The Association of Directors of Public Health
Policy Position: Alcohol

Key Messages

- Alcohol consumption and mortality have increased over the years, leading to significant financial and social cost across the UK.
- UK alcohol consumption remains higher than the average for all OECD countries.
- There are health inequalities associated with alcohol harm; despite alcohol consumption not being socially patterned, a lower socioeconomic status is associated with higher levels of alcohol-related ill-health and alcohol-attributable mortality.
- Alcohol policies should move their focus from treatment to prevention to reduce the affordability, availability and appeal of alcohol. Minimum unit pricing was the number one policy priority for ADPH members in our most recent policy survey.

ADPH Recommendations

National

Alcohol strategy: The Governments in all four nations should have in place a multi-faceted, wide-reaching strategy aimed at reducing alcohol harm. Northern Ireland should update their strategy as soon as feasible; England should also introduce a new alcohol strategy.

Investment in public health must be increased across the four nations. In England, the Public Health Grant needs £0.9 billion more a year to reverse years of funding cuts.[1]

Long term funding: Additional, long-term funding to tackle alcohol related harm is needed across all four nations to reverse years of cuts and to support evidence-based alcohol treatment intervention.

Independent body: A body independent from the alcohol industry should be established to regulate alcohol promotion, devise harm reduction measures, and educate the public about alcohol related harm. Governments in all four nations should adhere to guidance on engaging with industry stakeholders.[2]

Alcohol price: The Governments in all four nations should implement a minimum price of 65p per unit of alcohol and follow the evidence base built in Scotland and Wales.[3]

Tax: The Government should reintroduce the tax escalator on alcohol at 2% per annum ahead of inflation.

Licensing: England and Wales should introduce a public health licensing objective. Local public health authorities[1] should be supported with adequate resources and licensing powers.

Advertising: The Government should reduce children's exposure to alcohol through a ban to cinema, outdoor and bus advertising; introducing a TV watershed; restricting online exposure and alcohol sponsorship; and bringing alcohol in line with advertising restrictions on food high in fat, salt, and sugar.

[1] By local public health authorities we mean bodies with statutory local responsibility for public health functions (eg upper tier local authorities in England, Health Boards in Scotland and Wales, Public Health Service in Northern Ireland). These differ across the UK, Crown Dependencies, and associated territories. We have published a separate headline explainer on public health in each of these systems.

Labelling: The Government should introduce mandatory health labelling on alcohol, including the CMO's low risk drinking guidelines, guidelines for alcohol consumption whilst pregnant, and calorie content labels.

Training: All health and social care, criminal justice and education professionals should be trained to provide early identification on and brief alcohol advice to their clients.

Local

Public health authorities and commissioners should continue to take an evidence-based approach to establish alcohol treatment services that meet the needs of the local population. Public health authorities in England should work with ICBs to use ICS budgets to properly fund alcohol treatment.

The NHS should embed prevention of alcohol harm into local plans. The NHS should promote the systematic use of Alcohol Identification and Brief Advice (Audit C) for all relevant front line NHS staff.

Background

Covid-19 and lockdown measures have shifted drinking habits to inside the home.[4] Since 1987, alcohol has become 72% more affordable in the UK. Alcohol misuse is the biggest risk factor for death, ill-health and disability among 15-49 year-olds, and the fifth biggest risk factor across all ages.[5] [6]

How does alcohol cause harm to both individuals and society?

In 2021, there were 9,641 deaths from alcohol-specific causes in the UK, a 27.4% increase from 2019. Scotland and Northern Ireland had the highest rates of alcohol-specific deaths in 2020. People who are dependent on alcohol are also 2.5 times more likely to die by suicide than the general population.[7]

Alcohol also causes irreversible harm to health. Alcohol causes more than 200 different diseases and injuries: eg mouth, throat, stomach, liver and breast cancers; high blood pressure, cirrhosis of the liver; and depression.[8] [9] In 2020, alcohol caused 16,800 cases of cancer in the UK (46 cases per day).[10] Abuse is also usually more severe when alcohol is involved.[11] In the UK, one in five children live in a household where at least one parent has an alcohol use disorder. They are six times more likely to experience domestic violence, three times more likely to consider suicide, and twice as likely to develop an addiction.[12]

In 2021, 40% of pupils (aged 11-15) said they had the experience of consuming alcohol.[13] This is a decrease compared to previous years, but the number of young people consuming alcohol is still too high.

