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DRUG & ALCOHOL FINDINGS **Druglink page for January/February 2014**

HOW MANY DRINKERS SHOULD BE IN TREATMENT?

Depending on the criteria, Britain's performance in ensuring needy drinkers enter treatment can look anywhere from an abysmal 7% to an excellent 40%. Does where you draw the line depend on how you want to portray Britain's performance?

Depending on the criteria, Britain's performance in ensuring needy drinkers enter treatment can look anywhere from abysmal to excellent. Let's start with how many *are* in treatment. The handiest figures are for England, where about 110,000 adults were in specialist alcohol treatment during 2012/13. Based on a 2007 survey, this amounts to about 7% of all 1.6 million drinkers experiencing harm from their drinking. We can narrow 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 not very relevant 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, Britain's official authority on health interventions. 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% 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 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.

Now we have a range from treatment capturing numbers equivalent to an abysmal 7% of harmful drinkers, up 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. That 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. 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 can't find their ways to the bakers or don't like the bread they bake.

That this is at least partly the case for England was suggested more strongly by the report on alcohol treatment for England in 2011/12. 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.

Where would you draw the treatment need line? Harmful drinking, at least mildly dependent, moderately dependent, or severely dependent? Does it depend (to return to the introduction to this article) on whether you *want* to portray Britain's treatment access performance as abysmal or as excellent, perhaps depending in turn on whether you wish to argue for more resources or contain expenditure? Is severity of drinking/dependence the right way to draw the line? How about the duration of heavy drinking, whether the patient wants treatment, or how many patients we want to *afford* to treat?

This article is based on cell E2, one of 25 cells in the Alcohol Treatment Matrix constructed by Drug and Alcohol Findings for the Substance Misuse Skills Consortium. This and the corresponding Drug Treatment Matrix map treatment sectors and influences which might affect impact, and for each sub-territory (a cell) list the most important UK-relevant research, reviews and guidance.