

Vital 5 Alcohol Harm Policy Impact and Implementation Review

July 2024



FOREWORD

We are in the midst of a public health crisis, with deaths from alcohol across the UK at record highs. Across London, 1,500 people die from alcohol each year, and from 2019-2022, the South East of London has seen a 27% increase in deaths wholly attributable to alcohol.

Each year, alcohol-related harm costs South East London alone an estimated £902.5 million, equating to £504 per resident – enough to pay the salaries of over 25,000 NHS nurses. These costs are acutely felt in the areas of healthcare, crime, workplace productivity, and social services. Alcohol is also a crucial factor in domestic violence, which exacerbates health and societal inequities.

Alcohol harm continues to be a significant public health challenge, impacting individuals, families, and communities across South East London. The scale of these impacts, while daunting, is not immutable. This report delves into the profound societal, health, and economic costs of alcohol harm in the area, presenting evidence-based strategies that can make a substantial difference in the region. The importance of this work cannot be overstated.

In commissioning this report, Vital 5 systems partners sought to illuminate the path forward. It is a call to action for local authorities, healthcare providers, and community leaders to implement targeted interventions that address the root causes of risky alcohol use. We identify eleven policies that are recommended for implementation across four policy areas: regulating marketing – by prohibiting alcohol advertising in council-owned spaces; regulating availability – including outlet density and hours of sale; managing the drinking environment; and expanding alcohol identification and brief Interventions (IBA) alongside improving treatment.

Alcohol harm is also a matter of social inequality. People living in disadvantaged areas are far more likely to be hospitalised or die because of alcohol, despite being less likely to drink. The report recommends the introduction of a minimum unit price (MUP), which is estimated to reduce hospital admissions in London by 1,764 and save 33 lives each year, if set at a 62p rate, saving the NHS £4.1 million a year. Crucially, MUP has been shown to reduce health inequalities, disproportionately saving lives in the most disadvantaged communities.

The report also highlights emerging opportunities in the area of promotion of no and low-alcohol beverages. While evidence in these areas is developing, they may represent avenues for future policy and practice. Local licensing policies would play a role in supporting these initiatives, fostering healthier drinking environments and choices, and would not require legislative change.

This is a call to action to drive change. We envision a South East London where the harms of alcohol are significantly reduced, where communities are safer, and where health and wellbeing are prioritised over the economic interests of the alcohol industry. This report provides a robust foundation for these efforts, offering detailed insights and actionable recommendations for stakeholders to take forward.

Dr Emily Finch MD FRCPsych, Clinical Director Southwark and Addictions, South London and Maudsley NHS Foundation Trust.

Dr Ruth Hutt, Director of Public Health for Lambeth and Vice-Chair of the London Association for Directors of Public Health.

Co-chairs of the South East London Alcohol Harms Delivery and Oversight Group, a workstream of the South East London Integrated Care System and Kings Health Partners Vital 5 population health and inequalities programme.

CONTENTS

Executive Summary	4
Part 1: Policy and Evidence Review	8
1a) Situational Analysis: Cost Of Alcohol Harm In South East London	8
Introduction	8
Approach.....	8
Cost Of Alcohol Harm In SE London	9
1b) Policies And Interventions - Evidence Review	12
Introduction And Objective	12
Approach.....	12
Findings.....	12
Part 2: Modelling of the Potential Impact of Minimum Unit Pricing for London	42
Introduction	42
Methods	42
Results	44
Baseline Patterns Of Drinking And Alcohol-Attributable Harm In London.....	44
Modelling Impacts Of A Minimum Unit Price.....	48
Interpretation And Context.....	53
Part 3: Resources to Support Implementation of Local Interventions to Reduce Alcohol Harm in SE London.....	57
The Need For Strong National Leadership.....	57
Public Support For Action On Alcohol Harm.....	58
Local Policy Recommendations	58
Building Support And Coordinating Local Action On Alcohol Harm	59
Policy-Specific Guidance And Resources	60
Acknowledgements.....	64
Declarations of Interest	64
References.....	65
Appendix 1: 2021/22 Local Authority Alcohol Cost Profile Methodology.....	79
Appendix 2: Cost of Harm Infographics.....	82

EXECUTIVE SUMMARY

Part 1: Policy and evidence review

1A) Situational analysis: cost of alcohol harm in South East London

The health, societal and economic impacts of alcohol use are wide-ranging, and alcohol harm places significant financial strain on the UK. Data published by the Institute of Alcohol Studies in 2024 estimates the total societal costs of alcohol harm in England to be £27.4 billion. Breakdowns of the cost of alcohol harm at local authority or regional levels have rarely been available, but this report presents new estimates based on methods previously used by the Cabinet Office Strategy Report (2003). These show the costs of alcohol to society at local authority level, covering: healthcare, crime, social services, and workplace and economy costs for 2021-22.

The cost of alcohol harm to SE London in 2021-22 is estimated at a staggering £902.5 million.

This is equivalent to £504 per head of population. Crime accounts for the largest proportion of the costs (45.5%), followed by the workplace and economy costs (25.5%), health (16.6%) and social services (12.4%).

The cost of alcohol harm to each SE London borough is estimated to be:

- Bexley: £99.3m
- Bromley: £149.2m
- Greenwich: £156.3m
- Lambeth: £186.6m
- Lewisham: £148.4m
- Southwark: £165.9m

1B) Policies and interventions - evidence review

In the absence of a national alcohol strategy in the UK, a range of policies and interventions could be considered at a local level to address alcohol harm, health inequalities, and the costs to public services and wider society.

The objective of the evidence review was to identify a range of alcohol and licensing policy and practice interventions that may reduce alcohol harms at a population level - particularly in the context of diverse and deprived communities.

41 policies and interventions in seven policy areas were reviewed, following the framework of the Public Health England 2016 evidence review. Evidence was synthesised using a red-amber-green rating for each policy or intervention and the potential for implementation on a local level was indicated.

The evidence review identified 11 policies and interventions in four policy areas that are recommended for implementation in SE London:

- Regulating marketing
 1. Advertising bans: prohibiting alcohol advertising on council-owned spaces and infrastructure
- Regulating availability
 2. Density of alcohol outlets: through Statements of Licensing Policy and Cumulative Impact Policies
 3. Hours and days of sale: through Statements of Licensing Policy, Late Night Levies, Early Morning Restriction Orders
- Managing the drinking environment
 4. Multicomponent community programmes: such as 'Drink Less Enjoy More' tested in NW England
 5. Replacing glassware with safer alternatives: as in good practice licensing guidance
 6. Voluntary removal of the sale of high strength alcohol: 'Reducing the Strength' initiatives which focus on alcohol with high strength and low costs.
 7. Policing and enforcement approaches: multi-agency Cardiff Model for violence prevention
- Brief interventions and treatment
 8. Identification and brief advice (IBA) in primary healthcare: follow NICE guidance to routinely carry out alcohol screening as an integral part of practice
 9. Electronic IBA: follow NICE guidance to use as an adjunct to existing services
 10. Psychosocial and psychological interventions: follow existing NICE guidance
 11. Pharmacological interventions: follow existing NICE guidance

Part 2: Modelling of the potential impact of minimum unit pricing for London

Alcohol pricing policies are among the most effective approaches to reduce alcohol consumption and harms. Minimum unit pricing (MUP) sets a 'floor price' below which a fixed volume of alcohol (e.g. a UK unit) cannot be sold. The first comprehensive MUP policies affecting all types of alcohol were introduced in 2018 in Scotland and Armenia. Here we present local authority-level models, developed by the Sheffield Addictions Research Group (SARG), to estimate the potential local impacts of introducing an MUP in London.

In London, three-quarters of adults (aged 18+) drink alcohol. From this, the majority drink at moderate levels (72.5%), almost a quarter drink (23.7%) at increasing risk levels and 3.9% drink at higher risk levels. Most alcohol consumed and money spent on alcohol comes from higher and increasing risk drinkers, with higher and increasing risk drinkers accounting for 74% of alcohol consumption in London and 70% of all money spent on alcohol.

Overall, 1,525 people die each year in London due to alcohol, and there are 77,499 alcohol-attributable hospital admissions, costing the NHS £342.2 million. Alcohol-attributable deaths fall disproportionately on heavier drinkers, with 60% of all alcohol-

attributable deaths and 38% of alcohol-attributable hospital admissions coming from the 3% adults drinking at higher risk levels.

Alcohol-attributable harm is also seen in the impact of alcohol use in crime figures. Each year there are over a third of a million alcohol-attributable criminal offences in London, costing society over £1.7 billion.

There is significant socioeconomic variation in drinking patterns, with people living in the most deprived areas more than twice as likely to abstain from alcohol compared to people living in the least deprived areas. Despite lower levels of alcohol consumption, 74% of alcohol-attributable deaths and 60% of hospital admissions come from the most deprived 40% of the population.

The results from the models presented in this report show that while introducing a 30p MUP would have minimal impact on alcohol consumption (-0.1%), an MUP of 50p would reduce alcohol consumption by 1.3%, and a 70p MUP would reduce alcohol consumption by 5.7%. Since MUP policy affects cheaper alcohol, these policies would have less impact on moderate drinkers and those in higher socioeconomic groups.

Overall, a 50p MUP is estimated to increase consumer spending by £12.10 per drinker per year or 23p per week, a 2.3% rise. This increases for higher MUP levels, heavier drinkers, and those in more deprived groups. A 50p MUP is estimated to lead to 33 fewer deaths per year, while a 70p MUP would reduce alcohol-attributable deaths by an estimated 149 each year. Reductions in deaths are heavily skewed towards heavier drinkers and those in more deprived groups, with 79% of the deaths averted from a 50p MUP coming from the most deprived 40% of the population and deaths estimated to fall by 0.3% among moderate drinkers compared to 2.4% in higher risk drinkers under a 50p MUP.

Overall, introducing a 50p MUP is estimated to reduce annual hospital admissions due to alcohol in London by 1,764, a 2.3% fall. Patterns are similar to those for reductions in mortality, with larger reductions among heavier drinkers and the most deprived groups – a 50p MUP is estimated to lead to 26 fewer admissions per year in the least deprived socioeconomic groups, compared to 708 fewer admissions in the most deprived socioeconomic groups. These figures illustrate that the health benefits of MUP at all levels are greatest among heavier drinkers and those in the most deprived groups.

Regarding costs to society, a 50p MUP is estimated to reduce NHS costs by £4.1 million in the first year after implementation, and it is estimated to lead to 4,261 fewer offences per year, a 1.2% fall, with a societal value of £23 million.

These results illustrate that introducing a minimum unit price for alcohol would reduce alcohol consumption, improve population health, and reduce crime in London, saving the NHS and public services millions of pounds. They also show that the policy would have the largest impact on heavier drinkers and those in the most deprived groups in society, leading to a reduction in health inequalities. These findings are consistent with evidence from the evaluation of MUP in Scotland²⁵,

which has demonstrated that the policy has reduced alcohol consumption and alcohol-related harm, with the greatest reductions in the most deprived groups⁴. However, there are some important factors that should be considered when interpreting these results. The first of these is that London has the lowest estimated reduction in consumption, alcohol-attributable deaths, and hospital admissions of any region in England following an introduction of a 50p MUP. This is due to a combination of several factors, including higher rates of non-drinking in London, lower rates of alcohol-attributable mortality, and higher prices of alcohol on average than most other parts of the country, among other factors. The second key factor is that the results presented here reflect alcohol prices in 2018 and do not account for inflation since that date. MUP thresholds modelled would have to be increased in line with this inflation in order to achieve the estimated impacts presented in this report. As such, an MUP of 62.1p would be required to achieve the same estimated impact as the 50p MUP results presented in this report, if it were introduced today. Finally, as the results presented here reflect data from 2018 or earlier, when considering their relevance for the present day it is also important to consider the impact of the subsequent COVID-19 pandemic on alcohol consumption and harm.

Part 3: Resources to support implementation of local interventions to reduce alcohol harm in SE London

This report provides an overview of available resources to support with the implementation of local interventions identified in part 1. It is accompanied by a PowerPoint presentation that can act as a toolkit to help build support for action on alcohol harm.

PART 1: POLICY AND EVIDENCE REVIEW

Sadie Boniface,^{1,2} Kat Petrilli,^{1,3} Colin Angus,⁴ Katherine Severi¹

¹Institute of Alcohol Studies

²Addictions Department, Institute of Psychiatry, Psychology & Neuroscience, King's College London

³Addiction and Mental Health Group, University of Bath

⁴Sheffield Addictions Research Group, University of Sheffield

1A) Situational analysis: cost of alcohol harm in South East London

Introduction

South East London has a population of 1.8 million people (1). The proportion of people drinking at increasing or higher risk levels (>14 units a week) in South East London varies and is above the national average in all but one borough¹ (2). Nationwide, social inequalities in alcohol harm are stark. For example, rates of alcohol-specific deaths are twice as high in the most deprived areas of England and potential years of life lost are 2-3 times greater compared with the least deprived areas (3). Inequalities in alcohol harm have widened in the wake of the COVID-19 pandemic, with increases in alcohol specific deaths concentrated in the most deprived 20% of areas (4). Four of the boroughs in South East London ICS (Greenwich, Lambeth, Lewisham and Southwark) are ranked among the 15% most deprived local authority areas in the country (1).

The health, societal and economic impacts of alcohol use are wide-ranging, and alcohol harm places significant financial strain on the UK. Government estimates on the cost of alcohol harm have been criticised for being outdated (5) and breakdowns of the cost of alcohol harm at local authority or regional levels have rarely been available. IAS has produced updated cost profiles for all local authorities in England using the latest available data.

Approach

The cost profiles follow similar methods to those previously used by the Cabinet Office Strategy Unit Report (2003), which surveyed the evidence on the costs of alcohol to society. The profiles cover: healthcare, crime, social services, and workplace and economy costs for 2021-22. Numbers of higher risk drinkers were calculated using population figures from the Office for National Statistics Mid-2021 Population Estimates for England and Wales (6) in conjunction with the Health Survey for England regional estimated weekly alcohol consumption (7). Therefore, the final cost figures may not always accurately reflect local circumstances. Full alcohol cost profile methodology is presented in Appendix 1.

¹ England average 22.8%. Bexley 23.7%, Bromley 26.8%, Greenwich 17.5%, Lambeth 32.2%, Lewisham 28.7%, Southwark 31.2% (note - these are most recent data available from LAPE, but are from 2015-18)

Healthcare costs comprise the following: alcohol-related hospital admissions, outpatient visits, A&E attendances, ambulance journeys, healthcare professional appointments, alcohol dependency drugs, specialist treatment for alcohol and other alcohol-related healthcare. Costs of alcohol-related hospital admissions were taken directly from the Local Alcohol Profiles for England (8) and other healthcare costs were calculated using data supplied by NHS England.

Crime costs were calculated using Home Office crime figures (9). Total crime and cost data, including reported and unreported crime, were calculated following Home Office estimates (10). Total-alcohol related crimes were obtained following alcohol-related proportions per offence, as reported by the Department of Health (11).

The workplace and economy costs were estimated using data supplied by the Annual Survey of Hours and Earnings (12). These costs are broken down into: presenteeism (present at work but showing reduced productivity), absenteeism (not at work due to illness) and unemployment.

The social services costs were estimated using data supplied by the Department for Levelling Up, Housing and Communities and Ministry of Housing, Communities & Local Government (13). Costs are broken down into children's social services, children and young people's substance misuse services, and adult social services for alcohol misuse.

The national costs of alcohol harm in England are estimated to be £27.44bn per year. Across the population, the average cost per head of alcohol harm is £485 per year. These costs are broken down into the following categories:

- **£4.91 billion** cost to the NHS and healthcare in England – such as hospital admissions and ambulance call-outs.
- **£14.58 billion** cost to the criminal justice system, police, and wider crime and disorder.
- **£5.06 billion** cost to the wider economy due to lost productivity – such as people missing work or being less productive at work.
- **£2.89 billion** cost to social services.

The local authority cost profiles highlight the magnitude of alcohol harm in the South East London population. The cost to healthcare, other public services and the economy will provide a backdrop to the policy context and recommendations. These profiles are designed to support strategic planning and develop local understanding about the potential impact of alcohol on the local economy.

Cost of alcohol harm in SE London

Based on the above approach, the cost of alcohol harm to SE London in 2021-22 is estimated at £902,502,698. This is equivalent to £504 per head of population.

Crime accounts for the largest proportion of the costs, followed by the workplace and economy costs (Figure 1).

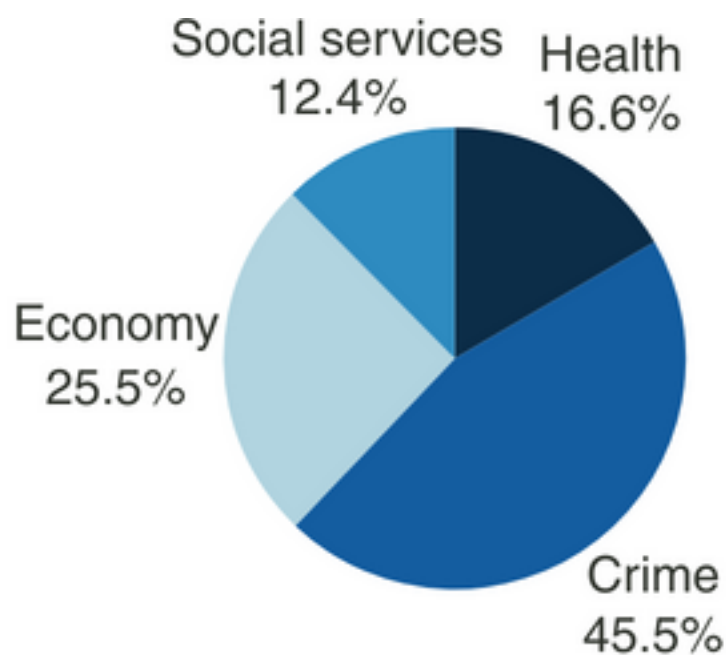


Figure 1: SE London cost of alcohol harm breakdown (based on a total of £902.5m)

A breakdown of the cost of alcohol harm in each SE London borough is presented in Table 1, with more detailed breakdowns of the costs presented as infographics in Appendix 2.

