

STRATEGY UNIT PROJECT ON TACKLING THE HARM ASSOCIATED WITH ALCOHOL MISUSE - SCOPING NOTE

Introduction

1. The large majority of people in Britain who consume alcohol, enjoy doing so without causing any harm to themselves or others. The concern for Government is the harm caused by the misuse of alcohol. Excess drinking can lead to a range of possible problems including:
 - crime, disorder and anti-social behaviour, particularly violent crime outside pubs and clubs and domestic violence;
 - a range of health impacts from accidents and injuries to serious chronic conditions, such as liver cirrhosis;
 - hazardous drinking by underage drinkers, who are more vulnerable to the detrimental health and other impacts of alcohol misuse;
 - problems for vulnerable groups e.g. children with alcohol-dependent parents or carers, those suffering mental illness and rough sleepers.
2. These are significant issues which cut across a number of policy agendas and need co-ordinated action from Government and service deliverers.

Trends in alcohol consumption

3. The individual and social harm related to alcohol misuse is matched by recent trends in alcohol consumption. Whilst the total quantity of alcohol consumed has increased by around a third since 1970, most of the increase was in the 1970s. What has been seen more recently is a trend towards more hazardous drinking patterns, such as binge-drinking, and increased drinking by particular groups, most notably teenagers and young-people, who may be more at risk of causing harm to themselves and others. Women's drinking has also increased significantly (particularly among younger age groups) relative to men's. For example:
 - Young women are now drinking, on average 12.6 units per week, a 66% increase since 1992. Young men are drinking, on average, 25.9 units per week, a 25% increase over the same period¹.

¹ ONS (2000) General Household Survey 2000. (Table 9.18; unweighted figures for 1992 have been corrected by the weighting factor applied in 1998 and 2000).

- The overall proportions of men and women drinking very heavily (over 50 and 35 units respectively) have remained reasonably stable. However, the numbers of 16-24 year olds drinking at levels consistent with hazardous drinking criteria is increasing significantly. In 2000, 9% of all 16-24 year old women drank heavily – nearly triple the figure doing so in 1988. The increase to 14% among 16-24 year old men was a more modest 30%.
- The numbers of people exhibiting some alcohol dependency appears to have increased significantly, rising from 4.7% in 1993 to 7.4% in 2000 (11.9% for men and 2.9% for women)². About 15% of young people exhibit some alcohol dependency, with men consistently at four times the risk of women.
- Potentially hazardous drinking by underage drinkers is a growing problem. The proportion of teenagers who drink is not increasing, but the average amount consumed by 11-15 year old drinkers doubled between 1990 and 2000, from 5.7 to 11.6 units a week for boys, and 4.7 to 9.1 units a week for girls³. 59 per cent of boys and 54 per cent of girls aged 15-16 said they had taken part in ‘binge’ drinking in the past month.
- Compared to other EU countries the UK’s overall per capita consumption is not high, though it has increased while consumption in some other countries has fallen. More significantly, the UK has one of the highest proportions of binge drinking particularly amongst young people and one of the worst problems with underage drinking.

Crime, Violence and Disorder

4. Violent crime, disorder and antisocial behaviour are often associated with alcohol: 40% of violent offences are committed when offenders are under the influence of alcohol, rising to 44% for domestic violence and 53% for stranger violence⁴. A fifth of victims of insulting, pestering or intimidating behaviour consider the perpetrators to be drunk. Almost one-in-ten 12-15 year-olds and one-in-three 16-17 year-olds admit that they have been involved in anti-social behaviour (arguing, fighting, criminal damage or theft) during or after drinking⁵. Early alcohol use has been shown to increase the likelihood of a young person becoming dependent on drugs such as heroin and crack-cocaine, which are heavily implicated in drug-related crime. A high proportion of all crime during the evenings and nights in

² ONS (2001) Psychiatric morbidity among adults living in private households, 2000. (Table 3.5).

