MCA Medical Council on Alcohol
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Dr Dominique Florin
Editor

From the Editor

In this issue: The MCA's work with medical students is at the centre of our mission. Amongst the activities is the annual essay prize, this year with the title 'Are we daft to drink?' The winning essay is by Jordan Bamford from Belfast Medical School. The full essay is published in the 2015 MCA Annual Report but a short version can be read here; it is a thoughtful and intelligent response to a stimulating question.

Also in this issue is an article by Dr Joss Bray, dually qualified in general practice and psychiatry and with extensive experience working in the addiction field. Dr Bray has written about the complex and changing context in which substance misuse services are delivered. His view is that in the midst of this, particular attention needs to be taken to ensure that the service users at the nexus of this system are treated with the highest standards of competence and compassion. Dr Bray has also supported the establishment of formal addiction training in the UK [1].

The issue of educating school-age children to avoid alcohol related harm is a thorny one. It is not in the mainstream of the MCA's work but is so self-evidently important as a preventative issue that we must pay attention to evidence of effective interventions. It is fair to say that high quality data has generally been sparse, so the Alcohol Education Trust is to be commended for not only developing an intervention but also completing an evaluation over several years. The results presented here are encouraging.

1 BMJ 2015; 351 doi: http://dx.doi.org/10.1136/bmj.h4027

In the medical press: The Chief Medical Officer's review of safe drinking guidelines is awaited. In the meantime, a piece of work from Sheffield Alcohol Research Group is relevant [2]. This used the concept of 'lay epidemiology' to look at how guidelines are framed and their relevance for drinkers. Amongst their findings were that units are not a helpful concept to manage their intake for many people, given a lack of fluency in calculating these. In addition the value of daily limits is reduced in those who mainly drink heavily at weekends. This is an important piece of work, extending the need to take both epidemiological and qualitative data into account in formulating guidelines.

The link between alcohol and cancer is much in the news. The evidence for a positive association is strong but complicated, and the literature is growing to rival the literature on alcohol and cardiovascular risk. A recent piece of research made the distinction between heavy and light to moderate drinkers [3,4]. In this latter category, the stongest evidence for a link between alcohol and cancer was for breast cancer in women and for cancers in male smokers. The fact that from the point of view of cancer, there is NO safe level of consumption of alcohol is a powerful message, putting alcohol on a par with smoking.

2 Lovatt, M., Eadie, D., Meier, P. S., Li, J., Bauld, L., Hastings, G., and Holmes, J. (2015) Lay epidemiology and the interpretation of low-risk drinking guidelines by adults in the United Kingdom. Addiction, doi: 10.1111/add.13072.

3 BMJ 2015; 351 doi: http://dx.doi.org/10.1136/bmj.h4238

4 BMJ 2015; 351 doi: http://dx.doi.org/10.1136/bmj.h4400

MCA 2015 symposium: This year's annual MCA symposium is on 'Alcohol; health, well-being and work'. This is a highly topical issue. The government has been consulting on some controversial approaches linking treatment for addiction to the receipt of benefits; a report by Dame Carol Black is awaited. Only a few tickets remain, so do contact the office for yours before they sell out.

Call for MCA committee members: The MCA depends on members who are experts in the field of alcohol and health, who give their time voluntarily to the organisation. It is undoubtedly increasingly challenging to combine clinical or academic roles with committee work such as at the MCA. However our activities are informed by the expertise and wisdom of our committee members; without their input the MCA would be a lesser organisation. If you feel able to give some time, please do consider joining one of our committees; further details are on the back page of this newsletter.

