

DRUG & ALCOHOL FINDINGS *Review*

analysis

This entry is our analysis of a review or synthesis of research findings considered particularly relevant to improving outcomes from drug or alcohol interventions in the UK.

The original review was not published by Findings; click [Title](#) to order a copy. Free reprints may be available from the authors – click [prepared e-mail](#). [Links](#) to other documents. [Hover over](#) for notes. [Click to](#) highlight passage referred to. Unfold extra text  The Summary conveys the findings and views expressed in the review. Below is a commentary from Drug and Alcohol Findings.

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▶ [A rapid evidence review of the effectiveness and cost-effectiveness of alcohol control policies: an English perspective.](#)

Burton R., Henn C., Lavoie D. et al.

The Lancet: 2017, 389, p. 1558–1580.

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An ambitious attempt to use research to understand the most effective and cost-effective set of policies for reducing alcohol-related harm in the English context, from taxation and price regulation to managing the drinking environment.

SUMMARY Alcohol-related harm is an internationally accepted public health challenge, with substantial economic and social costs to individual drinkers, the people around them, and wider society.

The UK Department of Health commissioned Public Health England to provide an overview of alcohol-related harm in England and possible policy solutions.

The featured review is one of the fruits this work, outlining the effectiveness and cost-effectiveness of policies to reduce alcohol-related harm, where effectiveness was defined as the degree to which an intervention reduced the public health burden (including health, social, and economic implications) of alcohol. The findings were interpreted within the English context, and considered most relevant to public health professionals and policy-makers in health and non-health sectors.

For reference, previous reports on this issue include a [report](#) from the Academy of Medical Sciences, an [expert summary](#) from the Alcohol and Public Policy Group (an international group of addiction scientists), and an [overview](#) by the World Health Organization. The free-access full Public Health England report is also available [here](#).

ALCOHOL CONTROL POLICIES FROM AN ENGLISH PERSPECTIVE

The featured review identifies the most effective and cost-effective set of policies for reducing alcohol-related harm in the English context, summarised here under the following headings; click the relevant link to skip forward:

1. [Taxation and price regulation](#)
2. [Regulating marketing](#)
3. [Regulating availability](#)
4. [Providing information and education](#)
5. [Managing the drinking environment](#)
6. [Preventing drink-driving](#)
7. [Brief interventions and treatment](#)

Main findings

Taxation and price regulation

An increase in the cost of alcohol has been consistently associated with a decrease in consumption, illustrating a phenomenon known as 'price elasticity' – the demand for a product showing sensitivity to price changes.

In general, people respond less to price changes of beer than wine and spirits. However, when it comes to places where alcohol is sold but cannot be consumed such as supermarkets (known as 'off-licensed premises'), people respond more to price changes of beer. Within the UK, heavy drinkers are more sensitive to price changes than moderate drinkers for most products, although they tend to switch to cheaper products when the price of their preferred product increases.

For tax increases to bring about reductions in harm first they need to be passed onto consumers through an increase in the price of the product. In the most part tax increases are passed on, but manufacturers and retailers may strategically try to moderate the effect, for example by increasing the price of their cheaper products by less than the tax increase and the price of more expensive alcohol by more than the tax increase.

One way governments can control this is by legislating a minimum price below which alcohol cannot be sold. The evidence base for minimum pricing is largely built on modelling studies in England and Australia, and natural experiments in Canada. English modelling studies have estimated that a minimum unit price set between £0.45–0.60 would reduce alcohol-related deaths and hospital admissions, with high-risk drinkers and less affluent people experiencing the greatest gains in health, and moderate drinkers only minimally affected. These results are confirmed by Australian modelling studies which showed that a minimum unit price of AUS\$2 has a greater impact on heavy drinkers and low-income households who consume larger quantities of alcohol.

The impact of minimum pricing in some Canadian provinces confirmed these findings. In Saskatchewan (a province in western Canada), a 10% increase in the minimum price of alcohol reduced total alcohol consumption by 8.4% within two years, with greater reductions for beer and spirits and alcohol bought in **off-licensed premises**. In British Columbia one year after implementation, the same price increase was associated with reductions in alcohol-related deaths (by around 32%), acute and chronic alcohol-related hospital admissions (by around 9%), traffic violations (by around 19%), and crime (by around 9%).