³ ONS (2001) Smoking, drinking and drug use among young people in England in 2000.

⁴ British Crime Survey, 2000.

⁵ Youth Lifestyle Survey, 1998/1999.

town and city centres is alcohol related. Coping with crime on weekend evenings imposes a major cost on police forces, with many being severely stretched at these times⁶.

Social welfare

5. There is a growing problem of alcohol use amongst young people and amongst students. Alcohol is an important factor in teenage pregnancies. There are also serious consequences for families where one or more parents are misusing alcohol: there are approaching one million children growing up in homes in which at least one parent has an alcohol problem.

Economic and financial costs

6. Industry estimates an economic cost of £3.6bn from absenteeism and impacts on productivity. The costs for the NHS have been estimated to be between £500m and £3bn a year⁷. A 1997 report suggested that the full cost to the economy (including an economic valuation on the lost years of life) are between 2% and 5% of a country's GDP⁸. The lower figure would give a cost of up to £20 billion a year at current prices. This is consistent with recent research; for example a report for the Scottish executive estimated the costs of alcohol at £1bn for Scotland alone⁹.

Health impacts

7. There is evidence that moderate levels of alcohol consumption (e.g. one to two units of alcohol per day) provide some health benefits for those groups at risk from cardiovascular disease (e.g. men over 40 and post-menopausal women). However, whilst the full impacts of alcohol on health are difficult to determine, the Chief

⁶ There are difficulties in determining of the link between alcohol misuse and crime, health, economic and other impacts. These include estimating the level of alcohol that an individual has consumed and to the extent to which alcohol caused or contributed to an incident or problem. The recording of alcohol consumption by individuals who are arrested or admissions to hospitals is not systematic or consistent. There are also problems with the consistency of definitions of the severity of incidents. This makes establishing a clear national picture of the size and range of the problems difficult. However, the weight of evidence, for example from the British Crime Survey, surveys of police forces and A&E departments and from specific case studies all show there are major costs associated with alcohol problems and misuse.

⁷ *Alcohol – can the NHS afford it?*, Alcohol Concern 2002 (based upon analysis by Royal College of Physicians).

⁸ There are a number of methodological issues in assessing the economic costs such as determining which resource costs and external costs are relevant. For example, if people are fully aware of the health risks they incur by drinking then the long term health costs suffered by the individual are not an external cost (though costs for the NHS would be).

⁹ *Alcohol Misuse in Scotland: Trends and Costs - Final Report*, October 2000, Prepared for the Scottish Executive by catalyst health economics consultants ltd. Scotland has one twelfth of the UK's population - though alcohol consumption there is higher. The study took account of the productivity costs but did not place a wider economic value on the lost years of life.

Medical Officer's 2001 report concluded alcohol can be a major contributor to death, injury and illness. There are many disorders to which alcohol has been found to contribute after allowing for confounding by demographic and other risk factors such as smoking. The evidence, from three major international reviews, for the long-term affect of alcohol on chronic disorders and its acute short-term effects, is summarised in Table 1.

Table 1: Long-term and short-term impact of alcohol on health

Chronic disorders	Percentage of cases attributable to alcohol¹⁰	Acute disorders	Percentage of cases attributable to alcohol
Oropharyngeal cancer	8 – 50	Fall injuries	15 - 35
Oesophageal cancer	14 – 75	Fire injuries	38 - 45
Liver cancer	12 – 29	Drowning	23 – 38
Female breast cancer	3 – 4	Work/machine injuries	7 – 25
Stroke	2 – 16	Suicide	17 – 41
Hypertension	1 – 11	Assault	27 – 47
Oesophageal varices	22 – 54	Child abuse	16
Unspecified liver cirrhosis	43 – 54	All-cause mortality	3 - 7
Acute pancreatitis	24 – 42		
Chronic pancreatitis	60 – 84		
Road injuries	37 – 43		
Water/air transport accidents	20		

- The WHO Global Burden of Disease Study showed that amongst established market economies in 1990 alcohol accounted for 10.3% of Disability Adjusted Life Years (DALYs) compared with 11.7% for tobacco, 4.8% for physical inactivity, and 2.3% for illicit drugs¹¹.

