drinkaware

Alcohol Health Alliance UK: Commission on Alcohol Harm
Call for Evidence

Submission from The Drinkaware Trust

17 February 2020

The Drinkaware Trust is an independent UK-wide alcohol education charity, funded largely by voluntary and unrestricted donations from UK alcohol producers, retailers and supermarkets. The Trust is governed independently and works in partnership with others to help reduce alcohol-related harm.

Drinkaware acknowledges the World Health Organisation's position on key influences on alcohol consumption and the 'best buys' of price, ease of purchase and the social norms around alcohol consumption. In this context, alcohol education and appropriate signposting have a role to play in supporting individuals to change behaviour; and through greater awareness of harms, can help increase the acceptability of, and political mandate for, policy interventions.

Drinkaware is providing its response based on its evidence and insights into drinking behaviour and attitudes, and our experience of delivering interventions to help reduce alcohol harm. We welcome the access of our research and evaluations to further contribute to policy development.

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

Physical Health?

There has been extensive research and medical evidence recognising, and strengthening, the impact of alcohol consumption on physical health, particularly on accidents, injuries, cancer and heart disease. Much of this evidence informed the decision in 2016 of the UK's Chief Medical Officers to lower the guidelines on how to keep health risks from drinking alcohol to a low level.[1] Indeed, the Chief Medical Officers concluded that drinking any level of alcohol regularly carries a health risk for everyone.[2] Since that time there has been extensive analysis in the UK (by University of Sheffield) of the fractions attributable to alcohol consumption of many physical conditions including several cancers.[3]

Despite the wealth of evidence, Drinkaware's research indicates that more work needs to be done to increase awareness among the population of alcohol's health impact.

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[1] Department of Health. (2016). *UK Chief Medical Officers' Alcohol Guidelines Review: Report from the Guidelines development group to the UK Chief Medical Officers*. London: Department of Health. [Online]. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/545739/GDG_report-Jan2016.pdf.

[2] Departments of Health, UK. (2016). *UK Chief Medical Officers' Low Risk Drinking Guidelines*. [Online]. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/545937/UK_CMOs__report.pdf.

[3] Webster, L., Angus, C., Holmes, J., Brennan, A., Gillespie, D. and Street, R. (2019). *Alcohol attributable fractions for England*. [Online]. Available at: https://www.sheffield.ac.uk/polopoly_fs/1.828724!/file/ScHARR_AAFs.pdf.

Data from The Drinkaware Monitor 2018, an annual survey of drinking behaviours among the UK population (aged 18-85),[4] found that although the link between alcohol and liver disease is well-recognised (68% spontaneous awareness), awareness of the risks of other health conditions due to alcohol such as heart disease (29% spontaneous awareness), and particularly cancer, remains low. For example, despite evidence that alcohol causes at least seven types of cancer,[5] just 24% of respondents – unprompted – linked alcohol to cancer. Furthermore, The Drinkaware Monitor found that just one in ten respondents spontaneously linked alcohol consumption to obesity risk.[6] Drinkaware has witnessed increasing consumer interest in the calorie content of drinks, evidenced by online search data. For example, in 2018, there were more than 126,000 unique visits to its 'calories in alcohol' page and approximately 1.1 million users of the online unit and calorie calculator. This highlights the additional work needed to raise awareness of health harms associated with alcohol among the public.

Mental health?

Alcohol impacts a range of mental health and wellbeing issues, from stress and anxiety to depression. Such issues not only arise from drinking too much alcohol but can also cause people to drink too much.

The Drinkaware Monitor uses the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS) to assess mental wellbeing, with the 2018 Drinkaware Monitor demonstrating that as many as 58% of drinkers drink alcohol for at least one reason associated with 'coping'. In addition, there is a clear gradient of 'drinking to cope' among younger drinkers (68% among those aged 18-24), compared to those in older age groups (25-34: 66%, 35-44: 66%, 45-54: 60%, 55-64: 51%, 65-75: 45%, 76+: 44%).

