

Interventions for alcohol dependence in Europe:

a missed opportunity to improve public health

Based on the book

Alcohol consumption, alcohol dependence and attributable burden of disease in Europe: potential gains from effective interventions for alcohol dependence

by Jürgen Rehm, Kevin D Shield and colleagues

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Alcohol consumption, alcohol dependence and attributable burden of disease in Europe: potential gains from effective interventions for alcohol dependence was published in May 2012. The full report is available free of charge from www.camh.net

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For more information about *Alcohol consumption, alcohol dependence and attributable burden of disease in Europe: potential gains from effective interventions for alcohol dependence* or this summary document, please contact:

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Foreword

The complexity of addressing excessive alcohol consumption and fighting alcohol related harm makes it one of the most serious threats to public health, social welfare and economic development in Europe and globally.

According to the World Health Organization (WHO), the global burden of alcohol, both in terms of morbidity and mortality, is substantial: alcohol consumption is responsible for 3.4% of deaths worldwide and is a well-known reason for increased risk of more than 60 diseases and strongly related to mortality from cirrhosis, chronic pancreatitis and hypertension.¹ Excessive alcohol consumption also increases the risk of depression and other mental and behavioural disorders.² Vice versa, such disorders may trigger alcohol dependence which is a common medical and behavioural disorder and a recognised chronic brain disease.³

In Europe, per capita alcohol consumption is by far the highest in the world. In the EU, one in 7 men and one in 13 women, aged between 15 and 64 years, die of alcohol-attributable causes. These mortality figures are devastating not only for the affected individuals and their families but have also a clear negative impact on labour and productivity. As such, excessive consumption of alcohol remains a central challenge with severe consequences for overall European welfare.

The report 'Interventions for alcohol dependence in Europe: A missed opportunity to improve public health' provides policy makers with new and comparable evidence on alcohol consumption and the burden of alcohol dependence in the EU. It highlights, for example, that more than 60% of the social costs that can be attributed to alcohol related harm in the EU (estimated at €155.8 billion in 2010) are estimated to have resulted from heavy drinking associated with alcohol dependence – a condition that affects 12 million Europeans. Building on the WHO report 'Alcohol in the EU: consumption, harm and policy approaches',⁴ where the value of brief interventions and treatment programmes, despite massive under-use, is recognised, this report recommends that current policy prevention priorities are supplemented by increasing the availability of treatment for alcohol dependence and at much lower thresholds.

Still, while increasing treatment efforts is indeed part of the box of tools for preventing alcohol related harm, effectively reducing the number of avoidable alcohol related deaths, social damage and cost to society will require a comprehensive and integrated approach, ranging from education and prevention to treatment and care, and involving all relevant stakeholders.

The EU has a very important role to play in coordinating such actions and policies and promoting best practices to support and complement national efforts. Although alcohol is high on the EU as well as many national policy agendas, it is often under prioritised in health policy due to difficulties in defining and addressing the problem. Indeed, the debate on alcohol has thus far neglected to address the issue of alcohol dependence in all its facets, instead focused only on the most extreme and visible cases of excessive drinking. If alcohol and alcohol related harm is to be truly addressed all types of alcohol dependence must be included in the debate and the holistic approach involving all existing measures must be fully accounted for in policy strategies on alcohol.

With the EU Strategy on Alcohol currently under evaluation, this report is a timely and fruitful contribution to the debate on EU alcohol and health policy. The EU institutions must rise to this challenge by renewing and improving the EU Alcohol Strategy with a view to achieving comprehensive and effective alcohol plans across Europe that include provisions on alcohol dependence. Never has the topic been more relevant or crucial in times of economic crisis and constrained health budgets.


Elena Oana Antonogescu
Member of the European Parliament

1 Ojesjö L, Hagnell O, Otterbeck L. Mortality in alcoholism among men in the Lundby community cohort, Sweden: a forty-year follow-up. *J Stud Alcohol* 1998; 59: 140-145

2 *ibid.*

3 Alcohol dependence is well recognised as a chronic brain disease - most notably in Edwards, G., & Gross, M. M. (1976). Alcohol dependence: Provisional description of a clinical syndrome. *British Medical Journal*, 1, 1058-1061 and Gilpin, N.W., Koob, G.F. (2008). Overview: neurobiology of alcohol dependence with a focus on motivational mechanisms. *Alcohol Research & Health*, 31, 185-95. The European Medicine's Agency (EMA) guidelines on the development of medicinal products for the treatment of alcohol dependence also underscores the genetic factors of alcohol dependence: http://www.emea.europa.eu/docs/en_GB/document_library/Scientific_guideline/2010/03/WC500074898.pdf. The World Health Organization (WHO) strategy 'A Global Strategy to reduce harmful use of alcohol' recognises the neurological affects of alcohol: http://www.who.int/substance_abuse/alcstratenglishfinal.pdf

4 http://www.euro.who.int/__data/assets/pdf_file/0003/160680/e96457.pdf

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Executive summary

Europe has the highest level of alcohol consumption in the world. While drinking patterns vary considerably across the region, overall alcohol consumption in the European Union (EU) is more than twice the global level. With high consumption comes a heavy burden and drinking alcohol is one of the major risk factors for avoidable death in early and middle adulthood. It contributes to the development of a range of non-communicable diseases, from cancer and cardiovascular disease and diabetes to cirrhosis of the liver, and, in most cases, the more alcohol consumed the higher the risks for alcohol-attributable disease.

In the EU, in 2004 (the latest year for which data are available), almost 95,000 men and more than 25,000 women aged 15 to 64 years died of alcohol-attributable causes. This means that one in seven male deaths and one in 13 female deaths in this age group were caused by alcohol.

