



‘It’s everywhere’ – alcohol’s public face and private harm

The report of the
Commission on Alcohol Harm

'It's everywhere' - alcohol's public face and private harm

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Foreword from Baroness Finlay



Alcohol is celebrated throughout our society and culture. Yet the harm caused by alcohol – physical, mental, economic and social – is everywhere, hidden in plain sight and often endured privately.

Alcohol harm impacts us all - in families, our communities, and throughout society. For too long, the onus has been on individuals, with drinkers urged to “drink responsibly”. We need to finally acknowledge the true scale of the harm caused by alcohol, which goes far beyond individuals who drink, and put the responsibility squarely with the harmful product itself. By doing so we will help to do away with the stigma and shame that surrounds those who are harmed by alcohol and often stops them from accessing the help that they need.

This is not a party-political issue. Governments of both left and right have allowed alcohol harm to rise unabated. The last Labour government brought in 24-hour licensing and froze spirits duty for ten years. The 2010 coalition government planned to introduce minimum unit pricing in England and Wales before dropping the policy and going on to cut duty, causing consumption, and harm, to increase.

The problem has been made more urgent by the COVID-19 pandemic. We did not go into this pandemic fighting fit - already 80 people were dying a day from alcohol-related causes in the UK. The full impact of the pandemic and lockdown upon health will become clear over time. We already know that domestic abuse, which is strongly associated with alcohol, rose significantly during lockdown and immediately afterward. We also know that some of those experiencing alcohol dependence, either their own or that of a

loved one, lost access to the vital services and support networks that they rely on.

For others, the difficulties of living through a pandemic - including bereavement, job insecurity and relationship difficulties - may have tipped their consumption into a more harmful level.

A healthy economy is driven by a healthy population. To be effective, a recovery strategy must include policies to help put an end to alcohol harm. Missing this opportunity would mean we will see the toll of increased alcohol harm for a generation. Like COVID-19, alcohol harm hits the poorest hardest and exacerbates existing health inequalities. Levelling up is a stated priority for the government and we are already seeing bold action on reducing obesity. To improve the nation’s health we need the same commitment to tackling all causes of preventable ill health, including alcohol.

Building on the excellent work of the Lancet Liver Commission led by Professor Roger Williams, who sadly passed away in July 2020, the Commission on Alcohol Harm heard from those with academic, professional and personal experience of alcohol harm. What follows is a snapshot of the myriad harms that alcohol causes in the UK, together with our evidence-based proposals for reform. I hope our recommendations provide a useful road map as we begin to navigate our way to recovery.



“ To the world outside everything was fine, a normal family. To have shared the secret burden that my brother and I carried would have brought shame on the entire family; we were led to believe we would become outcast. ”

Daisy,
Expert by
experience



Executive summary

“ I cannot explain in words the full extent of the impact [alcohol] has had on my life. ”

Expert by experience

The harm caused by alcohol is everywhere in society, though often hidden from view. Some types of harm, such as liver disease, are well-known. Others, like the trauma caused to the children living with an alcohol dependent parent or the sexual assault which is “*the norm*” for ambulance workers, are fully known only to those who experience it. As one individual explained to the Commission: “*my mother was what you might call a secret alcoholic. She never went to the pub or drank publicly, it was all done behind closed doors at home*”.¹

The Alcohol Harm Commission was set up to examine the full extent of harm across the UK: the physical, mental and social harm caused to people around the drinker, to wider society and to the drinker themselves. We considered the effectiveness of current alcohol policy and made recommendations for reducing harm.

It is those whose lives are affected by alcohol every day who best understand its impact and yet their voices are often missing from policy discussions. We set out to give these individuals a platform. Our public call for evidence received over 140 responses. In addition to experts by experience, we heard from hospitals, local councils, UK and devolved government, academics and universities, alcohol treatment providers, the alcohol industry, medical royal

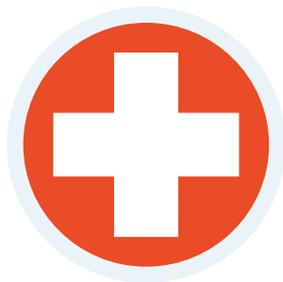
colleges, children’s charities, homelessness organisations, public health experts and older people’s representatives. We have included as many different voices in this report as we could.

Harm to those around the drinker – children, families and others

The Commission received overwhelming evidence about the harm caused to children and family life. We heard about the large numbers of children affected by parental alcohol use: an estimated 308,000 children currently live with at least one adult who drinks at a high risk level in England.² Harmful parental drinking can be linked with neglect and abuse. 39% of children who live with a parent or carer using alcohol problematically had also had domestic violence in their household in the last five years.³ The impact of parental alcohol use on children can be profoundly damaging: children living with an alcohol dependent parent are five times more likely to develop eating disorders, twice as likely to develop alcohol dependence or addiction and three times as likely to consider suicide.⁴ We heard that families affected by alcohol can struggle to access the support that they need.

In the case of foetal alcohol spectrum disorder (FASD), harm occurs even before birth and has lifelong consequences for mental and physical development. FASD is both prevalent and costly. The UK has the fourth highest level of prenatal alcohol consumption in the world⁵ and FASD is estimated to cost the UK £2bn a year.⁶ Despite its prevalence, there is a lack of

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- 1 Helen Wilson, written evidence
 - 2 Action for Children, written evidence
 - 3 The Children’s Society, written evidence
 - 4 The National Association for Children of Alcoholics, written evidence
 - 5 Institute of Alcohol Studies, written evidence
 - 6 NHS Ayrshire and Arran Fetal Alcohol Advisory & Support Team, written evidence
-



awareness amongst health and childcare professionals and a lack of clinical services able to make diagnosis.

Harm to society – the cost to public services and the economy

The Commission received evidence on the wide-ranging impact alcohol has on wider society through the burden it places on public services and the economy. In England, hospital admissions related to alcohol reached a record level of 1.26 million in 2018/19⁷ and the total cost of alcohol to the NHS is estimated at £3.5bn.⁸ The costs of alcohol are not limited to health: Policing Minister Kit Malthouse has noted that “alcohol-related crime in England and Wales is estimated to cost society around £11.4 billion per year”.⁹

Alcohol’s ill-effects on both health and crime fall disproportionately on the poorest, worsening existing inequalities.¹⁰ Reducing alcohol consumption and its costs to the NHS and the public purse will be essential as the government works to restore the nation’s health and rebuild the economy in the wake of COVID-19.



Harm to the individual – physical and mental effects

Alcohol health harm is already well-documented, and we know that alcohol is a major cause of death and disease. Many submissions highlighted that alcohol is the leading risk factor for ill health, early mortality and disability among those aged 15 to 49 in England.¹¹ The Commission received evidence on the array of conditions which are caused or exacerbated by alcohol including cancer. In particular, we heard that alcohol and mental ill health often go hand-in-hand and yet most services are poorly equipped to support people who are experiencing both alcohol use disorders and mental-ill health.

Changing the conversation and ending the policy vacuum

Alcohol harm currently takes place in a policy vacuum. The Commission heard that the last UK Government alcohol strategy was published in 2012. Since then, alcohol harm, including liver disease, has continued to rise. We also have a much clearer picture of the health problems caused by alcohol, with more evidence available on the causal link between alcohol and seven types of cancer.

The UK Government announced plans to publish an alcohol strategy in May 2018¹² but this was later dropped, with a government minister stating in January 2020 that they are “not planning a stand-alone strategy”.¹³ In the absence of clear direction from government, the alcohol industry has not taken steps to reduce harm and is failing in its basic responsibilities to consumers, for example by continuing not to provide basic health and ingredient information on product labels. This failure of self-regulation means it is incumbent on the government to set out a clear legal framework to protect and inform consumers.

We heard a strong message from witnesses

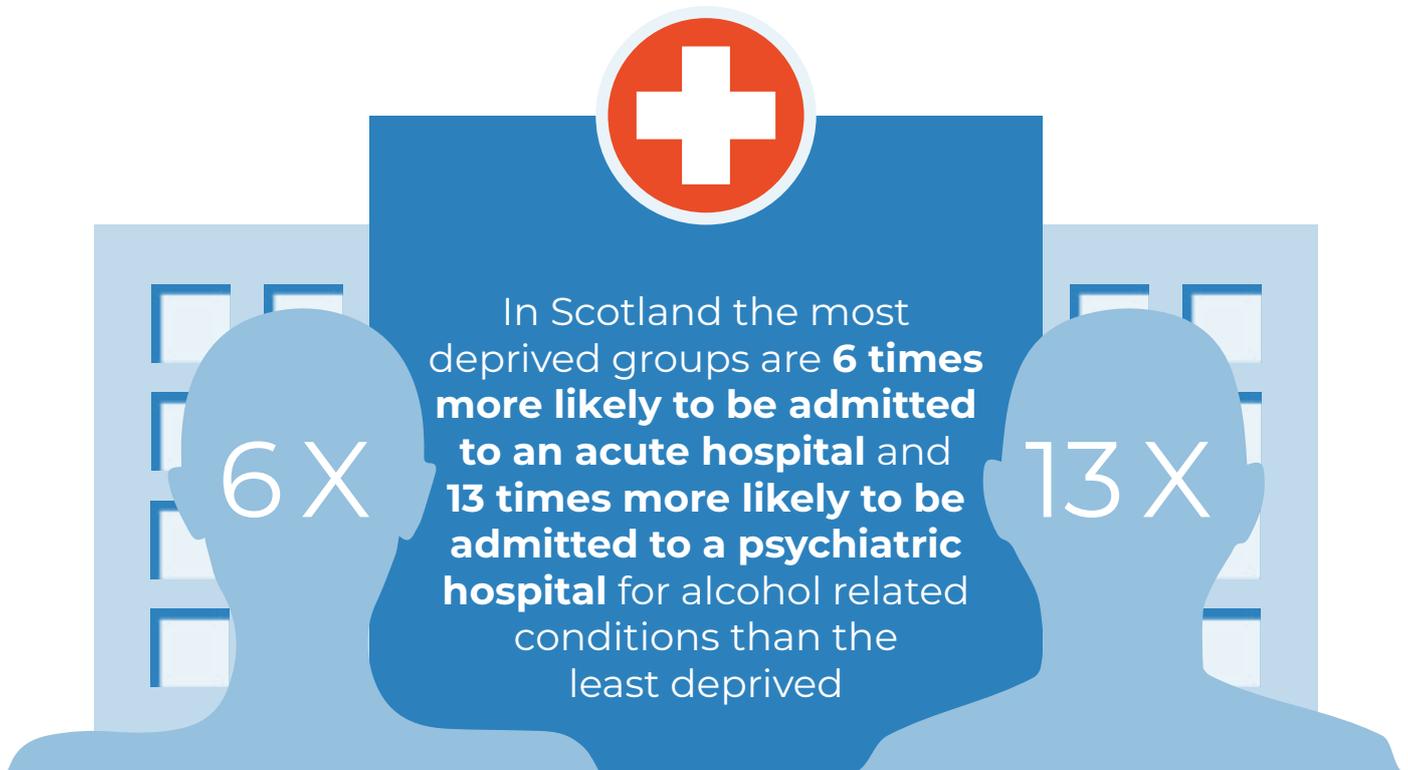
7 Public Health England, written evidence
 8 British Medical Association, written evidence
 9 Association of Police and Crime Commissioners (2020) Alcohol and drugs in focus
 10 Public Health England, Dr Carly Lightowlers, written evidence
 11 Public Health England, Humankind, Association of Directors of Public Health, Newcastle City Council Public Health, Camden and Islington Public Health, Northumberland Drug and Alcohol Steering Group, County Durham Public Health, Spectrum CIC, Balance, written evidence
 12 Hansard, HC Deb, 8 May 2018, c531
 13 Hansard, HL Deb, 21 January 2020, c1043

about the need for culture change around alcohol. The body of evidence received by the Commission indicates that alcohol is a harmful and addictive substance that must be carefully regulated, as is done with tobacco. Far from being an issue for individual responsibility as it is often framed by the industry, there is a compelling case for government intervention to end the cultural celebration and normalisation of alcohol in public whilst vulnerable individuals suffer harm and stigma behind closed doors.

The long list of vulnerable people in need of protection from alcohol harm includes alcohol dependent people, children, drink-drive collision victims, domestic abuse survivors, and those who experience crime and antisocial behaviour including emergency services personnel. It is unacceptable to leave their fate up to individual responsibility. Instead, we need systemic change to protect vulnerable individuals and communities.

We heard that despite a lack of leadership by the UK Government, there has been encouraging progress made by devolved governments – in particular with the introduction of minimum unit pricing

(MUP) in Scotland and, more recently, Wales. MUP has already led to a reduction of consumption in Scotland: the official Public Health Scotland evaluation found that MUP led to a net reduction in off-trade alcohol sales of between 4%-5% in its initial 12 months, compared to England and Wales where MUP had not been implemented.¹⁴



14 Public Health Scotland, MESAS (2020) Evaluating the impact of Minimum Unit Pricing (MUP) on sales-based alcohol consumption in Scotland: controlled interrupted time series analyses

Our recommendations

The Commission concluded that a UK Government alcohol strategy is required urgently. This strategy must be coordinated with devolved national governments so that reserved policies, such as alcohol duty, can complement devolved policies, such as minimum unit pricing.

The Commission began its work before the outbreak of COVID-19 but the pandemic means there has never been a more important time to improve the public's health. Measures to combat COVID-19 themselves have an impact on people's health, with 29% of people reporting drinking more alcohol during lockdown than they normally would.¹⁵ Reducing the £3.5bn cost of alcohol to the NHS¹⁶ would help to relieve pressure on the service and free up capacity to respond to the consequences of COVID-19.

The Commission assessed which policies should be included in the alcohol strategy. In light of the strength of evidence we received about the far-reaching and often devastating impact of alcohol on children and families, we recommend that the new alcohol strategy includes specific measures to support families and protect children from harm, including alcohol-fuelled violence.

The strategy must also be science-led and we recommend adopting the World Health Organization's evidence-based recommendations for reducing the harmful use of alcohol. This includes measures on affordability, availability and promotion of alcohol, better information for consumers, advice and treatment for people drinking at hazardous and harmful levels, and action to reduce drink driving. These should form the cornerstone of both the UK and devolved governments' alcohol policies.

Finally, we want to change the conversation and challenge alcohol's position in our culture. This means confronting the idea that alcohol harm affects only the weak or irresponsible. It also means addressing the stigma around alcohol use disorders, encouraging conversations about drinking to take place more easily and creating space for people to be open about the effects of alcohol on their health and those around them.

“ When I turn the door handle, I feel sick ... My biggest worry is that I'll come home from school to find her dead. ”

Expert by experience

15 King's College London (2020) Getting used to life under lockdown? Coronavirus in the UK
16 British Medical Association, written evidence



“ I can buy any alcohol, as much as I want, at any time of the day or night ... It's EVERYWHERE. It's really hard to escape alcohol. ”

Robert,
Expert by experience

Recommendations

1. A new comprehensive strategy

The UK Government must introduce a new alcohol strategy as part of the COVID-19 national recovery plans. The strategy must take account of the best available evidence and include population-level measures to reduce harm from alcohol. Its development must be free from influence by the alcohol industry. While the government must support economic recovery and our hospitality industry, this must be balanced with minimising harm from alcohol. It should include the interventions recommended by the World Health Organization, which we fully endorse.

An overarching theme for a new alcohol strategy must be the need for a change in culture around alcohol. This should include a focus on reducing stigma for those who are concerned about their drinking and their families. The strategy should also commit to regularly review emerging evidence around new developments in alcohol policy such as the growth of no- and low-alcohol products. [\(page 61\)](#)

“We’ll never treat ourselves out of this situation we’re in ... we have to start with prevention.”

Dr Helen McAvoy, Institute of Public Health in Ireland

2. Alcohol harm should be a specific part of the remit of the new Domestic Abuse Commissioner

The Domestic Abuse Commissioner role, being created as part of the Domestic Abuse Bill, must have a duty to have regard to the link between alcohol and domestic abuse in their work. Alcohol awareness must be embedded throughout all strands of the Commissioner’s work from preventing abuse to holding government and statutory bodies to account. The Commissioner also should examine the effectiveness of sobriety monitoring and other innovative approaches in reducing domestic abuse levels, and embed alcohol treatment and support in all these schemes. [\(page 19\)](#)

“I stayed in my bedroom, it was like a cage but the safest place possible. I was too scared to leave or to talk to anyone. The solution was to be invisible and quiet, hoping she would not come after me. But she did. She abused me, and my dad, mentally, emotionally, sometimes physically. For years, on a regular basis.”

Alexandra, Expert by experience

3. All professionals who have regular contact with children and families must have a core competency to intervene and provide support in cases where alcohol harm is evident

Professionals who have contact with children and families, including teachers, must have the competency to enable them to make interventions around alcohol and to signpost family members to receive help. This could be along the lines of the intervention and brief advice model used in healthcare settings. (page 22)

“Confusion stops practitioners being able to have the confidence to intervene and ask the questions to the family around alcohol.”

Helen Leadbitter, The Children’s Society

4. Action to prevent, identify and support Foetal Alcohol Spectrum Disorder

Midwives need clear guidance on how to communicate the Chief Medical Officers’ guidelines and alcohol advice appropriately to pregnant women. The forthcoming NICE quality standard must support clinicians to identify and diagnose FASD and make clear the support available to children and families affected by it. (page 25)

“I’m saying to everyone ‘he’s got FAS or ARND (Alcohol Related Neurodevelopmental Disorder)’. It is because I drank and they were saying ‘oh no don’t be silly’. They just wouldn’t have it. They just would not accept it. But I kept insisting that is what it was and I kept giving them information.”

Expert by experience

5. Reduced price promotion of cheap alcohol through increased alcohol duty and minimum prices with regular reviews of prices in relation to inflation and income

This must include the introduction of minimum unit pricing in England and Northern Ireland, an increase in alcohol duty to reverse real terms cuts since 2013, and a reform of duty structures so that stronger drinks always cost more. Duty reform should consider the case for differential duty rates between the on- and off-trade, and a levy on producers to offset some of the costs to society and the economy caused by their product. (page 38)

“I believe that if I hadn’t have been able to access that cheap cider, I may have gone into treatment sooner and got myself well.”