What is the economic cost of alcohol harm in the UK?

Alcohol harm costs both individuals and society. In 2021/22, there were 814,595 alcohol-related admissions to hospital in England, and 35,187 in Scotland.[14] [15] The cost of alcohol to the UK is at least £27 billion a year, £8.3 billion of overall UK health expenditure.[16] [17] [18] Alcohol is linked to both crime and anti-social behaviour, with an estimated cost to society of around £11.4 billion per year in England and Wales.[19] In Scotland, 46% of violent crime were committed by offenders under the influence of alcohol.[20]

Policy Context

What are the latest alcohol policy changes across the UK?

In 2021, the English Government published a new alcohol duty system which included a focus on the public health impact of alcohol harm.[21] The proposed system simplifies the rates and links duty to strength across

all types of alcohol for the first time. Alcohol duty rates will rise in line with inflation, apart from for drinks below 8.5% alcohol by volume (abv)[2] sold on licensed premises such as pubs.[22]

In 2021, Northern Ireland launched its new 10-year substance use strategy 'Preventing Harm, Empowering Recovery'.[23] The strategy contains a range of measures around prevention and early intervention, harm reduction, treatment and support, recovery and governance.

In the UK, both Scotland and Wales have minimum unit pricing (MUP), but England and Northern Ireland do not.[24] Public Health Scotland published an independent report in 2023 showing that MUP has had a positive impact on health outcomes, including addressing alcohol-related health inequalities.[25] The UK Government has said it will wait for the report in Scotland before considering whether to introduce MUP in England. Emerging evaluation findings from Scotland and Wales show that MUP is effectively targeting the heaviest drinkers. In 2018, Scotland experienced its lowest alcohol consumption rate in 25 years.[26] There has been a 7.6% reduction in weekly alcohol purchases by households, mostly from heavier drinking households.[27] MUP has also been associated with a 13.4% drop in alcohol-specific deaths and a 4% reduction in alcohol-specific hospitalisations, predominantly seen amongst most socioeconomically deprived groups.[28]

ADPH Position

A whole system approach and a life course approach to reducing alcohol harm

Alcohol use is a complex issue influenced by multiple factors with deprivation being both a cause and consequence of harm. There are strong links between alcohol use and health as well as determinants of health such as smoking, risk-taking behaviours, and drug use. These issues must be tackled holistically. Service planning and commissioning should take a whole-system approach and have the shared vision to improve outcomes from prevention through to recovery in specialist care, particularly in response to complex needs and health inequalities. Partnership and clear information exchange arrangements involving schools, housing, police, social care, health, and mental health services are key. Governments across all four nations should have in place multi-faceted strategy aimed at reducing alcohol harm.

Alcohol use impacts parents, young people, and the older population differently, linked to social, cultural, and geographic factors. Therefore, a life course approach should be adopted with the awareness that risk and protective factors develop over the lifetime. Evidence-based legislation and policy should be in place at regional and national levels to reduce the affordability (price), availability (place) and attractiveness (promotion) of alcohol products. The appropriate authorities should cooperate to prevent under-age and proxy alcohol sales.[17]

More public health funding is needed to reduce harm caused by alcohol

Investment in public health must be increased across the four nations. Public health needs to be funded sustainably and adequately in line with local population health need. In England, local authorities' public health funding has suffered a 26% cut (in real terms on a per person basis) since 2015/16.[29] Drug and Alcohol Services (youth) have seen the fourth largest cut, with a spending decrease of 28%. Drug and Alcohol Services (adult) has also suffered from a real terms spending decrease of 17%.[30] Although DsPH have been acting to manage these cuts, they have reached the limit of available efficiencies. Cuts to public

[2] Alcohol by volume (abv) is the percentage of pure alcohol per litre of product.

health funding will result in cuts to a range of services which can help to reduce harm caused by alcohol. Cuts to public health funding also have downstream effects on NHS Services. In our Public Health System Survey 2019, we asked DsPH about recent and planned changes to services. 47% of respondents had redesigned their alcohol services within the last three years and 24% had changed the provision. 8% of respondents reported that the changes have had a negative impact on services. [31]

Effective population-level actions at a local level to reduce alcohol harm

Local areas should undertake system wide self-assessment using Public Health England (PHE)'s local alcohol services and systems improvement tool (CLeaR) to review and set out local activity and ambitions.[32] Commissioning should be based on evidence-based guidelines, such as the NICE guidance. Monitoring and evaluation and quality governance mechanisms should be in place for assuring the quality and safety of alcohol treatment services, and they should be embedded in public health systems. [33]

Exposing the impacts of commercial tactics

Alcohol is produced for profit and the industry spends billions creating new markets and lobbying for favourable business conditions.[34] Although it does invest in corporate social responsibility (CSR), a review concluded that CSR activities in the WHO European Region: 'are unlikely to contribute to WHO targets but may have a public-relations advantage for the alcohol industry'.[35] The industry also utilises different tactics such as denial, distortion and distraction to shed doubt on public understanding of risk. These need to be called out if we are to counter commercial factors at play that increases alcohol-related harms.