Table 1: Cost of alcohol harm breakdown by SE London borough

Borough	Health	Crime	Economy	Social care	Total
Bexley	£21,618,066	£40,723,779	£27,383,978	£9,579,595	£99,305,418
Bromley	£28,656,988	£64,170,647	£41,269,079	£15,098,760	£149,195,474
Greenwich	£23,420,696	£79,861,231	£35,475,172	£17,584,290	£156,341,390
Lambeth	£27,749,892	£85,766,073	£48,180,331	£24,904,020	£186,600,316
Lewisham	£24,745,144	£68,012,798	£37,019,106	£18,665,295	£148,442,343
Southwark	£26,953,030	£72,147,244	£41,166,503	£25,636,930	£165,903,706
SE London	£149,864,866	£410,681,772	£230,494,170	£111,468,890	£902,509,698

1B) Policies and interventions - evidence review

Introduction and objective

In the absence of a national alcohol strategy in the UK, a range of policies and interventions could be considered at a local level to address alcohol harm, health inequalities, and the costs to public services and wider society.

Affordability, availability and acceptability are recognised as the three main influences on alcohol use (14), and policies across these areas are named by the World Health Organization as 'best buys' for non-communicable disease prevention (15).

The objective of this evidence review was to identify a range of alcohol and licensing policy and practice interventions that may reduce alcohol harms at a population level - particularly in the context of diverse and deprived communities.

Approach

Review question: *What is the population health impact of alcohol and licensing policy and practice interventions, and is there evidence in the context of diverse and deprived communities?*

An evidence review was conducted for a wide range of alcohol harm policies and interventions. The Public Health England (PHE) evidence review was used as a framework for the relevant policies and interventions, and to provide an initial high-level summary of the evidence base for each policy area. This was supplemented with other key resources for high-level evidence summaries (e.g. Alcohol: No Ordinary Commodity 3rd edition, World Health Organization (WHO) 'Best Buys' for non-communicable disease prevention).

To provide a current UK perspective, guidance and recommendations from key national bodies (e.g. National Institute for Health and Care Excellence, Association of Directors of Public Health, Government departments) were also summarised. To identify UK evidence, examples and evidence of implementation on sub-national levels, and evidence in the context of diverse and deprived communities, we hand-searched reference lists of the above key resources, consulted our professional network, searched our own files, and searched academic and grey literature.

Based on the evidence of effectiveness, whether there are examples relevant to the UK context and diverse and deprived communities, and the feasibility of implementation at a sub-national level or potential for ICB advocacy at a national level, a red-amber-green (RAG) rating was used to differentiate the potential for each policy area.

Findings

The evidence review is summarised in Table 2.

Taxation and price regulation

The relationship between alcohol prices and harm is well-established and increasing alcohol taxation is one of the WHO 'best buys' (15). Alcohol taxation and minimum pricing are both well-studied policies, with a strong UK and international evidence base, including evidence of narrowing health inequalities. Although they are sometimes discussed as competing pricing policy options, alcohol taxation and minimum unit pricing can be combined and implemented together (16,17).

The key difference between MUP and taxation is that an increase in taxation affects the price of all alcoholic products, whereas the introduction of an MUP affects only the prices of the cheapest products, sold below the MUP level. As the cheapest alcohol is typically bought by heavier drinkers, particularly heavier drinkers from more deprived groups, MUP therefore effectively targets these groups, who suffer the majority of alcohol-attributable harms (18). This is borne out by the evaluation of MUP's impact on health outcomes in Scotland, which found that the policy was associated with an estimated 13.2% reduction in alcohol-specific deaths, with the greatest falls in the most deprived groups (19).

Minimum pricing sets a floor price for alcoholic products (such as for a bottle of vodka), and minimum *unit* pricing is a special type of minimum pricing which sets a floor price for a fixed volume of alcohol (e.g. for a UK unit of alcohol) (17), and is in place in Scotland and Wales (17). The 2014 UK ban on selling alcohol at below the cost of alcohol duty plus value added tax (VAT) is analogous to introducing a minimum price but at a very low level, and therefore this policy had little impact (20). Neither taxation changes nor minimum unit pricing have been implemented at sub-national/regional/local levels in the UK, but the potential health gains from implementation are significant (see Part 2). Local advocacy can play an important role in building support and momentum for policy action at the national level, particularly for example around introducing minimum unit pricing in England, and uprating alcohol duties at annual Budgets.

Existing UK bans and restrictions on price promotions provide limited and mixed evidence of effectiveness, for example the 2011 multi-buy ban in Scotland (21). Current examples from England in Home Office Guidance, however, relate only to on-trade alcohol sales (22), and it is unclear how well this guidance is followed. There are transferable examples outside of alcohol, with restrictions applying to volume price promotions and free refills for high fat, salt and sugar (HFSS) foods from October 2025 (23). However alcohol is not included in these restrictions.

Further details on the estimated impact of minimum unit pricing in London is provided in part 2.

Regulating marketing

There is international evidence regarding advertising bans (16,20), and bans or comprehensive restrictions across multiple types of media are one of the WHO 'best buys' (15). However there have been few comprehensive evaluations in Europe, and these have not proven effectiveness (24). There is strong evidence that alcohol

advertising exposure is associated with younger initiation of drinking and heavier alcohol use among adolescents (25), mirroring the earlier case with tobacco (26).

There have not been blanket alcohol advertising bans in the UK through national legislation. Alcohol marketing has been subject to self-regulation through complaints-led systems run by the alcohol and advertising industries (Portman Group and Advertising Standards Authority, respectively) and some co-regulation with the Office for Communications (Ofcom). There is no evidence that self-regulation is effective (16,20), and recent examples of rulings illustrate flaws of the current approach – for example, a ruling that a cartoon bird on packaging did not appeal to children because it had an ‘unfriendly’ facial expression (27).

In terms of currently available local policy and intervention options, existing opportunities to regulate alcohol - and other unhealthy commodity - advertising on local authority-owned spaces and infrastructure have been introduced in only one third of Local Authorities (LAs) in England, but may be underutilised nationally (28).

Actions to reduce children’s exposure to alcohol marketing - such as advertising watersheds – hold promise but have not been implemented in the UK. There are related actions and evidence from other unhealthy commodities, however. A HFSS 9pm advertising watershed will be implemented from 2025 (29), and there is evidence that Transport for London’s HFSS advertising ban has had health gains and narrowed inequalities (30). Similarly to the HFSS price promotion restrictions mentioned above, alcohol is not included in these policies.

While the impact of alcohol marketing on children has been well-studied, there are other important vulnerable groups, such as heavier drinkers, people in recovery, women (31) and LGBTQ+ populations (32). Such groups are only recently becoming recognised in research and policy discussions on alcohol marketing regulation (33).

Regulating availability

Alcohol availability is primarily regulated through the alcohol licensing system.

There is good international evidence on alcohol outlet density policies and some alcohol harm outcomes (16,20). In the UK, observational research shows that alcohol outlet density is higher in more deprived areas (Scotland) (34,35) and that deprivation amplifies the impact of alcohol availability on violence (England) (36).

In the UK, alcohol outlet density is addressed through Statements of Licensing Policy and Cumulative Impact Policies (which are set out in Statements of Licensing Policy), for which there is mixed evidence for crime and health outcomes (see Table 2). There is also ongoing national advocacy for public health to be added as a fifth licensing objective in England and Wales (37), as it is in Scotland.

Local policy and intervention options on alcohol outlet density include promoting local authority Public Health teams to make representations as Responsible Authorities at licensing committee meetings, encouraging members of the public to make representations as Interested Parties, taking wellbeing approaches in Statements of Licensing Policy, and using Cumulative Impact Zones to focus on off-

trade availability rather than only on the night-time economy. These approaches can be applied in contexts of diverse and deprived communities.

Whilst there are relatively few studies which have quantitatively assessed the impact of licensing policy on harms, the majority of this evidence relates to Cumulative Impact Zones (CIZs), which seek to restrict further increases in the availability of alcohol in areas where availability is already high. One study found that the introduction of a new CIZ was associated with a short-term fall in the rate at which new licenses were granted, but that this was not sustained (38). A further pair of studies found that areas that had greater intensity of licensing activity, measured through both the implementation of CIZs and successful challenges to new licenses, saw 5% greater reductions in alcohol-related hospital admissions (39) and alcohol-related crimes (40) than areas with neither of these licensing approaches in place. All boroughs in South East London were classified as 'high' intensity in these studies on the basis of licensing activity between 2009 and 2015. The evidence that this association between CIZs and actively challenging license applications is causal was further strengthened by a study that looked at 5 local authorities, including Southwark, which actively increased their licensing activity between 2007/8 and 2011/12 (41). This study found evidence of a 6.3% fall in alcohol-related hospital admissions and a 4.6% reduction in violent crimes in these areas following the increase in licensing activity.

More recently, a 2020 study looked at the localised impact of specific licensing interventions, such as the closure of a specific premises following licensing reviews or the implementation of new local licensing guidance (42), finding some evidence to support that these interventions had had a positive impact on health and crime in the immediate area. Finally, a large study, Exilens, looked at the impact of local authority public health teams engaging in the alcohol licensing process (43). The quantitative component of this study did not find any evidence that increased public health team engagement with the licensing process led to reductions in alcohol-related harms (44), however qualitative findings from the study suggested that this engagement may still play an important role in shaping the licensing system to better address public health harms.

Regarding hours and days of sale, again there is good international evidence (16,20) and reduced hours of sale is a WHO 'best buy' (15). Notably, Australia has more developed temporal availability policy than in the UK. In two Australian states (Australia has a federated system), 'last drinks' policies – which restrict sales after a specified time – have led to reductions in assaults and alcohol-related serious injury presentations at emergency departments (45).

In the UK, hours and days of sale can be addressed through Statements of Licensing Policy, Late Night Levies, and Early Morning Restriction Orders (see Table 2). These policies may have potential, but are underutilised and have not been thoroughly evaluated.

Finally, UK policy action to increase availability of lower alcohol drinks as part of the 2011 Public Health Responsibility Deal did not have health benefits. The population health impacts of no and low alcohol drinks is being researched, but there is currently no evidence that they are reducing harm on a population level. They are a

very small share of the market, and are consumed predominantly by more socially-advantaged groups (46), so the potential for an impact on inequalities currently appears limited.

Providing information and education

In general, many policies and interventions that provide information and education do not have a strong evidence base for reducing alcohol use and harm, although there is potential for such interventions to focus on groups experiencing the most harm. There are examples where UK opportunities for action and evaluation in this area have been missed: for example, had there been a mass media campaign to accompany the 2016 update to drinking guidelines (47), this could have raised awareness. On a local level, there are examples of high-quality hard-hitting campaigns – for example Balance North East’s 2023 ‘Alcohol is Toxic’ campaign (48) – however academic evaluations are absent.

One area where the evidence is stronger is around alcohol labelling. This can include ingredient and nutritional information, drinking guidelines, and health warnings. There is international evidence that labels increase knowledge and awareness (16,20), as well as UK work finding that a significant minority of products do not display low-risk drinking guidelines (49). Ongoing policy debates on improving alcohol labelling can be contributed to by joining national advocacy efforts.

Managing the drinking environment

Multicomponent community programmes have an international evidence base for effectiveness in reducing alcohol harms (16,20). UK examples have also proven effective (50–52), and while such programmes are relatively resource-intensive, there is potential for implementation in diverse and deprived communities and to narrow inequalities.

Server training is ‘based on solid principle’ (20) and while impacts on alcohol harm are likely to be modest, it is good practice for licensed premises to adequately train their staff around responsibilities as well as legislation (for example the fact it is an offence under the Licensing Act 2003 if someone “sells or attempts to sell alcohol to a person who is drunk” (53)). Making servers liable for harm caused by their customers has some evidence, but also carries practical problems (20).

Interventions to replace glassware with safer alternatives is already recommended in good practice licensing guidance (54). Additionally regarding glassware, there is an international evidence base on glass size and shape and alcohol consumption, speed of alcohol consumption, and alcohol sales, including experimental studies in the UK (55).

Voluntary removal of the sale of high strength alcohol (typically strong beers and ciders) has been introduced as part of ‘Reducing the Strength’ interventions in the UK, including in parts of London. Guidance already exists on how to implement these interventions (56,57), and they can be implemented in diverse and deprived areas, however the alcohol consumption and health outcomes have not yet been well-evaluated.

Policing and enforcement approaches have an international and UK evidence base, although they typically focus on acute harms and violence and the impact on inequalities has not been well-studied.

There is limited evidence of effectiveness of public drinking bans in specified areas, and these are also problematic in context of diverse and deprived communities.

Preventing drink-driving

There is a range of existing policies and interventions to reduce drink-driving, including: blood alcohol concentration (BAC) limits, breath testing, graduated driver licensing, immediate licence revocation, alcohol interlock devices, preventive education programmes targeting drink-driving offenders, designated driver programmes, and media campaigns. In many of these areas, scope for local action is limited, with the exception of media campaigns, which can also be targeted at population groups. In terms of proportionality, car ownership is notably below the national average in South East London (57% in SE London ICB region vs. 77% in England and Wales) (58).

Brief interventions and treatment

The most well-studied setting for identification and brief advice (IBA) is primary care, where in the UK, clinical guidance already exists (59,60) and there is also evidence for beneficial impacts on inequalities (31,61).

In addition to face-to-face interventions, electronic IBA is also recommended as an adjunct to existing services (62).

Alcohol use disorders are highly prevalent in some marginalised groups, such as among people in contact with the criminal justice system (63). However, IBA in other populations such as adolescents, and other settings, such as emergency departments and criminal justice settings, sexual health clinics, pharmacies and workplaces has a more variable evidence base, and the impact on inequalities has not been well-studied (see Table 2).

National guidance already exists for IBA in hospital inpatients through the 'commissioning for quality and innovation' (CQUIN) schemes (64). Beyond IBA, there is emerging evidence for other interventions for hospital patients. These include ongoing research on alcohol care teams in acute hospitals (65), and an evaluation of assertive outreach for frequent hospital attenders (66), including in London.

Regarding alcohol treatment, psychosocial, psychological and pharmacological interventions are already recommended in clinical guidance (67). Disinvestment in alcohol treatment from 2013-14 onwards has been linked to reductions in access and completion of treatment (68), and the Association of Directors of Public Health now says investment and long-term funding is needed to reverse the impact of these cuts (37).

Table 2: Alcohol policy areas, evidence summaries, local implementation opportunities and inequalities considerations

Key to RAG rating: red = evidence lacking or weak, amber = promising UK evidence of effectiveness but evidence may be lacking for impact in diverse and deprived communities, green = strong UK evidence and potential for beneficial impact in diverse and deprived communities

Policy area*	High level summary of evidence base	Is there UK evidence and/or guidance?	Are there examples of sub-national implementation?	Is there evidence in the context of diverse and deprived communities?	RAG rating and potential for implementation
Taxation and price regulation					
Taxation	<p>Increasing tax is a highly effective and cost-effective approach to health improvement (20)</p> <p>Supported by Alcohol: No Ordinary Commodity 3 (ANOC3) consensus ratings (69)</p> <p>Recognised by WHO as a 'best buy' (15)</p>	<p>Cuts and freezes to alcohol duty from 2012-19 led to an estimated 2,000 deaths and 61,000 hospitalisations in England, costing the NHS £317m (70)</p> <p>The Association of Directors of Public Health (ADPH) and the Alcohol Health Alliance UK recommend that the duty escalator is reintroduced at 2% above inflation (37,71)</p>	No	<p>Some indication that people on low incomes are affected to a greater extent, but the same pattern was not observed for education or occupational grade. Small amount of unclear evidence regarding ethnic minorities (72)</p> <p>Cuts and freezes to UK alcohol duties have led to the largest increases in drinking in the most deprived groups, widening</p>	Requires national implementation

Policy area*	High level summary of evidence base	Is there UK evidence and/or guidance?	Are there examples of sub-national implementation?	Is there evidence in the context of diverse and deprived communities?	RAG rating and potential for implementation
				health inequalities (70)	
Minimum pricing	<p>Minimum prices effectively reduce health and other harms, is targeted at the heaviest drinkers who experience the greatest harm, and is cost-effective (20)</p> <p>Supported by ANOC3 consensus ratings (69)</p>	<p>50p minimum unit pricing introduced in Scotland in 2018 has led to a 13.4% reduction in deaths from alcohol, a 4.1% reduction in hospital admissions, and a 3% reduction in alcohol sales (73)</p> <p>Modelling studies exist for a range of minimum price levels for England (74)</p> <p>The ADPH recommends all UK nations have a minimum price of 65p per unit (37)</p>	<p>No – closest real-world examples would be state level implementation in Australia (Northern Territory) and province level in Canada – both federal systems</p> <p>However modelling has been done for local authorities in North East and North West England (75)</p>	<p>Greater reduction in health inequalities than taxation alone (73)</p> <p>One review concluded the effect is bigger for lower income groups, but that the same pattern was not seen by deprivation or occupational grade. No evidence regarding ethnic minorities (72)</p> <p>In Scotland, the largest reductions in deaths and hospital admissions was observed for those living in the 40% most deprived areas (73)</p>	Requires national implementation, or change to legislation to enable implementation at regional level
The relative and combined impact of taxation and	Combined taxation plus MUP increases impact and improves cost-effectiveness compared with MUP alone (20)	No	N/A	Greater reduction in health inequalities than taxation alone, but lower than the	Requires national implementation

Policy area*	High level summary of evidence base	Is there UK evidence and/or guidance?	Are there examples of sub-national implementation?	Is there evidence in the context of diverse and deprived communities?	RAG rating and potential for implementation
other pricing policies				reduction achieved with a MUP (20)	
Banning the sales of alcohol below the cost of taxation (duty plus VAT)	The ban on selling alcohol below the cost of taxation had minimal impact (20)	X	X	X	Requires national implementation
Bans or restrictions on price promotions	Restrictions on price promotions may reduce consumption, but more evidence is needed (20)	2011 Scottish ban on multi-buy promotions, evaluations have had mixed findings , but possible reductions in purchasing of wine and pre-mixed beverages (21) Home Office has Guidance on Mandatory Licensing Conditions relating to 'irresponsible promotions' by all on-licensed premises, which cover: drinking games, provision of alcohol free or for a fixed or discounted fee, rewards for consumption of alcohol, promotional	No	No	Regional implementation possible, and scope also exists for national action

