reducing alcohol harm:

recovery and informed choice for those with alcohol related health problems

BRITISH LIVER TRUST

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The British Liver Trust held a roundtable on harm reduction in September 2011, the discussion at that meeting has fed into the report and we are grateful to all participants.

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Foreword

by Kevin Barron MP

Reducing the harm caused by alcohol is one of the major challenges that we face as a nation.

It is also very high up on the agenda for MPs. We are only too aware of the significant impact that alcohol misuse has on local communities, placing huge pressures on our already overstretched local health and social care, police and criminal justice services.

But behind the headlines of binge drinking and street brawls, lies the devastating human impact of alcohol misuse, which is causing individuals serious, long-term, and often fatal, liver damage. Frighteningly, the numbers of people dying every week through alcohol misuse is the equivalent to a jumbo-jet crashing every 17 days.

Often when we think of alcohol services, we think of people who are severely dependent, for whom healthcare professionals will primarily be aiming to get them to give up on alcohol completely. However, around four times as many people are harmful drinkers than are severely dependent and there is no one-size fits all approach to how individuals should tackle their alcohol problem.

As the evidence in this report highlights, people should be offered tailored support and treatment to help them tackle their problem and this should include creative and innovative approaches. The report rightly talks about giving drinkers the 'self-confidence' to reduce the amount they drink and reduce the harm that alcohol is causing them. The forthcoming alcohol strategy will be an important opportunity to showcase the range of evidence-based interventions.

This is an uncertain time for health services with major reforms underway and a tough economic climate, but what is clear is that local government is going to take centre-stage in tackling alcohol misuse. This report gives MPs and campaigners an important tool to use when talking to the emerging decision makers locally, whether Directors of Public Health, members of Health and Wellbeing Boards, or local councillors to make the case for fully resourced alcohol services.

Tackling alcohol misuse will be one of the major local public health challenges in the reformed NHS and by prioritising alcohol services, local government has an historic opportunity to improve the lives of a great many people and stop preventable deaths across the country.

Executive summary

The challenge of alcohol misuse is reaching epidemic proportions in the United Kingdom; with the average intake of alcohol rising steadily, NHS admissions from alcohol increasing, and the current death toll from alcohol equivalent to a jumbo jet crashing every 17 days.

- The major health impact of alcohol misuse is on the liver, with an unequivocal relationship between alcohol consumption and liver disease. Alcohol accounts for 80% of deaths from liver disease, which is the fifth most common cause of death in the UK.
- National and local policy-makers must make the reduction of alcohol harm a priority, encompassing both patient centred approaches reflecting the needs of individual drinkers, and through to wider public health strategies to tackle the issue at a population level.
- Whilst the British Liver Trust also strongly supports work to tackle the pricing, availability and promotion of alcohol, in this report, our goal is to look at the appropriate individual support and treatments that will help to tackle the major challenge of alcoholic liver disease.
- This report makes the case that alcohol policy and services will be most effective if based on giving patients an informed choice over the range of recommended and appropriate goals that will work best for their recovery pathway.
- At present, alcohol and drugs policy and practice are closely linked with shared funding routes and some co-terminus services and are both underpinned by the philosophy that patients should be supported to complete their individual pathway to recovery from their substance problem.
- The Government's drug strategy 'Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life' recognised that recovery is an 'individual person-centred journey' but there have been concerns about a drive towards a narrow focus on abstinence-orientated recovery models.
- The British Liver Trusts suggests that in the case of alcohol misuse and the prevention of alcoholic liver disease, this approach may run counter to current

80%

Alcohol accounts for 80% of deaths from liver disease

There is overwhelming evidence that through treatment people with alcohol misuse problems can alter even entrenched behaviours.

clinical guidelines for alcohol misuse. This is because there are a range of problem drinkers, from harmful and hazardous drinkers to those with mild, moderate or severe dependence, each of whom will need a tailored approach with the interventions and appropriate treatment goals.

- For some drinkers, such as those who drink at harmful, hazardous levels or are mild dependent, the best option may be to reduce alcohol consumption and for those who are more severely dependent, they may need to follow complete abstention from alcohol.
- There is overwhelming evidence that through treatment people with alcohol misuse problems can alter even entrenched behaviours. Brief interventions and counselling such as Cognitive Behavioural Therapy (CBT) are effective tools for health professionals to help people to achieve their goals, reducing or abstaining from alcohol use.
- The reforms to the NHS, with alcohol services set to become the responsibility of local authorities, present a window of opportunity to reconfigure local alcohol services to ensure that patients are offered a tailored approach that is based on what will work best for them.
- Reducing alcohol harm echoes the Coalition Government's vision of 'No Decision About Me Without Me' in arguing that patient-informed choice needs to be at the heart of alcohol policies so that services offer a range of treatments aimed at goals that reflect each individual's recovery goals. The report makes a number of recommendations for national and local action:
  - **Nationally**, the forthcoming alcohol strategy should outline the importance of recovery approaches for alcohol which encompasses a range of treatment options, including reduced drinking as well as abstinence oriented approaches.
  - **Locally**, we recommend that commissioners should audit services to ensure that they follow NICE guidelines and they should 'invest to save' whilst ensuring that professional expertise remains in alcohol services.
  - **Directors of Public Health** should ensure that funding for alcohol services is prioritised within the overall ring-fenced public health budget and alcohol needs to be high on the agenda of local Health and Well-Being Boards.