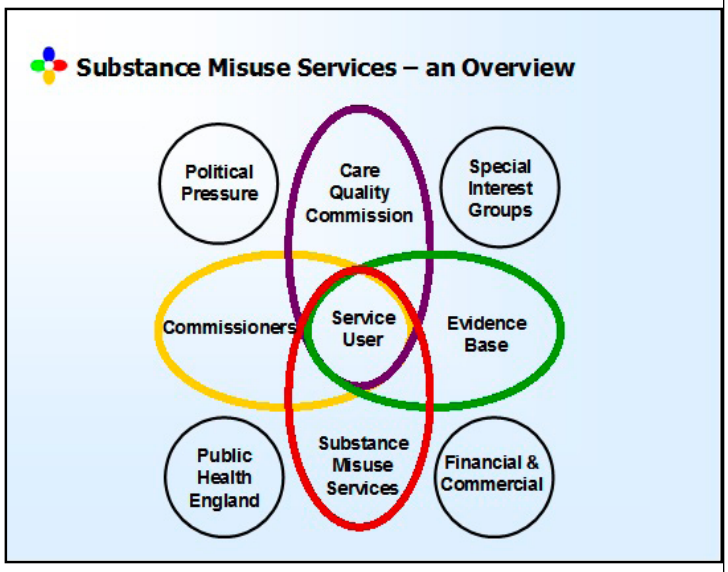
How Substance Misuse Services work in the UK - and how to make them better

Dr Joss Bray MRCPsych FRCGP, Founder of www.competentcompassion.org.uk. Clinical Lead for Spectrum CIC for Drug and Alcohol Recovery Teams in the North East Prisons.

This artiucle is based on a presentation by Dr Joss Bray at the RCGP 20th National Drug and Alcohol confernece in June 2015.

There are many players in the substance misuse treatment arena in the UK. They all have their roles to play, whilst at the same time being influenced by pressures in the system. This creates a complex situation which can lead to a less than perfect service delivery to the person who matters - that is the patient (or client, or service user - depending on your preference).

This is an attempt to visually represent the state of service provision currently in England - and while this will not exactly be the same in all parts of the UK, there are underlying principles that can be observed and used to understand how different parts of the system may interact.



So, looking each of the organisations briefly in turn -

Firstly we have the commissioners. Alcohol and drug commissioning is now largely in the hands of Local Authorities (LAs) with some additional work done by Clinical Commissioning Groups (CCGs) in particular areas. The funding for these services has been allocated by Public Health England (PHE) but PHE do not have any ability to direct how the funds are spent. PHE will try and influence LAs but they have no actual power over them. Crucially, this funding is part of LA income and is not ring fenced. Significant cuts in government funding for LAs means that services have also been cut - in some places by up to a third even in mid contract. This is despite LAs now having a statutory duty to improve the health of their population. Local politics and financial pressures can mean that evidence based interventions may be sidelined in favour of simply measuring so called "successful completions" - where people have come into services and who then leave apparently free of substance misuse problems as soon as possible - whether or not the other pressing issues in their lives that contribute to their problems have been resolved.

Secondly, the Care Quality Commission (CQC) has responsibility for inspecting services. It has recently updated its inspection policy and modus operandi for substance misuse services, but won't be able to give ratings. It will be looking at whether services are safe, caring, responsive, effective and well led as well as whether service user's needs and choices are taken into account. The CQC itself has its own pressures and is under increased scrutiny as to whether it is itself effective. At the time of writing I am unaware of a high level lead in the CQC solely with responsibility for substance misuse services - which I feel is disappointing - although specialist advisers are being actively recruited.

Thirdly, the evidence base is crucial to treatment services, but, as can be seen above, it is only one part of the system. Special interest groups have become vocal in promoting their particular view on what good treatment looks like. There are many debates on what "recovery" may be, but "maintenance" has become a word that now seems to be persona non grata, and harm reduction has taken a back seat. Now recovery can seem to equal abstinence which then equals 12 step programmes. Whilst there is no doubt that many people do well with this approach, there is also no doubt that many do not, and need a different treatment plan and a different idea of what recovery may look like. One size does definitely not fit all. The Strang report emphasises this as well - and in particular the (often implicit rather than explicit) push to get people "off their scripts" and counting as a "successful completion" is definitely not what Professor Strang seems to have in mind as being evidence based treatment. Perhaps the recent rises in drug related deaths in England and Scotland that seem to coincide with the new commissioning imperative of recent years is testament to that.

