The Need for a Health System Response to Alcohol-Related Harms

MCA Medical Council on Alcohol
EDUCATION | JOURNAL | POLICY | SUPPORT

Background

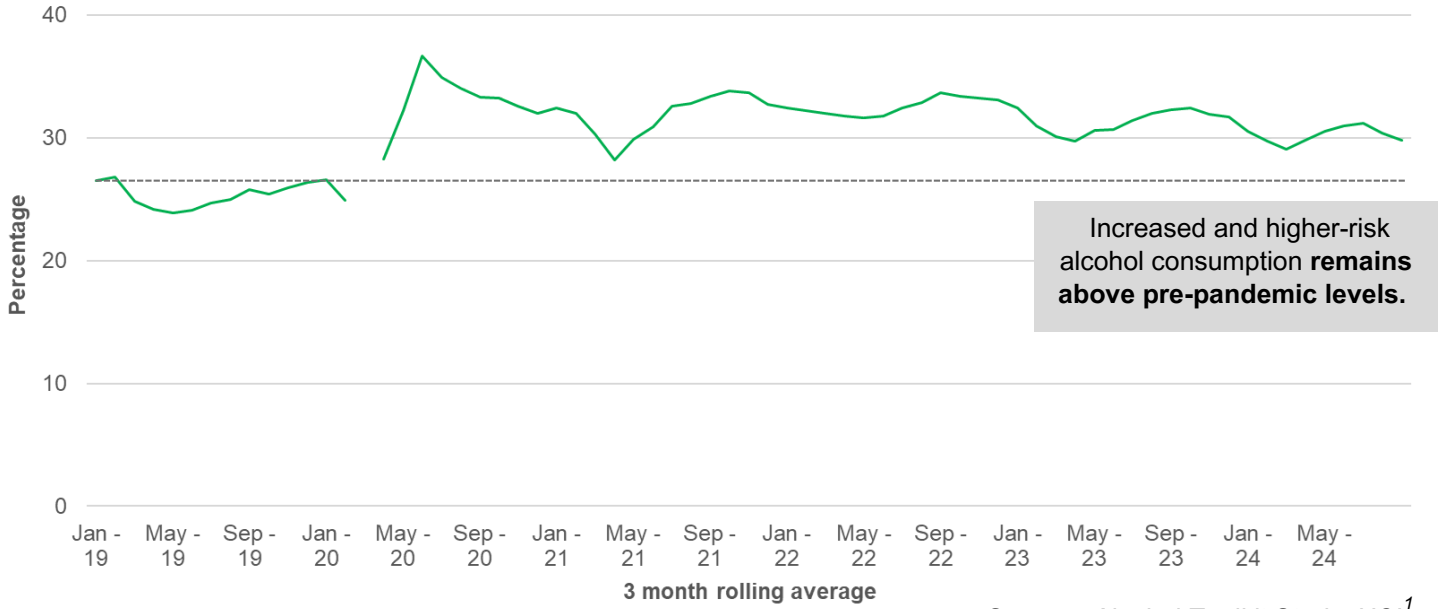
What We Know

Since 2020, alcohol consumption at levels likely to harm health have increased significantly.[1]

Alcohol is a small molecule (C_2H_2OH), which can permeate into every organ of the body, including the brain. Although it is widely available in society, and drunk at some level by approximately 80% of adults in the UK, it is now well established that there is no 'safe' level of alcohol consumption,[2,3] and that the physical and mental health harms caused by alcohol increase (at different rates) with the amount consumed.[4]

There was a rise in drinking at increased and higher risk levels during Covid, a trend which has been sustained.[1,5] During 2020, the rate of people drinking at higher-risk levels nearly doubled from an already historically high level of 4.8 million in February to 8.4 million by September the same year.[6]

Prevalence of Increasing and Higher Risk Drinking in England (2019-2024)



Source: *Alcohol Toolkit Study, UCL*[1]

Economic modelling based on the most recent data is clear that the impact of increased alcohol consumption at a population level will result in continued significant future alcohol-related health harms and widen the health inequalities for the most vulnerable in society.[7–9]

148,000 ADDITIONAL ALCOHOL-RELATED DISEASES

~10,000 ADDITIONAL PREMATURE DEATHS

£1.2BN ADDITIONAL COSTS TO THE NHS

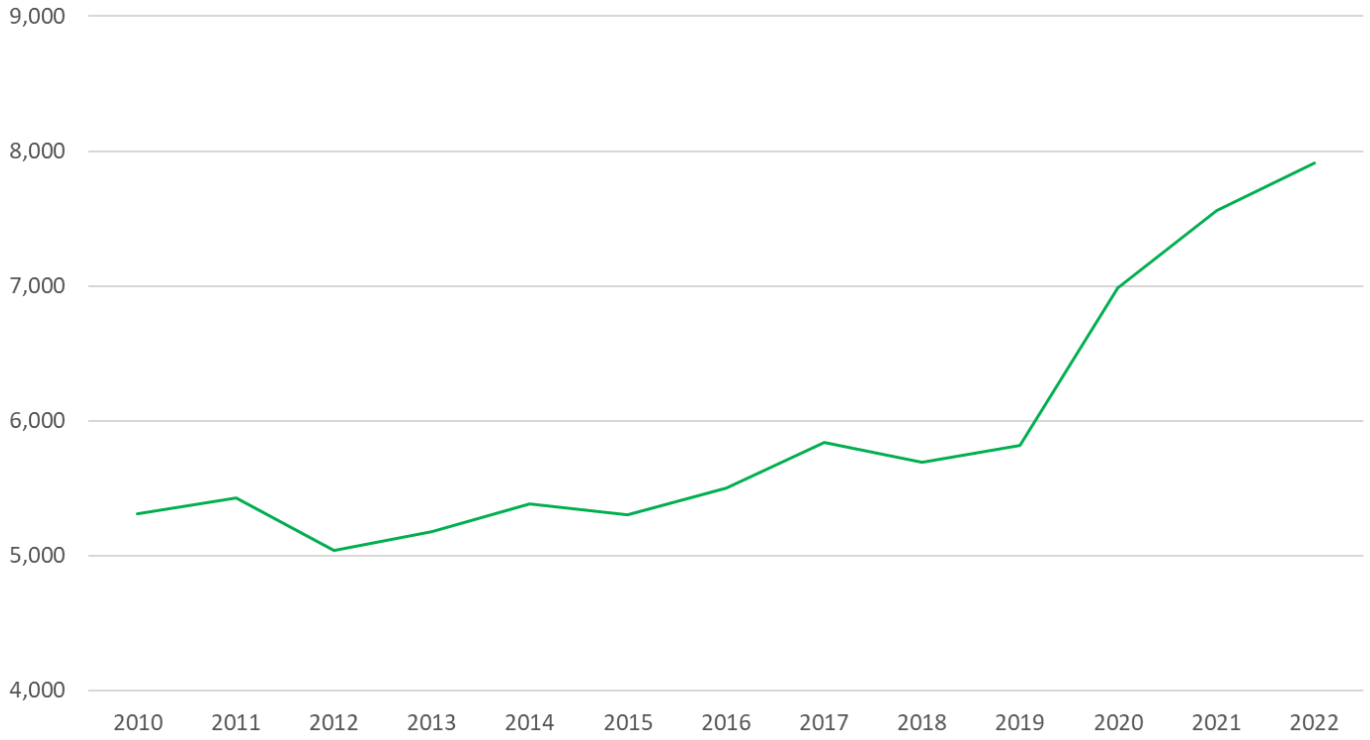
Estimated health harms **by 2035** if higher-risk drinking does not return to pre-pandemic levels

Source: *Institute of Alcohol Studies*[7]

In 2019, alcohol-specific mortality was at the highest rates since records began, and then increased a further 32.8% between 2019-2022[10]

The timing of this project has been driven by the growing evidence of significant and increasing alcohol-related health harms within the UK. Alcohol is currently the leading risk factor for premature death and ill-health among 15–49-year-olds in England.[11,12] The escalation of drinking prevalence at increased and higher-risk levels during the pandemic in the UK to a 32.8% rise in alcohol-specific deaths between 2019-2022, the majority caused by alcohol-related liver disease.[10]

Alcohol-Specific Deaths in England (2010-2022)

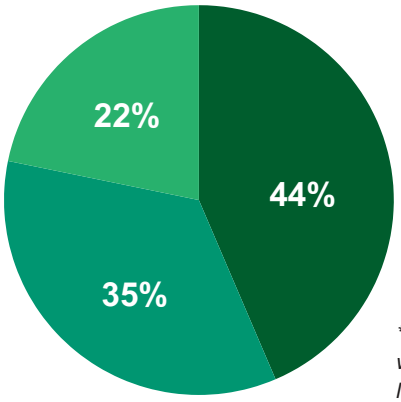


Source: *Local Alcohol Profiles for England, OHID*[5]

