Alcohol Harm

Response by the Royal College of Physicians and Surgeons of Glasgow

The Commission on Alcohol Harm welcomes written submissions addressing one or more of the following questions:

1. **What evidence has emerged since 2012 on alcohol's impact on:**
    - **Mental health?**
    - **Physical health:**

Since 2012 there has been an increased use of health services (including those for Mental Health). In particular there have been increased rates of admissions to hospital with decompensated liver disease. There has also been a rise in the incidence of hepatocellular carcinoma (HCC).

People are who are subject to alcohol harm are more likely to be homeless or in or were formerly in HM Prisons and have poorer access to health care.
The MESAS report (2019) evaluates Scotland's alcohol strategy http://www.healthscotland.scot/media/2587/mesas-monitoring-report-2019.pdf and outlines the mortality and some of the morbidity attributable to alcohol in Scotland

In 2017, 1,120 people died in Scotland due to a cause wholly attributable to alcohol (alcohol-specific), an average of 22 people per week. After reaching a peak in 2003, alcohol-specific deaths declined to 2012. Since 2012 the rate of death from alcohol-specific causes has risen overall for both men and women.

Alcohol-specific death rates are consistently higher in Scotland than in England & Wales. In 2017, rates were twice as high in men and 55% higher in women
In terms of morbidity 23,494 people in Scotland were admitted to a general acute hospital with an alcohol related diagnosis in 2017/18, with a total of 35,499 alcohol-related inpatient stays. Despite a downward trend since 2007/08, rates of alcohol-related hospital stays remain four times higher than in the early 1980s.

The most recent data show that rates of alcohol-specific death and alcohol-related hospital stays were more than twice as high in men as in women and were highest in the 55–64 year age group. Inequalities by area deprivation were stark: in the most deprived areas of Scotland, rates of alcohol-specific death were more than seven times higher and alcohol-related hospital stays were more than eight times higher when compared with the least deprived areas.

Self-reported alcohol consumption data show that 24% of adults in Scotland in 2017 exceeded the revised low-risk weekly drinking guideline for both men and women with a decline from 34% in 2003. Of those exceeding the guideline, mean weekly consumption was highest among those in the lowest income groups.

A further report from SHAAP "Dying for a Drink' provides further information on alcohol related deaths and includes figures related to mental health. The report emphasised further the link with deprivation https://www.shaap.org.uk/downloads/reports-and-briefings.html
The two main causes of alcohol-related deaths in 2017 were alcohol-related liver disease (738 deaths, 60%) and mental and behavioural disorders caused by alcohol (321 deaths, 22%). Total ARDs in 2017 were 1,235.

The report goes on to provide information on alcohol-attributable deaths (partly related to alcohol)

Alcohol-attributable deaths (AADs) include an appropriate proportion of a further 30 causes of death which are partially caused by alcohol. Using this wider definition, there were an estimated 3,705 deaths attributable to alcohol in Scotland in 2015. The main causes of AADs for people under 35 are intentional self-harm, road/pedestrian accidents and poisoning. The main causes of AADs for people over 35 are alcohol-related liver disease, mental and behavioural disorders and neoplasms of the breast and oesophagus.
Alcohol is often used by people with mental health problems, to self-medicate.

At the same time, it can exacerbate mental health problems because of its range of neuropsychiatric effects. There is a complex relationship between alcohol use, self-harm, and suicide. Alcohol dependence both increases the lifetime risk of suicide and is implicated in the act of suicide/self-harm. More than half (58%) of people known to mental health services in Scotland who died by suicide had a history of alcohol misuse
Alcohol Focus Scotland, BMA Scotland, Scottish Families Affected by Alcohol and Drugs, SHAAP. Changing Scotland's Relationship with Alcohol: Recommendations for Further Action. 2017. Available at http://www.shaap.org.uk/images/Alcohol-strategy-recommendations-Report_Final_12_4_17.pdf

2. What impact does alcohol have on the NHS and other public services?

Alcohol is known to be a huge issue for the NHS. This study shows the effect of alcohol on admissions, where emergency admissions due to alcohol made up 21% of admissions.
https://bmjopen.bmj.com/content/6/6/e010005

This recent paper estimated the cost to England annually to be £3.9 billion including health criminal justice and welfare costs. The cost alcohol-related violent crime is estimated at nearly £1 billion per annum
http://iea.org.uk/sites/default/files/publications/files/DP_Alcohol%20and%20the%20public%20purse_63_amended2_web.pdf

Alcohol costs Scotland are proportionally higher at around £3.6 billion each year, including £267m to the NHS, £209m to social care services, and £727m to the justice system
https://www.parliament.scot/S5_HealthandSportCommittee/Inquiries/DRB036_Alcohol_Focus_Scotland.pdf

The societal cost of alcohol misuse in Scotland for 2007. York Health Economics Consortium, University of York, 2010.

