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The alcohol harm reduction strategy for England

Overdue final report omits much that was useful in interim report

See also p 906

The United Kingdom as a whole has a serious problem in relation to the increasing levels of the adverse effects of drinking across gender and age groups.[1–4] The report from the prime minister's strategy unit has been awaited with great interest. It is years overdue. Counterparts in Northern Ireland, Scotland, and Wales have been published for some time. The production of the strategy was undertaken by civil servants who consulted widely and produced an interim report that had much to commend it.[5] A postgraduate thesis could be written to document and analyse the differences between the interim report, the final report, and the inconsistencies between different sections of the final document.[6] The latter has been neutered. Issues such as sex, children of problem drinkers, and pregnancy have virtually disappeared.

The harm minimisation strategy states that binge drinking and chronic drinking are the main targets of proposed action to reduce the "further increase in alcohol related harms in England." That this statement seems to accept the current high level of alcohol problems rather than setting out to reduce them substantially is depressing. Dates and targets for this would have been good. Adequate resources would, of course, be essential to facilitate the attainment of such objectives. Binge drinking is not new. It has been the pattern in the United Kingdom for centuries. We need to acknowledge that many young people engage in such behaviour because that is how they want to drink, or they are inexperienced and such activities have become normative. Individual drinking patterns often are not fixed; today's young binge drinker may be tomorrow's chronic drinker. Many chronic drinkers eventually cut down their consumption too. The complex relation people have with alcohol and how deeply embedded the use of alcohol is in our culture is not sufficiently acknowledged in the report.

One of the most curious statements in the document is the following: "There is no direct correlation between drinking and the harm experienced or caused by individuals." This assertion is contradicted by a vast literature. Countless studies have shown that negative (and positive) consequences are significantly associated with both levels and patterns of alcohol consumption.

Much of the report is hard to read and contains many ambiguous or misleading statements. The report implies, for example, that only males are vulnerable to sexual assault. It contains some minor irritating mistakes such as the strange claim that the term "units of alcohol" was first coined in 1987.[7]

The strategy is based on four elements: education and communication; identification and treatment; alcohol related crime and disorder; and supply and industry responsibility.

As the interim report stated more clearly, education and communication have a poor record. They should be treated as purely experimental and not as an effective or major arm of policy. This is briefly acknowledged, but the implications are ignored. Sadly politicians often fail to resist the lure of high profile (if generally unproductive) campaigns such as warning labels and other expensive symbolic gestures. Health promotion is important, but it needs to be evidence led, experimental, and cautious. Much more money should be spent in attempting to replicate and develop endeavours that have produced positive outcomes such as the Australian school health and alcohol harm reduction programme (SHAHRP), a harm minimisation programme for school students.[8 9 10] Most people learn about drinking from families and friends and not from official agencies so that is where one should start if one wants to change a drinking culture.

Notably, the biggest single part of the strategy document is devoted to crime and disorder. Some useful initiatives are cited, but far too much is left to voluntary discretion. Mandatory and evaluated local action programmes would be much better. These programmes could follow the lead of the classic Torquay Experiment or the Australian Surfers' Paradise Action Project, together with the rapid phasing out of all except toughened or safety drinking glasses for bar patrons.[11 12 13] Such initiatives need to be carefully evaluated.

The section on treatment is written as if evidence was sparse. The international literature on effectiveness of treatment is extensive and includes the findings of the impressive project match [14] and a large number of references to brief interventions. The latter topic registers over 249 000 hits on the search engine google.com

The final section of the strategy involves action to be carried out in cooperation with the beverage alcohol industry. Such cooperation is logical and necessary. Even so, what is proposed is unimpressive. Much of what is set out here is to be based on encouraging the industry to adopt better practices in relation to issues such as advertising and cheap drinks promotions. Such steps are needed, but they should rapidly become mandatory if full compliance is lacking. Voluntary agreements have a tendency to result in token or minimal compliance. The latter is unacceptable in relation to such an important health and social policy issue as alcohol.

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The strategy document states that it is a result of discussions between the Home Office, the Department of Health, and "other departments." This communication is praiseworthy. The strategy does offer a general policy framework that is in many ways reasonable. I have long supported the adoption of a coherent harm reduction approach to alcohol related problems.[15] It is apparent that big increases in the price of alcohol are not politically realistic. This does not justify the strategy document's curt dismissal of the possible role of taxation to prevent the future rise of alcohol consumption and its associated problems. We should consider what the role of tax might be if the already alarming situation deteriorates and other measures fail to check this. The best solution is to make harm reduction work.

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Evidence based policy or policy based evidence?

Willingness to take action influences the view of the evidence—look at alcohol

What should we do about alcohol? It is a major threat to the health of the public. Alcohol consumption in Britain has risen by more than 50% in the last 30 years, and alcohol associated deaths, particularly liver cirrhosis, have risen as a result.[1] Alcohol is, in addition, responsible for much morbidity, crime, family disruption, and harm to children. A simple prescription would be to review the scientific evidence of what would make a difference, formulate policies, and implement them—evidence based policy making. Unfortunately this simple prescription, applied to real life, is simplistic. The relation between science and policy is more complicated. Scientific findings do not fall on blank minds that get made up as a result. Science engages with busy minds that have strong views about how things are and ought to be.

In the 1980s when debates about fatty diets and heart disease risk were raging, I was struck that individual scientists seemed to have taken entrenched positions on the issue. One new piece of evidence would be even more reason for one camp to call for action to change the nation's diet; but, for the other camp, the same evidence represented a further nail in the coffin of a defunct hypothesis which strengthened the view that people should be left to enjoy their fish and chips without the interference of the food police, or the nanny state. It seemed to me then that people's willingness to take action influenced their view of the evidence, rather than the evidence influencing their willingness to take action.[2]

When it comes to government action, we find the same phenomenon. The topic of inequalities in health was unpopular in Britain in the 1980s. An impressive review of evidence was insufficient to convince a government to act.[3] A change of government in the 1990s meant that government was willing to take action on health inequalities. A review of the scientific evidence and accompanying policy recommendations[4] were sufficient for a government to implement many of them.[5] It is true that the science base had improved between Black's review at the end of the 1970s and Acheson's 20 years later. As a scientist with an obvious interest, I would like to think that this improvement in the science, despite some shortcomings,[6] helped with evidence based policy formation. I have to acknowledge that, in addition, Acheson's recommendations went with the grain of government policy. This no doubt helped. Government's willingness to take action influenced their view of the science.

Although it is understandable that governments should do what they want rather than what a group of scientists suggests they should do, it means that the model of evidence based policy in the first paragraph is something of a parody. Consider the recent example of alcohol. Two reports were published in England in March: one by the Academy of Medical Sciences, the other by the prime minister's strategy unit. The academy's report concluded that to control alcohol problems one needed to control alcohol; that is, reduce the average level of consumption in the population. The academy reached this conclusion on the basis that a strong correlation exists between average consumption, the prevalence of heavy drinking, and associated harm. It found the evidence for education

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