Introduction

Alcohol misuse is a major and growing health concern, particularly in relation to liver disease. Alcohol accounts for around 80% of deaths from liver disease[1] which is currently the fifth most common cause of mortality in England.[2] As detailed by the British Medical Association (BMA) and others, the harm to health within the UK from alcohol misuse has now reached epidemic proportions.[3]

In England, many people regularly drink above the recommended level set out by the Department of Health and are therefore increasing their risk of liver disease. Studies have shown that 37% and 20% of men drank more than four and eight units respectively on at least one day in the week. Among women, 29% and 13% drank more than three and six units respectively on at least one day in the week.[4]

Furthermore, during 2009 8,664 people died from alcohol-related causes in the UK and there were 1.1 million alcohol-related hospital admissions in 2009/10.[5]

Recovery and informed choice

National and local policies must make the reduction of alcohol harm a priority, encompassing patient centred approaches reflecting the needs of different types of problem drinkers, through to wider public health strategies to tackle the issue at a population level.

Alcohol harm reduction policies are closely linked with drug policies; drug and alcohol services tend to share addiction staff, premises and funding streams which means that drugs policy has some influence over alcohol policy and practice. Both drugs and alcohol services are underpinned by the concept of 'recovery', which is the process that each patient will go through to enable them to recover from their individual problems with drugs or alcohol in the long term. Each patient's recovery pathway will require a unique approach based on the interventions and treatment goals that are most likely to work for them.

In drugs policy there has been an increased drive towards 'abstinence-oriented recovery models', moving away from some harm reduction interventions, such as substitute prescribing. If this policy is applied to alcohol misuse, it would run counter to current NICE guidelines, clinical evidence, and most importantly 'patient-informed choice'.

Whilst for dependent drinkers, abstinence will usually be the end goal in a recovery pathway; this may differ greatly from the goals that work best for someone who drinks at harmful or hazardous levels. This report makes the case that alcohol policy should not be driven by a focus on specific treatment goals. Rather the key to supporting patients to tackle alcohol misuse and to improve survival rates from alcoholic liver disease is to promote improved lifestyle choice in alcohol services. The evidence outlined in this report demonstrates why alcohol policy will be most effective if it is based on giving patients an informed choice over the range of recommended and appropriate goals that will work best for their recovery pathway.

An unprecedented opportunity

Recent radical changes in the structure of public health services aim to facilitate and empower local authorities to lead on disease prevention and health promotion, while embracing the private sector and voluntary organisations. Directors of Public Health will play a key

8,664

people died from alcohol-related causes

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role in directing public health strategies and implementation, with treatment and prevention of alcohol misuse services being commissioned by local authorities.

A new national body, Public Health England, will co-ordinate health protection nationally and help establish the direction for health improvement initiatives, which Directors of Public Health will implement locally. Simultaneously, public health services need to become more sensitive and accountable to local communities’ needs. So, local Health and Well-Being Boards will draw on the expertise in the voluntary sector, local government, the NHS, other agencies and elected local representatives.

Meanwhile, the coalition government’s plan for the NHS envisages patients, carers and families exerting more influence and choice over services, a concept captured by the rubric: “No decision about me without me.”[6] So, patients, their carers and families should control care, and whenever possible, be able to choose the treatment and services that are most appropriate for their individual circumstances, rather than needing to fit into a ‘one size fits all’ service.

The reorganisation of public health services and the Government focus on ‘patient choice’ offers a ‘window of opportunity’ to reconfigure alcohol services to ensure that patients are offered a range of treatment approaches as part of their recovery pathway. This provides an opportunity to address the severe lack of treatment services to deal with the high level of demand, as highlighted in the ‘Alcohol Needs Assessment Research Project’ (ANARP).[7]

Purpose of this report

Against the backdrop of the NHS reforms and the focus on recovery, the British Liver Trust developed this report to help inform and provide a foundation for Directors of Public Health, Health and Well-Being Boards members and national policy-makers to reduce the harm arising from alcohol misuse.

