SHAAP

SCOTTISH HEALTH ACTION ON ALCOHOL PROBLEMS

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Research and Policy Briefing

№ 7 January 2015

Welcome to the sixth 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.

Chair Dr Peter Rice, former Consultant Psychiatrist, NHS Tayside Alcohol Problems Service

Director Eric Carlin

Policy Officer Vanessa Taylor

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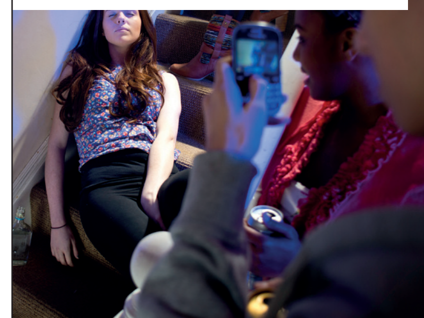
Alcohol and the Developing Adolescent Brain: Evidence Review



SHAAP's *Alcohol and the Developing Adolescent Brain: Evidence Review* has now been published. The report, drawn from the research of key researchers and clinicians, is an important and timely contribution on a vital area of public health, summarising evidence on brain development during adolescence so that those with responsibility for the well-being of young people can understand and think through implications for policy and practice.

The review examines how the brain develops during adolescence, the effects of alcohol on the developing adolescent brain, the role of genetics in alcohol consumption, the clinical implications of alcohol's effects on the brain and the effects of alcohol on psychological and cognitive function.

The research provides insight into the processes that underlie the impact of alcohol on the still developing adolescent brain and suggests that this could have longer-term effects. It is clear that there are significant differences between adult and adolescent brain functioning and

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there is some evidence that alcohol-associated brain structural effects are more pronounced in adolescents than in young adults.

The adolescent brain has a different and largely greater sensitivity to alcohol than the adult brain, which may lead to enduring changes, with some young people predisposed to be more susceptible to the impact of substances than others, with evidence females may be more likely to sustain white matter effects. As well as anatomical and functional variations, social drivers such as peer influence and social exclusion and other social contexts can have a stronger impact on young people and their decision-making, compared to adults.

The impact of alcohol on impulsivity and control processes has powerful implications for risk-taking and social functioning. The still developing and maturing structures of the brain mean that young people are less likely than adults to appreciate the adverse consequences of behaviour and comprehend its impact in the longer-term. Reasoning, decision-making and inhibitory control are all less developed in the adolescent brain. Impulsivity has been found to be a strong predictor of persistent alcohol use disorders into adulthood and identified as a risk-factor for early adolescent alcohol use.

We hope the report will be read widely and used to inform approaches to delivering Alcohol Brief Interventions (ABIs) and information giving in relation to alcohol. Understanding more about the underlying neurobiology of alcohol use in adolescence should inform development of pharmacological and cognitive prevention and treatment strategies.

For example, this may inform the design of public health messages and interventions designed to influence decision-making. Emerging findings around the reinforcing properties of substances also suggest there is scope to reconsider the current research focus, whereby studies typically focus on one substance at a time (for example, alcohol). It would also be useful to conduct investigations that would examine the interplay between addictive substances.

The key policy recommendations from the report are:

- Protecting young people from alcohol-related harm has to be within the context of a 'whole population' approach to reduce overall alcohol consumption.
- Protecting young people from alcohol-related harm should be embedded in national and local policy.
- Emerging evidence that the adolescent brain may be especially vulnerable to alcohol harms should inform all health-promoting activities.
- Emerging evidence that the adolescent brain may be especially vulnerable to alcohol harms should prompt investment in further exploratory research.

Copies of the report will be going out to all MSPs, Scottish MPs and MEPs and to all practice nurses in January. Extra copies are available from SHAAP on request or can be downloaded from our website at:

www.shaap.org.uk/news/new-shaap-report-alcohol-and-the-developing-brain-evidence-review.html

Minimum Unit Pricing

In an editorial on minimum unit pricing (MUP) in the British Medical Journal, Professor Tim Stockwell, Director of the Centre for Addiction Research of British Columbia and a Professor in the Department of Psychology at the University of Victoria, noted the "major implications" of the European Court of Justice's (ECJ) imminent ruling for the future of public health in Europe.