The average age of those dying from alcohol-specific causes is 54.3 years old, more than 20 years lower compared to the average age of mortality from all causes of death.[13] In 2018, around 18% of the overall number of potential working years of life lost was attributable to alcohol consumption. This was far higher compared to the total combined number of working years lost associated with the 10 leading causes of cancer deaths.[14]

Costs of Alcohol Harm to the Wider Economy: £5.056bn/year*

Unemployment: **£1,096m**



Presenteeism:
(Reduced productivity at work)
£2,206m

Absenteeism:
(Not at work due to illness)
£1,753m

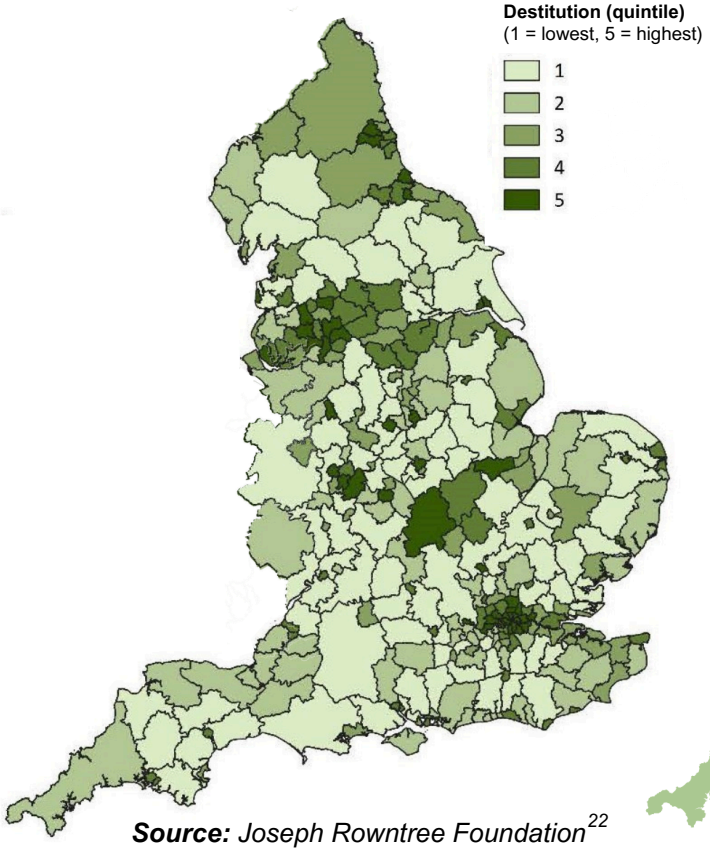
**The economic loss due to premature mortality was excluded from the 2024 calculation due to a lack of available data.*

Source: *Institute of Alcohol Studies*[15]

Alcohol harms disproportionally affect those who already hold the greatest burden of social and health inequalities[8,16]

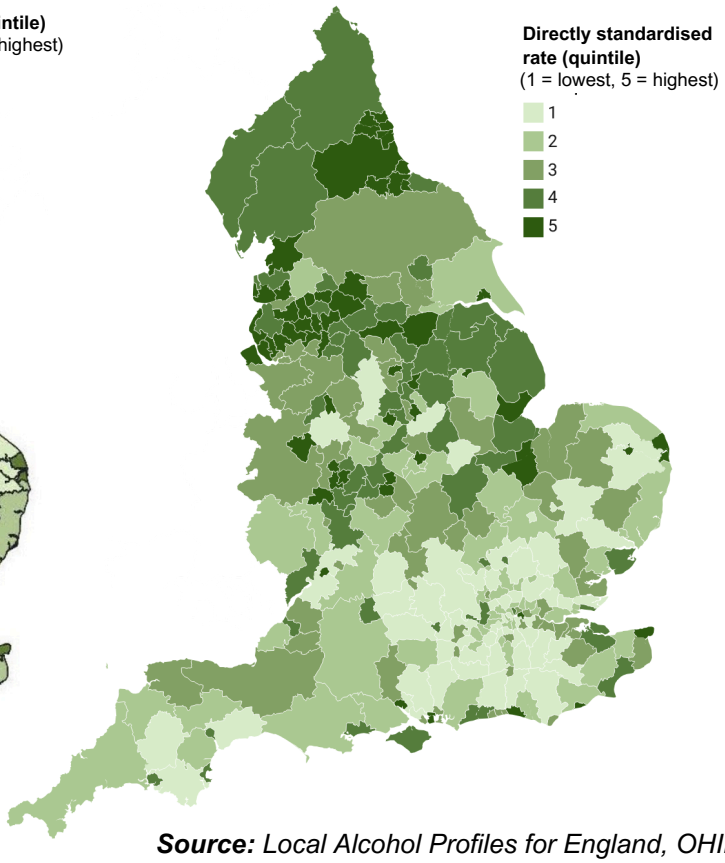
The 'Alcohol harm paradox' whereby health and social harms are higher in socially disadvantaged groups,[17,18] despite lower rates of consumption than more advantaged groups, means that alcohol consumption has the greatest detrimental impact on the most vulnerable in society and is a significant contributor to health inequalities.[19,20] During 2020, the rate of alcohol-specific mortality in the most deprived areas of the country was over twice that seen in the least deprived areas.[21]

The Geography of Destitution 2022

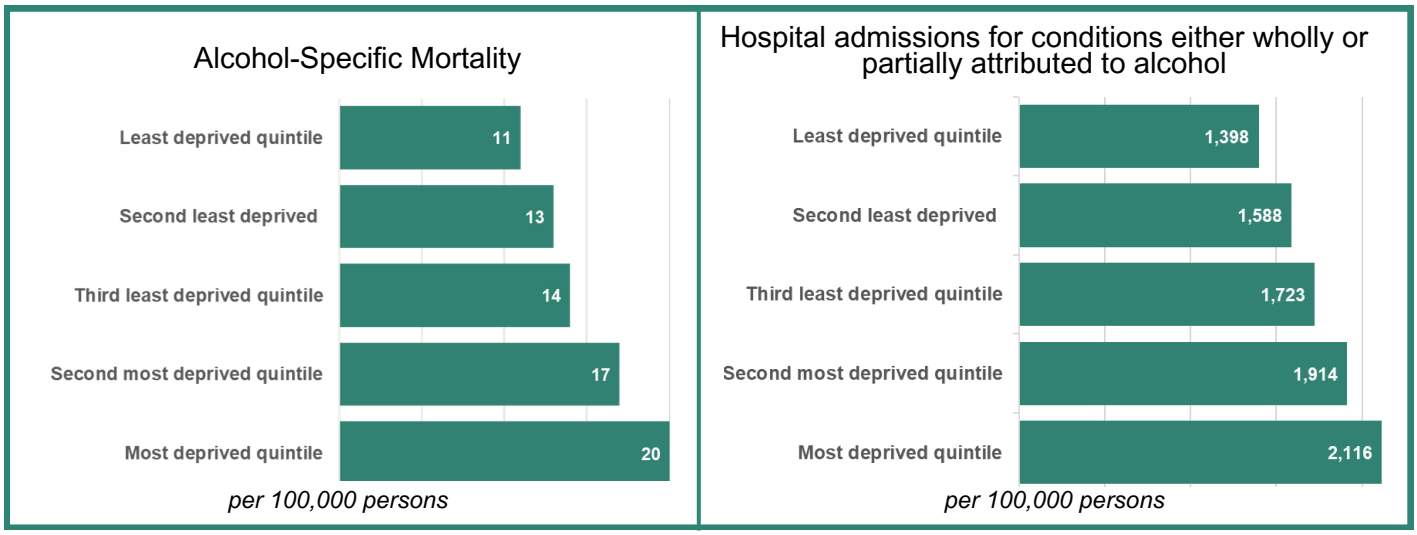


Source: *Joseph Rowntree Foundation*[22]

Alcohol-Related Mortality (2022)



Source: *Local Alcohol Profiles for England, OHID*[5]



