

**National Alcohol Harm Reduction Strategy
Consultation Document from the
Strategy Unit/Department of Health**

**Comments from the Royal College of Psychiatrists
January 2003**

1. The principles that should underpin the strategy (p.6)
 - i) Although the “what do we want to know” section on the previous page mentions the need for “key facts and figures”, we would have preferred to see under “principles” a statement that the strategy will be informed by the now very extensive research base bearing on design of effective alcohol policies. The public has a right to expect that when alcohol policies are being formed they are today evidence-based (see Edwards et al., 1994; Raistrick et al., 1999).
 - ii) We would like to have seen acknowledgement that alcohol policies must deal with the problem at the population as well as at individual level.
 - iii) The “principles” question sets up a false antithesis between personal versus government responsibilities. Individual people have responsibilities in this arena and so do governments, and government-backed public health strategies should assist individuals to make healthy choices. We see the need for government to accept responsibility as stemming from at least the following considerations:
 - Much of the harm done by alcohol is a matter of “externalities”, with the damage done not to the drinker but to those in the drinker’s environment. Government has a responsibility to protect families of drinkers, bystanders and people in the street, victims of drunken assault or of drink driving, from that kind of harm.
 - Government has a duty to protect the public from the very considerable costs and diversion of health care and social resources which are caused by alcohol; the cost issue incontrovertibly legitimises the government presence in this arena.
 - Within general public health principles we take it as given that any modern government will accept responsibility for the health of the nation as well as for the health of individual citizens. The aggregate level of harm done by alcohol requires government action to reduce that harm.
 - In addition the government has a legitimate role to play in preventing the harm alcohol may cause to the drinker.
 - iv) Alcohol is a psychoactive drug in the same way as are nicotine or opiates. The issues relating to consumer choice, individual responsibility, and the role of government in regulation of the use of alcohol in society are therefore different from other consumer commodities such as meat products or cereals. The Government’s strategy towards alcohol therefore needs to be congruent with its approach to other psychoactive drugs. We have seen a highly significant reduction in tobacco use and related harm in recent years due to a combination of increased taxation, government warnings, public education and other interventions. Lessons should be learned from this positive experience of effective public health strategies.
 - v) As with the tobacco industry, the alcohol industry has a natural vested interest in maintaining or increasing alcohol use. The industry should therefore be seen as having competing interests in the policy debate.
 - vi) There is extensive research evidence showing that harmful use of alcohol is not an all-or-nothing phenomenon, with the great majority of the population being “normal

drinkers” and a separate small “hard core” of harmful drinkers. The evidence shows that the problems lie on a continuum of severity with individuals moving in and out of harmful use of alcohol dependent on a range of factors including price, availability, and enforcement. This points to the need for both whole population and targeted interventions to reduce alcohol related harm.

- vii) We also feel it is important to point out that the strategy should not only cover harmful alcohol use, but should address the problem of the more severe end of the spectrum: alcohol dependence. While smaller in number, alcohol dependent drinkers individually have a higher level and wider range of more severe problems, are greater consumers of health and social care, and hence, incur greater costs to society. Strategies to address the severe end of the drinking spectrum are likely to be different from those to address harmful alcohol use, although in many cases they are not mutually exclusive. For example, there is evidence to suggest that whole population measures such as availability and cost have an impact across the spectrum of harmful use and dependence.

2. The cultural and behavioural issues around alcohol use and misuse (pps.6-7)

We are not sure how far any of the questions asked here relate to the practical business of policy formation.

