

## Written evidence from the Department of Health (GAS 01)

1. Our response below to the specific points in the terms of reference for the Committee's inquiry is supplemented by a background paper<sup>1</sup> which considers briefly:
  - the nature and seriousness of harm from alcohol in England (and the UK in some instances) today, along with some issues on alcohol and wellbeing
  - trends in alcohol consumption and harm
  - a brief summary of which policy interventions work to change which drinking behaviours

### ***Establishing who is responsible within Government for alcohol policy in general, policy coordination across Whitehall and the extent to which the Department of Health should take a leading role***

2. Alcohol policy particularly affects or is affected by a large number of different policy areas, for which other Government Departments are responsible, for example, the Department for Education, HM Treasury, the Department for Business, Innovation and Skills, the Department for the Environment, Food and Rural Affairs, the Department for Culture, Media and Sport, the Ministry of Justice, the Department for Communities and Local Government, the Department for Work and Pensions, the Scotland Office, the Wales Office, and the Northern Ireland Office.
3. Cross-Government policy coordination is vital. The Cabinet Office has worked closely with other Departments in development of the new Alcohol Strategy. The Cabinet sub-Committee on Public Health has a role in considering key public health policy issues such as alcohol, where a coordinated approach is essential to achieving shared and interdependent outcomes.
4. This coordination is equally important at a local level, as is made clear in the White Paper *Healthy Lives Healthy People*, which sets out the Government's overall strategy for public health. Health and Wellbeing Boards will bring together councils, the NHS and local communities to understand local needs and priorities. The boards will be able to promote integration of health and social care services with health related services like criminal justice services, education or housing to meet these needs.
5. Within central Government, the Department of Health and the Home Office jointly have lead responsibility for alcohol policy within Government. This has been the case for a number of years and has not changed. We believe that joint responsibility by the two Departments is right, as alcohol misuse in the UK has major social impacts as well as major health impacts.
6. Responsibility for alcohol licensing policy was transferred from DCMS to the Home Office in June 2010. Because of this, the Home Office also has lead responsibility for policies impacting on the pricing of alcohol.

### ***Coordination of policy across the UK with the devolved administrations, and the impact of pursuing different approaches to alcohol***

7. Health and education are devolved policy areas in Scotland, Wales, and Northern Ireland. Devolution in other policy areas varies, with criminal justice, policing, and licensing devolved in Scotland and Northern Ireland, but not in Wales.
8. Devolution recognises the value of devolved solutions for problems that differ from the average UK picture. Alcohol health and social harms are notably greater in Scotland than the UK average.<sup>2</sup> In both Wales and Northern Ireland, they are somewhat greater than the UK average.

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<sup>1</sup> Annex B

<sup>2</sup> <http://www.healthscotland.com/uploads/documents/15312-MESASsettingTheSceneReport.pdf>.

9. It is important for the UK Government and the Devolved Administrations to work together on all areas of public policy – to share best practice in areas that are devolved; and to ensure policy in areas of reserved policy such as alcohol taxation and the regulation of broadcast advertising is taken forward in a way that benefits the whole of the UK.

***The role of the alcohol industry in addressing alcohol-related health problems, including the Responsibility Deal, Drinkaware, and the role of the Portman Group***

10. Both the Alcohol Strategy and *Healthy Lives, Healthy People* make clear that everyone has a part to play in improving public health, including government, business, the third sector and individuals themselves. We have made clear from the start that the Responsibility Deal is just one strand of the Government's wide public health policy. It is part of our wider strategy to achieve responsible growth where economic development and businesses' role in improving health and wellbeing go hand in hand.
11. Priorities for action to improve public health are defined by Government; and informed by research, advice from scientists, health professionals and others. But this does not mean that Government is necessarily best placed to deliver them. **The Public Health Responsibility Deal** is a new mechanism to deliver on these priorities.
12. The Responsibility Deal taps into the potential for businesses to improve public health through their influence over food, physical activity, alcohol, and health in the workplace. These are areas where 'doing nothing' simply isn't an option, but the 'something' to be done is not necessarily best done by Government. However, that is not to say that Government does not have a role. The role of Government in this case is to facilitate action and to build the partnerships that will enable genuine advances to be made in a way that is consistent with the public health needs of the country.
13. A plenary group, chaired by the Secretary of State for Health, oversees the development the Public Health Responsibility Deal. This group includes senior representatives from the business community, the voluntary sector, non-governmental organisations and local government.
14. Alongside this, five networks – considering food, alcohol, physical activity, health at work and behaviour change - have been established to develop pledges for action that are the outputs of the Public Health Responsibility Deal. The networks are each supported by a Minister and industry and health NGO co-chairs. Their membership brings together a wide range of representatives from the business community, the voluntary sector, non-governmental organisations and local government.
15. Partners committing to pledges provide delivery plans, laying out how they intend to meet each of the pledges they have signed up to. They provide annual updates on their progress each year. A list of the alcohol pledges is included in Annex A.
16. The Responsibility Deal is already influencing what businesses are doing as well as peoples' choices towards a healthier lifestyle, e.g. calorie information on menus, significant reductions in salt and removing artificial trans fats; improved alcohol unit labelling and clear warnings for pregnant women; and simple practical actions by employers to improve staff health with a resulting benefit on productivity.
17. The successes so far clearly demonstrate the potential that this voluntary approach has and we are now looking to broaden the impact by focusing on areas that will make the biggest difference such as the new pledge to remove one billion units of alcohol from the market by 2015.<sup>3</sup>

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<sup>3</sup> "As part of action to reduce the number of people drinking above the guidelines, we have already signed up to a core commitment to "foster a culture of responsible drinking which will help people drink within guidelines". To support this we will remove 1bn units of alcohol sold annually from the market by Dec 2015 principally through improving consumer choice of lower alcohol products."

18. Companies signing up to this pledge are committing to reducing the number of units of alcohol that people drink, without necessarily reducing the number of drinks that they buy.
19. For example, Accolade Wines, the biggest wine company in the UK, is already leading the way in the drive towards lower alcohol wines - both through product innovation of new lighter wines and an incremental reduction in alcohol by volume (ABV) strength across large sections of their existing portfolio.
20. Their new 5.5% ABV wines are forerunners for a style that they are committed to extending across their portfolio and they have already gained listings in the major supermarkets. In addition to their commitment to lighter wines, they are also exploring ways to reduce the ABV on many of their different wine styles, whether by picking grapes earlier in the harvest or by other methods.
21. Modelling suggests that in a decade, removing one billion units from sales (from the current total of 52 billion units) is estimated to result in around 1,000 fewer alcohol related deaths per year; many thousands of fewer hospital admissions and alcohol related crimes, as well as substantial savings to health services and crime costs each year.
22. Reducing the amount of alcohol that people consume, without necessarily changing the number of drinks that they purchase has the benefit of both helping to reduce their chances of suffering an alcohol-related illness and also providing industry with a meaningful way to benefit public health without damaging the viability of their business.
23. Consumers will benefit from a greater range of choice of lower alcohol products and more easily available smaller measures, so that those looking to reduce their alcohol intake will find it easier to do so.
24. Achievement of the pledge will be measured on an industry-wide basis including using HMRC clearance data and sales data and ultimately assessed by the Alcohol Network's monitoring and evaluation sub-group.
25. They will determine if the 1 billion units reduction can be identified as resulting from actions taken as part of this pledge i.e. that consumers drink the same products but which now contain less alcohol by volume, consumers switch to lower alcohol products, the actions that companies take increases the market share of lower alcohol products at the expense of those with higher alcohol content and consumers switch to smaller measures.
26. **Drinkaware** is an independent, UK-wide charity funded by donations from the alcohol industry and not from the public purse. Current funders include nearly all major retailers, pub companies and producers, who have pledged approximately £5.2 million per year through to 2012.
27. Drinkaware aims to change the UK's drinking habits for the better. For those who choose to drink, they promote drinking within the lower-risk guidelines and look for innovative ways to challenge the national drinking culture.
28. One of the Responsibility Deal alcohol pledges is about support for Drinkaware: 'We commit to maintaining the levels of financial support and in-kind funding for Drinkaware and the "Why let the Good times go bad?" campaign as set out in the Memoranda of Understanding between Industry, Government and Drinkaware.
29. In addition, through the Responsibility Deal, Drinkaware has addressed unit awareness among adults and young adults through the development of two complementary initiatives with the British Beer and Pub Association and the Wine and Spirits Trade Association. The '2-2-2-1' creative, rolled out in pubs across the UK and in the off-trade, will provide consumers with a mnemonic device to help them remember unit guidelines.

30. As a market provider, Drinkaware is well placed to deliver some key messages, such as how strong drinks are (how many units are in each drink) and can reach environments (e.g. pubs) that no current Government brand can.
31. Their campaigns target those drinking above the lower-risk guidelines who are 30-45 year olds, employed, at-home and who drink to relax and unwind. This audience typically drinks wine and consumes alcohol above the lower-risk guidelines most days of the week.
32. The 2009 Addendum to the Drinkaware Memorandum of Understanding, requires a strategic review of their activities in 2012.
33. Under the aegis of a Steering Committee of stakeholders, the review will audit the effectiveness of Drinkaware's performance against its objectives. It will require a review of the policy context, an analysis of Board papers and a wide range of other documents, possible interviews with industry, government and public health community representatives.
34. The results will inform Drinkaware's 2013 - 2020 business planning and resources model.
35. **The Portman Group** was established in 1989 as a not for profit organisation funded by nine member companies who represent every sector of drinks production and collectively account for about 40% of the UK alcohol market.
36. It introduced a Code of Practice on the Naming, Packaging and Promotion of Alcoholic Drinks in 1996. All alcohol products sold or marketed in the UK are subject to the rules of the Code, which prevent alcohol being marketed to children or in a way that would encourage excessive or irresponsible consumption. This is a self-regulatory approach with enforcement - if a product is found to have infringed the Code, the Portman Group can issue a Retailer Alert Bulletin notifying retailers not to stock the product. The Code does not have legal status but is referenced in the statutory guidance that supports the Licensing Act.<sup>4</sup> Licensing authorities can attach conditions that require premises to comply with these bulletins.
37. Portman Group members introduced a number of initiatives to help educate the public about responsible drinking. These include improved labelling, the widespread promotion of responsible drinking messages and contributing to the creation of Drinkaware. Portman Group members continue to provide significant funding for Drinkaware's education and campaigning work.
38. The Portman Group has a direct interest in marketing, non-paid advertising and labelling; and regulates industry activity in these areas, working in partnership with the Advertising Standards Authority, which regulates paid advertising.
39. As part of the Responsibility Deal they have an interest in five of the eight collective pledges (labelling, funding for Drinkaware, on-trade information, under-age sales "Challenge" programs and advertising and marketing) and in some of the individual pledges that their members have made.
40. They have also published guidelines to businesses looking to implement the Responsibility Deal collective pledge on alcohol labelling and will report on the delivery of this pledge through an independent market survey.
41. A public consultation on the Portman Group Code of Practice on the Naming, Packaging and Promotion of Alcoholic Drinks (as part of the Responsibility Deal pledge on marketing) closed in January 2012. This considers, among other things, the introduction of a code on sports sponsorship.

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<sup>4</sup> Guidance issued under section 182 of the Licensing Act 2003

42. We will work with the Portman Group to make sure that the Code is robust and that it actively encourages marketing, which builds more positive associations.

***The evidence base for, and economic impact of, introducing a fixed price per unit of alcohol of 40p, including the impacts on moderate and harmful drinkers; evidence/arguments for setting a different unit price; the legal complexities of introducing fixed pricing***

*Government approach*

43. Currently, there is no minimum price threshold in place to prevent alcohol retailers from selling very cheap alcohol. As a consequence, alcohol has been so heavily discounted that it is now possible to purchase a can of lager for as little as 20p and a two litre bottle of cider for £1.69 with £42.1 billion being spent on alcohol in England and Wales in 2010 alone. The availability of such cheap alcohol has contributed to a culture of 'binge-drinking'<sup>5</sup> and excessive drinking, with significant impacts on health and crime.
44. As the Alcohol Strategy sets out, the availability of cheap alcohol in supermarkets and off-licences has resulted in practices such as 'pre-loading' at home prior to a night out. In a recent study, 66% of 17-30 year olds arrested in a city in England claimed to have 'pre-loaded'<sup>6</sup> before a night out, with pre-loaders two and half times more likely to be involved in violence than other drinkers. This has contributed to a fifth of all violent incidents occurring in, or around, a pub or club. Responsible retailers, particularly those in the on-trade that typically offer a more controlled drinking environment, are less able to address the issues that take place on or around their premises without Government intervention to reduce the availability of cheap alcohol in supermarkets and off-licences.
45. The Government has therefore committed to introducing a minimum unit price for alcohol, but will consult on the level to be set.
46. Government analysts have carried out an initial estimation of the potential impacts of a 40p minimum unit price on health and crime considering a range of evidence and data including the Sheffield University study. However, these are only initial estimates and further research will be carried out through the Government's Impact Assessment and forthcoming public consultation.

*Evidence base for a 40p MUP*

47. A large number of studies (including by the World Health Organisation and many academic reviews) agree that there is a close link between alcohol price changes and levels of consumption.
48. The expected impact of minimum unit pricing is borne out by experience in Canadian provinces that have implemented a similar policy: social reference pricing.<sup>7</sup> Looking at Canada, there is a correlation between provinces that have introduced minimum pricing and those that have experienced sustained reduction in violent crime.
49. Government analysts have estimated that a 40p minimum unit price would lead to an estimated 30,000 fewer alcohol-related hospital admissions per year after 10 years, and approximately 50,600 fewer total crimes per year. This is expected to lead to an annual saving of £140 million in health and crime costs after 10 years.
50. Minimum unit pricing could also bring wider benefits, for example to productivity, as suggested by the Sheffield University study. Further work will be required to understand the magnitude of these effects in more detail.

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<sup>5</sup> Binge drinking in the population is measured as the number who self-report drinking on their heaviest drinking day in the previous week more than 8 units per day for men and more than 6 units per day for women

<sup>6</sup> Barton, A. and Husk, K. (forthcoming) Controlling pre-loaders: alcohol related violence in an English night time economy. *Drugs and alcohol today*.

<sup>7</sup> Does minimum pricing reduce consumption? The experience of a Canadian province. *Addiction* (February 2012). T Stockwell et al.

### *Economic impact of a 40p MUP*

51. A minimum unit price set at 40p per unit is unlikely to affect the on-trade as there is a significant price disparity between the off-trade and on-trade. The level of the minimum unit price will need to take into account the impact on alcohol duty receipts. We will take forward further work on the economic impact of minimum unit pricing as part of the Government's Impact Assessment.

### *Impact on moderate and harmful drinkers*

52. There is substantial evidence to suggest that cheap alcohol is targeted by those who consume the most alcohol overall and by under 18s who drink alcohol. Furthermore, those who consume the most alcohol are known to 'shop around' for the cheapest form of alcohol.
53. ONS data from 2010 suggests that 22% of people say they drink regularly at levels above alcohol guidelines and academic research<sup>8</sup> suggests that alcohol drunk as part of a binge drinking occasion accounts for over 50% of alcohol consumed.
54. The aim of minimum unit pricing is to end the sale of very cheap alcohol, drunk disproportionately by hazardous and harmful drinkers. Therefore, it is important that the minimum unit price is set at a level which affects an appropriate proportion of the market. If the level is set too low then it might not have any substantial impact and if it is set too high then it may begin to affect the majority of consumers who drink responsibly (moderate drinkers).
55. Specifically, the Sheffield study found that those who buy more alcohol are most affected by the price of alcohol, and changes in spending affect mostly harmful drinkers, with hazardous drinkers somewhat affected and spending for moderate drinkers affected very little (in terms of their consumption and spending). This issue will be further assessed in the Government's Impact Assessment of minimum unit pricing.

### *Evidence/arguments for setting a different unit price*

56. The Sheffield study found that general price increases lead to reductions in mean alcohol consumption with increasing benefits as the price per unit increases. This is partly due to limited scope for switching between products (because prices increase across the board) and partly because all consumer groups are targeted equally.
57. Sheffield University found that higher minimum unit prices will reduce switching effects. The study estimated overall changes in consumption for 20p, 25p, 30p, 35p, 40p, 45p, 50p, 60p, 70p, and showed that increasing levels of minimum pricing lead to steep reductions in alcohol consumption. Specifically, Sheffield estimates that a 40p minimum unit price will reduce alcohol consumption by 2.4%.
58. The estimated effect of setting a minimum price of 35p or below is that only the very cheapest alcohol products in the off-trade are likely to be affected. This is likely to affect only a limited amount of 'loss-leading' products and is therefore unlikely to have a significant impact on reducing alcohol consumption and health and crime harms.
59. The estimated effect of setting a minimum price of 50p per unit or above is that products in the on-trade are more likely to be affected. This would have a more significant impact on health and crime harms, but may begin to affect moderate consumers disproportionately.
60. The Government is committed to reducing excessive alcohol consumption without unfairly penalising moderate drinkers. Therefore, the Government will consult on the level to be set for a minimum unit price and will consider the impact on moderate drinkers in its Impact Assessment.

### *The legal issues*

61. There are number of issues to consider when implementing minimum unit pricing. The Government continues to take legal advice and will consider any potential legal implications as we take forward this proposal and consult on a proposed level of minimum unit price.

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<sup>8</sup> Baumberg (2009), *Alcohol & Alcoholism* 44(5):523-528

## ***The effects of marketing on alcohol consumption, in particular in relation to children and young people***

62. The Government continues to work closely with the independent and industry media regulators to ensure that any emerging concerns about the possible impact of advertising and marketing have been fully examined and that the latest evidence on the effects of marketing on alcohol consumption is properly reflected in the regulatory codes.
63. The most extensive recent systematic review of research undertaken in this area was the University of Sheffield's, School of Health and Related Research review, commissioned by the Department of Health and published in 2008.<sup>9</sup>
64. The Sheffield review indicated that there was consistent evidence from longitudinal studies that exposure to TV and other broadcast media is associated with inception of and levels of drinking by young people. It noted that much of the evidence came in the form of cohort studies from the USA, New Zealand and otherwise outside the UK, but found there was sufficient consistency of effect across a wide range of advertising media to suggest the need for preventive measures, particularly as many of those affected are young people who are not legally able to purchase alcohol.
65. The Science Group of the European Alcohol and Health Forum published a review of longitudinal studies of the impact of alcohol advertising on young people in 2009, which came to similar conclusions.
66. We are also aware of a more recent study from the UK that has suggested exposure to alcohol marketing has an impact on both the likelihood of young people drinking and the frequency with which they drink, however, the authors note that further research exploring levels of exposure to alcohol marketing and association with youth drinking in the UK would be helpful.<sup>10</sup>
67. The Sheffield review found that there was substantial uncertainty in the evidence on the potential impact of advertising restrictions, including the effect of complete bans on alcohol advertising.
68. The Sheffield research also highlighted the on-going methodological debate on how advertising effects can and should be investigated and the inherent difficulties of evaluating the relationship between expenditure on advertising, restrictions on advertising, and alcohol consumption.

## ***The impact that current levels of alcohol consumption will have on the public's health in the longer term***

69. The long term trend of UK alcohol consumption has been to follow growth in GDP and we are now at around the EU average for consumption and harm, with a tendency above the average to drink in binge patterns resulting in a high level of crime and social impacts.
70. Long term illness caused by alcohol tends for the most part to be the result of many years of sustained heavy drinking. For some illnesses, such as oesophageal cancer, research has shown that risks to an individual heavy drinker would continue to grow for two years after stopping drinking. The risks would then begin to fall, taking more than 20 years to fall to the level of a non-drinker.<sup>11</sup>

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<sup>9</sup>Independent Review of the Effects of Alcohol Pricing and Promotion, Part A: Systematic Reviews, University of Sheffield, 2008

<sup>10</sup>Gordon R et al. (2010): The Impact of Alcohol Marketing on Youth Drinking Behaviour: A Two-stage Cohort Study, *Alcohol and Alcoholism* 45 (5): 470-480

<sup>11</sup>Rehm et al. *International Journal of Cancer* 121, 1132-1137 (2007)

***Any consequential impact on future patterns of service use in the NHS and social care, including plans for greater investment in substance misuse or hepatology services***

*Alcohol treatment and prevention*

71. While there has been some improvement in provision for treatment of people dependent on alcohol, it is very likely that there is still significant under-provision overall. We estimate that numbers of people in England mildly or severely dependent on alcohol rose by 24% between 2000 and 2007.<sup>12</sup> Without the decisive steps we are taking through our strategy to end the availability of cheap alcohol and to strengthen local powers to prevent the growth of alcohol misuse, it is likely that needs for treatment would grow in the future.
72. Levels of need vary greatly from place to place. It is right that plans for investment in alcohol treatment and prevention are for decision at local level. Our reforms to the NHS and Public Health will ensure a greater focus on commissioning of alcohol services to meet local needs.
73. The Department – and in future Public Health England – will support better local commissioning of alcohol treatment:
- Through Payment by Results (PbR) programmes. The tools and learning from these programmes will be made available for local areas to incorporate into their local commissioning and service delivery systems.
  - By developing an evidence-based model to enable local areas to estimate needs for specialist alcohol treatment
  - Through sharing best practice, including via the on-line Alcohol Learning Centre

*Liver disease*

74. Alcohol is currently the single largest cause of liver disease. Approximately 60 per cent of people with liver disease in England have alcoholic liver disease, which, in turn, accounts for 84 per cent of liver deaths.
75. Around 9 per cent of the male population and 4 per cent of the female population of England are thought to be drinking at harmful levels, which means they are consuming more than 50 units and 35 units of alcohol per week, respectively. More than 90 per cent of people who sustain drinking at these levels will go on to develop excessive fat accumulation in their livers – this is reversible if drinking is reduced, but, if not, 15-30% of those will develop more serious inflammation as a result and up to 10% could develop cirrhosis.<sup>13</sup>
76. The Department estimated that in 2006-07 liver disease was costing secondary and tertiary care in the NHS around £460 million per year. Based on a projected increase from Hospital Episode Statistics of 10% per annum, this would mean the cost of liver disease to the NHS would exceed £1 billion by 2015-16. This takes no account of the costs of GP visits for liver disease.
77. The Government believes that such severe financial pressure on the NHS from liver disease, as this is a preventable illness, is unacceptable. We expect the new Strategy to ameliorate this pressure.
78. The Liver Disease Strategy, to be published in due course, will set out our vision for how the NHS and local areas need to tackle liver disease better.

***Whether the proposed reforms of the NHS and public health systems will support an integrated approach to future planning of services for people who experience alcohol-related harm***

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<sup>12</sup> Data from the Adult Psychiatric Morbidity Survey, 2000 and 2007

<sup>13</sup> Unpublished report for the Department of Health, 'Unmasking Liver Disease: the forgotten killer', Bell Pottinger, 2009

79. The Government's reforms to public health and the NHS will empower local communities to shape their own responses to local issues. Preventing and responding to alcohol-related harm cannot be achieved by one agency or service alone. Effective partnership is essential.
80. Local authorities have a wide role covering such services as housing, benefits, and child care, a broad interest in the wellbeing of their communities, and a reach to all sections of the community, including deprived groups, which should enable them to carry out their new public health responsibilities effectively.
81. Local Authorities' new public health responsibilities will mean they take on the main responsibility for commissioning alcohol prevention and treatment services, as we have described in the Strategy. For the first time, they will receive a ring fenced public health grant.
82. Alongside LA commissioned services the NHS will continue to have a vital contribution to preventing and treating health harm from alcohol.
83. It is the role of the Health and Wellbeing Boards to bring the whole system together to enable key local agencies to agree a strategic approach. They will maximise opportunities for integration between the NHS, public health and social care in promoting joint commissioning. This will also help to address properly the needs of specific groups, such as offenders.
84. Health and Wellbeing Boards are responsible for understanding local needs and priorities through the joint strategic needs assessment (JSNA) and are responsible for developing a joint Health and Wellbeing Strategy, which will provide the basis for both NHS and Public Health commissioning decisions.
85. We have retained the power for the Secretary of State to issue guidance on the preparation of JSNAs, and under the Health and Social Care Act 2012 we have a new power to issue guidance on the preparation of Joint Health and Wellbeing Strategies (JHWSs). New guidance to support Health and Wellbeing Boards in discharging their duties regarding JSNAs and JHWSs is currently under development and we will consult on this shortly. This guidance will not prescribe form or content of JSNAs and JHWSs as they are local strategic planning processes and need to be sensitive to local circumstances. The guidance will, however emphasise the need to consider a wide variety of needs and how they impact upon health and wellbeing outcomes, including drug and alcohol misuse.
86. The current JSNA support packs for local areas include an overview of the local population using alcohol treatment services. In the future, Public Health England will have the key role in support local areas to have an understanding of how this impacts on the health and wellbeing of their local communities.

***International evidence of the most effective interventions for reducing consumption of alcohol and evidence of any successful programmes to reduce harmful drinking, such as:***

- ***Public health interventions such as education and information;***
- ***Reducing the strength of alcoholic beverages;***
- ***Raising the legal drinking age; and***
- ***Plain packaging and marketing bans***

*Public health interventions such as education and information*

87. In 2005, the Department of Health and the Home Office commissioned a review of international evidence on the effectiveness of alcohol harm reduction communications and related campaigns.<sup>14</sup> It found no clear cut evidence that mass media campaigns alone can achieve behavioural change, although clearly they have a role to play. It found that many evaluations do not measure behaviour change, but changes in awareness. It can also be difficult to separate the impact of a campaign from that of other interventions.

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<sup>14</sup> Edcoms (2005): Review of the evidence base around effective alcohol harm reduction, prepared for COI on behalf of DH and Home Office

88. The review did find useful evidence about how to understand and analyse the behaviour of different target groups and how to segment groups according to their attitudes and beliefs, how to use the right mix of media for each target group, and how to seek to use other influences such as social norms. Crucially, it was clear that mass communications need to be supported by other interventions, if they are to be effective.
89. Social marketing campaigns however, remain an important strand within any alcohol strategy. The evaluation of the integrated marketing campaigns focused on alcohol related health harms in 2010 and 2012 demonstrate the effectiveness of recent campaigns in encouraging self-identification amongst at risk drinkers, acceptance of the potential health risks and reframing the 'norms' around moderate drinking. These are important initial stages in the behaviour change journey.
90. A number of other international evidence reviews and studies have considered the effectiveness of education and information more broadly.<sup>15</sup> Their findings are broadly consistent with those of the review we commissioned in 2005. The Department's background paper considers further evidence from research we have commissioned.
91. There will be a UK-wide review of the alcohol guidelines, lead by Dame Sally Davies, the UK Government's Chief Medical Officer, so that people at all stages of the life can make more informed choices about their drinking.