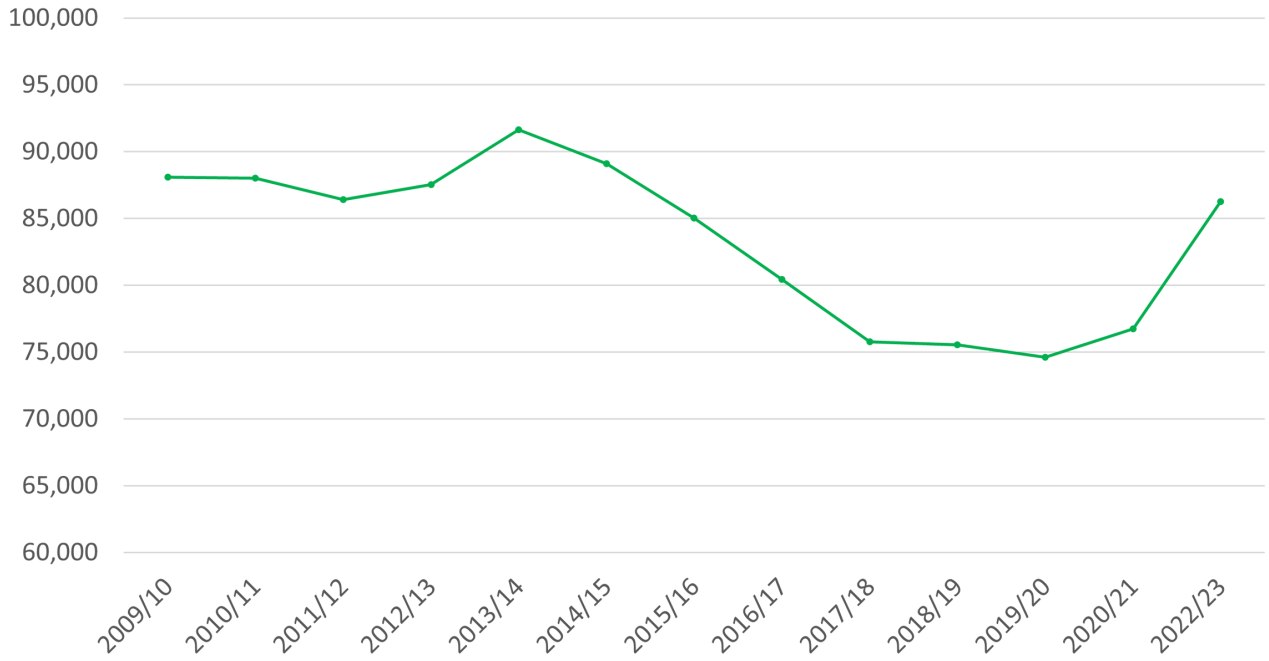
Source: *Local Alcohol Profiles for England, OHID*[5]

Only 15-18% of people who are alcohol dependent are currently accessing community alcohol services [21,23]

This is shockingly low compared with other illnesses – for instance 70% of those living with diabetes access health services.[24]

Between 2013/14 and 2020/21, there was a 16% reduction in the number of people in treatment for AUD, despite the number of people in need of care remaining stable.[21] While there was a modest rise over the subsequent two years, the numbers of people with alcohol dependence who are in treatment has not yet recovered to the levels seen in 2013/14. For those able to access alcohol treatment, latest data suggests that 59% complete the programme successfully and discharged as 'treatment completed'.[21]

Number of Adults in Treatment for Alcohol Only (2022/23)



Source: *National Statistics about Drug and Alcohol Misuse Treatment* [25]

Successive budget cuts have been identified as the key driver in the drop in treatment numbers post-2013.[26] As the quality and quantity of alcohol provision in the community has decreased there has been a significant increase in admissions to acute hospital for people in alcohol withdrawal.[23,27] This has increased further in the last few years i.e. as specialist services for patients with alcohol dependence have reduced there is a significant increase in admissions via unscheduled care to acute hospitals where people are often managed less appropriately, and effectively.[23] In Scotland, of all the medically assisted alcohol withdrawal (MAAW) episodes ('detoxes') undertaken in 2021/22, 94% were unplanned following admission to non-specialist acute hospital services, representing a missed opportunity for early intervention.[28]

Of people presenting to alcohol treatment services in 2022/23, 23% were parents living with children.[25] Problematic alcohol use severely impacts a parent's ability to care for their child, with research consistently showing significant adverse effects of parental alcohol problems on a child's health and development.[29] These children are at heightened risk of AUDs, mental health difficulties and adverse childhood experiences.[29]

In 2019/2020, parental alcohol use was a factor in 16% of cases referred to children's social services for assessment.[30] Supporting parents with problematic alcohol use is crucial for improving the well-being and quality of life of the approximately 3 million children living in households affected by parental alcohol problems.[31]

1 in 5 children live in a household affected by problematic alcohol use

Source: *The National Association for Children of Alcoholics* [31]

There has been a lack of political interest in addressing alcohol-related health harms

Alcohol is of course widely available, and there are conflicting economic, social, and health priorities around its perceived value in society. There has been very little political interest (beyond an occasional statement)[32] in addressing alcohol related harm for many years, not least due to the well documented activities of the alcohol industry and its front organisations which have presented a major barrier to policy progress in tackling alcohol harm.[32,34] Strategies and tactics have been compared to those employed by the tobacco industry to disrupt and delay public health policies and include legal challenges, denying or downplaying evidence of harm linked to their product and promoting ineffective self-regulatory and educational schemes.[35]

It is important not to underestimate the pervasive impact of lobbying on politicians by powerful actors such as the alcohol industry who aim to frame the debate as being a matter of individual responsibility rather than wider social inequalities,[36] neglect the addictive nature of the product and downplay the contribution of government policies and environmental factors to the prevalence of problematic alcohol use. This is despite clear evidence that the majority of the alcohol industry's profits are made from people drinking at increased and higher risk levels which is the main cause of alcohol-related health harms rather than from those drinking at lower-risk levels.[37]

Alcohol dependence is also a highly stigmatised condition,[38] and patients' access to, and experience of healthcare is significantly affected by both internalised (felt) and external (enacted) stigma towards them,[39,40] which are likely to have an impact on their health outcomes.[41] Stigma may in part be why there are no influential 'patient led' pressure groups to keep the health harms of alcohol on the policy agenda (unlike cancer, heart disease and dementia amongst many others).

Alcohol Treatment is still a Cinderella Service

The Dame Carol Black independent review of drugs, specifically excluded alcohol in its remit, but recommendations for treatment services include provision for people with AUD.[42-44] Cuts to alcohol treatment services have had a greater impact over the past decade, with a sharper decline in the number of people in treatment for alcohol dependence (19%) compared to those being treated for other substances (5%) in the three years leading up to 2016/17.[42-44] Prolonged austerity and the rise in integrated drug and alcohol treatment services resulted in the loss of alcohol-specific expertise in the sector, with the limited available resources often prioritised for opioid substitution treatment.[26]

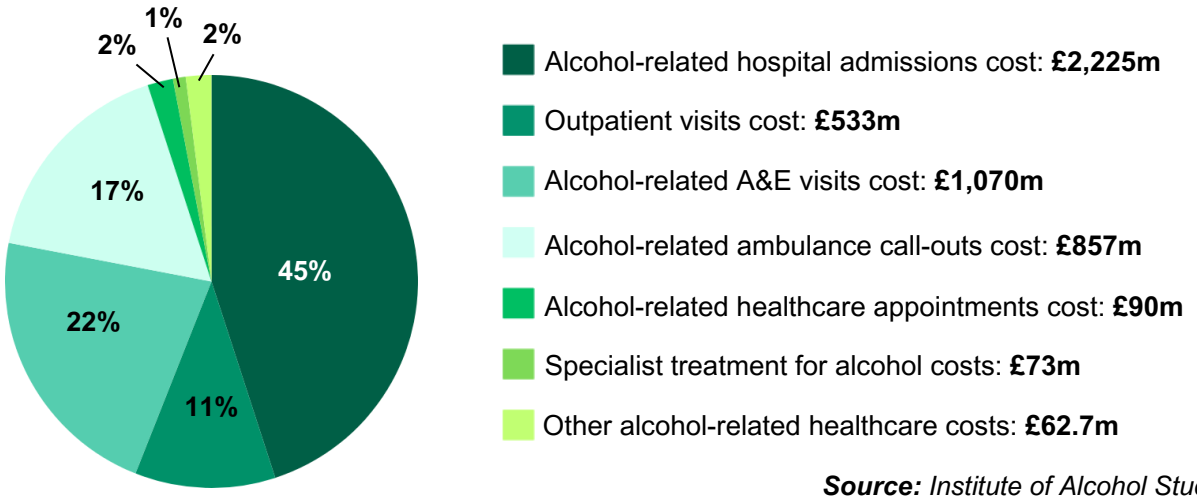
There is an urgent need for a health system response to addressing alcohol-related health harms

There is strong consensus among the public health community about the most effective primary prevention responses to alcohol related harm (upstream measures addressing the affordability, availability and promotion of alcohol e.g. Minimum Unit Pricing) which have robust evidence of effectiveness.[45] However, within the wider health and social care system there is an equally urgent need for a joined up strategic response to effective secondary prevention, treatment and ongoing support for people experiencing the full spectrum of alcohol-related harm.

