

INVITED  
COMMENTARY

# Reasons to be cheerful?

## INVITED COMMENTARY ON ... THE FUTURE OF SPECIALISED ALCOHOL TREATMENT SERVICES<sup>†</sup>

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<sup>†</sup>See pp. 253–259, this issue.

### SUMMARY

Alcohol policy varies in different jurisdictions and is subject to change. Understanding policy development requires an international perspective. Current models of alcohol treatment systems require an understanding of the different impacts of interventions on different patient groups and clarity in the description of interventions and populations. Several systematic reviews have evaluated the outcome of alcohol treatment favourably and shown it to be highly cost-effective.

### DECLARATION OF INTEREST

P.R. is Vice-Chair of Alcohol Focus Scotland (a national alcohol charity), a board member of Tayside Council on Alcohol (a voluntary-sector support agency) and an executive committee member of Scottish Health Action on Alcohol Problems.

### Treatment effectiveness

Rao & Luty's article repeats many of the points made by Dr Luty in his contribution to the recent debate in the *British Journal of Psychiatry* (Luty/Carnwath 2008). Carnwath's summary of the extent to which treatment effectiveness in this area has been subject to systematic review, and of the clear consistent conclusions reached, should be read as an adjunct to this piece. The selective use of evidence from individual trials is grist to the mill for 'a knock-about debate' (the journal Editor's description of the Carnwath/Luty discussion: Tyrer 2008) but is not the best way to summarise a complex evidence base for a general audience.

Rao & Luty cite Tucker & Roth's review as showing weakness in the evidence base (Tucker 2006). On the contrary, it states: 'The field has a number of efficacious treatments of varying intensity and duration that produce benefits for many treatment-seeking clients across a range of problem severity'. At the risk of labouring Carnwath's key point, if several interventions show a similar effectiveness, this does not mean the interventions don't work. These studies are conducted without 'no-intervention' groups because ethical committees take the view that the question of 'Is something better than nothing?' has been answered and are reluctant to approve such a study design.

Tucker & Roth's main theme is the need to look beyond efficacy findings, dominated by randomised controlled trials, to effectiveness studies that look at treatment access, treatment adherence and how acceptable the interventions are to people, among other real-life practice issues. One method that attempts to assess effectiveness is the health technology assessment (Gabbay 2006).

The 2003 health technology assessment *Prevention of Relapse in Alcohol Dependence*, undertaken by the Health Technology Board for Scotland (Slattery 2003) and updated in 2005, was one of the contributions to a conclusion that 'there is a substantial evidence base which underpins clinical practice and there is broad agreement on the future direction of treatment services' (Raistrick 2005). Part of this evidence base is on cost-effectiveness. Rao & Luty's own summary of the UK cost-effectiveness

P. G. Wodehouse said that it is seldom difficult to distinguish a Scotsman with a grievance from a ray of sunshine. However, the bleak future predicted for specialised alcohol treatment services in England by Rao & Luty (2009, this issue) and the pessimistic view of the prospects for an effective prevention policy in the UK contrast with the view from north of the Tweed.

The media areas of the websites of Scottish Health Action on Alcohol Problems ([www.shaap.org.uk](http://www.shaap.org.uk)), Alcohol Focus Scotland ([www.alcohol-focus-scotland.org.uk](http://www.alcohol-focus-scotland.org.uk)) and the Information Services Division of the National Health Service (NHS) Scotland ([www.alcoholinformation.isdscotland.org](http://www.alcoholinformation.isdscotland.org)) reflect a picture of increasing public recognition of alcohol-related harm and a wish to hear from the medical profession, including psychiatrists, on ideas for tackling the issue. We have also seen a willingness from the Scottish Government to implement prevention initiatives and invest in services guided by the findings of systematic reviews (Scottish Intercollegiate Guidelines Network 2003; Slattery 2003). These recent positive developments follow a long period of neglect, but show that things can change. Alcohol policies differ between governments (Crombie 2007) and it is important to distinguish between the constituent parts of the UK and Ireland.

data for alcohol treatment is inconsistent with their statement that economic analyses 'are uncommon and notoriously poor'.

