Alcohol (draft)

Introduction

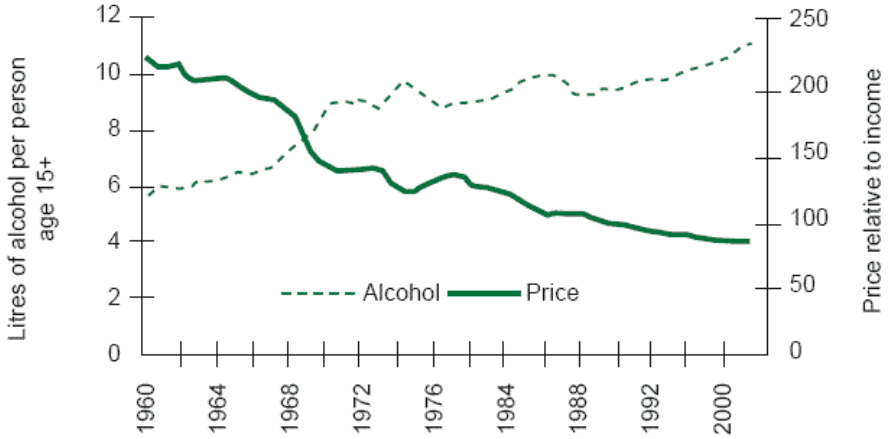
In Haringey, as in the rest of England, hospital admission rates due to alcohol are rising rapidly as more and more people are drinking to excess. Alcohol misuse is associated with a number of health-related problems including: cancers, liver disease, alcohol poisoning, accidental injuries, road traffic accidents, violence, and premature death. The Department of Health has estimated that the annual cost to the National Health Service for alcohol-related hospital admissions, A&E attendances and primary care was around £2.7 billion in England in 2006/07 (Alcohol Concern, 2011). In Haringey the Alcohol **Specific*** Mortality rate for men is higher than both London and England average

The impact of alcohol is wide reaching encompassing alcohol related health harms and injuries as well as significant social impacts including alcohol related crime and violence, teenage pregnancy, loss of workplace productivity and homelessness (DH 2007).

Locally and nationally alcohol is associated with domestic violence and other violent crime, as well as anti-social behaviour such as street drinking. Parental drinking is also a factor in a number of cases focused on the protection of children.

As alcohol has become increasingly affordable and available consumption has increased. Since 1970 the per capita consumption of alcohol has risen by 50% in the UK (Academy of Medical Sciences, 2004).

Table 1: Alcohol consumption relative to its price in the UK, 1960-2002 (Academy of Medical Sciences, 2004).



Advertising campaigns have also had a part to play in the increased consumption of alcohol through, for example, the targeted marketing to teenagers on Social Network sites. Brands such as Fosters, WKD and Carling have their own interactive websites and a presence on Facebook and Twitter. Most concerning is that there is no regulation of this activity (Alcohol Concern, 2011).

Tackling alcohol abuse is one of the top priorities for a new partnership between the Mayor of London, London Councils and the National Health Service, to improve the health of all Londoners (London Health Improvement Board, 2011). Haringey tackles these multi faceted issues through its Alcohol Harm Reduction Strategy which addresses the health and social harms, along with alcohol-related crime and anti-social behaviour. Delivery is supported by a yearly partnership alcohol action plan. Haringey's Alcohol strategy 'Dying for a Drink' can be found at http://harinet.haringey.gov.uk/haringey_alcohol_harm_reduction_strategy_2008-2011.pdf . This chapter focuses on the health harms associated with alcohol misuse amongst adults.

