SHAAP
SCOTTISH HEALTH ACTION ON ALCOHOL PROBLEMS
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#MUP saves lives
Research and Policy Briefing
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**Welcome to the 11th research and policy briefing published by SHAAP – Scottish Health Action on Alcohol Problems.**

SHAAP provides a coordinated, coherent and authoritative medical and clinical voice on the need to reduce the impact of alcohol related harm on the health and wellbeing of people in Scotland.

Our aims are:

- To raise awareness and understanding of the alcohol-related health problems with health practitioners, policy makers and the public.
- To evaluate current research and identify strategies to reduce alcohol-related health damage based on the best available evidence.
- To work together with key organisations in the alcohol field in Scotland, the rest of the UK and worldwide, in tackling alcohol misuse.

SHAAP was set up in 2006 by the Scottish Medical Royal Colleges, through their Scottish Intercollegiate Group (SIGA). We are governed by an Executive Committee made up of members of the Royal Colleges.

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## MUP update

The latest stage in the MUP court case was in held in the Scottish Court of Session in Edinburgh on 7th and 8th June and 7th and 8th July 2016. During these four days, the Court heard further evidence from both the Scottish Government and the Scotch Whisky Association.

A decision from the court proceedings is expected in the autumn.

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## MESAS alcohol consumption and price in Scotland 2015

**In 2015, 10.8 litres of pure alcohol was sold per adult in Scotland, figures released by NHS Health Scotland show. This is equivalent to 41 bottles of vodka, 116 bottles of wine, or 476 pints of beer per adult. Alcohol sales in Scotland were 20% higher than in England and Wales (17.4 units per adult). Almost 97% of this was due to higher sales in supermarkets and**



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**off licences and 63% of higher off-trade sales in Scotland was due to alcohol sold below 50 pence per unit. More than twice as much vodka was sold in off sales in Scotland than in England and Wales.**

Almost three quarters (74%) of all alcohol sold in Scotland was sold in supermarkets and off licences, with more than half (51%) sold below 50 pence per unit, the minimum unit price recommended by the Scottish Government. The average price per unit in Scotland in 2015 in on-licence premises was £1.74 compared to only 52 pence in supermarkets and off licences.

When broken down by alcohol type, 40% of spirits, 29% of beer, 18% of wine, 10% of cider, and 3% other drink types was sold below 50 pence per unit in supermarkets and off licences in Scotland in 2015. In 2015, wine sales reached their highest level for over 20 years, and sales of spirits increased for the first time in the last six years.

Overall, the data shows that the downward trend in alcohol sales in Scotland has reversed due to higher sales through supermarkets and off licences which coincides with a flattening of the price of alcohol sold by these retailers.

The data gives strong support to minimum unit pricing and highlights the need for its implementation as quickly as possible. Around 22 people a week are dying in Scotland because of alcohol and, despite recent falls, deaths have increased for the last two years. Given the link between consumption and harm, and evidence that affordability is one of the drivers of increased consumption, addressing price is essential.

## Model-based appraisal of the comparative impact of Minimum Unit Pricing and taxation policies in Scotland - Sheffield Alcohol Research Group

**Evidence from the latest version of the Sheffield Alcohol Policy Model[1] shows that a 28% increase in taxation would be required to achieve the same reduction in alcohol-related deaths among harmful and hazardous drinkers as would be achieved with a 50 pence minimum unit price (MUP).**

The research argues a MUP of 50p would be effective in reducing alcohol consumption among hazardous and harmful drinkers. Such reductions in consumption would lead to subsequent reductions in alcohol-related hospitalisations and mortality. When compared to a 50p MUP, a 28% increase in alcohol taxes would lead to slightly larger reductions in alcohol consumption among moderate and hazardous drinkers but crucially to smaller reductions in consumption among harmful drinkers, and in particular, harmful drinkers in poverty. Harmful drinkers in poverty are the group at greatest risk from their alcohol consumption.

Based on analysis of current (2014) consumption patterns, the model found that within the Scottish population 14.9% are abstainers, 60.5% are moderate drinkers, 19.1% are hazardous drinkers, and 5.4% are harmful drinkers. Hazardous drinkers consume 41.5% and harmful drinkers consume 29.4% of all alcohol consumed in Scotland. This accounts for 70.9% of total consumption. When analysed by socio-economic characteristics, a smaller proportion of those in poverty are hazardous and harmful drinkers compared to those not in poverty (18.6% vs 25.6%). However, on average, hazardous and harmful drinkers in poverty consume more alcohol than those not in poverty. Alcohol-related mortality and morbidity is concentrated among those consuming the most alcohol and among those with lower incomes.

A 50p minimum unit price would only directly affect products currently sold at less than 50p per unit. Hazardous and harmful drinkers purchase more of this cheap alcohol and it accounts for a greater share of the total amount of alcohol they purchase. This is especially true for harmful drinkers in poverty who purchase almost 3,000 units of alcohol per year for less than 50p (accounting for 62% of their purchases) compared to harmful drinkers not in poverty who purchase around 1,500 units per year below the 50p per unit threshold (44% of their total purchases). Furthermore, harmful drinkers spend a substantial amount of money on alcohol. Harmful drinkers in poverty are estimated to spend £2,484 per year and those not in poverty £2,341. The equivalent amounts for hazardous drinkers are £1,102 and £1,204 per year respectively, and only £230 and £378 per year for moderate drinkers.

The model predicts that a minimum unit price of 50p would reduce alcohol consumption in Scotland by 3.5% or 26.3 units per drinker per year. Reductions in consumption are estimated to be largest among harmful drinkers (7%, 246.2 units per drinker, per year) and hazardous drinkers (2.5%, 35.5 units per drinker, per year). The smallest reduction would be seen among moderate drinkers, who would experience an average reduction of 1.2% or 3.7 units per drinker per year.

