Alcohol Education and Research Council

*Alcohol policy: the need for evidence based policy*

**The response by the Alcohol Education and Research Council to the Consultation on the National Alcohol Harm Reduction Strategy**

***The Alcohol Education and Research Council (AERC) is an independent, charitable organisation set up under the Licensing (Alcohol Education and Research) Act 1981 with a broad-based, multi-disciplinary membership. Council members are appointed by the Secretary of State for Culture under the rules governing public appointments. They are unpaid and their role is akin to that of charitable trustees. The AERC seeks to reduce the harm caused by alcohol abuse. It is committed to enabling better policy and services by improving their evidence base, and building research, educational and evaluative capacity. It seeks to promote collaborative working between those who are committed to the same aims but work in different settings.***

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**SUMMARY**

The AERC welcomes the opportunity to contribute to the development of the *National Alcohol Harm Reduction Strategy'*. The strategy review provides an opportunity for assessing the size of the problem of alcohol misuse and the need for appropriate and adequate interventions. Its base in the Cabinet Office is appropriate because of the wide range of multi-disciplinary expertise, interests, cultures and perspectives which needs considering. *Our response does not seek to answer all the questions posed in the consultation document, but focuses on areas of particular concern.* In addition to our evaluation of the evidence-base the Council would like to make the following points:

- The medical, social, environmental and economic costs of the harm caused by alcohol misuse are enormous. The Council considers that the total amount spent on research and service development has been disproportionate to the size of the problem and the importance of alcohol to our culture and the drinks industry to the national economy.

- The Council is the only statutory body specifically established to fund research into the effects of alcohol, but it has a severely limited budget. It wishes to emphasise the long-standing need to enable better policy and services. This requires improvement of the evidence base, building capacity for policy and service evaluation, and improvement in the mechanisms for disseminating and implementing change across many sectors and professional groups.

- It also requires a mechanism for the evidence and its policy implications to be kept under review and reported to Parliament on a regular basis. The possibility should be considered of doing this through an agency, similar to those that already exist in the United States and Australia.

- The AERC with its statutory base, infrastructure, and independence, could be modified to take on this role. Its well-established networks and peer-review system already provide a foundation, and its membership could be changed and augmented as considered necessary.


The focus of the following comments reflects an emphasis upon developing and using the evidence-based research that will contribute to a reduction in alcohol-related harm. It comprises:

- some background information about the Council;
- general comments and recommendations, including the need for a strong evidence-base on which to develop policy and practice; and
- more specific comments on the existing evidence-base.

## THE ALCOHOL EDUCATION AND RESEARCH COUNCIL

The AERC was established in 1982 under the Licensing (Alcohol Education and Research) Act 1981 to administer the Alcohol Education and Research Fund, a charitable foundation established with assets from the former licensing compensation authorities. It has a broad-based multi-disciplinary membership (Annex 1). Council members, who are unpaid, are appointed by the Secretary of State for Culture and are selected, inter-alia, from public health, psychology, medicine, criminal justice, education, social services and the alcohol industry.

In recent years the Fund has generated an annual income of £600,000, of which approximately £400,000 has been allocated to funding research and action projects. These are selected by peer review, but supported and monitored by Council members and the Council's science secretary.

The Council is committed to funding research which has a practical application to reducing alcohol-related harm in society and which will encourage best practice. The results of research projects are disseminated widely by means of the *Alcohol Insights* publication series and are communicated specifically to Government Departments and other bodies with a particular interest in the conclusions.

## GENERAL COMMENTS

### Alcohol as a public health and order issue

Alcohol is not like public health problems such as tobacco or polio in which the only rational long-term strategy is total prevention. Used sensibly, as it is by most people most of the time, alcohol adds to the quality of life of a large proportion of the adult population. Definite health benefits of moderate drinking have been identified in middle age and beyond. But for many young people the early years of initiation into the use of alcohol are associated with conspicuous consumption and risk of harm. At times this leads to social nuisance to others. Unwanted associations include violence, teenage pregnancy, and the tragedies of drink driving and other accidents. Continued misuse in later life can have dire consequences for families, health, employment and society in general.

