



**Royal College of Psychiatrists in Northern Ireland Response  
to the *Consultation on Minimum Unit Pricing of Alcohol*  
22 June 2011**

The Royal College of Psychiatrists, Northern Ireland, welcomes the opportunity to respond to this consultation regarding proposals to introduce a minimum unit price for the sale of alcohol.

The Royal College of Psychiatrists is the statutory body responsible for the supervision of the training and accreditation of psychiatrists in the UK and for providing guidelines and advice regarding the treatment, care and prevention of mental and behavioral disorders.

The College has 320 members in Northern Ireland, including doctors in training. These doctors provide the backbone of the local psychiatric service, offering inpatient, day patient and outpatient treatment, as well as specialist care and consultation across a large range of settings.

As with other medical professionals, psychiatrists are all too aware of the harmful effects of excessive alcohol consumption. We therefore welcome the Department for Social Development and Department of Health's stated concerns and proposals.

The Royal College of Psychiatrists does not oppose responsible drinking, but has concerns about the impact of harmful and hazardous alcohol consumption.

Psychiatrists, who not only treat people with long-term alcohol abuse problems, but those whose drinking is contributing to and causing mental disorder and self harm, are all too aware of the impact of this.

Much of the work of our members is with the heaviest drinkers, including those with alcohol dependence, and this group has been shown to be sensitive to price increases. We believe that introducing minimum pricing, rather than simply curbing or banning promotions or raising taxation, has the potential to have a significant beneficial effect on the drinking of that group.

A recent survey in Edinburgh illustrated the influence of price on the beverage choices of people who use alcohol services, finding that 70% of the units of alcohol consumed were under 40p and 83% under 50p<sup>i</sup>.

This is consistent with our own members' observations in clinical practice where the popularity of super lagers in the 1990s was supplanted by white cider and vodka by the millennium as these drinks became cheapest.

According to the British Medical Association, 2007 sales of alcohol (including supermarket, off-licence, restaurant and bar sales) were high enough to put virtually every British adult over government guideline drinking levels<sup>ii</sup>. As the consultation notes, in Northern Ireland there is a cohort of drinkers who regularly exceed guideline drinking levels to a greater degree than elsewhere in the UK.

We commend the attention this consultation document pays to valuable research in Sheffield and Aberdeen. As noted, the Sheffield University study commissioned by the Department of Health in England, found policies that increase the price of alcohol can bring significant health and social benefits and lead to considerable financial savings in the health service, criminal justice system and in the workplace<sup>iii</sup>. This research, referenced throughout the consultation document, found that, in general, the more restrictive the policy, the greater the impact in reducing harm.

The University of Sheffield demonstrated that around two thirds of alcohol sold below 50p a unit is consumed by those drinking more than 50 units (35 for women) per week. Only 9% of cheap alcohol is consumed by moderate drinkers. A reasonable minimum unit price would therefore have very little impact on those who consume alcohol within healthy limits.

It is essential that the Northern Ireland Executive takes action to address this growing problem. We believe that minimum pricing will have a considerable benefit on reducing the harm which comes from the consumption of the cheapest forms of alcohol, will reduce the burden on society of alcohol abuse, and will have little impact on the majority of the population who enjoy alcohol in moderation.

Consultation Questions

**To what extent would you agree with the introduction of minimum pricing per unit of alcohol in Northern Ireland?**

We would strongly agree with proposals to ensure that alcohol is sold at a sensible price, and favour the mechanism of the introduction of a

minimum unit price to achieve this. We would suggest this should be at least 45 pence a unit to have the necessary impact.

The Royal College of Psychiatrists is not opposed to responsible drinking, and a minimum price and the measures set out above should not affect those who drink alcohol in moderation.

A further advantage would be that minimum pricing is straightforward to monitor and, unlike a below cost selling or loss leading ban, does not rely detailed information on production, promotion and distribution costs for its implementation.

**To what extent would you agree with the proposed principles on which a minimum pricing scheme for alcohol products may be established?**

**To what extent would you agree with the banning of below costs sales in Northern Ireland?**

While the Royal College of Psychiatrists favours minimum unit pricing, the College would support a ban on below-cost sales, and has concerns about alcohol discounting as a whole. This is particularly the case in relation to supermarket alcohol promotions, where discounting of beer and cider in particular is employed as a 'loss leader' to increase customer foot fall. Sheffield University has studied supermarket promotions selling beer at between 20-25 pence a unit.<sup>iv</sup> Around two thirds of beer sold in that price range is on promotion. Only 6% of the beer on promotion in that price range would have a recommended retail unit price above 40 pence. This indicates that cheap beer is being sold even cheaper.