There has not been a new national alcohol strategy for over a decade. The 2012 Strategy focussed on public health harms,[46] and prior to that the 2004 Alcohol Harm Reduction Strategy for England (AHRSE),[47] although broader in scope, still sets out the problem as *"alcohol misuse by a small minority is causing two major, and largely distinct, problems: on the one hand crime and anti-social behaviour in town and city centres, and on the other harm to health as a result of binge- and chronic drinking"*. The hope is that a new government with a focus on addressing health inequalities will recognise that having a health strategy for alcohol is an essential to 'Build an NHS fit for the Future'.[48]

Nearly 6% of all hospital admissions in 2021/22 were alcohol-related [11,49]

Cost of Alcohol Harm to the NHS & Healthcare Services in England: £4.91bn/year



Source: *Institute of Alcohol Studies*[15]

Over the last 20 years Alcohol Care Teams (ACTs) have evolved sporadically with different operational models driven by local clinicians concerned about the inadequate care that patients with co-morbid alcohol dependence received in their own clinical specialty. In 2019, the NHS Long Term Plan committed to 'optimise' alcohol care teams in 25% of acute hospitals with greatest clinical need, with the aim on reducing hospital bed days.[50] However, this was not joined up with pathways into other NHS physical or mental health services or the wider community based alcohol treatment system, and the programme was deprioritised in March 2024, with many teams now being dismantled having barely become established.

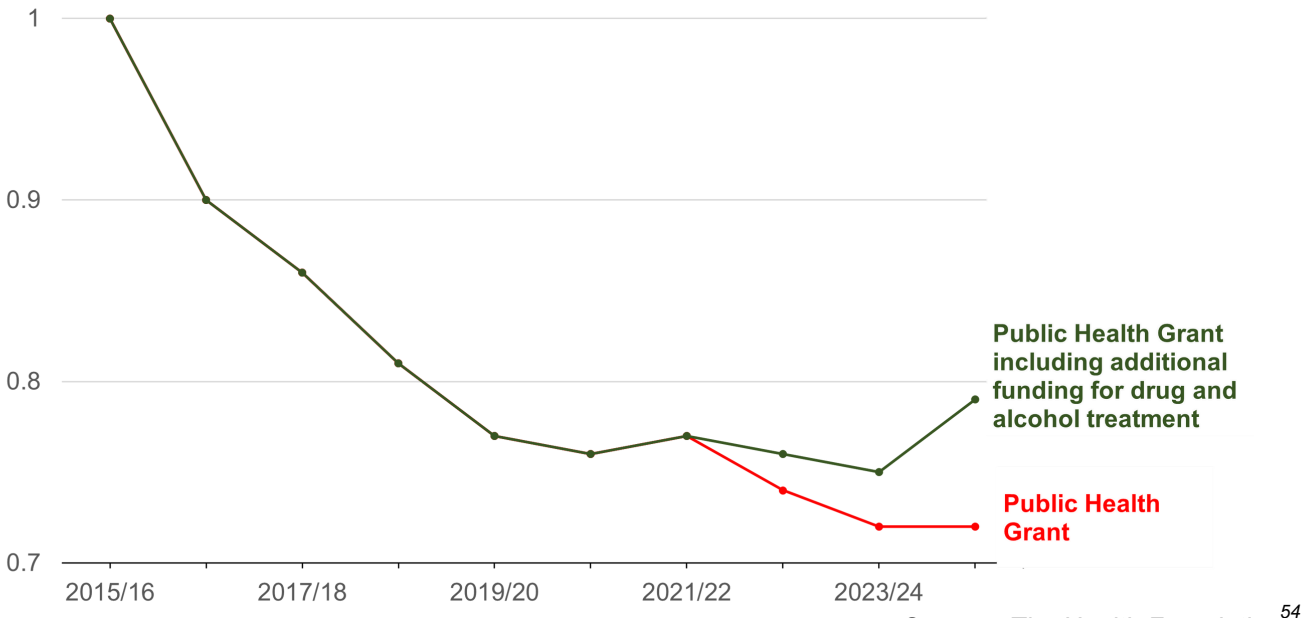
Screening, Brief intervention, and Referral for Treatment (SBIRT) in acute hospitals supported by a small specialist team is an effective model in identifying patients at risk, or with, ARH, and directing them to appropriate specialist treatment.[51] The long-term sustainability of ACTs depends on ongoing investment. Without continued financial support, many ACTs across the country could be lost, leaving hospitals without the specialised expertise that has been instrumental for addressing alcohol-related health harms in secondary care.

The move of addiction treatment into local authority commissioning, followed by twelve years of austerity, has reduced the level of clinical provision and quality of community addiction services[26, 43, 52]

The 2012 Health and Social Care Act brought significant reforms to the commissioning and provision of drug and alcohol treatment services in England, with local authorities given the responsibility for funding and commissioning specialist addiction services using the Public Health Grant (PHG).[53] The PHG has been heavily impacted by years of austerity, since 2015/16 the overall PHG has been cut by £630mn, reflecting a real terms reduction of 28%.[54] The PHG now stands at £3.6bn, equivalent to just 2.2% of the overall NHS England budget.[54] As local authorities are expected to use the PHG to fund a wide range of public health services in their locality, these cuts had a knock-on effect on their level of spending on drug and alcohol services, which fell by 27% in real terms throughout the same period.[21]

Rather than being cost-effective, cuts to specialist addiction services reflect a false economy, as every 5% reduction in yearly spending on alcohol treatment is associated with an extra 60 alcohol-related hospitalisations per 100,000 people in the population.[55] These budget cuts often resulted in the loss of specialised staff with alcohol-specific expertise, reduced treatment capacity and fewer people accessing specialist inpatient (Tier 4) services in England.[26,56] Despite recent increases as a result of the government's 10-year drug strategy,[57] spending has still not returned to 2014-15 levels, and is not sufficient to tackle the considerable unmet need for alcohol treatment.[21]

Change in public health allocations 2015/16–2024/25, England, real terms per person (GDP deflator)



Source: *The Health Foundation*[54]

The majority of NHS specialist in-patient addiction units has closed since 2012, with only five remaining in England by 2021.[58] In 2020/21, less than 1% of people in treatment for alcohol dependence in England and Wales received treatment in a residential rehabilitation setting, much lower in comparison to the European average of 11%.[59] As local authorities are now responsible for commissioning alcohol treatment services, there are significant regional disparities in the quality, availability and annual expenditure on alcohol treatment across the country.[21] There is also large geographic variation in the level of access to residential rehabilitation across England. Compared to those in the North of England, patients in the South of England are up to 13 times more likely to be placed in residential rehabilitation.[59]

The situation is especially critical for patients with advanced alcohol-related liver disease (ARLD), who face a high 1-year mortality rate.[60] This group of patients already face multiple additional barriers to engaging with treatment due to stigma from healthcare professions, their physical infirmity and potential confusion related to their condition.[61,62] Unfortunately, their risk of mortality is further increased by the limited availability of Tier 4 services across the country. Many patients die while awaiting placement in residential rehabilitation or a bed in one of the few in-patient detoxification units equipped to manage patients with decompensated ARLD.

There is a lack of integrated care pathways for those with complex needs

Since the Health and Social Care Act (2012) moved the commissioning of specialist addiction services in England from the NHS to local authorities, the broad range of physical and mental health needs of patients with alcohol dependence and alcohol-related harm ceased to be a priority within healthcare. The management of alcohol dependence and alcohol-related harms is currently commissioned and provided within different parts of the health system; mental health services, liver services, acute medicine, primary care, addiction services, and local authorities. All recognise the significant health harms of alcohol but current models of care and a lack of research into the treatment of comorbidity are a barrier to providing integrated care.