In services designated for Gastroenterology, the majority of male in-patients and a significant number of female in-patients have decompensated liver disease secondary to alcohol related liver disease. In addition, the well described increase in hepatocellular cancer incidence in the UK and particularly Scotland is largely related to patients with alcoholic cirrhosis.

3. What challenges do alcohol treatment services currently face in supporting people impacted by alcohol harm?

Chaotic lifestyle and non-attendance at clinics for some of these patients contribute to the challenges facing these services. Many individuals are also homeless or in custodial care. Many mainstream services are not set up to deal with the chaos that often comes with

having a substance use disorder and often work to a 9-5 Monday to Friday pattern with a tendency to discharge people who do not attend. Many such individuals end up in Emergency Services.

The current system shows inability to provide early brief intervention for e.g. first attendances at A& E of patients with excess alcohol, falls, injuries for all ages. Services for addiction effectively exclude older patients - either overtly or by being inappropriate for frailer housebound people.

4. What recent evidence is there of impacts caused by alcohol consumption on family life, relationships and sexual behaviour?

Impact on young people

For the first time in many years the SALSUS survey (which reports alcohol and drug use among young people) has shown that despite sustained falls in previous years, between 2015 and 2018, there was an increase in 13 and 15 year olds who had-'ever had an alcoholic drink', had 'been drunk in the last week' and had 'ever been drunk'.

Most 13-year olds were drinking at home and 15 years olds in their own or someone else's home.

The proportion of 13-year olds experiencing at least one adverse effect from alcohol increased from 45% in 2015 to 52% in 2018. The proportion of 15-year old girls experiencing at least one effect increased from 64% in 2015 to 68% in 2018. There was no increase for 15-year old boys.

Girls were more likely than boys to have an argument due to drinking alcohol (36% of girls, compared with 26% of boys), to have been sick (40%, compared with 33%) posted something online they wished they had not (19%, compared with 12%), sent a text/email that they wished they had not (34%, compared with 20%) and done something they later regretted (42%, compared with 32%). Boys were more likely to have had a fight (17% of boys, compared with 12% of girls) and to have tried drugs (17% of boys, compared with 13% of girls).

Among both age groups, young people were most likely to get alcohol from their home, from a friend or from a relative
https://www.gov.scot/publications/scottish-schools-adolescent-lifestyle-substance-use-survey-salsus-alcohol-report-2018/

Domestic abuse

While there is little evidence that alcohol causes domestic abuse per se, it will increase the severity and impact of abuse. It is also known that victims of abuse will turn to alcohol to self-medicate in order to deal with the resulting trauma.
https://www.who.int/violence_injury_prevention/violence/world_report/factsheets/fs_intimate.pdf

Adverse childhood experiences

Having a parent with a substance use disorder is one of the 10 adverse childhood experiences. Having 4 or more of these occur before the age of 18 is known to contribute the risk of experiencing a range of health conditions in adulthood such as heart disease, type 2 diabetes, engage in health harming behaviours (smoking, heavy drinking, drug use)

http://www.healthscotland.scot/population-groups/children/adverse-childhood-experiences-aces/overview-of-aces

5. What data exists to show alcohol's current impact on different demographic groups, including age, sex and social class

Age

Although alcohol consumption tends to reduce with age, latest statistics show that the over 65s were the only age group which did not experience an increase in the number of people identifying as teetotal between 2005 and 2017. The number of adults over 65 reporting as not drinking at all, decreased by 5%. This is largely explained by a decrease in the number of women over 65 reporting as teetotal – in 2005, 37.2% of women over 65 reported not drinking at all; this declined to 27.9% in 2017. However, younger people are more likely to 'binge drink' – creating habits that they may continue as they age.

The ageing population means that, far from diminishing, the problems of alcohol misuse in older people are set to rise, especially when combined with the drinking patterns that younger adults of today are adopting, and which they are likely to continue into their older years.