Professor Stockwell finds the opposition of industry to minimum unit pricing puzzling, especially when contrasted to Canada, where the policy has attracted and continues to enjoy the broad support of industry groups. As Dr Peter Rice, SHAAP Chair pointed out in his response (see below) MUP is supported by some sections of the alcohol industry based in Scotland while being opposed by global producers and some supermarkets.

While Professor Stockwell ponders whether this opposition is borne out of fears that the court judgment could set a precedent, SHAAP has been advised that the ECJ evaluates each case on an individual basis.

While some countries, including the Republic of Ireland, have expressed their intention to follow Scotland's lead in introducing minimum unit pricing, the Scottish Government has stressed that they see the policy as the best solution for Scotland and are not attempting to advocate a Europe-wide policy approach.

As Donald Henderson, the Scottish Government's Head of Public Health explained at SHAAP's seminar in Brussels in September this year: "We believe that it's the right policy for the problems which Scotland faces but we do not say that this is a policy that should be implemented all across Europe."

It is an important point reiterated by SHAAP's Chair, in the article below, when Dr Rice says: "Action that is justified for alcohol in Scotland may not be justified for obesity in Greece. However, this will be a test of the priority which the European Union and its institutions gives to health".

The following letter from SHAAP Chair, Dr Peter Rice in response to Professor Tim Stockwell's article on Minimum Unit Pricing appeared in the British Medical Journal in October (for a shortened version see: **www.bmj.com/content/349/bmj.g6307**. Full version reprinted below can be accessed at: **www.bmj.com/content/349/bmj.g5617/rr/771141**)

Re: Minimum unit pricing for alcohol

Professor Stockwell provides a very helpful synopsis which explains why health organisations throughout Europe support Minimum Unit Pricing (MUP) for alcohol and wish to see its introduction in Scotland. The political and legal processes mean that the

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implementation of the policy is complex and takes a long time and there is a risk that only those closely involved can keep track. However it is important that the broad support the medical profession and other groups have shown for MUP is maintained. The opponents of MUP would be happy for the issue to disappear into the long grass.

He expresses surprise that the alcohol industry has opposed MUP in the UK. The position is more complex than that. There is considerable support for MUP within the alcohol industry particularly among the pub trade and smaller producers.[1] The opposition comes from producers who operate globally and from large retailers,[2] in particular supermarkets and it has been those large organisations which have dominated the perception of the diverse industry interests.

Last month Scottish Health Action on Alcohol Problems, a project of the Scottish Royal Colleges and Faculties, held an event where industry supporters of MUP spoke of the harm which the proliferation of cheap supermarket alcohol caused to UK business and growth. Health experts spoke of the health harm.[2]

Regarding the significance of the current European Court of Justice consideration of the Scottish MUP legislation, our legal advice is that the ECJ considers the proportionality of each case individually. Action that is justified for alcohol in Scotland may not be justified for obesity in Greece. However, this will be a test of the priority which the European Union and its institutions gives to health.

[1] SHAAP. Scotland The Brave – Alcohol Policy in Scotland. **www.shaap.org.uk/images/mup-event-summary.pdf**
[2] Gornall, J. Under The Influence. BMJ 2014;348:f7646

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New Drink Driving Limit: "The Best Advice is None"

The new lower drink drive limit came into force in Scotland on 5th December, accompanied by a Scottish Government media campaign to raise awareness of the change, in time for the festive season.

MSPs voted unanimously to reduce the limit from 80mg to 50mg per 100ml blood, bringing Scotland into line with the majority of European countries, while introducing for the first time a different limit from the rest of the United Kingdom.

Welcoming the reduction, Eric Carlin, SHAAP's Director, said: "This is a measure we fully support that will save lives and increase safety on Scotland's roads. Even a small amount of alcohol can impair your ability to drive so if you're going to be driving; it is safer not to drink at all."

A government awareness campaign involving TV and radio adverts and social media was launched on 24th November with the message: "the best advice is none". The then Justice Secretary Kenny MacAskill said: "We are doing everything we can to make sure everyone is informed about the new lower level. "A persistent minority of people are still getting behind the wheel after drinking - that is unacceptable. It is putting lives at risk and it must stop. Our advice is simple, the best approach is to have no alcohol at all. Alcohol at any level impairs driving."

