# Public policy on alcohol in the United Kingdom: towards a safety net for the alcohol-dependent

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*Published in:*
Journal of Law and Medicine

*Publication date:*
2009

*Document Version*
Author accepted manuscript

# Title: Public Policy on Alcohol in the United Kingdom: Towards a Safety Net for the Alcohol Dependent

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**Funding: The Wellcome Trust**

# Public Policy on Alcohol in the United Kingdom: Towards a Safety Net for the Alcohol Dependent

**Abstract:**

Public policy on alcohol in the United Kingdom fails to support and may even undermine the well-being of those with the worst alcohol misuse problems, the alcohol dependent. This is partly because it evades the thorny issue of impaired control that characterises dependence. In addition, until recently, all UK alcohol policy focussed on improving individualised treatment for the dependent, rather than attending to the wider social and environmental factors that influence the condition. The efforts of policy to normalise 'sensible' drinking while stigmatising drunkenness also risk exacerbating the social vulnerability of the alcohol dependent. The paper examines these issues and concludes by pointing to a number of developments that are required to help ensure that the dependent do not continue to fall through policy that pertains to be inclusive.

## Introduction

Public alcohol policy in the United Kingdom (UK) - here the discussion will be limited to Scotland and England[1] - has received much criticism for its ineffectiveness.[2, 3] Although policy has, to date, failed to control the harms associated with alcohol misuse throughout the population, those with alcohol dependence problems fare particularly badly because the extreme misuse associated with their condition makes them particularly vulnerable and in need of assistance. Attempts to reform policy and introduce harm reduction strategies that have an evidence base to support their effectiveness – such as

price increases and restrictions on availability - are gathering pace.[4, 5, 6] But even where formal commitments have been made to adopt more rigorous policies, the interests of the dependent are still sidelined.[7] To help ensure that alcohol dependence receives better representation in future reforms of alcohol policy, it is important to highlight the failings of recent alcohol strategies.

Initially the paper will provide a brief overview of alcohol policy in Scotland and England. The policies of these jurisdictions will then be placed in the context of wider developments in public alcohol policy. After performing these tasks the paper will turn to examine the nature of alcohol dependence and the way in which it is characterised in certain UK policies. The paper will conclude by identifying practical and ethical commitments that are required to help policy offer a better response to alcohol dependence.

## Alcohol Policy in Scotland and England: Overview

The Scottish Executive issued its first *Plan for Action on Alcohol Problems* in 2002.[8] In 2007 an update to the original document was published.[9] In 2008 the new Scottish National Party (SNP) led administration issued a consultation document intended to aid its revision of alcohol policy.[10] Most recently, it has published a new policy document entitled *Changing Scotland's Relationship with Alcohol: A Framework for Action*.[11] In England the Prime Minister's Strategy Unit published its first dedicated *Alcohol Harm Reduction Strategy for*

*England* in March 2004.[12] This report was followed in 2007 by *Safe. Sensible. Social. The Next Steps in the National Alcohol Strategy*.[13] A consultation on alcohol policy in England was held in 2008.[14]

Most generally, this documentation aims to reduce or prevent harms that can be associated with alcohol misuse. This is an important policy goal because alcohol misuse is estimated to cost the Scottish economy £2.25 billon per annum;[15] and the English economy between £17.7 billon and £25.1 billion per annum.[16] Despite these costs, alcohol policy in Scotland and England acknowledges that alcoholic beverages have an important role as a social lubricant and bring substantial economic benefits.[17, 18] In 2009 the alcohol statistics for Scotland reported that alcohol sales for the United Kingdom were worth £33.7 billion in 2006/7; and duty receipts in 2007/8 for the UK around £8.3 billion.[19]

In light of the competing benefits and harms associated with alcohol consumption, policy in England and Scotland has to find ways to balance '… the pleasure enjoyed by the millions of people who drink responsibly',[20] against the harms excess consumption can cause. Currently, policy in England aims to do this largely by relying on information provision and initiatives to persuade individuals to reduce excess drinking.[21] A feature of this approach is the promotion of individual choice and personal responsibility as a way to

control the harms associated with alcohol misuse. As then Prime Minister, Tony Blair, stated in his foreword to the original strategy document in England '… it is vital that individuals can make informed and responsible decisions about their own levels of alcohol consumption'.[22]

