Collective Voice

Alcohol Health Alliance UK

Commission on Alcohol Harm: An Inquiry into the Effects of Alcohol on Society

February 2020

Collective Voice is the national alliance of drug and alcohol treatment charities.

We believe that anyone in England with a drug or alcohol problem should be able to access effective, evidence-based and person-centred support. We know that treatment and wider support has a transformative power for people with drug or alcohol issues, their families and communities. Drawing on the strengths of our members, we:

1. Tirelessly advocate for the needs of people who use drugs and alcohol by influencing partners in central and local government, the media, and allied organisations.
2. Coordinate and lead campaigns and alliances within our sector and with wider partners.
3. Promote the value brought by the voluntary sector to treatment and wider support.

1. What evidence has emerged since 2012 on alcohol's impact on:

- *Physical health?*

The effects of alcohol on physical health are clear and apparent. Alcohol is a causal factor in more than 60 medical conditions, from cancers to high blood pressure and cirrhosis of the liver.[1] It is therefore concerning that 2018/19 saw an eight per cent increase in hospital admissions related to alcohol consumption and a 19 per cent increase in admissions where the main reason was alcohol.[2] These figures present a serious challenge to health services across the country.

Meanwhile, the overall health cost to the population is staggering – in England in 2018, over 314,000 potential years of life were lost due to alcohol consumption related factors. This is the highest level since 2011.[3]

- *Mental health?*

[1] https://www.gov.uk/government/publications/the-public-health-burden-of-alcohol-evidence-review
[2] https://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/11/gid/1938132833/pat/6/par/E12000006/ati/102/are/E10000015; https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-alcohol/2019/part-1
[3] https://alcoholchange.org.uk/alcohol-facts/fact-sheets/alcohol-statistics

The link between alcohol use and mental health is complex, largely because of the cultural prevalence of alcohol and its frequent use to 'self-medicate' anxiety, depression, stress and other mental health problems. This not only means that some mental health problems can remain unaddressed but alcohol may also, in some instances, exacerbate the underlying issues. So alcohol consumption can be both a *causal* factor in some mental health problems and a *result* of poor mental health.[4]

Depression in particular can be highly comorbid with heavy drinking – estimates suggest 30-40 per cent of people with an alcohol use disorder also experience an episode of comorbid depression. Patients with co-morbid depression also have worse outcomes for alcohol treatment.[5]

In extreme cases, heavy drinking can also lead to alcohol-related brain damage (ARBD), sometimes referred to as 'wet brain'. ARBD can occur where heavy alcohol consumption changes the shape and structure of the brain, which can affect personality, mood, learning, memory and impulse control.[6] Long-term heavy drinking can also increase the risk of developing common forms of dementia, including Alzheimer's and vascular dementia.[7]

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

The overall economic burden of alcohol harm is significant – estimates place the annual cost between 1.3 and 2.7 per cent of GDP. But even this estimate may be limited because few studies look beyond the immediate harms to the person drinking.[8] Nevertheless, the burden on public services, particularly the NHS, is undeniable. From rates of alcohol-related hospital admissions to alcohol-fuelled violence in our public spaces creating strains on the police, public services repeatedly bear the brunt of alcohol harm in terms of time and resource. For the NHS in England alone, the annual economic cost is estimated to be £3.5 billion.[9]

Meanwhile there is a strong case for investment in services that prevent alcohol harms. PHE places the social return for every £1 spent on alcohol treatment at £3, rising to £26 over the course of ten years.[10] But local authorities do not see immediate returns for their investment, as they are largely felt in the wider field of public services, particularly healthcare and the criminal justice system. Meanwhile, alcohol treatment services have been heavily cut and remain a low political priority because they lack vote-winning appeal and there is a low level of public interest in, and empathy for, the people accessing services.

