

Impact and barriers: a national survey of UK adults on alcohol dependence



Publication date
28.01.2026

📞 0203 835 4705
✉️ services.uk@cleanslateclinic.com
🌐 www.cleanslateclinic.co.uk

Impact and barriers: a national survey of UK adults on alcohol dependence

Co-authors: Clean Slate Clinic, Adfam, The University of Sussex

Date: January 2026

Purpose: To present new empirical evidence on alcohol harm patterns in the UK, their impacts on families and workplaces, and barriers to accessing support



Foreword

Dr Dan Poulter

**Addiction Psychiatrist, Former MP
and Parliamentary Under-Secretary
of State for Health**

The United Kingdom's approach to alcohol harm has long been shaped by assumptions that no longer align with empirical reality. We have designed services for people who self-identify as "problem drinkers", commissioned awareness campaigns to address an information deficit, and targeted interventions toward specific demographics or geographic areas. This white paper demonstrates, through nationally representative data, that all three assumptions are fundamentally flawed.

During my time in Parliament and clinical practice, I witnessed the consequences of this misalignment: families recognising escalating risk in loved ones but finding no pathway to facilitate intervention; workers drinking in response to mounting occupational stress yet excluded from services framed around "heavy drinking" or "addiction"; NHS capacity stretched to breaking point while awareness campaigns continue to emphasise information provision rather than access.

The findings presented here are uncomfortable for policymakers because they challenge interventions we have funded for years. The evidence shows that 90% of higher-risk drinkers do not self-identify as heavy drinkers - suggesting a mismatch between cultural norms and clinical thresholds. It shows that "not knowing where to go for help" ranks only sixth among barriers, well below NHS wait times and fear of stigma. It shows that higher-risk drinking affects 30.8% of full-time workers, distributed across all income levels, with work stress cited at nearly twice the general rate.

What this white paper offers is not another call for more services, but a call for different services - designed around how people actually understand their drinking, how families



experience harm, and how the health system actually functions under capacity constraints. Policy implications include: the need to move from self-identification to objective screening as the gateway to care; family-inclusive pathways are needed to close the intervention gap between recognition and crisis; alcohol harm prevention must be integrated into workplace mental health support; and service nomenclature must shift to identity-neutral framing that reduces the stigma barrier.

These are not minor adjustments to existing frameworks. They represent a fundamental redesign of England's alcohol harm reduction strategy - from individual pathology to systemic response, from information campaigns to capacity-building, from targeted interventions to universal access models.

The data presented in the following pages come from a nationally representative study conducted in collaboration between Clean Slate Clinic, Adfam, and the University of Sussex. I commend this work to policymakers, commissioners, clinicians, and health system leaders as evidence that our current approach, however well-intentioned, systematically fails to reach the majority of people at clinical risk.

The question is not whether we can afford to redesign our approach to alcohol harm. Given hospital admissions of 339,916¹ annually and the diffuse family and workplace impact documented here, the question is whether we can afford not to.

Executive Summary

Public discourse on alcohol increasingly emphasises declining average consumption, particularly among younger cohorts. While per-capita consumption has fallen to its lowest figure since data collection began², hospital admissions for alcohol-specific conditions remain at 339,916 annually (2023/24)¹, indicating that population-level trends may obscure persistent concentrations of harm.

Drawing on nationally representative polling of 2,037 UK adults conducted in December 2025, this white paper identifies five empirical findings (Sections 2-6) with direct implications for policy design, service commissioning, and clinical pathway development.

First, clinical risk and self-identification are systematically misaligned. Among the 25.8% of adults meeting AUDIT-C criteria for increasing or higher risk of alcohol dependence, 90% do not self-identify as heavy drinkers. Among self-identified "moderate" drinkers, 58.6% meet clinical criteria for at least increasing risk. This disconnect is structural, not confined to individuals in denial, and has significant implications for service access models predicated on self-referral.

¹ Office for Health Improvement & Disparities, Alcohol profile: short statistical commentary, Feb 2025

² Research from IWSR published in the Financial Times December 2025

Infographic 1: Alcohol Risk Exists Largely Outside Self-Identification Threshold



Second, alcohol harm has substantial reach beyond the index population. Nearly half of UK adults (49.3%) report knowing someone they consider a heavy drinker. Of these, 25.1% identify a close family member, 18.1% a colleague, and 10.8% a partner. Among higher-risk drinkers themselves, 70% know someone they consider a heavy drinker. This diffuse social exposure suggests that families and colleagues may recognise escalating risk before formal services engage, yet current pathways offer limited mechanisms for family-supported intervention.

Third, the primary barriers to accessing support are system capacity and stigma, not information deficit. Among higher-risk drinkers, the most frequently cited barriers are long NHS wait times (24.5%), fear of stigma (24.1%), and cost of private healthcare (19.4%). “Not knowing where to go for help” ranks sixth at 16.9%, suggesting that awareness campaigns alone are unlikely to address the structural impediments preventing help-seeking behaviour.

Fourth, workplace prevalence is significant and associated with identifiable stressors. Among full-time workers, 30.8% meet AUDIT-C criteria for increasing or higher risk, with 40% of this cohort earning £50,000 per annum or more. Among higher-risk full-time workers, 58.2% attribute their drinking to specific life stressors, with work pressures cited at 1.8 times the general rate (25.7% vs 14.3%). This pattern suggests a stress-response dynamic rather than individual pathology, with implications for upstream workplace interventions.

Fifth, higher-risk drinking is cross-political and geographically distributed. All major political constituencies show 22-34% higher-risk drinking prevalence (a range of 11.9 percentage points), and no statistically significant regional variation was observed. This distribution indicates that targeted geographic or demographic commissioning strategies may systematically exclude substantial affected populations.

These findings challenge several assumptions embedded in current policy frameworks: that declining average consumption correlates with declining harm; that self-identification is a reliable service access mechanism; that information provision addresses the primary barriers; that workplace alcohol issues reflect individual pathology rather than systemic stress; and that demographic or geographic targeting efficiently captures affected populations.

The paper concludes with four evidence-linked recommendations: create alternative pathways that reduce NHS wait times and stigma barriers, including digitally-enabled home-based detoxification models; implement objective AUDIT-C screening and identity-neutral service framing; address upstream work stressors as a preventive strategy; and enable family-inclusive pathways with appropriate safeguards. These proposals are grounded in the empirical findings presented but require further testing, economic evaluation, and implementation research to establish effectiveness and cost-efficiency.



1. Dataset and Methodology

1.1 Data Collection and sample

This white paper draws on nationally representative polling conducted in December 2025 with 2,037 UK adults. The survey was designed to assess drinking patterns, service access barriers, and willingness to engage with alternative care models. Respondents were recruited to ensure demographic representativeness across age, gender, region, and socioeconomic status.

The following sections present five key findings that emerged from analysis of this dataset (Sections 2-6), each with direct implications for service design and commissioning.

1.2 Measurement Approach

Respondents were assessed using the Alcohol Use Disorders Identification Test - Consumption (AUDIT-C), a validated three-item screening tool aligned with WHO methodology. AUDIT-C evaluates:

- Frequency of drinking
- Typical amount consumed per occasion
- Frequency of binge drinking (6+ units in a single session)

Scores classify individuals into risk categories:

- 0 to 4 (low risk of alcohol dependence)
- 5 to 7 (increasing risk of alcohol dependence)
- 8 to 10 (higher risk of alcohol dependence)
- 11 to 12 (possible dependence)

AUDIT-C is the standard brief screening instrument recommended by NICE³ and used in NHS Health Checks, primary care settings, and hospital alcohol care teams. Its brevity (three questions) balances clinical utility with survey feasibility.

1.3 Limitations and Interpretive Caveats

The data are self-reported and subject to well-documented limitations:

Social desirability bias: Respondents may underreport socially stigmatised behaviours, particularly in direct questioning about alcohol consumption.

Recall error: Estimates of drinking frequency and quantity are prone to memory limitations, particularly for regular drinkers.

³ NICE (2011). Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. Clinical Guideline CG115.



Systematic underreporting: Alcohol consumption in surveys is historically underreported by 40-60% when compared to alcohol sales data.⁴ The findings presented here should therefore be interpreted as conservative estimates of actual prevalence.

What this polling shows:

- Self-reported drinking patterns, consumption levels, and AUDIT-C risk categories
- Exposure to others' heavy drinking (family, friends, colleagues)
- Self-reported barriers to accessing support
- Political and regional distribution of higher-risk drinking
- Cross-sectional associations between employment status, income, stressors, and drinking patterns

What this polling does NOT show:

- Actual health service utilisation by AUDIT-C category
- Causality between drinking patterns and hospital admissions or workplace outcomes
- Quantified workplace productivity losses (absenteeism, presenteeism)
- Long-term outcomes of any intervention
- Cost-effectiveness of proposed pathways
- Actual timing of family recognition relative to clinical presentation

What remains to be established through further research:

- Whether objective AUDIT-C screening integrated into routine care increases treatment uptake
- Optimal service framing to minimise identity resistance among the 90% who don't self-identify as heavy drinkers
- Whether addressing NHS wait times measurably increases service uptake and completion
- Whether NHS wait times are real or perceived
- Which specific patient pathways are associated with long NHS wait times. eg. primary care, secondary addiction services
- Workplace productivity gains from addressing higher-risk drinking among workers
- Cost-effectiveness of upstream stressor interventions (workplace mental health, financial support) versus downstream alcohol treatment
- Whether family-initiated pathways accelerate appropriate intervention
- Optimal balance of face-to-face versus remote delivery to address accessibility while reducing stigma and career barriers

These limitations do not invalidate the findings presented in Sections 2-6, but they do establish boundaries around what can be concluded from this dataset. The policy implications that follow are grounded in what the evidence demonstrates, not what it cannot measure.

⁴ Stockwell et al. 2004 Under-reporting of alcohol consumption in household surveys: a comparison of quantity-frequency, graduated-frequency and recent recall, *Addiction*



1.4 Data Sources for Contextual Benchmarking

Hospital admission data referenced throughout this paper are drawn from:

- Office for Health Improvement and Disparities (OHID) Local Alcohol Profiles for England
- NHS England Hospital Episode Statistics (HES), 2023/24

These data provide independent validation of alcohol harm levels and allow comparison between self-reported patterns and objective health system impact.

2. Self-Classification Failure is Systematic

2.1 The Scale of Misidentification

NHS alcohol treatment pathways and most workplace alcohol policies operate on a foundational assumption: that individuals at clinical risk will recognise their drinking as problematic and will therefore seek help, accept referral, or respond to messaging targeted at “heavy drinkers” or “problem drinkers.”⁵

These data show, however, that there is a significant mismatch between self-identity and clinical risk, not confined to a subset of individuals in denial. It is a structural feature of how people understand their drinking relative to clinical thresholds. Identity labels like “moderate,” “occasional,” and “heavy” are culturally determined and do not reliably predict AUDIT-C scores.

Evidence

25.8% of respondents (526/2,037) met AUDIT-C criteria for increasing risk of alcohol dependence or above.

Among those meeting clinical criteria for increasing risk (N=409):

- 27.1% (111/409) described themselves as an “occasional drinker”
- 67.5% (276/409) described themselves as a “moderate drinker”
- Only 5.4% (22/409) described themselves as a “heavy drinker”

Among those meeting clinical criteria for higher risk or possible dependence (N=117):

- 7.7% (9/117) described themselves as an “occasional drinker”
- 65.8% (77/117) described themselves as a “moderate drinker”
- Only 26.5% (31/117) described themselves as a “heavy drinker”

⁵ NHS England (2021). Adult Specialist Alcohol Misuse Services: Commissioning Standards. London: NHS England.

Among all higher-risk drinkers (AUDIT-C ≥ 5), 90% do not self-identify as "heavy drinkers."

Graph 1: Distribution of AUDIT-C scores across respondents

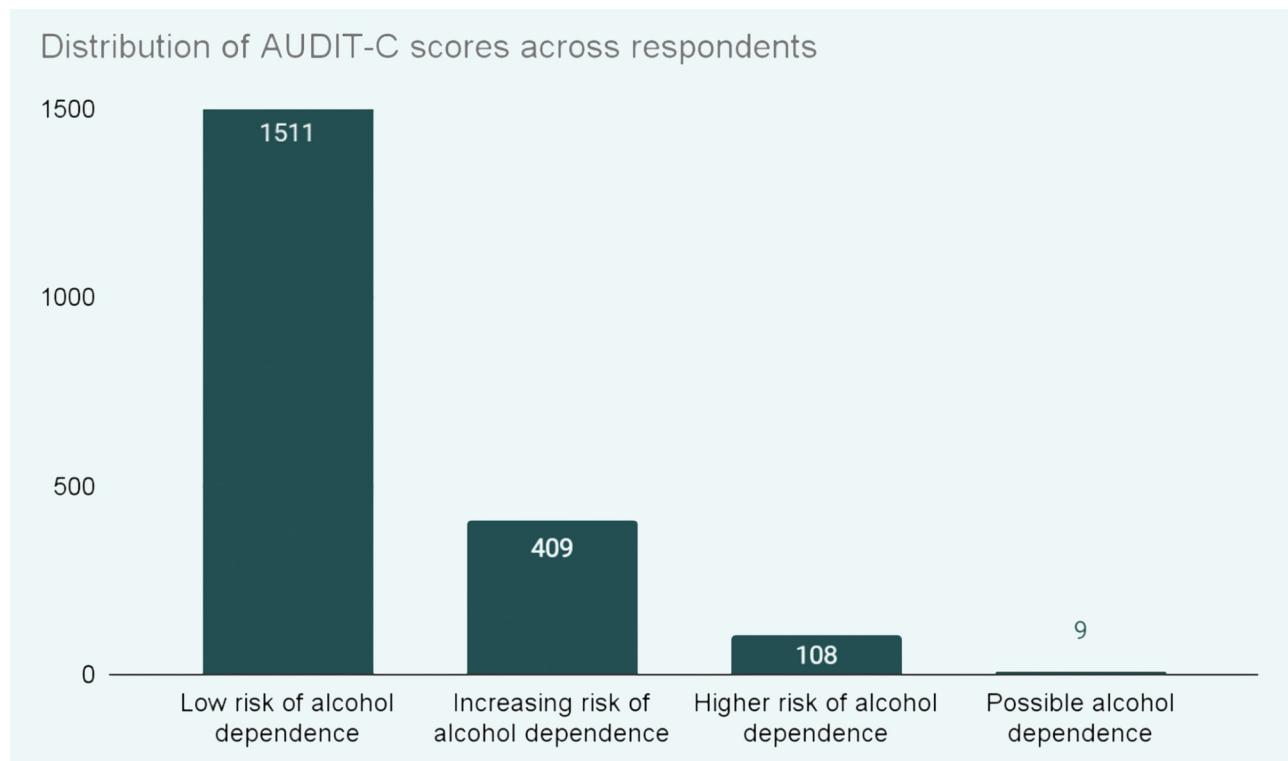


Table 1: AUDIT-C Risk by self-assessed drinking type

Self-Assessment	Low Risk	Increasing Risk	Higher Risk	Possible Dependence	Grand Total
A heavy drinker	4	20	25	5	54
A moderate drinker	249	276	73	4	602
A non-drinker	402	2	1		405
An occasional drinker	856	111	9		976
Grand Total	1511	409	108	9	2037



2.2 The “Moderate Drinker” Paradox

The disconnect between clinical risk and self-perception is particularly stark among self-identified “moderate” drinkers, a category that functions as the cultural default for socially acceptable drinking.

