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1. EXECUTIVE SUMMARY

This document is the product of an investigation into the scale of alcohol misuse in Haringey and the services and programmes in place to tackle this issue. Alcohol has wide-reaching social, economic and medical effects. Due to these wide-ranging effects it is not possible to cover all the facets of alcohol in one needs assessment. Although this document does contain information on alcohol and domestic violence, alcohol and safeguarding issues and alcohol and maternity services, it does not cover these in detail.

This investigation used a variety of methods, including the compilation of quantitative data, and qualitative methods, including a focus group, workshop, 17 semi-structured interviews and an extensive literature review. Views were sought across the public, local authority, NHS and 3rd sector organisations. These methods were combined to provide information on the needs of Haringey residents for alcohol services and whether these needs are adequately and appropriately met.

Although a high proportion of Haringey residents reporting not having an alcoholic drink in the past week, Haringey has the 2nd highest rate of binge drinking in London and there were 6062 wholly alcohol-attributable admissions to hospital in 2007/8.

Alcohol is often associated with violence and there are more hospital admissions and attendances at accident and emergency due to alcohol than due to illicit drugs in Haringey. During one quarter of 2008/9 42 violent crimes were associated with alcohol. Alcohol is also often associated with anti-social behaviour and in 2007/8, there were 45 calls to the anti-social behaviour action team due to alcohol-related issues.

The issue of the effects of alcohol consumption on young people has been highlighted recently by high-profile campaigns, the call for parents to refrain from allowing children under 15 from drinking alcohol and the calls by the Chief Medical Officer to consider passive drinking in the same manner as passive smoking. This investigation found that young people believe they can easily access alcohol and many reported that the only reason to drink was to get inebriated as fast as possible.

The National Social Marketing Centre estimates that the annual societal cost of alcohol misuse in England is £55.1 billion, including almost £3 billion costs to public health services and care services. In Haringey, £819,077 was allocated for alcohol services in 09/10. This was funded from a number of grants from LB Haringey and NHS Haringey.

A number of recommendations are included in this report, including:

- further research on alcohol consumption in Haringey, to include social marketing work and work investigating the contribution of ethnicity to the levels of admissions due to hypertension;
- improved joint commissioning and improved communication across sectors e.g. across the DAAT team and the PCT, across the Dual Diagnosis Unit and HAGA;
- further health promotion work, including training accident and emergency staff in brief interventions and considering the use of community pharmacies for health promotion.
2. AIMS

The overall aim of this assessment was to assess the availability and quality of alcohol services in Haringey and whether they were appropriate to the needs of the local population. The needs assessment aims to examine:

- The scale of alcohol misuse in Haringey
- The scale of ill-health due to alcohol misuse and other adverse effects in both in the person misusing alcohol and other people affected by their behaviour
- What services and interventions are in place in the borough
- The evidence base for these services and interventions
- Stakeholder views on gaps and priorities for services for alcohol misuse and associated problems

It is difficult to give a full account of all the areas of need due to alcohol misuse, alcohol affect so many facets of our society. This report has aimed to highlight the issues of domestic abuse and the link with alcohol misuse, issues of safeguarding and alcohol misuse and issues of alcohol misuse in maternity services. However, these are complex areas and they need further work to do them justice.

3. OBJECTIVES

The objectives of this needs assessment are:

- Planning of effective services and matching of the adequacy of services to meet needs and demands.
- Gathering Intelligence on the population, alcohol use and problems due to alcohol in the population and existing services
- Evaluating the equity of access to services
- Assessing the targeting of services
- Assessing the involvement of stakeholders in the provision of services
Although alcohol drinking is an integral part of many people’s family and social life, it is in reality a poison and an addictive substance. It can cause both physiological and psychological harm in users and has wider adverse social consequences. It has been estimated that 1 in 25 deaths worldwide is due to alcohol consumption (1).

Many of the medical consequences are well known such as alcohol poisoning and cirrhosis of the liver. Some of the other medical consequences are not so well known, for instance, it is not widely known that alcohol contributes to stroke and other cardiovascular diseases, cancer and congenital deformity. There are also the more acute problems which may be partly due to alcohol consumption such as assault, including domestic violence and sexual assault, and accidental injury.

