MCA Medical Council on Alcohol
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Alcoholis

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Editor

From the Editor

Welcome to the Summer 2026 issue of Alcoholis.

As well as our student competitions which are a feature of summer at the MCA, we are of course planning our autumn Symposium. We have started work on an important new project surveying undergraduate alcohol education in the growing network of UK medical schools. We have also been working with the Centre for Addiction and Mental Health Research at the University of Hull as well as other specialists in the field to develop a definition of Alcohol Related Cognitive Impairment. This latter work will be presented at our Annual Symposium.

Using survey data to understand drinking choices

In this issue we publish two articles which use the Alcohol Toolkit data set to look at motivations for making choices around alcohol consumption. The Alcohol Toolkit is a long running monthly drinking behaviour survey of adults in England which allows detection of changes over time in this group. Dimitra Kale and colleagues from UCL looked at tends in time of prevalence and motivations to reduce risky drinking. Lucy Burke and colleagues from Sheffield looked at how motivations to drink alcohol influence the choice to consume no/lo beverages. Both papers make the important point that understanding these factors should influence individual health professional and public health advice.

Health Improvement Competition

The biennial Health Improvement prize closes on the 31st July. Details are on the website and in this issue. Resident doctors who have completed a Health Improvement project on an alcohol theme are welcome to apply; any readers of this issue of Alcoholis please do pass on the details to relevant audiences. The winning posters will be exhibited at the MCA Annual Symposium on Alcohol and Health.

2026 MCA Symposium and Max Glatt Lecture

The 2026 Symposium will be held in person in London on 18 November, once again at the RCP which has proved an excellent venue. The programme is available to view in this issue of Alcoholis and on the website; booking is now open. We have taken care to include a particularly wide range of topics of relevance to all clinicians and researchers across the disciplines working on alcohol and health. We are also delighted to announce that the Max Glatt lecture will be given by Professor John Holmes from Sheffield, who has had an illustrious career using data to examine and influence policy changes in the alcohol field. Tickets are available now through the MCA website, do book soon to take advantage of the early bird offer.

Understanding why we drink alcohol reveals where no/lo drinks may be most effective at reducing alcohol-related harm

Lucy Burke, Sheffield University, co-authored by Dr Inge Kersbergen, Prof Jamie Brown and Prof Colin Angus.

In 2024, 9,809 alcohol-specific deaths were recorded in the UK, equating to an overall rate of 14.8 deaths per 100,000 people. While representing a welcome 6.3% decrease from the historic peak in 2023, sociodemographic health inequalities persist.[1]

A substantial gap exists between the most and least affluent areas. Residents in communities experiencing significant deprivation, such as Stoke on Trent or South Tyneside, are over five times more likely to die from an alcohol-specific cause than someone living in affluent suburban areas like Redbridge or Buckinghamshire.[2]

These figures highlight the need for dual-focused harm reduction strategies which not only target population-level harm, but also eradicate health inequalities between population groups. Evaluating any new policies involves asking not just if it works, but for whom it works. Through this lens we examine the use of alcohol-free and low-alcohol "no/lo" alternatives as a public health strategy.

The potential of no/lo alternatives to reduce alcohol harms

No/lo drinks are promoted by UK policymakers, featuring in successive government health and NHS long-term planning documents.[3,4] The hypothesised pathway to clinical benefit is simple: if products emulating the sensory profile of alcohol can significantly displace standard alcohol consumption, population-level public health harm should in consequence decline.

However, while current purchasing data suggests that consumption of no/lo drinks is more prevalent amongst heavier drinkers, a positive sign for harm reduction, it is also currently skewed towards more affluent groups.[5] If these trends continue, no/lo drinks may inadvertently widen health inequalities.

Box 1. What are no/lo drinks?

In the UK, alcohol-free and low-alcohol drinks, commonly described as no/los, are alcohol type drinks (e.g., beer, cider, wine, spirits) but with a much lower alcohol content.

- Alcohol-Free: ≤ 0.05% ABV
- Low-Alcohol: ≤ 1.2% ABV

These products attempt to imitate standard strength alcoholic drinks, by replicating the taste and appearance of standard alcohol, enabling the consumer to simulate the sensory experience of drinking alcohol.