Among self-identified “moderate” drinkers (N=602):

- 232 (38.5%) reported binge drinking at least monthly
- 353 (58.6%) met AUDIT-C criteria for at least increasing risk of dependence
- 441 (73.3%) drank two or more times per week

This pattern indicates that the label “moderate drinker” has become decoupled from behavioural or clinical definitions. For the majority of self-identified moderate drinkers (58.6%), their consumption patterns meet clinical thresholds that would warrant medical discussion of alcohol reduction. The cultural acceptability of twice-weekly drinking (73.3%) and monthly binge drinking (38.5%) within the “moderate” category suggests that population norms have shifted independently of clinical risk thresholds.

In effect, “moderate” has come to mean “socially typical” rather than “medically low-risk.”

2.3 Policy Implications

Service access models that depend on individuals self-identifying as “problem drinkers” or “heavy drinkers” will systematically exclude the majority of the higher-risk population. While NHS alcohol services do permit self-referral in many areas, the pathway still requires individuals to recognise their drinking as problematic enough to contact an “alcohol treatment service” - a threshold that 90% of higher-risk drinkers do not cross. Objective AUDIT-C screening integrated into routine health contexts (Primary Care, NHS Health Checks, workplace wellness assessments, pre-operative assessments) would identify risk independently of self-perception, mirroring the proven approach already used for cardiovascular risk and diabetes screening.

Service nomenclature is not a matter of marketing preference - it directly affects uptake. Identity-neutral framing (“supported reduction,” “change your relationship with alcohol,” “medical stabilisation”) reduces the identity barrier while maintaining clinical accuracy.

3. Family Impact and Social Exposure: The Diffuse Reach of Alcohol Harm

Current alcohol policy in England is primarily structured around the individual requiring treatment. NHS commissioning standards focus on assessment, treatment planning,



and recovery support for the person with alcohol dependence, with family involvement positioned as optional or supplementary. Local authority public health strategies typically measure prevalence among drinkers themselves, not exposure among family members, friends, or colleagues.

This individual-centric framing may substantially underestimate the population affected by alcohol harm and overlook potential intervention points that exist before formal service engagement.

3.1 Scale of Social Exposure

Nearly half (49.3%) of UK adults know someone they consider a heavy drinker, a prevalence rate that positions alcohol harm as a mainstream rather than marginal public health issue. This social diffusion has direct implications for where intervention opportunities exist and who can serve as agents of change.

Evidence

49.3% of all respondents (1,004/2,037) know someone they consider a heavy drinker. Of those who knew someone they considered a heavy drinker:

- 46.1% (463) identified a friend
- 25.1% (252) identified a close family member (parent, sibling, child)
- 18.4% (185) identified an extended family member (cousin, aunt/uncle)
- 18.1% (182) identified a colleague or someone they worked with
- 16.5% (166) identified a neighbour or acquaintance
- 10.8% (108) identified their partner

Among higher-risk drinkers (AUDIT-C ≥ 5), 70% know someone they consider a heavy drinker, compared to 45% among low-risk drinkers.

Table 2: Social Connection to a Heavy Drinker by AUDIT-C Score

Do you know a Heavy Drinker?	Low Risk	Increasing Risk	Higher Risk	Possible Dependence	Grand Total
I don't know anyone	49%	31%	27%	22%	44%
I'm not sure	6%	9%	3%	0%	6%
I know a heavy drinker	45%	61%	70%	78%	49%
An occasional drinker	1511	409	108	9	2037



This distribution reveals that while family exposure is substantial (21.5% of all adults know a family member who is a heavy drinker), it represents less than half of total social exposure. Friends represent the largest single category (46.1% of those who know a heavy drinker, or 22.7% of all adults), and workplace colleagues account for 18.1% of identified relationships (8.9% of all adults). Current intervention frameworks focus heavily on family involvement and professional referral, rarely considering peer relationships or workplace contexts as potential intervention points despite their prevalence.

3.2 Family Recognition Precedes Formal Service Engagement

Adfam's direct work with affected families consistently demonstrates that relatives identify escalating risk - often manifesting as withdrawal symptoms, behavioural changes, or recurring incidents - well before any engagement with formal services occurs.⁶ Family members recognise patterns that the individual may not acknowledge and that have not yet reached clinical attention.

The polling data support this qualitative observation at scale. Among higher-risk drinkers (AUDIT-C ≥5), 70% know someone they consider a heavy drinker, compared to 45% among low-risk drinkers. This suggests clustering: higher-risk drinking occurs within social networks where heavy drinking is more visible and potentially more normalised.

The gap between family recognition and service engagement represents a missed intervention window. Families currently have limited pathways to express concern or facilitate assessment without the individual's active cooperation. Unlike mental health services, where family-initiated assessments are more common (particularly for young people or in crisis situations), alcohol services are almost exclusively individual-initiated or professionally referred.

3.3 Policy Implications

The scale of social exposure - 49.3% of adults know a heavy drinker, including 21.5% with family exposure, 22.7% through friends, and 8.9% through workplace colleagues - reveals that current service models miss the majority of potential intervention points. Families, friends, and colleagues recognise escalating risk before formal services engage, yet have limited and inconsistent pathways to facilitate assessment or access support.

Two actionable opportunities emerge: first, develop family-inclusive pathways that allow concerned relatives to access advice, support assessment, and participate in treatment planning, with appropriate safeguards for coercion and domestic abuse contexts.

Second, establish guidance and mechanisms for the friend and colleague categories - who together represent significant social exposure - to safely express concern and direct someone toward help. Services that actively incorporate family members, friends,

⁶ Adfam (2016). "We Matter Too": The experiences of adult family members affected by their relatives' drug or alcohol use



and supportive colleagues as recovery capital may improve outcomes, but current commissioning rarely funds this integration adequately.

4. Workplace Prevalence and Work-Related Stressors

Most workplace alcohol policies in the UK focus on fitness-for-work, safety-critical roles, and disciplinary response to impairment or incidents. The Health and Safety Executive recognises alcohol as a workplace risk primarily in contexts where intoxication creates immediate safety hazards (construction, transport, manufacturing).⁷ Employee Assistance Programmes typically offer support for “problem drinking” but depend on self-referral or manager concern - the same barriers identified in Section 2.

This incident-focused approach assumes that workplace alcohol issues are exceptional, concentrated in high-risk sectors, and visible through performance problems. The following data challenge all three assumptions.

4.1 Prevalence Across Income Levels

Among full-time workers, 30.8% (280/910) meet AUDIT-C criteria for increasing or higher risk - a rate second only to students (32.4%) and significantly higher than other employment groups. Retirees show the lowest rate of higher-risk drinking, creating a statistically significant employment-based pattern.

This prevalence is distributed across all income brackets, challenging the assumption that workplace alcohol issues concentrate in lower-income or high-stress manual sectors.

Among the 280 higher-risk full-time workers:

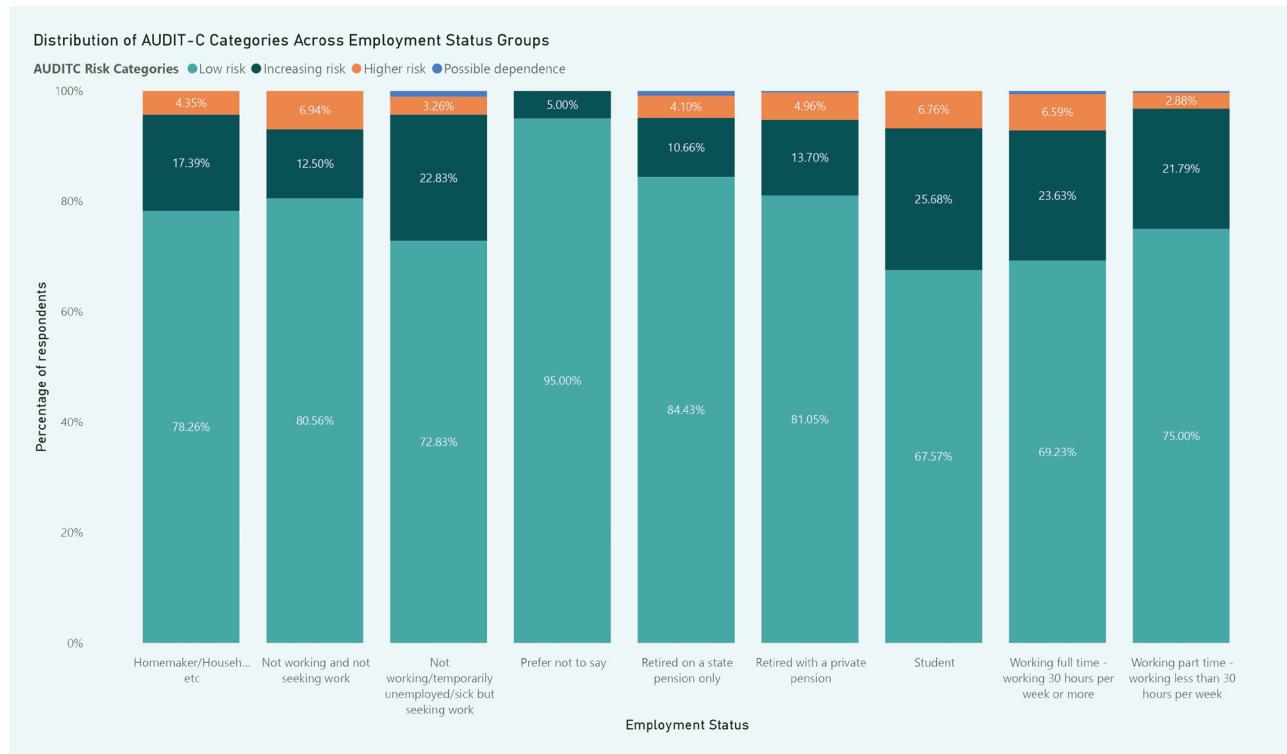
- 112 (40%) earn £50,000 or more
- 35 (13%) earn £100,000 or more
- 92 (32.9%) are female
- Only 27 (9.6%) self-identify as “heavy drinkers”

⁷ Health and Safety Executive. Drug and alcohol misuse at work: A guide for employers. London: HSE.