With relation to supermarket promotions, higher minimum prices lead to greater harm reductions, and this escalates steeply – for example, there is relatively little impact from a 20p minimum price, but 30p, 40p, 50p and 60p have increasing effects. Similarly, a ban on just BOGOFs (buy-one-get-one-free) does not affect health harm very much, but banning discounts larger than 10%, or even a total ban on sales promotions in the off-trade lead to substantial estimated harm reductions<sup>y</sup>.

We would welcome moves to curb quantity promotions that encourage people from drinking to excess, in particular from drinking more alcohol than they had intended or would otherwise consume. For example, selling three boxes of beer for the price of two.

**To what extent would you agree with a ban on the sale of alcohol below the rate of duty plus VAT in Northern Ireland?**

The Royal College of Psychiatrists would certainly support a ban on the sale of alcohol below the rate of duty plus VAT, however we do not believe that is the most effective mechanism.

Minimum pricing will have an effect on the price of the cheapest alcohol. Duty increases may not affect the price to the consumer, depending on decisions made by producers and retailers.

***To what extent would you agree that increasing taxation (a matter for the UK government and not NI Assembly) should be used to address the harmful effects of problem drinking?***

Taxation increases, if passed on to consumers, bring across the board price increases, but do not impact on the alcohol

consumption of heavy drinkers<sup>vi</sup>. This is probably because heavy drinkers move to cheaper brands. Minimum pricing is an effective way of preventing this “trading down.”

**To what extent would you agree with a ban on the introduction of a social responsibility levy in Northern Ireland?**

The BMA report ‘Under the influence: the damaging effect of alcohol marketing on young people’ makes it clear that voluntary regulation of advertising has not worked. While the alcohol industry has a “Drink Aware” campaign, we do not believe that this is sufficient to change the attitudes and behaviours of people in Northern Ireland. We would back the BMA’s call for a compulsory levy on the alcohol industry to fund an independent public health body to oversee alcohol related research, health promotion and policy advice<sup>vii</sup>.

Minimum pricing is key to tackling alcohol abuse, but the broader culture of binge drinking in Northern Ireland means that the promotion of alcohol through advertising and sports sponsorship will need to be addressed.

**To what extent would you agree that a social responsibility levy should apply to all on and off licensed premises and registered clubs in Northern Ireland?**

On initial suggestion this is an attractive proposition. However given that many licensed pubs, hotels, restaurants etc have suffered from the low cost alcohol sold by supermarkets, it wouldn’t seem appropriate to then penalise them for merely selling alcohol. Also it would be very difficult to cost this levy appropriately. A consideration of repeated costs to the criminal justice system associated directly with a particular premises may be a way to stop selling alcohol to those already

intoxicated, as repeat offenders could be given one-off fines (for example, venues where the PSNI are repeatedly having to intervene within say 20 yards of the front door) or could be widened to involvement of the ambulance service, and criminal justice system. Venues could have to pay servicing costs for additional street cleaning services required if it is apparent that patrons are frequently fouling the area by urinating or vomiting.

## **Equality**

The Department would welcome views, with supporting data wherever possible, on the potential equality impacts for those who may be affected by the issues discussed in the consultation document.

**Please see Section 8 of the document.**

What impact do you perceive the policy to have on the following equality categories?

<b>Equality Category</b>	<b>Negative Impact</b>	<b>No Impact</b>	<b>Positive Impact</b>
Religious beliefs		X	
Political opinion		X	
Racial group		X	
Gender		X	
Marital status		X	
Age		X	
Persons with a disability persons without		X	
Persons with dependents or persons without		X	
Sexual orientation		X	

## **Health Issues**

The World Health Organisation has also stated that availability of alcohol plays a key role in consumption, and recommends regulations including the number and location of alcohol retail outlets, and the days and hours of retail sales<sup>viii</sup>. The British Medical Association recommends UK Governments should ensure that the density of alcohol outlets is taken into account in planning or licence applications<sup>ix</sup>. The Royal College of Psychiatrists would support this. Marketing of alcohol also plays a significant role in consumption. There is evidence that restricting marketing will reduce harmful drinking, but there will be a greater impact when that is combined with other interventions such as pricing<sup>x</sup>.