Until recently Scottish alcohol policy shared the reliance of its English counterpart on personal responsibility, informed choice and persuasion to control alcohol related harm.[23] However, the foreword to the consultation exercise held by the new administration announced that the costs associated with alcohol are now so substantial that '… [w]e can no longer afford to view alcohol misuse simply as an individual choice…'.[24] Thus, the Scottish Government has announced the introduction of measures, including minimum pricing and the levy of a social responsibility tax on the alcohol trade, to reduce consumption at a population level.[25]

## Towards Inclusive Alcohol Policy and Public Health

Recent public policy on alcohol in the UK is part of a wider development that has seen policy in this area move from having a narrow focus on 'alcoholism' pre-1970, to its current focus on the 'alcohol problems' or the misuse that exists throughout society.[26] This development occurred as a response to empirical data which showed that the general population experiences problems with alcohol that do not constitute 'addiction' or dependence.[27] Indeed, most of the costs that alcohol misuse presents to society come from the majority who misuse alcohol to a lesser degree, rather than from a minority with chronic misuse or dependency problems.[28] This information led to the development of policy that understands and seeks to address alcohol misuse as a population or public health issue.[29]

In its work on treatment for alcohol misuse the Institute of Medicine has explained that an advantage of utilising the general concept of 'alcohol problems' rests on its ability to incorporate diversity.[30] Edwards *et al*. have emphasised that the definition of alcohol problems that '… will best inform policy development will take cognizance both of alcohol-related problems and alcohol dependence.'[31] Thus, positioning the concept of 'alcohol problems' at the heart of policy is not intended to exclude the dependent, but

rather to help inform an inclusive response to the full range of drinking problems that exist within society.

It is important to include alcohol dependence within policy for a number of reasons. Firstly, it has been estimated that around 12% of men and 3% of women in the UK have some degree of dependence on alcohol.[32] Babor *et al*. note that while mild degrees of dependence in the population produce a 'significant public health burden', more severe dependence is responsible for an 'intense clustering of problems'.[33] In addition to undermining the well-being of the dependent person, these different types of harm are – as with other forms of alcohol misuse - associated with lost productivity, burdens on the National Health Service and incalculable but significant 'social harm' experienced by the families and close contacts of a dependent person.[34] Addressing such issues warrants and requires a policy response. This is not least because, secondly, individuals develop dependency problems partly as a result of environmental conditions;[35] and recovery from the condition can be aided or impeded by social environment.

Alcohol policy in Scotland and England claims to reflect the shift towards inclusive, population based alcohol policy. The initial Scottish policy document consistently employed the term 'alcohol problems' to refer to the 'whole spectrum of harm (actual or potential)' associated alcohol misuse.[36] Similarly, the most recent policy framework published by the Scottish

Government has announced its commitment to '…a whole population approach'.[37] In doing so, it emphasises that the job of policy:

> … isn't about only targeting those with chronic alcohol dependencies or those who suffer the greatest health inequalities, (although we recognise that these groups suffer the greatest harm and that they require specific supports and interventions).[38]

This strongly suggests that the Scottish strategy is inclusive of dependence, even though it is not solely focussed on the condition. In England alcohol policy is identified as a 'key feature' of the government's public health policy.[39] The aim of policy is to identify and treat all types of 'alcohol problems'.[40] This includes helping a '… significant minority of drinkers who are at greatest risk of harming themselves or others'.[41] In addition, the fact that Scottish and English policy highlights the importance of improving treatment for alcohol dependence illustrates that both jurisdictions view it as an issue that warrants public attention.[42, 43] However, the inclusive pretentions of public policy on alcohol in these jurisdictions are imperfect. This has ramifications across the spectrum of alcohol misuse. The focus here is on how policy fails to satisfactorily incorporate alcohol dependence.