Not only does alcohol misuse affect health, but alcohol affects many of the social determinants of health, such as housing, employment, crime and disorder. The social consequences of excess alcohol consumption include crime and disorder; abuse and neglect of loved ones, including children; family breakdown; homelessness; unemployment and poverty; and poor educational achievement.

A BIT OF HISTORY......

Alcohol consumption was higher during the late Middle Ages, the 18th Century gin epidemic, and the beginning of the 20th Century. There was a sharp decline in consumption during World War I due to reduced opening hours, the sale of reduced-strength beer and other measures to curb drinking. There was a similar decline in drinking during the depression, but since the early 1950’s per capita consumption of pure alcohol has more than doubled to 9.4 litres in 2004 and then declined to 8.9 litres in 2006 (2).

The societal problems caused by alcohol are not just the modern scourge they are often portrayed as in contemporary society. Hogarth produced the prints Gin Lane and Beer Street in 1751 (front cover); Gin Lane is the most famous of these prints, portraying a stark picture of the effects of excess alcohol. However, it is more informative to view both prints together as the prints show not only the consequences of alcohol misuse, but also pronounced health inequalities. The wealthy, healthy occupants of Beer Street flourish at the expense of the destitute, addicted occupants of Gin Lane.
AND A BIT ABOUT THE PRESENT

Recently, there has been much interest in the levels of alcohol misuse in the UK (3). Alcohol consumption has been rising in the UK since the late 1970s with a particular rise in the consumption of wine and spirits. In recent years there has been alarm at the increase in ‘binge drinking’ i.e. the consumption of large quantities of alcohol at a single session and the increased consumption of ‘alcopops’.

In 2006, men aged 45-64 years and women aged 16-24 years were the heaviest drinkers. 8% of men were drinking over 50 units per week and 5% of women were drinking over 35 units per week, i.e. harmful drinking (3).

The National Alcohol Strategy: Safe, Sensible, Social (DH 2007) (4) included an action point to monitor changes in drinking habits over time and identify potential factors influencing drinking culture and contributing to rising levels of alcohol consumption in the UK. This was taken on by the Rowntree Foundation who reported their findings this year. The most notable trends were an increase in drinking among women, an increase in drinking among middle and older age groups and a possible recent decrease in drinking among 16-24 year olds. This study suggests that further research is needed to investigate whether women and older and middle-aged men are aware that their drinking behaviour might be harmful to their health; whether they understand the alcohol content of commonly consumed drinks; know what safe drinking limits are and what the risks of excessive consumption are. This study also identified a need for research on the influence of the family on drinking, i.e. when and why do family provide alcohol to their children; and what drinking behaviour do they expect of their children and how do they enforce it? (2).
The Chief Medical Officer introduced the concept of passive drinking in his 2008 report and this year there has been a consultation on alcohol and young people (5) (6). There is particular concern at levels of heavy and binge drinking, especially amongst teenage girls and young women. And there is some evidence of an increase in serious liver disease in young people due to alcohol (7).

Figure 2 - Percentages of men and women with weekly alcohol consumption at levels of ‘increasing risk’ and ‘higher risk’

Source: Health Improvement Analytical Team Department of Health 2008

THE ROLE OF THE ALCOHOL INDUSTRY AND PROMOTIONAL ACTIVITIES

The Department of Health made a commitment in Choosing Health (8) to work with the Portman Group, an industry group formed to promote sensible drinking and prevent alcohol misuse, to cut down binge drinking. This report described the rules governing alcohol advertising as a good example of regulation evolving and modernising to keep up with changes in society and marketing techniques (8). However, five years on, the BMA has published a scathing report on the promotion of alcohol and called for a comprehensive ban on all alcohol marketing (9).

Certainly, marketing works. There has been a recent upsurge in the consumption of cider due to what has been termed ‘the Magners effect’ (10). A few years ago just £3.4 million was spent per annum on cider in the UK. This has now jumped to £46 million per annum after a £25 million advertising campaign by Magners Cider, demonstrating the success of promotional activity.

The communications regulator (OfCOM) and the Advertising Standards Authority (ASA) regulate the promotion and sales of alcohol. There are many regulations relating to the way that alcohol is marketed and in addition to these, there are industry codes and standards. Despite this, however, promotional activities that aim to encourage excessive drinking are commonly seen in both licensed premises such as clubs and bars, and off-license premises such as supermarkets. In addition, drinks manufacturers use specific advertising strategies such as sponsorship of events and celebrity endorsements to reinforce the image of alcohol.
as desirable. This is evident after watching just a few minutes of music videos where certain brands are placed in the videos to reinforce their image as a premium brand.