In relation to socio-economic status, the absolute difference in reductions in consumption between those in poverty and those not in poverty is very small for moderate drinkers (9.8 compared to 2.7 units per drinker per year). This difference is much larger for hazardous drinkers - 88.1 units

1 **http://www.shef.ac.uk/polopoly_fs/1.565373!/file/Scotland_report_2016.pdf**



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for those in poverty compared to 29.7 units for those not in poverty – and is larger again for harmful drinkers – 680.9 units for those in poverty and 180.9 for those not in poverty. Such results demonstrate the importance of separating moderate drinkers in poverty from hazardous and harmful drinkers in poverty when considering equity implications of minimum unit pricing.

The model further estimates that a 50p MUP would lead to 2,036 fewer deaths and almost 40,000 fewer hospital admissions during the first 20 years following implementation. After 20 years, when the full effect of the policy can be seen, there would be an estimated 121 fewer deaths and 2,042 fewer hospital admissions each year. Again, reductions in mortality would be largest among harmful drinkers in poverty – the group at the greatest risk of experiencing harm as a result of their drinking. At full effect of the policy, there would be 15.3% fewer alcohol-related deaths per year compared to a reduction of 4.4% in harmful drinkers not in poverty. The equivalent reductions among hazardous drinkers are 10.8% and 4.4%.

MUP is a more robust and targeted approach to reducing alcohol-related harm than taxation, as taxation imposes greater costs on low risk drinkers.

## Alcohol Brief Interventions 2015/16 – ISD Scotland

New figures released by ISD Scotland shows that there were 97,245 Alcohol Brief Interventions (ABIs) delivered in Scotland in 2015/16. This is 59% more than the target figure of 61,081 for 2015/16.

At national level both the target for ABI delivery and the expectation of delivery of 80% of the target to be delivered in priority settings were met. All but one NHS Board (NHS Western Isles) exceeded their target for ABI delivery.

There is large variation between individual NHS Boards in the distribution of ABI delivery across different settings. There has been a threefold increase in the number of ABIs delivered in 'wider' settings (other than priority settings) over the last three years.

### Context

The Scottish Government Local Delivery Plan (LDP) Standard for Alcohol Brief Interventions has two elements: it stipulates a minimum number of Alcohol Brief Interventions to be delivered in any setting, and specifies that a minimum of 80% of those need to be delivered in 'priority' settings (Primary Care, Accident & Emergency and Antenatal settings), as opposed to 'wider' settings (e.g. Criminal Justice and Community services such as Social Work). A target was introduced by the Scottish Government in 2008/09 setting minimum numbers of interventions to be delivered by each NHS Board, and this evolved into an LDP standard in 2012/13.

## EU AVMSD Follow-up Study on the exposure of minors to alcohol advertising on linear and non-linear audio-visual media services and other online services, including a content analysis – European Commission Report

**The study is a follow-up evaluation[2] of the first report on the application of the Audio-visual Media Service Directive (AVMSD) which was published on 4th May 2012. The report indicated that, with regard to alcohol advertising, further investigations were necessary to assess the exposure of minors to commercial communications and advertising for alcoholic beverages. The purpose of this study is to answer three research questions:**

- How much alcohol advertising does an average minor (below age of 18) watching linear audio-visual media services (i.e. television broadcasting) in the European Union (EU) see?
- How much alcohol advertising does an average minor see on non-linear audio-visual media services (i.e. on demand audio-visual media services) and other online services in the EU?
- For audio-visual media services (both linear and non-linear) and other online services, what type of alcohol advertising does an average minor see in the EU? Are minors specifically targeted by alcohol advertising? How appealing is alcohol advertising to minors? Do the provisions of the AVMSD and their application afford the required level of protection?

### Research Question 1: How much alcohol advertising does an average minor watching linear audio-visual media services in the EU see?

The analysis for research question one is based on two datasets. The first consists of data on general viewing patterns and alcohol advertising impacts in nine Member States – Austria, Czech Republic, Finland, Germany, Italy, the Netherlands, Romania, Spain, and the UK. The second consists of data on global advertising impacts, both for the total market and for the subset of alcohol brands, for 23 Member States. Both datasets are from 2013.

An analysis of both datasets found that approximately 7.3% of the total number of alcohol impacts seen in the EU on linear audio-visual media

2 **http://www.zaw.de/zaw/werbepolitik/audiovisuelle-medien/1Alcoholstudy-finalreport.pdf**



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services in 2013 were seen by minors. This ranges from 5-9% for the nine selected Member States in dataset one. In absolute terms, this means that, on average, a minor saw 200 alcohol impacts in 2013, while an adult saw over 450 in the same period. Similar results were seen for each member state.

When broken down by sector, the study reveals that the beer sector had the highest share of both the number of spots and the number of impacts seen.

In most member states the majority of alcohol advertising spots and alcohol impacts were seen on commercial channels but that the average impact per spot appeared to be higher on public channels. The majority of these spots aired on generalist or on entertainment and movie channels, although the majority of impacts were seen on generalist channels. This may be explained by the relatively high viewing rate for these channels.

For adults, the peak time of day for alcohol impacts was 21:00 to 23:59 across all member states. With the exception of one member state, this was also the peak time for 15-17 year olds. For the 4-14 year old age group, the peak occurred between 17:00 and 20:59 in four member states and between 21:00 and 23:59 in five member states.

## Research Question 2: How much alcohol advertising does an average minor see on non-linear audio-visual media services and other online services in the EU?