Drinks promoted as alcohol alternatives but not specifically aiming to mimic established alcoholic drinks, such as kombucha and adult soft drinks, are not classed as no/lo drinks.

Does why we drink matter when evaluating the public health potential of no/los?

To understand the public health potential of no/lo drinks, it is useful to first consider why people drink alcohol. My PhD research explored whether the sociodemographic patterning of no/lo consumption could be better understood by exploring how this relates to the reasons people drink alcohol. Data came from the Alcohol Toolkit Study, a monthly, nationally representative cross-sectional survey of British adults.[6] Focusing on a sample of 2,549 adults who consume alcohol, I used path analysis, which is an extension of multiple regression. This statistical method that allowed me to unpick both direct and indirect relationships between sociodemographic characteristics, alcohol drinking motives, alcohol and no/lo consumption (see Figure for an illustration of the conceptual model). This method allowed me to understand whether sociodemographic differences in no/lo consumption may be at least partly explained by the different reasons different demographic groups drink alcohol.

No/lo alcohol consumption was measured as a binary variable, comparing never/occasional use against more regular consumption (defined as consuming no/lo drinks less than monthly vs. at least monthly). Alcohol consumption was measured using the AUDIT-C[7] and items from Cooper's (1994) Modified Drinking Motives Questionnaire (DMQ-R)[8] captured drinking for the following reasons:

- Enhancement: Drinking for the "buzz".
- Conformity: Drinking to fit in.
- Social: Drinking to facilitate or enhance social occasions.
- Coping: Drinking as a strategy to manage negative emotions or depression.

The findings highlighted the psychological nuances of alcohol consumption. As this data is cross-sectional it is not possible to infer causation.

Sociodemographic characteristics included age, gender, education and social grade.

1. People who drink alcohol to conform are more likely to drink no/los

After accounting for sociodemographic characteristics and alcohol consumption, drinking to conform was the only drinking motive directly associated with drinking no/los. Participants, more likely to be men, who reported drinking alcohol to "fit in" were significantly more likely to report drinking no/los at least monthly. For these adults, no/los appear to serve as an effective tool for meeting social expectations without the need for alcohol. This finding supports qualitative research reporting the ability to participate in alcohol-centric occasions as a key benefit.[10] For people whose drinking is influenced by social participation, no/lo drinks may be a useful harm reduction tool.

2. Drinking to cope partly explains socioeconomic differences in consumption

Consistent with previous literature, households where the main earner had a manual, routine, or semi-skilled occupation (social grade C2DE) were significantly more likely to report drinking to cope

with depression, a motive strongly linked to hazardous drinking.[11] However, while hazardous drinking generally correlates positively with regular no/lo use, this relationship was weakened for those drinking to cope. For those using alcohol to manage psychological distress or escape their problems, no/lo drinks appear unappealing.

3. People who drink for inebriation may not find no/lo drinks appealing

Similarly, individuals who drink for hedonistic reasons e.g., the "buzz" or because "drinking is fun", showed no increased likelihood of consuming no/lo products. Even though these motives are associated with hazardous alcohol consumption, these drinks are less likely to be consumed by those who prioritise these psychoactive effects of alcohol.

4. Drinking motives mask demographic trends

Finally, the study demonstrated how drinking motives can obscure demographic patterns. Among men, those drinking to fit in were more likely to consume no/lo products, whereas those drinking for how it made them feel were not. The conflicting associations between drinking motives and no/lo consumption help explain why a factor like gender might not appear significant in simpler regression models as the effect is dependent on the individual's underlying reason for drinking.

Figure: Conceptual model illustrating direct and indirect pathways to no/lo consumption

This model shows how sociodemographic variables may directly and indirectly relate to alcohol-free and low-alcohol consumption, mediated by individual drinking motives and alcohol consumption.