And fourthly, there are the providers of substance misuse services themselves. We have seen the dramatic rise of non statutory organisations in the last few years. These can now be large charities with multimillion pound turnovers - which can be in excess of £100 million. The larger ones tend to be able to put more resources into complicated and long tendering processes, and often seem to be able to bid at a lower cost than smaller organisations. Smaller charities and community interest companies can feel at a disadvantage without the infrastructure needed to win tenders. Conversely, large organisations run the risk of growing so rapidly that they outstrip their available infrastructure and have trouble providing the services and support to staff that are required. All are under pressure to compete to keep or win services and make savings as well as meet commissioning targets. This can lead to less staff doing more than ever. The commissioning cycle often results in considerable uncertainty and anxiety for service users and staff.

This leaves the person in the middle - the service user. We can see in the diagram that where all the major players meet there is a small space where the important things happen - the actual treatment and therapy, the life skills development, tools for maintaining recovery, help to find work or training, help to find suitable accommodation, help with family stresses, encouragement and visible success represented by peer mentors, social activities, counselling, health

improvement, harm minimisation, crime reduction, screening, dual diagnosis work etc - the list could go on a lot longer. When organisations and pressures pull in their own directions, it is this space that gets squeezed. I believe that this is why it often feels like that for those of us working in the middle. The space is pressurised and is becoming more so.

So what is the answer? I believe that we need to start looking at what is actually most important to the people who need help.

This is the actual one to one interaction between service user and staff. This is where quality actually resides. What the service user wants and needs is simple - they want the person who is helping them to be competent and compassionate. This is the key to excellent service provision. One without the other is at best not going to work and at worst it is dangerous. "Competent Compassion" as a concept encapsulates the quality that we want to be able to provide - even in the face of all the pressures in the system.

Simply put, competence is about understanding all the relevant issues and being able to make an informed and reasonable action plan based on evidence and experience. Compassion is caring about the service user, trying to understand and even feel the problems from their point of view, and demonstrating that you are trying your best to help them.

But can competent compassion be measured and developed? Yes I believe so. The website www.competentcompassion.org.uk explores this in more detail and has some background articles and comments which expand the concept - although it is essentially very simple. There are also "Competent Compassion Check Ups" in development, which can simply and quickly give an indication of how staff are doing. There is one for the professional, one for the service user and one for an observer. They can be used together or separately and are meant to be reflective and formative as well as being able to measure progress both in competence and compassion.

In summary - alcohol and drug treatment seems to have lost focus on the individual and their treatment due to competing pressures in the system. Things that are important are not measured and things that are not as important are over emphasised. There is too much at risk to ignore this any longer. We need to come back to focus on a measure of the real quality of care that is delivered. That is based on competent compassion being at the heart of services for some of the individuals who need it the most. My belief is that this refocusing will actually be the key to providing the better outcomes that we all want, and that many desperately need.

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Strang Report: http://www.nta.nhs.uk/uploads/medications-in-recovery-main-report3.pdf

2015-16 NAAD Competition

The latest comeptition is now open and entrants must submit two youtube videos, one for fellow health professionals and one for patients, on the theme of 'Alcohol and Obesity'. The videos need to be no longer than 5 minutes long.

Alcohol and Obesity

The relationship between alcohol and obesity is complex and influenced by lifestyle, genetic and social factors. There may be common neural pathways associated with excess alcohol and food consumption. Alcohol drinkers may not be aware of the calories contained in alcoholic drinks. The effects of alcohol on body weight may be more pronounced in overweight and obese people. Excess body weight and alcohol consumption appear to act together to increase the risk of liver cirrhosis; drinking alcohol in patients who are overweight, or particularly obese, carries a much greater risk of liver damage.

The biennial MCA National Alcohol Awareness Day competition will open on 1st November 2015 and entries must be received by 31st March 2016. It is open to UK medical students. For more information please look on our website **www.m-ca.org.uk/medical_students/naad_competition**

Due to the nature of this competition please ensure that any ethical issues regarding participant consent is agreed in writing prior to submission.