**Perspective of advertisers:**

The results from the study indicated that from the perspective of advertisers, the level of exposure of minors to alcohol advertising on non-linear audio-visual media services and other online services is supposed to be limited because

- The measures that online services have in place to help advertisers to advertise their products responsibly and in compliance with all applicable laws and regulations and thereby to restrict, or even prevent, the exposure of minors to alcohol advertising
- The choice of advertisers for online services that offer data gathering/ age verification and/or for which there is availability of audience data demonstrating that at least 70% of the likely audience is above the Legal Purchasing Age
- The numerous self-regulation initiatives that are in place at the company, sector, industry and national level.

This perspective was partially confirmed by the results from online data capture. Of the more than 2,000 online screen captures taken as part of the study, only four unique advertisements for alcohol brands were found. One of these advertisements advertised a non-alcoholic drink and was only found on the profile of an adult. The others were captured at least once on the profiles of minors.

**Perspective of the viewers:**

The results indicate that viewers perceived quite a substantial amount of exposure by minors. Although alcohol advertisements are the least recalled type of advertisement by minors aged 9-17 across the nine selected member states, 23.9% of these minors recalled having seen an alcohol advertisement online in the last month. The results also indicated that recall, and thus perceived awareness of alcohol advertising, increases both with age and online activity.

Respondents aged 9-17 were asked if they could describe an alcohol advertisement they had recently seen and 23.6% could do so. Furthermore, 80% of these respondents, on average, indicated they could recall the brand being advertised. The results show that both the memory of having seen alcohol advertising as well as active brand recognition increases both with age and online activity.

The results from the two perspectives vary and this could be the result of a number of different factors including an over-estimation of self-reported exposure, recall bias and a lack of a clear definition of advertisement in the survey; over-estimation of exposure based on online capture; and the limited scope of online data capture. Therefore, based on such discrepancies, it can be difficult to draw overall conclusions regarding the level of exposure of minors to alcohol advertising. What is clear, however, is that exposure to alcohol advertising increases with age and online activity and that both the online services and industry aim to ensure minimal exposure through the implementation of measures and self-regulation.

**Research Question 3: For audio-visual media services (both linear and non-linear) and other online services, what type of alcohol advertising does an average minor see in the EU? Are minors specifically targeted by alcohol advertising? How appealing is alcohol advertising to minors? Do the provisions of the AVMSD and their application afford the required level of protection?**

The study conducted a content analysis to assess exposure against two criteria – elements derived directly from article 22 of the AVMSD and to assess in a more general sense, whether advertisements can be considered as appealing to minors. One of the challenges in defining such criteria is that most of the elements of advertising have general appeal i.e. they are likely to stimulate a response in wider audiences and not only in one target group. Previous research on minors' perceptions of alcohol advertising shows that it is possible to say that adverts containing humour and music are likely to appeal to minors. However, these elements also appeal to and attract adult viewers, and are thus used widely in advertising. It is therefore possible to say that such elements are indeed appealing to minors but they are not necessarily


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targeted at them specifically or appeal only to them.

A wide variety of themes are used in advertisements, the most common one being the association between alcohol and sociability and depicting alcohol with a humorous tone. The study revealed that 87% of television advertisements and 63% of online advertisements analysed contained at least one element deemed appealing to minors. Evidence from existing literature shows that, for minors, the most important context of using alcohol is partying and celebration but that only 17% of advertisements sampled depicted this.

Associations of social and sexual success, popularity, sociability and enjoyment with alcohol are part of the wider cultural representations of what drinking is about and these were also the most common and central themes in advertisements. Given the role of sociability in advertisements, and the high relevance and appeal of social relations and belonging to minors, it is plausible to say that alcohol advertising is likely to be appealing to minors.

The study also found that 25% of the sample of advertisements analysed reflect at least one of the criteria described in the AVMSD, although this does not necessarily constitute infringement per se.

### Recommendations for further research

The study makes a number of recommendations for further research:

- Analyse exposure overtime through longitudinal studies. This could be a way to analyse the effectiveness of new regulation.
- Include viewing data from a larger sample of channels to allow for more detailed relative analyses.
- Include other forms of advertising in the scope of the study, such as product placement.
- Include adults in the sample in order to facilitate a comparison between self-reported exposure to minors and adults.

## 'Upper weekly alcohol limit can be purchased for just £2.17' – MUP Briefing by Alcohol Concern Wales

**New research by Alcohol Concern Wales has found that it is possible to purchase 14 units of alcohol – the Chief Medical Officers' recommended upper weekly limit – for as little as £2.17. The findings are presented in their briefing paper 'Cheap booze on our streets'[3] which argues minimum unit pricing is the most effective measure for reducing alcohol-related harm in Wales. The Welsh Government's Draft Public Health (Minimum Price for Alcohol) (Wales) Bill proposes the introduction of a 50p per unit minimum price. However, much will depend on the outcome of the MUP case in Scotland.**

Today in Wales, alcohol is 54% more affordable than it was 35 years ago when compared to average household income. The majority of this cheap alcohol is sold in the off-trade (supermarkets and off-licences), where alcohol is routinely offered at reduced prices to attract people into stores. Typically, it is heavy drinkers who most favour cheap alcohol which is bought and consumed in the greatest quantities and therefore causes the most harm.

Against this backdrop, the study, carried out in January this year, aimed to provide a snapshot of where, how and what brands of alcohol were being sold in the off-trade under the 50p per unit threshold proposed by the Welsh Government.

The research was carried out in six urban areas – Bangor, Carmarthen, Mold, Penarth, Pontypool, and Rhyl – which were selected as they provided a cross-section of typical, mid-sized towns and cities from across Wales. Data and evidence was gathered from physical visits to retail outlets to identify and record instances where alcohol was being sold below 50p per unit. The individual price, alcohol content (units/abv), drink type, brand name, retailer, location and date were all recorded for each instance and photographic evidence captured where possible.