Key Issues and gaps (locally in Haringey)

- Alcohol related hospital admissions in Haringey have doubled between 2002 and 2011.
- In Haringey the Alcohol **Specific* and alcohol Attributable**** mortality for males is higher than both London and England averages.
- The corresponding rates for women are higher than the London average Local Alcohol Profiles for England (LAPE), 2011).
- Male deaths from Chronic Liver Disease are higher than both London and England averages. The corresponding female figure is higher than the London average (LAPE, 2011).
- There is a visible street drinking population that consists of 'traditional' street drinkers along with individuals from Eastern European countries.
- There are higher alcohol related ambulance call outs in the more deprived East of the borough.
- The number of under-eighteen year olds admitted to hospital with alcohol specific conditions between 2007/08 to 2009/10 was 53. This is low in comparison to other areas such as Liverpool (n= 384) (LAPE, 2011).
- Synthetic estimates of crimes relating to alcohol show that all alcohol recorded crime and violent crime attributable to alcohol in Haringey has decreased slightly between 2006/07 and 2010/11(LAPE, 2011).
- Synthetic estimates of sexual crimes attributable to alcohol have increased slightly between 2006/07 and 2010/11(LAPE, 2011). Given the under reporting of sexual crimes; it is probable that this figure is actually higher.

* A list of conditions that are specifically caused by alcohol, e.g. Alcoholic Liver Disease.
** A list of conditions which are partially caused by alcohol, e.g. Hypertension.

Who is at risk and why (locally in Haringey, in London and nationally)

Men are more likely to drink heavily than women. 38% of men and 16% of women consume more alcohol than is recommended (DH 2004, ANARP Project). Whilst those from higher income households are more likely to drink at higher levels than those from lower income households it is the most deprived fifth of the UK population who suffer two to three times greater loss of life attributable to alcohol; three to five times higher death rates due to alcohol specific causes and two to five times more admissions to hospital because of alcohol than wealthy areas (Department of Health, 2009). This is a pattern that is recognisable in Haringey with the majority of alcohol-related and alcohol-specific hospital admissions coming from the East of the borough. The lowest income groups are more likely to suffer negative effects of 'risky' health behaviours than their less poor counterparts (Department of Health, 2009). Research also suggests that those most susceptible to developing problematic substance misuse problems are from 'vulnerable groups' such as children in care, persistent absentees or excludees from school, young offenders, the homeless and children affected by parental substance misuse. *(DfES:*2005, *The NHS Information Centre: 2011*). It is estimated that liver disease could overtake stroke and coronary heart disease as a cause of death within the next 10-20 years (Alcohol Concern, 2011).

In particular in Haringey:

- Males are more at risk than females; due to higher rates of liver disease, alcohol related admissions and alcohol related mortality.

- Men from the Irish community seem particularly vulnerable in relation to alcohol related problems in Haringey.

At a national level the Department of Health (DH) use the terms 'increasing risk' and 'higher risk' to refer to individuals who are drinking at levels that increase risk. DH use the terms 'Binge drinking' and 'dependent drinking' to refer to two sub-groups of people who potentially fall into the categories of lower, increasing and higher risk drinking. Tables 2 and 3 below describe the UK population consumption patterns and the definitions of alcohol categories.

Table 2: DH estimates of UK alcohol consumption numbers of population.