*Reducing the strength of alcoholic beverages*

92. The following international examples are taken from a rapid literature review by the Centre for Public Health, Liverpool John Moores University.
93. In Australia in the early 1980s differential tax rates for low (<3%abv) and full strength beers were introduced to promote consumption of lower-alcohol beer. Between 1980 and 2002, per capita consumption fell by 24% and lower strength beers now make up more than 20% of the total beer market.<sup>16</sup>
94. 50% of beer sales in the USA are now made up by <4.5% products and between 1999 and 2005 beer shipments increased by 8% but volume of pure alcohol rose by only 6%, suggesting that consumers were substituting lower strength products for regular / higher strength beers. A number of States have also introduced restrictions on the sale of beer e.g. Oklahoma and Utah only permit the sale of beer below 4% abv from supermarkets, petrol stations and convenience stores. In Oklahoma, full strength beers can only be sold from off-licences and by 2003 98% of beer sold was under 4% abv.<sup>17</sup>
95. A further study in the USA among university students found that substituting lower alcohol beers for regular beers did not result in a higher number of drinks being consumed when the students were unaware of the alcoholic content of the drink. It also recorded lower Blood Alcohol Concentration (BAC) levels when the lower-alcohol beers were consumed. A more recent study replicated these results.<sup>18</sup>
96. Studies conducted in Sweden found no significant additive trend among purchasing patterns following the introduction of a lower alcohol beer, although they also found no significant substitution effect as well. There was some evidence of both substitution and addition (consumers choosing the lower alcohol product over higher strength beers plus an increase in consumption of the lower alcohol beer in situations where no alcohol was previously consumed), but some of this was attributed to the relatively lower price of the lower alcohol beers compared to regular strength drinks.<sup>19</sup> However, abolition of the sale of higher strength beers in grocery

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<sup>15</sup> Anderson P, Baumberg B, Alcohol in Europe: a public health perspective: report to the European Commission, Institute of Alcohol Studies, 2006; WHO Expert Committee on Problems related to Alcohol Consumption, 2<sup>nd</sup> Report, World Health Organisation, 2007

<sup>16</sup>AC Neilsen (2006)

<sup>17</sup> International Centre for Alcohol Policies (2007)

<sup>18</sup> Geller et al (1991), Segal and Stockwell (2009)

<sup>19</sup> Skog (1988) and Whitehead and Szandrowska (1977)

stores is credited with an overall reduction in alcohol consumption and alcohol-related harm amongst young people.<sup>20</sup>

97. Conversely, Finland found that allowing medium strength beers to be sold in grocery stores resulted in an increase in consumption. This is attributed to people switching up from lower strength beers rather than switching down from other higher strength drinks.<sup>21</sup>

#### *Raising the legal drinking age*

98. We are not aware of any international studies comparing the effectiveness of different minimum purchase ages in different countries, for example 18 or 21, although there is evidence that raising a minimum purchase age reduces harm.<sup>22</sup> Minimum purchase ages vary between countries, although 18 is the most common legal limit within Europe.
99. We believe that a minimum purchase age should be set with reference to the evidence of harm to adolescents from drinking alcohol. The Chief Medical Officer for England published guidance on the consumption of alcohol by young people in December 2009. The report provides a comprehensive review of the scientific evidence on the links between alcohol-related harm and children and young people. It details key studies from an epidemiological review of the harms associated with adolescent alcohol consumption, upon which the guidance is based. It also draws on findings from a review of the associations between alcohol use and teenage pregnancy and consultation with the public, including parents and young people. The new advice was that:
- An alcohol-free childhood is the healthiest and best option.
  - If children do drink alcohol, they should not do so until at least 15 years old.
  - If 15 to 17 year olds drink alcohol, it should be rarely, and never more than once a week. They should always be supervised by a parent or carer.
  - If 15 to 17 year olds drink alcohol, they should never exceed the recommended adult daily limits (3-4 units of alcohol for men and 2-3 units for women).
100. There is substantial evidence that introducing or raising a minimum purchase age reduces harm to young people from alcohol, including road casualties, alcohol-related injury admissions to hospital, and deaths from alcohol-related injury.
101. There is good evidence on the importance of enforcement and that low and inconsistent levels of enforcement can make it easy to purchase alcohol under age, especially when there is little community support for under age enforcement.<sup>23</sup>
102. The Government believes its actions set out in the Strategy to improve enforcement and increase penalties for businesses selling to under 18s are consistent with the evidence base and that this should be a priority for action in local communities. We very much welcome extended industry support for Community Alcohol Partnerships, which mobilise community support for better enforcement on under age purchase. We would wish to see this go further in the future.

#### *Plain packaging and marketing bans*

103. We have noted in the Strategy that some countries, such as Norway, have banned alcohol advertising altogether. France has banned TV and cinema advertising of alcohol, with controls on the content of advertising in other media. As we have noted already, evidence on the impact of such restrictions is very limited and it is very hard to show that they are proportionate.
104. Where there has been evidence of likely harm sufficient to justify action, UK regulators have acted robustly. In 2005, the advertising regulators, Ofcom and the Advertising Standards

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<sup>20</sup> Ramstedt (2002)

<sup>21</sup> Mustonen and Sund (2002) and Osterberg (2012)

<sup>22</sup> Anderson P, Baumberg B, Alcohol in Europe: a public health perspective: report to the European Commission, Institute of Alcohol Studies, 2006

<sup>23</sup> Wagenaar, AC and Wolfson, M (1994): Enforcement of the legal minimum drinking age in the United States, *Journal of Public Health Policy* 15: 37-53; Wagenaar AC and Wolfson, M (1995): Detering sales and provision of alcohol to minors: A study of enforcement in 295 counties in four states, *Public Health Reports* 110: 419-7

Authority (ASA) significantly strengthened the alcohol advertising rules in response to evidence which suggested that advertising has some influence on young viewers' attitudes to drinking

105. The current 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 extensive scheduling restrictions to protect young people.
106. As part of their most recent review of the advertising codes, the ASA's code writing bodies, CAP and BCAP, undertook a comprehensive analysis of the latest research in this area, which included assessment of the Sheffield review. The advertising regulators' analysis of the existing research highlighted uncertainty in relation to the evidence on the potential impact of alcohol advertising and on the merits of more extensive restrictions. CAP and BCAP took the view that there was insufficient evidence to suggest the already robust alcohol advertising rules needed to be strengthened further. However, as set out in the Government's Alcohol Strategy, we will work with the ASA and Ofcom to examine ways to ensure that adverts promoting alcohol are not shown during programmes of high appeal to young people. We will also work with them to ensure the full and vigorous application of ASA powers to online and social media.
107. In addition to the advertising codes the Portman Group's Code of Practice, supported throughout the alcohol industry, applies to the naming, packaging and promotion of alcoholic drinks. We look to the Portman Group to ensure that the UK drinks industry continues to promote its products in a socially responsible way, reflecting the best evidence. In broad terms, the Portman Group's Code rules reflect the restrictions in the CAP and BCAP codes for advertising, for example, in prohibiting any encouragement of immoderate drinking, any association of drinking with sexual or social success, or inclusion of images of people aged under 25.
108. Plain packaging is not an intervention widely used for alcohol and we are not aware of any research on this.
109. We will continue to monitor the effectiveness of the UK's advertising and marketing regulatory regimes to ensure the rules implemented by the regulators continue to be based on best evidence and sufficient to protect the public – children and young people in particular.

May 2012

**Annex A**

## **Responsibility Deal Alcohol Network – Alcohol Pledges**

### **A1 – Alcohol Labelling**

We will ensure that over 80% of products on shelf (by December 2013) will have labels with clear unit content, NHS guidelines and a warning about drinking when pregnant.

### **A2 – Awareness of Alcohol Units in the On-trade**

We will provide simple and consistent information in the on-trade (e.g. pubs and clubs), to raise awareness of the unit content of alcoholic drinks, and we will also explore together with health bodies how messages around drinking guidelines and the associated health harms might be communicated.

### **A3 – Awareness of Alcohol Units etc in the Off-trade**

We will provide simple and consistent information as appropriate in the off-trade (supermarkets and off-licences) as well as other marketing channels (e.g. in-store magazines), to raise awareness of the units, calorie content of alcoholic drinks, NHS drinking guidelines, and the health harms associated with exceeding guidelines.

#### **A4 - Tackling Under – Age Alcohol Sales**

We will provide simple and consistent information as appropriate in the off-trade (supermarkets and off-licences) as well as other marketing channels (e.g. in-store magazines), to raise awareness of the units, calorie content of alcoholic drinks, NHS drinking guidelines, and the health harms associated with exceeding guidelines.

#### **A5 – Support for Drinkaware**

We commit to maintaining the levels of financial support and in-kind funding for Drinkaware and the “Why let the Good times go bad?” campaign as set out in the Memoranda of Understanding between Industry (MoU), Government and Drinkaware.

#### **A6 – Advertising & Marketing Alcohol**

We commit to further action on advertising and marketing, namely the development of a new sponsorship code requiring the promotion of responsible drinking, not putting alcohol adverts on outdoor poster sites within 100m of schools, and adhering to the Drinkaware brand guidelines to ensure clear and consistent usage.

#### **A7 – Community Actions to Tackle Alcohol Harms**

In local communities we will provide support for schemes appropriate for local areas that wish to use them to address issues around social and health harms, and will act together to improve joined up working between such schemes operating in local areas as:

- Best Bar None and Pubwatch, which set standards for on-trade premises;
- Purple Flag which make awards to safe, consumer friendly areas;
- Community Alcohol Partnerships, which currently support local partnership working to address local issues, such as under-age sales and alcohol related crime, are to be extended to work with health and education partners in local Government; and
- Business Improvement Districts, which can improve the local commercial environment.

#### **A8 – Unit Reduction**

As part of action to reduce the number of people drinking above the guidelines, we have already signed up to a core commitment to “foster a culture of responsible drinking which will help people drink within guidelines”.

To support this we will remove 1bn units of alcohol sold annually from the market by Dec 2015 principally through improving consumer choice of lower alcohol products.

#### **Individual Pledges**

- Asda By 30th April 2011 we will no longer display alcohol in the foyers of any our stores.
- Asda We will provide an additional £1m to tackle alcohol misuse by young people.
- Heineken We will aim to remove 100 million units of alcohol from the UK market each year through lowering the strength of a major brand by 2013.
- Heineken We will distribute 11 million branded glasses into the UK on trade showing alcohol unit information by end of 2011.
- Diageo Three year project to extend the NOFAS-UK “What Do You Tell A Pregnant Woman About Alcohol” programme across England & Wales to inform over 1 million pregnant women of what they need to know about alcohol in pregnancy
- Diageo Molson Coors, Heineken & Bacardi Brown Forman. We; Bacardi Brown-Forman Brands, Diageo, Heineken and Molson Coors commit to working with the BII (British Institute of Innkeeping) and The Home Office to support the continuation and further development of the Best Bar None scheme for at least the next three

years. We will invest at least £500,000 (commencing May 2011) and add a further 20 schemes in that time.

- Wine & Spirits Trade Association

Community Alcohol Partnerships (WSTA & supporting partners) We will expand the reach of Community Alcohol Partnerships (CAPs) in the UK through an investment of at least £800,000 by alcohol retailers and producers over the next three year . This will allow us to significantly increase the number of CAP schemes in local communities and extend the remit of CAPs beyond tackling under-age sales to wider alcohol-related harm and in particular.

## Annex B

### The evidence on alcohol misuse and harm in England today

1. This evidence paper has been written in support of the Government's alcohol strategy and as part of the Department's evidence to the Health Committee's inquiry. It considers briefly:
  - the nature and seriousness of harm from alcohol in England today, along with some issues on alcohol and wellbeing
  - trends in alcohol consumption and harm
  - our view of which policy interventions work to change which drinking behaviours

### The nature and seriousness of harm from alcohol

#### *The costs of alcohol misuse*

2. We estimate the costs of alcohol misuse in England as follows:
  - NHS costs, at about £3.5bn per year at 2009-10 costs<sup>24</sup>
  - Alcohol-related crime, at £11bn per year at 2010-11 costs<sup>25</sup>
  - Lost productivity due to alcohol, at about £7.3bn per year at 2009-10 costs (UK estimate)<sup>26</sup>

We estimate total costs at about £21bn per year. This does not include any estimate for the economic costs of alcohol misuse to families and social networks.

#### *Levels of alcohol consumption*

3. People who drink alcohol vary enormously in how much they drink and how often, where and what they drink.
  - Over half (57%) of the population in 2009 said that they had not drunk alcohol, or drank alcohol only once in the previous week. 16% of the population were classified as non-drinkers.<sup>27</sup>
  - Around a quarter of adult men (26%) and a fifth of women (18%) reported drinking at levels which are above the NHS guidelines. 2.2m people (7% of men and 4% of women) said they drank more than twice the NHS guidelines, putting themselves at most risk of illness and death from alcohol.

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<sup>24</sup> The Department of Health has updated the previous estimate of around £2.7bn at 2006-07 prices, using the same methodology

<sup>25</sup> The Home Office has recently updated the estimate of the cost of alcohol-related crime: £11 billion in 2010/11 prices. This figure includes the cost of general offences (like violent crime) that are alcohol-related, the cost to the Criminal Justice System of alcohol specific offences (like drink driving) and the cost of issuing Penalty Notices for Disorder. This estimate was arrived at using the same methodology as that which lay behind the widely quoted figure of £8-13 billion in 2006/07 prices. The previous estimate was presented as a range due to a methodological uncertainty, which has now been resolved. Further information is available on request from the Home Office.

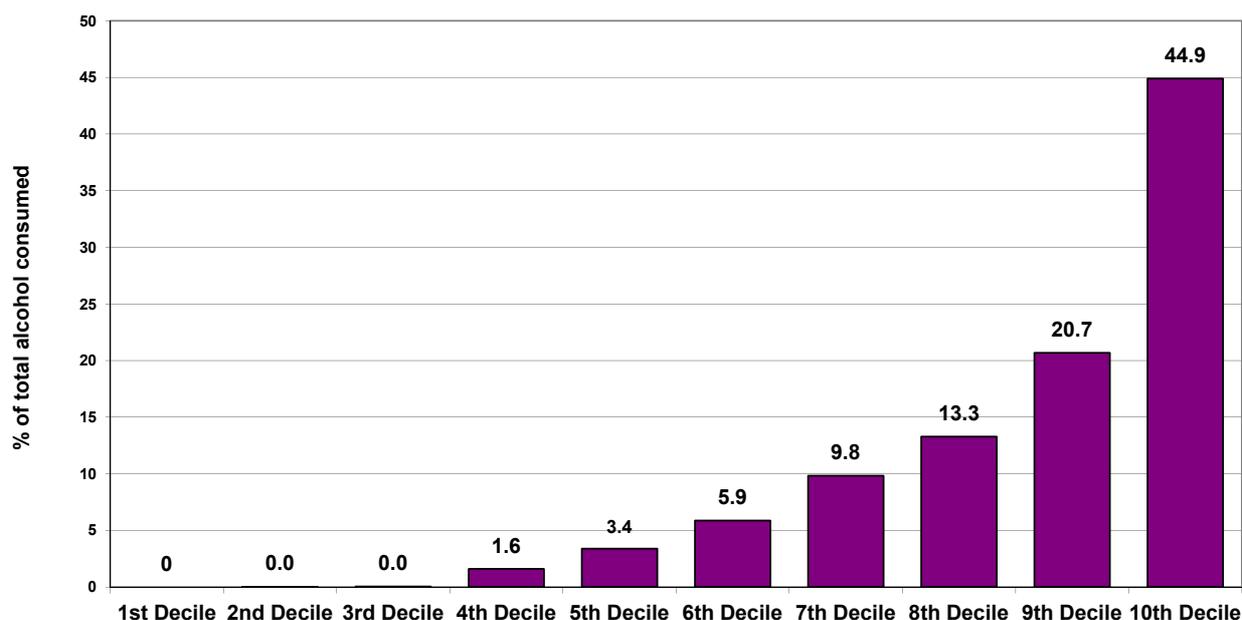
<sup>26</sup> The Department of Health has updated the previous estimate of around £6.4bn at 2006-07 prices, using the same methodology

<sup>27</sup> Statistics on Alcohol, England 2011, Table 2.1 (Information Centre for Health and Social Care)

- While public concern has tended to focus on binge drinking by young people and young adults, it is worth noting that heavy drinking is not just a problem for the young. Particularly for men, drinking above the NHS guidelines in 2009 was greater for the age 45-64 group (31%) than for 16-24s (23%). The pattern was different for women with more 16-24s (23%) drinking above the guidelines than 45-64s (20%).

4. Self-reported data from surveys tend to underestimate true consumption levels. HM Revenue & Customs data show alcohol sold in the UK that is 67% more than the total that people report to surveys, e.g. those from the Office of National Statistics.
5. Taking account of under-reporting, we estimate that the highest consuming 10% of the population are drinking more than 40% of all alcohol consumed in the UK.

More than 40% of alcohol consumption is concentrated in 10% of the population<sup>28</sup>



### **Binge drinking**

6. Some drinkers in England drink to drunkenness, a pattern known as 'binge drinking'. In England, this is measured imperfectly in population surveys by reference to those who say they drank more than double the NHS guideline limits for men (i.e. more than 8 units) and women (i.e. more than 6 units) on their heaviest drinking day in the previous week. This is not a perfect measure, as people vary a great deal in how drunk they become from the same amount of alcohol.
7. Several comparative studies within Europe show most northern European countries reporting more binge drinking compared with southern European countries, with the UK among those showing most weekly or monthly binge drinking.<sup>29</sup>
8. The UK has compared poorly with other European countries for drinking by 15-16 year old students in regular ESPAD<sup>30</sup> surveys. The UK is consistently in the top five European countries for binge drinking and drunkenness among school children.<sup>31</sup> Compared with other countries, young people in the UK are more likely to report that they drink alcohol at least weekly.<sup>32</sup>

<sup>28</sup> Policy options for alcohol price regulation: the importance of modelling population heterogeneity, Meier et al, *Addiction* 105, 383-393, 2009

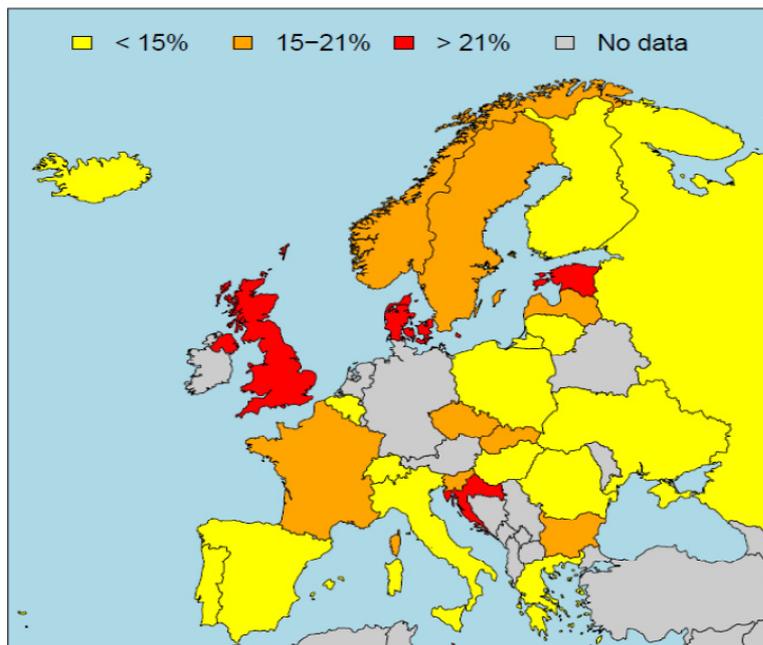
<sup>29</sup> Anderson P, Baumberg B, *Alcohol in Europe: a public health perspective: report to the European Commission*, Institute of Alcohol Studies, 2006 – this considers a range of comparative studies and methodological issues

<sup>30</sup> European School Survey Project on Alcohol and other Drugs, [www.espad.org](http://www.espad.org)

<sup>31</sup> ESPAD, 2007, Figure 29b

<sup>32</sup> Currie C, Gabhainn SN, Godeau E, et al (eds) (2008): *Inequalities in young people's health: Health behaviour in school aged children*. International report from the 2005/23006 survey, WHO policy series: Health policy for children and adolescents, Issue 5

9. Studies from the UK have shown that exposure to alcohol marketing has an impact on both the likelihood of young people drinking and the frequency with which they drink.<sup>33</sup> These findings are consistent with the evidence of a number of longitudinal studies from other countries.<sup>34 35</sup> The Government's Alcohol Strategy proposes further work in the UK to minimise the harmful effects of alcohol advertising for young people.



Binge drinking in 15-16 year old students in Europe, defined as 5+ drinks on a single occasion, 3 or more times in 30 days  
Source: ESPAD 2007 (Hibbell et al 2009). The data for Denmark and Spain has limited comparability.

### **Harms to health and social impacts from alcohol**

10. Over 60 diseases or conditions can be caused by drinking alcohol.<sup>36</sup> Alcohol can impact on health through three linked mechanisms:
11. **Direct biochemical effects on the body:** through long term consumption. The four biggest disease groups are heart disease, stroke, liver disease, and cancer.
12. In pregnancy, alcohol can cause a range of harms to the foetus, including miscarriage, low birth weight, cognitive deficiencies, and fetal alcohol spectrum disorders (FASD).
13. Like any food, alcohol contributes to calorific intake. We estimate that for adults who drink 9% of energy intake on average comes from alcohol.<sup>37</sup> This is in a context where six in ten adults are overweight or obese.<sup>38</sup>
14. Risks of these diseases, broadly, rise in line with levels of consumption, with a main exception – there is a 'J-shaped curve' for heart disease, meaning that low levels of drinking are associated with reduced risks for men over 40 and women post-menopause.<sup>39</sup> This effect lessens for people over 70.<sup>40</sup>

<sup>33</sup> Gordon R et al. (2010): The Impact of Alcohol Marketing on Youth Drinking Behaviour: A Two-stage Cohort Study, *Alcohol and Alcoholism* 45 (5): 470-480.

<sup>34</sup> Anderson et al (2009): Impact of Alcohol Advertising and Media Exposure on Adolescent Alcohol Use: A Systematic Review of Longitudinal Studies. *Alcohol and Alcoholism* 44 (3): 229-243

<sup>35</sup> Booth et al. (2008): Independent review of the effects of alcohol pricing and promotion

<sup>36</sup> Corrao et al. (2004): A meta-analysis of alcohol consumption and the risk of 15 diseases. *Preventive Medicine* 38, 613-9

<sup>37</sup> National Diet and Nutrition Survey 2008/09 - 2009/10

<sup>38</sup> Health Survey for England 2009

<sup>39</sup> Gunzerath et al. (2004): National Institute on Alcohol Abuse and Alcoholism Report on moderate drinking: *Alcoholism: Clinical and Experimental Research* 28, 829-47. Corrao et al. (2000): Alcohol and Coronary Heart Disease: a meta-analysis. *Addiction*, 95(10), 1505-23

<sup>40</sup> Groenbaek et al. (1998): Alcohol and mortality: Is there a U-shaped relation in elderly people? *Age and Ageing* 1998, 27, 739-44

15. **Drunkenness**, due to single, heavy drinking episodes ('binge drinking'), has been shown to have a number of health and social consequences on the drinker and/or on other people, such as:

- Injuries, for example from falls
- Violence and aggression, including alcohol-related crime and disorder and domestic violence<sup>41</sup> increase with drunkenness and with heavier drinking in general. If the heavy drinker is a parent, this can contribute to a variety of childhood mental and behavioural disorders.<sup>42</sup> Systematic reviews have suggested that alcohol is a contributory factor in 16% of child abuse cases<sup>43</sup>
- Increased risk of stroke,<sup>44</sup> heart arrhythmias, and sudden coronary death, even in people with no evidence of pre-existing heart disease<sup>45</sup> - any protective effect of regular, moderate consumption may be lost through binge drinking, even if this is infrequent.
- Harming home life or marriage<sup>46</sup>
- Damaging work performance<sup>47</sup>
- Limiting young people's educational attainment<sup>48</sup>

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<sup>41</sup> Wells S, et al (2005): Drinking patterns, drinking contexts and alcohol-related aggression among late adolescent and young adult drinkers. *Addiction* 100, 933-944. Wechsler et al (1994): Health and behavioural consequences of binge drinking in college: a national survey of students at 140 campuses, *JAMA*, 272, 1672-1677 Wechsler et al (1995): Correlates of college student binge drinking. *American Journal of public health*, 85, 921-6. Wechsler et al (1998): Changes in binge drinking and related problems among American college students between 1993 and 1997: results of the Harvard School of Public Health College Alcohol Study. *Journal of American College Health*, 47, 57-68. Komro et al (1999): The relationship between adolescent alcohol use and delinquent behaviours. *Journal of Child and Adolescent Substance Abuse*, 9, 13-28. Bonomo et al (2001): Adverse outcomes of alcohol use in adolescents. *Addiction*, 96, 1485-96. Swahn (2001): Risk factors for physical fighting among adolescent drinkers. *American Journal of Epidemiology*, 153, S72. Richardson and Budd (2003): Alcohol, Crime and Disorder: a study of young adults. Home Office Research Study, 263. London, *Home Office Research, Development and Statistics Directorate*. Swahn and Donovan (2004): Correlates and predictors of violent behaviour among adolescent drinkers. *Journal of Adolescent Health*, 34, 480-92. Wells et al (2005): Drinking patterns, drinking contexts and alcohol-related aggression among late adolescent and young adult drinkers. *Addiction*, 100, 933-944. Mirrlees-Black (1999): Domestic violence: Findings from a new British Crime Survey self-completion questionnaire. *Home Office Research Study* No 191. London, Home Office. Abbey et al. (2001): Alcohol and Sexual Assault. *Alcohol Health and Research World*, 25(1), 43-51. Brecklin and Ullman (2002): The roles of victim and offender alcohol use in sexual assaults: results from the National Violence Against Women Survey. *Journal of Studies on Alcohol*, 63(1), 57-63. White and Chen (2002): Problem drinking and intimate partner violence. *Journal of Studies on Alcohol*, 63, 205-214. Lipsey et al. (1997): Is there a causal relationship between alcohol use and violence? A synthesis of evidence. In: Galanter, M. ed. *Alcohol and Violence: Epidemiology, Neurobiology, Psychology, Family Issues. Recent Developments in Alcoholism*, Vol 13, New York, Plenum Press, pp 245-282. Greenfeld (1998): Alcohol and Crime: An analysis of national data on the prevalence of alcohol involvement in crime. Report prepared for the Assistant Attorney General's National Symposium on Alcohol Abuse and Crime. Washington DC, US Department of Justice. Heinz A. et al. (2011): Cognitive and neurobiological mechanisms of alcohol-related aggression. *Nature*, Vol 12, 400-413. McKinney, CM. et al. (2010): Does Alcohol Involvement Increase the Severity of Intimate Partner Violence? *Alcohol Clinical and Experimental Research*, Vol 34, No 4 655-8. Foran HM. and O'Leary D. (2008): Alcohol and Intimate Partner Violence: A meta-analytic review. *Clinical Psychology Review*, 28, 1222-34. Klostermann KC. and Fals-Stewart W. Intimate partner violence and alcohol use: Exploring the role of drinking in partner violence and its implications for intervention. *Aggression and Violent Behaviour*, 11, 587-97.