- i) “Alcohol misuse” in this context is not in our view a helpful term. The policy aim is to prevent “harmful drinking” (as defined by the World Health Organisation) and the resulting “alcohol-related harm”.
- ii) Alcohol use is embedded in culture, but there is little evidence to suggest that attempts to influence cultural attitudes toward drinking *per se* are likely to be effective. Such approaches detract attention from the fact that where effective leverage can more probably be got on drinking behaviour is through ecological measures impacting on price and access. Cultural shifts may follow legislative or regulatory change (drink driving provides an example), but can seldom be engineered in the abstract.
- iii) Both binge drinking and heavy regular drinking can, and often do, lead to harm, albeit usually of a different nature. Also there is evidence that individual drinkers can sustain both drinking patterns either simultaneously or consecutively during the course of a drinking career. Therefore it would be inappropriate to focus the strategy on one drinking pattern to the exclusion of another.
- iv) There are a great many sociocultural factors that influence drinking patterns (as suggested in question 8). It is not clear that wider social engineering as implied by the question (e.g. on work, marriage, family planning, higher education) will have the desired impact on harmful alcohol use, compared to more direct strategies to address harmful alcohol use.
- v) The strategy does need to address the rapidly increasing alcohol problem amongst younger women. However, it is important to note that in terms of hazardous drinking men still have more than twice the prevalence of women, and in terms of alcohol dependence the male:female ratio is 4:1 (Singleton et al., 2001). So men remain the larger group. In terms of ethnic minorities, in general terms the prevalence is roughly equivalent to the white British population, with some differences between ethnic groups.
- vi) While alcohol has positive effects (including employment, revenue, exports, pleasure), the aim of the strategy should be “harm reduction” as in the title of the consultation paper, rather than being about increasing exports or revenue. Also it is not clear that anyone is talking about prohibiting alcohol use as implied in question 10.
- vii) As suggested above many factors influence alcohol use. Of these the greatest evidence exists in relation to marketing and advertising, price, availability,

regulatory and legal factors as being the most influential and potentially open to effective government intervention.

3. Health: prevention, treatment and impact on the NHS (p7)

- i) Harmful use of alcohol can be defined as any harm to the individual drinker or to the wider society caused by alcohol. The WHO International Classification of Diseases, 10th Revision provides operational criteria for harmful use of alcohol and alcohol dependence. Hazardous and harmful use of alcohol can be simply measured using the WHO AUDIT questionnaire which has a very high level of validity and reliability.
- ii) The most effective approach to hazardous and harmful alcohol use is screening and brief intervention. Several meta-analyses of the international literature (including several UK studies) show clearly that opportunistic brief interventions carried out in medical settings (e.g. primary care, general hospitals, A&E departments) are both effective and cost effective (although less research has so far been carried out on the latter). More research is needed to establish the effectiveness of these interventions in other settings and populations (e.g. the criminal justice system, mental health services, the workplace).
- iii) The effectiveness and cost effectiveness of specific interventions for individuals with established alcohol dependence is less clear than with hazardous and harmful drinkers. However, meta-analysis points to the cost effectiveness of psychological interventions (particularly cognitive behaviour therapy, and motivational interviewing) and some pharmacological interventions (e.g. acamprosate, naltrexone, and to a lesser extent, disulfiram). The results of a large UK multicentre trial of the effectiveness and cost effectiveness of Social Behavioural Network Therapy are eagerly awaited.
- iv) While opportunistic brief interventions are effective in hazardous and harmful alcohol use, we know that screening and intervention is rarely carried out in practice in the typical non-specialist clinical setting. If these approaches were employed routinely, they would be likely to have a large public health impact. Some of the barriers to implementation in primary care include lack of training (from undergraduate to postgraduate level), lack of resources, competing priorities, limited access to specialist sources of advice, support and referral for complex cases. These problems could be addressed by having such interventions at the heart of a national alcohol strategy, and appropriate funding and resources to implement them. Putting specialist alcohol workers into medical settings, whose role it is to do this work, and who want to do this work, would be a simple way forward, rather than expecting overstretched primary care staff to take on yet another responsibility. This will of course require significant investment.
- v) Relatively little attention has been paid to the most effective methods of organisation and delivery of alcohol treatment for people with harmful alcohol use and alcohol dependence (Alcohol Concern, 2002). This includes issues of access and availability of services, care pathways, stepped care, and the respective roles of specialists and non-specialists.
- vi) The strategy needs a strong element of research and development to determine the most appropriate way forward. However, it is clear that we already have cost effective approaches that should be extended and made more widely available than at present. Existing research shows a wide variation in the availability of alcohol treatment services across the UK. It is also clear that the availability of alcohol services now lags well behind that of drug services despite the greater population prevalence of harmful alcohol use and alcohol dependence.