There is evidence that the burden of disease due to alcohol misuse is now falling on a younger age group, both in men and women (11). Binge drinking in particular is harmful to health and significantly increases the risk of alcohol dependence (12) and the social, educational and economic adverse effects of alcohol in later life (13). The Drinkaware Trust\(^1\) has recently launched a campaign targeting 18-24 year-old binge drinkers, aiming to ‘challenge the perceptions and attitudes towards drinking and social acceptability of drunkenness’. This is a substantial campaign, costing £100 million, but has resulted in criticism as Drinkaware are backed by the alcohol industry and this campaign has been perceived by Alcohol Concern as a means for the drinks industry to try to avoid mandatory legislation on passing on health information to consumers.

Many manufacturers and retail outlets do not put sufficient information on alcohol products to enable people to make informed choices about what they drink. Alcohol Concern published a report recently (14) that highlighted problems with alcohol labelling in the UK. There has been a voluntary agreement between the Government and the drinks industry to improve labelling and include unit content on alcoholic products since 1998. This was extended to include unit content and government guidelines on sensible drinking on the majority of products by the end of 2008, and was accompanied by the Know Your Limits campaign to raise public knowledge about units of alcohol and the dangers of exceeding recommended levels of drinking. However, a report on the progress of the scheme released in March 2008 showed that only 57% of products showed unit information (14).

Alcohol Concern investigated alcohol labelling, in-store information and promotions in five major supermarkets to determine how alcohol is promoted by major retailers and what information was available for customers. Only 56% of promoted products had unit information on the label and only 18% promoted products had information on sensible drinking levels. The situation was better when supermarket own-brands were checked – 95% of these had unit labels and 44% had information on sensible drinking. Alcohol concern conclude that current labelling does not sufficiently protect public health and that supermarkets are contributing to heavy drinking by promoting cheap, poorly labelled, alcohol.

Whilst the alcohol industry resists compulsory warnings on drink labels, and involves itself in partnership working and health education, the industry is marketing its products very successfully. The BMA claims that the increase in alcohol consumption in the general population is having an effect on young people, who respond to pro-alcohol marketing and, perceiving that alcohol is socially acceptable, drink more alcohol. (9).

**ALCOHOL POLICY**

\(^1\) The Drinkaware Trust raises public awareness of sensible drinking advice and the dangers of alcohol misuse. This charity was formed in 2006 by the Portman Group which now concentrates on its work with industry, rather than educational work.
In the UK, the prevailing view is that a reduction in alcohol consumption to sensible or lower risk levels is sufficient even for those people who are dependent on alcohol. This contrasts with the view in the USA (where much research on alcohol misuse originates) that abstinence should be promoted as the only effective way to treat alcohol misuse (15) (16).

In 2004, the Department of Health published ‘Choosing Health, the Alcohol Needs Assessment Research Project’ (ANARP) (8), (17) and the Alcohol Harm Reduction Strategy for England, followed in 2005 by Alcohol Misuse Interventions; Guidance on developing a local programme of improvement (18). Safe, sensible, social – The next steps in the National Alcohol Strategy (2007) (4) reviewed progress since these publications and outlined further action to be taken to reduce alcohol-related ill-health and crime.

TARGETS

Public Service Agreement (PSA) 25 is a set of cross-government targets aimed at reducing the harm caused by alcohol and drugs (HM Treasury 2009). PSA 25 calls for a focus on 18-24 year old binge drinkers, young people under 18 who drink alcohol and harmful drinkers (19).

A number of the targets set out in PSA25 are pertinent to health and to PCTs and Local Authorities. These include indicator 2 (See Appendix B) – the rate of alcohol-related hospital admissions and Indicators 4 and 5 – the percentage of the public who perceive drug use or dealing/drunk and rowdy behaviour to be a problem in their area. PSA 14 aims to increase the number of children and young people on the path to success and this links to alcohol and drug use. In addition, PSA 23 – making communities safer, relates to reducing alcohol-related violent crime.

Further information on PSA targets is given in Appendix B.