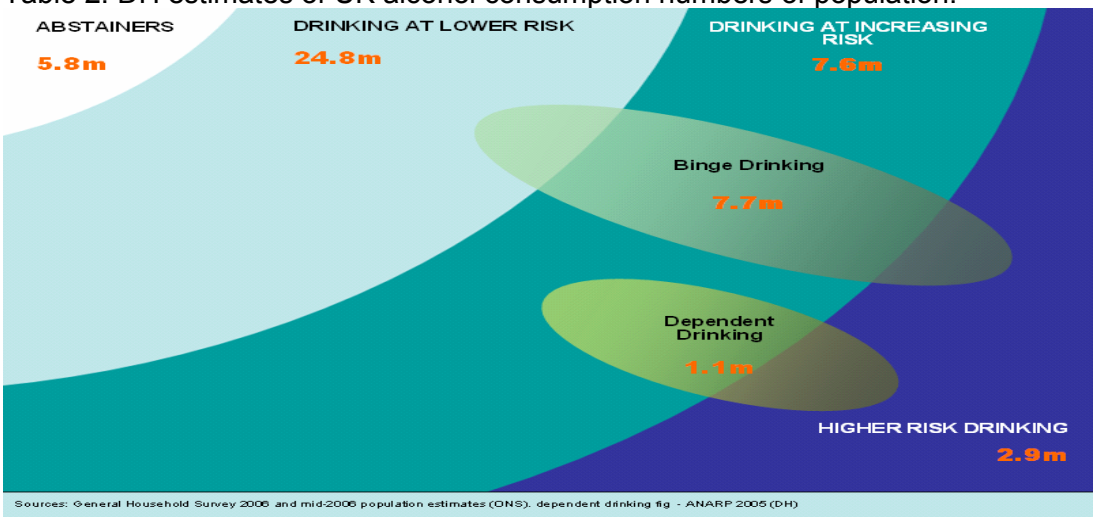


Table 3: Explanation of DH alcohol consumption categories.

Risk	*Men*	*Women*
Lower Risk (Following recommended daily drinking guidelines)	No more than 3-4 units per day on a regular basis	No more than 2-3 units per day on a regular basis
Increasing Risk	4 or more units per day on a regular basis	3 or more units per day on a regular basis
Higher Risk	8 or more units per day on a regular basis or 50+ units per week	6 or more units per day on a regular basis or 35+ units per week

Source: DH presentation to Haringey GP's, Don Lavoie, November, 2011

Using the DoH RUSH* model, DoH estimated that during 2010 2.4 million Londoners were drinking alcohol at increasing and higher levels and that a further 280,000 were dependent on alcohol in order to function in their daily life (London Health Improvement Board, 2011).

* The RUSH Model is a model for estimating the required capacity for alcohol treatment systems at the local or regional level (Rush, 1990)

The level of need in the population (locally in Haringey)

North West Public Health Observatory (NWPHO) synthetic estimates suggest that 19.02% of the local population are drinking at increasing risk and 4.79% are drinking at high risk within Haringey (NWPHO, 2011). However, only a small percentage of this population will go onto become dependent drinkers and require specialist alcohol treatment.

The National Treatment Agency for Substance Misuse (NTA) administers the National Alcohol Treatment Monitoring System (NATMS). NATMS data indicates that 576 adults were accessing specialist alcohol treatment services during November 2011 in Haringey (NDTMS, 2011). However, alcohol data has only been collected since 2009 and local intelligence tells us this figure is an underestimate. Currently, the data collection systems in place for alcohol are simply not robust enough and therefore level of need is difficult to estimate. However, national and local trends of alcohol related hospital admissions suggest the upward trend in alcohol related admissions will continue meaning the need is likely to increase, at least in the short to medium term.

Current services in relation to need (locally in Haringey)

The current service provision is comprehensive and consists of:

- Identification and Brief Advice for alcohol in primary care and at the North Middlesex Hospital emergency department and gastroenterology wards and out patients.
- A community alcohol treatment service (Haringey Action Group on Alcohol)
- Specialist alcohol workers available in GP settings
- Street outreach programmes to traditional 'street drinkers', and to individuals from Eastern European communities
- Social reintegration services including access to supported housing and education, training and support
- A specialist domestic violence worker
- Abstinence based day programme
- Services for children and families affected by substance misuse
- Support for families and carers
- Inclusion of alcohol in the NHS Health Checks Programme

For a full list of services offered and contact details for the above services please see:
http://www.haringey.gov.uk/haringey_drug_and_alcohol_service_directory_2010.pdf
However, early identification and treatment are only part of the solution to tackling alcohol misuse. Making alcohol less affordable is recognised as one of most effective ways of reducing alcohol related harm (NICE, 2010), yet to date the UK government have not introduced a minimum price for alcohol although extensive evidence exists that raising alcohol prices reduces consumption on a societal level (Rabinovich, 2009).

Alcohol is one of the priority areas of the governments Public Health Responsibility Deal (2011). This deal aims to encourage businesses to support public health initiatives. There has been scepticism expressed around the possible success of the deal as in order to be effective it would lead to a loss in business profits. For example, a reduction in alcohol consumption would lead to a decrease in sales and therefore profits for the alcohol industry.