It will be argued that policy in England and Scotland does not address alcohol dependence satisfactorily because it is not grounded on an accurate or consistent account of the condition. It also fails to understand dependence as a condition that needs to be addressed as a social and not just as an individual

treatment issue. A ramification of this is that policy does not consider dependence as an issue which needs to be integrated within public initiatives to manage alcohol related harm, or give attention to how policy measures might themselves impact on those with dependency problems. A case in point is the central health promotion strategy to cultivate a society that regards sensible alcohol consumption '… as a pleasurable part of life',[44] but in which drunkenness is socially rejected. It will be suggested that this apparently commonsense approach is in fact overly simplistic and practically and ethically fails those at greatest risk, the alcohol dependent. The examination of these issues must be grounded on an understanding of alcohol dependence.

## The Nature of Dependency

Two main frameworks are used internationally to diagnose alcohol dependence syndrome. Both require the identification of a collection of signs and symptoms. The tenth *International Classification of Disease* (ICD-10) issued by the World Health Organisation (WHO) defines dependence syndrome as:

> A cluster of physiological, behavioural, and cognitive phenomena in which the use of a substance takes on a much higher priority for a given individual than other behaviours that once had greater value.[45]

Within this framework a diagnosis of dependence requires the individual patient to have exhibited three of six criteria within a 12-month period. These

criteria are: withdrawal symptoms; 'a strong desire or sense of compulsion'; 'difficulties in controlling substance-taking'; tolerance - where the individual requires increased doses to obtain the desired effect; 'progressive neglect of other interests'; and persistent use despite harmful consequences.[46] Similarly, in its fourth edition of *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) the American Psychiatric Association (APA) requires the clinical presence of three or more of the following: tolerance, withdrawal, uncontrolled use, unsuccessful attempts to cut down, disproportionate time spent obtaining and using the substance, other life activities given less importance, continued use despite resulting physical or psychological problems.[47]

Recent exchanges over the impending revision of the DVM-IV framework have emphasised the importance of increasing the attention given to impaired control within this diagnostic tool. In this respect, debate has focussed on identifying the best term (addiction or dependence) to articulate the compulsive nature of the condition.[48, 49, 50] The aim of such debates has been to emphasise the 'compulsive' nature of substance use while avoiding a term that stigmatises (like addiction),[51] or which places restrictions on those in need of pain relief because they show evidence of pharmacological tolerance or withdrawal (physical dependence).[52] In his contribution to this debate Erickson is keen to stress that it is inappropriate to reduce 'dependence'

(addiction) to withdrawal and tolerance.[53] Similarly, Hymen has noted that the current '… focus on compulsive use as the defining features [sic] of addiction superseded previous views that focused on [physical] dependence and withdrawal'.[54]

The association between dependency (addiction) and impaired control receives support from work in neuroscience. This suggests that the 'likely' area of the brain responsible for producing dependence is the mesolimbic dopamine system.[55] It appears that the repeated 'overstimulation' of this 'reward pathway' in the brain can lead over time to usage becoming increasingly habitual and compulsive.[56, 57] Leshner has argued that '… changes in brain structure and function is what makes it [addiction], fundamentally, a brain disease'.[58]

**Critical Appraisals of Compulsion and Impaired Control**

The role of impaired choice in dependency has been the subject of much debate.[59, 60, 61] Morse, for example, has argued that while compulsion and impaired control are possible identifiers of dependency within ICD-10, they are not necessary components of a positive diagnosis.[62] While this is true, ICD-10 clearly states that:

> A central descriptive characteristic of the dependence syndrome is the desire (often strong, sometimes overpowering) to take psychoactive drugs…[63]

The reason for the optional role of compulsion and craving within the ICD-10 diagnostic framework is, as the WHO explains, because '… the subjective awareness of compulsion to use drugs is most commonly seen during attempts to stop or control substance use'.[64] The desire (craving) to use the substance comes to the fore when the supply dries up, or efforts are made to suspend consumption. It is for this reason that diagnosis can be made without compulsion being present although the trait remains at the heart of the syndrome.