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[4] https://www.mentalhealth.org.uk/a-to-z/a/alcohol-and-mental-health

[5] https://www.nationalelfservice.net/mental-health/depression/depression-in-patients-with-alcohol-use-disorders/

[6] https://alcoholchange.org.uk/alcohol-facts/fact-sheets/alcohol-and-the-brain

[7] https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(18)30022-7/fulltext

[8] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/733108/alcohol_public_health_burden_evidence_review_update_2018.pdf

[9] https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2018-09-05/170778/

[10] https://www.gov.uk/government/publications/alcohol-and-drug-prevention-treatment-and-recovery-why-invest/alcohol-and-drug-prevention-treatment-and-recovery-why-invest

The impact of alcohol on the NHS and public services is also complicated by the commissioning landscape. While the NHS takes the strain in providing acute healthcare responses to alcohol-related harms, its financial position is significantly more secure than the distinct substance misuse services commissioned through the public health grant. Substantial increases in NHS funding have now been guaranteed by law until 2024, but the PH grant has seen significant yearly reductions, with the unsurprising outcome that substance misuse services have, on average, seen funding fall by over a quarter since 2015. With the costs of running an effective treatment service dwarfed by NHS expenditure on responding to alcohol-related harms, the case needs to be better made that treatment services help reduce NHS costs by keeping people out of acute health settings.

Substance misuse services are also much better placed to deal with the non-clinical aspects of a person's substance misuse, from providing psycho-social interventions to more holistic support with housing, employment and mental health needs. However, this capacity has been reduced by funding pressures, meaning services are being asked to do more with less, which can be detrimental to staff wellbeing and negatively impact the therapeutic relationship, and leave some local people's need unmets.

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

Recent reports from the Recovery Partnership/Adfam[11] and the Advisory Council on the Misuse of Drugs[12] point to the critical combining effect of reduced funding and changes to commissioning on outcomes for people in substance misuse treatment, which threatens to push services 'beyond the tipping point'. The reductions in funding for services through the PH grant are stark, with an average of over a quarter of funding lost at local authority levels since 2015. In some areas, cuts are as high as 50 per cent. At service level, lower funding means reductions in the number of people in treatment, a reduction in the quality of service, or possibly both, leaving a substantial portion of needs unmet by potentially life-saving treatment. Latest estimates suggest four in five adults in England with a dependency on alcohol are not accessing alcohol treatment.[13]

People presenting for treatment with multiple complex needs, from housing to mental health or involvement in the criminal justice system, may be particularly affected by funding cuts, which can lead to the stripping away of expertise in an attempt to preserve 'core' treatment services.

Changes to the way that substance misuse services are commissioned, specifically the increasing integration of alcohol and drugs support, make it hard to assess the proportion of funding lost specifically to alcohol services, though one 2016 estimate placed specific cuts at 14 per cent[14] while

[11] http://www.recovery-partnership.org/uploads/5/1/8/2/51822429/state_of_the_sector_2017_-_beyond_the_tipping_point.pdf

[12] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/642811/Final_Commissioning_report_5.15_6th_Sept.pdf

[13] https://www.gov.uk/government/publications/alcohol-treatment-inquiry-summary-of-findings/phe-inquiry-into-the-fall-in-numbers-of-people-in-alcohol-treatment-findings

[14] https://www.kingsfund.org.uk/blog/2016/08/local-government-public-health-budgets

local funding losses may range from 10 to 58 per cent.[15] Cuts to alcohol treatment funding also exist in the context that spending on alcohol services from the PH grant is less than half than that spent on drugs services.[16]

This is not to say that integration of alcohol and drug services, largely as a by-product of reduced overall funding for substance misuse, is in and of itself a barrier to alcohol treatment. The PHE deep dive found that integrated services can work well, with better streamlined commissioning and improved cost effectiveness. And integration itself does not necessarily lead to a fall in numbers of people in treatment for alcohol dependency.[17]

But the PHE inquiry did find in many areas where services had been reconfigured that stakeholders perceived a reduced focus on the needs of people who use alcohol and a loss of alcohol expertise within the workforce.[18]

Pressures on services and lost expertise may also lead to missed identification of new trends relating to alcohol harm, such as changes in the way young people misuse alcohol, and people presenting for alcohol treatment only may also feel alienated by a combined drug and alcohol service, believing their problem is not relevant to the available service.

Alcohol Change UK's 'The hardest hit' report[19] outlines the litany of problems facing alcohol treatment services as a result of changes to funding and commissioning, from service availability to community outreach and delivery. Particularly concerning is the effect on detox and rehabilitation services – almost half of respondents to the survey that underpinned the report said there was insufficient availability of community detoxification in their areas. The loss of community detox centres is a well-recognised crisis (London has just one residential detox centre left), and some in the sector point to the consequential pressure placed on A&E, where there is a lack of expertise around substance misuse.[20]

The Alcohol Change report also found less than half of respondents felt commissioning was working well in their areas. The two key problems identified were the speed of retendering cycles and lack of commissioning expertise.[21]