In addition, there is a steep social gradient to the degree to which drinking motivations indicate lower wellbeing, further compounding health inequalities as certain coping reasons are common among those in lower SEGs compared to higher SEGs—specifically, 'drinking to forget about problems' (DE: 44% vs. AB: 33%), and 'drinking because it helps when you feel depressed of nervous' (DE: 45% vs. AB: 36%).[7]

Awareness of the impact of alcohol on mental health also needs to be improved (11% unprompted awareness). It is important to ensure that the psychological effects of alcohol are given parity of esteem with physical health harms; the potential is for alcohol to disproportionately impact individuals in lower SEGs — in line with the recognised 'alcohol harm paradox' – whereby people in lower SEGs suffer disproportionately from the adverse health effects of alcohol.[8]

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

Drinkaware is concerned by recent NHS Digital evidence indicating that the impact of alcohol on NHS services is growing, with 358,000 admissions to hospital in 2018/19 where the main reason was due

[4]Conducted by YouGov for Drinkaware, with a representative sample of 8,906 UK adults aged 18 to 85 online, between 14th May and 5th June 2018. Data have been weighted to be representative of the UK adult population (aged 18 to 85) according to gender, age, social grade, and region.

[5] Bagnardi, V., Rota, M., Botteri, E., Tramacere, I., Islami, F., Fedirko, V., Scotti, L., Jenab, M., Turati, F., Pasquali, E. and Pelucchi, C. (2015). Alcohol consumption and site-specific cancer risk: a comprehensive dose–response meta-analysis. *British Journal of Cancer*, *112*(3), 580-593.

[6] Gunstone, B., Piggott, L., Butler, B., Appleton, A. and Larsen, J. (2018). *Drinking behaviours and moderation among UK adults: Findings from Drinkaware Monitor 2018*. London: YouGov and Drinkaware.

[7] Appleton, A., and James, R. (2018). *Adults (18-75) in the UK who drink alcohol for coping reasons*. Drinkaware. [Online]. Available at: https://www.drinkaware.co.uk/media/1852/drinking-to-cope-jan-2018.pdf.

[8] Bellis, M.A., Hughes, K., Nicholls, J., Sheron, N., Gilmore, I. and Jones, L. (2016). The alcohol harm paradox: using a national survey to explore how alcohol may disproportionately impact health in deprived individuals. *BMC public health*, *16*(1), 111.

to drinking alcohol, 6% higher than 2017/18 and 19% higher than 2008/09.[9] We do not have unique evidence to add to this question but remain concerned by this evidence.

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

Only one in five individuals with alcohol dependency seek treatment.[10]

Research suggests the reasons behind this include fear of stigma or shame, a lack of perception of treatment need, as well as fear of giving up alcohol.[11] In addition, the National Institute for Health and Care Excellence (NICE) has noted that alcohol-dependent adults often present with problems associated with alcohol use, such as depression, but not specifically for the alcohol problem itself.[12] Failure to identify and address the underlying alcohol problem by health professionals can result in delayed access to effective alcohol interventions until problems become chronic and difficult to treat. This evidence highlights the importance of early identification and brief advice (IBA) and specialist treatment referrals for those with possible dependence.

According to statistics on the pathways into treatment, approximately two-thirds of individuals in England starting treatment in 2018/19 self-referred (65%).[13]

Drinkaware has sought to widen the use of IBA beyond clinical settings specifically through digital and supermarket interventions. In 2019, The Drinkaware DrinkCompare calculator (developed based on the principles of IBA), had 315,125 completions, and supermarket activity in 100 ASDA stores across the UK delivered 7,032 IBAs (6,520 face-to-face, 541 digital) to shoppers over two days.

Our unpublished evidence indicates that IBA could be more comprehensively incorporated into both clinical (e.g. general health check and early health interventions) and non-clinical settings, to help raise awareness of harmful drinking increase early identification and self-referral to reduce longer term risks to health.

There is a need for further evaluation of the impact of IBA in non-clinical settings.

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[9] NHS Digital. (2020). *Statistics on alcohol, England 2020*. [Online]. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-alcohol/2020.