- vii) The national alcohol strategy should be both consistent with, and take advantage of the experience of the national drugs strategy in relation to prevention and treatment in health settings. We commend the government's strategy in relation to illicit drugs. At the heart of the drugs strategy is the precept that, in broad terms, "treatment works". The same is true for harmful alcohol use and dependence. Further the government has commendably introduced an effective method of implementing improvements in the access to, and quality of, treatment for drug misuse through, nationally, the National Treatment Agency and locally, the Drug Action Teams and Joint Commissioning Groups. Further the recently published national service framework for substance misuse (Models of Care) has brought clarity to the commissioning and delivery of drug misuse services, backed by substantial increased funding to realise the objectives of the strategy. We recommend a similar approach to harmful alcohol use and dependence. It would be simplest to integrate the planning, commissioning and delivery of alcohol intervention services into existing structures such as the National Treatment Agency and Drug Action Teams rather than setting up parallel structures. If so, it will be necessary to recognise the differences as well similarities between alcohol and illicit drugs and increased costs. But, since many drug misusers also drink harmfully this could have benefits for both the alcohol and drug strategies.
- viii) The most effective approaches towards alcohol and mental illness comorbidity are currently unclear. We recommend appropriate research into new methods of intervention in this group. As alcohol is the most common drug used harmfully by people with mental illness (e.g. up to 50% of psychiatric admissions, and 30% of outpatients) this should be seen as a priority. Screening and brief intervention would be an appropriate place to start given its performance in other medical settings thus far.

4. Crime, disorder and antisocial behaviour (pp8-9)

- i) Research shows clear links between alcohol and crime and disorder: from alcohol-related violence in A&E attenders, to surveys of victims of crime, to police data on arrests, to surveys of the convicted and prison populations. Also general population and other studies show that in people with mental disorders, the risk of violence is considerably increased by alcohol (e.g. MacArthur Foundation, Epidemiological Catchment Area study). All point to the clear effects of excessive alcohol intake both acutely (in terms of violent incidents) and chronically (in terms of reoffending).
- ii) Unfortunately, efforts to prevent and reduce alcohol-related reoffending have been limited. We believe that this misses a clear opportunity to reduce alcohol related crime, disorder, and antisocial behaviour, which is of considerable concern to the UK taxpayer. Alcohol-related offenders consume considerable resources of the police, the courts and the probation and prison services, as well as the costs of dealing with their victims.
- iii) The national drugs strategy has recognised the need to route more drug misusing offenders into help and treatment, rather than the criminal justice system. The drugs strategy recognises the considerable potential cost savings associated with this approach, since treatment is much more cost effective than criminal justice disposal. Savings are realised not just in terms of reoffending, but also in terms of the health and social wellbeing of the drug misuser. Further, the majority of violent offenders in prison have a history of either harmful use of alcohol or alcohol dependence, but the services that exist are directed mainly towards drug misusers.
- iv) Many of our members routinely carry out pre-sentence assessment of alcohol- (as well as drug-) related offenders and advise on treatment options. As we assess

both alcohol- and drug-related offenders in the criminal justice system we are aware that some the criminal justice initiatives that are part of the drugs strategy, could be appropriately applied to alcohol. For example, Arrest Referral Schemes, prison 'in-reach' (CARATS) and Drug Treatment and Testing Orders (DTTOs) would all be applicable (with appropriate modification) to a large proportion of alcohol-related offenders. We would be keen to see this developed in the alcohol field and there is research, mainly from the US, that supports its effectiveness. The new Criminal Justice Bill includes a proposal for an Alcohol Treatment Requirement under Section 192. We welcome this proposal, but wish to point out that this is likely to have significant resource implications. Considerable resources have been made available for DTTOs for drug misusers, and this level of resourcing will need to be considered for Alcohol Treatment Orders if they are to be enacted. We recommend pilot research to assess the feasibility and effectiveness of these approaches in alcohol-related offenders as a first step.