Table 3: Drinking Risk by Work Status

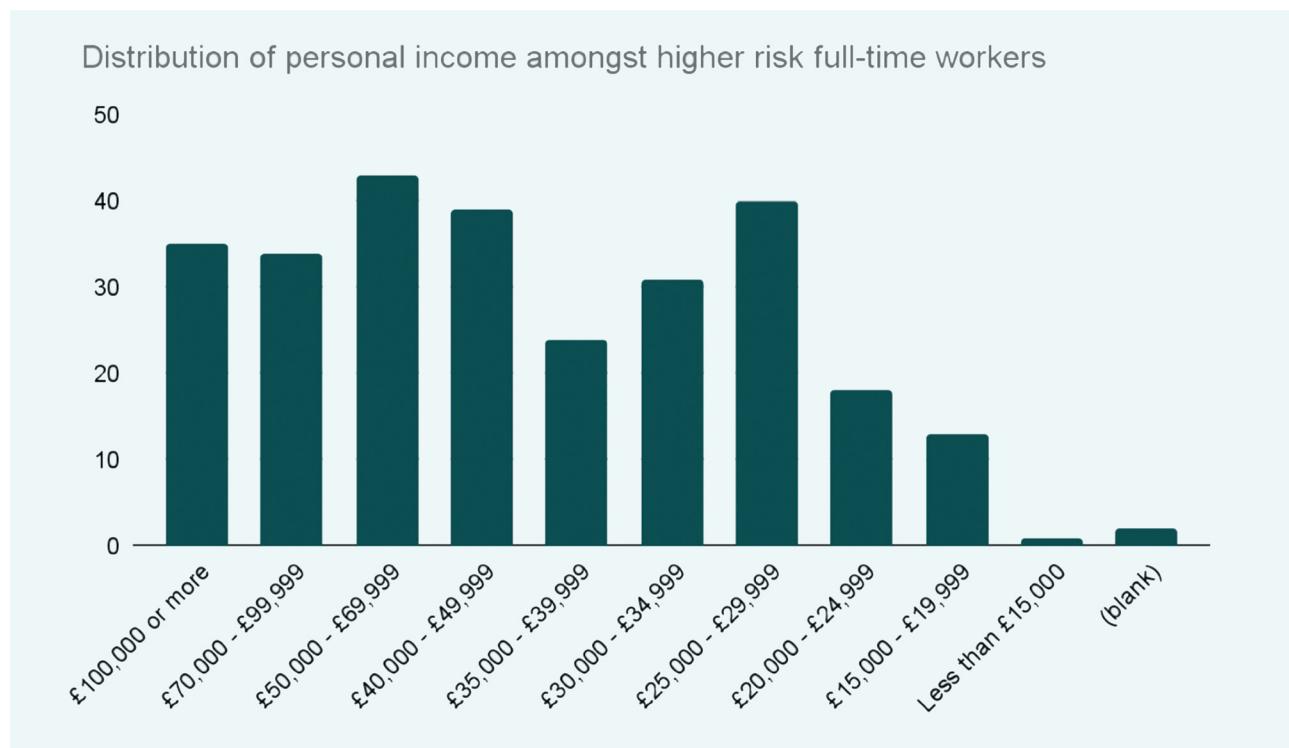
Row Labels	Low Risk	Increasing Risk	Higher Risk	Possible Dependence	Grand Total
Working full time - working 30 hours per week or more	69.23%	23.63%	6.59%	0.55%	100.00%
Retired with a private pension	81.05%	13.70%	4.96%	0.29%	100.00%
Working part time - working less than 30 hours per week	75.00%	21.79%	2.88%	0.32%	100.00%
Retired on a state pension only	84.43%	10.66%	4.10%	0.82%	100.00%
	78.26%	17.39%	4.35%	0.00%	100.00%
Homemaker/					
Not working/ temporarily unemployed/ sick but seeking work	72.83%	22.83%	3.26%	1.09%	100.00%
Not working and not seeking work	80.56%	12.50%	6.94%	0.00%	100.00%
Student	67.57%	25.68%	6.76%	0.00%	100.00%
Prefer not to say	95.00%	5.00%	0.00%	0.00%	100.00%
Grand Total	74.18%	20.08%	5.30%	0.44%	100.00%

Graph 2: Distribution of AUDIT-C Categories Across Employment Status Groups



There was a statistically significant association between employment and alcohol risk category, $\chi^2(df) = 46.06, p = 0.004$, Cramér's $V = 0.08$, indicating a negligible effect size. Specifically, there are a significantly lower number of increasing risk drinkers in people who are retired than other employment groups, and a significantly higher number of increasing risk drinkers in those who are working full-time in comparison to other groups.

Graph 3: Distribution of personal income by full-time workers with increasing or high risk drinking



The finding that 40% of higher-risk workers earn £50,000+ has two implications: first, workplace support cannot be targeted solely at specific sectors or income levels - it must be universally accessible; second, the 9.6% self-identification rate among higher-risk workers mirrors Section 2's finding (90% of higher-risk drinkers don't self-identify as heavy), confirming that workplace programmes requiring self-disclosure will systematically exclude the majority at clinical risk.

This workplace prevalence connects to Section 3's finding that 8.9% of all adults (18.1% of those who know a heavy drinker) identified a work colleague. The combination of high prevalence (30.8%) and high social visibility suggests that workplace-based intervention points exist but remain largely unutilised.

4.2 Work-Related Stressors as Primary Attribution

When asked "In the last 12 months, which of the following factors, if any, have led you to drink alcohol?", higher-risk full-time workers attributed their drinking to identifiable life stressors at significantly higher rates than the general drinking population.

Evidence:

Among all current drinkers (N=1,667), 41.3% identified at least one stressor; among higher-risk full-time workers (N=280), 58.2% identified at least one stressor.



Comparative rates for specific stressors:

Stressor	All Drinkers	Higher-Risk Workers	Multiplier
None of the above	58.7% (979)	41.8% (117)	—
Work pressures	14.3% (238)	25.7% (72)	1.8x
Cost-of-living crisis	11.0% (183)	21.4% (60)	1.9x
Loneliness and social isolation	12.4% (207)	17.5% (49)	1.4x
Relationship or family issues	12.1% (201)	15.0% (42)	1.2x
Debt	6.5% (108)	11.8% (33)	1.8x
Parenting stress	5.6% (95)	9.6% (27)	1.7x
Working from home	3.7% (61)	8.9% (25)	2.4x

Work pressures are the most commonly cited factor among higher-risk workers (25.7%), followed by cost-of-living crisis (21.4%). The 2.4x multiplier for working from home is notable given the shift to hybrid working post-pandemic.

This pattern suggests that for the majority of higher-risk workers (58.2%), drinking is attributed to external pressures rather than representing isolated individual pathology. The workplace is not merely the context where drinking problems manifest - for many workers, work-related stress is the stated driver of consumption patterns.

4.3 Policy Implications

The combination of high workplace prevalence (30.8%), low self-identification (9.6%), and stressor-driven patterns (58.2% attribute drinking to specific pressures) requires a fundamental reframing of workplace alcohol policy from individual pathology to systemic response. Current approaches - focused on impairment incidents, safety-critical roles, and self-referral to Employee Assistance Programmes - miss the majority of affected workers and fail to address upstream causal factors.

Two shifts are required. First, recognise that addressing work pressure, workload management, and occupational stress is alcohol harm prevention, not merely mental health support - this means measuring alcohol consumption as an outcome of workplace mental health interventions and large employers recognising the link between work-related stress, alcohol harm and mental health.



Second, integrate objective AUDIT-C screening into workplace health assessments and wellness programmes rather than relying on self-identification or manager concern, mirroring the approach already used for cardiovascular risk and metabolic health in occupational health settings.

5. Barriers to Accessing Support: Capacity and Stigma

Alcohol harm reduction strategies in England have historically emphasised awareness-raising and information provision as primary interventions. Public Health England's 2016 strategy included "improve public awareness of alcohol harms" as a key action area.⁸ Alcohol Change UK's "Dry January" campaign focuses on education and behaviour change messaging. NHS "Better Health" campaigns emphasise helping people "know their limits" and understand "where to get help."

This approach assumes that the primary barrier to accessing support is lack of knowledge - that people don't recognise harm, don't know services exist, or don't understand how to access them. The following data challenge this assumption fundamentally.

5.1 Hierarchy of Barriers Among Higher-Risk Drinkers

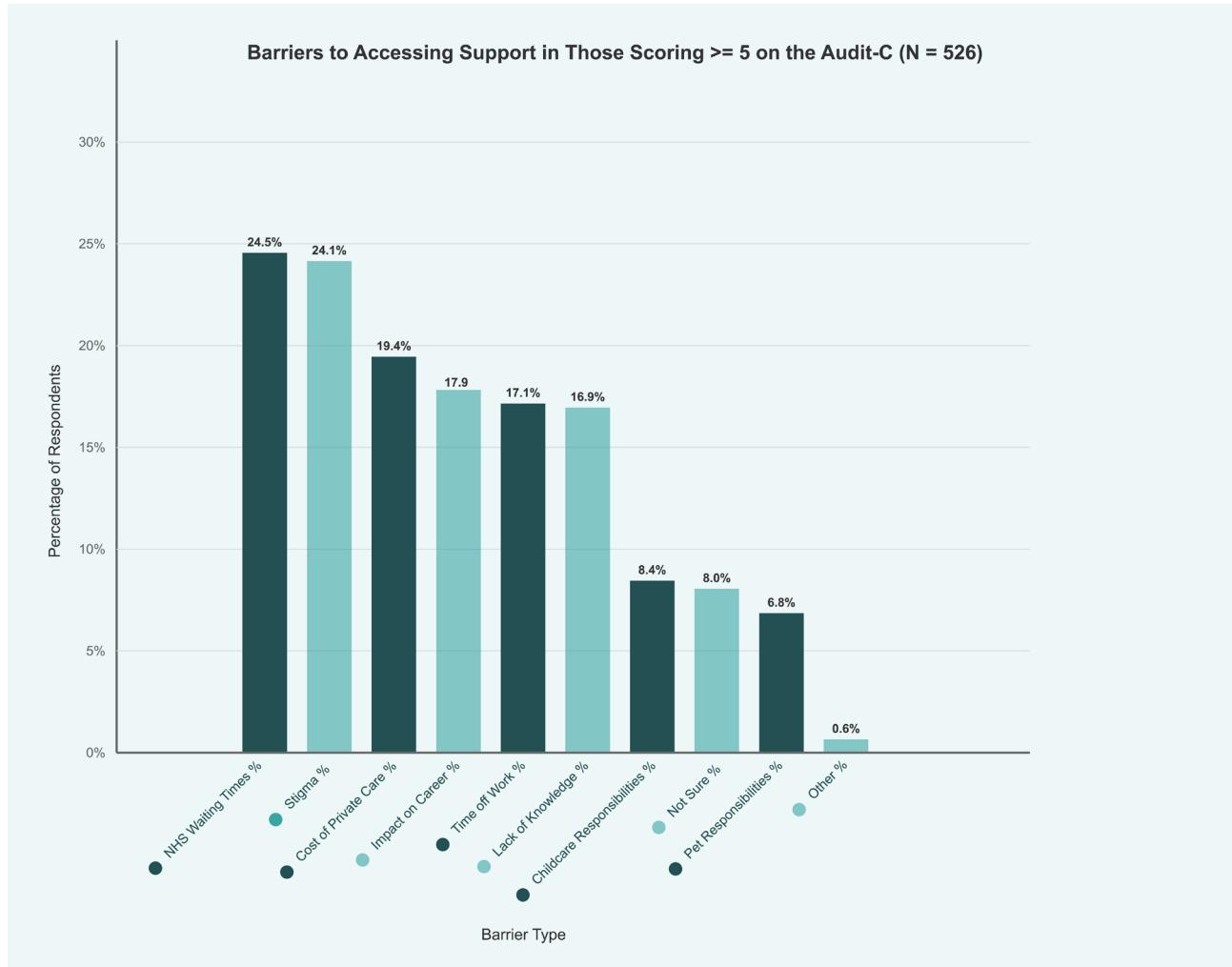
Among higher-risk drinkers (N=526), 57.2% identified at least one barrier to accessing support when asked "If you were addicted to alcohol, which of these factors, if any, might prevent you from getting medical help?"

Barrier prevalence (ranked):

1. Long NHS wait times – 24.5% (129)
2. Fear of stigma – 24.1% (127)
3. Cost of private healthcare – 19.4% (102)
4. Worries about the impact on career - 17.8% (94)
5. Difficulty taking time off work – 17.1% (90)
6. Not knowing where to go for help – 16.9% (89)
7. Childcare responsibilities – 8.3% (44)
8. Pet responsibilities – 6.8% (36)

⁸ Public Health England (2016). The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies

Graph 4: Barriers to accessing support amongst higher risk drinkers



The top three barriers reveal a system capacity and stigma crisis, not an information deficit. NHS wait times rank first (24.5%), indicating that system inability to provide timely access is the primary obstacle. Fear of stigma ranks second (24.1%), connecting directly to Section 2's finding that 90% of higher-risk drinkers do not self-identify as "heavy drinkers" - services framed around accepting that identity create an insurmountable threshold for most. Cost of private healthcare ranks third (19.4%), creating a policy gap: those unable to access NHS services in reasonable timeframes and unable to afford private care have no viable pathway.

Critically, "not knowing where to go for help" ranks only sixth at 16.9% - substantially lower than system capacity, stigma, and cost. This ordering directly contradicts the assumption underlying awareness campaigns: that information provision is the primary barrier. The data suggest that people broadly know services exist; they face structural barriers of capacity, stigma, and affordability in accessing them. Career impact concerns (17.8%) and difficulty taking time off work (17.1%) connect directly to Section 4's workplace findings, suggesting that traditional clinic-based models requiring visible absence from work systematically exclude working populations.



5.2 Demographic Variation in Barrier Perception

While the overall hierarchy is consistent, certain cohorts experience specific barriers at significantly higher rates (see Appendix A for full statistical analysis):

Age-related patterns:

- Respondents aged 18-24 report NHS waiting times as a barrier significantly more often than other age groups
- Respondents aged 25-34 report multiple barriers at elevated rates: cost of private healthcare, not knowing where to access support, need to take time off work, and career impact
- Respondents aged 35-44 report career impact and childcare as barriers more frequently

Geographic variation:

- Greater London residents are significantly more likely to cite career impact as a barrier compared to other regions (consistent with higher-status employment concentration)

Ethnicity-based differences:

- Black/Black British respondents significantly more likely to cite cost of private healthcare as a barrier
- Black British and Mixed-descent respondents more likely to cite career impact
- Asian/Asian British respondents significantly more likely to report childcare as a barrier

Employment status:

- Homemakers report childcare as a barrier significantly more often than other employment groups

These patterns suggest that universal service models must incorporate flexibility around timing (for working-age groups), cost (particularly for ethnic minority groups facing economic barriers), and childcare provision (for parents, especially from Asian/Asian British communities). Current one-size-fits-all commissioning may systematically exclude specific demographics.

5.3 Policy Implications

The barrier hierarchy - system capacity (24.5%), stigma (24.1%), and cost (19.4%) - requires a fundamental reorientation of alcohol harm reduction strategy. Current approaches emphasizing awareness campaigns and information provision address the sixth-ranked barrier while leaving the top three largely unaddressed.

Three evidence-based priorities emerge. First, commission pathways that reduce or bypass NHS wait times through rapid-access models, potentially incorporating virtual



delivery to reduce time-off-work barriers (17.1%) and career concerns (17.8%).

Second, adopt identity-neutral service framing and confidential delivery models to address stigma barriers, which affect nearly one-quarter of higher-risk drinkers and connect directly to the 90% who don't self-identify as "heavy drinkers."

