Alcohol dependence in public policy: towards its (re)inclusion

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Alcohol Dependence in Public Policy: Towards its (Re-)Inclusion

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Abstract:

Public policy on alcohol in the United Kingdom relies on health promotion campaigns that encourage individuals who misuse alcohol to make healthier choices about their drinking. Individuals with alcohol dependence syndrome have an impaired capacity to choose health. As a result, individuals with amongst the worst alcohol misuse problems lie largely outside the reach of choice-based policy. However, such policy has been widely criticised and efforts to reform it are underway. This paper argues that the BMA's recent attempt to improve policy on alcohol in the UK by introducing strategies which have been shown to control drinking within populations still gives insufficient attention to alcohol dependence. This is because it fails to accurately and consistently characterise alcohol dependence and gives insufficient attention to the social challenges it presents.

Keywords: Alcohol dependence; Public policy; Public health

Introduction

For many years, alcohol dependence (alcoholism) was at the heart of efforts to control alcohol problems. The realisation that lower levels of alcohol misuse, rather than dependence, cause most harm in society led to the development of policies with a wider population focus.[1, 2] As a result, alcohol dependence now receives little attention as a public issue in policy concerning alcohol in

Scotland and England.[3, 4] This situation helps to sustain the stigma and ignorance that surrounds the condition and undermines efforts to address it. The recent British Medical Association (BMA) recommendations for alleviating alcohol problems are more inclusive than UK government policy, but will do little to improve the public response to dependence (addiction).[5] This paper will argue that the treatment of dependence in policy (actual or proposed) raises ethical issues which, if addressed, could help society respond more effectively to the condition and prevent the dependent from being excluded and disenfranchised.

Public Health Policy and Alcohol Misuse

Individual Behaviour Change: Contemporary Policy

Public policy aimed at reducing alcohol misuse in Scotland and England currently gives priority to changing the harmful drinking behaviour of individuals.[6] In this respect, young binge drinkers have received considerable attention due to the association between public drunkenness, anti–social behaviour and acute harms.[3, 4] Public health information campaigns such as 'Know your Limits' (England) and 'Don't Push It' (Scotland) endeavour to raise awareness of the dangers of drinking to excess in a single session.[7] The primary strategy employed by policy to control such misuse is the promotion

of informed choice or 'sensible drinking' through education initiatives which it is hoped will alter individual behaviour.[3, 4]

The focus on individual choice and personal responsibility allows government to address the costs and harms associated with alcohol misuse without imposing unpopular restrictions on individual liberty**.** However, as Faden has highlighted, public information strategies of this kind have been criticised for amounting to nothing more than 'token efforts' to deal with politically sensitive issues.[8] Indeed, alcohol policies in the UK that employ information provision as a central component have been widely criticised as a 'recipe for ineffectiveness'.[9]

Changing Drinking Environments: Conventional Public Health

Alcohol harm control policies can also use strategies to manage consumption at a population level.[10] Concerns over the failure of education based alcohol policy in the UK, have led to calls for such alternatives to be introduced.[5, 11] This turn to more conventional public health measures, like price increases and restricted hours of sale, is supported by a greater commitment to the public (common) good and an awareness of the role environment plays in sustaining or jeopardising health. A recent example of this approach is the report by the BMA entitled *Alcohol Misuse: Tackling the UK Epidemic.*[5]

The BMA report surveys rates of alcohol consumption in the UK, identifies the burden alcohol misuse imposes on society and charts effective approaches for managing these costs and harms. The report notes that the UK is one of the largest consumers of alcohol in Europe,[12] and that around 90% of the population drink alcohol;[13] of this group, the majority drink in moderation. But the BMA highlights that alcohol misuse contributes to: significant health harms and increased levels of crime and social disorder. In addition, alcohol misuse undermines road safety, contributes to lost productivity and spurs familial breakdown.[14] In England it has been estimated that the annual social cost of alcohol misuse is around £55.1 billion and in Scotland £1.13 billion.[15]