- v) While we welcome some of the Home Office's proposed changes to the alcohol licensing laws, we are very concerned that allowing 24 hour licences might encourage increased harmful use of alcohol. It is possible, but as yet unproven, that 'staggering' pub closing times might disperse alcohol related disorder. But it could equally have the opposite effect. We recommend caution in developing this policy, and suggest that it should be properly piloted and evaluated in a controlled fashion before it is enacted. However, a short term pilot could fail to detect longer term unwanted effects, such as an overall increase in harmful alcohol use over time after the changes come into effect. Further we believe greater consideration should be given to treatment interventions (as in iv above) rather than criminal justice responses alone.
- vi) In response to question 33 we believe that in developing a strategy to combat alcohol related disorder, considerably more weight should be given to the rights of those who stand to suffer from alcohol related disorder (e.g. victims of violence, local residents, night economy workers, police, ambulance and health workers) than to the rights of drinkers to drink. The same principle has become accepted in terms of passive smoking, where the risks to non-smokers are less tangible, immediate, or arguably, serious, than in the case of alcohol. Again the alcohol strategy should be consistent with that for tobacco in this respect.
- vii) In response to question 34, drink driving policies have been effective, whilst not eradicating the problem altogether. We believe the research evidence points to a beneficial effect of reducing the drink driving limit from 80mg/100ml to 50mg/100ml. Research shows significant impairment of driving behaviour occurs below 80mg particularly in younger and less experienced drivers, and those who drink alcohol infrequently. Further, research shows that increasing the minimum legal drinking age from 18 to 21 combined with active enforcement has a significant impact on alcohol related road accidents and deaths in this age group. At a minimum we would advocate bringing the driving alcohol limit into line with most other EU countries (i.e. 50mg/100ml).
- viii) The experience of drink driving policies also shows that introduction of new laws without adequate publicity or enforcement is likely to be ineffective.
- ix) In relation to question 35, we believe that domestic violence is a crime which should be actively dealt with by the police whether alcohol-related or not. In our experience assaults taking place between sexual partners in the domestic setting are often treated less seriously by the police than those taking place between strangers in other settings, particularly when alcohol is involved. We can see no justification for this, and the laws regarding assault should be applied uniformly. Having said that, people who commit alcohol related domestic violence, particularly repeated offenders, could benefit from alcohol interventions either voluntarily or as part of their sentence.

5. Implications for vulnerable groups (young people & families)

- i) Question 36. The prevalence data shows that the UK has the highest rates of intoxication and binge drinking amongst young people in Europe. The age of initiation to alcohol use closely follows nicotine. The measures that are effective in delaying the onset and progression of alcohol use in young people are yet to be determined. It is possible that harmful alcohol use is part of a developmental process, where alcohol gradually increases with age, and a variety of factors (e.g. parental discipline and alcohol use, peers' alcohol use, psychological dysfunction, the local environment and availability) all act as modulating factors.
- ii) There is significant heterogeneity in the adolescent population. Research shows that groups of young people with vulnerabilities such as psychiatric disorders (ADHD, conduct disorder, depression and anxiety disorders), runaways, problems at school particularly truants and those excluded, those in the care system, those whose parents misuse alcohol, those in the juvenile justice system have greater problems with alcohol.
- iii) There is abundant literature, mainly derived from the US about risk factors for substance abuse, that is alcohol and illicit drugs. The terms and definitions need to be considered, as alcohol or drug USE is seen by many as normative adolescent behaviour and not indicative of any vulnerability. For those who use alcohol in a harmful way, the risk factors are not specific to alcohol, but to a range of substances and other interrelated factors. There is a complex and interconnected network of risk and protective factors for adolescent harmful drug and alcohol use spanning the multiple social and ecological spheres in which teens live. Risk factors can be conceptualised within broad domains including biological, psychological, social and environmental. The primary biological based risk factor is a family history of substance use disorders. Psychological factors include coping strategies, temperament and behaviour. Specific categories of social and environmental factors include peer, family, school and community influences and traumatic and negative life events. Some of these risk factors include high levels of family conflict and stress, low levels of family bonding and cohesion, poor parental monitoring and behaviour management skills, exposure to substance using peers and associated with delinquent peers, low bonding at school and other prosocial environments, etc. Individual factors include, early aggression, early conduct disorder, ADHD (but this usually mediated through concurrent conduct disorder), poor school attainment, and disaffection at school with later disruptive behaviours and expulsion. In clinical experience, it is of significant note that the children with significant problems have very poor literacy skills, even to the level of almost no ability to read or write, and it is not surprising that they are unable to keep up at school, become disaffected and are expelled for disruptive behaviour. This further increases their risk factors, removes any protective factors and allows affiliation with like-minded peers. The educational involvement with these adolescents needs to be addressed. Environmental risk factors include neighbourhood disorganisation and poverty, tolerance to substance and alcohol use and an acceptance of its harmlessness.
- iv) It appears that multiple risk factors combine across the various pathways to heighten an individual's likelihood of developing harmful alcohol use. In research at least since the early eighties, researchers have looked at this multiple risk model to try and identify specific factors that might increase risk. It seems to be the multiplicity of risk rather than any one unique factor. For example, Brook (1992)