[10] Public Health England. (2018). *Alcohol and drug treatment for adults: statistics summary 2017 to 2018.* [Online]. Available at: https://www.gov.uk/government/publications/substance-misuse-treatment-for-adults-statistics-2017-to-2018/alcohol-and-drug-treatment-for-adults-statistics-summary-2017-to-2018.

[11] May, C. and Nielsen, A.S. (2019). Barriers to Treatment for Alcohol Dependence. *Journal of Drug and Alcohol Research*, *8*(2), 1-17.

[12] National Collaborating Centre for Mental Health, National Institute for Health and Care Excellence. (2011). *Alcohol use disorders: The NICE Guideline on the Diagnosis, Assessment and Management of Harmful Drinking and Alcohol Dependence* (No. 115). RCPsych Publications.

[13] Public Health England. (2019). *Adult substance misuse treatment statistics 2018 to 2019: report*. [Online]. Available at: https://www.gov.uk/government/publications/substance-misuse-treatment-for-adults-statistics-2018-to-2019/adult-substance-misuse-treatment-statistics-2018-to-2019-report#people-in-treatment-substance-sex-age.

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

Drinking too much over an extended period of time can turn temporary sexual dysfunction into impotence[14]. Drinking alcohol can also affect fertility in men and women, and women who drink over the UK Chief Medical Officers' (CMO) low risk drinking guidelines of 14 units a week can take longer to become pregnant and can suffer from menstrual and fertility problems. Drinkaware fully supports and has made efforts to widen awareness of the CMO's guideline advising against drinking of any alcohol in pregnancy or when trying to conceive.

In 2014 Drinkaware commissioned an investigation into drinking motivations, norms and rituals in the night-time economy.[15] This identified vulnerability and sexual harassment as hidden issues within club culture and the night-time economy, and that drunken sexual harassment is prevalent, normalised, and even expected, on a night out.

In addition, Drinkaware/You Gov research conducted in 2017 (with 2,000 UK adults, aged 18-24) found that 72% of 18-24-year-old men and women who drink in bars, clubs or pubs surveyed had witnessed sexual harassment on a night out, with 79% women stating that they expected inappropriate comments, touching and behaviour to take place when they went out. [16] Two-thirds (63%) of women and a quarter of men (26%) said that they had been on the receiving end of some form of sexual harassment.

This insight led to the development of an awareness-raising campaign which demonstrated a shift in attitudes towards unwanted sexual attention and harmful drinking behaviour[17] and the development of Nightlife Crew (formerly Drinkaware Crew)[18] a training programme for employees in large clubs, festivals and venues to support the welfare of customers on a night out.

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

While harmful drinking is a feature across demographic groups, there is evidence that drink preferences, occasions, and motivations differ, with implications for harm more severe among lower-income groups.

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[14] NHS Choices website. Male sexual problems. The Information Standard member organisation. Last reviewed: 10/06/2014. Available at: http://www.nhs.uk/Livewell/men4060/Pages/Malesexualdysfunction.aspx

[15] Christmas, S. and Seymour, F. (2014). *Drunken nights out: motivations, norms and rituals in the night-time economy*. Drinkaware. Available at: https://www.drinkaware.co.uk/media/1567/drinkaware_drunken-nights-out-report_full-report_vfinal-pdf-version-without-page-breaks-_dec-2014-amend.pdf.

[16] You Gov. (2017). *Inappropriate behaviour in pubs, bars and clubs*. Drinkaware. [Online]. Available at: https://www.drinkaware.co.uk/media/1813/drinkaware-1824s-report-v40_bars.pdf.

[17] Wood, M. and Shukla, P. (2017). You wouldn't sober, you shouldn't drunk: A behavioural change approach to changing attitudes and responses to unwanted sexual attention in pubs and clubs. *Alcohol and Alcoholism*, *52*(6), 737-745.

[18] Drinkaware. (2017). *Helping create a safer night-time economy. Drinkaware Crew Pilot*. Drinkaware. [Online]. Available at: https://www.drinkaware.co.uk/media/1855/drinkaware-crew-report-jan-2017.pdf.