However, there is a growing consensus that the role compulsion, craving and impaired control play in dependence requires clarification. In their seminal characterisation of alcohol dependence, Edwards and Gross point to the problems that exist with the terminology used to describe the subjective loss of control reported by the dependent.[65] More recently, Hymen has indicated the limitations of the term 'compulsion'.[66] Similarly, Foddy and Savulescu have highlighted that the use of the term 'compulsion' in the context of dependence is problematic because it incorrectly suggests substance use is literally 'irresistible'.[67]

Overstating the nature of compulsion associated with dependence could misrepresent and have a detrimental impact on efforts to formulate better responses to the condition. This is because if the dependent are incorrectly

portrayed as automatons it could appear that only extremely coercive measures could help to suspend or minimise their drinking. Such measures might include prohibition or imposing severe restrictions on the freedom of the dependent. It is most unlikely that such measures would be practically or ethically viable.

Alternatively, the notion that 'compulsion' does not literally bind the dependent to use their substance of choice could easily lead to the assumption that alcohol dependence is a non-problem. However, this position tends to ignore state-of-the-art work on dependence (addiction) that supports the notion that dependence involves some degree of impaired control.[68, 69] As a result it risks underestimating the assistance needed by many with dependency problems because it finds it difficult to rationalise subjective experiences of craving - experiences which are authenticated by the WHO diagnostic tool. If employed as the basis for public policy this approach would threaten to leave those with the worst alcohol misuse problems unsupported and potentially untreated because it views impaired control as inauthentic.

Edwards and Gross suggest that an appropriate way to understand the impact of craving is that it leads control over alcohol consumption to become '… variably and intermittently impaired rather than "lost" '; [70] while Hymen suggests that compulsion is most accurately described as the 'diminished

ability to control drug use'.[71] These accounts allow for the insights from neuroscience and reports of craving experienced by the dependent to be treated as valid. But they do not exempt the dependent from having responsibility for managing their condition. This is important because, as Watson notes, a central feature of the controversy that surrounds the role of impaired control experienced by the dependent is the notion that they are 'absolved from responsibility'.[72]

Work in neuroscience is leading efforts to emphasise that the dependent do have responsibilities for their condition. Erickson, for example, has suggested that the failure of science to 'properly educate the public' about dependency has resulted in the notion that individuals with this condition lack responsibility.[73] Similarly, Volkow has stated that, like those with more traditional diseases (such as diabetes), it is up to the dependent person to 'take responsibility to do the correct things, including changes in lifestyle and taking medication' to maintain their health.[74] For individuals with dependency problems to be aware of their responsibilities they must receive an accurate diagnosis and consistent information on the measures that are required to manage their dependency problem(s). However, many people who live with alcohol dependence do not access treatment or other support services, this makes it important to provide information on the condition more widely within the public forum. This is also desirable to aid the families

and close contacts of the dependent. In addition, policy must seek to cultivate social environments that take issue with the stigma that can impede attempts to recover from dependency problems.[75]

It has also been inferred that because there is evidence to show that some individuals with dependency problems can 'just stop' their substance use, impaired control for all is a fiction.[76, 77] However, such claims are often based on an understanding of dependence that does not take into account the increasingly sophisticated work on the relationship between impaired choice, environment, responsibility and dependency rooted in contemporary neuroscience. As Leshner argued some ten years ago, addiction is a '… brain disease for which the social contexts in which is has developed and is expressed are critically important'.[78] He illustrates the importance of environment by drawing on the example of the thousands of veterans who became addicted to heroin in Vietnam, but gave up the drug with relative ease on their return home when their contexts radically changed.[79] Yet the influence of environmental factors on the course of dependence can be overlooked. Foddy and Savulescu, for example, cite the Vietnam case to show that individuals can stop taking their substance of choice without making reference to the change in context which Leshner suggests facilitated behaviour change in many cases.[80]

The influence that environment and social attitudes have on the capability of individuals to successfully manage their dependency problem points to the importance of creating societies that are better equipped to prevent and support recovery from the condition. This has led Levy to argue that society shares responsibility with the dependent person for their well-being.[81] More specifically, given the role of environment in the relapse of dependent drinkers Levy claims '… the addict will not be entirely to blame. Blame should instead be shared: between the addict and many social actors... that ensured the addict would confront temptation…'.[82] This emphasises that it is necessary for policy to recognise the social nature of dependence. However, public policy on alcohol should not be primarily concerned with apportioning blame for dependent drinking, but rather with clarifying the nature of alcohol dependence and articulating the positive measures required to respond to the condition within populations. The starting point for such work must be an accurate and consistent account of the nature of alcohol dependence.