noted that for alcohol, 8% of participants with one risk factor reported alcohol abuse compared to 43% of participants with four risk factors. Of course substance use itself can result in risk for continued and escalated use with early onset seen as predictor of future development of substance use disorder.

- v) There are also difficulties of the definition of what is a safe level of alcohol use in a young person. Clearly this will be less than in an adult and will be affected by age, body size/weight, gender, stage of development, and vulnerability factors.
- vi) Question 37. Special at risk groups (as well as the above) include young pregnant drug users, their partners and families, homeless youngsters, those involved in the criminal justice system, and those with comorbid psychiatric disorders. Also children who live in the context of domestic violence, suffer from PTSD, depression and anxiety, low self esteem, aggressiveness, criminality, antisocial behaviour, and poor school performance are particularly at risk.
- vii) As substance misuse and antisocial behaviour in young people have shown a parallel rise over the past 50 years, it would be reasonable to assume that they share common risk factors for socially disapproved behaviour. However, studies of the ordering of onset of these problems show that antisocial behaviour usually precedes substance misuse. The relationship is likely to be bidirectional as well as sharing common aetiological factors.
- viii) Question 38. One of the key inter-related issues is one of co-morbidity of mental health problems. There is much research on the prevalence of mental health disorders in those with harmful alcohol use/dependence in the adult literature and the child literature. Much of the literature is from clinical samples but general community samples also note the increased co-morbidity of substance abuse and dependence and that of psychiatric disorder. Firstly substance misuse is frequent among adolescents, not just use or experimentation. Large scale trials have reported on this prevalence of substance use disorder (SUD) in adolescence. In most studies, the rates of SUD increased with age, with rates ranging from 1.5% in 14 year olds to 8.7% in 18 years. Substance misuse co-occurred frequently with other psychiatric disorders, particularly anxiety and affective disorders, conduct disorder and ADHD and with other substance use disorders. About one third of those with one type of SUD have at least one other type of SUD, with alcohol use disorders being the most common. Clinical samples report frequent comorbidity with estimates of conduct disorders ranging from 40-70% and ADHD from 20-30%. This high association of psychiatric disorders and substance misuse/dependence emphasises the need to recognise the complexity of the issues and the need for comprehensive assessments and treatments. Failure to assess the psychiatric disorder and to attempt to manage/treat it, may affect continued use of alcohol and of the psychiatric disorder.
- ix) Of further import is that of family problems, and educational difficulties. As noted earlier, many who have difficulties with reading skills may become disaffected with school because they are unable to participate in other lessons because of these difficulties, this disaffection may manifest in disruptive behaviours with risk of exclusion and or continued truancy. It behoves society and the education system to review the educational experience for some children, adapt a more appropriate system for those not academically minded, and work with psychiatry and other services to rehabilitate some children back into the school system. This will reduce risk factors and increase the protective factors.
- x) It is of note that depression combined with substance misuse and conduct disorder, are the most common predisposing and probably causal factors in adolescent suicide. Hawton has noted that treatment of substance misuse is essential in reducing suicide rates.
- xi) Question 39. In relation to services, The Health Advisory Service in 1995 identified a framework services involving child and adolescent psychiatry, the 'tiered