### The need for a strong evidence base and capacity for evaluation

The medical, social, environmental and economic costs of the harm caused by alcohol misuse are considerable, but only small amounts are spent researching better policies, services and education. Research funding is hugely disproportionate in relation to the social importance of alcohol, the income from alcohol taxation to government, the employment and profitability generated by the industry, and the workload on welfare, criminal justice and health services. A good strategy needs good evidence and there are many areas where the evidence is not strong enough to justify a particular policy.

Evidence changes as research progresses and there is a distinction to be drawn between interventions that work and have been shown to work and interventions that may be effective but for which there is, as yet, no strong evidence. For example, the evidence for the effectiveness of school-based interventions is rather weak but there may be effective programmes that have not yet been properly evaluated.

In Australia and the USA single, independent agencies have been created with the expertise and resources to oversee the development of high quality, co-ordinated and effective research, monitoring and evaluation. We propose that the UK adopts a similar model to achieve these objectives

The Council was disappointed to see that the Consultation Document contains only four references to research, in questions 15, 44, 53 and 56.

**Developing the evidence base**

A recent report *'100% Proof: Research for Action on Alcohol'* (1) provides an overview of the gaps in the evidence base. Several AERC members contributed to this study, convened by Alcohol Concern and the Council strongly supports the central conclusions that:

- the report's recommendations should form the basis of discussions with interested parties on the development of a coherent alcohol research programme; and
- mechanisms should be established to ensure the central collection and sharing of information on alcohol research. These included:
    a. Standardising agreed data collection instruments of measurement and implementing their routine use in research practice.
    b. Providing a clearinghouse for co-ordinated research projects in the UK.
    c. Commissioning research; and
    d. Promoting the development of a training and career structure for researchers and interested practitioners.

The Council believes this document provides a good basis for developing a United Kingdom agency on the US and Australian models. To develop such a programme we recommend the establishment of a working group to bring together representatives of institutions and organisations concerned with the conduct and funding of alcohol research.

The AERC would be happy to organise and fund such a group and if there were sufficient consensus accompanied by appropriate funding, the Council would be prepared to extend its remit to provide this central agency. We believe that, by its statutory base, infrastructure, independence, and well-established networks and peer-review system it is well placed to take on this role.

A successful strategy will require support from a majority of the public and also from the alcohol industry. A particular strength of the AERC is its wide membership, including representatives of the industry.

**The Scottish Precedent**

The Scottish Alcohol Plan (2) also refers to the value of the Research Forum and emphasised the need to know more about what works in tackling alcohol problems in order to make sure that scarce resources are used wisely. It advocates better co-ordination of research effort, more accessible research results, and more and better evaluation of services.

In its implementation of the Plan the Scottish Executive has:

- commissioned a review of gaps in research knowledge and evaluation practice;
- undertaken consultation on research needs, with the aim of drawing up a future programme of research and evaluation, the outcomes of which are directly related to action and good practice; and
- allocated funding for this purpose.

We recommend that the National Strategy should take account of this work in progress but should propose that additional work should be undertaken on a United Kingdom basis.

**Influencing practice**

Crucially important is a focus upon dissemination as well as the initiation and management of change. There is a great deal of evidence indicating that research findings often do not influence practice. This concern is highlighted in the Research Governance agenda (3), which also quite sensibly suggests that public money should only be spent on research that is seen to benefit the public. The Council proposes that more attention and research funding focuses upon identifying ways in which research findings can be translated into policy and practice. More specifically, a meta-analysis of completed research studies in this area should be commissioned.

## SPECIFIC COMMENTS

**The principles that should underpin the strategy**

The European Charter on Alcohol was published in 1995 (4), and endorsed by all Member States of the European Union. The Alcohol Education and Research Council would like to emphasise that a national policy should take account of the rights enshrined in it, (Annex 2). In particular, the right to a family, community and working life protected from accidents, violence and other negative consequences of alcohol consumption. Similarly the WHO Stockholm Declaration in 2001 on Alcohol and Young People proposes that a priority is to invest in the health and well being of young people, in order to ensure that they enjoy a good quality of life and a vibrant future in terms of

work, leisure, family and community life. Specific targets, policy measures and support activities for young people are suggested. (5)

In the following sections the focus is upon the evidence-base existing at the moment. In summarising the evidence we have been particularly influenced by the publications listed in Annex 3.

