Alcohol policy and the preventive paradox
19th March 2012
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Topics

• What is the problem with alcohol?
  • Epidemiology
  • The preventive paradox

• Policy options
  • Pricing
  • Screening and brief intervention
  • Treatment
Alcohol:
It’s a drug Jim, but not as we know it.
## Alcohol is a toxic and dependence producing DRUG

### Acute effects
- Highly variable
- Pleasure, relaxation
- Impaired judgement, coordination, balance
- Mood effects
- Argumentativeness and aggression
- Drowsiness
- Impaired consciousness
- Coma, respiratory depression and death.

### Chronic effects
- Toxic effects on organs
- Over 60 diseases
- Psychiatric disorders
- Foetal alcohol effects
- Psychoactive effects: alcohol dependence
- 2nd leading cause of disability after tobacco in developed countries
- No universally “safe” level
Chronic liver disease and cirrhosis mortality rates per 100,000 population, 1950-2006
“A large number of people at a small risk may give rise to more cases of disease than the small number who are at high risk”

But

“A measure that brings large benefits to the community offers little to each participating individual”
## Population versus high risk strategy

**Population**

**Benefits**
- Potentially large benefit to society
- Cost effective
- Early intervention prevents harm

**Limitations**
- Benefit to individual small – low motivation of individuals and physicians
- Can challenge vested interests or social norms
- Hence hard to implement

**Targeted at high risk**

**Benefits**
- Benefit for individuals large
- Motivation greater
- More acceptable to society & easier to implement

**Limitations**
- Costly
- ‘Palliative’ rather than preventive
- Less overall benefit to society
- Opportunity cost for whole population
Alcohol misuse in a typical English adult population of 250,000

- Dependent, 2,500
- Harmful, 9,500
- Abstain, 32,500
- Hazardous, 60,500
- Low risk, 145,000

5,500 alcohol related admissions
So the issue is more complex than simply restricting price and availability for the whole population.
Measures targeted at more severe alcohol problems

• Harmful alcohol use and alcohol dependence
• Smaller in number than hazardous
• But
• Disproportionate burden on NHS
  • 66% of alcohol specific admissions by 16% of patients
• Exponential risk functions
• Health inequalities
• Preference for low cost alcohol
  • Alcohol dependent patients
  • 83% < 50p per unit
  • 70% < 40p per unit
45% of alcohol consumption is concentrated in 10% of the population
Figure 5.1: Relative risk for ascitic cirrhosis in groups with different consumption levels. The solid curve is an exponential regression curve, fitted by the maximum likelihood method, while the points are empirically determined. (Data from Pequignot et al. 1978)
Alcohol-related death rate by Scottish Index of Multiple Deprivation, 2005
Impact of minimum price per unit of alcohol on consumption

Change in consumption (%)

minimum price (p)
Evidence-Base for SBI

- **Freemantle 1993** - 6 trials in primary care
  24% drop in consumption (95% CI 18 to 31%)

- **Moyer 2002** – 56 trials, 34 relevant to PHC
  Consistent positive effect, NNT 8-12 (smoking=20)
  Cost savings found at 4 years in the USA

- **Kaner 2007** – 29 trials in PHC & A&E
  Consistent positive effects ~7 drinks less/week
  Evidence strongest for men, less work on women
  No significant benefit of longer versus shorter BI

- **National Institute for Healthcare and Clinical Excellence 2010**
  Public health guidelines recommend implementation
## SIPS in numbers

<table>
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<tr>
<th></th>
<th>Staff trained (n)</th>
<th>Approached (n)</th>
<th>Eligible (n)</th>
<th>Positive (n)</th>
<th>Consent (n)</th>
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<tbody>
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- **ED**
  - Staff trained: 278
  - Approached: 5,992
  - Eligible: 3,737
  - Positive: 1,491
  - Consent: 1,204

- **PHC**
  - Staff trained: 195
  - Approached: 3,562
  - Eligible: 2,991
  - Positive: 900
  - Consent: 756

- **CJS**
  - Staff trained: 227
  - Approached: 967
  - Eligible: 860
  - Positive: 574
  - Consent: 525

- **Totals**
  - Staff trained: 700
  - Approached: 10,521
  - Eligible: 7,588
  - Positive: 2,965
  - Consent: 2,485

Consent rate: 84%
Changes in the proportion of AUDIT positives overall and by intervention at 6 and 12 months.
Alcohol Needs Assessment Research Project (ANARP)

The 2004 national alcohol needs assessment for England
Gap between need and access (PSUR) by region

Prevalence Service Utilisation Ratio

North East
Yorks and Humber
Eastern
South East
East Midlands
West Midlands
South West
London
North West
ENGLAND
Specialist treatment for alcohol dependence

- Effective and cost effective
- But
- Low level of access
- 50% failure to engage
- 75% non-completion
- Assertive outreach more costly but improved engagement
Conclusions

- **MUP potentially large impact**
  - More acceptable than general alcohol duty increase
  - More targeted than general duty increase
  - Open to legal challenge

- **Widespread implementation of SBI**
  - Potentially better targeted
  - Less acceptable and difficult to implement
  - More costly than MUP

- **Increased treatment access/engagement for alcohol dependence**
  - Most targeted
  - More acceptable and easier to implement
  - Most costly