Alcohol consumption contributes substantially to illness and disability as well as to death. In 2004 (the latest year for which data are available), over 4 million Disability-Adjusted Life Years (DALYs) – years of life lost either due to premature death or due to disability – were caused by alcohol consumption, corresponding to 15% of all DALYs in men and 4% of all DALYs in women.

Heavy drinking, consuming at least 60 grams of alcohol in a day on average for men and at least 40 grams in a day on average for women, causes the overwhelming majority of the alcohol-attributable health burden. Drinking five or more drinks on any occasion almost daily or several times a week is an indicator of chronic heavy drinking, while drinking to this extent up to once a week indicates irregular heavy drinking. Both chronic and irregular heavy drinking are linked to a range of specific health risks. Almost 80% of all male and over two thirds of all female net alcohol-attributable deaths were due to heavy drinking in 2004. Furthermore, heavy drinking accounted for a staggering 90% of alcohol-attributable net DALYs.

Alcohol dependence is a maladaptive pattern of alcohol use in which the individual has lost control of his or her drinking.

In 2005 (the latest year for which data are available), an estimated 5.4% of all men and 1.5% of all women aged 18 to 64 years in the EU suffered from alcohol dependence. This represents nearly 11 million people living with the disorder across the EU and this figure rises to approximately 12 million if older age groups are taken into account.

Alcohol dependence causes the overwhelming majority of the net burden attributable to alcohol and, perhaps unsurprisingly, most of the impact of alcohol dependence stems from heavy drinking. In 2004, alcohol dependence accounted for more than 70% of the overall alcohol-attributable mortality. The impact of alcohol consumption and alcohol dependence goes far beyond the drinker, to affect his or her family, friends, employers and society as a whole. Detrimental social effects include healthcare costs, divorce, child neglect, crime, traffic accidents, absenteeism and lost productivity in the workplace.

Together, the many social costs that can be attributed to alcohol represented an estimated €155.8 billion in the EU in 2010 and more than 60% of these costs are estimated to have resulted from heavy drinking associated with alcohol dependence.

A substantial portion of the alcohol-related burden is avoidable. Policy measures are already in place to varying degrees in different countries to reduce the burden through prevention of harmful consumption and its consequences. Examples include taxation policies, marketing bans and initiatives to reduce drink driving. However, the burden of alcohol consumption, and particularly of alcohol dependence, remains alarmingly high and additional measures must be put into place to address this.

Alcohol dependence is currently massively undertreated. Less than 10% of people with alcohol dependence receive treatment in Europe in spite of the fact that effective treatment options are available.

If effective treatment of alcohol dependence can be delivered to a sizeable proportion of people in the EU who are living with alcohol dependence, a substantial part of the overall alcohol-attributable burden could be reduced. Increasing the proportion of people with alcohol dependence who receive treatment for the condition is a realistic goal with the potential to deliver measurable results in terms of lowering alcohol-related harm. Due to the burden of heavy drinking, effective treatment must work to reduce the average level of drinking in people with alcohol dependence, i.e. to reduce the number of heavy drinking occasions either through complete abstinence or reduction in consumption.

A study was conducted to quantify the potential reduction of alcohol-attributable mortality achievable if treatment coverage was expanded to up to 40% of people with alcohol dependence in the EU. A statistical model was developed and used to simulate the impact on mortality of expanding coverage of five types of alcohol dependence treatment interventions, all of which have proven to be effective in randomised clinical trials. The interventions examined were: pharmacotherapy, cognitive behavioural therapy, motivational interviewing, and two types of brief intervention. The findings demonstrate that expanding coverage of treatment with the overall most effective intervention (pharmacotherapy) to 40% of all people with alcohol dependence in the EU would result in a reduction of 11,700 deaths (10,000 men and 1,700 women) within the first year.

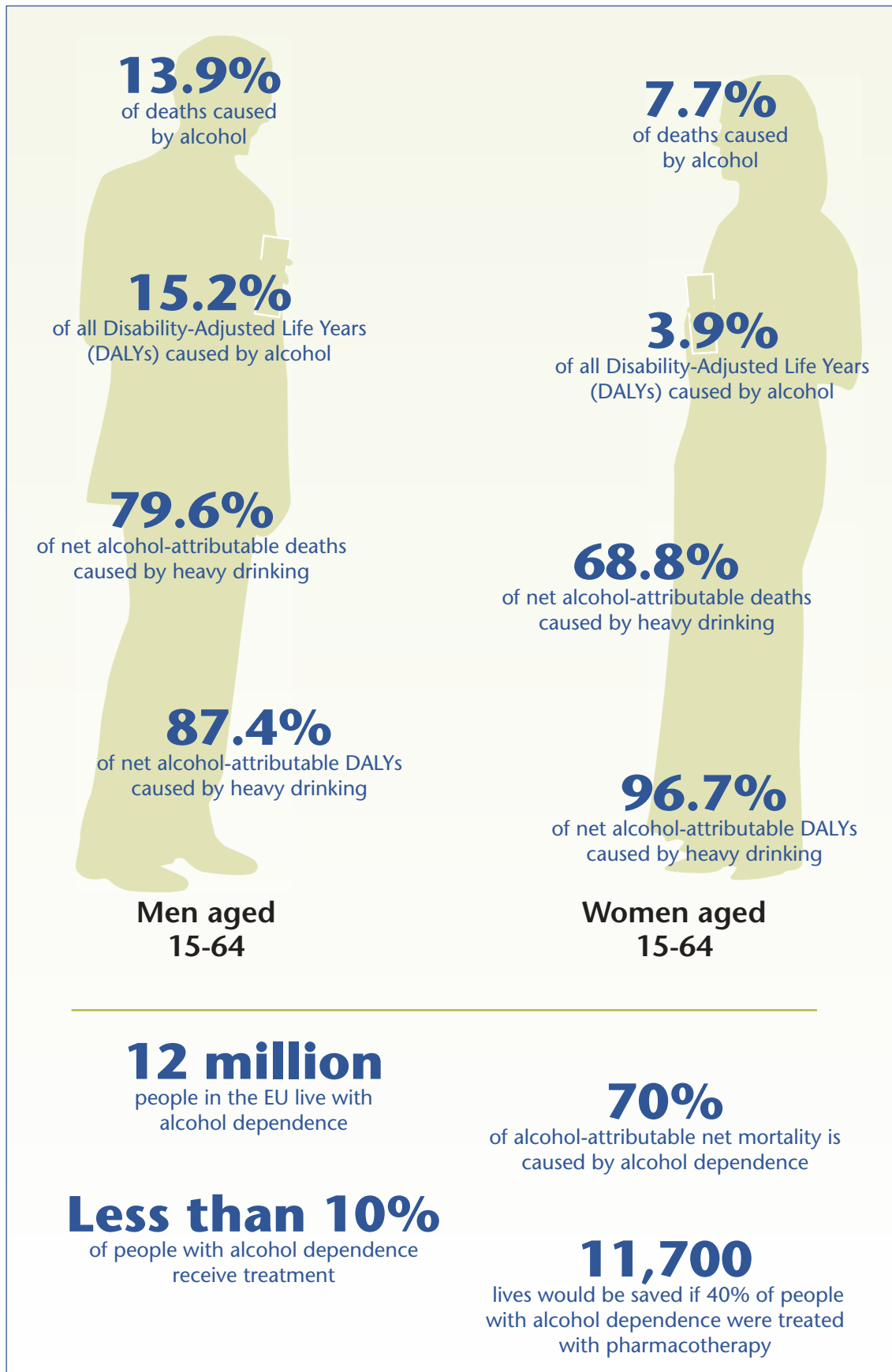
Treating 40% of people living with alcohol dependence in Europe with the most effective type of intervention (pharmacotherapy) would prevent 13% of alcohol-attributable deaths in men and 9% in women.