<sup>42</sup> Gmel, G. Rehm, J. (2003): Harmful alcohol use. *Alcohol Research and Health* 27, 52-62. Rossow, I. (2000): Suicide, violence and child abuse: review of the impact of alcohol consumption on social problems. *Contemporary drug problems* 27, 397-434

<sup>43</sup> English DR, et al, (1995): The quantification of drug caused morbidity and mortality in Australia. Canberra: Commonwealth Department of Human Services and Health. Ridolfo B, Stevenson C, (2001): The quantification of drug caused mortality and morbidity in Australia, 1998. Canberra, Australian Institute of Health and Welfare

<sup>44</sup> Hillbom, M. and Kaste, M. (1982): Alcohol intoxication: a risk factor for primary subarachnoid hemorrhage, *Neurology*, 32, 706-11

<sup>45</sup> Robinette et al. (1979): Chronic alcoholism and subsequent mortality in World War II veterans, *American Journal of Epidemiology*, 109, 687-700. Suhonen et al. (1987): Alcohol consumption and sudden coronary death in middle-aged Finnish men. *Acta Medica Scandinavica*, 221, 335-341. Wannamethee and Shaper (1992): Alcohol and sudden cardiac death, *British Heart Journal*, 68, 443-8. Mukamal et al. (2005): (i) Drinking frequency, mediating biomarkers, and risk of myocardial infarction in women and men. *Circulation*. 112(10): 1406-13. (ii) Alcohol consumption and risk of atrial fibrillation in men and women: the Copenhagen City Heart Study. *Circulation*, 112(12), 1736-42.

<sup>46</sup> Leonard and Rothbard (1999): Alcohol and the Marriage Effect. *Journal of Studies on Alcohol* (Suppl 13) 139-146S. Fu and Goodman (2000): Association between health-related behaviours and the risk of divorce in the USA, *Journal of Biosocial Science*, 32, 63-88

<sup>47</sup> Marmot et al. (1993): Alcohol consumption and sickness absence: From the Whitehall II Study. *Addiction*, 88, 369-82. Rehm and Rossow (2001): The impact of alcohol consumption on work and education. In Klingemann H. Gmel G. eds. *Mapping the Social Consequences of Alcohol Consumption*, pp 67-77, Dordrecht: Kluwer Academic Publishers. Gmel and Rehm (2003): Harmful Alcohol Use, *Alcohol Research and Health*, 27, 52-62. Mangione et al. (1999): Employee Drinking Practices and Work Performance. *Journal of Studies on Alcohol*, 60, 261-270. Other studies are summarised and assessed in *Alcohol, Work and Productivity, Scientific Opinion of the Science Group of the European Alcohol and Health Forum*, September 2011.

16. The risk of alcohol **dependence** rises with both the volume of alcohol consumption<sup>49</sup> and a pattern of binge drinking.<sup>50</sup> The risk of dependence is increased by starting drinking at a young age.<sup>51</sup> Alcohol dependence is most common among young adults. In 2007, there were an estimated 1.6m moderately or severely dependent on alcohol in England. We estimate that, on a like for like basis, the numbers dependent rose by 24% between the 2000 and 2007 UK Adult Psychiatric Morbidity Surveys.
17. A clear association exists between mental ill health and alcohol misuse. Alcohol psychoses and dependence account for a major part of the burden of ill health from alcohol, though a small proportion of deaths. Symptoms of depression and anxiety have been shown to increase with alcohol consumption.<sup>52</sup> People with depression and mood disorders are at increased risk of alcohol dependence and vice versa.<sup>53</sup> Many depressive syndromes improve markedly within a short period (days or weeks) of abstinence.<sup>54</sup>

### **Alcohol and violence**

18. Research suggests:

- a substantial proportion of incidents of aggression and violent crime involves one or more participants who have been drinking alcohol<sup>55</sup>
- increased risks of involvement in violence, including homicide, among heavy drinkers, with the risks stronger for intoxication than for overall consumption<sup>56</sup>
- an overall association between greater alcohol use and criminal and domestic violence, with particularly strong evidence from studies of domestic and sexual violence;<sup>57</sup> the relationship is moderated by other factors such as culture, gender, and social class
- Personality has also been found to be a mediating factor in the link between aggression and alcohol consumption. Studies have demonstrated that people who have high trait levels of

<sup>48</sup> A number of studies are summarised in the Chief Medical Officer for England's, *Guidance on the consumption of alcohol by children and young people: Supplementary Report, 2009*

<sup>49</sup> UK Adult Psychiatric Morbidity Survey, 2000. A number of other studies are summarised in the Chief Medical Officer for England's, *Guidance on the consumption of alcohol by children and young people: Supplementary Report, 2009*

<sup>50</sup> Caetano et al: DSM-IV alcohol dependence and drinking in the US population: a risk analysis, *Annals of Epidemiology*, 7, 542-549. Bonomo et al. (2004): Teenage drinking and the onset of alcohol dependence: A cohort study over seven years. *Addiction*, 99, 1520-8. A number of other studies are summarised in the Chief Medical Officer for England's, *Guidance on the consumption of alcohol by children and young people: Supplementary Report, 2009*

<sup>51</sup> De Wit et al. (2000): Age at first alcohol use: a risk factor for the development of alcohol disorders. *American Journal of Psychiatry*, 157: 745-50

<sup>52</sup> Alati et al. (2005): Is there really a J-shaped curve in the association between alcohol consumption and symptoms of depression and anxiety? Findings from the Mater University Study of pregnancy and its outcomes. *Addiction* 100, 643-651

<sup>53</sup> Regier et al. (1990): Comorbidity of mental disorders with alcohol and other drug abuse: Results from the Epidemiologic Catchment Area (ECA) study. *Journal of the American Medical Association*, 264: 2511-2518 Merikangas et al. (1998): Comorbidity of substance use disorders with mood and anxiety disorders: Results of the International Consortium in Psychiatric Epidemiology. *Addictive Behaviours: An International Journal*, 23(6): 893-907 Pirkola et al. (2005): DSM-IV mood-anxiety- and alcohol use disorders and their comorbidity in the Finnish general population. *Soc Psychiatry psychitar epidemiol* 40, 1-10

<sup>54</sup> Brown and Schuckit (1988): Changes in depression among abstinent alcoholics. *Journal of Studies on Alcohol*, 49: 412-7 Dackis et al. (1986): Evaluating Depression in Alcoholics. *Psychiatry Research*, 17(2): 105-9 Willenbring (1986): Measurement of Depression in Alcoholics. *Journal of Studies on Alcohol*, 49: 412-7 Davidson K.M. (1995): Diagnosis of depression in alcohol dependence: changes in prevalence with drinking status. *British Journal of Psychiatry*, 166: 199-204

<sup>55</sup> Murdoch, Pihl and Ross (1990): Alcohol and crimes of violence: present issues *International Journal of the Addictions*, 25, 1065-81. Budd (2003): Alcohol-related assault: findings from the British Crime Survey. Home Office on-line report 35/03 <http://www.homeoffice.gov.uk/rds/pdfs2/rdsolr3503.pdf>

<sup>56</sup> Rossow (2000): Suicide, violence and child abuse: review of the impact of alcohol consumption on social problems. *Contemporary drug problems*, 27, 397-434. Wells et al. (2000): Alcohol-related aggression in the general population. *Journal of Studies on Alcohol*, 61, 626-632

<sup>57</sup> Mirrlees-Black (1999): Domestic violence: findings from a new British Crime Survey self-completion questionnaire. Home Office research study No 191, London, Home Office. Abbey et al. (2001): Alcohol and sexual assault, *Alcohol Health and Research World*, 25(1), 43-51. Caetano et al. (2001): Alcohol-related intimate partner violence among white, Black and Hispanic couples in the United States, *Alcohol Research and Health*, 25, 58-65. Brecklin and Ullman (2002): The roles of victim and offender alcohol use in sexual assaults: results from the National Violence Against Women Survey, *Journal of Studies on Alcohol*, 63(1), 57-63

aggression are more likely to behave aggressively under the influence of alcohol, but not necessarily when they are sober.<sup>58</sup>

- A review of experimental studies has found that we are also affected by how we expect to behave when drunk. Studies have shown that when people believe they are consuming alcohol, they are more likely to be aggressive (even if they have not actually drunk any alcohol at all) than if they believe that they are consuming non-alcoholic drinks. However, the effect on aggression of drinking alcohol is greater than drinking a placebo.<sup>59</sup>
- Studies have found that the belief that alcohol is linked with aggressive behaviour is stronger in some cultures than others. However, there is little evidence showing cultural variations in the link between alcohol and observed aggressive behaviour (rather than the belief that alcohol and aggression are linked).<sup>60 61</sup>

### **Alcohol and crime**

19. There is a strong link between alcohol and crime, disorder and anti-social behaviour, particularly violent crime. In 2010/11, according to the British Crime Survey, the victim believed the offender to be under the influence of alcohol in 44% of violent incidents (around 930,000), a significant reduction since 2009/10. This was the case in over a half (58%) of incidents of stranger violence and just under a third (31%) of domestic violence incidents. Nearly a quarter (24%) of BCS respondents in 2010/11 considered people being drunk or rowdy in public places to be a very or fairly big problem in their local area.
20. There is a link between the amounts of alcohol an individual drinks and increased offending. According to analysis of the Offending Crime and Justice survey,<sup>62</sup> adult binge drinkers (18 to 65) were significantly more likely to have offended in the past 12 months than any other drinking group. Nearly a fifth (19%) of all adult binge drinkers reported committing an offence in the previous year compared with 6% of other regular drinkers and 3% of those who occasionally or never drank alcohol. There is also some evidence that people who 'pre-load' before going out for further drinking are more likely to become involved in violent crime. A small scale local study found that those pre-loading were 2.5 times more likely to have been in a fight.<sup>63</sup>
21. Many of those are not long-term or repeat offenders, but acting up on alcohol. A recent evaluation of Alcohol Arrest Referral schemes found that around six out of ten individuals participating in the schemes had no previous arrest history in the previous six months.<sup>64</sup> This finding is consistent with a study of arrests around licensed premises in the West Midlands, which found that around 40% of those arrested for one or two violent offences had no other criminal involvement over a period of several years.
22. A significant amount of violence is linked to the night-time economy.<sup>65</sup> As Figure 11 shows, a fifth (20%) of all violent incidents in 2010/11 took place in or around a pub or club. This rises to 30% for stranger violence. More than two thirds (67%) of violent offences occur in the evening or at night and 45% at the weekend.<sup>66</sup>

*Figure 11: Location and timing of violent offence*

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<sup>58</sup> Miller, C., D. Parrott, and P. Giancola, *Agreeableness and Alcohol-Related Aggression: The Mediating Effect of Trait Aggressivity*. *Experimental Clinical Psychopharmacology*, 2010. 17(6): p. 445-455.

<sup>59</sup> Bushman, B. and H. Cooper, *Effects of Alcohol on Human Aggression: An Integrative Research Review*. *Psychological Bulletin*, 1990. 107(3): p. 341-354. These studies focus on male reactions to alcohol and there is evidence that this is not applicable in females. For further information, see Gussler-Burkhardt, N. and P. Giancola, *A Further Examination of Gender Differences in Alcohol Related Aggression*. *Journal of Studies on Alcohol and Drugs*, 2005. 66(3): p. 413-422.

<sup>60</sup> MacAndrew, C. and R.B. Edgerton, *Drunken Comportment: A Social Explanation* 1969: Aldine.

<sup>61</sup> Lindman, R. and A.R. Lang, *The Alcohol-Aggression Stereotype: A Cross Cultural comparison of beliefs*. *International Journal of Addictions*, 1994. 29(1): p. 1-13.

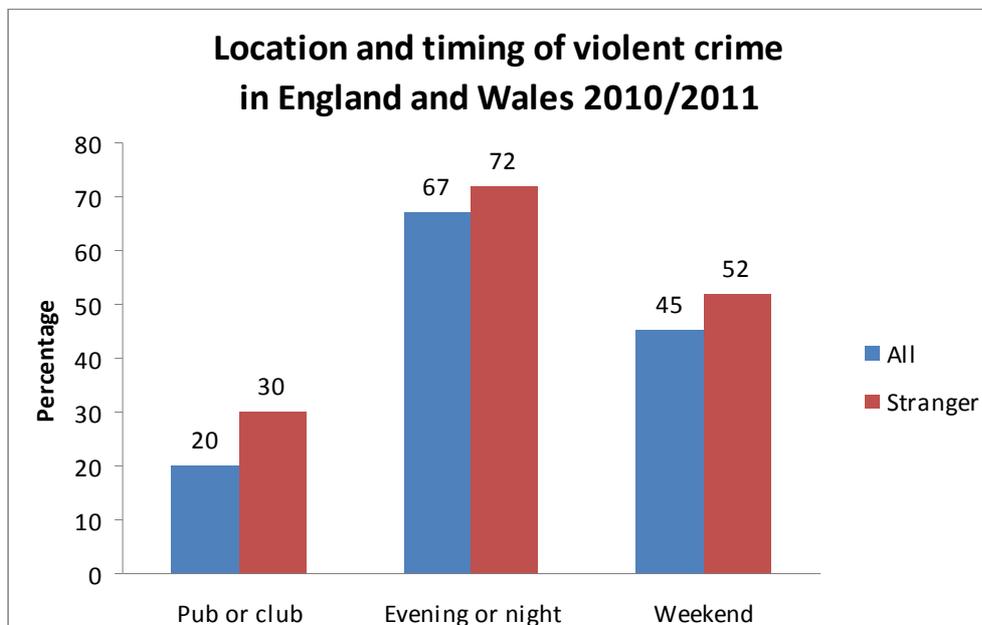
<sup>62</sup> Matthews S. and Richardson A. (2005): *The 2003 Offending Crime and Justice Survey: alcohol-related crime and disorder*. *Home Office Research Findings* 261

<sup>63</sup> Hughes K. Anderson Z. Morleo M. and Bellis M.A. (2008): *Alcohol, nightlife and violence: the relative contributions of drinking before and during nights out to negative health and criminal justice outcomes*, *Addiction*, 103(1), 60-65

<sup>64</sup> Blakeborough L, and Richardson A (2012) *Summary of findings from two evaluations of Home Office Alcohol Arrest Referral pilot schemes*. *Home Office Research Report 60*. Home Office: London

<sup>65</sup> *Crime in England and Wales, 2010/11*

<sup>66</sup> Chaplin R. Flatley J. and Smith K. (2011): *Crime in England and Wales 2010/11*, Home Office Statistical Bulletin 10/11, Home Office, London – Tables 7: <http://www.homeoffice.gov.uk/science-research/research-statistics/crime/crime-statistics/bcs-supplementary-tabs/>



Source: British Crime Survey 2010/11

### ***The burden of disease and death from alcohol***

23. Disability adjusted life years (DALY) are a measure of combined ill health (adjusted for severity) and premature death. Alcohol is 10% of the UK burden of disease and death, as measured by DALYs lost – smoking is 15%.<sup>67</sup> By this measure, alcohol is one of the three biggest lifestyle risk factors for disease and death in the UK, after smoking and obesity. This takes account of the net benefit from a reduced risk of heart disease for moderate consumption.
24. It is important to note that DALYs take account of long term health damage and loss of life, short term accidents and injuries, which account for a high proportion of early deaths, and the burden of ill health linked to dependence. It is all of these together that account for alcohol's importance as a risk factor.

### ***Alcohol and health inequalities***

25. ONS data suggests lower than average consumption among those with the lowest weekly incomes.<sup>68</sup> Health harm from alcohol appears to be highest among these groups. Over the years 2001-2005, alcohol-specific mortality in the most deprived quintile of local authorities in England was 5.5 times the rate of the least deprived.<sup>69</sup>
26. We need to understand more about why our current measures of drinking patterns do not account for the higher levels of alcohol related harms falling on more deprived communities. However, some of the disproportionate impact of alcohol on deprived communities may be due to under-reporting by higher risk drinkers in these groups – a recent study in Greater Manchester<sup>70</sup> found that under-reporting was most evident with higher risk drinkers. Other possible reasons could include combinations of apparently lower risk levels of regular drinking with binge drinking, combinations of problematic drinking with smoking and unhealthy diets, and better access to social and financial support and to treatment and care by better off individuals.

<sup>67</sup> Balakrishnan R. et al. (2009): The burden of alcohol-related ill health in the United Kingdom, *Journal of Public Health*, Vol 31, No 3, 366-373

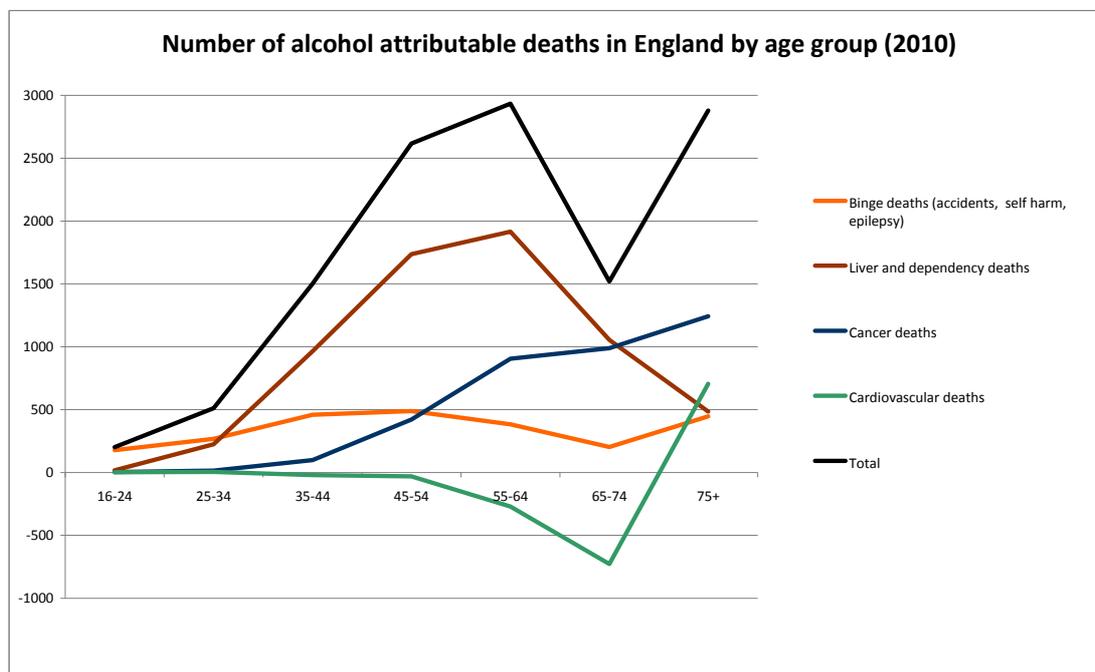
<sup>68</sup> Information Centre for Health and Social Care: Statistics on Alcohol: England, 2011, Table 2.11

<sup>69</sup> Indications of Public Health in the English Regions, 2008, Table 10

<sup>70</sup> Centre for Public Health (Liverpool John Moores University): Improving accuracy in recording alcohol consumption: a survey in Greater Manchester, May 2011

## Alcohol harm and the life course

27. Risks to health from alcohol occur at every age of life. This graph shows how the biggest net risks affect different adult age groups in England.<sup>71</sup> The relatively young ages of those suffering deaths due to alcohol is apparent.



28. In England, the average years of life lost for men and women dying from alcohol-attributable conditions during 2003-2005 was 20 years and 15 years respectively.<sup>72</sup>

## Harm to young people from alcohol

29. The Chief Medical Officer for England's 2009 guidance that young people under 15 should not drink alcohol at all is based on the fact that young people who start drinking alcohol at an early age drink more frequently and more than those who delay drinking; as a result, they are more likely to develop alcohol problems in adolescence and adulthood. Beginning to drink before age 15 is associated with:<sup>73</sup>

- increased health risks, including alcohol-related injuries,
- truancy, exclusion, and lower educational attainment
- involvement in violence
- suicidal thoughts and attempts
- having more sexual partners
- pregnancy and sexually transmitted infections
- using drugs
- employment problems

30. Young people who binge drink in adolescence (i.e. under 18) are more likely to be binge drinkers as adults and have an increased risk of developing alcohol dependence in young adulthood. They are also more likely to experience drug use and dependence, be involved in crime and be a victim of crime, and to achieve lower educational attainment by the time they are adults.

<sup>71</sup> North West Public Health Observatory: Analysis based on Jones L, Bellis MA, Dedman D, Sumnall H, Tocque K. 2008 . Alcohol-attributable fractions for England. Alcohol-attributable mortality and hospital admissions. North West Public Health Observatory, Centre for Public Health, Liverpool John Moores University. ISBN: 978-1-906591-34-2 (data updated to 2010 mortality; NWPHEO, March 2012)

<sup>72</sup> Indications of Public Health in the English Regions, 2007, Association of Public Health Observatories

<sup>73</sup> Chief Medical Officer for England, Guidance on the consumption of alcohol by children and young people: Supplementary Report, 2009

31. Research undertaken by North West Public Health Observatory<sup>74</sup> found there was an association between alcohol-related hospital admissions and teenage pregnancy, in both males and females. This was true even after controlling for the effect of deprivation. The same was true of the more common sexually transmitted infections. There is evidence that alcohol consumption and being drunk can result in lower inhibitions and poor judgements regarding sexual activity and risky sexual behaviour. Early alcohol consumption means that young people have an increased likelihood of having sex at a younger age. Alcohol misuse is linked to a greater number of sexual partners, regretted or coerced sex. There is also a strong relationship between hazardous alcohol consumption and non-consensual sex.<sup>75</sup>

### **Impact on productivity of alcohol misuse**

32. Work for the Prime Minister's Strategy Unit published in 2003<sup>76</sup> summarised damage to productivity as:

- increased sickness absence
- unemployment and early retirement from inability to work
- premature deaths among economically active people of working age

33. Our updated estimate (above) using the same methodology suggests a loss from all three factors of up to £7.3bn per year in 2009-10.

34. Research suggests additionally that heavy drinking and binge drinking episodes increase the risks of poor work performance and that the costs are likely to be considerable.

### **Fire and alcohol**

35. The Department for Communities and Local Government (DCLG) carried out a study in 2011 into fires that occurred in people's homes. This showed that alcohol resulted in 2,656 fires, resulting in 60 deaths and 1,267 injuries. The remaining 27,502 fires resulted in 85 deaths and 4,512 injuries.<sup>77</sup> Where alcohol was a contributory factor, 49% of fire incidents resulted in casualties, compared to 14% for other fire incidents.

36. The estimated cost of fires where alcohol was suspected to be a contributing factor was almost £131 million. This compares to just over £286 million for other fires in the study.

### **Attitudes of the public – how good is the public's understanding?**

37. There is good evidence that the public in general underestimates the risks of excessive alcohol consumption. This is not unique to the UK.<sup>78</sup>

38. ONS surveys show that in 2009 only 13% of the public said they keep a check on the number of units they drink. This was the same figure in 1997. 90% of people had heard of units of alcohol (up from 79% in 1997), and the more people drank the more likely they were to have heard of units. Knowledge of the actual number of units in a particular drink was lower, but for frequent beer drinkers 69% know the correct number of units and 83% of frequent wine drinkers similarly.

39. Monitoring by Drinkaware suggests that (a) accurate understanding of the daily guidelines can be improved through social marketing and (b) this can easily be lost again, if social marketing campaigns are not sustained.<sup>79</sup>

40. After the Department of Health's *Alcohol Effects* campaign in February 2010, awareness of the link with mouth cancer moved from 5% to 24%.

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<sup>74</sup> Bellis M. et al. (2009): Contributions of Alcohol to Teenage Pregnancy: An initial examination of geographical and evidence based associations. North West Public Health Observatory

<sup>75</sup> Gunby et al. Gender differences in alcohol-related non-consensual sex; cross-sectional analysis of a student population, *BMC Public Health* 2012, 12: 216

<sup>76</sup> Strategy Unit Alcohol Harm Reduction Project, Interim Analytical Report, 2003

<sup>77</sup> Although the DCLG Incident Recording System return does not distinguish between alcohol or drugs related fires, it is possible to separate out casualties that were under the influence of either substance. The study concluded that while there will be a few only drugs related fires, the vast majority of fires were where alcohol was a contributing factor, or at least alcohol or alcohol and drugs related.

<sup>78</sup> The World Health Report, 2002, Reducing Risks, Promoting Healthy Life, World Health Organisation

<sup>79</sup> Ability to state the guidelines correctly for women fell from 36% to 31% and for men from 34% to 30% between 2009 and 2010 (Drinkaware Trust)

41. Individual long term health risks from alcohol can be difficult to grasp, in the same way as long term risks from over-eating and obesity.

### ***Alcohol and Wellbeing***

42. The Government's wellbeing agenda seeks to give policy a broader focus than just economic growth. It sees quality of life as equally important.

43. Some drivers of wellbeing are those commonly considered in Government policy, for example, individuals' own and their family's health and the experience of crime in their local community.

44. Other drivers relate to issues like social relationships, social trust, and the opportunities for people to control or influence their situations.

45. The main positive impact of moderate alcohol consumption on adults' wellbeing seems to relate to social forms of alcohol consumption, although research in this area is limited.<sup>80</sup> Recent research in the North West of England shows a complex picture.<sup>81</sup>

46. While, clearly, alcohol consumption also happens in social settings in people's own homes, there may be a particular value in the ways in which well run pubs provide opportunities for social interaction as part of an experience involving moderate drinking and sometimes eating.

47. However, an approach which does not favour 'normalising' alcohol consumption at the expense of alternatives could be important for young people, given the evidence of the harm alcohol can do to their wellbeing, and for young adults, given that many still choose not to drink alcohol, or to drink it infrequently.<sup>82</sup>

48. There is good evidence, from what people themselves tell researchers, that excessive alcohol consumption is bad for individuals' own wellbeing, not just for their health. It can also be damaging to the wellbeing of families and others close to heavy drinkers.<sup>83</sup>

### ***Trends in alcohol consumption and harm***

49. Trends in consumption have broadly followed growth in Gross Domestic Product (GDP), with gradual, but sustained, long term growth – UK consumption per head doubled between 1950 and the peak in 2004. Consumption fell by 12% from 2004 to 2009, of which 9% occurred in the two years 2008 and 2009. There was no further fall in 2010. The recent fall should also be viewed in the context of the long term rise of 91% in consumption per head since 1960.

50. The rising level of abstainers from alcohol is a trend of longstanding. 9% of the population were non-drinkers in 1992 and 16% in 2009.<sup>84</sup> HMRC data on trends in consumption per head therefore understates the growth in consumption per drinker over that period.

