STRATEGY UNIT/ DEPARTMENT OF HEALTH "NATIONAL ALCOHOL HARM REDUCTION STRATEGY" CONSULTATION DOCUMENT

COMMENTS FROM:
THE NATIONAL ADDICTION CENTRE

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The NAC welcomes this opportunity to comment on the National Alcohol Harm Reduction Consultation Document, published in October 2002. In our view it is a "broadbrush" document, not a consultation document, and does not constitute the basis for a comprehensive National Alcohol Strategy.

What is meant by "Harm Reduction"? Why a Harm Reduction Strategy rather than a comprehensive Alcohol Strategy? Is there a perception that Harm Reduction strategies for alcohol can be set up in the same way as Harm Reduction strategies for drug misuse? A strategy that encompasses shatterproof glass at one end of the spectrum and proposals to extend licensing hours at the other is a strange mix, with potential for muddle and confusion.

The list of 61 questions is, in our view, too long. A National Alcohol Strategy should set out clear objectives, with measures and strategies to support these objectives. The alcohol field is informed by a very strong evidence base on what works and, in many areas, can show not only what is effective but also cost effective.

We have chosen to address the issues generally, but have also answered questions specific to health, in an endeavour to highlight the evidence base for this area.

The National Addiction Centre

The National Addiction Centre (NAC) was established in 1991 to bring together and network the skills of scientists and clinicians working on many aspects of Addiction. The mission statement of as follows:

"The NAC is a network of clinicians, researchers and clinical teachers sharing a commitment to excellence in work directed at the prevention and treatment of substance misuse, and to the support and strengthening of national and international endeavours in this field. It will make science and scholarship useful."

Much of the clinical, research and teaching work of the NAC is within the clinical services of the South London and Maudsley NHS Trust, and within the research and teaching activities of the Addiction Research Unit of the Institute of Psychiatry. An MSc in Clinical and Research Aspects of Addiction was established in 1994.

Other important documents relevant to this consultation exercise

A Steering Group from **The Society for the Study of Addiction** (SSA) recently reviewed the evidence base for a National Policy within a contemporary and historical perspective and published its analysis in a book entitled **"Tackling Alcohol Together"- the Evidence Base for a UK Alcohol Policy (edited by Raistrick et al, 1999).** The Steering Group comprised 11 academics, including 2 from the NAC. Evidence-based position papers were invited from 19 other academics. The policy mix set out in this book included proposals for both national and local measures.

Four Primary Objectives were outlined, together with 16 key measures and 8 strategies to support the objectives (Chapter 12, pp229-238). The Objectives were as follows:

1. To increase public information and debate about alcohol
2. To encourage the Drinks and Leisure Industries to introduce innovative schemes to discourage drunkenness
3. To maximise community and domestic safety
4. To reduce alcohol-related health problems below 1990 indicator levels.

Many of the ingredients needed to make such a policy happen are already in place. However the authors stated that "our cultural ambivalence towards alcohol potentially has the capacity to dissipate the energy generated by a national policy".

Alcohol Concern published its **Proposals for a National Alcohol Strategy for England** in 1999. This comprehensive document, based on a national consultation exercise, set out clear objectives and action targets, and proposed an administrative framework to coordinate the implementation of the Strategy. It highlighted the need for alcohol misuse to be tackled on many fronts and sought to reconcile conflicting interests within the overall aim of reducing alcohol-related harm.

Two further documents take a national perspective and should be consulted:

(1) **Alcohol –can the NHS afford it?** (**Royal College of Physicians**, **2001)** and

(2) **100% Proof: Research for Action on Alcohol (Alcohol Concern**, **2002).**

Both documents were the result of Working Groups, on which the NAC was represented.

The **Institute of Medicine Monograph (1990) "Broadening the Base of Alcohol Problems"** is another important publication. This report focuses on *the actions of alcohol as a drug* and the totality of the context in which those actions occur (Chapters 2 and 3).

The Principles That Should Underpin the Strategy

Alcohol policies in Europe follow two main models, one targeted at total population alcohol consumption and the other targeted at heavy and dependent drinkers. The former strategy is supported by Ledermann's theory (Ledermann, 1956); by Skog (1985) and the "preventive paradox" (Rose, 1981; Kreitman, 1986). In England, recent work confirmed that heavy alcohol consumption was associated with problem drinking (Colhoun et al, 1997)**. A National Alcohol Strategy should therefore seek to reduce alcohol consumption across the whole population**. However, the consultation document appears to be directed towards reducing harm among heavier drinkers. Restricting access to and availability of alcohol is not discussed at length. The title suggests a reactive rather than a proactive focus (i.e. tacking problems downstream rather at their source).

The main issues for policy makers are summarised in Chapter 10 of Edwards et al (1994). Effective policies cannot be modelled exclusively in terms of "picking off little pieces of the continuum " or "trying to manipulate extremes of behaviour" (p205). The authors make two important and relevant points:

1. Prevention measures which influence the generality of drinkers will often also impact on heavy or problematic drinkers
2. Many of the target populations are widely distributed in the drinking population, rather than being concentrated only among heavy drinkers.

Thus alcohol policy should aim to reduce the occurrence of problems, firstly by operating measures that bear on consumption (e.g. alcohol availability) and

secondly by targeting specific high-risk behaviours or contexts. These two policy responses are interactive and mutually supportive.

Health: Prevention, Treatment and the Impact on the NHS

Q14 - A good definition of harmful drinking can be found in the Royal College of Physicians document (xi) and in a chapter by Marshall (2001) on Needs Assessment and Alcohol (both in reference list).

Q15 - From a public health perspective, alcohol consumption plays a major role in morbidity and mortality. The impact of alcohol on health is underestimated when the focus is alcohol dependence or "alcoholism". Taking an alcohol problems or alcohol-related harm perspective broadens the target population. This is discussed in the Institute of Medicine Monograph (1990, p30).

