Insight into drug prevention policies and landscape across the UK home nations

1. **What noteworthy drug prevention measures and activities are being implemented currently in your respective Home Nation, either at the local, regional, or devolved administrational level.**

Despite rising levels of alcohol-related hospital admissions and deaths, and an increase in harmful drinking, there has been a stark lack of substantial preventative action to curb alcohol harm in England.

The last national alcohol strategy is now over a decade old, with many of the promised policies either not implemented or of unclear status.[1] However, there have been a few noteworthy developments in recent years that should be considered as a springboard to build on.

Alcohol duty reform

The affordability of alcohol is directly linked to levels of consumption and associated harms and has increased dramatically in recent years (up 14% since 2010).[2] Effective alcohol taxation can help to curb escalating affordability while simultaneously raising revenue for the public purse: when an alcohol duty escalator was in place between 2008 and 2012/13 (ensuring an annual increase of 2% above inflation), deaths from alcohol-related liver disease fell.[3]

We welcomed the 2023 reform of alcohol duty to a strength-based system that ensures more harmful drinks cost more. This can also encourage alcohol producers to reformulate their products with lower strengths, which will benefit population health.[4]

However, the government now need to introduce an automatic uprating mechanism to ensure that the public health benefits of alcohol duty are not lost through inflation or future cuts, and revise duties on cider to ensure they attract the same duty as beer (**see more in Q4**).

Alcohol Care Teams

Alcohol care teams (ACTs) are teams of specialists, mainly location in acute UK hospitals. There is clear evidence that they reduce acute hospital admissions, readmissions, and mortality, and improve the quality and efficiency of alcohol care.[5]

With almost 6% of hospital admissions in England alcohol-related,[6] ACTs are a proactive way to drive down readmissions, and bridge the gap between secondary and community care.[7] They are cost-effective across all four elements of alcohol-related harm: crime and social disorder, families and family networks, the workplace, and health.[8] Implementation of an alcohol specialist nurse service in Nottingham improved the health outcomes and quality of care for detoxification and alcohol-related cirrhosis patients, resulting in a saving of 36.4 bed days per month in detoxification patients and a reduction in bed days used in the cirrhotic group from 6.3 to 3.2 days per month.[9]

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[1] The Health Foundation (2022) Addressing the leading risk factors for ill health: A review of government policies tackling smoking, poor diet, physical inactivity and harmful alcohol use in England.
[2] NHS Digital (2021) Statistics on Alcohol, England 2021.
[33] Williams, R. et al. (2018) Gathering momentum for the way ahead: fifth report of the *Lancet* standing commission on liver disease in the UK. *The Lancet,* 392(10162).
[4] https://www.dailymail.co.uk/news/article-13031249/beer-John-Smiths-alcohol-strength-slashed-prices-Shepherd-Neame-Carlsberg-Fosters-Old-Speckled-Hen.html
[5] Moriarty, K. (2019). Alcohol care teams: where are we now? *Frontline Gastroenterology*
[6] NHS Digital (2021). Statistics on alcohol, England 2021.
[7] Moriarty, K. (2019). Alcohol care teams: where are we now. *Frontline Gastroenterology.*
[8] Ibid.
[9] Ryder, S. D. et al (2010). Effectiveness of a nurse-led alcohol liaison service in a secondary care medical unit. *Clinical Medicine*.

The NHS Long Term Plan set aside £27 million to support the implementation of specialist ACTs in 25% of hospitals with the highest rates of alcohol-dependence related admissions, estimated to prevent 50,000 admissions over five years.[10]

Although there has been an increase in the number of trusts in England with an alcohol specialist nurse service, many hospitals are not resourced to provide the optimal seven-day service.[11] We would now call for a national roll out, with an ACT in every acute hospital.

2. **How would you describe the drug prevention landscape in your respective country? Descriptions could include the level of funding, degree of cross-departmental integration and specialism dedicated to prevention.**

As outlined above, alcohol harm reduction strategies in England are woefully inadequate. Inaction in England means we are falling behind our neighbours. We are now the only UK nation with no minimum unit pricing (MUP) policy in place, or plan to introduce one. It would cost an estimated additional £170 million annually for England to have the same proportion of access to treatment as Scotland.[12]