The study found, that across all six locations, there were repeated examples of alcohol products on sale for less than 50p per unit. The cheapest recorded price was 15.5p per unit for a 3-litre bottle of high strength cider. Indeed, cider (and perry) represented all the products at the cheaper end of the scale and retailing for less than 24 pence per unit. Such a low selling price for these products can be partly explained by current tax arrangements where cider duty is set at a much lower rate than other alcoholic beverage types. This low price culture, and its associated health harms, could be overcome by bringing cider duty in line with beer duty. The study also found many other types of alcohol, including beer, wine and spirits, on sale in the 25-49 pence per unit price bracket. In total, 113 different alcoholic products, in 18 retail outlets, were identified on sale for less than 50p per unit.

The Welsh Government remains committed to MUP for Wales which it acknowledges that, whilst not a silver bullet that will solve all of the country' s alcohol problems, would have significant benefits to the health of the nation by reducing alcohol misuse and alcohol-related harms. The briefing argues that additional measures such as tax rises, voluntary agreements with retailers, and tougher rules on in-store promotions, many of which are already in place in Scotland, will also be beneficial for reducing alcohol-related harm but work best when they are used in

3 **http://www.alcoholconcern.org.uk/wp-content/uploads/2015/05/40672-ACW-Cheap-booze-on-our-streets-Briefing-E-FINAL.pdf**



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conjunction with MUP. Minimum Unit Pricing is a targeted approach that will reduce harms associated with alcohol and would effectively remove the cheap, high-strength alcohol which is attractive to the most harmful and hazardous drinkers from sale. MUP improves health and ultimately saves lives.

## Alcohol consumption as a cause of cancer – Addiction journal article

**Alcohol consumption, even at moderate levels, causes seven types of cancer, new research has found. The research paper, *'Alcohol consumption as a cause of cancer'*[4], published in the journal Addiction, states that there is a causal relationship between alcohol consumption and seven types of cancer – breast, oropharynx, oesophagus, liver, colon, larynx, and rectum. Although there still remains incomplete knowledge of the biological mechanisms which cause cancer, the paper argues that there is enough epidemiological evidence to demonstrate a causal link between alcohol consumption and these seven cancers.**

For all of these cancers, there is a dose-relationship, where cancer risk increases with increased consumption. However, the research also found there is risk associated with low levels of consumption, although this varies by type of cancer. Recent evidence has found that light to moderate consumption in women was associated with an increased total risk of cancers, especially breast cancer, where a significant increase in risk is seen from the first drink. Modelling has shown that, compared with non-drinkers, women who regularly drink two units a day have a 16% greater risk of developing breast cancer and subsequently dying from it. The research also suggests that it is likely that alcohol consumption is causally associated with other types of cancer including pancreatic, prostate and skin cancers.

For some cancers, the associated risk of developing cancer can be reversed when alcohol consumption stops. The research suggests that for laryngeal and pharyngeal cancers, quitting alcohol was associated with a 15% reduction in risk after five years, and equivalence with never drinkers after 30 years. Other cancers, such as oesophageal and cancers of the head and neck, are actually associated with a period of increase risk immediately after quitting, before declining and reaching similarity with never drinkers after 20 years.

The research also questions previously reported assumptions of consumption of alcohol, particularly red wine, as having a cardio-protective effect. While the causal relationship is not as strong, such claims, according to the author, are increasingly disingenuous and irrelevant in relation to the increased risk of alcohol consumption on a range of cancers. Any protective effect, which is disputed, is heavily outweighed by the increased risk to multiple cancers.

The paper concludes that there is no safe level of alcohol consumption with respect to cancer risk and argues that this message should be strongly promoted. Such a message is particularly challenging to the alcohol industry marketing efforts, especially in relation to breast cancer, given the known relationship with alcohol, and the high profile nature of the disease. Population level policies to control alcohol consumption, instead of industry favoured individual choice arguments, are more likely to be effective at reducing alcohol-related harms, and more strongly supported by the evidence in relation to cancer risk.

It is estimated that alcohol is responsible for 5.8% of all cancer deaths worldwide (approximately 500,000). The highest risks are associated with the heaviest drinking but a considerable burden is experienced by drinkers with low or moderate levels of consumption. Therefore, population-wide reductions in levels of alcohol consumption will have an important effect on the incidence of these types of cancers, compared to solely targeting the heaviest drinkers which has much more limited potential.

## Worrying gaps in awareness : almost nine in ten adults do not link alcohol and cancer - Cancer Research UK report

**New research published by Cancer Research UK and the University of Sheffield highlights a worrying lack of awareness of the links between alcohol and cancer among adults in England. The report *'An Investigation of Public Knowledge of the link between Alcohol and Cancer'*[5] found that only 13% of adults surveyed identified cancer as a potential health outcome of alcohol consumption. This is particularly significant given that alcohol is believed to be responsible for approximately 12,800 cases of cancer in the UK annually.**

The aim of the study was to explore understandings of the relationship between alcohol consumption and different health conditions, in particular different types of cancer; attitudes to health information and labelling; and perceptions of who is responsible for reducing alcohol related harm. The findings in the

4 Connor, J (2016) 'Alcohol consumption as a cause of cancer' Addiction 111: doi: 10.1111/add.13477 **http://onlinelibrary.wiley.com/doi/10.1111/add.13477/pdf**

5 **http://www.cancerresearchuk.org/sites/default/files/an_investigation_of_public_knowledge_of_the_link_between_alcohol_and_cancer_buykx_et_al.pdf**



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report are based on a survey of 2,100 adults in England in July 2015.