The 2001 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness stated that "the combination of mental illness and substance abuse is probably the greatest clinical problem facing general adult mental health services."<sup>xi</sup>

People with mental health problems are at an increased risk of alcohol misuse problems, and vice versa<sup>xii</sup>. This relationship is complex with alcohol both contributing to some psychiatric disorders, and being more common among people with mental health conditions who seek to 'self medicate.'

In the general population, individuals who indulge in considerable high levels of alcohol are at risk of developing depression and psychotic mental illness later in life<sup>xiii</sup>. Dependence on alcohol, harmful drinking and binge drinking are associated with a significant increase of risk of dementia, and it has been predicted that there may be a disproportionate increase in alcohol-related dementia in future generations.<sup>xiv</sup>

Although alcohol use does decline with age, a significant number of older people consume alcohol at dangerous levels. The Royal College of Psychiatrists has published *Our Invisible Addicts*<sup>xv</sup>, a report on the impact of alcohol on older people that demonstrates the complex relationship between alcohol use and mental and physical health problems and the higher mortality rate linked to substance abuse in older people. With a rapidly aging population in Northern Ireland, this report is particularly pertinent here.

The complex relationship between mental health problems and alcohol misuse by older people include intoxication and delirium, withdrawal syndromes, anxiety, depression and cognitive changes/dementia. Among older people, psychosocial factors (including bereavement, retirement, boredom, loneliness, homelessness and depression) are all associated with higher rates of alcohol use.

Current recommended 'safe limits' for alcohol consumption are based on work in younger adults. Because of physiological and metabolic changes associated with ageing, these 'safe limits' are too high for older people; recent evidence suggests that the upper 'safe limit' for older people is 1.5 units per day or 11 units per week. In older people, binge drinking should be defined as >4.5 units in a single session for men and >3 units for women.

Alcohol also exacerbates previous mental illness in the population as a whole. For example, individuals who suffer from schizophrenia can suffer a relapse after drinking alcohol.

Alcohol consumption within the context of the family can lead to an unstable environment for children, which results in mental health problems in future generations.

Figures from the upcoming National Inquiry into Suicide and Homicide by People with a Mental Illness are not yet available, but we would expect they would support the experience of psychiatrists in Northern Ireland that alcohol is a major factor in both suicide and homicide. We would recommend the findings of the National Inquiry report are taken into consideration when reviewing consultation responses.

There is a stark correlation between suicide and self-harm and excessive alcohol intake. Alcohol predisposes to suicidal behaviour because it has a depressive effect, it increases impulsivity, it impairs problem solving, and it can lead to adverse life events<sup>xvi</sup>. Studies from around the world have reported a high prevalence of alcohol use disorders among people who have died by suicide<sup>xvii</sup>, including a Northern Ireland study that showed 43% of suicides had used alcohol at the time of death<sup>xviii</sup>. The National Inquiry reported that 62% of people who died by suicide in Northern Ireland who had been in contact with mental health services within one year of death had a history of alcohol abuse. English researchers found that alcohol dependence was a factor in up to a third of self-harm incidents, and that alcohol was an independent predictor of suicide following non-fatal self-harm.<sup>xix</sup> The researchers noted evidence that alcohol is implicated in 15–25% of completed suicides. In a report based on the National Morbidity Survey of 2000, a fourfold increase in suicidal behaviour was identified among those with alcohol-related problems compared with those without such problems<sup>xx</sup>.

National suicide rates tend to rise with greater consumption of alcohol, and it has been demonstrated that reducing levels of consumption can lead to lower suicide rates.<sup>xxi</sup> Indeed, in the

former USSR the political process of perestroika between 1984 to 1990 led to much stricter controls on alcohol, including substantially higher prices fewer retail outlets and reduced tolerance of public drunkenness. During this time the suicide rate fell by 32% for men and 19% for women.<sup>xxii</sup>

### **Any other areas/issues which you feel may be affected**

There is wide acceptance that heavily discounted supermarket alcohol is the main reason for the closure of good quality pubs and specialist off licenses with subsequent unemployment. Introducing a floor price would restore the balance of competition based on quality rather than on price.

Anecdotal evidence suggests cheap supermarket alcohol has had a particular impact on pubs in rural areas, with customers preferring to drink at home.

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### **References**

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