Both complete abstinence and a reduction of alcohol consumption as possible treatment outcomes are taken into account in these figures.

Given the substantial health burden attributable to alcohol consumption and, in particular, to alcohol dependence in Europe, current alcohol policy prevention measures should be supplemented with measures to expand treatment coverage.

It is suggested that treatment for alcohol dependence should be made available at much lower thresholds and should be implemented as an additional policy option supplementing other proven effective alcohol policy measures such as taxation, advertising bans and measures to address drink driving.

Statistics at a glance



Policy situation and recommendations

Alcohol policy today addresses prevention of harmful consumption with some consideration for treatment

The World Health Organization (WHO) global strategy to reduce the harmful use of alcohol focuses on prevention of harmful consumption of alcohol; by means of, for example, increased taxation, pricing policies and drink driving reduction initiatives. The global strategy includes treatment under one of ten policy target areas, stating that health services should provide prevention and treatment interventions to individuals and families at risk of, or affected by, alcohol dependence and associated conditions.

The EU strategy to reduce alcohol-related harm focuses on five areas: protecting young people and children; preventing drink driving; reducing alcohol-related harm among adults; raising awareness and collecting reliable data. While the strategy acknowledges that treatment interventions appear effective to prevent alcohol-related harm, treatment and treatment systems are not featured because the responsibility for these lies at a national level.

Recommendations to supplement current alcohol policy

Given the extent of the burden of alcohol dependence, and the strong evidence which shows the effectiveness of treatment interventions for improving public health:

- Current prevention policy priorities should be supplemented by increasing treatment capacity

While some of the preventive efforts currently in force are directed at avoiding future alcohol use disorders, policy makers should not neglect people who are currently suffering from alcohol-related disease:

- Availability of treatment for alcohol dependence should be increased and at much lower thresholds

“EUFAMI, the pan European representative federation for families and carers of people with mental illness, welcomes the recently published work on interventions for alcohol dependence in Europe, including the policy recommendations contained within the report. The adverse effects of alcohol dependence on families can be severe, and yet much of this burden goes unreported and as a result is not addressed.”

Kevin Jones, European Federation of Associations of Families of People with Mental Illness (EUFAMI)*

“European Men's Health Forum is a not for profit organisation seeking to improve men's health in Europe through addressing inequalities in healthcare, health literacy and EU/national health policy. Across Europe there are unacceptable differences in health between the sexes and men themselves. Harm through alcohol abuse is a good example and contributes significantly to the often enormous variation in average life expectancy found within and between member states.”