71% of adults and 48% of young people entering alcohol treatment services require mental health treatment[63,64]

The loss of qualified health professionals in the sector following years of budget cuts have meant that many treatment services are increasingly staffed by workers who lack the necessary skills, qualifications and experience to manage co-occurring mental health problems.[43] While these workers often have valuable experience, people with more severe dependence or complex needs, such as those with mental health problems, require expert interventions from mental health professionals. With diminished funding available for specialist addiction treatment services, local authorities have been unable to host an adequate number of training posts for addiction psychiatrists.[65] This has led to the number of training places falling by 58% between 2011 and 2019.[53]

Whilst community addiction services are not commissioned or funded to provide mental health treatment, they frequently encounter patients with mental health conditions. The lack of addiction psychiatrists and other mental health practitioners in the sector means that many community addiction services may not have sufficient expertise to address complex mental health conditions, while mental health services are often reluctant to treat patients until their alcohol use is under control, leading to a vicious cycle where patients with both conditions often fall through the cracks. Concerningly, despite the high prevalence of mental health difficulties amongst young people seeking treatment for alcohol dependence, 29% were not receiving mental health treatment.[63]

> *…I went to [the hospital] and said to them, 'I am having intrusive suicidal thoughts. I don't know why. I'm frightened'. And their response was, 'Unless you reduce your alcohol to 13 units a week, you will receive no treatment from the NHS or from private practice'. And I came out of [the hospital] and thought, 'Well, that's it then. That's it. Nothing is going to change; I'm not going to get any help'. Three weeks later, I had planned and organized my suicide…*
>
> **(Bobby, male, 50–59 years)**[66]

Between 2010 and 2020, 48% of people who died by suicide while under the care of mental health services had a history of problematic alcohol use

The National Confidential Inquiry into Suicide and Homicide (NCISH) 2010-2020[67] demonstrated that of those who die by suicide while under the care of Mental Health (MH) services:

- Those with a primary diagnosis of alcohol use disorder (AUD) were significantly more likely than those with other mental health diagnoses to have had only a single contact with mental health services (20% vs 9%).
- The number of patients with AUD seen by mental health services fell from 165/year before 2012 to 106/year thereafter (with a downward trend over the seven years) despite the known increase in AUD incidence during this time.

The reduction in numbers of those with AUD known to NCISH coincides with the Health and Social Care Act of 2012. The move of commissioning of addiction treatment services out of the NHS to the local authority, resulted in a shift of provision from MH services into the social care sector. Therefore it is likely that the fall in number (of patients with AUD who died by suicide under the care of MH services), may be the result of some suicidal patients with a primary diagnosis of AUD never being seen by MH services.[67,68] Of note, after 2012, the rates for a primary diagnosis of AUD of patients dying by suicide under the care of MH were lower in England (6%) where these changes to the provision of services were made compared to NI (20%), and Scotland (13%) where addiction services primarily remained within MH services.[67]

There is a lack of skills in the management of alcohol dependence in the generalist healthcare (and specialist) workforce[43,69]

There is an urgent need to address the missed opportunities for early identification of harmful alcohol consumption within the healthcare system to address the rise in preventable deaths. Only a tiny percentage of alcohol dependent patients accessing healthcare are reviewed by a qualified specialist clinician and a mere 23% of referrals to specialist community addiction services come from health services.[21] Primary care practitioners are an important first point of contact for individuals with problematic alcohol use, yet they may lack the necessary time and knowledge to screen for alcohol use disorders, provide brief interventions, and refer patients to appropriate community specialist addiction treatment services.[56] Moreover, as alcohol is related to over 200 health conditions,[70] non-specialist healthcare professionals within acute and secondary mental healthcare settings frequently encounter patients with alcohol-related harms, but similarly, they often lack the necessary training to screen for and adequately manage patients with alcohol dependence.

Mortality from ALRD has quadrupled since 1970,[62,71] and in 2022 76% of alcohol-specific deaths were driven by alcohol-related liver disease (ALRD).[10] Despite evidence of high recovery rates from liver disease when ARLD is detected early,[72] 3 in 4 people with cirrhosis are diagnosed at an advanced stage of the disease, often when treatment options are limited.[73] A quarter of those diagnosed with ARLD die within 60 days of being admitted to hospital.[74] Therefore, the lack of universal screening procedures and early interventions contributes to the rise in preventable deaths related to harmful alcohol consumption and incurs higher costs in secondary care due to untreated alcohol dependence.[75]

Assertive outreach delivers effective results for high-need, high-cost repeat attenders

Assertive outreach has proven to be an effective strategy, particularly for individuals with severe alcohol dependence who are frequent users of healthcare services. In 2015/16, just 9% of people with alcohol dependence accounted for 59% of all alcohol-related hospital admissions.[76] These 54,000 patients in England accounted for over 365,000 hospital admissions, costing the NHS an estimated £858 million.[76] Targeting these high-need individuals through assertive outreach is cost-effective and can deliver significant improvements to their health and overall quality of life. A randomized controlled trial of an alcohol assertive outreach team showed the number of abstinent days for patients rise from 14% to 68%, and inpatient bed days reduced from 26.8 to 1.2.[77]

Expanding assertive outreach across England to care for over 50,000 high-need, high-cost patients was estimated to cost around £161 million but could produce savings of around £575 million, translating to a return of £3.42 for every £1 invested in assertive outreach services.[76,78] Despite these proven benefits, the availability and quality of assertive outreach services vary widely across the country, with some areas reporting no services at all, while others have seen cuts in funding since 2013.[75]

Enablers to Change

1. A set of ‘standards’ for alcohol care teams has recently been developed by Alcohol Care Team Innovation and Optimisation Network (ACTION).[79]

2. Research is underway to generate a robust evidence base for the function and impact of specialist services in acute hospitals.[80]

3. The (upcoming) UK clinical guidelines for alcohol treatment, has involved patient input to define ‘principles of care’ for the first time.[81,82]

4. The 2022 curriculum for general psychiatry by the Royal College of Psychiatrists established the ability to ‘demonstrate skills in assessing and managing patients with addictions’ as a core competency for trainee psychiatrists.[83]

5. ICBs have the potential to break down the silos between public health and NHS services, ensuring that patients with AUD receive more comprehensive and coordinated support across different parts of the health system for both their alcohol dependence and related health conditions.[43]

6. The UK government's 10-year drug and alcohol treatment workforce plan, spanning 2024-2034, is designed to address critical shortages in professionals who provide treatment and support to those with substance use disorders. While primarily focused on drug treatment, the strategy emphasizes the expansion and upskilling of the workforce responsible for treating addiction, which includes alcohol use disorders.[84]

What We are Suggesting

Macro

- A funded, National Alcohol Strategy focusing on the **treatment** and **secondary prevention** of alcohol dependence and alcohol-related harm in clinical populations across the health system. This is an essential part of addressing health inequalities, **in addition to the primary prevention measures that tackle the affordability, availability and promotion of alcohol.**
- **Sustained funding to rebuild specialist services** to manage the most complex patients who are currently unable to access treatment and are consequently admitted to acute hospitals as unscheduled care.

Local Health Systems

- Only 15-18% of patients with alcohol dependence are accessing community addiction services. Each Regional/National Health Board needs an **'Alcohol lead'** to ensure people with alcohol dependence and alcohol-related harm are able to access services that meet their physical and mental health needs across the entirety of the local health system.
- All local health systems must implement an **accelerated alcohol treatment pathway** for alcohol dependent patients with severe and life-threatening physical illnesses (e.g decompensated liver cirrhosis) who are currently dying before they are able to access the treatment they need.
- **Involvement of people with lived experience of AUD/ARH** in the development and review of alcohol treatment pathways across the health system as per (upcoming) UK clinical guidelines principles of treatment [81,82] and ACTION standards.[79]
- As comorbid alcohol dependence is a well-established factor for suicide and suicidal behaviour, **all ICBs should include a recognition and response to how to integrate the management of alcohol dependence** within their suicide prevention strategies.
- Each Local Authority should commission **specialist inpatient alcohol treatment beds** to provide timely access to acute treatment and divert people from unscheduled non-specialist acute care.

Mental Health Services

- Follow the NCISH recommendations that **staff working in MH services are competent in the assessment and management of alcohol use** as part of their suicide prevention implementation.[67,68]
- **Implement an effective crisis care pathway** in each locality to respond to the needs of suicidal people who are also alcohol dependent.
- Have clear policies for the **management of co-morbid alcohol dependence** and withdrawal for all patients requiring inpatient admission, and rebuild the staff competencies to deliver parity of care.[58]
- Implement NHS guidance on **screening for AUD/ARH** as part of the initial assessment.[85,86]

Acute Hospitals

- Have a **system for universal screening of alcohol consumption** on admission which can provide 'real time' data to enable clinical staff to identify patients and manage alcohol dependence and alcohol-related harm at an early stage of their hospital admission
- A **consultant led multi-disciplinary Alcohol Care Team** to improve quality of care, staff training and implementation of evidence-based management of alcohol use disorders, including alcohol withdrawal.

What We are Suggesting

Young Person's Services

- Both addiction services and CAMHS to have access to **inpatient medically assisted withdrawal** from alcohol for young people with accelerating alcohol dependence and alcohol-related harm to access.