¹⁰ This is the proportion of cases estimated to be solely caused by the risk factor alcohol after allowing for confounding factors. The estimates are ranges from studies in Australia, USA, and Canada. Source: WHO (2000) International guide for monitoring alcohol consumption and related harm. (Geneva: WHO)

¹¹ C.J.L. Murray (ed., 1996) The Global Burden of Disease. (WHO/World Bank). Disability adjusted life years are an estimate of the extent to which an average lifespan has been shortened by a disorder, plus the years lived with a disability or illness which has reduced the quality of life, i.e. burden = premature mortality + disability.

9. Deaths directly resulting from alcohol poisoning and liver cirrhosis in the UK, rose from 3,853 in 1994 to 5,508 in 1999. Deaths that are related to alcohol have been estimated at up to 40,000 year in the UK.
10. Alcohol also has an impact on the NHS. For example, an estimated one in six A&E admissions are for alcohol related injuries or problems. It is claimed this rises to 80% at peak times on Friday and Saturday evenings.
11. Alcohol is a contributory factor in 20-30% of all accidents. The number of drink-drive accidents has recently risen from 10,100 in 1998 to 11,780 in 2000 and the number of drink-driving convictions has increased – halting a downward trend over the last two decades. It is also notable that around 40% of pedestrian road casualties have been drinking.

The Government's Role

12. There are a number of good reasons why Government could play an active role in trying to prevent or mitigate the harmful effects of alcohol misuse. They include:
 - helping individuals make informed choices about potential risks (to themselves and others);
 - protecting the vulnerable, particularly children and people suffering from mental illness;
 - providing treatment and care for those who develop alcohol-related problems;
 - intervening to strike a balance between respecting individual choice and protecting society from the ill-effects of alcohol – both the effects themselves (e.g. crime, domestic violence, negligent parenting and anti-social behaviour etc) and the avoidable costs to the tax-payer (which include considerable costs to the NHS as well as costs to the economy through absenteeism etc).

Current policy within Government

13. Currently, lead policy responsibility for alcohol rests with the Department of Health, but other departments – including the Home Office and DCMS – also have policy interests. This structure requires good co-ordination to be effective.
14. The Government declared its intention to introduce **a cross-cutting strategy for tackling alcohol misuse** in the 1998 Green Paper and the 1999 White Paper *Our Healthier Nation*. The **Department of Health** has been leading on the strategy.

15. The Department of Health sponsors the National Treatment Agency, which currently deals only with drugs treatment, although it is possible that this remit could be expanded to include alcohol in future. The Department of Health is also funding the pilot of a training course in brief interventions for GPs and practice nurses.
16. **DCMS** took over responsibility for licensing from the Home Office following the General Election in 2001. Following the White Paper '*Time for reform: Proposals for the Modernisation of our licensing laws*' published by the Home Office in 2000, DCMS plan to introduce the Alcohol and Entertainment Licensing Bill. This will provide freedom for longer opening hours, rationalise the existing legislation covering premises that sell alcohol, and pass control of licenses from magistrates to local government. These changes will be a key step in the development of night-time economies in town and city centres, may help tackle town-centre crime and disorder associated with 'last orders' binge-drinking behaviour.
17. The **Home Office** leads on tackling crime and anti-social behaviour resulting from alcohol misuse. The recent Criminal Justice and Police Act 2001 gave the Police the powers to order the immediate closure, for up to 24 hours, of unruly or excessively noisy licensed premises; and to seize alcohol from those who are drinking in designated public places. It also introduced the requirement that all staff serving alcohol have a legal duty to satisfy themselves that a customer is not underage; and provided a legal basis for underage test purchasing.
18. Problems of alcohol are being addressed through a number of the Crime and disorder reduction partnerships. An action plan for 'Tackling alcohol related crime, disorder and nuisance' was produced in August 2000 and is being developed as one strand of crime reduction polices in SR2002. The Home Office is exploring further initiatives on the use of safety glasses and plastic bottles in licensed premises. The use of fixed penalties for being drunk and disorderly is being piloted in five areas.
19. There are also important links with drugs initiatives, though policies on this are being developed. Local delivery of the drugs strategy is co-ordinated by Drugs Action Teams (DATs) most of which also cover alcohol. In April 2002 each DAT produced Young People's Substance Misuse Plans detailing how education, prevention and treatment activities for drugs and alcohol will be expanded and integrated within wider provision for children and young people.
20. **The Department of Transport** leads on drink driving policies including the limits on alcohol levels in blood. **DfES** have an important role in providing education on

