▶ Alcohol-use disorders: Preventing the development of hazardous and harmful drinking.

National Institute for Health and Clinical Excellence
National Institute for Health and Clinical Excellence, 2010.

In these UK national prevention guidelines, experts prioritised population-wide changes like price rises and outlet restrictions which affect everyone, independent of the choices they make. But in England government prefers to target what they see as the troublesome minority, not the responsible majority.

SUMMARY The UK Department of Health asked the National Institute for Health and Clinical Excellence (NICE) to produce public health guidance on the prevention and early identification of alcohol-use disorders among adults and adolescents. The guidance is for government, industry and commerce, the NHS and all those whose actions affect the population's attitude to – and use of – alcohol. This includes commissioners, managers and practitioners working in local authorities, education and the wider public, private, voluntary and community sectors.

When writing the recommendations, the Programme Development Group considered evidence of effectiveness (including cost-effectiveness), fieldwork data and comments from stakeholders and experts.

Population versus individual approach

A combination of interventions are needed to reduce alcohol-related harm – to the benefit of society as a whole.

Population-level approaches are important because they can help reduce the aggregate level of alcohol consumed and therefore lower the whole population's risk of alcohol-related harm. They can help:
• those who are not in regular contact with the relevant services;
• those who have been specifically advised to reduce their alcohol intake, by creating an environment that supports lower-risk drinking.

They can also help prevent people from drinking harmful or hazardous amounts in the first place.

Interventions aimed at individuals can help make people aware of the potential risks they are taking (or harm they may be doing) at an early stage. This is important, as they are most likely to change their behaviour if it is tackled early. In addition, an early intervention could prevent extensive damage.

This NICE guidance provides authoritative recommendations, based on a robust analysis of the evidence, which support current government activities. The recommendations could form part of a national framework for action. National-level action to reduce the population's alcohol consumption requires coordinated government policy. It also needs government, industry and key non-governmental organisations to work together.

Policy and practice

This guidance makes the case that alcohol-related harm is a major public health problem. On the basis of the best available evidence, it also identifies the policy options that are most likely to be successful in combating such harm. Policy recommendations (recommendations 1 to 3) are based on extensive and consistent evidence which suggests that the issues identified deserve close attention. This evidence also suggests that policy change is likely to be a more effective – and more cost-effective – way of reducing alcohol-related harm among the population than actions undertaken by local health professionals. Practice recommendations (4 to 12) support, complement – and are reinforced by – these policy options. They include screening and brief interventions.

RECOMMENDATIONS FOR POLICY

The Chief Medical Officer should coordinate the alcohol harm-reduction strategy for England across government, supported by the Department of Health.

The following departments and national agencies should also be involved:
• Advertising Standards Authority;
• Department for Business, Innovation and Skills;
• Department for Children, Schools and Families;
• Department for Culture, Media and Sport;
• Department for Environment, Food and Rural Affairs;
• Department of Communities and Local Government;
• HM Treasury;
• Home Office;
• Ministry of Justice;
• National Treatment Agency;
• Ofcom;
• Office of Fair Trading.

Organisations that should be consulted include:
• advertisers;
• alcohol producers;
• national non-governmental organisations (for example, Alcohol Concern and the Royal Medical Colleges);
• off- and on-sale retailers.

Recommendation 1: price

Making alcohol less affordable is the most effective way of reducing alcohol-related harm. The current excise duty varies for different alcoholic products (for historical reasons and under EU legislation). This means that the duty does not always relate directly to the amount of alcohol in the product. In addition, an increase in the duty levied does not necessarily translate into a price increase as retailers or producers may absorb the cost. There is extensive international and national evidence (within the published literature and from economic analyses) to justify reviewing policies on pricing to reduce the affordability of alcohol.

What action could be taken?

Consider introducing a minimum price per unit. Set the level by taking into account the health and social costs of alcohol-related harm and its impact on alcohol consumption. Consider initiating a review of the excise duty regime with fellow EU member states. The aim would be to obtain a pan-EU agreement on harmonisation which links alcohol duty to the strength of each product.