Specialist Addiction Services

- A requirement for each Regional Health System to provide **access to specialist services at the requisite level and quality** for the needs of their local population.
- Improve the **links with and into community alcohol services** and rebuild the quality of care delivered by them, based on the (upcoming) UK clinical guidelines for alcohol treatment.
- All specialist community services to have **clear KPIs for alcohol treatment measures** to drive improved quality.
- **Rebuilding of the specialist workforce** (psychiatry, nursing, psychology, social workers) to enable the delivery of high quality specialist addiction services, development of the evidence base and training and advocacy across the health system.

Primary Care

- Screening in primary care for problematic alcohol use and ARLD with a **specific integrated pathway for alcohol treatment and liver monitoring** to enable both referral to specialist addiction services and the early identification of ARLD.

Workforce training

- All health and social care professionals to have **training in the identification of alcohol-related harm and AUD.**
- All health and social care professionals **working in services where there is a potential 'high risk' from ARH** (e.g liver services, mental health services, maternity care) receive training in the identification, assessment, and management (or referral) of alcohol dependence and alcohol-related harm.

Involvement of Lived Experience

- Given the normalisation of alcohol consumption in society, and the stigma enacted towards and felt by people with alcohol related harm, there is a great need to **actively involve the recovery community,** including lived experience recovery organisations (LEROs), **in the design and delivery of training and service provision**, and undergraduate medical education as part of 'humanising healthcare' in this area.[87]

Research

- Prioritisation of clinical research into the most effective ways to **manage comorbid alcohol dependence as part of a holistic treatment plan** for people presenting with other physical and mental health conditions.

Definitions

Table 1.
Definitions of Different Patterns of Drinking [88]

Term	Definition
Lower risk drinking	Defined by the chief medical officers as regularly drinking below 14 units per week, spread evenly over the course of a week.
Increasing risk drinking	Defined by the National Institute for Health and Care Excellence (NICE) as regularly drinking over the recommended 14 units per week. This reflects drinking between 15-50 units per week for males, and 15-35 units per week for females.
Higher-risk drinking	Defined by NICE as regularly drinking more than 50 units per week for males and drinking more than 35 per week for females.

Table 2.
Definitions of Alcohol-Specific and Alcohol-Related Health Conditions [11]

Term	Definition
Alcohol-Specific Conditions	Conditions that are wholly caused by alcohol consumption, such as alcohol-related liver disease, alcohol poisoning, and alcohol-related pancreatitis.
Alcohol-Related Conditions	Conditions that are partially caused or exacerbated by alcohol consumption, such as hypertension, stroke, and certain cancers.

Definitions

Table 3.
Definitions of Primary, Secondary and Tertiary Prevention [89]

Term	Definition
Primary Prevention	Aims to prevent the onset of disease or injury before it occurs, often in the form of public health educational campaigns and promoting guidance on lower risk drinking.
Secondary Prevention	Aims to intervene and halt or slow the progression of a disease that has already occurred though early detection and treatment. Often in the form of screening programs and psychological interventions.
Tertiary Prevention	Aims to help patients manage and ameliorate the impact of an ongoing illness or injury to mitigate complications, improve quality of life and increase their life expectancy.

Abbreviations

ACT	Alcohol Care Team
AUD	Alcohol Use Disorder
ARH	Alcohol-Related Harm
ARLD	Alcohol-Related Liver Disease
ACTION	Alcohol Care Team Innovation and Optimisation Network
CAMHS	Child and Adolescents Mental Health Service
CMO	Chief Medical Officer
ICB	Integrated Care Board
LEROs	Lived Experience Recovery Organisations
MCA	Medical Council on Alcohol
NCISH	National Confidential Inquiry into Suicide and Safety in Mental Health
OHID	Office for Health Improvement and Disparities

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References

1. Alcohol toolkit study. Alcohol toolkit study for community prevalence. 2024. Accessed August 9, 2024. https://www.alcoholinengland.info/graphs/monthly-tracking-kpi
2. Department of Health. *UK Chief Medical Officers' Low Risk Drinking Guidelines.* Published online 2016. Accessed August 19, 2024. https://assets.publishing.service.gov.uk/media/5a80b7ed40f0b623026951db/UK_CMOs__report.pdf
3. World Health Organization. *No level of alcohol consumption is safe for our health*. January 4, 2023. Accessed August 19, 2024. https://www.who.int/europe/news/item/04-01-2023-no-level-of-alcohol-consumption-is-safe-for-our-health
4. Rehm J, Gmel GE, Gmel G, et al. The relationship between different dimensions of alcohol use and the burden of disease—an update. *Addiction*. 2017;112(6):968-1001. doi:10.1111/ADD.13757
5. Local Alcohol Profiles for England. LAPE_Statistical_Tables_for_England_2022. Published online 2024. Accessed September 17, 2024.
6. Public Health England. *Wider Impacts of COVID-19. 2020.* Accessed October 3, 2024. https://analytics.phe.gov.uk/apps/covid-19-indirect-effects/
7. Boniface S, Card-Gowers J, Martin A, Retat L, Webber L. *The COVID Hangover Addressing Long-Term Health Impacts of Changes in Alcohol Consumption during the Pandemic.* Institute of Alcohol Studies; 2022.
8. Angus C, Henney M, Pryce R. Modelling the longer-term health and health inequality impacts of changes in alcohol consumption during the COVID-19 pandemic in England. *J Public Health*. 2024;46(2):286-293. doi:10.1093/PUBMED/FDAE010
9. Angus C, Henney M, Pryce R. *Modelling the Impact of Changes in Alcohol Consumption during the COVID-19 Pandemic on Future Alcohol-Related Harm in England.* July 2022. doi:10.15131/shef.data.19597249.v1
10. Office for National Statistics. Alcohol-specific deaths in the UK registered in 2022. April 24, 2024. Accessed August 6, 2024. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/alcoholrelateddeathsintheunitedkingdom/registeredin2022
11. Department of Health and Social Care. Local Alcohol Profiles | Fingertips. May 2024. Accessed September 16, 2024. https://fingertips.phe.org.uk/profile/local-alcohol-profiles
12. Brauer M, Roth GA, Aravkin AY, et al. Global burden and strength of evidence for 88 risk factors in 204 countries and 811 subnational locations, 1990–2021: a systematic analysis for the Global Burden of Disease Study 2021. *The Lancet*. 2024;403(10440):2162-2203. doi:10.1016/S0140-6736(24)00933-4
13. Public Health England. *The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An Evidence Review*. PHE; 2016. Accessed September 16, 2024. https://assets.publishing.service.gov.uk/media/5b6c5703ed915d3119112af6/alcohol_public_health_burden_evidence_review_update_2018.pdf