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

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[15] https://s3.eu-west-2.amazonaws.com/files.alcoholchange.org.uk/documents/The-hardest-hit.pdf?mtime=20181116174247
[16] https://s3.eu-west-2.amazonaws.com/files.alcoholchange.org.uk/documents/The-hardest-hit.pdf?mtime=20181116174247
[17] https://www.gov.uk/government/publications/alcohol-treatment-inquiry-summary-of-findings/phe-inquiry-into-the-fall-in-numbers-of-people-in-alcohol-treatment-findings
[18] https://www.gov.uk/government/publications/alcohol-treatment-inquiry-summary-of-findings/phe-inquiry-into-the-fall-in-numbers-of-people-in-alcohol-treatment-findings
[19] https://s3.eu-west-2.amazonaws.com/files.alcoholchange.org.uk/documents/The-hardest-hit.pdf?mtime=20181116174247
[20] https://nhssmpa.org/blog/city-roads-inpatient-units-close
[21] https://s3.eu-west-2.amazonaws.com/files.alcoholchange.org.uk/documents/The-hardest-hit.pdf?mtime=20181116174247

The impact of alcohol consumption on family life and relationships is wide ranging, from children's early impressions of 'normal' alcohol consumption by their parents to the occasional strains of a hangover on a relationship to the negative consequences of drunken behaviour, which themselves can range from simple misunderstandings to serious arguments and fights.[22] But in statistical terms, the numbers are clear – almost one in three people in the UK have been negatively affected by someone else's substance misuse.[23] That statistic includes people affected by someone else's drug use, as well as alcohol, but given the prevalence of alcohol as society's chief drug of choice, the quantum of alcohol-related harm is likely to be enormous. The harms themselves can range from mental health problems and financial issues to violence and abuse.

The potential impact of alcohol consumption on children is particularly alarming, from the effects of foetal alcohol spectrum disorder to the intergenerational nature of alcohol dependency and the impact on adverse childhood experiences.

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

Statistics from 2018 show that overall, white men and women over the age of 16 are more likely to drink at hazardous, harmful or dependent levels than black, Asian and minority ethnic (BAME) people.[24] This disparity was previously noted in 2010 by the Joseph Rowntree Foundation, which found most BAME groups have higher rates of abstinence and lower levels of drinking than white people.[25]

However, the same report also noted the differences across minority ethnic groups, as well as the possibility of underreporting in some areas. For example, women from South Asian communities, who are more likely to be expected to be abstinent, may also be more likely to hide their alcohol consumption. Similarly, some Muslim men, and men from minority ethnic groups who are also on lower incomes, reported not knowing where to access support for an alcohol problem. These issues can hamper commissioners' and services' estimates of local needs in particular communities.[26]

This sentiment was echoed in PHE's 2018 deep dive, which found that funding cuts had led to a loss of community outreach that may be affecting some BAME communities.[27] A 2015 report by the Recovery Partnership/Adfam also highlighted a range of potential barriers preventing BAME people

[22] https://alcoholchange.org.uk/alcohol-facts/fact-sheets/alcohol-and-families
[23] https://adfam.org.uk/about-us/blog/15
[24] https://www.ethnicity-facts-figures.service.gov.uk/health/alcohol-smoking-and-drug-use/harmful-and-probable-dependent-drinking-in-adults/latest
[25] https://www.jrf.org.uk/sites/default/files/jrf/migrated/files/ethnicity-alcohol-literature-review-summary.pdf
[26] https://www.jrf.org.uk/sites/default/files/jrf/migrated/files/ethnicity-alcohol-literature-review-summary.pdf
[27] https://www.gov.uk/government/publications/alcohol-treatment-inquiry-summary-of-findings/phe-inquiry-into-the-fall-in-numbers-of-people-in-alcohol-treatment-findings

from accessing treatment, from stigma and shame attached to them and their families, to concerns about confidentiality and lack of language or cultural understanding within services.[28]

Drinking patterns also vary by age. Younger people are increasingly less likely to drink alcohol than older generations, who are also more likely to drink regularly and at higher risk levels. But while these are useful indicators of general trends, they can also mask more accurate assessments of particular groups. For example, although men are more likely to binge drink than women, this disparity is less apparent with younger age groups.[29]