Regularly review the minimum price per unit and alcohol duties to ensure alcohol does not become more affordable over time.

Recommendation 2: availability

International evidence suggests that making it less easy to buy alcohol, by reducing the number of outlets selling it in a given area and the days and hours when it can be sold, is another effective way of reducing alcohol-related harm. In Scotland, protection of the public's health is among the objectives of licensing decisions.

What action could be taken?

Consider revising legislation on licensing to ensure:
- protection of the public's health is one of its objectives;
- health bodies are responsible authorities;
- licensing departments can take into account the links between the availability of alcohol and alcohol-related harm when considering a licence application (that is, they can take into account the number of alcohol outlets in a given area and times when it is on sale and the potential links to local crime and disorder and alcohol-related illnesses and deaths);
- immediate sanctions can be imposed on any premises in breach of their licence, following review proceedings.

Consider reducing personal import allowances to support the introduction of a minimum price per unit of alcohol.

Recommendation 3: marketing

There is evidence that alcohol advertising does affect children and young people. It shows that exposure to alcohol advertising is associated with the onset of drinking among young people and increased consumption among those who already drink. All of the evidence suggests that children and young people should be protected as much as is possible by strengthening the current regulations.

What action could be taken?

Ensure children and young people's exposure to alcohol advertising is as low as possible by considering a review of the current advertising codes. This review would ensure:
- the limits set by the Advertising Standards Authority for the proportion of the audience under age 18 are appropriate;
- where alcohol advertising is permitted there is adequate protection for children and young people;
- all alcohol marketing, particularly when it involves new media (for example, web-based channels and mobile phones) and product placement, is covered by a stringent regulatory system which includes ongoing monitoring of practice.

Ofcom, the Advertising Standards Authority and the government should keep the current regulatory structure under review.

Assess the potential costs and benefits of a complete alcohol advertising ban to protect children and young people from exposure to alcohol marketing.

RECOMMENDATIONS FOR PRACTICE

Recommendation 4: licensing

Who is the target population?

Alcohol licence-holders and designated supervisors of licensed premises.

Who should take action?

- Local authorities;
- Trading standards officers;
- The police;
- Magistrates;
- Revenue and customs.

What action should they take?

Use local crime and related trauma data to map the extent of alcohol-related problems before developing or reviewing a licensing policy. If an area is 'saturated' with licensed premises and the evidence suggests that additional premises may affect the licensing objectives, adopt a 'cumulative impact' policy. If necessary, limit the number of new licensed premises in a given area.

Ensure sufficient resources are available to prevent under-age sales, sales to people who are intoxicated, proxy sales (that is, illegal purchases for someone who is under-age or intoxicated), non-compliance with any other alcohol licence condition and illegal imports of alcohol.

Work in partnership with the appropriate authorities to identify and take action against premises that regularly sell alcohol to people who are under-age, intoxicated or making illegal purchases for others.

Undertake test purchases (using 'mystery' shoppers) to ensure compliance with the law on under-age sales. Test purchases should also be used to identify and take action against premises where sales are made to people who are intoxicated or to those illegally purchasing alcohol for others.

Ensure sanctions are fully applied to businesses that break the law on under-age sales, sales to those who are intoxicated and proxy purchases. This includes fixed penalty and closure notices (the latter should be applied to establishments that persistently sell alcohol to children and young people).

Recommendation 5: resources for screening and brief interventions

Who is the target population?

Professionals who have contact with those aged 16 and over.

Who should take action?

- Chief executives of NHS and local authorities;
- Commissioners of NHS healthcare services;
- Commissioners from multi-agency joint commissioning groups;
- Managers of NHS-commissioned services.

What action should they take?

Chief executives of NHS and local authorities should prioritise alcohol-use disorder prevention as an 'invest to save' measure.