The assumption that secondary prevention (the detection of high-risk individuals or early pathology) threatens specialised services is depressing to see in print. Targeted screening, identification and early intervention are good medical practice. We would expect treatment specialists in cardiovascular disease, diabetes and breast cancer to support these prevention services and they do. It would be perverse to do anything other than support a stepped-care approach based on outcome evidence. However, such an approach relies on clarity in describing types of intervention, an issue that has been recognised for some years now (Heather 1995.) For instance, there is an important difference between brief opportunistic interventions of the type that might be achieved by a general practitioner skillfully delivering advice in primary care, and brief treatment that would be delivered by a specialised practitioner. A four-session motivational interviewing programme is an example of the latter, not the former. Brief does not always mean simple.

*Models of Care for Alcohol Misuse* (MoCAM), produced by England's National Treatment Agency for Substance Abuse (2006), makes clear the need for specialised interventions. The evidence base for the in-patient elements of this has moved on considerably from the early studies of the 1970s and '80s with unselected populations (Rychtarik 2000). A stepped-care structure means that people coming into residential, including in-patient, treatment have not responded well to less-intensive interventions. This selection is a crucial element in achieving health gain from residential treatment (Moos 2000).

In Scotland, NHS boards have been directed that the new investment in alcohol services of £100 million between 2008 and 2011 (£20 for every resident of the country) should comply with the guidance of the Scottish health technology assessment (Slattery 2003) and the Scottish Intercollegiate Guidelines Network's (2003) review on the management of harmful drinking and alcohol dependence in primary care. We should welcome this example of government policy following the research evidence base.

## Prevention

With regard to prevention, Rao & Luty also take a bleak view. They note that the *Alcohol Harm Reduction Strategy for England* (not applying to the whole of the UK, please note) published by the Prime Minister's Strategy Unit in 2004 was

unenthusiastic about the strategies recognised by the World Health Organization as being of greatest effectiveness in preventing alcohol-related harm. These include action on alcohol pricing, availability (including hours of opening), number of outlets, legal purchase age and lower drink-driving limits.

However, 5 years is a long time in politics. Over the past 18 months, there have been important developments. November 2007 saw the chief executives of the UK's major supermarkets summoned to Downing Street. They were informed by the Prime Minister Gordon Brown of his concern about their alcohol pricing policies and about his willingness to act if they do not change their practices. In March 2008 the UK government committed to raise alcohol excise duties by 2% above the rate of inflation for the next 4 years. In June 2008, the Scottish Government consulted on proposals to introduce a minimum retail price for alcohol, end discounts for multiple purchase, limit alcohol displays in supermarkets, introduce an age limit of 21 for off-sales purchase and requested the UK government to lower the drink-drive limit to 50 mg/dl (Scottish Government 2008).

## Conclusions

In treating alcohol problems there has been a worldwide movement towards a rational stepped-care model. This follows the developing knowledge of the effectiveness of different styles and intensity of interventions for different levels of severity. For instance, we now probably know more about who benefits from in-patient treatment versus community treatment in alcohol misuse than in any other area of psychiatry.

The politics of the prevention and treatment of alcohol misuse are important. Political direction changes at a different pace and for different reasons than scientific opinion. The medical profession, including psychiatrists, can influence things. However, selective and partial policy and effectiveness reviews, coloured by a sense of helplessness (even if it is learnt from long experience), aren't the way to do it.

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## POEM

# 'Death' by Elizabeth Jennings

Selected by Femi Oyeboade

### Elizabeth Jennings (1926–2001)

was born in Boston, Lincolnshire to a medical family. Her father was the Chief Medical Officer. She read English at St Anne's College, Oxford, and later worked as a librarian at Oxford City Library. She was awarded a Commander of the Order of the British Empire (CBE) in 1992. She had a psychiatric hospital admission in the early 1960s and is reported to have attempted suicide. Two volumes of poetry describe her experience of being in a mental hospital, *Recoveries* (1964) and *The Mind has Mountains* (1966). 'Death' is reproduced from *Elizabeth Jennings: New Collected Poems* (ed. M. Schmidt), published by Carcanet. © 2002 Estate of Elizabeth Jennings.

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They did not speak of death  
 But went round and round the subject deviously.  
 They were out of breath  
 With keeping it at bay. When would they see  
 That they were burdened with  
 Dying like other men?  
 Immediate mourners know the whole of grief  
 When they've seen the dying in pain  
 And the gradual move toward the end of life.  
 O death comes again and again  
 And starts with the crying child and the  
 doctor's knife.