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Scotland's favourite drug – is there hope?

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Scotland has a problem. Every day six people die of alcohol-related disorders (ARD). The average death rate in Scotland is twice that of the UK as a whole; of the 20 localities in the UK with the highest ARD mortality only five are outwith Scotland.[1] This grim statistic is reflected in deaths from cirrhosis (historically a reliable surrogate marker of 'alcoholism' – the so-called 'Jellinek formula'), which have been spiralling exponentially in the last decade – more so in Scotland than in England – while the rate in Europe as a whole has been falling.[2]

The impact of ARD on the health service in Scotland is colossal, especially for acute medicine, A&E departments and trauma services. The cost exceeds £400 million annually.[3] This, coupled with the costs to social services, criminal justice and losses to industry and so on, means that the overall impact on Scotland's economy is now estimated to exceed £2 billion a year. And none of this can truly reflect the burden of human misery and social disintegration that alcohol excess/misuse is responsible for.

So how may the 'thinking Scot' approach this problem from within a culture where many enjoy a drink legally and responsibly and some, indeed, may derive a modest benefit in health terms? It is important first to understand the underlying dynamics of the problem. The frequency of ARD is directly and convincingly related to levels and patterns of consumption; and this is expressed not only at an individual level but also at a population level. Clearly, however, since Scotland's per capita consumption is not twice that of England's, other factors are important. Prominent among these is social deprivation, where alcohol-related harm rises with increasing depcat score (index of deprivation) given similar consumption levels.[4]

Considerations such as these have led to a policy over the years – much favoured by the beverage industry – of targeting the high-risk groups. 'Why punish or restrict us all for the problems of the few?' But many years ago Kreitman pointed to a flaw in this – if we really wish to tackle the problem at a society level. This is now one of society's most major problems, so we must. What Kreitman showed, in what he termed the preventive paradox, was that although the small proportion of really heavy and excessive (and addicted) drinkers produced the most problems individually (not surprisingly), nevertheless the large proportion of moderate and 'hazardous' drinkers produced some problems individually that additively contributed the major burden to society.[5] Hence a population *as well as* a targeted approach is necessary if we are to tackle Scotland's problem. There are signs that the government is now accepting this principle.

There is a widespread, nearly universally held, view among experts in the field that the sheet anchor of strategy must be a reduction in overall consumption – and perhaps also the encouragement of lower-strength beverages. Furthermore, alcohol must not be considered an ordinary commodity like bread and milk but a drug with potential for harm.[6]

The key factors controlling consumption are as follows:

1. *Affordability* – cost in relation to available money. This opens the opportunities for government taxation measures (not a devolved issue in Scotland), for minimal pricing strategies and for the abolition of deep discounting and irresponsible promotions.
2. *Accessibility* – including outlet density and hours of opening. This opens the opportunity for acceptable and effective licensing laws and their enforcement (which *is* a devolved issue in Scotland).
3. *Drinking culture*, which is related to peer pressures, social norms, media portrayal, advertising and promotions. This is clearly the most difficult to influence, and change is certainly a long-term aim.

While there is more than ample evidence to implicate these factors controlling consumption, there is scant evidence to support the use of some measures popular with governments and beverage industries – notably health education (except as a part of much broader approaches).

National strategies to control alcohol misuse must therefore involve measures to reduce consumption across the population, together with a range of harm reduction policies. Good examples of the latter would be random breath testing and a lower blood alcohol limit for vehicle drivers, training for people who serve and sell alcohol and strictly enforced 'no alcohol' areas. For strategies to be effective they must involve the whole nation and must carry the confidence of the public with them.

For its part, the Scottish government has produced its Plan for Action (2002), updated in 2007, and is publishing a revised strategy this summer. The Nicholson Committee report has led to a new licensing act (due to be fully operational by September 2009), and among the new and unique components includes promotion of public health as one of its five licensing objectives (not included in the corresponding English act).[7] More money than ever before is to be made available, much of it for a range of schemes involving early recognition and brief interventions (especially in primary care) for which there is strong evidence of effectiveness.[8] Support continues for several alcohol initiatives and agencies, including those led by Scotland's alcohol charity, Alcohol Focus Scotland ('promoting responsibility, reducing harm, changing culture').

It is vital, therefore, that the medical profession should be in the forefront of the action. Following its highly successful role in the anti-smoking campaign led by Sir John Crofton, former President of the College, and others, the RCPE has decided to make alcohol misuse the key public health issue in its strategy. The previous and present presidents have backed this enthusiastically and have worked to raise the issue's profile. After adopting its own internal alcohol policy the College has decided to put its energies into a collaborative effort with other colleges and faculties.

A decade ago two Fellows of this College set up a small taskforce involving the three Scottish Colleges and most other colleges/faculties – the Scottish Intercollegiate Group on Alcohol (SIGA). With financial support from the government and generous hosting by this College it has given birth to an advocacy body, Scottish Health Action on Alcohol Problems (SHAAP) with, among other things, active engagement with government ministers and MSPs, expert workshops on the pricing of alcohol and barriers to brief (minimal) intervention.[9,10] This brings together physicians, psychiatrists, public health practitioners, A&E consultants, surgeons, paediatricians, general practitioners and others.

In addition, there is, of course, much interesting and important work being done by other UK medical bodies, including NHS Health Scotland, NHS Quality Improvement Scotland, Information Services Division, SIGN, the Public Health Institute, the Medical Council on Alcohol and the Nursing Council on Alcohol. The College is represented on the Scottish Ministerial Advisory Committee on Alcohol Problems and doctors on Alcohol and Drugs Action Teams but perhaps not adequately on local alcohol licensing forums and not at all on the national forum – because it has been disbanded!

Is there then any cause for optimism in what Dr Samuel Johnson, in another age of alcohol epidemics, called 'these melancholy circumstances'? There is, but it will be a lengthy process requiring widespread commitment, resources and a determination to change. The drinking culture in the UK is in part a symptom of much that underpins our society and its values. But experience from the seatbelt and 'smoking in confined places' initiatives suggests that culture can respond to measures that can be seen to be beneficial and fair. The tipping point in the smoking campaign came with the knowledge of the role of passive smoking. The 'hidden harm' (and not so hidden!) of alcohol may prove a similar vital trigger.

Alcohol is a worldwide problem, and government departments need to work together over a wide base, not just Health and Justice but Education, Trade and Industry, Treasury and others. There is a need for strong, clear, consistent messages from the medical profession. There is also an urgent need for a 'coalition' of all those organisations involved in any way with the use and misuse of alcohol. Physicians must play a pivotal role in this.

At the outbreak of the First World War, Lloyd George remarked that Britain faced two enemies – the Kaiser and alcohol, and of the two he feared alcohol more. There is now another war which for the good of Scotland must be won.

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