Segmentation of the UK population based on AUDIT-C, drinking motivations, occasions and perceived likelihood of future health harms, identifies eight segments,[19] two of which Drinkaware considers to be particularly at risk of harm.

The first we have described as '*risky social drinkers*'. 89% of this group drink weekly or more often; 71% drink five or more units on a typical drinking day; 90% of this group drink at 'increasing' (40%) or 'higher risk' (50%) levels; and occasions cluster around nights out with friends, home get-togethers, and meals out.

The '*risky social drinkers'* tend to drink alcohol for social (40%) or enhancement (33%) reasons. While this group is predominantly younger (63% aged 18-44), and skewed towards males (59%), and higher social grades (63% in AB1C), there is still a significant proportion of older (37% aged 45 and over), female (41%) and C2DE (37%) individuals that comprise this group, and therefore, engage in harmful drinking behaviours and are at risk of the harms associated with alcohol.

The second 'risky' segment are less frequent drinkers but who drink large amounts when they do drink. Indeed, 93% of this segment drink weekly or more often, and fewer than one-third (31%) drink six times or more per week; 58% typically drink seven units or more in a drinking day. According to AUDIT-C scores, almost all of this group (97%) drink at increasing (28%) or higher risk (69%) levels. This segment is the most likely to frequently drink at home alone or with a partner. Although predominantly male (70%), and older (72% aged 45 and over), more than a quarter of this segment is female (30%), and aged 18-24 (28%), and is relatively evenly split across social grade (47% ABC1 vs. 53% C2DE).

Harmful drinking cuts across demographic groups, which highlights the importance of population-wide alcohol education. However, research on the impact of alcohol consistently demonstrates that the burden disproportionately falls onto lower social grade communities.[20] The persistence of the 'alcohol harm paradox'[21] highlights the necessity to address this important health inequality.

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

Alcohol-related sickness and absence is estimated to cost UK industry £7.3 billion a year,[22] with a further £1.2-1.4 billion a year estimated to be the result of alcohol-related presenteeism.[23] In addition, in 2016 alcohol was the leading risk factor globally of premature death among the population aged 15-49 years — with 3.8 per cent of deaths in women and 12.2 per cent of deaths in men attributable

[19] Gunstone, B., Piggott, L., Butler, B., Appleton, A. and Larsen, J. (2018). *Drinking behaviours and moderation among UK adults: Findings from Drinkaware Monitor 2018*. London: YouGov and Drinkaware. Available at: https://www.drinkaware.co.uk/media/293021/drinkaware-monitor-2018-report_v100.pdf.
[20] Katikireddi, S.V., Whitley, E., Lewsey, J., Gray, L. and Leyland, A.H. (2017). Socioeconomic status as an effect modifier of alcohol consumption and harm: analysis of linked cohort data. *The Lancet Public Health*, 2(6), e267-e276.
[21] Bellis, M.A., Hughes, K., Nicholls, J., Sheron, N., Gilmore, I. and Jones, L. (2016). The alcohol harm paradox: using a national survey to explore how alcohol may disproportionately impact health in deprived individuals. *BMC public health*, *16*(1), 111.
[22] Home Office. (2012). *A minimum unit price for alcohol. Impact Assessment*. (November 2012). Home Office, London. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/157763/ia-minimum-unit-pricing.pdf.
[23] Institute of Alcohol Studes. (2019*). Financial headache. The cost of workplace hangovers and intoxication to the UK economy*. [Online]. Available at: http://www.ias.org.uk/uploads/pdf/IAS%20reports/rp35062019.pdf.

to alcohol.[24] As the majority of adults in the UK are employed and spend a significant proportion of their time at work, the workplace can provide important opportunities for prevention of alcohol harm and early identification.

In addition, employment has a role in supporting addiction recovery. Dame Carol Black's independent review found that the employment rate for those who develop problematic dependence is less than half that of the rest of the population.[25] As such, guidance is needed for organisations on how to develop a workplace culture that can support people who have a complex relationship with alcohol.