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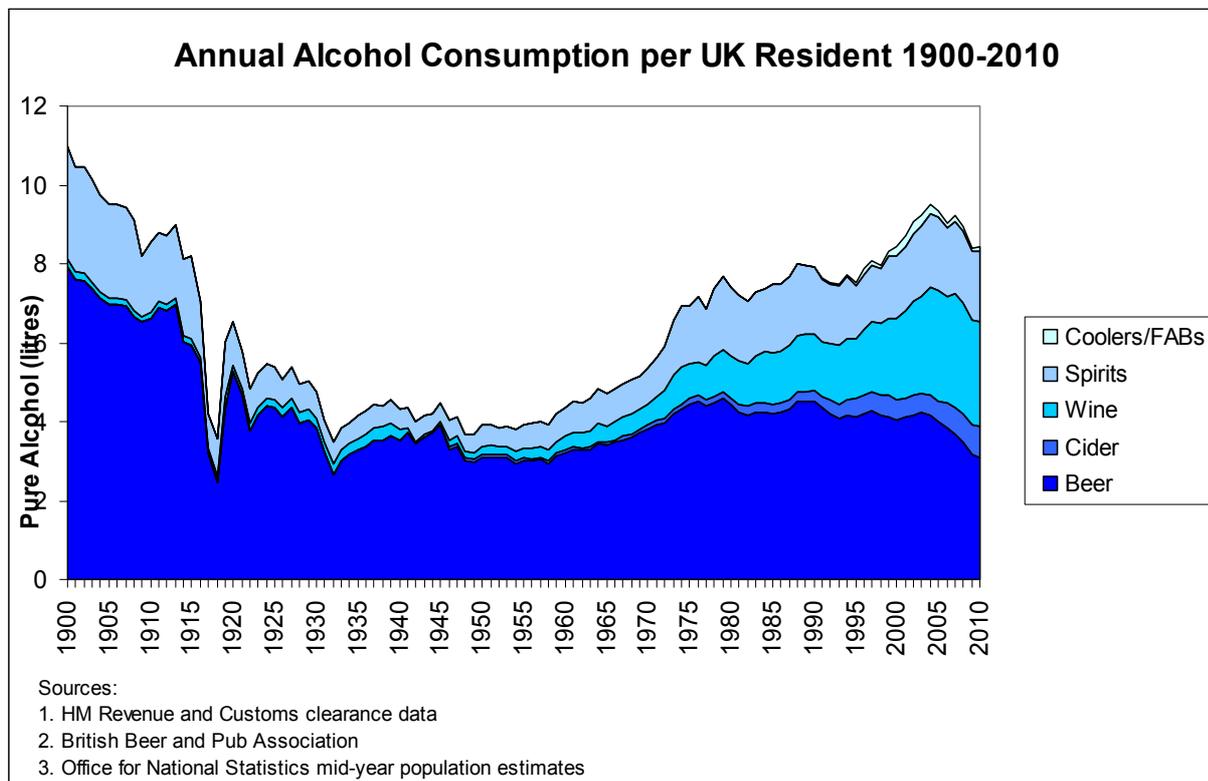
<sup>80</sup> Molnar et al. (2009): A longitudinal examination of alcohol use and subjective wellbeing in an undergraduate sample. *Journal of Studies on Alcohol and Drugs*, Vol 70(5)

<sup>81</sup> Bellis et al. (2012): Variations in risk and protective factors for life satisfaction and mental wellbeing with deprivation: a cross-sectional study, *North West Public Health Observatory (Centre for Public Health)*

<sup>82</sup> In 2009 62% of 16-17 year olds and 39% of 18-24 year olds said they drank no alcohol in the week before the survey. DH analysis of ONS General Lifestyle Survey

<sup>83</sup> *Alcohol's harm to others: reduced wellbeing and health status for those with heavy drinkers in their lives*, by Sally Casswell, Ru Quan You and Taisia Huckle, *Addiction* 106, 1087-1094, 2011

<sup>84</sup> Statistics on Alcohol, England: 2004 and 2011



51. UK average consumption is now at about the EU average, having been much below it. The average long term trend in EU countries was an increase to the mid-1970s, followed by a long term decline from about 15 litres pure alcohol per head to 11 litres per head.<sup>85</sup> Countries such as France or Italy have shown much bigger declines in consumption per head since 1961 and are now very close to and below the UK level respectively.<sup>86</sup>
52. Binge drinking is measured imperfectly in population surveys in England by reference to those who say they drank more than double the NHS guideline limits for men (i.e. more than 8 units) and women (i.e. more than 6 units) on their heaviest drinking day in the previous week. This is not a perfect measure, as people vary a great deal in how drunk they become from the same amount of alcohol. Recent trends in self-reported data used as a measure of binge drinking were as follows. Data before 2006 are not directly comparable, due to a change of methodology.<sup>87</sup>
- a decline from 23% in 2006 to 19% in 2010 for men drinking more than 8 units on at least one day.
  - a decline from 15% in 2006 to 12% in 2010 for women drinking more than 6 units on at least one day.
53. The decline between 2006 and 2010 was most marked for men and women aged 16-24 – from 30% to 24% for men and from 27% to 17% for women,<sup>88</sup> suggesting a possible link to economic weakness over that period.

### ***Trends in alcohol consumption by young people***

54. Survey data on drinking by 11-15 year olds<sup>89</sup> suggests some reasons for encouragement, but with continuing concerns. While fewer young people are drinking, those who drink do have not reduced how much they drink. Data on units drunk before 2007 are not directly comparable, due to a change of methodology:

<sup>85</sup> Figure 4.1 in Anderson P, Baumberg B, Alcohol in Europe: a public health perspective: report to the European Commission, Institute of Alcohol Studies, 2006

<sup>86</sup> WHO, European Status Report on Alcohol and Health, 2010

<sup>87</sup> Smoking and Drinking among Adults, 2009, a report on the 2009 General Lifestyle Survey, ONS; and: General Lifestyle Survey Overview: A report on the 2010 General Lifestyle Survey, ONS

<sup>88</sup> Smoking and Drinking among adults, 2009, ONS

<sup>89</sup> Smoking, drinking and drug use among young people in England in 2010, Information Centre for Health and Social Care, July 2011

- The proportion of 11-15 year old pupils who reported they had drunk alcohol in the last week fell from 18% in 2009 to 13% in 2010. The level has fallen in most years since 2001, when it was 26%.
- In 2010, average alcohol consumed by pupils who had drunk in the last week was 13 units.
- Alcohol consumed by those pupils who do drink was 12.7 units in 2007 (when the methodology changed) and 12.9 units in 2010.

### ***The changing market dynamics***

55. Since 2000, off-trade sales (eg. supermarkets, off-licences) of alcohol have come to be dominant over on-trade sales (eg. pubs, clubs). By 2009, the off-trade share had advanced to 65%.<sup>90</sup>

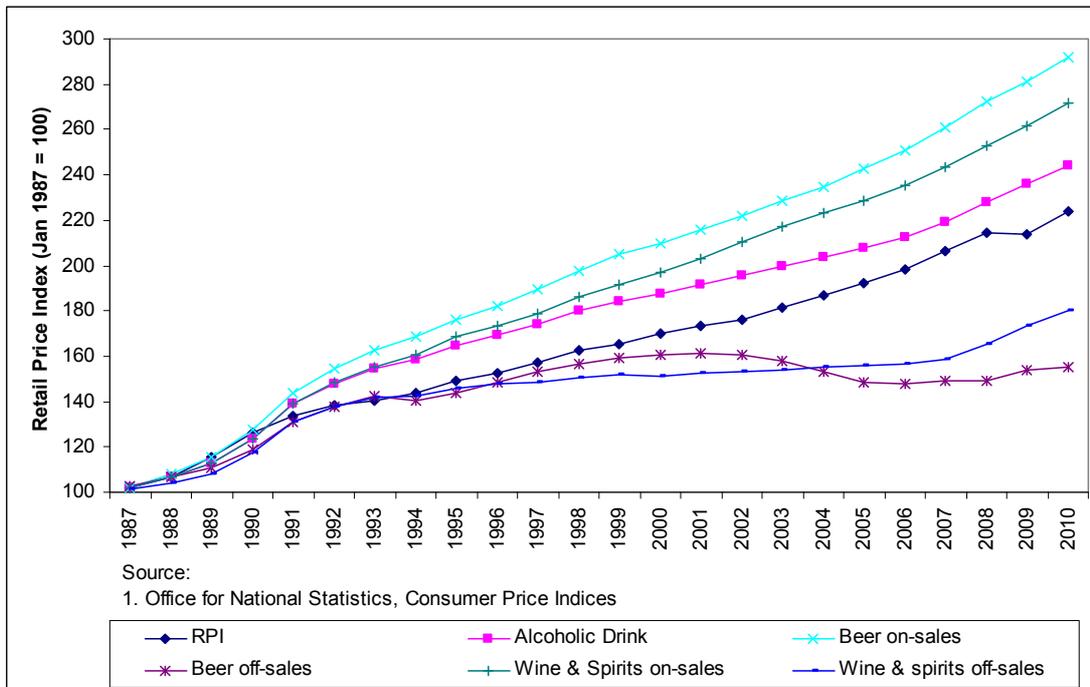
<b>Year</b>	<b>Litres per head of 100% alcohol consumed</b>	<b>Litres per head of 100% alcohol consumed</b>	<b>Litres per head of 100% alcohol consumed</b>
<b>1.</b>	<b>2. On Trade</b>	<b>3. Off Trade</b>	<b>4. Total Trade</b>
2000	3.9	4.5	8.4
2001	3.9	4.8	8.7
2002	4.0	5.1	9.1
2003	3.9	5.3	9.2
2004	3.7	5.8	9.5
2005	3.5	5.8	9.4
2006	3.4	5.7	9.0
2007	3.2	6.0	9.2
2008	3.0	6.0	8.9
2009	2.9	5.5	8.4

56. The off-trade's dominance of alcohol sales is the culmination of a long term trend to liberalise alcohol retailing. For example, in 1978 only one third of supermarkets had a licence to sell alcohol.<sup>91</sup> Until the Licensing Act 2003 came into force (in late 2005), there were effective quantity limits on individual purchases from the off-trade – no more than 12 bottles of wine, for example.
57. The price of off-trade alcohol has fallen in real terms and this is probably a major factor in the off-trade's increasing market share. Off-trade prices of wine and beer were broadly stable in cash terms and so well below Retail Price Inflation (RPI) from 1998 to 2006. On-trade prices have risen faster than RPI.

### **Price trends in the on-trade and off-trade**

<sup>90</sup> BBPA Statistical Handbook, 2010

<sup>91</sup> Central Policy Review Staff report on alcohol, 1979



58. The following table suggests that a higher proportion of moderate drinkers than excessive drinkers choose to drink in the on-trade, but that young adult binge drinkers and many under 18s (many of whom will be 16-17 year olds) have tended to choose the on-trade as a preferred venue for drinking. This would tend to support the Government's policies set out in our Strategy for tougher penalties and better enforcement on under-age sales of alcohol and to restrict the availability of cheap alcohol, particularly in the off-trade.

*Drinking patterns in the on- and off-trades (2007)<sup>92</sup>*

	Average units per drinker per week	% consumption in the on-trade	% consumption in the off-trade
<b>11-17 year old drinkers</b>	12.5	77%	23%
<b>18-24 year old binge drinkers</b>	27.2	64%	36%
<b>Age 25+ moderate drinkers</b>	5.8	45%	55%
<b>Age 25+ increasing risk drinkers</b>	27.4	36%	64%
<b>Age 25+ higher risk drinkers</b>	69.9	32%	68%
<b>Average for all drinkers</b>	15.8	37%	63%

<sup>92</sup> Independent /review of the Effects of Alcohol Pricing and Promotion, University of Sheffield, 2008, from Table 28

### **Promotional offers on alcohol**

59. It is well established that people like offers and buy more when products are on offer, there is lots of evidence that when there are volume offers people buy more. The influence of multiple unit price promotions (volume offers) on sales was first evidenced by a field study by Blattberg and Neslin (1990).<sup>93</sup>
60. The decision about whether to consume the additional alcohol requires a trade-off between the pleasure derived from consumption today with the possible health harm in the future as a result of drinking too much today. Empirical studies have shown that the standard economic assumption that people will have the same preferences in the future as they have today, that is they will be able to balance today's enjoyment with their desire for a healthy future, is incorrect and in fact people tend to overvalue the pleasure derived from consumption today.<sup>94</sup>
61. It is not unreasonable to expect that when people buy a bigger portion (because alcohol is on a volume based discount) they will tend to consume more. This is confirmed by research in other product areas such as food<sup>95</sup> and would be consistent with clear findings on the effects of discounted alcohol promotions on increased drinking,<sup>96</sup> as many such promotions are volume-based promotions.

### **Trends in alcohol-related harm**

62. Over the last ten years, health harms have continued to grow. Alcohol-attributable deaths in England rose by 7%, from 14,406 in 2001 to 15,479 in 2010. Over the same period, alcohol-specific deaths, i.e. from conditions wholly caused by alcohol, rose by 30%. In contrast, total deaths in England fell by 7%.<sup>97</sup> The rate of liver deaths in the UK has nearly quadrupled over 40 years, a very different trend from most other European countries. Chronic liver disease can be driven by factors other than alcohol, notably obesity, although alcohol remains the main driver in the UK.
63. The rate of alcohol-related hospital admissions has also continued to rise by an average of 4% each year over the eight years 2002-03 to 2010-11. (Alcohol-related admissions are defined in the Public Health Outcomes Framework by reference to admissions where the primary diagnostic code is for an alcohol-related condition.)

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<sup>93</sup> Blattberg, R. C. & Neslin, S. A. (1990). *Sales Promotion: Concepts, Methods, and Strategies*. Englewood Cliffs, NJ: Prentice-Hall, Inc.

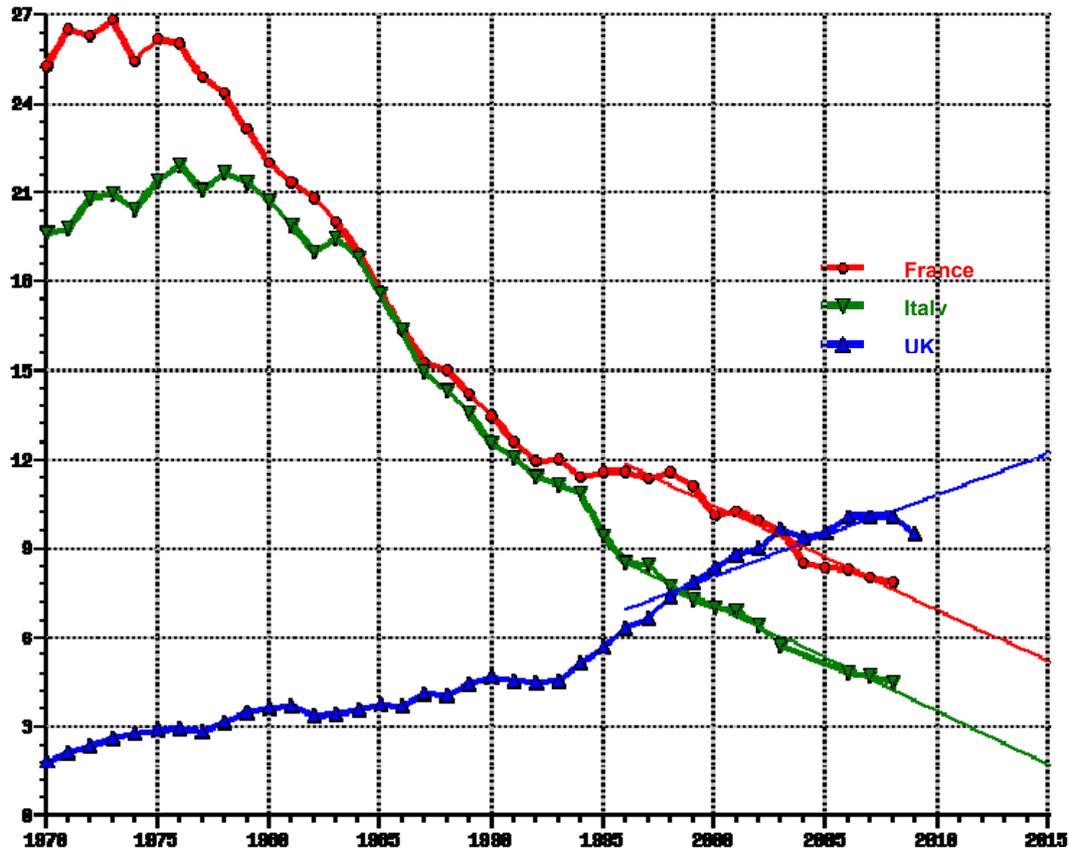
<sup>94</sup> See for example: Loewenstein, G (1987). Anticipation on the valuation of delayed consumption. *Economic Journal*, 87, 666-84.

<sup>95</sup> Just, D.R. (2006), Behavioral Economics, Food Assistance, and Obesity *Agricultural and Resource Economics Review* 35/2 (October 2006) 209–220

<sup>96</sup> Independent Review of the Effects of Alcohol Pricing and Promotion, Part B, University of Sheffield, 2008

<sup>97</sup> Jones L, Bellis MA, Dedman D, Sumnall H, Tocque K. 2008. Alcohol-attributable fractions for England. Alcohol-attributable mortality and hospital admissions. North West Public Health Observatory, Centre for Public Health, Liverpool John Moores University. ISBN: 978-1-906591-34-2.

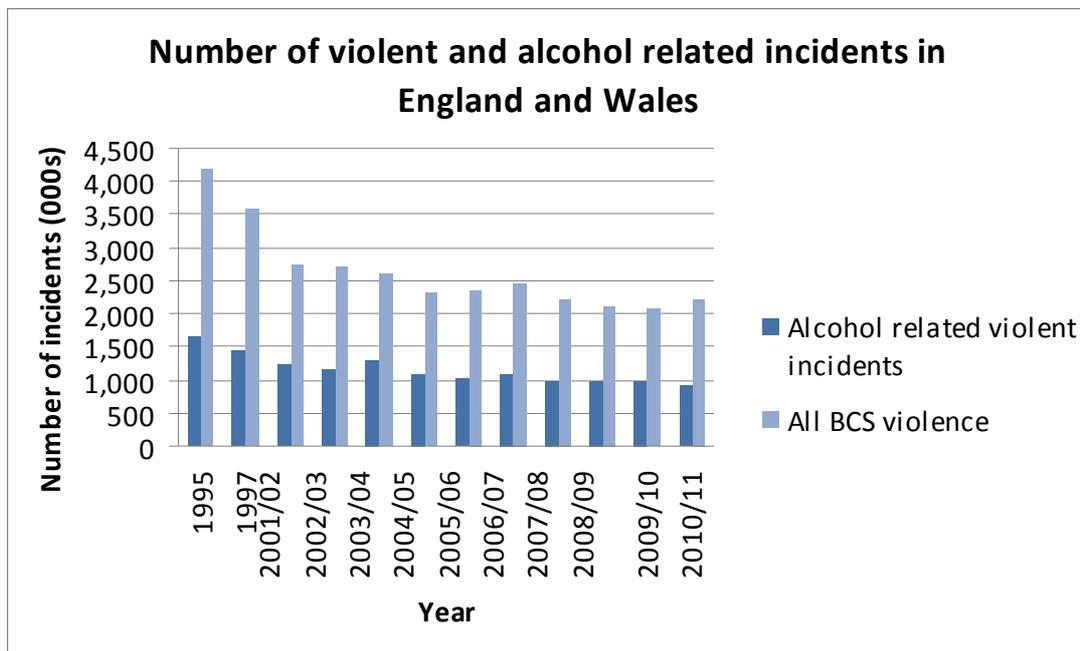
### Standardised Death Rate, chronic liver disease and cirrhosis, age 0-64 per 100,000



Source: WHO/Europe, European HFA Database, January 2012

64. There have been significant decreases since 1995 in the number of violent incidents believed by victims to involve offender(s) under the influence of alcohol. This is in the context of the overall fall in the number of violent crimes in which the proportion of alcohol-related incidents has remained similar over this period - 41% in 1995 and 44% in 2010/11.<sup>98</sup>

*Alcohol-related violent crime in England and Wales*



Source: Adapted from British Crime Survey 2010/11<sup>99</sup>

**Drink driving**

65. Drink driving remains a significant cause of death and injury, even though drink drive casualties fell by more than 75% between 1979 and 2009. Deaths in Great Britain fell from 560 in 2006 to 380 in 2009.

66. Alcohol-related deaths are the third highest cause of deaths among under 25s, with drink drive deaths nearly half of these.

**Policy Interventions**

***What kinds of interventions work to change drinking behaviour – and for whom?***

67. Research shows that, typically, drinking patterns evolve as individuals grow and move through life, in response to changing social groups, partners, family, or work pressures. Life events such as becoming a parent, divorce, bereavement, or a health scare, may influence drinking - the same life events may trigger more drinking in one person, less in another.

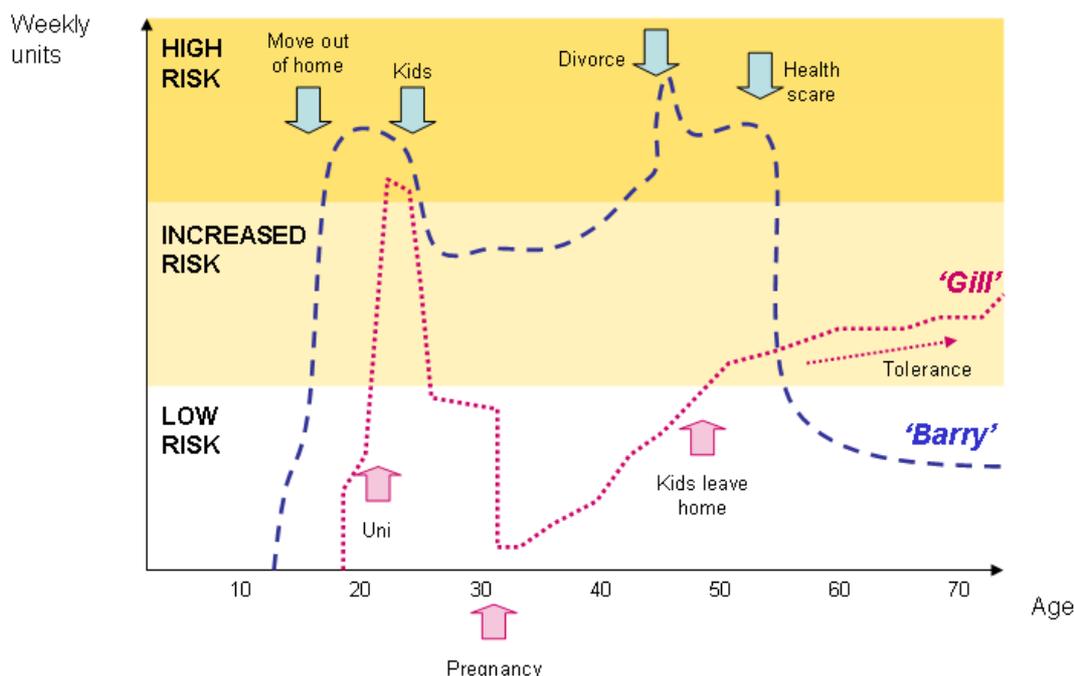
68. Many people who drink heavily later cut down, without consciously being motivated – for example, they may feel they 'have to' for work reasons, or feel less desire to drink with family responsibilities. In one study, only one third of a high risk cohort maintained higher risk drinking levels for as long as 8 years.<sup>100</sup>

<sup>98</sup> Chaplin R. Flatley J. and Smith K. (2011): Crime in England and Wales 2010/11. *Home Office Statistical Bulletin 10/11*, Home Office, London

<sup>99</sup> Chaplin R. Flatley J. and Smith K. (2011): Crime in England and Wales 2010/11. *Home Office Statistical Bulletin 10/11*, Home Office, London

<sup>100</sup> Birmingham Untreated Heavy Drinkers study

**Many people dip in and out of different drinking patterns throughout their lifetime in response to life events<sup>101</sup>**



69. Cutting down drinking with no direct intervention is most common among former binge drinkers,<sup>102</sup> particularly in early adulthood.<sup>103</sup> It is less common among those who are living alone, unemployed, or unavailable for work.<sup>104</sup>

70. Key points are:

- 'At risk' drinkers are not a static group. Many will dip in and out of risky drinking patterns throughout their lifetime.
- Anyone drinking to excess may be at risk over time – at risk of health harm or at risk of dependence on alcohol. It is not currently possible to predict an individual who is most at risk.
- Changing behaviour across a lifetime indicates broad reaching interventions, sustained over the long-term.<sup>105</sup>
- There are some key stages in the lifecourse:
  - young people drinking too early and too much increase their risks of drinking problems and dependence later in life
  - young adults who drink heavily are also at particular risk of alcohol dependence, which may increase in severity and later become entrenched for a minority
- Yet, because many people change drinking patterns throughout their lifetime, all stages of life including adulthood and old age matter; typically, chronic diseases from long term heavy drinking will be incurred in middle age, resulting in early death.

**Price interventions**

<sup>101</sup> Source: COI, created from Birmingham Untreated Heavy Drinkers study, wave 5 (2007) *please note, typical example, does not reflect specific individuals*

<sup>102</sup> Know Your Limits campaign tracking data, 2008: Females aged 25-40 claimed most success

<sup>103</sup> Jefferis et al. (2005): Adolescent drinking level and adult binge drinking in a national birth cohort. *Addiction*, 100: 543-9

<sup>104</sup> Birmingham Untreated Heavy Drinkers study

<sup>105</sup> Babor T et al. *Alcohol: no ordinary commodity. Research and public policy.* Oxford University Press, 2003 provides broad ranging discussion of evidence on harm from alcohol and effective policy interventions

71. The strongest evidence for reducing population consumption is through increasing the price of alcohol.
72. A large body of evidence from extensive research on alcohol price also confirms that lower alcohol prices, or increasing affordability of alcohol, increase both consumption and harm.<sup>106</sup> Lower prices or increasing affordability over a period of time may be likely, therefore, to reduce the impact of other interventions. While raising price is effective for reducing a population's consumption, the evidence shows that this is no less effective for regular heavy drinkers and is particularly effective for young drinkers under 18.<sup>107</sup>
73. The aim of minimum unit pricing is to end the sale of very cheap alcohol, drunk disproportionately by the heaviest drinkers. There is substantial evidence (IFS, Sheffield University study and other academic reviews) to suggest that cheap alcohol is targeted by those who consume the most alcohol overall and by under 18s who drink alcohol. The expected impact of minimum unit pricing is borne out by experience in Canadian provinces that have implemented a similar policy: social reference pricing.<sup>108</sup> There is a correlation between Canadian provinces that have introduced social reference pricing and those that have experienced a sustained reduction in violent crime.