The top three will receive a financial prize to support an alcohol-related placement in the UK or abroad. Recent placements have been in Australia, the USA, Vienna and Scotland. The videos will also be promoted by the MCA.

1st Place	**£750**
2nd Place	**£500**
3rd Place	**£250**

How to Apply?

To apply send your youtube video links to **info@m-c-a.org.uk** In your email please remember to include the following:

- **Full name**
- **University/Medical School**
- **Name of course and year of study**
- **Contact telephone number**
- **Contact address**

Closing date is 31st March 2016. To apply send your video / video links to info@m-c-a.org.uk.

Are we daft to drink?

Jordan Bamford, Queens University Belfast

Every year the MCA holds an essay competition; this year the topic was 'Are we daft to drink?', in this age of increased awareness about alcohol related problems. The winning entrant was Jordan Bamford from Queens University Belfast. A summaryof the winning essay is below; for the full essay please go to http://www.m-c-a.org.uk/medical_students/MCA_Legacy_essay_competition

Introduction

In the age of 'pub crawls'[1], 'neknominate'[2] and in general 'getting smashed' culture, it appears that we are daft to drink. The message is clear – the public campaigns say it loud and proud; we know the risks of alcohol – yet we still indulge. However to say that 'daftness' is the root of this problem is in many ways insensitive.

Alcohol

Alcoholic beverages contain the alcohol, ethanol. This substance is colourless, flammable and possesses psychoactive properties. When we drink alcohol, it travels through our digestive tract and is absorbed into our bloodstream - measurable amounts of alcohol are found in the blood within minutes of ingestion.[3] Alcohol on the short term, causes its effects by affecting the central nervous system. Small amounts of alcohol can produce a euphoric like effect and cause people to relax, however a large amount of alcohol is capable of causing coma or death. It is widely established that excessive and regular drinking of alcohol is very dangerous for a person's health.[4] The effects of alcohol can be catastrophic – in fact alcohol was found to be the most harmful drug when considering both its damage to the consumer and others by a body of drug-harm experts for the Independent Scientific Committee On Drugs, in 2010. [5] It is not only a causal factor in many diseases, but also a precursor to injury and violence – it is a burden on health care systems globally.[6]

On examination of the trends of alcohol consumption within the UK over time, we have identified that alcohol use in the United Kingdom has risen per head of the adult population during post World War Two years, and in fact more than doubled between the mid-1950s and the late 1990s.[7] It is this paradox I want to address - alcohol is dangerous – when compared to other drugs (including heroin, cocaine and methamphetamines) it was found to cause the most harm, yet we can also identify that as a population, a large proportion of alcohol is consumed. I am now going to discuss the various factors which influence why we drink alcohol.

Social Norm

There are lots of reasons for consuming alcohol – and these reasons also affect the amount the individual consumes. One study found that both 'to relax' and to have a 'good time' were the highest reasons given by individuals in the study for binge drinking over a period of 12 years.[8] This suggests along with other evidence[9] that social factors dominate the reasons as to why individuals consume alcohol.

The use of alcohol is central in human society and has always been a social activity.[10] One of the key social factors for drinking is the fact that alcohol consumption is a social norm. Most youth in the UK at the present moment would agree that alcohol use is 'needed' for a 'good night out'. Reports are highlighting that excessive alcohol consumption is the norm in young adulthood. Additionally it has been found that most of today's young adults find it difficult to actually imagine alternatives to excessive drinking that support group socialising.[11] In particular it has been found that excessive intake of alcohol is promoted when drinking in friendship groups – alcohol has an important cultural role nowadays.

