▶ Alcohol treatment in England 2012–13.

Public Health England.
Public Health England, 2013.

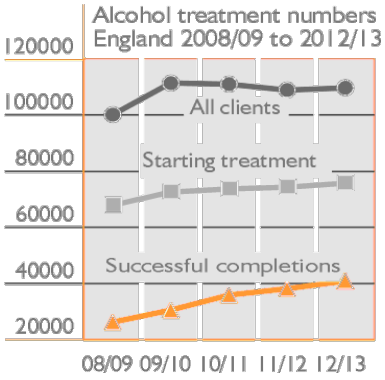
In England nearly 110,000 patients were in specialist alcohol treatment in 2012/13 and over a third left as planned free of dependence. These numbers probably mean most dependent drinkers who could benefit from treatment do without it, perhaps partly because so few find their way to treatment via their GPs and other medical services.

Summary The featured report presents and comments on data from the National Drug Treatment Monitoring System on people who have received specialist treatment for alcohol problems in England between 1 April 2012 and 31 March 2013. This account draws on the data source as well as the featured report.

Main findings

Headline findings were that, compared to last year, slightly more people were in treatment during the year (up from 108,906 to 109,683), including slightly more who started or returned to treatment (up from 74,353 to 75,773). Also, more patients successfully completed treatment, up from 38,174 to 40,908. These numbers should be set in the context of estimates that 1.6 million people in England may have some degree of alcohol dependence, of whom 250,000 are moderately or severely dependent.

Though the total numbers treated at some time in a year have fluctuated, new presentations have increased each year since figures were collected, from 67,912 in 2008/09 to 75,773. Successful completions too have risen steadily from 26,270 in 2008/09 to 40,908 ▶ chart. These now represent a record 58% of all treatment leavers in a year, up steadily since bottoming at 48% in 2009/10. In contrast, the proportion of patients who 'dropped out' of treatment has fallen to 26% of all those leaving, the lowest figure yet recorded, down from a peak of 33% in 2009/10; some may have left because they had got all they wanted from treatment. Waiting times too have steadily improved; in 2008/09, 78% of patients waited fewer than three weeks to start their treatment, in 2012/13, 89%.



In 2012/13, 71% of all people in alcohol treatment were aged 30 to 54 and nearly two-thirds (64%) were men. Those who entered treatment that year came via a number of routes. At 40%, self-referral was most common. Next at 18% was referral from primary care surgeries (involving 13,541 patients), to be expected given that around one in five people seeing a GP drinks above lower-risk levels. Referrals from hospital accident and emergency departments accounted for 1% of all treatment entrants, 1066 patients. It should be remembered that some people recorded as self-referrals would have been encouraged to seek treatment by health professionals.

On 1 November 2012 how treatment types were recorded changed. Before this change, the great majority of all treatment journeys between April and the end of October 2012 involved some form of psychosocial support, either formal therapies like cognitive-behavioural therapy, motivational enhancement therapy and 12-step facilitation therapy, or inputs such as keyworking, care management and brief packages of counselling. Formal psychosocial therapy was the sole recorded intervention in 38% of cases, the largest proportion. About 10% of treatment journeys involved prescribed medications to help patients detoxify or prevent relapse. Over the whole year, 10,400 patients – 9% of all those in treatment that year – were admitted for inpatient alcohol treatment, and 4134 patients (4%) were in residential rehabilitation.

Of the 70,194 people who during 2012/13 left treatment and were still out of treatment at the end of the year, 58% did so because they had successfully completed treatment, having been judged free of dependence and no longer in need of specialist or structured treatment, though they may be receiving some form of support. These successes represent 37% of all patients in treatment at some time during the year; 58% of successful completers were not drinking at all when they left treatment.

The authors' conclusions

Although data for 2012/13 show that the alcohol treatment system is continuing to function well for those who access services, more needs to be done. Along with other bodies, local authorities now have responsibility for commissioning alcohol services to meet identified need in their areas. It is vital in tackling effects of drinking on health and crime that alcohol treatment is easily accessible, that the full range of effective NICE-recommended treatment options is available, and that treatment services are properly joined up with the NHS and other partners, including mutual aid groups.