alcohol through the national curriculum, alongside other work on drug misuse. **DEFRA** have the sponsorship role for the food and drinks industry.

21. **Treasury and Customs and Excise** have the leading role on taxation of alcohol, in developing policies and collecting revenue. Excise duty accounts for around 20% of household expenditure on alcohol and VAT accounts for another 15%. Customs estimate that around £750m of tax revenue is fraudulently evaded on alcohol, and there are also enforcement costs for Customs. This fraud is often perpetrated by organised crime. Customs have had recent successes in reducing the level of cross channel smuggling of alcohol.
22. In the **Office of the Deputy Prime Minister**, other policies and programmes where alcohol plays an important role include the SEU work on teenage pregnancies and prisoners and probation; the NRU initiatives on regeneration in deprived areas, where the problems of substance misuse are often disproportionately worse; and the Homelessness Directorate's interest in tackling the high incidence of alcohol dependency amongst the homeless.

Current and potential policies

23. There are a range of policy levers that are, or might be, used to reduce the worst harms associated with misuse of alcohol and the risks of young people developing harmful drinking patterns. These include licensing and policing measures, prevention through education and awareness raising, brief interventions to provide advice through PCTs or at hospitals, treatment programmes, working with industry on serving policies, control of inappropriate drinks promotion and advertising and marketing. The effectiveness of these will depend upon the groups and problems that are being targeted. Research suggests that some measures e.g. brief interventions, stricter enforcement of licensing and extending opening hours can be successful in reducing the problems of alcohol misuse. However there is currently only limited evidence on the cost-effectiveness of different measures.
24. There are potentially a number of specific interventions that would help to tackle the problems associating with alcohol misuse, without interfering with people's legitimate right to drink. The Strategy Unit (SU) project will seek views on existing and other possible interventions and investigate whether they are likely to prove effective.

The range of delivery agencies

25. Co-ordination of different initiatives and setting the direction are likely to be as important as some of the individual measures. Co-ordination between different delivery agents on the ground, as well as at the centre – and between the public, voluntary and commercial sectors – could also help maximise effectiveness of existing as much as planned initiatives.

Why a Strategy Unit Project?

26. There are two main reasons why the SU would add value in this area:

- Alcohol is a genuinely strategic and cross-cutting issue, with a range of departmental and other interests and perspectives. Although overall alcohol consumption is stable, the misuse of alcohol appears to be growing and some of the problems associated with drinking may be getting worse. Policies and programmes both across and within Departments need to be well co-ordinated, not least because many of the costs and policy levers lie outside the lead departments. The Department of Health has lead policy responsibility for alcohol misuse although many of the costs fall on the criminal justice system. The likely extension of opening hours, following licensing reform, will highlight the case for a clear and joined-up approach on the range of potential alcohol-related problems.
- There is also a clear need for rigorous analysis of the evidence base and fresh and innovative thinking about new ways of tackling problems such as hazardous drinking by the young, all of which are suited to SU's method of working.