The Scottish Parliament voted to reduce the drink-drive limit in November 2012 but implementation was delayed for almost two years by an administrative backlog at the Home Office, who had to approve breath testing devices for the new lower limit. The limit south of the border remains 80mg. Initial moves for a joint approach with Westminster were dashed when the UK Government decided not to go ahead with the lower limit.

The advice from SHAAP and other alcohol campaigners like Alcohol Focus Scotland echoes that from the Scottish Government and Police Scotland. SHAAP Chair, Dr Peter Rice said:

> *"People need to think very carefully if they are planning to drive the day after drinking alcohol. As individuals absorb and metabolise alcohol at different rates, dependent on a whole range of factors, it is very difficult to predict how quickly your body will be free from alcohol the following day. Drinks can be deceptive, with many beers increasing in alcoholic strength over recent years along with the size of wine glasses. The best option if you're driving is not to take the risk and drink nothing at all."*

More Scots Give up Alcohol: Scottish Health Survey 2013

More people are giving up drinking alcohol, according to figures released in December from the 2013 Scottish Health Survey (SHES).

One in five women (20%) and 12% of men said they did not consume alcohol at all in the past year. The percentage of those who abstain from alcohol has almost doubled since 2003 from 5% to 9% for women and from 4% to 7% for men.

While during the decade 2003-2013, average weekly consumption of alcohol has fallen from 19.8 units to 13.7 units per week for men and from 9 units per week to 6.8 units for women, this remains significantly higher than in the rest of the UK.

Almost one in four (22%) men and one in six (16%) women consume alcohol at 'hazardous or harmful' levels, which is defined as more than 21 units per week for men or 14 units for women. This has dropped from 33% and 22% since 2003 respectively, yet there has been little change from 2012-3.

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A drop in the percentage drinking more than the government's low risk drinking guidelines has been driven primarily by the trend towards giving up alcohol, rather than an increase in those following the official guidelines.

The Scottish Health Survey (SHeS) is commissioned by the Scottish Government to provide data on of Scotland's population that cannot be obtained from other sources.

Availability of and Need for Specialist Alcohol Treatment Services

Around 1 in 4 alcohol dependent adults in Scotland accessed specialist alcohol treatment 2012, according to findings from NHS Health Scotland released in November. This research is part of the Monitoring and Evaluating Scotland's Alcohol Strategy (MESAS).

Assessing the availability of and need for specialist alcohol treatment services in Scotland examines the availability, demand and utilisation of specialist alcohol treatment services in Scotland and the impact of the additional £85 million of resources (totalling £120 million over three years), that accompanied the 2009 National Alcohol Strategy, Alcohol: A Framework for Action. These extra resources were allocated to improve the identification, support and treatment of problem drinkers and the development of the alcohol treatment workforce.

The main findings of the report include:

- 149 specialist alcohol treatment services delivered tier 3 and 4 interventions to almost 32,000 individuals (two thirds men) across Scotland during 2012. Almost two-thirds of patients were treated in tier 3 only services. Half of the services offered tier 3 interventions only, 43% offered tier 3 and tier 4, with just 1 in 14 delivering tier 4 only.
- More than 8 out of 10 specialist alcohol treatment services also delivered drug treatment services.
- Scottish Health Survey figures indicate that 3.1% of people over 16 were possibly alcohol dependent in 2012: almost 138,000 individuals.
- The Prevalence Service Utilisation Ration (PSUR) was estimated to be 1:4.3. This means that in 2012 around 1 in 4 alcohol dependent adults accessed specialist alcohol treatment. This compares to an equivalent PSUR in England of approximately 1:14
- While it is estimated that two thirds of people with alcohol dependence in Scotland are not accessing treatment, internationally a PSUR of 1 in 5 is regarded as high and 1 in 10 as low.
- It was not possible to compare the 2012 PSUR figure to previous estimates due to methodological differences between the two studies.

A comprehensive mixed methods approach was used. A survey of specialist alcohol treatment services delivering tier 3 and 4 interventions (with a response rate of 87.2%), collated data on service availability and on individual service users, including information on demand in the form of individuals in treatment.

The estimate for the numbers requiring treatment was obtained from the number of those scoring 16 or over (possible dependence) in the AUDIT questionnaire of the 2012 Scottish Health Survey. The Prevalence-Service Utilisation Ratio (PSUR) was calculated by combining this estimate with the numbers already in treatment, with a sensitivity analysis undertaken to account for the likely underestimation of alcohol consumption by survey respondents.