Implications for Clinical Practice

The study findings suggest that when considering no/lo drinks as a harm reduction strategy, it is worthwhile to consider why people drink alcohol in the first place. If a patient finds it difficult to navigate social or professional situations where alcohol consumption is the norm and a socially valued activity, no/lo alternatives may be a useful recommendation.

However, for patients drinking to cope, and those specifically seeking the psychoactive elements of alcohol, no/lo substitutes alone appear unlikely to be successful. Those drinking to cope require support to manage their underlying distress, breaking the cycle of alcohol use to alleviate depression in the short term. For those seeking positive reinforcement from alcohol, it may be useful to explore alternative sources to achieve positive affect and identify ways to reduce the relative value of alcohol.

Within alcohol treatment and recovery services, advice surrounding no/lo products is likely to vary case by case. For those with severe alcohol use disorder (AUD), the sensory equivalence of no/lo products (the smell, taste, and look of a beer bottle or spirit glass) may induce cravings and risk relapse. Practitioners should treat no/los not as a universal recommendation, but as an individualised, risk-assessed tool. It is important to note that this study captured general no/lo consumption, not specifically whether it was substituting alcohol. Further targeted research is required to see how these psychological motives function within clinical populations. An ongoing UK study is currently exploring if and how practitioners discuss and recommend no/lo options in clinical settings, which will provide much-needed guidance.[12]

Implications for Wider Policy Frameworks

Individual behaviour is heavily influenced by the environment. To ensure no/lo products can serve as an effective, equitable tool for harm reduction, we should also consider how they function within a wider policy framework. Qualitative research consistently identifies price as a barrier to uptake. Consequently, these products may play a valuable role in augmenting the impact of population-level pricing policies, such as alcohol duty reform and Minimum Unit Pricing (MUP), if they are made significantly more affordable than their full-strength counterparts.[13] For no/los to effectively reduce alcohol harms, they must be integrated into a broader effort to tackle health and socioeconomic inequalities across the UK.

ACKNOWLEDGEMENTS

This article reports the findings from a study published as part of my Wellcome funded PhD, co-authored by Dr Inge Kersbergen, Professor Jamie Brown, and Professor Colin Angus. The originating study was funded by a Wellcome Trust PhD grant (218462/Z/19/Z, grant recipient LB). The views presented are my own, and not necessarily those of my funder.

DECLARATION OF INTERESTS

LB, and her co-authors IK and JB have received funding for ongoing, unrelated research on alcohol-free and low-alcohol drinks from Alcohol Change UK (ACUK), which received <0.6% of its funds in 2024 to 2025 from Lucky Saint, an organisation that produces and sells non-alcoholic drinks, and owns a pub that sells standard alcoholic drinks. In March 2025, Lucky Saint became an associate member of The Portman Group, a United Kingdom self-regulatory organisation that is fully funded and controlled by the alcohol industry. ACUK has a strict policy of not accepting any funds from, nor being subject to any influence whatsoever from, the alcohol industry, including through its investment portfolio. ACUK has confirmed that it is in full compliance with this policy.

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2026 MCA Symposium on Alcohol & Health

Wednesday 18 November 2026 at the RCP, London

#MCASymp2026

Programme

09:00 Registration & Refreshments

09:30 Welcome

09:40 **Dr Ashwin Dhanda,** 'Psychosocial interventions for alcohol use disorder: the role of peers and integrated care.'

10:00 **Dr Lynsey Corless,** 'Clinical trials in Alcohol-related Liver Disease: Current activity and horizon scanning.'

10:20 Q&A Discussion

10.35 **Prof Colin Drummond,** Alcohol Dependence as a Diagnostic Syndrome

10:55 Refreshments Break and visit Exhibitor Stands

11:15 MCA Annual General Meeting (AGM) *MCA members only

11:55 Competition Winners' Presentations

12:00 **Max Glatt Lecture, Prof John Holmes,** *'From minimum unit pricing to the future of alcohol policy.'*

13:00-13.50 Lunch and visit Exhibitor Stands

13:50 Welcome Back - Afternoon session

13:55 **Dr Phillipa Case,** Hull University, Alcohol-Related Cognitive Impairment Project

14:20 **Dr Louise Sell & Ms Hazel Jordan,** 'Alcohol Clinical Guidelines increasing the focus on quality; one year on.'