In terms of the challenges we face in addressing England's alcohol problems, the data in this report presents only a small part of the picture. The health problems and costs associated with alcohol misuse are rising year on year, and there needs to be an increased focus on preventative measures to catch people before their problems escalate to the point where they need treatment.

FINDINGS The main concern of the report seems to be that while those receiving treatment are doing reasonably well and progressively better, there are too few of them. On the face of it this seems a valid and serious concern, but depending on the criteria, England's performance in ensuring needy drinkers enter treatment can look anywhere from abysmal to excellent.

Based on a 2007 survey, the roughly 110,000 adults in specialist alcohol treatment during 2012/13 amounts to about 7% of all 1.6 million drinkers experiencing harm from their drinking. NICE, Britain's official health advisory body, narrowed this down further to the approximately 1 million adults who also score as at least mildly dependent on alcohol. On this basis, numbers in treatment represent about 10% of the drinkers who might need this help. Based on a Canadian model, in 2009 the UK Department of Health estimated that provision should be made for 15% of dependent drinkers to access specialist treatment, a figure accepted by NICE. However, the model was not based on an assessment of the proportion of all dependent drinkers who might profit from treatment, but largely on the relapse rate (defined as a return to drinking) after treatment.

Not only is the 15% figure questionable, but also the estimate of numbers dependent; by design, the questionnaire used to assess this was not based on clinical criteria. Putting that serious concern to one side, its results can nevertheless be used to narrow down further to the numbers who perhaps really ought to be in treatment. NICE has calculated that 260,000 adults are at least moderately dependent, suggesting that numbers in treatment represent over 40% of the 'really' in-need population.

The upshot is that the treatment capture rate can range from the equivalent of just 7% of harmful drinkers to a creditable 40% or more of those also at least moderately dependent. The lower figure can be justified as the percentage of all those who *might* need help, the higher

as perhaps closer to those who really *do* need treatment to overcome their dependence. The higher figure gains support from US findings that three quarters of dependent drinkers remit without treatment and just 10% most clearly need and most often access this kind of help – the heaviest and most consistent drinkers with multiple psychological problems and on average about nine years of dependence behind them.

NICE also appears to draw the line nearer to (and perhaps even above) the moderate dependence level, which would imply that England has the capacity to treat 40% or more of the in-need population.

Another reason why unmet need is not necessarily so huge as it appears is that structured specialist treatment is not the totality of support available to problem or even dependent drinkers.

So while we may suspect that capturing 110,000 of the UK's problem drinkers in treatment is not enough, there is no clear way to determine whether and the degree to which this is the case. Good waiting time figures have (in respect of drug addiction treatment) been used as an indicator that treatment supply is keeping up with demand. Good waiting times for alcohol treatment may mean the same, but perhaps only because need is not reflected in demand because dependent drinkers are divorced from routes to treatment – much as a hungry population may not result in demand for bread if they cannot find their ways to the bakers which supply it, or do not care to eat the bread they bake.

That this is at least partly the case for England was suggested more strongly by the corresponding report for the previous year. It expressed concern at how few people had successfully been referred to specialist treatment by GPs or accident and emergency departments, despite the fact that around one in five people seeing a GP is drinking at risky levels, and an estimated 35% of emergency attendances are alcohol-related: "An aim for the coming years is that these two key routes will become more active in identifying and referring people who need treatment for harmful drinking and alcohol dependency". If there was cause for concern then, there is even more cause now. Referrals from GPs fell from 14,330 to 13,541; accident and emergency department numbers increased from 872 to 1066, still a small proportion of the potential. Down from 15,202 the previous year, in 2012/13 these two sources accounted for 14,607 treatment starts – a movement in the wrong direction, suggesting that screening and intervention rates and/or quality in these two prime settings for identifying dependent drinkers have in England yet to reach adequate levels.

A sister report offers a similar analysis of treatment for problems with drugs other than alcohol in England in 2012/13.

Thanks for their comments on this entry to Alex Fleming of Public Health England. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

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