Alcohol Research UK broadly supports the approach adopted in this very useful policy document. Alcohol is not an ordinary commodity. It is the nation’s favourite drug and must be the focus of strong measures to prevent harm to users, children, families and the wider society. Alcohol has been causally implicated in more than 60 categories of disease, illness and injury, including a variety of cancers, cardiovascular illnesses and traumatic conditions. We welcome the approach adopted by the government’s strategy for England and Wales, especially the emphasis on price, marketing and availability.

This paper comments on the evidence-base underpinning some of the key policy proposals within the Strategy and outlines research funded by Alcohol Research UK relevant to these proposals. It is intended to inform those working in the alcohol field – eg. health and social care workers, voluntary organisations, researchers, policymakers, etc – as well as journalists, programme-makers and interested members of the public.

We will be responding in depth to the Government’s consultations on particular elements of the Strategy in due course.

The paragraph numbers in each section below refer to those in the published Strategy document.

The pricing of alcohol
(Paragraphs 2.5 and 2.9 of the Strategy document)
A comprehensive analysis of 1003 sets of data from 112 studies, including information spanning two centuries and many countries, found a significant negative relationship between alcohol price and drinking (1). On average, the authors estimated that a 10% increase in the retail price of alcohol reduced consumption by 4.4%. Other studies have found larger impacts on rates of liver disease than would be expected given the percentage change in price (2), suggesting that problem drinkers respond relatively more to changes in price than other drinkers. Other evidence shows that increases in alcohol taxes have led to reductions in serious harms, including alcohol-related mortality (3), liver cirrhosis (4), road accidents (4),
youth suicide (5) and alcohol dependence (6). It would appear that heavy drinkers are not impervious to changes in the price of their favourite beverage.

**Minimum Unit Pricing**

(Paragraph 2.8)

It is clear that price increases provide governments with a powerful strategy for reducing both consumption and related harms. The effectiveness of overall price increases, however, can be blunted if drinkers are able to choose cheaper, lower-quality products to compensate. Minimum Unit Pricing (MUP) is a very promising approach that would eliminate to some extent the availability of cheap alcohol beverages. Although it is clear that increasing price is linked to reduced consumption across populations, studies of MUP on individual consumption have only recently been initiated.

Canada was the first to implement and evaluate MUP. An innovative study from British Columbia (7) reported that minimum pricing effectively reduced consumption. A 10% increase in the minimum prices of all types of alcoholic beverage reduced total consumption by 3.4%.

*Alcohol Research UK* is currently funding a study of the effects of MUP among patients with severe alcohol damage in Scotland, with baseline data currently being collected.

**Marketing by the alcohol industry**

(Paragraph 2.12)

*Alcohol Research UK* funded a systematic review of the evidence from studies which evaluated the relationship between alcohol advertising or marketing and alcohol use in young people at a later point in time.

Seven studies met the review inclusion criteria. Five were conducted in USA, one in Belgium and one in New Zealand. The studies provided data on more than 13,000 young people aged 10 to 26 years old.

All studies demonstrated that exposure to marketing resulted in an increase in consumption as would be expected. These included exposure to direct advertising using broadcast and print media and indirect methods such as in-store promotions and portrayal of alcohol drinking in films, music videos and TV programmes.

In one study those young people who gave a positive response to alcohol adverts at the age of 18 were heavier drinkers and reported more alcohol related aggression at the age of 21.
Availability of alcohol  
(Paragraphs 3.7 and 3.18)  
Overall, more alcohol is consumed when it is easily available. A natural experiment in Sweden demonstrated this very clearly. The study examined consumption and alcohol-related problems when beer, up to 4.5% alcohol, was allowed to be sold in grocery stores. Eight years later this permission was reversed. When permission was granted total consumption increased by 15% and fell by about the same amount when the decision was reversed (8). There was also a drop in motor cycle accidents and a drop in hospital admissions for alcohol related problems in those under 20 (9).

A number of studies funded by Alcohol Research UK support the government’s multi-component approach. These include the following:

Community Interventions  
(Paragraph 3.21)  
Alcohol Research UK funded three interventions jointly known as the United Kingdom Community Alcohol Prevention Project (UKCAPP). Community Interventions were initiated in Cardiff, Birmingham and Glasgow. The project demonstrated that British communities can generate the kind of coordinated action which studies in the USA and Sweden have shown can reduce alcohol-related violence and injury, creating substantial cost-savings for society.

The UKCAPP report documents how all three were able to generate activity of the kind they sought.

Alcohol Research UK also funded evaluation of the initial work on the Community Alcohol Partnership (CAP) project in St Neots, Cambridgeshire. This provides a well documented example of a local initiative that has gone on to be adopted and adapted by a diverse range of local areas. It is one of the promising approaches identified in a more recent review funded by alcohol research UK.