### **Limiting availability**

74. Limiting availability is also well evidenced to reduce harm. Limiting availability through:
  - Reduced premises density
  - Enforcing refusal to serve customers when drunk
  - Restricting late night trading
  - Enforcing the law on age of purchase

is most effective in reducing binge drinking and alcohol-related crime<sup>109</sup> and drinking by young people.<sup>110</sup>

### **Brief interventions**

75. Brief intervention (IBA) by health care workers is well evidenced and a cost-effective route to reduce consumption and harm among at risk drinkers
76. A short interview with a trained health care professional at a 'teachable moment', such as a time of concern about the individual's health, or after an accident, can change both attitudes and drinking behaviour.
77. This is effective for at risk drinkers, for those drinking above NHS guidelines. Dependent drinkers will usually need specialist treatment.
78. At least one in eight at risk drinkers reduce their drinking and experience improved health as a result – an even better outcome than for smoking cessation services.
79. Initial summary findings (March 2012) from the Alcohol Screening and Brief Intervention Research (SIPS) project may be found at: <http://www.sips.iop.kcl.ac.uk/>. These cover primary care, hospital emergency departments, and probation. Later summaries are expected to report on impacts on health and re-offending.

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<sup>106</sup> *Independent Review of the Effects of Alcohol Pricing and Promotion, Part A: Systematic Reviews*, University of Sheffield, 2008

<sup>107</sup> *Modelling to assess the effectiveness and cost-effectiveness of public health related strategies and interventions to reduce alcohol-attributable harm in England using the Sheffield Alcohol Policy Model version 2.0*, Report to the NICE Public Health Programme Development Group, 2009; *Interventions on Control of Alcohol Price, Promotion and Availability for Prevention of Alcohol Use Disorders in Adults and Young People*, University of Sheffield review for the NICE Public Health Programme Development Group, 2009

<sup>108</sup> Does minimum pricing reduce consumption? The experience of a Canadian province. *Addiction* (February 2012). T Stockwell et al.

<sup>109</sup> *Interventions on Control of Alcohol Price, Promotion and Availability for Prevention of Alcohol Use Disorders in Adults and Young People*, University of Sheffield review for the NICE Public Health Programme Development Group, 2009

<sup>110</sup> Anderson P, Baumberg B. *Alcohol in Europe: a public health perspective: report to the European Commission*, Institute of Alcohol Studies, 2006

80. Brief interventions were not found to be effective in a pilot scheme aiming to reduce offending in those individuals arrested for an alcohol-related offence.<sup>111</sup>

### **Specialist treatment and support**

81. Specialist treatment and support is effective in treating severe alcohol dependence, but is usually accessed only in response to harm being experienced.
82. Alcohol dependence is a long-term condition, which may involve recurring relapses even after good quality treatment. Sufferers typically also experience multiple health problems and are heavy users of health services. Treating alcohol dependence, where successful, has been shown to prevent future illnesses and reduce health service use.
83. The Royal College of Physicians have long advocated the appointment of dedicated Alcohol Liaison Nurses in major acute hospitals to provide an in-reach service including staff training; advice on management of alcohol withdrawal and referral to specialist alcohol services in the community.<sup>112</sup>  
<sup>113</sup> Over an 18-month period, an Alcohol Liaison Nurse service in the Royal Liverpool Hospital had prevented about 15 admissions or re-admissions per month.
84. The UK Alcohol Treatment Trial (UKATT) found that £1 invested in treatment would save £5 in future costs across the public sector.<sup>114</sup> These include reduced costs of health care and in the criminal justice system. 25% of patients involved in the UKATT study had a successful outcome, reporting no continuing alcohol-related problems and 40% of patients reported being much improved, reducing their alcohol problems by two thirds.<sup>115</sup>
85. NICE has reviewed the clinical evidence and cost-effectiveness information and released guidance on alcohol dependence and harmful alcohol use <http://www.nice.org.uk/guidance/CG115>. This guidance outlines the need to provide a comprehensive package of treatment for dependent drinkers that include assessment and engagement; care co-ordination; withdrawal management; psychosocial interventions; pharmacotherapy; and recovery services.
86. The High Impact Changes promoted by DH advocate the increase in treatment and support for dependent drinkers.<sup>116</sup>

### **Education and information**

87. Evidence for changing drinking behaviour through education or information alone is limited. But information can change attitudes and reinforce motivation among some groups.
88. A review of international evidence has shown limited evidence for mass media campaigns changing drinking behaviour, but some evidence that they can change attitudes.<sup>117</sup>
89. The evidence from research commissioned by the Department of Health is that the impact of communicating health risks is greater for less entrenched drinkers and those more motivated by long term health, such as people aged 35-54, those in ABC1 social groups, and many women. Younger adults tend not to see long term health risks as compelling.<sup>118</sup>

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<sup>111</sup> Blakeborough L. and Richardson A. (2012): Summary of findings from two evaluations of Home Office Arrest Referral pilot schemes, *Home Office Research Report 60*, Home Office, London

<sup>112</sup> *Alcohol – can the NHS afford it?* London: Royal college of Physicians, (2001)

<sup>113</sup> Alcohol Care Teams: to reduce acute hospital admissions and improve quality of care ([arms.evidence.nhs.uk/resources/qipp/29420/attachment](http://arms.evidence.nhs.uk/resources/qipp/29420/attachment))

<sup>114</sup> UKATT Research Team (2005b). cost-effectiveness of treatment for alcohol problems: Findings of the UK alcohol Treatment Trial. *British Medical Journal*, 331, 544–547.

<sup>115</sup> UKATT Research Team (2005a). Effectiveness of treatment for alcohol problems: Findings of the randomised UK alcohol Treatment Trial (UKaTT). *British Medical Journal*, 311, 541–544.

<sup>116</sup> Signs for improvement – commissioning interventions to reduce alcohol-related harm (2009). Department of Health. London

<sup>117</sup> Edcoms (2005): Review of the evidence base around effective alcohol harm reduction, prepared for COI on behalf of DH and Home Office; BMA Board of Science (2008): Alcohol Misuse: Tackling the UK Epidemic

<sup>118</sup> 2CV (2008) Insight and action to help reduce levels of hazardous and harmful drinking, Qualitative research debrief

90. Research for previous Department of Health and Home Office campaigns suggests that most heavy drinkers in particular are not motivated to change their drinking behaviour by information alone. For them to change drinking behaviour consciously would require, inter alia:
- A change in the balance of risks and consequences against the perceived benefits and enjoyment from their drinking
  - Willingness to take personal responsibility and self-belief in the ability to change – even after cutting down as part of our research, many heavy drinkers did not believe they would sustain this.
  - A positive social and physical environment, a supportive network of friends or family and limited drinking triggers or temptations

## Written evidence from the British Beer & Pub Association (GAS 07)

The BBPA is the leading trade association for the brewing and pub sector. Our members represent around 95 per cent of all beer brewed in the UK, and own over half the country's pubs.

### Introduction

1. Alcohol consumption and most measures of problem drinking have been in decline over the last five or six years.
2. Health outcomes have not responded to changes in consumption, questioning the effectiveness of population-level policy interventions.
3. Government policy should focus on tackling alcohol-related harm, rather than aiming to reduce total alcohol consumption.
4. The brewing and pub sectors take responsibility extremely seriously.
5. Brewers and pub owners have fully engaged with the Public Health Responsibility Deal (PHRD), leading to tangible and immediate benefits for consumers.
6. Brewers and pub owners have demonstrated leadership in many areas, in particular alcohol labelling, innovation in lower-strength products and reducing product strengths, supporting consumer information campaigns and providing unit information in pubs.
7. Our members have differing views on minimum pricing. The evidence to suggest that minimum pricing will improve public health or reduce binge drinking is inconclusive at best.
8. The marketing of alcohol in the UK is covered by a very strong self-regulatory system, and further regulation in this area would not be a necessary or proportionate response.
9. Voluntary measures, with Government and industry working together, have proved successful and should be continued and enhanced.
10. The brewing and pub industries contribute significantly to the UK economy, adding nearly £20 billion to the UK economy. The sector contributes over £11 billion in taxation to the Treasury and support almost one million jobs.<sup>119</sup>
11. The sector employs 1 in 12 of all working, young adults.

### Alcohol consumption and harm in the UK

12. Based on HMRC alcohol 'clearances', consumption per capita has fallen by 13 per cent since 2004. Alcohol consumption in the UK is currently just below the European average, with Britons drinking less than the French, Germans and Spanish, amongst others.<sup>120</sup>
13. However, many commentators observe that the pattern of alcohol consumption is key to addressing alcohol-related harm. The trends in those consuming more than double the recommended 'regular' daily intake<sup>121</sup> have been downwards for a number of years. Since 2005, the proportion of men drinking more than 8 units on their heaviest drinking day in a week fell from 23 per cent to 19 per cent in 2010. The percentage of women drinking more than 6 units on their heaviest drinking day was 15 per cent in 2005 and 13 per cent in 2010.<sup>122</sup>
14. Drinking at 'harmful' levels has also fallen significantly. The proportion of men drinking more than 50 units a week fell from 9 per cent in 2005 to 6 per cent in 2010. For women the proportion drinking more than 35 units a week has fallen from 5 per cent in 2005 to 3 per cent in 2010.<sup>123</sup>
15. The decline in 16 to 24 year olds consuming double the daily guidelines within the last week has been even more significant. Since 2005, for young men this has fallen from 32 to 24 per cent and for young women from 27 to 17 per cent.<sup>124</sup>
16. The proportion of young people (11 to 15 year olds) who have tried alcohol has fallen from 59 per cent in 2004, to 45 in 2010 (England only).<sup>125</sup>
17. The review in the methodology for has reduced the headline figure quoted for alcohol-related admissions. The primary diagnosis method shows that the number of hospital admissions attributed to alcohol consumption increased faster than total admissions between 2002/03 and 2005/06 (23 per cent vs 11 per cent), but has increased at a slower rate in the last four years (12

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<sup>119</sup> Oxford Economics, Local impact of the beer and pub sector

<sup>120</sup> HM Revenue & Customs & BBPA

<sup>121</sup> Sometimes used as a proxy for 'binge drinking'

<sup>122</sup> ONS, General Lifestyle Survey 2010, Table 2.4

<sup>123</sup> Ibid., Table 2.2

<sup>124</sup> Ibid., Table 2.4

<sup>125</sup> Smoking, Drinking and Drug Use Among Young People in England, Table 3.1

per cent vs 15 per cent) (England only). Alcohol-related admissions make up just over one per cent of all hospital admissions.<sup>126</sup>

18. The primary diagnosis method is a more realistic way to measure alcohol-related admissions.
19. Alcohol-related violent crime has fallen by 40 per cent since 1995, and by 11 per cent since 2004/05.<sup>127</sup>

### **Responsibility for alcohol policy across Government(s)**

20. There is little co-ordinated policy for beer and pubs across Government departments. Beer is predominantly brewed from UK-produced agricultural produce and therefore responsible to DEFRA. Pubs are a central part of the country's tourism offering and responsible to DCMS, whilst licensing is the responsibility of the Home Office. The Department of Health clearly has a major role to play in alcohol policy, particularly as the service provider for those who suffer from alcohol-related harm. More support for the industry from BIS would be welcome.
21. The BBPA respects the democratic and legal rights of the devolved Parliaments to implement policies that suit the needs of their populations. We therefore appreciate that in certain circumstances policies will vary across jurisdictions. However, where possible, policy should be consistent, particularly around product labelling.

### **The role of the alcohol industry in addressing alcohol-related health problems**

22. BBPA believes the industry has a key role in addressing alcohol-related harms. Our members have an inherent interest in the responsible consumption of their products and believe that beer is there to be enjoyed and pubs are the home of sociable and responsible drinking. Industry expertise can be harnessed, as is being demonstrated through the PHRD and campaigns such as "Why Let The Good Times Go Bad?" to ensure the right consumer reach to raise awareness, encourage a responsible attitude to alcohol and provide the information to make informed decisions.
23. The brewing and pub industry has been fully engaged in the Department of Health's PHRD throughout. The largest members of the Association have signed up to all relevant pledges.
24. Approximately 90 per cent of packaged beer now produced carries the core alcohol messaging.<sup>128</sup> Pubs display unit awareness literature in premises, on websites and through social media. These are examples of voluntary agreements which are implemented quickly and are far more effective than legislation.
25. The brewing industry has embraced the opportunity offered by the Treasury's decision to cut excise duty on beers of 2.8% abv or below. In excess of twenty new brands have been brought to market, supported by significant innovation and investment in marketing. The industry believes this threshold could be increased to 3.5% abv through negotiation with the European Union.
26. Brewers and pub owners have also invested significant resources into Drinkaware as part of a programme to 'increase awareness and understanding of the role of alcohol in society, encouraging individuals to make informed choices about their drinking.' BBPA members contribute over £2 million per year to Drinkaware and significantly more through in-kind contributions.
27. BBPA's biggest producer members are also members of the Portman Group, which has played a leading role in developing industry self-regulation. Their Code of Practice places restrictions on the marketing of alcohol products, and provides an advisory service. The Portman Group was also one of the first organisations to recognise the need for self-regulation through digital media and introduced comprehensive digital marketing guidelines in 2009. They have been regulating online marketing in the UK since 2003.
28. This combines with the Advertising Standards Authority rules on paid-for advertising. This regime is regarded as one of the strictest anywhere in the world.

### **The evidence base for, and economic impact of, introducing a fixed price per unit of alcohol of 40p**

29. The BBPA's membership has a range of views on the subject of minimum pricing.

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<sup>126</sup> NHS Information Centre, Statistics on Alcohol, England, 2011, Table 4.5

<sup>127</sup> Home Office, Crime in England & Wales, 2009-10, Table 3.20

<sup>128</sup> Unit content, Chief Medical Officers' daily drinking guidelines and drinking while pregnant advice

30. Whilst there is clearly a relationship between alcohol pricing and alcohol consumption, evidence of a link between pricing and harmful consumption is less well established. Are the heaviest drinkers affected by increased prices? The Sheffield study, in line with most international evidence, found that the heaviest drinkers are least responsive to changes in price.<sup>129</sup>
31. The BBPA believes that it is important that alcohol should be retailed in a manner that is socially responsible and supports a ban on below-cost selling. BBPA supports measures targeted to help those who misuse alcohol, alongside education, awareness, and a tax system that encourages consumers towards lower-strength drinks like beer. Whilst minimum pricing might cut the differential between the price of beer in a supermarket or pub, it must not be seen as the answer to pub closures which are clearly down to high taxation. Minimum pricing is, by definition, a blunt tool and clearly the higher the minimum price the greater the impact on the vast majority who enjoy alcohol responsibly; particularly those on the lowest incomes.
32. Minimum pricing may be a breach of European competition law. BBPA has a real concern that a minimum price would ultimately be achieved through, or result in, higher beer taxation. Beer taxation would have to rise by 80 percent to achieve the same effect as minimum pricing, damaging both brewers and community pubs, costing tens of thousands of jobs. UK consumers already endure the second highest beer tax rate in Europe, paying 40% of the total tax bill, with a rate that is an astonishing 11 times higher than in the largest beer market, Germany.
33. The key piece of research, from Sheffield University (SchARR),<sup>130</sup> on which the policy of minimum pricing is based is inconclusive on the impact it would have on alcohol-related harm. For example, the latest research suggests that harmful drinkers consume over 70 units per week on average, which will be reduced by less than 3 units per week<sup>131</sup> (based on a 45p minimum price).
34. The reduction in health harms claimed in the SchARR research at 40 pence per unit is based on reductions in consumption. For example, SchARR suggests a minimum price would lead to a 2.4 per cent fall in consumption in alcohol, and therefore 7,481 fewer alcohol admissions in the first year. Alcohol consumption actually fell by more than double that amount (-6.1 per cent), but alcohol-related hospital admissions increased by 9,000 in 2009.<sup>132</sup>
35. The level of the minimum unit price will be consulted upon and as well as considering the proportionality and effectiveness, Government needs to consider any unintended consequences.
36. If minimum unit pricing is to be introduced, the Government needs to ensure that it is implemented in a fair and reasonable method, minimising the impact on pubs.

### **The effects of marketing on alcohol consumption, in particular in relation to children and young people**

37. The UK has some of the tightest restrictions on the marketing of alcohol in the world, particularly designed to avoid exposing children and young people to alcohol advertising. The large decline in youth consumption over the period that self-regulation has been in place serves as proof that alcohol advertising is not encouraging children to consume alcohol.
38. Research into the link between advertising and alcohol consumption remains inconclusive, and many studies have found no correlation. For example, a study by Gerard Hastings at the University of Stirling found no association between awareness of alcohol marketing at age 13 and either the onset of drinking, or the volume of alcohol consumed two years later.
39. Research has consistently shown that the key influence on consumption by young people is parents and peers. Young people (11 to 15 year olds) are more than twice as likely to have tried alcohol if one or more of the people they live with consume alcohol.<sup>133</sup>
40. Alcohol advertising bans are in place in France and Norway. Neither appears to have been successful in reducing alcohol-related harm. A review of the French ban, conducted by Dr. Alain Rigaud, President of the French National Association for the Prevention of Addiction and Alcoholism concluded that 'no effect on alcohol consumption could be established' from it. In Norway, alcohol consumption increased by nearly 30 per cent in a decade after the ban was introduced.

<sup>129</sup> University of Sheffield, Modelling alcohol pricing and promotion effects on consumption and harm, p.51

<sup>130</sup> From the School of Health and Related Research (SchARR)

<sup>131</sup> [http://www.sheffield.ac.uk/polopoly\\_fs/1.1500211/file/scotlandupdatejan2012.pdf](http://www.sheffield.ac.uk/polopoly_fs/1.1500211/file/scotlandupdatejan2012.pdf)

<sup>132</sup> <http://www.nice.org.uk/guidance/index.jsp?action=download&o=45668>

<sup>133</sup> Smoking, Drinking and Drug Use among Young People, 2010

## **The impact that current levels of alcohol consumption will have on the public's health in the longer term**

41. Most indicators of harmful consumption are in decline. Furthermore total consumption in the UK remains at or below the levels of our European neighbours.
42. There is also no direct correlation between per capita alcohol consumption and levels of alcohol-related harm across Europe. There are clearly other factors at play, such as patterns of consumption, income levels and wider socio-economic factors, dietary habits, prevalence of smoking, culture, etc.
43. The WHO points out that 'the relatively small proportion of deaths in western European countries, in spite of the high level of alcohol consumption in these countries, can be explained by the drinking patterns, the age structure, and the beneficial impact of low-risk drinking in these countries'.<sup>134</sup>
44. There is a need to understand that total population consumption does not necessarily correlate with total population harm.
45. In the UK in recent decades there has been a growth in sales of stronger drinks. Whilst all drinks can be abused, we firmly believe that Government policy should be encouraging the consumption of lower-strength beverages. The ability to become intoxicated quickly and to dangerous levels from drinking average-strength beers is constrained by volume and capacity. This is recognised by the WHO Global Alcohol Strategy.<sup>135</sup>

## **Public health interventions such as education and information**

46. Education and information campaigns in the UK, and in other countries, have led to a much greater knowledge amongst consumers. In the UK, the proportion of people who are aware of measuring alcohol consumption in units has increased from 75 per cent in 1998 to 90 per cent in 2009 as a result of education campaigns. This is much higher amongst regular drinkers.<sup>136</sup>

## **Reducing the strength of alcoholic beverages**

47. The international evidence for the impact of this policy is limited. However this is a policy approved by the WHO in their Global Alcohol Strategy. The pledge under the PHRD to remove one billion units through the reduction of alcohol strengths and promoting lower-strength alternatives was (as far as we are aware) a world first. Other nations, particularly Spain and Australia, have seen considerable growth in their lower-alcohol beer categories when given the appropriate level of support from Government and industry. This market is still constrained by barriers to advertising lower-strength beers. Of course, beer is already relatively lower in strength than other alcohol products, and should therefore be supported by Government policy.

## **Raising the legal drinking age**

48. The age at which individuals are allowed to purchase alcohol in the UK is 18.<sup>137</sup> This is broadly consistent with the rest of Europe, and much of the world. Indeed, many countries have a lower legal age of purchase. The BBPA is unaware of any evidence that suggests increasing the legal purchasing age would be a proportionate or effective measure.

## **Plain packaging and marketing bans**

49. There is very little international evidence on the effectiveness of plain packaging on alcohol products, with no examples of this being implemented in any other country. As packaging of alcohol products is unlikely to be a key determinant as to whether, and how much, alcohol is consumed, we do not believe this should be considered as a realistic policy option. This would also be completely disproportionate for alcohol which, unlike tobacco, has potential health benefits when consumed in moderation.

*May 2012*

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<sup>134</sup> WHO Global Alcohol Report

<sup>135</sup> [http://www.who.int/substance\\_abuse/activities/gsrhuae/en/](http://www.who.int/substance_abuse/activities/gsrhuae/en/)

<sup>136</sup> NHS Information Centre, Statistics on Alcohol: England, 2011, Table 3.1

<sup>137</sup> With the exception of having alcohol bought for you as an accompaniment to food, in the presence of an adult, where the legal age is 16 for the purchase of beer and wine

## Written evidence from Drinkaware (GAS 16)

### 1. About Drinkaware

- 1.1 Drinkaware provides consumers with information to make informed decisions about the effects of alcohol on their lives and lifestyles. Our public education programmes, grants, expert information, and resources help create awareness and effect positive change. An independent charity established in 2007, Drinkaware works alongside the medical profession, the alcohol industry and government to achieve its goals.
- 1.2 Drinkaware is entirely funded by voluntary donations from across the drinks industry, but operates completely independently from it. Our board is made up of five members of the health community, five members of the drinks industry and three independents. This structure enables the organisation to act independently whilst being fully funded through voluntary donations from industry.
- 1.3 Our behaviour change campaigns are designed using an evidence-based approach. Drinkaware provides consumers with best evidenced information and facts about alcohol. Our independent medical advisory panel checks all information, web, and printed materials to ensure their accuracy and that it reflects the most current evidence.
- 1.4 We promote responsible drinking and find innovative ways to challenge the national drinking culture to help reduce alcohol misuse and minimise alcohol-related harm. One example is our five-year £100 million 'Why let good times go bad?' campaign which is already delivering measurable results.<sup>138</sup>
- 1.5 Drinkaware was established following a Memorandum of Understanding between the Portman Group, the Department of Health, the Home Office, Scottish Executive, Welsh Assembly Government and Northern Ireland Office. This enabled the Portman Group's former campaigning arm – called the Drinkaware Trust – to be transformed into an independent charity in 2007.
- 1.6 We provide accessible, free-of-charge, evidence-based information about alcohol and its effects on employers, young people, teachers, parents and community workers. Using a range of media, such as interactive educational resources, film, social media, multimedia and outdoor advertising, we help dispel myths and present the best evidenced facts about alcohol.
- 1.7 Our campaigns focus on specific demographics as our evidence suggests that this targeted approach yields results.

### 2. Declaration of interest

- 2.1 Drinkaware welcomes the opportunity to submit evidence to this inquiry. As the leading source of alcohol information for consumers in the UK, with more than 320,000 unique visitors coming to its website every month, Drinkaware is one of the primary resources consumers turn to for evidence-based advice.
- 2.2 Our brand is displayed on at least 5 billion drinks containers every year and independent research shows that 44% of consumers questioned believe that the Drinkaware logo is a prompt to consume alcoholic drinks responsibly.<sup>139</sup>
- 2.3 This submission, following the publication of the Government's Alcohol Strategy, responds to a number of the Committee's key terms of reference. It provides a detailed response to subject areas where Drinkaware is able to supply clear evidence and where it does not conflict with

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<sup>138</sup> For information on research and campaigns visit <http://www.drinkaware.co.uk>

<sup>139</sup> Base: All those who have definitely/probably seen the logo in the last 9 months (417Jul 11) among 1,000 adults 16+, Britain. Source: Charity Awareness Monitor, Jul 11, nfpSynergy.

our Memorandum of Understanding which precludes us from commenting directly on policy matters.

### 3. Summary of our views

3.1 Our views can be summarised as follows:

- Evidence suggests that the Alcohol Strategy's emphasis on a "long-term and sustained action by local agencies, industry, communities and Government" is appropriate.
- The strategy makes positive reference to two of our current programmes. The first is a campaign to make information more easily available to 18-24 year olds, entitled "Why let good times go bad?" and the second is the research project we are facilitating in Wales on the use of "social norms".
- Whilst irresponsible and harmful drinking amongst young people remains problematic, levels of this activity have declined and it is important that young people know that the majority (55%) of 11–15 year olds have never drunk alcohol; a percentage that has increased in recent years.<sup>140</sup>
- Alcohol misuse among young adults remains an issue which needs to be tackled, but evidence suggests that we should not overlook other at-risk drinkers.
- Tackling alcohol misuse among under-18s is a key area for Drinkaware. Parents are the biggest influence on their child's attitudes to drinking. Drinkaware research<sup>141</sup> highlights that 72% of the 10-17 year olds questioned say their parents are the first people they would approach with questions about alcohol, yet half (50%) of those who have had a drink report it was their parents who supplied them with the alcohol the last time they drank<sup>142</sup>.
- Drinkaware's Parents' campaign<sup>143</sup> seeks to give parents support and age appropriate advice on how to talk to their children about alcohol in the pre-teen years. It encourages parents to delay the age of their first drink to the UK Chief Medical Officers' guidance of 15 years old<sup>144</sup>.
- Educational public health interventions based on acquiring 'life-skills' have a strong evidence base for reducing alcohol misuse among under-18s. Drinkaware has begun to roll out a life-skills based programme called In:tuition in UK schools.
- Another of Drinkaware's target groups is middle class working professionals (aged 25-44) who drink regularly (at least once a week). The proportion of this group who drink regularly is considerably higher than for the 18-24s age group (67% vs. 47%)<sup>145</sup>, evidence which was confirmed by recent ONS statistics<sup>146</sup>.
- In response to this problem, Drinkaware launched a drinks tracker in May 2011 called MyDrinkaware. The new tool is an easy-to-use multi-faceted tool, which supports people in their efforts to moderate their drinking and engages with wider lifestyle issues. It combines a drink diary, budget manager and diet programme into one online and mobile tool and delivers personalised feedback on the risk levels associated with a person's alcohol consumption.

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<sup>140</sup> NHS Information Centre, Smoking, drinking and drug use among young people in England in 2009, 2010. P. 10.

<sup>141</sup> Drinkaware KPI and Insight Research – Young People aged 10-17 and their Parents, Ipsos Mori, 2012

<sup>142</sup> Ibid When asked about the last time they were drinking, 50% of 10-17 year olds who have had a drink say their parents gave them the alcohol.

<sup>143</sup> Drinkaware.co.uk/parents

<sup>144</sup> The UK Chief Medical Officers recommend an alcohol-free childhood is the healthiest and best option.