Policy area*	High level summary of evidence base	Is there UK evidence and/or guidance?	Are there examples of sub-national implementation?	Is there evidence in the context of diverse and deprived communities?	RAG rating and potential for implementation
		<p>posters, and dispensing alcohol directly into the mouth (22)</p> <p>In England, volume price promotions and free refills for a high fat, salt and sugar (HFSS) foods will be restricted from 1 October 2025 under The Food (Promotion and Placement) (England) Regulations 2021 (23), but alcohol is not included in the restrictions</p>			
Regulating marketing					
Advertising bans	<p>Complete advertising bans are a highly effective and cost-effective approach to health improvement (20)</p> <p>Supported by ANOC3 consensus ratings (69)</p>	No	Bristol City Council introduced a new policy in 2021/2022 which prohibited advertising of HFSS foods, alcohol, gambling and payday loans across council-owned advertising spaces (76)	No	Regional implementation possible, and scope also exists for national action

Policy area*	High level summary of evidence base	Is there UK evidence and/or guidance?	Are there examples of sub-national implementation?	Is there evidence in the context of diverse and deprived communities?	RAG rating and potential for implementation
	<p>Recognised by WHO as a 'best buy' (15)</p> <p>However there have been few comprehensive evaluations in Europe, and these have not proven effectiveness (24)</p>		<p>Sheffield City Council introduced a new Advertising and Sponsorship Policy in 2024 which prohibits products and brands linked to adverse outcomes for climate change, health and wellbeing from being advertised or promoted on council owned billboards or via council communications channels and sponsorship agreements. Restricted products and brands include airlines, airports, fossil-fuelled cars, fossil fuel companies, gambling, alcohol, vaping and unhealthy food (77).</p> <p>Regarding unhealthy commodities generally (alcohol, tobacco, gambling, unhealthy foods), only a third of local authorities in</p>		

Policy area*	High level summary of evidence base	Is there UK evidence and/or guidance?	Are there examples of sub-national implementation?	Is there evidence in the context of diverse and deprived communities?	RAG rating and potential for implementation
			England have a policy relating to alcohol advertising and sponsorship on local authority-owned spaces/infrastructure (29)		
Industry self-regulation of alcohol marketing	Industry self-regulation is unlikely to be effective. Little evidence of beneficial effect (20) Supported by ANOC3 consensus ratings (69)	No – in contrast, ADPH recommends an independent body should be established to regulate alcohol promotion (37)	X	X	Requires national implementation
Specific actions to protect children from exposure to alcohol marketing	Reducing child exposure to alcohol marketing would theoretically impact alcohol consumption by children (20)	Not for alcohol, but for HFSS foods - a 9pm advertising watershed is expected, but implementation is delayed to 2025 (29) The ADPH recommends a ban on cinema, outdoor and bus advertising; a TV watershed; restricting online exposure and alcohol sponsorship; and bringing alcohol in line with advertising	Not for alcohol, but for HFSS foods – Transport for London’s (TfL) 2019 advertising ban was designed to reduce childhood obesity, and has been linked to lower purchases of unhealthy foods (78) and health and economic gains (30)	Not for alcohol, but TfL’s HFSS advertising ban is expected to have reduced health inequalities in London (30)	Regional implementation possible, and scope also exists for national action

Policy area*	High level summary of evidence base	Is there UK evidence and/or guidance?	Are there examples of sub-national implementation?	Is there evidence in the context of diverse and deprived communities?	RAG rating and potential for implementation
		restrictions HFSS foods (37)			
Regulating availability					
Density of alcohol outlets	<p>Reducing the density of alcohol outlets may reduce social disorder and road traffic crashes (20)</p> <p>Supported by ANOC3 consensus ratings (69)</p>	<p>Statements of Licensing Policy – must be published every five years by local authorities (England, Wales, Scotland) to say how they intend to implement the Licensing Act. They cover spatial and temporal availability, and should be taken into account in every licensing decision. There are no evaluations of their impact on licensing decisions over time (45), but evidence from England that more intense alcohol licensing policies are associated with reduced crime and</p>	<p>Some Statements of Licensing Policy have taken a wellbeing approach, e.g. in Newcastle-upon-Tyne (45)</p> <p>Cumulative Impact Policies – in Southwark, SE London, the Cumulative Impact Zones had no effect on the proportion of licence applications receiving objections (82). However in these zones, there were greater increases in numbers of eateries and takeaways (83), in line with other evidence that in practice these policies are used to alter environments more broadly than capping numbers of licensed premises (45). In</p>	<p>Can be implemented in areas with greater deprivation (20)</p>	<p>Regional implementation possible, and scope also exists for national action</p>

Policy area*	High level summary of evidence base	Is there UK evidence and/or guidance?	Are there examples of sub-national implementation?	Is there evidence in the context of diverse and deprived communities?	RAG rating and potential for implementation
		<p>hospital admissions (39,40)</p> <p>Cumulative Impact Policies (England and Wales) – these are set out in Statements of Licensing Policy, and are specific areas/zones where the combined impact of licensed premises presents a concern. Local government has powers to influence licensing application decisions. The Scottish equivalent is an ‘overprovision’ policy (45). A systematic review of UK interventions (mainly Cumulative Impact Zones) did not identify clear evidence for health or crime outcomes (79)</p> <p>Public Health England and Public Health</p>	<p>Islington, N London, Cumulative Impact Zones had a moderate reduction in crime, but no impact on ambulance callouts or alcohol sales (84)</p> <p>Most examples of Cumulative Impact Zones have concerned the night-time economy. However, in a proposed Cumulative Impact Zone in the Wirral, where health and deprivation data were provided as supporting evidence, more than half of licensed premises were off-licenses (85) and the number of off-licenses was cited as a problem in the licensing committee meeting (86)</p> <p>Cheshire and Merseyside developed guidance for members of the public who wish to gather evidence and make</p>		

Policy area*	High level summary of evidence base	Is there UK evidence and/or guidance?	Are there examples of sub-national implementation?	Is there evidence in the context of diverse and deprived communities?	RAG rating and potential for implementation
		<p>Wales have guidance for local public health teams to use their role as a Responsible Authority to make Representations (80,81)</p> <p>ADPH recommends England and Wales introduce a public health licensing objective, and that local public health authorities are supported with adequate resources and licensing powers (37). Public health is a licensing objective in Scotland already, but there is no clear evidence of benefits for health and crime outcomes (44)</p>	Representations as 'Interested Parties' (87)		
Hours and days of sale	Reducing hours of sale may reduce alcohol-related harm (20)	Statements of Licensing Policy – covered above	Process evaluation of Late Night Levies in a London borough found some positives, but did not assess alcohol-	No evidence regarding impact on socio-economic inequalities or ethnic minorities (72)	Regional implementation possible, and scope also

Policy area*	High level summary of evidence base	Is there UK evidence and/or guidance?	Are there examples of sub-national implementation?	Is there evidence in the context of diverse and deprived communities?	RAG rating and potential for implementation
	<p>Supported by ANOC3 consensus ratings (69)</p> <p>Recognised by WHO as a 'best buy' (15)</p>	<p>'Late Night Levies' – an additional fee charged by local authorities to licensed premises open after midnight, through the Police Reform and Social Responsibility Act (2011) (45). Examples are at city level – see next cell</p> <p>Powers also exist under the same Act for 'Early Morning Restriction Orders', prohibiting the sale of alcohol in an area from 12-6am, however none had been introduced (as of 2020) (88)</p> <p>ADPH recommends England and Wales introduce a public health licensing objective, and that local public health authorities are supported with</p>	<p>related outcomes (89). Some limited in-house evaluation from Cheltenham and Newcastle councils also (in (45))</p>		<p>exists for national action</p>

Policy area*	High level summary of evidence base	Is there UK evidence and/or guidance?	Are there examples of sub-national implementation?	Is there evidence in the context of diverse and deprived communities?	RAG rating and potential for implementation
		adequate resources and licensing powers (37). Public health is a licensing objective in Scotland already, but there is no clear evidence of benefits for health and crime outcomes (44)			
The responsibility deal pledge to “remove 1 billion units of alcohol sold annually from the market by”... “improving consumer choice of lower alcohol products”	Public-private partnerships are not shown to bring about effective changes which benefit public health (20)	The evaluation of the 2011 ‘billion unit pledge’ was flawed (90), and the market share of no and low alcohol products remains small (46)	X	No and low alcoholic drinks are more likely to be drunk by people in higher occupational grades (46)	Requires national implementation
Providing information and education					
Mass media campaigns which aim to change	(Non-industry sponsored) campaigns increase knowledge and awareness, little direct	X	X	Can be directed at inequality groups (20)	Regional implementation possible, and scope also

Policy area*	High level summary of evidence base	Is there UK evidence and/or guidance?	Are there examples of sub-national implementation?	Is there evidence in the context of diverse and deprived communities?	RAG rating and potential for implementation
alcohol consumption	impact on behaviour, not cost-effective (20)				exists for national action
Social marketing approaches	No firm conclusions can be made (20)	X	X	Can be directed at inequality groups (20)	Regional implementation possible, and scope also exists for national action
Social norm approaches	No firm conclusions can be made (20)	X	X	Can be directed at inequality groups (20)	Regional implementation possible, and scope also exists for national action
Alcohol education programmes	Little (lasting) evidence of effectiveness or cost-effectiveness (20)	X	X	X	Regional implementation possible, and scope also exists for national action
Labelling of alcoholic beverages	Labels increase knowledge and awareness (20) Supported by ANOC3 consensus ratings (69)	ADPH recommends mandatory health labelling, including drinking guidelines, pregnancy warning, and calorie labels (37)	Only in experimental settings, or in jurisdictions in Canada (federal system) (91,92)	X	Requires national implementation
Managing the drinking environment					

Policy area*	High level summary of evidence base	Is there UK evidence and/or guidance?	Are there examples of sub-national implementation?	Is there evidence in the context of diverse and deprived communities?	RAG rating and potential for implementation
Multicomponent community programmes	<p>Small reductions in acute harms, cost-effective, cost-saving and can be scaled up (20)</p> <p>Supported by ANOC3 consensus ratings (69)</p>	Examples are at city/town level – see next cell	<p>Yes – ‘Drink Less Enjoy More’ programme in NW England. This programme aimed to increase awareness of existing legislation and support bar staff around selling alcohol to intoxicated people, and promote ‘responsible drinking’ in the night-time economy. The programme included community mobilisation and awareness-raising; responsible bar server training; and active law enforcement of existing legislation, and achieved a reduction in alcohol sales to intoxicated people (50–52)</p> <p>A 2007 review also identified four examples in UK towns and cities (93)</p>	Can be implemented in areas with greater deprivation (20)	Regional implementation possible, and scope also exists for national action
Server training	Impact is small and the research is characterised by self-reported measurements (20)	X	X	X	Regional implementation possible, and scope also

Policy area*	High level summary of evidence base	Is there UK evidence and/or guidance?	Are there examples of sub-national implementation?	Is there evidence in the context of diverse and deprived communities?	RAG rating and potential for implementation
	Supported by ANOC3 consensus ratings (69)				exists for national action
Server liability	Impacts are small and predominantly focus on acute harms (20) Supported by ANOC3 consensus ratings (69)	X	X	X	Regional implementation possible, and scope also exists for national action
Replacing glassware with safer alternatives	Replacing glassware with safer alternatives is based on sound principle and may reduce injuries (20)	Glass alternatives are included in good practice licensing guidance (54)	No	No	Regional implementation possible, and scope also exists for national action
Voluntary removal of the sale of high strength alcohol	Voluntary removals of high strength alcohol may reduce acute alcohol-related harm but easily undermined (20)	Examples of voluntary sales restrictions ('Reducing the Strength') are at city/regional level – see next cell Local Government Association and Association of Convenience Stores both published guidance on setting up	Evidence of high rates of voluntary compliance where trialled in London (95) and the Wirral (85) - but can be circumvented (96) - and an absence of evidence on health outcomes	Can be implemented in areas with greater deprivation (20)	Regional implementation possible, and scope also exists for national action

Policy area*	High level summary of evidence base	Is there UK evidence and/or guidance?	Are there examples of sub-national implementation?	Is there evidence in the context of diverse and deprived communities?	RAG rating and potential for implementation
		Reducing the Strength schemes (56,57) For HFSS foods, Tesco voluntarily removed volume-led promotions, ahead of legislation, and introduced 'Better Baskets' zones with healthier products (94)			
Policing and enforcement approaches	Resource intensive interventions with possible short term reductions in acute harm (20) Supported by ANOC3 consensus ratings (69)	Examples are at city level - see next cell	The Cardiff Model combines police and emergency department data to inform policing and other strategies for violence prevention (i.e. a multi-agency approach that includes the police), and has been found to be effective and cost-effective (97)	No	Regional implementation possible, and scope also exists for national action
Public drinking bans	Negatively impact marginalised groups, such as the homeless with little benefit (20) Supported by ANOC3 consensus ratings (69)	Home Office guidance on Designated Public Place Orders (98)	In 2011 TfL introduced a drinking ban, but no evaluation has been completed	Can displace marginalised groups to new, less safe, areas (20)	Regional implementation possible, and scope also exists for national action

Policy area*	High level summary of evidence base	Is there UK evidence and/or guidance?	Are there examples of sub-national implementation?	Is there evidence in the context of diverse and deprived communities?	RAG rating and potential for implementation
Preventing drink-driving					
BAC limits	<p>Lowering the drink-driving limit would reduce road traffic crashes, casualties, and fatalities, by a small amount (20)</p> <p>Supported by ANOC3 consensus ratings (69)</p>	<p>The BAC limit was reduced from 80mg/100ml to 50mg/100ml in Scotland in 2014 – evaluations have found this has not had an effect on collisions, which may be because of lack of enforcement and that alternative modes of transport did not improve (99,100)</p>	No	No	Requires national implementation
Breath testing	<p>Breath testing drivers is an effective and cost-effective way of reducing drink-driving, road traffic crashes, casualties, and fatalities (20)</p> <p>Supported by ANOC3 consensus ratings (69)</p>	<p>Mandatory ('random') breath testing has been legal in Northern Ireland since 2016 but is not available to police in Great Britain, who can only do a breath test if they suspect the driver has been drinking, has been involved in an accident, or has committed a moving traffic offence (101)</p>	X	No	Requires national implementation

Policy area*	High level summary of evidence base	Is there UK evidence and/or guidance?	Are there examples of sub-national implementation?	Is there evidence in the context of diverse and deprived communities?	RAG rating and potential for implementation
Graduated driver licensing	<p>Effective in reducing road traffic crashes, casualties, and fatalities in novice drivers. Cost-effective but requires resources (20)</p> <p>Supported by ANOC3 consensus ratings (69)</p>	No	No	No	Requires national implementation
Immediate licence revocation	<p>Immediate licence revocation is effective in North America, transferability may be limited (20)</p> <p>Supported by ANOC3 consensus ratings (69)</p>	No	No	No	Requires national implementation
Alcohol ignition interlock devices	<p>Alcohol ignition interlock effectively reduce drink-driving reoffending whilst installed and can be cost-effective (20)</p> <p>Supported by ANOC3 consensus ratings (69)</p>	<p>Home Office trials 2006-08 had a high drop-out rate, frequent attempts to circumvent the interlock devices, and no reduction in alcohol use compared to control group (101)</p> <p>Devices are also used voluntarily and by freight and passenger</p>	<p>Interlocks were also trialled by Durham Constabulary in 2018, but this scheme did not apply to people convicted of drink-driving (101)</p>	No	Regional implementation possible, and scope also exists for national action

Policy area*	High level summary of evidence base	Is there UK evidence and/or guidance?	Are there examples of sub-national implementation?	Is there evidence in the context of diverse and deprived communities?	RAG rating and potential for implementation
		transport companies (101)			
Preventive education programmes targeting drink-driving offenders	Preventive education programmes may reduce reoffending (20) Supported by ANOC3 consensus ratings (69)	A 1999 evaluation of England and Wales drink-driving rehabilitation courses found reoffending was reduced (101) There is unmet need for specialist rehabilitation programmes for people with alcohol use disorder or mental health problems (101)	No	No	Regional implementation possible, and scope also exists for national action
Designated driver programmes	Firm conclusions cannot be made, on balance, may reduce the propensity to drink-drive or agree to be a passenger of a drink-driver (20) Supported by ANOC3 consensus ratings (69)	X	X	X	Regional implementation possible, and scope also exists for national action
Mass media campaigns to prevent drink-driving	Mass media campaigns are effective in reducing drink-driving and the	These campaigns take place in the UK but are not routinely evaluated (101). In the Isle of	Campaigns are run by police forces and align with National Police Chiefs' Council	Can be directed at inequality groups (20)	Regional implementation possible, and scope also

Policy area*	High level summary of evidence base	Is there UK evidence and/or guidance?	Are there examples of sub-national implementation?	Is there evidence in the context of diverse and deprived communities?	RAG rating and potential for implementation
	associated crashes, casualties, and fatalities	Man, alcohol hospital admissions have decreased and public awareness of their drink-driving campaign, drink-driving arrests, and night bus use have all increased (101)	campaigns in summer and Christmas (101)		exists for national action
Brief interventions and treatment					
Identification and brief advice (IBA) in primary health care	<p>IBA is effective in reducing hazardous and harmful consumption in primary health care, and is cost-effective (20)</p> <p>Supported by ANOC3 consensus ratings (69)</p>	<p>Recommended in NICE guidance (59,60)</p> <p>The ADPH recommends health and social care, criminal justice and education professionals are trained to provide early identification and brief alcohol advice (37)</p> <p>Screening and simple feedback is as effective as brief advice or lifestyle counselling (102)</p>	<p>N/A already nationally recommended by NICE</p> <p>Opportunities exist in South East London for stronger collaboration on service commissioning and development (103)</p>	<p>Those in the lowest socioeconomic groups are estimated to experience the greatest absolute reduction in harms (20)</p> <p>In England, a greater proportion of IBA in primary care is delivered to disadvantaged groups (61)</p>	Regional implementation possible and national clinical guidance already exists

Policy area*	High level summary of evidence base	Is there UK evidence and/or guidance?	Are there examples of sub-national implementation?	Is there evidence in the context of diverse and deprived communities?	RAG rating and potential for implementation
IBA in emergency departments	IBA is efficacious at reducing hazardous and harmful alcohol consumption (20)	<p>Screening and an information leaflet has a similar effect to brief advice or lifestyle counselling (104)</p> <p>The ADPH recommends health and social care, criminal justice and education professionals are trained to provide early identification and brief alcohol advice (37)</p>	Only in experimental context e.g. (104)	No	Regional implementation possible, and scope also exists for national action
IBA in criminal justice settings	Hazardous and harmful alcohol consumption reduced, offending reduced with most intensive interventions (20)	<p>Screening and an information leaflet has a similar effect to brief advice or lifestyle counselling in probation (63)</p> <p>The ADPH recommends health and social care, criminal justice and education professionals are trained to provide early</p>	Only in experimental context e.g. (63)	No	Regional implementation possible, and scope also exists for national action

Policy area*	High level summary of evidence base	Is there UK evidence and/or guidance?	Are there examples of sub-national implementation?	Is there evidence in the context of diverse and deprived communities?	RAG rating and potential for implementation
		identification and brief alcohol advice (37)			
eIBA	Short-term, reductions in hazardous and harmful consumption (20) Supported by ANOC3 consensus ratings (69)	Recommended in NICE guidance, as an adjunct to existing services (62)	N/A already nationally recommended by NICE Opportunities exist to collaborate on commissioning of eIBA in South East London	No	Regional implementation possible and national clinical guidance already exists
IBA in adolescents	Currently no clear evidence of benefit in this age group (20) Supported by ANOC3 consensus ratings (101)	X	X	X	Regional implementation possible, and scope also exists for national action
IBA in sexual health clinics	Evidence suggests sexual health clinics are not effective settings for IBA (20)	X	X	X	Regional implementation possible, and scope also exists for national action
IBA in pharmacies	Evidence suggests pharmacies are not effective settings for IBA (20)	X	X	X	Regional implementation possible, and scope also exists for national action
IBA in the workplace	Promising results; not clear which employee type may benefit most.	UK research on digital interventions in workplaces suggest	No	No	Regional implementation possible, and

Policy area*	High level summary of evidence base	Is there UK evidence and/or guidance?	Are there examples of sub-national implementation?	Is there evidence in the context of diverse and deprived communities?	RAG rating and potential for implementation
	Some employees may be unwilling to disclose information (20)	low rates of participation (105) and one trial had null findings (106)			scope also exists for national action
Psychosocial and psychological interventions	Behavioural couple's therapy, CBT, SBNT, MET, and behavioural interventions recommended by NICE as an effective therapy (20)	Recommended by NICE (67) The ADPH recommends public health authorities work with ICBs to use ICS budgets to properly fund alcohol treatment, and says investment and long-term funding are needed to reverse cuts (37)	N/A already nationally recommended by NICE Opportunities exist in South East London to collaborate on service commissioning and development	No	Regional implementation possible and national clinical guidance already exists
Pharmacological interventions	Recommended by NICE as an effective therapy (with an adjunct of psychosocial therapy) (20)	Yes, already recommended by NICE (67)	N/A already nationally recommended by NICE	No	Regional implementation possible and national clinical guidance already exists

*Categories of policy areas are based on the framework from the Public Health England evidence review (20).