Furthermore, work culture and peer pressure from colleagues is a factor. Drinkaware's research indicates that among working adults (who drink), two-fifths (43%) agree that there is too much pressure to drink when socialising with work colleagues. One in five report that co-workers have pressured them to drink more than they'd set out to. Men, in particular, are more likely than women to report having experienced pressure to drink from their boss or superior (13% compared with 8%).[26]

Drinkaware has developed Drinkaware at Work, an accredited employee training programme to equip employees with an understanding of the health harms associated with alcohol, its effect on the workplace, and strategies to reduce alcohol consumption, as well as to support employers, through the provision of resources, to develop workplace environment that promotes safer alcohol consumption.[27]

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

Drinkaware acknowledges that there are links between alcohol and violent behaviour and crime, but we do not have our own or new evidence to contribute in this area.

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

Independently, alcohol is associated with more than 200 disease and injury conditions, including chronic liver disease, cancers, cardiovascular disease, acute alcohol poisoning, and foetal alcohol syndrome.[28] Comorbid use of alcohol and tobacco exacerbates the health effects of either substance alone and increases the risk of cancers such as cancers of the mouth and throat.[29,30]

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[24] Griswold, M.G., Fullman, N., Hawley, C., Arian, N., Zimsen, S.R., Tymeson, H.D., Venkateswaran, V., Tapp, A.D., Forouzanfar, M.H., Salama, J.S. and Abate, K.H. (2018). Alcohol use and burden for 195 countries and territories, 1990–2016: a systematic analysis for the Global Burden of Disease Study 2016. *The Lancet,* 392(10152), 1015-1035.
[25] Black, C.M. (2016). *An independent review into the impact on employment outcomes of drug or alcohol addiction and obesity*. Department for Work and Pensions. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/573892/employment-outcomes-of-drug-or-alcohol-addiction-and-obesity-print.PDF.
[26] Gunstone, B. and Samra, S. (2019). *Drinking behaviours and peer pressure in relation to alcohol: Drinkaware Monitor 2019*. London: YouGov and Drinkaware.
[27] Drinkaware. *Drinkaware at work*. Available at: https://www.drinkaware.co.uk/alcohol-awareness-training.
[28] World Health Organization. (2019). *Global status report on alcohol and health 2018*. World Health Organization.
[29] Pelucchi, C., Gallus, S., Garavello, W., Bosetti, C. and La, C.V. (2006). Cancer risk associated with alcohol and tobacco use: focus on upper aero-digestive tract and liver. *Alcohol Research & Health*, 29(3), 193-198.
[30] Dal Maso, L., Torelli, N., Biancotto, E., Di Maso, M., Gini, A., Franchin, G., Levi, F., La Vecchia, C., Serraino, D. and Polesel, J. (2016). Combined effect of tobacco smoking and alcohol drinking in the risk of head and neck cancers: a re-analysis of case–control studies using bi-dimensional spline models. *European Journal of Epidemiology*, 31(4), 385-393.

Data from the 2018 Drinkaware Monitor confirms that smokers are twice as likely than non-smokers to exceed the Chief Medical Officers' low risk drinking guidelines of 14 units per week (34% vs. 17%).[31] Additionally, almost half of people within the heaviest drinking segment also smoke tobacco (44%).

2020 YouGov Profiles data indicates a link between alcohol and other addictive behaviours.[32] For example, adults drinking in excess of the low risk drinking guidelines are more likely than the general population to have ever smoked tobacco (63% vs. 47%), to gamble either online or on the high street (76% vs. 66%), and to have used cannabis products (58% vs. 31%).

In addition, people who drink more than 36 units per week are more likely than the general population to have ever smoked tobacco (69% vs. 47%), smoke every day (21% vs. 11%), and engaged in gambling, either online or high street (82% vs. 66%). They are also more likely to have used cannabis products (46% vs. 31%).

(9) What effect does the current approach to alcohol marketing have on alcohol harm?

Marketing:

We acknowledge that awareness of Drinkaware arises in large part due to signposting on alcohol brand marketing; with 45% of brand recognisers recalling Drinkaware on brand advertising and 49% on drinks packaging.[33] There is clearly consumer demand for impartial, medically-evidenced information, as demonstrated by more than 10.5m unique visitors to drinkaware.co.uk in 2019, 4.5m of which were seeking health-related information.