England and Northern Ireland

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_110258](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110258)

Scotland <http://www.scotland.gov.uk/Topics/Health/health/Alcohol>

Wales <http://wales.gov.uk/topics/health/ocmo/publications/position/alcohol/?lang=en>

<sup>145</sup> Base: 25-44 year old ABC1 (723). Source: Ipsos MORI Social Research Institute. November 2011.

<sup>146</sup> General Lifestyle Survey: A report on the 2010 General Lifestyle Survey

- Evidence suggests that changing attitudes towards drinking is critical to reducing alcohol misuse in the UK. Drinkaware believes that, while it is highly valuable to provide information to consumers on the consequences of excessive drinking, this action should be balanced by simultaneously taking action to address the underlying foundations of popular attitudes towards alcohol.

#### **4. Question 1: Who is responsible within Government for alcohol policy in general, policy coordination across Whitehall and to what extent should the Department of Health take a leading role?**

- 4.1 Drinkaware's Memorandum does not permit the organisation to comment on policy, this includes the extent to which individual Government departments take a leading role on alcohol policy. However, as a charity with a national perspective, we have evidence to suggest that the Alcohol Strategy is correct to highlight the importance of effective partnership working at both the local and national level.
- 4.2 Drinkaware has worked with the UK Government in communicating unit guidelines. This work has included coordinating campaigns and messages to reflect Government advice as well as practical partnerships including mail drops of a "unit and calorie calculator" to more than 2.3 million households in support of the Change4Life January 2011 campaign activity.
- 4.3 Drinkaware engages with all major departments involved in alcohol policy implementation to ensure that we are communicating the best evidenced information once it has been established by Government and to share our research findings. This includes the Department of Health, the Home Office, the Department for Education and the Department for Transport.

#### **5. Question 2: How well does the coordination of policy across the UK with the devolved administrations work, and what is the impact of pursuing different approaches to alcohol?**

- 5.1 Drinkaware's Memorandum does not permit the organisation to comment on policy, this includes the coordination of policy. However we do know that the success of alcohol education, both through Drinkaware and other bodies, is predicated on credibility amongst consumers.
- 5.2 Drinkaware is one of the primary resources consumers turn to for evidence-based advice on low-risk drinking. It is essential that its advice is trusted and seen as credible by consumers, including the 320,000 unique users who come to our website every month looking for information about alcohol and the 175,000 who have accessed MyDrinkaware to understand more about their drinking and its impact on their body. Whilst Drinkaware has extensive experience of working with the UK and devolved Governments on specific initiatives, maintaining a reasonable level of convergence on any unit guidelines is necessary to achieve acceptance by consumers and ultimately shape their behaviour.
- 5.3 However, Drinkaware also acknowledges that consumers are not a homogenous group and that targeted communication based on nationally accepted guidelines can be highly effective. For this reason, Drinkaware runs campaigns aimed at young people (18-14), adults (30-45) and parents, and has launched a life-skills education programme, In:tuition, for use in schools.
- 5.4 As the Government's Alcohol Strategy highlights, the factors contributing to harmful alcohol use are complicated and any effective response should also be adapted for local circumstances. As an example, in 2010 Drinkaware joined forces with the Newquay Safe Partnership providing strategic guidance, a national perspective and an alcohol-free café offering advice and support for 16 and 17 year olds visiting the area.

- 5.5 Cornwall PCT were active members of the Newquay Safe Partnership and multi-agency specialists offered support and assistance for people with minor injuries or other issues. This led to a much reduced demand on front line services – in particular the ambulance service.
- 5.6 In its first year (2009–2010), the Newquay Safe Partnership’s headline achievements were:
- No deaths or serious alcohol-related injuries in the area
  - Anti-social behaviour down 19%
  - Rowdy / nuisance behaviour down 22%
  - Violence against the person down 7%
  - Alcohol-related violence down 9%
  - Sexual offences down 7%
  - Drug offences down 14%
  - Theft down 15%
- 5.7 Drinkaware has also successfully worked with each of the devolved Governments of the UK to assist the delivery of alcohol related messaging and the execution of research.
- 5.8 Drinkaware has worked with the Scottish Government, supporting its Alcohol Awareness Week activities in 2008, 2009 and 2010. Drinkaware provided almost 400,000 unit measure cups to help consumers in Scotland easily identify the number of units of alcohol in wine, beer and spirits and assist them in moderating their drinking behaviour.
- 5.9 We also fund Scottish Sports Future’s Jump2it programme, an activity-based schools programme that addresses healthy lifestyles, which is delivered to primary school aged children through a mixture of information provision and physical activity via Glasgow Rocks basketball players and qualified coaches.
- 5.10 Over a 7 month period, researchers utilised a range of evaluation methods primarily across 10 selected case study schools with the aim of gaining an indication of the impact on pupils of the Jump2it programme.
- 5.11 The resulting survey of 666 pupils shows that, following a 6 – 8 week period, pupils demonstrated a significant increase in knowledge of diet, alcohol, smoking and exercise. This was the case for both those pupils who received the standard programme and those who participated in the extended version.
- 5.12 In 2009/10 the Welsh Government funded Drinkaware to research social norming in relation to drinking practices amongst the student population across universities in Wales.
- 5.13 The project takes a multi-component approach, including a toolkit and a social norming intervention. The toolkit and social norming intervention materials were provided to universities during the summer of 2011 and the intervention took place in the first two terms of the 2011/12 academic year.
- 5.14 Measures of success will include observed changes in student consumption rates, observed student drinking patterns and the use and engagement of the toolkit by university staff. The results of the evaluation will be published in August 2012.
- 5.15 In Northern Ireland Drinkaware is supporting “My Name is Katie” an early intervention project funded by the Department of Justice Community Safety Unit Project and set to educate parents on how to talk to children about alcohol. The project will be operating initially in the Coleraine Borough Council area before being run out in Limavady, Ballymoney and Moyle.

5.16 The programme is based on the evidence that although parents might be tempted to delay speaking to their children about alcohol until they are older and more mature, opening a dialogue in their pre-teen years is crucial to delaying the age of first drink<sup>147</sup>.

## **6. Question 3: What is the role of the alcohol industry in addressing alcohol-related health problems, including the Responsibility Deal, Drinkaware and the role of the Portman Group?**

6.1 Drinkaware is currently undergoing an audit and review, the result of which will determine the effectiveness of activity to date and priorities for the organisation from 2013 onwards, including its campaigns, funding and structure.

6.2 As part of a process established between Government, industry and the public health community this follows from the 2009 review which led to a higher level of funding for Drinkaware and the involvement of more industry partners.

6.3 One of the key pledges of the Responsibility Deal is the continuation of industry support for Drinkaware. This currently takes the form of around £5.2m in financial support and a target has been set for £50m of in-kind support across all three campaigns in 2012.

6.4 A major example of the impact of this support is our 'Why let good times go bad?' campaign which was launched in 2009. 'Why let good times go bad?' is a five-year £100m project to challenge the social acceptability of drunkenness among young UK adults, and operates in partnership with more than 40 drinks industry companies and the UK Government.

6.5 The 'Why let good times go bad?' target is to achieve £20m in support, of which £5m is from media buy (rate-card valued advertising) and £15m from in-kind support from partners. In 2011, industry support achieved a significantly higher value of £27m, thus exceeding the target for this campaign.

6.6 Targeted at 18–24 year olds, the campaign warns of the risks of binge drinking and encourages drinkers to adopt smarter drinking tips. These include eating before drinking, alternating alcoholic drinks with water or soft drinks, and looking after friends when consuming alcohol.

6.7 An independent evaluation among a representative sample of 18-24 year olds, conducted by Millward Brown, following the 2011 'Why let good times go bad?' campaign activity found that:

- 27% recalled seeing the campaign – double that of industry norms
- 8 out of 10 claimed to be adopting at least one of the campaign tips
- 56% claimed it made them consider drinking differently
- 82% agreed 'They could personally relate to it'
- 72% agreed 'It was the sort of advertising they would talk about with friends'
- 66% agreed 'The advertising clearly communicated that 'drinking too much alcohol can ruin a good night out'

6.8 In 2011 Drinkaware and the British Beer and Pub Association (BBPA) developed a new '2-2-2-1' unit campaign providing a simple and quick way to gauge the number of units in the four most popular drinks—a pint of beer, a 175ml glass of wine, a 330ml bottle of 5% beer, and a 25ml pour of spirits.

6.9 Through a partnership with the Wine and Spirits Trade Association (WSTA), Drinkaware has helped develop a similar '2-2-2-1' campaign for use in the off-trade sector, which replaces a pint of beer with a 440ml can of 4% beer and a 330 ml bottle of 5% lager with a 330ml

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<sup>147</sup> Spoth RL., Lopez Reyes M., Redmond C, Shin L., 1999. Assessing a public health approach to delay onset and progression of adolescent substance use: latent transition and log-linear analyses of longitudinal family preventative intervention outcomes. *Journal of Consulting and Clinical Psychology*, 67: 619-630.

bottle of ready to drink (RTD) lager. When approved, it is anticipated that the campaign will be rolled out in the majority of retail outlets across the UK.

**7. Question 4: Do you think the proposed reforms of the NHS and public health systems will support an integrated approach to future planning of services for people who experience alcohol-related harm?**

7.1 As a national charity our resources are completely free and will be available for all new bodies established through the Health and Social Care Act reforms. We have successfully worked with a wide range of bodies and will continue to help administrations deliver well-evidenced and targeted campaigns.

**8. Question 5: What evidence exists of the most effective international interventions for reducing consumption of alcohol and evidence of any successful programmes to reduce harmful drinking, such as:**

- **Public health interventions such as education and information;**
- **Reducing the strength of alcoholic beverages;**
- **Raising the legal drinking age; and**
- **Plain packaging and marketing bans.**

8.1 Drinkaware has considerable insight into public health interventions and has recently built on European evidence of success in reducing harmful behaviour choices to develop a UK-specific initiative called In:tuition.

8.2 In:tuition is a life-skills resource aimed at providing teachers with the tools required to equip learners with the knowledge and skills to make lifelong healthy decisions, develop greater self-esteem and self-confidence and enhance cognitive and behavioural competency to reduce and prevent a variety of health risk behaviours. Across the UK, 38 schools are taking part in the In:tuition pilot and 459 schools have registered to use the programme.

8.3 In:tuition was informed by international examples of rigorously evaluated, best-evidenced life-skills based education programmes, which have been shown to be effective in preventing alcohol and other substance misuse – reducing alcohol misuse by 28-31%.<sup>148</sup>

8.4 Evidence such as the EU-Dap trial, UNPLUGGED, a multi-centre study implemented by nine partners from seven different European countries with funding from the European Commission formed a key basis in the development of the In:tuition programme.

8.5 UNPLUGGED aimed “both to develop a theory-based school programme for the prevention of use of tobacco, drugs and alcohol, and to assess its effectiveness by mean of a rigorous experimental design.”

8.6 The UNPLUGGED programme was developed by the EU-Dap Intervention Planning Group and evaluated roughly 7000 12-14 year old students during the 2004-2005 school year. The contents of the programme were dedicated to decreasing drug initiation and/or delaying the switch from experimental to repeated drug consumption.

8.7 UNPLUGGED focused on a “life-skills” programme where intra- and interpersonal skills, enhancing young people’s self-discipline, were used to increase learners’ understanding of self-respect, respect for others and their trustfulness, feelings, individuality and privacy.

8.8 According to the EU-Dap trial, “results have shown that comprehensive social influence programmes do help prevent the use of alcohol, tobacco and other drugs.” The UNPLUGGED programme was found to be effective in preventing the onset of alcohol, tobacco and other

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<sup>148</sup> Base: 25-44 year old ABC1 (723). Source: Ipsos MORI Social Research Institute. November 2011.

drug use. Results from an 18 month follow-up study found that “persisting beneficial program effects were found for episodes of drunkenness... in the past 30 days.”<sup>149</sup>

- 8.9 After one year the evaluation showed that pupils who participated in the UNPLUGGED school curriculum had a 30% lower probability to have smoked cigarettes (daily), to have experienced drinking to intoxication, and a 23% lower probability to have used cannabis in the past month, compared to students who followed the usual educational curricula.<sup>150</sup>
- 8.10 Adapted for the UK context, Drinkaware’s cross-curricular programme builds the esteem, confidence and decision-making skills of learners aged 9 to 14, so they can make more informed decisions about a range of issues – including alcohol, sex and relationships, personal finance, health and civic responsibility. Research, such as the 2011 Foxcroft and Tsertsvadze Cochrane collaboration<sup>151</sup>, suggests that a ‘life-skills’ based approach to teaching, encompassing current guidance, is one of the best ways to achieve these outcomes.

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<sup>149</sup> Faggiano et al (2010). The effectiveness of a school-based substance abuse prevention program: 18-Month follow-up of the EU-Dap cluster randomized controlled trial

<sup>150</sup> Faggiano et al (2008). The effectiveness of a school-based substance abuse prevention program: EU-Dap cluster randomised controlled trial

<sup>151</sup> Foxcroft and Tsertsvadze (2011), Universal school-based prevention programs for alcohol misuse in young people: The Cochrane Library

## Written evidence from Alcohol Health Alliance UK (GAS 27)

### About the Alcohol Health Alliance UK

The Alcohol Health Alliance UK (AHA) is a group of 31 organisations whose mission is to reduce the damage caused to health by alcohol misuse. The Alcohol Health Alliance works 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 a group has existed specifically to co-ordinate campaigning on alcohol, which brings together medical bodies, patient representatives and alcohol health campaigners.

### Members of the Alliance:

Academy of Medical Royal Colleges, Action on Addiction, Alcohol and Health Research Trust, Alcohol Concern, Alcohol Focus Scotland, Balance North East, British Association for the Study of the Liver, British Liver Trust, British Medical Association, British Society of Gastroenterology, College of Emergency Medicine, Drink Wise North West, Faculty of Dental Surgery, Faculty of Occupational Medicine, Faculty of Public Health, Institute of Alcohol Studies, Medical Council on Alcohol, National Addiction Centre, National Heart Forum, National Organisation for Foetal Alcohol Syndrome, Royal College of Anaesthetists, Royal College of General Practitioners, 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 of England, Royal Pharmaceutical Society, Royal Society for Public Health, Scottish Health Action on Alcohol Problems, Scottish Intercollegiate Group on Alcohol.

### 1. Summary

- The AHA welcomes *The Government's Alcohol Strategy* (2012) and its acknowledgement of the harms associated with current levels of alcohol consumption in England.
- A number of issues need to be addressed at the same time to successfully reduce the negative health and social impacts of alcohol. The most effective interventions address price, availability and marketing of alcohol, and should be coupled with efforts in early identification and ongoing treatment of both acute and chronic alcohol-attributable health harms.
- The strategy makes clear commitments to address areas such as pricing and licensing. The AHA particularly applauds the proposal of a minimum unit price for alcohol, and the recognition that affordability is a major factor in driving levels of excessive consumption and associated health harms.
- However the strategy's commitments in other areas are weaker, particularly in relation to restricting alcohol marketing and investing in a range of patient-focused treatment services. The ongoing involvement of the alcohol industry in public health campaigns is also an area of concern. A lack of action in these areas will hinder the government's capacity to ensure widespread changes to consumption and its health and social consequences.
- The strategy proposes interventions for specific groups within the English population, including offenders and young people who binge drink. While the AHA welcomes these measures, we are concerned about the lack of actions and investment to address the significant proportion of the population who regularly drink at or above published guidelines over a sustained period of time, which can lead or contribute to a range of chronic illnesses.
- A strong national framework, underpinned by effective governance, quality research and evaluation, will be essential in supporting local authorities and clinical commissioning groups to deliver effective services for their communities in the new public health system.

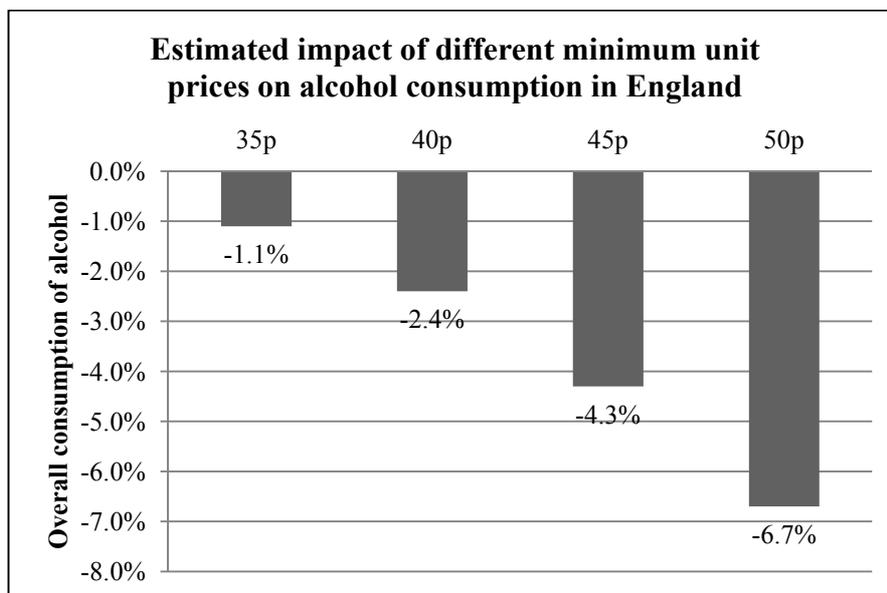
## **2. Overall response to *The Government's Alcohol Strategy***

- 2.1 The growing costs to individuals and society of excessive alcohol consumption are well documented. Alcohol is a factor in over 40 serious medical conditions, is a contributing factor in accidents, violence, self-harm and sexual assault, and recent analysis indicated 3% of all deaths in the UK in 2005 were attributed to alcohol consumption.<sup>1</sup> In 2009/10 there were 1.1 million alcohol related admissions to hospital in England, more than twice as many as in 2002/03.<sup>2</sup> 2003 estimates indicated that the annual cost of health, crime and employment problems caused by alcohol consumption at around £20bn a year, and there strong evidence that these costs are continuing to rise.<sup>3</sup>
- 2.2 The AHA welcomes *The Government's Alcohol Strategy* ('the strategy') as an important step forward in addressing the negative impacts of alcohol consumption in England. For the first time we are seeing clear government acknowledgement that there is a need to reduce consumption in order to tackle the negative impacts of alcohol on public health and social disorder.
- 2.3 While we welcome the intent of the strategy, the AHA is concerned about the absence of specific targets and timeframes for achieving changes in consumption, violent crime and incidence of alcohol-related chronic conditions.
- 2.4 The strategy focuses on the effects of young people binge drinking, and the social disorder caused by excessive alcohol consumption. The AHA would like to see this focus to be equitably balanced to better acknowledge the long term health harms, including chronic disease and alcohol dependence. There is a large section of the population that is consuming well over the recommended limits, often in their own homes, and storing up problems (and demand for services) for the future.<sup>4,5</sup>
- 2.5 Quality research and evaluation will be essential to implementing the strategy's actions. The AHA welcomes the recent launch of the NIHR School for Public Health Research, and would like to see further commitments to ensure alcohol-related interventions and initiatives have the longitudinal, large-scale and rigorous monitoring and evaluation processes, as well as commissioning independent research, required for national and local bodies to make informed decisions about the most effective ways to allocate resources.

## **3. Establishing a minimum unit price**

- 3.1 The AHA strongly supports the Government's commitment to introduce a minimum price on alcohol in England and Wales. This step acknowledges the clear relationship between price and the consumption of alcohol and associated harms, which is supported by substantial and robust evidence and modelling.<sup>4,6,7,8 9</sup>
- 3.2 Minimum unit pricing is particularly important in helping to address alcohol consumption's contribution to chronic disease and will primarily target harmful and hazardous drinkers, with comparatively little impact on the spending of moderate drinkers.<sup>8</sup> Evidence shows that it is the cheapest alcohol that is causing high levels of harm – in the UK on average, harmful drinkers buy 15 times more alcohol than moderate drinkers, yet pay 40% less per unit.<sup>10</sup>
- 3.3 Modelling conducted by the University of Sheffield found that increasing levels of minimum pricing show substantial increases in effectiveness (see Figure 1 below). The AHA supports the introduction of a minimum unit price of at least 50p per unit, which the modelling suggests would reduce total alcohol consumption by 6.7%, saving around 20,000 hospital admissions in the first year and 97,000 a year once the policy has been in place for ten years. This would result in direct costs saved in relation to health, crime and workplace impacts in England of £7.6 billion over ten years.<sup>8</sup>

### **Figure 1**



Data taken from University of Sheffield 2009.<sup>8</sup>

- 3.4 Once it has been implemented it will be essential to establish an effective mechanism for reviewing and adjusting the minimum unit price over time to account for inflation and rising disposable incomes. The AHA recommends this occurs on an annual basis as a minimum. Robust independent evaluation of the impact of the minimum unit price will be essential.
- 3.5 Further consultation should also be taken on how best to use the additional profits generated by retailers through a minimum unit price, which are estimated at several hundred million pounds. Given the limited investment in alcohol treatment services as previously identified by the Health Select Committee<sup>9</sup> and National Audit Office,<sup>11</sup> the AHA would like the government to explore introducing a levy that would see the funds reinvested in specialist alcohol treatment services.

### **Banning multi-buy discounts**

- 3.6 The strategy also commits to consulting on a ban of multi-buy promotions in the off-trade. The AHA strongly supports this ban. The University of Sheffield modelling shows that increasing restrictions in off-trade discounting (ie through multibuys) does have increasing effects in a similar way to minimum pricing. Restrictions to 40%, 30%, 20% and 10% discounting give estimated consumption changes of -0.1%, -0.3%, -1.6%, -2.8% respectively. A 2.8% reduction in consumption is similar to the change estimated for a 40p minimum price (see Figure 1 above).<sup>8</sup>
- 3.7 The AHA argues that this ban should be expanded to include multi-buy discounts in the on-trade as well as the off-trade.

## **4. Addressing marketing and advertising**

- 4.1 Evidence shows that exposure to alcohol marketing encourages children to drink at an earlier age and in greater quantities than they otherwise would. The Science Committee of the European Alcohol and Health Forum concluded in 2009 that "alcohol marketing increases the likelihood that adolescents will start to use alcohol, and to drink more if they are already using alcohol."<sup>12</sup>
- 4.2 The Health Select Committee reported in 2010 that the current regulatory framework for alcohol marketing was inadequate.<sup>9</sup> Current controls are intended to limit the exposure of children to alcohol advertising, however clear failures with the controls can be identified. For example, an OFCOM audit of exposure showed that for approximately every five 24 year olds, four 10 year olds saw the same TV alcohol advert - this does not protect children.<sup>13</sup> A study funded by the Medical Research Council showed that in the UK 96% of 13 year olds were aware of alcohol advertising and had, on average, come across it in more than five different media.<sup>9</sup>
- 4.3 The OFCOM data shows that overall levels of TV advertising are declining, normal advertising comprises only around £250 million of the total £800 million spend – the remainder goes on other forms of marketing such as football sponsorship, promotions, musical festivals and viral and internet promotions where the potential exposure of children is even more problematic.<sup>9</sup>

- 4.4 While the government's strategy recognises the link between marketing and consumption, the actions outlined focus on working within the current structures and do not go far enough to curb children's exposure to alcohol advertising. The evidence above highlights that relying on the Advertising Standards Agency alone is insufficient.
- 4.5 AHA supports a UK adapted version of *Loi Evin*. The *Loi Evin* is a French framework that allows alcohol marketing and promotion in media that is used by adults, but not where a large proportion of children and young people make up the audience. The *Loi Evin* model provides a simple framework that can offer clarity on what marketing practices can and cannot be implemented whilst ensuring that children and young people are protected from an exposure that poses a risk to their health and wellbeing. It has been upheld in by the European Court of Justice, which found in 2004 that the measure is proportionate, effective, and consistent with the Treaty of Rome.<sup>14</sup>
- 4.6 Children and young people's exposure to alcohol marketing should be monitored by an independent body, with no representation within this body from the alcohol industry. This monitoring should be performed systematically and routinely to monitor trends over time. Particular attention should be paid to ensuring that marketing through digital, online and social media is adequately monitored and regulated.

## **5. The role of the alcohol industry**

- 5.1 The AHA welcomes the acknowledgement in the strategy that "industry needs and commercial advantages have too frequently been prioritised over community concerns".<sup>15</sup> However the AHA remains concerned that the strategy reinforces existing roles and structures for industry involvement. Evidence indicates that industry self-regulation is not an effective strategy due to industry's conflicts of interest.<sup>16</sup> The AHA would like to see an immediate commitment to an independent evaluation of the current responsibility deal initiatives.
- 5.2 The strategy restates the government's commitment to Drinkaware. While the AHA acknowledges that Drinkaware contributes to raising public awareness about the risks of excessive alcohol consumption, it is important to acknowledge that Drinkaware's reliance on alcohol industry funding means it has a very specific remit and limited role in a wide-ranging public health strategy.
- 5.3 In line with WHO recommendations, while we believe business must play a part and have the opportunity to engage with health issues, health experts must lead on setting policy priorities.<sup>17</sup> Although businesses have a role to play in protecting and promoting the health and wellbeing of their employees and the wider community, and implementing and supporting public health initiatives it is not the place or responsibility of business to define public health policy or to be responsible for public health information, as in many cases this is in direct conflict with their interests and responsibilities to their shareholders and employees.
- 5.4 To address this conflict of interest the AHA recommends that industry contributes to funding for public health initiatives via a truly independent charity or blind trust, constituted as a grant-giving foundation to support bodies operating for the public good with a track record of reducing alcohol harm, without involvement from industry representatives. All programmes and policies should be subject to proactive monitoring and independent evaluation, including those with private investment.

## **6. Greater investment in effective interventions**

- 6.1 There is a clear need to provide care for a large and growing group of patients with alcohol-related health problems. Presently a lack of coordinated action means that care is imperfect and spending is poorly targeted and ineffective, very few hospitals have dedicated alcohol services and only 5.7% of dependent or harmful drinkers access treatment, compared to 67% of dependent or harmful drug users.<sup>19</sup>
- 6.2 The strategy proposes interventions for specific groups within the English population, including offenders and young people who binge drink. While the AHA welcome these measures, we are concerned by the lack of actions and investment to address the significant proportion of the population who regularly drink at or above published guidelines over a long period of time, which can lead to or contribute to a range of chronic health conditions.
- 6.3 The strategy raises a number of health risks such as foetal alcohol spectrum disorders and mental illness, along with highlighting the value of early identification and treatment of alcohol disorders. A comprehensive system of care is required to successfully address the wide spectrum of health harms, however the strategy fails to provide any specific actions or funding in these areas.