Commissioners should ensure a local joint alcohol needs assessment is carried out in accordance with World class commissioning and Signs for improvement. They should also ensure locally defined integrated care pathways for alcohol treatment are reviewed.

Commissioners should ensure their plans include screening and brief interventions for people at risk of an alcohol-related problem – hazardous drinkers – and those whose health is being damaged by alcohol – harmful drinkers. This includes people from disadvantaged groups.

Commissioners should make provision for the likely increase in the number of referrals to services providing tier two, three and four structured alcohol treatments as a result of screening. These services should be properly resourced to support the stepped care approach recommended in Models of care for alcohol misusers.

Commissioners should ensure at least one in seven dependent drinkers can get treatment locally, in line with Signs for improvement.

Commissioners should include formal evaluation within the commissioning framework so that alcohol interventions and treatment are routinely evaluated and followed up. The aim is to ensure adherence to evidence-based practice and to ensure interventions are cost effective.

Managers of NHS-commissioned services must ensure an appropriately trained nurse or medical consultant, with dedicated time, is available to provide strategic direction, governance structures and clinical supervision to alcohol specialist nurses and care givers.

Managers of NHS-commissioned services must ensure community and voluntary sector providers have an appropriately trained professional who can provide strategic direction, governance structures and supervision to those providing screening and brief interventions.

Managers of NHS-commissioned services must ensure staff have enough time and resources to carry out screening and brief intervention work effectively. Staff should have access to recognised, evidence-based packs. These should include: a short guide on how to deliver a brief intervention, a validated screening questionnaire, a visual presentation (to compare the person's drinking levels with the average), practical advice on how to reduce alcohol consumption, a self-help leaflet and possibly a poster for display in waiting rooms.

Managers of NHS-commissioned services must ensure staff are trained to provide alcohol screening and structured brief advice. If there is local demand, staff should also be trained to deliver extended brief interventions.

Recommendation 6: supporting children and young people aged 10 to 15 years

Who is the target population?

Children and young people aged 10 to 15 years who are thought to be at risk from their use of alcohol.

Who should take action?

Any professional with a safeguarding responsibility for children and young people and who regularly comes into contact with this age group.

What action should they take?

Use professional judgement to routinely assess the ability of these children and young people to consent to alcohol-related interventions and treatment. Some will require parental or carer involvement.

Obtain a detailed history of their alcohol use (for example, using the Common Assessment Framework as a guide). Include background factors such as family problems and instances of child abuse or under-achievement at school.

Use professional judgement to decide on the appropriate course of action. In some cases, it may be sufficient to empathise and give an opinion about the significance of their drinking and other related issues that may arise. In other cases, more intensive counselling and support may be needed.

If there is a reason to believe that there is a significant risk of alcohol-related harm, consider referral to child and adolescent mental health services, social care or to young people's alcohol services for treatment, as appropriate and available.

Ensure discussions are sensitive to the child or young person's age and their ability to understand what is involved, their emotional maturity, culture, faith and beliefs. The discussions (and tools used) should also take into account their particular needs (health and social) and be appropriate to the setting.

Recommendation 7: screening young people aged 16 and 17 years

Who is the target population?

Young people aged 16 and 17 years who are thought to be at risk from their use of alcohol.

Who should take action?

Health and social care, criminal justice and community and voluntary professionals in both NHS and non-NHS settings who regularly come into contact with this group.

What action should they take?

Complete a validated alcohol screening questionnaire with these young people. Alternatively, if they are judged to be competent enough, ask them to fill one in themselves. In most cases, AUDIT should be used. If time is limited, use an abbreviated version (such as AUDIT-C, AUDIT-PC, CRAFFT, SASQ or FAST). Screening tools should be appropriate to the setting. For instance, in an emergency department, FAST or the Paddington Alcohol Test (PAT) would be most appropriate.

