Alcohol dependence

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ADULT PSYCHIATRIC MORBIDITY SURVEY 2014 CHAPTER 10

Summary

- According to the Alcohol Use Disorders Identification Test (AUDIT), 16.6% of adults drank at hazardous levels (AUDIT scores of 8 to 15), 1.9% were harmful or mildly dependent drinkers (AUDIT scores of 16 to 19) and 1.2% were probably dependent drinkers (AUDIT scores of 20 or more). As in previous years, men were more likely than women to drink at hazardous levels and above. Most adults drank at lower risk levels (57.5%) or did not drink at all (22.8%).
- Of men aged 16 to 64, between a quarter and a third drank at hazardous levels or above. Such drinking was less common in men aged 65 and older. In women, drinking at hazardous levels or above was most common in 16 to 24 year olds (25.6%). In the 25 to 64 year age-groups, between 13% and 15% drank at these levels, while rates in older women were lower.
- Harmful, mildly dependent, and probably dependent drinking was most common in men aged 25 to 34 (6.6%). The proportions drinking at this level were lower in older age-groups. In women, drinking at this level was most frequent in those aged 16 to 24.
- Levels of hazardous drinking have declined in men over the past fifteen years (36.8% in 2000 among 16 to 74 year olds; 32.4% in 2007; 27.9% in 2014), and remained stable in women.
- Overall, levels of harmful and dependent drinking have remained stable. However, this masks trends divergent between age groups. AUDIT scores of 16 or above have become less common in 16 to 24 year olds (6.2% in 2007, 4.2% in 2014), but more common in 55 to 64 year olds (1.4% in 2007, 2.8% in 2014).
- Self-diagnosis and diagnosis by professionals of alcohol or drug dependence was most frequent among people whose AUDIT scores indicated probable dependence: but even then such diagnoses were reported only by a minority. Of those with probable dependence, 42.2% reported that they had at some time experienced alcohol or drug dependence, and 34.2% reported that they had received such a diagnosis from a professional.

- White British men and women were more likely to drink at hazardous, harmful or dependent levels than their counterparts in other ethnic groups.
- Adults aged less than 60 and living in households with no children were more likely to be drink at hazardous levels or above than those who lived with children. In particular, men aged under 60 living alone were almost twice as likely to drink at harmful or mildly dependent levels or above than men in any other type of household. In contrast, adults aged over 60 living alone or with another adult were the least likely to drink at hazardous levels or above.
- Men and women in receipt of Employment and Support Allowance (ESA) were more likely than those who did not receive this benefit to be harmful or mildly dependent drinkers or above. 10.8% of men and 9.4% of women on ESA drank at these levels, compared with 4.9% of men and 2.1% of women who did not receive ESA. There was a similar pattern for other benefits.
- A third of adults with probable alcohol dependence (AUDIT 20+) were receiving treatment and services for a mental or emotional problem. They were also more likely than others to use health and community care services. Furthermore, 6.1% of this group were in receipt of medication intended to treat substance misuse and 6.3% were in substance misuse counselling.

10.1 Introduction

The impact of alcohol consumption

In England, alcoholic drinks are widely available and widely consumed by the majority of the adult population. Most people who drink do so without adverse consequences. However, alcohol is responsible for a considerable degree of health and social harm.

Alcohol-related harms exist on a continuum, and include acute and chronic health and social consequences, as well as harm to people other than the drinker. According to the World Health Organisation (WHO), alcohol is wholly or partly responsible for over 200 different disease conditions. Alcohol is identified as a Grade 1 carcinogen (the most carcinogenic type) and is responsible for 4%

of all cancers worldwide (WHO 1988; Rehm et al. 2009). Excessive alcohol consumption is a leading cause of disability in the UK and Europe (WHO 2010).

Acute harms from alcohol include accidents, injuries, collapse, self-harm and in severe cases, acute alcohol poisoning. Alcohol misuse does not only harm those who drink. It is implicated in 53% of violent incidents in England and Wales (ONS 2015a). Results from the Crime Survey for England and Wales 2015 indicated that one in ten adults had witnessed drinking-related antisocial behaviour in their local area (ONS 2015b). In 2013, 4% of all road traffic accidents and 14% of all deaths reported in road traffic accidents involved at least one driver over the drink-driving limit (Department of Transport 2015). Alcohol misuse is associated with violence and marital breakdown, and children of problem drinkers are more likely to suffer emotional and behavioural problems, and to perform poorly at school (Cuijpers et al. 2006).

There is evidence that heavy drinkers have poorer levels of mental health. Alcohol misuse often co-exists with common mental disorders, such as depression and anxiety, as well as with misuse of other substances (Grant et al. 2004; Weich et al. 2011; McManus 2009). High levels of hazardous and dependent drinking have been recorded in people being treated for serious mental health problems. Alcohol dependence and other problems associated with alcohol misuse are also frequent in homeless people and prisoners, again often in combination with poor mental health (Drummond et al. 2008; Light et al. 2013).

Alcohol-related hospital admissions continue to increase in England and exceed one million per annum (HSCIC 2015). Between 2003/04 and 2013/14 hospital admissions due wholly or partly to alcohol consumption more than doubled (HSCIC 2015). In 2013/14 the commonest wholly attributable cause of alcohol admissions was mental and behavioural disorders due to use of alcohol, including alcohol dependence and related conditions (204,450), followed by alcoholic liver disease (53,310), and toxic effects of alcohol (35,620). The most common partly alcohol-attributable causes of hospital admission were cardiovascular disease (511,260) followed by cancer (86,650), unintentional injuries (50,720) and intentional injuries including self-harm and assault (9,350). These are likely to be an underestimate of the true burden of alcohol on NHS hospital services due to the well-recognised under-diagnosis of alcohol use

disorders in hospital settings. Wholly attributable alcohol deaths have also increased by 23% from 2001 (5,479 deaths) to 2013 (6,592 deaths) (HSCIC 2015).

In 2012, it was estimated that the cost of alcohol misuse in England was around £21 billion a year; as well as costs to the health service, this included the costs of crime and anti-social behaviour and the impact on productivity in the workplace (Home Office 2012).

Policy and guidance

In recent years the government has made alcohol misuse a strategic priority. The 2012 *Government's Alcohol Strategy* identified ways to reduce the harm caused by alcohol: by increasing the price of alcohol, banning multi-buy promotions, improving the early identification and treatment of those with alcohol problems, and addressing alcohol-related crime and disorder.