Steven, Expert by experience

6. Restrictions on availability of retail alcohol through reduced hours of sale and reduced density of retail outlets

Local authorities across the UK must have greater powers to refuse licensing applications and to limit the number of licensed premises in an area. In England, Wales and Northern Ireland, they must be allowed to consider the impact on public health of new premises when deciding whether to grant licence applications, as is the case in Scotland. (page 33)

“My dad can’t help drinking. Every day we need bread, milk etc from the shop next to our house. When he goes in, the temptation is too much for him. It’s not his fault when it’s staring him in the face. Maybe if we didn’t live near a shop he wouldn’t be able to get drink as easily.”

Expert by experience

7. Comprehensive restrictions on alcohol advertising across multiple media, including restrictions on sponsorships and activities targeting young people

Children must be protected from exposure to alcohol advertising, including through effective age verification online, and a restriction on alcohol advertising in cinemas to films with an 18 certificate. Regulations must cover digital media, including influencers, and should be regularly assessed to keep up with developments in technology. Alcohol sponsorship of professional sport should be phased out. Advertising should be monitored by an independent regulator. (page 55)

“We are fed images of alcohol everywhere, adverts, people drinking on the tv, in soaps, people meet at the pub, sports sponsorship by alcohol brands etc.”

Focus group participant, Big Alcohol Conversation

8. Alcohol labelling to provide consumers with information about alcohol harm

All alcohol product labels must include:

- ▶ the Chief Medical Officers’ guidelines on low-risk consumption
- ▶ a prominent health warning
- ▶ units provided in a whole container and typical serving
- ▶ ingredients and nutritional information such as calories.

(page 46)

“It is absurd in a pub that you buy a pint, it doesn’t have to tell you how many calories are in it, but you buy a bag of crisps to go with the pint, by law, it has to give you the number of calories.”

Adrian Chiles, TV presenter

9. Treatment and care for alcohol use disorders and co-occurring conditions

There must be sufficient funding for treatment, with treatment available at a level to meet need. Detecting and managing alcohol use disorders should be a core competency for all clinicians to ensure that people who present at, for example, mental health services are able to access the support they require. Treatment should have the flexibility to be personalised and patient-led in order to meet the diverse needs of those who require it. Individuals may have specific treatment needs as a result of characteristics such as age, disability, gender, sexual orientation, race, religion or family circumstances. (page 56)

“We’re left begging to get people admitted for detox.”

Dr Michael Kelleher

10. Brief psychosocial interventions for people with hazardous and harmful alcohol use, with appropriate training for providers at all levels of healthcare

As alcohol affects so many different parts of the body, alcohol screening and brief interventions should be part of routine practice in new settings within healthcare, such as dentistry and breast clinics. Interventions can be extended to settings outside healthcare including bereavement services and driving lessons. Digital options should be explored as an opportunity to extend brief interventions into new spaces. (page 44)

“[The police] were the first people I ever, ever admitted to, ‘I think I might have a drink problem’.”

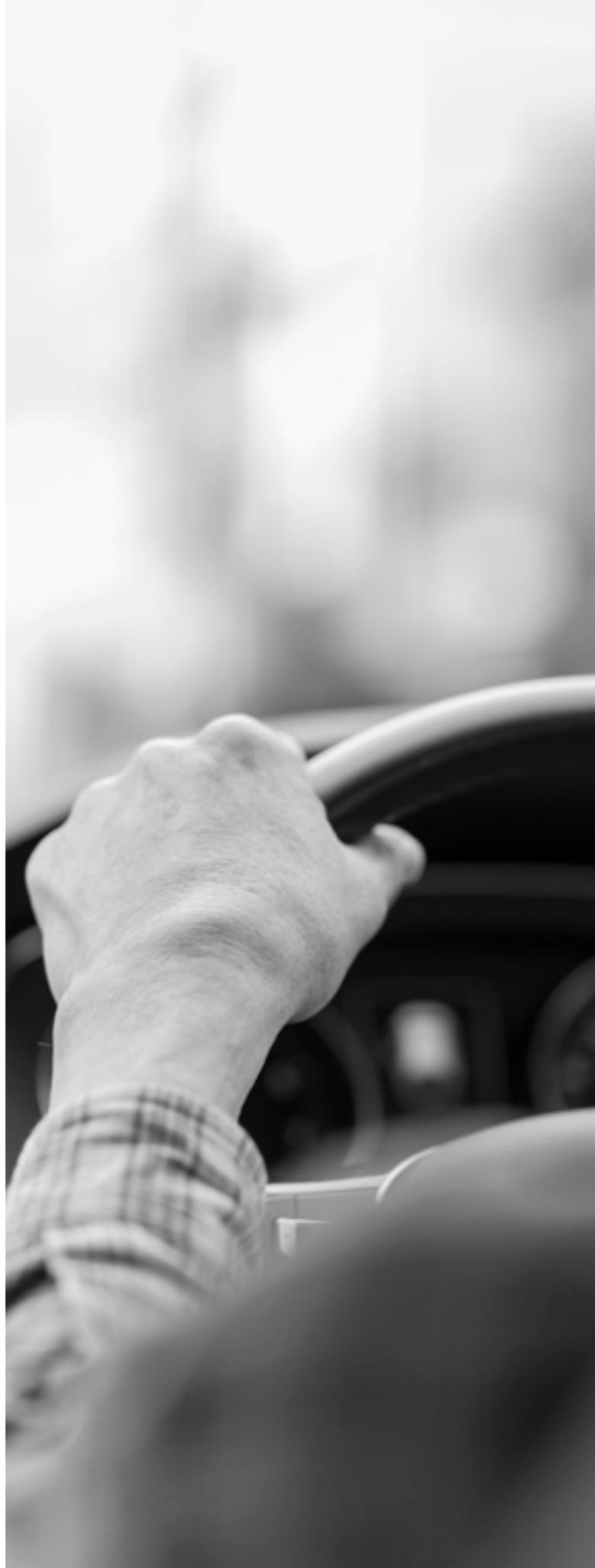
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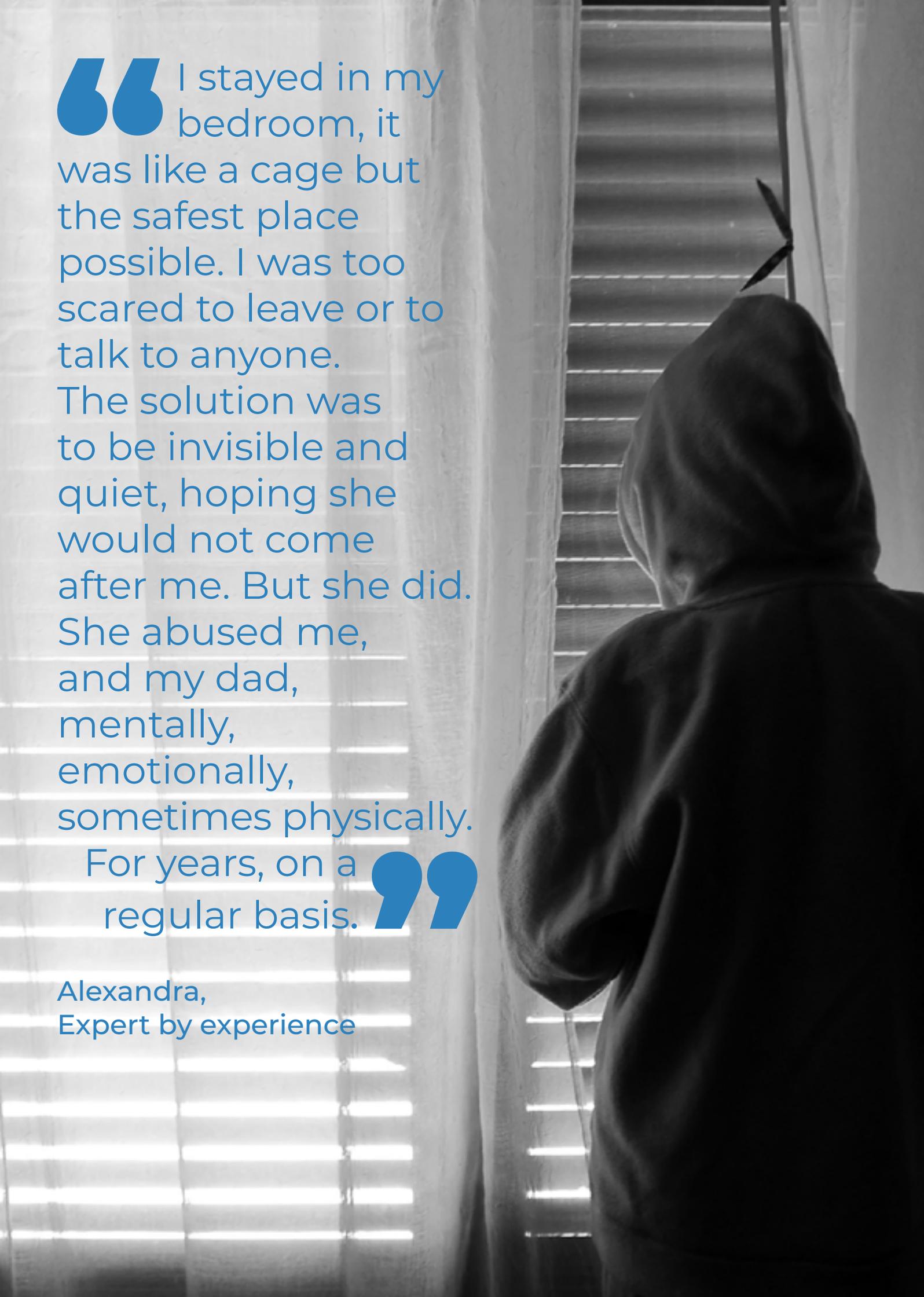
11. Action to reduce drink driving

The UK Government must reduce the drink drive limit in England and Wales into line with Scotland and the rest of Western Europe, if not lower. The new limit should be properly enforced by new powers for the police to carry out random breath-testing. (page 27)

“Delivering a death message to a parent, brother, sister, son or daughter to inform them that someone has been killed by a drink driver is not something I ever got used to.”

Police Sergeant Mike Urwin



A person wearing a dark hoodie is seen from behind, looking out a window with horizontal blinds. The scene is dimly lit, with light filtering through the blinds, creating a somber and contemplative atmosphere. The person's face is obscured by the hood and shadows.

“ I stayed in my bedroom, it was like a cage but the safest place possible. I was too scared to leave or to talk to anyone. The solution was to be invisible and quiet, hoping she would not come after me. But she did. She abused me, and my dad, mentally, emotionally, sometimes physically. For years, on a regular basis. ”

Alexandra,
Expert by experience

Harm to those around the drinker

As with smoking, the harm caused by alcohol does not stop with the drinker. It can have a devastating impact on those surrounding the drinker including children and family.

Children and families

“Alcohol has ruined our family life”

The Children’s Commissioner for England has reported that 308,000 children currently live with at least one high risk drinker over the age of 18, and 472,000 children live with an adult reported to be dependent on alcohol or drugs.¹⁷

Parental alcohol use can put children at risk. Action for Children highlighted that alcohol was a factor in 91,110 child in need assessments in England in the year ending March 2019 – 18.3% of those assessments where information was available.¹⁸ Helen Leadbitter from The Children’s Society described a “large increase” in child in need assessments that include alcohol and an increase in the use of alcohol and drugs “as recorded risk factors within safeguarding assessments”.¹⁹

Growing up with a harmful drinker can have serious health consequences. It is one of ten Adverse Childhood Experiences which “contribute to the risk of experiencing a range of health conditions in adulthood such as heart disease, type 2 diabetes, and engaging in health harming behaviours (smoking, heavy drinking, drug use)”.²⁰ Children with an alcohol dependent parent are five times as likely to develop eating disorders, twice as likely to develop alcohol

“ Every person whose life is lost is a tragedy, and it’s an avoidable tragedy, and it doesn’t just affect the people themselves, it affects their families, it affects the people who love them and love them if they die. ”

Eric Carlin, SHAAP

dependence or addiction and three times as likely to consider suicide.²¹ They are at risk of “being withdrawn, having concentration difficulties at school, and depression” as well as anti-social behaviour problems and difficulties with friendships.²²

Action for Children explained how “the unpredictability of their parents’ behaviour can have a negative impact on children: they might feel nervous about not knowing what to expect when they arrive home from school”.²³ One woman, who wished to remain anonymous, wrote about the impact of her father’s drinking:

“From the ages of 12 –18, I experienced depression and anxiety due to living with my parents in an increasingly toxic environment ... This led me to harm myself in multiple ways as a young person, including undereating, abusive drinking and self-harm”.²⁴

An expert by experience told us about his father’s drinking and how he went on to develop alcohol dependence himself:

17 Action for Children, written evidence

18 Ibid

19 Helen Leadbitter, oral evidence session, 2 March 2020

20 Royal College of Physicians and Surgeons of Glasgow, written evidence

21 The National Association for Children of Alcoholics, written evidence

22 Professor Jim Orford (Addiction and the Family International Network), written evidence

23 Action for Children, written evidence

24 Anonymous, written evidence

"I experienced my father's alcoholism as a child ... life was chaotic and money was often desperately short ... I was a fearful teenager and struggled to cope with life. I found alcohol in 6th form and ... drank my way through college".²⁵

Others told us of struggling to develop friendships and of experiencing post-traumatic stress disorder, suicidal ideation, binge-eating and intrusive thoughts. Helen Wilson told us:

"I grew up not knowing what it was to be loved and accepted unconditionally. Home was not a place of safety and sanctuary, but a place [to be] feared and avoided if possible ... The impact of having an alcoholic parent is that you just aren't supported and nurtured in a way that prepares you for adulthood. You are also left with multiple problems".²⁶

Melissa described her mother's drinking, which was linked to verbal, physical and emotional abuse: *"there is no describing the emotional scars that this sort of abuse leaves behind ... after she died, it hit me like a tonne of bricks the extent of damage I had to try and get over".²⁷*

“ The atmosphere at home was horrific due to his mood swings, drinking, emotional abuse and our total fear of him ... We were terrified of him and his drinking bled into every aspect of our lives. It also continued to affect us all after his death. **”**

Expert by experience

- 25 Anonymous, written evidence
- 26 Helen Wilson, written evidence
- 27 Melissa, written evidence
- 28 Anonymous, written evidence
- 29 The National Association for Children of Alcoholics, written evidence
- 30 Anonymous, written evidence
- 31 Anonymous, written evidence
- 32 Melissa, written evidence
- 33 Donna, written evidence

We heard that some children blamed themselves for their parents' drinking. One woman wrote: *"as a child I had no understanding of alcoholism and assumed I was bad/to blame".²⁸* Another said: *"I thought I was the reason he drank. I thought that if I tried harder, was nice enough or clever enough, he wouldn't need to drink. But however hard I tried, I was never good, nice or clever enough because he always drank".²⁹* Another woman wrote: *"I blamed myself for the family unrest. I thought if I took care of everyone it would make it better. I grew up with an over sense of responsibility for my parents whose lives were unmanageable and chaotic".³⁰*

One individual described the conflict she felt: *"the mental anguish of this on a child is quite something: hating your own mother for how she is treating you, and then also fearing for her when she threatened to remove herself from your life. And yet you still love your parents".³¹*

Many individuals spoke of deception and secrecy, including Melissa:

"Her drinking became so out of control that it ended her marriage. She became secretive! Hiding vodka bottles around the house, stealing money to buy alcohol, it was as if her love for her family was sidelined and sadly overtaken with her love for alcohol".³²

This feeling of being sidelined in favour of alcohol was echoed by others:

"It was an illusion that I could do anything about her drinking. My attempts succeeded only in driving a further wedge between us. I was shocked by her attachment to bottles of whisky and felt less loved and respected, by comparison".³³

In some cases, children can be forced to take on caring responsibilities: 23% of children living with a parent or carer using alcohol harmfully were also young carers. Their caring roles have a profound effect on them, with 19% of these children reporting low well-being.³⁴

Adult relations can also be negatively affected by familial drinking. Substance use and family charity Adfam reported that one in three adults in the UK are affected by a relative's alcohol use.³⁵ Professor Orford

described “a decline in the quality of family relationships, ranging from diminished communication to physical violence, emotional abuse and ‘coercive control’. Loss of trust is a significant factor”.³⁶ A woman with lived experience described the impact her husband's alcohol dependence had on her whole family: “Alcohol has ruined our family life”, she wrote. “We don't ever go out as a family anymore ... [My daughters] both think it is my fault and I should have kicked him out years ago”.³⁷



Drawings from young people as part of the Children's Society's I Feel ... When You Drink project

34 The Children's Society, written evidence
 35 Adfam, written evidence
 36 Professor Jim Orford (Addiction and the Family International Network), written evidence
 37 Anonymous, written evidence

Domestic abuse

“We were terrified of him”

Police Sergeant Mick Urwin emphasised the link between alcohol and domestic abuse:

*“My personal experience of dealing with domestic incidents over 30 years is that the vast majority were alcohol related with the offender (male or female) having drunk excessively prior to offending or be alcohol dependent”.*³⁸

Research supports a link between alcohol and domestic violence: between 25% and 50% of those who perpetrate domestic abuse have been drinking at the time of assault, with some studies putting the figure as high as 73%.³⁹ Parental alcohol misuse was a documented factor in 37% of cases where a child was seriously hurt or killed between 2011 and 2014.⁴⁰ A 2016 Home Office review of domestic homicides found that substance use was mentioned as a factor in just over half of all reviews into intimate partner homicides.⁴¹ According to The Children's Society, 39% of children living with a parent or carer with problematic alcohol use were also living in households where there had been domestic violence in the last five years, almost three times the comparable rate for children in general.⁴²

“My sister and I were subjected to nightly tirades of abuse and bullying and often left to pick up the pieces after she had passed out. The impact upon us was massive. I regularly felt so helpless and upset that I wished I didn't exist.”

Helen Wilson, Expert by experience

“Depending on the excess of alcohol, the bigger the fight.”