Third, develop affordable non-NHS options for those unable to wait and unable to afford private care - the current gap leaves 19.4% facing cost barriers with no viable pathway. Demographic variation in barrier perception (Section 5.2) requires commissioning flexibility rather than uniform service models.

6. Distribution Patterns: The Case for Universal Policy Frameworks

Alcohol harm reduction policy in England has historically involved targeted interventions: geographic focus on high-prevalence areas (North East, North West), demographic targeting of young people and specific ethnic groups, and sector-specific workplace interventions. Local authority commissioning frequently prioritises high-deprivation areas based on assumptions about where harm concentrates.

This targeting approach assumes significant geographic, demographic, and political variation in alcohol harm. The following analysis tests these assumptions across three dimensions: political affiliation, regional distribution, and age patterns.

6.1 Cross-Political Distribution

Higher-risk drinking prevalence across major political constituencies shows a narrow range of 11.9 percentage points (22.4% to 34.3%), indicating that alcohol harm is genuinely cross-political rather than concentrated in specific ideological groups.

Table 4: Increased and Higher-Risk Drinking by Voting Intention

Table 4: Increased and Higher Risk Drinking by Voting Intention

Party	Higher-Risk %	Sample Size
The Green Party	27.8%	137
Scottish National Party	34.3%	35 (small sample)
Reform UK	29.8%	419
Labour	28.0%	425
Conservative	23.0%	356
Liberal Democrat	22.4%	170

Range: 11.9 percentage points (22.4% to 34.3%)

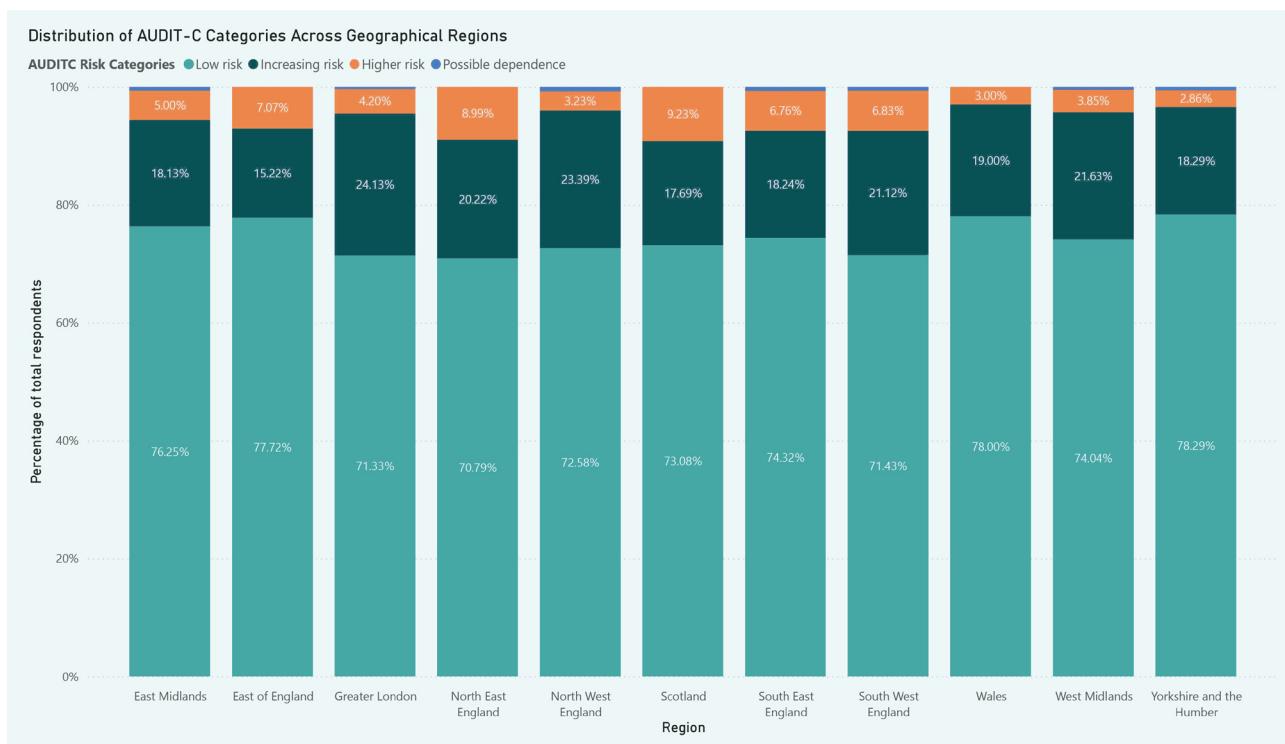
The variation likely reflects demographic composition of party support bases (age, gender, geographic distribution) rather than political ideology influencing drinking patterns. Notably, Reform UK - often associated with "traditional values" messaging - shows the second-highest prevalence (29.8%), while the lowest prevalence appears among Liberal Democrats (22.4%).

Policy significance: All major political constituencies contain substantial higher-risk cohorts (22-34%). Policy messaging framed around specific political values or targeted at particular partisan demographics will systematically miss 60-70% of the affected population. Alcohol harm reduction requires genuinely non-partisan framing and universal rather than ideologically targeted approaches.

6.2 Regional Distribution

No statistically significant association was observed between region and AUDIT-C risk category ($\chi^2 = 28.67$, $p = 0.535$). Higher-risk drinking prevalence varies by only 7.5 percentage points across UK regions, indicating relatively even national distribution.

Graph 5: Distribution of AUDIT-C Categories Across Geographical Regions



No statistically significant association was observed between region and AUDIT-C risk category ($\chi^2(df) = 28.67$, $p = 0.535$).

Regional prevalence ranges:

Region	Higher-Risk %	Sample Size
North East England	29.2%	89
South West England	28.6%	161
North West England	27.4%	248
South East England	25.7%	296
East Midlands	23.8%	160
Greater London	28.7%	286
Wales	22.0%	100
West Midlands	26.0%	208
East of England	22.3%	184
Scotland	26.9%	130
Yorkshire & The Humber	21.7%	175

Range: 7.5 percentage points (21.7% to 29.2%)

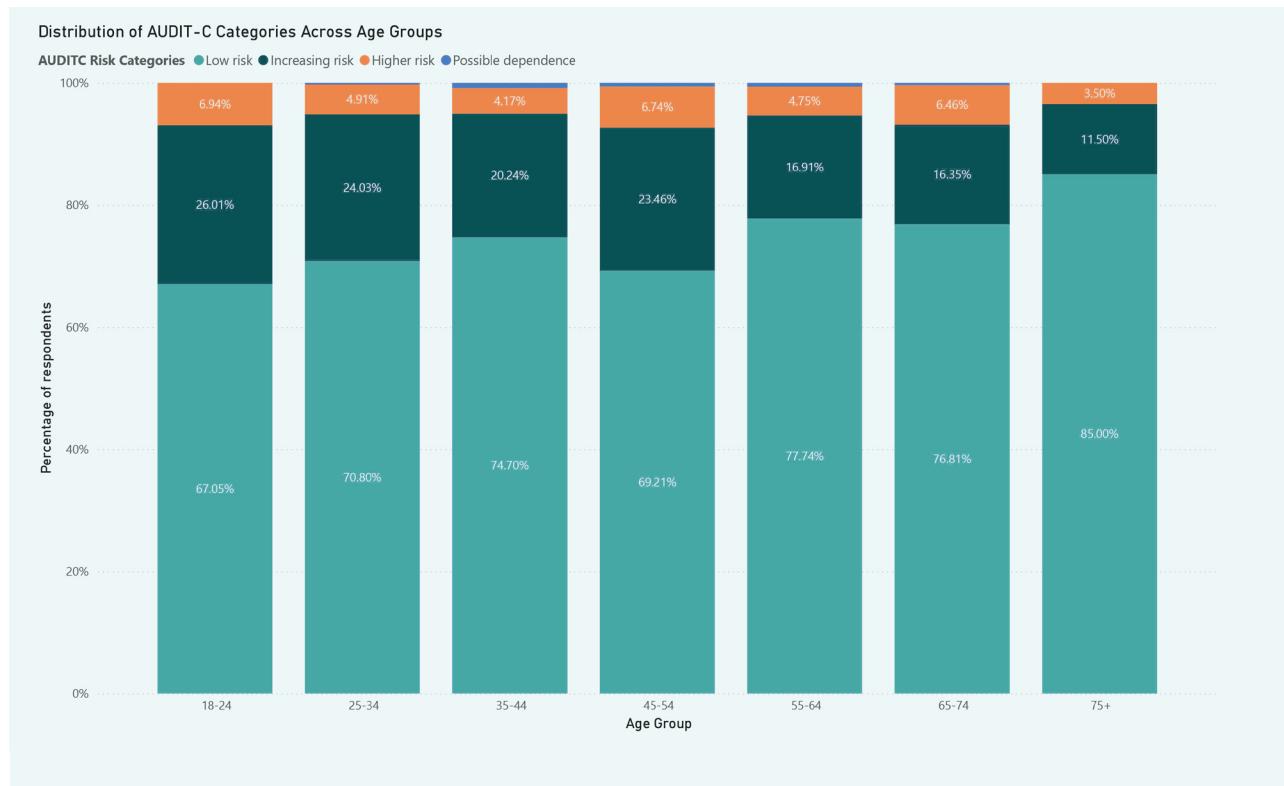
This even distribution contrasts with other public health challenges where geographic concentration is pronounced (e.g., cardiovascular disease, type 2 diabetes, smoking prevalence all show significant regional variation). The lack of geographic clustering for alcohol harm suggests that local factors (e.g. deprivation, unemployment, regional culture) do not drive prevalence in the way often assumed.

Policy significance: The absence of regional variation supports national policy frameworks and universal commissioning standards. National-level policy coordination may be more efficient than fragmented local approaches.

6.3 Age Distribution

A statistically significant but negligible association exists between age and AUDIT-C risk category ($\chi^2 = 34.81$, $p = 0.010$, Cramér's $V = 0.08$). The negligible effect size ($V = 0.08$) indicates that while the relationship is detectable, age explains less than 1% of variance in drinking risk. Only those aged 75+ show significantly lower prevalence of increasing/higher-risk drinking compared to other age groups.

Graph 6: Distribution of AUDIT-C Categories Across Age Groups



There was a statistically significant association between age group and alcohol risk category, $\chi^2(df) = 34.81, p = 0.010$, Cramér's $V = 0.08$, indicating a negligible effect size. Specifically, the age group 75+ indicated a significantly lower number of people in the increasing/higher risk drinking categories than other groups.

This challenges the widely cited narrative that declining alcohol consumption among younger cohorts will naturally resolve alcohol harm over time. While drinking patterns differ by age - younger adults binge more frequently, older adults drink more regularly - overall AUDIT-C risk prevalence remains relatively stable across working-age populations (18-74).

Pattern differences by age:

Frequency (4+ times per week):

- Increases with age: 4.5% (18-24) - 18.5% (75+)
- Reflects shift from episodic to regular drinking with age

Binge drinking (weekly or more):

- Highest among 18-24 (8.1%) and 25-34 (12.1%)
- Notable spike among 45-54 (8.5%)
- Declines after 55



Policy significance: Age-based targeting, whether focusing prevention on young people or treatment on older adults, misses substantial at-risk populations across the age spectrum. The pattern suggests different intervention approaches may be needed (binge-focused for younger, frequency-focused for older) but not different prevalence assumptions. Policies assuming alcohol harm will “age out” as younger, lower-consumption cohorts replace older generations are not supported by these cross-sectional data.

6.4 Policy Implications

The absence of significant variation across political constituencies (11.9 percentage point range), regions ($p = 0.535$), and working-age groups (negligible effect size) creates a strong evidence base for universal policy frameworks rather than targeted interventions. Current commissioning approaches that prioritize specific geographic areas, demographic groups, or political constituencies risk systematically excluding substantial affected populations.

Three implications for commissioning and strategy: first, national-level policy coordination and service standards may be more efficient than fragmented local authority approaches, given the lack of regional variation; second, alcohol policy messaging must be genuinely non-partisan and avoid ideological framing, as all political constituencies show 22-34% prevalence; third, age-based prevention strategies (focusing on youth) or treatment strategies (focusing on older adults) miss substantial at-risk populations across the age spectrum - universal screening and access models are required rather than age-targeted programmes.

7. Alternative Pathway Models

7.1 Clinical Evidence for Home-Based Detoxification

The barriers identified in Section 5 (NHS wait times (24.5%), stigma (24.1%), and cost (19.4%) point toward the need for pathways that exist outside traditional inpatient models while maintaining clinical safety and efficacy.

Community-based alcohol withdrawal is not experimental. NICE Clinical Guideline 100 explicitly recommends community-based withdrawal for patients with mild to moderate dependence who have adequate social support.⁹ The clinical evidence base demonstrates no significant difference in completion rates or safety outcomes between properly screened home-based and inpatient detoxification.¹⁰

⁹ NICE (2011). Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. Clinical Guideline CG115.

¹⁰ Hayashida M et al. (1989). “Comparative effectiveness and costs of inpatient and outpatient detoxification of patients with mild-to-moderate alcohol withdrawal syndrome.” New England Journal of Medicine 320(6):358-365



Medically assisted home detoxification typically involves:

- Initial clinical assessment to determine suitability (excluding high-risk presentations: severe dependence, seizure history, significant comorbidities, unstable housing)
- GP or specialist prescribing of appropriate medication (typically benzodiazepines with thiamine supplementation)
- Daily or twice-daily remote monitoring via telehealth
- Pharmacy-dispensed medication to prevent stockpiling
- Escalation protocols to inpatient care if complications arise

This model replicates the clinical oversight of inpatient units while allowing patients to remain in their home environment. Some evidence suggests improved long-term outcomes, potentially because the patient learns to manage triggers in their actual living context rather than in an artificial clinical setting.

