NATIONAL ALCOHOL HARM REDUCTION STRATEGY

Response to Consultation Document

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Although I have a view on most of them, it would probably be counter-productive to attempt to answer all 61 questions in the Consultation Document. Therefore, after responding to the more general issues raised in the section on principles that should underpin the strategy, I will confine attention to the section in which my own work is mainly located, the treatment and prevention of alcohol problems.

The principles that should underpin the strategy

1. Why should the Government get involved in managing the harmful effects of alcohol misuse? At what point does Government intervention become justified?

Although millions of people in our society enjoy drinking alcohol and alcohol has many tangible benefits for individuals and for society, it is not a commodity like any other that can be left to the influence of free-market forces but rather a potentially intoxicating, addictive and poisonous psychoactive drug, the consumption of which must be carefully controlled. Governments are elected to protect the interests of citizens and are equally responsible for protecting people from the harmful effects of legal drugs like alcohol as from those of illegal drugs. Government intervention is justified to reduce alcohol-related harm in whatever form it takes.

2. How far is alcohol misuse a matter of individual responsibility and when does Government have a responsibility to intervene, whether through services, legislation and persuasion?

Decisions to drink alcohol and how much to drink are, of course, matters of individual choice and responsibility. However, like any other human behaviour, drinking is shaped by influences of which drinkers are often unaware and over which they have little or no control. Thus control of aspects of the physical and social environment that research shows are relevant to excessive drinking is a matter of collective responsibility and therefore the province of local and central government. The most appropriate means to reduce harm – whether through services, legislation or persuasion – should be identified by research and implemented in practice. As was the case in relation to legislation on the use of seat belts in motor vehicles, if evidence shows that persuasion is ineffective in leading to reduced harm, then Government is justified in introducing legislation.

3. How can we strike a balance between individual and community rights and choices?

As pointed out above, alcohol, as a powerful psychoactive drug, is a special kind of commodity and the balance struck between individual and community rights must reflect this fact. Although no sensible person would now recommend the general prohibition of alcohol, it is arguable that the failure of prohibition contributed to this balance swinging too far in the other direction – to harmful *laissez-faire* policies on the marketing and sale of alcohol products. Whatever the reason for this change, it is clear that, as in other countries, there is an alarming increase in the level of alcohol-related harm in Britain, particularly among young people, and that the activities of the alcohol industry must be more closely regulated as part of the attempt to reduce this harm. If such measures (e.g., stricter regulation of alcohol advertisements, abolition of "happy-hours" and similar promotional activities in which excessive drinking is openly encouraged) are seen as a restriction of individual freedom, then it should be frankly conceded that individual rights are being to some extent curtailed in the interests of community welfare.

4. What are the respective roles and responsibilities of consumers, voluntary groups, commercial interests and others?

Suffice it to say here that, as implied in the responses above, commercial interests must be persuaded to act in a more responsible manner in the marketing and retailing of alcohol. If they cannot be so persuaded, the Government should intervene to regulate their activities more closely. However, given the example of alcohol advertising, where self-regulation by the alcohol and advertising industries has blatantly failed to protect consumers, I think it unlikely that commercial interests can be persuaded voluntarily to act more responsibly and that Government regulation will be necessary.

5. What principles should underpin a national alcohol harm reduction strategy?

The over-riding principle informing the strategy should, obviously, be the identification, development, implementation and promotion of measures to reduce alcohol-related harm. All other considerations should be subordinate to this.

Health: prevention, treatment and impact on the NHS

14. How do you define harmful drinking? What factors do you take into account in deciding whether heavy drinking has become problematic drinking?

Harmful drinking can be defined by the presence of alcohol-related harm to the individual, to other people directly affected by the drinking and to the wider society. For the purposes of treatment, drinking only becomes problematic when someone, the drinker or others, complains that it is a problem. Drinking problems can result from

alcohol dependence, from regular excessive consumption or from acute intoxication and none of these types of problem should be emphasised at the expense of the others.