A potential concern with tax increases is that they may have a greater financial impact on less affluent people who tend to spend a larger proportion of their income on alcohol. However, on average, less affluent households consume less alcohol than high-income consumers and are more likely to *not* drink, and subsequently, are less likely to be financially impacted by changes in tax. To the extent that less affluent groups are more likely to suffer the harms associated with alcohol consumption, increasing the price of alcohol through tax has the potential to reduce health inequalities.

One **meta-analysis** (a method of combining the outcomes of similar studies) found that doubling the rate of tax is associated with a decrease in alcohol-related mortality by an average of 35%, as well as further reductions in violence, crime, road fatalities, and sexually transmitted infections. Modelling studies have predicted that taxation leads to large gains in health and life expectancy and is a cost-effective approach to prevention and health improvement. In England, a 10% increase in the price of alcohol is estimated to substantially reduce alcohol-related hospital admissions and deaths, amounting to over £22 billion in societal benefits over a 20-year period.

Comparing the two different policy types, in England taxation would need to increase by 28% to match the reduction in alcohol-related deaths estimated to result from a £0.50 minimum unit price. But they need not be implemented alone. English modelling studies have shown that combining a gradual increase in alcohol tax (annual increases in line with inflation plus 2%) with a £0.60 minimum unit price would have the greatest impact in reducing alcohol consumption and harm – estimated to reduce alcohol-related hospital admissions at the 20th year by about 28,000 compared with about 17,000 for minimum unit pricing only and about 11,000 for gradual tax increases alone. The benefits would be mostly accrued by high-risk drinkers and those in the lowest socioeconomic groups.

Over a period of five years, freezing alcohol tax is estimated to cost society over £540 million, while cutting tax would cost £870 million. A 2% gradual increase (followed by a four-year freeze) is estimated to save £1.2 billion, a £0.60 minimum unit price £3.2 billion, and the two in combination over £4 billion.

In 2014, the UK Government implemented a ban on the sale of alcohol below the cost of 'excise duty' (a tax on goods produced in the same country as they are consumed) and VAT in England and Wales. Modelling estimates are that this would reduce consumption by less than 0.1%, leading to no reduction in harm, while depending on the price set minimum unit pricing can have a 40–50 times greater impact. This was because the ban affected only 1% of units consumed by harmful drinkers compared with 44% of units under a £0.50 minimum unit pricing policy.

In 2011, the Scottish Government introduced a ban on quantity-based price discounts sold in **off-licensed premises**, such as 'buy one, get one free', though straightforward discounting such as 'half-priced wine' was still allowed. Two studies evaluated the impact of this ban. The higher-quality study reported reductions in sales of around 3% by 2012, largely driven by reductions in sales of wine and premixed beverages. A modelling study estimated the impact of a complete ban on discounting in **off-licensed premises** in England and reported small reductions in consumption, largely because these price promotions only affect a small proportion of sales and restrictions can be easily circumvented, for example by lowering the price of a product.

Regulating marketing

Marketing is a commercial strategy used to drive sales among new consumers, drive sales away from rival products, increase the frequency of purchase, and drive brand preference. Publicly available information on alcohol marketing is scarce and this has hindered research on the effects on alcohol consumption and harm. But there are two main aspects of marketing that governments can regulate: population exposure and the content of advertising.

The advertising industry in the UK is governed by codes of practice that are set by two industry committees: the Committee of Advertising Practice, and the Broadcast Committee of Advertising Practice. The codes are enforced by the Advertising Standards Authority, and in the case of broadcasting, also overseen by the independent statutory regulator, Ofcom.

Complete marketing bans are rarely implemented, so their evaluation depends mostly on modelling studies, which estimate that advertising bans represent one of the most effective and cost-effective approaches to prevention and health improvement, with the level of effectiveness decreasing as the policy moves from a complete to a partial ban. Among 11–18 year-olds, a TV-based advertising ban is estimated to reduce consumption by 9% in the UK.

A pragmatic alternative to a complete marketing ban is to implement legislation that dictates what advertisers are permitted to do. In 1991, France passed the Loi Évin (alcohol and tobacco policy law), which stipulated what advertising media can be used and the content of transmitted messages. The legislation permitted alcohol advertising in adult media only, and ensured that promotional messages were factual and verifiable. The Loi Évin represents a real-world framework for marketing regulation that is closed to interpretation and cannot easily be circumvented, and where strict penalties for contravening the law deter inappropriate marketer activity. [To read the Institute of Alcohol Studies' description of the Loi Évin, click [here](#).]

