Faculty of Public Health response to consultation on alcohol harm February 2020

This paper forms the response of the UK Faculty of Public Health to the call for evidence by the Commission on Alcohol Harm's inquiry into the effects of alcohol on society. The UK Faculty of Public Health (FPH) is a joint faculty of the three Royal Colleges of Physicians of the United Kingdom (London, Edinburgh and Glasgow). We are a membership organisation for approximately 4,000 public health professionals across the UK and around the world and our role is to improve the health and wellbeing of local communities and national populations. We do this by supporting the training and development of the public health workforce and improving public health policy and practice in partnership with local and national governments in the UK and globally.

The response is structured around the 10 key questions posed by the Commission. If further information is required, please email policy@fph.org.uk.

1. What evidence has emerged since 2012 on alcohol's impact on:

- Physical health?
- Mental health?

The impact on physical health can be traced through the impact on alcohol related deaths. The most recent ONS report was released in January 2020.

A detailed analysis of data from Scotland was produced by the Scottish government in 2018.

The impact of alcohol can also be traced through trends on alcohol-related hospital admission rates, though this will only include those who are ill enough to require admission to hospital, and not the much greater number who may attend A&E, primary care or simply take time off work because they are too ill to get themselves into work. National Statistics in Scotland reported in 2019 on trends in hospital alcohol admission rates.

This provides a detailed breakdown of hospital admissions for both physical health problems and psychiatric inpatient stays by sex, age group, deprivation and broad category of health problems. It details the continued preponderance of males over females and the much higher rates in the most socioeconomically deprived groups. The decreasing trend in the psychiatric hospital admissions should be considered in the light of the decreasing number of psychiatric beds and the move to provide more care in the community. The majority (93%) of patients were admitted to acute general hospitals for alcohol related conditions, with only 7% admitted to a psychiatric unit.

For physical health problems, approximately half of patients admitted were new patients. The most common age of admission for men was 55-64 years, but women were younger in general with their admissions peaking at 45-54 years.

For mental health problems the most common age of admission was 35-44 and 45-54 for both males and females.

People in the most deprived tenth of the population were 6 times more likely to be admitted to an acute hospital for an alcohol related condition, but 13 times more likely to be admitted to a

psychiatric hospital for an alcohol related condition compared to the most affluent group in the population (least socioeconomically deprived). The increase in risk of alcohol across the range of intake on several cancers has been increasingly recognised and contributed to the revision of CMO recommendations in England. The calorie content of alcohol also contributes to the growing obesity epidemic.

2. What impact does alcohol have on the NHS and other public services?

The impact would need to be assessed against the proportion of deaths that are diagnosed as alcohol-related. For the UK as a whole, there is an excellent Parliamentary briefing on the impact of alcohol to the NHS and wider society, as well as the different categories of harm which was the subject of question one in this consultation.

In Scotland in 2018, there were 58,503 registered deaths in Scotland. Of these deaths, 1,136 were alcohol specific deaths (1.94% of the total registered deaths). However, this does not include the number of deaths where 'alcohol contributed to', rather than where alcohol was the sole cause of an individual's death. When alcohol attributable fraction is considered, the proportion of alcohol related hospital admission and deaths is much higher. Detailed information was published in 2018 by Public Health Information for Scotland.

In summary, 6.4% of the population aged 16 years or over were admitted to hospital at least once with condition that was partly or wholly related to alcohol in 2015, and 6.5% of deaths in the same time period were wholly or partly attributable to alcohol. Alcohol caused 8.0% of the burden of disease in Scotland in terms of disability adjusted life years.

The impact on other public services is not something routinely collected by the NHS; however the most recent CRESH report shows that alcohol related death rates were twice as high in areas with the highest outlet density, hospital admissions were almost twice as high and crime rates were four times as high in areas with the most alcohol outlets in Scotland compared to the least.

3. What challenges do alcohol treatment services currently face in supporting people impacted by alcohol harm?

The challenges faced are numerous and begin from the problems of identifying an individual with alcohol related problems in the community (primary care, emergency departments and acute services) and delivering the alcohol brief interventions. For those patients identified in the hospital setting and referred to the acute alcohol liaison team, not all patients will consent to meeting the team; of those seen who agree to services in hospital, a substantial proportion do not have a prompt appointment in the community with the community addiction teams and are not followed up assertively. Many do not attend any appointments. Of those who do attend the fall off after one visit is substantial and the majority of patients are lost to follow up rather than reaching the end of their treatment. Services are not stratified to provide for the needs of the diverse population such as women, young people and patients with co-morbid mental health problems. Male-orientated services are not attended by women. Young people do not get the support they need from adult services, and consistently people with severe and enduring mental health problems do not have their alcohol dependence addressed or even identified.