Professor Ian Banks, President, European Men's Health Forum (EMHF)*

* For more information on EUFAMI and EMHF please see page 22 of this document

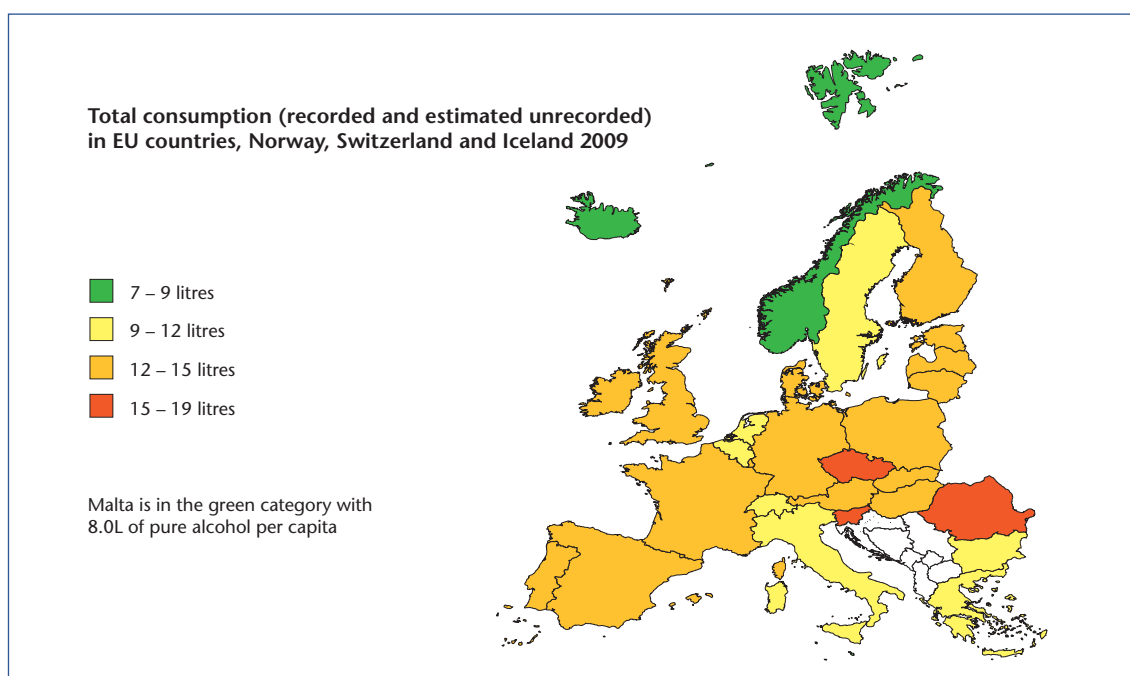
Drinking in Europe: who, what and how much?

Alcohol consumption is higher in Europe than in any other region in the world¹

While the current volume of alcohol consumption in the EU has been stable for several years, it is more than twice the global level. However, within Europe there is an enormous range of consumption. Recorded consumption is increasing in Central-East and Eastern European countries and, to a lesser extent, in the Nordic countries while decreasing in Central-West and Southern European countries.

Figure 1: Adult consumption in litres

The figure below indicates the per capita consumption, in litres of pure alcohol, for adults (15+ years) in EU countries (2009)



Drinking patterns vary dramatically across Europe

Traditional regional drinking patterns are still relevant, but modern lifestyles and globalisation are causing these to evolve:

- *Mediterranean pattern* characterised by: almost daily consumption of wine, often with meals and the avoidance of irregular heavy drinking
- *Central European pattern* characterised by: almost daily consumption of beer and avoidance of heavy drinking, but with more drinking taking place outside meal times than in the Mediterranean region
- *Northern and Eastern European pattern* characterised by: non-daily drinking of spirits with irregular heavy drinking and very heavy drinking episodes

¹ European Alcohol Action Plan, 2000-2005, World Health Organization Europe, http://www.euro.who.int/__data/assets/pdf_file/0004/79402/E67946.pdf

Both levels and patterns of drinking, such as binge drinking, impact on alcohol-related consequences

- Levels of drinking in the EU are highest in Central and Eastern Europe, and lowest in the Nordic countries and parts of Southern Europe
- Patterns of drinking, mainly based on irregular heavy drinking occasions, are most detrimental in Eastern Europe, the Nordic countries and the British Isles

Alcohol consumption may be under-reported

- Unrecorded consumption in Europe is estimated to be around 13% of total consumption (compared to 30% globally)
- Cross-border shopping, undeclared wine production, drinking alcohol not labelled for human consumption and 'moonshine' contribute to under-reporting

To learn more about this subject please refer to 'Key Indicators of Alcohol Consumption in Europe' in the full report, page 18:
http://www.camh.net/Research/Research_publications/CAMH%20Alcohol%20Report%20Europe%202012.pdf

Snapshot interview

Professor Jürgen Rehm

Given the regional variations in consumption, how do the data for European countries compare with global drinking levels?

Overall, even though there are differences between regions in drinking style and level, alcohol consumption is much higher in all parts of the EU than in any other part of the world except the Eastern European countries around Russia. The same can be said about the prevalence of heavy drinking.

The alcohol-attributable burden of disability and disease

Alcohol causes or contributes to a wide range of diseases

Alcohol causes or contributes to the development of a wide range of diseases from various cancers to liver, gastrointestinal, neuropsychiatric, cardiovascular and infectious diseases as well as unintentional (e.g. traffic accidents, falls, drowning) and intentional (e.g. suicide, self-harm, violence) injuries.

- In most cases, the relationship between alcohol and disease is 'dose-dependent': the more alcohol consumed, the greater the risk of disease
- In 2004 (the latest year for which data are available) alone, almost 95,000 men and more than 25,000 women aged 15 to 64 years died of alcohol-attributable causes in the EU (this takes into account the protective effect of alcohol consumption for some conditions, notably ischaemic heart disease)
- This represents a huge number of Potential Years of Life Lost (PYLL): 1,684,000 in men and 408,000 in women; making alcohol-attributable disease responsible for 16% of all PYLL in men and 8% in women

Measuring Disability-Adjusted Life Years (DALYs) gives a picture of the years lost by drinkers either through early death or through disability caused by alcohol-related disease. In 2004, 4,043,000 DALYs were lost due to alcohol-attributable diseases in the EU; this represents 15.2% of all DALYs in men and 3.9% in women.

Heavy drinking causes the majority of the alcohol-related burden of disability, disease and death

- In 2004, 77.3% of all net alcohol-attributable deaths and 89% of all net alcohol-attributable DALYs were caused by this type of harmful drinking; this corresponds to 92,600 deaths in total in just one year

Drinkers can cause significant harm to the health of others

Low birth weight and foetal alcohol syndrome (FAS) caused by a mother drinking during pregnancy, homicide and violence carried out by someone who has been drinking and injuries often resulting from drink driving accidents are all examples of how alcohol consumption causes harm to those other than the drinker. The burden of this harm cannot be ignored:

- In the EU in 2004, a total of 7,710 deaths were attributable to harm caused by other people's alcohol consumption
- The drinking of others was responsible for 218,560 DALYs in the same year

To learn more about this subject please refer to 'Alcohol-Attributable Burden of Disease in Europe' in the full report, page 31:
http://www.camh.net/Research/Research_publications/CAMH%20Alcohol%20Report%20Europe%202012.pdf

Snapshot interview

Kevin Jones, European Federation of Associations of Families of People with Mental Illness (EUFAMI)

What strain does alcohol dependence put on families?