Since the Health and Social Care Act 2012, responsibility for commissioning alcohol services now sits with upper-tier and unitary local authorities in England. Funding for these services comes from the ring-fenced public health grant that each local authority receives to provide a wide range of public health interventions and services.[13] In addition to the public health grant, the government will invest an additional £533 million to "rebuild local authority commissioned substance misuse treatment services in England."[14] Local authorities have undergone cuts to public health budgets in most years after assuming responsibility from the NHS.[15] Smaller budgets have led several local authorities to combine alcohol and other drug treatment services, resulting in the deprioritisation of alcohol treatment compared to drugs, a reduction in alcohol specialisation, and increased barriers to alcohol users approaching services.[16]

The overall Public Health Grant, from which treatment budgets are drawn, was £850 million lower in 2019 than in 2015/16, representing a 24% cut in real terms per head.[17] In the four years from 2016/17, local authority drug and alcohol treatment services faced real-terms budget cuts of 15%.[18] There has been considerable regional variation in spending cuts, with some areas experiencing cuts of 40% between 2014/15 and 2017/18 (compared with a national average of 14%).[19] We very much welcome the increase in funding outlined in the government's 10-year Drug Strategy.[20] However, despite these recent increases, spending has still not matched 2014-15 levels, and this investment is not enough to tackle the massive unmet need for alcohol treatment.[21] It has also been suggested that alcohol services have lost out to drug treatment provision, and that an 'alcohol-only' treatment offer could make services more accessible.[22]

[10] Hansard (2020). Response to Written Question, UIN 91927.
[11] Williams, R. et al. (2017). New metrics for the Lancet Standing Commission on Liver Disease in the UK. *Lancet*.
[12] Estimated by an Alcohol Health Alliance working group in 2018.
[13] Alcohol Concern (2014). A measure of change: An evaluation of the impact of the public health transfer to local authorities on alcohol.
[14] HM Government (2021) From harm to hope: A 10-year drugs plan to cut crime and save lives
[15] The King's Fund (2022) Local government public health funding: putting the jigsaw together without the picture on the box
[16] PHE (2018). PHE inquiry into the fall in numbers of people in alcohol treatment: findings.
[17] The Health Foundation (2019) Creating healthy lives.
[18] AHA (2021). Alcohol Health Alliance responds to new figures revealing extent of cuts to treatment services.
[19] Dame Carol Black (2020) Review of Drugs: Executive Summary.
[20] DHSC and the Home Office (2021). Largest ever increase in funding for drug treatment
[21] National Audit Office (2023) Alcohol treatment services.
[22] House of Commons Committee of Public Accounts (2023) Alcohol treatment services: 54th report of session 2022-2023

An inquiry by Public Health England found that reduced budgets were a key driver in a reduction in alcohol treatment numbers post-2013.[23] Stakeholders reported several possible factors associated with service reconfiguration and reduced capacity that contributed to falling treatment numbers, listed below.[24]

- A loss of focus on the specific needs of alcohol users;
- Prioritisation of limited resources on opioid substitute treatment;
- Barriers to alcohol users approaching the service, including a perception that the service focused on the needs of drug users;
- Barriers to alcohol users engaging in treatment after initial contact, including a lack of alcohol specific treatment pathways within integrated services and a loss of alcohol treatment expertise among staff; and
- Referral pathways and multi-agency working had become less effective.

These indicate a prioritisation of drug treatment over alcohol, despite the fact that more people die from alcohol every year than other drugs.

The same inquiry found that numbers of people accessing alcohol treatment increased where there was: [25]

- Leadership commitment to alcohol treatment and a strategic approach by local authorities to alcohol harm reduction;
- Commitment to service improvement (as opposed to just cost-saving);
- Intention by commissioners to increase numbers in alcohol treatment to meet unmet need;
- Commissioners work with providers to ensure alcohol-specific needs were addressed in service models and service cultures were appropriate for alcohol users;
- Very accessible services, in a wide range of non-stigmatising settings;
- Services actively promoted and clearly identifiable as being for alcohol users;
- Alcohol-specific treatment pathways/interventions;
- Staff with alcohol-specific competences and roles; and
- Quick access to treatment.

3. What are the significant barriers currently faced for the implementation of effective prevention interventions?

As indicated above, inadequate funding to public health grants remains a significant barrier despite recent increases. This is occurring within a wider context of funding pressures and cuts across the board. Fundamental resource such as senior NHS advisors and dedicated teams within the Office for Health Improvement and Disparities are being stripped back, leaving a void of specialist knowledge and policy-making resource.