Individual and focus group interviews with service commissioners, providers and users in three Alcohol and Drug Partnership (ADP) areas examined barriers and facilitators to developing specialist alcohol service capacity.

The positive impact on service delivery of the additional resources was evidenced in all three case study areas by service providers and service users, particularly in relation to the effect of having additional staff. Benefits included: increased focus on recovery and preventative work; changing referral routes and service pathways, convergence with drug treatment services; growth of the third sector; positive relationships between stakeholders; increasing service user involvement; and peer-led recovery services. Ongoing issues around service gaps; service planning staffing; demand and missed appointments were also identified in the interviews.

It also explores the feasibility of assessing the capacity of specialist alcohol treatment services within a small number of case study areas. In the two ADP areas where a capacity assessment exercise was undertaken, direct service user contact was found to account for approximately one third of staff time on alcohol-related activities.

This research has established a baseline PSUR from which future change can be measured. Identifying the range of specialist alcohol treatment services delivering tier 3 and 4 interventions available across Scotland and the beneficial impact of additional investment will inform future development and improvement of alcohol treatment services in Scotland.

Drinking in Pregnancy and Fetal Alcohol Syndrome

Drinking in pregnancy has been the subject of much media coverage and debate, with the recent unsuccessful court case against a mother of a seven year old girl born with foetal alcohol syndrome (FAS) as a result of her mother's excessive drinking.

The case brought by a local authority in the North West of England centred on the argument that the child, who is now in the care of the local authority,

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had been poisoned by her mother, while in utero, equivalent to an attempt at manslaughter. Lawyers argued the mother's action constituted the crime of poisoning under section 23 of the Offences Against the Person Act 1861.

In the original case in 2011, a court found that the mother's alcohol consumption was "directly attributable to a crime of violence" and that the child was eligible compensation, but this judgement was overturned by the upper tribunal of the Administration Appeals Chamber, after a challenge by the Criminal Injuries Compensation Authority. The three appeal court judges then ruled in November 2014 that the woman had not committed a criminal offence by heavy drinking in pregnancy.

The claim arose from the substantial financial costs to the local authority of providing long-term care for the severely disabled child. Lawyers for the council argued that the child was entitled to payments from the Criminal Injuries Compensation Authority (CICA) as the victim of a violent crime. They claimed that the child's mother ignored repeated warnings from social workers and antenatal medical staff that her drinking risked harming her unborn baby, consuming a "grossly excessive" amount of alcohol throughout her pregnancy, consisting of half a bottle of vodka and eight cans of high-strength lager on a daily basis.

The case has raised issues about the clarity of advice given to women about the dangers of alcohol in pregnancy. Foetal Alcohol Syndrome (FAS) was first identified in 1973. It is estimated that 100 children are born with FAS in Scotland annually. Many go undiagnosed because diagnosis of FAS is made very difficult by the complexity of different symptoms. Fetal Alcohol Spectrum Disorders (FASD) is an umbrella term for neurological damage as a result of alcohol consumption during pregnancy.

A quarter of all women interviewed within the 2011 Growing Up in Scotland survey reported alcohol consumption during pregnancy. Women from higher social classes and with higher incomes were more likely to drink alcohol during pregnancy, contrary to expectations.

While lawyers for the local authority argued that winning their case would have secured the funding needed to provide the child's continuing care, many health professionals felt this case was driven by considerations of responsibility for care costs and would have set a dangerous precedent by equating the mother's drinking to a crime.

As no safe level of alcohol consumption in pregnancy has been able to be established, the potential dangers of drinking in pregnancy have to be clearly communicated to the public. Yet criminalising pregnant women who have alcohol dependence would be a retrograde step that would undoubtedly deter women from seeking help from their midwife or medical staff. "I don't believe at all it is worth going down this route to criminalise women," said the founder of the FASD Network UK, Maria Catterick.

In a joint statement, Ann Furedi, chief executive of the British Pregnancy Advisory Service, and Rebecca Schiller, co-chair of Birthrights, argued that the case had "very serious" implications for "a pregnant woman's fundamental right to bodily autonomy", saying: "Viewing these cases as potential criminal offences will do nothing for the health of women and their babies. There is a strong public interest in promoting the good health of pregnant women and babies, but, as longstanding government policy recognises, this interest is best served by treating addiction and substance abuse in pregnancy as a public health, not criminal, issue."