When an alcohol problem enters a family circle, all members of that family are affected. Family members may blame themselves for their relative's problems; they can feel hurt, angry, lonely and inadequate. They may isolate themselves socially because of a sense of shame or take on an increased burden of responsibility. Alcohol problems can place a strain on all aspects of family life and relationships, leading in turn to reduced mental and physical health. On the other hand, families can play a key role in supporting the alcohol dependent person on their path to recovery. They can act as a support system and play a vital role in recognising the early indications of relapse.

Snapshot interview

Professor Ian Banks, President, European Men's Health Forum (EMHF)

How successful has the EU been in including an alcohol dimension into mental health policy?

The apparent lack of emphasis on alcohol dependence as an issue for mental health in Europe is at once disturbing and also perplexing. If the World Health Organization statistics are anything to go by an already critical situation is about to degenerate even further with immeasurable impact on health care delivery, the economy and of course human misery. Alcohol dependence is as a small pebble thrown into a pool. As the ripples move out they engulf the partner, family, workplace, healthcare professional and the economies.

Perhaps part of the problem is a failure to fully recognise alcohol dependence as a true disease rather than a sign of weak personality or stupidity.

Alcohol dependence is a widespread and devastating condition

Alcohol dependence (AD) is characterised by the inability to control one's own drinking

The Diagnostic and Statistical Manual of Mental Disorders (DSM IV) defines alcohol dependence as “a maladaptive use of alcohol with clinically significant impairment as manifested by at least three of the following criteria within any one year period: tolerance; withdrawal; taken in greater amounts or over a longer time course than intended; desire or unsuccessful attempts to cut down or control use; social, occupational or recreational activities given up or reduced; continued use despite knowledge of physical or psychological consequences of that use.”

Alcohol dependence is a widespread condition within the EU

- Based on the most recent data available from large general population surveys and WHO Regional Office for Europe figures, in 2005 an estimated 5.4% of all men and 1.5% of all women aged 18 to 64 years suffered from alcohol dependence
- This represents nearly 11 million people living with the disorder across the EU
- If all age groups are incorporated, this estimated figure rises to approximately 12 million people

There are differences in the regional prevalence of alcohol dependence

Countries located in Southern Europe (primarily along the Mediterranean Sea) had the lowest rates of alcohol dependence:

- These predominantly wine-drinking countries have lower alcohol consumption and more favourable drinking patterns (with less irregular heavy or binge drinking) than other European countries
- However, it should be acknowledged that the high social stigma associated with alcohol problems and alcohol dependence in these countries may contribute to under-reporting of the condition

The prevalence of alcohol dependence for people aged 18 to 64 years was noticeably higher in the rest of Europe, especially in the Nordic countries (7.4% for men and 2.7% for women) and the Central-East and Eastern European countries (7.8% for men and 1.5% for women). In Central-West and Western Europe it was 6.2% for men and 1.9% for women.

Perhaps unsurprisingly given their high consumption levels and tendency for heavy binge drinking, the Central-East and Eastern European countries, and the Baltics in particular, have the highest prevalence of alcohol dependence.

To learn more about this subject please refer to 'Alcohol Dependence: Prevalence and Associated Harm' in the full report, page 55:
http://www.camh.net/Research/Research_publications/CAMH%20Alcohol%20Report%20Europe%202012.pdf

Snapshot interview

Professor Jürgen Rehm

Is alcohol dependence a disease?

Of course, alcohol dependence is a disease as clearly defined by all major disease classification systems. Moreover, it is a brain disease the effects of which can be measured in changes in the brain function.

Snapshot interview

Diane Goslar, alcohol dependent person working with the Royal College of Psychiatrists, UK

How difficult is it to avoid alcohol when you have a problem?

Someone who was receiving treatment for a drugs problem said to me that it must be even harder trying to reduce or come off alcohol. Why? Well, he said, because alcohol is so pervasive and prevalent in our society it must be like having a dealer on every corner for you. A dealer on every corner. Think about that then maybe you'll realise how difficult it is.

Alcohol dependence is responsible for a high proportion of the alcohol-related burden

Alcohol dependence is responsible for 71% of the net mortality attributable to alcohol

- 77% of the net burden of alcohol on mortality stems from heavy drinkers
- The majority (71%) of alcohol-attributable burden is caused by alcohol dependence
- The main pathway between alcohol dependence and mortality is heavy drinking: higher levels of consumption are clearly linked to higher mortality risks

About 60% of social costs attributable to alcohol are due to alcohol dependence

- The social costs of alcohol consumption are wide ranging and can include crime; traffic accidents; family issues, such as child neglect and divorce; unemployment and absenteeism; dependence on society and significant healthcare costs
- The social costs of alcohol consumption were estimated to reach €155.8 billion in 2010 and 62% of these costs are estimated to result from heavy drinking associated with alcohol dependence
- While there are challenges in calculating the social cost of alcohol dependence alone, it is estimated to be between €50 billion and €120 billion for 2010; even if the lower estimate is taken, this is a huge burden for EU countries to bear

Benefits lie in reducing the overall consumption of alcohol by people with alcohol dependence through reducing total consumption and the number of heavy drinking days