**Children, young persons and families**

Children who grow up in environments where one or both parents misuse alcohol or have alcohol related problems tend to develop physical and psychological problems themselves (6). There are very few specialised resources available to help these young people and treatments or help for them is commonly exceedingly rare and difficult to access. Generalist services commonly do not identify the links between childhood problems and parental alcohol misuse.

Families as a whole are also often badly affected when a key member (spouse, parent, child) develops a serious alcohol problem (7). Some interventions have been demonstrated to be effective in reducing symptoms, and enabling family members to cope in ways which are more helpful to their physical and psychological health, and there is some evidence that such interventions also mean that the problem drinking member is more likely to seek treatment, and more likely to improve (8).

**Age restrictions**

Age restrictions on the consumption and purchase of alcohol play a role in the prevention of alcohol-related problems but they should be based upon good research evidence and also have public support. Researchers and policy makers in this field have not yet reached a consensus view.

- An Australian study found that overall levels of male juvenile crime rose by between a fifth and a quarter after the lowering of the legal purchasing age to 18 in some states during the 1970s. (9). Similarly, in the USA, the reduction of the legal drinking age was associated with an increase in alcohol consumption and alcohol-related road accidents involving young people. Subsequently, when drinking ages in the USA were raised, the rate of traffic accidents among young people fell. (10; 11, p137).
- On the other hand it has been argued that the alcohol-relatedness of automobile accidents is based on police impressions and thus is purely subjective. (12,13). Furthermore, higher accident rates may be due to factors other than young peoples' drinking behaviour. Changes in the economy, freedom to drive at an earlier age, changes in the price of gasoline and more young people owning automobiles could, it has been argued, account for increases in automobile accidents in some of these studies. (14)

More research is needed to disentangle the complex factors involved but, in the meantime, the research evidence does not support any relaxation of the minimum legal purchasing age. Internationally the norm is 18 years (15)

There is evidence that laws relating to young people should be more strictly enforced. For example, a study funded recently by the AERC uncovered clear evidence that it is relatively easy for 15 year olds, as well as 13 year old girls, to purchase alcohol in pubs, supermarkets and off-license premises. (16). This study, was cited by the Government during the passage of the Criminal Justice and Police Bill as an authority for changing the licensing law so as to allow test purchases by young people under 18. This was subsequently enacted as section 31 of the Criminal Justice and Police Act 2001.

**Education of children and young people**

Children and young people are entitled to a broad based education, which includes alcohol, tobacco and drug education. However, we need to be clear what the main purpose of this education is to be. Raising levels of knowledge and awareness is relatively straightforward but attempts to change behaviour through education are a great deal more complex and problematic. This is reflected in the lack of good evidence supporting the effectiveness of school-based approaches in prevention

The AERC has funded work on appropriate educational materials and methods of evaluating school-based approaches. There are many promising leads but we have concluded that there is a need for a variety of small and large scale studies before particular approaches can be championed. The Alcohol Education and Research Council and The World Health Organisation recently funded Professor David Foxcroft and colleagues to carry out a systematic review of this field. One intervention, the Strengthening Families Programme, turned out to be more promising than the rest. The Strengthening Families Program focuses upon parent training, children's skills training and family skills training. Young people receiving this intervention between the ages of ten and fifteen were much less likely to have ever been drunk four years later than those in a control group. (17;18; 19)

It should be emphasised that even if we find a programme that shows promise we need to consider very carefully the capacity of schools to prioritise and deliver such a programme in what is already an overloaded curriculum. A family or community based initiative such as the one cited above would seem to point the way forward, particularly if the alcohol education was delivered as a part of a broader based health promotion package.

**Cost benefits from minimal interventions**

The AERC has funded a solid body of research on brief interventions and the evidence points to the effectiveness of such approaches, in newly identified non-dependent problem drinkers, across a range of medical settings. In addition to the benefits to the individual drinker one of the arguments in favour of the implementation of minimal interventions is that they may save money for the health care system in the longer run. Evidence to support this proposition is beginning to accumulate (20,21), although one USA study did not find this effect (22). A Swedish study found that excessive drinkers who

had received a minimal intervention also showed an 80% reduction in sickness absenteeism from work in the four years following the intervention as well as a 60% reduction in days in hospital over five years and a 25% reduction in mortality from all causes over 10-16 years following intervention (23: 11, p167).