X = not investigated further, based on limited support for this policy/intervention in the high-level summary

Based on the evidence review in Table 2, the policies and interventions with the strongest evidence base relevant to the UK and to diverse and deprived communities and that can also be implemented on a regional (or local, or otherwise sub-national) level are summarised in Figure 2.

The evidence review covered seven policy areas, based on those covered in the 2016 PHE evidence review, and the recommended interventions and policies cover four of the seven policy areas. Of the recommended interventions and policies that can be implemented regionally, these cover marketing (n=1), availability (n=2), managing the drinking environment (n=4), and brief interventions and treatment (n=4).

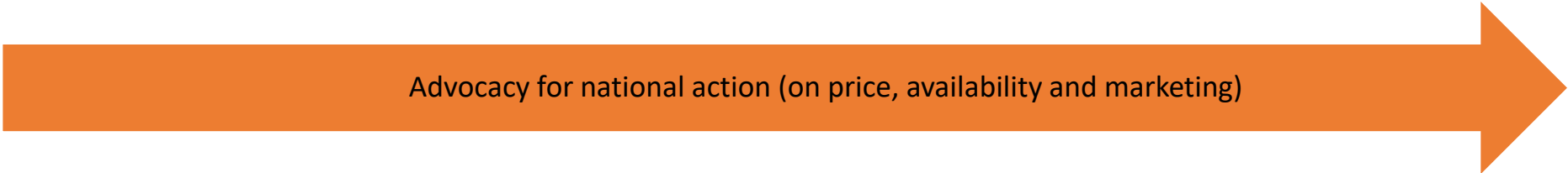
Opportunities to intervene in taxation and price regulation are lacking at a regional or local level, so even though the evidence is strong, currently opportunities beyond advocacy for national level action are limited. Regional minimum unit pricing has been explored by a consortium of local authorities in the North West of England previously, and it may be possible to make a proposal via the Sustainable Communities Act 2007 for the licensing mandatory conditions to be updated to mandate a minimum unit price.

The recommended interventions and policies also vary in scale and complexity. Some are focused interventions, such as replacing glassware with safer alternatives, which is a specific intervention set in the night-time economy with the aim of preventing violence. In contrast, other recommended policies have a broader range of possibilities for how they could be implemented and the potential impacts on alcohol harm. For example, advertising bans on council-owned spaces and infrastructure could refer to some or all alcoholic products, could further include no- and low alcohol alternatives, and could be part of wider unhealthy commodity advertising restrictions. Outcomes of these policy options include but are not limited to young people's drinking initiation, levels of alcohol use among adults, health indicators such as overweight and obesity, and impacts on the healthcare system.

Figure 2: Recommended alcohol interventions and policies for SE London

Regulating marketing	Regulating availability	Managing the drinking environment	Brief interventions and treatment
<p>1. Advertising bans: prohibiting alcohol advertising on council-owned spaces and infrastructure</p>	<p>2. Density of alcohol outlets: through Statements of Licensing Policy and Cumulative Impact Policies</p> <p>3. Hours and days of sale: through Statements of Licensing Policy, Late Night Levies, Early Morning Restriction Orders</p>	<p>4. Multicomponent community programmes: such as 'Drink Less Enjoy More' tested in NW England</p> <p>5. Replacing glassware with safer alternatives: as in good practice licensing guidance</p> <p>6. Voluntary removal of the sale of high strength alcohol: 'Reducing the Strength' initiatives</p> <p>7. Policing and enforcement approaches: multi-agency Cardiff Model for violence prevention</p>	<p>8. Identification and brief advice (IBA) in primary healthcare: follow NICE guidance to routinely carry out alcohol screening as an integral part of practice</p> <p>9. Electronic IBA: follow NICE guidance to use as an adjunct to existing services</p> <p>10. Psychosocial and psychological interventions: follow existing NICE guidance</p> <p>11. Pharmacological interventions: follow existing NICE guidance</p>

Advocacy for national action (on price, availability and marketing)



PART 2: MODELLING OF THE POTENTIAL IMPACT OF MINIMUM UNIT PRICING FOR LONDON

Introduction

As outlined in part 1, alcohol pricing policies are among the most effective approaches to reduce alcohol consumption and harms and feature as one of the World Health Organization's 'best buy' policies (15). Historically alcohol taxation has been the primary mechanism for increasing alcohol prices, however in recent years minimum unit pricing (MUP) has received increasing attention as a harm-reduction tool. An MUP sets a 'floor price' below which a fixed volume of alcohol (e.g. a UK unit) cannot be sold. The first comprehensive MUP policies affecting all types of alcohol were introduced in 2018 in Scotland and Armenia and they have subsequently been introduced in Wales, the Republic of Ireland and Australia's Northern Territory (17).

The Sheffield Addictions Research Group (SARG) is one of the leading alcohol policy research centres in the world, particularly in the field of modelling the potential impacts of policy changes. SARG modelling played a significant role in the policy processes that led to the implementation of MUP in Scotland (107), Wales (108) and Ireland (109). In 2018, SARG led a research project, funded by the National Institute for Health Research, which developed local authority-level models to estimate the potential local impacts of introducing an MUP in the North of England (75,110). This analysis estimated the impact of a range of MUP policies, ranging from 30p to 70p per unit, on alcohol consumption, alcohol-attributable hospital admissions and deaths, alcohol-related crime and health inequalities. As part of this project additional models were produced to estimate the impact of introducing an MUP at regional level, including for London, however these results have not previously been published. Here we present, for the first time, these estimates of the potential impact of an MUP for London alongside some discussion of how events since 2018 might influence their interpretation.

Methods

The analyses presented here are taken from the Sheffield Alcohol Policy Model (SAPM), an advanced policy appraisal tool that has been widely used to estimate the potential impacts of a range of policies from alcohol taxation(70,111), MUP (112), restrictions on price-based promotions (113) and delivery of Alcohol Brief Interventions (74) in the UK and internationally. SAPM is a hybrid econometric-epidemiological model that draws together a wide range of UK and international evidence on alcohol consumption, responses to alcohol policies, and associations between alcohol consumption and health. The modelling presented here is based on the local authority level version of SAPM developed in 2018 (SAPM-LA v4.0). See Brennan et al. for a full description of the model methods and data sources used (75).

Alcohol consumption data was taken from the Health Survey for England and adjusted to match the demographic characteristics and alcohol consumption patterns of London using a novel 'reweighting' approach (114). Data on alcohol purchasing and prices paid was taken from the Living Costs and Food Survey, calibrated to

match the distribution of prices paid and beverage preferences in London using market research data from Nielsen (for sales in shops) and CGA Strategy (for sales in pubs, bars, restaurants and nightclubs). The introduction of an MUP was modelled by assuming that all products sold below the MUP level would increase in price up to the MUP level, while the prices of products sold above this would remain unchanged, in line with evidence on actual price changes observed in Scotland following the introduction of MUP (115). Changes in prices paid for each individual were converted to changes in alcohol consumption using price elasticities estimated using UK data (116).

Data on mortality for 45 separate health conditions for which alcohol has been identified as a causal risk factor were obtained from the Office for National Statistics (ONS) for London, broken down by age (18-24, 25-34, 35-54, 55+), sex and quintile of the Index of Multiple Deprivation (IMD). Rates of hospital admissions for the same 45 health conditions by age, sex and IMD were calculated using Hospital Episode Statistics data and the 'broad measure' of admission as defined by the UK Health Security Agency (117). Annual NHS costs associated with each condition were taken from previously published estimates (118). Counts of recorded offences for a range of 14 alcohol-related crimes were obtained from ONS, apportioned by age and sex using evidence on the equivalent proportions of conviction rates (119) and adjusted for under-reporting of crime using Home Office estimates of unrecorded crimes, with estimates of the societal cost of each offence category taken from the same source (120). Associations between levels of alcohol consumption and risks of mortality or hospital admission were taken from a review of international epidemiological evidence (121), accounting for the fact that many chronic alcohol-related health conditions can take several years to develop (122), while associations between alcohol consumption and crime were based on data from the Offending Crime and Justice Survey (118).

For each modelled policy we present estimates of the impact on mean alcohol consumption, how these changes vary across drinker groups (moderate: those drinking within the UK Chief Medical Officers' low risk drinking guidelines of 14 units per week, increasing risk: those exceeding the guidelines, but drinking no more than 50 units per week for men or 35 units per week for women, and higher risk: those drinking more than 50 units per week for men or 35 units per week for women) and IMD quintiles as well as how consumption is estimated to change in both the on-trade (pubs, bars, restaurants and nightclubs) and off-trade (shops). We also present estimates of changes in spending on alcohol as well as changes in alcohol-attributable hospital admissions, deaths and NHS costs. In addition to modelling the impact of different MUP policies, our modelling approach also enables the estimation of the current (i.e. prior to the implantation of any policy) levels and patterns of alcohol consumption and harm in London and how this compares to the rest of England.

It is important to note that this work was undertaken in 2018, using data from before that date. Therefore, the results presented here reflect patterns in alcohol consumption and trends from almost a decade ago and, particularly, from before the COVID-19 pandemic. All prices and costs are presented in 2018 values, to align with the MUP thresholds modelled. The potential impacts of this are discussed later.

Results

Baseline patterns of drinking and alcohol-attributable harm in London

Estimates of the baseline patterns of alcohol consumption and spending in London are presented in Table 3. Three-quarters of adults (aged 18+) in London drink alcohol, with a mean annual consumption of 609 units, equivalent to 11.7 units per week and at an average annual cost of £528, or £10.12 per week. Just under three-quarters of drinkers in London (72.5%) drink at moderate levels of no more than 14 units per week. Almost a quarter of drinkers (23.7%) drink at increasing risk levels and 3.9% drink at higher risk levels. These higher risk drinkers consume an average of 3,964 units a year, equivalent to 1744 pints of beer, 440 bottles of wine or 151 bottles of vodka, spending an average of £2,810. There is also significant socioeconomic variation in drinking patterns, with people living in the most deprived 20% of areas more than twice as likely to abstain from alcohol than those living in the least deprived 20% of areas (32.6% vs. 15.7%). Drinkers in less deprived areas spend more on alcohol: £598 per year in the least deprived quintile compared to £504 in the most deprived and drink slightly more on average: 631 units per year compared to 608 units per year.

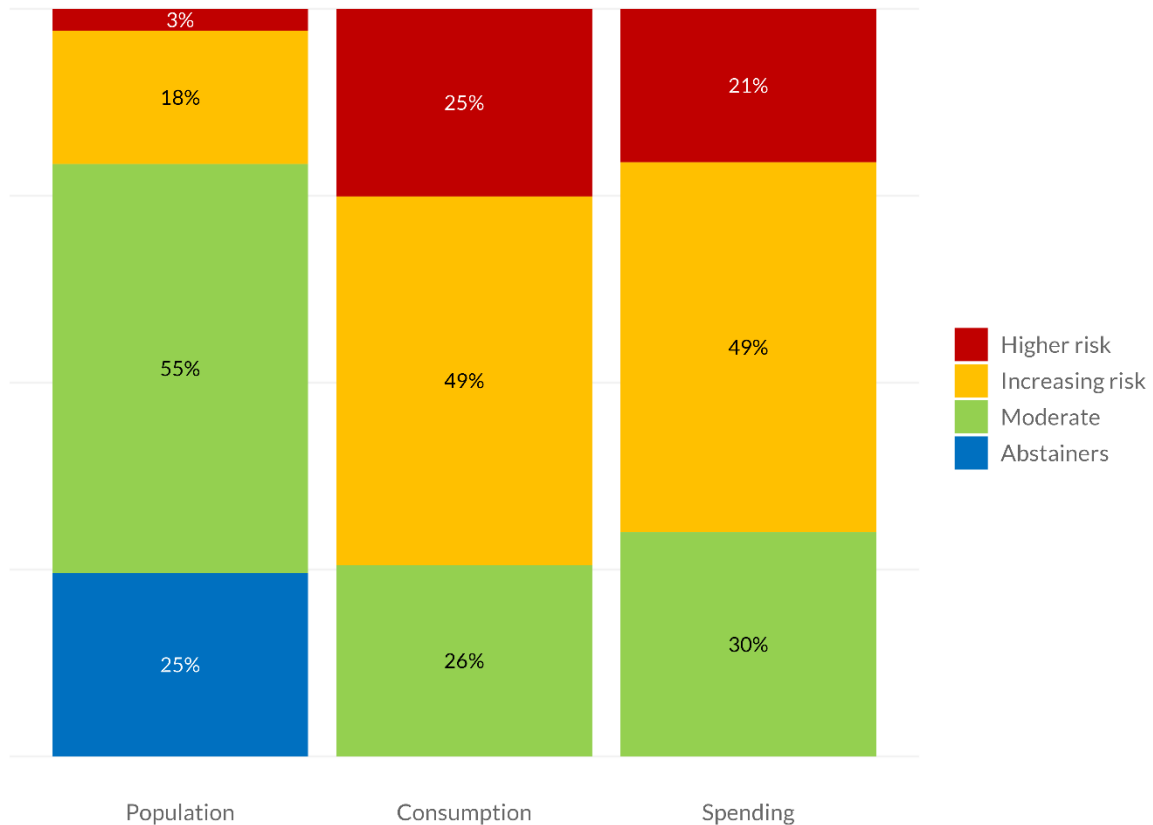
Table 3: Baseline patterns of alcohol consumption and spending in London

	Abstinence Rate	Drinker population	Proportion of all drinkers	Average annual consumption (units)	Average annual spend on alcohol
Population	24.6%	4,870,430	100.0%	609	£528
Drinker Group					
Moderate	31.0%	3,530,780	72.5%	215	£219
Increasing Risk	0.0%	1,151,895	23.7%	1,271	£1,105
Higher Risk	0.0%	187,755	3.9%	3,964	£2,810
IMD quintile					
IMDQ1 (least deprived)	15.7%	542,743	11.1%	631	£598
IMDQ2	18.1%	830,773	17.1%	614	£555
IMDQ3	22.2%	1,076,114	22.1%	593	£522
IMDQ4	26.6%	1,467,674	30.1%	611	£506
IMDQ5 (most deprived)	32.6%	953,126	19.6%	608	£504

The extent to which the adult population is spread across drinker groups, and the proportion of alcohol sales and spending on alcohol that is accounted for by each group, is illustrated in Figure 3. This highlights that almost half of all alcohol sold is purchased by the 18% of adults who drink at increasing risk levels, while the 3% drinking at higher risk levels account for a quarter of consumption. It also illustrates the extent to which alcohol sales depend on those drinking above the low risk

drinking guidelines, with 70% of all money spent on alcohol in London coming from the 21% of adults drinking more than 14 units per week.

Figure 3: Proportion of the population, alcohol sales and spending on alcohol by drinker level



Estimates of the health burden of alcohol in London and how this varies across drinker and IMD groups is shown in Table 4, which reports the estimated number and rate of deaths, hospital admissions and NHS costs that are attributable to alcohol. Note that these figures include both ‘alcohol-specific’ deaths and admissions (those from conditions that are only caused by alcohol, such as alcohol poisoning or alcoholic liver disease), as commonly reported by ONS (123), but also deaths and admissions from conditions that are partially attributable to alcohol, including cancers and injuries.