Focus on key groups that may be at an increased risk of alcohol-related harm. This includes those:
- who have had an accident or a minor injury;
- who regularly attend genito-urinary medicine (GUM) clinics or repeatedly seek emergency contraception;
- involved in crime or other antisocial behaviour;
- who truant on a regular basis;
- at risk of self-harm;
- who are looked after;
- involved with child safeguarding agencies.

When broaching the subject of alcohol and screening, ensure discussions are sensitive to the young person's age and their ability to understand what is involved, their emotional maturity, culture, faith and beliefs. The discussions should also take into account their particular needs (health and social) and be appropriate to the setting.

Routinely assess the young person's ability to consent to alcohol-related interventions and treatment. If there is doubt, encourage them to consider involving their parents in any alcohol counselling they receive.

Recommendation 8: extended brief interventions with young people aged 16 and 17 years

Who is the target population?

Young people aged 16 and 17 years who have been identified via screening as drinking hazardously or harmfully.

Who should take action?

Health and social care, criminal justice and community and voluntary sector professionals in both NHS and non-NHS settings who regularly come into contact with this group.

What action should they take?

Ask the young person's permission to arrange an extended brief intervention for them.

Appropriately trained staff should offer the young person an extended brief intervention.

Provide information on local specialist addiction services to those who do not respond well to discussion but who want further help. Refer them to these services if this is what they want. Referral must be made to services that deal with young people.

Give those who are actively seeking treatment for an alcohol problem a physical and mental assessment and offer, or refer them for, appropriate treatment and care.

Recommendation 9: screening adults

Who is the target population?

Adults.

Who should take action?

Health and social care, criminal justice and community and voluntary sector professionals in both NHS and non-NHS settings who regularly come into contact with people who may be at risk of harm from the amount of alcohol they drink.

What action should they take?

NHS professionals should routinely carry out alcohol screening as an integral part of practice. For instance, discussions should take place during new patient registrations, when screening for other conditions and when managing chronic disease or carrying out a medicine review. These discussions should also take place when promoting sexual health, when seeing someone for an antenatal appointment and when treating minor injuries.

Where screening everyone is not feasible or practicable, NHS professionals should focus on groups that may be at an increased risk of harm from alcohol and those with an alcohol-related condition. This includes people:
- with relevant physical conditions (such as hypertension and gastrointestinal or liver disorders);
- with relevant mental health problems (such as anxiety, depression or other mood disorders);
- who have been assaulted;
- at risk of self-harm;
- who regularly experience accidents or minor traumas;
- who regularly attend GUM clinics or repeatedly seek emergency contraception.

Non-NHS professionals should focus on groups that may be at an increased risk of harm from alcohol and people who have alcohol-related problems. For example, this could include those:
- at risk of self-harm;
- involved in crime or other antisocial behaviour;
- who have been assaulted;
- at risk of domestic abuse;
- whose children are involved with child safeguarding agencies;
- with drug problems.

When broaching the subject of alcohol and screening, ensure the discussions are sensitive to people's culture and faith and tailored to their needs.

Complete a validated alcohol questionnaire with the adults being screened. Alternatively, if they are competent enough, ask them to fill one in themselves. Use AUDIT to decide whether to offer them a brief intervention (and, if so, what type) or whether to make a referral. If time is limited, use an abbreviated version (such as AUDIT-C, AUDIT-PC, SASQ or FAST). Screening tools should be appropriate to the setting. For instance, in an emergency department FAST or PAT would be most appropriate.

Do not offer simple brief advice to anyone who may be dependent on alcohol. Instead, refer them for specialist treatment (see recommendation 12). If someone is reluctant to accept a referral, offer an extended brief intervention (see recommendation 11).

Use professional judgement as to whether to revise the AUDIT scores downwards when screening:
- women, including those who are, or are planning to become, pregnant;
- younger people (under the age of 18);
- people aged 65 and over;
- people from some black and minority ethnic groups.

If in doubt, consult relevant specialists. Work on the basis that offering an intervention is less likely to cause harm than failing to act where there are concerns.