The strongest evidence for the impact of advertising on alcohol consumption comes from reviews of longitudinal studies [based on repeated observations of outcomes over a period of time] and cohort studies [where particular groups are followed over time to establish links between risk factors and health outcomes]. These studies report consistently that exposure to alcohol advertising is associated with an increased likelihood that children will start to drink, or if they're already drinking, drink in greater quantities. While the relationship between marketing and underage alcohol consumption does not directly provide evidence that limiting marketing will reduce consumption, the evidence is sufficient to support policies that reduce children's exposure to marketing.

Given that more than half of all TV alcohol adverts seen by children in the UK are aired before 9pm, watershed bans [where the 'watershed' is the dividing line between broadcasting that is suitable for the whole family, and that which is suitable for an adult audience] have been identified as appropriate policy. When the Netherlands introduced a watershed ban, commercial operators responded by increasing alcohol advertising shown after 9pm from over 7,500 adverts to over 23,000. Exposure of all ages increased as a result, but whereas exposure of adults increased by 52%, exposure of children aged 12–17 years increased by 62% and exposure of children aged 6–11 years increased by only 5%. A subsequent study compared the rate of children in the UK seeing TV alcohol adverts with children in The Netherlands, and found that watershed bans may be able to protect young children from exposure to TV alcohol advertising, but more effective measures are required to protect teenagers who go to bed later.

To date, no research has evaluated the impact of banning sports sponsorship, despite it resulting in a considerable number of children being exposed.

Digital and social media have changed the nature of marketing, with alcohol companies increasingly moving into this area. The potential power and reach of digital marketing is demonstrated by the fact that 86% of the UK adult population has regular access to the internet, increasing to 99% of those aged 16–24 years. Little data exists that measures the prevalence of online alcohol marketing, however social media case studies show a considerable media presence of alcohol brands. Age verification filters request that a viewer of a website confirm they are aged 18 years and older, but in their current form are inadequate and easily

circumvented. Nonetheless, using similar approaches to online gambling could enable correct verification of 85% of the UK adult population.

Marketing regulations can be embedded by law (statutory regulation), by industry codes of conduct (self-regulation), or by a combination of both (co-regulation). Three reviews have demonstrated considerable violations of content guidelines within self-regulated alcohol marketing codes, suggesting that the self-regulatory systems that govern alcohol marketing practices are not meeting their intended goal of protecting vulnerable populations.

Regulating availability

Policies that regulate the availability of alcohol are based on the theory that easier access to alcohol increases consumption and related harms. Regulation can occur at the retail level by specifying where and when alcohol can be purchased and to whom it can be sold – in England this is largely done through the Licensing Act 2003 – and at the production level by encouraging producers to market lower strength products.

Applying evidence-based policies within the constraints of the Licensing Act 2003 has proven difficult. Legislation requires that all licensing decisions examine evidence about specific outlets or local areas and consider the licensing objectives. As 'public health' is not a licensing objective, local authorities may struggle to present a health argument as a counterpoint to a licensing decision. Furthermore, health bodies typically present data at the population level and therefore cannot demonstrate 'cause and effect' between individual outlets and harm. Nonetheless, local areas with more effective licensing strategies have demonstrated a small additional reduction in alcohol-related hospital admissions compared with their less stringently regulated counterparts.

Most research about the relationship between 'outlet density' (the number of alcohol outlets within a geographical area) and alcohol consumption and harm has been carried out in Australia and North America. Broadly speaking, the evidence for a relationship between higher **outlet density** and social disorder is strong; for alcohol consumption, the evidence is less clear; and for chronic health harms, the evidence is emerging. Whether these relationships are causal or coincidental is uncertain. Added complexities, such as people driving to out-of-town shopping centres or purchasing alcohol online, are largely unaccounted for in the scientific literature to date.

International reviews and studies report that increasing the time and days on which alcohol is sold increases alcohol consumption and harm, particularly road traffic accidents and injuries.