- Effective treatment must work to reduce the average level of drinking by people with alcohol dependence, i.e. to reduce the number of heavy drinking occasions
- Average drinking can be reduced by achieving abstinence or by substantially reducing the amount consumed
- Because of the dose-dependent relationship between heavy drinking and mortality, reducing the number of heaviest drinking occasions has the potential to deliver an overly proportional benefit in terms of deaths avoided

Implications for alcohol policy: reducing heavy drinking must be at the heart of policy to reduce the harm caused by alcohol

- If effective treatment of alcohol dependence can be delivered to a sizeable proportion of people with alcohol dependence in the EU, a substantial part of the overall alcohol-attributable burden could be reduced
- A comprehensive approach should be taken to the reduction of alcohol-attributable risk in Europe
- Current prevention policy priorities should be supplemented by increasing treatment capacity and the availability of treatment for alcohol dependence at much lower thresholds

To learn more about this subject please refer to 'Alcohol Dependence: Prevalence and Associated Harm' in the full report, page 55:
http://www.camh.net/Research/Research_publications/CAMH%20Alcohol%20Report%20Europe%202012.pdf

Snapshot interview

Professor Jürgen Rehm

What is the contribution of alcohol dependence to the overall mortality burden of alcohol?

For a long time, alcohol dependence has been seen to be more disabling than fatal. Results of newer studies, however, show a substantial contribution of alcohol dependence to mortality, with an approximately 9-fold mortality risk in adults up to age 40 compared with the general population of same sex and age. Given these results, it is not surprising that alcohol dependence is responsible for more than 70% of the net burden of alcohol-attributable mortality.

Snapshot interview

Diane Goslar, alcohol dependent person working with the Royal College of Psychiatrists, UK

Has your alcohol problem caused any lasting damage?

I was shocked and very upset to recently learn that I have some brain damage and that it is very probably due to chronic alcohol abuse. That is frightening. This abnormality was first spotted by my optician during a routine examination. He didn't understand what the abnormality showed and so referred me to a neurologist. After scans this brain damage was confirmed. My mind is very precious to me and to have brain damage because of alcohol misuse is most distressing.

Snapshot interview

Professor Ian Banks, President, European Men's Health Forum (EMHF)

From a men's health perspective, what are the main challenges for early diagnosis of alcohol dependence?

Numerous studies including the recent EC commissioned report on the state of men's health in Europe clearly show that late diagnosis is sadly a common feature of men's use of primary care services. These delays must contribute to the invariably worse outcomes seen in many medical conditions common to both sexes. Alcohol dependence is no exception with liver disease and mental health problems, not least suicide on a rapid rise across Europe.

This gives some clue to the barriers which exist for men but which are made all the more impassable when compounded by embarrassment and social exclusion. We do need more research to discover more about these barriers and of course the way men would approach overcoming them with appropriate support.

Effective interventions for alcohol dependence exist but are underutilised across Europe

Effective treatments to address alcohol dependence are available in the EU

- The treatments for alcohol dependence most commonly used in the EU are: psychological interventions including Cognitive Behavioural Therapy (CBT); Motivational Interviewing (MI); brief psychotherapeutic interventions; variations of the 12-step approach advocated by organisations such as Alcoholics Anonymous, and pharmacological approaches, usually in conjunction with psychological therapies
- Two thirds of treatments for alcohol dependence involve psychotherapeutic interventions either alone or in combination with pharmacotherapy
- Pharmacological treatment is used in about 50% of cases, and 60% of all pharmacological treatment is administered in combination with psychological therapy
- Reduced drinking is an accepted treatment goal in all EU countries apart from Cyprus and Malta

Current treatments are effective in reducing drinking and reducing mortality

- People with alcohol dependence who are treated and either achieve abstinence or reduce the amount of alcohol they drink have a higher chance of survival than those who do not
- An analysis of seven randomised clinical trials demonstrated that brief interventions (short one-to-one counselling sessions delivered with the aim of moderating alcohol consumption and eliminating harmful drinking practices) administered to heavy drinkers admitted to hospital resulted in both a significant reduction in alcohol consumption and a substantial reduction in mortality risk at one year of follow-up

Less than 10% of people with alcohol dependence receive treatment in the EU

- Like most mental health disorders, alcohol dependence is severely undertreated and the overwhelming majority of dependent individuals do not receive any form of treatment
- Overall, there is not much variation in treatment rates between countries

There is a lack of national guidance on the treatment of alcohol dependence

- In spite of the scale of the problem represented by alcohol dependence, only around one third of countries have national guidelines in place for its treatment

To learn more about this subject please refer to 'The Medical Treatment System for Alcohol Dependence' in the full report, page 74:
http://www.camh.net/Research/Research_publications/CAMH%20Alcohol%20Report%20Europe%202012.pdf

Snapshot interview

Professor Falk Kiefer, Professor of Addiction Research, University of Heidelberg, Germany

What are the main barriers to treatment?

A key barrier to the initiation of treatment for alcohol dependence is the currently low level of diagnosis by GPs. Alcohol dependence extensively contributes to Disability-Adjusted Life Years lost and is an important risk factor for several secondary diseases. People with alcohol dependence are therefore often in close contact with their GP, which should lead to the opportunity for greater diagnosis and treatment for alcohol dependence.

A further barrier is the behaviour of the patients themselves. For many patients, a pattern of addictive behaviour is preferred over other behaviours and therefore they have a strong desire to continue this behaviour. An attempt by GPs to restrain the behaviour rather than motivate the patient often generates resistance, and confrontational intervention does not lead to any therapeutic effect. Furthermore, many patients are afraid of the consequence of a lifelong ban on alcohol in the case of a diagnosis of alcohol dependence.

Snapshot interview

Professor Ian Banks, President, European Men's Health Forum (EMHF)

How important is early diagnosis?

Early recognition and treatment are as essential as for cardiovascular disease. Damage to the man and his environment has generally already started and even reached an advanced stage before intervention takes place.