References

14. Public Health England. Working Years of Life Lost Due to Alcohol Mortality Ad Hoc Statistical Release.; 2020. Accessed September 16, 2024. https://assets.publishing.service.gov.uk/media/5f1039f53a6f40039079e5fc/Working_years_of_life_lost_due_to_alcohol_mortality.pdf
15. Institute of Alcohol Studies. Costs of Alcohol Harm in England. 2024. Accessed July 25, 2024. https://www.ias.org.uk/factsheet/economy/?_la_sort=cost_per_head_high_to_low
16. Bramley G, Fitzpatrick S, Edwards J, et al. *Hard Edges Mapping Severe and Multiple Disadvantage.* Lankelly Chase; 2015.
17. Institute of Alcohol Studies. Alcohol and Health Inequalities. IAS; 2020. Accessed August 11, 2024. https://www.ias.org.uk/wp-content/uploads/2020/12/Alcohol-and-health-inequalities.pdf
18. Tolstrup JS, Kruckow S, Becker U, et al. Socioeconomic inequalities in alcohol-related harm in adolescents: a prospective cohort study of 68,299 Danish 15-19-year-olds. *EClinicalMedicine*. 2023;62:102129. doi:10.1016/j.eclinm.2023.102129
19. Boyd J, Bambra C, Purshouse RC, Holmes J. Beyond behaviour: How health inequality theory can enhance our understanding of the 'alcohol-harm paradox.' *Int J Environ Res Public Health*. 2021;18(11). doi:10.3390/ijerph18116025
20. Probst C, Kilian C, Sanchez S, Lange S, Rehm J. The role of alcohol use and drinking patterns in socioeconomic inequalities in mortality: a systematic review. *Lancet Public Health*. 2020;5(6):e324-e332. doi:10.1016/S2468-2667(20)30052-9
21. National Audit Office. Alcohol Treatment Services. NAO; 2023. Accessed August 9, 2024. https://www.nao.org.uk/wp-content/uploads/2023/02/alcohol-treatment-services.pdf
22. Fitzpatrick S, Bramley G, Treanor M, et al. *Destitution in the UK 2023*. Joseph Rowntree Foundation; 2023. Accessed November 20, 2024. https://www.jrf.org.uk/deep-poverty-and-destitution/destitution-in-the-uk-2023
23. Phillips T. Treatment data and impact on unscheduled care.
24. National Diabetes Audit 2021-22, Type 1 Diabetes - Overview - NHS England Digital. Accessed October 3, 2024. https://digital.nhs.uk/data-and-information/publications/statistical/national-diabetes-audit-type-1-diabetes/nda-type-1-2021-22-overview
25. National Statistics about Drug and Alcohol Misuse Treatment. NDTMS - ViewIt - Adult BETA. 2024. Accessed October 16, 2024. https://www.ndtms.net/ViewIt/AdultBeta
26. Public Health England. *PHE Inquiry into the Fall in Numbers of People in Alcohol Treatment: Findings.* PHE; 2018. Accessed August 6, 2024. https://www.gov.uk/government/publications/alcohol-treatment-inquiry-summary-of-findings/phe-inquiry-into-the-fall-in-numbers-of-people-in-alcohol-treatment-findings#introduction
27. Phillips T, Huang C, Roberts E, Drummond C. Specialist alcohol inpatient treatment admissions and non-specialist hospital admissions for alcohol withdrawal in England: An inverse relationship. *Alcohol and Alcoholism*. 2021;56(1):28-33. doi:10.1093/alcalc/agaa086
28. Public Health Scotland. *Alcohol related hospital statistics - Scotland financial year 2021 to 2022*. PHS; 2023. Accessed October 4, 2024. https://publichealthscotland.scot/publications/alcohol-related-hospital-statistics/alcohol-related-hospital-statistics-scotland-financial-year-2021-to-2022/

References

29. Children's Policy Research Unit UCL. *Parental Alcohol Misuse and the Impact on Children: A Rapid Evidence Review of Service Presentations and Interventions.* Institute of Child Health; 2018. Accessed October 16, 2024. https://www.drugsandalcohol.ie/29806/1/parental-alcohol-misuse-and-impact-on-children.pdf
30. Public Health England. Parents with alcohol and drug problems: Adult treatment and children and family services. May 10, 2021. Accessed October 16, 2024. https://www.gov.uk/government/publications/parents-with-alcohol-and-drug-problems-support-resources/parents-with-alcohol-and-drug-problems-guidance-for-adult-treatment-and-children-and-family-services
31. The National Association for Children of Alcoholics. Research. Accessed October 16, 2024. https://nacoa.org.uk/research-resources/research/
32. Public Accounts Committee. Government not taking "appalling" harms from alcohol seriously enough. May 24, 2023. Accessed August 19, 2024. https://committees.parliament.uk/committee/127/public-accounts-committee/news/195391/government-not-taking-appalling-harms-from-alcohol-seriously-enough/.
33. Gornall J. Under the influence. *BMJ*. 2014;348. doi:10.1136/BMJ.F7646
34. McCambridge J, Mialon M, Hawkins B. Alcohol industry involvement in policymaking: a systematic review. *Addiction*. 2018;113(9):1571-1584. doi:10.1111/ADD.14216
35. Obesity Health Alliance, Alcohol Health Alliance, Action on Smoking and Health, Institute of Alcohol Studies. *Killer Tactics: How Tobacco, Alcohol and Unhealthy Food and Drink Industries Hold Back Public Health Progress.* August 2024.
36. Petticrew M, Maani N, Pettigrew L, Rutter H, Van Schalkwyk MC. Dark Nudges and Sludge in Big Alcohol: Behavioral Economics, Cognitive Biases, and Alcohol Industry Corporate Social Responsibility. *Milbank Quarterly*. 2020;98(4):1290-1328. doi:10.1111/1468-0009.12475
37. Bhattacharya A, Angus C, Pryce R, Holmes J, Brennan A, Meier PS. How dependent is the alcohol industry on heavy drinking in England? *Addiction*. 2018;113(12):2225-2232. doi:10.1111/add.14386
38. Kilian C, Manthey J, Carr S, et al. Stigmatization of people with alcohol use disorders: An updated systematic review of population studies. *Alcohol Clin Exp Res*. 2021;45(5):899-911. doi:10.1111/acer.14598
39. Link BG, Phelan JC. Stigma and its public health implications. *Lancet*. 2006;367:528-529. doi:10.1016/S0140-6736(06)68184-1
40. Phillips C, Darch R, Farmbrough A. More than a 'lifestyle' choice? Does a patient's use of alcohol affect professionals' perceptions of harm and safeguarding responsibilities when it comes to self-neglect? A case study in alcohol-related liver disease. *Gastrointestinal Nursing*. 2021;19(Sup6):S18-S26. doi:10.12968/gasn.2021.19.Sup6.S18
41. Jones S, Howard L, Thornicroft G. "Diagnostic overshadowing": Worse physical health care for people with mental illness. *Acta Psychiatr Scand*. 2008;118(3):169-171. doi:10.1111/j.1600-0447.2008.01211.x
42. Black CD. Review of Drugs Summary (Accessible Version). Home Office; 2020. Accessed August 7, 2024. https://www.gov.uk/government/publications/review-of-drugs-phase-one-report/review-of-drugs-summary

References

43. Black CD. Independent Report of Drugs Part Two: Prevention, Treatment, and Recovery. Home Office; 2021. Accessed August 8, 2024. https://www.gov.uk/government/publications/review-of-drugs-phase-two-report/review-of-drugs-part-two-prevention-treatment-and-recovery
44. Black CD. From harm to hope: A 10-year drugs plan to cut crime and save lives - GOV.UK. 2022. Accessed August 12, 2024. https://www.gov.uk/government/publications/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives
45. University of Stirling, Alcohol Health Alliance UK, British Liver Trust. *Health First : An Evidence-Based Alcohol Strategy for the UK.* University of Stirling; 2013. https://ahauk.org/wp-content/uploads/2015/03/Health-First-An-evidence-based-alcohol-strategy-for-the-UK-condensed-download-size.pdf
46. HM Government. *The Government's Alcohol Strategy.* 2012. Accessed August 8, 2024. https://assets.publishing.service.gov.uk/media/5a755606ed915d7314959292/alcohol-strategy.pdf
47. Cabinet Office. *Alcohol Harm Reduction Strategy for England.* 2004.
48. Labour Party. Change: Labour Party Manifesto 2024. 2024.
49. NHS England Digital. Hospital Admitted Patient Care Activity, 2021-22. September 22, 2022. Accessed October 3, 2024. https://digital.nhs.uk/data-and-information/publications/statistical/hospital-admitted-patient-care-activity/2021-22
50. NHS England. NHS England » Alcohol dependency programme. Accessed August 8, 2024. https://www.england.nhs.uk/ourwork/prevention/alcohol-dependency-programme/
51. Barbosa C, McKnight-Eily LR, Grosse SD, Bray J. Alcohol screening and brief intervention in emergency departments: Review of the impact on healthcare costs and utilization. *J Subst Abuse Treat*. 2020;117. doi:10.1016/j.jsat.2020.108096
52. HM Government. Summary letter from Lord Darzi to the Secretary of State for Health and Social Care. Accessed October 3, 2024. https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england/summary-letter-from-lord-darzi-to-the-secretary-of-state-for-health-and-social-care
53. Public Accounts Committee. Alcohol Treatment Services Fifty-Fourth Report of Session 2022-23 Report, Together with Formal Minutes Relating to the Report. PAC; 2023. www.parliament.uk.
54. The Health Foundation. Options for restoring the public health grant. Accessed October 3, 2024. https://www.health.org.uk/publications/long-reads/options-for-restoring-the-public-health-grant
55. Roberts E, Hotopf M, Drummond C. The relationship between alcohol-related hospital admission and specialist alcohol treatment provision across local authorities in England since passage of the Health and Social Care Act 2012. *The British Journal of Psychiatry*. 2021;218(4):230-232. doi:10.1192/BJP.2020.120
56. Roberts E, Hillyard M, Hotopf M, Parkin S, Drummond C. Access to specialist community alcohol treatment in England, and the relationship with alcohol-related hospital admissions: qualitative study of service users, service providers and service commissioners. *BJPsych Open*. 2020;6(5). doi:10.1192/bjo.2020.80