Denying that a successful verdict would have been likely to lead to prosecutions of pregnant women who drink in pregnancy, Neil Sugarman, solicitor for the council insisted the case was about securing future treatment and services for the child in question and not about the rights of women or criminalising pregnant women who drink alcohol, adding: "had there been governmental recognition of the fact that children damaged by alcohol and drugs need rapid and long-term access to specialist services, we would not be having this argument".

The challenge for healthcare professionals and policymakers is to reduce the incidence of children born with FAS and FASD and to ensure access to diagnosis and care for those affected. Lack of clarity over safe levels of alcohol consumption in pregnancy lead to confusion, according to Dr Shonag MacKenzie, lead obstetrician at Northumbria Healthcare NHS Trust, who said: "A small amount can lead to more drinks … the only absolutely safe policy is no alcohol at all in pregnancy."

"We are told that alcohol is a poison on the one hand" notes Catterick, "but on the other hand we are told that maybe it's OK to drink one or two units."

The current advice of the Scottish Government is unequivocal that women should avoid alcohol if pregnant or trying to conceive yet there are mixed messages on alcohol consumption during pregnancy across the UK.

In England, the Department of Health recommends that pregnant women should avoid alcohol completely. However, it adds that if expectant mothers do drink, they should limit their intake to one or two units of alcohol once or twice a week to minimise the risk to the foetus.

Guidance from NICE is that women should avoid all alcohol during the first trimester because of an increased risk of miscarriage, and to limit alcohol consumption to one or two units of alcohol once or twice a week for the rest of the pregnancy.

The Royal College of Obstetricians & Gynaecologists (RCOG) advocates abstinence throughout pregnancy, while noting that small amounts of alcohol in pregnancy (one to two units once or twice a week) have not been found to be harmful.

A large study by University College London, published in the Journal of Epidemiology and Community Health in 2010[1] found that while children born to heavy drinkers were more likely

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to have behavioural and emotional problems, the children of light drinkers (defined as three to six units a week) exhibited no such problems. A series of Danish studies in 2012[2] also found no association between low to moderate alcohol intake in early pregnancy and adverse neuropsychological effects.

The chief medical officer for England is currently in the process of reviewing their alcohol guidelines, with new draft advice expected this year. In September last year, twelve directors of public health in the North East of England published an open letter decrying the mixed messages, calling for consistent and clear advice to be communicated by all healthcare professionals throughout all stages of pregnancy, saying: "We want to send a clear message to parents-to-be that alcohol and pregnancy don't mix – the safest option is an alcohol free pregnancy".

The case attracted much interest in the mainstream press. Vicky Allan in the Sunday Herald argued the issue of women drinking heavily in pregnancy is more about the problem of alcohol dependence than about the "attitudes of pregnant women", adding:

> *"Drinking in pregnancy is not a separate issue to drinking more generally, it is just one of the crisis points where we recognise the damage alcohol does. We are harsh in our judgement of alcoholics in all areas of society, particularly of those at the bottom. Sometimes we imagine mere sanctions are all that is needed to motivate. But is criminalising a woman for drinking really any more likely to change her behaviour than the thought that her child might be born with disabilities?" (Sunday Herald, 9th November 2014)*

Delivering the court's judgement, Lord Justice Treacy concluded: "The state's view that a child should not be able to claim compensation for what is done, or not done, during pregnancy, should rationally also lead to the conclusion that, save in the exceptional circumstances expressly recognised by Parliament, there should be no criminal liability for what a mother does, or does not do during pregnancy."

While the UK Government no longer awards compensation for FAS, the child's claim was lodged before the rules changed in November 2012. The ruling will have implications for up to 80 claims in preparation involving children diagnosed with FASD. The case could be appealed to the Supreme Court.

Saying she hoped the case would highlight the dangers of drinking in pregnancy, Julia Brown, chief executive of the Foetal Alcohol Spectrum Disorders (FASD) Trust, said: "There are no winners in a case like this". Furedi and Schiller agreed: "Pregnant women deserve support and respect, not the prospect of criminal sanction for behaviour which would not be illegal for anyone else."

