INVITED COMMENTARY

AN ALCOHOL STRATEGY FOR ENGLAND: THE GOOD, THE BAD AND THE UGLY

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INTRODUCTION

On March 15, 2004, the UK Government published its long awaited National Alcohol Harm Reduction Strategy for England (NAHRSE) (PMSU, 2004). The Government first announced its plans to prepare an alcohol strategy in 1998, and it is unclear why it has taken 6 years to publish it. The delay may be related to disagreements between government departments with competing interests in alcohol policy. A similar alcohol policy initiative in 1979 by the last Labour Government resulted in a report (Alcohol Policies) that was never published in the UK, but instead was published in Sweden without the agreement of the UK Government (Bruun, 1982). So at least we should be grateful that England has an alcohol strategy. Or should we?

We certainly need a strategy to combat the rising tide of alcohol problems in the UK. It is clear from the published research and the Government’s Interim Analytical Report, upon which the strategy is allegedly based (PMSU, 2004), that between 1960 and 2002 alcohol consumption in the UK has doubled, whilst the price of alcohol relative to income has halved over that period (Academy of Medical Sciences, 2004). This has been accompanied by a large increase in alcohol-related harm.

While there are some welcome measures revealed in the strategy, it has been broadly criticized by those interested in public health (Alcohol Concern, 2004; British Medical Association, 2004; Royal College of Psychiatrists, 2004). This paper reviews the development of the strategy, its content, and identifies some of the ‘good’, the ‘bad’ and the ‘ugly’ parts.

THE GOOD

First the good parts. NAHRSE highlights the scale of excessive drinking and alcohol problems in the UK over the past two decades. There are now 8.2 million adults in the UK drinking above the safe weekly drinking limits (21 units of alcohol per week for men and 14 for women; 1 unit = 10 g alcohol). Alcohol now costs the taxpayer around £20bn per annum though a combination of social, health, work, crime and public disorder related costs: the highest published estimate in recent years. That is a cost of an average of nearly £2500 per annum for each person drinking above safe levels in the country. This compares with the £30bn that the alcohol market creates annually. Alcohol has been implicated in 30 000 hospital admissions and 22 000 premature deaths annually, and up to 70% of admissions to A&E departments at peak times (PMSU, 2003).

Other welcome strategic plans are better public education about the harms associated with alcohol, and greater emphasis on enforcing the laws relating to under-age drinking and serving alcohol to customers who are already intoxicated. The strategy also recognizes the need for a broad spectrum of early identification and treatment for people affected by alcohol misuse either directly or indirectly. As a means of taking this forward, the strategy proposes more education for health professionals to equip them to identify and intervene with people with alcohol problems, a needs assessment and audit work to identify gaps between demand and provision of services for people with alcohol problems, and the development of integrated care pathways for vulnerable people affected by alcohol (e.g. the mentally ill, rough sleepers, and young people).

The strategy nominates national and local bodies responsible for tackling alcohol problems, including expanding the role of the National Treatment Agency for Substance Misuse (NTA) (a Special Health Authority currently responsible for the delivery and development of substance misuse treatment services in England) to include alcohol.

Academics in the addiction field should welcome the proposals for the commissioning of new research, audits, and the routine collection of better prospective data on alcohol problems. Alcohol research in the UK has been chronically under-resourced (Alcohol Concern, 2002).

There is also recognition of the need for more ‘joined-up government’ in tackling alcohol problems. There are at least 10 government departments with varying, and in some cases competing, interests in alcohol policy. The strategy proposes joint responsibility for delivering the strategy by the Home Office (responsible amongst other things for crime and policing) and the Department of Health (which has responsibility for public health and the National Health Service). However, it suggests that these two departments should have ‘light touch central arrangements’. Herein lies the problem at the heart of the strategy: many in the field believe it lacks the ‘teeth’ to deliver any meaningful reduction in alcohol problems.