The findings identified a lack of understanding of the link between alcohol and the risk of developing certain types of cancer. The survey reported a high level of awareness of the links between alcohol and liver cancer (80%). Less than half of respondents (48%) were aware of alcohol as a risk factor for cancers of the mouth and throat and only 18% linked alcohol consumption to the risk of developing breast cancer. This is despite evidence which shows that the risk for liver cancer only starts to increase at higher levels of consumption over prolonged time periods, whereas there is a much greater risk from alcohol consumption at far lower levels for mouth, throat, and breast cancers. Alcohol causes 3,200 cases of breast cancer each year compared to only 400 cases of liver cancer. Indeed, knowledge of the link between alcohol and breast cancer was much lower than for cancers of the bladder (54.3%) and brain (31.8%) where there is no current evidence that alcohol is a causal factor. The findings suggest there is widespread uncertainty about the relationship between alcohol consumption and cancer. Reasons for this could include the complexity of risk factors and the differing levels at which risk starts. Accurately reflecting the risk of cancer posed by alcohol can be challenging for public health messaging.

The study also showed that only one in five people could correctly identify the previously recommended maximum number of units that should not be exceeded in a day, as recommended at that time in 2015. Among drinkers, as few as one in 10 men (10.8%) and one in seven women (15.2%) correctly identified these recommended limits and used them to track their drinking habits. The recommended weekly drinking allowance is now the same for both men and women, following a review by the UK Chief Medical Officers (CMOs) in January 2016.

There was a high level of support for all types of health information labelling, with only 10% of those surveyed opposed to it. Standardised displays of alcohol by volume (ABV) percentage and the number of units on labels of alcoholic drinks were the most popular, with the more than three quarters of respondents supporting this type of health messaging. However, there was no clear consensus on which statements or types of messages were the most or least persuasive. For example, the message 'alcohol causes 1 in 20 cancers' was found to be the most and least persuasive by almost a quarter of respondents in each case. Such variance in the effectiveness or persuasiveness of messages supports the argument for health information messages to be regularly revised to ensure they remain fresh for consumers.

Tackling alcohol-related harms was primarily viewed as the responsibility of individuals (81%), the alcohol industry (71%) and national level government (63%). Work places (35%) and charities (33%) were viewed as having the least responsibility. The study did not investigate what people specifically meant by responsibility. For example, with regards to individual responsibility, it is likely that this was interpreted as self-responsibility, rather than that of others. For those who viewed industry as responsible, the researchers suggest that it would be interesting to know whether this is restricted to measures already outlined in the Responsibility Deal, or whether more comprehensive action from industry would be preferred, given the widespread criticism of the Responsibility Deal by public health advocates. Furthermore, only 49% of study participants agreed that local government had responsibility, compared to a much larger number who believe this is the role of national government. According to the researchers, this is significant as local authorities hold much of the responsibility for the prevention of alcohol-related harm through their role in setting local licensing policy and also in commissioning alcohol screening/brief interventions and specialist treatment.

## Understanding the relationship between poverty and alcohol misuse

**In June 2016, researchers at Liverpool John Moores University published a report[6] which provided a rapid review of the evidence on poverty and alcohol misuse in an attempt to understand their causal linkages and examine the UK evidence of how much problem alcohol use is both a response to, and driver of, poverty.**

Alcohol use is one of the top five leading risk factors for death and loss of health in the UK. Evidence from around the world shows a clear and persistent upward relationship in the risks of alcohol-related deaths by socioeconomic status (SES), such that people with lower income, education or occupational status are much more likely to die or suffer from a disease related to their alcohol use.

Key findings of the report suggest that people who experience social and economic disadvantage in early life or adulthood are at greater risk of adopting problem drinking behaviours in later life. Intergenerational disadvantage appears to generate higher risks of problem drinking behaviours in later life. This is influenced by a range of factors such as stress, neighbourhood effects/influence of place, and SES over the lifecourse. Furthermore, problem alcohol use has an effect on employment, particularly around physical and mental health problems preventing individuals from returning to work, despite being motivated to do so. Consequently, this has an effect on the benefit system with more

6 **http://www.cph.org.uk/wp-content/uploads/2016/06/Understanding-the-relationship-between-poverty-and-alcohol-abuse-2.pdf**



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individuals with problematic alcohol use accessing the welfare benefits system. However, the relationship between these factors is complex and affects different groups of individuals differently. Studies in the UK have not considered the dynamic nature of poverty and whether it has different impacts on problem alcohol use or patterns of drinking. The report argues/concludes that there is insufficient evidence to establish that problematic alcohol use is a cause of poverty in the UK. While problem alcohol use inevitably has social and economic consequences for some, people who are poor or living in poverty may be less able to avoid or buffer these consequences and are at greater risk of marginalisation because of their drinking behaviours than people who are more affluent.

The research also reviews the effectiveness and cost-effectiveness of policies and interventions aimed at preventing and reducing problematic alcohol use. From a whole population perspective, evidence suggests that policy measures targeting price, availability and marketing of alcoholic drinks may be effective and efficient ways of tackling problem alcohol use across society. Key regulatory levers include limiting or reducing alcohol outlet density and different pricing and taxation approaches/measures. There is currently a lack of evidence to make suggestions about which approaches to preventing alcohol-related harm might impact directly on the relationship between problem alcohol use and poverty. Taking a whole population approach to alcohol-related harm via policy measures that target price, availability and marketing of alcohol are likely to be the most effective way of tackling problem alcohol use.

The report makes a number of recommendations for future/ further research and policy to better understand the relationship between poverty and alcohol use/misuse.