The implementation of the ambitions set out in the Government's strategy has included some of the key proposed strategies, such as setting a minimum unit price for alcohol and banning multi-buy promotions, not being carried forward. In 2007, a Public Service Agreement (PSA) target was set to 'reduce the harm caused by alcohol and drugs'. One indicator of success was defined as reducing the number of alcohol-related hospital admissions, to be achieved in part by improving at every level the services available to those who wanted to drink less. The target to reduce alcohol related hospital admissions has been reiterated in the most recent Public Health Outcomes Framework (DH 2013).

In 2016, the UK Chief Medical Officer published new guidelines on alcohol, based on the recommendation of an expert review of the association between alcohol consumption and health harms (DH 2016). This review identified a lower than previously thought beneficial effect of alcohol and evidence of a stronger association with certain types of cancer and other health harms than was previously identified. Based on this evidence, the guidelines advised that for both men and women, it is safest not drink more than 14 UK units of alcohol per week (112g of pure ethanol), and within that to avoid alcohol binges by spreading drinking over 3 or more days per week. The revised advice in pregnancy is that the safest approach is to abstain.

Patterns of consumption

In 2014, Health Survey for England data showed that 85% of men and 79% of women consumed some alcohol in the last year (Craig et al. 2015). The proportion of adults who do not drink at all has increased over the past decade from 11% of men and 16% of women in 2006 to 15% of men and 21% of women in 2014. In particular, the proportion of non-drinkers among young people aged 16 to 24 has increased from 17% of young men and 16% of young women in 2006 to 22% of young men and 23% of young women in 2014 (DH 2016; Craig and Mindel 2007).

Among adults who had drunk alcohol in the last year, the median weekly consumption was 9.2 units by men and 3.8 units by women. Overall, 63% of men reported average weekly consumption of no more than 21 units (until the publication of new guidelines, the recommended lower risk limit for men), and 62% of women drank no more than 14 units a week. A further 17% of men and 12% of women drank at increasing risk levels (22 to 50 units a week for men, 15 to 35 units for women). 5% of men and 4% of women drank more than these amounts (considered higher risk consumption according to NHS guidance at the time) in an average week.

In England in 2014, 59% of men and 43% of women reported drinking alcohol every week. 17% of men and 9% of women had drunk alcohol on five or more days in the last week. The proportion of men drinking alcohol in the last week increased with age, and was highest for those aged 55 to 64 years. A similar trend was evident among women – the proportion of women who drank in the last week increased up to the 45 to 54 age group, and declined thereafter.

The Adult Psychiatric Morbidity Survey (APMS) focuses on the prevalence of hazardous, harmful and dependent drinking, collectively classified by the tenth International Classification of Disorders (ICD-10) as alcohol use disorders (National Institute of Alcohol Abuse and Alcoholism 2013). It has been estimated that a minority of the population consumes the majority of all alcohol consumed in England: 70% of the alcohol is consumed by the 20% of the population whose drinking is classed as hazardous, harmful or extreme (Sheron and Gilmore 2016).

10.2 Definition and assessment

'Alcohol use disorders' encompass a range of conditions defined in the ICD10. In this chapter we consider 'harmful alcohol use' (an established pattern of drinking causing damage to health) and 'alcohol dependence' as defined by ICD10 (including signs of addiction to alcohol). We also consider hazardous drinking (an established pattern of drinking increasing the risk of health harm). Initial questions about alcohol consumption were asked by the interviewer face to face. All participants who drank alcohol, even if just occasionally, were then routed to the remaining alcohol use questions. These were administered using computer-assisted self-completion interview (CASI), consistent with the approach used on the 2000 and 2007 surveys.

The primary measure presented in this chapter is the Alcohol Use Disorders Identification Test (AUDIT) (Saunders et al. 1993). The AUDIT takes the year before the interview as a reference period, consists of 10 items and covers the following areas:

- Alcohol consumption (frequency of drinking, typical quantity, frequency of heavy drinking)
- Alcohol-related harm (feeling of guilt or remorse after drinking, blackouts, alcohol-related injury, other concern about alcohol consumption)
- Symptoms of alcohol dependence (impaired control over drinking, increased salience of drinking, morning drinking).

Answers to all questions are scored from zero to four, and summed to give a total score ranging from 0 to 40. A score of:

- Non-drinker or low risk drinking (scores up to 7)
- Hazardous drinking (scores from 8 to 15)
- Harmful drinking and/or mild dependence (scores from 16 to 19)
- Probable dependence (scores 20 or more).

A rationale for using these AUDIT score thresholds is presented in Room et al. 2005. Alcohol dependence was further assessed using the Severity of Alcohol

Dependence Questionnaire (SADQ) (Stockwell et al. 1979) to provide an alternative estimate of the prevalence of alcohol dependence. This measure was also used in the 2000 and 2007 surveys. The SADQ consists of 20 items, covering a range of dependence symptoms, with the six months before the interview as the reference period. Answers to all questions are scored from zero to three, and summed to give a total score ranging from zero to 60. The thresholds indicate different levels of alcohol dependence:

- None or mild dependence (scores up to 14)
- Moderate dependence (scores from 15 to 30)
- Severe dependence (scores from 31 to 60) (NICE 2011).

Because of the focus of the SADQ on symptoms of dependence, for example symptoms following a period of heavy drinking, it was asked only of participants with an AUDIT score of 10 and above. Note that an error in the AUDIT scoring syntax used in 2007 has been identified. The 2007 data has been revised so that it is correct and is consistent with the 2000 and 2014 analyses. Further details of how the AUDIT and SADQ questionnaires were scored are provided in Appendix B.

10.3 Results

Prevalence of hazardous, harmful or dependent drinking, by age and sex

In 2014, the majority (57.5%) of adults drank alcohol, but at low risk levels. 22.8% of adults did not drink.

The remaining 19.7% – around one in five adults – drank at hazardous levels or above, as indicated by an AUDIT score of 8 or more. Most of these (16.6% of all adults) were hazardous drinkers, with an AUDIT score between 8 and 15. A further 1.9% of adults were harmful or mildly dependent drinkers (AUDIT score 16 to 19), and 1.2% were probably dependent drinkers (AUDIT score 20 or more). This indicates that 3.1% of the population drank at a level considered to be harmful or probably dependent. If all adults in the population had been assessed, it is likely (95% confidence interval (CI)) that the proportion drinking at harmful or probably dependent levels would be between 2.6% and 3.6%.