There are specific problems associated with alcohol use in older people, spanning a range of physical and mental health conditions. Alcohol overuse can cause or exacerbate anxiety, depression, poor sleep, self-neglect, malnutrition, memory problems and confusion. When it comes to physical health, alcohol can contribute to incontinence, liver and kidney problems, hypothermia and poor balance and falls. In addition, alcohol can interfere with the efficacy of prescription medications, which older people use significantly more than other population groups.

The evidence around alcohol consumption and the development of dementia is unclear. While there is evidence that heavy drinking (or binge drinking) causes brain damage, there is also evidence to suggest that people who do not drink at all may be at an increased risk of developing dementia and there is insufficient evidence regarding whether heavy drinkers are at increased risk compared to moderate drinkers.

Research has suggested a paradox in the link between alcohol consumption and frailty over the life course. High consumption of alcohol in midlife is a predictor of frailty, whereas in old age, zero consumption of alcohol is associated with frailty. The researchers suggest that this may be because those who choose not to drink in old age do so because they are experiencing ill health and are therefore more susceptible to frailty already.

The UK alcohol guidelines of 14 units a week for both men and women may still be too generous for older people. Physiological changes related to ageing may make alcohol consumption riskier than in younger adults. Some experts have suggested a lower limit of 11 units of alcohol a week. There are also those who would argue that for some, particularly older, individuals with significant physical and mental health comorbid disorders, there are no 'safe limits' for alcohol consumption. We should however note that older people also report the pleasure of meeting with friends and family and consuming alcohol adds to their lives.

Older people who drink alcohol at a harmful level may also experience difficulty in accessing the services that they need and may not be identified as drinking too much. This issue exists both with NHS staff failing to assess for alcohol problems when - for instance - an older

person attends A&E after a fall, and with family members who may excuse excess alcohol consumption as a comfort later in life.

In addition, services aimed at tackling substance misuse are often targeted at young people, which may discourage older drinkers from accessing the services that would most benefit them.

Alcohol Focus Scotland (undated). Alcohol information. Available at: www.alcohol-focus-scotland.org.uk/alcohol-information (accessed 27 September 2019)
Office for National Statistics (2018) Adult drinking habits in Great Britain: 2017. Available at: www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/drugusea... (accesed 27 September 2019)
Dyson J (2006) 'Alcohol misuse and older people' Nursing Older People 18:7;32-35
Alcohol Concern (2011) Hidden harm? Alcohol and older people in Wales. Available at: https://alcoholchange.org.uk/publication/hidden-harm-alcohol-and-older-p... (accessed 27 September 2019)
Alzheimer's Society (undated) Alcohol and dementia. Available at: www.alzheimers.org.uk/about-dementia/risk-factors-and-prevention/alcohol (accessed 4 October 2019)
Strandberg A, Trygg T, Pitkälä K (2018) 'Alcohol consumption in midlife and old age and risk of frailty' Age and Ageing,47:248-254
Crome I, Crome P (2018) 'Alcohol and Age' Age and Ageing 47:164-167

Social Deprivation

Some of the references in previous questions show a greater effect in men and geographical areas of social deprivation.
Inequalities in alcohol-related harm persist, with people living in our most deprived areas eight times more likely to die or be admitted to hospital due to alcohol use than those in our most affluent communities. Alcohol Consumption and Price in Scotland 2015, NHS Health Scotland, 2016.

6. **What impact does alcohol have on economic productivity and is there evidence of this changing since 2012?**

7. **What current evidence is there of links between alcohol and violent behaviour and other crime?**

Alcohol is closely associated with violent behaviour-although not a direct cause for it. Some of the associations are outlined in this policy paper from the WHO https://www.who.int/violence_injury_prevention/violence/world_report/factsheets/pb_violencealcohol.pdf
In just over half (54%) of violent crime, the victim said the offender was under the influence of alcohol. Scottish Crime and Justice Survey 2014/15.
Alcohol Focus Scotland outlines some of its statistics https://www.alcohol-focus-scotland.org.uk/media/310765/alcohol-and-violent-crime-april-18.pdf

8. **What recent evidence is there of links between alcohol and other addictive behaviours (such as smoking, drug use and gambling)?**

   (unsure of evidence)

9. **What effect does the current approach to alcohol marketing and licensing have on alcohol harm?**

The initial assessment of the impact of minimum unit pricing in Scotland appears to have shown some mixed results, with apparent less beneficial effect on younger drinkers. Dr Ewan Forrest (Glasgow Royal Infirmary) presented data on this at the September 2019 meeting of the British Association for the Study of the Liver. We understand he has already been asked to comment on this to the Commission.

