

## EDITORIAL

‘For Debate’

### NICE but Needy: English Guidance on Managing Alcohol Dependence is not Backed up by Government Alcohol Policy

Laura Williamson\*

Institute for Applied Health Research, Glasgow Caledonian University, Buchanan House (306), Cowcaddens Road, Glasgow G4 0BA, UK

\*Corresponding author: E-mail: laura.williamson@gcu.ac.uk

#### THE NICE GUIDANCE

The English National Institute for Health and Clinical Excellence (NICE) published a clinical guideline in the year 2011 on alcohol-use disorders to improve treatment in England, Wales and Northern Ireland for alcohol dependence and harmful use (NICE, 2011). Clinical guidance on these topics already exists in Scotland (*Scottish Intercollegiate Guidelines Network*, 2003). The NICE guidance has been developed by the National Collaborating Centre for Mental Health (NCCMH) for use in primary, secondary, community and social care. It is the third part of a series of NICE publications on managing the harms associated with alcohol misuse. The other documents in the series are a public health guideline on alcohol problems (NICE, 2010), and clinical guidance on managing alcohol-use disorders which concentrates on alcohol-related problems seen in the acute general hospital (*National Clinical Guidelines Centre*, 2010).

Like other NICE guidelines, the guidance begins by outlining two main ‘principles of care’ on which its clinical recommendations are based. The first is ‘building a trusting relationship and providing information’ (2011, p. 14). This includes the importance of respecting the dignity and privacy of patients and acknowledging ‘... that stigma and discrimination is often associated with alcohol misuse and that minimising the problem may be part of the service user’s presentation’ for treatment (2011, p. 14). The second principle, ‘working with and supporting families and carers’, encourages families to be involved in treatment, providing them with information and identifying and meeting their needs (2011, p. 14). In the latter principle, NICE reflects a consensus among those working in the field of addiction that social and environmental factors influence drinking and recovery (Edwards and Gross, 1976; Leshner, 1997; Volkow and Li, 2005).

The evidence base reported in the full NICE guideline by the NCCMH illustrates further the importance attached to the social dimensions of dependence. It states, for example, that all degrees of alcohol misuse can ‘... stem from a range of environmental and social factors’ (NCCMH 2011, p. 78); this includes the affordability of alcohol, high levels of alcohol consumption in the population and cultural attitudes surrounding alcohol (NCCMH, 2011, p. 25). The document notes that negative life events can lead to alcohol problems, but also provide the impetus for individuals, including those who are dependent on alcohol, to stop drinking—though positive life events also support recovery (NCCMH, 2011, p. 78). The full guideline states that obstacles to treatment

include ‘... internal and external stigma ...’ and ‘... an apprehension towards discussing alcohol-related issues with healthcare professionals ...’ (NCCMH, 2011, p. 79). Factors that can help facilitate treatment and recovery are identified as including supportive social networks (NCCMH, 2011, p. 79); those with less social stability and contacts not associated with alcohol do not fare as well in recovery as individuals with such support (NCCMH, 2011, p. 26f). This emphasizes, in part, why the family and friends of those with dependency problems ‘require information and support from healthcare professionals’ (NCCMH, 2011, p. 80).

The NICE guidance is likely to have a positive influence on the treatment of alcohol dependence. The guidance will help to target the limited funding that is available for alcohol treatment, but it is likely that it will still encounter considerable financial constraints. Treatment for alcohol problems continues to fare poorly in the funding stakes compared, for example, to illegal drug use (Prime Minister’s Strategy Unit, 2004; Department of Health, National Audit Office, 2008, p. 7). Yet evidence of the cost effectiveness of alcohol treatment supports efforts to improve its provision (UKATT, 2005; Raistrick *et al.*, 2006). The success of the guidance will also be impeded by the reluctance of many living with alcohol dependence to enter treatment (Drummond *et al.*, 2005; NICE, 2011). This is partly due, as NICE acknowledges, to the social stigma that surrounds the condition (Turning Point, 2003; WHO, 2004; NICE, 2011; Schomerus *et al.*, 2011a). In addition, the efforts of NICE to improve the therapeutic support available for alcohol dependence may be compromised if the guidance is not supported adequately by public policy. Indeed, the failure of policy to attend to the particular challenges associated with the alcohol dependence may hamper efforts to improve treatment. It will be argued here that policy risks increasing the stigma that surrounds dependence and eroding the trust needed to encourage dependent drinkers to seek treatment.

#### ALCOHOL POLICY: AN OBSTACLE TO A NICE RESPONSE TO DEPENDENCE?

##### *Implicit stigmatization*

Since at least 1995 when the Inter-Departmental Working Group on Sensible Drinking published its report, policy in the UK has promoted ‘sensible’ or ‘responsible’ drinking and condemned ‘irresponsible’ consumption (Department of Health, 1995). In 2004, the *Alcohol Harm Reduction Strategy for England* identified information provision as the

first of its key aims (Prime Minister's Strategy Unit, 2004, 17). In his Foreword to the Strategy then Prime Minister, Tony Blair, stated that individuals are expected to make '... informed and responsible decisions about their own levels of alcohol consumption' (Prime Minister's Strategy Unit, 2004, p. 3). A key aim of the strategy was to secure 'long term change in attitudes to irresponsible drinking' (2004, p. 5); the document focuses on what it terms 'chronic' and 'binge' drinking (2004, 4f).