15. How clear is the evidence for the health costs and the health benefits of alcohol? Are there key pieces of research of which we should be aware? Where are the gaps in the evidence?

Evidence for the health costs of excessive drinking is, of course, overwhelming and need not be repeated here. Although not an epidemiologist, I accept that moderate alcohol consumption has a cardio-protective effect. However, these positive effects apply to only low levels of consumption (below 2 units per day) and only to middle-aged and older people with a significant risk of heart disease. Moreover, the beneficial effects can be obtained in other ways (e.g. regular exercise, daily aspirin) and they are a relatively unimportant consideration in the development of policy on alcohol. There are inevitably gaps in the evidence on both the health costs and possible health benefits of drinking (see Section II in Heather, Peters & Stockwell, 2001).

16. What are the costs for the NHS both directly and indirectly due to alcohol? We will be examining evidence on this but would welcome your views and any evidence you think we should be aware of.

Evidence for the very substantial costs to the NHS arising directly and indirectly from excessive drinking will be available from other sources. However, there is good evidence that some of these costs could be avoided by the widespread implementation of screening and brief alcohol interventions in health-care settings. Research from the USA (e.g., Fleming *et al.*, 2000, 2002) has demonstrated large reductions in the use of health services and consequent financial saving to the health care system among patients who have received brief alcohol intervention in primary health care. Similar research in the UK is urgently needed. Meanwhile, it is a reasonable assumption that early and brief interventions in primary health care and a range of other medical and non-medical settings would lead to substantial cost savings for the NHS.

17. What, in your experience, are the most appropriate means of prevention of alcohol dependence and serious alcohol misuse? What forms of training are most appropriate for professionals in health and social care, as well as other fields, who play a role in prevention?

While peer-led education and programmes linked to community action appear somewhat more promising, evidence shows that standard alcohol education in schools is largely ineffective and may even be harmful. The temptation to Government to rely on appeals to this form of putative prevention because of its political convenience should be avoided. What is needed is a fundamental change in public attitudes to excessive drinking, similar to what has occurred over the last 20-30 years in relation to smoking. A major obstacle to such a change is the received idea among the public that "alcoholism" (i.e., severe alcohol dependence) is the only form of alcohol-related harm with which they should be concerned. The Government should therefore launch mass-media campaigns to introduce to the public the concept of "risky drinking" and

relate the harms that alcohol can bring about to the consumption of the large proportion of the population drinking at risky levels.

Mass media campaigns of this kind would act synergistically with an increased quantity and quality of alcohol education for health, social care and criminal justice system professionals to raise the general level of awareness of alcohol-related harm in this country. By providing suitable incentives to educational establishments and health care organisations, Government should ensure that adequate alcohol education is included in basic curricula and as a key component of ongoing professional development.

18. "Brief interventions" can be offered to patients who have been identified as at risk from alcohol misuse. They may consist of a short session with a doctor or nurse to discuss a patient's drinking and to offer help and support to cut down on alcohol intake, if the patients wishes to do this. How effectively do you think those at risk are identified? How well have you found brief interventions to work and how might they work better?

Given that, as seems likely, Government is unwilling to lower per capita alcohol consumption by means of taxation, which would be the most effective method of reducing alcohol-related harm, the next best alternative would be the widespread and routine implementation of screening and brief alcohol intervention (SBI) in medical and other settings. The evidence has shown beyond any reasonable doubt that SBI, at least in medical settings, is effective in helping excessive drinker lower consumption to safer levels (Moyer *et al.*, 2001). Unfortunately, the evidence also shows that general medical practitioners, hospital physicians, nurses, social workers, probation officers and other "frontline" workers have not incorporated SBI into their routine practice. As someone who has been involved in the attempt to persuade health care professionals to implement SBI for the last 20 years, I have found that it is easy to become discouraged about prospects for the success of these efforts. However, perhaps the main reason for this failure so far has been to almost complete lack of support for practical implementation from Government. It is arguable that the single most important measure that could be introduced in the National Alcohol Harm Reduction Strategy is clear policy providing the necessary incentives and encouragement for health care and other professional workers to routinely identify excessive drinkers and offer them brief advice and counselling. In combination with environmental changes and a change in public attitudes to excessive drinking, such a policy would significantly lower the level of alcohol-related harm in this country.

