Alcohol-related harm – a growing crisis: time for action

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It is impossible to switch on the television or open a newspaper at present without finding some reference to the growing alcohol culture in the UK. The health, social and law and order implications are being felt across the country with growing concern. The media seem to have united in the face of this epidemic and there are calls for action. It is now a year since the Government produced its long-awaited *Alcohol harm reduction strategy* for England[1] and more recently its public health White Paper, *Choosing health*,[2] but the general consensus from the medical profession is that they concentrate too heavily on law and order issues and fail to address health issues. To compound the problem, the Government is, controversially, in the process of changing licensing laws, enabling alcohol to be purchased 24 hours a day. The conference examined the drinking culture in the UK and explored what action should be taken from the perspective of health.

Alcohol and the NHS: the Royal College of Physicians report

The Royal College of Physicians Alcohol Committee published a report in 2001, *Alcohol – can the NHS afford it?*,[3] detailing their recommendations for an alcohol strategy for the NHS. Many of the measures were not incorporated into the Government's *Alcohol harm reduction strategy* and the White Paper, *Choosing health*, has only a small section on alcohol. The Royal College of Physicians recommendations included the appointment of dedicated alcohol health workers in trusts, and questionnaires screening all patients for hazardous drinking on admission to hospital. Very few trusts have implemented these recommendations due to lack of funding. There should be a higher profile for treating alcohol misuse in relation to treatment for drug misuse, which seems to have stolen the limelight in recent years. The appointment of an alcohol 'Tsar' could help to coordinate and improve services. NHS trusts need to implement the measures suggested in the Royal College of Physicians report, in the absence of clear guidance from government.

Alcohol, physical assault and injury: practical preventive measures

Accident and emergency (A&E) statistics can be used to target policing to locations where alcohol-related violence commonly occurs. Not all alcohol-related assaults will be reported to police and A&E figures represent a more accurate reflection of the level of violence. There is some suggestion, however, that targeted policing merely serves to disperse the trouble to other locations without actually reducing the overall level. An alternative in the form of crime reduction partnerships, which combine health authorities, the police and victim support groups, are being formed in local communities. The objectives of these partnerships are violence prevention and integrated victim services.

Alcohol dependence and treatment strategies

There has been a subtle shift in funding in recent years, from alcohol misuse services into drug misuse services. This has resulted in under-funding and a need for commitment and resources to be made available. Alcohol misuse services provide treatment that enables people dependent on alcohol to achieve safe alcohol withdrawal and prevent drinking relapses. The most effective therapies for prevention of relapse include teaching alternative coping skills and eliciting motivation to change. For those with hazardous drinking patterns, brief interventions can result in a 24% reduction in alcohol consumption. There is a need for national guidelines on alcohol misuse to provide a coordinated, inter-agency approach for the management of these complex patients. Such a framework is underway – *Models of care*, being drawn up by the National Treatment Agency, which may be a step in the right direction.

Liver disease and alcohol

Alcohol causes half of all liver disease, the vast majority of deaths due to liver disease, but less than 2% of liver research is on alcohol-induced liver disease. It is difficult to obtain funding for research into alcoholic liver disease, possibly because there is a tendency to see it as self-inflicted and therefore not

worthy of research. The majority of patients admitted to hospital with alcohol-induced liver disease are not alcohol dependent (unpublished data, C Nelson, J White). What is emerging is that alongside the alcohol dependants (the traditional alcoholics), there is a separate group of patients whose motivations to drink are different. Rather than drinking because they are depressed or a loved one has died, they drink to be sociable or because they are bored (unpublished data, C.Nelson, J.White). Their drinking patterns are that of out-of-control social drinking rather than physical dependence on alcohol. Many in this group are slowly and silently causing damage to their livers and are completely unaware of it because they feel physically well. The first time most of them become aware is when they present with alcoholic hepatitis or cirrhosis, and the mortality rates are high when this happens. Severe alcoholic hepatitis has a 20–60% mortality and acute variceal bleeding has a 25% first-bleed mortality. This is not a small group of people. There are an estimated 20,000-30,000 heavy social drinkers silently developing end-stage liver disease in the UK. Good public education programmes are urgently needed, so that these people can recognise the harm they are doing to themselves. They have a right to know, and the majority would probably cut down their alcohol intake if they knew.