Peer Pressure and peer association

A significant amount research has concluded that the consumption of is to a large extent influenced by peer pressure and peer association[12-13] Individuals model their behaviour in front of their peers in an attempt to impress them. People today find themselves in an environment where alcohol consumption is viewed as a positive and socially acceptable. In 1979 Tajfel introduced the concept of social identity.[14] The theory shows that a significant part of an individual's self-concept is formed via their peer groups. 'In-groups' are viewed more positively than 'out-groups'. If we take today's society – in particular students, we can see that it may be deemed essential that a person is associated with the 'in-group' in order to be socially accepted. Non-drinkers in today's society could well be considered an 'out-group' as they are seen as not fitting in with a majority of their peers. In social circles where alcohol is being consumed young adults nowadays feel a degree of self-consciousness – and that can lead to them consuming alcohol[15] It is this concept of social identity, peer pressure and a desire to be accepted which explains why changes in alcohol intake for a given individual is related to their peers alcohol use.[16]

The Role of the Media

Studies have found that the media can play a role in our attitude towards alcohol and therefore our likelihood of drinking.[17-18] It has been found that the media may well cause an escalation of alcohol consumption in adolescents. It has been shown that exposure to alcohol use in movies and binge drinking amongst adolescents is robustly linked and in fact is relatively unaffected by cultural differences.[19] A huge worry is that adolescents nowadays are often getting information about alcohol from these sources in the media – and these can give a warped sense of reality. One report has found that adolescents who responded in their study were more inclined to get information from television, internet and magazines than from their doctor/health professional about alcohol use.[20] This report also found that about 60% of their respondents were exposed to alcohol advertisements on a daily basis, startlingly 11 to 12 year olds were exposed at this level of frequency just as much as older age groups.

A Coping Strategy

A common reason people give for drinking alcohol is 'to cope'. Studies have found that there is a correlation between stressful events in a person's life, and consumption of alcohol.[21] Alcohol is seen as a coping mechanism by many people when life gets hard, or when faced with a stressful event. People use alcohol because of its psychoactive properties – to quell feelings of anxiety, stress or depression. It has been estimated that up to 12 million adults in the UK drink alcohol in order to help them relax or overcome feelings of depression.[22] People are using alcohol to self-medicate their feelings away.

Addiction

According to Government statistics, more than 1.4 million people are dependent on alcohol in the UK.[23] In Europe, alcohol addiction is a major issue. People who suffer from addiction/dependency are likely to have increased tolerance to alcohol, but suffer from very strong symptoms of withdrawal when they do not drink. As dependency increases alcoholics can experience withdrawal fits and drink to escape/avoid these symptoms.[24]

Several factors can contribute to alcoholism, including genetics, brain chemistry and personality.[25] Research is showing that genes are responsible for about half of the risk for alcoholism. This meansthat genes alone do not determine if you are going to be an alcoholic – the rest is explained by interaction with your environment. It has

been found that multiple genes play a role in a person's risk for developing an addiction to alcohol. Researchers are also discovering that our epigenome plays a role too.[26,27]

Many addicts themselves feel that it is their personality which predisposes them to becoming addicted. In one study they found that when interviewing recovering alcoholics, that these individuals felt an inevitability with regards to their addiction.[28] However simultaneously the respondents also felt that their life experiences played a role in their addiction too. They felt that their own contextual factors and culture surrounding alcohol played a role in their alcoholism.

Alcohol addiction is an explanation as to why some people drink – physical/psychological dependence on this substance is not easily overcome – it requires a good standard of care to support these individuals through their recovery.

Conclusion: Are We Daft To Drink?

I began this essay by explaining the paradox before us – we know the dangers of alcohol, yet a large proportion of our population is engaged with its consumption. It is a popular component of modern culture – and it can be very easy to say that those who consume it are daft. However, in my essay I have described a number of reasons for the consumption of alcohol that I believe do not constitute as being simply daft.

Blaming people, judging people and labelling individuals as daft will not promote a change in society or culture nor will it benefit the people who consume alcohol. I do not believe that any one individual is daft for consuming alcohol. I do, however, believe that we are daft as a society if we allow this trend of normalising alcohol consumption to continue. There are lots of changes which need to be implemented to address this issue. Particularly the very easy accessibility to alcohol and its cheap price are huge issues which promotes a nation of drinkers. And finally I believe that the public health campaigns designed to convey the risks of alcohol need to change. These campaigns need to be more widely available around the country so everyone truly knows the risks alcohol pose, and they should also address some of the reasons as to why people begin to drink alcohol.