Reducing the affordability of alcohol through taxation and MUP

A 2019 report commissioned by the Institute of Alcohol Studies showed that the decision to abolish the alcohol duty escalator in 2012/13 and the subsequent duty cuts and freezes have led to increased alcohol consumption and substantial increases in alcohol related harms and associated costs.[36] Alcohol-specific deaths levelled out when the alcohol duty escalator was in place between 2008 and 2013. Therefore, the Government should reintroduce the tax escalator on alcohol at 2% per annum ahead of inflation.

ADPH supports the evidence review of alcohol policy which concludes that reducing the affordability of alcohol through taxation and MUP is the most effective and cost-efficient way of reducing alcohol harm, which is also recommended by WHO.[37] Modelling work by Sheffield University and Cancer Research UK found that over a 20-year period, a 50p MUP of alcohol in England could reduce deaths linked to alcohol by around 7,200. It would also reduce healthcare costs by £1.3 billion.[38] In the first year the 50p MUP was implemented in Scotland, alcohol sales fell to their lowest level since records began in 1994. In our 2019 survey of UK DsPH, 83% of respondents said that they strongly supported the introduction of an MUP of 50p in England. MUP would have an imperceptible impact on the cost of alcohol consumption for lower risk drinkers and would not lead to changes in pub prices. This policy would also help to tackle health inequality, as research by Sheffield University indicates that 82% of the reduction in deaths would be amongst routine and manual workers.[39]

A public health licensing objective should be introduced

Public Health is a responsible authority in the alcohol licensing framework.[40] This presents opportunities to prevent alcohol-related harms, where public health teams can marshal evidence of harm to meet the requirements of the licensing process. Hospital and ambulance data should be shared routinely to inform improvements in community safety and licensing activity. Local crime, health and social care data should also be used to map the extent of alcohol-related problems as part of licensing policy.

80% of respondents to our 2019 membership survey supported policies to amend licensing legislation to empower local authorities to control the total availability of alcohol, gambling and junk food outlets.[41] Limiting the density and opening hours of alcohol outlets in towns and city centres could reduce alcohol related harm in the nighttime economy.[42] [43] The introduction of a public health licensing objective in Scotland in 2011 has led to increased engagement, strengthened working relationships and increased use of health evidence in licensing policy development.[44] England and Wales should introduce a public health licensing objective, which should be adequately resourced to ensure it can be implemented correctly. The Licensing Act should be revised to take account of population level data more effectively.[45]

Alcohol promotion and labelling should be regulated

Evidence demonstrates that there is a relationship between the exposure of children to alcohol marketing and alcohol consumption. A recent survey found that 95% of ten and 11-year-olds recognised a beer brand.[46] An independent body should be established to regulate alcohol promotion, including product and packaging design, in the interests of public health. The Government should ban alcohol advertising where children are likely to be exposed to it. This could include putting an end to cinema, outdoor and bus advertising, introducing a TV watershed and restricting exposure online and alcohol sponsorship.

Voluntary schemes on labelling have not been fully implemented by drinks manufacturers, even though placing health information on alcohol products is strongly supported by the public. A report found that more than a third of alcohol product labels fail to display the current CMO's low risk drinking guidelines of 14 units a week.[47] The Government should introduce mandatory health labelling including these guidelines. Labels should include alcohol content, nutritional content (in line with regulations for soft drinks and food products) and warnings of health risks such as drinking during pregnancy. Labels should also highlight the link between alcohol and cancer, as only 13% of adults are aware of the link.[48]

Systems to identify and address the health harms of alcohol use

A wide range of health and social care services (eg mental health, criminal justice settings, primary care, education and hospitals, including maternity services) should be able to routinely screen for problematic alcohol use. They should be aware of local services that can offer early help and treatment and throughout their approach they should apply the principles of trauma informed practice. Outreach and satellite services should engage underserved populations to improve access to treatment. Alcohol use should also be addressed across the wider children's agenda, including safeguarding, offending, mental health and children's care.[17] Targeted intervention and specialist referral pathways should be in place for pregnant alcohol users in line with guidelines, which highlights that healthcare commissioners and those responsible for providing local antenatal services should work with local agencies, including social care and third-sector agencies that provide substance misuse services, to coordinate antenatal care.[49] There should be specific interventions to raise awareness of the harms of drinking for at-risk groups. Taking a public health approach to serious violence also presents a significant opportunity to prevent alcohol related harms.