## Alcohol Dependence in Policy: Evading Impaired Control

Throughout its development, despite its commitment to addressing 'alcohol problems' in an inclusive manner, public policy on alcohol in Scotland has repeatedly failed to address the issue of impaired control. The initial *Plan for Action*, for example, provided a glossary that defined a number of specific

conditions that are pertinent to our examination.[83] Firstly, 'alcohol dependence' was defined as:

> Physical dependence characterised by withdrawal symptoms when the alcohol intake comes to an end. These symptoms include physical tremor, confusion, nausea, agitation, sometimes abnormal mental experiences or epileptic-type fits.

Similarly, 'alcohol addiction' as a:

> … way of describing an individual with alcohol dependence, who continues to drink to avoid withdrawal symptoms, and who needs to ensure continued access to supplies of alcohol.

The *Plan* did not cite specific sources to support its definition of these terms, but explained it was referring to what they 'commonly mean'.[84] Both definitions failed to acknowledge the role of craving and impaired control in alcohol dependence. The document made no attempt to explain why this feature was omitted from consideration, or why the complex syndrome of 'alcohol dependence' that includes craving was equated with, or reduce to 'physical dependence' that does not. As a result the *Plan for Action* linked alcohol dependence and addiction solely with efforts to avoid withdrawal symptoms.

However, a year after the Executive published its *Plan for Action* the Health Technology Board for Scotland and NHS Scotland issued a document entitled *Prevention of Relapse in Alcohol Dependence*. The report recommends that the

drugs acamprosate and disulfiram are used in treatment as 'adjuncts to psychosocial interventions'.[85] The report explains that the role of acamprosate in relapse prevention is that it 'appears to decrease craving'.[86] This led to a situation in which a public policy document defined dependency solely in terms of withdrawal symptoms, without any mention of craving. But, concurrently, a document dedicated to dependence and its treatment acknowledged the role craving plays and the need to treat it.

The failure to acknowledge impaired control within public policy is perhaps not surprising because, as West has noted:

> … withdrawal symptoms in themselves pose little social threat… By contrast, the compulsion to use drugs… poses a very serious long-term threat to the well-being of suffers and others and is very difficult to tackle with interventions that are practicable and ethical.[87]

Thus one of the greatest challenges for policy is to articulate how society should understand and respond to impaired control. Yet this is precisely the feature that public policy in Scotland sidestepped by failing to highlight its role within its initial public policy document. However, even policy documentation that utilises a fuller definition of dependence can still fail to address dependence and impaired control satisfactorily. There are examples of this within Scottish and English policy.

The definition of alcohol dependence given in the glossary of the recent discussion paper dedicated to alcohol policy in Scotland improves greatly on previous Scottish documentation. It does this by essentially relying on the ICD-10 definition of alcohol dependence.[88] However, in doing so it refers only to the 'strong desire to drink' which can characterise dependence, rather than to the 'sense of compulsion' which is also referred to within the WHO's diagnostic framework.[89] More significant is that the resulting policy framework document - despite its claim to adopt a 'whole population approach' -[90] only mentions dependence to emphasise that alcohol misuse 'is not just about those with chronic dependency...',[91] and that it is important to improve treatment for the condition.[92] As a result public policy on alcohol in Scotland continues to make no reference to the how society and communities should understand or respond to impaired control.

In England the *Interim Analytical Report* that preceded the publication of England's first alcohol strategy adopts the WHO categorisation of dependence. Thus, it acknowledges it has many different signs and symptoms including compulsion, tolerance, withdrawal and an impaired capacity to control drinking.[93] The same definition is used in a glossary that accompanies the *Alcohol Harm Reduction Strategy*.[94] Yet alcohol dependence is only referred to in passing within the document itself.[95] Instead the text concentrates on

responding to binge and chronic drinking; dependency is not identified within this debate.[96]