International evidence also stresses the importance of making alcohol less available by controlling the number of outlets selling alcohol and having shorter opening hours (NICE, 2010) . Specific concerns have been raised about the lack of regulation in social media and alcohol advertising aimed at young people (NICE, 2010).

Service users and carers opinion (locally in Haringey)

The local alcohol service HAGA has a well established user forum and a user run physical exercise group, 'Wheels for Recovery'. Carers have their own service, 'Chrysalis', and a newsletter.
An annual service user and carers survey is completed. This survey covers opinions of service users and carers of both alcohol and drug services. The main conclusions in 2010 were:

- A high level of confidence in treatment services; over 90% thought their treatment plan would work.
- Not all service users reported being offered education, training, support and life skills training.
- Alcohol was not systematically screened for across all substance misuse agencies.
- It was felt that consideration should be given to how alcohol use is tackled by drug services as part of key working sessions.

At the time of writing the current service user survey is out to consultation and its findings will inform the tender specification for an integrated substance misuse treatment system.

Expert (professionals) opinion and evidence base

The first Alcohol Harm Reduction Strategy for England was published in 2004. An update on the progress made through the national strategy was published in 2007 (Department of Health, 2007). The evidence base around interventions to prevent and respond to alcohol misuse has grown substantially since 2007 and expanded rapidly during 2010 with the publication of three sets of guidance on alcohol by NICE (NICE, 2010). This guidance not only emphasised the importance of interventions at a national level but also promoted the use of Identification and Brief Advice around alcohol by a wide range of practitioners and not only specialists in the alcohol field (NICE, 2010). The

evidence base on effectiveness of IBA is well documented and includes a Cochrane Review on the subject (Kaner et al, 2007). All of Haringey's alcohol provision is informed by this guidance and evidence base.

Guidance has been published for commissioners of alcohol services to improve services provided (Department of Health, 2009). The National Treatment Agency (NTA) has recently taken over responsibility for alcohol and we await information from them on the operating systems that will be instigated.

Nationally, there is a move towards combining alcohol and drug services together. This is evidenced by the NTA becoming responsible for monitoring alcohol service provision and is being taken forward in our commissioning plans in 2012/13.

Projected service use in 3-5 years and 5-10 years

National and local trends of alcohol related hospital admissions suggest the upward trend in alcohol related admissions will continue. Increased emphasis on alcohol misuse identification and improved patient pathways in short term may increase demand for treatment. However, in the longer term the earlier identification of alcohol problems through Identification and Brief Advice should ultimately mean a reduction in alcohol harm, hospital admissions and specialist treatment.

The National Alcohol Treatment Monitoring System (NATMS) is the best data collection method currently available for dependent drinkers. NATMS data for November 2011 reports that Haringey have 430 individuals currently in treatment (2011). It also reports a growth year on year in the numbers in treatment. All indictors point towards this trend continuing in the short to medium term.

Unmet needs and service gaps

The main gaps/unmet needs are:

- Current provision of IBA for alcohol problems is limited to clinical settings. There is a need to extend the coverage of IBA to staff working in community settings in line with recent guidance (NICE, 2010). This increase in access and coverage will ensure that more people will be identified earlier who may be at risk of developing alcohol problems.
- There is a need for more targeted work with communities who appear to be particularly vulnerable to developing alcohol problems e.g. the Irish and Polish communities.
- The Alcohol Liaison Service (ALS) at the North Middlesex Hospital is currently being evaluated in order to improve provision and develop a model that can be used across the NCL Sector.
- There are capacity issues in the provision of extended brief advice in clinical settings.
- An increasing number of clients in treatment has led to additional counselling requests. This places pressure on the provision of this type of intervention to cope with demand.
- Information sharing from the Whittington Hospital remains inadequate.
- The emergency department data sharing protocol on alcohol and violent incidents needs to be robustly established to ensure that timely data is delivered to partners.