### Research recommendations:

- Further longitudinal research required to better understand the dynamic nature of poverty, its relationship with alcohol consumption, and the mechanisms which link them.
- Research is needed to better understand the links between actions (both external and individually led) that facilitate routes out of poverty with problem alcohol use. It is important to better understand how the duration of poverty may influence problem alcohol use as a response to the stressors that accompany poverty.
- There has been little investigation on how employment and income changes may affect substance use, including alcohol. Gaps remain in our understanding of how changes in employment status and employment conditions have affected alcohol use in the UK context.
- The 'alcohol harm paradox' suggests that health harms from alcohol use are unequally distributed towards more deprived populations. It is important to better understand whether there is similar inequality with regards to social outcomes.

### Policy recommendations:

- It is clear that there is a complex relationship between alcohol use, poverty and (un) employment. Policy actions that are based on an assumption of a sequential relationship between these indicators are unlikely to successfully address them.
- Local licensing boards should be further encouraged to consider the impact of neighbourhood deprivation profiles in their licensing decisions.

## 'Youthful Abandon: Why are young people drinking less?' An Institute of Alcohol Studies report

**In July 2016, the Institute of Alcohol Studies (IAS) published a report examining declining alcohol consumption among young people in Britain and presented a number of theories as possible explanations for this decline. The report, *'Youthful Abandon: Why are young people drinking less?'*[7], argues that the reason for the decline in youth alcohol consumption is poorly understood.**

Underage drinking in the UK is in long-term decline. In 2003, 61% of 11-15 year-olds in England had tried alcohol; by 2014 this had fallen to 38%, with acceleration from 2009. Similar falls have been experienced in Scotland, where SALSUS data from 2013 has reported the lowest level of youth drinking recorded at 19% for 15-year olds, and 4% for 13 year olds. The fall has occurred at all levels of consumption, across both genders and in all socio-demographic groups. However, levels of youth drinking still remain high – two fifths continue to drink. To maintain or accelerate this decline, the report argues that we need to understand what has driven the decline so far and presents seven theories as possible explanations. These are better legal enforcement of minimum purchase ages, rise in new technology, changing social norms, happier and more conscientious children, better parenting, demographic shifts, and lower affordability and economic confidence.

Although none of the outlined hypotheses offer a categorical causal explanation for declining youth alcohol consumption, the report argues that better parenting and lower affordability

7 **http://www.ias.org.uk/uploads/pdf/IAS%20reports/rp22072016.pdf**



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and economic confidence are the most plausible explanations.

The family environments of young people are known to have a significant impact on their likelihood of drinking. Consequently, the theory suggests that changes in parenting behaviour and efficacy are causes of the decline in underage alcohol consumption. Better parenting means that parents are less likely to drink in front of their children, less likely to approve of their children drinking, more likely to know the whereabouts and activities of their children, and have warmer and closer relationships with them. For example, in 2008, 45% of 11-15 year-olds reported that they believed that their parents would be unhappy with them drinking; by 2014, this had risen to 56%.

Alcohol consumption is strongly influenced by price and economic context. Since 2008, as a result of the economic recession, alcohol has become less affordable and this has significantly contributed to a reduction in underage/youth consumption. The same affordability trends have reduced alcohol consumption among adults and this has fed through to lower drinking among children and young people who are also heavily influenced by family environments and the drinking habits of their parents.

The report argues that a number of commonly held theories, in particular enforcement of ID and increased use of social media, only offer a limited explanation for the decline in youth drinking. Enforcement of ID checks to eliminate underage selling only play a minor role as very few children (around 6%) have ever purchased alcohol directly themselves; they are much more likely to be supplied by friends or family. Furthermore, there is as of yet little evidence that young people are spending more time online instead of drinking. Indeed, in both Scotland and England, children who spend more time online are more likely to drink, arguably due to their greater exposure to alcohol marketing strategically targeted at their age group by the alcohol industry. Changing demographics, including increased immigration and an ageing society (which posits that young people drink more), offer limited explanation for declining alcohol consumption. White children continue to drink in far greater numbers than children from any other ethnic group, although children with ethnic minority peers are less likely to consume alcohol. The greatest frequency of drinking is reported in the 45-64 age group. Drinking alcohol is thus not a young person's pursuit and explaining it as such leads to implausible theories/explanations.

Further theories/explanations examined in the report include a shift in social norms away from underage drinking and happier and more contentious children with better educational and welfare outcomes. According to the report, there is no compelling evidence for a shift in social norms away from underage drinking. Although acknowledging that underage drinking is clearly now less socially acceptable, the report argues that the idea that young people are rejecting the example set by their parents and older generations does not account for or explain that children of heavier drinking parents are more likely to drink themselves. On the other hand, the report argues there is some evidence to suggest that improvements in children's welfare and educational performance are associated with lower drinking.

The report concludes that declining affordability of alcohol and better parenting are the most plausible explanations for declining underage alcohol consumption. Changing social norms have had an impact but have yet to find persuasive evidence as to why they have changed. Improvements in child welfare and time spent online and on social media are other plausible explanations but suffer from a lack of robust evidence. By contrast, stricter ID policies and immigration may have reduced drinking but their impact is small. The report recommends further research to evaluate the theories explaining the fall in underage drinking, how they fit together, and what other mitigating factors might be significant. It concludes that reducing the affordability of alcohol, by raising alcohol duty above inflation, will significantly limit children's access to and consumption of alcohol.

## Data intelligence summary: Alcohol consumption and harm among under 18 year olds. Public Health England Briefing August 2016

**Figures collated from a number of surveys by Public Health England examining alcohol consumption among under 18s show that there is an ongoing downward trend in alcohol consumption in this age group. Under 18s are less likely to drink alcohol than the previous generation. However, by age 17 half of all girls and almost two-thirds of boys reported drinking alcohol every week.**

Levels of alcohol consumption among young people in the UK are higher than the European average and there are groups of young people who are taking risks and experiencing harm. Evidence suggests that pre-teen drinking behaviour is particularly important as, although many pre-teens have yet to explore alcohol, examining the situations in which they drink – how they obtain alcohol, who they drink with, where, when and what they drink – could be used to help to inform effective policy and alcohol prevention strategies to alleviate the associated risks of youth drinking.