Snapshot interview

Diane Goslar, alcohol dependent person working with the Royal College of Psychiatrists, UK

Due to your alcohol dependence you now have to be abstinent – how does it feel?

If you can't drink alcohol, particularly in social settings, you really feel like an outsider. It's rather like looking at the outside world from the inside of a goldfish bowl. You also think that everyone's looking at you. Stop it...

Increasing treatment for alcohol dependence could save lives and benefit society

Assessing the impact on mortality of expanding treatment to a higher proportion of people with alcohol dependence

- The fact that the majority of the mortality burden of alcohol consumption stems from alcohol dependence, and that fewer than one in 10 people with alcohol dependence receive treatment, strongly identify improving coverage of treatment as an important public health objective
- Professor Rehm and colleagues modelled the potential impact on mortality of expanding treatment to up to 40% of people living with alcohol dependence in the EU from a public health perspective
- Data from published systematic reviews and meta-analyses were used to model the impact of increasing the coverage of interventions which have proven to be effective in randomised controlled clinical trials:
 - Cognitive Behavioural Therapy (CBT)
 - Motivational Interviewing (MI)
 - Two types of brief intervention (BI)
 - Pharmacological treatment (based on the use of acamprosate and opioid agonists)
- The average effectiveness of each intervention was based on an independent Cochrane review of interventions for alcohol dependence
- The methodology is described in detail in the full report, available at:
http://www.camh.net/Research/Research_publications/CAMH%20Alcohol%20Report%20Europe%202012.pdf

Expanding treatment coverage to 40% could result in almost 12,000 fewer deaths over 12 months

- 13% of the burden of mortality in men (about 10,000 deaths) and 9% of the burden in women (more than 1,700 deaths) could be prevented if 40% of people living with alcohol dependence in the EU were treated with pharmacotherapy (the most effective overall of the interventions modelled)
- This points to substantial improvements in both the health of individual drinkers and to the public health burden imposed by alcohol dependence
- Reflecting current practice, these figures take into account both abstinence and reduced consumption as treatment goals

Increasing treatment for alcohol dependence is an opportunity to reduce mortality and ultimately to improve public health

- Treatment of alcohol use disorders does not currently play a prominent role in either EU or WHO strategies
- Given the amount of burden linked to alcohol dependence, it is suggested that current priorities should be supplemented by increasing treatment capacity for this disease
- Arguably, in addition to striving to prevent future alcohol use disorders, countries have an ethical obligation to help people who are currently suffering from this devastating disease

To learn more about this subject please refer to 'Intervention Scenarios' in the full report, page 79:
http://www.camh.net/Research/Research_publications/CAMH%20Alcohol%20Report%20Europe%202012.pdf

Snapshot interview

Professor Falk Kiefer, Professor of Addiction Research, University of Heidelberg, Germany

Many people who are alcohol dependent may not consider abstinence as a treatment goal. What are the alternatives today to abstinence and is alcohol reduction an option for these people?

As with the treatment of other diseases, following the diagnosis of alcohol dependence a stepped care approach should be chosen. The first stage with a non-treated or early-stage patient is therefore to implement a reduction of alcohol consumption approach and support them with a psychotherapeutic and/or pharmacological treatment. Patients in the early stages of alcohol dependence often respond well to reduction attempts. In cases where the reduction of alcohol consumption remains unsuccessful and further additional support is not available, a timely limited abstinence goal is added. According to clinical experience, patients who have not yet failed at their reduction goal are not ready for abstinence.

A reduction goal does not invalidate the goal of total abstinence, but is (a) a first low-threshold treatment goal which is easier to accept both for patients and physicians as a first step and (b) an alternative treatment goal for severely dependent patients, for whom reduction is a necessary treatment goal between abstinence and non-treatment.

Snapshot of alcohol dependence in selected countries

Figures based on most recent data available

Bulgaria	
Total alcohol consumption (2009)	11.5 litres per adult
Proportion of drinkers who drink heavily several times a week (2009)	8%
Number of people with alcohol dependence aged 18-64 (2004)	Men: 184,500 Women: 35,900
Prevalence of alcohol dependence (%) for men and women aged 18-64 (2004)	Men: 7.3% Women: 1.4%
Deaths attributable to alcohol dependence per 100,000 people aged 15-64 (2004)	0.85
Guidelines for the treatment of alcohol dependence	No guidelines available
Denmark	
Total alcohol consumption (2009)	12.9 litres per adult
Proportion of drinkers who drink heavily several times a week (2009)	7%
Number of people with alcohol dependence aged 18-64 (2005)	Men: 83,000 Women: 32,300
Prevalence of alcohol dependence (%) for men and women aged 18-64 (2005)	Men: 4.8% Women: 1.9%
Deaths attributable to alcohol dependence per 100,000 people aged 15-64 (2004)	6.19
Guidelines for the treatment of alcohol dependence	Professional guidelines available
France	
Total alcohol consumption (2009)	12.7 litres per adult
Proportion of drinkers who drink heavily several times a week (2009)	7%
Number of people with alcohol dependence aged 18-64 (2001-2002)	Men: 1,001,700 Women: 284,700
Prevalence of alcohol dependence (%) for men and women aged 18-64 (2001-2002)	Men: 5.3% Women: 1.5%
Deaths attributable to alcohol dependence per 100,000 people aged 15-64 (2004)	3.93
Guidelines for the treatment of alcohol dependence	National guidelines available

Germany	
Total alcohol consumption (2009)	12.9 litres per adult
Proportion of drinkers who drink heavily several times a week (2009)	14%
Number of people with alcohol dependence aged 18-64 (1997-1999)	Men: 1,445,000 Women: 338,900
Prevalence of alcohol dependence (%) for men and women aged 18-64 (1997-1999)	Men: 5.4% Women: 1.3%
Deaths attributable to alcohol dependence per 100,000 people aged 15-64 (2004)	3.96
Guidelines for the treatment of alcohol dependence	National and professional guidelines available