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Unlike the UK drugs strategy (Home Office, 2002), the alcohol strategy has few if any clear targets against which its effectiveness can be assessed over the coming years. This also means that all the key stakeholders, including the Home Office and Department of Health, the NTA, and the National Health Service, have no specific endpoints to which to aspire. In a policy environment increasingly driven by targets, a strategy that is light on targets will be afforded lower priority by those responsible for its implementation.

Further, unlike the UK drugs strategy, the alcohol strategy has no new money allocated to implement it. In fact, no existing monies have been pledged towards its implementation either. It is unclear how the government expects that the strategy can have any impact without specific funding.

Even some of the more welcome elements such as extending the role of the NTA to include alcohol and the development of Drug and Alcohol Action Teams responsible for delivery of the strategy at a local level lack clarity. The only clear (and welcome) target in relation to alcohol treatment services is the development of a ‘Models of Care Framework’ (essentially a national service framework) for the organization and delivery of alcohol services, to be established by the end of 2004. However, unlike the Models of Care for substance misuse (NTA, 2002) which has been accompanied by a substantial increase in funding for implementation of improvements in the quality and capacity of drug misuse services, the alcohol strategy is silent on the issue of funding for treatment services.

It is suggested in the strategy that more research and audit is needed before implementation of a programme of improvement in treatment services can begin. This will delay urgently needed improvements and create a ‘planning blight’ in which local and national agencies responsible for treatment commissioning will be reluctant to begin any new initiatives until the government announces what it believes is needed (Alcohol Concern, 2004).

The strategy places much emphasis on characterizing the alcohol problem in England in terms of ‘binge drinking’. Indeed the Prime Minister recently described binge drinking as ‘the new British disease’ (Blair, 2004). While binge drinking is a matter of concern, to characterize it as either ‘new’ or a ‘disease’ is without foundation. Furthermore, it characterizes the English problem with alcohol as a minority problem, lending spurious support to the conclusion that whole population measures to deal with alcohol problem are inappropriate, and targeted measures, particularly involving heavier policing, represent the way forward. Alcohol problems exist across the age range and are not restricted to people frequenting city centre pubs on Friday and Saturday nights as the Prime Minister’s analysis of the problem implies.

There are many parts of the strategy which will be surprising to anyone who has a passing knowledge of the evidence base on alcohol policy. The highly authoritative report published by the World Health Organization, *Alcohol: No Ordinary Commodity—Research and Public Policy* (Babor et al., 2003), and the recently published report by the National Academy of Medical Sciences, *Calling Time: the Nation’s Drinking as a Major Health Issue* (Academy of Medical Sciences, 2004), clearly define which alcohol policies are evidence-based and which are not.

Room (2004) has pointed out that none of the policies that have a ‘high impact’ and cost little to implement have found their way into NAHRSE. Instead, there is an emphasis on policies of ‘low impact’. Increasing taxation and pricing of alcoholic drinks are rejected by the strategy. This is in spite of a considerable research base from many different countries over many years. Indeed, the Interim Analytical Report (PMSU, 2003) showed the striking positive relationship between alcohol’s affordability in the UK and the UK population’s alcohol consumption.

Measures to restrict the availability of alcohol through licensing and other measures have not been proposed in the strategy. There is substantial evidence that restricting availability can be effective in combating alcohol misuse. The Interim Analytical Report states that ‘Rising levels of consumption have been accompanied by the growth over the last 25 years in availability’. It goes on to show that applications for alcohol on-licenses have increased by 145% over the past 20 years. The link between increased availability and harm is indirectly acknowledged. However, instead of proposing restrictions on this massive expansion in availability, the strategy will rely on a ‘voluntary social responsibility scheme’ for the alcohol industry. Indeed, a parallel exercise to review the licensing laws, the first major change for a century (Department for Culture, Media and Sport, 2003), includes 24 h licensing, which runs the risk of increasing rather than ameliorating alcohol misuse (Drummond, 2000).

Other highly effective strategies, including reducing the maximum permissible blood alcohol level for driving to 50 mg% in line with most of the rest of the Europe, graduated driving licensing for young drivers, and increasing the minimum drinking age, have all been rejected.