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2014-15 LEGACY ESSAY COMPETITION WINNERS

The full list of winners were:

1st Place: Jordan Bamford, Queens University Belfast

2nd Place: Nancy Bray, Warwick Medical School

3rd Place: Linda Skelly, Lancaster University Medical School

With grateful thanks to the judges: Dr Iain Smith & Dr Anne McCune. To read the top three essays please visit the MCA website (http://www.m-c-a.org.uk/medical_students/MCA_Legacy_essay_competition)

Alcohol Education Trust

Helena Conibear, Director

Helping pupils to avoid risky behaviour in adolescence and into adulthood has always proved challenging for schools. Should teachers confront issues such as alcohol, drugs and sex head-on? Or does discussing them too early encourage experimentation and contribute to the risk?

The strategy of The Alcohol Education Trust Talk about alcohol programme for helping and supporting young people in making difficult decisions, based on information and knowledge, has been under detailed analysis by The National Foundation for Education Research (NFER) between 2011- 2015.

NFER's final follow up when pupils were aged 15/16 shows the programme has had a significant impact on delaying the age at which young people start to drink.

The evidence-based and peer-reviewed programme, aimed at 11-18 year olds, provides teachers with a structured approach to discussing issues around drinking, and includes a 100-page paper and online teacher workbook of lesson plans, work-sheets, information sheets, games and ideas which can be adapted to suit the knowledge and experience of the age group.

Teachers also have access to the 500-page www.alcoholeducationtrust.org website, with further games and quizzes and dedicated sections for staff and parents. Schools are encouraged to involve parents and a booklet is available to this end, with opportunities for the Alcohol Education Trust (AET) representatives to address parents in school on how best to support their children.

The evaluation, which began in 2011 and included a student questionnaire undertaken over four time points from Year 8 to when the pupils were in Year 11, examined the behaviour of two groups of pupils – one which had undertaken the programme (the intervention group) and a comparison group which had not, but might have acquired information in other ways.

The evaluation found that there was value in the early intervention approach of the programme and in returning to alcohol education at different stages in pupils' personal development as they become more likely, with age, to experiment with alcohol.

Researchers Sarah Lynch, Jack Worth and Sally Bradshaw found that students in the intervention group were significantly less likely (79% of the comparison versus 64% of the intervention group) to have had their first drink by the time they were 15-16 years - even though, by that age, knowledge about alcohol consumption and its effects on the two groups was roughly equal, with the comparison group having caught up with the intervention group.

Crucially, overall, the report found "fewer students in the intervention group than in the comparison group had ever been drunk or experienced binge drinking, which is likely to be because more students in the comparison group had ever drunk alcohol". However, when restricting analysis to those who had ever had an alcoholic drink, there was no statistically significant difference between the groups in prevalence of drinking to get drunk.

Across all students in the sample at age 15-16, 29 per cent of the intervention group and 37 per cent of the comparison group drank frequently.

The attitudes towards drinking were also marked between the two groups. The most common experiences among 15-16 year olds when drinking alcohol were feeling relaxed and outgoing (48 per cent of all intervention students and 65 per cent of all comparison students) and forgetting about problems for a while (34 per cent and 49 per cent).

The analysis found noticeable increases in the proportion of students who had experienced some negative consequences of drinking alcohol. For example, a quarter of the intervention group compared with 32% of the comparison group had ever had a hangover; 18% compared with 24% respectively had ever got sick, while 17% compared with 21% had ever done something they regretted because of drink. The proportions of students across the whole sample having these experiences were greater in the comparison group, but this could have been because the analysis found that more young people in that cohort drank alcohol overall.

By this age, students in both groups were admitting that having a drink was a fun and sociable thing to do, suggesting that getting the right messages across was vital in the years leading to students leaving school. It was not only facts about alcohol and its effects that were important, but some of the lesson activities helped young people to cope better with the potential pressures around youth and alcohol consumption, the NFER study found.