approach' that sought to accomplish this joined up approach, by producing a framework that avoided duplication, allowed communication, identified appropriate tasks etc. This model covered commissioners and providers of services. This was further developed to young people services for substances in the HAS report, and further developed in the review of adolescent drug services. The Models of Care project has used this model for adult drug services. There also needs to be coordination of commissioners and strategy/policy makers, not just providers. For example, in the children systems, many areas have completed a needs assessment, such as CAMHS, substance services, social services, education etc. Yet there has been little joining up of these needs assessment (many of the vulnerable groups are known to many services and agencies). This represents unnecessary duplication, expense and demonstrates little communication and coordination. There was an attempt to map all plans, programmes etc within government for children. This is a 'bookcase' that demonstrates the planning system, from strategy to implementation.

- xii)** Another important issue is resources, that is funding, but also workforce capacity and competence of this workforce. This is particularly important in services for substance misuse and dependence with the small number of specialists available and the reduced capacity of general psychiatry. For example there is only one addiction psychiatrist nationally with a full time responsibility for drug misuse in young people. Very few services cater adequately for young people with alcohol dependence. The competence of commissioners (not always competent and often in short term positions with multiple changes of Trusts, health authorities, boundaries changes with review of services again etc), the long bureaucratic process from idea to implementation, competition for resources, the emphasis on numbers through services rather than quality, poor IT equipment and little culture for evaluation in services (this expected but no money attached), data protection and difficulty exchanging information of people, all limit the effectiveness of joined up services.
- xiii)** Specialist alcohol services for young people tend to use models imported in largely unmodified form from North America. There is a need for UK based research on the most effective models of care for this group. However, the majority of models that are utilised in the US are not widely available in the UK: e.g. Multisystemic therapy, Communities that Care, or 12 step Minnesota Model programmes designed for this group.
- xiv)** Formal family therapy is more effective than family education. Structural strategic family therapy involving all family members is particularly useful. Family therapy often involves skills training for parents, so helping to change their management policies. Recovering peers and mentors can be helpful in promoting engagement in treatment.
- xv)** Characteristics of more effective programmes include appropriately trained and competent staff, family involvement, and the availability of specialist substance misuse services. Length of treatment is important in residential programmes (in both young people and adults). Behavioural skills orientated therapies have been shown in meta-analysis to reduce re-offending and harmful alcohol use. Intensive multimodal therapies are more effective than brief therapies in more established problems. Many of these treatments are capable of being integrated into mainstream services (see below).
- xvi)** Question 40. In relation to the issue of mainstream services, within the adolescent population, there is a huge overlap of groups, for example, many vulnerable people will be truants, in the criminal justice system, have family and psychiatric problems all interconnected. Most of these vulnerable children and adolescents are already in touch with mainstream services, though they may not be recognised or their care coordinated. For example, a young person in temporary

- accommodation, may not have been assessed for harmful alcohol use, or psychiatric disorder or their educational ability/performance may not be known.
- xvii)** For these people to be treated in mainstream services, requires a more joined up framework (tiered approach), a recognition of complexity and multiple problems, with services adopting a comprehensive approach to assessment and a multi component response to treatment. This will require much training in the work force, greater coordination and communication between services, (this takes time and needs resources), improved IT facilities and greater communication and coordination between services and commissioners.
 - xviii)** The use of opportunistic screening and brief motivational alcohol interventions, widely studied in adults, would be beneficial in mainstream young peoples services. However, these will need appropriately trained and skilled staff to carry out the interventions. As young people tend to use multiple substances e.g. alcohol, drugs, and tobacco, the separation of treatment for each substance is probably unrealistic, particularly within mainstream services.
 - xix)** Positive developments within adolescent alcohol services are knowledge of the tiered framework, and an increased awareness of the need to work together. But there are problems with capacity, staff competence, sharing of information, time taken to share, difficulty in engagement of these vulnerable children which often results in discharge rather than active engagement and assertive outreach. There is also minimal involvement with the children's systems and that of young people substance misuse services.