Similarly, *Safe. Sensible. Social: The Next Steps in the National Alcohol Strategy* refers to 'responsible' and 'irresponsible' consumption and identified one of its aims in controlling misuse as the provision of '... new kinds of information and advice' for harmful drinkers and their close contacts (Department of Health, 2007, p. 59). Dependent drinkers were among those targeted by this information. The report suggested that the dependent are worth targeting with information on sensible drinking because many are able to reduce the amount they drink without treatment (2007, p. 59). Indeed, some individuals with dependence problems have been identified as controlling their drinking without treatment (Heather and Robertson, 1997, 65f); and more public information on alcohol dependence is required. However, the report made no allowance for those who do experience difficulty controlling their drinking. Most recently, the coalition government has declared its intention to adopt a '... social marketing emphasis on creating positive peer pressure towards responsible drinking' (Responsibility Deal Working Group, 2010, p. 5).

The 'education and persuasion' measures that urge 'responsible' drinking in England (and elsewhere) have been heavily criticized for their ineffectiveness in securing a change in drinking behaviour (Babor *et al.*, 2003; BMA, 2008; WHO, 2007). But such initiatives are believed to affect attitudes and knowledge (Anderson and Baumberg, 2006, 252f). Thus, the strategy could impact on dependent drinkers even though it is not targeted at this group. As the Inter-Departmental Working Group on Sensible Drinking, for example, note, its recommendations are not 'framed particularly to influence treatment of problem drinkers or indeed their recognition' (Department of Health, 1995, p. 23). But the prominence of 'responsible' drinking initiatives and the relative lack of specific information on alcohol dependence may promote in the public consciousness the notion that all heavy drinkers, even the alcohol-dependent, are simply 'irresponsible' if they do not respond to education campaigns. This is because policy has tended not to acknowledge or flag-up in the public forum the 'difficulties in controlling substance-taking' or the 'strong desire or sense of compulsion' that ICD-10 identifies as characterizing alcohol dependence (WHO, 1992); or the social determiners that influence the development of the condition. Those who do not drink 'sensibly' are, therefore, portrayed as being blameworthy for their continued drinking and, as a result of this, risk being stigmatized.

In 2004, the Alcohol Needs Assessment Research Project found that only 5.6% of dependent drinkers in England accessed treatment (Drummond *et al.*, 2005). Any additional obstacle to dependent drinkers entering treatment is undesirable. The implication that dependent drinkers are simply 'irresponsible' risks acting as such a barrier and of exacerbating the communal and familial tensions often associated

with the condition. It is also unlikely to help (re-)build the stable social networks that NICE suggests are important in recovery. Indeed, this implicit stigmatization of dependence risks working against the main principles of care presented by the NICE guideline; namely, the need to build trusting, respectful relationships that minimize stigma and to support families to understand dependence and become involved in treatment.

The 'sensible' or moderate drinking message is a feature of alcohol control policies in many countries (Babor *et al.*, 2003, p. 190; Anderson and Baumberg, 2006, 252f). The *Alcohol Reform Bill* in New Zealand, for example, aims to 'support a safe and responsible drinking culture' (New Zealand Government, 2010, p. 1). Similarly, Canada's National Alcohol Strategy Working Group recommends the need to cultivate a 'culture of moderation' and the provision of information on the importance of 'drinking sensibly' (National Alcohol Strategy Working Group, 2007, p. 7). Interestingly, its recommendations acknowledge that for some 'the concept of drinking sensibly means not drinking at all' (2007, p. 7); despite which it still considers it suitable to refer to the harms associated with drinking 'irresponsibly' and to do so without any investigation of the nature of responsibility or dependence (2007, p. 23).

It is important to acknowledge that the 'sensible' drinking message can be presented in a manner that is less problematic for the alcohol dependent. In this respect, the use of terms such as 'excessive' and 'low-risk' consumption (WHO 2006; CDC, 2011) carry less negative moral overtones for the alcohol dependent than 'responsible', 'sensible' and 'irresponsible'. This is also the case with the term 'harmful' drinking which features in English and international policy (Prime Ministers Strategy Unit, 2004; WHO, 2006). However, there is still a risk of the dependent being implicitly stigmatized by policy if its relevance for their condition is not made explicit. Furthermore, the highly financed 'responsible' drinking campaigns of the alcohol industry pose by far the greatest risk of stigmatizing the dependent. This is because these 'high quality, pro-drinking messages' (WHO, 2007) are internationally ubiquitous, intended to promote alcohol products, normalize drinking and place the blame for excess drinking on the individual drinker, rather than acknowledging the multi-factorial influences on all forms of alcohol misuse.