She hit me once but she generally just calls me terrible names.”

Regan, 15, Expert by experience, Nacoa submission

The link between alcohol and domestic abuse is complex. Despite them often occurring together, alcohol is not a cause of abuse and nor is it ever a justification. Alcohol may be consumed by the victim as well as the perpetrator, as Inspector Donald Wade of Northumbria Police explained:

*“Within the most challenging domestic violence relationships, we find that not only is the perpetrator drinking, but also that the victim is drinking, and they may well be drinking because of the violence and the dreadful circumstances they're in, and they're drinking to try and take the edge off that, or they may well be drinking along with the perpetrator because they think if they drink with them, they're less liable to commit acts of violence on them”.*⁴³

The fact that the violence takes place behind closed doors makes it particularly difficult to address. Niven Rennie of the Violence Reduction Unit in Scotland told us: *“part of the problem we've got in violence reduction is that a significant percentage of the violence that's occurring is occurring inside the home and it's far more difficult to police”.*

38 Sergeant Mick Urwin, written evidence

39 County Durham Public Health, written evidence

40 Adfam, written evidence

41 Home Office (2016) Domestic Homicide Reviews: Key findings from analysis of domestic homicide reviews

42 The Children's Society, written evidence

43 Inspector Donald Wade, oral evidence session, 30 March 2020

Inspector Donald Wade told us how domestic abuse can increase around sporting events:

*“For big sporting events, there would be a much greater policing response because we’re very much tuned into the alcohol issues, especially domestic violence issues which become problematic during those events because of drinking at home”.*⁴⁴

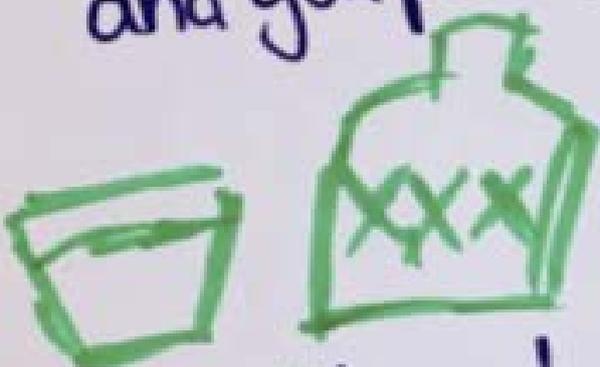
**Recommendation:
Alcohol harm should be a specific part of the remit of the new Domestic Abuse Commissioner**

The Domestic Abuse Commissioner role, being created as part of the Domestic Abuse Bill, must have a duty to have regard to the link between alcohol and domestic abuse in their work. Alcohol awareness must be embedded throughout all strands of the Commissioner’s work from preventing abuse to holding government and statutory bodies to account. The Commissioner also should examine the effectiveness of sobriety monitoring and other innovative approaches in reducing domestic abuse levels, and embed alcohol treatment and support in all these schemes.



HELPLESS

I'm stuck here, unable
to help you get over
this burden, but I can't
and you pour another one



I beg you to stop, please
listen to me, please it's
me. But I can't help you,
you pour another one.

try, attempt after attempt
but nothing I do helps you. I
just want to help, but I
can't and you drink
the rest.



Drawing from young person as part of the Children's Society's
I Feel ... When You Drink project

Why we need better support for families

“People are utterly desperate”

Even though families can be damaged by harmful drinking, family members can also play an important part in helping those who drink harmfully. Scottish Families Affected by Alcohol and Drugs told us that families should be seen as “*an asset, even where the family unit or family relationships are fragile or damaged*” with family support able to “*improve outcomes for whole families*”.⁴⁵ Similarly NICE recommends encouraging families and carers to be involved in the treatment and care of people who drink at harmful levels.⁴⁶

Despite their potential to help, families struggle to know how to support their loved ones and where to access support for themselves. Though he has experienced alcohol dependence himself, Alastair Campbell told us:

*“When I saw it with my son, I know I was doing the things that I shouldn’t be doing, just because you’re helpless. So you need somebody, whether it’s a doctor or it’s an adviser ... to say: ‘Don’t say, just don’t drink, don’t make that sort of threat, do this’. And at least give you the structure then to try to help ... The alcoholic’s lost in their own world, but around them are these people [who] are utterly desperate and don’t know what to do”.*⁴⁷

“ My mother’s drinking has impacted and destroyed 14 of my family members. ”

Expert by experience

Family support services provide family members with the opportunity to discuss the impact that their loved one’s drinking has upon them. A survey by family and substance use charity Adfam of family support service practitioners found that the support available to families is insufficient. It also found “*insufficient awareness amongst professionals on the needs of families affected by drugs and alcohol*”.⁴⁸

One of the reasons families do not receive the outside help they need is due to confusion amongst professionals about who has responsibility to intervene and how it should be done. Helen Leadbitter from The Children’s Society explained:

*“When do we think about supporting families? For example, is it when it crosses over with domestic violence? Is it when that person, who is alcohol-dependent, has their own specific health needs? Is it ... looking at preventative services? This confusion stops practitioners being able to have the confidence to intervene and ask the questions to the family around alcohol”.*⁴⁹

Dr Helen McAvoy from the Institute of Public Health in Ireland agreed that alcohol support is “*not just an issue for addiction services*” arguing that alcohol should be addressed in child and family services, prison services and mental health services.⁵⁰ Camden and Islington Council argue that services must be designed with a ‘Think Family’ approach to ensure that “*all family members of the person with problematic substance use are identified and given the right support as early as possible*”.⁵¹

Emily Lowthian from Cardiff University told us that schools and teachers should be better empowered to address familial alcohol use:

“A lot of the teachers know parents who have substance misuse, but they don’t tend to talk about it ... we need that connection between the agencies

45 Scottish Families Affected by Alcohol and Drugs, written evidence
46 Adfam, written evidence
47 Alastair Campbell, oral evidence session, 11 March 2020
48 Adfam, written evidence
49 Helen Leadbitter, oral evidence session, 2 March 2020
50 Dr Helen McAvoy, oral evidence session, 11 March 2020
51 Camden and Islington Council, written evidence

*and contacts for teachers, so actually how to know if there is a child affected by substance misuse [and] how to support children, and perhaps families, experiencing that”.*⁵²

We heard of the role that stigma and fear plays in stopping families from reaching out for support:

*“Families and children like us didn’t and won’t discuss it for fear of being separated, being taken away from parents, being singled out ... feeling embarrassed, scared of repercussions and fear of retribution”.*⁵³ Expert by experience

*“To the world outside everything was fine, a normal family. To have shared the secret burden that my brother and I carried would have brought shame on the entire family; we were led to believe we would become outcasts”.*⁵⁴ Daisy, Expert by experience

*“We were always encouraged to appear ‘normal’”.*⁵⁵ Expert by experience

*“If we start to reduce the stigma around alcohol misuse, like we’ve done with mental health then maybe [families would reach out to get help]. Having somewhere that those struggling with alcohol misuse and mental health issues can go for help is in short supply”.*⁵⁶ Jo Huey, Expert by experience

The Children’s Society recommended that there should be training for all professionals who work with children and families *“on how best to remove and address the barriers and issues of stigma that exist for children and families when seeking help and support”.*⁵⁷

“ I blamed myself for the family unrest. I thought if I took care of everyone it would make it better. I grew up with an over sense of responsibility for my parents whose lives were unmanageable and chaotic. ”

Expert by experience

Recommendation:
All professionals who have regular contact with children and families must have a core competency to intervene and provide support in cases where alcohol harm is evident

Professionals, including teachers, who have contact with children and families must have the competency to allow them to make interventions around alcohol and to signpost family members to receive help. This could be along the lines of the intervention and brief advice model used in healthcare settings.

52 Emily Lowthian, oral evidence session, 2 March 2020

53 Anonymous, written evidence

54 Daisy, quoted in the National Association for Children of Alcoholics, written evidence

55 Anonymous, written evidence

56 Jo Huey, written evidence

57 The Children’s Society, written evidence



up to **17%** of UK children
could have symptoms consistent
with FASD

Prevalence is particularly high
among more vulnerable groups

75% of children
referred for adoption medicals
had a history of antenatal
alcohol exposure



FASD-related neurological
difficulties affect:

- ▶ focus and attention
- ▶ understanding
- ▶ communication
- ▶ executive function
- ▶ social skills
- ▶ memory
- ▶ academic progress
- ▶ decision-making

26% of 18-25
year olds are **not
aware** of the Chief
Medical Officers'
guidance that it is
safest not to drink
if you are, or could
become, pregnant



Prenatal alcohol exposure “Woeful lack of awareness and understanding”

Alcohol can harm children even before they are born. Alcohol consumption during pregnancy can lead to miscarriage, preterm birth, low birthweight and a range of neurological and physical development issues classified under the umbrella term Foetal Alcohol Spectrum Disorders (FASD).⁵⁸

The UK has the fourth highest level of prenatal alcohol use in the world.⁵⁹ A study in Glasgow found that 40% of pregnancies assessed were exposed to some alcohol, with 15% exposed to “significant” consumption.⁶⁰ Though we heard that “*there are no reliable studies for the prevalence of FASD in the UK*”,⁶¹ a 2018 study found that up to 17% of UK children could have symptoms consistent with FASD.⁶² Prevalence is higher amongst certain groups: a study of 45 children found that 75% of children referred for adoption medicals had a history of antenatal alcohol exposure.⁶³ It is the most common cause of non-genetic learning disability worldwide,⁶⁴ and is estimated to cost the UK £2bn a year.⁶⁵

Alcohol consumption in pregnancy can cause brain damage which affects individuals’ focus, understanding, communication, social skills, memory and decision-making. Jenny, an adoptive parent of a child with FASD, told us her son has poor memory, struggles with relationships and understanding others’ perspectives, and was excluded from primary school aged seven.⁶⁶

There is insufficient awareness of the risks of drinking during pregnancy. A recent survey of 18-25 year olds found that over a quarter (26%) of respondents were unable to identify

“Alcohol use is a sensitive topic and women may be reluctant to honestly disclose [they are drinking while pregnant]. There are stigma and fear factors associated with alcohol use that can make these conversations uncomfortable.”

Royal College of Midwives

the Chief Medical Officers’ (CMOs’) guidance that it’s safest not to drink while pregnant or if you could become pregnant.⁶⁷

The Royal College of Midwives emphasised the need for consistent advice. For a period of two years, the NICE advice stated there was a low risk to the unborn baby from low-level drinking while the UK CMOs’ guidance advised that the safest option in pregnancy is not to drink alcohol at all.⁶⁸

The Royal College of Midwives also recommended better training to give midwives the “*necessary skills and knowledge to address the topic of alcohol*”.⁶⁹ There is also potential for innovative approaches to communicating with women before they become pregnant, for example through providing information alongside contraception or in family planning clinics.

Despite its prevalence, there is insufficient knowledge about FASD amongst healthcare and childcare professionals. We were told of “*a lack of commissioned clinical services in the UK able to make a diagnosis of FASD*”.⁷⁰ Many children are misdiagnosed with other

58 Royal College of Midwives, written evidence

59 Institute of Alcohol Studies, written evidence

60 Alcohol Focus Scotland, written evidence

61 UK FASD Research Collaboration, written evidence

62 Cheryl McQuire et al. (2018) Screening prevalence of fetal alcohol spectrum disorders in a region of the United Kingdom: A population-based birth-cohort study, Preventive Medicine

63 NHS Ayrshire & Arran Fetal Alcohol Advisory & Support Team, written evidence

64 British Paediatric Surveillance Unit, written evidence

65 NHS Ayrshire and Arran Fetal Alcohol Advisory & Support Team, written evidence

66 Jenny, written evidence

67 National Organisation for Foetal Alcohol Syndrome-UK (2020) National poll of young adults

68 Royal College of Midwives, written evidence

69 Ibid

70 UK FASD Research Collaboration, written evidence

neurodevelopmental conditions, leading to inadequate treatment and management.⁷¹ There are significant challenges around diagnosis as “no two presentations are the same. There are more than 400 associated conditions that are known to co-occur, making individuals with FASD extremely medically complex”, according to FASD UK Alliance.⁷²

Evidence from the UK National FASD Clinic noted:

*“There remains, however, inconsistency in knowledge and understanding of this condition in many practitioners across all areas. Further, there is no real consistent approach to either clinical commissioning or research in this field. For what is a common disorder, it therefore lags far behind. Because the condition presents as one of the many comorbidities identified linked to those diagnosed, it is often not recorded and missed as a cause [of] underlying presentations”.*⁷³

This was supported by Jenny’s difficulty in getting a diagnosis for her son, finding a “woeful lack of awareness and understanding about the prevalence of FASD by the health and social care professionals”. She explained:

*“It was only when aged 12 years another adoptive parent mentioned FASD. As soon as we began to read about the condition we realised it was exactly what our son had. We were aware that the local paediatric services had no knowledge or experience of FASD”.*⁷⁴

This was reflected in another parent’s experience:

“I’m saying to everyone ‘he’s got FAS or ARND (Alcohol Related Neurodevelopmental Disorder)’. It is because I drank and they were saying ‘oh no don’t be silly’. They just wouldn’t have

“ It has made a tremendous difference to have the diagnosis. For many years we have been told by professionals that our son is ‘stubborn’, ‘lazy’ and essentially too challenging. We now understand that he is brain damaged.”

Jenny, Expert by experience

*it. They just would not accept it. But I kept insisting that is what it was and I kept giving them information”.*⁷⁵

Clinical guidelines in Scotland highlight the importance of early diagnosis and give clear guidance for clinicians.⁷⁶ They have been hailed as “a beacon for change”.⁷⁷ NICE is in the process of developing a quality standard for FASD but its schedule has been affected by COVID-19.⁷⁸

Recommendation: Action to prevent, identify and support Foetal Alcohol Spectrum Disorder

Midwives need clear guidance on how to communicate the CMOs’ guidelines and alcohol advice appropriately to individual pregnant women. The forthcoming NICE quality standard must support clinicians to identify and diagnose FASD and make clear the support available to children and families affected by it.

71 NHS Ayrshire and Arran Fetal Alcohol Advisory & Support Team, written evidence

72 FASD UK Alliance, written evidence

73 UK National FASD Clinic, written evidence

74 Jenny, written evidence

75 Personal testimony quoted in UK National FASD Clinic, written evidence

76 Health Improvement Scotland (2019) [SIGN 156 - Children and young people exposed prenatally to alcohol: a national clinical guideline](#)

77 UK FASD Research Collaboration, written evidence

78 NICE (2020) [Fetal alcohol spectrum disorder](#)

Drink driving “It is devastating”

Drink driving is another example of how alcohol harms people other than the drinker themselves. The British Medical Association noted that alcohol is a significant cause of road traffic collisions, responsible for 8,600 deaths or injuries in the UK in 2017.⁷⁹ In 2017, the Department for Transport estimated that 310 pedestrians and 110 cyclists were casualties in drink drive incidents, including 60 children aged 0-15.⁸⁰

Police Sergeant Mick Urwin described the impact that drink driving can have on individuals. As well as the perpetrators who lose “*their licence, on most occasions their job and possible imprisonment*”, the greatest impact is “*on the family of someone killed or seriously injured by a drink driver. It is devastating*”. He explained “*delivering a death message to a parent, brother, sister, son or daughter to inform them that someone has been killed by a drink driver is not something I ever got used to*”.⁸¹

The ex-wife of a man living with alcohol dependence described her fears about drink driving:

*“One of the biggest fears I still have is that he drink drives ... I managed to persuade him to have a breathalyser immobiliser fitted in his car but I am sure he can override it. Having a conversation with your ten year old twins about not getting in the car when they think daddy has had a drink is not normal or healthy but sadly essential”.*⁸²

No significant progress has been made in reducing drink drive casualties in recent years. Jyoti Atri from Public Health Wales explained:

*“[In Wales] the rates of slight incidents, they’re defined as slight, has gone down from 2010 to 2016. However, the number of slight accidents is still over 200. The number of fatal and serious accidents, whilst much lower, has been pretty stable over that period. I think that suggests there’s still room for further improvement in terms of prevention”.*⁸³

Fire officers reported to the All Party Parliamentary Group on Alcohol Harm that they now rescue more people from road traffic collisions than house fires, many of which are due to drink driving.⁸⁴

A survey by Drink Wise, Age Well of 16,700 people over 50 found that drink driving was commonplace amongst higher risk drinkers: 30% reported that they had driven when they thought they were over the legal alcohol limit in the last 12 months.⁸⁵ 39% of participants in the Big Alcohol Conversation thought that drink driving was an issue where they live.⁸⁶

Yet England and Wales have far higher drink drive limits than most similar countries. SHAAP and Alcohol Change UK recommended lowering the drink drive limit in England and Wales to 50mg of alcohol per 100ml, bringing it into line with Scotland and most other countries in the EU.⁸⁷

To be effective, drink drive limits have to be enforced. A report by the World Health Organization notes that “*multiple systematic reviews support using sobriety checkpoints to reduce drink-driving harms*”. Alongside blood alcohol limits, the World Health Organization recommends “*promoting sobriety checkpoints and random breath-testing, administrative suspension of licences, graduated driving licences for novice drivers, and ignition interlocks to reduce alcohol-impaired driving*”.⁸⁸

79 British Medical Association, written evidence

80 Department for Transport (2016) [Reported road casualties in Great Britain: final estimates involving illegal alcohol levels: 2017](#)

81 Sergeant Mick Urwin, written evidence

82 Anonymous, written evidence

83 Jyoti Atri, oral evidence session, 2 March 2020

84 Alcohol Change UK, written evidence

85 Addaction and Drink Wise, Age Well, written evidence

86 Greater Manchester Health and Social Care Partnership, written evidence

87 Alcohol Change UK and SHAAP, written evidence

88 World Health Organization (2018) Global status report on alcohol and health

“ Having a conversation with your ten year old twins about not getting in the car when they think daddy has had a drink is not normal or healthy but sadly essential. ”

Expert by experience

Public Health England noted that “enforced legislative measures to prevent drink-driving are effective and cost effective”, and highlighted that there can be cost-savings from having lower alcohol limits for young drivers. Their submission, which drew from their 2016 evidence review, stated “reducing drink-driving is an intrinsically desirable societal goal and is a complementary component to a wider strategy that aims to influence drinkers to adopt less risky patterns of alcohol consumption”.⁸⁹

Recommendation: Action to reduce drink driving

The UK Government must reduce the drink drive limit in England and Wales into line with Scotland and the rest of Western Europe, if not lower. The new limit should be properly enforced by new powers for the police to carry out random breath-testing.