Whilst the British Liver Trust also supports wider interventions on reducing alcohol harm - on pricing, availability and promotion, the aim of this report is to make recommendations to ensure people with and affected by alcohol related health problems are able to access appropriate support and treatments for their needs. It follows on from our work to develop patient reported outcomes measures for alcohol dependence relating to alcoholic liver disease.

Furthermore, we hope that this report will help to guide the implementation of the Government’s forthcoming Alcohol Strategy, which is expected early in 2012. It is important to note that the expected alcohol strategy has been developed with the alcohol industry. The British Liver Trust, Alcohol Health Alliance and others have concerns that this will affect the credibility and proposed direction of the strategy.

Types of drinking

Harmful drinking
A pattern of psychoactive substance use that is causing damage to health. The damage may be physical (e.g. hepatitis) or mental (e.g. depressive episodes secondary to heavy alcohol intake).[8]

Hazardous drinking
A pattern of drinking that increases the risk of harmful consequences for the user. In contrast to harmful use, hazardous use refers to patters of use that are of public health significance despite the absence of any current disorder in the individual user. The term is used currently by World Health Organisation but is not a diagnostic term in ICD-10[9] (ICD is an International Classification of Diseases endorsed by the World Health Organisation. It is the international standard diagnostic classification for all general epidemiological, many health management purposes and clinical use.)

Dependence
A cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state.[10] There are three levels of dependence: mild, moderate and severe which are measured by the Severity of Alcohol Dependence Questionnaire (SADQ or SAD-Q). The SADQ is a short, self-administered, 20-item questionnaire designed by the World Health Organisation.

The heavy burdens imposed by alcohol misuse

Alcohol misuse imposes heavy burdens on individuals, their families, the NHS and society generally. Numerous reports examine these burdens in detail, including those published by the British Medical Association[11] and, more recently, Alcohol Concern.[12]

This section offers a brief overview of some of the key themes to set the context for the discussion about reducing alcohol harm and recovery.

Liver damage: the clinical hallmark of alcohol misuse

The liver is the organ most commonly damaged by alcohol. Indeed, liver disease causes 80% of the mortality related directly to alcohol and possibly around a quarter of the total attributable mortality. Currently, liver disease is the fifth most common cause of death in England. However, the prevalence is growing and mortality from liver disease could overtake stroke and coronary heart disease as a cause of death within 10 to 20 years.[20]

Alcohol related liver disease (ALD) ranges from hepatic steatosis (fatty liver) to fibrosis (scarring) and cirrhosis. More than 90% of drinkers develop alcoholic steatosis, although this level of damage is usually reversible.

There is unequivocal evidence of a relationship between alcohol consumption and liver disease. For instance, rates of liver cirrhosis rise by 14% in males and by 8% in women for each litre increase in per capita alcohol consumption. Moreover, the increased risk of liver cirrhosis becomes significant at relatively low levels of consumption - above 25g of alcohol per day (equivalent to between two and three glasses of wine). The risk of liver cirrhosis doubles with consumption above 50g alcohol daily and rises approximately fivefold with 100g a day.[21]

Against this background, liver death rates offer a good measure for the success of alcohol policy.[22] Therefore, monitoring rates of liver disease and mortality offers a potential tool by which the effectiveness of alcohol harm reduction strategies and other interventions can be assessed.

Evidence shows that harm reduction, both a reduction of consumption and abstinence, improves the histology and/or survival of patients with any stage of alcoholic liver disease. This report outlines how harm reduction can be prioritised in alcohol policy.[23]

A common killer

According to the World Health Organisation, alcohol kills about 2.5 million people worldwide annually, from a variety of causes including injuries, car accidents, violence, suicide and a plethora of alcohol-related diseases.[13] In the UK, alcohol-related mortality far exceeds that associated with illegal drugs. The Office for National Statistics estimates there were 8,664 alcohol-related deaths in 2009,[14] more than double the 4,023 recorded during 1992.[15] The current death toll from alcohol is equivalent to a passenger filled Jumbo jet crashing every 17 days.[16] By way of comparison, 1,738 people died due to drug misuse in 2008.[17] Furthermore, alcohol consumption either causes directly, or increases the risk of, around 60 diseases and injuries,[18] including heart disease, stroke and certain cancers.[19]

The mid-life drinking crisis

Despite the fact that young people's binge-drinking attracts many headline writers' and politicians' ire, middle-aged men are the most likely to die from alcohol misuse. In 2009, 5,690 males (17.4 per 100,000 population) and 2,974 (8.4 per 100,000) females died from causes wholly alcohol-related in the UK. Rates of alcohol-related deaths peak among men and women aged 55 to 74 years: 41.8 and 20.1 per 100,000 population respectively.[24] Men also accounted for 63% of alcohol-related hospital admissions in 2009/10. Older men and women were more likely to need alcohol-related hospital admissions than younger people.[25] In 2008, 21% of older men reported drinking more than 4 units of alcohol on at least one day a week, and 7% more than 8 units; 10% of older women said they drank more than 3 units of alcohol on at least one day in the week, and 2% of this age group drank at least 6 units.[26]