Ireland	
Total alcohol consumption (2009)	12.9 litres per adult
Proportion of drinkers who drink heavily several times a week (2009)	12%
Number of people with alcohol dependence aged 18-64 (2004)	Men: 86,100 Women: 26,600
Prevalence of alcohol dependence (%) for men and women aged 18-64 (2004)	Men: 6.4% Women: 2.0%
Deaths attributable to alcohol dependence per 100,000 people aged 15-64 (2004)	1.42
Guidelines for the treatment of alcohol dependence	No guidelines available

Italy	
Total alcohol consumption (2009)	9.6 litres per adult
Proportion of drinkers who drink heavily several times a week (2009)	16%
Number of people with alcohol dependence aged 18-64 (2001-2003)	Men: 149,800 Women: 93,600
Prevalence of alcohol dependence (%) for men and women aged 18-64 (2001-2003)	Men: 0.8% Women: 0.5%
Deaths attributable to alcohol dependence per 100,000 people aged 15-64 (2004)	0.17
Guidelines for the treatment of alcohol dependence	No guidelines available

Lithuania	
Total alcohol consumption (2009)	13.0 litres per adult
Proportion of drinkers who drink heavily several times a week (2009)	6%
Number of people with alcohol dependence aged 18-64 (2004)	Men: 104,200 Women: 21,600
Prevalence of alcohol dependence (%) for men and women aged 18-64 (2004)	Men: 9.9 Women: 1.9
Deaths attributable to alcohol dependence per 100,000 people aged 15-64(2004)	0.79
Guidelines for the treatment of alcohol dependence	No guidelines available

Poland	
Total alcohol consumption (2009)	13.6 litres per adult
Proportion of drinkers who drink heavily several times a week (2009)	3%
Number of people with alcohol dependence aged 18-64 (2004)	Men: 1,058,200 Women: 205,500
Prevalence of alcohol dependence (%) for men and women aged 18-64 (2004)	Men: 8.4 Women: 1.6
Deaths attributable to alcohol dependence per 100,000 people aged 15-64 (2004)	3.95
Guidelines for the treatment of alcohol dependence	National guidelines available

Romania	
Total alcohol consumption (2009)	16.3 litres per adult
Proportion of drinkers who drink heavily several times a week (2009)	19%
Number of people with alcohol dependence aged 18-64 (2007)	Men: 155,000 Women: 50,000
Prevalence of alcohol dependence (%) for men and women aged 18-64 (2007)	Men: 2.2% Women: 0.7%
Deaths attributable to alcohol dependence per 100,000 people aged 15-64 (2004)	2.74
Guidelines for the treatment of alcohol dependence	No guidelines available

Spain	
Total alcohol consumption (2009)	13.1 litres per adult
Proportion of drinkers who drink heavily several times a week (2009)	15%
Number of people with alcohol dependence aged 18-64 (2000/2001)	Men: 173,600 Women: 28,410
Prevalence of alcohol dependence (%) for men and women aged 18-64 (2000/2001)	Men: 1.2 Women: 0.2
Deaths attributable to alcohol dependence per 100,000 people aged 15-64 (2004)	0.49
Guidelines for the treatment of alcohol dependence	No national guidelines, but some professional guidelines are available

UK	
Total alcohol consumption (2009)	12.5 litres per adult
Proportion of drinkers who drink heavily several times a week (2009)	14%
Number of people with alcohol dependence aged 18-64 (England only, 2007)	Men: 1,745,500 Women: 683,300
Prevalence of alcohol dependence (%) for men and women aged 18-64 (England only, 2007)	Men: 9.3% Women: 3.6%
Deaths attributable to alcohol dependence per 100,000 people aged 15-64 (2004)	1.28
Guidelines for the treatment of alcohol dependence	National and professional guidelines available

Methodology and bibliography

For a full description of the methodology employed by Professor Rehm and colleagues to model the potential reductions in mortality achievable with greater treatment coverage, as well as full citations for all sources used in preparing their report of which this document is a brief summary, please refer to the full report, available at:

http://www.camh.net/Research/Research_publications/CAMH%20Alcohol%20Report%20Europe%202012.pdf

About EUFAMI and EMHF

The following organisations have reviewed the full report *Alcohol consumption, alcohol dependence and attributable burden of disease in Europe: potential gains from effective interventions for alcohol dependence*, and provided their support to this summary document:

EUFAMI (European Federation of Associations of Families of People with Mental Illness)



EUFAMI was founded in 1992 after a congress at which carers from all over Europe shared their experiences of helplessness and frustration when living with severe mental illness. They resolved to work together to help both themselves and the people they cared for. EUFAMI Members are national and regional organisations that support family, carers and people with mental illness throughout Europe.

EUFAMI has an ongoing commitment to improving care and welfare for people affected by mental illness and enables its member organisations to act jointly at a European Level, combining their efforts and sharing experience.

EUFAMI is a democratic organisation, registered in Belgium as an international non-profit organisation.

Find out more about EUFAMI: www.eufami.org

EMHF (European Men's Health Forum)



European Men's Health Forum, registered as an NGO in Brussels 2002 is the only European organisation dedicated to the improvement of men's health in all its aspects. It drives collaboration of a wide range of stakeholder groups in Europe.

EMHF was initiated by The Men's Health Forum, the leading advocate of men's health in England and Wales, with the support and collaboration of partners who share its aim of tackling the poor state of male health across all the countries of Europe. EMHF aims to provide a platform for stakeholders to contribute their expertise, and learn from others about the most appropriate approaches to improve men's health in their particular context.

Find out more about EMHF: www.emhf.org