“ Delivering a death message to a parent, brother, sister, son or daughter to inform them that someone has been killed by a drink driver is not something I ever got used to. ”

Police Sergeant Mick Urwin

2017 casualty estimates:

310
pedestrians

110
cyclists
in drink drive
incidents

including

60
children

89 Public Health England, written evidence

“ My mum had never been in trouble with the police, broken the law or stepped a foot out of line until her addiction with alcohol got too advanced and her world around her started to fall apart. ”

Melissa, Expert by experience



Harm to society

The impact on inequalities

“A disproportioned rate of violence”

Alcohol harm cuts across society but the worst impacts are experienced by the poorest. This is true for both health harm and crime.

Explainer: the alcohol harm paradox

Alcohol is strongly linked to health inequalities, often referred to as the ‘alcohol harm paradox’. The House of Commons Library described the paradox: “the burden of alcohol harm falls more heavily on individuals from lower socio-economic backgrounds, despite drinking the same amount, if not less, than those of higher socio-economic status”. There are several possible explanations for this paradox, including different patterns of consumption and alcohol’s interaction with other unhealthy commodities.

We received a lot of evidence of the alcohol harm paradox. Public Health England’s evidence noted that “*individuals living in high deprivation areas suffer disproportionate alcohol-related harm*”, with an increase in mortality rates as levels of deprivation increase.⁹⁰ The Faculty of Public Health highlighted that in Scotland the most deprived 10% of the population were “*6 times more likely to be admitted to an acute*

hospital for an alcohol related condition” and “*13 times more likely to be admitted to a psychiatric hospital for an alcohol related condition*” than the least deprived 10%.⁹¹

Jyoti Atri from Public Health Wales told us that, in Wales, average self-reported drinking over 14 units a week is 22% in the least deprived areas, compared to 14.5% in the most deprived areas, yet harm is more pronounced among the more deprived population.⁹² Dr Helen McAvoy from the Institute of Public Health in Ireland noted: “*Northern Ireland has particular vulnerabilities, it is a more socioeconomically deprived region of the UK, which raises the level of alcohol related harm*”.⁹³

The alcohol harm paradox means that ending alcohol-related harm is an important route to reducing health inequalities.⁹⁴ Dr Benjamin Hawkins from the London School of Hygiene and Tropical Medicine explained how this influenced policy in Scotland:

*“A key driving factor for bringing [minimum unit pricing] onto the agenda in Scotland, was this issue of health inequalities ... the often-cited example of the east end of Glasgow for example having particularly poor male life expectancy associated with things like alcohol consumption and cigarette consumption”.*⁹⁵

Alcohol-related violence and anti-social behaviour also have a worse impact on poor communities. Dr Carly Lightowlers from the University of Liverpool told us:

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- 90 Public Health England, written evidence
 - 91 Faculty of Public Health, written evidence
 - 92 Jyoti Atri, oral evidence session, 2 March 2020
 - 93 Dr Helen McAvoy, oral evidence session, 11 March 2020
 - 94 Public Health England (2016) Health matters: harmful drinking and alcohol dependence, health inequalities and alcohol dependence
 - 95 Dr Benjamin Hawkins, oral evidence session, 23 March 2020
-

*“More socio-economically deprived populations and areas experience a disproportioned rate of violence associated with alcohol drinking and/or availability ... Crime Survey for England and Wales findings show that lower socioeconomic groups experience higher incidence and prevalence rates of alcohol-related violence, including domestic and acquaintance violence”.*⁹⁶

“If you look at a map of the distribution of liver mortality in Southampton, there’s a massive hotspot in a few really deprived areas in the city.”

Professor Nick Sheron

The health service

“Problems all year round”

Alcohol harm puts great pressure on the NHS. The total cost to the NHS of alcohol harm is estimated to be £3.5bn a year.⁹⁷ Alcohol-related hospital admissions reached a record level in 2018/19, with 1.26 million alcohol-related admissions.⁹⁸

According to the Royal College of Emergency Medicine, 12-21% of all attendances to emergency department are related to alcohol.⁹⁹ This figure rises to 70% at certain peak times.¹⁰⁰ This has a knock-on effect: *“alcohol-related cases overload emergency departments, impacting on wait times for non-alcohol-related patients”.*¹⁰¹

A survey of emergency service workers by the Institute of Alcohol Studies found that alcohol is a major cause of ambulance callouts, with 37% of ambulance service time spent dealing with alcohol-related

“Alcohol-related cases overload emergency departments, impacting on wait times for non-alcohol-related patients.”

Alcohol Change UK

incidents.¹⁰² The Association of Ambulance Chief Executives made a “conservative” estimate of 350,000 alcohol-related callouts per year, costing £81.1m in England (not including costs associated with 999 or 111 centres).¹⁰³

Modelling by the University of Sheffield found that introducing a 50p minimum unit price in England could provide £1.3bn in NHS cost savings over 20 years.¹⁰⁴

Alcohol fuelled crimes

“£11.4 billion per year”

Alcohol use is strongly associated with crime and violence. In 2017/18, nearly half a million violent crimes were committed under the influence of alcohol in England and Wales, making up 39% of all violent offences.¹⁰⁵ That may be an underestimate, according to Police Sergeant Mick Urwin:

*“In my experience that figure in reality is much higher, as a large portion of offences are not reported to police, especially where domestic violence is concerned. My experience has been many victims do not contact police and, if hospital treatment is required, the real cause of an injury may not be revealed to avoid police involvement”.*¹⁰⁶

Policing Minister Kit Malthouse described the estimated cost of alcohol related crime on society as being around £11.4bn per

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- 96 Dr Carly Lightowlers, written evidence
97 British Medical Association, written evidence
98 Public Health England, written evidence
99 Royal College of Emergency Medicine, written evidence
100 Institute of Alcohol Studies, written evidence
101 Alcohol Change UK, written evidence
102 Institute of Alcohol Studies, written evidence
103 Association of Ambulance Chief Executives, written evidence
104 Cancer Research UK, written evidence
105 Institute of Alcohol Studies, written evidence
106 Sergeant Mick Urwin, written evidence

year.¹⁰⁷ The Home Office also cited alcohol as a key driver of crime in their Modern Crime Prevention Strategy.¹⁰⁸ Warrington Council cited a national survey of people in prison, in which 38% of respondents perceived their drinking to be a big problem, and 70% reported being under the influence of alcohol when they committed the offence for which they had been incarcerated.¹⁰⁹

Inspector Donald Wade highlighted research by the Northumbria Police Harm Reduction Unit:

*“We looked at all arrests for Sunderland and South Tyneside over a ten-day period in April 2019. There were 301 people arrested and, of those 301 arrested, 96 presented at the custody desk were assessed as being intoxicated ... Of those 96, 79% were repeat offenders, and jointly those repeat offenders were responsible for 2,197 arrests over their offending lifetime ... all those who were brought in intoxicated, 50% were brought in for violence, and that was everything from common assaults to the lowest level of assault right through to homicide”.*¹¹⁰

“ Just imagine what it’s like trying not to drink and going round a place like London and noticing all the places where drink is available and pushed at you, it’s relentless. ”

Alastair Campbell

Why we need to reduce availability

“When the off-licences started 24-hour service, I drank more often”

The availability of alcohol is determined by the number of shops selling alcohol in a given location and the hours in which alcohol is on sale. The availability of alcohol can make it more difficult for individuals who wish to avoid drinking to do so, as explained by an expert by experience:

*“My dad can’t help drinking. Every day we need bread, milk etc from the shop next to our house. When he goes in, the temptation is too much for him. It’s not his fault when it’s staring him in the face. Maybe if we didn’t live near a shop he wouldn’t be able to get drink as easily”.*¹¹¹

There is a correlation between crime and the density of shops selling alcohol. Niven Rennie from the Violence Reduction Unit in Scotland told us that crime rates are four times higher in communities with a greater density of alcohol outlets.¹¹² Alcohol Focus Scotland stated:

*“Research has found a consistent relationship between alcohol availability and violence. In particular, the concentration of premises selling alcohol in an area (‘outlet density’) has been found to be associated with higher levels of alcohol-related crime, domestic violence and murder. A recent Scottish study found that neighbourhoods with the most outlets had significantly higher crime rates than neighbourhoods with the least”.*¹¹³

There is also a correlation between alcohol availability and deprivation. Statistics show that provision of alcohol is 40% greater in Scotland’s deprived communities than elsewhere.¹¹⁴ Paul Darragh from the British

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- 107 Association of Police and Crime Commissioners (2020) Alcohol and drugs in focus
108 Office of the Durham Police, Crime and Victims’ Commissioner, written evidence
109 Warrington Council, written evidence
110 Inspector Donald Wade, oral evidence session, 30 March 2020
111 Scottish Families Affected by Alcohol and Drugs, written evidence
112 Niven Rennie, oral evidence session, 2 March 2020
113 Alcohol Focus Scotland, written evidence
114 Alcohol Focus Scotland (2017) Changing Scotland’s relationship with alcohol
-

Medical Association in Northern Ireland noted that in areas of social deprivation *“there is a clustering of off-licences ... licensing authorities need to be able to deal with that.”*¹¹⁵

Alice Wiseman from the Association of Directors of Public Health told us how limiting hours of sale could also help to protect children: *“I submitted a representation against an application to serve alcohol at eight o’clock in the morning on the basis that we needed to think about how we protect children from alcohol harm on their journey to and from school”*.¹¹⁶

Yet local authorities lack sufficient ability to control the availability of alcohol in their areas.¹¹⁷ Local authorities in England and Wales are mandated to consider four objectives when deciding whether to grant

“ [I was] drinking from around 11:30am to 11:30pm, briefly stopping, when they used to close at three o’clock, for food or to sleep. When the off-licences started 24-hour service, I drank more often. ”

Expert by experience

115 Dr Paul Darragh, oral evidence session, 11 March 2020

116 Alice Wiseman, oral evidence session, 2 March 2020

117 Institute of Alcohol Studies, Public Health and Wellbeing Greenwich, Cambridgeshire County Council, Association of Directors of Public Health, ExILEnS team, Institute of Social Marketing and Health, University of Stirling, Cornwall Public Health and the Safer Cornwall Partnership, Faculty of Public Health, British Medical Association, Northumberland Drug and Alcohol Steering Group, County Durham Public Health, Mary Bailey, Balance, Office of the Durham Police, Crime and Victims’ Commissioner, Sergeant Mick Urwin, written evidence

118 Cambridge Council, Cornwall Public Health, Association of Directors of Public Health, Dr Carly Lightowlers, Greater Manchester Health and Social Care Partnership (74% of participants in the ‘Big Alcohol Conversation’ felt public health should be taken into consideration when making alcohol licensing decisions), Institute of Alcohol Studies, London Borough of Lambeth, Alcohol Change UK, Public Health and Wellbeing Greenwich, Cambridgeshire County Council, Royal College of Psychiatrists, Association of Directors of Public Health, ExILEnS team, Institute of Social Marketing and Health, University of Stirling, West Sussex County Council, Cornwall Public Health and the Safer Cornwall Partnership, Newcastle City Council Public Health, Dr Carly Lightowlers, British Medical Association, Northumberland Drug and Alcohol Steering Group, County Durham Public Health, Mary Bailey, Balance, Office of the Durham Police, Crime and Victims’ Commissioner, Sergeant Mick Urwin, written evidence

119 ExILEnS team, Institute of Social Marketing and Health, University of Stirling, written evidence

120 Niven Rennie, oral evidence session, 2 March 2020

121 Ibid

122 Licensing authorities in England and Wales can designate a Cumulative Impact Area (CIA) which allows them to consider the number of establishments when deciding whether to grant further premises licences. However, it is not possible for authorities to use CIAs to reduce existing oversupply.

a licence to a new premises, objectives which do not currently include public health. In Scotland, by contrast, public health is a licensing objective which local authorities must consider. Many submissions supported increased consideration of public health in licensing decisions on a UK-wide basis, requiring licensing boards to consider the impact that a premises would have upon public health before granting a licence.¹¹⁸ Preliminary evidence from a large study into the impact of alcohol licensing in England and Scotland suggests that *“the public health objective for licensing may give rise to greater opportunity to successfully argue against the granting of some licences”*.¹¹⁹

However, a public health objective alone is not enough. Niven Rennie of the Violence Reduction Unit Scotland stated that *“97% of licensing applications are approved”* in Scotland.¹²⁰ In England, Wales and Scotland, despite the public health objective in the latter, the number of licensed premises continues to grow with no clear mechanism for licensing boards to reduce the density of premises in areas that are oversupplied.^{121 122}

Sergeant Mick Urwin wrote:

“In my view, venues applying for licenses should be required to prove that the locality needs another alcohol outlet rather than the current position of an assumption one should be granted.”

This ... should be the default position in all licence applications".¹²³

We also heard examples of effective use of existing powers by local authorities. Jez Bayes explained that Cornwall Council use a tool to inform licensing decisions, using local data including hospital admissions, referrals into alcohol treatment, violence, anti-social behaviour and traffic collisions. *"It's allowed us to begin to get involved in a few cases: revocations and objecting to extensions"*, he told us. However, this did not remove the need for additional licensing powers: *"we need to have some kind of control and push-back to make sure that where we're selling alcohol, we're selling it in respect of the local context as sensibly and responsibly as possible"*.¹²⁴

**Recommendation:
Restrictions on availability
of retail alcohol through
reduced hours of sale
and reduced density of
retail outlets**

Local authorities across the UK must have greater powers to refuse licensing applications and to limit the number of licensed premises in an area. In England, Wales and Northern Ireland they must be allowed to consider the impact on public health of new premises when deciding whether to grant licence applications, as is the case in Scotland.

**Police and the
emergency services**

"Sexual assault is the norm"

In a survey by the Institute of Alcohol Studies, 96% of emergency service workers reported being threatened or verbally abused by someone who appeared to be intoxicated, with half sustaining an injury through dealing with an intoxicated person.



equivalent to more than

**1 FIRE
A DAY**

Between a third and a half of front-line service personnel said they had been sexually harassed or abused by intoxicated members of the public.¹²⁵

According to the British Medical Association, *"alcohol is also a leading factor in abuse towards NHS staff"*, with the number of physical assaults totalling 56,435 in 2016/17.¹²⁶

Police officers are at particular risk of assault. An inquiry by the Alcohol Harm All-Party Parliamentary Group (APPG) found that *"90% of officers expect to be assaulted on a Friday and Saturday night, and for female officers, sexual assault is the norm"*.¹²⁷

123 Sergeant Mick Urwin, written evidence
124 Jez Bayes, oral evidence session, 2 March 2020
125 Institute of Alcohol Studies, written evidence
126 British Medical Association, written evidence
127 Alcohol Change UK, written evidence

“ My Mum
smoked and
she set the house
on fire (when drunk)
when I was 14. We
were all very lucky to
get out alive.
We only did as my
sister aged 16 “
woke up.

Expert by experience

“ Drugs and alcohol cost the whole of the Northern Ireland economy. ”

Dr Paul Darragh, British Medical Association

A large proportion of police time is taken up by alcohol-related incidents. In a survey of police officers in the North East of England, 6 in 10 respondents said alcohol-related crime took up at least half of their time, while 1 in 10 said it constituted 80-100% of their workload.¹²⁸

Fire services are also affected. The London Fire Brigade attended 1,120 accidental alcohol-related fires over three years, equivalent to more than one incident every day.¹²⁹ A 2011 study showed that fires caused by alcohol were more likely to result in casualties and deaths.¹³⁰ We heard that, in Greater Manchester, alcohol is a factor in 44% of all accidental fire deaths.¹³¹

Employment and the economy

“I had to cancel meetings, I was just so ill”

The costs of alcohol to the economy and society eclipses the economic contribution of the alcohol industry. In 2012, the government estimated the cost of alcohol to society at £21bn in England and Wales.¹³² More recent research suggests this figure is higher: at least £27bn and as high as £52bn.¹³³ In contrast, the revenue to the Treasury from alcohol duties is estimated at just £12bn.¹³⁴

Public Health England note that the costs are not absorbed by drinkers alone: “the financial burden which alcohol-related harm places on society is not reflected in its market price, with taxpayers picking up a larger amount of the overall cost compared to the individual drinkers”.¹³⁵



There is also a negative economic impact from the number of working years lost due to premature deaths caused by alcohol. Public Health England referenced its 2016 evidence review which stated “alcohol has caused more years of life lost to the workforce than the 10 most common cancers combined. In 2015, 167,000 working years of life were lost to alcohol”.¹³⁶

- 128 Balance, written evidence
 129 Alcohol Change UK, written evidence
 130 Institute of Alcohol Studies, written evidence
 131 Greater Manchester Health and Social Care Partnership, written evidence
 132 Public Health England, written evidence
 133 Lancet Commission on Liver Disease, written evidence
 134 HMRC (2019) UK Alcohol Duty Statistics July 2019. Figure refers to the tax year 2018/19
 135 Public Health England, written evidence
 136 Ibid

Alcohol use is associated with unemployment, absenteeism and decreased output.¹³⁷ The Institute of Alcohol Studies calculated that a further £1.2bn-£1.4bn is lost due to individuals being less productive at work due to the effects of alcohol consumption.¹³⁸

Increasing alcohol prices through minimum unit prices and taxes would create financial gains for the taxpayer. Research which modelled the economic and employment impact of duty increases found *“an increase in alcohol duty rates, if used to fund increased general government expenditure, results in a net impact of 17,041 [full time equivalent] additional jobs and a rise in [gross value added] of £847 million”*. The report further noted that *“the combined outcome of better health outcomes arising from lower consumption of alcohol and higher economic activity can be seen as a ‘double dividend’”*.¹³⁹

Why we need to reduce affordability

“It’s all about price”

To reduce the burden on the NHS, public services and the economy, and to reduce health inequalities, increasing the price of alcohol should be an important part of any new alcohol strategy.