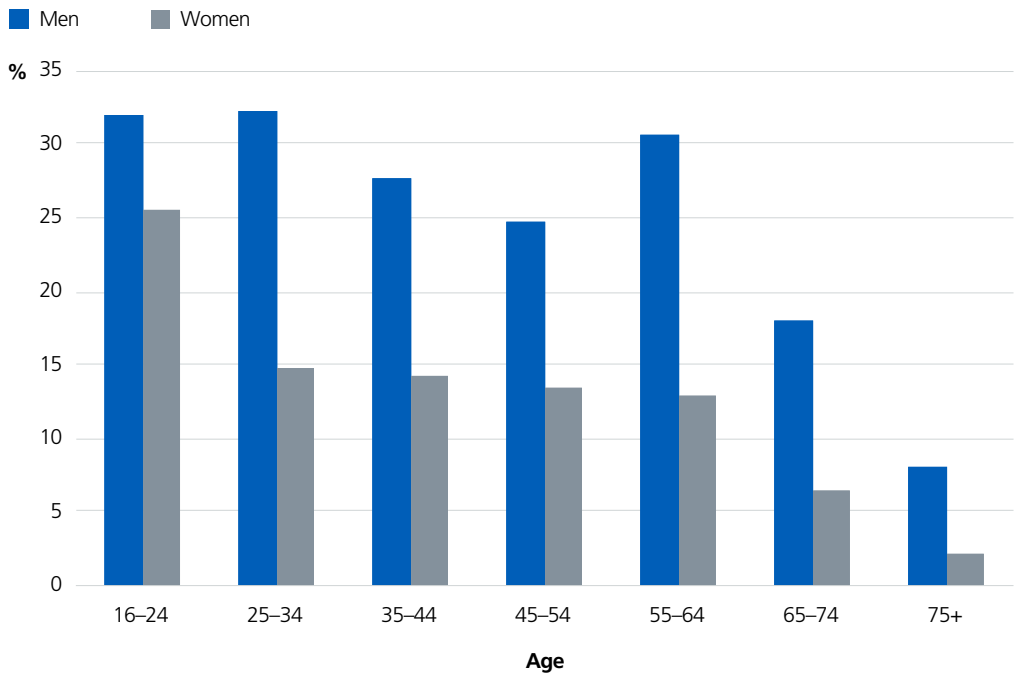
As in previous years, men were more likely than women to drink at hazardous levels or above. 26.3% of men and 13.4% of women had an AUDIT score of 8 or more, including 4.4% of men (95% CI: 3.6% to 5.4%) and 1.8% (95% CI: 1.4% to 2.4%) of women with an AUDIT score of 16 or more.

Among men, drinking at hazardous levels or above was most prevalent among those aged 16 to 64, varying between a quarter and a third across the age range with no clear pattern. Adults aged over 64 were less likely to drink at this level; 18.1% of men aged 65 to 74 and 8.1% of those aged 75 and over.

Among women, 25.6% of those aged between 16 and 24 drank at hazardous levels or above. Between the ages of 25 and 64, this proportion was lower and fairly constant, around one in seven. As with men, older women were much less likely to drink at hazardous levels or above; 6.3% of 65 to 74 year olds and 2.3% of those aged 75 and over. **Table 10.1**

Figure 10A: Drinking at hazardous levels or above in the past year (AUDIT score of 8 or more), by age and sex

Base: all adults

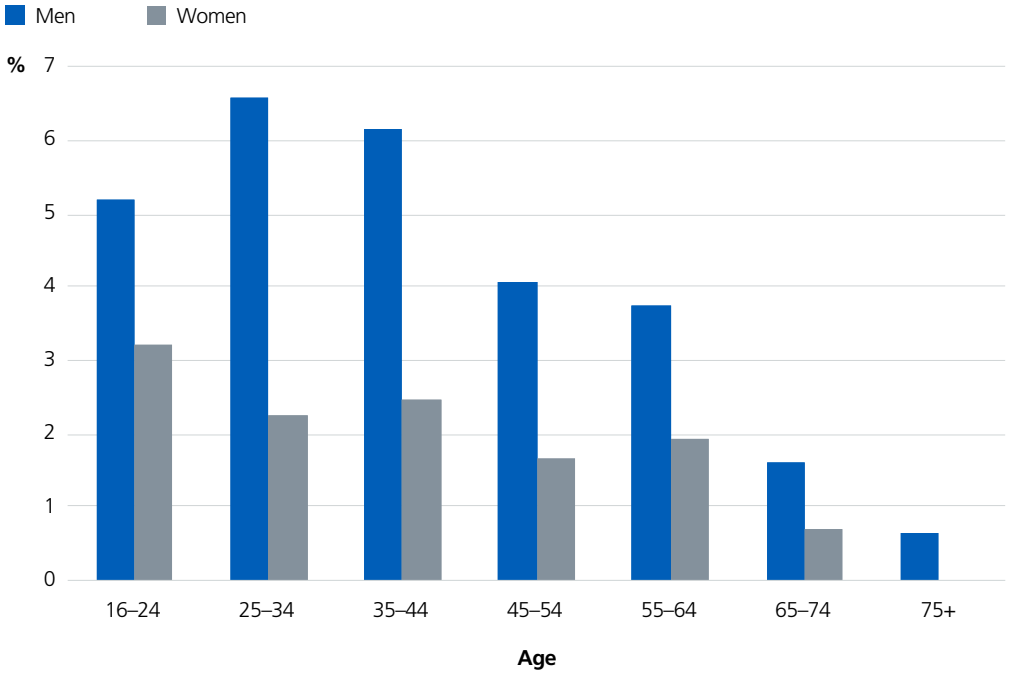


Almost one in ten men aged 25 to 34 (6.6%) had an AUDIT score of 16+, indicative of harmful drinking, mild dependence or probable dependence. This proportion declined thereafter with age to 0.6% of those aged 75 and over. Among women, drinking at these levels was highest in the youngest age group (3.2%), was around 2% for women aged between 25 and 65, and declined to 0.7% of women aged 65 to 74. No female participants aged 75 or over were in this group.

