Commentary

Diazepam with your dinner, Sir? The lifestyle drug-substitution strategy: a radical alcohol policy

B.G. CHARLTON

Summary

Over recent decades the drink problem in the British Isles has grown to become arguably the worst in the Western world, combining the high average alcohol intake of southern Europe with binge-drinking typical of extreme latitudes. Since the problem continues to worsen, and traditional strategies regulating price and access are probably untenable, radical new alcohol policies are required. The drug-substitution strategy is based on an assumption that most people use lifestyle drugs rationally for self-medication purposes, to achieve specific desired psychological effects, especially enhanced well-being. When there is access to an equally effective, but safer, alternative drug, then people would tend to switch to it (especially when the substitute is legal and socially-acceptable).

There are several safer lifestyle drug-substitutes for alcohol, including benzodiazepines, SSRIs and marijuana. Southern Europeans use alcohol mainly as an anxiolytic social lubricant, taken in low but frequent doses with high annual per capita consumption, and for this pattern, benzodiazepines might be a medically safer lifestyle drug-substitute. Northern Europeans traditionally use alcohol in high doses as a euphoric intoxicant, and for this pattern, marijuana might be a safer and less-antisocial substitute. Since this risk-benefit calculus implies that there are better alternatives to alcohol, government policy should promote safer lifestyle drug-substitutes by removing legal barriers and altering the balance of economic and social incentives.

Introduction

The drink problem in the British Isles, and especially Ireland, has become arguably the worst in the Western world, and seems to be getting worse.\(^1\)\(^2\) Over the past couple of decades, consumption has grown to combine the high average per capita alcohol intake of the southern European viniculture nations with the binge-drinking habits typical of northern latitudes.\(^3\) Traditional alcohol control policies, such as increasing cost by taxation and reducing access by licensing restrictions,\(^2\) will probably not be possible under modern conditions. A new and radical alcohol strategy is urgently required.

The drug-substitution strategy is based on an assumption that most people use lifestyle drugs rationally, in order to achieve specific psychological effects.\(^4\)\(^6\) Since drinkers are behaving as rational agents, they will prefer to use equally-effective substitutes that are safer, as long as these substitutes are easily available, legal and socially acceptable.

The lifestyle drug-substitution strategy implies that modern governments should alter the balance of economic and social incentives, and encourage people to replace alcohol with safer substitutes.
Rational self-medication

The approximate doubling in average per capita alcohol consumption per year in the British Isles is easily understandable in economic and social terms, since it has accompanied a halving in real price, faster economic growth, and progressive liberalization of licensing laws. Since lifestyle drug usage is sensitive to price, availability and alternatives,\(^1,2,7\) it may be assumed that drug users conform to the usual economic model of being rational agents. This implies that individuals take drugs to obtain benefits, and in the case of alcohol the main benefit sought is a feeling of enhanced well-being. In other words, people drink as a form of self-medication to attain specific psychological states: either alleviating undesired feelings or promoting desired feelings.\(^4\)

However, the socially problematic northern European cultural pattern of binge drinking (large amounts of alcohol per average drinking session), seems to be largely unaffected by price and prohibition since, contrary to common belief, it has turned out that bingeing is not a compensatory response to restrictive licensing laws. More liberal licensing combined with lower real prices has merely allowed people to binge more severely and more frequently than they did before.\(^1,3\) The conclusion is that while per capita consumption is sensitive to price and availability, binge-drinking is apparently related to extreme latitude (presumably, like Seasonal Affective Disorder, having something to do with extreme variations in day length throughout the year).

The aim of a modern alcohol policy should therefore be two-fold: firstly, to reduce the medical harm caused by excessive average per capita volume of alcohol consumption (‘total annual alcohol’), and secondly to reduce the mainly social harms caused by the pattern of binge drinking. While traditionally the total annual alcohol was effectively controlled in by a combination of punitive taxation and ‘partial prohibition’ of access,\(^2\) the fact that these mechanisms have progressively been dismantled implies that there are powerful socio-political and economic trends which prevent these strategies being used in the future.\(^1\)

Lifestyle drug substitution

A new and radical way of reducing both the medical and social harm of alcohol would be substituting equally effective but safer agents.