More attention is afforded to alcohol dependence in *Safe. Sensible. Social*. This document categorises alcohol dependence as a health cost that can arise as a result of 'harmful drinking'.[97] A goal of the report is to extend its advertising campaign 'Know Your Limits' to address the risks associated with harmful drinking.[98] It appears that the government intends to target this educational campaign directly at dependent drinkers.[99] Support for this comes from its observation that '[m]any people who drink harmfully, including dependent drinkers, are able to reduce the amount they drink without needing professional treatment.'[100] As a result the report suggests that even dependent drinkers will respond to information-based campaigns. However, we have seen that it should not be assumed that because *some* dependent drinkers can stop drinking and report little difficulty managing cravings this experience can be generalised because many factors influence dependence problems**.** More importantly, the ICD-10 definition cited within the original report by the Prime Minister's Strategy Unit identifies the difficulty in controlling substance use as a characteristic of alcohol dependence.[101] Thus, if policy is to assist those made vulnerable by alcohol dependence it needs to develop strategies to address the interests of individuals that *do* have difficulty controlling usage and not only those who can stop with ease. As it stands, the

claim in the report regarding the ease with which *some* dependent drinkers can control their substance use serves to airbrush from policy questions regarding how it might address the needs of those who find it more difficult to 'just stop' drinking, or who repeatedly relapse despite concerted efforts to stop.

## Responsible Drinking and Cultural Change: Implications for Dependence

Alcohol policy in Scotland and England highlights the positive aspects of alcohol consumption and the benefits of the trade that surrounds it. In this respect, the English policy document *Safe. Sensible. Social* explains that alcohol '… can play an important and positive role in British culture.'[102] Similarly, the update to the *Plan for Action* in Scotland emphasised that its aim was to allow alcohol to be '…recognised as a component of a healthy lifestyle'.[103] More recently, the discussion document on alcohol policy issued by the Scottish Government has portrayed the 'sensible enjoyment' of alcohol as '… the mark of a mature society at ease with itself'.[104] The policy framework document issued by the Scottish Government presents alcohol as '… an integral part of Scottish life'.[105] Thus the message policy gives regarding alcohol is that it is a substance for everyone - over a certain age - providing it is used responsibly. No consideration is given to how this policy position might impact on those who live in some way with dependency problems. As a result the efforts of

many to avoid alcohol are unsupported within policy and the ignorance surrounding the condition remains unchallenged amongst the dependent, their families and wider society.

Public policy documents on alcohol in England and Scotland also share a commitment to secure a 'cultural change' in attitudes towards the acceptability of excess consumption.[106, 107, 108, 109, 110, 111] In this respect, the initial *Plan for Action* in Scotland stated that measures to '… make a difference to the cultures surrounding drinking in Scotland are among the most important in this Plan'.[112] The update to the *Plan* continued these efforts to promote 'a culture of responsible drinking' in which people do not consume alcohol '… for the sake of getting drunk'.[113] Similarly, in England the original document on alcohol policy issued by the Prime Minister's Strategy Unit identified its efforts to alter 'the culture of drinking to get drunk' as '… the first key aim of the strategy'.[114] This initiative to make 'drunkenness unacceptable' also features in *Safe. Sensible. Social*.[115]

Until recently the primary way in which policy has attempted to bring about the desired change in attitudes towards excess alcohol consumption has been through information provision and education campaigns that urge responsible consumption. Public health advertisements have highlighted the harm that excess consumption can cause to the 'reputation' of the individual drinker.[116] For example, advertisements in England have shown young female

and male drinkers covering themselves in vomit and urine before they go out for the evening accompanied by the slogan 'You wouldn't start a night like this, so why end this way?'.[117] Similarly, the 'Tonight You Decide' campaign in Scotland refers to the loss of self-respect that accompanies the alcohol-fuelled deterioration of a young female drinker because she did not choose to drink sensibly.[118] These efforts to cultivate a culture of shame around drunkenness aim to degrade inebriated drinkers. Importantly for our purposes, they aim to do so regardless of whether a degree of impaired control (dependence) is involved.