Alcohol liaison nurses within acute hospital settings have key role in the systematic early identification of alcohol misuse in people admitted to hospital and in co-ordination of ongoing support, tiered depending on the level of misuse. However commissioning of such services is not uniform and patchy. There is a national shortage of addiction psychiatrists to oversee the management of those with dependency.

4. What recent evidence is there of impacts caused by alcohol consumption on family life, relationships and sexual behaviour?

One major and recent report of relevance here was PHE's Harm to Others report in 2019:

For specific, more detailed look at an area of the UK with one of the highest alcohol burdens, some information from the West of Scotland is cited below:

Audits undertaken in NHS Greater Glasgow and Clyde have shown that a large proportion of patients with alcohol dependence were socially isolated, over half lived alone and up to two thirds had no social network. Up to 4% of the sample audited had children taken into care, and many had close family of friends who also had alcohol problems. Poor relationships with adult children were common. The proportion of women who had experienced domestic abuse ranged from one third to three quarters of the sample audited. This evidence was presented at the Faculty of Public Health conference in Dunblane in 2019.

In the Scottish Prisoners Survey of Young Offenders, 39% reported that alcohol affected their relationships with their family. The figure drops to one third in adult offenders: Scottish Prison Service Prisoner Survey 2015.

5. What data exists to show alcohol's current impact on different demographic groups, including age, sex and social class?

This has already been presented in the report on alcohol deaths, alcohol related hospital discharges, alcohol outlet density and the impact of alcohol in the ScotPHO report which assessed the burden of disease due to alcohol. For the UK as a whole, see the harms section of the 2016 PHE report on the public health burden of alcohol.

6. What impact does alcohol have on economic productivity and is there evidence of this changing since 2012?

The Institute of Alcohol Studies' report Splitting the Bill found that the alcohol industry contributed 2.5% to the gross domestic product in 2015. The alcohol industry is responsible for around 770 000 jobs, 2.5% of all UK employment. Of these, 560 000 are poorly paid and typically part-time jobs; only one third of employees have full-time positions and the median wage was £6.82, the second lowest of all occupations tracked by the Office for National Statistics (ONS). Alcohol producers provide fewer than 30,000 jobs and their average wage exceeds £16.00 per hour.

The UK has a small surplus in alcohol trade of £1.7 billion, composed almost entirely of export of spirits. This amounts to 2% of the country's current account deficit. The government raises £11 billion in tax revenue from alcohol excise duty in England. The cost of alcohol to the tax payer is estimated to be between £8-12 billion. The impact on the economy is assessed from reports of workers. Finding include:

Employment costs

Presenteeism: 28% of workers go to work hung over, negatively affecting their performance.

Absenteeism: up to 53% of high risk drinkers are likely to be absent from work on any given day (Australian evidence), and Norway and Sweden have shown that a one litre increase in total per capita alcohol consumption is associated with a 13% increase in absence in men.

Unemployment: heavy drinking is associated with a higher risk of unemployment, with a heavy drinkers' chances of finding work equivalent to the effect of not having a degree.

Premature death: alcohol reduces the size of the labour market. It was estimated than 167,000 years of working life were lost in England in 2015, or 16% of all working years lost.

These employment costs are estimated to be in the range of £8-£11 billion or 0.4-0.6% of GDP. When the wider societal costs are considered the bill is estimated to be between £21-52 billion.

Impact on the Economy

In economic terms, lower alcohol consumption may not have any economic impact, if people maintain their spending on alcohol to buying more expensive drinks. If spending on alcohol declines, spending on other goods is likely to rise to compensate and so boost other industries.

In the long run, when productive capacity is the main constraint on the economy, lower alcohol consumption is likely to have a positive effect by boosting productivity and labour supply. In the short run, when a shortage of demand is the main constraint on the economy, it depends what products are substituted for alcohol. US modelling suggested lower alcohol spending can raise employment and the ONS economic multiplier estimates a £10 decrease in alcohol spending could increase or decrease national income by a most £1 billion.

7. What current evidence is there of links between alcohol and violent behaviour and other crime?

Evidence from licensing studies, of which there is a wide literature, have shown that areas with high outlet density have higher levels of crime including violent crime. This was documented in the most recent CRESH report. It has also been found in numerous local studies conducted as part of the overprovision assessment for licensing policy purposes.