[1] Kelly, Y. et al (2010) *Light drinking during pregnancy: still no increased risk for socioemotional difficulties or cognitive deficits at 5 years of age?* J Epidemiol Community Health doi:10.1136/jech.2009.103002

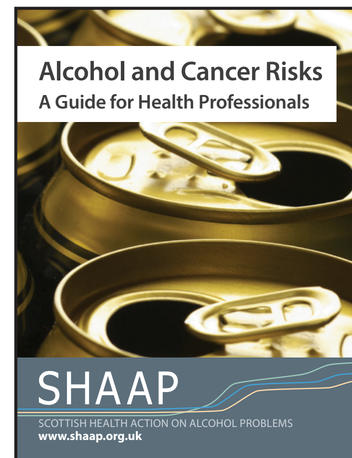
[2] Kesmodel et al, the Lifestyle During Pregnancy Study Group. *The effect of different alcohol drinking patterns in early to mid pregnancy on the child's intelligence, attention, and executive function.* BJOG 2012; DOI: 10.1111/j.1471-0528.2012.03393.x.

Alcohol and Cancer, A Guide for Professionals: New Edition Available

SHAAP has published a new edition of its 2013 publication, Alcohol & Cancer Risks: A Guide for Health Professionals.

The guide was produced to summarise for health professionals the links between alcohol consumption and cancers, so that they can use opportunities in their work to intervene to reduce the risks. It was produced following an expert workshop convened by SHAAP.

A growing body of evidence links alcohol consumption with the development of cancer. Alcohol consumption has been causally related to cancers of the oral cavity, pharynx, larynx, oesophagus, liver, colorectum and female breast. A major study of selected European countries, including the UK, found 10% of all cancer cases



in men and 3% of all cancer cases in women are attributable to current and former alcohol consumption.

The incidence of cancer cases attributable to alcohol consumption in Scotland underlines the necessity of action to reduce alcohol consumption, both at the individual and population level:

- Amongst health professionals there needs to be an increased understanding of the relative risks of consuming alcohol. Improving the rates of awareness within health professional groups will need information to be tailored to specific professional needs.
- Low rates of awareness in public audiences may need information to be tailored to the specific needs of target groups.
- Understanding and communicating "risk" is as much a challenge for professionals as the general public.

Hard copies are available from the SHAAP office on request or from our website at:

www.shaap.org.uk/images/shaap_cancer_risks_booklet.pdf

Licensing Research from Alcohol Focus Scotland

Neighbourhoods with the highest number of licensed premises have alcohol-related death rates more than double those in neighbourhoods with the fewest,

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according to a report launched by Alcohol Focus Scotland at their National Licensing Conference in October.

Professor Jamie Pearce and Dr Niamh Shortt from Edinburgh University presented their findings on neighbourhood outlet density related to alcohol consumption and health inequalities. The main findings of the study include:

- Across Scotland neighbourhoods with higher numbers of alcohol outlets had significantly higher alcohol-related death rates
- Alcohol-related death rates in neighbourhoods with the most alcohol outlets were more than double the rates of those with the fewest outlets
- There were 34 alcohol-related deaths per 1,000 population in neighbourhoods with the most off-sales outlets, compared with 13 per 100,000 in neighbourhoods with the fewest
- Alcohol-related hospitalisation rates were also significantly higher in neighbourhoods with the most alcohol outlets

Dr Evelyn Gillan also presented findings from AFS' Review of Licensing Statements. Statements were found to be very variable, with only 10 licensing boards reporting overprovision (4 more than in 2010). In terms of content, statements tended to contain lots of information about processes, which could be collated elsewhere to focus more on policy. The evidence base is typically not demonstrated, and even where collected, fail to show how evidence has influenced policy. AFS are advocating the creation of an alcohol outlet register similar to that for tobacco.

Neil Rennick, Director of Justice at the Scottish Government, speaking in place of the then Justice Secretary, Kenny MacAskill, reiterated the commitment of ministers to Minimum Unit Pricing, adding that the Scottish Government will "fight all the way" to see the policy implemented.

Nalmefene Recommended by NICE

A drug to help people reduce their alcohol consumption has been recommended by the UK's National Institute for Health and Care Excellence (NICE).