Alcohol sold in the UK was 64% more affordable in 2018 than it was in 1987. Disposable household income has increased and the price of alcohol has fallen relative to other retail prices. So pricing is an issue.

Alcohol sponsorship of sport remains an issue in the UK and it is widely acknowledged that many young people associate alcohol brands with sports teams. The public in general see alcohol as part of the enjoyment of sporting events. This mainstream level of sponsorship of major events maintains the association of alcohol and sport.

France and Norway have banned alcohol sponsorship from sport. Scottish women's football has taken the step of refusing alcohol or gambling sponsorship of their sport.
There is evidence that exposure to alcohol marketing increases the likelihood that young people will start to drink, and to drink more if they are already drinking. Under the influence: The damaging effect of alcohol marketing on young people. British Medical Association, 2009 and Impact of Alcohol Advertising and Media Exposure on Adolescent Alcohol Use: A Systematic Review of Longitudinal Studies. Anderson et al, 2009.

10. **What policy changes would help to reduce the level of harm caused by alcohol? Are there policy responses from other governments (including within the UK) that have been successful in reducing harms caused by alcohol that could be implemented in the UK?**

Alcohol Focus Scotland outlines these general policy approaches, 'Increasing price, reducing availability and restricting marketing are amongst the most effective - and cost-effective - policy measures to reduce alcohol consumption and harm.' https://www.parliament.scot/S5_HealthandSportCommittee/Inquiries/DRB036_Alcohol_Focus_Scotland.pdf.

Alcohol Focus Scotland, BMA Scotland, Scottish Families Affected by Alcohol and Drugs, SHAAP. Changing Scotland's Relationship with Alcohol: Recommendations for Further Action. 2017. Available at http://www.shaap.org.uk/images/Alcohol-strategy-recommendations-Report_Final_12_4_17.pdf

We consider price, marketing/advertising, availability, position (eg the entrance to supermarkets etc) are likely to have an impact.
There is more evidence below:

A. There are a variety of sales and marketing strategies used in other countries which could be considered in the UK, for example in Australia, alcohol is sold in a completely different part of supermarkets and not sold from the same till points. This means that to buy alcohol along with shopping you have to pay for your groceries, exit that part of the store and purchase your alcohol in what is effectively a different store. This means that children and young people do not see alcohol among or as part of normal grocery shopping as perhaps they do in this country.

B. Minimum unit pricing implemented in Scotland in 2018 has shown some early evidence decrease in alcohol purchasing. This is part of a longer-term evaluation due to extend till 2023 and which should be followed closely to determine whether the positive effects extend to alcohol related harm. The policy was designed to target high strength cheap alcohol which is consumed by the majority of very heavy drinkers eg white cider.

   "The increase in purchase price was higher in lower income households and in households that purchased the largest amount of alcohol. The reduction in purchased grams of alcohol was greater in lower income households and only occurred in the top fifth of households by income that purchased the greatest amount of alcohol, where the reduction was 15 g of alcohol per week (6 to 24)." https://www.bmj.com/content/366/bmj.l5274

C. Scotland reduced the drink driving limit for alcohol in 2014. While this has had a small effect on the amount of alcohol sold in pubs, there was no measurable difference in the incidence of road traffic accidents in the two years prior to the change compared with the two years following the change. Authors of this article site the lack of enforcement of the policy, as one of the possible reasons for this lack of change. This reinforces the need to back up any policy change with a means of ensuring that it is enforced and monitored. Lewsey J, Haghpanahan H, Mackay D et al. Impact of legislation to reduce the drink-drive limit on road traffic accidents and alcohol consumption in Scotland: a

The World health Organisation outlines a variety of general approaches to alcohol policy and marketing in its paper Global Strategy to Reduce the Harmful Use of Alcohol (2010) including https://www.who.int/substance_abuse/msbalcstragegy.pdf and Tackling Harmful Alcohol Use: Economics and Public Health Policy. OECD Publishing, 2015. http://dx.doi.org/10.1787/9789264181069-en.
A lower alcohol limit for older patients is suggested.

Early interventions should be developed for all ages in both in primary care and after A and E attendances.

One of our reviewers suggested the use of a voluntary alcohol consumption quotas related to health status which could be monitored by an electronic card at the point of sale.

Dr Richard Hull FRCP Glasgow
Honorary Secretary
Royal College of Physicians and Surgeons of Glasgow

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Please note: There is no requirement to answer every question. Choose the question or questions you can answer best.