AUDIT scores indicating probable dependence (20+) were evident in 1.9% of men and 0.6% of women. This was most prevalent among men aged between 35 and 44 (3.1%) and women aged between 16 and 24 (1.1%). **Table 10.1**

Figure 10B: Harmful drinking/mild or probable dependence (AUDIT score of 16 or more), by age and sex

Base: all adults



Trends in hazardous and dependent drinking: 2000 to 2014

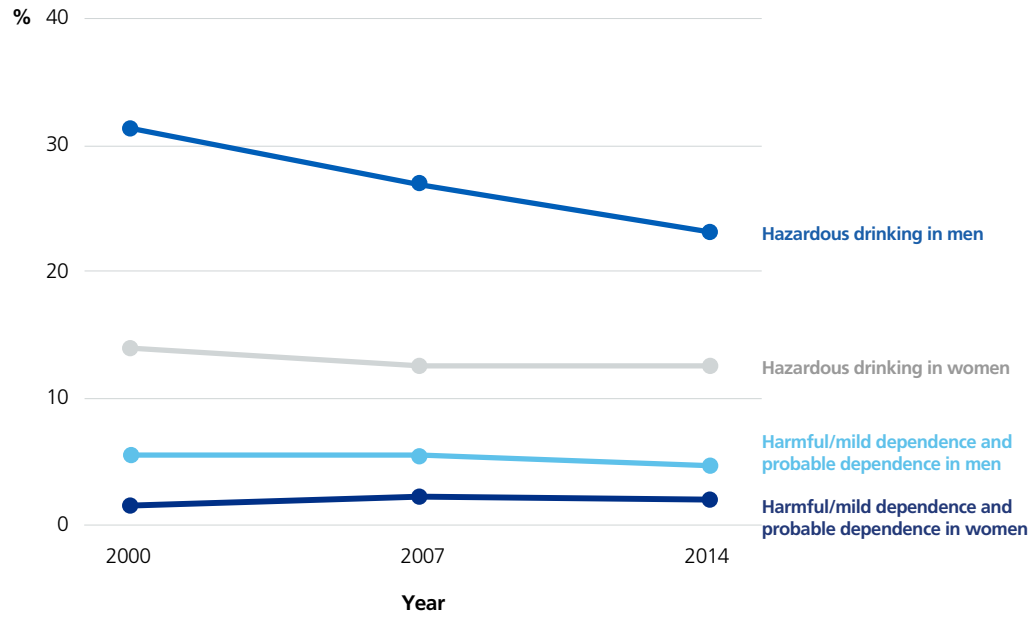
Comparisons of 2014 findings with previous survey years (2000 and 2007) are based on adults aged between 16 and 74, as the 2000 survey did not interview those aged 75 or more.

The proportion of men who were hazardous drinkers or above (AUDIT scores of 8 or more) was less in 2014 than in previous years: 27.9%, compared with 36.8% in 2000 and 34.4% in 2007. The proportion of women drinking at this level did not change over the same period.

Overall, the proportion of men and of women who were harmful or mildly dependent drinkers or probably dependent (AUDIT scores of 16 or more) did not change over time. However, there were indications of changes in the proportion drinking at this level within particular age groups. Young adults aged 16 to 24 were less likely to have an AUDIT score of 16 or more than in previous years: 4.2% drank at this level in 2014, compared with 6.8% in 2000 and 6.2% in 2007. Men and women aged between 55 and 64 were more likely to have AUDIT scores of 16 or more than in previous years: 2.8% in 2014, compared with 1.3% in 2000 and 1.4% in 2007. These results are consistent with there being differences between generations over time. Other differences over time within age groups were not statistically significant. **Table 10.2**

Figure 10C: Hazardous, harmful and dependent drinking in the past year by sex: 2000, 2007 and 2014

Base: adults aged 16–74



Self-diagnosis and professional diagnosis of alcohol or drug dependence

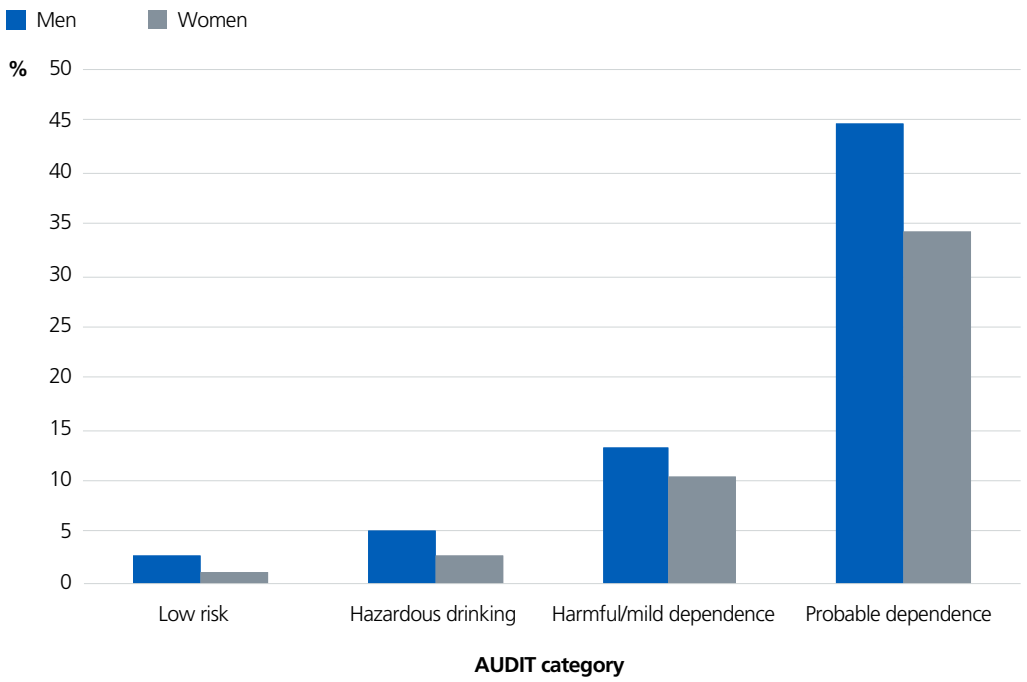
All participants were asked whether they had ever been alcohol or drug dependent, and whether they had been given this diagnosis by a doctor, psychiatrist or other professional. This analysis compares responses according to the level of risk indicated by AUDIT scores, based on reported behaviour over the last year. It should be noted that there were relatively small numbers of women with scores indicating mild or probable dependence on alcohol (AUDIT 16+).