7.2 Digital Delivery: Addressing Capacity and Stigma Barriers Simultaneously

Digital delivery mechanisms, such as video consultations, app-based monitoring, and asynchronous messaging with clinical teams, offer potential solutions to multiple barriers identified in this white paper:

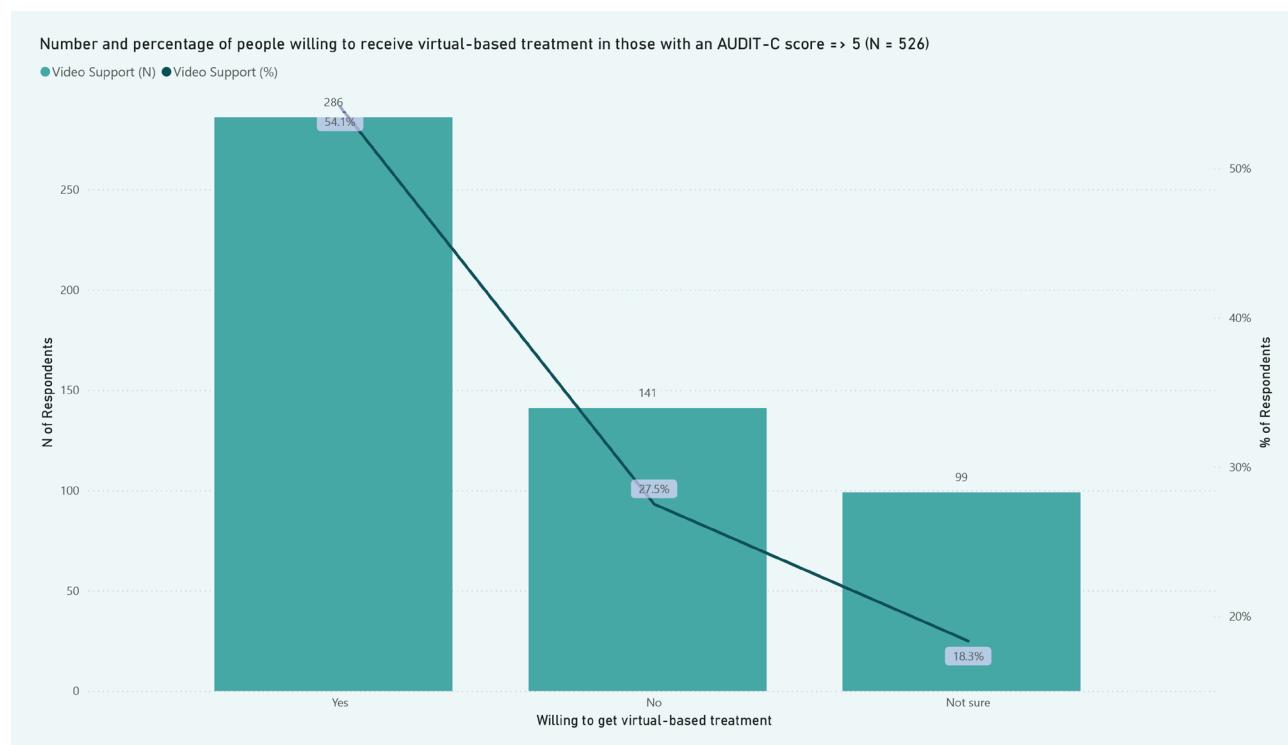
- Capacity: Virtual pathways can serve more patients per clinician-hour than face-to-face models, potentially reducing wait times without proportional increases in workforce.
- Stigma and career concerns: Remote access eliminates the need to attend a physical “alcohol clinic” (addressing the 24.1% stigma barrier) and reduces time off work (addressing the 17.1% barrier). Consultations can occur from a patient’s car, home office, or private space.
- Geographic access: Digital models remove travel barriers, particularly relevant for rural populations and those with caring responsibilities.
- Identity-neutral framing: Digital-first services are more easily framed as “health optimisation” or “supported reduction” rather than “addiction treatment,” addressing the 90% who don’t self-identify as heavy drinkers.

Public receptiveness to digital models:

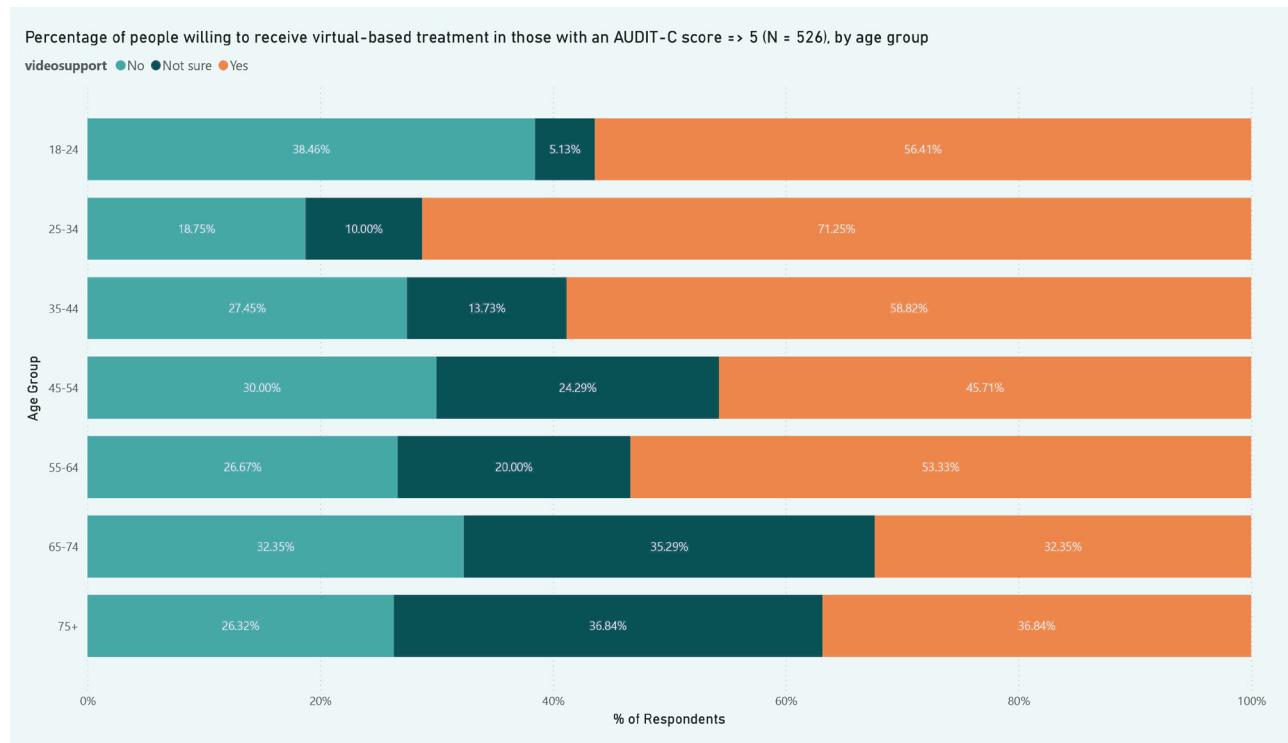
When asked whether they would be willing to receive virtual treatment from an addiction specialist via video call if addicted to alcohol, 45.2% of respondents said yes, 27.8% said no, and 27.0% were unsure. This 45% baseline acceptance is notable given that:

- The question was framed around “addiction” rather than identity-neutral framing
- Respondents were considering a hypothetical scenario, not expressing current need
- Digital health literacy and comfort with telehealth have increased substantially post-pandemic

Graph 7: Number and percentage of people willing to receive virtual-based treatment with an AUDIT-C score => 5



Graph 8: Percentage of people willing to receive virtual-based treatment based on age



There was a statistically significant association between age and willingness to engage with virtual treatment in those scoring ≥ 5 on the AUDIT-C, $\chi^2(df) = 56.60$, $p < 0.001$, Cramér's V

= 0.23, indicating a moderate effect size. Specifically, those aged 25-34 were significantly more willing to engage with virtual treatment than other age groups, and those aged 65-74 significantly less willing to engage with virtual treatment than other age groups.

Emerging models in practice:

Several service models have demonstrated feasibility of digitally-enabled alcohol pathways. GP-led virtual detoxification programmes combine remote clinical oversight with daily pharmacy dispensing, replicating inpatient clinical rigor at home. These models report completion rates comparable to or better than traditional services while serving patients who cite work commitments and stigma as barriers to conventional treatment. App-based support platforms provide asynchronous access to psychoeducation, peer support, and clinical guidance, lowering the threshold for engagement.

7.3 Policy Implications

The evidence for community-based and digitally-enabled pathways, supported by NICE guidance, clinical outcome data, and the barrier analysis in Section 5, creates three commissioning opportunities that would directly address the system capacity crisis identified as the primary obstacle to accessing support.

First, develop tiered pathway systems that reserve inpatient beds for complex cases rather than defaulting to hospital-based detoxification for all presentations. Home-based medically assisted withdrawal with digital monitoring (currently limited availability) should be commissioned more widely for mild-to-moderate dependence, allowing inpatient services to focus on genuinely complex presentations (severe dependence, seizure history, unstable housing, significant comorbidities). This reallocation improves system efficiency without reducing clinical safety and directly addresses the 24.5% citing NHS wait times as the primary barrier.

Second, commission digital-first pathways that explicitly address stigma and workplace barriers through remote delivery, identity-neutral service naming, and flexible scheduling. These models should be positioned as mainstream health optimisation services rather than specialist addiction treatment, reaching the 90% of higher-risk drinkers who don't self-identify as heavy drinkers and the 24.1% deterred by stigma.

Third, explore affordable pathways that address the cost barrier (19.4%) for those unable to access NHS services in reasonable timeframes and unable to afford private care. Options could include commissioning mixed models where NHS funding supports core operations while patients contribute to service costs aligned to contingency management principles, or social enterprise models that operate between NHS and private market pricing. The current binary - free NHS with extended wait times versus expensive private care with immediate access - leaves a substantial cohort with no viable pathway.



8. Conclusion

This white paper does not argue that alcohol harm is a new problem in the UK. Rather, it demonstrates that the shape of the problem and the barriers to addressing it are fundamentally different from what current policy frameworks assume.

Five empirical findings challenge core assumptions embedded in England's alcohol harm reduction strategy:

First, the vast majority of people at clinical risk do not recognise themselves in services framed around "heavy drinking" or "problem drinking." This is not a failure of individual insight - it is a structural mismatch between culturally determined identity labels and clinical risk thresholds. Services designed to be accessed by people who self-identify as heavy drinkers will systematically exclude the vast majority of the higher-risk population.

Second, alcohol harm has diffuse social reach, with nearly half of UK adults knowing someone they consider a heavy drinker. Families, friends, and colleagues recognise escalating risk before formal services engage, yet current pathways offer virtually no mechanism for concerned others to facilitate assessment or access support. The intervention window that exists between social recognition and crisis presentation remains largely unutilised.

Third, the primary barriers preventing help-seeking are system capacity and stigma, not information deficit. "Not knowing where to go for help" ranks sixth among barriers cited by higher-risk drinkers, well below NHS wait times, fear of stigma, and cost of private care. Awareness campaigns that emphasise information provision address the wrong problem.

Fourth, higher-risk drinking among full-time workers is prevalent (30.8%), distributed across all income levels, and strongly associated with work-related stressors. The majority of higher-risk workers attribute their drinking to identifiable external pressures - work stress, cost-of-living crisis, isolation - suggesting that upstream interventions addressing workplace mental health and economic strain may be as important as downstream alcohol treatment.

Fifth, higher-risk drinking shows no statistically significant regional variation and limited variation across political constituencies or age groups. This even distribution undermines the rationale for geographically targeted or demographically focused commissioning, supporting instead universal policy frameworks and service access models.

Collectively, these findings point toward a fundamental redesign: from self-identification to objective screening, from information campaigns to capacity-building, from individual



pathology to systemic stress response, from targeted interventions to universal access, from crisis response to early intervention pathways that families and colleagues can activate.

The central policy question is not whether alcohol harm is serious - hospital admissions of 339,916 annually (2023/24) establish that beyond doubt. The question is whether England's alcohol support system can be redesigned to match how people actually understand their drinking, how families experience harm, how workers navigate career concerns, and how the NHS actually functions when 24.5% of higher-risk drinkers cite wait times as the primary barrier to accessing care.

The evidence supports four interconnected priorities: alternative pathways that reduce wait times and stigma barriers; objective AUDIT-C screening with identity-neutral service framing; upstream workplace stress interventions as alcohol harm prevention; and family-inclusive pathways with appropriate safeguards. This redesign is both necessary and achievable - but only if policymakers are willing to commission services based on empirical reality rather than assumptions about how people should behave when facing alcohol-related harm.

Appendix A – Variation in Perceived Barriers.

Cohort Analysis

This appendix provides detailed statistical analysis of barrier perception among higher-risk drinkers (AUDIT-C ≥ 5 , N=526) across demographic characteristics. The main text (Section 5.2) summarises key patterns; full statistical results are reported here for transparency and replicability.