6.4 The AHA is calling for the full implementation of the NICE guidelines relating to alcohol dependence, which provide an excellent, evidenced-based guide to effective intervention, treatment and referral systems that involve a wide range of health professionals.<sup>4,5</sup> In particular the AHA would like to see additional support and funding for:

### ***Early diagnosis and treatment of alcohol use disorders***

- 6.5 A wealth of evidence shows that early interventions are both effective and cost effective.<sup>4,5,18,20</sup> An extra £217 million invested in alcohol services – double the current level – would bring about an annual saving of £1.7 billion for the NHS in England.<sup>21</sup>
- 6.6 The NICE Guidance on alcohol use disorders states that primary prevention of alcohol-related harm at primary care level is both effective and cost effective.<sup>4</sup> This should be incentivised through including a measure in the Quality and Outcomes Framework for GPs to record the alcohol intake of their patients and to give brief advice where indicated. For patients who do not respond to simple advice there should be a stepped programme of further intervention.
- 6.7 Cost effective treatment interventions for alcohol dependence have been described in NICE guidelines<sup>5</sup> but are currently available only to a small proportion of those who could benefit from it. This will require sustained investment in specialist alcohol services to achieve parity for services for drug misusers.

### ***Secondary care services***

- 6.8 Healthcare modelling methodology suggests that if each district general hospital established a 7 day Alcohol Specialist Nurse Service to care for patients admitted for less than one day and an Assertive Outreach Alcohol Service to care for frequent hospital attendees and long-stay patients, it could result in a 5% reduction in alcohol-related hospital admissions, with potential cost savings to its locality of £1.6 million per annum. This would equate to savings of £393 million per annum if rolled out nationally.<sup>18</sup>
- 6.9 The AHA recommends that there should be a multidisciplinary 'Alcohol Care Team', a 7 day Alcohol Specialist Nurse Service and an 'Assertive Outreach Alcohol Service' in every District Hospital. Transitions between teams and services should be quick and seamless in order to increase the efficiency and cost effectiveness of the service.<sup>18</sup>

## **7. The changing public health system**

- 7.1 The AHA believes there is potential to work more closely with local authorities to drive change and innovation, and deliver services targeted to the needs of local communities. However, with the changes to the public health system come risks that must be mitigated. These include: unjustifiable variation, piecemeal and fragmented service provision, an absence of quality evaluation metrics, and a lack of information sharing and best practice. The AHA are keen to work with central and local government to identify mechanisms that deliver on the localism agenda, whilst protecting the need for coordinated, integrated and evidence-based policy-making and service delivery.
- 7.2 A national service framework on alcohol, which could be adapted to local needs, would be an effective way of keeping costs down, sharing best practice and getting the best value for money. A framework could be led by a dedicated alcohol team within Public Health England, with established experts leading the research work at the highest level, setting out principles for action, rather than prescriptive plans. This allows for local areas to develop plans to meet local needs with the backing of expertise and knowledge provided by PHE.
- 7.3 Leaving it to each individual council to decide on priorities may result in some choosing to ignore alcohol harm, even where significant problems exist. There must be robust measures for holding local authorities accountable for these decisions. The AHA recommends that an expert, influential and independent Director of Public Health – supported by robust data analysis and outcome monitoring systems – will be essential.
- 7.4 Likewise, the NHS Commissioning Board should provide local commissioning groups with guidance on the best practice for commissioning comprehensive alcohol treatment services, based on the NICE guidance and the forthcoming quality standard on alcohol dependence. They must hold clinical commissioning groups to account on their performance against a set of indicators relating to alcohol treatment services, linking to the shared mortality improvement area to reduce the under 75 mortality rate for liver disease in the NHS Outcomes Framework.

## 8. Measures to reduce drink driving

- 8.1 The AHA is concerned that there is no mention of measures to reduce drink driving in the strategy. Despite a substantial decline in levels of drinking and driving in Great Britain since the 1980s, drivers drinking alcohol still kill and injure scores of people each year. In 2009 there were 11,990 reported casualties involving drivers over the legal limit (5% of all road casualties) and an estimated 380 people killed in drink drive accidents (17% of all road fatalities).<sup>22</sup>
- 8.2 The AHA fully supports the recommendations of the 2010 North Review into the Drink and Drug Driving law. In particular, the AHA calls for the present drink drive blood alcohol content limit to be lowered from 80mg% to 50mg%, and giving police unrestricted power to require anyone driving a vehicle on the public highway to give a preliminary breath test.<sup>23</sup>

## 9. Coordination of alcohol policy

- 9.1 Policies relating to alcohol fall under a broad range of governmental departments, including the Home Office, the Department of Health, the Treasury, the departments of Culture, Media and Sport and Transport and Communities and Local Government and the Ministry of Justice. There is therefore a particularly strong case for a cross-departmental unit on alcohol, and the AHA suggests that such a unit could be led by the Chief Medical Officer – reporting to the Home Affairs (Public Health) Cabinet Sub-committee. A cross governmental alcohol unit could maximise the impact of the different strands of the government's strategy and ensure there is rigorous evaluation applied to all aspects of the strategy.
- 9.2 A cross governmental alcohol unit would also be well placed to coordinate policy with the devolved administrations. Greater consistency around policies relating to the price, availability and promotion of alcohol will be important in ensuring success across the UK. In particular, efforts to introduce a minimum unit price on alcohol are already well underway in Scotland and under discussion in Northern Ireland – therefore it is important that the timeframes for introducing a minimum unit price in England and Wales aligns as closely as possible with the devolved administrations.

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## Written evidence from The Portman Group (GAS 54)

1. The Portman Group is the responsibility body for UK drinks producers. We regulate the promotion and packaging of alcoholic drinks sold or marketed in the UK; challenge and encourage the industry to market its products responsibly; and lead on best practice in corporate alcohol social responsibility.

### EXECUTIVE SUMMARY

2. The vast majority of adults in the UK enjoy sociable drinking, with 78% drinking within Government guidelines.<sup>152</sup> Patterns of consumption are improving.
3. The Alcohol Strategy (the Strategy) recognises the value of effective self-regulation of alcohol marketing and the Portman Group's leadership role alongside Ofcom and the Advertising Standards Authority.
4. Drinks producers are effective, committed partners in tackling alcohol misuse and creating a responsible drinking culture. Profit and social responsibility are not mutually exclusive. The industry's sustainable future is linked to playing its part in reducing harms, alongside other stakeholders, such as parents and employers.
5. The Public Health Responsibility Deal (RD) works – partnership working has delivered unprecedented voluntary commitments since launch.
6. Industry-led innovation has resulted in fast, collective solutions to reducing harms: local partnerships combatting anti-social behaviour and underage purchasing; raising awareness of sensible drinking guidelines; and a wider range and availability of lower-alcohol drinks (resulting in a market reduction of 1 billion units).
7. Government policy should build on the RD partnership and be evidence-based. It must target the minority misusing alcohol and not penalise the majority drinking responsibly. Policy should not overburden responsible business partners.
8. We invite the Committee to consider two areas:
  - The need for consistent Government-led alcohol statistics updated regularly, including both consumption patterns and harms.
  - Widespread introduction of effective employee alcohol policies, such as those used by drinks companies.

### ALCOHOL TRENDS IN CONTEXT

9. **Alcohol is commonplace in society** – in 2010, 84% of the working-age population in England drank alcohol.<sup>153</sup>
10. **UK per capita consumption has fallen** from 9.5 to 8.3 litres per head<sup>154</sup> between 2004 and 2011. Consumption in the UK is equal to the European average and lower than many of our European neighbours, including Spain, Ireland and France.<sup>155</sup>
11. **Majority drink within weekly guidelines** - in 2010, 74% of men drank less than 21 units p/w (2005: 69%) and 83% of women drank less than 14 units p/w (2005: 79%).<sup>156</sup>

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<sup>152</sup> Government's Alcohol Strategy 2012

<sup>153</sup> Office for National Statistics, General Lifestyle Survey Overview 2010, Published 8 March 2012

<sup>154</sup> HM Customs and Excise & British Beer & Pub Association, New figures show UK alcohol consumption down again in 2011, 11 March 2012.

<sup>155</sup> OECD Health Data ,2010; WHO, 2010

<sup>156</sup> Ibid., Table 2.2

12. **Drinking at harmful levels falling** – in 2010, 6% of men drank more than 50 units p/w (2005: 9%) with the equivalent for women down to 3% from 5%).<sup>157</sup>
13. **Binge drinking down** – in 2010, 19% of men drank more than 8 units on their heaviest drinking day (2005: 23%) and 13% of women drank over 6 units (down from 15% in 2005).<sup>158</sup>
14. **Young people binge-drinking at lowest recorded levels** – in 2010, only 17% of 16-24 year old women drank more than 6 units on their highest drinking day (2005: 27%) and 24% of young men drank more than 8 units (2005: 32%).<sup>159</sup>
15. **Fewer 11-15 year olds trying alcohol** – in 2010, 55% had never had an alcoholic drink (2001: 39%) with the percentage reporting past week drinking falling by over half from 26% to 13%.<sup>160</sup>

## ALCOHOL-RELATED HARMS

16. **The number of hospital admissions for which alcohol is the primary diagnosis** stood at just under 195,000 in England in 2009/10, up from 142,000 in 2002/3.<sup>161</sup>
17. There were 8,790 **alcohol-related deaths in the UK** in 2010, whilst doubling since the early 1990s, have remained broadly flat over the last five years.<sup>162</sup>
18. There were just under a million **alcohol-related incidents of violent crime** in 2010, accounting for 50% of all violent crime, with volumes having fallen from 1.6 million in 1995.<sup>163</sup>
19. **Drink-driving fatalities have fallen by 85% since 1979 to** 250 fatalities and 1,230 seriously-injured casualties in 2010.<sup>164</sup>

## DETAILED RESPONSES

### ***A Responsibility within Government***

20. Given the cross-cutting nature of alcohol policy, effective coordination across Government is vital. Policies should be evidence-based and consider the impact upon all sectors of society.

### ***B Co-ordination of alcohol policy across the UK***

21. The UK is a single market, and consistent regulation (e.g. product labelling, marketing, and licensing law) provides clarity for consumers and businesses and prevents discriminatory regulatory burdens harming growth, investment or jobs.
22. However, alcohol misuse is particularly concentrated in a number of local areas, such as Blackpool, Salford, Liverpool, Manchester and North Tyneside, which consistently score in the top 20% of local authorities in England (and significantly above the national average) across a basket of measures of alcohol related harm, such as health, mortality, crime and binge drinking.
23. To counter this and avoid penalising the responsible drinking majority, we advocate a locally targeted partnership approach which involves bringing the weight of national organisations

<sup>157</sup> Ibid, Table 2.2

<sup>158</sup> Ibid, Table 2.4

<sup>159</sup> Ibid, Table 2.4.

<sup>160</sup> NHS Information Centre, *Smoking, Drinking and drug use among young people in England 2010*, 28 July 2011, table 3.3b.

<sup>161</sup> NHS Information Centre, *Statistics on alcohol: England 2011*, table 4.1.

<sup>162</sup> Office for National Statistics, *Alcohol-related deaths in the United Kingdom 2010*, January 2012.

<sup>163</sup> Home Office Statistical Bulletin, *Crime in England and Wales 2009-2010*, July 2010

<sup>164</sup> Department for Transport, *Reported Road Casualties in Great Britain, 2010 Annual Report*

(alcohol producers, retailers, police, NHS, employers etc.) behind effective local schemes (such as Best Bar None, Purple flag, Pubwatch, and Community Alcohol Partnerships) in a co-ordinated way.

### ***C Industry involvement – alcohol-related health problems***

24. The Alcohol Strategy recognises the need for effective self-regulation and the Portman Group's role in achieving this.
25. The Responsibility Deal is the right approach. It enables industry to deliver practical measures quickly to effect positive behaviour change. It encourages local partnerships to reduce anti-social activity and uses innovative consumer marketing and education programmes (eg the industry-funded Drinkaware) to communicate the Government's sensible drinking guidelines and promote responsible behaviour.
26. In the UK, alcohol marketing is subject to strict controls ensuring that alcohol promotion is socially responsible and targeted only at 18 and overs.
27. Three regulatory bodies control standards of alcohol marketing; the Portman Group, the Advertising Standards Authority (ASA) and Ofcom, ensuring there are no regulatory gaps (see Appendix A).
28. The Portman Group Code (the Code) – introduced in 1996 - covers the responsible naming, packaging and promotion of alcohol. It prohibits associations with social/sexual success or harmful or irresponsible consumption.
29. An alleged breach of the Code is referred to an Independent Complaints Panel. Where complaints are upheld, licensed retailers are instructed not to stock the product. The Code is commended to licensed retailers under the Licensing Act (see para 38). A press release reporting the breach can inflict reputational damage on producers. Since 1996, over 80 products have been removed from the market.
30. Our aim is to prevent irresponsible products or promotions coming to market. Our free pre-launch Code Advisory Service received over 500 requests for advice in 2011. We also offer a comprehensive industry Code training programme.
31. We conduct third party audits; watch for problematic products/promotions; and monitor the Trade Marks Registry for new alcoholic products. Many producers have their own internal marketing codes which go over-and-above the minimum required by our Code.
32. The Code must reflect changing environments and marketing practices, so regular reviews have taken place. These ensure there is balance between protecting children and legitimately marketing products to adults.
33. Our RD pledge to review the Code is already underway. We are in the consultation phase and will develop a new edition of the Code during the summer and expect to launch it in autumn 2012.

### ***D Minimum Unit Pricing (MUP)***

34. The Portman Group does not wish to comment on MUP. Our focus is on reducing harm by enforcing effective self-regulation through our Code of practice and the collective leadership actions of our member companies.

### ***E Effects of marketing on alcohol consumption.***

35. The UK has some of the most effective self-regulatory codes to ensure alcohol is marketed responsibly and not to children.

36. The Secretary of State's Guidance on the Licensing Act commends the Portman Group Code:

*"The Code is an important weapon in protecting children from harm because it addresses the naming, marketing and promotion of alcohol products sold in licensed premises in a manner which may appeal to or attract minors. The Secretary of State commends the Code to licensing authorities and recommends that they should commend it in their statements of licensing policy."*

37. Critics believe alcohol marketing encourages people, particularly under 18s, to start drinking earlier or to drink more<sup>165</sup>. However, official statistics show fewer young people (16-24) and children (11-15) are drinking (see paras 14, 15 above).

38. The influence of marketing on alcohol consumption is subject to various studies. Whilst there is longitudinal research showing a modest relationship between marketing exposure and drinking among young people; the strength of association varies between studies.<sup>166</sup>

39. The lack of evidence is recognised in the Strategy:

*"So far we have not seen evidence demonstrating that a ban is a proportionate response but we are determined to minimise the harmful effects of alcohol advertising."*

40. Furthermore, the marketing impact on young peoples' drinking behaviours is likely to be outweighed by other factors (such as family environment, peer behaviour, socioeconomic status, and personal attitudes).<sup>167 168 169</sup>

41. The Strategy has asked us to look at other ways to tighten self-regulation around retail, sponsorship and marketing. These are being addressed in our Code review.<sup>170</sup>

42. The Strategy has also given a clear mandate to ASA and Portman Group to review any advertising rules which currently inhibit the promotion of lower strength alcohol products; this is being addressed by our Code review.

43. Whilst regulating social media is new territory for many, digital alcohol marketing has been subject to our Code rules since 2003.<sup>171</sup> The Portman Group led on introducing comprehensive digital guidelines for the industry in 2009. These are recognised as best practice and we share our experience with our European counterparts.

## ***F Impact of current level of alcohol consumption***

44. We have some concern about the consistent use of alcohol trend data and invite the Committee to consider a call for Government-led statistics which are updated regularly.

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<sup>165</sup> [www.ias.org.uk/resources/factsheets/advertising.pdf](http://www.ias.org.uk/resources/factsheets/advertising.pdf)

<sup>166</sup> Anderson, P., de Bruijn, A., Angus, K., Gordon, R., & Hastings, G. (2009). Impact of alcohol advertising and media exposure on adolescent alcohol use: A systematic review of longitudinal studies. *Alcohol and Alcoholism*, 44, 229–243.

<sup>167</sup> Epstein, J. A., Griffin, K. W., & Botvin, G. J. (2008). A social influence model of alcohol use for inner-city adolescents: Family drinking, perceived drinking norms, and perceived social benefits of drinking. *Journal of Studies on Alcohol and Drugs*, 69, 397–405.

<sup>168</sup> Scholte, R. H. J., Poelen, E. A., Willemsen, G., Boomsma, D. I., & Engels, R. C. (2008). Relative risks of adolescent and young adult alcohol use: The role of drinking fathers, mothers, siblings, and friends. *Addictive Behaviors*, 33, 1–14.

<sup>169</sup> Fisher, L. B., Miles, I. W., Austin, S. B., Camargo, C. A., & Colditz, G. A. (2007). Predictors of initiation of alcohol use among U.S. adolescents: Findings from a prospective cohort study. *Archives of Pediatrics & Adolescent Medicine*, 161, 959–966.

<sup>170</sup> <http://www.portmangroup.org.uk/?pid=1003&level=1>

<sup>171</sup> The ASA extended its remit to regulate the majority of online marketing in March 2011. Any alcohol marketing not within ASA remit is covered under our Code.

45. For example, the Strategy reported that the number of hospital admissions in which alcohol related health conditions were present, but not necessarily the primary diagnosis, stood at 1.2m in 2010/11 having more than doubled since 2002/3.
46. However DH announced a consultation in 2012 having previously expressed the view that the calculation used was inadequate as a public health indicator,<sup>172</sup> preferring a focus instead on primary diagnosis alone (for which admission levels are significantly lower at just under 200,000).
47. External commentators are also commenting on the shortcomings of alcohol trend data *Straight Statistics*.<sup>173</sup>

### **G Impact on future patterns of NHS services**

48. Not within PG remit.

### **H Proposed reforms of the NHS**

49. Not within PG remit.

### **I International evidence of the most effective interventions**

50. The UK is at European average for alcohol consumption per adult. However, it is drinking patterns not population-wide consumption that determine harms and these derive from differing cultural, societal and familial norms. Effective interventions may not transfer from one country to another and need to be evidence based in the country where they are applied (See also section M).

### **J Education and information**

51. We recognise that education, changing social norms and law enforcement are essential to change behaviour.
52. It is important to provide information and education programmes to help people make sensible choices about their drinking. In recent years, numerous awareness campaigns have been run by Government and the Drinkaware Trust. Evidence suggests that more people understand units and the Governments recommended drinking guidelines.<sup>174</sup>
53. More work is needed to help consumers understand how many units are in their drinks and the health impacts of drinking above the guidelines.
54. Drinks producers have committed to feature clear unit content, NHS guidelines and a warning about drinking when pregnant on over 80% of products on shelf by December 2013.<sup>175</sup>

### **K Reducing the strength of alcoholic beverages**

55. As part of the RD, the alcohol sector has launched a new pledge to introduce a wider range of lower-alcohol products.

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<sup>172</sup> DH: Improving outcomes and supporting transparency Part 2: Summary technical specifications of public health indicators, January 2012

[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_132558.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132558.pdf)

<sup>173</sup> Nigel Hawkes, Straight Statistics – ‘Alcohol admissions set to tumble’ <http://www.straightstatistics.org/article/alcohol-related-hospital-admissions-set-tumble>

<sup>174</sup> Summary from Office for National Statistics (ONS) General Lifestyle Survey 2010, published March 2012 and Office for National Statistics (ONS), *Omnibus Survey Report: Drinking Adults’ Behaviour and Knowledge in 2009*, 2010.

<sup>175</sup> www.RDA etc

56. This is an innovative initiative to grow a new lower-alcohol market, providing more consumer choice, helping to reduce the amount of pure alcohol they consume without affecting the number of drinks purchased. It will also remove 1 billion units of alcohol from the drinks market without penalising the responsible majority.
57. For example, a consumer who usually drinks a product at 5% ABV and substitutes it for a 4% ABV product will consume 20% less alcohol, if purchasing the same number of drinks. Evidence from other areas of behavioural science suggests they are unlikely to increase volume consumption.

### ***L Raising the legal drinking***

58. Not within PG remit.
59. However, it is unlikely that there would be strong support for raising the legal purchasing age and we believe it would be harmful if under 21s were to seek alcohol from illicit or harmful sources.
60. If we want to create a healthier drinking culture, where alcohol is respected it should not be turned into a social taboo.
61. At 18, people are old enough to vote, drive and fight for their country and they should be trusted to drink alcohol.
62. Preventing underage sales is more effective. Industry innovations (e.g. age verification through Challenge 21, Challenge 25, and local partnerships such as Community Alcohol Partnerships and Best Bar None) have important roles to play.
63. Alongside this, there must be rigorous enforcement of existing laws to prevent underage sales and selling to those who are intoxicated.

### ***M Plain packaging and marketing bans***

64. We note that plain packaging is not in the Strategy but is a policy being considered for tobacco products. Alcohol and tobacco are fundamentally different products.
65. Banning marketing risks commoditising alcohol to the point that it can only be marketed primarily on price or % ABV strength rather than brand position.
66. Much attention has been paid to the *Loi Evin*, which significantly restricts alcohol marketing and sponsorship in France. The Government's official evaluation report<sup>176</sup> in 1999 stated that the *Loi Evin* had been 'ineffective' in reducing high-risk drinking patterns. The French anti-alcohol NGO ANPAA accepts that the effects of the law are 'weak'.
67. The UK Government's partnership with industry enables it to lead Europe in responsibility measures such as voluntary labelling and innovating lower-alcohol drinks.

### **Declaration of Interest**

68. We are a not-for-profit organisation funded by nine member companies<sup>177</sup> who represent every sector of drinks production and collectively account for more than half the UK alcohol market.

May 2012

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<sup>176</sup> La loi relative à la lutte contre le tabagisme et l'alcoolisme: Rapport d'évaluation, Octobre 1999.

<http://www.ladocumentationfrancaise.fr/var/storage/rapports-publics/004000708/0000.pdf>

<sup>177</sup> Current member companies are: AB InBev; Bacardi Brown-Forman Brands; Beverage Brands; Carlsberg; C&C Group; Diageo; Heineken; Molson Coors; and Pernod Ricard.

**APPENDIX A**

**ALCOHOL MARKETING REGULATION TABLE**

Regulator	Ofcom	Advertising Standards Authority	Portman Group
Remit	Television programme sponsorship  (Also broadcast editorial standards)	All advertising, eg: <ul style="list-style-type: none"> <li>• television</li> <li>• radio</li> <li>• press</li> <li>• poster</li> <li>• cinema</li> <li>• direct mail</li> <li>• internet</li> <li>• mobile phones (SMS and Bluetooth)</li> </ul>	All other alcohol producer marketing activities, eg: <ul style="list-style-type: none"> <li>• naming</li> <li>• packaging</li> <li>• sponsorship (excluding TV programme sponsorship)</li> <li>• sampling</li> <li>• press releases</li> <li>• producer-generated point-of-sale materials</li> <li>• brand websites (except those areas covered by the ASA)</li> </ul>
Nature of system	Statutory	Co-regulatory (broadcast)  Self-regulatory (non-broadcast)	Self-regulatory (but consistent with and complementary to the entire co-regulatory system)
Rules written by	Ofcom	BCAP, but approved by Ofcom (broadcast)  CAP (non-broadcast)	Portman Group
Adjudicating body	Ofcom	Independent ASA Council chaired by the Rt Hon Lord Smith of Finsbury	Independent Complaints Panel chaired by Sir Richard Tilt
Funded by	Government	Advertising industry	Drinks producers

## Supplementary written evidence from The Portman Group (GAS 54A)

### Regional Data – Q156

Whilst it is encouraging that the overall national context around drinking patterns and harms is showing improvement across many indicators, some local areas have disproportionately high alcohol-related harms, with a particular concentration in the North West and North East. For example, data on the North West regional Health authority website<sup>178</sup> shows:

- Rates of alcohol specific mortality and liver disease in Blackpool are nearly 3 times the national average
- Alcohol specific hospital admissions in Liverpool are nearly 2.5 times the National average
- Binge drinking in North Tyneside, and indeed much of the North East, is 1.5 times the national average

The alcohol industry has developed a number of schemes to support local areas in promoting responsible drinking and combatting alcohol related harms, details of which can be found below.

The Portman Group will be working with local partners and the alcohol industry over the next year to ensure these, and similar schemes, are appropriately targeted where they would be of most benefit to effectively meet pressing local needs.

### Best Bar None

Best Bar None is a national award scheme supported by the Home Office and aimed at promoting responsible management and operation of alcohol licensed premises. It was piloted in Manchester in 2003 and found to improve standards in the night time economy, with premises now competing to participate. It has since been adopted by 100 towns and cities across the UK and is now being taken up internationally.

The aim of BBN is to reduce alcohol related crime and disorder in a town centre by building a positive relationship between the licensed trade, police and local authorities.

It reduces the harmful effects of binge drinking as well as improves the knowledge and skills of enforcement and regulation agencies, licensees and bar staff to help them responsibly manage licensed premises.

The process of becoming recognised by BBN includes meeting minimum standards and culminates with a high profile award night with category winners and an overall winner.

Responsible operators are recognised and able to share good practice with others. A scheme can also highlight how operating more responsibly can improve the profitability of an individual business and attractiveness of a general area.

The following areas currently operate the scheme:

#### *England & Wales*

- Altrincham
- Aylesbury Vale
- Barnsley
- Bedford
- Birmingham
- Bishop Auckland
- Bournemouth
- Bradford
- Brent
- Bromley
- Calderdale
- Camden
- Leeds
- Leicester
- Lincoln
- Luton
- Manchester
- Middlesbrough
- Nationwide – NUSSL
- Newcastle City Centre
- Newcastle under Lyme
- Newport, South Wales
- Northamptonshire
- North Lincolnshire

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<sup>178</sup> (<http://www.lape.org.uk/data.html>)

- Carlisle & Eden
- Ceredigion – covering Aberystwyth, Cardigan, Lampeter, Aberaeron, Llandysul, Tregaron
- Cheltenham
- Chester-le-Street
- City of York & Selby District
- Consett
- Conwy and Denbighshire
- Cornwall
- Croydon
- Darlington
- Derby City Centre
- Doncaster
- Durham City Centre
- Ealing
- East Lindsey
- East Riding including Bridlington, Beverley, Driffield, Hornsea, Coltingham, Hessle, Goole, Howden & Pocklington
- Filey
- High Wycombe
- Hull
- Ipswich
- Isle of Wight
- Islington
- Jersey
- Kensington & Chelsea
- Kingston upon Thames
- Kingston upon Hull
- Kirklees
- Norwich
- Nottingham
- Oldham
- Peterhead
- Plymouth
- Poole
- Portsmouth
- Reading
- Redbridge
- Rochdale
- Rhondda Cynon Taff
- Sefton
- Scarborough
- Sheffield
- Shropshire
- Solihull
- Southampton
- Stafford
- Stockport
- Sunderland
- Sutton
- Swindon
- Thames Valley Area – covering Newbury
- Wakefield
- Walsall
- Watford
- Whitby
- Wigan
- Woking

#### *Scotland*

- Aberdeen City Centre
- Aberdeenshire – covering Fraserburgh, Peterhead, Inverurie
- Angus – covering Forfar, Kirriemuir, Brechin, Montrose and Monifeith
- Central – covering Falkirk Town centre and Stirling City Centre
- East Lothian – covering Musselburgh
- Mid Lothian – covering Dalkeith and Aberlady
- Fife – covering Kircaldy, Dunfermline, Glenrothes, Leven, Cupar, Cowdenbeath and St Andrews
- Northern – covering Inverness City Centre
- Strathclyde – covering Glasgow City Centre
- Tayside – covering Dundee City Centre and Perth City Centre
- West Lothian – covering Livingston, Bathgate, Linlithgow, East Calder, Whitburn, Fauldhouse, Newton village, Broxburn, Seafeld, Uphall and Armadale
- Scottish Borders – covering Galashiels Town centre

#### **Community Alcohol Partnerships (CAPs)**

Launched in 2007, Community Alcohol Partnerships were originally developed by the Retail of Alcohol Standards Group in an effort to tackle underage drinking and is now a standalone Community Interest Company.