6. Education and communication pp9-10

- i) We know from general research on advertising that it can be extremely effective in selling products and changing attitudes. If it were not so, it is unlikely that the alcohol and tobacco industries (amongst many others) would make such extensive use of it. The usual advertising media have recently been enhanced by extensive merchandising, sports sponsorship, and mobile phone messaging and the internet to reach new audiences, particularly young people to promote alcohol. This has been highly successful particularly in young people in relation to Alcopops and premium beers.
- ii) Advertising by the alcohol industry increasingly uses imagery of a sexual nature to sell alcohol, much of it, but by no means exclusively, directed at young women, on prime time TV and in cinemas, clearly at enormous expense. Positive images of women drinking excessively have also increasingly, almost imperceptibly, become part of the staple diet of TV soap operas and popular TV series. The increase in alcohol consumption and harmful alcohol use in young women should therefore be of no surprise. This is reminiscent of the tobacco industry's relationship with the film industry throughout a large part of the 20th century.
- iii) The alcohol industry often claims (as does the tobacco industry) that it aims to persuade existing drinkers to shift brands rather than increase consumption overall. The industry also rather coyly suggests that it does not condone or encourage excessive drinking, whereas the motivation and self interest behind the advertising is hardly concealed.
- iv) In contrast the health messages behind "safe drinking" and the negative impact of excessive drinking have received scant attention, with the notable exception of the drink driving campaigns and some Scottish Health Education campaigns. Further safe drinking messages tend to be confused both in content and to whom they are targeted. As a consequence these messages lack impact and are overwhelmingly outgunned by the highly professional promotional advertising of the alcohol industry in terms of quality, clarity of message, popular appeal, and sheer market penetration.

- v) If the government engaged the same talented advertising agencies as does the alcohol industry on communicating public health messages concerning the harmful use of alcohol, we would expect the tide to turn in terms of increasing alcohol related harm. The same advertising formula applied to drink driving and anti-smoking has been highly successful in reversing the trends and reducing harm.
- vi) Alcohol advertising appears to be largely unregulated at present. While voluntary codes of practice currently exist in relation to what should and should not be used to sell alcohol, these appear to be flouted cynically. If the government is serious about reducing alcohol related harm, then the existing rules regarding alcohol advertising should be actively enforced. The next step would be to look at the introduction of warning labels on advertising and alcohol products, as with the tobacco industry, followed by restrictions on the extent and nature of advertising and sponsorship of sport. We find it incomprehensible given the large and growing level of alcohol related harm in the UK, that such measures are not already in place, as is the case in some other western industrialised societies.
- vii) Advertising to promote awareness of the negative effects of alcohol should not be restricted to “safe drinking” messages, which appear to be of little import to the public after 15 years of, albeit meagre, promotion. Few people are completely unaware of these messages, but they lack impact or popular credibility compared to e.g. drink driving messages. People do not generally identify with the safe drinking message. Advertising public health messages needs to get real: the consequences of binge drinking (e.g., assaults, domestic violence, child abuse, permanent injury/disability, getting a criminal record: all the realities seen every weekend around England); the consequences of chronic excessive drinking (e.g., depression, suicide, job loss, divorce, children in care, chronic illness, premature death: all the things we are aware of in many of, but clearly not restricted to, our celebrities, but do not identify in ourselves).
- viii) Historians are likely to look back on our current policy towards alcohol advertising as incongruous (given our current approach to tobacco advertising), and as an halcyon era when the alcohol industry was given virtually unlimited licence to promote a product with harmful effects without being expected to take any responsibility for the consequences.
- ix) The research also shows that education about “sensible drinking” in our schools does not compete effectively with the positive advertising messages of the alcohol industry, or the social pressures young people face from their peers. While we believe educational efforts with respect to alcohol should be part of young peoples’ (and adults’) education, to promote this as the only way forward would be to waste money and effort. What is needed is political will to work at all levels described in this section from general education, to restricting advertising, to appropriate health warnings, through to facilitating access to help for those affected: joined-up messages, rather than the currently perceived ambivalence to the adverse effects of alcohol.