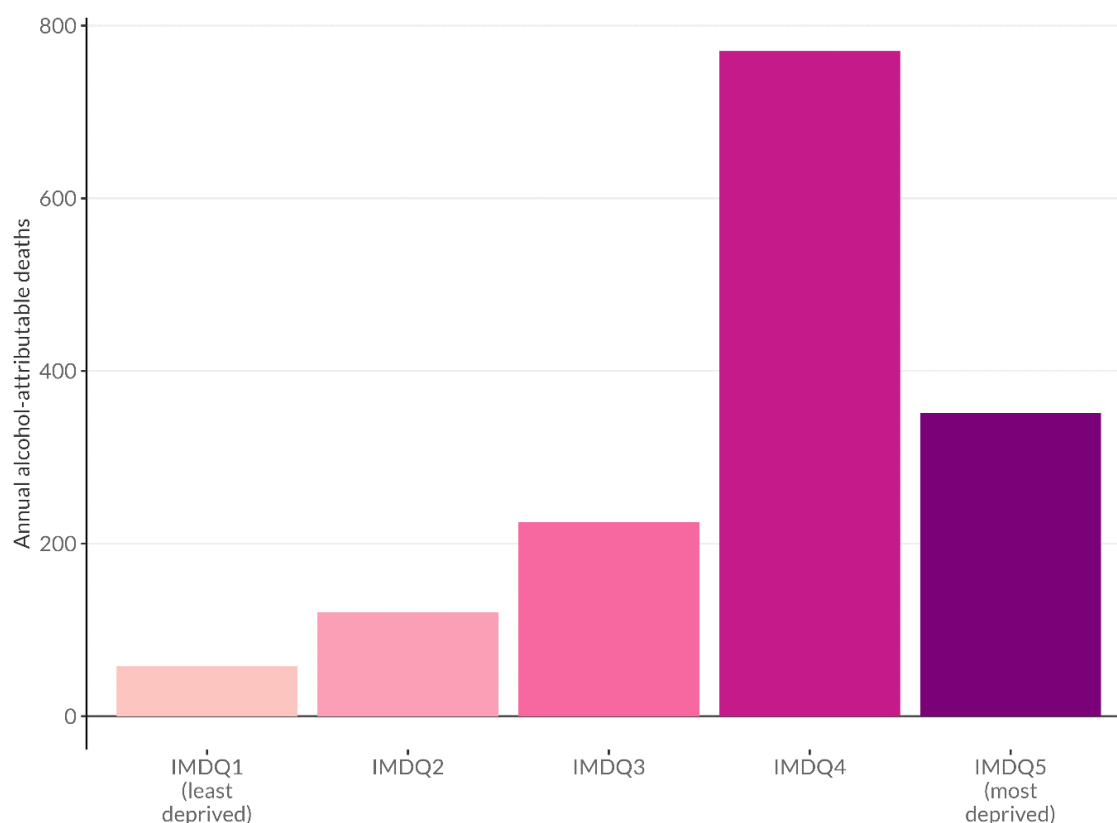
Overall, 1,525 people die each year in London due to alcohol, and there are 77,499 alcohol-attributable hospital admissions, costing the NHS £342.2 million. This burden falls disproportionately on heavier drinkers, with 60% of all alcohol-attributable deaths and 38% of alcohol-attributable hospital admissions coming from the 3% of adults drinking at higher risk levels.

Table 4: Baseline alcohol-attributable harms in London

	Drinker group				IMD quintile				
	All Drinkers	Moderate	Increasing Risk	Higher Risk	IMDQ1 (least deprived)	IMDQ2	IMDQ3	IMDQ4	IMDQ5 (most deprived)
Annual Alcohol-Attributable Deaths									
Deaths	1,525	127	480	918	58	120	225	771	351
Deaths per 100,000 drinkers	24	2	42	489	9	12	16	39	25
Annual Alcohol-Attributable Hospital Admissions									
Admissions	77,499	10,100	37,643	29,755	5,912	10,642	14,662	23,548	22,734
Admissions per 100,000 drinkers	1,201	197	3,268	15,848	918	1,049	1,060	1,177	1,609
Annual NHS Costs Due To Alcohol (£millions)									
NHS Costs	£342.2	£40.5	£157.7	£144.1	£23.7	£43.8	£63.1	£106.3	£105.3
NHS Costs per 100,000 drinkers	£5.3	£0.8	£13.7	£76.7	£3.7	£4.3	£4.6	£5.3	£7.4

The health burden of alcohol also falls unequally across the socioeconomic spectrum, with 74% of alcohol-attributable deaths and 60% of hospital admissions coming from the most deprived 40% of the population, in spite of lower levels of alcohol consumption. As illustrated in Figure 4, the highest rates of alcohol-specific deaths are in the 4th IMD quintile, driven in part by lower rates of abstinence than the most deprived quintile.

Figure 4: Socioeconomic profile of alcohol-attributable deaths in London



Finally, Table 5 shows the estimated burden of alcohol-attributable crime in London, broken down by offence types. Each year there are over a third of a million such criminal offences, costing society over £1.7 billion. Note that these costs include both the direct costs associated with crime (policing, criminal justice and the cost of stolen or damaged goods or property) as well as a financial valuation of the physical and mental harms experienced by the victims of alcohol-attributable crime. Criminal damage was the most common alcohol-attributable offence, followed by violent offences, while alcohol-attributable sexual offences had the highest cost to society.

Table 5: Baseline alcohol-attributable crimes in London

	Alcohol-attributable offences	Annual cost (£m)
Criminal damage	128,946	£165.5
Public order offences	45,398	£42.2
Robbery	2,194	£23.6
Sexual offences	20,204	£909.8
Theft	54,379	£95.5
Violent offences	96,172	£508.7
Total	347,293	£1,745.3

Modelling impacts of a minimum unit price

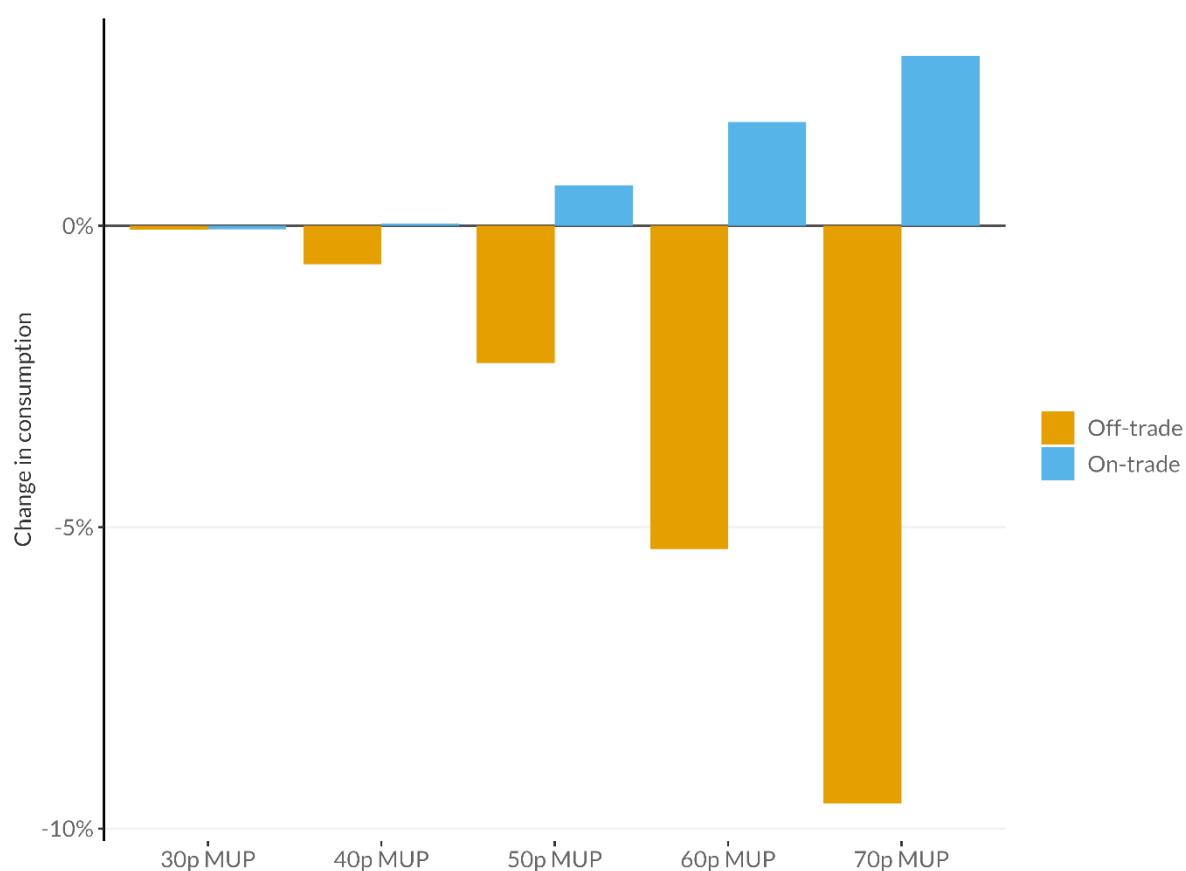
The estimated impact of introducing an MUP on alcohol consumption in London is shown in Table 6. Overall, a 30p MUP is estimated to have a minimal impact on alcohol consumption (-0.1%), due to the low proportion of alcohol sold below 30p/unit. An MUP of 50p is estimated to reduce alcohol consumption by 1.3%, equivalent to 8.2 units per drinker per year, while a 70p MUP would reduce alcohol consumption by 5.7%. These impacts are not equal in all population groups, with smaller impacts on moderate drinkers and those in higher socioeconomic groups, as these groups buy less of the cheaper alcohol affected by the MUP policy.

Table 6: Modelled impacts of MUP on alcohol consumption

	Drinker group					IMD quintile			
	All Drinkers	Moderate	Increasing Risk	Higher Risk	IMDQ1 (least deprived)	IMDQ2	IMDQ3	IMDQ4	IMDQ5 (most deprived)
Baseline									
Drinker population	4870430	3530780	1151895	187755	542743	830773	1076114	1467674	953126
Mean consumption (units/drinker/year)	609	215	1271	3964	631	614	593	611	608
Policy impact (relative change)									
30p MUP	-0.4 (-0.1%)	-0.1 (-0.1%)	-1.9 (-0.1%)	3.8 (0.1%)	0 (0%)	-0.3 (0%)	-0.3 (-0.1%)	-0.5 (-0.1%)	-0.6 (-0.1%)
40p MUP	-2.6 (-0.4%)	-0.4 (-0.2%)	-9 (-0.7%)	-3.6 (-0.1%)	-0.7 (-0.1%)	-2 (-0.3%)	-2.1 (-0.4%)	-3.1 (-0.5%)	-3.9 (-0.6%)
50p MUP	-8.2 (-1.3%)	-1.2 (-0.6%)	-25.6 (-2%)	-32.9 (-0.8%)	-2.6 (-0.4%)	-6.4 (-1%)	-6.8 (-1.2%)	-10 (-1.6%)	-11.6 (-1.9%)
60p MUP	-19 (-3.1%)	-3.2 (-1.5%)	-54.9 (-4.3%)	-96.3 (-2.4%)	-7.9 (-1.2%)	-15.5 (-2.5%)	-16.6 (-2.8%)	-23 (-3.8%)	-24.9 (-4.1%)
70p MUP	-34.4 (-5.7%)	-6.6 (-3.1%)	-94.5 (-7.4%)	-188.8 (-4.8%)	-17.1 (-2.7%)	-29.2 (-4.8%)	-30.9 (-5.2%)	-40.9 (-6.7%)	-42.9 (-7.1%)

Although all modelled MUP policies reduce alcohol consumption in all population groups, there is an important difference between the impacts of MUP on shop-bought alcohol (the off-trade) and alcohol bought in pubs, bars, nightclubs and restaurants (the on-trade). As prices are typically higher in the on-trade, MUP policies at the levels we have modelled have no direct impact on the prices of alcohol sold in pubs and bars. However, our modelling captures the fact that people will substitute between drink types and purchase locations when prices change, so a rise in prices in shops leads some drinkers to shift some of the drinking from the off- to the on-trade. This can be seen in Figure 5, which shows the relative changes in alcohol consumption in the on- and off-trades separately. For MUP levels at 50p or higher this substitution is estimated to reduce overall alcohol consumption, but to increase consumption in the on-trade.

Figure 5: Estimated total changes in alcohol consumption by purchase location



The estimated impacts of the modelled MUP policies on consumer spending on alcohol are presented in Table 7. Overall, a 50p MUP is estimated to increase consumer spending by £12.10 per drinker per year or 23p per week, a 2.3% rise. Increases are larger for higher MUP levels, heavier drinkers and those in more deprived groups, although the difference between IMD quintiles is smaller than across drinker groups.

Table 7: Modelled impacts of MUP on spending on alcohol

	Drinker group					IMD quintile			
	All Drinkers	Moderate	Increasing Risk	Higher Risk	IMDQ1 (least deprived)	IMDQ2	IMDQ3	IMDQ4	IMDQ5 (most deprived)
Baseline									
Drinker population	4870430	3530780	1151895	187755	542743	830773	1076114	1467674	953126
Average annual spend on alcohol	528	219	1105	2810	598	555	522	506	504
Policy impact (relative change)									
30p MUP	£1.1 (0.2%)	£0.1 (0.1%)	£1.1 (0.1%)	£18.7 (0.7%)	£0.8 (0.1%)	£0.8 (0.1%)	£1 (0.2%)	£1.2 (0.2%)	£1.4 (0.3%)
40p MUP	£3.5 (0.7%)	£0.6 (0.3%)	£4 (0.4%)	£54.8 (2%)	£3 (0.5%)	£3 (0.5%)	£3.2 (0.6%)	£3.6 (0.7%)	£4.4 (0.9%)
50p MUP	£12.1 (2.3%)	£2.6 (1.2%)	£18.5 (1.7%)	£152.6 (5.4%)	£11 (1.8%)	£11.4 (2%)	£11.6 (2.2%)	£12.2 (2.4%)	£14 (2.8%)
60p MUP	£27.2 (5.1%)	£6.6 (3%)	£44.5 (4%)	£308 (11%)	£26.2 (4.4%)	£26.4 (4.8%)	£26.4 (5.1%)	£27 (5.3%)	£29.6 (5.9%)
70p MUP	£43.9 (8.3%)	£11.5 (5.2%)	£71.9 (6.5%)	£482.6 (17.2%)	£45 (7.5%)	£43.7 (7.9%)	£43 (8.2%)	£43 (8.5%)	£46.1 (9.1%)

The estimated impact of MUP policies on alcohol-attributable mortality in London is shown in Table 8. A 50p MUP is estimated to lead to 33 fewer deaths per year, while a 70p MUP would reduce alcohol-attributable deaths by an estimated 149 each year. Reductions in deaths are heavily skewed towards heavier drinkers and those in more deprived groups, with 79% of the deaths averted from a 50p MUP coming from the most deprived 40% of the population.

Table 8: Modelled impacts of MUP on alcohol-attributable deaths

	Drinker group				IMD quintile				
	Population	Moderate	Increasing Risk	Higher Risk	IMDQ1 (least deprived)	IMDQ2	IMDQ3	IMDQ4	IMDQ5 (most deprived)
Baseline									
Annual alcohol-attributable deaths	1,525	127	480	918	58	120	225	771	351
Policy impact									
30p MUP	0	0	1	-2	0	0	0	0	0
40p MUP	-9	0	-1	-8	0	-1	-1	-4	-3
50p MUP	-33	0	-11	-22	0	-2	-5	-15	-11
60p MUP	-82	-2	-31	-49	-1	-5	-12	-39	-25
70p MUP	-149	-4	-62	-84	-3	-10	-22	-71	-44

However, when comparing impacts between groups, it is important to account for the fact that the sizes of these groups varies, particularly the number of people drinking at different levels. This can be done by calculating the impact of each MUP policy on rates of alcohol-attributable deaths, which is shown in Table 9. This approach demonstrates that deaths are estimated to fall by 0.3% among moderate drinkers compared to 2.4% in higher risk drinkers under a 50p MUP.

Table 9: Modelled impacts of MUP on alcohol-attributable death rates

	Drinker group				IMD quintile				
	Population	Moderate	Increasing Risk	Higher Risk	IMDQ1 (least deprived)	IMDQ2	IMDQ3	IMDQ4	IMDQ5 (most deprived)
Baseline									
Annual alcohol-attributable deaths per 100,000 drinkers	23.6	2.5	41.7	488.8	9	11.9	16.3	38.5	24.9
Policy impact (relative change)									
30p MUP	0 (0%)	0 (0%)	0.1 (0.3%)	-0.8 (-0.2%)	0 (0.1%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
40p MUP	-0.1 (-0.6%)	0 (-0.1%)	-0.1 (-0.2%)	-4.1 (-0.8%)	0 (0%)	0 (-0.4%)	-0.1 (-0.6%)	-0.2 (-0.5%)	-0.2 (-0.8%)
50p MUP	-0.5 (-2.2%)	0 (-0.3%)	-0.9 (-2.2%)	-11.7 (-2.4%)	0 (-0.4%)	-0.2 (-1.6%)	-0.4 (-2.2%)	-0.8 (-2%)	-0.8 (-3.1%)
60p MUP	-1.3 (-5.3%)	0 (-1.2%)	-2.7 (-6.6%)	-25.8 (-5.3%)	-0.2 (-1.9%)	-0.5 (-4.1%)	-0.9 (-5.3%)	-1.9 (-5%)	-1.8 (-7.1%)
70p MUP	-2.3 (-9.8%)	-0.1 (-3%)	-5.4 (-12.9%)	-44.6 (-9.1%)	-0.4 (-4.5%)	-0.9 (-8%)	-1.6 (-9.8%)	-3.5 (-9.2%)	-3.1 (-12.6%)

Equivalent estimates of the impact of each modelled MUP policy on alcohol-attributable hospital admissions are shown in Table 10 and Table 11. Overall, introducing a 50p MUP is estimated to reduce annual admissions due to alcohol in London by 1,764, a 2.3% fall. Patterns are similar to those for reductions in mortality, with larger reductions among heavier drinkers and the most deprived groups – a 50p MUP is estimated to lead to 26 fewer admissions per year in the least deprived IMD quintile, compared to 708 fewer admissions in the most deprived quintile.