Overall, 2.8% of adults said that they felt they had been alcohol or drug dependent at some point in their life. Men were more likely than women to report this, both overall (4.3%, compared with 1.5%) and within each level of drinking risk. Among men, the proportion increased from 2.6% of those with an AUDIT score of 7 or less, to 44.8% of those with an AUDIT score of 20+ (indicating probable dependence). Among women, the corresponding range was from 1.0% of those whose recent drinking was at low risk levels to 34.2% of those with probable dependence.

Table 10.3

Figure 10D: Self-identified as having ever experienced alcohol or drug dependence, by AUDIT category and sex

Base: all adults

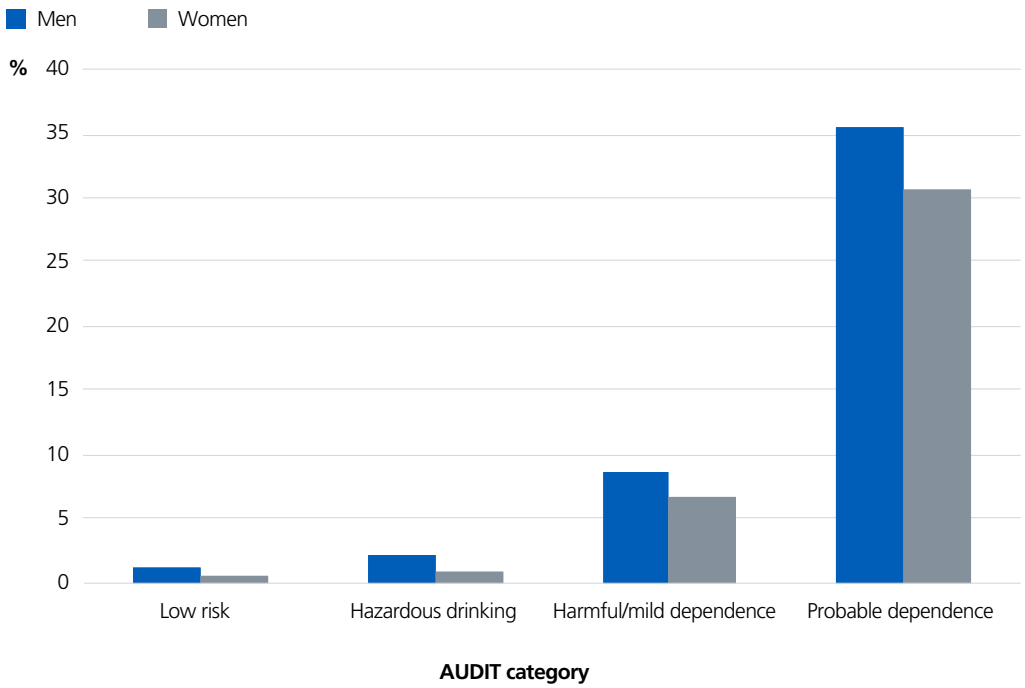


Those participants who said that they had been drug or alcohol dependent were asked whether they had ever been diagnosed with alcohol or drug dependence by a doctor, psychiatrist or other professional. Overall, 1.6% of adults reported this; again, this was more common in men than women. The proportion of men who had been diagnosed increased from 1.3% in the low risk group, to 4.3% of those whose drinking was classed as harmful or mildly dependent (AUDIT score of 16 to 19) and 35.3% of those with a score of 20+, indicating probable dependence. In women, levels of reported diagnosis were increased from 0.7% of those with AUDIT scores of 0–7 to 6.7% of those with AUDIT scores of 16 to 19.The group with a score of 20+ had a much higher likelihood of diagnosis; 30.8% reported that they had been diagnosed with alcohol or drug dependence at some time.

Very few participants, 0.6%, reported that they had been diagnosed with alcohol or drug dependence in the last year. This included 13.7% of men and 24.4% of women with an AUDIT score of 20+. **Table 10.3**

Figure 10E: Ever diagnosed by a professional with alcohol or drug dependence, by AUDIT category and sex

Base: all adults



The Severity of Alcohol Dependence Questionnaire (SADQ)

Surveys in the APMS series also measured alcohol dependence using the SADQ, described in Section 10.2 above. This was asked of participants scoring 10 or more on the AUDIT, and among this group the SADQ score showed strong concordance with the AUDIT score. **Table 10.4**

Characteristics of hazardous and dependent drinkers

Ethnic group

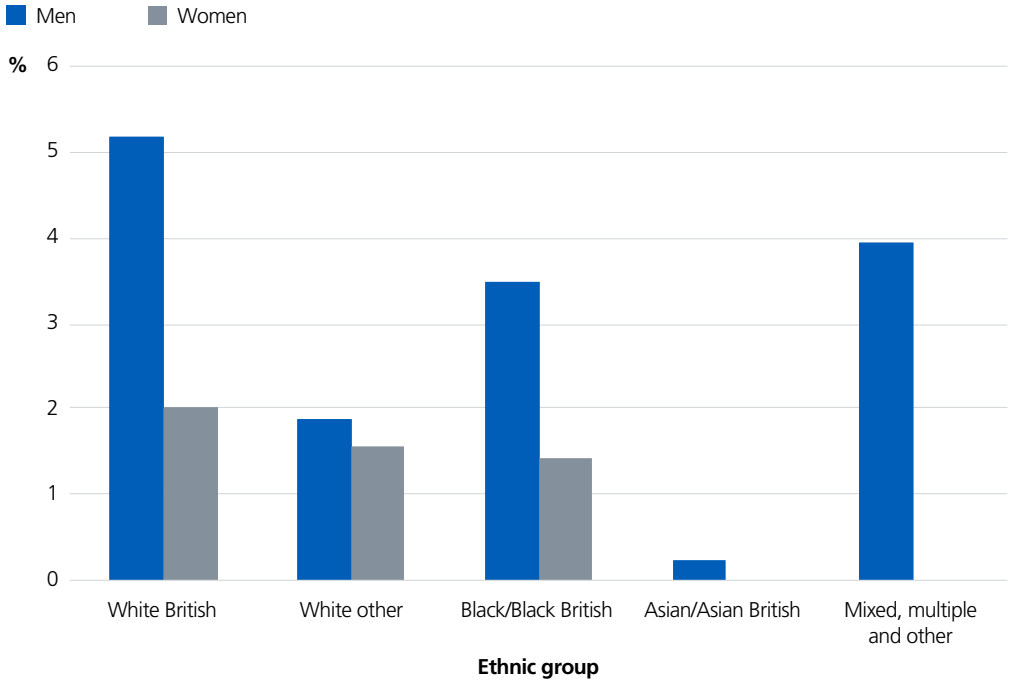
Comparisons between ethnic groups are based on age-standardised estimates to account for differences in the age profile of different groups.

