

SU/DoH Consultation
National Alcohol Harm Reduction Strategy

Dear colleagues,

This note responds to your request for comments on the Consultation Document.

My overarching comment is that the document's framing and questions tend to steer consideration away from the most effective measures that a government can take to reduce harms from drinking. There is thus a considerable risk that the end of your process will be a document with many fine phrases but which has roughly the effectiveness of hand-wringing.

An example of this is the framing of Area of enquiry (vi): the shape of the market and market-based solutions. Many of the most effective strategies of reducing alcohol-related harm involve the government intervening in the marketplace, controlling the time, place and conditions of sales of alcohol (notably -- through taxes -- controlling the price at which it is sold). These could be viewed as having to do with (vi), but the flavour of Questions 51-55 certainly so not invite responses of thinking in that direction.

Related to this, your Strategy needs to face up to the fragmentation across branches of government of decisions which affect the rates of harm from alcohol. The old 1980s Central Policy Review Staff report on alcohol (published only in Sweden, beyond the reach of the Official Secrets Act) was very good on this topic, doing its best enumerate the responsibilities split between, as I remember, about 25 different ministries at the time. Recent developments in the UK government tend towards fragmenting things further -- for instance, the removal of the licensing issue from the Home Office, which will make the important coordination of this with actions against alcohol-related crime just that more difficult. A useful exercise to include in your interim analytical report would be to update to the present the enumeration of departmental responsibilities in minimizing alcohol problems which was done by the Central Policy Review Staff.

A policy issue which arises out of this, and which is not addressed in your set of 61 questions, is how your government may best coordinate and concert activities across departments with the goal of effective reductions in alcohol problems. One possible solution, of course, is an "alcohol tsar", on the model of the drugs tsar. The harm to British society from drinking, however it is measured, is substantially greater from alcohol than from all illicit drugs taken together. On the other hand, alcohol is woven more deeply into the warp and woof of the culture than illicit drugs, and thus more government responsibilities and activities impinge on alcohol issues. There is thus a stronger case to be made for alcohol than for drugs for the need of some such coordination with the power to affect decisions and priorities in different ministries. Another mechanism, used in France with some success for several decades, was a "high committee" on alcohol attached to the Prime Minister's office (unfortunately this arrangement was merged away a few years ago). There are undoubtedly other potential solutions and models which should be considered, but the issue does need to be addressed, and solved with an arrangement which is not toothless. Viewed from afar (and by the academic studies such as that by R. Baggott, *Alcohol, Politics and Social Policy*. Aldershot: Gower Publishing, 1990), the experience in Westminster seems to have been of relatively ineffective effort, rendered so not only by the influence of a relatively united and concentrated alcohol industry, but also by the diffuseness and lack of coordination of government activities.

Herewith some comments on particular questions from your list.

1. The question is poorly phrased, in that there are harmful effects also from alcohol use which would not qualify as "alcohol misuse" in the usual definitions of that phrase. For instance, the risk curve for female breast cancer from amount of drinking has a low threshold, if any threshold at all. It is too convenient a solution for those of us who are drinkers but do not think of ourselves as "misusers" to limit the questions to alcohol misuse, something engaged in only by the other fellow.

Many of the harmful effects of alcohol use are to people other than the drinker him/herself. Most principles of government would accept that government intervention is justified in preventing, ameliorating, or countering the effects of drinking on others. This notably includes members of the drinker's family, including children. But it also includes friends, acquaintances and strangers -- e.g., someone who is injured as a result of drinking driving, or of a drunken brawl.

In a welfare state, where the state is the provider of health services and of disability and unemployment benefits, there is a direct impact of the harms from alcohol use on the state budget. The state thus has an interest in preventing and ameliorating the harms from the point of view of reducing these state expenditures.

Beyond these two areas, we get to more contentious territory. Is it the state's business if someone decides to drink themselves to death? Is addiction per se (the "alcohol dependence syndrome") to be viewed as a harm which the state should be responding to? In two areas closely related to alcohol, illicit drugs and tobacco, the British state and polity obviously have made the choice to intervene in personal behaviour, vigorously for illicit drugs and less so for tobacco (but with such measures as warnings on packs, advertising restrictions, high taxes). The health and social burden resulting from individual choices about drinking is greater than the health and social burden from illicit drugs or from tobacco.