**Specialist treatment**

Specialist treatment for major alcohol problems is better than no treatment. A rough estimate is that the rate of naturally occurring improvement is one-third, whereas two-thirds of individuals receiving treatment show some improvement. American findings show that treatment for alcohol problems as a whole produces net gains for the health care system and is, therefore, a worthwhile and efficient use of financial resources. It has been estimated that for every US$10,000 invested, treatment saves about US$30,000 in medical spending for the managed care provider. (24, 11: p194). The treatments that have been shown to be effective include pharmacological and psychosocial approaches (25). The availability of these treatments, practised by fully trained personnel, will be found to be limited and uneven if Scottish data are representative of the UK. (25)

**Dual diagnosis**

Patients who suffer from both alcohol dependency and other mental conditions are particularly difficult to treat. The Council is currently funding one such study but it is clear that further work is required. The Royal College of Psychiatrists has produced guidelines, including a training manual (26) that will assist work in this area.

**Community Action**

There is good evidence that communities can be encouraged to drink less hazardously by targeting a wide range of subsystems. Media advocacy can pave the way for community action and changes in alcohol policy. For example, providing information on local or national problems such as under-age purchasing will help to increase public acceptance for policy measures designed to counteract the problem. In the US Harold Holder and colleagues carried out a well-designed community action research project with the goal of reducing alcohol-related injuries and deaths in three separate communities. The project involved community mobilisation, responsible beverage service in licensed premises to reduce the risk of having intoxicated and/or underage customers in bars or restaurants, reduced availability of alcohol being sold to minors, as well as policies on outlet numbers and density. The project reduced alcohol related crashes by 10%, lowered sales to minors, increased the responsible alcohol serving practices and increased community support and awareness of alcohol problems. (27)

**Monitoring consumption**

The aim of an Alcohol Strategy is to ensure that drinking is safe and sensible. In other words the main focus should be upon hazardous drinking patterns rather than per capita consumption.(28). Over the last 20 years mortality

from liver cirrhosis has steadily increased, probably as a result of increasing levels of hazardous drinking (29). The largest increases were in people aged 35 to 44 years where the death rate went up 8-fold in men and almost 7-fold in women. The number of hazardous drinkers needs to be continuously monitored and any increase should be seen to be a warning sign that requires a strategic response.

Even though drinking patterns should be the main concern, per capita consumption is a useful proxy measure of cultural changes. The risk of becoming a hazardous drinker depends, *to some extent*, upon the "wetness" of the drinking culture to which the person belongs. The drinking habits of a person living in an environment where drink is cheap, freely available and where heavier drinking is the norm, will tend to be more hazardous than those of a person living in a relatively dry environment. There is not a perfect relationship but populations with lower mean consumption levels tend to have lower proportions of heavy drinkers. In the UK between 1979 and 1982 the mean consumption fell by 9% from 7.6 litres per year to 6.9 litres per year. (30). This fall in consumption was followed by a 16% fall in drunkenness convictions, a 19% fall in admissions to hospital for alcohol dependence, a 7% fall in drinking and driving convictions and a 4% fall in cirrhosis mortality. (11, p100). Since mean alcohol consumption provides a proxy measure of the "wetness" of a society then one objective might be to ensure that per capita consumption does not increase dramatically.

**Number and type of outlets**

Research from the US has suggested a relationship between the number of outlets and specific alcohol-related problems such as road accidents and assaults. The problem here is that of uncovering a cause of alcohol related problems or simply a correlation. In the UK a relationship was demonstrated between number of outlets and consumption, especially for wine but not for spirits. Also in the UK the rise in the number of outlets selling alcohol has been accompanied by a growth in alcohol consumption (11, p131). The number of outlets increased by 55% between 1960 and 1995, from 129,367 to 201,148. Over the same period the number of off-licence outlets alone almost doubled. Meanwhile, average alcohol consumption rose from 5.7 litres of pure alcohol per year for every person aged 15 and over in 1960 to 7.6 litres by 1995. The extent to which increasing the availability of alcohol is the cause of alcohol related problems is one of those important areas that requires further methodologically sound research.