7. Economic costs and benefits of alcohol (p11)

- i) Our understanding is that on the basis of existing cost benefit analyses, the costs of harmful alcohol use (through policing and criminal justice, health service costs, lost productivity, premature death etc.) are approximately equal to the benefits (employment, tax revenue, export income etc.). This appears to hold true across several countries that have different degrees of permissiveness in relation to alcohol and different levels of alcohol consumption. Clearly these estimates are based on a range of assumptions (e.g. to what extent alcohol creates employment, what proportion of illness and death can be directly or indirectly attributed to alcohol). Nevertheless, what we do know is that per capita alcohol consumption is

- currently increasing in the UK, as is the proportion of the population drinking in a harmful way, as is the morbidity and mortality associated with alcohol. The latter is going to incur increased health and other costs.
- ii) These estimates are also unable fully to take account of the growing cross border importation of cheap alcohol which has become an important feature of the past 10 or more years, with day trips to France yielding alcohol not entirely for “personal use”, as HM Customs and Excise has pointed out.
 - iii) The question is whether or not we are satisfied with the alcohol industry being left to its own devices in relation to advertising and profit making on the basis that it is good for our economy, and the costs of the adverse consequences are (probably) being met by the increased revenue accrued. We don’t feel this is prudent, particularly in the light of this, and other, countries experiences with tobacco.
 - iv) We do not advocate prohibition of alcohol. Nor do we feel that the NHS and other public services (e.g. police, probation, prison, social services) are in a good position to meet the rising tide of adverse consequences of alcohol. The tax on alcohol is not in the UK hypothecated towards combating the adverse consequences (through advertising, treatment, research) as it is in some other countries. If it was this might have to some extent a damping effect on the adverse effects.
 - v) We believe it comes to a simple choice between on the one hand leaving the alcohol industry to its own devices, and meeting the mounting costs associated with increased alcohol consumption and as a result, increased harm (providing of course that these increased costs are actually met, which they are not being at the moment). On the other hand we could take a pragmatic middle way in which we accept that as long as alcohol is legally produced and marketed in the UK, we can also limit the adverse effects through appropriate expenditure on public health advertising, restrictions and warnings on industry advertising, restrictions on licensing and availability, server training and responsibility, adequate enforcement of existing alcohol laws (e.g., minimum age restrictions, serving intoxicated customers), adjusting levels of taxation (in relation to the Retail Price Index), adequate control of illegal importation, harmonising drink driving limits with the rest of the EU, adequate services for those affected by the adverse effects of alcohol (including drinkers themselves and wider society), and an appropriate level of research and development into combating the problems.
 - vi) Is this mere fantasy? More draconian policies have been effectively enacted in relation to tobacco, and yet few smokers commit violence or cause road accidents as a result of their addiction; few children end up in care because their parents smoked; few people lose their livelihood because of smoking; and smoking does not tend to cause anti-social behaviour or disorder. Unattractive as smoking may be, and injurious as it is to the health of smokers, compared to alcohol, it pales into insignificance as a public health, criminal justice or social problem. Why should the two drugs be treated so differently?

8. Documents that should be read in conjunction with this response.

Further relevant information can be found in:

1. Alcohol Research Forum (2002) 100% Proof: Research for Action on Alcohol. Alcohol Concern, London.
2. Edwards, G. et al., (1994) Alcohol Policy and the Public Good. Oxford Medical Publications, Oxford.

3. Raistrick, D. et al. (1999) Tackling Alcohol Together: The Evidence Base for a UK Alcohol Policy. Free Association Books, London.
4. Singleton, N. et al., (2001) Psychiatric morbidity in adults living in private households, 2000. ONS, London.