The Scottish Government has recently announced its intention to legislate to introduce measures that do not rely on information provision and which help to 'denormalise' alcohol use.[119] It aims to do this by employing minimum pricing and restrictions on alcohol promotions.[120] These measures are likely to help prevent the development of alcohol dependence because they promise to be more successful at reducing alcohol consumption than education.[121] However, they offer little assistance or support to those who already live with dependency problems. This is because dependence is still not addressed by policy in a manner that will increase public understanding of the condition or improve the way policy responds to it.

It is a cause for concern that the 'cultural change' message, a key element of public policy on alcohol, risks increasing the stigma that surrounds

dependence, rather than helping to dispel it by raising public awareness of the condition. This is not least because policies that further stigmatise the dependent are likely to maintain obstacles to their entry into treatment programmes. It is estimated, for example, that only around 5.6% of people in England who require treatment for alcohol dependence access it.[122] This woefully low take-up of services is influenced partly by poor availability,[123] but individuals also opt not to accept treatment even when it is available due to the stigma that surrounds the condition and its treatment.[124] Hence the cultural change strategy could itself undermine the attempts of policy to improve treatment for alcohol problems such as dependence. This is because it leads to all excess drinkers being portrayed as merely irresponsible without providing any specific information or support for those whose problem with alcohol is complicated by impaired control. This misses an opportunity to provide a more nuanced, inclusive account of the responsibilities that pertain in respect of alcohol problems.

## Conclusion: Towards a Safety Net for the Alcohol Dependent

The virtual omission of dependence from public policy on alcohol in Scotland and England represents a practical and moral failing. This is because policy does not utilise a comprehensive or consistent account of what constitutes dependence. As a result it is not equipped to address the full range of 'alcohol

problems' that exist in society. This leaves individuals with the worst alcohol misuse problems – the dependent - in a vulnerable, precarious position and unsupported by the very public policy documents that are intended to address alcohol related harms. It is a positive sign that the recent *Safe, Sensible, Social – Consultation on Further Action* has sought to gauge public opinion on what can be done, other than providing treatment, to help the dependent.[125] This concluding section points to a number of changes that are required to prevent the dependent from falling through policy. The measures that will be identified should be viewed as supplemental to general initiatives, like those recently adopted in Scotland, aimed at improving the public health response to alcohol misuse by adopting preventive strategies such as price controls.

***Dependence Incorporated within General Public Policy Documentation***

Efforts should be made to respond to alcohol dependence within general public policy – though specialised treatment is also required - rather than by producing separate strategies dedicated to the condition. This is important because policy documents narrowly dedicated to dependence would be unlikely to cultivate the public awareness of the condition needed to aid prevention efforts, or to create environments that are more supportive of the dependent. Targeted policies could also worsen the stigma encountered by the dependent.[126]

*Consensus Statement on the Nature of Dependence and Impaired Control*

Policy can only generate strategies to help society, individual drinkers and their families understand and live more successfully with alcohol dependence if it provides a thorough account of its characteristics and employs this consistently. Unless a rationale is supplied for its omission, this account should include the role impaired control can play in dependent drinking. Importantly, public policy documentation should not present a different account of the significance of impaired control and craving to that found in treatment literature.

The internationally recognised ICD-10 framework has proved insufficient to foster a detailed, consistent account of alcohol dependence within, let alone across, Scottish and English policy. The formulation of an interdisciplinary consensus position on the nature of alcohol dependence within UK policy documentation would encourage deeper thought on the condition and much needed debate between all stakeholders – professional and public - on how best to address alcohol dependence. Without this more explicit and precise account of alcohol dependence within UK policy documentation it is likely that the interests of the dependent will not receive the level or type of attention they require and merit.

*Dependence as a Public Issue*

It is necessary to foster greater public awareness of dependence, while avoiding any return to the notion that dependence only requires a social response (e.g. criminal justice provision) rather than treatment.[127] Currently the lack of accurate information available on alcohol dependence in the public forum means that - despite the failure of information campaigns to secure widespread changes in drinking behaviour – educational initiatives dedicated to this condition would be beneficial. This is because they could help to overturn the stigma that surrounds it, alert people to signs of dependence developing and provide those who in some way live with the condition with the resources to help them cope with the difficult challenges it presents. An example of the type of information provision that could help to raise awareness of dependence is the advertisement dedicated to 'Alcoholism' by *Face the Issue.com* that usefully highlights the association between chronic drinking and the insidious rise of impaired control.[128]