Strengthening Families  
(Paragraph 5.22)  
Alcohol Research UK funded research that brought to light the effectiveness of the ‘Strengthening Families Programme: For Parents and Young People 10–14’ (SFP10–14) as an intervention for the primary prevention of alcohol misuse. One of the strong features of this programme is that results actually improve over the four
year follow-up period, while gains during the first year of conventional prevention programmes tend to decline in subsequent years. Further information is on the Alcohol Research UK website

Screening for hazardous drinking (Paragraph 5.17)
A very widely used screening test for alcohol misuse is the Alcohol Use Disorders Identification Test (AUDIT), which was developed in a World Health Organization collaborative project across six countries. Although AUDIT has been well validated and is turning out to be a very useful screening test, there are some situations, such as busy clinics as well as Accident and Emergency departments, where AUDIT takes too long to administer routinely. Alcohol Research UK funding led to the development of the Fast Alcohol Screening Test (FAST) which is now being used by many doctors’ clinics and A&E departments. It is the screening instrument of choice for nurses and GPs in many areas.

Brief interventions and the “teachable moment” (Paragraph 5.9)
Maxillo-facial surgeons see a regular stream of young male casualties with alcohol-related facial injuries. The majority of them have been involved in a fight, usually on a Friday or Saturday night. They attend an A&E department, receive appropriate treatment and are given an appointment for a follow-up clinic within the next 10 days. This clinic provides an ideal opportunity to influence the drinking patterns of these young men. Can advice given at this point, when the young men are concerned about their good looks, influence future alcohol consumption? Alcohol Research UK funded a brief intervention study (10) to look at this possibility. The motivational intervention lasted for less than 20 minutes and was given by the nurse as she removed stitches. Even though this intervention was very brief, it resulted in a significant change in alcohol consumption during the following year when compared to treatment as usual. There was a reduction of 55% in the number of young men drinking over the recommended limits compared to a drop of 8% in the comparison group. It is important to note that this brief but effective dialogue with the nurse was completed as part of a routine service without the need for additional resources or additional time.
A&E departments see a large number of patients who misuse alcohol. Alcohol Research UK therefore funded a (11) that has had a significant impact on practice and policy. After screening, those who were referred on to an alcohol health worker were drinking less at follow-up. At six months they were drinking 23 units of alcohol a week less than those given an information leaflet; at twelve months the difference was 14 units. Furthermore, those referred to the alcohol health worker had on average fewer visits to A&E over the following 12 months. Attendance at A&E provides a ‘treatable moment’ in which opportunistic identification of alcohol misuse can potentially help patients develop insight into the consequences of their drinking and promote improved health.

Training in brief interventions for alcohol problems should be an essential element of medical and nursing training.

For more intensive interventions we strongly support the statement that: “Increasing effective treatment for dependent drinkers will offer the most immediate opportunity to reduce alcohol related admissions and to reduce NHS costs. Treating alcohol dependence, where successful, has also been shown to prevent future illnesses” (paragraph 5.21)

The need for good research

Although Alcohol Research UK welcomes many of the measures in the Government’s strategy, one disappointing aspect is the lack of explicit reference to the need for high quality research to evaluate these measures. As has been made clear here, Alcohol Research UK has already funded research that is directly relevant to the strategy and will continue to do so. Although policies may seem promising and be based on what appears to be sound reasoning, it is essential that their effects are carefully evaluated under real-world conditions.

One important example of the need for research concerns the effects of MUP. Although there is good evidence to substantiate the link between price increases and reduced alcohol-related harm in general, there is little specific research on the effects of MUP. As mentioned above, Alcohol Research UK has funded a study to investigate the effects of the policy, when it is introduced in Scotland, on the consumption, health and welfare of patients whose lives have been harmed by their
drinking. However, it is also necessary to evaluate other aspects of the policy, including its effects on binge drinking among young people and middle-aged drinkers whose regular consumption puts their health at risk. The Government should be urged to fund independent research into the effects of this and other policies included in the strategy. For its part, Alcohol Research UK will continue to fund and promote research that can lead to a reduction in alcohol-related harm in the UK.

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Alcohol Research UK

Alcohol Research UK is a new independent charity launched in September 2011, taking over the work of the Alcohol Education and Research Council. It aims to reduce of alcohol-related harm to individuals, families and communities by funding research and other projects that help us understand the causes of alcohol harm, the problems it creates and the solutions that work best in tackling it.

Alcohol Research UK is the only organisation that is exclusively dedicated to funding and building a comprehensive evidence base to underpin the development of policy and practice around alcohol issues.

Visit our website.

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