Consult relevant specialists when it is not appropriate to use an English language-based screening questionnaire, for example, when dealing with people whose first language is not English or who have a learning disability.

Biochemical measures including of blood alcohol concentration should not be used as a matter of routine to screen someone to see if they are drinking hazardously or harmfully. Biochemical measures may be used to assess the severity and progress of an established alcohol-related problem, or as part of a hospital assessment, including assessments carried out in emergency departments.

Recommendation 10: brief advice for adults

Who is the target population?

Adults who have been identified via screening as drinking a hazardous or harmful amount of alcohol and who are attending NHS or NHS-commissioned services or services offered by other public institutions.

Who should take action?

Professionals who have received the necessary training and work in:
• primary healthcare;
• emergency departments;
• other healthcare services (hospital wards, outpatient departments, occupational health, sexual health, needle and syringe exchange programmes, pharmacies, dental surgeries, antenatal clinics and those commissioned from the voluntary, community and private sectors);
• the criminal justice system;
• social services;
• higher education;
• other public services.

What action should they take?

Offer a session of structured brief advice on alcohol. If this cannot be offered immediately, offer an appointment as soon as possible thereafter.

Use a recognised, evidence-based resource that is based on FRAMES principles. It should take 5–15 minutes and should:
• cover the potential harm caused by their level of drinking and reasons for changing the behaviour, including the health and wellbeing benefits;
• cover the barriers to change;
• outline practical strategies to help reduce alcohol consumption, to address the 'menu' component of the FRAMES model;
• lead to a set of goals.

Where there is an ongoing relationship with the patient or client, routinely monitor their progress in reducing their alcohol consumption to a low-risk level. Where required, offer an additional session of structured brief advice. or, if there has been no response, offer an extended brief intervention.

Recommendation 11: extended brief interventions for adults

Who is the target population?

Adults who have not responded to structured brief advice. on alcohol and require an extended brief intervention or would benefit from this for other reasons.

Who should take action?

NHS and other professionals in the public, private, community and voluntary sectors who are in contact with adults and have received training in extended brief intervention techniques.

What action should they take?

Offer an extended brief intervention to help people address their alcohol use. This could take the form of motivational interviewing or motivational-enhancement therapy. Sessions should last from 20 to 30 minutes. They should aim to help people to reduce the amount they drink to low risk levels, reduce risk-taking behaviour as a result of drinking, or to consider abstinence.

Follow up and assess people who have received an extended brief intervention. Where necessary, offer up to four additional sessions or referral to a specialist alcohol treatment service (see recommendation 12).

Recommendation 12: referral

Who is the target population?

Those aged 16 years and over who attend NHS or other public services and may be alcohol-dependent. (For those under 16 see recommendation 6.)

Who should take action?

NHS and other professionals in the public, private, community and voluntary sectors who have contact with anyone aged 16 and over.

What action should they take?

Consider making a referral for specialist treatment if one or more of the following has occurred. They:
• show signs of moderate or severe alcohol dependence;
• have failed to benefit from structured brief advice and an extended brief intervention and wish to receive further help for an alcohol problem;
• show signs of severe alcohol-related impairment or have a related co-morbid condition (for example, liver disease or alcohol-related mental health problems).

An update on the evidence behind the report was published in March 2014. None of the new findings were considered to possibly requires changes to the original guidance. Among these, new studies on alcohol pricing were considered to strengthen the original recommendations and in particular the call for a minimum unit price. Similarly considered strengthened were calls for controls on availability and in particular restricting the concentration of alcohol outlets and controlling marketing. Evidence from the SIPS studies in England on primary care screening and brief interventions was considered unlikely to have an impact on the original recommendations.

FINDINGS COMMENTARY The expert group responsible for the featured report were all in a position to be well aware of the dangers of drinking and/or involved in initiatives to curtail these, and their remit was to recommend ways to cut the risks. There were no alcohol industry representatives or 'ordinary' members of the (overwhelmingly) drinking public. The report which emerged focused almost entirely on dangers; the only benefit acknowledged was a possible reduction in the risk of some cardiovascular diseases among certain sections of the population; overall, the verdict was that "drinking alcohol is never without risk".