One strategy is to provide nurse-led clinics which can be used to increase rates of abstinence in patients with alcoholic liver disease by ensuring close follow-up. In Southampton, one specialist nurse (1/5 whole time equivalent) saved the trust £90,000 in one year (unpublished data, K Tull, N Sheron) by reducing admissions. More research into alcoholic liver disease is needed, which could be funded by 1% of alcohol turnover going to research in this area (as suggested in the Royal College of Physicians 2001 report).[3]

Strategies for primary care

In primary care in the Newcastle area, patients who are identified by screening to have evidence of harmful drinking are given brief interventions consisting of 5–10 minutes of structured advice. The advice is given during routine consultations by practice nurses or GPs on an opportunistic basis when patients seek help for other problems. There has been much research into brief interventions (56 trials, 34 in primary care), and systematic reviews have shown evidence of a decrease in alcohol-related problems and mortality with their use. The number needed to treat to have an effect is 8–12 patients, compared to 20 for smoking cessation advice. A major issue brought up by GPs in the audience at the conference, was that lack of time during consultations was likely to be the limiting factor in the implementation of this. Alcohol does not attract quality points in the new GP contract and therefore there is no financial incentive for GPs to address it, in the face of many other pressures. Interestingly, GPs and practice nurses are less likely to give advice to patients who they perceive to be similar to themselves in terms of social status and alcohol consumption, for example other professionals. In other words, they benchmark other people's drinking against their own, which provides some truth to the old saying that the definition of someone with an alcohol problem is somebody who drinks more than their doctor.

Conference programme

- **Alcohol and the NHS – an overview (RCP report)**
  Professor Chris Day, British Society of Gastroenterology, University of Newcastle upon Tyne
- **Alcohol, physical assault and injury, and practical measures to prevent them**
  Professor Jonathan Shepherd, Cardiff University
- **Alcohol dependence and treatment strategies**
  Dr Eilish Gilvarry, Clinical Director, Newcastle, North Tyneside and Northumberland Drug and Alcohol Service
- **Liver disease – damage limitation strategies for the future**
  Dr Nick Sheron, Royal College of Physicians Alcohol Committee and University of Southampton
- **Strategies for primary care – what works?**
  Dr Eileen Kaner, University of Newcastle upon Tyne
- **Can advertising change a drinking culture?**
  Dr Avril Nash, University of Hertfordshire
- **Alcohol in an international context – the evidence base**
  Mr Robin Room, Director, Centre for Social Research on Alcohol and Drugs (SoRAD), Stockholm University, Sweden
- **Implications for alcohol policy in the UK**
  Professor Sir Michael Marmot, Director, International Centre for Health and Society, University College London

Can advertising change a drinking culture?

Advertising influences younger rather than older people in terms of beliefs about alcohol: ideas about alcohol seem to be fixed by age 20. Many alcohol adverts have strong appeal for children, especially those that use cartoons and animal characters. We need to decrease the appeal of alcohol advertising to children and young people. Ofcom (the Office of Communications) have recently changed the advertising regulations so that alcohol adverts should not appeal strongly to children but, bizarrely, they are not proposing to ban alcohol advertising before 9 pm. In France, alcohol adverts have been banned from television altogether. In the Government White Paper, *Choosing health*, there is a commitment to restrict the advertising of unhealthy foods but not alcohol, making it easier to advertise alcohol than crisps. Counter-advertising may be a useful strategy, but there have been mixed findings with its use in the USA. Strategies include putting warnings on bottles and television adverts. A good counter-advertising campaign is difficult to produce and needs to be effective, not just informative or shocking.