White British adults were more likely to drink at hazardous levels or above than other groups. 30.8% of White British men had an AUDIT score of 8 or more, compared with 18.4% of non-British White men, 6.6% of Black men, 4.7% of Asian men, and 12.9% of men from other or mixed ethnic groups. Similarly, 14.8% of White British women had AUDIT scores of 8 or more, compared with 11.6% of other White women, 7.4% of Black women, 2.6% of Asian women, and 7.2% of women from other ethnic groups.

The pattern for AUDIT scores indicating harmful drinking, mild dependence or probable dependence was slightly different, although prevalence was still highest among White British adults. 5.2% of White British men had AUDIT scores of 16 or more, compared with 0.2% of Asian men and 2% to 4% of men in other groups. 2.0% of White British women drank at this level, compared with 1.6% of non-British White women and 1.4% of Black women. No Asian women or women from other ethnic groups were identified as drinking at this level of risk. **Table 10.5**

Figure 10F: Harmful drinking/mild or probable dependence (AUDIT score of 16 or more), by ethnic group and sex (age-standardised)

Base: all adults



Region

Comparisons between regions are based on age-standardised estimates to account for differences in the age profile between regions.

The overall proportion with hazardous, harmful or dependent drinking varied across regions. It was highest in the North West (25.2%) and lowest the East of England (15.5%).

The variation between regions for the proportions with AUDIT scores indicating likely dependence was not statistically significant.[1] **Table 10.6**

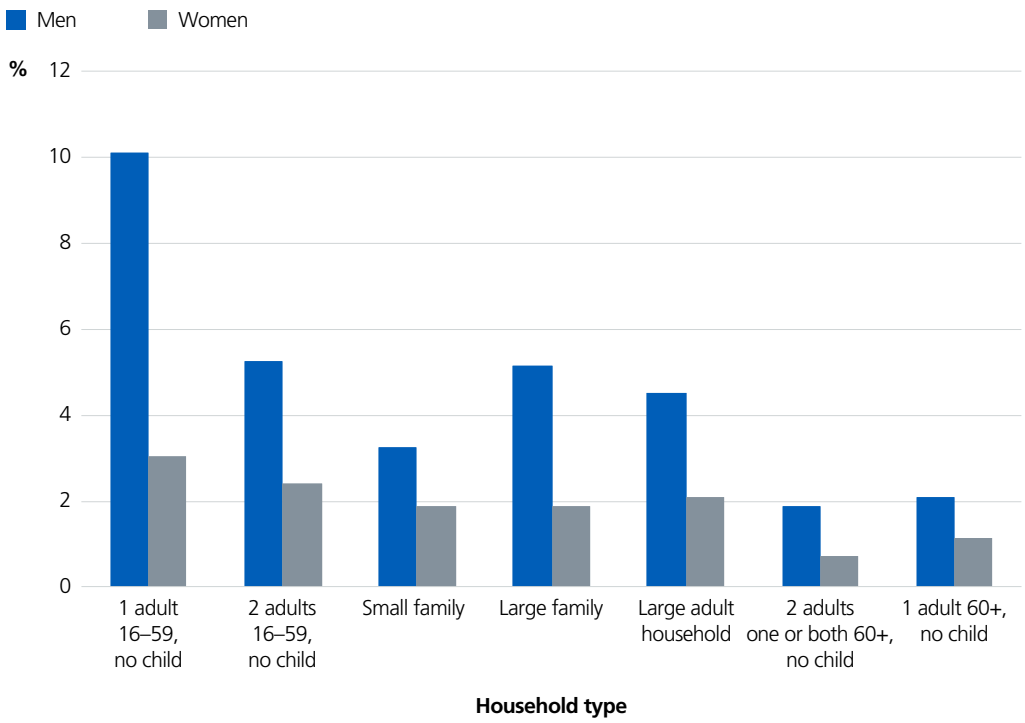
1 Note that the 'London effect' – the high proportion of non-drinkers in London when compared with other English regions – does not persist through to differences in the proportions of adults in higher categories of consumption, whether measured by quantities consumed or the AUDIT's broader criteria (Craig et al 2014).

Household type

There were strong relationships between the type of household people lived in and their AUDIT score. Broadly, drinking at hazardous levels or above (an AUDIT score of 8 or more) was most common in households entirely composed of adults aged under 60, particularly in people aged under 60 who lived alone (35.6% of men, 18.6% of women). Adults who lived in households with children (small or large families) were less likely to drink at this level. Households comprising one or two adults over 60 were least likely to drink at hazardous levels or above (for example, 18.0% of men and 6.4% of women aged over 60 who lived alone). There was a similar pattern in the prevalence of AUDIT scores indicating harmful drinking, mild dependence or probable dependence. **Table 10.7**

Figure 10G: Harmful drinking/mild or probable dependence (AUDIT score of 16 or more), by household composition and sex

Base: all adults



Employment status

Comparisons between groups are based on age-standardised estimates to account for differences in the age profile between individuals within different employment categories. This analysis is limited to adults aged between 16 and 64.

Among both men and women, drinking at hazardous levels (an AUDIT score of 8 or above) was highest among those in employment (31.4% of men, 17.4% of women) and lowest among those classed as economically inactive (22.9% of men, 12.1% of women).Variation by employment status for AUDIT scores of 16+ were not statistically significant. **Table 10.8**

Benefit status

Comparisons between groups are based on age-standardised estimates to account for differences in the age profile between individuals in receipt of different types of benefit. For Employment and Support Allowance (ESA) and any out-of-work benefits (JSA and ESA), the analysis is limited to adults aged between 16 and 64.