The impact on society

Alcohol is also responsible for numerous injuries managed by the NHS and crimes dealt with by the police and judicial service. In 2007-08, alcohol contributed to more than a million crimes. For instance, 45% of violent crime victims believed that their attackers had been drinking and 37% of domestic violence cases involve alcohol.[28] Alcohol misuse is also a key factor in child and elder abuse and many victims of alcohol-related violence have themselves been drinking.[29] The NHS in England spends £2.7 billion managing the consequences of alcohol misuse, a figure that economists expect to rise to £3.7 billion.[30] Whilst the Home Office estimates that alcohol misuse costs society up to £25.1 billion per year.[31]

Families of problem drinkers also shoulder a considerable economic burden. For example, marriages troubled by alcohol problems are twice as likely to end in divorce, which can have profound financial consequences. Moreover, alcohol misuse drains the family's economic resources through the cost of alcohol itself, medical and childcare expenses, alcohol-related morbidity and mortality, lost employment opportunities, legal costs and decreased eligibility for loans.[32]

This evidence suggests that reducing harm associated with alcohol misuse can produce economic benefits. Alcohol Concern estimate that investing an extra £217 million improving alcohol services – double the current level – would save the NHS £1.7 billion in England annually.[33]

Table 1: Increased risks of ill health to harmful drinkers[27]

Condition	Men (increased risk)	Women (increased risk)
Hypertension (high blood pressure)	Four times	Double
Stroke	Double	Four times
Coronary heart disease	1.7 times	1.3 times
Pancreatitis	Triple	Double
Liver Disease	13 times	13 times

Harm reduction, recovery and informed choice

As outlined in the previous chapter, alcohol misuse causes significant harm to health, individuals and wider society. There are a range of tools that can be used to tackle the harm caused by alcohol misuse which come under the broad concept of 'harm reduction'.

These harm reduction tools can be targeted at individuals, through screening patients, providing psychological and medical interventions and setting treatment goals aimed at reducing alcohol consumption. In addition, harm reduction at an individual level involves blood borne virus testing, nutritional advice, smoking cessation and general health advice, whereas wider population-level harm reduction strategies focus on crime prevention, tackling alcohol pricing, promotion and availability and implementing public health campaigns.

Individual harm reduction strategies

This report is focused on harm reduction at an individual level, specifically looking at the approaches that will be most effective in helping patients to tackle their problems with alcohol.

Over the years, numerous authors proposed different definitions of harm reduction at an individual level. In the alcohol misuse setting, three objectives underpin harm reduction strategies:[34]

- To reduce the harmful consequences arising from alcohol misuse.
- Incorporating drinking goals – either moderation or abstinence – that are compatible with the individual drinkers' needs.
- To promote access to services by offering alternatives to traditional alcohol prevention and treatment.
- Individual harm reduction and the recovery approach

National and local harm reduction policies are increasingly underpinned by the recovery approach. This 'person-centred' approach to care services entails each patient being seen as being on their own individual pathway to recovery from alcohol misuse. The pathway will be different for each patient involving different goals and objectives and incorporating the harm reduction approaches mentioned above.

Recovery is also at the heart of Government's drugs and alcohol agenda. The Coalition Government is due to publish an alcohol strategy in the coming months and published a drugs strategy in 2010, 'Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life'[35] which focuses primarily on drug misuse but also encompasses alcohol.

The most commonly used definition of recovery comes from a UK Drug Policy Commission consensus report in 2008. This states that: 'the process of recovery from problematic substance use is characterised by voluntarily-sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society.'[36]

The 2010 Drug Strategy states that: "this government will work with people who want to take the necessary steps to tackle their dependency on drugs and alcohol, and will offer a route out of dependence by putting the goal of recovery at the heart of all that we do."[37] The ultimate goal of the strategy is to help people become free from their dependence and also from substitute prescribing (e.g. methadone). Whilst the strategy recognises that substitute prescribing has a role to play in the recovery pathway, it should be the "first step" rather than last.

Recovery and the differences between drugs and alcohol

Alcohol and drugs policies are closely interlinked; their services are often co-terminus sharing the same staff and delivering similar services, particularly for severe alcohol and drug dependence. Additionally, through shared funding streams, drugs policy has some influence over alcohol policy and services.

The emphasis on recovery is a positive development in both alcohol and drugs policy and in practice recovery approaches for both areas share many similarities, including concern with addressing the social causes of dependency problems (such as homelessness and family breakdown) and social integration. Both imply a pathway of voluntarily-sustained control over a substance and can incorporate a range of harm reduction interventions.