Alcohol in an international context

Patterns of alcohol consumption vary around the world, from the South European wine-drinking cultures to drinking to

achieve intoxication in developing countries. The UK lies somewhere between these two extremes. In Europe, only Italian and French men drink more than British men (measured in occasions per year) and only Italian females drink more than British females. But the real difference is in the pattern of drinking, as the proportion of binges is higher amongst the British than either the French or the Italians. We are also showing a unique trend in Europe in that we are increasing our alcohol intake and deaths from alcoholic liver disease, whereas in France, for example, this is decreasing. The most cost-effective and effective strategies for decreasing alcohol consumption are to decrease the availability of alcohol and to increase the tax on alcohol. This has been shown consistently in other countries when they have changed legislation on availability of alcohol or tax on alcohol. For example, in Russia between 1985 and 1988 alcohol was made less available during an anti-alcohol campaign. Total alcohol consumption decreased by 25% and deaths from alcohol-specific causes decreased by 54% the next year.

If we increase the price of alcohol, are we not punishing ordinary low-level drinkers as well as heavy drinkers? The answer is no, because rationing and/or increased taxes on alcohol hit heavy drinkers hardest. For example, if we increased tax on alcohol by 100%, an average £4 bottle of wine (currently taxed at £1.23 per bottle) would cost £5.23 instead. This would hit a heavy drinker who buys 20 bottles of wine per week hardest, as their cost for the week would be £104.60 instead of £80. An average drinker who drinks 2 bottles of wine per week would spend £10.46 per week instead of £8 per week. An international consensus on alcohol consumption is needed, as local and national controls on alcohol no longer seem to suffice.

Health policy in the UK

In the UK, alcohol-related crime costs £7.3 billion per year, and alcohol-related health costs total £1.7 billion per year. One-third of A&E attendances and 150,000 hospital admissions are alcohol

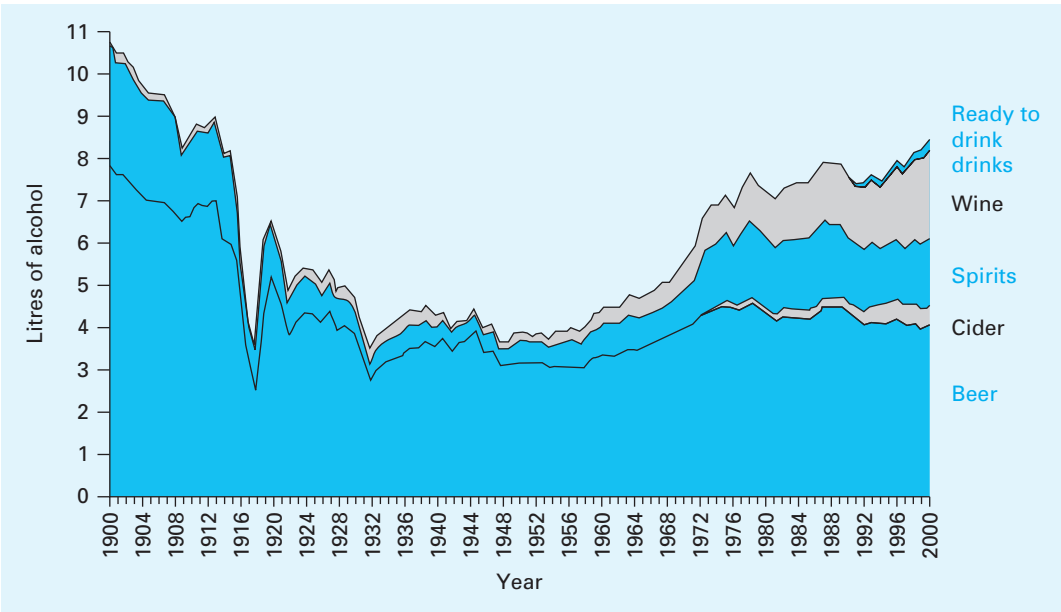

Fig 1. Alcohol consumption in the UK, 1900–2000. Per capita consumption of 100% alcohol. (Reproduced with permission from *Calling time. The nation's drinking as a major health issue*, Academy of Medical Sciences, 2004.)[4]