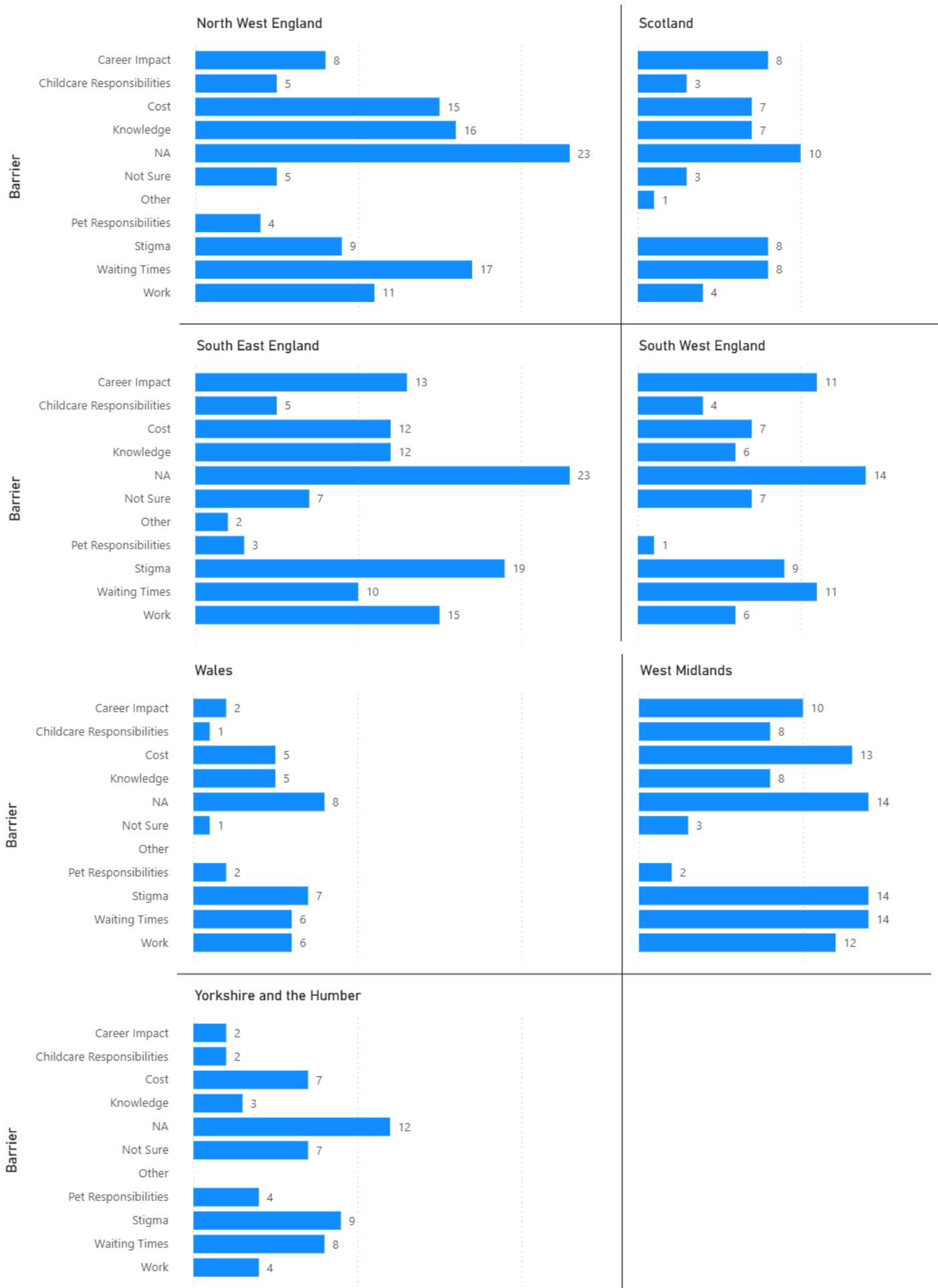
For each demographic dimension, we report chi-square tests of association between the characteristic and each barrier. Statistically significant associations ($p < 0.05$) are noted with effect sizes (Cramér's V: 0.1=small, 0.3=medium, 0.5=large).

A.1 Regional Variation

There was a statistically significant association between regions and some identified barriers to accessing support in those scoring ≥ 5 on the AUDIT-C. Notably, between regions and the perceived impact on career $\chi^2(df) = 18.80$, $p = 0.043$, Cramér's V = 0.19, with a small-medium effect. Specifically, people living in Greater London are significantly more likely to indicate the potential impact on their career as a barrier to accessing support than people from other regions.

Barriers to Accessing Support in Those Scoring ≥ 5 on the AUDIT-C (N = 526), by region

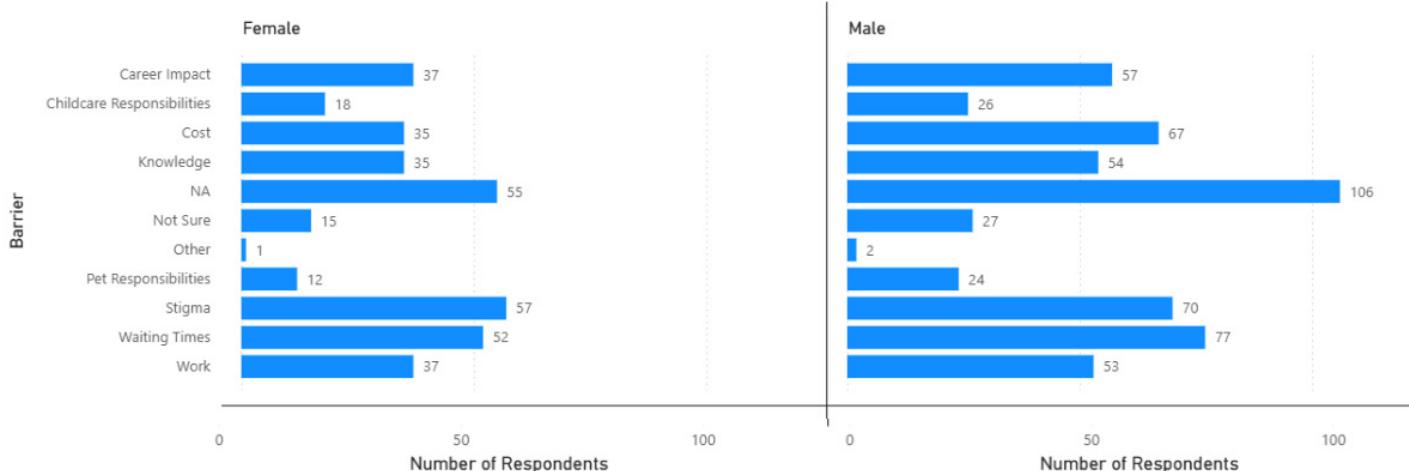




A.2 Gender

No statistically significant association was observed between genders and barriers to accessing support in those scoring ≥ 5 on the AUDIT-C ($\chi^2(df) = 0.44$, $p = 0.507$).

Barriers to Accessing Support in Those Scoring ≥ 5 on the AUDIT-C (N = 526), by gender



A.3 Age Groups

There was a statistically significant association between age groups and some identified barriers to accessing support in those scoring ≥ 5 on the AUDIT-C. Notably, between age groups and: the cost of private healthcare ($\chi^2(df) = 27.95$, $p < 0.001$, Cramér's V = 0.23, knowing where to get help ($\chi^2(df) = 22.82$, $p = 0.001$, Cramér's V = 0.21), NHS waiting times $\chi^2(df) = 13.45$, $p = 0.036$, Cramér's V = 0.16, the need for time off work ($\chi^2(df) = 28.50$, $p < 0.001$, Cramér's V = 0.23), the impact on career ($\chi^2(df) = 32.22$, $p < 0.001$, Cramér's V = 0.25), and childcare ($\chi^2(df) = 25.45$, $p < 0.001$, Cramér's V = 0.22).

Specifically, those aged between 25 and 34 reported the costs of private healthcare as a barrier to support significantly more often than other age groups, and those in the 55-64 age group reported it less often than other age groups.

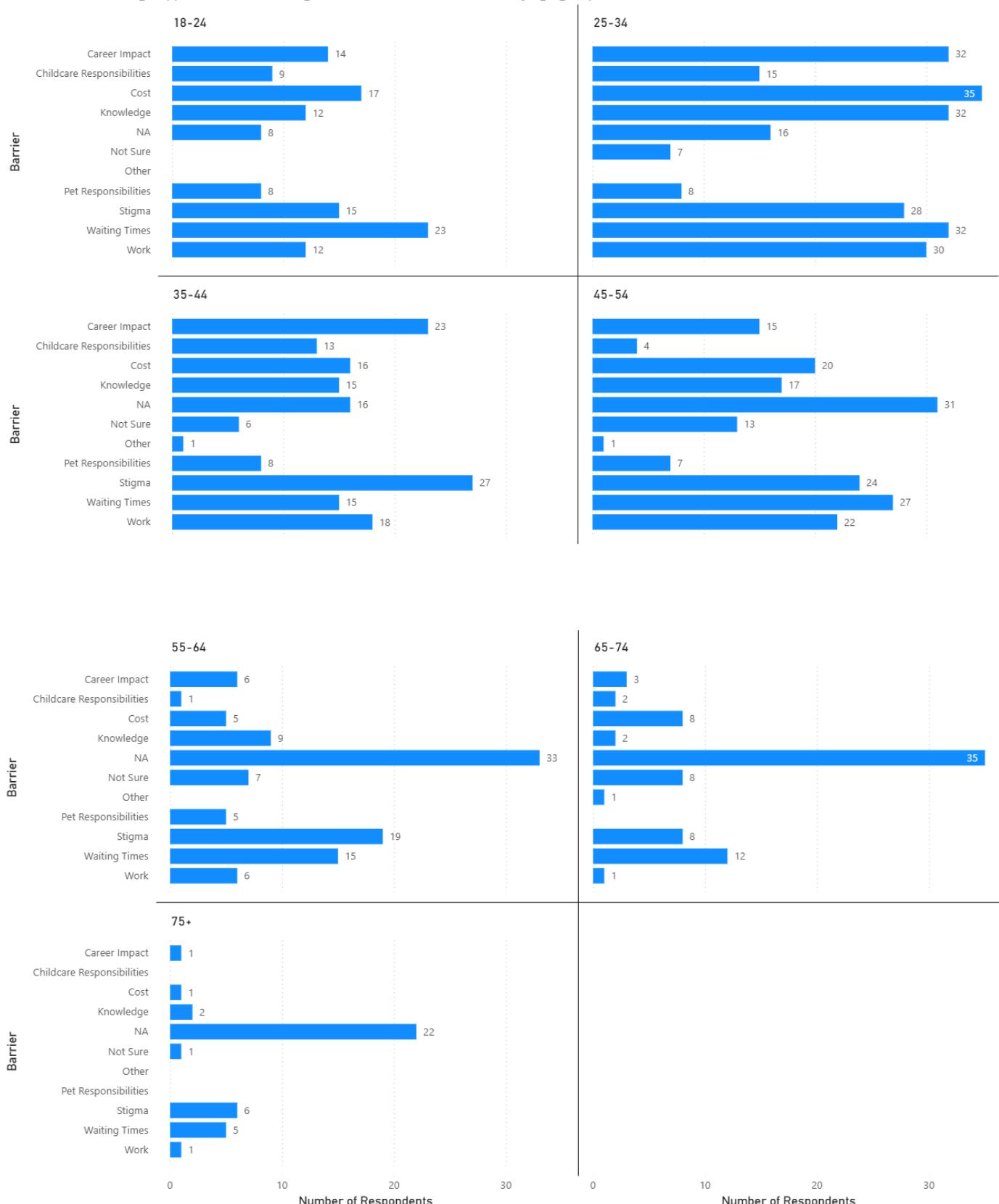
Those aged between 25 and 34 reported a lack of knowledge of where to access support as a barrier significantly more often than other age groups, and those aged 65-74 reported this significantly less.

Those aged between 18 and 24 reported long NHS waiting times as a barrier to accessing support significantly more often than other age groups. People aged 25-34 reported the need to take time off work as a barrier to accessing support significantly more often than other age groups, and those aged 65-74 reported it significantly less.

Those aged 25-34 and 35-44 were significantly more likely to report the potential impact on their career as a barrier to accessing support, whereas those aged 55-64 and 65-74 reported this barrier less frequently.

Respondents aged 35-44 were more likely to report childcare as a barrier to accessing support in comparison to other age groups, whereas those aged 55-64 were less likely to report this as a barrier in comparison to other age groups.

Barriers to Accessing Support in Those Scoring ≥ 5 on the AUDIT-C (N = 526), by age group