Since the 2012 UK Government’s Alcohol Strategy noted that *“cheap alcohol is too readily available”*, off-trade beer is 15% cheaper and off-trade wine and spirits 14% cheaper.¹⁴⁰ This was in large part due to successive real-terms cuts to alcohol duty. Off-trade prices have fallen more than in the on-trade.¹⁴¹ A participant from the

“ I believe that if I hadn’t been able to access that cheap cider, I may have gone into treatment sooner and got myself well. ”

Steven, Expert by experience

Manchester Big Alcohol Conversation stated:

“The price that supermarkets sell alcohol at is way too cheap and is only encouraging people to drink behind closed doors where people are less likely to see that somebody has a problem”.¹⁴²

Joanne Good, whose daughter Megan tragically died at the age of 16 after drinking cider on New Year’s Eve told us: *“it’s all about price ... we need to tackle the price of it first”*.¹⁴³ Expert by experience Steven Sawyer explained the impact cheap alcohol had upon him: *“I believe that if I hadn’t been able to access that cheap cider, I may have gone into treatment sooner and got myself well”*.¹⁴⁴

There is evidence that measures to address affordability are *“the most effective, and cost-effective, approaches to prevention and health improvements”*.¹⁴⁵ This was reinforced by Professor John Holmes from Sheffield University who told us: *“increasing the price of alcohol is an effective way of reducing alcohol consumption and related harm”*.¹⁴⁶

Minimum Unit Pricing

Minimum Unit Pricing (MUP) was recommended by several organisations as

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- 137 Ibid
 - 138 Institute of Alcohol Studies, written evidence
 - 139 Ibid
 - 140 Institute of Alcohol Studies (2020) Budget 2020 analysis
 - 141 Ibid
 - 142 Greater Manchester Health and Social Care Partnership, written evidence
 - 143 Joanne Good, oral evidence session, 20 March 2020
 - 144 Steven Sawyer, oral evidence session, 20 March 2020
 - 145 Public Health England, written evidence
 - 146 Professor John Holmes, oral evidence session, 11 March 2020
-

a way to reduce alcohol affordability.¹⁴⁷ MUP sets a floor price based on the amount of alcohol a product contains. It was introduced in Scotland in May 2018 and in Wales in March 2020. Data from Scotland suggest that MUP led to a net reduction in alcohol sales of between 4%-5% in its initial 12 months, compared to England and Wales where MUP had not been implemented.¹⁴⁸ There are also indications that the greatest reduction has been among the heaviest drinkers.¹⁴⁹

Cancer Research UK highlighted research into the effectiveness of MUP which showed a 50p MUP in England would lead to almost 22,000 fewer hospital admission and 525 fewer deaths per year after 20 years. This would potentially save the NHS £1.3bn. The strongest impact would be amongst those living in poverty.¹⁵⁰

Other real-world case studies have also demonstrated declines in consumption and harm following price increases: A 10% increase in minimum prices in Saskatchewan, Canada led to an 8.43% decline in consumption; price increases in British Columbia, Canada were linked to reduced acute and chronic alcohol related admissions in hospitals.¹⁵¹ The Welsh Government reinforced this point, noting “evidence from around the world on the impact of price on the consumption of alcohol suggests that introducing an MUP could have an important impact on reducing levels of hazardous and harmful drinking and would help to save lives”.¹⁵²

“ It’s all about price ... we need to tackle the price of it first. ”

Joanne Good, Expert by experience

Alcohol Taxation

MUP and increasing alcohol taxation are complementary policies. Public Health England emphasised that taxation alongside MUP would “lead to substantial reductions in harm and increases in government revenue” with a greater reduction “than that achieved by an MUP in isolation”.¹⁵³ The British Medical Association noted that “controlling price requires a two-fold approach” combining an annual above-inflation increase in alcohol duties with the complementary measure of minimum unit pricing to specifically address the cheapest, highest-strength drinks.¹⁵⁴

Modelling by Sheffield University found that changes to alcohol duty since 2012 have led to over 2,000 additional deaths and almost 66,000 additional hospital admissions in England and Scotland in the period 2012-2019.¹⁵⁵ Professor Nick Sheron told us that “each tax freeze costs around 300 lives in terms of liver mortality”.¹⁵⁶

The 2019 Conservative manifesto committed to a review of alcohol taxation. This will allow the government to remove the anomalies in the system which allow for certain products like white cider to be sold at extremely low prices. The Joint Public Issues Team, a group

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- 147 The Children’s Society, Public Health England, Association of Directors of Public Health (submission also noted that 83% of Directors of Public Health who responded to a survey showed strong support for the introduction of MUP in England), Cancer Research UK, British Medical Association, Institute of Public Health in Ireland, Alcohol Change UK, Institute of Alcohol Studies, Royal College of Psychiatrists, Glasgow Caledonian University, West Sussex County Council, Joint Public Issues Team, Centre for Ageing Better, SHAAP, Camden and Islington Public Health, British Association for the Study of the Liver, WDP, Scottish Families Affected by Alcohol and Drugs, Northumberland Drug and Alcohol Steering Group, County Durham Public Health, Mary Bailey, Balance, Office of the Durham Police, Crime and Victims’ Commissioner, Drugs and Alcohol Team, South Gloucestershire Council, London Borough of Lambeth, Quaker Action on Alcohol and Drugs, Newcastle City Council Public Health, written evidence
- 148 Public Health Scotland, MESAS (2020) Evaluating the impact of Minimum Unit Pricing (MUP) on sales based alcohol consumption in Scotland: controlled interrupted time series analyses
- 149 Institute of Alcohol Studies (2020) Minimum Unit Pricing in Scotland: what we know so far about its effects on consumption and health harms
- 150 Cancer Research UK, written evidence
- 151 Ibid
- 152 Welsh Government, written evidence
- 153 Public Health England, written evidence
- 154 British Medical Association, written evidence
- 155 Colin Angus and Madeleine Henney (2019) Modelling the impact of alcohol duty policies since 2012 in England & Scotland, University of Sheffield
- 156 Professor Nick Sheron, oral evidence session, 11 March 2020

of four Christian churches recommended “a new alcohol tax designed so that tax rates are directly linked with alcohol strength rather than price or alcohol type, as is the current situation, raising additional revenue for government rather than alcohol manufacturers”.¹⁵⁷ Such a tax could be scalable so that stronger drinks are taxed at a higher rate per unit, thus incentivising the development and production of lower strength products.

The review will allow the government to explore differential duty rates between the on- and off-trade which could help to attenuate the trend towards greater consumption of off-trade alcohol. Further opportunities include the option to investigate levies on producers to address the financial impact of the harm caused by their products. A recent report by the Social Market Foundation has more detail on the opportunities for reform.¹⁵⁸

Public Health England emphasised the importance of ensuring that taxation and pricing policies are “updated in line with changes in income and inflation, to retain the impact on affordability”.¹⁵⁹ We were told that reintroducing an annual automatic above inflation increase in alcohol duty in 2019 would have saved over 5,000 lives in England and Scotland by 2032.¹⁶⁰ We suggest that an independent body should regularly review the level of MUP and alcohol duty, following the model of the minimum wage set by the Low Pay Commission.

Recommendation: Reduced price promotion of alcohol through increased alcohol duty and minimum prices with regular reviews of prices in relation to inflation and income

This must include the introduction of minimum unit pricing in England and Northern Ireland, an increase in alcohol duty to reverse real terms cuts since 2013, and a reform of duty structures so that stronger drinks always cost more. Duty reform should consider the case for differential duty rates between the on- and off-trade, and a levy on producers to offset some of the costs to society and the economy caused by their product.

157 Joint Public Issues Team, written evidence

158 Social Market Foundation (2019) Pour decisions? The case for reforming alcohol duty

159 Public Health England, written evidence

160 County Durham Public Health, written evidence



“ I had to
cancel
meetings, I
was just
so ill. ”

**Susan Laurie,
Expert by
experience**

Harm to the individual

Physical health

“Even at relatively small amounts, it is toxic”

Public Health England wrote that over 10 million people currently drink at levels which increase their risk of health harm, further noting that:

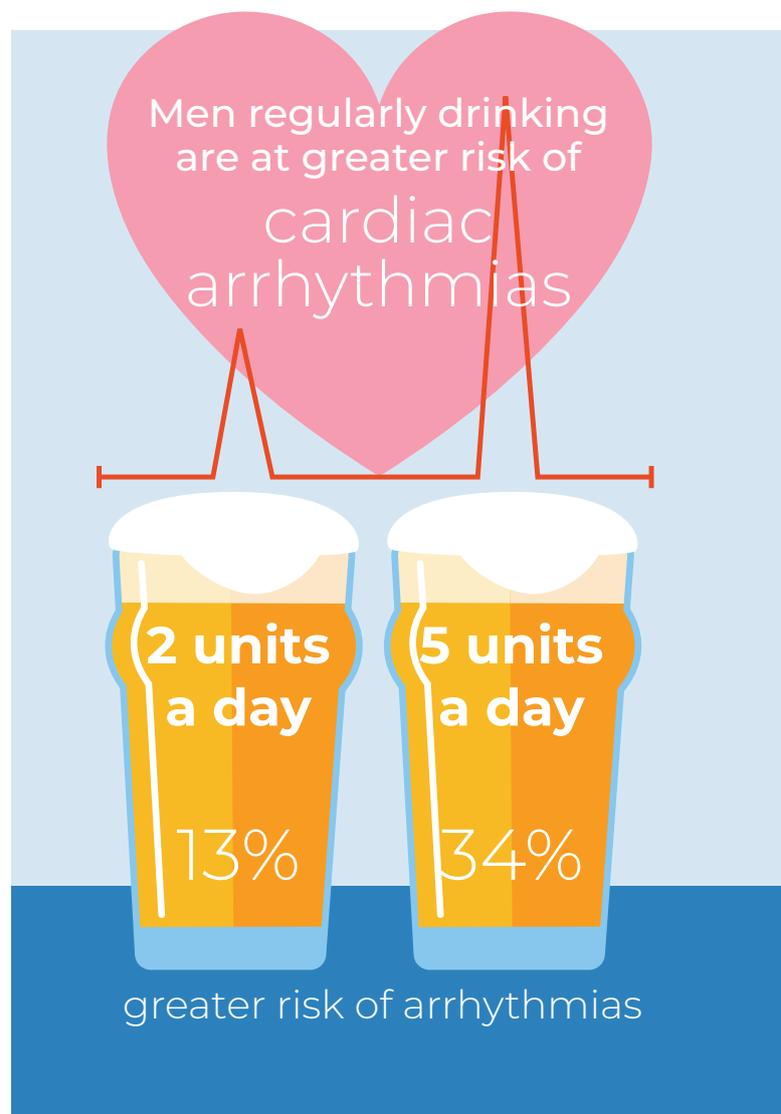
*“Alcohol is a leading cause of premature death – in England, the average age at death of those dying from an alcohol-specific cause is 54.3 years while the average age of death from all causes is 77.6 years ... In England, in 2015, there were an estimated 301,000 potential years of life lost due to alcohol in persons aged under 75, meaning that alcohol causes more years of life lost in England ... than from the 10 most frequent cancer types combined”.*¹⁶¹

There were 5,698 alcohol-specific deaths in the UK in 2018/19. Though this is 2% lower than the previous year, overall the numbers have risen 7% in a decade.¹⁶² Professor Roger Williams of the Lancet Commission on Liver Disease noted alcohol’s impact as a cause of ill health, stating: *“people spend 20% of their lives in ill health ... they are ill because of alcohol, obesity, no exercise”.*¹⁶³

Alcohol can contribute to around 200 health conditions.¹⁶⁴ Submissions mostly focused upon cancer, liver disease and obesity, though we also received evidence of its adverse effects on cardiovascular disease, alcohol-related brain damage and on increasing the risks of surgery.

Professor Roger Williams told us that *“cardiovascular disease is strongly linked*

*with alcohol consumption.”*¹⁶⁵ Men who regularly drink two units of alcohol a day are at a 13% greater risk of cardiac arrhythmias, whilst those drinking five units a day are at a 34% increased risk.¹⁶⁶ Recent research found an increased risk of all-cause mortality above a 12.5 unit per week threshold, including an increased risk for stroke and heart failure.¹⁶⁷



- 161 Public Health England, written evidence
- 162 British Association for the Study of the Liver, written evidence
- 163 Professor Roger Williams, oral evidence session, 11 March 2020
- 164 Public Health England, written evidence
- 165 Professor Roger Williams, oral evidence session, 11 March 2020
- 166 Institute of Alcohol Studies, written evidence
- 167 British Association for the Study of the Liver, written evidence

Alcohol affects the functioning of the brain. In the most serious cases, it can result in alcohol-related brain injury. Change Grow Live highlighted the “*increasing evidence of overlap between alcohol related and other progressive/non progressive brain disorders*”.¹⁶⁸ Drink Wise, Age Well noted that the numbers of people admitted to hospital in Scotland with alcohol-related brain damage is at “*an all-time high*”. Upon screening service users for their programme, they found that 50% of those screened had some level of cognitive impairment on entering the programme.¹⁶⁹

Alcohol use can also impact individuals’ response to surgical procedures. The Centre for Perioperative Care told us:

*“For hazardous drinkers - consuming five or more alcoholic drinks per day - the post-operative complication rate increases by 200–400%, compared to those consuming only up to two drinks. Research suggests that a period of abstinence from alcohol for one month in advance of surgery significantly decreases morbidity and mortality”.*¹⁷⁰

Cancer

Cancer Research UK presented evidence that alcohol causes seven types of cancer (mouth, upper throat, larynx, oesophageal, breast, bowel, and liver) and is responsible for an estimated 11,900 cases of cancer a year in the UK.¹⁷¹ The Faculty of Dental Surgery at the Royal College of Surgeons of England highlighted that the “*increased risk of oral cancer is one of the most important effects of high alcohol consumption*”.¹⁷²

For some cancers, such as breast cancer, the risk is increased even at lower levels of drinking.¹⁷³ This was reinforced by Professor Annie Anderson who told us:

*“Not drinking alcohol is better for cancer prevention ... there’s a huge amount of evidence there in relation to cancer and we shouldn’t be allowed to forget that even at relatively small amounts, it is toxic”.*¹⁷⁴

8% of breast cancer cases are caused by drinking alcohol.¹⁷⁵ Women who regularly drink two units of alcohol a day are at a 16% greater risk of developing breast cancer, whilst those drinking five units a day are at a 40% greater risk.¹⁷⁶ Professor Nick Sheron from the University of Southampton explained the relative cancer risks in comparison to cigarettes:

*“As far as men are concerned, a bottle of wine, in terms of cancer risk, is the equivalent of smoking five cigarettes. A bottle of wine for women, in terms of cancer risk, is the same as smoking ten cigarettes, and that difference is because alcohol is a very significant risk factor for breast cancer”.*¹⁷⁷

Liver disease

Hospital admissions for alcohol-related liver disease were up 76% in 2018/19 compared with 2008/09, a significant rise in just ten years.¹⁷⁸ The British Society for Gastroenterology highlighted the rise of alcohol-related liver mortality:

“While mortality rates from other common diseases are falling in the UK, liver disease deaths have increased dramatically, with a 400% increase in the standardised mortality rate during 1970-2010.”

Professor Roger Williams described the high mortality rates for alcoholic liver disease admissions with 23.4% mortality at 60 days.¹⁷⁹ Consultant Liver Specialist Dr Alastair MacGilchrist told us that patients

168	Change Grow Live, written evidence
169	Drink Wise, Age Well written evidence
170	Centre for Perioperative Care, written evidence
171	Cancer Research UK, written evidence
172	Faculty of Dental Surgery at the Royal College of Surgeons of England, written evidence
173	Cancer Research UK, written evidence
174	Professor Annie Anderson, oral evidence session, 23 March 2020
175	Cancer Research UK, written evidence
176	Institute of Alcohol Studies, written evidence
177	Professor Nick Sheron, oral evidence session, 11 March 2020
178	British Association for the Study of the Liver, written evidence
179	Professor Roger Williams, oral evidence session, 11 March 2020

Alcohol caused
11,900
cases of
CANCER

in the UK in 2015,
the equivalent of
33 people
PER DAY



Alcohol plays a causal role in

mouth

pharynx

larynx

oesophageal

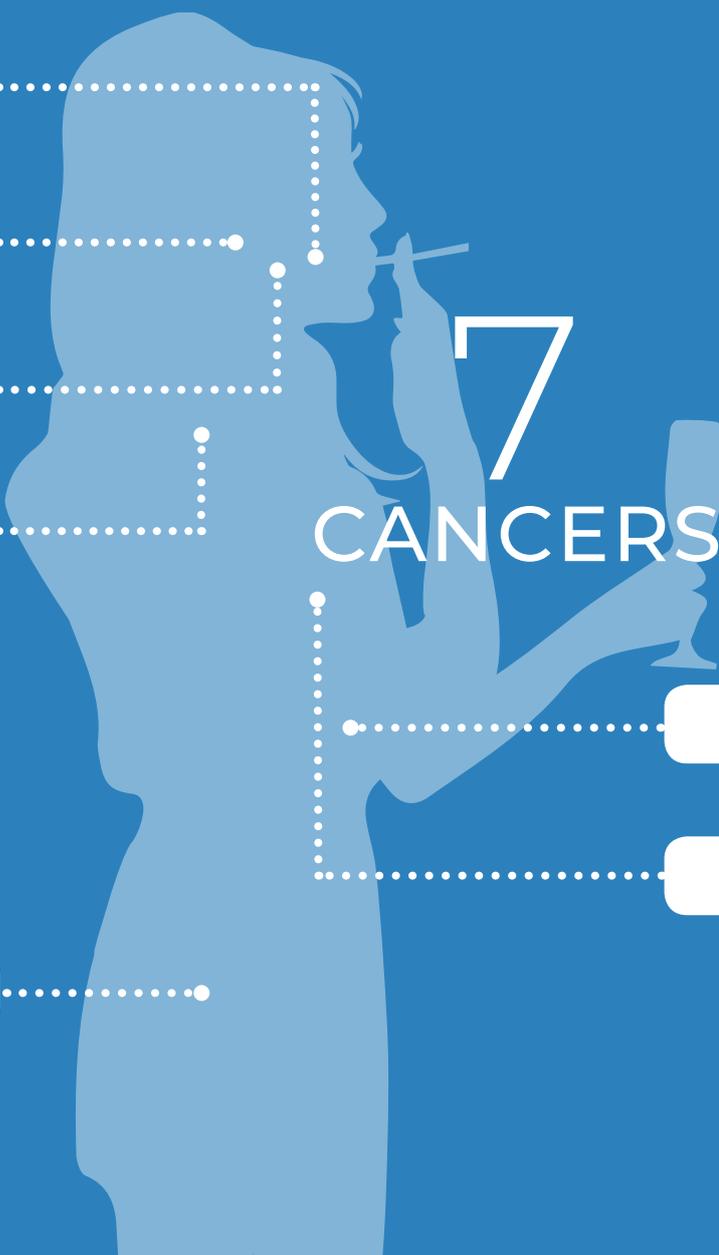
bowel cancer

the risk of some of these cancers is even higher for those who simultaneously drink and smoke