Nalmefene (also called Selincro and manufactured by Lundbeck) has now been made available to patients in England who drink at least half a bottle of wine or three pints a night. The drug has been licensed for use in Scotland by the Scottish Medicines Consortium since October 2013. The drug is designed to reduce the urge to drink alcohol and is licensed for use in conjunction with psychosocial counselling support.

Nalmefene acts by affecting an individual's opioid receptors, which help control the brain's motivational system. The reinforcing effects of alcohol are reduced, inhibiting the urge to drink. It should help people gradually reduce their alcohol consumption so is unsuitable for patients with more severe alcohol problems who need to stop immediately. A pill costs £3, can be taken up to once a day, and can be used as required to reduce alcohol cravings, up to once a day.

"Many people have a difficult relationship with alcohol even though they have a very stable lifestyle, maintain jobs and a social life and would not automatically assume they have a problem," said Professor Carole Longson, Director of NICE's Health Technology Evaluation Centre, adding:

> *"Alcohol dependence is a serious issue for many people. Those who could be prescribed nalmefene have already taken the first big steps by visiting their doctor, engaging with support services and taking part in therapy programmes. We are pleased to be able to recommend the use of namelfene to support people further in their efforts to fight alcohol dependence. When used alongside psychosocial support nalmefene is clinically and cost effective for the NHS compared with psychosocial support alone."*

In three phase III trials, involving just under 2000 individuals, the drug was found to cut patients' alcohol intake by an average of 61 per cent after six months, with results maintained after one year. However, the trials also found a strong placebo effect. Lyndsey Dudley, a spokeswoman for NICE, said nalmefene could help individuals who "probably don't even recognise themselves as an alcoholic", comparing it to a nicotine patch to help with smoking cessation.

Fictional examples of suitable patients provided by nalmefene's manufacturer, Lundbeck, include 39 year old Sue, who "looks forward to a glass of wine after work when the kids go to bed but always finishes the bottle while cooking and eating with her husband, and opens a second bottle a few days each week".

It is estimated that over two million people in Britain have mild alcohol dependence. Expectations for the first year are that the drug will be prescribed to 35,000 patients, based on 60% of those expected to be treated for psychosocial intervention for mild alcohol dependence. The Sunday Times reported that the drug had been prescribed on less than 100 occasions in the 12 months since its approval by the Scottish Medicines Consortium. To put this in context, there were over 100,000 brief interventions delivered in Scotland in 2013/14 with 63%, of these in Primary Care.

Professor Jonathan Chick, of Queen Margaret University in Edinburgh, said: " Nalmefene is for people who are concerned about their drinking, have tried to cut down, have been given brief advice/counselling by their doctor and are still regularly drinking more than low-risk levels. The risks start at 14 units per week for women and 21 for men, but patients who will be prescribed nalmefene will be drinking higher amounts than that, and will have provoked changes in their brain patterns which have led to difficulty controlling their drinking."

Next Research & Policy Briefing: March 2015

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Royal College of Physicians of Edinburgh

SHAAP/SARN Alcohol Occasionals Seminars 2015

Scottish Health Action on Alcohol Problems (SHAAP) and the Scottish Alcohol Research Network (SARN) are delighted to announce the 2014-15 series of lunchtime 'Alcohol Occasional' seminars to showcase new and innovative research on alcohol use. All the 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.

These events provide the chance for researchers, practitioners and policy makers and members of the public to hear about new alcohol related topics and discuss and debate implications for policy and practice. The theme of the seminars for 2014-5 is Alcohol and Mental Health.

Date	Speaker	Topic
26th February 2015	**Dr Fiona Cuthill** Edinburgh University	Staying Strong: Resilience, Alcohol and Destitution following the Asylum Process in the UK
23rd April 2015	**Dr Anne Whittaker** Advance Practitioner (Clinical Research) Substance Misuse Directorate, NHS Lothian and Senior Lecturer/Reader, Edinburgh Napier University School of Nursing, Midwifery and Social Care	Recovery, Mental Health, Alcohol and Nursing
18th June 2015	**Dr Aisha Holloway** University of Edinburgh	Alcohol-Related Brain Disorders

Important: These events are popular and places are limited. We need you to confirm if you would like to attend these events. You can do this by registering via EventBrite. If you have not booked, you will not have a place.

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