### *Explicit stigmatization*

In 2010, the Westminster coalition government published its new Drug Strategy. This government declares that its strategy represents 'an entirely new ambition to reduce drug use and dependence' and to 'increase the numbers recovering from their dependence'—including severe alcohol dependence (HM Government, 2010, 3f). Previous alcohol strategies had considered alcohol dependence together with other forms of alcohol misuse; now alcohol and drug dependence are considered together. It appears from this development that the particular challenges associated with dependence (e.g. impaired control) will receive more focused and, therefore, improved attention and treatment. However, the Drug Strategy enforces 'sanctions' on benefit claimants who are dependent on alcohol (and drugs) if they do not engage with treatment services (HM Government, 2010, p. 23).

The implications of this policy sit uncomfortably with the NICE recommendations. The NICE guidance emphasizes the importance of ‘supportive, empathic and non-judgemental’ treatment provision that provides patients with ‘privacy and dignity’ (NICE, 2011). The introduction of coerced treatment (for some) in England raises concerns over how the treatment environment envisaged by NICE can be attained when policy makers perceive that a satisfactory approach is to press-gang dependent drinkers into treatment. This concern is heightened by comments made by the Prime Minister, David Cameron, in connection with the recent publication of data by the Department for Work and Pensions. This revealed that, as of August 2010, 42,360 people with what it termed ‘alcoholism’ were being paid incapacity benefit. Of this number, 13,080 had been receiving benefits for between 5 and 10 years and 12,880 for more than 10 years (Department for Work and Pensions, 2011). Employment minister, Chris Grayling, stated that dependent drinkers should not be left on benefits but helped to ‘turn their lives around’ (Mulholland, 2011). However, speaking on the BBC the Prime Minister asserted:

a lot of people who pay their taxes and work hard will think ‘that’s not what I pay my taxes for, I pay my taxes for people who are incapacitated through no fault of their own’. (Cameron, 2011)

The implication of this is that the alcohol dependent are blameworthy for their condition. This claim moves the stigmatization of the alcohol dependent in English policy debates from being implicit and perhaps unintentional, to explicit.

Another issue raised by withdrawing benefits from dependent drinkers who refuse treatment is whether sufficient, quality, timely treatment is available to meet the need created by the policy. In this respect, when the Labour government planned to introduce a similar policy Martin Plant commented (O’Dowd, 2009):

There is a shortage of treatment services in England and Wales and in Scotland for people with drinking problems. To penalise people for not using services that do not exist would be a very unwise thing to do.

Waiting times for initial assessment have been found to be between 4 weeks and 18 months (Turning Point, 2003, p. 8; Drummond *et al.*, 2005); and the delay accessing a detox place between 3 weeks and 12 months (Turning Point, 2003, p. 10). The failure to substantially improve treatment before the implementation of a policy that removes benefits from drinkers if they do not enter treatment is unlikely to create the type of treatment relationships or environments recommended by NICE.

The full NICE guidance emphasizes the importance of cultivating treatment environments in which patients feel no ‘apprehension’ about seeking treatment (NCCMH, 2011, p. 78). However, coercing already stigmatized dependent drinkers into treatment by removing their benefits, while continuing to provide inadequate treatment is unlikely to create the confidence among dependent drinkers in treatment services recommended by NICE. Furthermore, the anxiety of the alcohol dependent is likely to be exacerbated by the

Prime Minister’s view that they are to blame for their condition. Dependent drinkers do have responsibilities for managing their condition (Volkow, 2004). Yet delivery of these responsibilities is influenced by a range of factors such as the stigma that surrounds dependence—including the ‘self-stigma’, or internalization of negative attitudes that alcohol-dependent individuals perceive to exist towards them in society (Schomerus *et al.*, 2011b), secure social networks and the availability of quality treatment. Until government successfully addresses the challenges presented by these issues and begins to create the supportive environment envisaged by NICE the responsibilities of dependent drinker cannot and, arguably, should not be relied on to solve the problems associated with harmful drinking in England or elsewhere.

## CONCLUSION: TOWARDS PUBLIC POLICY SUPPORT FOR DEPENDENCE?

The publication of NICE’s clinical guidance on dependence and harmful alcohol-use should be welcomed. However, if the guidance is to have teeth, policy must adopt an integrated, comprehensive approach to alcohol problems. The NICE clinical guidance is unable to address many issues that exacerbate dependence making a suitable policy response essential to support its endeavours. As Raistrick *et al.* (2006) suggest in their review of treatments, it is necessary to place and view therapeutic initiatives within their wider context and within a framework that unites treatment, prevention and public health. They emphasize that ‘an integrated treatment system... sits within a cultural and social environment’ (2006, p. 171). As this implies, although the competence of clinicians is a key aspect of successful treatment and recovery, the dependent reside in social environments—familial, communal and socio-labour—that influence the development of their dependence on alcohol, and their ability to acknowledge their drinking problem, receive treatment and avoid relapse. To support the treatment of alcohol dependence, policy must avoid cultivating environments in which the stigma surrounding the condition thrives and trust is undermined, trust that NICE indicates should be at the heart of treatment programmes.

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