Most eggs in pricing and availability baskets

When it came to how to reduce the risks, their report firmly prioritised national policy initiatives to tighten the alcohol availability environment in ways which affect the entire population, independent of each individual's choices. Most importantly of all, alcohol would become less affordable (by setting a minimum price per unit of alcohol), but it would also become less available in other ways (by reducing the number of outlets and times they can sell) and less visible and visibly acceptable (through the implementation of stringent controls on marketing, particularly of the kind which might influence young people).

Such actions are thought "likely to be a more effective – and more cost-effective – way of reducing alcohol-related harm among the

population than actions undertaken by local health professionals". The expected impact was to cut average consumption across the nation and with it the population's risk of alcohol-related harm. Benefits will it was thought be experienced across the board. Even dependent drinkers are expected to cut back and/or become fewer. This will happen because the average level of drinking across a population is linked to the extent of excessive drinking. As the former recedes, so too will the latter, cutting the tally of people with severe alcohol-related problems. This new environment is expected to be more conducive to individual-level interventions, helping tip the balance towards moderation in the way individuals respond to advice to cut back, brief interventions, and treatment.

These lines of argument are plausible and backed by considerable evidence, though little which directly tests the underlying assumptions. More below.

In the British context, the reliability of the links between average consumption and the prevalence of excessive drinking and harm seem challenged by experience from 1990 to 2010, when a drop in average consumption was paired with a rise in heavy episodic drinking. Rather than the two varying together, it has been argued that there was a "polarisation of the distribution of consumption ... heavy drinkers drink even higher volumes whilst moderate drinkers appear to have decreased their average intake". In turn it was argued, this partly explains why the expected co-variation of average consumption and harm failed to materialise. Instead there was a "continuing increase in alcohol related morbidity and mortality, despite a recent downturn in population level consumption".

While this calls in to question the presumed impact of availability restrictions on excessive drinking, it by no means invalidates it. What caused recent per capita drinking reductions is unclear, but it was certainly not explicit policies to cut availability. It could be that a reduction caused by such policies *would* reduce excessive drinking and related harm. This was the conclusion of research led by the author responsible for the questioning observations referred to above, though largely on the basis of studies which related harm to each individual's intake, rather than the average across a society. Also, health gains among moderate drinkers of the kind associated with slightly lowering consumption (such as a gradual cumulative impact on chronic diseases) take years or decades to become apparent, while some associated with fewer heavy drinkers (such as reduced accidents and injuries) are immediate or more rapid. Given these time scales, it could be that the recent reduction in average consumption in Britain really will be associated with the expected improvement in health across the population.

Support for the report's priorities comes from two recent reviews. One judged there was strong evidence that raising alcohol taxes reduced both excessive alcohol consumption and related harms, though it relied primarily on North American studies; even within Europe, a given consumption change has impacts which differ greatly across nations. Another gap in the analysis was that it was unable to explicitly account for the potential impact of drinkers switching to other beverages. The second review focused on tax and price impacts on health. It found a weak but statistically significant link between higher prices and taxes and better health, mortality and other health and social improvements, which was probably due to higher prices curbing consumption. However, all but one study fell short of assessing the impact on all deaths from whatever cause; the others may have missed some impacts positive or negative. The exception which did assess overall mortality found this weakly related to US state alcohol taxes, such that higher taxes were associated with fewer deaths, but the link was not strong enough to eliminate the possibility that it was due to chance rather than to a real causal effect.