Efforts to promote a greater public understanding of alcohol dependence would also benefit from generating a wider awareness of tools that aid the identification of dependency problems. Currently, the most well know of available resources is the CAGE questionnaire. This uses thoughts of needing to 'Cut' down consumption, 'Annoyance' at being criticised for drinking levels, 'Guilt' at level of drinking and the consumption if alcoholic 'Eye-

openers' first thing in the morning to help diagnose dependence.[129] Other more detailed tools which allow for the identification of varying levels of dependence also exist, such as the Severity of Alcohol Dependence Questionnaire (SADQ),[130] and the Leeds Dependence Questionnaire (LDQ).[131] Wider knowledge of these tools could play a useful role in the identification, prevention and treatment of dependency problems.

Finally, it is important to communicate publically that alcohol dependence is a chronic problem, rather than an acute event that will be permanently remedied if treated once.[132] Without this insight it is likely that relapses will be construed as a failure of treatment, so again obstructing entry into or the return to therapy. In addition, within a drinking culture in which individual choice is billed the primary determiner of 'sensible' consumption those who repeatedly return to patterns of excess consumption are likely to met by increasingly harsh (moral) judgements and perhaps social and/or familial rejection.

***Renewed and Explicit Ethical Foundations***

Public policy on alcohol in Scotland and England assumes responsibility for addressing the full range of alcohol problems that exists in society. In recent years it has endeavoured to fulfil these responsibilities largely by providing information and deferring to the choices and responsibilities of individual

drinkers. This approach has had little positive impact on alcohol misuse within the population and is particularly unsuitable for addressing dependency problems. Even recent efforts in Scotland to introduce harm control initiatives that seek to alter drinking environments do not approach alcohol dependence as a public health issue. Thus, both jurisdictions continue to fail the dependent. A more explicit ethical commitment within public policy on alcohol would provide support in two important areas; namely, the endeavour to address alcohol misuse (inclusively) as a public health issue; and in helping to ensure that responsibility for addressing dependence is not obfuscated amongst stakeholders. Both issues have an important role to play in providing a safety net for the dependent within policy.

The emergent tradition of public health ethics prioritises prevention, population level initiatives and community well-being.[133] Grounding public alcohol policy overtly on this approach would provide it with the capacity to sanction measures that impose restrictions on individual liberty, if they support the good of society.[134] As the Nuffield Council on Bioethics has indicated, a public health ethic acts as a natural ally for those whose aim is to protect public health by introducing policies that impose some form of restriction on the availability of alcohol.[135] This can support the introduction of measures like increased pricing to lower alcohol consumption and associated harms (including dependence) across society.

Importantly, an explicit commitment to a public health ethic would also support secondary and tertiary prevention efforts that aim to stop the condition worsening and prevent relapses.[136] This is because, as Gostin has emphasised, public health initiatives are '… intended to benefit the whole population without knowingly harming individuals or groups' and are rarely content to promote 'aggregate benefit'.[137] Hence a public health ethic would not be content to allow the dependent to be sidelined within policy because they are a minority group and the costs associated with dependence lower than other forms of misuse. This approach is rooted in the realisation that the well-being of individuals who make-up communities is, practically and morally, interdependent. Furthermore, the importance afforded to social justice issues within public health ethics means that citizens with dependency problems made vulnerable by the worst alcohol misuse problems within society would warrant special and not less attention within policy.

Finally, work to clear the muddied waters regarding choice and responsibility in the context of alcohol dependence - and alcohol policy more generally - is an essential aspect of improving the way in which the condition is addressed. In this respect, the tendency within policy to defer to the responsibility of individual drinkers must be rebalanced within a broader account of social responsibilities. This approach should include a full account of the responsibilities that dependent drinkers have for managing their condition.

But to make this meaningful it is important for policy to identify, and deliver on its responsibilities for protecting public health in respect of *all* degrees of alcohol misuse. This not only necessitates the provision of a level of treatment that makes recovery from dependency realistic, but the creation of environments in which recovery is not mired in ignorance and shame. This will require policy to address dependence explicitly, accurately and as a public issue.

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