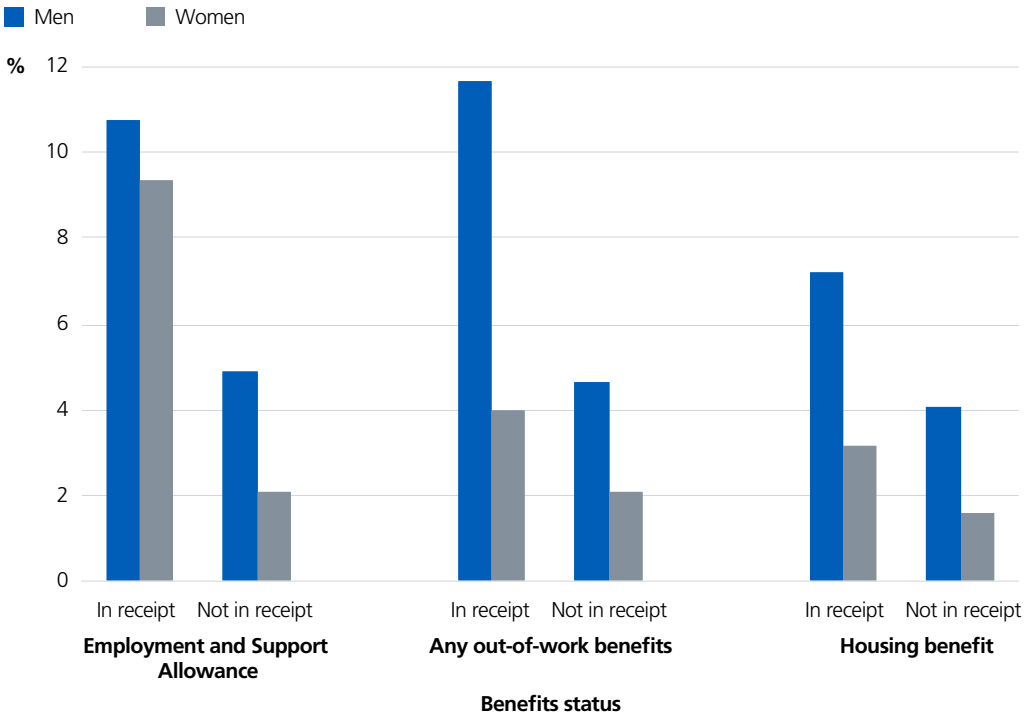
The proportions of adults with AUDIT scores of 8 or more were not significantly different according to whether or not they were in receipt of ESA. However, both men and women in receipt of ESA were more likely than those who were not to have AUDIT scores of 16 or more (indicating that their drinking was harmful or dependent). 10.8% of men and 9.4% of women in receipt of ESA had AUDIT scores of 16 or more; unusually the proportions were similar for men and women. The equivalent proportions among those who were not in receipt of ESA were 4.9% of men and 2.1% of women.

A similar pattern was seen for adults in receipt of any kind of out-of-work benefits (although the difference was less pronounced among women). The proportion with AUDIT scores of 8 or more were similar, regardless of benefit status. But men and women in receipt of out-of-work benefits were more likely to be harmful or mildly dependent drinkers or probably dependent than those who were not. 11.7% of men and 4.0% of women in receipt of these benefits had AUDIT scores of 16 or above, compared with 4.6% of men and 2.0% of women who were not in receipt of these benefits.

Adults living in households in receipt of housing benefit were less likely to drink at hazardous levels or above (AUDIT score of 8 or more) than those who were not. This difference was more pronounced among men (18.2% compared with 26.7% respectively) than among women (12.2% and 13.2% respectively). Conversely, the proportions whose drinking was harmful, mildly dependent or probably dependent were higher in people in receipt of housing benefit. 7.2% of such men and 3.1% of such women had AUDIT scores of 16 or more, compared with 4.1% of men and 1.6% of women who were not receiving this benefit. **Table 10.9**

Figure 10H: Harmful drinking/mild or probable dependence (AUDIT score of 16 or more), by benefit status and sex (age-standardised)

16–64 (out of work benefits); all adults (Housing benefit)



Treatment for a mental or emotional problem

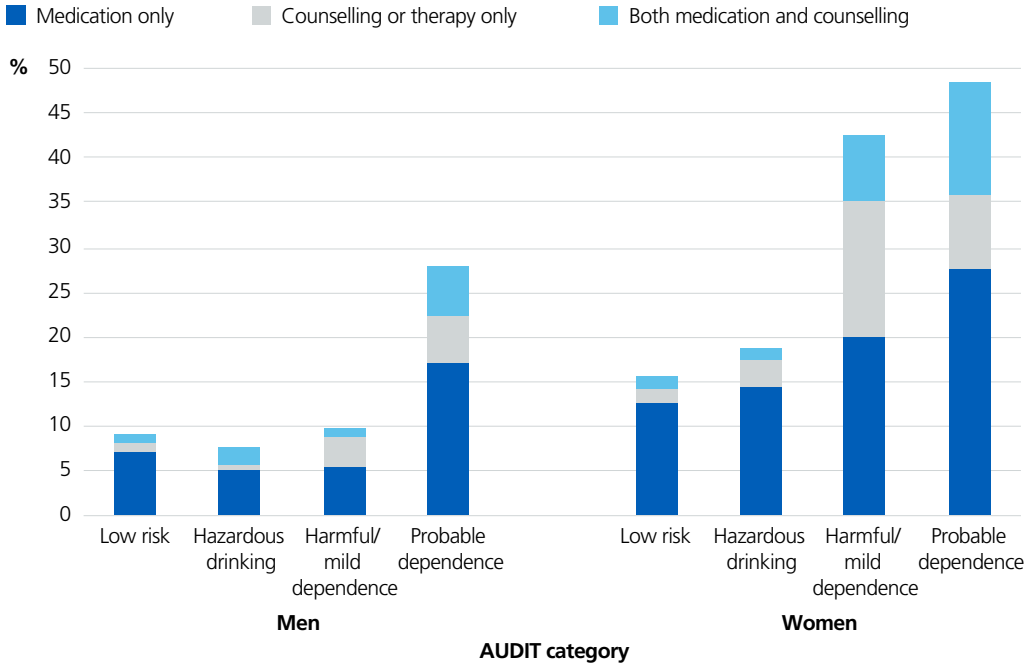
The following analysis compares current treatment for a mental or emotional problem by AUDIT scores. It should be noted that there were relatively small numbers of women identified with mild or probable dependence on alcohol (16+), and also that treatment refers to any psychotropic medication or psychological therapy, and was not necessarily for an alcohol-related disorder.