We believe alcohol marketing could be used more powerfully to communicate alcohol harms and more could be done to direct the public to Drinkaware's information and resources.

Licensing:

Drinkaware would welcome increased focus on alcohol-vulnerability in licensing, with training and a dedicated in-venue vulnerability role recognised as best practice for venues/ condition for festival licenses.

In 2014 Drinkaware commissioned a report on Drunken Nights Out: motivations, norms and rituals in the night-time economy. This identified vulnerability and sexual harassment as a hidden issue within club culture and the night-time economy. This led to the development of Nightlife Crew – a training scheme to keep young people safe on a night out. Through the development of the programme in venues across the UK, Drinkaware has seen the need for a dedicated vulnerability role in Night-Time Economy (NTE) venues. Nightlife Crew training equips staff with the ability to identify alcohol-related vulnerability and take steps to help prevent customers from coming to harm. The scheme – which now

[31] Gunstone, B., Piggott, L., Butler, B., Appleton, A. and Larsen, J. (2018). *Drinking behaviours and moderation among UK adults: Findings from Drinkaware Monitor 2018.* London: YouGov and Drinkaware. Available at: https://www.drinkaware.co.uk/media/293021/drinkaware-monitor-2018-report_v100.pdf.
[32] YouGov Profiles, 26 January 2020 dataset. Total sample was 18,058 Low Risk Drinkers (>16 units per week) and 3,170 High Risk Drinkers (>36 units per week).
[33] Drinkaware Internal Brand Tracking, You Gov 2017.

includes Festival and Street Crew - has been supported by the Home Office; Police and licensing officers and raises the capability of NTE workers in reducing alcohol harm.

Drinkaware would support further standardised licensing training - including training of licensing committee members, as well as personal license holders, which would include knowledge of alcohol harm and alcohol-related vulnerability and would support further prevention, crime reduction and community safety initiatives.

(10) What policy changes would help reduce the level of harm caused by alcohol?

Drinkaware acknowledges the World Health Organisation 'best buys' relating to reducing the harmful use of alcohol, – price (affordability), ease of purchase (availability) and the social norms around its consumption (acceptability). Within this framework, alcohol education including signposting to advice and intervention has an important role to play to increase the acceptability of, and political mandate for, appropriate policy interventions. The contribution of alcohol to a range of mental and physical harms must be acknowledged in multiple health policy areas, and activities to help prevent harm mainstreamed, not marginalised, recognising that alcohol does not only impact a minority of the population.

Drinkaware's suggested policy changes for the Commission are in areas relevant to our remit and underpinned by our evidence and experience. These are:

1. Alcohol should be elevated in the national prevention agenda, given the impact of alcohol on health harms such as mental health, cancer, cardio-vascular disease and stroke and other co-morbidities;

2. Drinkaware would welcome increased provision and support for health professionals to deliver alcohol brief interventions, as our qualitative research with health professionals highlights issues with resources, capacity and training;

3. Drinkaware would welcome further independent academic evaluation of delivery of IBA in non-clinical settings to reach at-risk drinkers. Drinkaware has experience of delivering IBA in community settings such as supermarkets and football clubs which have been shown to have a positive impact and reach new audiences;[34]

4. Drinkaware would welcome increased focus on alcohol-vulnerability in licensing, with alcohol-vulnerability training and a dedicated vulnerability role recognised as best practice for venues/ condition for festival licenses. We would also suggest further standardised licensing training - including for Licensing Committee members, as well as Personal License Holders, which would include knowledge of alcohol harm and alcohol-related vulnerability; and.

[34] Hall, N., Mooney, J.D., Sattar, Z. and Ling, J. (2019). Extending alcohol brief advice into non-clinical community settings: a qualitative study of experiences and perceptions of delivery staff. *BMC Health Services Research*, 19(1), 11.

5. More should be done by employers to improve the understanding of alcohol harm risks at a population level and to contribute to wider efforts to tackle harmful drinking. Drinkaware endorses wider alcohol education in occupations and industries where there is a defined health and safety need.