Table 10: Modelled impacts of MUP on alcohol-attributable hospital admissions

	Drinker group				IMD quintile				
	Population	Moderate	Increasing Risk	Higher Risk	IMDQ1 (least deprived)	IMDQ2	IMDQ3	IMDQ4	IMDQ5 (most deprived)
Baseline									
Annual alcohol-attributable admissions	77,499	10,100	37,643	29,755	5,912	10,642	14,662	23,548	22,734
Policy impact									
30p MUP	5	-10	86	-71	3	-2	4	-3	2
40p MUP	-439	-32	42	-449	-3	-42	-55	-150	-189
50p MUP	-1,764	-75	-268	-1,422	-26	-161	-244	-625	-708
60p MUP	-4,573	-226	-976	-3,371	-109	-447	-706	-1,616	-1,696
70p MUP	-8,706	-535	-2,088	-6,083	-266	-897	-1,410	-3,051	-3,082

Table 11: Modelled impacts of MUP on rates of alcohol-attributable hospital admissions

	Drinker group				IMD quintile				
	Population	Moderate	Increasing Risk	Higher Risk	IMDQ1 (least deprived)	IMDQ2	IMDQ3	IMDQ4	IMDQ5 (most deprived)
Baseline									
Annual alcohol-attributable admissions per 100,000 drinkers	1200.5	197.4	3268	15847.7	918.2	1049.3	1059.6	1177.3	1608.6
Policy impact (relative change)									
30p MUP	0.1 (0%)	-0.2 (-0.1%)	7.5 (0.2%)	-38 (-0.2%)	0.5 (0.1%)	-0.2 (0%)	0.3 (0%)	-0.1 (0%)	0.2 (0%)
40p MUP	-6.8 (-0.6%)	-0.6 (-0.3%)	3.7 (0.1%)	-239.4 (-1.5%)	-0.4 (0%)	-4.2 (-0.4%)	-4 (-0.4%)	-7.5 (-0.6%)	-13.4 (-0.8%)
50p MUP	-27.3 (-2.3%)	-1.5 (-0.7%)	-23.2 (-0.7%)	-757.3 (-4.8%)	-4 (-0.4%)	-15.9 (-1.5%)	-17.7 (-1.7%)	-31.2 (-2.7%)	-50.1 (-3.1%)
60p MUP	-70.8 (-5.9%)	-4.4 (-2.2%)	-84.7 (-2.6%)	-1795.2 (-11.3%)	-16.9 (-1.8%)	-44 (-4.2%)	-51 (-4.8%)	-80.8 (-6.9%)	-120 (-7.5%)
70p MUP	-134.9 (-11.2%)	-10.5 (-5.3%)	-181.2 (-5.5%)	-3240 (-20.4%)	-41.4 (-4.5%)	-88.5 (-8.4%)	-101.9 (-9.6%)	-152.5 (-13%)	-218.1 (-13.6%)

The patterns of these reductions in alcohol-attributable deaths and hospital admissions across drinker groups are visualized in Figure 6 and across IMD quintiles in Figure 7. These figures illustrate that the health benefits of MUP at all levels are greatest among heavier drinkers and those in the most deprived groups.

Figure 6: Modelled impacts of MUP on health outcomes by drinker group

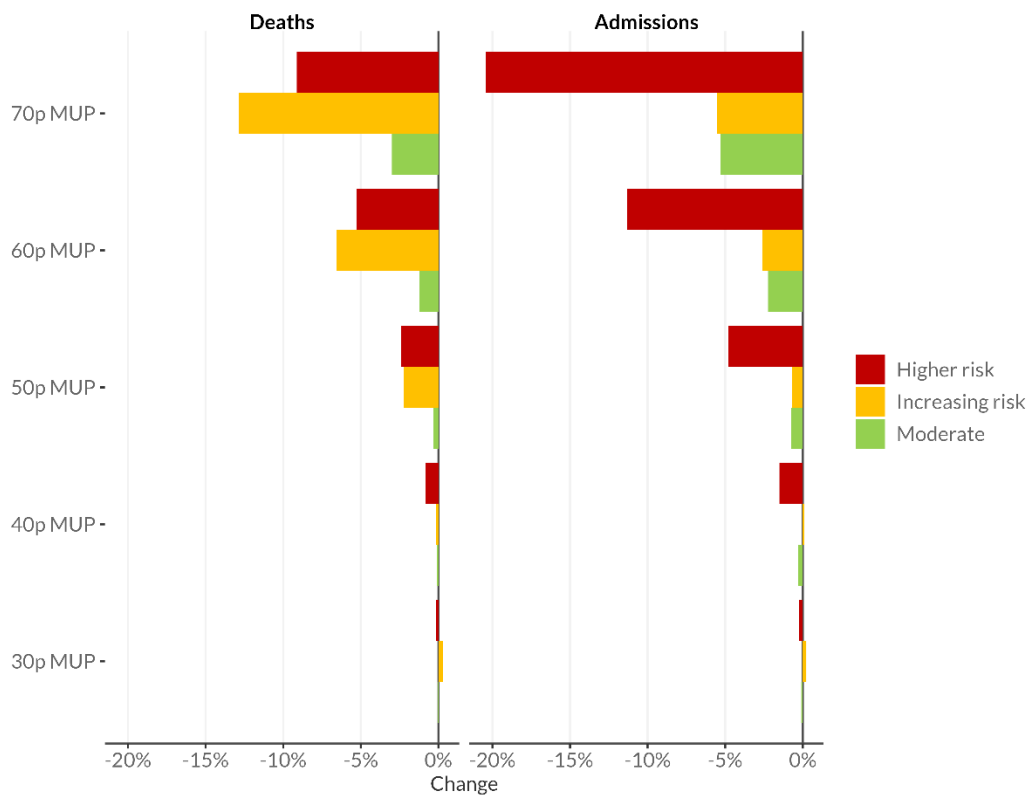
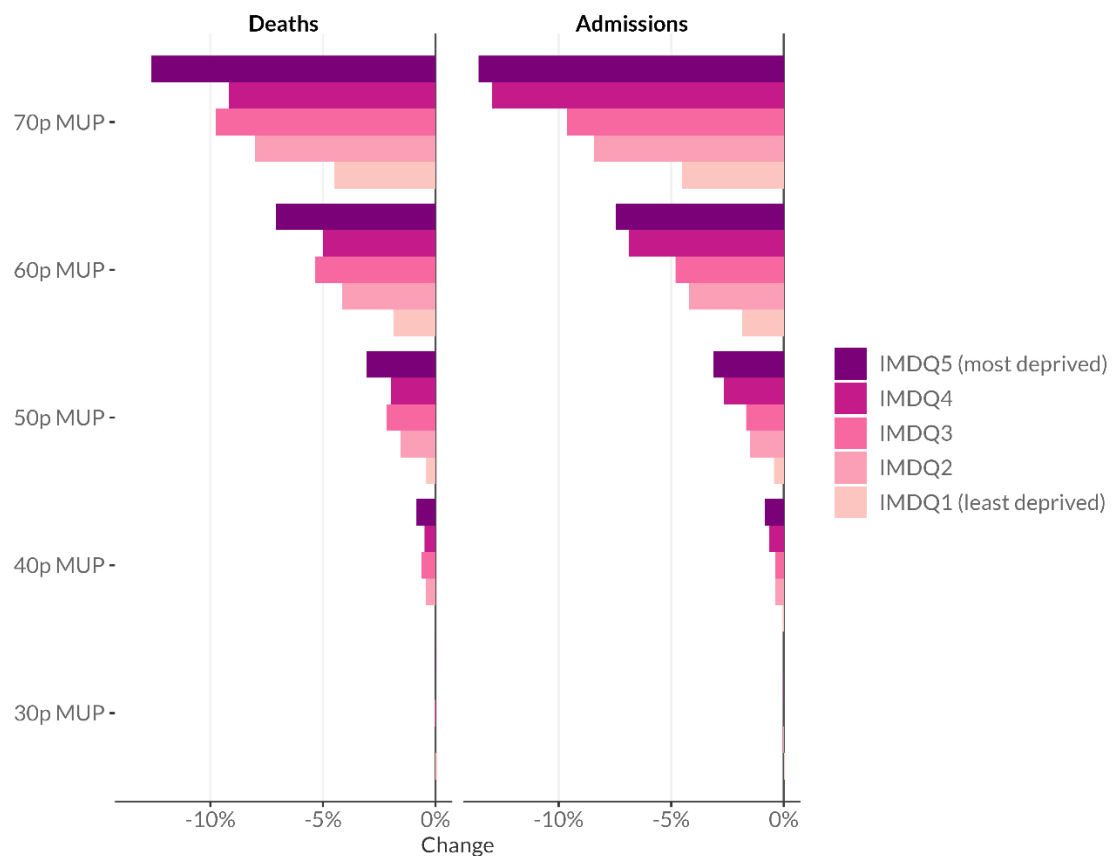


Figure 7: Modelled impacts of MUP on health outcomes by IMD quintile



The corresponding impacts of these reductions in alcohol-attributable ill health on NHS costs are shown in Table 12. A 50p MUP is estimated to reduce NHS costs by £4.1 million in the first year after implementation, and almost £100 million over the following 20 years. Higher MUP thresholds are estimated to lead to larger cost savings.

Table 12: Modelled impacts of MUP on NHS costs attributable to alcohol

	Change in NHS costs due to alcohol (£millions)		
	Year 1	Year 20	Cumulative over 20 years
30p MUP	-£0.0	£0.0	£0.1
40p MUP	-£1.1	-£1.1	-£24.1
50p MUP	-£4.1	-£4.3	-£94.7
60p MUP	-£10.0	-£11.0	-£238.7
70p MUP	-£18.3	-£20.8	-£446.5

Finally, the estimated impact of MUP on alcohol-attributable crime is shown in Table 13. A 50p MUP is estimated to lead to 4,261 fewer offences per year, a 1.2% fall, with a societal value of £23 million.

Table 13: Modelled impacts of MUP on alcohol-attributable crime

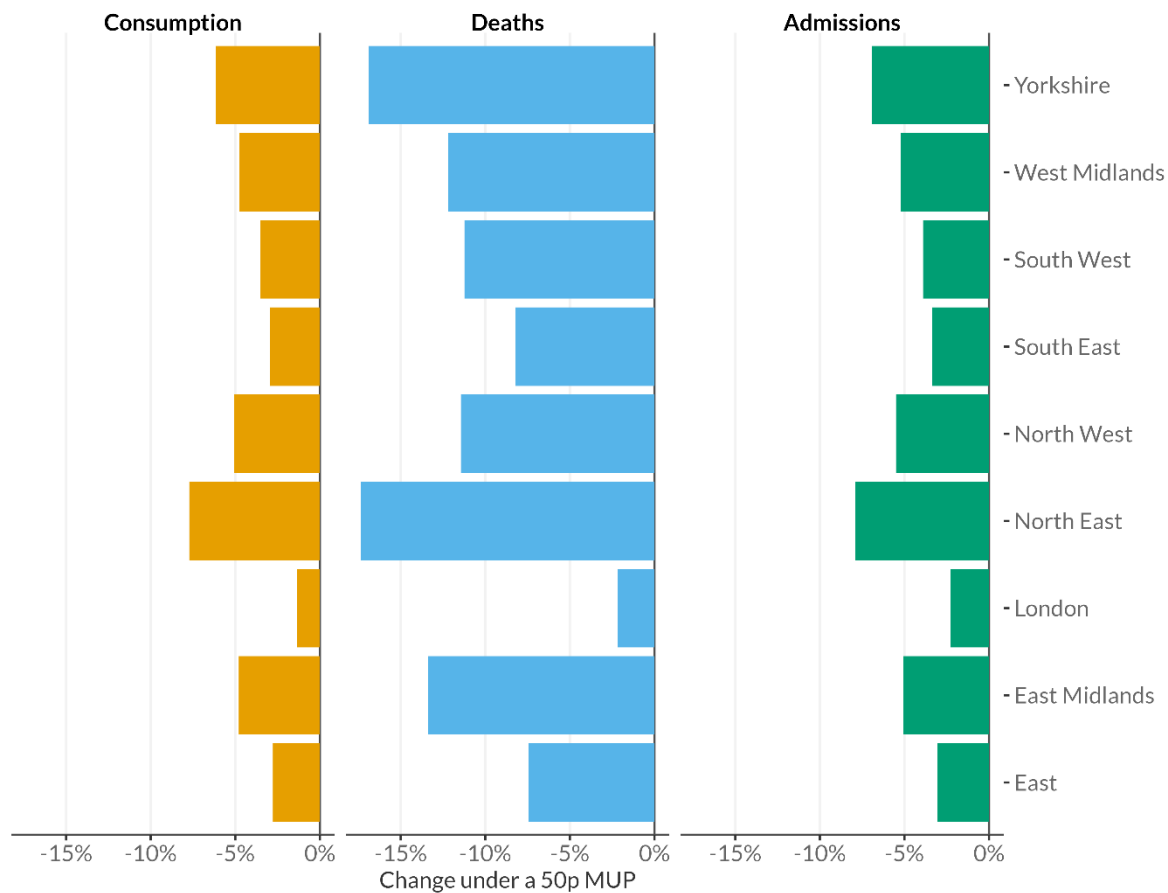
	Alcohol-attributable offences	Annual cost (£m)
Baseline	-347293	-£1745m
Policy impact (relative change)		
30p MUP	-365 (-0.1%)	-£2m (-0.1%)
40p MUP	-1584 (-0.5%)	-£9m (-0.5%)
50p MUP	-4261 (-1.2%)	-£23m (-1.3%)
60p MUP	-8850 (-2.5%)	-£49m (-2.8%)
70p MUP	-15069 (-4.3%)	-£83m (-4.7%)

Interpretation and context

These results illustrate that introducing a minimum unit price for alcohol would reduce alcohol consumption, improve population health, and reduce crime in London, saving the NHS and public services millions of pounds. They also show that the policy would have the largest impact on heavier drinkers and those in the most deprived groups in society, leading to a reduction in health inequalities. These findings are consistent with evidence from the evaluation of MUP in Scotland, which has demonstrated that the policy has reduced alcohol consumption (124) and alcohol-related harm, with the greatest reductions in the most deprived groups (19).

However, there are some important factors that should be considered when interpreting these results. The first of these is that although these results illustrate the potential effectiveness of MUP at reducing alcohol consumption and harm in London, a comparison across all regions of England in Figure 8 shows that London has the lowest estimated reductions in consumption, alcohol-attributable deaths and hospital admissions of any region in England following the introduction of a 50p MUP.

Figure 8: A comparison of modelled impacts of a 50p MUP between English regions



This is the case due to a combination of several factors, including that London has higher rates of non-drinking than other regions, lower average alcohol consumption among drinkers, and lower rates of alcohol-attributable mortality. Additionally, London has higher prices for alcohol on average than most other parts of the country, and a greater proportion of alcohol is bought in the on-trade, meaning that a smaller proportion of alcohol sales are affected by any MUP threshold.

The second key factor is that the results presented here reflect alcohol prices in 2018 and do not account for inflation since that date. At the time of writing, overall inflation has risen by 24.3% since 2018. This implies that the MUP thresholds modelled would have to be increased in line with this inflation in order to achieve the estimated impacts presented in this report. As such, an MUP of 62.1p would be required to achieve the same estimated impact as the 50p MUP results presented in this report, if it were introduced today. Table 14 shows the equivalent 2024 values for all MUP thresholds modelled in this report.

Table 14: MUP levels after adjusting for inflation

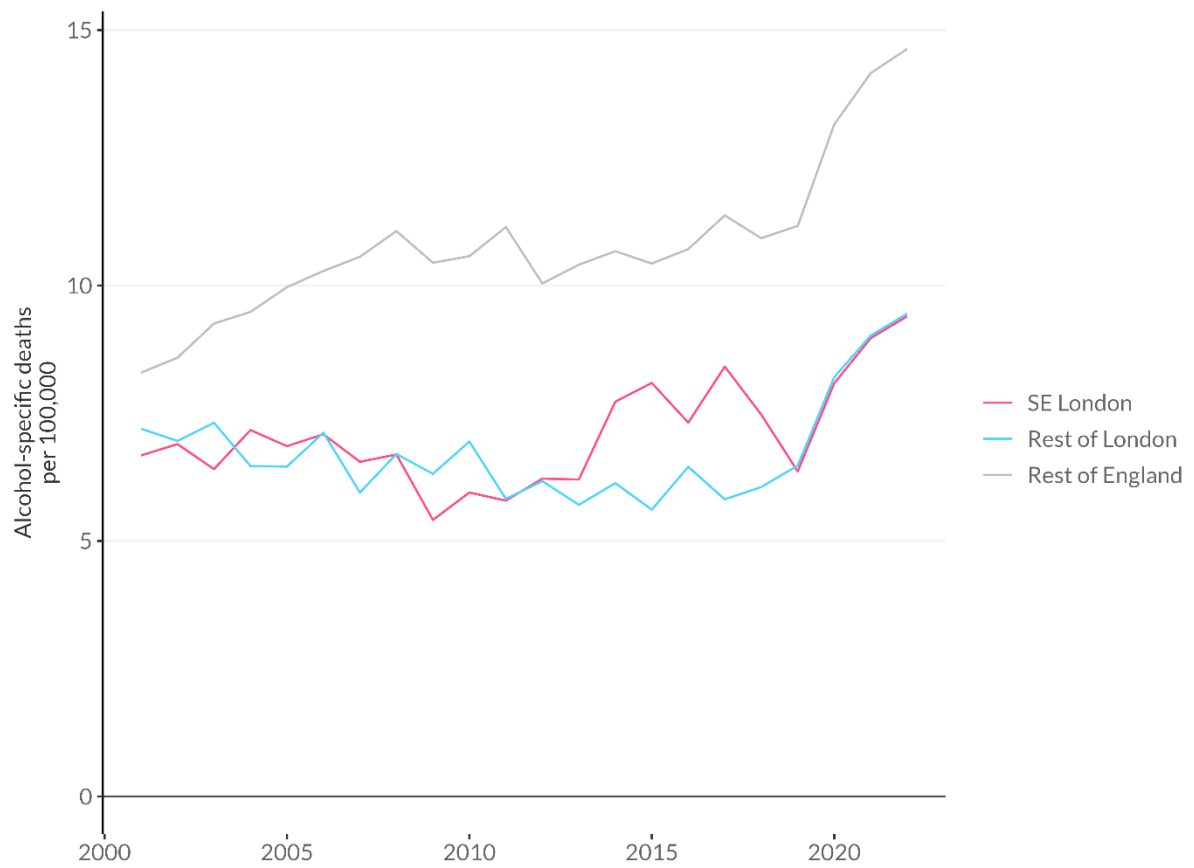
Modelled MUP level	Equivalent 2024 level
30p	37.3p
40p	49.7p
50p	62.1p
60p	74.6p
70p	87p

Finally, as the results presented here reflect data from 2018 or earlier, when considering their relevance for the present day it is also important to consider the impact of the subsequent COVID-19 pandemic on alcohol consumption and harm. Although at a population level alcohol consumption remains at similar levels to 2018 (125), this obscures the fact that there was a significant polarisation in drinking at the start of the pandemic, with moderate drinkers reducing their alcohol intake, or giving up alcohol entirely, while heavier drinkers increased their alcohol intake on average (126). This is a pattern that has been observed in many other developed countries (127) and the available evidence to date suggests that these increased levels of heavy drinking may have persisted in subsequent years (128).