Recommendations for Commissioning

- Increase early Identification of alcohol problems (Haringey Council, 2012) by developing a training programme for staff that may be in contact with people with alcohol issues e.g. safeguarding staff, domestic violence staff.
- Extend IBA across North Central London, emergency departments through the development of a CQUINN.
- Ensure individuals involved with the Criminal Justice System are screened for alcohol issues and develop more coherent treatment pathways with the police and probation services.
- To maximise the impact of work around health inequalities; combine alcohol interventions with other Public Health work streams.
- Ensure that alcohol continues to be an integral part of the NHS Health Checks Programme.
- Continue to encourage service user and carer involvement by working with service users to increase social capital to enable recovery.
- Increase provision of extended brief advice in alcohol hubs in GP surgeries.
- Re-tender both alcohol and drug treatment services as a joint tender in line with the national move to combine alcohol and drug services.

Recommendations for further needs assessments

- Establish the needs of the Irish community within Haringey and examine what interventions will lead to recovery.
- Establish the needs of individuals from Eastern European countries. We know that this group is over represented in the numbers of local street drinkers.
- The impact of IBA training and the levels of resulting referrals in the community needs to be monitored/evaluated.

Key Contact

Marion Morris, Drug and Alcohol Strategy Manager, Public Health Directorate, marion.morris@haringey.gov.uk; telephone : 0208 489 6909

Summary of data tables for commissioners

Table 1: Alcohol Consumption compared to price relative to income in the UK, 1960-2000
Table 2: DH estimates of UK alcohol consumption numbers of population
Table 3: Explanation of DH alcohol consumption categories

References

- Academy of Medical Sciences, 2004, "Calling time : the nations drinking as a major health issue".
- Alcohol Concern, 2011, "New Media, New Problem", London
- Alcohol Concern, 2011, "Making Alcohol a Health Priority", London
- Department of Health (2005) Alcohol Needs Assessment Research Project (ANARP): The 2004 national alcohol needs assessment for England. London.
- Department of Health (2007) Safe. Sensible. Social. The next steps in the National Alcohol Strategy. London
- Department of Health, 2011, "The Public Health Responsibility deal", London.
- Department of Health, 2009, "Signs for Improvement: Commissioning Services to reduce alcohol related harm", London.
- Haringey Council, 2012, "Haringey Health and Well Being Strategy 2012-2015 (Draft)". Available at: www.haringey.gov.uk
- HM Government, 2007, "Safe, Sensible, Social: The next steps in the national alcohol strategy", London.
- Kaner E et al, 2007, "Brief Interventions for excessive drinking in primary health care settings". Cochrane Database of systematic reviews, Issue 2.
- Local Alcohol Profiles for England, 2011. Available at: www.nwpho.org.uk
- London Health Improvement Board, 2011, "Taking Action on Alcohol in London: the case for Action".
- Murali V & Oyebode F, 2004, "Poverty, Social Inequality and mental health", Advances in psychiatric treatment, Vol 10, pg 216-224.
- National Drug Treatment Monitoring System (NDTMS), 2011. NDTMS Restricted Statistics. Available at: www.ndtms.org.uk
- National Institute for Clinical Excellence (NICE), 2010, "Alcohol Use Disorders: Reducing Harmful Drinking", PH 24, available at: www.nice.org.uk/ph24
- NICE, 2010, "Alcohol use disorder: diagnosis, assessment and management of harmful drinking and alcohol dependence", CG115, Available at: www.nice.org.uk/CG115
- NICE, 2010, "Alcohol use disorders – physical complications", CG100. Available at: www.nice.org.uk/CG100
- NWPHO (2011), Alcohol data. Available at: www.nwpho.org.uk
- Rabinovich L et al (2009), "The affordability of alcohol beverages in the European Union: Understanding the link between alcohol affordability, consumption and harms", Rand Europe.
- Rush B (1990), "A systems approach to estimating the required capacity of alcohol treatment services", British Journal of Addiction, Vol 85, pg 49-59.