Another surprising conclusion reached by the Prime Minister’s Strategy Unit is that there is insufficient evidence, particularly in the UK to implement brief interventions for excessive drinkers in medical and other settings. The strategy instead proposes a series of pilot studies of brief intervention. Brief interventions have the largest evidence base of effectiveness of any intervention in the alcohol field, with meta-analyses of published randomized controlled trials (RCTs) showing 20–30% reductions in excessive drinking at 1 year follow-up (Moyer et al., 2002). Indeed, the first, and statistically powerful, trial of brief intervention in primary care showing highly significant benefits was conducted in the UK (Wallace et al., 1988). The National Institute for Clinical Effectiveness (the body in England responsible for producing guidelines on what should be provided by the National Health Services) recognizes at least one positive RCT as ‘grade A’ evidence for an intervention. In the case of brief interventions we have numerous RCTs and meta-analyses supporting its implementation without further delay.

The ugliest aspect of this strategy is that extensive evidence provided to the Prime Minister’s Strategy Unit by experts in alcohol policy was excluded from the final document. Interestingly, those excluded policies could be characterized as...
being either unacceptable to the alcohol industry, and hence
the government departments responsible for it, or would cost
significant new monies to implement, or would risk alienating
voters (particularly the notion of increasing the cost of
alcohol). Nor did members of the Advisory Group likely to be
critical of these aspects of a strategy have any opportunity to
ccomment on the strategy document before it was published. So
we now have a curious situation where the UK government
has taken firm action with another addictive substance,
tobacco, including large increases in taxation, restrictions on
advertising, and substantial increases in funding for treatment
interventions, but has left the alcohol strategy largely in the
hands of industry self regulation.

CONCLUSIONS

At best, this is a weak strategy, narrow in its scope, lacking
in clear objectives or targets, not supported by any funding
commitment, that defers any immediate action, and that ignores
the extensive evidence base for effective alcohol policies. It
represents a missed opportunity for making a real difference
to the huge burden of excessive drinking on English society.

At worst, this strategy will be highly damaging. The
predicted lack of impact of the strategy by virtue of the lack of
evidence-based alcohol policies within it, combined with the
introduction of 24 h licensing which takes effect in 2005, may
not only fail to stem the rapidly increasing level of alcohol
problems, but may also further accelerate the increasing trend.

To characterize the alcohol problem in England as a
minority issue attracting an increasingly fierce police response
towards individuals, risks a return, ironically, to the 18th
Century when the problem was seen by some prominent
sermonizers as one of individual moral turpitude, rather than
there being an inherent problem with the commodity alcohol
itself. Alcohol policy research has come a long way in helping
us understand alcohol problems and identifying the most
effective policy responses at a whole population level, as well as
humane ways of providing help and treatment at an
individual level. This strategy casts aside over 300 years of
progress in alcohol policy and consigns us to an era when
alcohol was portrayed as predominantly a problem of deviant
individuals requiring criminal sanctions.

So what is at the root of the Government’s failure to
implement a strategy consistent with the evidence base? One
explanation could be that Westminster is under the influence.
The Government is heavily lobbied by the alcohol industry
which generates employment and revenue. So any strategy
that is unacceptable to, or risks the profitability of, the alcohol
industry has been rejected. Those concerned with alcohol
research or public health clearly do not carry the same
influence in Government circles as the alcohol industry,
otherwise the strategy would have looked very different, and
‘inconvenient’ evidence would not have been excluded from
it. This has happened in spite of the fact that the alcohol
industry submissions to the Government on alcohol policy
have a clear conflict of interest.

The Government also does not want to do anything that will
alienate the voting public, and putting restrictions on the
nation’s drinking might risk doing that. So it is much easier
to tinker at the edges of the problem rather than tackling it
effectively. However, if voters were more aware of how much of
their taxes increasingly are being spent on mopping up
the alcohol problem, they might be more sympathetic to
implementing the needed policies. But this strategy does not
attempt to persuade the public of that. Instead we are living in
an era of alcohol policy, where justice is harsh, and evidence-
based alcohol policies are a distant dream, yet to be embraced
by those responsible for public health policy.

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