The pandemic has also coincided with a sharp increase in alcohol-specific deaths in England, rising from 5,820 deaths in 2019 to 6,984 in 2020, a 20% increase (123). Figures have continued to rise in 2021 and 2022, with alcohol-specific deaths in 2022 being 35.9% higher than they were 2019. The changes in alcohol consumption discussed above are likely to be an important factor in these increases, however other factors such as difficulties accessing healthcare services during the acute phases of the pandemic, or the closure of in-person specialist alcohol treatment services are also likely to have played a role (129). As the extent to which these different factors have contributed to the increase in alcohol-specific deaths is not fully understood, it is difficult to know whether this increase will continue in coming years.

Figure 9 shows the time trends in alcohol-specific deaths since 2001 in South East London, the rest of London, and the rest of England. This shows the lower rates of alcohol harm in the capital compared to the rest of the country, and the starkness of the pandemic-era increase in all regions. However, the trend for South East London in particular is less clear, with higher rates of alcohol-specific deaths than the rest of London in 2014-18, followed by a fall in 2019. It is therefore less clear to what extent the rise in deaths in 2020 is the effects of the pandemic, rather than a return to the higher levels of the previous 5 years. In either case it is clear that alcohol-specific deaths in South East London have been rising for over a decade, suggesting a greater need for effective policy action to stem this rise.

Figure 9: Trends in alcohol-specific death rates 2001-2022



PART 3: RESOURCES TO SUPPORT IMPLEMENTATION OF LOCAL INTERVENTIONS TO REDUCE ALCOHOL HARM IN SE LONDON

The need for strong national leadership

This report has presented evidence to demonstrate the scale of alcohol harm in SE London, which places significant strain on families, communities and public services, and comes with vast financial costs. The good news is there is strong evidence to show what can work to reduce alcohol harm. However, leadership and commitment are key to the success of any public policy and decisions taken by central government will determine how impactful local interventions can be.

National government can enable strong local action through setting national priorities for health and care, establishing the legal powers and responsibilities of local authorities, and allocating proportionate resources to local services (130). National action on policies that address the price, availability and marketing of alcohol, alongside adequate funding for treatment and support, will create an environment that will better enable local policies to have meaningful impact. High profile organisations are currently campaigning for a national alcohol strategy. The Alcohol Health Alliance, a coalition of more than 60 organisations including medical royal colleges, charities, unions and treatment providers, published a [2023 Manifesto for a future free from alcohol harm](#) (131). This calls for the UK Government to adopt the following interventions as part of a national evidence-based alcohol strategy:

- Commit to introducing evidence-based prevention policies – including reducing the availability, marketing and affordability of alcohol – to save lives and reduce pressure on the NHS
- Introduce minimum unit pricing for alcohol in England, to prevent the sale of ultra-cheap high strength drinks that lead to high social costs
- Ensure alcohol duty at least keeps pace with inflation and that all stronger products are always taxed at a higher rate than lower strength products.
- Include ‘public health’ as a licensing objective in England and Wales so that licensing bodies have to consider local alcohol harm data when making their decisions
- Include alcohol in the definition of ‘unhealthy products’ under the marketing regulations for products high in fat, sugar and salt
- Give responsibility for ensuring alcohol marketing practices adhere to higher standards to an independent body with no links to the alcohol or advertising industries
- Introduce mandatory alcohol product labelling that provides consumers with information relating to ingredients, calories, units, Chief Medical Officers’ guidelines, and health risks such as alcohol during pregnancy and cancer
- Scale up and commit to long-term funding of proven and cost-effective early interventions and treatment across the UK, and deliver on better coordination between alcohol treatment and other services such as mental health, domestic abuse, and housing support

- Bring forward an effective cross-government strategy to reduce health inequalities, recognising the key role that alcohol plays in driving these inequalities

Organisations representing local government stakeholders play an important role in advising national alcohol policy. The Association of Directors of Public Health (ADPH) has for years advocated for the introduction of minimum unit pricing in England and, alongside the Local Government Association (LGA), called for the addition of health as a licensing objective (132,133). Both organisations have advocated for public health funding to be protected and for certainty around long-term funding for addiction services. Supporting advocacy efforts for high impact national alcohol policies is a key enabler for local actions to reduce harm.

Public support for action on alcohol harm

The UK public supports action on alcohol harm. The Alcohol Health Alliance published opinion polling data in 2023 describing UK public attitudes towards alcohol and the government's response (134). Key findings included:

- The majority (55%) of people who expressed an opinion did not think that the government is taking enough action on alcohol
- 70% of people wanted government policy to be protected from the influence of the alcohol industry and its representatives
- 76% of people thought the number of units in a product should be legally required on alcohol labels, with the majority of people supporting more and better labelling of alcoholic products overall
- Over half of people would welcome improved marketing regulations, especially the introduction of health warnings on marketing materials and separate display areas for alcohol and its marketing in shops, and
- There was demonstrable support amongst respondents from all political backgrounds for tackling the affordability of alcohol.

Decisionmakers can be confident that many of the high-impact policies to reduce alcohol harm often have the support of the public. Working with NGOs, campaigning and community groups can help to raise awareness of alcohol harm among the public and communicate key issues relating to evidence based interventions to help build support for policy action.

Local policy recommendations

The local policies identified in the evidence review as high-impact for SE London are listed in Figure 2. A PowerPoint presentation accompanies this report which includes resources to help make the case for action on alcohol harm and build support for effective policies, and provides links to the guidance and resources to support the implementation and evaluation of these interventions which are presented below.

Building support and coordinating local action on alcohol harm

Demonstrating the scale of alcohol harm in SE London will be a critical first step in building support for policy action. This report presents evidence to illustrate the financial burden alcohol harm places on each London borough, estimating costs linked to health care, crime, lost productivity and social services. Individual cost profiles are available at the IAS website (135).

The Office for Health Improvement and Disparities (OHID) provides data on local alcohol health harms and allows local authorities to compare their indicators with other local authorities and benchmark against the England or regional average (136). The OHID Local Profile provides data on mortality (alcohol specific and alcohol-related), hospital admissions (narrow and broad measures) by age and sex, incidence of alcohol-related conditions, and the percentage of dependent drinkers in a chosen area.

Identifying and engaging with key stakeholders is key to building support for change. Local alcohol partnerships bring together key stakeholders that can work together to share information and coordinate approaches to tackling alcohol harm. Key stakeholders with responsibilities for addressing alcohol harm include:

- local politicians and senior decision-makers
- directors of public health
- local authority alcohol commissioners
- other local government officers from public health, trading standards, housing, children's services and social care
- NHS commissioners
- NHS providers of primary, secondary and mental health care
- police and other organisations involved in community safety, offender management and crime reduction
- Jobcentre Plus staff and representatives from local housing services
- local voluntary and community sector services
- service user and carer representatives

Before its transition to OHID, Public Health England developed the alcohol CLearR (Challenge services, Leadership and Results) initiative to support local alcohol partnerships to assess how effective their local system and services are at preventing and reducing alcohol-related harm (137):

This approach helps partnerships to develop action plans for improvement through its focus on 3 main areas:

1. *Challenge for the services that deliver interventions to prevent or reduce alcohol-related harm.*
2. *Leadership for the alcohol agenda, which involves considering how local structures and governance arrangements can support collaborative action to reduce alcohol harm.*

3. *Results achieved through recent activity to reduce alcohol harm, evidenced by national and local data sources.*

The CLear approach asks partnerships to review progress against their priority alcohol objectives within the context of other plans to improve people's health in the local area. CLear will have more impact if the partnership sees alcohol as part of the bigger local picture and understands how reducing alcohol harm can help to meet other local objectives. This can also help make the case for continued investment in alcohol harm reduction.

The [CLear self-assessment tool](#) provides guidance to local alcohol partnerships in conducting an assessment (138).

Policy-specific guidance and resources

1. Marketing

- *Advertising bans: prohibiting alcohol advertising on council-owned spaces and infrastructure*

A number of local authorities in England have introduced restrictions on advertising for products which are damaging to health. As outlined above, Transport for London restricts adverts that directly feature food and/or non-alcoholic drink considered to be high in fat, salt and sugar (139), and this policy has also been adopted by other local authorities including Haringey, Southwark and the Royal Borough of Greenwich. More recently, Sheffield City Council announced an Advertising and Sponsorship Policy 2024-2026 which prohibits promotion of alcohol and other health harming products on council-owned sites and via council communications channels (77).

Relevant resources:

- Sustain have produced a [Healthier Food Advertising Policy Toolkit](#) (140) for local government. This resource acts as a guide for local decisionmakers and advisors through the entire process of initiating discussion about, building support for, implementing and evaluating policies to restrict unhealthy food advertising.
- [Sheffield City Council Advertising and Sponsorship Policy 2024-2026](#) (77) outlines the scope and purpose of the policy to prohibit alcohol advertisement on council-owned property and includes key information on definitions, rules, principles, responsibilities and decision-making.

2. Availability

- *Density of alcohol outlets: through Statements of Licensing Policy and Cumulative Impact Policies*
- *Hours and days of sale: through Statements of Licensing Policy, Late Night Levies, Early Morning Restriction Orders*

Policies that reduce the availability of alcohol are linked to reductions in alcohol-related harms and the current Licensing Act 2003 allows local decisionmakers to restrict the density of alcohol outlets via cumulative impact policies. Whilst there

is currently no statutory licensing objective to protect and promote public health, directors of public health are responsible authorities who must be notified and permitted to make representations in licensing decisions. There are a number of resources available to guide public health representatives to contribute to local licensing decisions within the current regulatory framework. As outlined above, a number of high profile organisations support the introduction of an additional statutory licensing objective to better empower local decisionmakers to protect and promote public health and wellbeing.

Relevant resources:

- [Home Office revised Guidance issued under section 182 of the Licensing Act 2003](#) outlines the responsibilities of Licensing Authorities to meet their obligations under the licensing legislation (141).
- The Local Government Association has produced a guide for directors of public health [Public Health and the Licensing Act 2003](#) to promote effective participation by public health teams in licensing decisions (142).
- Public Health England produced [Alcohol licensing: a guide for public health teams](#) (last updated 2020) (143). This guidance helps public health teams understand their role as a responsible authority and provides a step-by-step guide to making representations to a licensing authority. It provides information for public health teams inputting into local [statement of licensing policies](#) (SLP) (144) and advice on collecting evidence.

3. Managing the drinking environment

- *Multicomponent community programmes: such as 'Drink Less Enjoy More' tested in NW England*
- *Replacing glassware with safer alternatives: as in good practice licensing guidance*
- *Voluntary removal of the sale of high strength alcohol: 'Reducing the Strength' initiatives*
- *Policing and enforcement approaches: multi-agency Cardiff Model for violence prevention*

A number of policy options are available within the Licensing Act 2003 to manage the drinking environment with the objective of reducing alcohol harms, particularly acute harms associated with intoxication. These include serving alcohol in reusable plastic containers as opposed to glass, enforcing bans on the sale to intoxicated patrons and reducing the strength of alcoholic products on sale. Multi-agency partnerships, including with police and enforcement bodies, can be effective at preventing alcohol-related violence and disorder.

Information Sharing to Tackle Violence (ISTV), often known as the 'Cardiff model', involves the collection of anonymised information by Accident and Emergency (A&E) departments that is shared with local Community Safety Partnerships (CSP) on a monthly basis. The data covers all A&E attendances resulting from violent incidents, including the time, date and specific location of the incident and primary means of assault (for example a weapon or body part used). Implementation of the Cardiff Model can prevent alcohol-related violence by helping policy to identify hotspots, including specific licensed premises. A multi-

agency Violence Reduction Unit was established in London in 2018 to assess and take action on data collected via the Cardiff Model, which can also be used to tackle knife crime.

Relevant resources:

- An [Evaluation of the Cheshire and NW Merseyside Drink Less Enjoy More intervention](#) outlines how a multi-agency approach focussed on the core principles of community mobilisation, responsible bar server training and strengthened police engagement, led to a reduction in sales to 'pseudo drunk' actors (52).
- The Local Government Association published [Reducing the Strength: Guidance for councils considering setting up a scheme](#) which provides information on principles and design of a scheme to encourage retailers to cease serving high-strength cheap products, including legal considerations relating to competition law. Case studies are presented for Suffolk and Portsmouth (57).
- [Guidance for London policymakers on the implementation of the Cardiff Model](#) outlines resources available to support the implementation of ISTV (145). These include resources for health professionals, policy makers, researchers and analysts.

4. Brief interventions and treatment

- *Identification and brief advice (IBA) in primary healthcare: follow NICE guidance to routinely carry out alcohol screening as an integral part of practice*
- *Electronic IBA: follow NICE guidance to use as an adjunct to existing services*
- *Psychosocial and psychological interventions: follow existing NICE guidance*
- ~~*Pharmacological interventions: follow existing NICE guidance*~~

Alcohol IBA is simple, structured and brief advice given to a person after completing a validated alcohol screening tool. It is a preventative approach aimed at identifying and providing brief advice to increasing and higher-risk drinkers. It is not a treatment and it is not aimed at dependent drinkers. The advice includes feedback on the individual's score from the identification tool and information about harm from alcohol; aimed at motivating risky drinkers to reduce their alcohol consumption to lower risk levels.

Written information may also be provided. IBA is usually delivered by a trained health professional in a health-related setting. However, it does not need to be limited to this setting. Non-health professionals have been trained and delivered IBA in a variety of settings including probation services, housing and youth services. Use of apps and web-based programmes linking individuals direct to IBA is becoming increasingly popular. IBA is an opportunity to reach and educate a wide range of people who may not be aware of the role of units, lower risk drinking limits and the risks associated with alcohol.

Relevant resources:

- The Health Innovation Network South London has produced a [Toolkit for Commissioning Alcohol Identification and Brief Advice](#)(103). This toolkit brings together the evidence base and guidance for alcohol IBA, including tips for commissioning across a range of different settings, a framework for ensuring quality elements are considered in the commissioning process and case studies to illustrate topics, all in one easy-to-use online resource.
- Health Education England also provides a range of comprehensive e-learning courses on [alcohol identification and brief advice](#) (146)
- The [5 alcohol-use screening tests](#) (147), known as the alcohol use disorders identification test (AUDIT) tools, help healthcare professionals to assess a patient's level of risk to alcohol harm.

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APPENDIX 1: 2021/22 Local Authority Alcohol Cost Profile

Methodology

This methodological summary has been produced to support the 2021/22 local authority cost profiles produced for England. Links to all data sources are included throughout the electronic version of the document.

All population figures used throughout the profiles have been taken from the [Office for National Statistics Mid-2021 Population Estimates for England and Wales](#) and have been used in conjunction with [Health Survey for England regional estimated weekly alcohol consumption](#) to calculate numbers of higher risk drinkers. Therefore, given differences in local alcohol consumption, the final cost figures may not always accurately reflect local circumstance.

These profiles are designed to support strategic planning and develop local understanding about the potential impact of alcohol on the local economy. They are not intended to be used primarily as a comparator tool. The cost estimates should also not be used as the sole basis for commissioning local services but should supplement locally derived cost-related information.

NHS & HEALTHCARE COSTS

The overarching methodology behind the NHS costs is taken from the 2008 Department of Health document entitled '[The cost of alcohol harm to the NHS in England](#)' – this document should be consulted for further detail on the methodology. Where possible, all data sources in the document were updated, and where not otherwise stated, unit costs were taken from the most up to date figure published in the [PSSRU Unit Costs of Health and Social Care](#) and inflated when necessary. The NHS costs are broken down into the following sections:

Alcohol related hospital admissions:

The costs of hospital admissions were obtained from the [Office for Health Improvement and Disparities' Alcohol Profiles](#) and inflated to 2021-22.

Outpatient visits:

Average outpatient attendances were calculated with data supplied by NHS England [on outpatient attendances in 2021-22](#) and population figures. This resulted in an average of 1.69 outpatient visits per person. Outpatient attendance was assumed to be [twice as high for higher risk drinkers](#). Excess outpatient attendance per LA was calculated using higher risk estimates, based on higher risk drinkers using outpatient services 1.69 times more per year than the average patient. Excess outpatient attendance per LA was multiplied by unit costs.

A&E attendances:

A&E attendances by region were calculated based on the assumption that [35% of visits are alcohol-related](#). [A&E attendances data](#) was supplied by NHS England. Alcohol related attendances were then estimated for each region and split across constituent local authority (LA) areas based on overall head of population. Alcohol-related A&E visits per LA were multiplied by unit costs.

Ambulance journeys:

[Ambulance callouts by region](#) were supplied by NHS England. Alcohol related callouts were then estimated for each region and split across constituent LA areas based on overall head of population, based on the assumption that [35% of visits are alcohol-related](#). This assumption was further supported by further research showing that [37% of ambulance service time](#) is taken up dealing with alcohol-related incidents. Alcohol-related ambulance callouts per LA were multiplied by unit costs.

Healthcare professional appointments

Average number of healthcare professional appointments per person were calculated using [data](#) supplied by NHS England and population estimates. This includes both GP and other practice staff consultations. Number of alcohol-related GP consultations were calculated based on an estimated of [28.5% of GP visits](#) being alcohol related for higher risk drinkers. Alcohol-related healthcare professional appointments were multiplied by unit costs.

Alcohol dependency drugs:

[Numbers and costs of alcohol dependency prescription items](#) were supplied by NHS Digital. Total costs were worked out by region and then split across constituent LA areas based on numbers of higher risk drinkers.

Specialist treatment for alcohol:

No new estimates for the cost of specialist treatment were available. Therefore national 2008/09 costs were inflated to 2021/22 prices using [CCEMG – EPPI-Centre Cost Converter](#) and then split across LA areas based on numbers higher risk drinkers.

Other alcohol-related healthcare:

This indicator includes the cost of alcohol-related counselling, community psychiatric nurse visits, health visitors and usage of 'other services'. [Annual usage rates](#) for these services were multiplied by the number of higher risk drinkers per LA to derive annual LA usage. The LA usage for each of the services was then multiplied by their respective unit costs.

CRIME COSTS

The overarching methodology behind the crime costs is taken from the 2008 Department of Health (DH) document entitled '[Safe, Sensible, Social – Consultation on further action Impact Assessments](#)' – this document should be consulted for further detail on the methodology.

General offences that are estimated to be attributable to alcohol:

Crime totals by CSP were taken from [Home Office crime figures](#). Crime totals per LA were multiplied by their respective [offence code multiplier](#), taken from a report published by the Home Office, to account for the fact that crime figures are underestimates since not all crimes are reported to the police. Total alcohol-related crimes per LA were obtained by multiplying total crimes per LA by [alcohol-related proportions](#) per offence code, taken from the Department of Health's report. Alcohol-related crimes per LA were multiplied by [unit costs](#) for all costs associated with a crime (anticipation, consequence and response), as reported by the Home Office.

