less sensitive to higher prices than moderate drinkers, in terms of their overall alcohol consumption. Consequently, whilst all drinkers have to pay more for their purchases, moderate drinkers would be more responsive to price changes than those whom the Government is targeting. Based upon the University of Sheffield research, we estimate that a minimum price at 40 pence per unit would reduce consumption amongst harmful drinkers by only 2.3%."

33. This means that minimum pricing is an incredibly blunt instrument which imposes significant costs across large sections of society, whilst having very limited benefits in terms of curbing the excesses of the minority.

³⁷⁵ Cambridge News. *The party's over for underage drinkers*. 07/07/2007. http://www.cambridge-news.co.uk/cn_news_home/DisplayArticle.asp?id=328865

³⁷⁶ Meier, P, INDEPENDENT REVIEW OF THE EFFECTS OF ALCOHOL PRICING AND PROMOTION Part A: Systematic Reviews, 2008, p 34, http://www.dh.gov.uk/en/PublicHealth/Healthimprovement/Alcoholmisuse/DH_4001740?IdcService=GET_FILE&dID=178732&Rendition=Web

Mandatory retailing code

34. The Policing and Crime Bill, currently progressing through Parliament, proposes the creation of a mandatory code for retailers. Existing laws are already in place allowing those in breach of regulations to face penalties—these laws need to be fully enforced before any new measures are considered.

35. Individuals and those licensees who repeatedly fail in their legal obligations should be held. Further restricting the commercial freedom of retailers and venues would be indiscriminate in its approach and penalise licensees and retailers which operate effective policies towards the responsible sale of alcohol.

36. The underlying issue which must be acknowledged in an alcohol retailing code is that there is a shared responsibility on the part of both the retailer and the patron when it comes to alcohol service and consumption.

37. Existing laws are already in place allowing those individuals and transgressing licensees in breach of the law to face penalties—these laws need to be fully enforced before any new measures are considered.

Chief Medical Officer's Guidance

38. A recent study found that the wide availability of social sources, including parents and relatives, meant that reducing availability of alcohol from commercial sources has only a moderate impact on the amount of alcohol consumed by underage drinkers. Of those surveyed that did consume alcohol, 87% secured alcohol from social sources at least once over the relevant 30 day period.³⁷⁷

39. SABMiller welcomes the British Chief Medical Officer's Guidance on the Consumption of Alcohol by Children and Young People published in January 2009 which advises parents on how to encourage their children, and themselves, to develop a responsible attitude to drinking.

40. This guidance is an important contribution to reducing the harm caused by underage drinking and will hopefully discourage parents, friends and relatives from providing alcohol to those under the legal drinking age.

SOLUTIONS

Fair taxation for beer

41. The Department of Health's 2008 consultation for tackling alcohol misuse—*Safe, Sensible, Social: Consultation on further action*—cites “a shift to higher alcohol strength beverages, including a shift from beer to both wine and spirits” as one of factors responsible for the rise in harmful alcohol consumption. The decisions taken in the 2008 Pre Budget Report, at best do little to address this trend, and at worst actively undermine the work of the Department of Health and the Home Office, both of which are seeking to tackle the effects of alcohol misuse and its impact on public health and crime.

42. This shift to the consumption of higher strength alcohol will be exacerbated in the future by the incoming beer duty escalator which and the expected restoration of the 17.5% rate of VAT in January 2010. Again, beer will be the hardest hit by these increases and the duty on beer will rise a further 40% by 2012. The decisions taken on excise duty for alcohol will do little to reverse the trend identified by the Department of Health.

43. If HM Treasury wants to support the Department of Health and Home Office's initiatives to tackle alcohol misuse, there should be a downward adjustment to the excise duty rate for beer and the removal of the beer duty escalator at the earliest opportunity. This will aid the Government's objective of reducing alcohol misuse by providing a financial incentive for consumers to choose lower strength alcohol products.

A targeted approach, fully enforced

44. Instead of seeking to tackle alcohol misuse through blanket measures such as high prices that unfairly penalise the vast majority of adult drinkers who consume alcohol sensibly and legally, the UK should target the small minority who harm themselves or others when drinking alcohol.

45. These targeted efforts should include strict enforcement of existing laws on underage drinking, disorderly or violent behaviour, and drink driving; early medical screening and treatment for people with alcohol problems; educating parents on how to talk with their children about not drinking while being good role models themselves if they choose to drink; and penalising retailers who violate the laws regarding sale or serving of alcohol to name just a few.

46. The existing laws governing the sale and consumption of alcohol already provide the police and other enforcement agencies with the power to prevent much alcohol misuse and crime—these laws need to be fully enforced.

³⁷⁷ Mallie J Paschall, Joel W Grube, Carol Black, and Christopher L Ringwalt; *Is Commercial Alcohol Availability Related to Adolescent Alcohol Sources and Alcohol Use? Findings from a Multi-Level Study*; *Journal of Adolescent Health*; 2007 August; 41(2): 168–174. <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2213632>

Personal responsibility

47. Tackling harmful drinking patterns will only be effective if people accept their individual responsibility. Increased pricing and restrictions on retailing will not solve the problem of alcohol misuse. These are a small part of a wider issue which has individual judgement and accountability at its heart.

48. While government, public services and industry have a role to play in raising awareness about the potential harm of excessive alcohol consumption, much of the information about alcohol is conveyed through informal channels. In particular, family and peers play a key role in the development of attitudes, awareness and behaviours around drinking.³⁷⁸ Government and industry initiatives should seek to support them in their role.

49. Parents play a crucial role in teaching their children about the responsible consumption of alcohol. By strengthening their knowledge about alcohol consumption they can ensure that their children grow up to be responsible. Providing parents with accurate and balanced sources of information, such as TalkingAlcohol.com, means they can feel more confident in carrying out this responsibility.

50. Several of SABMiller's businesses offer resources for parents to talk with their children about not drinking, such as *Let's Keep Talking* in the United States and *We Can All Be Parents* in Colombia.

Medical intervention

51. We encourage the development of medical interventions that can be adapted to a variety of health care settings for the identification, intervention, and treatment of people with alcohol problems.

52. Those individuals who have developed alcohol dependence require particular attention and treatment approaches, including psychological therapy, treatment with special medications, motivational interviewing and other interventions. Some individuals are able to modify their alcohol consumption and continue as moderate and non-problem drinkers. For others, abstention from alcohol is the only possible approach to dealing with the problem.

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³⁷⁸ Houghton, E, & Roche, A M (Eds). (2001). *Learning about drinking*. Philadelphia, PA: Brunner-Routledge.