Over the past ten years, the report shows there has been a strong downward decline in alcohol consumption among 11 to 15 year old boys and girls, although the most recent data available suggests that for girls, this decline may be starting to level off. In 2014, a survey of 15 year olds reported that 62%



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of respondents had drunk alcohol and 6% were classified as regular (weekly) drinkers. Girls were more likely than boys to have had a drink (65% and 60% respectively) and to have been drunk in the past month (18% of girls, compared to 12% of boys), although they were slightly less likely to be regular drinkers (7% of girls, compared to 6% of boys). Young white people were also much more likely to have drunk alcohol (72%) than those from black and minority ethnic communities (27%). Drinking behaviours also varied by deprivation with young people from the least deprived areas more likely to have drunk alcohol (66%) and to be regular drinkers (8%) than their counterparts from the most deprived areas (44% and 4% respectively). This is similar to the pattern observed in adult drinkers.

The figures show that alcohol-specific hospital admissions have fallen by 50% in less than 10 years. There is a downward trend across both genders, although recent analysis suggests that this could be levelling off. Unlike in adults, the number and rate of admissions is higher for girls than for boys. For girls, hospital admissions rise sharply from age 13 and peak at 15 whereas in boys, admissions continue to rise throughout their teenage years. It has been suggested that the age of alcohol initiation is the single biggest predictor of future alcohol use. Among under 18s, the majority of hospital admissions were for intoxication and this admission cause has seen a sharp decline over the past decade. Admissions for alcohol poisoning have remained largely stable over the same period and the report argues this could suggest that the numbers of young people engaged in the most harmful drinking behaviours has not reduced.

Hospital admission data can be used to compare the relationship between consumption and harm. It could be suggested that areas with a high prevalence of 15 year olds reporting drinking alcohol in the last month would be linked to areas with higher rates of under 18s hospital admissions. The report argues that, although the figures show a clear association, there are several outliers that do not conform. The majority of outliers are areas with higher than expected levels of harm and are areas which are the most deprived. As with the pattern observed in adults, this demonstrates that the alcohol harm paradox is also present in youth people living in deprived communities.

Using hospital admission data may not be the best way to measure or assess the extent of harm experienced by young people from their drinking. In terms of consequences from drinking, needing to go to hospital was only reported in 0.6% of cases, and was in fact the least reported consequence by young people. Other harmful consequences such as doing something they later regretted (15.7%), getting into a fight (2.8%) and hurting themselves (8.6%) were reported much more frequently and had a greater impact on how young people experienced harm. Hospital admission data, the report argues, is used because it is much more readily available, but this doesn't make it the best or most accurate indicator.

Among adult populations there is a strong interaction between alcohol consumption and smoking, both in terms of amount drunk and frequency of consumption. This relationship also holds with young people. Data from a 2014 survey of 15 year olds shows that those who smoke were much more likely to drink frequently – 26% of current smokers reported drinking every week, compared to only 8% of non-smokers. Deprivation also has a role to play in the relationship. Those in the most deprived areas are more likely to abstain from both drinking and smoking - 50% compared to 34% in least deprived areas. However, among those who do drink, 16% of those in deprived areas also smoked, compared with 10% in less deprived areas.

The report concludes that there are fewer young people drinking alcohol today than they did in the past and fewer are suffering the associated health harms, in particular those requiring hospital treatment. Despite these recent declines, the proportion of under 18s consuming alcohol in the UK remains well above the European average and the majority of 17 year olds drink alcohol. The gender differences seen between boys and girls in terms of both consumption and harm suggests the need for interventions to be tailored to meet specific needs, including the need to intervene with girls slightly earlier than with boys. The strong interaction with smoking suggests that joint action to tackle both behaviours would be beneficial, and this may also help to reduce health inequalities as alcohol-related harms and smoking prevalence are more likely to occur and be higher in more deprived areas.

**https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/542889/Alcohol_consumption_and_harms_in_under_18s.pdf**

## Update of UK Chief Medical Officers' Low Risk Drinking Guidelines

**In January 2016, the UK Chief Medical Officers' (CMOs) published a set of low risk drinking guidelines. Following a period of consultation, the guidelines have been updated[8] to take account of the comments received. The updated guidelines state that people have a right to accurate information and clear advice about alcohol and its health risks; and that there is a responsibility on government is provided to citizens in an open way, so they can make informed choices**

### Weekly drinking

**For both men and women, the CMOs recommend:**

- To keep health risks from alcohol low, it is recommended not to drink more than 14 units of alcohol a week on a regular basis.

8 UK Chief Medical Officers' Low Risk Drinking Guidelines August 2016 **http://gov.wales/docs/dhss/publications/160825guidelinesen.pdf**



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- If an individual regularly drinks for than 14 units per week, it is best to spread this drinking evenly over 3 or more days, and to have at least 2 alcohol-free days per week.
- The risk of developing a range of health problems (including cancer) increases the more that is drunk on a regular basis.

The guidelines acknowledge that people vary in how they metabolise and/or react to alcohol, and people of different ages and weights can be affected differently by consuming similar amounts. Nevertheless, the CMOs argue that the new weekly guideline of 14 units provides advice that the majority of the population can follow to help keep long-term health risks low. A weekly limit was deemed most appropriate as most people do not drink on a daily basis.

The latest research evidence suggests that when drinking within the low risk guidelines, overall levels of risk are broadly similar for men and women, although the risks of immediate harms, such as death from accidents, are greater for men, and longer-term harms from illnesses are greater for women.