The phrasing in terms of "at what point does Government intervention become justified?" frames the discussion at

the individual level, implicitly in terms of picking a point on some continuum of individual drinking patterns at which the Government suddenly becomes interested. Note that such a framing is not how policies on tobacco or illicit drugs are considered. In general, it is not an appropriate framing when the concern is with the population at large, as with general issues of public health. Behaviour which does not result in harm in an individual instance may still result in substantial harm in the population as a whole. The risk of a drinking driver causing a crash from a single episode of driving after drinking may be about 1 in 1000, but that is not accepted as an argument that the state should not be concerned about drinking-driving.

2. The question assumes that individual responsibility and Government responsibility are alternatives. This seems to me a false apposition. At a minimum, government has a responsibility to intervene whenever others are potentially harmed by alcohol use, and has an interest in intervening whenever the state finances are adversely affected by it.

5. The fundamental principle, of course, is that measures taken under the strategy should be effective in reducing alcohol-related harm. If effectiveness has not been demonstrated, a high priority should be given to testing the effectiveness of any strategy which is in place. In most cases the measures should also be cost-effective. The measures should maintain the maximum of individual autonomy and choice about behaviour, including drinking behaviour or abstaining, while (1) protecting the interests of others from the effects of the drinker's alcohol use; (2) holding down governmental expenditures (including local governments) on dealing with the casualties and other adverse effects of drinking; (3) influencing the patterns and circumstances of drinking so as to minimize harm to the drinker him/herself as well as to others.

It should be noted that these principles give weight to the autonomy and choice of individual drinkers, that is, to consumers. They do not give weight to the private interests in the alcohol market. The interests of the consumers and of these commercial interests are not the same. Given the substantial harms from alcohol, the state's interest in controlling the market in alcohol outweighs the claims of commercial interests.

6. Alcohol misuse is not a particularly useful term for a discussion of alcohol policy. There are many different social and health harms related to alcohol, and the "risk curve" for each differs by amount and pattern of drinking. (A popular book by Leonard Gross, *How Much Is Too Much?*, explored this some years ago.) Mostly, the risk curves are smooth (though differently shaped) -- there is no sudden jump which would identify a point at which "use" or "eu-use" becomes "misuse". When I was involved in discussions about advice to drinkers in Canada, the formulation we found most accurate and useful was "low-risk drinking", to identify threshold patterns of drinking below which risks of various sorts are minimal. You can find the Canadian guidelines on this and some of the material behind them at: http://www.apolnet.org/actpacks/ap_low.html and http://www.camh.net/addiction/pims/low_risk_drinking.html

7. (1) overall volume of drinking; (2) high-consumption occasions; (3) drinking in or followed by circumstances with risk of harm; (3) breaking the temporal connection between drinking occasions and risky circumstances (e.g., separating the drinking from driving home) (4) the excuse value of intoxication ("it doesn't count because I was drunk").

It seems to be difficult to change (4). And it seems to be difficult to change covert norms of approval for intoxication in particular circumstances and populations. It seems to be easier to change the *frequency* with which such occasions occur. So both (1) and (2) are potentially affected by such government actions as taxes and physical availability (number of outlets, opening hours & days). (3) has been affected by drinking-driving policies; the same kind of approach can potentially be applied to the connections between drinking and other risky circumstances. Though there is little evidence on this, environmental interventions like providing late-night underground or bus services may also have an effect in reducing alcohol-related harm.

8. Yes, there is a relationship. But such factors are probably not very important in what strategies are emphasised -- only in terms of making decisions about priorities for target groups for targeted interventions.

9. Drinking among young British women is indeed worrisome, but young men's drinking still produces the most problems. More research is needed about patterns among British minorities, but rates of heavy drinking and alcohol problems are usually lower than in the mainstream British population.

10. People get a lot out of drinking, including out of getting drunk. In modern British life, drinking is deeply entwined in sociability, in courtship, in having fun. But it is not clear how much the sociability, courtship and fun would disappear without the drinking. People whose drinking causes them enough problems that they end up in AA still find that all three are possible, though they could not imagine before giving up drinking that they could ever have sex with a new partner, for instance, without being drunk.