However, while the 2010 Drug Strategy says that recovery is an 'individual person-centred journey' and recognises the role of 'medically assisted recovery', there have been concerns in that there has been a tendency towards a narrow focus on abstinence-orientated recovery models, with a loss of recognition of the role of NICE-recommended harm reduction interventions, such as substitute prescribing.

In the field of alcohol, this policy focus on abstinence-orientated recovery models run counter to the NICE guideline on alcohol use disorders. Furthermore, there are a number of important distinctions between drugs and alcohol problems which mean that recovery pathways for alcohol misuse will differ to those for drug misuse. NICE describes alcohol use problems as including hazardous and harmful drinkers and those with mild, moderate and severe alcohol dependence. The treatment goals and interventions for each person will vary significantly. For instance NICE recommends brief interventions for harmful and hazardous drinkers, compared with planned assisted withdrawal for dependent drinkers.[38]

Broadly, evidence suggests that individuals who have been severely dependent on alcohol should aim to abstain from alcohol. Those who have not been severely dependent on alcohol can aim at reduced drinking. Many people who initially chose reduction in a harm reduction programme change their goal to abstinence. By offering a choice of treatment goals, patients are more likely to remain in treatment, without an increased risk of uncontrolled drinking,[40] offering the opportunity to discuss abstinence when appropriate.

> “By offering a choice of treatment goals, patients are more likely to remain in treatment.”

Recovery and patient-informed choice

Ensuring that patients have a choice over the strategies and treatment goals that work best for them will be the key to supporting successful alcohol recovery pathways. In particular, clinicians and policy makers will need to individualise the approach to each person.

A recovery pathway which offers the option of reduced drinking may recruit less severely dependent problem drinkers, who may be disenfranchised from abstinence-focused services aimed at heavy dependent drinkers. In one study, around two-thirds of socially stable problem drinkers with mild to moderate alcohol dependence successfully moved to reducing their level of drinking to a moderate level. Importantly, pre-treatment consumption levels in these investigations were lower than those normally reported in traditional alcoholism studies,[41] highlighting the value of harm reduction in less severely dependent problem drinkers.

Furthermore, as reduced drinking attempts to “meet people where they are” with respect to their motivation to change high-risk behaviour,[42] the approach can reach drinkers who would otherwise “fall through the cracks” or never present for treatment.[43] For example, some of those consuming harmful levels of alcohol (such as young people or those who social life revolves around a drinking culture) may not want to change their drinking behaviour. However, harm reduction can match these individuals at that stage and by, for example, discussing the negative consequences, motivate change from harmful towards safer drinking.[44]

Harm reduction offers a pragmatic and practical solution to the challenge posed by problem drinking. The next section of the report examines the evidence base and clinical guidelines that support the provision of a range of treatment approaches as part of a patient’s recovery pathway.

Evidence for providing a range of alcohol treatment approaches

> **I agree with the statements in the report that heavy drinkers find it far easier to move to moderate drinking than abstinence and are more likely to attend clinics and take advice.**
>
> **Professor Chris Day**

There is overwhelming evidence that suggests that interventions aimed at people with alcohol misuse problems can alter even entrenched behaviours. Indeed, approximately 50% to 60% of alcohol-dependent men and women substantially improve during the year after treatment. Outcomes in the first 12 months generally predict patients' status between 3 and 5 years later and several factors are associated with a relatively good prognosis, including:

- More intense treatment
- Less severe alcohol problems
- Less cognitive impairment
- Fewer co-morbid psychiatric disorders
- Greater self-confidence about the outcome.[45]

The WHO emphasises that alcohol use forms a continuum[46] from life-long abstinence at one end to chronic treatment-resistant severe dependency at the other. Patients can move along this continuum. Therefore, services need to provide a range of alternatives for particular populations and problems[47] as well as for patients at different stages in their pathway towards sobriety. This section summarises the evidence supporting an approach that ensures that patients are able to pursue treatment goals based on what works best for them.

Offering a range of treatment options

A recovery approach should include setting goals of reduced drinking as well as abstinence rather than emphasising the latter alone. This approach does not assume that everyone who misuses alcohol can sustain safe levels of consumption. Rather harm reduction assumes that for appropriate people the goal of moving to moderate (i.e. consuming a safe level of alcohol) drinking is as acceptable, realistic and appropriate as aiming at abstinence.[48] The choice depends on each patient's individual circumstances at that time. (It's important to recognise that alcohol misuse is dynamic. A person who feels that reduced consumption is appropriate at one stage in their life may prefer abstinence at another time or vice versa). As Marlatt and Witkiewitz comment, "harm reduction encourages abstinence, but recognises that an abstinence-goal is not always desirable for individuals making decisions about their drinking behaviour".