A series of robust, well-designed Australian studies demonstrate that reducing late-night hours of sale in places that are licensed for people to consume alcohol ('on-licensed premises') such as bars substantially reduces rates of violence. Reducing the opening hours of **on-licensed premises** targeting the most densely populated areas with simultaneous enforcement is also cost-effective.

One of the aims of the Licensing Act 2003 was to allow extended on-licence opening hours and thereby to stagger closing times. A small body of research showed that this may have shifted alcohol-related violence later into the night, while in most hospitals, admissions relating to alcohol actually increased. Licensing in England has been increasingly viewed as an administrative process in a system primarily defined by market demand. This may have led to an overprovision of alcohol outlets, possibly explaining the limited changes observed in evaluations of the Licensing Act 2003.

In March 2011, the English Government launched the Responsibility Deal – a public-private partnership involving voluntary agreements by businesses and public bodies to make health-promoting changes. A specific **pledge** was to "remove 1 billion units of alcohol sold through improving consumer choice of lower alcohol products". While an initial government evaluation reported that the pledge had been successful, other research questioned the validity of this analysis, arguing that consumer responses and changes in alcohol tax were not adequately accounted for. Further analysis confirmed these concerns, concluding that most industry activity would have happened regardless of the pledge. Most actions related to the launch and promotion of new lower-strength products, potentially increasing the total number of alcohol units in the market.

Providing information and education

As with other products, consumers have a right to understand the risks associated with alcohol consumption, and policies in this area reflect this right.

UK health surveys show that while many respondents can correctly identify liver disease as a potential harm caused by alcohol, fewer are able to recall other harms such as cancer. Policies

that provide information and education can help to reduce this 'knowledge deficit', and increase the acceptability of alcohol policies. For example, people who are aware that alcohol is a risk factor for cancer are more likely to support alcohol control policies, including increases in taxation and strict marketing regulations.

Evaluations of mass media, and social norms or social marketing campaigns are often available, but tend to use poor quality designs and lack the detail required to draw confident conclusions about effectiveness and cost-effectiveness, and are not always available in a form that meets the standards required for academic publishing.

Well-executed campaigns reaching high public exposure are sufficient for raising awareness, particularly for making links between alcohol consumption and cancer, but industry-sponsored messages and campaigns are reported to be ineffective. Emerging research evaluating voluntary, temporary, abstinence-based challenges such as 'Dry January' suggest this is associated with a change toward healthier drinking. Alcohol education programmes in schools and higher education settings are a popular intervention, but their effectiveness is poorly supported by the evidence, so can't be deemed cost-effective either. Reported benefits tend to be seen only in the short-term and are often not replicated.

Evaluations of information labels on alcoholic beverages report that this information increases consumer awareness but is insufficient to change alcohol consumption. Evaluations largely rely on voluntary action by industry, or poorly-implemented mandatory labels in the USA.

In England, alcohol labelling is subject to a voluntary agreement between industry and government. In 2011, industry signatories pledged to ensure that 80% of alcohol products would have clear, legible labelling consisting of information on alcohol units, government consumption guidelines, and a pregnancy warning. Despite signatories meeting this pledge, only 57% of labels met best practice as defined by the [Portman Group](#) [set up/funded by the drinks industry]. This was mirrored by a previous evaluation of a voluntary agreement in 2007, where there was widespread non-compliance, with only 2% of samples using the agreed format. Small fonts and small labels and their colours and backgrounds may have obscured many messages. Similar side-stepping was seen with industry 'drink responsibly' messages. The [Organisation for Economic Co-operation and Development](#) (OECD) concluded that "the delivery of education messages by private sponsors [is found to] have no significant public health effects", a view echoed by the British Medical Association and confirmed by empirical evidence.

Despite alcohol having a high calorie content [calories [measure](#) the amount of energy in an item of food or drink], and the fact that alcohol accounts for nearly 10% of the calorie intake amongst adults who drink, there are no voluntary or mandated agreements to display nutritional information on alcoholic beverages in the UK. Against a backdrop of increasing liver disease and obesity, and with recognition of the combined effect of obesity and alcohol consumption on liver disease, the absence of research literature on nutritional labelling of alcohol is noteworthy.

The overarching finding that providing information and education does not produce sustained behavioural changes may arise from the fact it is delivered in an environment with widespread and unrestricted marketing of alcohol. The alcohol industry [attempts to](#) "reinforce and exaggerate strong pro-alcohol social norms", which have the power to overshadow health information campaigns.