LICENSING

There is evidence that increased licensing hours are associated with increased alcohol consumption and alcohol-related problems and that reducing the opening hours reduces the chances of harm. The changes to licensing laws in England in 2003 increased the availability of alcohol by allowing 24-hour opening in England and Wales and this has undoubtedly led to an increase in consumption (2). It is interesting that public health was not considered when the Government changed the licensing laws (12).

The delivery agreement for PSA25 states that laws and licensing powers introduced to tackle alcohol-fuelled crime and disorder, and protect young people need to be used widely and effectively (19).

TAXATION AND PRICING

In 2008 alcohol tax was increased. It was estimated that a 10% rise in the price of alcohol would reduce adult alcohol-related mortality by up to 37%. A national review of evidence on the relationship between alcohol price, promotion and harm was published in 2008 by Sheffield School of Health and Related Research (ScHARR) (20). This reported that the health harms due to alcohol (particularly chronic disease related to alcohol), alcohol-related crime
and alcohol-related unemployment and absenteeism all reduce as the cost of alcohol increases. Prevented deaths occurred disproportionately in harmful drinkers.
TREATMENT

In Choosing Health, the government pledged to ensure all health professionals could identify alcohol problems early and would pilot screening and brief interventions in primary care, hospital settings and accident and emergency departments (8). Following the publication of the Alcohol Harm Reduction Strategy, the SIPS (Screening and Intervention Programme for Sensible drinking) pilot was introduced (21) and the Alcohol Needs Assessment Research Project was published in 2005 (17). The SIPS project is due to publish the results of the trailblazer SIPS pilots in autumn 2009 and this will add to the body of evidence on effective brief interventions and their cost-effectiveness (21).

The Alcohol Learning Centre (www.alcohollearningcentre.org.uk) was launched in 2008 to provide online training for health professionals and a commissioning framework was developed by the Department of Health following the publication of Safe. Sensible. Social (4).

There is a commitment in public health to develop a programme for improving alcohol treatment services based on an audit of demand and the Models of Care framework, funded via the pooled treatment budget of substance misuse (8) (17).

Alcohol treatment is currently provided by GPs and specialist addiction services, but most alcohol treatment services in England are found in the voluntary sector (17). In recent years there was an emphasis on the treatment for misuse of class A and B drugs, rather than alcohol. This has led to underfunding of services for alcohol misuse and the waiting time for treatment is much longer for alcohol misuse than for drug misuse (22).

The forthcoming year should see the publication of clinical guidelines from the National Institute for Health and Clinical Excellence on the prevention and management of alcohol misuse.

CRIME AND DISORDER/ SOCIAL ENVIRONMENT

The Department of Health has worked together with the Home Office on alcohol-related crime and disorder. An arrest referral pilot has been funded by the Home Office.

PSA 25 suggests agencies such as the police, local authorities, prison and probation, the NHS and third sector collaborate to shape an environment that promotes sensible drinking, i.e. changing the drinking culture in Britain and shifting away from binge drinking (19).

EDUCATION

The Alcohol Harm Reduction Strategy has led to various alcohol education campaigns, including campaigns with the alcohol industry, e.g. with the Portman Group. The government has consulted on the need for legislation on alcohol labelling and targeted information has been launched for people who drink at harmful levels and their friends and families. A number of national campaigns have been launched such as Know Your Limits, Units: They Add Up and television campaigns highlighting the problem of binge drinking.
5. METHODS

The scale of alcohol misuse and the health consequences of this in the borough was subject to a quantitative analysis of hospital admissions data, crime data and ambulance service data.

The services and interventions available in the borough were investigated by interviews with key stakeholders and a review of information available from these services.

The following people were interviewed for the needs assessment. Most interviews were conducted in person, but a small number were conducted by telephone.

Joe Benmore  Haringey Probation Service
Keith Betts Environmental Health, London Borough of Haringey
Sheena Carr Public Health NHS Haringey
Colin Chapman Drug Advisory Service Haringey (DASH)
Fiona Cook Haringey Advisory Group on Alcohol
Jin Lim Public Health NHS Haringey
Ian McGregor Haringey Advisory Group on Alcohol
Eliza Mechan Community Safety, London Borough of Haringey
Cindy Mukombegumi Dual Diagnosis Unit, St Ann’s Hospital
Chinele Nwajiobi NHS Enfield
Libby Ranzetta Ranzetta Consulting
Angela Small Eban
Linda Somerville Public Health NHS Haringey/Haringey Drug and Alcohol Team (DAAT)
Otis Williams Community Safety, London Borough of Haringey
Trevor Hubbard London Ambulance Service
Sarah Hart Haringey Drug and Alcohol Team (DAAT)
Terry Grant Young Fathers Project London Borough of Haringey

Equity of access to services was assessed by data analysis and by discussion with stakeholders.