Service access criteria should not exclude people based on levels of drug dependence, or on diagnoses (or lack of diagnoses) of mental illness, and the principles of 'no wrong door' and 'everyone's businesses' should be evidenced in commissioning, service delivery and practice.[50] Commissioners should monitor how many people are declined access to services because of their dependence on alcohol or drugs.

Service users and community engagement in service planning and delivery

Service user involvement (SUI) is important for service planning and delivery. It is about making sure that

the people who use services are meaningfully involved in strategic planning, commissioning, and service delivery processes, so that care pathways and services could be geographically and culturally appropriate to the people who use them.[51] It is an opportunity to engage people in their own long-term recovery, while at the same time inspiring others.[36]

Quick access to effective and evidence-based alcohol treatment

Excessive alcohol consumption can result in conditions such as alcohol-related brain damage, liver cirrhosis and other alcohol-related liver disease.[52] Early identification and treatment are crucial. Commissioning and services should be coordinated to improve service users' access to services including for wound care, sexual health, dental health, and cardiovascular health. Different treatment goals should be supported, including harm reduction, abstinence, maintenance, and relapse prevention, through individually tailored packages of psychosocial, prescribing and recovery support interventions. Alcohol treatment services in all settings should be in line with NICE guidance and apply the principles of trauma informed practice. [53] [54] There should also be local reviews of alcohol-related deaths and action in response to their findings.

Effective recovery and employment support for alcohol misusing populations

Alcohol dependent populations require comprehensive support for recovery, through the lens of trauma informed practice. There should be effective care pathways between hospitals and community services to ensure that interventions continue after discharge. Targeted support should especially be provided to people with co-occurring mental health issues and alcohol and drug problems.

Peer mentoring and support should be integral parts of local service delivery. People in treatment should have access to a range of peer-based recovery support options, including 12-step (AA, NA, CA), SMART Recovery and other community recovery organisations. Service users, their families and carers should be involved at the heart of planning and commissioning. User and community led initiatives or social enterprises should be supported by local commissioners and services.[17]

Job Centre Plus (JCP) and the Work and Health Programme (WHP) providers should collaborate locally to support the education, training, and employment (ETE) needs of the alcohol misusing population. There should be an integrated approach to address health and housing needs on discharge from hospital, residential rehab, or prison. Treatment providers, JCP and WHP should engage with employers to address negative preconceptions about employing people with a history of alcohol dependence.

NHS should play a stronger role in alcohol treatment and harm reduction

ADPH welcome the renewed commitment to reducing alcohol dependence through the NHS Long Term Plan, however it is crucial that new services are integrated with existing local authority alcohol interventions and supported by national policy change.[55] The NHS has a greater role to play in prevention of alcohol harm. In England, this could be realised through ICSs.

A skilled workforce to provide effective interventions

A whole system workforce strategy should be in place to help ensure that local public health teams are competent to commission and deliver safe and effective alcohol and drug services and there is sufficient public health experience to plan and implement population level interventions. A full range of addiction specialist and non-specialist medical and professional competencies should be available among the treatment workforce, including doctors, nurses, psychologists, and social workers.

About ADPH

The Association of Directors of Public Health (ADPH) is the representative body for Directors of Public Health (DsPH) in the UK. It represents the professional views of all DsPH as the local leaders for the nation's health.

The Association has a heritage dating back over 160 years and is a collaborative organisation, working in partnership with others to strengthen the voice for public health. It seeks to improve and protect the health of the population through collating and presenting the views of DsPH; advising on public health policy and legislation at a local, regional, national and international level; facilitating a support network for DsPH; and providing opportunities for DsPH to develop professional practice.

This policy position statement has been developed in collaboration with the ADPH Council, the ADPH Addiction PAG and the English Substance Use Commissioners Group.

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