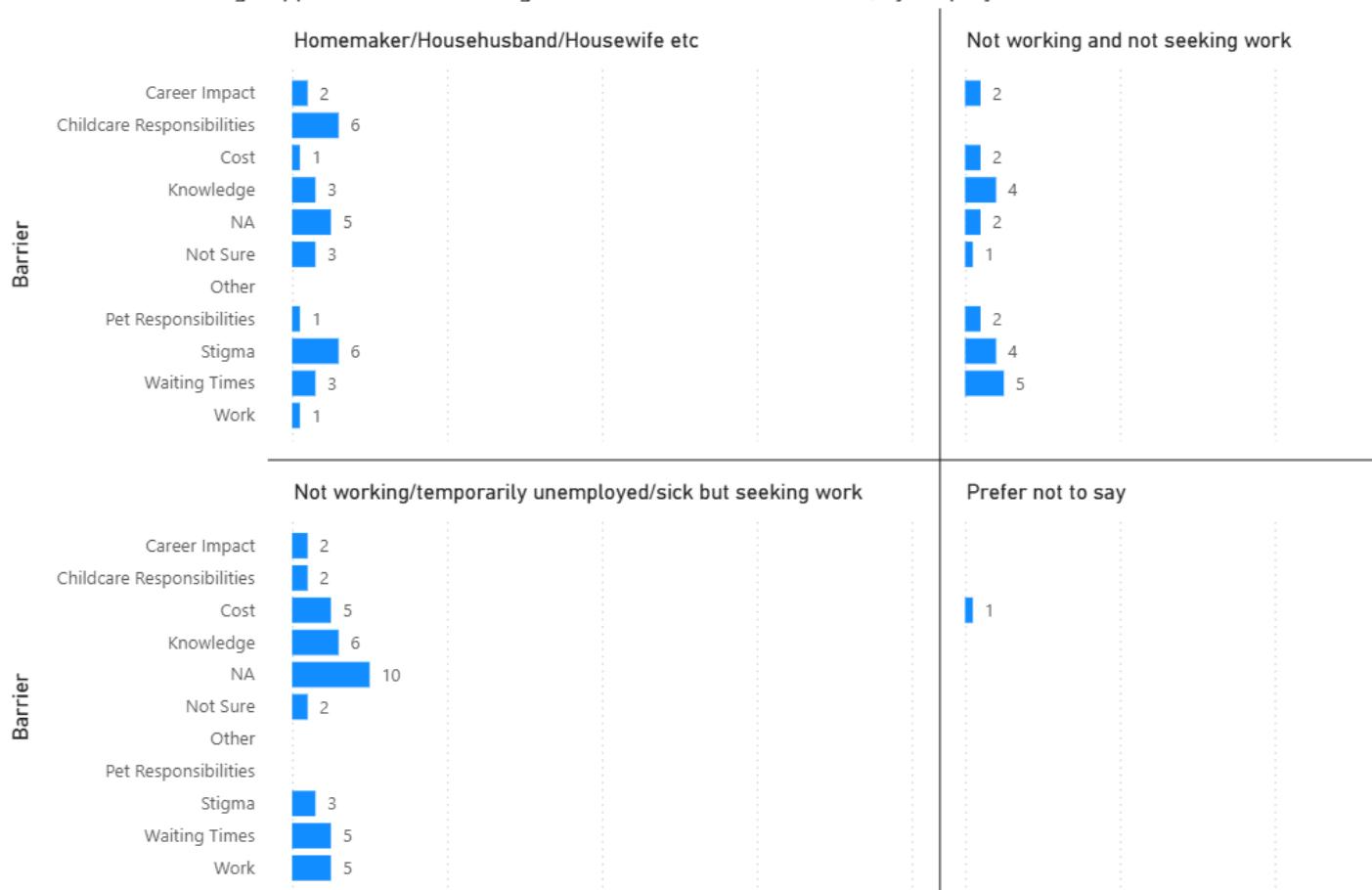
A.4 Employment Status

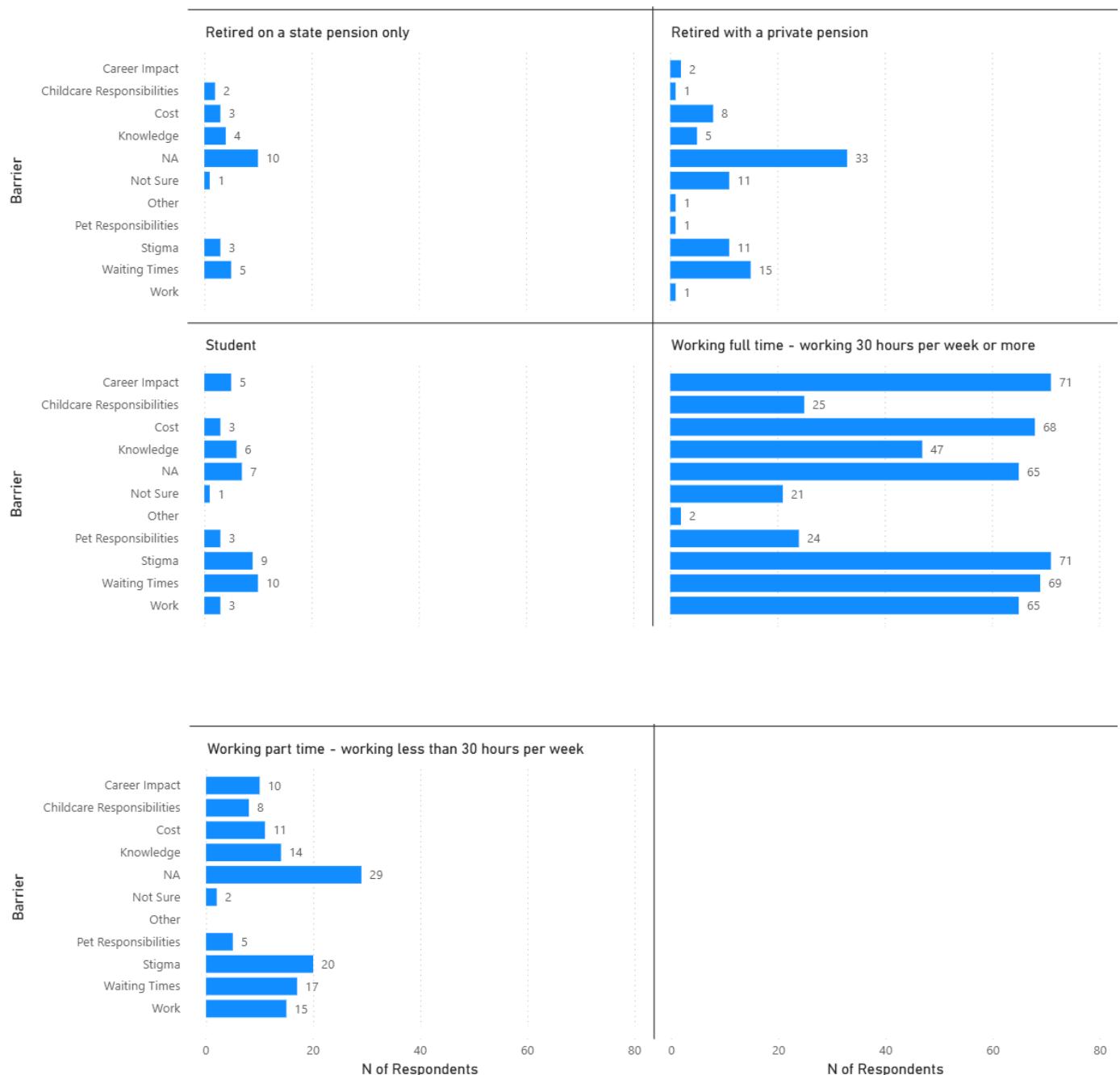
There was a statistically significant association between employment groups and some identified barriers to accessing support in those scoring ≥ 5 on the AUDIT-C. Notably, between employment groups and: the cost of private healthcare ($\chi^2(df) = 15.71, p = 0.047$, Cramér's $V = 0.17$), the need for time off work ($\chi^2(df) = 28.31, p < 0.001$, Cramér's $V = 0.23$), the impact on career ($\chi^2(df) = 28.86, p < 0.001$, Cramér's $V = 0.23$), and childcare ($\chi^2(df) = 20.32, p = 0.009$, Cramér's $V = 0.20$).

Specifically, homemakers, people retired on a private pension and part-time workers reported costs of private healthcare as a barrier less frequently than other employment groups, whereas those in full-time employment reported this barrier more frequently. People who were retired on a private pension reported needing time off work and the impact on their career as barriers to accessing support less frequently than other employment groups, and people working full time reported these more frequently.

Homemakers reported childcare as a barrier to accessing support significantly more often than other employment groups.

Barriers to Accessing Support in Those Scoring ≥ 5 on the AUDIT-C (N = 526), by employment status



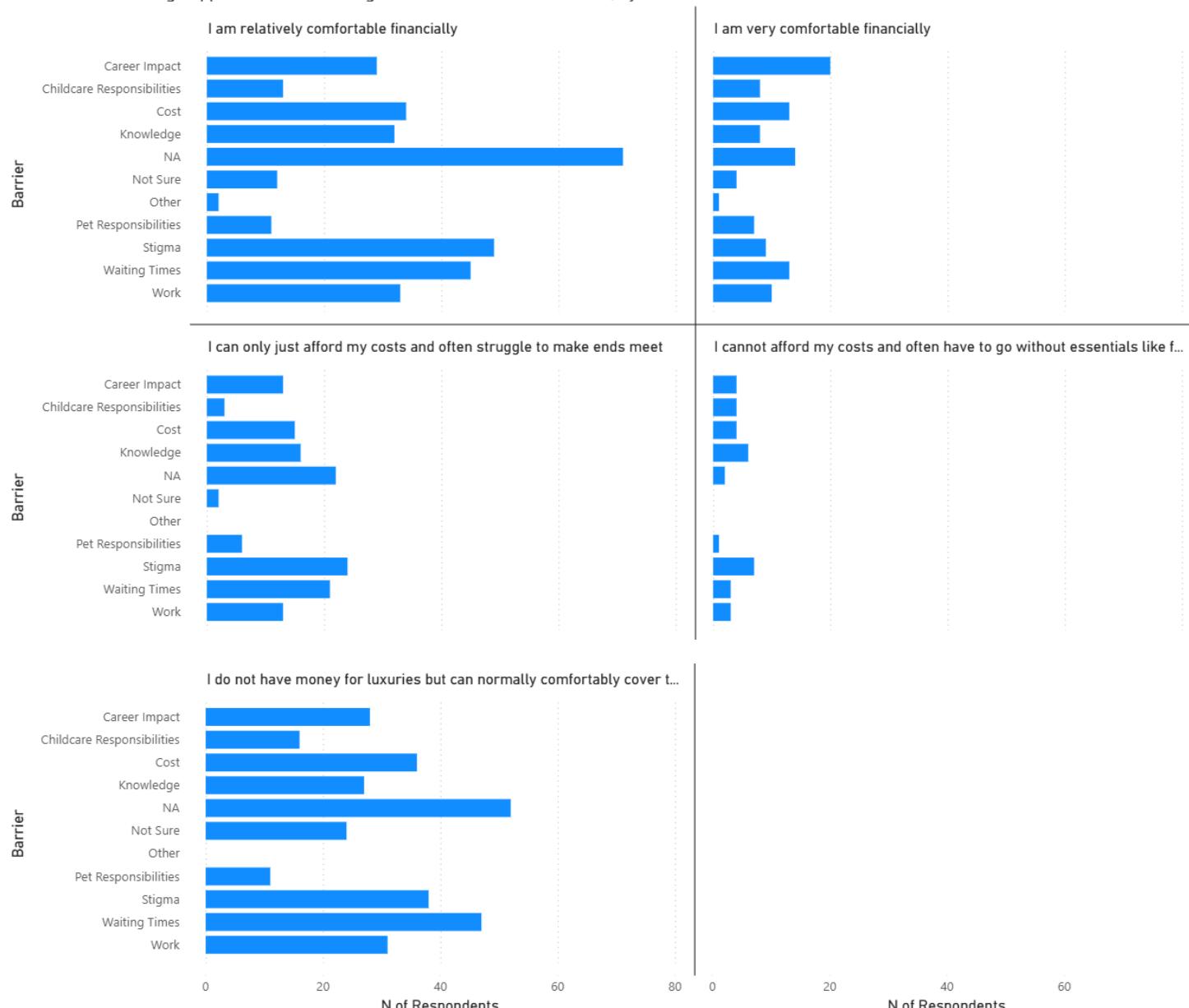


A.5 Financial Status

There was a statistically significant association between financial status groups and some identified barriers to accessing support in those scoring ≥ 5 on the AUDIT-C. Notably, between finance groups and: stigma ($\chi^2(df) = 10.60, p = 0.032$, Cramér's V = 0.14), impact on career ($\chi^2(df) = 15.10, p = 0.005$, Cramér's V = 0.17), and childcare ($\chi^2(df) = 11.59, p = 0.021$ Cramér's V = 0.15).

Specifically, those indicating that they often cannot afford basic costs of living and those who are very financially comfortable report stigma as a barrier less often than other finance groups, whereas those who can only just afford to meet basic needs report stigma as a barrier more often. Those who are very comfortable are significantly more likely to report the potential impact on their career as a barrier than other finance groups. Those who cannot afford general costs and often go without essentials report childcare as a barrier to accessing support more frequently than other finance groups.

Barriers to Accessing Support in Those Scoring ≥ 5 on the AUDIT-C (N = 526), by financial status