Despite the costs and harms that alcohol misuse generates, the BMA stresses that there '… is a substantial body of evidence demonstrating that targeted and population-wide alcohol control policies can reduce alcohol-related harm.'[16] The BMA recommends that the current reliance of UK policy on education campaigns should be replaced or supplemented by these proven strategies. More precisely, it calls for the introduction of alcohol policies that: control the availability and price of alcoholic beverages, cultivate responsible retail practices, address drink driving, maintain educational initiatives as part of a wider alcohol strategy, use early intervention and treatment programmes. In addition, the BMA argues that national policies should be based on international cooperation.[17]

Alcohol Dependence in 'Alcohol Misuse: Tackling the UK Epidemic'

The BMA notes that alcohol has addictive properties and binge drinking '… significantly increases the risk of alcohol dependence… '.[18] In its survey of alcohol misuse the BMA reports that between 1.1 million and 2.9 million people in the UK are dependent on alcohol.[19] Dependence is identified as being linked to various health harms including psychiatric impairment, cardiovascular disease and liver disease.[20] The condition is also associated with a wide range of social harms. In this respect, the report quotes a member of the BMA as lamenting that dependence '… destroys individuals and slowly but inevitably pulls the family down on the back of "they like their drink".[21] The BMA emphasise that individuals who have dependency problems can benefit from specialist treatment programmes – if they consent to participate.[22] For this reason it calls for the funding of treatment services to be 'significantly increased'.[23]

Excluding the Alcohol Dependent

Current policy is primarily focussed on providing individuals with information to encourage them to make healthier choices about their drinking. This approach fails to acknowledge or make allowances for the role of impaired agency within alcohol dependence. As a result individuals with

amongst the worst alcohol misuse problems lie largely outside the reach of public policy. However, this paper will contend that the BMA's recent attempt to improve alcohol in the UK also fails to satisfactorily address the issue of alcohol dependence. More specifically, the BMA's 'targeting' of dependence does not accurately represent the condition and its 'population-wide' focus is not extended to incorporate the social challenges that confront those who live with dependence.

Targeting Policy: A Partial Portrayal of Dependence

The BMA use the definition of alcohol dependence employed by the World Health Organisation (WHO) in ICD-10.[24] This account requires the identification of various signs and symptoms for a positive diagnosis of dependence syndrome (See Box 1). [25]

Box 1 The ICD-10 Characteristics of Alcohol Dependence
Diagnosis requires the identification of three of the following within a 12-month period: 1. Strong desire or sense of compulsion to take the substance 2. Difficulties in controlling substance-taking behaviour 3. A physiological withdrawal state 4. Evidence of tolerance 5. Progressive neglect of alternative pleasures or interests 6. Persisting with substance use despite clear evidence of overtly harmful consequences.

In respect of the first criterion, the BMA refers only to 'a strong desire' to take the substance.[26] It does not mention the more extreme compulsion that the

dependent can experience and which is included in ICD-10. However, the BMA does refer to the experience of one of its members who treated a patient so desperate for alcohol that they resorted to drinking nail varnish and hair spray when their alcohol supply dried up.[27] This type of desperate action is all too familiar for those who treat or live with alcohol dependence. It also casts doubt on the decision to present dependence as involving only a 'strong desire' and explains why the WHO insists that a '… central descriptive characteristic of the dependence syndrome is the desire (often strong, sometimes overpowering) to take psychoactive drugs…'.[28]

When explaining why individuals misuse alcohol the BMA suggests that, in the case of dependent drinkers, this relates to the 'need to overcome symptoms of withdrawal' and tolerance (the need to consume more of a substance to achieve the original effect).[29] The BMA omits from its explanation of why people with dependency problems misuse alcohol any reference to impaired control, compulsion, or craving.[30] The BMA's selective use of its chosen diagnostic tool raises concern over how fairly and accurately dependence is represented within its recommendations. This is an important issue because without a clear account of the nature of dependence, neither dependent drinkers nor their close contacts, nor wider society, nor general practitioners can begin to understand how they should respond to the condition.