Managing the drinking environment

The 'night-time economy' refers to economic activity that occurs between the hours of 6pm and 6am and involves the sale of alcohol for consumption in [on-licensed premises](#) such as bars, pubs, and restaurants. The night-time economy provides local employment, economic investment, and regeneration, but is also associated with heavy drinking and high levels of serious alcohol-related harm.

Community-based programmes typically include increased enforcement activity, improved serving practices and standards of licensed premises, and the attempt to coordinate and strengthen local prevention activity. One well-implemented and evaluated programme in Stockholm (Sweden) reported that these programmes can reduce the sale of alcohol to intoxicated customers and police-recorded violence in the immediate zone and neighbouring areas. There were also indications of the programmes being cost-effective – saving €39 for every €1 invested [[calculated from](#) the estimated cost of the programme and the average cost of violent crime, and the subsequent overall savings for the judicial system, production losses, health care issues, and other damages] – and feasible to implement.

There is no strong evidence of the effectiveness of training or educating about the harms of serving alcohol to people who are underage or intoxicated. When training increases knowledge and reduces the self-reported tendency to 'overserve', the impact is generally small. Greater

benefits are reported when servers are held legally responsible for harm caused by their customers, though implementation is expensive and there are issues regarding burden of proof. Increasing policing and enforcement has been shown to bring about small reductions in sales to underage or intoxicated customers in the short-term, but the cost of these resources has been overlooked in published evaluations.

Empirical evidence does not demonstrate that replacing glassware with plastic alternatives substantially reduces violence or police-recorded crime. In practice, many establishments use glass alternatives, which is included as an example of good practice in the guidance for UK licensing conditions. While most interventions in the night-time economy are carried out in and around **on-licensed premises**, some interventions have focused on the harm associated with purchases in **off-licensed premises**. An example is the voluntary agreement by local retailers to remove the sale of high-strength alcohol products, mostly defined as those that are stronger than 6.5% alcohol by volume. Over a period of one year in Manchester, removing the sale of high-strength alcohol was associated with greater reductions in alcohol-related crime and antisocial behaviour compared with areas that continued to sell high-strength alcohol. The scheme was reliant on the ability to deploy resources from the local neighbourhood [police] teams, and its effectiveness may be undermined if alcohol is readily available from nearby areas.

Public drinking bans, operationalised in England as Designated Public Place Orders, are implemented to address crime and disorder in public places caused by street drinking, and do not aim to reduce alcohol consumption per se. Low-quality evidence shows these restrictions negatively impact marginalised groups, particularly homeless people, and can result in displacement to more covert and less safe places.

Preventing drink-driving

There is a direct relationship between the amount of alcohol consumed and one's ability to drive safely, with an increased risk of a crash occurring above a blood-alcohol level of 40 mg alcohol per 100 ml blood, where the current English drink-driving limit is 80 mg/100 ml, and typical legal limits in Europe are 50 mg/100 ml or lower.

Drink-driving prevention policies use legal measures to encourage people to follow (and deter them from not following) the law, and non-statutory approaches to inform people of the risks of drink-driving and to adopt safer alternatives.

High-quality evidence supports setting and enforcing a blood-alcohol limit for drivers and applying a penalty if the law is broken. Estimates for Great Britain suggest that lowering the legal limit from 80 mg/100 ml to 50 mg/100 ml would avert about 25 deaths and 100 serious injuries each year, and the beneficial impact of these policies would be seen soon after implementation. Increasing the punishment for driving over the legal limit by immediately revoking a person's licence after they fail a breath test across all blood-alcohol levels reduces crashes to a greater degree than punishments that are determined by judicial review. Few health-economic evaluations were identified for drink-driving policies, however, a review of the cost-effectiveness of breath-testing reports benefit-cost ratios ranging from 2:1 to 57:1.

In some countries, the legal limit is set lower for different population groups such as learner drivers or commercial drivers. These can be implemented alongside other restrictions such as driving curfews and passenger restrictions. Reductions of around 8–14% among young drivers have been observed in graduated driver programmes (designed to provide new drivers with driving experience and skills in a gradual way, in low-risk environments), with restrictions including night-time driving curfews and passenger restrictions having the potential to avert as many as 47% of injuries in young drivers in Great Britain – equivalent to savings of up to £849 million per year.