The proportion receiving treatment for a mental or emotional problem was higher among those whose AUDIT score indicated likely dependence on alcohol. 9.2% of men who were at low risk of alcohol-related harm were currently receiving treatment, compared with 7.7% of men who were hazardous drinkers and 9.8% of men classified as harmful or mildly dependent. The proportion of men with probable dependence receiving treatment for a mental or emotional problem was more than twice as high – 27.7%. Among women, 15.5% in the low risk category and 18.7% of hazardous drinkers were receiving treatment. This proportion increased to 42.5% of harmful or mildly dependent drinkers, and 48.5% of women who were probably dependent on alcohol.

The majority of those receiving treatment were on medication only, with a minority receiving psychological therapy or a combination of therapy and medication. For example, among men with an AUDIT score indicating probable dependence, 17.0% were on medication only, 5.3% received psychological therapy only, and 5.5% received a combination of both. The corresponding proportions among women with probable dependence were 27.6%, 8.3% and 12.6% respectively. **Table 10.10**

Figure 10I: Currently receiving treatment for a mental or emotional problem, by AUDIT category and sex

Base: all adults



Psychotropic medication

Of adults with an AUDIT score below 20, including those whose drinking was harmful or mildly dependent, around one in ten reported taking some kind of psychotropic medication. This proportion was more than doubled in adults with an AUDIT score of 20 or more. This pattern was similar for most types of psychotropic medication, particularly medication for anxiety (taken by between 8% and 12% of those with an AUDIT score of less than 20, compared with 22.3% of those with an AUDIT score of 20+); and antidepressants (taken by between 8% and 13% of those with AUDIT scores below 20, compared with 25.0% of those with AUDIT scores of 20+). Furthermore, 6.1% of people with probable dependence (AUDIT 20+) were in receipt of medications used to treat substance misuse. **Table 10.11**

Psychological therapy

The proportions of adults receiving psychological therapy ranged from 2.5% in the low risk category to 13.2% of those whose AUDIT score of 20 or more indicated probable dependence. Adults with an AUDIT score of 20 or more were most likely to be receiving alcohol or drug counselling (6.3%), followed by psychotherapy or psychoanalysis (3.6%) and other forms of counselling (3.3%). **Table 10.12**

Service use

Adults with an AUDIT score of 20 or more, indicating probable dependence, were much more likely to have used health services for a mental or emotional problem than those with a lower AUDIT score. 36.9% reported speaking to a GP about a mental or emotional problem in the last year, including 18.8% who had spoken to a GP in the last two weeks. This was much higher than for adults in lower risk AUDIT categories.

Adults with probable dependence on alcohol were also more likely than others to have attended hospital in the last three months because of a mental or emotional problem, either as an inpatient (2.2%) or an outpatient (2.7%). **Table 10.13**

Community and day care service use was also higher in probably dependent adults than in those whose risk of alcohol-related harm was lower. 18.6% of this group reported using one or more services, compared with between 6% and

11% of those with lower AUDIT scores. This included 9.0% who had attended a community day care centre, 6.5% who had attended a self-help or support group, and 5.6% who had seen a community psychiatric nurse (CPN). **Table 10.14**

Unmet treatment requests

Although relatively few participants said that they had requested a particular treatment in the past 12 months but did not get it, this was more likely in those with higher AUDIT scores. 1.5% of those with an AUDIT score of 7 or less reported this, compared with 1.9% of those with a score between 8 and 15, 5.1% of those with a score between 16 and 19, and 5.1% of those with a score of 20 or more. **Table 10.15**

10.4 Discussion

The prevalence of hazardous drinking, as measured in APMS 2014, is similar to that in the 2014 Health Survey for England (HSE), which found 22% of men and 16% of women were drinking at levels of increased or higher risk (DH 2016). The prevalence of drinking at harmful or dependent levels was highest among young adults, men aged 25–34 and women aged 16–24, declining gradually with increasing age. This is a similar pattern to that seen in previous APMS surveys as well as the HSE in recent years, suggesting a gradual 'maturing out' of heavy drinking.

Although levels of hazardous drinking and above have remained broadly stable since 2000, there are indications of a decline in harmful or mildly dependent drinking among the youngest adults (aged 16 to 24) and an increase among those aged 55–64.

As in previous APMS surveys, men had a higher prevalence than women across the whole spectrum of alcohol use disorders, while participants from ethnic minority groups had lower prevalence rates than their white British counterparts. Regional variations in hazardous drinking seen in previous surveys were less apparent in 2014. Hazardous drinking and above was highest among people in employment compared to those who were economically inactive. However adults receiving Employment and Support Allowance and out-of-work

benefits were more likely to be harmful or dependent drinkers than those not receiving benefits, although there were no significant differences in hazardous drinking between these economic groups.

It should be noted that, as with less common conditions such as psychotic disorders, a survey of the household population may under-represent alcohol dependent adults, who are more likely to be homeless or in an institutional setting and therefore not included in the survey. Moreover, problematic drinkers living in private households may, like other problematic substance users, be relatively less likely to respond to surveys, as they may be somewhat less available, able or willing to answer survey questions. There is also an issue in interpreting and extrapolating prevalence rates of more severe alcohol use disorders of relatively low prevalence to the wider population of England, due to relatively small numbers with moderate and severe dependence identified by this survey.

Only around a third of men and women with probable alcohol dependence recalled having ever been diagnosed by a doctor or professional as having alcohol or drug dependence. A quarter of men and half of women with probable dependence were currently receiving treatment for a mental or emotional problem, mostly medication only, and were more likely to use health services, including inpatient, community and primary care, than those with less severe alcohol use disorders or low risk drinkers. However, in those of both sexes with probable dependence only a small proportion (6.1%) were being prescribed medication for substance dependence. Dependent drinkers were also more likely than other groups to have requested, but not received, treatment. Overall these findings suggest that alcohol dependence remains both under-diagnosed and under-treated in England (Cheeta et al. 2008; Brown et al. 2016).

10.5 Tables

Prevalence and trends

Table 10.1 Harmful and dependent drinking in the past year, by age and sex

Table 10.2 Trends in harmful and dependent drinking in the past year, by age and sex: 2000 to 2014

Characteristics

Treatment and service use

10.6 References

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