19. Do current treatments for alcohol dependence and hazardous drinking work? Are they sufficiently tailored to meet differing individual needs? Are there other forms of treatment we should be aware of? Is there a need for guidance for the commissioners of local treatment services? How should individuals best access treatment services?

There is a range of treatments for alcohol dependence that have been shown to be effective (see, e.g., Miller & Wilbourne, 2002). (Treatment for hazardous drinking is best considered under the heading of "brief interventions" – see above.) Important new information on the relative effectiveness and cost-effectiveness of leading

approaches to the treatment of alcohol problems will become available with the completion of the United Kingdom Alcohol Treatment Trial (UKATT Research Team, 2001) and the publication of its results later this year or early in 2004. Our knowledge from research of how different treatments may be tailored to meet differing individual needs is at present poor but some improvement in this respect may come from the UKATT findings. Meanwhile, as will probably be known, an excellent summary of evidence on effective treatment for alcohol dependence has recently been produced by NHS Scotland (2002).

Health commissioners should certainly be given guidance regarding effective treatment in this field. In 1998, Dr. Duncan Raistrick and I were commissioned by the Department of Health to write a review of the effectiveness of treatment for alcohol problems (Raistrick & Heather, 1998) but this has never been published. Although some sections are inevitably slightly out-of-date by now, we believe that this document is still relevant to the National Strategy, particularly our suggestions for providing a continuum of care from hazardous drinking to severe alcohol dependence. (A copy of this document has been forward to Dr. Rannia Leontaridi at the Strategy Unit.)

The majority of people with alcohol problems in the UK receive no treatment or help for their problem. The main way in which this situation might be ameliorated is by making the provision of treatment more "extensive" rather than "intensive" (see Humphreys & Tucker, 2002).

20. What can be learnt from drugs prevention and treatment?

Very little. The evidence-base relating to treatment of alcohol problems is far larger and more scientifically sophisticated than that for illicit drugs; the treatment of illicit drug problems has much to learn from research on the treatment of alcohol problems. Moreover, methods employed in the attempt to prevent an increase of illicit drug problems have obviously and dramatically failed to work and not much guidance for the prevention of alcohol problems can be expected from this source.

21. How, in your experience, can we minimise and prevent the injuries that are presented to A&E departments as a result of alcohol-related assaults (often with glasses and bottles) or home and workplace alcohol-related accidents?

Discussion of how to reduce this type of harm may be found in Plant, Single and Stockwell (1997). One important aspect of this is the creation of safer drinking environments (see Homel, McIlwain & Carvolth, 2001).

22. What are the links between alcohol misuse and mental health problems, including depression and suicide? How are service – both those aimed at prevention and treatment – best co-ordinated?

The comorbidity of alcohol and mental health problems is well documented but research and practice in this area in the UK lags far behind that in, for example, the USA. Indeed, it is no exaggeration to say that the neglect of this type of comorbidity here is a national disgrace and it is again essential that the National Strategy introduce

measures for the more effective and humane treatment of comorbid problems. The research evidence indicates that, rather than a sequential or parallel approach, an integrated approach to treatment is required (Mueser & Kavanagh, 2001) this means that resources for adequate training of both mental health and addiction professionals, together with adequate provision of treatment facilities, must be found.

What the Consultation Document omits

There is no mention of the need to increase the quantity and quality of research on alcohol problems in Britain. It is essential that the National Strategy pays specific attention to way in which research can be better funded and carried out. It is also essential that the effects of any new measures introduced by the National Strategy be properly evaluated. An important source here is a recent report by Alcohol Concern (2002) and I recommend that this be closely consulted.

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