Executive Summary

In the UK there are approximately 40,000 premature deaths a year related to alcohol consumption. This puts into perspective the approximate 1,500 lives claimed by all the illegal recreational drugs combined. Over the last 30 years alcohol has become an increasing problem in Britain's communities, causing a shift in public perception and government thinking on the subject. Problem drinking is on the increase, especially among women, and there is a clear link between the amount drunk and various indices of harm, i.e. health, crime, productivity and social harms. The massive costs of alcohol misuse to both the individual and society are just being realised and underline the need for a targeted alcohol strategy, set in context of our current cultural attitudes and legal approach to other drugs. As *Lord Wilson*, who chaired the morning session and introduced the seminar, emphasised, debate on what to do about this growing problem is urgently needed, although it may prove difficult to bring rationality to a subject that often elicits more emotion than understanding due to the vested interests involved, and the large proportion of the population who drink.

In order to create an evidence-based policy on alcohol, it is necessary to understand the neurophysiological effects of alcohol and compare these with the effects of other psychoactive drugs. *David Nutt* looked at the brain mechanisms that underlie the actions of both legal and illegal drugs, which are only now beginning to be understood. The pleasurable effects of alcohol arise from the activation of the same pathways as those activated by natural activities such as sex and eating, as well as by other illegal drugs. The effect of alcohol on the major transmitters, GABA and glutamate, explains many of the acute dangers of intoxication. Its effects on amine and peptide function, notably serotonin, dopamine and the endorphins, contribute to its pleasurable effects, and to dependence and craving.

The same receptor mechanisms are involved in the tolerance, withdrawal and dependence seen in both illegal drug and alcohol misusers, underlying a common addictive potential. A genetic predisposition to alcohol dependency or risk-taking behaviour in general may present itself in the form of specific variations in receptors or receptor subtypes. Similarities between the action of alcohol and other drugs on the brain indicate the need to study these substances conjointly and establish a research policy that considers the effects of one substance within the framework of all others.

Leslie Iversen considered the comparison of alcohol and cannabis, an illegal drug but one considered "soft" and used more prolifically than any other. Although cannabis and alcohol act on different targets in the brain, their associated intoxicated states have certain similarities. However, whereas alcohol in overdose can kill, cannabis cannot. The health risks associated with cannabis are generally related to its route of administration – smoking, often in conjunction with tobacco. The health risks associated with alcohol use are both more severe and more prevalent. Public opinion is moving towards the legalisation of cannabis. Britain regulates alcohol use by standardising quality and taxing consumption, so it is difficult to understand why cannabis use cannot be controlled in a similar way. Some consistency of legislation is required in relation to the relative harmfulness of these drugs.

The massive health implications of alcohol misuse were considered by *Ian Gilmore*, bringing to light its damaging effects on both the brain and the rest of the body. Alcohol is a major contributing factor to accidental injury and acute deaths. Death rates from cirrhosis have been increasing rapidly in the last ten years in England and are approaching those seen in other European countries where the trend is on the decline. Evidence suggests alcohol consumption may reduce the risk of mortality by heart attack, but increases the likelihood of all other fatal conditions including cancer and stroke. Closer analysis shows that any beneficial effects only come into play when alcohol is consumed later on in life. Binge drinking is particularly dangerous, mortality risks considerably increasing with the amount consumed in any one session.

The enormous burden of alcohol on health services was examined by *Colin Drummond,* who also looked at the potential treatment approaches to alcohol misuse. On a population level, it cannot be disputed that there is a significantly greater problem with drinking than with drug use. Even conservative estimates of annual alcohol-related NHS costs are in the billions of pounds. Although alcohol misuse is common, it is currently seldom identified or treated in medical settings. A system that caters for the full spectrum of problem drinking is urgently required, and must be backed by sufficient funding and political will.

Jonathan Chick drew attention to the worsening problem of alcohol, and talked about the possible effects of advertising on younger people who are drinking more and dying at an earlier age. He also emphasised the need for more effective treatments, which as well as saving lives, would actually give net savings to the health service due to reduced subsequent psychiatric and physical disease-related costs. Brief interventions have been shown to be effective in some populations, but the number needed to be screened to avert one case of alcohol dependency is very large, and the interventions prove difficult to implement. Psychosocial treatments are more effective than pharmaceutical treatments, but there is a shortage of specialists qualified to administer them.

There currently exists an indefensible imbalance between central spending on treatment and prevention for illicit drugs (£95 million a year) compared to that for alcohol (£1.1 million a year). This is a major contributing factor to the rapidly increasing numbers of problem drinkers in Britain.

The economics of alcohol and other drugs also goes some way to explaining current trends in use and misuse, as discussed by *Christine Godfrey*. Alcohol has been found to be a compliment rather than a substitute for other drug use. Because polydrug use is the norm, increasing the price of alcohol may simply increase the consumption of another drug. The price of drugs has been shown to affect their consumption. Relatively recent reductions in the cost of alcohol parallel an upward trend in problem drinking countrywide. In addition, incomes, information about the effects of the drug, advertising, marketing and supply all influence the consumption of a substance.

The social costs of alcohol and tobacco are far greater than those of all the illegal drugs put together. The World Health Organisation places illicit drugs seventeenth on the scale of the world's greatest social costs whereas alcohol is fifth. Social costs include premature deaths, unemployment and social disability, and victim costs. A considerable amount of research is available on the economic aspects of alcohol and other recreational drugs, but this is seldom used to inform debate because it is not accessible to the wider public.