14:45 **Dr Emily Finch,** Co-Occuring Substance Use and Mental Health Disorders (CoSUM) Report

15:10 Q&A Panel and Discussion

15:35 Close – Refreshments available

Booking & Pricing	Regular	**Early Bird** (closes 14 September 2026)
MCA Member	£179	£160
Non-Member	£269	£240
Concession MCA Member	£179	£160
Concession Non-Member	£1119	£110

For Group Discounts and to book visit: www.m-c-a.org.uk/symposia/2026

Signed up delegates will be able to view the entire symposium online after the event.

Trends in motives for attempts to reduce alcohol consumption among risky adult drinkers in England: a representative population survey, 2017–2024

Kale D, Buss V, Oldham M, Brown J, Shahab L, Jackson S.
Drug Alcohol Depend Rep. 2025; 15:100340. https://doi.org/10.1016/j.dadr.2025.100340

Introduction

There has been an increase in the proportion of risky drinkers (Alcohol Use Disorders Identification Test Consumption (AUDIT-C) score ≥5 (Bush et al., 1998)) motivated to reduce their consumption in England since the Covid-19 pandemic (Buss et al., 2024; Jackson et al., 2021). Understanding motives to reduce alcohol consumption, how they differ among various population groups, and how they have changed over time is important for developing effective public health interventions.

Previous research has consistently shown that health concerns are the most common reason for attempting to reduce alcohol consumption, including current or future health problems, improving fitness, or losing weight (Beard et al., 2017; Britton and Bell, 2015; Epler et al., 2009; Pennay et al., 2019). Social influences, financial considerations and advice from healthcare professionals may also motivate alcohol reduction (Beard et al., 2017; Britton and Bell, 2015). Recent societal events, including the Covid-19 pandemic and the subsequent cost-of-living crisis, may have altered people's motivations to reduce alcohol consumption.

This study therefore estimated time trends in motives for attempts to reduce alcohol consumption among risky adult drinkers in England between 2017 and 2024 and explored differences by sociodemographic characteristics and alcohol consumption levels.

Methods

Data were drawn from the Alcohol Toolkit Study, a nationally representative monthly survey of adults in England (Beard et al., 2015; Fidler et al., 2011). The analysis focused on 11,974 adults (mean [Standard Deviation] age= 45.8 [15.7] years, 60.1% men) drinking at risky levels, who reported at least one attempt to reduce their alcohol consumption in the past year between January 2017 and August 2024. Participants reported motives for their most recent attempt to reduce alcohol consumption, grouped into four categories: (i) health concerns (e.g., current/future health problems, improving fitness, weight loss), (ii) cost (e.g., alcohol being too expensive), (iii) social factors (e.g., pressure or support from family/friends) and (iv) health professional advice. Time trends in the proportion of attempts to reduce alcohol consumption motivated by each motive were estimated, and prevalence ratios were calculated to compare changes in prevalence across the period.

Prevalence of motives for attempts to reduce alcohol consumption

Across the study period, health concerns were the most reported motive for attempts to reduce alcohol consumption (72.3%). The most frequent specific health-related reasons were improving

fitness (37.9%), weight loss (36.1%), concerns about future health (31.5%) and current health problems (10.7%). Social factors were the second most common motive (17.3%), followed by cost (12.8%) and health professional advice (6.3%). These patterns align with prior research identifying health concerns as the primary motivator for reducing alcohol consumption, alongside social and financial factors (Beard et al., 2017; Britton & Bell, 2015; Epler et al., 2009; Pennay et al., 2019). Health concerns were more frequently reported by individuals aged 45–54 years, women, those in more advantaged social grades and participants with AUDIT-C>7. Social factors were more frequently reported by younger individuals, those from mid-range social grades and those with AUDIT-C>7. Cost was more frequently endorsed by younger participants, those from less advantaged social grades and those with AUDIT-C>7. Health professional advice was more common among older individuals, men, those from less advantaged social grades and with AUDIT- C>7.