7
CANCERS

liver cancer

breast cancer



dying from liver disease as a result of alcohol damage has become a routine occurrence in inpatient wards in secondary care: *“if the [gastrointestinal] team have a death that’s an exception. Every month there are several liver patients who have died, without exception. It’s an unexceptional event, liver disease kills you”*.¹⁸⁰

Liver disease *“develops completely silently, there are no signs or symptoms that you’re getting liver disease”*, according to Professor Nick Sheron. He added:

“More than 75% of people who are alive, right now, with cirrhosis and who are going to die of cirrhosis have no idea that they have liver disease and they’re not being picked up until they come into hospital as an emergency admission”.¹⁸¹

Dr MacGilchrist explained:

“Often, it’s people who have been found accidentally to have liver damage when somebody’s done a blood test or done a scan. They feel perfectly well and they’re a bit stunned to be told that they’ve got severe damage to the liver that might prove fatal within a relatively short space of time ... my principal message is that liver disease is silent until it’s irreversible”.¹⁸²

Professor John Dillon explained the missed opportunities to intervene that become apparent when reviewing liver deaths:

“If you look back through the notes, going back through the history, there are points of contact that these people have had in the past where there could have been opportunities to intervene. Now, people may have intervened and tried to improve things at that time, I don’t know, but those opportunities didn’t work. So the first time that they come to overt notice is when they get admitted in liver failure and one in five of them will die on their first admission to hospital”.¹⁸³

Why we need more identification and brief advice “They really are impactful”

One way to identify individuals who are at risk and to intervene earlier is through identification and brief advice (IBA). They are simple measures that can be carried out in different contexts, identifying individuals drinking at hazardous and harmful levels and giving them information about reducing their consumption. For harmful drinkers, fully resourced, specialist referral should be routine.

There remains room for improvement in IBA provision. Professor John Dillon explained: *“we need to get better at spotting people earlier in the community. In that out-patient setting, in general practice, with better use of our technology”*.¹⁸⁴ Professor Annie Anderson highlighted missed opportunities in routine screening, stating: *“I can’t believe women still come in for breast screening and nobody mentions lifestyle risk factors and the possibility of reducing risk even after the age of 50”*.¹⁸⁵ TV Presenter Adrian Chiles talked about how his own harmful drinking was ignored by a range of professionals. He described how he had seen *“a psychiatrist, a cardiologist and a gastro person just to do with reflux and everything. None of them were really bothered about the alcohol aspect at all, the cardiologist was completely uninterested”*.¹⁸⁶

Clare Beeston from NHS Scotland described the obstacles to increasing IBA explaining that *“some of the barriers are competing time, competing priorities, as well as things like the challenges of getting [IBA] into the*

“ Liver disease is silent until it’s irreversible. ”

Dr Alastair MacGilchrist

180 Dr Alastair MacGilchrist, oral evidence session, 23 March 2020

181 Professor Nick Sheron, oral evidence session, 11 March 2020

182 Dr Alastair MacGilchrist, oral evidence session, 23 March 2020

183 Professor John Dillon, oral evidence session, 23 March 2020

184 Ibid

185 Professor Annie Anderson, oral evidence session, 23 March 2020

186 Adrian Chiles, oral evidence session, 11 March 2020

most effective areas like primary care".¹⁸⁷ We were told that GPs in England now screen fewer patients for high risk drinking following withdrawal of financial incentives.¹⁸⁸

However, we also heard examples of good practice. A 2012 Cochrane Review found "one-to-one dietary interventions in the dental settings can change behaviour", including interventions aimed at reducing alcohol consumption. As part of the Healthy Living Dentistry programme, practices promote "public health campaigns such as Dry January and [have] conversations with patients to raise awareness of key health issues such as reducing alcohol consumption". The Faculty of Dental Surgery at the Royal College of Surgeons of England believes there is a strong case for rolling out this programme across the UK.¹⁸⁹

IBAs are usually associated with the health and social care setting, but there is scope to expand them to other sectors. Niamh Cullen of Calderdale Council described innovative work in her local area:

"We rolled [IBA] out across our professional services, but then looked at more innovative places as well like barbershops and hairdressers, but then people started to create some really good ideas. Driving instructors were absolutely fantastic with young people, so you could pay the driving instructors for an hour's lesson plus, do [IBA] training with them and they really are impactful. That was our plan, [IBA] everywhere".¹⁹⁰

We heard from witnesses that harmful drinking can be triggered by adverse life events. There would therefore be benefits to rolling out IBA across services that support people in difficult life situations such as bereavement services, victim support and the police. Alastair Campbell told us: "*[the police] were the first people I ever, ever admitted to, 'I think I might have a drink problem'".¹⁹¹*

There is also scope for innovation through the use of technology. Lambeth Council reported that they have built an inexpensive comprehensive IBA delivery system using DrinkCoach, an online IBA tool.¹⁹² Technology cannot replace face-to-face interactions and access to technology is not universal. However, digital innovation may allow greater audiences to be reached by IBA.

Recommendation: Brief psychosocial interventions for people with hazardous and harmful alcohol use, with appropriate training for providers at all levels of healthcare

As alcohol affects so many different parts of the body, alcohol screening and brief interventions should be part of routine practice in new settings within healthcare such as dentistry and breast clinics. Interventions can be extended to settings outside healthcare including bereavement services and driving lessons. Digital options should be explored as an opportunity to extend brief interventions into new spaces.

Obesity and nutrition

The Institute of Public Health in Ireland told us that alcohol "*can make a significant contribution to levels of overweight and obesity in the adult population*".¹⁹³ Adults who drink get nearly 10% of their daily calorie intake on average from alcohol. However, studies have shown that up to 80% of adults did not know the calorie content of common drinks.¹⁹⁴

A 125ml glass of 12% ABV wine has about 114

187 Clare Beeston, oral evidence session, 23 March 2020

188 Change Grow Live, written evidence

189 Faculty of Dental Surgery at the Royal College of Surgeons of England, written evidence

190 Niamh Cullen, oral evidence session, 2 March 2020

191 Alastair Campbell, oral evidence session, 11 March 2020

192 London Borough of Lambeth, written evidence

193 Institute of Public Health in Ireland, written evidence

194 Department of Health and Social Care (2020) Tackling obesity: empowering adults and children to live healthier lives

calories¹⁹⁵. By comparison, a 330ml can of Coca-Cola contains 139 calories¹⁹⁶. This means that, per ml, wine contains more than double the calories of Coca-Cola.

Professor of Public Health Nutrition Annie Anderson from the University of Dundee advocated thinking about the role of alcohol as an “everyday contributor, particularly around obesity”.¹⁹⁷ She added that alcohol also has an impact on nutrition and health in general as:

*“High alcohol intakes can impact on nutrient absorption and metabolism, and particularly B vitamins, thiamine and folate. For many people with a high alcohol intake and low nutrient status immune function is likely to be affected”.*¹⁹⁸

A ready-to-drink (RTD) alcoholic drink is a mix of an alcohol product with a soft drink. Research by Action on Sugar indicates that a standard 500ml RTD can contain up to 49.1g of sugar per bottle – more than 12 teaspoons of sugar.¹⁹⁹ However, alcoholic drinks are not required to display the amount of sugar they contain.

Why we need product labelling “Industry is failing to do the absolute minimum”

Alcohol is exempt from the labelling requirements for food and non-alcoholic drinks. Alcoholic drinks are only required to display the volume and strength (in ABV) and common allergens. Information on nutritional values (including calories), ingredients, health warnings or even how many units of alcohol the product contains is not required, and is therefore largely absent from labels.

Professor of Public Health Nutrition Annie Anderson told us: “I’m shocked how far

alcohol is always kept out of nutrition policy”.²⁰⁰ TV Presenter Adrian Chiles, who explored labelling in a programme for BBC Panorama explained:

*“It is absurd in a pub that you buy a pint, it doesn’t have to tell you how many calories are in it, but you buy a bag of crisps to go with the pint, by law, it has to give you the number of calories ... on an alcoholic product you don’t have to provide nutritional information including calories ... if you’ve got ... alcohol free [beer], it’s got all the nutritional information and how many calories on it, ordinary [beer], they don’t have to put it on there”.*²⁰¹

Where information is available on labels, in many cases it is inaccurate, in a small font size or in an inaccessible format. A recent report by the World Health Organization cited a study which found that the mean font size for guidelines on products was 8.17, smaller than the 10-11 font size that is considered optimal for legibility.²⁰² As Adrian Chiles put it: “I didn’t realise I needed reading glasses actually until I was trying to see silver on white, on a [lager] can”. He added: “it says, ‘For more information go to Drinkaware.co.uk,’ as if anybody, in a pub, is going, ‘Oh hang on, I’ll just check with Drinkaware on this’. It’s just a complete nonsense”.²⁰³

We heard that requirements for improved information should not be confined to product labels but should also cover promotional activity. In her oral evidence, Alison Douglas from Alcohol Focus Scotland stated:

“What we should be requiring at an absolute minimum is that for every message, every marketing message that the industry puts out, that there is a health message required to be in there. Obviously with tobacco we have the

195 “Eurocare (2018) What’s in this drink?”

196 “Coca Cola, How many calories are there in a 330ml can of Coca-Cola original taste?”

197 Professor Annie Anderson, oral evidence session, 23 March 2020

198 Ibid

199 Action on Sugar (2020) Sugar content of ready-to-drink alcoholic beverages

200 Professor Annie Anderson, oral evidence session, 23 March 2020

201 Adrian Chiles, oral evidence session, 11 March 2020

202 Mark Petticrew, Nick Douglas, Cecile Knai, Mary Alison Durand, Elizabeth Eastmure and Nicholas Mays (2015) Health information on alcoholic beverage containers: has the alcohol industry’s pledge in England to improve labelling been met? Addiction

203 Adrian Chiles, oral evidence session, 11 March 2020

health messaging on cigarette packets. Industry is failing to do the absolute minimum ... with its marketing and advertising it's not providing or giving information about the basic guidelines or about the health consequences of drinking alcohol".²⁰⁴

An expert by experience told us about the impact that marketing without health information has had upon her mother:

"[My mother's] ability to still easily find alcohol is a constant battle as it is readily everywhere and advertised. But the health implications are not advertised well enough and a lot of people are unsure of the signs to look for".²⁰⁵

There is support from the public for stronger information requirements. 73% of those who participated in the Big Alcohol Conversation felt that all alcohol sold should have information about how it can affect health.²⁰⁶ As well as information on nutritional information and alcohol content, the UK Chief Medical Officers' guidance that "*it is safest not to drink more than 14 units a week on a regular basis*" should also be included on alcohol product labels.

Recommendation: Alcohol labelling to provide consumers with information about alcohol harm

All alcohol product labels must include:

- ▶ the Chief Medical Officers' guidelines on low-risk consumption
- ▶ a prominent health warning
- ▶ units provided in a whole container and typical serving
- ▶ ingredients and nutritional information such as calories

“ It says, ‘For more information go to Drinkaware.co.uk,’ as if anybody, in a pub, is going, ‘Oh hang on, I’ll just check with Drinkaware on this’. It’s just a complete nonsense. ”

Adrian Chiles, TV presenter

204 Alison Douglas, oral evidence session, 23 March 2020

205 Anonymous, written evidence

206 Greater Manchester Health and Social Care Partnership, written evidence



“ We shouldn’t
be allowed to
forget that even at
relatively small
amounts, ”
it is toxic. ”

**Professor Annie
Anderson**

Alcohol and mental ill health

“We can’t treat your mental health if you are using substances”

Alcohol can be related to depression, anxiety, isolation, unhealthy eating patterns, self-harm and suicidal ideation. As expert by experience Meirion Evans told us that harmful drinking, addiction and mental ill health are closely linked.²⁰⁷

Alcohol can make mental ill health worse. Expert by experience Jade Roman told us: “I’ve got quite severe mental health problems [and] when I drank they would really get out of control”.²⁰⁸ Another individual wrote: “the more I drank the more my mental health suffered; I became very withdrawn from society and would only come out if there was drink involved”.²⁰⁹

This was reinforced by personal testimony from St Mungo’s written evidence:

*“I do struggle with mental health, I get depression and anxiety really badly ... I started drinking to fall asleep because of stuff that had gone on for years and years ... So I couldn’t sleep, I was depressed, and then progressively my tolerance got higher, so my intake got higher, and then I started feeling crap the next day. I found out that if I have a beer in the morning, I feel fine, and you start day drinking, and then it gets worse and worse”.*²¹⁰

The link between alcohol and suicide is especially concerning. Dr Helen McAvoy told us that alcohol is involved in around half of all self-harm presentations and that almost half (46%) of all people presenting with suicidal ideation in Northern Ireland between 2012 and 2018 had consumed alcohol.²¹¹ The leading cause of alcohol-attributable death among men aged 25-34 is intentional self-harm.²¹²

“ I’ve got quite severe mental health problems [and] when I drank they would really get out of control. ”

Jade Roman, Expert by experience

Despite their common co-occurrence, we heard that individuals experiencing both mental ill health and alcohol dependence struggle to get the support they need. One individual told us:

*“During my active addiction I had bouts of psychosis and panic attacks, doctors were baffled, not understanding that I suffered from a disease and just prescribed anti-anxiety and sleep medication which I abused”.*²¹³

William Adams from the Welsh Emergency Department Frequent Attendees Network described this from a clinical perspective:

*“I’ve seen it [on] many occasions where people with low level anxiety that probably just need some sort of self-help group or therapy work that would work for them, but they’re told, ‘You’re not right for us because you’ve got an alcohol problem.’”*²¹⁴

This was reinforced by charity SFAD who told us that addiction and mental health services “bounce individuals backwards and forwards, claiming ‘we can’t treat your mental health if you are using substances’ and vice versa”.²¹⁵

Treatment provider Changing Lives explained that there is clear guidance from NICE and Public Health England “that mental health and substance misuse services have a shared responsibility to provide support”. Despite this, “the research

207 Meirion Evans, oral evidence session, 2 March 2020

208 Jade Roman, oral evidence session, 2 March 2020

209 Anonymous, written evidence

210 St Mungo’s, written evidence

211 Dr Helen McAvoy, oral evidence session, 11 March 2020

212 Lisa Jones and Mark A. Bellis (2013) Updating England-specific alcohol-attributable fractions, Centre for Public Health, Liverpool John Moores University

213 Anonymous, written evidence

214 William Adams, oral evidence session, 2 March 2020

215 Scottish Families Affected by Alcohol and Drugs, written evidence

shows that most people are required to address their substance use before they can access mental health support – even though they may be using substances in response to their poor mental health”.²¹⁶

Elizabeth Perrers, whose son Steven died at the age of 38, described the difficulty she experienced in trying to get help for her son. She explained: “we found out in 2018 that Steven could have been referred to the mental health unit for alcohol abuse way back in 2013”.²¹⁷

The need for better integration of services for those with co-occurring alcohol and mental ill health was raised repeatedly.²¹⁸ Dr Kelleher described the difficulties of attempting to treat one without the other:

*“Rather than being two conditions, they’re one part of a whole part of an individual. So we see people who have social anxiety who drink when they’re socially anxious and they detox, you detox them, and they’re told they have to wait six months to get psychological therapy and the addiction services have no psychologists left”.*²¹⁹

Dr Helen McAvoy agreed:

*“It’s really important that we emphasise the footprint that alcohol leaves on people’s mental health resilience, mental illness and suicide. We cannot resolve those issues without addressing alcohol”.*²²⁰

Why we need better treatment for those with alcohol dependence

“I had absolutely zero support”

Treatment is essential to help those with alcohol dependence towards recovery. Treatment has many aspects to it and can take many forms such as detox, residential rehab, community treatment and recovery communities.

We received evidence of several barriers into treatment including:

- ▶ lack of funding and availability
- ▶ poor pathways into treatment
- ▶ insufficient personalisation and flexibility in treatment
- ▶ lack of integration between formal treatment, mutual aid and peer support.