Indeed, even heavy drinkers who are resistant to treatment can engage with harm reduction programmes. For these patients, a harm reduction approach may include education about moderate use and medications.[49] Harm reduction can also encompass the management of another pervasive problem: the substitution of one psychoactive drug for another, such as cannabis for alcohol.[50]

Offering patients the choice between moderate drinking and abstinence could engender self-confidence, one factor associated with a good outcome.[51] Indeed, Rosenberg notes that "convincing evidence" suggests that less severe dependence and "a persuasion" that controlled drinking is possible increases the likelihood of success.[52]

> “harm reduction encourages abstinence, but recognises that an abstinence-goal is not always desirable”

Therefore, when assessing whether patients will be able to move to controlled levels of moderate consumption, clinicians need to consider:

- The patient's enduring personal characteristics
- Whether social and psychological characteristics are amenable to change
- Whether precipitating events are transitory or entrenched.[53]

For example, reduced drinking as a treatment goal may be more appropriate for a financially stable and otherwise healthy patient who before the death of a close family member drank moderately for many years and who agrees to grief counselling than for an economically disenfranchised person with liver damage, a long history of heavy drinking and chronic post-traumatic stress disorder.

Ironically, given the factors linked to a good outcome and the value of early intervention, alcohol services have tended to focus more on severely dependent drinkers than on engaging people with mild dependence or harmful drinking, who are more likely to respond to treatment. Around four times as many people are harmful drinkers than are severely dependent. However, harmful drinkers may not view themselves as dependent drinkers and, therefore, do not access traditional alcohol services.[54]

Nevertheless, severely dependent drinkers also benefit from being able to access a range of options and may re-evaluate their goals as treatment progresses. For example, Hodgins *et al* reported that at the initial assessment:

- 46% of people with chronic alcohol dependency chose abstinence
- 44% chose moderate drinking
- 9% were unsure.

After the first four weeks of treatment, two-thirds of the patients chose abstinence. Patients who changed from a goal of reduced drinking to abstinence were older, had more severe alcohol problems, and were more likely to maintain their weekly alcohol consumption goals during the 16-week

treatment. Patients who changed goals also consumed less alcohol during the 12-month follow-up.[55]

NICE guidance on treatment options

NICE guidance for the management of alcohol use disorders clearly states that patients should be offered a range of treatment options. NICE suggest that the "treatment and care" of people who misuse alcohol should consider their "needs and preferences. Patients should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals."[56] Therefore, services should offer treatments with the goal of reduced drinking as well as abstinence.

NICE argues that therapists should agree the goal of treatment with the patient. So, NICE regards abstinence as "the appropriate goal" for most alcohol dependent people and for those who misuse alcohol and have significant psychiatric (e.g. depression) or physical (e.g. alcohol-related liver disease) co-morbidities. However, NICE comments that when a patient prefers reduction, but considerable risks remain, therapists should strongly emphasise that abstinence is the most appropriate outcome. But services should not refuse treatment to users who do not agree to abstinence.[57] As Marlatt and Witkiewitz conclude: "Treatment, regardless of the treatment goal, is preferable to no treatment".[58]

NICE also suggests that for patients who drink harmful amounts of alcohol or who are mildly dependent without co-morbidity, a moderate level of drinking may be an appropriate goal provided:

- The patient can call on adequate social support
- The service user does not prefer abstinence
- There aren't other reasons for advising abstinence.[59]

An approach informed by evidence of what works

Brief interventions are highly effective for people with harmful alcohol use. Indeed, the WHO notes that "substantial evidence" supports screening and brief intervention for alcohol problems in primary health care.[60] For example, a meta-analysis of 22 randomised controlled trials encompassing more than 5,800 patients found that after one-year's follow up, brief intervention reduced patients' alcohol consumption by 38g a week.[61] The WHO Brief Intervention Study Group found that five minutes of simple advice were as effective as 20 minutes of counselling. Brief interventions may also be effective in primary care for cannabis, benzodiazepines, amphetamines, opiates and cocaine,[62] which underscores the approach's validity for dependency issues.

Clinicians and other healthcare professionals who encounter people with drinking problems should offer brief interventions aiming at harm reduction that:

> "Treatment, regardless of the treatment goal, is preferable to no treatment."