27. The SU project will provide the main vehicle for progressing the analysis and conclusions for the cross-cutting Government strategy on alcohol misuse. The team will work closely with DH and other key departments such as the Home Office and DCMS.

28. The aims of the project will be:

- To analyse the problems and the possible instruments and policies for tackling the harm caused by alcohol misuse – with a particular focus upon alcohol related crime and anti-social behaviour, and vulnerable or 'at risk' groups;
- To analyse existing activities across Government and the links with external organisations to explore how resources and programmes might be better joined-up;

- To suggest the changes in data collection and analysis needed to improve understanding of the problem, evaluate success of policies and achievement of any targets;
- To provide the analysis and key conclusions to underpin the Government's alcohol misuse strategy.

Key questions and issues

29. Key questions the project will consider include:

- What are the key drivers and trends in alcohol consumption and in patterns of drinking?
- What factors cause people to misuse alcohol?
- What is the evidence on underage and young people's drinking, and the negative impacts, including crime and anti-social behaviour?
- What is the evidence on the links between alcohol misuse and health, crime, disorder, domestic violence, family breakdown, rough sleeping etc?
- What is the boundary between non-harmful and harmful drinking?
- How do high risk behaviours, such as hazardous drinking, smoking, illicit drug use etc correlate?
- How should instruments be targeted at different groups e.g. by age, socio-economic class, geographically?
- What policies will reduce crime and disorder associated with excessive drinking by some? Which measures are most cost-effective?
- What policies work on education, prevention and treatment, both for influencing problem drinking and tackling alcohol dependency? Are existing treatment programmes cost-effective and do these have the right level of resourcing?
- Is it possible, and if so how, to bring about changes in drinking culture (particularly amongst young people) to reduce the harm from alcohol misuse?
- Could more be done to align the interest of pubs, retailers and the brewing industry with the objective of encourage people to enjoy drink sensibly?
- Is it possible to raise concern about healthy lifestyles, including alcohol, amongst the more at-risk groups?

Timescale and team

30. The project will start work in July 2002 and aim to complete early in 2003. The project team intends to work closely with a wide range of stakeholders including industry representative bodies, voluntary organisations and other NGOs, external experts and academics, medical bodies, police and criminal justice organisations and service deliverers, as well as with central and local Government.
31. The project will undertake an extensive process of consultation with all stakeholders and relevant groups. This paper is intended to start this process and we would welcome views on any of the areas it covers. In addition, we will make use of a variety of other consultation routes, including meetings and workshops, together with surveys and further research through the summer and autumn. We expect to issue a further consultation paper jointly with the Department of Health later in the year covering the key issues identified by the SU project and the alcohol harm reduction strategy.
32. The project team will be drawn from both key Whitehall departments and outside Government. Hazel Blears, Parliamentary Under-Secretary of State at the Department of Health, who leads both on alcohol and public health more generally, will be sponsor Minister for the project.
33. **We would like to hear from you** with your views on:
- Our proposal for this project – is it tackling the most relevant issues, where are the gaps in our analysis, are we analysing the problem in the right way?
 - The evidence base – do you have, or know of, good-quality data and information on the nature of the problems or the effectiveness of interventions that we could use in our analysis?
 - Possible interventions – do you have ideas or evidence for new interventions that might prove effective?
 - Best practice and case studies - Are there any good examples either in the UK or overseas we should look at?
 - Any other comments on the approach or the analysis.

How to get in touch

To contact the SU Alcohol Project team, either email: SU-alcohol@cabinet-office.x.gsi.gov.uk, or telephone on: 0207 276 1434, or write to:

SU Alcohol Project Team
Strategy Unit
Admiralty Arch
The Mall
London
SW1A 2WH

Any formal submissions may be posted on this website unless authors request otherwise.

Strategy Unit
19 July 2002