Time trends in motives for attempts to reduce alcohol consumption

Between January 2017 and August 2024, the proportion of attempts motivated by health concerns increased overall (from 70.5% to 76.8%). Health-motivated attempts rose through 2020-2021, peaked in early 2021, declined slightly in 2022, and increased again by mid-2023. These changes were largely driven by improving fitness, weight loss, and future health concerns. The increase in health motives was most pronounced among women, individuals from less advantaged social grades, and those with AUDIT-C 5–7. Attempts motivated by cost increased from 10.7% in January 2017 to 20.2% in August 2024. Cost remained stable prior to 2020 and increased steadily thereafter, coinciding with economic pressures associated with the Covid-19 pandemic and subsequent cost-of-living crisis in UK. Time trends differed by age, with cost-motivated attempts fluctuating more among older (≥65) individuals but showed a fairly steady increase among those <65. Attempts motivated by social factors increased from 13.3% to 25.5%, with the proportion remaining stable until 2019, then increasing in 2020 (peaking at 21.4 % in March 2021), declining slightly in 2021-2022, and increasing again from mid-2023. No significant interaction was observed with age, gender, social grade and alcohol consumption. Attempts motivated by health professional advice remained low, rising from 4.4% to 7.0%, with no significant variation by age, gender, social grade, or alcohol consumption.

Implications

These findings highlight several implications for public health policy and intervention strategies. Given the central role of health concerns, particularly fitness and weight management, policies such as calorie labelling on alcohol products could encourage reductions in alcohol consumption (Steptoe et al., 2024). The rising importance of cost as a motive for alcohol reduction underscores the potential effectiveness of interventions highlighting financial savings from reduced drinking. Tailored interventions may also be needed to reflect demographic differences; for example, campaigns targeting women could focus on fitness and weight management, while campaigns for individuals from less advantaged social grades could address both health and financial motivations. Finally, the low uptake of health professional advice highlights missed opportunities in healthcare settings to support risky drinkers, reinforcing the need to improve the delivery of brief interventions and screening practices (Beyer et al., 2018; Johnson et al., 2010).

Conclusions

Overall, between 2017 and 2024, health concerns remained the most common motive for attempts to reduce alcohol consumption among individuals drinking at risky levels. Attempts motivated by health concerns generally increased, while those motivated by cost and social factors nearly doubled. Attempts driven by health professional advice showed an uncertain increase and were the least common. Policies incorporating calorie, weight, and cost-related information in public health campaigns could help individuals make informed decisions about their alcohol consumption.

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★ Quality Improvement COMPETITION ★

Medical Council on Alcohol

2026 Quality Improvement Prize

This competition is open to all resident doctors in any specialty working in the UK, in any non-consultant training grade. You should report a completed audit, clinical governance or quality improvement project on an alcohol-related health harm topic and reflect current best practice guidelines/ evidence.

The topic can reflect the full range of interventions from prevention to detection to treatment.

Please submit your entry as one A3 size poster in a structured abstract format describing a Quality Improvement project.

The MCA Quality Improvement Prize is one of a number of regular competitions run by the MCA.

To view all MCA competitions please go to **www.m-c-a.org.uk**

Quality Improvement Prize

Entrants must be current resident doctors working in the United Kingdom.

Word count: 500-700 words *(figures and references not included in word count)*.

If your submission is part of a team effort with others, please confirm your own contribution.

Please inform the MCA if you have used ChatGPT or similar software for any part of your entry.

The winning entrants will receive:

1st Prize	**£750**
2nd Prize	**£500**
3rd Prize	**£300**

Application

To apply go to our website: **m-c-a.org.uk/education** and upload your A3 poster *(in both pdf and jpeg formats)*.

You will also need to include the following:

- **Full name**
- **Contact e-mail**
- **Contact telephone number**
- **Contact address**

All winners shall receive free attendance at the MCA 2026 Annual Symposium on 18.11.26.

If appropriate the winning entries will be published in the MCA newsletter Alcoholis and exhibited at the MCA Annual Symposium.

Opening date:	**1 March 2026**
Closing date:	**31 July 2026**

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