Community Alcohol Partnerships are developed within individual communities to tackle underage drinking and related antisocial behaviour. CAPs are tailored to suit local needs and, depending on the nature and extent of the problem, different methods of best practice will be adopted in order to best tackle the issue. The range of measures that could be adopted includes:

### **Enforcement**

- Joint Police & Trading Standards activity
- Visible Trading Standards and Police coordinated operations in hot spot areas

### **Education**

- Retailers, Police and the Local Authority communicate agreed messages
- Handouts developed for school and in store use
- Local schools, sixth form colleges and youth clubs engaged
- Engagement with parents as well as young people
- Health Authority involvement

### **Partnership Working**

- Early intelligence sharing
- Training for independent retailers
- Buddying systems
- Co-ordinated signage and leaflets
- Regular meetings

Community Alcohol Partnerships is funded with contributions from the some of the UKs largest drinks producers as well as large and small retailers

The following areas currently have CAPs up and running:

- Bath (Midsomer Norton)
- Berkshire (Caversham)
- Cambridge (St Neots, South Cambs, Ely & Soham, Wisbech)
- Devon (Tiverton, Crediton, Cullompton)
- Durham (Stanley)
- Hampshire – (Gosport, Havant & Gosport)
- Islington
- Kent (Edenbridge, Maidstone, Whitstable, Margate, Cliftonville, Canterbury, Thanet, Swanley)
- Norfolk (Great Yarmouth)
- Powys (Brecon)
- Reading (Tilehurst, Caversham)
- Shropshire (Ludlow, Oswestry)
- South Yorkshire (Barnsley – Dearne, Peniston, Grimethorpe, Kendray&Worsbrough)
- Sussex East (Hastings)
- Scotland (Rosyth)
- Northern Ireland (Derry/Londonderry)

### **Purple Flag**

Purple Flag has been designed as an objective assessment that will help improve town or city centres at night. Most significantly it is designed to provide recognition that areas are managing their night time experience, and thus help overcome any negative public perceptions that may exist. Purple Flag provides the opportunity for successful centres to present themselves in their true colours and in a positive light to town centre users, including operators, residents, tourists and visitors.

Purple Flag aims to raise the standard and broaden the appeal of centres between 1700 and 0600. The scheme is managed by the ATCM working alongside the Purple Flag Advisory Committee – a partnership of key stakeholder groups, including central and local government, police, business and consumers.

Areas that reach or surpass Purple Flag standards can fly the flag! Benefits include:

- A raised profile and an improved public image
- Increased visitors
- Increased expenditure
- Lower crime and anti-social behaviour
- A more successful mixed-use economy

Purple Flag has been developed by ATCM from original research undertaken by the Civic Trust as part of the "NightVision" project. This showed that:

- More people would use centres at night if they were safer, more accessible and offered more choice
- A good mix of clientele can lessen intimidation and improve perceptions
- A wider range of attractions and consumers leads to longer term economic viability

The following places have all achieved the purple flag standards:

AYLESBURY	HIGH WYCOMBE
BANGOR	KINGSTON UPON THAMES
BATH	LEICESTER SQUARE, WESTMINSTER
BELFAST	LIVERPOOL
BIRMINGHAM	MANCHESTER
BOURNEMOUTH	NOTTINGHAM
BRISTOL	OXFORD
CANTERBURY	PRESTON
CLERKENWELL, ISLINGTON, LONDON	STOCKTON HEATH – WARRINGTON
COVENT GARDEN, WESTMINSTER	TORQUAY
DERRY – LONDONDERRY	VICTORIA – WESTMINSTER
ENNISKILLEN	WINCHESTER
HALIFAX	

### **Pubwatch**

Pubwatch is a scheme set up and run by licensees to reduce crime and disorder in pubs and clubs. Supported by the police, it is a national initiative, which is proved to reduce violence and other types of criminal acts such as drug dealing and vandalism.

The scheme works by creating links between licensees, allowing information – such as the identity of troublemakers – to be passed quickly between each other and police. It also provides a forum where licensees can share problems and solutions.

There are a number of advantages for licensees joining the scheme, including:

- membership of Pubwatch deters troublemakers
- a reduced risk of licensees, staff and customers being assaulted or abused
- less damage caused to property and smaller repair bills
- it is good for trade – Pubwatch helps create a pleasant environment to work and socialise in.

There are also advantages for the police, such as:

- officers know more about potential troublemakers and get better quality information which they can act upon
- by receiving more precise details in calls for assistance, police can make the best response
- violence in and around licensed premises reduce
- improving the working relationship between police and the licensed trade.

Nationally, police statistics show a significant decrease in violent offenders in those pubs where the scheme operates. The rapid growth of Pubwatch shows the scheme is valued by both the licensed trade and police. A detailed map of Pubwatch areas can be found on the National Pubwatch website.<sup>179</sup>

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<sup>179</sup> <http://www.nationalpubwatch.org.uk/NPWWmapping/>

## Written evidence from Alcohol Concern (GAS 62)

### 1. Summary:

- Drinking alcohol is a freedom that many enjoy, however this must be balanced with the need to avoid harm and improve health. Pricing is one of the most effective measures to address excessive consumption and alcohol-related harms.
- A minimum unit price (MUP) of at least 50p would result in lower consumption levels and a significant reduction in alcohol-related harms, whilst ensuring that alcohol remains affordable for moderate drinkers.
- In addition to price increases, the most effective strategies to reduce alcohol-related harm, include restrictions on the physical availability of alcohol, brief interventions with at-risk drinkers and treatment of drinkers with alcohol dependence.
- Children and young people are especially vulnerable to the effects of alcohol marketing. Consequently, such marketing should be firmly regulated and restricted to adult only audiences.
- Current health spending priorities need to be rebalanced, with much greater expenditure in areas such as alcohol treatment and advice services.
- Central guidance and support for the development of cohesive and comprehensive services to tackle alcohol problems should be provided via a specialist team within Public Health England

### 2. Alcohol consumption and public health

- 2.1 There is overwhelming scientific evidence that excessive consumption significantly increases risk to long-term health. Alcohol is a factor in more than 40 serious medical conditions, including liver disease and mouth, food pipe, bowel and breast cancer,<sup>180</sup> and one of the major preventable causes of death in England and Wales. Liver disease, in particular, to which alcohol is the key contributor, is the only major cause of death still increasing year-on-year.<sup>181</sup> UK deaths from liver cirrhosis increased more than five-fold between 1970 and 2006.<sup>182</sup> In contrast, in France, Italy and Spain, the number of deaths decreased by at least 50% and are now lower than those in the UK.<sup>183</sup>
- 2.2 As the Government's alcohol strategy acknowledges, alcohol misuse also places a huge burden on the NHS. It is estimated to cost the NHS £2.7 billion every year. The number of hospital admissions due to alcohol misuse was 1.1 million in 2009/10, a 100% increase since 2002/03.<sup>184</sup> If the rise continues unchecked, by the end of the current Parliament 1.5 million will be admitted to hospital every year as a result of drinking.<sup>185</sup>

### 3. Minimum unit price

- 3.1 Alcohol Concern has been campaigning for a MUP for a number of years, and we are strongly welcome the Government's decision to commit to this measure.
- 3.2 A culture of alcohol overuse has developed. Recent qualitative research conducted on behalf of Alcohol Concern, found that heavy drinking is typically regarded by drinkers as an essential part of 'a good night out', with drunkenness seen by some as not only acceptable, but as something to look forward to, even though it often led to regrettable incidents.<sup>186</sup> It is clear that changes to our drinking behaviour are needed, and an increasing body of evidence shows that the affordability of alcohol is a key driver in achieving this.<sup>187</sup>

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<sup>180</sup> Cancer Research UK (2008) *Alcohol and cancer*, online, available from <http://www.cancerresearch.org.uk> [Accessed 23/02/10].

<sup>181</sup> Office for National Statistics (2008) *Health statistics quarterly*, Winter 2008, No.40, Newport, ONS.

<sup>182</sup> House of Commons Health Select Committee (2010) *Alcohol: First report of session 2009-10*, Volume 1, London, The Stationary Office.

<sup>183</sup> *ibid.*

<sup>184</sup> North West Public Health Observatory (2009) *Alcohol-Related Hospital Admissions*, North West Public Health Observatory and Centre for Public Health.

<sup>185</sup> Department of Health (2010) *Alcohol Ready Reckoner V.5.1*, London, Department of Health.

<sup>186</sup> Alcohol Concern (2010) *A drinking nation? Wales and alcohol*, London, Alcohol Concern.

<sup>187</sup> Bailey, J. et al. (2011) *Achieving Positive Change in the Drinking Culture of Wales*, Glyndwr University Wrexham and Bangor University, London, Alcohol Concern.

- 3.3 A meta-analysis of the effects of alcohol prices and taxes on drinking, by Wagenaar et al, concluded that “price affects drinking of all types of beverages, and across the population of drinkers from light drinkers to heavy drinkers. We know of no other preventative intervention to reduce drinking that has the numbers of studies and consistency of effects seen in the literature on alcohol taxes and prices”.<sup>188</sup>
- 3.4 There have been limited examples of minimum pricing policies which have been undertaken. A locally imposed minimum pricing restriction in Australia resulted in a 19.4% reduction in alcohol consumption, fewer hospital admissions for alcohol-related illnesses and fewer arrests.<sup>189</sup> A recent study of MUP in British Columbia, Canada, which has been in place for 20 years, found that a 10% increase in minimum prices reduced consumption of spirits and liqueurs by 6.8%, wine by 8.9%, alcoholic sodas and ciders by 13.9%, beer by 1.5%, and all alcoholic drinks by 3.4%.<sup>190</sup>
- 3.5 As part of a Sheffield University study in 2009, the potential effects of different minimum pricing levels were examined.<sup>191</sup> The study found that the more intensive the pricing policy, the greater the harm reduction. Low minimum prices were found to have little impact, but the effectiveness accelerates rapidly from a MUP of 40p up to 70p. A MUP of 40p would result in a reduction in consumption of 2.7%, 3,600 fewer hospital admissions and 1,100 fewer crimes per year. A MUP of 50p would see a 7.2% reduction in consumption, 8,900 fewer hospital admissions and 4,200 less crimes per year. This impact would be even greater if the policy is combined with an off-licence discount ban.
- 3.6 Using the same data sources as the Sheffield study, which indicate that 80% of alcohol is consumed by 30% of the population and that the bottom 30% consumes only 2% of alcohol, it has been shown that, based on a 50p MUP, the bottom 30% of consumers would spend 10p per week more on alcohol, the middle 40% £1.09 and the top 30% £4.16 (if consumption remained the same).<sup>192</sup> Alcohol Concern advocates at least 50p MUP, which would result in a significant reduction in alcohol-related harms whilst ensuring that alcohol remains affordable for moderate drinkers.
- 3.7 An effect of a MUP might also be to encourage alcohol producers to reduce the alcoholic content of their products.<sup>193</sup> Wine usually has an alcohol content of 12%, meaning that a standard bottle contains 9 units of alcohol. A bottle selling at a price for 3 bottles for £10 would cost £3.33 and a MUP of 50p would increase this to £4.50; however, by reducing the alcohol content to 9%, the price could still be £3.38, thus facilitating a reduction in alcohol content.

#### 4. The effectiveness of other interventions

- 4.1 According to a recent review,<sup>194</sup> the most effective strategies to reduce alcohol-related harm from a public health perspective include, in rank order, price increases, restrictions on the physical availability of alcohol, drink-driving counter measures, brief interventions with at-risk drinkers, and treatment of drinkers with alcohol dependence. Another review concludes that regulatory approaches (including those that manage price, availability and marketing of

<sup>188</sup> Wagenaar, A. C., Salois, M. J. and Komro, K. A. (2008) *Effects of beverage alcohol price and tax levels on drinking: A meta-analysis of 1003 estimates from 112 studies*, p187, Presented at the 34<sup>th</sup> Annual Alcohol Epidemiology Symposium of the Kettil Bruun Society for Social and Epidemiological Research on Alcohol, Vicotir, British Columbia, June 2-6, 2008.

<sup>189</sup> Gray, D. et al. (2000) *Beating the grog: An evaluation of the Tennant Creek liquor licensing restrictions*, Australian and New Zealand Journal of Public Health, 24(1), pp39-44.

<sup>190</sup> Stockwell, T. et al. (2012) *Does minimum pricing reduce alcohol consumption? The experience of a Canadian province*, Addiction, online, available from <http://onlinelibrary.wiley.com/doi/10.1111/j.1360-0443.2011.03763.x/full> [Accessed 04/04/2012].

<sup>191</sup> School of Health and Related Research (2009) *Model-Based Appraisal of Alcohol Minimum Pricing and Off-Licensed Trade Discount Bans in Scotland: An Scottish Adaptation of the Sheffield Alcohol Policy Model version 2*, online, available from <http://www.scotland.gov.uk/Publications/2009/09/24131201/0> [Accessed 04/04/2012].

<sup>192</sup> Record, C. And Day, C. (2009) *Britain's alcohol market: How minimum alcohol prices could stop moderate drinkers subsidising those drinking at hazardous and harmful levels*, Clinical Medicine, 9(5), pp421-425.

<sup>193</sup> *ibid.*

<sup>194</sup> *ibid.*

alcohol) reduce the risk and the experience of alcohol-related harm, whereas educational approaches (including school-based education and public education programs) do not.<sup>195</sup>

- 4.2 Educational programmes and persuasion strategies, typically favoured by the drinks industry, are expensive and compared with other interventions appear to have little long-term effect on alcohol consumption levels and drinking-related problems, especially compared with £800m spent on promoting alcohol through advertising. Studies have shown that although they can increase knowledge and change attitudes, actual alcohol use amongst participants largely remain unaffected.<sup>196</sup> Other researchers argue that, even with adequate resources, strategies which try to use education to prevent alcohol-related harm are unlikely to deliver large or sustained benefits, and that “education alone is too weak a strategy to counteract other forces that pervade the environment”.<sup>197</sup>
- 4.3 Conversely, there is evidence that introducing restrictions on physical availability can have a positive effect in reducing harm. Several international studies have identified a link between outlet density and physical violence. Limiting outlet density within a community may be effective because this may increase the time and convenience that a typical drinker encounters in obtaining alcohol; limiting competition between retailers and thereby reducing the likelihood of cut-price promotions and under-age sales; and avoiding high crowd density that frequently accompanies the bunching of outlets that may exacerbate incidences of violence.<sup>198</sup> We therefore welcome measures in the Government’s Alcohol Strategy to strengthen licensing arrangements.
- 4.4 A combination of law enforcement and sustained publicity campaigns has substantially reduced the number of drink-drive accidents in recent years. Despite this, 17% of all road fatalities in 2009 were a result of drink-driving.<sup>199</sup> It is therefore surprising that there is no mention of specific measures to reduce drink-drive accidents in the new strategy. Alcohol Concern supports the recommendations of Sir Peter North,<sup>200</sup> in particular the need to lower the legal blood alcohol limit to 50mg of alcohol in 100ml of blood, which would bring the country in line with many other European countries, including France, Spain, Germany, Italy and the Netherlands.
- 4.5 Evaluations of the effects of alcohol warning labels on drinks products are limited to the US, which have shown improved awareness of safe drinking, but only slight evidence of any effects in changing actual drinking behaviour.<sup>201</sup> The tobacco labelling experience, however, offers strong evidence that warning labels can be effective in shifting behaviour. According to Ferrence et al,<sup>202</sup> unlike cigarette warnings, alcohol warning labels are often “vague and equivocal” and are not presented “in a vivid manner that evokes emotional reactions”.
- 4.6 Plain packaging of cigarette products is gathering increasing support, with Australia set to become the first country to enforce this through legislation. To our knowledge, there are no studies of the potential effectiveness of plain packaging for alcohol products, and research in this area would be welcome. Labelling is clearly part of the alcohol marketing mix, illustrated

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<sup>195</sup> Anderson, P. (2009) *Global alcohol policy and the alcohol industry*, Current Opinion in Psychiatry, 22(3), pp253-257.

<sup>196</sup> op. cit. Babor, T. et al. (2010).

<sup>197</sup> op. cit. Bailey, J. et al, p31. (2011)

<sup>198</sup> Alcohol Concern (forthcoming) *Full to the brim? Explaining the relationship between outlet-density and alcohol-related harm*, London, Alcohol Concern.

<sup>199</sup> Department for Transport, online,

<http://webarchive.nationalarchives.gov.uk/20110503151558/http://dft.gov.uk/pgr/statistics/datatablespublications/accidents/casualtiesgbar/rrcgb2009> [Accessed 23/04/2012].

<sup>200</sup> Sir Peter North (2010) *Report of the Review of the Drink and Drug Driving Law*, online, available from <http://webarchive.nationalarchives.gov.uk/20100921035225/http://northreview.independent.gov.uk/docs/NorthReview-Report.pdf> [Accessed 23/04/2012].

<sup>201</sup> Wilkinson, C. and Room, R. (2009) *Warnings on alcohol containers and advertisements: International experience and evidence of effects*, Drug & Alcohol Review, 28(4), pp426-435.

<sup>202</sup> Ferrence R., Hammond D., Fong G.T. Warning labels and packaging, in Bonnie R.J., Stratton K., Wallace R.B., eds.(2007) *Ending the tobacco problem: blueprint for the nation*, Committee on Reducing Tobacco Use: strategies, barriers, and consequences, Washington: National Academy Press, pp435–448.

by a leading drinks company's recent decision to include images of James Bond on packaging as part of its sponsorship deal with the movie franchise.<sup>203</sup>

## 5. Alcohol marketing and the drinks industry

- 5.1 Children and young people are particularly vulnerable to the effects of alcohol marketing, especially those who are already showing signs of alcohol-related problems. Such marketing manipulates this vulnerability by shaping their attitudes, perceptions and expectancies about alcohol, which then influence their decision to drink.<sup>204</sup>
- 5.2 A number of recent studies have shown a clear association between alcohol marketing and youth drinking behaviour, and which conclude that the alcohol industry should not be involved in making alcohol policy.<sup>205 206 207 208</sup> This is a position endorsed by the World Health Organisation, which chooses not collaborate with any of the sectors of the alcohol industry.<sup>209</sup>
- 5.3 Alcohol Concern's own research has highlighted the frequency and volume of exposure by children and young people to alcohol advertising. In the UK over £800 million is spent on alcohol advertising. Over one million children were exposed to alcohol advertising during the televised England games of the World Cup in June 2010.<sup>210</sup> In a study of more than 400 children aged 10 and 11, the number of these able to identify alcohol branding and advertising was found to be comparable to, and in some cases, greater than those who recognised brand and advertising for products known to appeal to and often aimed at children, such as ice cream and cake.<sup>211</sup>
- 5.4 It is therefore disappointing that the Government's new strategy fails to provide firm action to strengthen regulations on alcohol marketing, especially given that many young people feel that current regulations do not provide adequate protection to their peers. A survey of over 2,300 under-18s suggests that people from this age group are highly aware of alcohol promotion and that existing rules are insufficiently robust to protect them from unnecessary exposure. Similarly, Alcohol Concern's Youth Alcohol Advertising Council, a group of 10 under-18s from across the country that meet quarterly to review selected alcohol advertising against key principles of the Advertising Standards Code, have identified what they regard as frequent breaches of compliance with both the wording and spirit of the Code.<sup>212</sup> The group has made a number of complaints about alcohol advertising and very few have been upheld.
- 5.5 It is also concerning to find in the new strategy the wish to encourage "advertising which builds more positive associations (for example, between alcohol and positive socialising) instead of negative ones (for example, between alcohol and wild, disinhibited behaviour)". Current rules rightly prohibit advertising that implies that alcohol can enhance the social success of an individual or event, although a study of the industry's internal marketing documents by Hastings et al<sup>213</sup> concluded that, in practice, this a theme frequently

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<sup>203</sup> Crummy, M. (2012) *James Bond swaps Martini for Heineken*, the drinks business, 3<sup>rd</sup> April 2012, online, available from <http://www.thedrinksbusiness.com/2012/04/james-bond-swaps-martini-for-heineken> [Accessed 05/04/2012].

<sup>204</sup> Anderson, P. (2007) *The impact of alcohol advertising: ELSA project on the evidence to strengthen regulation to protect young people*, Utrecht, National Foundation for Alcohol Prevention.

<sup>205</sup> Jones, S. C et al. (2008) *How effective is the revised regulatory code for alcohol advertising in Australia?*, Drug and Alcohol Review, 27(1), pp29-38.

<sup>206</sup> op. cit Anderson, P. (2009).

<sup>207</sup> Hastings, G. et al. (2010) *Failure of self-regulation of UK alcohol advertising*, BMJ, 340, b5650.

<sup>208</sup> Gordon, R. et al. (2011) *Assessing the cumulative impact of alcohol marketing on young people's drinking: Cross-sectional data findings*, Addiction Research & Theory, 19(1)

<sup>209</sup> World Health Organisation (2007) *WHO Expert Committee on problems related to alcohol consumption*, WHO Technical Report Series (2<sup>nd</sup> report), Geneva, WHO.

<sup>210</sup> Alcohol Concern (2010) *Overexposed: Alcohol marketing during the World Cup 2010*, London, Alcohol Concern.

<sup>211</sup> Alcohol Concern (2012) *Making an impression: Recognition of alcohol brands by primary school children*, London, Alcohol Concern.

<sup>212</sup> Alcohol Concern (2011) *Youth Advertising Standards Advisors: Autumn 2011 Report and Youth Advertising Standards Advisors: Winter 2011 Report*, London, Alcohol Concern.

<sup>213</sup> Hastings et al. (2010) *"They'll drink bucket loads of the stuff": An analysis of internal alcohol industry advertising documents*, Stirling, Institute for Social Marketing, University of Stirling & the Open University, Memorandum to the House of Commons Health Committee Report on Alcohol, Session 2009-10.

incorporated into alcohol advertising. Young people in the UK have by far the most positive expectations of alcohol in Europe and are least likely to feel that it might cause them harm;<sup>214</sup> implying that alcohol is an aid to socialising is unlikely to be helpful in this context.

- 5.6 Alcohol Concern believes the Government should seriously review the role performed by the Advertising Standards Authority and the Portman Group in relation to the regulation of advertising. More should be done to pre-empt advertising. There is also more that can be learned by France who have stricter controls over advertising in place such as the restriction only to advertise 'factual' information (e.g. ABV strength, ingredients, point of origin) rather than emotional or social associations and also their controls over sponsorship of events which appeal to young people.

## **6. Investing in treatment services**

- 6.1 Around half of the £2 billion spent on public health and treatment currently goes on drugs initiatives meanwhile, latest available figures show that local PCTs spend an average of £600k a year on alcohol treatment and counselling services, representing just 0.1% of a typical PCT's yearly spending.<sup>215</sup> Yet nationally 13–20% of all hospital admissions are alcohol-related and this figure is widely considered to be an underestimate, as coding of alcohol-related disorders is 'notoriously inaccurate' and evidence of alcohol-related problems can easily be missed or ignored.<sup>216</sup> There is an urgent need to provide care for a large and growing group of patients with alcohol-related health problems. Presently a lack of coordinated action means that 'care is imperfect and spending is poorly targeted and ineffective', very few hospitals have dedicated alcohol services and only 5.6% of dependent or harmful drinkers access treatment, compared to 67% of dependent or harmful drug users<sup>217</sup>
- 6.2 Historically, there has been a lack of high-level support for alcohol services, which has resulted in a piecemeal approach to planning and development. With 1.6 million people in England experiencing alcohol dependency,<sup>218</sup> support for this group must be made a greater priority than indicated in the strategy.
- 6.3 The Strategy does propose interventions for some specific groups, including offenders and young people who binge drink, but fails to address the significant proportion of the population who, although not dependent, regularly drink at or above published guidelines over a long period of time, which can lead to or contribute to a range of health conditions. We believe that there should be full implementation of the NICE guidelines relating to alcohol treatment, which provide an excellent, evidenced-based guide to effective intervention and referral systems.
- 6.4 Changes to the public health system that are due to take place in 2013 offer real opportunities to develop a more cohesive and cost-effective approach to preventing and treating alcohol problems. However there is also a serious risk that a lack of appropriate expertise and guidance will lead to these opportunities being lost, or to an unacceptable disparity in the level and quality of services across the country. Local authorities and their colleagues in clinical commissioning groups will require support in the form, perhaps, of a national service framework that could be adapted to local needs, backed up by the opportunity to share best practice. Such a framework could be led by a dedicated alcohol team within Public Health England, with established experts setting out, and supporting the implementation of, principles for action, rather than prescriptive plans.
- 6.5 Similarly, the NHS Commissioning Board should provide local commissioning groups with guidance on the best practice for commissioning comprehensive alcohol treatment services, based on the NICE guidance and the forthcoming quality standard on alcohol dependence.

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<sup>214</sup> The European School Survey Project on Alcohol and Other Drugs (ESPAD) (2007) *The 2007 ESPAD Report Substance Use among Students in 35 European Countries*, online, available from: [www.espad.org/documents/Espad/ESPAD\\_reports/2007/The\\_2007\\_ESPAD\\_Report-FULL\\_091006.pdf](http://www.espad.org/documents/Espad/ESPAD_reports/2007/The_2007_ESPAD_Report-FULL_091006.pdf) [accessed 2 June 2011].

<sup>215</sup> National Audit Office (2008) *Reducing Alcohol Harm: Health services in England for alcohol misuse*, London, NAO.

<sup>216</sup> The British Society of Gastroenterology and the Royal Bolton Hospital NHS Foundation Trust, 2011

<sup>217</sup> Department of Health, 2004

They must hold commissioning consortia to account on their performance against a set of indicators relating to alcohol treatment services, linking to the shared mortality improvement area to reduce the under 75 mortality rate for liver disease in the NHS Outcomes Framework.

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