- Educate patients about safe levels of consumption
- Emphasise the dangers of heavy drinking
- Suggest ways to reduce or cease alcohol consumption
- Help patients identify and avoid situations in which heavy drinking is most likely to occur. [63]

Against this background, drinkers who want to move towards reduced consumption can use a variety of techniques and strategies, including Cognitive Behavioural Therapies (CBT). CBT typically encompasses elements such as:

- Self-monitoring of drinking behaviour
- Goal setting
- Analysis of drinking behaviour
- Learning to respond differently to situations associated with drinking
- Strategies for modifying drinking behaviour[64]

For example, stimulus-control training helps the person to walk past their favourite bar or attenuate the impact of other drinking 'cues'. Similarly, a person using CBT may modify their drinking behaviour by decreasing the rate and amount they drink, planning how much they will drink during a session in advance, and setting other limits. Goals during CBT could include:

- Defining a maximum number of units consumed a week
- Setting a minimum frequency of abstinent days per week
- Abstinence during high-risk situations (eg when angry, with certain people or before driving)
- A maximum drinking rate (eg no more than one pint per hour)
- Changing the type or strength of alcoholic beverage (eg no doubles).[65]

Against this background, Heather *et al* concluded that moderation-oriented cue exposure (MOCE) is as effective as behavioural self-control training (BSCT) – a type of CBT - in both moderately and more severely dependent people.[66] BSCT typically includes:

- Self-monitoring of drinking and urges to drink
- Setting specific goals
- Controlling the rate of alcohol consumption and learning to refuse a drink
- Agreeing a behavioural contract that includes rewards and consequences for adhering to the goals
- Identifying and managing triggers for excessive drinking
- Functional analysis of drinking behaviour
- Training in relapse prevention.[67]

MOCE assumes that exposure to cues – such as a certain bar or a preferred drink - can elicit conditioned responses that induce craving for alcohol.

Treatment involves systematically exposing patients to cues, such as the sight and smell of their preferred drink, without consuming the beverage. Treatment continues until the craving subsides – so called "extinction".[68] Heather et al concluded that "assuming they prefer it to abstinence and that it is not contra-indicated on other grounds, there seems no reason why patients showing a higher level of dependence …should not be offered a moderation goal".[69]

Another approach, called guided self-change, aims to assist problem drinkers recognize and resolve drinking problems. Fundamentally, the approach uses motivational strategies - such as offering advice, removing barriers to change and decreasing the attractiveness of drinking - to engender self-change by marshalling the patient's personal resources. Guided self-change, CBT and many other strategies are compatible with both abstinence and non-abstinence treatment goals as part of an overarching harm reduction approach.[70]

As these examples illustrate, health professionals have several approaches in their armoury that help people either drink moderately or abstain as appropriate as part of a harm reduction programme.

Public health opportunities for reducing alcohol harm

Government health reforms are set to make alcohol a core local public health priority, with responsibility for alcohol services moving from the NHS to local government. Directors of Public Health, working as the lead health advisors to local authorities, will be charged with using the £5.2 billion ring-fenced public health budget to commission not just public health prevention strategies for alcohol misuse but the full range of treatment and harm reduction alcohol services.

This reconfiguration offers Directors of Public Health an unprecedented opportunity to develop a unified, robust and cohesive alcohol harm-reduction programme that encompasses NHS, public health and social care services, as well as the police and judicial system, the licensing authority and the voluntary sector. Therefore, public health teams should use the perspective offered by local government to assess all local strategies for alcohol misuse and ascertain whether current services meet the population's needs. For example, the Rush Model,[71] which estimates the required capacity of alcohol treatment services, combined with local and national statistics, can identify gaps in, and demand for, alcohol treatment.

This 'needs assessment' will inform public health teams' discussions with, for example, town planning and licensing authorities about the appropriate local density of off- and on-licensed premises. The assessment will also help public health teams ensure that alcohol services are part of general medical services rather than being predominately a specialist service. To facilitate the shift towards the routine assessment of drinking behaviour, public health teams, local specialist services, and primary and secondary care NHS teams will need to collaborate and develop a unified 'care-pathway' as well as efficient and effective local service models for alcohol misuse.

A unified care pathway

The NICE alcohol dependence quality standard and guidelines on alcohol misuse should guide the shape of local care pathways.

- The care pathway should show clearly that healthcare professionals should screen patients opportunistically for hazardous and harmful alcohol consumption in, for example, A&E, gastroenterology and psychiatry departments as well as in primary care. Clinicians should screen people for harmful, hazardous and dependence drinking and offer a clear pathway, including outpatient. In other words, the local care pathway should overtly state:
- When to screen for alcohol disorders and the most appropriate validated instrument in each setting
- When to offer brief intervention and when to move to more intensive treatment, including the role of pharmacotherapy

- On-going monitoring of harmful, hazardous and dependent drinkers, both those who switch to moderate drinking and those managed through abstinence
- The importance of offering harmful, hazardous and dependent drinkers the choice, as appropriate, of moderate drinking or abstinence; however, professionals should always offer treatment even if drinkers do not agree to abstinence when indicated medically
- That goals of treatment should be individualised to the patient, but should be explicitly stated and agreed
- The roles for social workers and voluntary organisations; many people who misuse alcohol also need to contend with complex social problems
- The role of psychiatric services and when to refer patients with psychiatric problems (e.g. if patients are not suicidal, refer after 3-4 weeks of abstinence to determine the extent to which psychiatric symptoms are secondary to the alcohol misuse)

While care pathways should be clear and comprehensive, they also need to be flexible to deal with, for example, changing goals (such as a switch from moderate drinking to abstinence) during treatment. While the care pathway offers the framework for management, the details should be individualised to each patient .