The findings also highlighted the strong influence of the family on the age of onset of drinking, and suggested that school needed to consider strategies around parental engagement. Students with greater numbers of siblings, a poor relationship with their father, and who lived with someone who usually drank alcohol in the home had an increased likelihood of ever having had a drink. "This suggests the importance of the AET information for parents, to support them in making responsible decisions about their own alcohol consumption, acting as role models for their children, setting boundaries and knowing where their children are and who they are with," the study said.

An earlier analysis of the programme, Talk About Alcohol: an Evaluation of the Alcohol Education Trust's Intervention in Secondary Schools,* published in 2013, interviewed teachers who had used the resources. It found that staff who had delivered Talk About Alcohol thought they were a comprehensive, 'ready to go' package which worked well in series and that the resources offered a good range of materials to work from, and were accessible to students.

They were particularly impressed with the short films, scenarios and role play, which worked well in the classroom. Overall, the programme was found to be "straightforward", engaging for students and could be effectively delivered.

Two teachers mentioned that their school had conducted an end of unit review of the sessions and they reported one or more of the following among students: greater knowledge about alcohol and its effects on the body; greater understanding of legal issues around alcohol e.g. buying alcohol by proxy; greater awareness of drinking patterns among young people their age ('that not everyone is drinking'); and feeling more prepared to avoid drinking if they want to.

The most recent NFER evaluation concluded: "The impact on delaying the onset of drinking is evidence that the Talk about Alcohol intervention is effective as an early intervention programme.

"The evidence suggests the value in a harm minimisation approach and in re-visiting alcohol education at different stages – for example, via early intervention before they begin drinking (the average age of first drink is 13), before young people begin to drink more frequently (around age 15), and as they approach adulthood.

"Giving young people the facts about alcohol is not the only factor likely to influence behaviour – helping young people to develop resilience, rehearsal strategies, and self-management skills to manage risk is also important. Messages about responsible drinking are important at this age."

To learn more about the Alcohol Education Trust Talk about alcohol programme and to order resources email kate@alcoholeducationtrust.org or visit www.alcoholeducationtrust.org

Key messages for school leaders and teachers

- Re-visit alcohol education at different key stages – for example, early intervention before they begin drinking (the average age of first drink is 13), and before young people began to drink frequently (around age 15) as they approach adulthood.
- Give young people the facts about alcohol and messages about responsible drinking. It helps to develop resilience, rehearsal strategies, and self-management skills to manage difficult situations.
- Consider how to engage parents in alcohol education programmes, as evidence highlights that family influences drinking behaviour.

Key messages for policy-makers

- There is evidence of impact of the Talk about Alcohol intervention, particularly in delaying the age at which teenagers start to drink. The materials can clearly support policy priorities concerning alcohol.
- The evidence suggests that knowledge alone is not sufficient to change behaviour and identifies that a broader skills-based approach is 'what works' – this information will support Public Health England in understanding how to address its priority to reduce harmful drinking and alcohol-related hospital admissions .[1]

You can view the full report here www.nfer.ac.uk/publications/AETX01

References:
1. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366852/PHE_Priorities.pdf

NFER Surveys November 2011 - January 2012 & January to March 2015:

Table C:Have you ever had a whole alcoholic drink - more than just a sip/taste?

	Baseline Age 12-13 Intervention	Baseline Age 12-13 Comparison	Survey 4 Age 15-16 Intervention	Survey 4 Age 15-16 Comparison
	%	%	%	%
Yes	41	43	64	79
No	57	55	35	21
No response	2	2	2	1
N =	**2142**	**2268**	**900**	**1146**

A single response question.

Due to rounding, percentages may not sum to 100.

Table D: How often do you usually drink alcohol? (Among the whole sample)

How often do you usually have an alcoholic drink?	Baseline Age 12-13 Intervention	Baseline Age 12-13 Comparison	Survey 4 Age 15-16 Intervention	Survey 4 Age 15-16 Comparison
	%	%	%	%
Only a few times a year/ special occasions	29	32	30	38
Once a month or more *(frequently)*	7	8	29	37
I never drink alcohol now	5	4	5	3
Never had a drink	57	55	35	21
No response	2	2	1	1
N =	**2142**	**2268**	**900**	**1146**

A single response question.