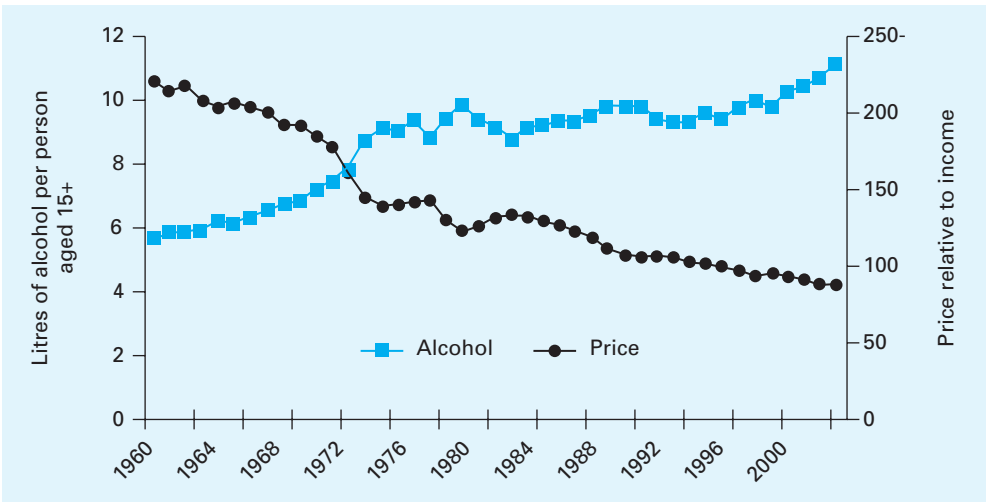

Fig 2. Consumption of alcohol in the UK (per person aged 15+) relative to its price, 1960–2002. (Reproduced with permission from *Calling time. The nation's drinking as a major health issue*. Academy of Medical Sciences, 2004.)[4]

related.[4] Alcohol consumption is increasing (Fig 1) and heavy drinking is linked to average level of consumption. There is a clear association between decreasing alcohol prices (relative to income) over the last 30 years and increasing consumption (Fig 2). A 10% rise in UK alcohol prices would produce a decrease in deaths directly related to alcohol of 29% for males and 27% for females.[5] These measures of increasing price and decreasing availability, shown to be effective in other countries, are the only solutions.

Conclusions

Social drinking is out of control in the UK. This has massive implications for the health of the people involved, a proportion of whom are silently developing end-stage liver disease. The lack of public education means that most are unaware of the dangers. In its recent *Alcohol harm reduction strategy* and public health White Paper, *Choosing health*, the Government has missed the opportunity to address the serious health issues associated with alcohol, instead putting the emphasis on law and order. While the law and order element is important, the health issues need addressing or an even bigger timebomb of costly alcohol-related liver disease will build up for the future.

At present, there is a serious shortfall in funding for alcohol services and research, so services are stretched to the limit and new solutions are not being sought.

The only strategies which have been shown to reduce the consumption of alcohol are reduced availability and increasing price. With the introduction of new licensing laws, however, the availability of alcohol will increase and consumption will increase. This is the wrong way to be moving.

The Royal College of Physicians, which is trusted and respected by the public, must continue to lead the way in raising these issues and campaigning for more action by government.

References

1 Prime Minister's Strategy Unit. *Alcohol harm reduction strategy.* London: Cabinet Office, 2004.

2 Department of Health. *Choosing health: making healthy choices easier.* London: DH, 2004.

3 Royal College of Physicians Alcohol Committee. *Alcohol – can the NHS afford it?* Report of a working party of the Royal College of Physicians. London: RCP, 2001.

4 The Academy of Medical Sciences. *Calling time: the nation's drinking as a major health issue.* London: AMS, 2004.

5 Norstrom T. Mortality and population drinking. In Norstrom T (ed), *Alcohol in postwar Europe: consumption, drinking patterns, consequences and policy responses in 15 European countries.* Stockholm: Almqvist and Wiksell International, 2002:157–75.