Screening: not universal but still important

Mass screening in GPs' surgeries, accident and emergency departments, hospitals and elsewhere was recently seen as a feasible and effective way to reduce the public health burden of drinking which exceeds national 'safe drinking' guidelines. Now the ambition in England and Scotland has been scaled back to screening new patients and/or those thought possibly at risk, diluting the hoped-for public health benefits of a mass programme. This change is reflected in the featured report, which without being entirely explicit, encourages screening to take place only in circumstances where both patient and doctor might feel it was 'natural' and justified to ask about a patient's drinking. The evidence appendix cautions that, "Clinical consultations for non-alcohol-related medical problems can be an inappropriate time to discuss alcohol use, given that users are focused on the condition for which they are seeking advice", and recognises the greater acceptability of discussing drinking "in a context that is related to the purpose of the visit (such as lifestyle assessment or chronic condition monitoring)". Quality standards developed by NICE and based partly on the featured report are however explicit that the expectation is that staff will screen "opportunistically", meaning as the opportunity presents itself, which is in turn expected to be in certain types of medical encounters but not others.

Even in this less ambitious form, screening remains important. Diligently implementing it in the recommended circumstances and for the recommended patients (which include new patient registrations and medicine reviews) could cumulate over the years to a high-coverage programme, and minor gains per individual can sum to appreciable public health gains.

Whether this will happen depends on how widely screening and brief interventions are implemented and how effective they are. On both counts the SIPS studies in England give little reassurance. A report has been published on the primary care findings and informal reports were made available on the study's emergency department and probation trials. NICE's update report considered these findings unlikely to have an impact on the original recommendations, but this itself seems unlikely.

In all the SIPS studies it seems that a year later the proportion of risky drinkers had fallen by about a sixth, and whatever the intervention, it made no substantial difference. Most basic was a simple warning that the patient or offender was drinking "above safe levels, which may be harmful to you" plus advice to read the alcohol information and advice booklet handed to the client. Supplementing this with an individualised brief intervention based on relatively sophisticated counselling techniques and scientific understandings made no difference, seemingly undermining the featured report's specification that brief interventions should use a recognised, evidence-based resource based on FRAMES principles. In SIPS too, even among what should have been the most promising settings, numbers screened also seem to have been small and achieving them often required specialist support, a finding which might shake confidence in the possibilities for such initiatives to affect population-wide health without their being backed by persuasive carrots and/or sticks to encourage widespread and effective implementation.

One in seven?

NICE's report follows its predecessors in stipulating that provision be made for at least one in seven dependent drinkers to be treated in each local area. This Findings analysis reveals that this proportion is based on assumptions and findings of questionable relevance to the UK, and that depending on how you define treatment need, treatment services in England may be capturing numbers equivalent to an abysmal 7% of harmful drinkers ranging up to a creditable 40% or more of those also at least moderately dependent. The conclusion is that while we may suspect that in 2012/13 capturing 110,000 of England's problem drinkers in treatment was not enough, there is no clear way to determine whether this was the case.

Policy plusses and minuses

For more see these hot topics on pricing policy, on controlling alcohol-related disorder including licensing law and allied developments, and on brief interventions.

In 2011 the UK government's Home Office hedged its bets on the key tactic recommended in the featured report – an across-the-board and appreciable price rise – judging that "on balance" the evidence "suggests" that increasing the price of alcohol "may" reduce alcohol-related harms. It also pointed out that there were other influences on consumption and harm which operate at the level of the individual or of drinking cultures and environments rather than national taxation and availability restrictions.

So far it is these more restricted levers which the UK government prefers to rely on most, applying them to what is perceived as particularly troublesome drinkers/drinking patterns (especially young 'binge' drinkers), while avoiding population-wide measures of the kind advocated by NICE and other public health and alcohol experts. The following year, the 2012 alcohol strategy's commitment to a minimum per unit price for England was abandoned on the grounds that it might penalise responsible drinkers. However, the Scottish government is pressing ahead with legislation which may yet be derailed by arguments that minimum pricing contravenes UK devolution and/or European Union free trade laws. Despite this being introduced seemingly successfully in Scotland, elsewhere in the UK it was a similar story with respect to the now abandoned proposal to ban off-licence promotions offering discounts contingent on

buying several drinks at once.