Alcohol industry influence is also a significant barrier for effective prevention interventions. Research has shown that industry-led initiatives consistently promote narratives around individual responsibility to quell the need for population level policies.[26] Industry groups such as the British Beer and Pub Association (BBPA) have also criticised important public health advances such as the Chief Medical Officers' revise low-risk drinking guidelines,[27] and consistently lobby the government in the run up to Budgets, calling for freezes or cuts to alcohol duty.

[23] PHE (2018). PHE inquiry into the fall in numbers of people in alcohol treatment: findings.
[24] PHE (2018). PHE inquiry into the fall in numbers of people in alcohol treatment: findings.
[25] PHE (2018). PHE inquiry into the fall in numbers of people in alcohol treatment: findings.
[26] van Schalkwyk, May CI, et al. "Distilling the curriculum: An analysis of alcohol industry-funded school-based youth education programmes." PLoS One 17.1 (2022): e0259560.
[27] The Drinks Business, UK alcohol guidance 'out of line' with Europe (accessed January 2024).

Currently, alcohol labelling, packaging and promotion is in part regulated by the industry-funded Portman Group. This self-regulatory model is ineffective in protecting children and vulnerable people from harmful alcohol marketing.

Consumers drinking above the low-risk guidelines account for 68% of total alcohol sales revenue, with the heaviest drinking 4% of the population accounting for nearly a third of sales.[28] Due to this conflict of interest, decision-making for effective alcohol harm reduction measures must be free from industry influence.

Finally, the lack of action on alcohol indicates a distinct lack of political will: no national strategy for over a decade; a consultation on alcohol labelling not implemented almost four years after it was announced; and no plan to consult officially on minimum unit pricing in England despite a growing evidence-base of success in the other nations.

4. **What are the most effective prevention interventions and service models in your Home Nation and how would you evaluate the impacts?**

The World Health Organization (WHO) recommend several cost-effective interventions to prevent and reduce harm from alcohol, including reducing availability, affordability, marketing, and facilitating access to screening, brief interventions, and treatment.[29] These policies should form part of a comprehensive national strategy on alcohol, subject to a robust and independent evaluation.

Raise prices on alcohol through excise taxes and pricing policies

As mentioned above, although the shift to a strength-based duty system is welcomed, more action is needed to ensure the public health benefits of alcohol duty are not eroded by increasing affordability. Modelling has predicted that returning to the alcohol duty escalator in England would save over 5,000 lives and prevent 160,000 hospitalisations over 12 years.[30] Additionally, the Government should end cider exceptionalism and tax these products relative to their alcohol content, as the current duty structure incentivises producers to continue making cheap, high-strength cider that causes considerable harm to consumers.[31]

Additionally, MUP reduces consumption of the cheapest, strongest drinks causing considerable harm. In the first two and a half years, MUP reduced alcohol-specific deaths in Scotland by 13.4%, 40% of which were concentrated in the most deprived communities.[32] The full report from the Scottish government details the policy's implementation and evaluation process.[33]

Enforce bans or comprehensive restrictions on alcohol advertising, sponsorship, and promotion

Exposure to alcohol marketing shapes children's alcohol use, increasing the likelihood of starting to drink at a younger age, and drinking more.[34] Over three quarters (75.8%) of the public support limiting children's exposure to alcohol ads.[35] As an age-restricted and harmful product, alcohol

[28] Add ref: Aveek's paper recruiting heavy loyalists of tomorrow
[29] https://www.who.int/initiatives/SAFER
[3030] Angus, C. & Henney, M. (2019) Modelling the impact of alcohol duty policies since 2012 in England and Scotland. *The University of Sheffield and Institute of Alcohol Studies*.
[31] Alcohol Health Alliance (2024) Budget submission spring 2024
[32] Wyper, G. et al. (2023) Evaluating the impact of alcohol minimum unit pricing (MUP) on alcohol-attributable deaths and hospital admissions in Scotland. *Public Health Scotland.*
[33] Scottish Government (2023) Alcohol (minimum pricing) (Scotland) Act 2012: Report on the operation and effect of the minimum pricing provisions 2018-2013.
[34] Sargent, J. D., & Babor, T. F. (2020) The Relationship Between Exposure to Alcohol Marketing and Underage Drinking Is Causal. *Journal of studies on alcohol and drugs,* s19.
[35] UCL TARG (2022). Alcohol in England.

should be included in the secondary legislation defining less healthy products subject to advertising restrictions as set out in the Health and Care Act 2022.[36]

Strengthen restrictions on availability

Availability of alcohol is directly related to levels of harm. There are also clear links between availability and inequalities: in England, alcohol outlet density increases with increasing neighbourhood deprivation.[37] Introducing 'public health' as a licensing objective in England and Wales would enable licensing bodies to consider local harm data when making their decisions.