11. There are a lot of commonalities in the drinking cultures in anglophone countries where much of the population has roots in Britain or Ireland. There are some special features to English drinking -- for instance, that so much of

the drinking has remained in pubs and restaurants; though even here Ireland outranks the UK. There are certainly regional differences in the UK, and within England. These differences are affected by a number of factors: longer-term historical and cultural differences in the place of drinking in everyday life; the differential impact of the temperance movement; differences in economic development and the economic base in recent decades; and so on. One issue which this question brings to the forefront is whether the Strategy is to be for England or for the UK. While there are now alcohol strategies for all parts of the UK except England, it would be a mistake to confine the Strategy only to England, since there are many important elements of the strategy (e.g., alcohol taxes) which can presently only be dealt with on a UK-wide basis.

12. All of the above, and more. The government's ability to influence behaviour is much greater for some factors than for others. It has a unique ability, for instance, in the legal and regulatory area, and strong abilities in the financial and environmental areas. Its ability to influence through fashion, family background or education and information is quite limited.

13. Attitudes to risk certainly affect the use of alcohol, primarily in terms of whether and in what circumstances people get intoxicated: presumably the risk-averse are less likely to, the risk-seeking more likely. Attitudes to long-term health risks probably have less effect on the use of alcohol, though the idea that alcohol is heart-protective has certainly provided an easy rationale for the otherwise concerned to drink up.

14. Harmful drinking is defined by the WHO in terms of drinking-related harm to health, physical and mental having occurred. It is thus distinguished by WHO from "hazardous drinking", where there is risk of harm but none has necessarily occurred. It is important for public policy to take into account also the social harms from drinking. "Problematic drinking" presumably refers to hazardous drinking. Under any reasonable definition of "heavy drinking", it would be likely to be "hazardous drinking". From a population viewpoint, rather than in terms of an individual patient in the surgery, the question of when heavy drinking "becomes" problematic drinking is not very answerable or useful.

15. The evidence for the health costs is very substantial. You should pay attention to the new World Health Organization estimates of alcohol's contribution to the burden of disease in the Global Burden of Disease estimates (a summary was published recently in *Lancet*). The detailed work underlying these estimates is still in press. You should be able to get hold of the relevant in-press material from Dr. Juergen Rehm (jtrehm@aol.com). There is presently a change unfolding in the evidence on the net effects of alcohol on the hearts of the population at large. At the individual level, the weight of the evidence is that a drink or two every second day or daily is heart-protective for men over 40 or so and post-menopausal women. On the other hand, the individual-level studies show that heavy drinking is bad for the heart, and particularly sporadic or repeated intoxication seems to be very bad. At the population level, the relevant question is what happens to heart disease mortality and morbidity as the population's consumption level changes up or down. Drinking is a social activity, with people influencing each other in their drinking, so that there is some linkage between the change at one level of drinking and the change at another. It is clear that in populations with a lot of heavy drinking, reducing the alcohol consumption level reduces the heart mortality rate. Most dramatically, when alcohol consumption fell by about 25% in Russia in the Gorbachev era (taking into account unregistered consumption), male mortality from circulatory diseases fell by 9% (Leon et al.). In Western European populations, ARIMA time-series analyses have generally shown no significant net effect on heart mortality when alcohol consumption levels changes (Hemstroem in *Addiction* Supplement 1 for 2001), although there was a significant positive relation in Spain for most subanalyses. Mats Ramstroem, a colleague of mine, has presented by not yet published data showing a significant positive effect in Canada. Rehm et al., in an unpublished analysis as part of the WHO GBD analyses, did a pooled time-series analyses taking into account drinking pattern which found not net effect on heart mortality for countries with the pattern of drinking including the UK.

At a minimum, then, the analyses suggest that there would be no adverse health effect on British hearts if the overall alcohol consumption level fell in Britain. There would be a reduction in heart disease if you can figure out a way to reduce binge drinking among middle-aged Britons.

17. The means of prevention of alcohol dependence and serious alcohol misuse are mostly the same as for reducing the harms from drinking in the population. Taxes have proven strong effectiveness; availability restrictions (number of outlets, hours and days of sale) have some effect; at the individual level brief interventions seem to have as much effectiveness as more intensive interventions. The evidence of the effectiveness of situational limits like drinking-driving measures and enforced server intervention programs on alcohol dependence is not there, but there is probably at least a minor effect. There is a need of training in brief interventions, and concerning supporting effective policies for reducing alcohol-related harm. The knowledgeable efforts of British doctors, for instance, have been very important in creating an environment for a public health-oriented tobacco policies.