Due to rounding, percentages may not sum to 100.

MCA 2015 Symposium: Alcohol; health, well-being & work

11th November 2015, BMA House

AGM

09.00 Registration & Coffee
09.30 AGM (MCA members only)
10.15 MCA Legacy Essay Competition - winners presentation
10.30 Session Break

Max Glatt Lecture

10.45 Welcome & Introduction to the Max Glatt Lecture, Professor Colin Drummond, MCA Chairman
11.00 'It's all in our genes - or is it?', Dr Marsha Morgan, Principal Research Associate & Honorary Consultant Physician, Institute for Liver and Digestive Health, UCL Medical School
11.45 Medal Presentation
12.00 Session Break - Lunch
12.30 A hands-one workshop on the practicalities of breath and blood tests; consent and fitness for testing, Mr Mike Watkins, Occupational Health Nurse, Royal United Hospital, Bath

Alcohol; health, well-being & work

13.30 Welcome & introduction by Dr Colin Payton, Consultant Occupational Physician, Royal United Hospital, Bath
13.45 TfL's Drug and Alcohol Assessment and Treatment Service - an unusual service provision, Dr Olivia Carlton, Head of Occupational Health for Transport for London
14.10 Q & A
14.15 *Personal Experieces of recovering from alcohol dependence whilst continuing to work,* Professor James Davenport, Department of Computer Sciences, University of Bath
14.40 Q & A
14.45 *How healthy workplace initiatives can drive improvement in services for Alcohol and Substance abuse*, Dr Mary E Black, Homerton University Hospital NHS Foundation Trust
15.10 Q & A
15.15 Session Break
15.30 *Driver safety and the role of biomarkers of alcohol use*, Dr Kim Wolff, Reader in Addiction Science & Postgraduate Education, KCL
15.55 Q & A
16.00 *Our liver vacation: Is a dry January really worth it?*, Dr Rajiv Jalan, Professor of Hepatology, Institute for Liver and Digestive Health, UCL Medical School
16.25 Q & A
16.30 Session Close and Meeting Summary and Close

This is a CPD approved event . Costs to attend are £65 for MCA members (£30 for MCa retired members) and £90 (£80 for nurses) for non members.

To book please either book directly through the MCA website or by emailing info@m-c-a.org.uk

Latest 'Alcohol & Alcoholism' Journal News

Latest Open Access Articles:

The Cognitive and Behavioural Impact of Alcohol Promoting and Alcohol Warning Advertisements: An Experimental Study by Kyle G. Brown, Kaidy Stautz, Gareth J. Hollands, Eleanor M. Winpenny, and Theresa M. Marteau (Alcohol Alcohol. 2015, 10.1093/alcalc/agv104)

Call for new board members

The MCA has the three main committees:

**** Executive***

**** Education***

**** Journal***

These committees are made up of members from all specialties. We depend absolutely on our committee members' expertise, time and energy to make the MCA an effective organisation. Currently we are looking for new members, particularly for the Education and Journal committees. If you would be interested and could attend 2 or 3 half day meetings per year in London, do please contact the MCA office to discuss (info@m-c-a.org.uk).

How to Submit an article

We welcome articles from all healthcare professionals. If you would like to submit an article please either email the article to info@m-c-a.org.uk or contact us directly:

Tel: 0207 487 4445

By Post: MCA, 5 St Andrews Place, London, NW1 4LB

SAVE THE DATE!

The 2016 AGM and Symposium will take place on 16th November at BMA House. Please save this date in your diaries.

MCA Medical Council on Alcohol

EDUCATION | JOURNAL | POLICY | SUPPORT

Alcoholis, the quarterly bulletin for health care professionals, is published by the Medical Council on Alcohol. Views expressed by contributors are not necessarily those of the MCA. We welcome any articles or comments from other parties which may be published.

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