Facilitate access to screening, brief interventions and treatment

Intervention and brief advice (IBA) is a cost-effective intervention to reduce alcohol consumption before the point that treatment for dependence is needed.[38] IBA requires initial screening, structured brief advice or extended brief interventions for those identified as high risk, and referral to specialist services for those identified to be most at risk of dependent drinking.[39] It is estimated to save £1.23 for every £1 spent.[40] IBA should be incorporated more thoroughly into primary care and A&E, dentists, and routine screening such as breast screening. Some local authorities have innovatively rolled out IBA via digital tools and to places such as hairdressers and driving instructors.[41] However, as increased screening is likely to lead to more referrals, there must be capacity in treatment services to facilitate a higher number of patients. Currently, an estimated 82% of adults in need of specialist treatment for alcohol are already not receiving it.[42]

78% of alcohol-specific deaths are due to alcohol-related liver disease (ARLD),[43] which often goes undetected until an advanced stage.[44] Tragically, 1 in 4 people diagnosed with ARLD in hospital die within 60 days.[45] Earlier detection of ARLD can stimulate a change in high-risk drinking behaviour and save lives.[46] Routinely commissioning FibroScan services within community treatment centres, GP surgeries, A&E and other frontline services, would enable services to better reach people who have not previously engaged in treatment but who may be at higher risk of liver damage.[47]

As mentioned above, ACTs should be extended from the 25% of hospitals with the highest rates of alcohol-dependence related admissions and be implemented in all acute hospitals. Placing addiction nurses in GP practices in disadvantaged areas has also been shown to increase engagement with alcohol services, and reduce use of GP, emergency department and hospital admissions.[48]

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[36] Department for Culture, Media & Sport and Department of Health & Social Care (2022) Introducing further advertising restrictions on TV and online for products high in fat, salt or sugar: consultation on secondary legislation.
[37] Angus, C. et al. (2017). Mapping patterns and trends in the spatial availability of alcohol using low-level geographic data: a case study in England 2003-2013. International Journal of Environmental Research and Public Health.
[38] Public Health England (2018). PHE inquiry into the fall in numbers of people in alcohol treatment: findings.
[39] Brown, J. et al (2016) Comparison of brief interventions in primary care on smoking and excessive alcohol consumption. *British Journal of General Practice.*
[40] Drummond, C. et al. (2019) Assertive outreach for high-need, high-cost alcohol-related frequent NHS hospital attenders: The value-based case for investment. *NIHR.*
[41] Alcohol Harm Commission (2020) 'It's everywhere' – alcohol's public face and private harm. *Alcohol Health Alliance.*
[42] Office for Health Improvement & Disparities (2021) Adult substance misuse treatment statistics 2020 to 2021: report.
[43] Office of National Statistics (2022) Alcohol-specific deaths in the UK: registered in 2021.
[44] British Liver Trust (accessed Jan 2024) Liver disease in numbers – key facts and statistics
[45] Roberts, S. E. et al. (2019) Early and late mortality following unscheduled admissions for severe liver disease across England and Wales. *Alimentary Pharmacology & Therapeutics,* 49(10): 1334-45.
[46] Subhan, M. et al. (2022). Transient elastography in community alcohol services: Can it detect significant liver disease and impact drinking behaviour? *Biomedicines,* 10(2): 477.
[47] Turning Point (2023) A sobering thought: the scale of alcohol harm and what we can do about it.
[48] Mohan, A. et al. (2022) Exploring the management of alcohol problems in Deep End practices in Scotland. *University of Dundee, University of Stirling, SHAAP.*

There should be named alcohol leads in every Integrated Care System, to ensure community alcohol treatment providers, experts by experience, hepatology and gastroenterology teams and emergency services work in partnership to co-produce pathways to enable improved access and more joined up person-centred services to reduce alcohol-related harms.[49]

IBA and treatment systems should be culturally literate, with adequate language provision, including in IBA materials such as AUDIT-C scratchcards. Service location should reflect the needs of diverse local communities. In some cases, this might involve more discrete locations that could be visited for reasons other than alcohol support.[50]

[49] Turning Point (2023) A sobering thought: the scale of alcohol harm and what we can do about it.

[50] Galvani, S. et al. (2023) Supporting solutions for South Asian women: Developing models for alcohol support. *Manchester Metropolitan University; Alcohol Change UK*