Mass media campaigns are commonly used to inform people of the risks and punishments associated with drink-driving, and in countries with existing prevention activities, have been found to reduce drink-driving and alcohol-related road traffic crashes. These campaigns can be cost-effective, despite the high costs of development and implementation.

'Designated driver' campaigns can be enacted at the population level, encouraging people to abstain from alcohol at a social gathering so they can be fit to drive others home. They can also be implemented in **on-licensed premises** where people are given incentives to act as designated drivers. Self-reported behaviours following a population-level designated driver programme showed that it increased people's tendency to use a designated driver, but did not change the prevalence of people drink-driving or riding with a drink-driver.

Some people with convictions for drink-driving continue to do so, and are rearrested or involved in further crashes. Policies with the specific aim of preventing drink-driving reoffending include 'alcohol ignition interlocks' and preventive education programmes.

- Alcohol ignition interlocks are installed in a vehicle and measure the driver's alcohol consumption using a test that detects the level of alcohol in the breath. In order to start the engine, the driver must provide a valid sample and subsequent samples at the random request of the device. Invalid samples are logged and an alarm is triggered until the engine is switched off. Ignition interlocks have been found to reduce reoffending in both first-time and repeat offenders and can be cost-effective. If the device is uninstalled, reoffending rates return to those recorded before installation.
- Preventive education programmes focus on increasing awareness of the impact of alcohol on driving and provide advice for changing behaviour. Some evaluations have demonstrated reductions in drink-driving reoffending associated with these programmes. However, it is difficult to determine their independent effect because many programmes include additional components.

Brief interventions and treatment

Screening and brief interventions or brief advice are typically delivered by general health care workers and target non-treatment-seeking drinkers, with the aim of helping them to reduce their alcohol consumption.

Primary health care is the most extensively studied setting, with reviews and **meta-analyses** consistently reporting that screening and brief advice reduces hazardous and harmful consumption six and 12 months later. Modelling what would happen if every patient received screening and brief advice at their next registration with a new general practitioner (GP) in England, one study produced estimates that over 20 years, it would reduce alcohol-related deaths by almost 2,500 and alcohol-related hospital admissions by almost 125,000. People in the lowest socioeconomic groups would be expected to experience the greatest reduction in harm overall, but the lowest proportionate reduction because they experience a higher baseline level of alcohol-related harm.

Across other settings and specific populations:

- Similar reductions in hazardous and harmful consumption have been reported in the criminal justice setting, and using electronic screening and brief advice, though only in the short-term.
- Workplace screening and brief advice does seem to be effective, though it is not clear for which type of employee it would be most beneficial. Barriers to delivery in this setting include employees being anxious about the consequences of disclosing heavy drinking to their employer.
- The effectiveness of screening and brief advice for adolescents is currently not clear.
- Screening and brief advice in emergency departments is effective at reducing average weekly alcohol consumption at six months and 12 months. However, a randomised controlled trial in England suggested that delivering screening and brief advice in a typical emergency department setting might be difficult without substantial additional staff support.
- There is little empirical support for the effectiveness of screening and brief advice in community pharmacies.
- There is a small evidence base to suggest that screening and brief advice within a sexual health setting would not be effective or cost-effective.

For specialist treatment, the National Institute for Health and Care Excellence (NICE) has published national guidelines for the treatment of harmful and dependent drinking, which includes a review of treatment effectiveness. The approaches are broadly categorised as pharmacological or psychosocial. NICE reviewed the effectiveness of 12 different psychosocial therapies for reducing harmful and dependent drinking. Overall, the evidence supported the use of couple's therapy, cognitive-behavioural therapy, social behaviour and network therapy, and behavioural therapies, over no intervention or other active interventions.

NICE reviewed four pharmacological therapies for preventing relapse back to dependent or heavy drinking. They proposed that pharmacological treatments should be delivered in combination with psychosocial support, and endorsed acamprosate, naltrexone, and nalmefene, but not disulfiram because of lower-quality research and a greater potential for harm. By comparison with standard care, acamprosate resulted in health-care savings of about £68,900 (after costs).