There is evidence that light to moderate drinking can have health benefits. However the cardio-protective effect of alcohol has been shown only for men over 40 and post-menopausal women. It should be remembered that the main preventive factors in coronary heart disease are still diet, stopping cigarettes and exercise. Alcohol has not been shown to confer any health benefits on people under the age of 30 years.

The relationship between alcohol and breast cancer is still controversial but a recent pooled analysis of cohort studies showed that alcohol is associated with a linear increase in breast cancer incidence in women over the range of consumption reported by most women (Smith-Warner et al, 1998).

Gaps in the evidence are set out in the Alcohol Concern (2002) document, p29 also in the Royal College of Physicians document.

Q16 – The financial burden of alcohol problems to the NHS is summarised in the Royal College of Physicians (2001) document (p18-19).

Q 17 – The answer to this question is set out in detail in the Raistrick et al (1999) and Edwards et al (1994).

Q18 – The evidence for brief interventions is summarised By Nick Heather in the Alcohol Concern (2002) publication, also in an Evidence Briefing published by the Health Development Agency (2002). We believe that there is a need for a public

debate on brief interventions and the issue of alcohol problems in Primary Care, before any further calls are made for GPs to do more work in this area.

Q19 – There is increasing evidence that treatment for alcohol dependence is effective (Miller et al, 2000; Miller and Wilbourne, 2002). However they are only effective in the context of the individual strengths and social environment of the patient.

Q20 – Lessons include reducing availability of alcohol and increasing availability of at access to treatment.

Q22 – The links between alcohol misuse and mental health problems are well documented. See summary in Alcohol Concern (2002) document (pp 33-35).

Education and Communication

Q 43 - Currently individuals are advised to adopt the sensible drinking message. At the same time, however, alcohol consumption is being encouraged and legitimised as a result of the potential extension of licensing hours and its wider availability (e.g. at service stations), and the cardio-protective effects are advocated. This gives a mixed message.

Summary of the research evidence and levers of policy (Edwards et al, 1994).

1. **Alcohol taxation** is an effective policy instrument.
2. **Environmental measures** to restrict physical access to alcohol e.g. minimum legal drinking age, restriction on sale of alcohol.
3. **Drink driving** is an example of the successful application of scientific findings to policy development. However drink driving countermeasures must be vigorously enforced and given a high public profile.
4. **Education.** Present evidence does not support deployment of education strategies as a main policy unless these are placed in the wider context of community action. Their only impact is likely to be in the longer term and via heightened political and public awareness.
5. “**Safe/sensible” limits**. There is no evidence to support efficacy of campaigns to teach the public to count the number of units they drink. There is always a

concern that this legitimises drinking up to the safe limit. In fact there is no safe limit, but a continuity of risk. Risk does not increase until a level of 3 standard drinks/day for men or women is reached. In view of the data about risk for breast cancer in women, the limit should be set lower for women.

6. **Coronary heart disease**: Most of the achievable benefit from drinking is achieved with a level of intake of 1 drink every 2 days. The message being "heard" by the public is that "alcohol is good for the heart" and this only encourages "drinking for the heart".
7. **Community action programmes**: Community backing is a prerequisite for the success of any public health policy, alcohol included.
8. **Treatment:** Treatment can support public health goals. If treatment is to make an impact, it must be delivered on a community-wide basis. Different levels and types of problems require different types and degrees of intervention. Brief interventions have been shown to be effective in primary care. More severe alcohol problems require appropriate treatments ranging from pharmacotherapy to cognitive behavioural, motivational and twelve step strategies. The evidence base for effective treatments is growing.

References/Bibliography

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Proposals for a National Alcohol Strategy based on detailed research and a major national consultation exercise. Intended as a significant contribution to any Government led alcohol strategy initiative. Would "if followed through, lead to a reduction in the incidence of alcohol misuse and its associated harm and costs."

Alcohol Concern (2002). 100% Proof: Research for Action on Alcohol. London: Alcohol Concern.
In 2000 Alcohol Concern brought together a number of experts to provide an overview of UK research and make recommendations for future research. The report highlighted the absence of significant funding in this area and the urgent need to develop a coherent alcohol research programme

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Miller WR, Wilbourne PL (2002). Mesa Grande : a methodological analysis of clinical trials of treatment for alcohol use disorders. Addiction 97, 265 - 277

Raistrick D, Hodgson R, Ritson B (1999). Tackling Alcohol Together: the Evidence Base for a UK Alcohol Policy. London : Free Association Books
'Tackling Alcohol Together' was a Society for the Study of Addiction Project that used a Steering Group to commission position papers for experts in various subject areas, in order to collate the evidence base for a national alcohol policy. Comprehensive, up to date, focusing on UK.

Rose G (1981). Strategy of Prevention : Lessons from Cardiovascular Diseases. BMJ 282, 1847 - 1851

Royal College of Physicians (2001). Alcohol – can the NHS afford it? London : Royal College of Physicians
This report was based on the recommendations of a working group set up by the Royal College of Physicians in 2000, to explain the burden of alcohol use on the general hospital workload. The recommendations are comprehensive and highlight the need for individual trusts to spell out their own strategies in the context of a

higher profile for alcohol problems nationally, the need for further training, integration with mental health services and a research strategy.

Skog OJ (1985). The collectivity of drinking cultures : a theory of the distribution of alcohol consumption. British Journal of Addiction, 80, 83 - 99

Smith-Warner SA, Spiegleman D, Yaun S et al (1998). Alcohol and Breast Cancer in Women: A Pooled Analysis of Cohort Studies. JAMA – Vol 279, No. 7