**Restrictions on purchasing times**

In the UK, recent licensing reforms have extended permitted hours. Unfortunately other changes, such as a recession and unemployment, were occurring at the same time making the available evidence difficult to interpret. Evidence from other countries concerning the effects of altering the hours during which alcohol can be sold suggests a significant positive relationship, with longer hours leading to increased problems and shorter hours being followed by a reduction in such problems (31; 11, p133). For example, extending the hours in Western Australia resulted in increased

violence (32). On the other hand a study of Scotland's liquor licensing changes uncovered no deleterious effects (33).

The Licensing Bill currently before Parliament provides for a substantial extension in the permitted hours in England and Wales. The Council recommends that the consequences of extending these hours should be closely monitored. It is possible that immediate violent incidents linked to closing times will be reduced but noise and nuisance in the early hours will increase. Also the levels of hazardous drinking might increase or decrease. A well-designed research project would be needed in order to check that extending licensing hours results in fewer problems rather than more.

## Developing the evidence base

Without significant investment in the continuous development of an evidence base, policy initiatives will fluctuate aimlessly between diverse approaches. It is clear from the findings summarised above that an important strand of an alcohol strategy should be work directed towards understanding and unravelling the complex processes involved. In addition to solid research, which needs substantial funding, there is a need for continuous monitoring and evaluation of a range of initiatives. Such an approach would result in a progressive and incremental growth of evidence relating to national and local initiatives. Effective interventions should multiply and ineffective ones would fade away. The objectives of the National Strategy should be translated into measurable outcomes, which the National Audit Office will be able to audit and review.

All of the above approaches to monitoring, evaluation and research could be overseen by one independent body. The Alcohol Education and Research Council provides one possible model. Its statutory base, infrastructure, independence, well-established networks and peer-review systems provide a potentially efficient organisation to be the basis for this. Its members are already appointed under the rules for other public appointments, and they could be changed or augmented as felt appropriate.

### References


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## ANNEXES

**Annex 1**

### Membership of the AERC

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|---|---|
| Dr Noel Olsen | Chairman |
| **Members** | |
| Mr John Bennett | Director, Health Citizenship and Community Education<br>Birmingham City Council |
| Dr Jonathan Chick | Consultant Psychiatrist<br>Royal Edinburgh Hospital |
| Professor Ilana B Crome | Professor of Addiction Psychiatry<br>Keele University |
| Professor Robin Davidson | Consultant Clinical Psychologist<br>Belvoir Park Hospital, Belfast |
| Ms Perminder Dhillon | Senior Lecturer (Research)<br>University of Central Lancashire |
| Mr Henry Fairweather | Group Human Resources Director<br>Scottish and Newcastle plc |
| Mr Peter Harraway | Formerly of the London Probation Area and currently of the National Probation Directorate |
| Dr John Kemm | NHS Executive<br>West Midlands |
| Ms Gaye Pedlow | Group Alcohol Policy Director<br>Diageo plc |
| Mr David Rae | Managing Director<br>North British Distillery Co Ltd |
| Mrs Daljit Sidebottom | Young People's Health Co-ordinator<br>North Somerset PCT |
| Dr Betsy Thom | Senior Research Fellow, School of Social Sciences,<br>Middlesex University |
| Professor Richard Velleman | Director of Research and Development for Avon and Western Wiltshire Mental Health Care Trust |

**Annex 2**

## The European Charter on Alcohol

- **All** people have the right to a family, community and working life protected from accidents, violence and other negative consequences of alcohol consumption.
- **All** people have the right to valid impartial information and education, starting early in life, on the consequences of alcohol consumption on health, the family and society.
- **All** children and adolescents have the right to grow up in an environment protected from the negative consequences of alcohol consumption and, to the greatest extent possible, from the promotion of alcoholic beverages.
- **All** people with hazardous or harmful alcohol consumption and members of their families have the right to accessible treatment and care.

**Annex 3**

## Key publications:


1. Raistrick, D., Hodgson, R and Ritson, B. (1999) *Tackling Alcohol Together*
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