Incorporating Dependence in Population Focussed Policy

The implicit suggestion within the BMA report that preventing lower levels of alcohol misuse in the population will have a positive impact on levels of dependence is important.[31] This is not least because the BMA recommend measures that have been shown to effectively control alcohol misuse within populations. However, relying on general public health policies to address dependence is insufficient because, in their present form, the recommendations do not take account of the public challenges that confront the dependent and their close contacts. This point can be explained by drawing on the social obstacles that confront treatment initiatives.

The BMA identifies the need to improve treatment for alcohol misuse. But it notes that even when treatment is offered to people with dependency problems '… many may not be willing to accept treatment places…'.[32] The BMA does not explore the reasons for this. However, part of the explanation for why people refuse treatment, or even refuse to admit that they have a problem with alcohol, relates to the negative attitudes and stigma that surround dependency.[33, 34] People living with dependency problems must strive for recovery (often relapsing along the way) within communities and families which often despise them and/or their condition. If dependent drinkers are to be diagnosed and feel able to enter and remain in treatment

programmes then the stigma which surrounds the condition must also be addressed. This requires (re-)incorporating alcohol dependence within public policy and educating the public about the condition. It is important to emphasise that the characteristics of dependence should be understood within the public forum and not only by specialist professional groups.

However, the recommendations the BMA makes about education and alcohol misuse focus primarily on the need to make sensible drinking guidelines clearer to consumers. The report does recommend that the public should be made aware of the '… adverse effects of alcohol misuse…' but makes no reference to dependence.[35] Thus, it is unclear whether the intention is to cultivate an understanding the interrelationship of different forms of alcohol misuse. Unless clarity is provided on this point, it is likely that the addictive qualities of alcohol and the nature of dependence will remain, at best, clouded within public discourse.

Ethics, Dependence and Public Policy

Currently individuals with the worst alcohol problems receive the least attention in current and proposed policy. Evidence supporting alcohol dependence as a 'chronic relapsing brain disease' with genetic, environmental and neurological roots continues to grow.[36] Ethically, this makes it increasingly important to formulate a public response that is able to

appreciate its social nature. Although dependence impacts on a minority of the population it has serious implications for the health and well-being of individuals, families and communities. Indeed, the fact that current and proposed policy address dependence as a treatment issue illustrates that there is agreement on the importance of responding to the condition. However, neither actual nor proposed policy utilises an ethical framework that is able to consistently support the importance of addressing dependence as a public issue. A number of points must be addressed in respect of current and prospective policy in order to offer the dependent and their close contacts greater support.

Choice Focussed Policy and Impaired Agency

The current focus on individual choice is problematic for a number of reasons. Firstly, it fails to attend to the social influences that can positively and negatively influence dependency. Secondly, the promotion of individual choice overlooks that those with alcohol dependence syndrome have, by definition, an impaired capacity to make healthy choices about their drinking. Choice based policy implies that all excessive drinkers are able to choose to stop drinking. This suggestion is too simplistic and likely to further problematise the way dependent drinkers are perceived within society. Despite the impaired agency that characterises dependence, there is a growing consensus that the dependent have responsibilities for their own

drinking.[37] This makes it important for policy to articulate what these responsibilities might be and identify how individuals can be supported to attain them.