WORKPLACE AND THE ECONOMY

The overarching methodology behind the workplace costs is taken from the 2008/09 Liverpool John Moore's University (LJMU) document entitled '[The economic and social costs of alcohol-related harm in](#)

[Leeds'](#) – this document should be consulted for further detail on the methodology. The workplace and economy costs are broken down into the following sections:

Presenteeism:

[Annual Population Survey](#) figures for full and part-time workers, and salary estimates from the [Annual Survey of Hours and Earnings](#) were used to calculate presenteeism based on full-time workers losing [full-time workers losing 0.68 days and part-time workers losing 0.34 days per year](#).

Absenteeism:

[Annual Population Survey](#) figures for full and part-time workers, and salary estimates from the [Annual Survey of Hours and Earnings](#) were used to calculate absenteeism based on updated sick day estimates from the [OSF Sickness absence in the UK labour market](#) of 5.15 days (average for 2021/22) per year for a full-time worker.

Unemployment:

High risk drinker figures and [Annual Population Survey](#) figures for economically active males and females were used to calculate reduced employment based on male and female heavy drinkers losing [11.4 and 8.1 days of employment respectively per year](#).

SOCIAL SERVICES

The overarching methodology behind the workplace costs is taken from the 2008/09 LJM document entitled '[The economic and social costs of alcohol-related harm in Leeds](#)' – this document should be consulted for further detail on the methodology. The social services costs are broken down into the following sections:

Children social services:

[Total expenditure on children's social care](#) per LA was taken from data published by the Department for Levelling Up, Housing and Communities and Ministry of Housing, Communities & Local Government. It was then assumed from the LJM report that between 14% and 34% of the cost was attributable to alcohol.

Children and young people substance misuse services

[Total expenditure on children and young people substance misuse services](#) per LA was taken from data published by the Department for Levelling Up, Housing and Communities and Ministry of Housing, Communities & Local Government. It was then assumed from the LJM report that between 15% and 45% of the costs was attributable to alcohol.

Adult Services:

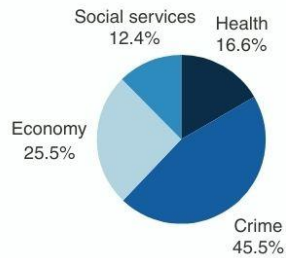
[Total expenditure on adult social services for substance misuse \(alcohol\)](#) per LA were taken from data published by the Department for Levelling Up, Housing and Communities and Ministry of Housing, Communities & Local Government.

APPENDIX 2: Cost of harm infographics

2021-2022
COST OF ALCOHOL HARM IN

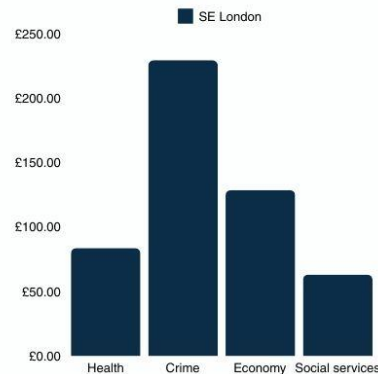
SE LONDON

COST BREAKDOWN



OVERALL COST: £902.5m
£504 PER HEAD

COST PER HEAD



NHS & HEALTHCARE: £149.9m



CRIME & DISORDER: £410.7m

116,097 estimated alcohol-related crimes

Including reported and unreported crimes:

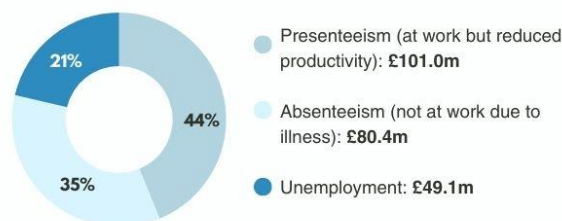
- 19,074 for criminal damage
- 22,474 for violence against the person
- 68,390 for theft

Anticipation of crime: £25.3m

Consequence of crime: £262.1m

Response of crime: £123.3m

WIDER ECONOMY £230.5m



SOCIAL SERVICES £111.5m

Local authority budget estimated to be attributable to alcohol:

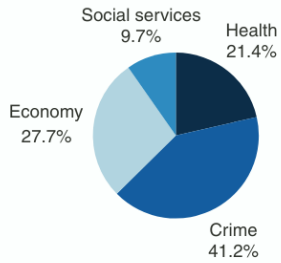
Children social services: £105.3m

Alcohol misuse services
For adults £5.8m
For children £354,690

2021-2022
COST OF ALCOHOL HARM IN

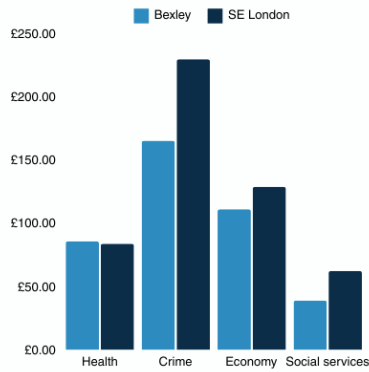
BEXLEY

COST BREAKDOWN

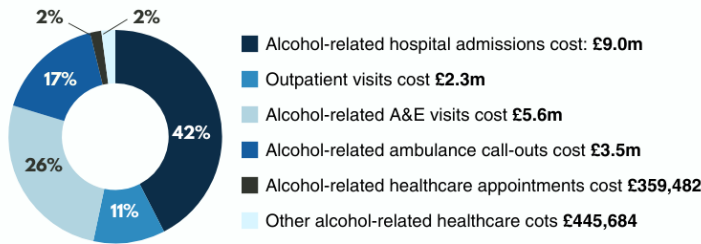


OVERALL COST: £98.8m
£401 PER HEAD

COST PER HEAD



NHS & HEALTHCARE: £21.1m



CRIME & DISORDER: £40.7m

11,986 estimated alcohol-related crimes

Including reported and unreported crimes:

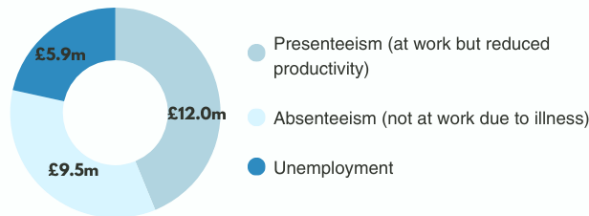
- 2,461 for criminal damage
- 2,371 for violence against the person
- 6,660 for theft

Anticipation of crime: £2.7m

Consequence of crime: £25.4m

Response of crime: £12.6m

WIDER ECONOMY £27.4m



SOCIAL SERVICES £9.6m

Local authority budget estimated to be attributable to alcohol:

Children social services: £8.7m

Alcohol misuse services

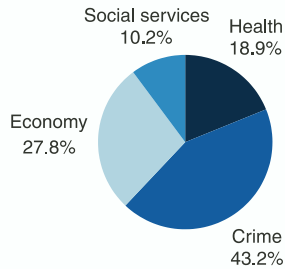
For adults £850,000

For children £40,635

2021-2022
COST OF ALCOHOL HARM IN

BROMLEY

COST BREAKDOWN

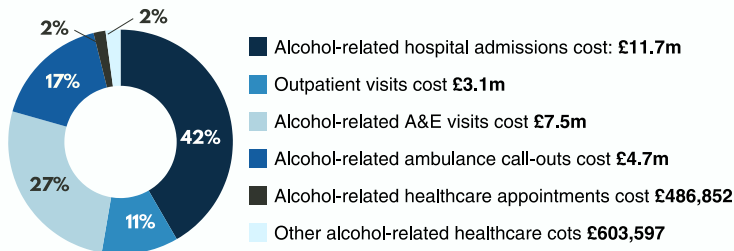


OVERALL COST: £148.6m
£450 PER HEAD

COST PER HEAD



NHS & HEALTHCARE: £28.0m



CRIME & DISORDER: £64.2m

25,325 estimated alcohol-related crimes

Including reported and unreported crimes:

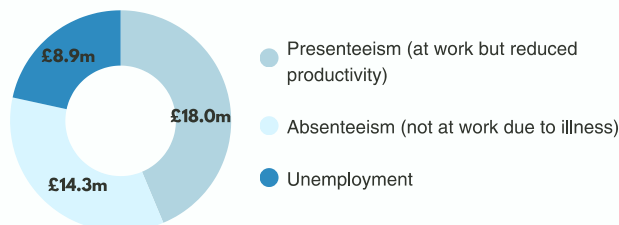
- 3,164 for criminal damage
- 3,107 for violence against the person
- 18,350 for theft

Anticipation of crime: £5.6m

Consequence of crime: £39.3m

Response of crime: £19.3m

WIDER ECONOMY £41.3m



SOCIAL SERVICES £15.1m

Local authority budget estimated to be attributable to alcohol:

Children social services: £14.5m

Alcohol misuse services

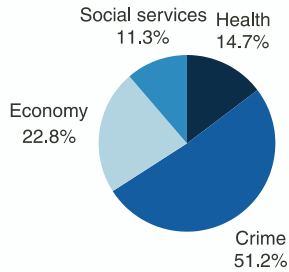
For adults £537,000

For children £60,480

2021-2022
COST OF ALCOHOL HARM IN

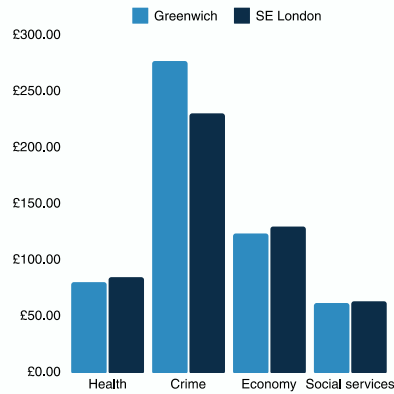
GREENWICH

COST BREAKDOWN

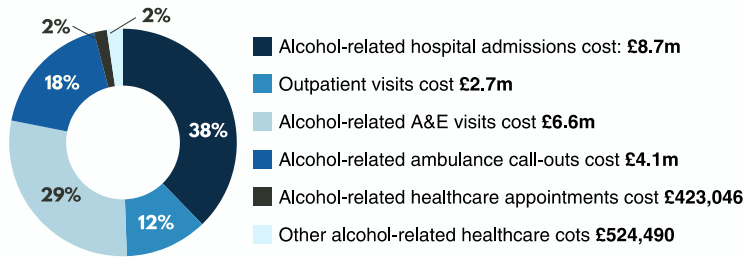


**OVERALL COST:
£155.9m
£539 PER HEAD**

COST PER HEAD



NHS & HEALTHCARE: £23.0m



CRIME & DISORDER: £79.9m

**20,280 estimated
alcohol-related crimes**

Including reported and unreported crimes:

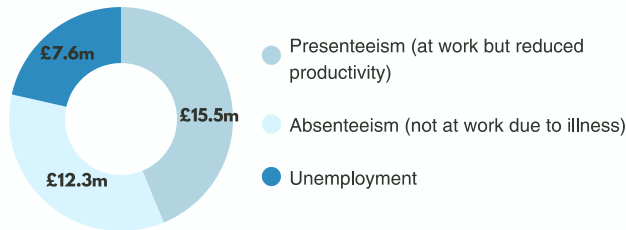
- 3,338 for criminal damage
- 4,254 for violence against the person
- 11,533 for theft

Anticipation of crime:
£4.6m

Consequence of crime:
£51.7m

Response of crime:
£23.5m

WIDER ECONOMY £35.5m



SOCIAL SERVICES £17.6m

Local authority budget estimated to be attributable to alcohol:

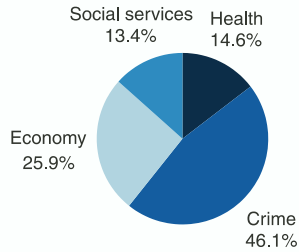
Children social services: £17.5m

Alcohol misuse services
For children £127,890

2021-2022
COST OF ALCOHOL HARM IN

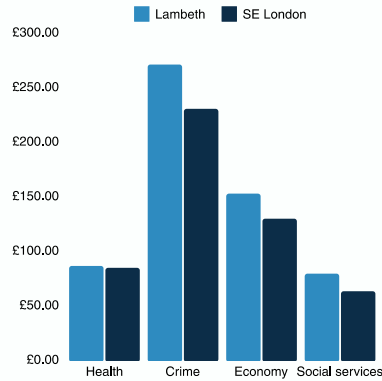
LAMBETH

COST BREAKDOWN

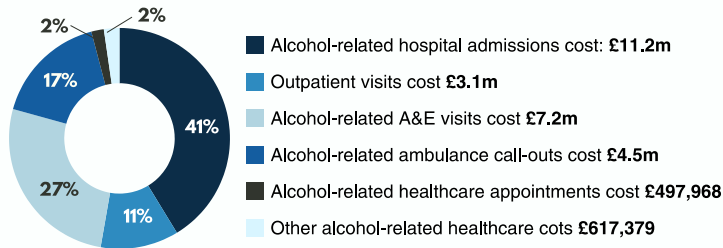


OVERALL COST:
£186.0m
£586 PER HEAD

COST PER HEAD



NHS & HEALTHCARE: £27.1m



CRIME & DISORDER: £85.8m

19,207 estimated alcohol-related crimes

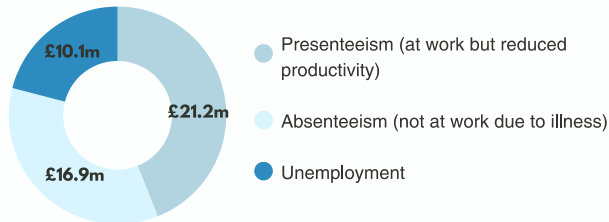
- Including reported and unreported crimes:
- 3,530 for criminal damage
 - 4,775 for violence against the person
 - 9,300 for theft

Anticipation of crime: £4.1m

Consequence of crime: £56.4m

Response of crime: £25.3m

WIDER ECONOMY £48.2m



SOCIAL SERVICES £24.9m

Local authority budget estimated to be attributable to alcohol:

Children social services: £22.7m

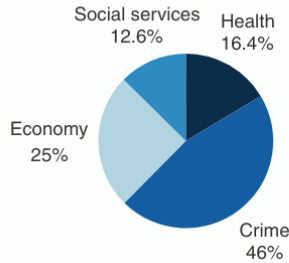
Alcohol misuse services

For Adults £2.2m
For children £21,420

2021-2022
COST OF ALCOHOL HARM IN

LEWISHAM

COST BREAKDOWN

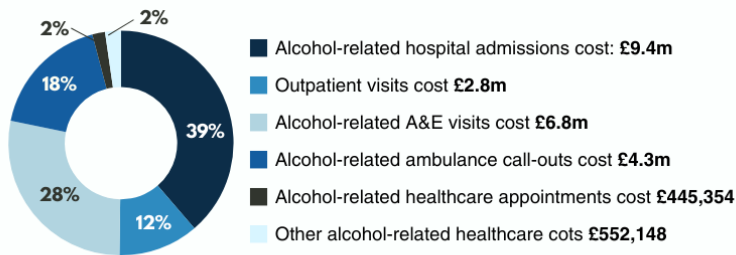


OVERALL COST:
£147.9m
£493 PER HEAD

COST PER HEAD



NHS & HEALTHCARE: £24.2m



CRIME & DISORDER: £68.0m

19,773 estimated alcohol-related crimes

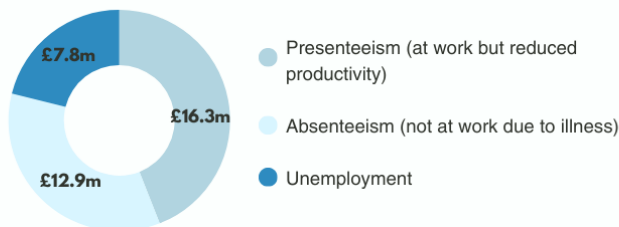
- Including reported and unreported crimes:
- 3,510 for criminal damage
 - 4,016 for violence against the person
 - 11,274 for theft

Anticipation of crime: £4.2m

Consequence of crime: £43.1m

Response of crime: £20.7m

WIDER ECONOMY £37.0m



SOCIAL SERVICES £18.7m

Local authority budget estimated to be attributable to alcohol:

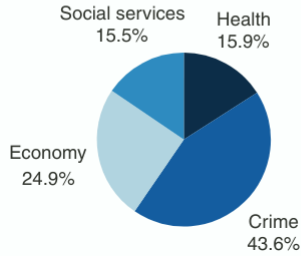
Children social services: £18.4m

Alcohol misuse services
For Adults £255,000
For children £36,855

2021-2022
COST OF ALCOHOL HARM IN

SOUTHWARK

COST BREAKDOWN

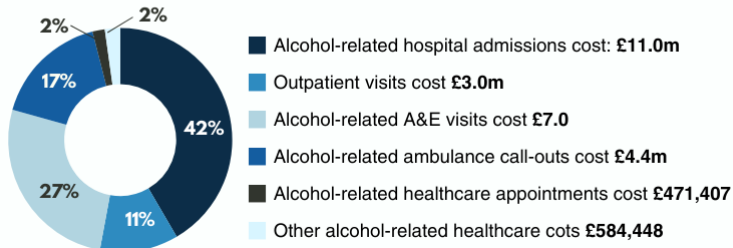


OVERALL COST:
£165.3m
£540 PER HEAD

COST PER HEAD



NHS & HEALTHCARE: £26.4m



CRIME & DISORDER: £72.2m

19,525 estimated alcohol-related crimes

Including reported and unreported crimes:

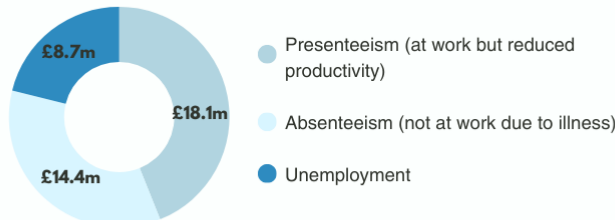
- 3,071 for criminal damage
- 3,951 for violence against the person
- 11,273 for theft

Anticipation of crime: £4.1m

Consequence of crime: £46.1m

Response of crime: £22.0m

WIDER ECONOMY £41.2m



SOCIAL SERVICES £25.6m

Local authority budget estimated to be attributable to alcohol:

Children social services: £23.6m

Alcohol misuse services

For Adults £2.0m

For children £67,410