The importance of audit

Regular audit helps the public health team, commissioners and other stakeholders improve alcohol services. For example, commissioners could audit:

- The balance between alcohol services that aim to overcome dependence and those that reduce harm more widely to ensure an appropriate balance that meets the community's needs[72]
- The proportion of hazardous and harmful drinkers that receive a personalised assessment that is repeated regularly and the treatment plan adjusted accordingly[73]
- The number of hazardous and harmful drinkers screened using a validated measure in each setting and the outcome (e.g. brief intervention, referral to other services and so on)
- The proportion of hazardous and harmful drinkers that are referred to specialists after not responding to extended brief intervention or following identification of severe alcohol dependence
- The proportion of hazardous and harmful drinkers that abstained from alcohol or switched to reduced drinking and the outcome (e.g. attained their individual treatment goals)
- The rate of change in 28-day readmissions
- Compliance with NICE guidelines and quality standards for alcohol dependence and harmful alcohol use
- Number of alcohol-related admissions

Consider innovations

- Public health teams should also consider whether integrating technological and other innovations into existing services could help further reduce the harm associated with alcohol. Examples of recent innovations include:
  - Using systemic prompts to remind the primary care team to follow up routinely patients who move to reduced alcohol use or abstinence – such as opportunistically when patients consult for another problem. Friedmann and colleagues suggest that systemic prompts might increase the likelihood of appropriate assessment and intervention.[74]
  - Mobile technologies (such as smart phone and computer applications) can offer daily self-monitoring or near real-time self-assessment of alcohol-related behaviour.[75]
  - Web-based 'low intensity treatments', such as Down Your Drink Kingston (www.dyd.kingston.nhs.uk/), offer an alternative means to engage high risk drinkers.
- While innovations can help, they augment rather than replace 'traditional' alcohol support services, which remain the foundation of treatment.

Recommendations for policy-makers

1

The forthcoming Alcohol Strategy should address the needs of hazardous, harmful and dependent drinkers and outline the importance of a range of treatment options for patients, including reduced or moderate drinking as well as abstinence-orientated interventions.

2

Directors of Public Health should assess the current demand for, and capacity of, alcohol treatment services, and identify gaps. The Joint Strategic Needs Assessment could stratify treatment and recovery populations (eg at risk patients, problem drinkers, severely dependent people). This stratification will improve stakeholder's understanding of differential rates of recovery,[76] thereby aiding planning of future services.

3

Directors of Public Health should use the move to local government to reduce duplication and co-ordinate harm reduction responses from all local stakeholders as well as ensuring that the diverse agencies involved in delivering alcohol services engage with local voluntary groups. Alcohol should be high on the agenda for local Health and Well-Being Boards.

4

Public health and the primary and secondary care NHS teams need to collaborate and develop a unified 'care-pathway' and local service models for hazardous, harmful and dependent drinkers. Commissioners need to ensure that all stakeholders are committed to the pathways and models.

5

Commissioners should ensure that systems are in place to detect and manage alcohol misuse in primary care, A&E, specialist and general hospital settings and other appropriate centres. The system should encompass: screening; brief interventions and referral for specialist services as appropriate; and regular follow-up care and assessment.

6

Commissioners should audit services to ensure that they follow NICE and other appropriate national and local guidelines, meet quality standards, and have outcome measures such as liver mortality in place.

7

Commissioners should "invest to save" and increase funding for alcohol treatment services. Alcohol Concern estimates that investing an extra £217 million in alcohol services – double the current level – would save the NHS £1.7 billion in England annually.[77] Funding for alcohol services should be ring fenced.

8

Currently savings are being made in alcohol services through the cutting of more expensive professional staff such as specialist doctors and psychologists. It is vital that expertise is maintained in alcohol services so that the NHS and voluntary sector can work together to deliver the full range of NICE recommended treatments. Commissioners should purchase services which meet the needs of all people attending for help, which will require the full range of professional expertise.

9

Many hazardous, harmful and dependent drinkers have physical, mental health and social problems that require complex interventions from several different agencies. Therefore, a co-ordinated approach from several stakeholders as well as charities and other voluntary agencies is essential to reduce the risk of recidivism and overall harm to the patient and the local community.

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