Additionally, alcohol has been linked to crime, including violent crime. 46% of violent offenders were found to be under the influence of alcohol, and victims reported being under the influence of alcohol in 25% of cases (Scottish Crime and Justice Survey 2017-18).

This finding was confirmed in the Scottish prisoners' survey and the Scottish young offenders survey, where 60% of young people reported being drunk at the time of the offence. Amongst adults, 41% of prisoners reported being drunk at the time of the offence.

For the most violent offenders, 19% of homicides in Scotland were committed under the influence of alcohol in 2016/17: Homicide in Scotland 2016-17, National Statistics Publication, Crime and Justice, Scottish Government.

8. What recent evidence is there of links between alcohol and other addictive behaviours (such as smoking, drug use and gambling)?

Local audits in the Glasgow area have shown a strong association with smoking and alcohol dependence in both males and females. There is also an association with drug use among patients who died as a result of their alcohol dependence. Other substance misuse was particularly common in women, who also had very high levels of psychiatric morbidity. This was reported at the recent faculty of public health conference in Dunblane and also examined in the SHAAP publication 'Dying-for a drink' where alcohol was found to be a factor in 27.5% of drug related deaths.

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9. What effect does the current approach to alcohol marketing and licensing have on alcohol harm?

Alcohol marketing has been consistently shown to initiate alcohol consumption, increase the volume of alcohol consumed and contribute to harm associated with excessive consumption. The harm is particularly detrimental to:

- young people under the legal drinking age who are exposed to advertising on a daily basis in multiple locations;
- people recovering from alcohol dependence, where exposure to alcohol contributes to relapses into drinking behaviour; and
- people who are already heavy drinkers, who drink even more irresponsibly when exposed to marketing messages.

Detailed research on this topic has been undertaken by the University of Stirling and the attached sources are a useful summary:


ADPs - Alcohol Marketing Dec 19.pdf


Dr Nathan Critchlow on Alcohol Marketing f

Alcohol licensing is a means of regulating the sales of alcohol both on and off-sales. In Scotland, 73% of alcohol is purchased in off-sales premises. Licensing laws in Scotland have been revised and updated several times since the introduction of the Licensing (Scotland) Act 2005. The objectives of the licensing legislation are to prevent crime and disorder, ensure public safety, prevent public nuisance, protect children and young people from harm and to protect and improve public health. The last objective is not part of the English legislation. In addition to these objectives, the licensing board have a responsibility to produce a policy within 18 months of the local council election and to assess over-provision (whether the licensing board considers that their area, or parts of it have an excess number of alcohol premises of all kinds or specific types of premises). It remains unclear whether there are any means to ensure that all licensing boards produce an up to date policy. There continues to be a reluctance on the part of some councillors to accept the evidence that high outlet density leads to increased alcohol consumption, that extending the hours of operation leads to further alcohol consumption, or that the harms from excessive consumption due to the number and hours of operation of licensed premises in terms of health and social harms and lost productivity outweigh any small profit gained by the licensee and staff paid at close to minimum wage for working the excessive hours.

A review of licensing policies was carried out by Alcohol Focus Scotland and the operation of the licensing system was assessed in the Taking Stock report.

Despite legislation requiring the licensing boards to consider overprovision and public health as part of their licensing policy, there continues to be a reluctance by licensing boards to accept over-provision as part of their policy. Some licensing boards do not have an over-provision area in their policy, despite having health and crime data to support the implementation of such a policy. The majority of licence applications continue to be granted. In city centres the high density of on sales outlets has not resulted in a decline in the granting of new premises licence due to the mistaken belief that the licensed trade contributes to the economy, but ignoring the obvious health and crime problems associated with the high density of city centre attractions. Some local boards think that they can sell their city as a vibrant and exciting place to be due to its large number of night clubs, pubs and casinos, claiming it is for the tourists, while ignoring the fact that most of its clients are

from the local vicinity and suffer the effects of alcohol on the ability of their workers to function the following day.

Additionally, the creep of alcohol licensing has not only extended to bars in cinemas, but alcohol is now served to customers actually sitting watching a film. It is also sold in newsagents, chemists, hair dressers, cafes and coffee shops, fast food premises and florists. It is hard to avoid even if you want to, exposing children, young people and those recovering from alcohol dependence to alcohol on a regular basis.