Funding and availability

There is insufficient treatment available to those who need it. Treatment provider Change, Grow, Live told us that services in England experienced “real term funding cuts of over £100 million, an average of 30% per service” since 2012.²²¹ We heard from St Mungo’s that reductions in funding for treatment mean that 12,000 fewer

“ During my active addiction I had bouts of psychosis and panic attacks, doctors ... just prescribed anti-anxiety and sleep medication which I abused. ”

Expert by experience

216 Changing Lives, written evidence

217 Elizabeth Perrers, written evidence

218 WDP, Dr Tony Rao, Greater Manchester Mental Health NHS Trust, Humankind, Action Together, Greater Manchester Health and Social Care Partnership, Institute of Alcohol Studies, London Borough of Lambeth, Alcohol Change UK, Public Health and Wellbeing Greenwich, Association of Directors of Public Health, Faculty of Public Health, Scottish Families Affected by Alcohol and Drugs, Changing Lives, Public Health Dorset, Northumberland Drug and Alcohol Steering Group, Professor Gareth Roderique-Davies and Professor Bev John, County Durham Public Health, St Mungo’s, Royal British Legion, Spectrum CIC, West Midlands Alcohol Forum, Recovery Cymru, Mary Bailey, William Adams, Saul Turner, Jo Huey, written evidence

219 Dr Michael Kelleher, oral evidence session, 11 March 2020

220 Dr Helen McAvoy, oral evidence session, 11 March 2020

221 Change Grow Live, written evidence

rough sleepers accessed alcohol and drug treatment in 2018-19 than if treatment had remained at the level it was at in 2010.²²² Niamh Cullen told us that when she started working at Calderdale Council there were seven people in a drug and alcohol commissioning team. She is now the only member of the team, serving a population of 220,000.²²³

Pathways into treatment

Consultant Liver Specialist Dr Alastair MacGilchrist told us that *“there is a need for clinicians to be better educated about pathways in their local area”*.²²⁴ Tom Bennett illustrated this point with his personal experience:

“I was a regular attendee at my GP who would prescribe me some benzodiazepines on repeat prescription, with very little psychosocial support or advice. She ... lacked the expertise, and I had absolutely zero support offered to me at that time, and my family had to dig deep into their pockets for me to be able to access some private residential support”.²²⁵

A mother described her difficulties getting support for her daughter who was *“totally chaotic and unable to function due to extremely heavy drinking”*. When she contacted her local service for help, they responded that her daughter must phone up to make an appointment and then attend at an agreed time. As the mother explained: *“they expected her to behave like a well person when she was extremely unwell”*.²²⁶

Expert by experience Melissa told us about the lack of support offered to her mother in hospital:

“I found her at home alone, with her eyes rolling into the back of her head and needed to call an ambulance because I thought she was dying. The hospital

later told me, her blood sugars will be monitored until they are back up to a safe level and then she’ll be discharged. No support given to her or to me because she denied having a problem and so was allowed home for this to happen again weeks later”.²²⁷

By contrast, expert by experience Jade Roman described the good practice she experienced after being admitted to hospital:

“They had an alcohol liaison officer there ... if anybody is admitted because of an alcohol-based problem, whether it be that they’ve injured themselves or that they’ve got something physically wrong with them, you are asked, ‘Would you like to just have a chat with them?’ ... he just had a chat and said, ‘Do you think you might have a problem?’ That’s how I accessed services rather than seeing a leaflet and going oh, I should probably go to that, they came to me ... that was a really helpful pathway for me”.²²⁸

Treatment provider Humankind reported a lack of funding for alcohol liaison posts in hospitals which results in *“missed opportunities to refer patients into community-based alcohol treatment services for specialist post discharge support”*.²²⁹ BASL told us that 17% of hospitals do not have a single alcohol specialist nurse and that most hospitals are unable to provide a 7-day service. They argued that there should be Alcohol Care Teams in all acute hospitals.²³⁰ Support available in hospitals should be strongly linked with the community, as Dr Michael Kelleher

“ We’re left begging to get people admitted for detox. **”**

Dr Michael Kelleher

- 222 St Mungo’s, written evidence
- 223 Niamh Cullen, oral evidence session, 2 March 2020
- 224 Dr Alastair MacGilchrist, oral evidence session, 23 March 2020
- 225 Tom Bennett, oral evidence session, 23 March 2020
- 226 Anonymous, written evidence
- 227 Melissa, written evidence
- 228 Jade Roman, oral evidence session, 2 March 2020
- 229 Humankind, written evidence
- 230 British Association for the Study of the Liver, written evidence

commented: “there’s a need for every hospital to have a care team ... and that they have links out to the community”.²³¹ A link between the hospital and community can be provided by an Assertive Outreach team, who can follow up with dependent drinkers to ensure treatment attendance. Andrew Misell from Alcohol Change Wales explained:

*“In terms of pathways to treatment, what we’ve often found, at the sharpest end, is that the average dependent drinker is not always capable of making their own way into treatment and there’s quite a high drop-out. We’re very much supportive of initiatives like Assertive Outreach ... actually going out and finding people who are drinking at the sharp end, rather than expecting them to come in under their own volition; they won’t, most often”.*²³²

Personalisation and flexibility

Treatment needs vary considerably between individuals so treatment provision must be flexible enough to meet the needs of all.

Age UK told us that fewer than 15% of older adults who drink problematically access treatment, in part due to services being designed for younger people. Particularly residential services often involve activities in which older people are unable to participate.²³³ Older people from black and minority ethnic backgrounds in particular face challenges in accessing treatment, such as increased stigma and cultural and family values.²³⁴

We heard from the Joint Public Issues Team, a group of four churches, about insufficient support for women in alcohol treatment services with only limited women-only treatment spaces.²³⁵

According to Alcohol Change UK, cost pressures have led to “one-size-fits-all alcohol interventions which are focused on

“ They expected her to behave like a well person when she was extremely unwell. ”

Expert by experience

*treating motivated clients”, as clients with more complex needs often require a less standard model of treatment.*²³⁶ Similarly, the Bury and Rochdale Care Organisation described a “one size service that all patients have to be shoehorned into”.²³⁷ Lambeth Council noted the lack of integration between services for patients with alcohol, social care, mental health and housing needs with individuals having to access several different services.²³⁸

Author and expert by experience Susan Laurie described her attempts to get help and lamented the lack of effective options available to her. She explained: “over the years I tried so many different things, you know, going to the GP a lot and being sent for counselling, to going to AA meetings, and I was in rehab twice”. She commented: “I’m convinced that if there’d been different treatment options available I wouldn’t have become extreme”.²³⁹

Expert by experience Jo Huey explained: “we need to offer a selection of services and it needs to be client focused ... everyone is individual and when they get the right support for them, the statistics will do the talking”.²⁴⁰

“ I’m convinced that if there’d been different treatment options available I wouldn’t have become extreme. ”

Susan Laurie, Expert by experience

- 231 “Dr Michael Kelleher, oral evidence session, 11 March 2020” gambling
- 232 Andrew Misell, oral evidence session, 2 March 2020
- 233 Age UK, written evidence
- 234 Dr Tony Rao, written evidence
- 235 Joint Public Issues Team, written evidence
- 236 Alcohol Change UK’s Blue Light project, written evidence
- 237 Bury & Rochdale Care Organisation, written evidence
- 238 London Borough of Lambeth, written evidence
- 239 Susan Laurie, oral evidence session, 11 March 2020
- 240 Jo Huey, written evidence

Integration between formal treatment, mutual aid and peer support

We heard from witnesses that many services do not take advantage of the strengths of peer-to-peer networks. Jardine Simpson from the Scottish Recovery Consortium described “a vast range all across Scotland of continued support” such as peer to peer support and mutual aid which is “not in any way being optimised by ... colleagues within treatment services”.²⁴¹ Dermot Craig from Aberdeen in Recovery pointed out that this was in part due to attitudes: “we are still fighting and battling against an inherent lack of willingness to even acknowledge that we can bring something valid and very beneficial to the whole support system”.²⁴²

Liver Specialist Dr MacGilchrist commented:

*“The question asked was whether commissioners or health workers were good at signposting to the many and varied alcohol services. I think the answer in general is no”.*²⁴³

The value of these types of services was underlined to us. Expert by experience Tim Norval described ongoing peer support as “the backbone of my recovery”.²⁴⁴ Another individual, Donna, explained: “I came close to death from suicide ... what would have helped me, through it all, would have been to find 12-step recovery sooner”.²⁴⁵ An expert by experience anonymously told us: “I wish that 12-step recovery was more widely recognised and recommended to help those who suffer”.²⁴⁶

We heard from Eric Carlin, a trustee of Alcoholics Anonymous (AA), about the Cochrane Review which showed that AA and other 12 step programmes are “highly effective in terms of enabling people to achieve and maintain abstinence over years, and ... also incredibly economically effective”.²⁴⁷

Rising interest in social prescribing in the NHS presents an opportunity for more healthcare professionals to signpost alcohol dependent people to AA or other alcohol mutual help organisations. However, given the funding issues explored above, it should not be used as a low-cost alternative to formal treatment, where formal treatment is required.

Regardless of which treatment method is chosen, after-care must be an essential component. Expert by experience Andrew

Recommendation: Treatment and care for alcohol use disorders and co-occurring conditions

There must be sufficient funding for treatment, with treatment available at a level to meet need. Detecting and managing alcohol use disorders should be a core competency for all clinicians to ensure that people who present at, for example, mental health services are able to access the support they require. Treatment should have the flexibility to be personalised and patient-led in order to meet the diverse needs of those who require it. Individuals may have specific treatment needs as a result of characteristics such as age, disability, gender, sexual orientation, race, religion or family circumstances.

McCutchion explained: “it’s important that whatever these interventions are, they are not just there you are, your detox, a bit of Antabuse, on your way. It is a life-long thing”.²⁴⁸

“ We were always encouraged to appear ‘normal’.”

Expert by experience

- 241 Jardine Simpson, oral evidence session, 23 March 2020
- 242 Dermot Craig, oral evidence session, 23 March 2020
- 243 Dr Alastair MacGilchrist, oral evidence session, 23 March 2020
- 244 Tim Norval, oral evidence session, 2 March 2020
- 245 Donna, written evidence
- 246 Anonymous, written evidence
- 247 Dr Eric Carlin, oral evidence session, 23 March 2020
- 248 Andrew McCutchion, oral evidence session, 2 March 2020

Alcohol culture and the stigma of dependence

“I’m worthless. I’m not worthy of the treatment”

We heard about a culture in the UK which encourages and normalises drinking:

“A lot of middle class people drink all the time and tend to normalise drinking. It’s such a daily part of some people’s lives it’s scary. And often I don’t think it’s seen as a problem, people just accept it. But there are serious health concerns that need to be addressed.”²⁴⁹

This celebration of alcohol in our society obscures the fact that it is an addictive and harmful product. Concerns were raised about products such as gin and tonic flavoured yoghurt which normalise the consumption of alcohol.²⁵⁰ Further normalisation occurs through how alcohol is sold, as Alice Wiseman from the Association of Directors of Public Health explained:

“When I was a kid, when you went to the supermarket, the aisle that had alcohol in it, you weren’t allowed to walk down unless you were over the age of 18. Now ... you’ll see the ‘back to school’ aisles and at the end of that aisle there’ll be the alcohol for the parents. All of these things are changing the way that we view alcohol.”²⁵¹

The child of an alcohol dependent parent told us:

“Alcohol is still often seen as something fun and cool. Even birthday cards have messages with ‘You know what rhymes with birthday? Vodka!’. We would never see that with crack cocaine or ecstasy pills. Alcohol can become a terrible addiction with the power to destroy the drinker and all the people around”.²⁵²

The normalisation of harmful alcohol consumption makes it easy for individuals to lose perspective about the amount they are drinking. TV presenter Adrian Chiles explained:

“Every drinker I know goes, ‘14 units, ridiculous, nobody drinks less than that’. Well, that’s just not true, most drinkers ... are drinking less than 14 units a week ... The social norming of excess drinking is something [the alcohol industry] absolutely rely on”.²⁵³

The fact that alcohol is an accepted part of our culture and the focus by government and industry on “individual responsibility” implies that an individual who experiences harm from drinking has been irresponsible and that the problem is with the individual rather than with the product itself. This can lead to a culture of secrecy and stigma, a theme which we heard about frequently. One expert by experience told us “my mother was what you might call a secret alcoholic. She never went to the pub or drank publicly, it was all done behind closed doors at home”.²⁵⁴ An expert by experience explained: “there are many addicts who stumble through life leaving a trail of disaster behind them, just as I did, but manage to create a façade of normality”.²⁵⁵

The existence of stigma makes it harder for people to seek help, either for themselves or family members. Discussing his own alcohol dependence, expert by experience Tim Norval explained how it felt: “the stigma we carry, ‘I’m worthless. I’m not worthy of the treatment. I’m not worthy of the support”.²⁵⁶ Anna Clementson told us that stigma can equally apply to someone else’s alcohol use: “the stigma that is still out there makes it harder for young people to talk openly about their parents having an addiction”.²⁵⁷

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- 249 Participant in Big Alcohol Conversation, Greater Manchester Health and Social Care Partnership, written evidence
250 Joint Public Issues Team, written evidence
251 Alice Wiseman, oral evidence session, 2 March 2020
252 Alexandra, written evidence
253 Adrian Chiles, oral evidence session, 11 March 2020
254 Helen Wilson, written evidence
255 Anonymous, written evidence
256 Tim Norval, oral evidence session, 2 March 2020
257 Anna Clementson, written evidence
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The ubiquity of alcohol in society also has the effect of making recovery more challenging:

*“Families affected by alcohol, including families in recovery, self-exclude from a whole range of family activities where alcohol is available, to avoid the wider consequences of their loved one drinking or relapsing. This includes family and social events such as weddings or birthday parties, clubs and concerts, sporting events, community festivals, cinemas and bookshops”.*²⁵⁸

Why we need marketing restrictions

“We are fed images of alcohol everywhere”

Part of the reason for the culture of alcohol consumption is due to marketing. As a focus group participant in the Big Alcohol Conversation described:

*“We have a big drinking culture where drinking is normal and it is clearly a problem. It doesn't help that every social situation is marked by having a drink. We are fed images of alcohol everywhere, adverts, people drinking on the tv, in soaps, people meet at the pub, sports sponsorship by alcohol brands etc”.*²⁵⁹

Alison Douglas from Alcohol Focus Scotland highlighted the role of marketing in normalising alcohol consumption and encouraging “us to see it as a part of everyday life”.²⁶⁰

The Faculty of Public Health highlighted that the current legal framework around marketing “has a particularly detrimental effect on young people, people recovering from alcohol dependence, and people who are already heavy drinkers”.²⁶¹ UK children aged 10-15 years are exposed to 11% more TV alcohol advertising than adults.²⁶² Research has found that 82% of young people recalled

“ Young people are knowledgeable of, and are able to discuss the presumed connotations behind, a variety of alcohol brands ”

Dr Nathan Critchlow

seeing at least one form of alcohol marketing in the preceding month and 17% of young people reported owning alcohol-branded merchandise.²⁶³ Children as young as 10 can readily identify alcohol brands, logos and characters from alcohol advertising on TV.²⁶⁴

Though there are some regulations on broadcast alcohol advertising, these are inadequate to properly protect young people. The Centre for the Development and Evaluation of Complex Interventions for Public Health Improvement at Cardiff University noted:

*“Current UK codes of advertising practice restrict content of mainstream media alcohol ads, in terms of types of drinking portrayals and the suggested benefits of consumption, but not in frequency or timing, meaning levels of exposure can be intense for young viewers, with ads commonly identified both before and after the watershed”.*²⁶⁵

Increasingly, alcohol marketing is an online as well as broadcast issue. We heard that there is a need for greater regulation online, including around self-reported age verification which official alcohol sites use to filter out under-18s. County Durham Public Health described such systems as “ineffective”.²⁶⁶

We heard about good practice from other European countries. In France, alcohol marketing is not allowed to use lifestyle

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- 258 Scottish Families Affected by Alcohol and Drugs, written evidence
 - 259 Greater Manchester Health and Social Care Partnership written evidence
 - 260 Alison Douglas, oral evidence session, 23 March 2020
 - 261 Faculty of Public Health, written evidence
 - 262 County Durham Public Health, written evidence
 - 263 Cancer Research UK, written evidence
 - 264 Alcohol Focus Scotland, written evidence
 - 265 DECIPHer, Cardiff University, written evidence
 - 266 County Durham Public Health, written evidence
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messages and has to include a health message. Ireland is bringing in restrictions on some outdoor advertising, cinema advertising and watershed time restrictions. The Scottish Government is planning to consult on measures to restrict alcohol marketing.²⁶⁷ France and Norway do not permit alcohol sponsorship in sport. Scottish women's football now refuses alcohol or gambling sponsorship.²⁶⁸

Sports sponsorship is one form of marketing which allows alcohol brands become aligned with activities which are central to British culture. Dr Nathan Critchlow explained that sport sponsorship now works across multiple on-line and off-line channels, such as match update websites and viral videos, which both explicitly promotes products and blends them among other content.²⁶⁹ Evidence suggests an association between alcohol sports sponsorship and harmful drinking among schoolchildren and sportspeople.²⁷⁰

**Recommendation:
Comprehensive restrictions
on alcohol advertising
across multiple media,
including restrictions on
sponsorships and activities
targeting young people**

Children must be protected from exposure to alcohol advertising, including through effective age verification online, and a restriction on alcohol advertising in cinemas to films with an 18 certificate. Regulations must cover digital media, including influencers, and should be regularly assessed to keep up with developments in technology. Alcohol sponsorship of professional sport should be phased out. Advertising should be monitored by an independent regulator.