18. The crucial question about brief interventions is how their use can be built into and supported by the way doctors

and other health care providers are paid for their work. Swedish researchers and policymakers are more or less giving up on this strategy because they have not been able to get Swedish GPs to implement it. The compensation arrangements for Swedish GPs give no incentive for implementation, and doctors seem to find it aversive to be asking these "personal" questions (though they are quite happy to lecture patients about smoking). Australian experience, as I read the articles from there, is similar. If brief interventions are ever to live up to their potential, the challenge is to face up to what needs changing in the health system, including compensation arrangements, to get them widely and systematically implemented.

19. The current state of the literature, however unpalatable it may be, is that every modality works a little bit and they all work about the same. Project MATCH struck a tough blow against the idea of "tailoring" treatments to meet individual needs. In this circumstance, the best approach is to focus on a variety of different low-cost interventions (spiritual vs. non-spiritual, for instance), which can be chosen between, and perhaps tried as alternatives one after another, with more intensive treatment reserved for cases which do not respond to low-cost interventions (stepped care).

Studies are needed of how the treatment system actually works in the UK -- when and under what circumstances people come into what forms of treatment. We are currently carrying out a large study of this type in Sweden. Without such research, there is no evidence-based answer to the last 2 questions under 19.

20. There are a lot of lessons to be learned about what does not work.

21. Again, this is a fertile area for detailed studies. There is currently a big intervention study going on in Canada about reducing violence in pub environments (Kathryn Graham at Centre for Addiction & Mental Health, London, Ontario; from memory, I think kgraham@uwo.ca). Experimenting with alcohol control measures (closing hours, requirements about the furniture, etc. of pubs) is also likely to be fruitful. Preventing alcohol-related assaults and accidents in other environments is an important area, but the research is less developed.

22. The WHO GBD estimates include an estimate for the proportion of depression attributable to alcohol -- again, ask jtrehm@aol.com for these. The links are multiple, and there is a big literature arguing for combined treatment for mental disorders and alcohol problems. However, when I looked at the evidence base for the relative effectiveness of this compared with separate treatment a few years ago, it was very scanty. Come back to me if you want more on this.

23. The evidence is strong. See a paper by Rossow and myself on this (Room & Rossow, *Journal of Substance Use* 2001). This is also reviewed in the WHO GBD materials.

25. The reality is strong, but the perceptions are probably even stronger. Go and sit in any criminal court and listen to the cases -- the perceptions are partly fueled by the experience of police, emergency doctors, and others who pick up the pieces. Note that only part of the effect is pharmacological -- cultural expectations also play a part in creating the link.

Criminology discussions which argue there is no proven causal link are relying on a criterion for causality, a necessary and sufficient relation, by which there would also be no proven causal link between tobacco smoking and lung cancer. The alcohol link is neither necessary nor sufficient, but it is still causal, as epidemiologists would use the term.

34. Drink-drive policies show that general deterrence works, particularly when applied to a subpopulation (car owners) who have something to lose. The DD literature also teaches that the threatened penalty should be certain and quick, which means it should not be too severe, given the functioning of British-style legal systems. The main lesson from DD for the rest of alcohol policy is that regulatory measures applied at a population level are much more effective than education campaigns, etc.

DD policies in Britain lag behind the rest of Europe and other English-speaking countries. Australia has shown that random breath testing on an intensive and sustained basis has strong effects in driving down the DD rate. Britain's BAL is out of step with the rest of Europe, and DD casualties will be reduced if it is lowered.

35. Important to take it into account, based on research rather than ideology, but difficult to make an impact on. See the work by Ken Leonard on this -- e.g. in the same *Journal of Substance Use* issue referenced above.

41. The literature is overwhelmingly clear that alcohol education or public information campaigns are not effective except in very special circumstances. This is not what you or I want to be true, so the finding is resisted, but it is clear. Money spent in this area is feel-good money, not part of a serious alcohol strategy to reduce harm.

The one exception, regarding counter-advertising, is the recent experience from tobacco in Florida, Massachusetts, and California. Intensive campaigns by government agencies attacking the tobacco industry as "not in business for your health" impressed teenagers enough, at least in the short run, that smoking rates went down. Apparently the

spectacle of a market-oriented government attacking a major industry was unusual and impressive enough that it had an effect. However, the campaigns proved politically unsustainable, and have all been or are being discontinued.

I've run out of time for the moment to respond. Please excuse any typos in the above. However, I will be back in my office in Sweden on January 10 and would be glad to elaborate or tackle some of the other questions if this would be useful.

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