References

57. HM Government. Largest ever increase in funding for drug treatment. Accessed October 3, 2024. https://www.gov.uk/government/news/largest-ever-increase-in-funding-for-drug-treatment
58. Sinclair J, Barnes TRE, Lingford-Hughes A, et al. Management of medically assisted withdrawal from alcohol in acute adult mental health and specialist addictions in-patient services: UK clinical audit findings. *BJPsych Open*. 2023;9(3). doi:10.1192/BJO.2023.45
59. Phoenix Futures. *Making Rehab Work: Mapping the Route to Make Specialist Care for People with Complex Needs Accessible.* 2021. Accessed October 3, 2024. https://www.phoenix-futures.org.uk/files/b417f2b855a31a9c2228a1d1253b5b27.pdf
60. Hydes T, Gilmore W, Sheron N, Gilmore I. Treating alcohol-related liver disease from a public health perspective. *J Hepatol*. 2019;70(2):223-236. doi:10.1016/J.JHEP.2018.10.036
61. Hemrage S, Parkin S, Kalk N, Shah N, Deluca P, Drummond C. Treatment engagement in comorbid alcohol use disorder and alcohol-related liver disease: A qualitative exploration of barriers and facilitators with service users. *Alcohol: Clinical and Experimental Research*. 2024;48(10):1965-1978. doi:10.1111/ACER.15427
62. Allison MED, Verne J, Bernal W, et al. Deaths from alcohol-related liver disease in the UK: an escalating tragedy. *The Lancet*. 2023;401(10375):418-420. doi:10.1016/S0140-6736(22)02583-1
63. Office for Health Improvement & Disparities. *Young people's substance misuse treatment statistics 2022 to 2023: report*. January 25, 2024. Accessed October 3, 2024. https://www.gov.uk/government/statistics/substance-misuse-treatment-for-young-people-2022-to-2023/young-peoples-substance-misuse-treatment-statistics-2022-to-2023-report
64. Office for Health Improvement & Disparities. *Adult substance misuse treatment statistics 2022 to 2023: report*. December 10, 2023. Accessed October 3, 2024. https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2022-to-2023/adult-substance-misuse-treatment-statistics-2022-to-2023-report#mentalhealth
65. Royal College of Psychiatrists. *Training in Addiction Psychiatry: Current Status and Future Prospects.* RCPsych; 2020. Accessed August 8, 2024. https://www.rcpsych.ac.uk/docs/default-source/members/faculties/addictions-psychiatry/training-in-addiction-psychiatry---current-status-and-future-prospects-(web).pdf?sfvrsn=14de2911_2
66. Jackson K, Kaner E, Hanratty B, Gilvarry E, Yardley L, O'Donnell A. Understanding people's experiences of the formal health and social care system for co-occurring heavy alcohol use and depression through the lens of relational autonomy: A qualitative study. *Addiction*. 2024;119(2):268-280. doi:10.1111/add.16350
67. The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). *Annual Report: UK Patient and General Population Data, 2010-2020.* NCISH*; 2023.* Accessed August 8, 2024. https://documents.manchester.ac.uk/display.aspx?DocID=66829
68. The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). *Suicide by People in Contact with Drug and Alcohol Services: A National Study 2021 to 2022*. NCISH; 2024. Accessed August 8, 2024. https://documents.manchester.ac.uk/display.aspx?DocID=71822

References

69. Rimmer A. Addiction psychiatry could be wiped out in a decade without urgent government funding, college warns. *BMJ*. 2020;368:m635. doi:10.1136/bmj.m635
70. World Health Organization. *Global Status Report on Alcohol and Health 2018.* WHO; 2018. Accessed October 3, 2024. https://iris.who.int/handle/10665/274603
71. Williams R, Alessi C, Alexander G, et al. New dimensions for hospital services and early detection of disease: a Review from the Lancet Commission into liver disease in the UK. *The Lancet*. 2021;397(10286):1770-1780. doi:10.1016/S0140-6736(20)32396-5
72. Verrill C, Markham H, Templeton A, Carr NJ, Sheron N. Alcohol-related cirrhosis—early abstinence is a key factor in prognosis, even in the most severe cases. *Addiction*. 2009;104(5):768-774. doi:10.1111/J.1360-0443.2009.02521.X
73. Williams R, Aspinall R, Bellis M, et al. Addressing liver disease in the UK: A blueprint for attaining excellence in health care and reducing premature mortality from lifestyle issues of excess consumption of alcohol, obesity, and viral hepatitis. *The Lancet*. 2014;384(9958):1953-1997. doi:10.1016/S0140-6736(14)61838-9
74. Roberts SE, John A, Brown J, Napier DJ, Lyons RA, Williams JG. Early and late mortality following unscheduled admissions for severe liver disease across England and Wales. *Aliment Pharmacol Ther*. 2019;49(10):1334. doi:10.1111/APT.15232
75. Alcohol Concern. *The Hardest Hit: Addressing the Crisis in Alcohol Treatment Services.* Alcohol Research UK; 2018. Accessed August 8, 2024. https://s3.eu-west-2.amazonaws.com/sr-acuk-craft/documents/The-hardest-hit.pdf
76. Drummond C, Wolstenholme A, Blackwood R, Kimergard A. Assertive Outreach for High-Need, High-Cost Alcohol-Related Frequent NHS Hospital Attenders: The Value-Based Case for Investment.; 2019.
77. Moriarty KJ. Alcohol care teams: where are we now? *Frontline Gastroenterol*. 2020;11(4):293-302. doi:10.1136/FLGASTRO-2019-101241
78. Alcohol Change UK. *The Alcohol Treatment Levy.* Alcohol Research UK; 2018. Accessed August 8, 2024. https://s3.eu-west-2.amazonaws.com/files.alcoholchange.org.uk/documents/The_treatment_levy_briefing_paper_ALL_CHANGES.pdf
79. Alcohol Care Team Innovation & Optimisation Network. S*tandards for Alcohol Care Teams Second Edition.* ACTION; 2024. Accessed August 19, 2024. https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/alcohol-care-team-innovation-optimisation-network-(action)/action-standards---second-edition.pdf?sfvrsn=5b33c406_4
80. National Institute for Health and Care Research. Programme of Research for Alcohol Care Teams: Impact, Value and Effectiveness (ProACTIVE). April 2024. Accessed August 19, 2024. https://fundingawards.nihr.ac.uk/award/NIHR152084
81. Office for Health Improvement & Disparities. *UK Clinical Guidelines for Alcohol Trea...Elements of Alcohol Treatment Core Elements of Alcohol Treatment.* OHID; 2023. Accessed August 7, 2024. https://www.gov.uk/government/consultations/uk-clinical-guidelines-for-alcohol-treatment/uk-clinical-guidelines-for-alcohol-treatment-core-elements-of-alcohol-treatment

References

82. Office for Health Improvement & Disparities. *UK Clinical Guidelines for Alcohol Treatment: Specific Settings and Populations.* OHID; 2023. https://www.gov.uk/government/consultations/uk-clinical-guidelines-
83. Royal College of Psychiatrists. *General Psychiatry: Royal College of Psychiatrists Higher Specialty Curriculum (ST4 – ST6).* RCPsych; 2022. https://www.rcpsych.ac.uk/docs/default-source/training/curricula-and-guidance/general_psychiatry_curriculum_march_2019.pdf
84. NHS England. 10-year strategic plan for the drug and alcohol treatment and recovery workforce (2024–2034). Accessed October 3, 2024. https://www.england.nhs.uk/publication/10-year-strategic-plan-for-the-drug-and-alcohol-treatment-and-recovery-workforce-2024-2034/
85. Public Health England. *Better Care for People with Co-Occurring Mental Health and Alcohol/Drug Use Conditions: A Guide for Commissioners and Service Providers*. PHE; 2017. Accessed October 4, 2024. https://assets.publishing.service.gov.uk/media/5a75b781ed915d6faf2b5276/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf
86. Public Health England. How to use the ASSIST-Lite screening tool to identify alcohol and drug use and tobacco smoking. 2021. Accessed October 4, 2024. https://www.gov.uk/government/publications/assist-lite-screening-tool-how-to-use/how-to-use-the-assist-lite-screening-tool-to-identify-alcohol-and-drug-use-and-tobacco-smoking#
87. Humanising Healthcare | Our story. Accessed October 3, 2024. https://www.humanisinghealthcare.net/about
88. Alcohol Change UK. Understanding the language around different patterns of drinking. Accessed September 23, 2024. https://alcoholchange.org.uk/policy/policy-insights/understanding-the-different-patterns-of-drinking
89. Prevention | Local Government Association. Accessed September 23, 2024. https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/integration-and-better-care-fund/better-care-fund/integration-resource-library/prevention