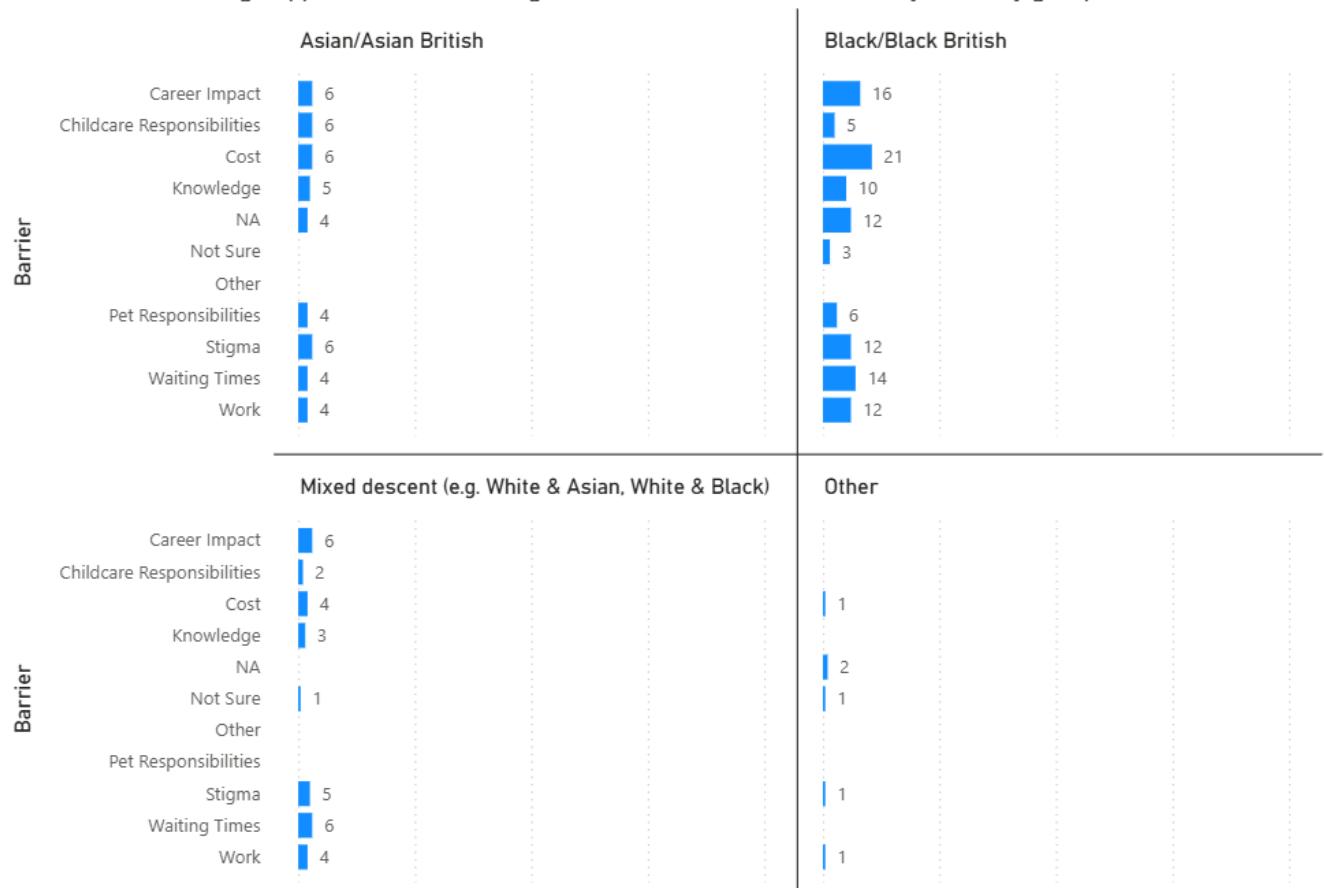


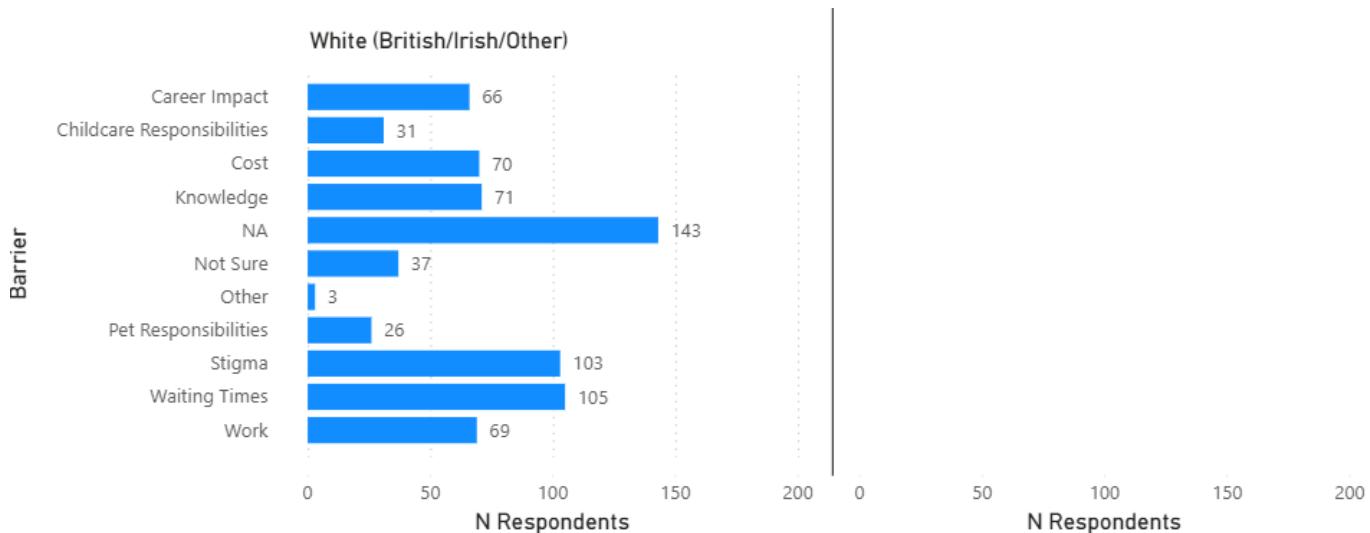
A.6 Ethnicity

There was a statistically significant association between ethnicity groups and some identified barriers to accessing support in those scoring ≥ 5 on the AUDIT-C. Notably, between ethnic groups and: the cost of accessing private healthcare ($\chi^2(df) = 15.76$, $p = 0.003$, Cramér's $V = 0.17$), impact on career ($\chi^2(df) = 12.32$, $p = 0.015$, Cramér's $V = 0.15$), and childcare ($\chi^2(df) = 10.10$, $p = 0.039$, Cramér's $V = 0.14$).

Specifically, Black/Black British respondents were significantly more likely to indicate the cost of private healthcare as a barrier to accessing services than other ethnic groups. White British individuals were less likely to indicate the impact on their career as a barrier to accessing support, whereas Black British and Mixed-descent respondents were more likely to indicate this as a barrier than other ethnic groups. Asian/Asian British respondents were significantly more likely to report childcare as a barrier to accessing support than other ethnic groups.

Barriers to Accessing Support in Those Scoring ≥ 5 on the AUDIT-C (N = 526), by ethnicity group

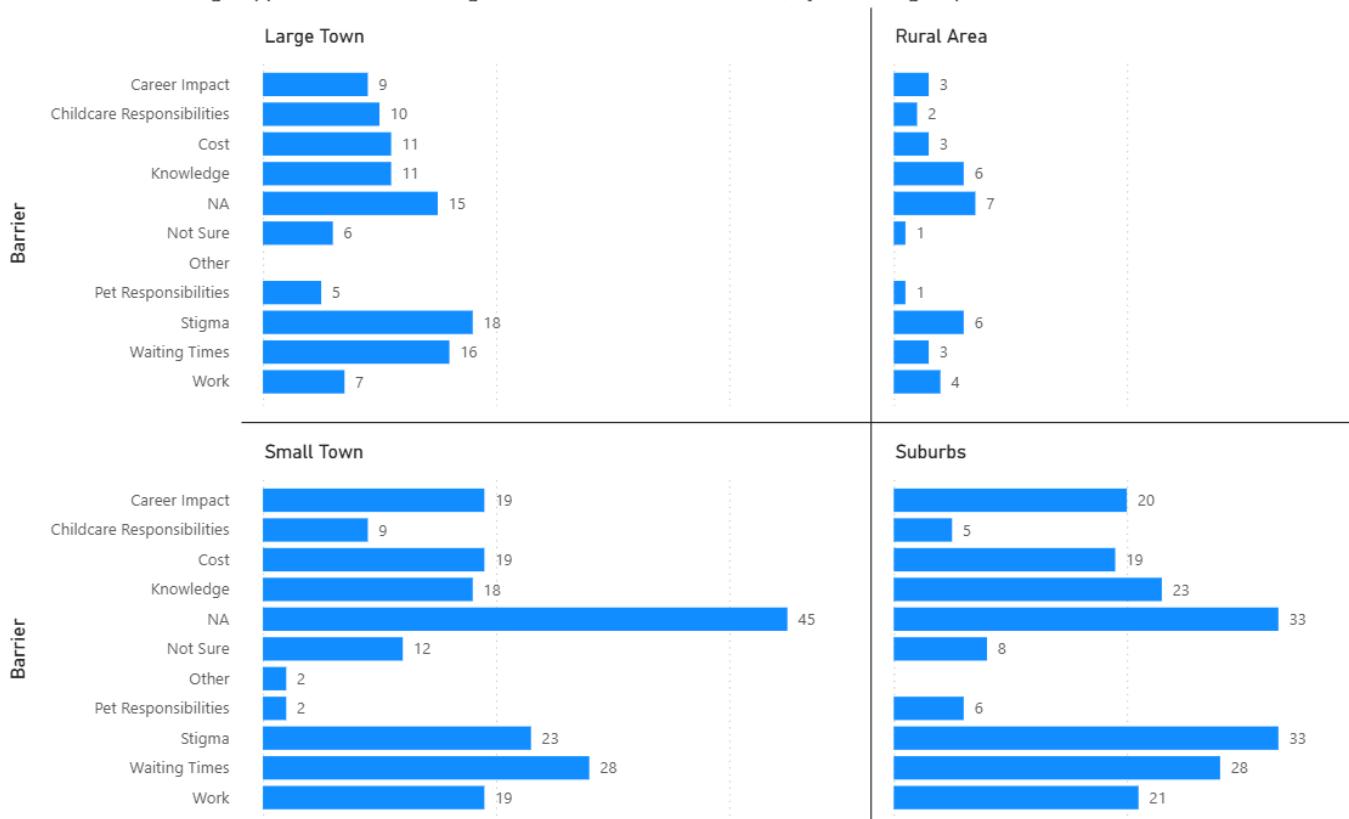


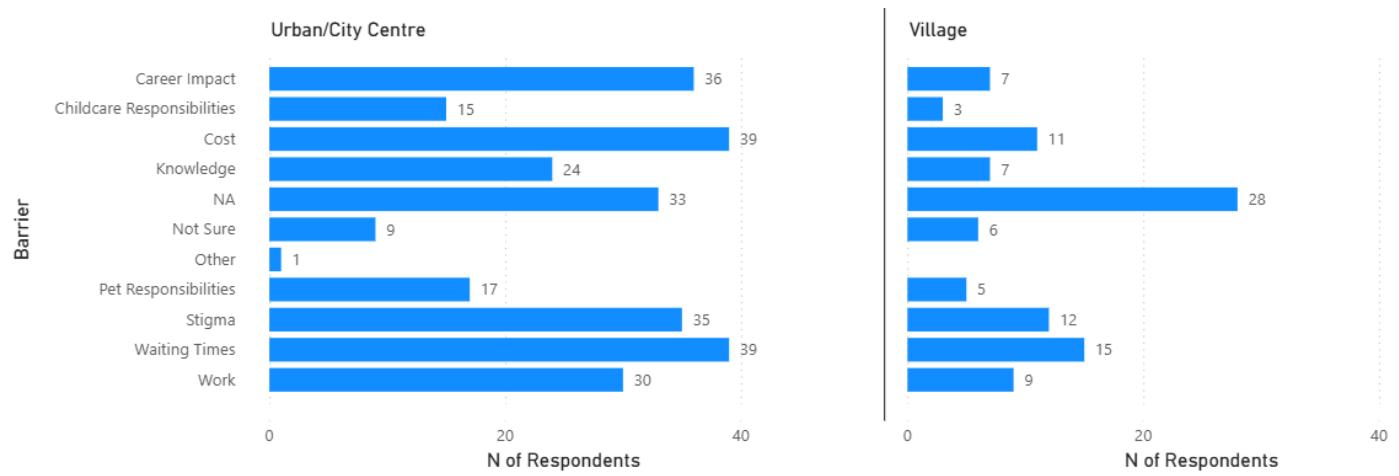


A.7 Rural vs Urban Location

No statistically significant association was observed between location type and barriers to accessing support in those scoring ≥ 5 on the AUDIT-C ($\chi^2(df) = 0.75$, $p = 0.84$).

Barriers to Accessing Support in Those Scoring ≥ 5 on the AUDIT-C (N = 526), by location group

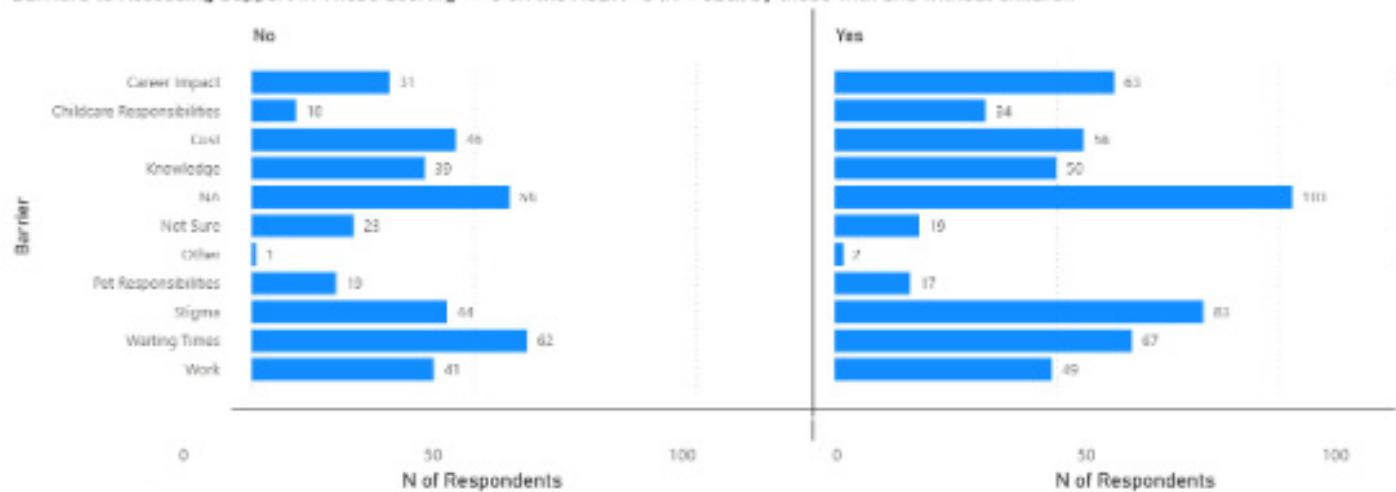




A.8 Parental Status

There was a statistically significant association between whether people had children and some identified barriers to accessing support in those scoring ≥ 5 on the AUDIT-C. Notably, those with children reported childcare as a barrier to accessing support more frequently than those without children ($\chi^2(df) = 6.80$, $p = 0.009$, Cramér's $V = 0.11$).

Barriers to Accessing Support in Those Scoring ≥ 5 on the AUDIT-C (N = 526), by those with and without children



Attributions

Data source: More In Common polling for Adfam, The University of Sussex, and Clean Slate Clinic, December 2025

www.moreincommon.org.uk