Outside Scotland, the major pricing initiative is a 'below-cost' price ban to be implemented subject to parliamentary approval by April 2014. It will affect very few promotions and is intended to target 'problem' drinkers, on whom it is projected to have little impact. Additionally, Public Health Responsibility Deal agreements with the alcohol industry loosely commit them to implement guidelines on issues such as under-age sales, responsible marketing, and labelling.

Some of what the featured report wanted on licensing law has been implemented, but not in England and Wales making health impact a relevant issue in licensing decisions, seen as a key change by campaigners for more health-oriented alcohol policies. In Scotland prevention of health harm has for several years been among the objectives which must be considered while making licensing decisions. However, in what may prove a step in this direction, as called by the featured report, from 2012 licensing authorities in England and Wales have themselves been 'responsible authorities' under licensing law, meaning they can initiate action for example to oppose new licences or review an existing licence.

For the great majority of drinkers in England and Wales, little will change as a result of these initiatives and nor will their drinking change, unless they choose to make these changes in response to other influences.

Action on brief interventions in England includes an expectation that Directors of Public Health will include these among attempts to address the population-wide determinants of ill health. As yet no decision has been made to incorporate alcohol screening and brief intervention in to the national quality framework for primary care, a major national practice driver. However, screening remains among the practices commissioners must offer to incentivize through cash rewards. From April 2013 this work was also incorporated in the NHS Health Check for older adults.

Scottish national policy is more prescriptive, prioritising screening and brief intervention, backed by a health service target for 2008/09–2010/11 to deliver 149,449 brief interventions supported by dedicated funding. The target was exceeded and has been extended to later years. An evaluation found that "healthcare staff saw the delivery of [alcohol brief interventions] as a worthwhile activity for NHS staff", but of the three settings, only primary care practices really accepted the challenge. Even there it seems most risky drinkers were not screened and the quality of the work was unclear; emergency departments and ante-natal clinics accounted for few patients.

Related guidance

Other related NICE guidance documents are listed below.

Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence Assessment of what evaluation research means for alcohol dependence treatment in Britain, featuring reviews of the literature on the topics it covers.

Alcohol use disorders: diagnosis and clinical management of alcohol-related physical complications Clinical guidelines on the medical care of people suffering acute alcohol withdrawal or alcohol-related lack of thiamine, liver disease, or inflammation of the pancreas.

Services for the identification and treatment of hazardous drinking, harmful drinking and alcohol dependence in children, young people and adults Guidance for commissioners on how to organise and procure alcohol treatment and brief intervention services in an area which implement related national clinical guidance and satisfy policy requirements.

Alcohol dependence and harmful alcohol use quality standard Concise statement of 13 practices which constitute high quality health care for problem drinkers and good practice in identifying and advising hazardous drinkers. The standards may be used to assess and reward providers and health service commissioning authorities.

Thanks for their comments on the original entry to Iain MacAllister of the Health Analytical Services Division of the Scottish Government and Eileen Kaner of the Institute of Health and Society at Newcastle University who chaired the expert group behind the report. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

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Achieving positive change in the drinking culture of Wales STUDY 2011
Identifying cost-effective interventions to reduce the burden of harm associated with alcohol misuse in Australia REVIEW 2008
Supporting partnerships to reduce alcohol harm: key findings, recommendations and case studies from the Alcohol Harm Reduction National Support Team ABSTRACT 2011
Alcohol screening and brief intervention in primary health care STUDY 2012
Alcohol screening and brief intervention in emergency departments STUDY 2012
Effectiveness of screening and brief alcohol intervention in primary care (SIPS trial): pragmatic cluster randomised controlled trial STUDY 2013
Alcohol dependence and harmful alcohol use quality standard DOCUMENT 2011
Independent review of the effects of alcohol pricing and promotion STUDY 2008
Cost-of-alcohol studies as a research programme DOCUMENT 2012