An Australian study reported that a combination of naltrexone and counselling was cost-effective compared with standard care only. A combination of nalmefene with a psychosocial intervention averted about 4,900 cases of alcohol-related disease and injury and 250 deaths per 100,000 patients compared with a psychosocial intervention alone after five years. More quality-adjusted life years [[where](#) one quality-adjusted life year is equal to one year of life in perfect health] were gained with nalmefene than with psychosocial interventions alone.

The authors' conclusions

Alcohol-related harm is influenced by three key factors: price (affordability), how easy it is to purchase (availability), and social norms (acceptability). The challenge for policy-makers in England seeking to mitigate the health, social, and economic harms caused by alcohol is to implement the most effective and cost-effective set of policies for the English context.

The featured review identified such policies, and described evidence of their varying effectiveness and cost-effectiveness, concluding that:

- Increases in tax boost government revenue and deliver substantial health and social returns. Like taxation, marketing regulations return large health benefits and have the potential to change drinking behaviour at an early age, preventing later problems. Robust marketing regulations are strongly supported by the evidence base, particularly those that reduce the level of exposure in children.
- The combination of tax increases and setting a minimum per-unit price at which alcohol can be sold are estimated to lead to substantial reductions in harm and increases in government revenue greater than those achieved by a minimum unit price in isolation.
- Policies that sufficiently reduce the hours during which alcohol is available for sale, particularly late-night sales in places that are licensed for people to consume alcohol, can substantially reduce the alcohol-related public health burden, and are cost-effective when simultaneously enforced and targeted at the areas with the greatest concentrations of alcohol outlets.
- Although playing an important role in increasing knowledge and awareness, there is little high-quality evidence to suggest that providing information and education is sufficient to lead to substantial and lasting reductions in alcohol-related harm. However, these policies increase public support for more stringent (and effective) policies.
- Labels on alcoholic beverages may not change drinking behaviour, but consumers have a right to be better informed. These policies should be considered as an important component in any overall policy approach.
- Enforced legislative measures to prevent drink-driving are effective and cost-effective, but in England are estimated to lead to minimal public health gains compared with policies such as taxation. Nonetheless, reducing drink-driving is an intrinsically desirable societal goal. Both should be considered complementary components to a wider strategy that aims to influence drinkers to adopt less risky patterns of alcohol consumption.
- Screening and brief advice and specialist treatment for drinkers who are already at risk show favourable returns on investment, but success depends on large-scale implementation and dedicated treatment staffing and funding streams.

The above were described in the report under seven topic headings, representing seven different types of alcohol policy. However, according to the [Organisation for Economic Co-operation and Development](#), a combination of alcohol policies is needed to create a 'critical mass effect' – changing social norms around drinking to increase the impact on alcohol-related harm.

Research in the United States echoes this point, showing that 'stronger' overall policy environments are associated with lower levels of heavy drinking and alcohol-related harm. Hand-in-hand with this is 'consistency' of policy. For example, warning labels highlighting the risks of alcohol consumption would be undermined by a unit price that encourages heavy consumption.

FINDINGS COMMENTARY Approaches to alcohol policy differ widely across the UK, particularly in terms of their alignment with what are known to be the most effective or cost-effective measures. A [2015 paper](#) produced by the Alliance for Useful Evidence reviewed UK alcohol policy going step-by-step through 'what the evidence says', and 'what is happening in practice'. In this, Scottish policy was found to come closest to evidence-based recommendations, framing alcohol as a whole population issue, in contrast with UK government policy which is influenced to a greater extent by prevailing beliefs about personal responsibility for drinking and drinking problems.

That report helps to put the findings of the featured review in context, [demonstrating](#) that alcohol policy development and decision-making in the UK is not being driven by scientific evidence alone, and that governments are not so much ignoring the evidence, as interpreting it through particular cultural, political and ideological lenses. Furthermore, across the board, the level of industry involvement in policy design and implementation exceeds their role as producers and distributors of alcohol, which has the potential to undermine public health and promote weak or ineffective policies.

The [hot topics archive](#) in the Effectiveness Bank covers many of the issues raised in the featured review, from [controlling alcohol-related crime and disorder](#), to [minimum pricing](#), [screening and brief interventions](#), and [social norms messaging](#). To understand the political and scientific context for how we measure alcohol-related harm, turn to this [Effectiveness Bank hot topic](#).

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