While alcohol must be looked at in the context of other drugs, it is also important to put current alcohol and drug legislation in a historical context in order to understand how we arrived at the present position. *Virgina Berridge* reviewed the progression of alcohol and other drug legislation over the past 150 years. In this period opiates fell from a position of accepted medical and recreational use to a position where their use incurs the most severe penalties. In more recent years, smoking tobacco, which currently kills approximately 120,000 people a year in the UK, has become less culturally acceptable, while the popularity of alcohol and the drinking culture has increased. It would be logical to assume that these differences reflect the relative harmfulness of the substances concerned, but legislation is not always based on rational criteria and a host of other factors are involved.

Historically, the moderate use of both alcohol and opiates was not considered harmful because moderate users were able to maintain good health and continue working. Technological changes pushed alcohol and tobacco into mass production, while opiates moved into the medical domain with purification processes and the invention of the hypodermic syringe. A strongly prohibitionist regime controlling the worldwide trade of drugs came into existence in the 1920s under American influence. Alcohol was not a serious candidate for overall international regulation because alcohol taxes were (and still are) a crucial component of western finance, and alcohol industry interests were (and still are) allied with political interests. On the other hand, coca and opium were not produced by the industrial nations so there was little interest in protecting their markets. In addition, the recreational use of these substances competed with that of alcohol and tobacco, and their associated industries.

The afternoon session of the seminar was chaired by *Sir Michael Rawlins*, who stressed the need for any alcohol strategy to adopt long-term aims and objectives in order to reverse current trends. Alcohol is embedded in western culture and consumption depends largely on personal choice. It may no longer be an option to try to educate young people to choose not to drink or take illegal drugs. Even educating the youth about safe and sensible use may prove a gargantuan task, because many young people already have entrenched attitudes that it is cool to be out of control. If a strategy can target and change this underlying belief the prizes are immense. If it cannot, the costs will continue to escalate.

Hazel Blears, who is the Minister in charge of the alcohol strategy, gave a talk on the government's viewpoint on the alcohol problem and the potential for interventions. The government is committed to producing an alcohol strategy by 2004. Because alcohol holds legal status, it is necessary to use a different framework to that used when developing a drug strategy. Vulnerable groups in society should be a clear focus for interventions. Some factors that affect the choice to drink can be controlled, like that of price, availability and advertising. Others are beyond government control like personality, ethnicity, age, family status and life experiences. A good policy depends on the strength of the evidence that underpins it, so the real threats posed by alcohol to the individual and the wider community need to be established with more research. Policies must reflect the reality of cultural issues, focusing on measures which will make real differences to people's lives, while acknowledging the present situation in which drinking is an accepted cultural activity.

Mike Trace, who was involved in creating the National UK Drug Strategy in 1998, questioned why drug and alcohol policy had been kept separate and why the alcohol strategy has taken six years to develop. Over 90% of the population will use alcohol at some point in their lives and 10% will become problem drinkers. Despite the high profile given to drug problems, alcohol problems remain much more prevalent, indicating the need for more focus on this drug. The

current legal status of a substance determines the nature of the problems associated with its use. For example, most alcohol-related crime results from the way people behave under its influence, whereas drug-related crime is predominantly property crime carried out by addicts to feed their habits.

Alcohol policy in the past has depended on well-meaning intentions, but new policy must be based on evidence and rational thought processes. More investment is desperately needed but it is crucial to be clear on which processes to promote before backing them. The framework for a National Alcohol Strategy is developed but is not yet populated with accurate data. Although a strategy is yet to emerge in parallel with the National Drug Strategy, the time lag has given the government the opportunity to assess the evidence thoroughly, hopefully enabling it to produce a coherent, evidence-based programme of action.

Once the context has been set and the effects, both individual and social, established then it becomes necessary to consider possible lines of action. *Colin Blakemore* underlines how the present drug strategy has clearly failed. For all the efforts of the War on Drugs since the 1920s, never have drugs been more freely available at such a low cost. The Draconian polices have resulted in a vast increase of notified drug addicts in spite of massive investment. The present classification of drugs makes little sense, reflecting the prejudices and misconceptions of a previous era.

As discussed earlier, alcohol is a drug and has features in common with other drugs, both legal and illegal. Like most of the social drugs, it is parasitic on natural mechanisms in the brain associated with pleasure and motivated behaviour. It activates the same receptor mechanisms as eating, sex and gambling. *Colin Blakemore* proposes a rational classification of psychoactive substances based on the principal that all drugs should lie on a unified scale of harm. On this scale, illegal drugs would lie in relation to those already accepted by society, and there would be a continuous review of the scientific and sociological evidence determining their relative positions. In this way, key questions such as 'Does the drug harm individuals other than the user?' 'Is its use costly to society in other ways?' and 'How do the risks compare to legal drugs?' can be answered, and the policy controlling their use adjusted accordingly.

Alcohol and tobacco are at the top, or near the top, of every index of harm, yet hold legal status and are widely accepted in British culture. Despite the risks associated with alcohol misuse and the resulting costs to society, its marketing remains virtually unrestricted and problem use is increasing rapidly in the UK, especially among women and young people. A means of arresting and reversing these worrying trends needs to be found while respecting people's freedom of choice.