Looking at substance misuse alongside other areas of multiple and complex need is crucial. St Mungo's report Knocked Back revealed that drugs and alcohol caused the deaths of 380 people sleeping rough in 2018, and the number of people sleeping rough with an alcohol or drug problem is increasing – 12,000 people in 2018/19 were estimated to have their drug and alcohol treatment needs unmet.[30] The recent Lankelly Chase report, Gender Matters, also highlights the importance of looking at the effects of multiple and complex needs through a gendered lens. Of the 17,000 people estimated to be experiencing the four primary domains of disadvantage as defined by the report (substance misuse, interpersonal violence and abuse, homelessness, and poor mental health) 70 per cent are women.[31]

It is also hard to divorce alcohol use from other factors that shape a person's life, particularly in the context of socio-economic status and disadvantage, which can lead to stark health inequalities. Figures for 2018 show the alcohol-specific mortality rate of men in the UK in the most disadvantaged socio-economic class was almost four times higher than for men in the least disadvantaged class. For women, the figure was 3.3 times higher.[32] A 2016 evidence review by PHE also found half of the over 1 million hospital admissions for related to hospital consumption are in the three lowest socio-economic deciles.[33]

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

The government's Modern Crime Prevention Strategy makes clear the link between alcohol and crime and violence – in around half of all violent incidents the victim believed the offender was under the

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[28] http://www.recovery-partnership.org/uploads/5/1/8/2/51822429/regional_roundtable_treatment_and_recovery_in_bme_communities.pdf
[29] https://alcoholchange.org.uk/alcohol-facts/fact-sheets/drinking-trends-in-the-uk
[30] https://www.mungos.org/publication/knocked-back/
[31] https://lankellychase.org.uk/wp-content/uploads/2020/02/Gender-Matters-summary-report-Feb-2020-1.pdf
[32] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/datasets/alcoholspecificdeathsintheunitedkingdomsupplementarydatatables
[33] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/733108/alcohol_public_health_burden_evidence_review_update_2018.pdf

influence of alcohol.[34] And the economic burden of alcohol-related crime, estimated at £11 billion, is substantial. The link between alcohol use and domestic abuse and violence is particularly concerning, as underlined by the aforementioned Gender Matters report[35] and in wider international research.[36]

For these reasons, alcohol treatment services need to be understood as a vital ingredient in crime reduction and should be made available to those in need at any point from arrest through to custodial settings and release from prison. These treatment services not only provide immediate support such as detoxification but also help to put in place the fundamental building blocks for behaviour change and desistance from potential future crimes.

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

Alcohol is often used problematically alongside drugs. This can increase the complexity of treatment required, which poses problems for treatment services that are already under pressure from reduced funding and a client group that frequently presents with other multiple complex needs. There is also a risk that, due to funding cuts, services may overlook a person's alcohol problem if they present for treatment for a drug dependency.

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?**

The evidence of alcohol harm from the treatment sector is clear and unambiguous in terms of the overarching problems. Reduced funding for local services as a result of cuts to the PH grant have resulted in lower capacity to support the numbers of people presenting for treatment, lower quality of service in some cases, and a move to integrating alcohol and drug services that can result in reduced focus and expertise devoted specifically to reducing alcohol harms. Cuts have also hampered services' ability to reach people who are not presenting for treatment. Meanwhile, our understanding of alcohol-related harms is only increasing, from macro-level understanding of the societal effects of alcohol on public health and relationships, to better knowledge about the intersection of alcohol misuse with other domains of severe and multiple disadvantage.

For these reasons, we welcome the government's renewed focus on addiction, including alcohol dependency, in the form of a new strategy and a dedicated monitoring unit.[37] While the scope and content of these core initiatives remain unclear, we hope they will take heed of the strong body of evidence as to what works at both the intervention and system level. Healthcare's increasing shift to system-wide partnership working, from integrated care networks to primary care networks and inclusion health projects, is a vital opportunity for a fresh approach to alcohol harm prevention and

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[34] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/509831/6.1770_Modern_Crime_Prevention_Strategy_final_WEB_version.pdf
[35] https://lankellychase.org.uk/wp-content/uploads/2020/02/Gender-Matters-full-report-Feb-2020.pdf
[36] https://onlinelibrary.wiley.com/toc/14653362/36/1
[37] https://vote.conservatives.com/news/conservatives-to-launch-new-plan-to-tackle-addiction

treatment. Voluntary sector treatment providers can, and should, play a vital role in supporting a renewed focus on alcohol harms by building recovery capital within communities and using social prescribing to provide holistic, wrap-around care for those most in need.