In addition to the traditional model of operation, the growth of the online sales of alcohol is continual and poorly regulated or managed by the current licensing system which was designed to consider the traditional on an off-sales premises in their localities. Grocery stores and supermarkets deliver alcohol to the door, as do restaurants and takeaway establishments. In addition to the wine clubs, large retailers such as Amazon are now delivering alcohol over a wide area, and often outwith the jurisdiction of the licensing board where the deliveries are made, thus effectively bypassing the local licensing system. When applications come in for places delivering online sales, they often state a very small capacity for on sales, but they have a very large and well stocked warehouse that is not open to the public and therefore not considered in the application.

Furthermore, the occasional licence system is not well regulated in some areas and multiple occasional licence applications have been submitted for months on end without notifying other partners, because it is an occasional licence and not a premises licence. Months later an application for a premises licence from a business e.g. a hair dresser or corner shop is eventually submitted in an area where there where grounds for public health objections, but this is brushed aside as the premises has already been operating with occasional licences for months.

Revised guidance on the 2005 Licensing (Scotland) Act is long overdue and contracted discussions between licensing lawyers and Alcohol Focus Scotland on the validity of public health evidence and overprovision has still not produced a response that will protect public health.

10. What policy changes would help to reduce the level of harm caused by alcohol? Are there policy responses from other governments (including within the UK) that have been successful in reducing harms caused by alcohol that could be implemented in the UK?

The World Health Organisation (‘Alcohol, No Ordinary Commodity’: Babor T, Editor) has identified policies to reduce alcohol related harm including those that are most effective and cost effective to implement.

A whole population approach will produce the most effective results due to the large proportion of the population who are exceeding the recommended low risk drinking guidelines. The most effective policies are those that target price, advertising and sponsorship and availability (days of week and hours of day).

In terms of price, the evaluations of minimum unit pricing (MUP) are encouraging, though the level of the MUP should be evaluated; emerging evidence from Scotland will be very informative. The introduction of the alcohol duty escalator has been shown to complement the MUP and also targets premium alcohol that would not be addressed by the MUP as it is already above the threshold. A ban on multi-buy discounts has resulted in a decrease in impulse buying and buying more than was originally intended.

Studies on alcohol marketing, already mentioned above, result in non-drinkers becoming drinkers, drinkers consuming more than they had originally intended and heavy drinkers developing more problematic drinking. Alcohol advertising and sponsorship results in children and young people commencing drinking, it leads to people who are recovering from alcohol dependence relapsing and

it leads to the general population normalising alcohol consumption and drinking more. Brands target has been designed to encourage young people and women to consume alcohol.

Alcohol sponsorship and advertising needs to cease not only in the traditional radio, TV, billboards and print media, but also on social media and web advertising. Sporting and cultural events should be alcohol free. There should be no alcohol permitted in schools and further and higher educational establishments.

High outlet density needs to be targeted as a public health issue, both on and off sales. There should be no 24 hour licensed premises. On sales premises should be restricted to a maximum of 13 hours operation per day with no exception for funerals, sports tournament and cultural events. Casinos to not need to operate until 6.00am on the morning or be associated with alcohol consumption. Traditional alcohol free premises such as cinemas, newsagents, hair dressers and cafes should remain alcohol free.

Off-sales premises should have a maximum hour of operation restricted and enforced as in Scotland. There should also be restrictions on the display of alcohol in store as in the Scottish legislation, and restrictions in the proportion of shelf space that is permitted as a size of the premises in grocery stores. A grocery store does not need half of its shelf space given over to alcohol sales. A radical review of what grocers are permitted to sell should be considered, including separate alcohol only counters or the state monopolisation of alcohol sales for any alcohol by volume greater than 5% such as in Scandinavia.

Close regulation of the on line market needs to be implemented. This needs to address the responsibility to protect children and young people from harm and dependent drinkers who are too unwell to walk to the store, but can now have alcohol delivered to their door. Consideration needs to be given to protect areas where the licensing board have implemented an overprovision policy to protect their population, but where the online sale of alcohol is effectively by-passing this. This applies not only to supermarkets and grocery stores, but also internet sales companies, which have a wide distribution area. Fast food companies, restaurants and takeaways should not need to retail alcohol as a home delivery product to be able to compete on the market.

If the government is serious about protecting the population from alcohol related harm it has the potential to use a wide range of evidence to achieve this including the best buys advocated in the WHO Alcohol No Ordinary Commodity to reverse the harm caused by the relaxation of the UK's licensing policy and taxation laws. 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.