The demographics of alcohol harm

“It’s across the population”

Gender

Gender differences in alcohol harm rates are stark. Twice as many men as women die of alcohol-specific causes: rates of alcohol-specific age-standardised deaths per 100,000 population are at 14.8 for men and 6.9 for women.²⁷¹ Men drink more and experience higher rates of alcohol-related harm than women, but rates of alcohol-related admissions of women to NHS hospitals have risen by over 30% from 2008/09 to 2014/15. This is leading to concerns that women are ‘closing the gap’ with men.²⁷²

Age

Alcohol consumption is higher in older age groups, with 55-64 year olds drinking more than any other age group. They are also more likely to be suffering the consequences of high rates of alcohol consumption at a younger age.²⁷³ The physical process of ageing makes it harder for the body to break down alcohol, making older people more vulnerable to alcohol harm.²⁷⁴ Indeed, in 2011, the Royal College of Psychiatrists made a recommendation of 11 units of alcohol as the

“ There is this view amongst many people that alcohol is a problem of young people over drinking and binge drinking. We need to be absolutely clear it’s across the population but particularly for older adults. ”

Professor Annie Anderson

267 ExILEnS team, Institute for Social Marketing and Health, University of Stirling, written evidence
268 Royal College of Physicians and Surgeons of Glasgow, written evidence
269 Dr Nathan Critchlow, oral evidence session, 23 March 2020
270 Institute of Alcohol Studies, written evidence
271 British Association for the Study of the Liver, written evidence
272 Northumberland Drug and Alcohol Steering Group, written evidence
273 Institute of Alcohol Studies, written evidence
274 Age UK, Centre for Ageing Better, written evidence

safe upper limit for drinking specifically for older people.²⁷⁵

Survey data indicates older people may drink heavily due to a change in life circumstance such as retirement, fewer opportunities to socialise, bereavement, or a change in financial circumstances.²⁷⁶ Addaction (now known as We Are With You) noted that half of higher risk drinkers gave their reason for increasing their alcohol use in later life as being a “*loss of a sense of purpose*”.²⁷⁷ Expert by experience Tim Norval told us: “*isolation is the biggest one, and I think in the over 50s it’s trapping people into using*”.²⁷⁸

Harmful drinking among older people is more likely to go undetected. Lambeth Council emphasised that the increasing numbers of older people who drink harmfully at home “*are generally not known to treatment services and are reluctant to engage following hospital discharge*”.²⁷⁹ The Centre for Ageing Better described how harmful drinking amongst older people is less likely to be identified by professionals due to “*loss of social contact meaning excessive alcohol consumption can be hidden, and stigma around drinking which results in older adults being less likely to seek help*”.²⁸⁰

Conversely, drinking rates are falling among younger people. A 2018 Public Health Wales survey found 9% of secondary school children reported drinking alcohol in the last week, compared with 36% when the same survey was carried out in 1986. This trend is reflected across the UK.²⁸¹

Geography and ethnicity

The British Association for the Study of the Liver (BASL) highlighted the clear variation in the geographical distribution of alcohol-related health harm:

“Most striking is a widening North-South

*divide in the number of alcohol-specific hospital admissions, which in 2015/16 ranged from 228.6 to 1681.0 per 100,000 population, a 7.4-fold difference between Clinical Commissioning Groups”.*²⁸²

Two recent studies conclude that Irish ethnicity is associated with a high risk of health harm. BASL’s evidence noted:

*“The first used Hospital Episode Statistics to demonstrate that admissions were related to both geography and ethnicity with higher rates among White Irish in the south of England, among South Asians in the Midlands and among White British in the north of England ... The second study found that the first episode of alcohol-related liver disease was highest in White Irish men and women while the first episode of any alcohol-related condition was highest in Irish men and lowest in Pakistani and Chinese”.*²⁸³

BAC-IN CIC, a drug and alcohol recovery support service for people from the BAME community, point out that the high levels of abstinence amongst minority communities in research literature is misleading. Service providers believe the prevalence of harmful alcohol use in these communities is underestimated.²⁸⁴ Andrew Misell from Alcohol Change Wales reflected on the same point in his oral evidence:

*“We don’t know enough about drinking within certain British ethnic communities, particularly communities where drinking is officially taboo such as Muslims, some Hindus ... we’re not yet meeting the needs of people who are drinking within communities where, officially, no one is drinking”.*²⁸⁵

275 Dr Tony Rao, written evidence

276 Centre for Ageing Better, written evidence

277 Addaction, written evidence

278 Tim Norval, oral evidence session, 2 March 2020

279 London Borough of Lambeth, written evidence

280 Centre for Ageing Better, written evidence

281 Jyoti Atri, oral evidence session, 2 March 2020

282 British Association for the Study of the Liver, written evidence

283 Ibid

284 BAC-IN CIC, written evidence

285 Andrew Misell, oral evidence session, 2 March 2020

Homeless people

There are especially high rates of alcohol harm among the homeless population.²⁸⁶ According to homelessness charity St Mungo's, four in ten people sleeping rough in London have a recorded alcohol problem. Moreover, in 2016, the majority of deaths of people living on the streets was caused by drug and alcohol problems.²⁸⁷ Camden and Islington Public Health wrote that "*super-strength alcohol is a significant contributor to harm*" in Camden and Islington. Other organisations agreed, including Thames Reach who found super-strength drinks to be "*one of the biggest causes of premature death of homeless people in the UK*".²⁸⁸

Other vulnerable sections of society

Alcohol harm is greater amongst members of the armed forces. The Royal British Legion highlighted the higher prevalence of harmful alcohol use among the armed forces community than among non-veterans.²⁸⁹

LGBTQ+ individuals are more likely to use alcohol and drugs, which may be due to the "*normalisation and availability of alcohol in this group, particularly on the commercial gay scene, and the role of alcohol in identity construction*".²⁹⁰

There are higher rates of alcohol use among some professions. County Durham Public Health noted that the highest proportion of young workers drinking excessively is in manual jobs such as construction, and in professional and financial services, where a third of staff report heavy drinking.²⁹¹



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- 286 St Mungo's, Action Together, Greater Manchester Health and Social Care Partnership, Camden and Islington Public Health, Professor Gareth Roderique-Davies and Professor Bev John, Royal College of Physicians and Surgeons of Glasgow, County Durham Public Health, Spectrum CIC, Dr Hannah Carver, Dr Tessa Parkes and Professor Catriona Matheson (University of Stirling), British Medical Association, written evidence
- 287 St Mungo's, written evidence
- 288 Camden and Islington Public Health, written evidence
- 289 Royal British Legion, written evidence
- 290 Scottish Families Affected by Alcohol and Drugs, written evidence
- 291 County Durham Public Health, written evidence
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Links with other addictions

“38 times the risk”

Smoking

The link between drinking and smoking is well established. Smoking rates are much higher among individuals with substance use disorders than in the general population, with half of all smoking-related deaths thought to come from that cohort. The gradual decline in smoking rates among the general population have not been reflected in this group; smoking rates have remained constant among those with a substance use disorder.²⁹² Young people who consume alcohol are more likely to smoke than those who do not.²⁹³

Both alcohol and tobacco are independently harmful to those who consume them and when used together they have an exacerbating impact. The Faculty of Dental Surgery at the Royal College of Surgeons of England noted: *“it has been estimated those who drink and smoke heavily have 38 times the risk of developing oral cancer as those who abstain from both”*.²⁹⁴ Cancer Research UK’s evidence noted:

“The interaction between alcohol and smoking is complex but for some cancers evidence shows that together smoking and alcohol cause more damage to cells in the body which makes both together much worse for cancer risk than either one alone”.²⁹⁵

Suzanne Cass from ASH Wales explained that *“mouth cancer rises sharply with those who drink alcohol while they’re smoking because it enables the chemicals to be drawn more easily into the lining of the mouth”*.²⁹⁶

Gambling and gaming

Gambling frequency has a high correlation with hazardous drinking patterns and alcohol dependence indicators. In a survey of 263 Welsh adults cited by Alcohol Change UK,

“Whilst drinking he would gamble. We had a joint account and I logged in to check on something and all our savings had gone, over £10,000! ... As well as losing all our savings he had multiple credit card debts. He convinced me to re-mortgage the house for £150,000 to pay off the credit card gambling debts.”

Expert by experience

24% of participants said they “always drank alcohol when gambling”.²⁹⁷

Professor Gareth Roderique-Davies and Professor Bev John of the University of South Wales also examined the link between alcohol and gambling, finding *“strong relationships between drinking and gambling behaviours ... The emerging pattern was that individuals with high risk gambling behaviour drink alcohol as a coping strategy, whilst high risk drinkers gamble for enhancement”*.²⁹⁸

Evidence around alcohol and gambling was also backed by powerful personal testimony of the effects of these co-existing addictions. One individual married to a man with alcohol dependence wrote:

“Whilst drinking he would gamble. We had a joint account and I logged in to check on something and all our savings had gone, over £10,000! ... As well as losing all our savings he had multiple credit card debts. He convinced me to re-mortgage the house for £150,000 to pay off the credit card gambling debts”.²⁹⁹

292 Mandy Powell, oral evidence session, 2 March 2020

293 Cancer Research UK, written evidence

294 Faculty of Dental Surgery at the Royal College of Surgeons of England, written evidence

295 Cancer Research UK, written evidence

296 Suzanne Cass, oral evidence session, 2 March 2020

297 Alcohol Change UK, written evidence

298 Professor Gareth Roderique-Davies and Professor Bev John, written evidence

299 Anonymous, written evidence

There are some examples of good practice in recognising the relationship between alcohol and gambling. The Welsh Government, for example, is improving links between substance misuse teams and gambling treatment services in Wales.³⁰⁰

Other drugs

Spectrum CIC, a treatment service provider in the North of England, highlighted regional data from their services showing that for 470 people who are accessing specialist services for alcohol in North Yorkshire, 14% have a secondary drug dependence (7% cannabis, 6% cocaine, 1% benzodiazepines and 0.5% heroin).³⁰¹

Inspector Donald Wade of Northumbria Police explained that drug use had to be addressed in conjunction with harmful alcohol use: *“the two of them go hand-in-hand, especially when you look at the likes of cocaine misuse around the night-time economy. There is a lot of join-up”*.³⁰²

300 Welsh Government, written evidence

301 Spectrum CIC, written evidence

302 Inspector Donald Wade, oral evidence session, 30 March 2020

Why we need a comprehensive strategy

“Nothing has really changed”

Alcohol harm currently occurs in a policy vacuum. Since the last UK Government alcohol strategy was published in 2012 much more has become known about the health problems caused by alcohol, with more evidence available on the causal link between alcohol and seven types of cancer. The UK Government announced plans to publish an alcohol strategy in May 2018³⁰³ but this was subsequently dropped. A government minister stated in January 2020: “we are not planning a stand-alone strategy”.³⁰⁴

Successive governments, from across the political spectrum, have not done enough to reduce consumption and change the culture around alcohol. We heard about a lack of leadership by the UK Government, and that “England, the biggest part of the UK, is lagging” behind Scotland and Wales.³⁰⁵ In the absence of a clear policy direction, a vacuum has emerged. According to Professor John Holmes from the University of Sheffield: “successive UK governments tended to view alcohol as a problem of individual and industry responsibility”.³⁰⁶ Professor Roger Williams, Chair of the Lancet Commission on Liver Disease, described his “serious doubts” about the “onus on the individual for reducing their alcohol consumption as put forward in the Government’s Green Paper on Prevention”.³⁰⁷

Alison Douglas from Alcohol Focus Scotland described an “abdication of responsibility by the UK Government in putting out public health messages. They’ve basically

delegated that to Drinkaware”.³⁰⁸ Drinkaware is a charity substantially funded by the alcohol industry.

Dr Nathan Critchlow from the University of Stirling highlighted government inaction in relation to marketing regulations:

“Nothing has really changed in the UK in how we regulate alcohol marketing for over ten years. Ireland are implementing new restrictions. Scotland are considering doing so. At a UK level, ... is where ... lots of these things are actually regulated, like broadcast [advertising]. I think we’re getting left behind, both internationally, and our approach to alcohol seems to be at odds with considering restrictions elsewhere [such as junk food marketing]”.³⁰⁹

Dr Benjamin Hawkins from the London School of Hygiene and Tropical Medicine explained how a lack of focus and ambition led the UK Government to abandon plans to bring in minimum unit pricing in England:

“The policy sort of drifted. There was no impetus to actually drive it forward. There was no signposting by the government that this was something they were committed to doing, and would be seeing through as there was in Scotland”.³¹⁰

303 Hansard, HC Deb, 8 May 2018, c531

304 Hansard, HL Deb, 21 January 2020, c1043

305 Alastair Campbell, oral evidence session, 11 March 2020

306 Professor John Holmes, oral evidence session, 11 March 2020

307 Professor Roger Williams, oral evidence session, 11 March 2020

308 Alison Douglas, oral evidence session, 23 March 2020

309 Dr Nathan Critchlow, oral evidence session, 23 March 2020

310 Dr Benjamin Hawkins, oral evidence session, 23 March 2020

To understand the lack of impetus from the UK Government, it is necessary to take into account the influence that the alcohol industry has upon policy formation. Alastair Campbell explained: *“the alcohol industry is a very, very powerful force, on government, and understandably, you know, you’re talking about a multi-billion pound market ... the alcohol industry has a power that the smoking and tobacco industry used to have”*.³¹¹ This was reinforced in evidence from County Durham Public Health which stated: *“the interests of the industry are put ahead of the needs of individuals and communities”*.³¹²

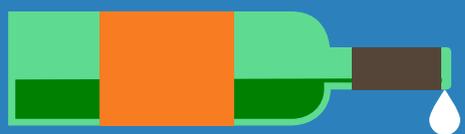
The new strategy must move away from idea of personal responsibility. Professor Annie

Anderson noted that there will be *“very little total public impact if we work only at the individual level”*.³¹³ The strategy must also have a focus on population-wide prevention measures. As Dr Helen McAvoy Institute of Public Health in Ireland explained:

“We’ll never treat ourselves out of this situation we’re in ... we have to start with prevention”.³¹⁴

80

alcohol-related
deaths each day
in the United Kingdom



5,698

alcohol-specific
deaths
in the UK in 2018/19

Recommendation: A new comprehensive strategy

The UK Government must introduce a new alcohol strategy as part of the COVID-19 national recovery plans. The strategy must take account of the best available evidence and include population-level measures to reduce harm from alcohol. Its development must be free from influence by the alcohol industry. While the government must support economic recovery and our hospitality industry, this must be balanced with minimising harm from alcohol. It should include the interventions recommended by the World Health Organization, which we fully endorse.

An overarching theme for a new alcohol strategy must be the need for a change in culture around alcohol. This should include a focus on reducing stigma for those who are concerned about their drinking, and their families. The strategy should also commit to regularly review emerging evidence around new developments in alcohol policy such as the growth of no- and low-alcohol products.

311 Alastair Campbell, oral evidence session, 11 March 2020

312 County Durham Public Health, written evidence

313 Professor Annie Anderson, oral evidence session, 23 March 2020

314 Dr Helen McAvoy, oral evidence session, 11 March 2020



“ The alcohol industry is a very, very powerful force on government, and understandably, you know, you’re talking about a multi-billion pound market ... the alcohol industry has a power that the smoking and tobacco industry used to have. ”

Alastair Campbell

Terminology

We are aware that there are differing views on terminology. We have sought to avoid the use of problematic language where possible, whilst simultaneously following the principle that people's ability to define themselves should be respected. We have therefore attempted to avoid the use of terms that can contribute to stigma such as "alcoholic", "alcohol abuse" and "alcohol misuse". However, to remain faithful to those who have given evidence, where we quote directly from evidence and sources, or use the name of an organisation, we have used the original terms.

Deaths from alcohol can be classified as specific or related/attributable. The two measures cannot be compared. Alcohol specific deaths are calculated using an Office for National Statistics definition.³¹⁵ They are deaths from conditions which are only caused by alcohol, so they exclude cancers and other conditions which may be caused by alcohol in conjunction with other risk factors. They are a good measure of trends where the population is sufficiently large to avoid random variation. Alcohol-related or alcohol-attributable deaths are calculated by estimating (based on evidence) a fraction of all causes of death that is attributable to alcohol. They are more likely to be affected by differences in how the calculation is made but they show a truer picture of the burden of disease on society and the NHS.

315 Office for National Statistics (2018) Alcohol specific deaths in the UK: registered in 2017

How we conducted our inquiry

The Commission was established to examine the current evidence on alcohol harm, recent trends in alcohol harm and the changes needed to reduce the harm caused by alcohol. The Commission's remit was also to examine the need for a new comprehensive alcohol strategy for England, which takes account of the strategies in place in Scotland, Wales and Northern Ireland, and to consider UK-wide priorities in areas where policy is not devolved.

The Commissioners are:

Chair: Baroness Finlay of Llandaff
Crispin Acton, Expert Advisor, Institute of Alcohol Studies; formerly at Department of Health
Baroness Boycott
Lord Brooke of Alverthorpe
Hardyal Dhindsa, Police and Crime Commissioner for Derbyshire; Lead for Alcohol and Substance Misuse, Association of Police and Crime Commissioners
Prof Sir Ian Gilmore, Chair, Alcohol Health Alliance UK
Baroness Hayter of Kentish Town
Prof Keith Humphreys, Professor of Psychiatry, Stanford University; Honorary Professor of Psychiatry, King's College London
Baroness Jenkin of Kennington
Baroness Jolly
Kenny MacAskill MP
Prof Martin McKee CBE, FMedSci, Professor of European Public Health, London School of Hygiene and Tropical Medicine
Prof John Newton, Director of Health Improvement, Public Health England
Paul Ogden, Senior Advisor, Public Health and Equalities, Local Government Association
Lord Ribeiro CBE, FRCS
Prof Jonathan Shepherd CBE, FMedSci, Crime and Security Research Institute, Cardiff University
Derek Thomas MP

The Commission received over 140 submissions of written evidence from organisations and individuals, of which around 40 were from people with direct lived experience of alcohol harm. The voices of people who have experienced alcohol harm are often overlooked and the Commissioners sought to ensure their voices were heard in this report. As noted in Lionel Joyce's submission: "*evidence normally means statistics derived from hospital and coroner's reports – for me it means attending funerals and hearing of cancers, heart attacks, fights, significantly more domestic violence, primarily male on female*".

The Commission was careful to take account of conflicts of interest in evidence we received. We were pleased to see in evidence received from those connected with the alcohol industry that they have recognised that harm is caused by alcohol, but Commissioners concluded that it is not appropriate for those who have a commercial interest to have a role in the development of our recommendations.

We heard testimony from 39 witnesses in 4 oral evidence sessions held in March.

The Commission analysed the evidence received and considered additional evidence where relevant. All evidence used is listed in the footnotes.

The costs of the Commission were borne by the Alcohol Health Alliance UK, which also provided research support, assistance with the writing of the report, and acted as the secretariat.

Acknowledgements

The Commission would like to thank everyone who provided written and oral evidence, advice or support.

Lead researcher: Richard Fernandez

Researchers: Aidan Rylatt, Jennifer Keen

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Design: Emma Vince

Image credits

p.3 Official portrait of Baroness Finlay of Llandaff. Credit: UK Parliament, released under licence: creativecommons.org/licenses/by/3.0/

p. 17 and p. 20 Drawings used courtesy of the Children's Society, created by users of the Community Hidden Harm Awareness Team (CHHAT)

“ The power lies in your hands to act for the good of the population and protect and improve public health and protect children and young people from harm.

Lack of action is not due to lack of evidence. ”

Faculty of Public Health