Alcohol Dependence as a Public Issue

Alcohol dependence impacts on all members of society whether via direct experience of the condition or the costs and harms it imposes. In addition, the environments that exacerbate an individual's drinking will often serve as cues to relapse after periods of abstinence.[38] The role social factors play in influencing an individual's drinking has led Levy to suggest that society has a responsibility for the drinking of a dependent person.[39] The social responsibilities that exist in respect of dependence must be articulated within policy if they are to become public currency. Without this approach it is likely that the dependent will continue to be dismissed as the local drunk, or as a self-harmer that warrants little public assistance, except treatment when they have 'hit rock bottom'. However, if presentations of dependence as a chronic, relapsing brain disease are correct then it is wholly inadequate and morally reprehensible for policy not to articulate how it intends to address dependency as a public and not just a treatment issue.[40]

Box 2 Ethical Issues: Alcohol Dependence and Policy

- **Individuals with the worst alcohol problems are overlooked.**
- **Informed choice ignores the impaired agency of the dependent.**
- **Preventing dependence should not ignore those currently affected.**
- **Commitment to the common good is missing from public policy.**
- **Social responsibility and not just treatment should be central to efforts to address dependence.**
- **A full and accurate account of dependence is crucial to identifying ethical issues and defeating stigma.**

Addressing Stigma and Shame

Another reason why it is important to generate a public response to alcohol dependence is that, unlike other forms of alcohol misuse, it is thoroughly stigmatised within society. Stigma is well known to undermine public health.[41] In the context of dependence (addiction) Erickson highlights, the 'negative stereotypes… stigma, prejudice, anger, and misunderstanding' that surround addiction have 'killed many people'.[42] This starkly highlights the need for policy to identify and overturn these prejudices by cultivating a greater awareness and understanding dependence (addiction) as one type (or degree) of alcohol misuse. Nussbaum makes the point that Alcoholics Anonymous, which is widely seen as amongst the most successful programmes available to support recovery from alcohol dependence, has at its heart a commitment to avoid shaming its members.[43] Ultimately, public policy should aspire to create societies that are similarly supportive. The failure to incorporate dependence within public policy misses this opportunity to help cultivate such environments. As a result social

marginalisation will continue to harm the recovery chances of the dependent and frustrate clinical endeavours to treat it.

Conclusion

Plans to develop a more conventional public health strategy to address alcohol misuse in the UK will not necessarily incorporate alcohol dependence. This is despite that fact that the proposed measures aim to reduce the level of alcohol consumption within the population as a whole. Part of the problem within the BMA's report is its selective use of the ICD-10 definition. This allows it to side-step the issue of impaired choice and the difficulties it raises for the medical profession and society. It is important that policy in the UK reviews the nature of alcohol dependence and presents a consistent and clear account of the condition which can be used in the public forum to help generate more adequate responses to it.

In addition, despite its excellent ethical work in other areas, the BMA's failure to produce a report that responds to all morally relevant interests - even those that are difficult for its members to address – rests in a failure of ethics. It is significant that the dependent are not sidelined in social policy because the BMA – or current policy - embrace a utilitarian ethic which would allow the

interests this minority group to be disregarded. This is apparent because both current policy and the BMA report highlight the importance of improving treatment for serious drinking problems like dependence. However, neither current policy, nor the BMA report adopts an ethical framework to inform their strategies and help them identify and communicate the ultimate aims of public alcohol policy. Without this ethical support, there is no explicit commitment to adopt measures (social and/or medical) that actively encourage efforts to protect a minority group like the dependent.

The practical and ethical limitations of the BMA report point to the need to conduct an urgent ethical review of the aims, scope and methods of alcohol policy in the UK. Part of this report needs to articulate in a manner fit for public consumption the ethical goals and strategies that inform public policy in respect of treatment and social action. This is necessary for marginalised groups like the alcohol dependent, but also to foster public understanding of coercive public health measures. As the Scottish Parliament's recent rejection of measures to increase the legal age at which citizens can purchase alcohol from off-sale premises shows, coercive public health measures will struggle to find their feet in the age of autonomy.[44]

Summary Points
• **Public alcohol policy gives insufficient attention to alcohol dependence and so further disenfranchises an already vulnerable group.** • **Alcohol dependence must be viewed as a public issue.**

- **The role of compulsion should be clarified and used to foster an understanding of the issues raised by dependence.**
- **An ethical review of the issues associated with the use and control of alcohol is required.**

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