It is recommended that the weekly guideline or regular drinking requires an additional recommendation regarding the need to avoid heavy drinking. There is clear evidence that heavy drinking even on a small number of days increases risks to health. It is therefore recommended that people who drink as much as 14 units a week on a regular basis should spread their drinking evenly over 3 or more days per week.

## Single occasion drinking

**For both men and women, to keep their short-term health risks low:**

- Limiting the amount of alcohol consumed on a single occasion
- Drinking more slowly, drinking with food, and alternating with water
- Planning ahead to avoid problems

Improperly judging and accounting for the risks of drinking too much on a single drinking occasion can cause accidents resulting in injury and even death in some cases, misjudging risky situations, and losing self-control. The risks of injury to a person who has been drinking regularly are found to increase by two to five times when 5-7 units are consumed in a 3-6 hour period.

Unlike with weekly drinking, advice was not given on a specific number of units for single drinking occasions. There were a number of reasons for this including there can be large scale variation in the short-term risks faced by different people drinking the same amount, and the actual risk by any particular individual can also be substantially altered by a number of factors such as how fast the alcohol is consumed, the environment in which it is consumed, and prior knowledge or consideration of how they are affected by alcohol.

## Pregnancy and drinking

**The CMO guideline is that:**

- If an individual is pregnant or planning to get pregnant, the safest approach is not to drink at all, to minimise risk to the unborn baby.
- Drinking in pregnancy can lead to long-term harm to the baby, with the greater the quantity of alcohol consumed, the greater the risk.

The guidelines are based on a precautionary approach and recommend that it is safest to avoid alcohol completely during pregnancy.

Alcohol can have a wide range of differing impacts on the foetus, including a range of lifelong disorders known by the umbrella term 'foetal alcohol spectrum disorders' (FASD). The severity and nature of FASD are linked to the amount of alcohol consumed and the stage of foetus development at the time of consumption. Evidence from research on the effects on a baby from low levels of drinking in pregnancy are uncertain and difficult to interpret. Therefore, the safest approach and the only way to guarantee no risk is to abstain from alcohol consumption.

The guidelines take account of the known harmful effects of alcohol on the foetus, the evidence from the level of risk from drinking, the need for clarity and simplicity in providing advice to women, and the uncertainties that exist about any safe level of alcohol consumption.

## Next Research & Policy Briefing: December 2016

### About our people

**Dr Peter Rice** Chair

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Peter was a Consultant Psychiatrist with NHS Tayside Substance Misuse Service. He has advised the Scottish Government on Alcohol Policy and has led a working group on Substance Misuse and Mental Health.

**Eric Carlin** Director
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Eric has held membership of the UK's Independent Scientific Advisory Committee on Drugs and the UK Government's Advisory Council on the Misuse of Drugs. Eric was previously CEO of Mentor UK and Angel Drug Services.

**Jennifer Fingland** Policy Officer
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Jennifer started working at SHAAP in July 2015, having previously worked with Skills Development Scotland, the National Trust for Scotland and Diabetes UK Scotland. Jennifer has an MSc in Policy Studies from the University of Edinburgh and an MA in Politics and Public Policy from the University of Glasgow.

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SARN

# SHAAP/SARN Alcohol Occasional Seminars, 2016–17: Alcohol and Health Inequalities

**Scottish Health Action on Alcohol Problems (SHAAP) and the Scottish Alcohol Research Network (SARN) are pleased to announce our programme for the lunchtime 'Alcohol Occasional' seminars. These showcase innovative research on alcohol use and provide the chance for researchers, practitioners and policy makers and members of the public to hear and discuss alcohol related topics.**

The theme for this seminar series, from October 2016, is 'Alcohol and Health Inequalities'. This series of presentations will provide insights and stimulate discussion about alcohol and health inequalities in different contexts, drawing on a range of disciplines and opening up debate about implications for policy and practice. Following the seminars, SHAAP will produce briefing papers, which will aim to capture the main themes and to communicate these to a wider audience. You can access reports from previous seminars here - **www.shaap.org.uk/alcohol-occasionals.html.**

All of the Alcohol Occasional seminars will be run in conjunction with the Royal College of Physicians of Edinburgh and will take place from 12.30 – 14.00 at their historic premises at 9 Queen Street Edinburgh, EH2 1JQ. Lunch will be provided free of charge. To attend a seminar, please sign-up via Eventbrite through the events page on our website - **shaap.org.uk/events**.

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### Tackling Health Inequalities in Scotland & Implications for Alcohol Policy

Dr Katherine Smith, Global Public Health Unit, The University of Edinburgh

Thursday 13th October 2016

### Does harm from drinking differ by socioeconomic status? Exploring the alcohol harms paradox

Dr S Vittal Katikireddi, MRC/CSO Social and Public Health Sciences Unit, University of Glasgow

Monday 5th December 2016

### How inclusive are we? A trans perspective on alcohol and drug services in Scotland

Oceana Maund and Vic Valentine, Scottish Transgender Alliance

Tuesday 24th January 2017

### Alcohol admissions and health inequalities: is the tide finally turning?

Neil Martin, Research and Information Manager, Balance, the North East Alcohol Office

Monday 27th February 2017

### Alcohol problems in criminal justice settings: an opportunity not to be missed

Dr Lesley Graham, Clinical Lead for Alcohol, Drugs and Health in Justice Settings, ISD Scotland

Monday 13th March 2017

### Drinking in pregnancy: a comparison between areas of high and low deprivation in Scotland

Dr Andrew Symon, Senior Lecturer, Mother and Infant Research Unit, University of Dundee

Thursday 11th May 2017

### Alcohol Deaths in Glasgow 2010. Has Service Redesign had an Impact?

Dr Catherine Chiang, NHS Greater Glasgow & Clyde

Wednesday 14th June 2017