A variety of alternatives are required to cover the many and various psychological effects of alcohol that are sought by the rational drinker.\(^6\) Southern Europeans use low doses of alcohol at relatively high frequency (i.e. taken throughout the day), such that the drug functions mainly as an anxiolytic social lubricant. Northern Europeans use high-dose alcohol during leisure time as a mood-altering intoxicant, to escape from unpleasant feelings or to release wild euphoria.\(^1,3\) The pattern of binge-drinking is medically harmful, but its main problem is harm to other people: accidents, aggression and violence (including suicide).

The most obvious substitute for alcohol as a ‘southern European’ social lubricant are the anxiolytic benzodiazepines such as diazepam, which induce a subjectively similar muscular relaxation and pleasantly warm glow of well-being.\(^8\) Benzodiazepines cause serious problems for some people,\(^9\) but the fact that they can cause real harm is not the point. The proper consideration is that overall benzodiazepine usage is considerably less harmful than alcohol usage.\(^8\) The most shocking fact concerning these two broadly equivalent lifestyle drugs is that currently it is the more dangerous one which is widely available, while the safer agent is highly restricted and socially-sanctioned.

Another, more medically acceptable, drug substitute for alcohol would perhaps be the selective serotonin-reuptake inhibitors (SSRIs).\(^6\) Over the past couple of decades, SSRIs have largely replaced the benzodiazepines as the prescribed drug-of-choice for the treatment of anxiety disorders, including social phobia.\(^5,7\) When these drugs become available without prescription and over the counter (which will probably happen soon), they might well provide a better self-medication alternative to drinking for ‘Dutch courage’.\(^6\) However, some people find that SSRIs tend to make them feel somewhat emotionally-blunted and diminish subjective well-being,\(^5\) so they may not prove popular lifestyle drugs.

Since hundreds of thousands of people in the UK and Ireland regularly get drunk during their leisure hours, it is clear that a lifestyle drug that induces a state of euphoric release is needed, and alcohol is currently the only legal and available intoxicating agent. Marijuana is probably a safer and less antisocial alternative to high-dose alcohol.\(^7\) There seems to be a broad consensus that marijuana intoxication is less medically harmful than high-dose alcohol bingeing, and (if hippies are any guide) intermittent marijuana usage largely avoids the social problems of aggression and violence typical of drunkenness. It would make sense for governments of Northern European
countries to promote marijuana intoxication as a socially-preferable alternative to binge drinking.

**Implications**

Rational drug policy must avoid applying the traditional intrinsically-biased cost-benefit calculus by which lifestyle drugs are evaluated against ‘no drugs’, with ‘no drugs’ assumed to have no ill effects. Such a ‘drug versus-no-drug’ calculus does not, in practice, exclude established lifestyle drugs such as alcohol and tobacco, because their long-term usage renders them socially acceptable and generates powerful interest groups to defend them. However, new or culturally unfamiliar agents are restricted on the basis that ‘the last thing we need’ is a greater choice of lifestyle drugs.

But if consumers are rational, as suggested by the economic evidence,\(^2,7\) then a choice of lifestyle drugs is a good thing, because rational users will seek the optimal risk-benefit profile. Public policy regarding the legalization and availability of benzodiazepines and marijuana should therefore evaluate the *relative* individual and cultural risks of the alternative agents, and choose ‘the lesser of two evils’.

The crux of the alcohol problem is that a very harmful drug – alcohol – is cheaply and freely available and socially tolerated; while safer alternatives are available only illegally or on prescription. If the drug-substitution strategy were accepted, then policy makers would aim to alter the balance of preference between alternative lifestyle drugs by tilting the scales in favour of the safer substitute. This might be achieved by manipulating price, availability, access, attitudes and by providing information. If artificial barriers of legality and access are removed, then it is likely that changes in social mores will follow, albeit more slowly.

In practice, the substitution strategy amounts to government *actively* promoting safer lifestyle drug alternatives to alcohol: a situation so radical as to seem incredible. Yet if alcohol usage, and especially binge-drinking, continues to rise, and present policies continue to fail, then some such paradigm shift seems inevitable. Eventually, it might become common to hear a waiter offering benzodiazepines instead of a bottle of plonk.

**References**