Targeting of services was assessed by discussions with key stakeholders and a literature review.

The involvement of stakeholders in alcohol misuse services in the borough was assessed by discussions with stakeholders and reference to service documentation.

A literature review was performed using PubMed, NHS Evidence and websites from the Department of Health, Alcohol Concern, Alcohol Policy, ONS, London Health Observatory, North West Health Observatory. Secondary sources were identified using the material obtained from the above.

Need was assessed by analysing the data from both quantitative and qualitative sources and literature. The following were considered: is there a mismatch of services? Are there sufficient services? Are services accessible? Is there any duplication of services and effort?
Are there any opportunities for service redesign or is there a need for further investment in any areas?

6. RESULTS

COSTS TO THE HEALTH SERVICE OF ALCOHOL MISUSE

The cost of alcohol misuse in the UK is substantial, both in terms of direct costs (e.g. costs to hospital services and the criminal justice service) and indirect costs (e.g. loss of productivity and the impact on family and social networks). The NHS spends millions every year on treating and dealing with alcohol problems and the criminal justice system also spends similarly large amounts dealing with alcohol-related and drink-driving offences (12) (23).

The National Social Marketing Centre (www.nsms.org.uk) estimated that the total annual societal cost of alcohol misuse in England is £55.1 billion including:

- £21 billion cost to individuals and families/households (e.g. loss of income, informal care costs)
- £2.8 billion cost to public health services/care services
- £2.1 billion cost to other public services (e.g. criminal justice system costs, education and social services costs)
- £7.3 billion cost to employers (e.g. absenteeism)
- £21.9 billion in human costs (measured in disability-adjusted life years (DALYs) (11) (12)

The costs of alcohol treatment are not as high as those for drug treatment and the Public Accounts Committee reported that for each of the estimated 1.1 million dependent drinkers approximately £197 is spent on specialist alcohol treatment services, compared with £1,744 per head for drug treatment (24).

In 2008, the NAO report ‘Reducing Alcohol Harm’ (21) concluded that there was wide variation in alcohol services provision and that many PCTs did not have a clear picture of local needs for alcohol services, that often there was no local strategy, or if there was one it was inadequate, and that there was scope to secure better value for money from PCT expenditure on alcohol services.
PREVENTION OF ALCOHOL MISUSE

There is new draft guidance from the National Institute for Health and Clinical Excellence (NICE) on preventing the development of hazardous and harmful drinking. This is in addition to NICE guidance on school-based interventions on alcohol, the prevention of cardiovascular disease and the management of alcohol dependence.

Both national and individual approaches need to be taken to deal with alcohol and its societal consequences. Population level interventions can help reduce the level of alcohol consumed in the country and lower the risk of alcohol-related harm for the population. These would help reduce the number of people who start drinking harmful or hazardous amounts of alcohol and the culture change would help create an environment where it is easier not to drink, or to cut down drinking. This is especially important for people advised to cut down their drinking. NICE make the point in their draft guidance that legislation on drink-driving was enacted on less evidence than that available for their guidance on prevention.

PRICING

In 2008, the Chief Medical Officer called for action to make alcohol less affordable and there is a body of evidence to support this [CMO report, ScHARR report]. NICE concurs that increasing the real cost of alcohol appears to be the most effective way to reduce alcohol-related harm. A minimum price per unit would prevent people, especially young people, from drinking greater quantities of cheaper drinks, and would prevent retailers from selling alcohol below cost price.
LICENSING, ADVERTISING AND ENFORCEMENT

The Government is currently legislating to introduce a new code of practice for alcohol retailers. This mandatory code will include a requirement to display alcohol units and health related information, and discretionary local licensing conditions (Department for Children, School and Families 2009).

The draft NICE guidance supports the use of licensing laws to reduce the number of outlets selling alcohol and the times at which it is available. In Scotland, public health has been included in the new licensing objectives and NICE support the introduction of this objective into English law.

NICE are considering recommending the use of local health crime data to develop or review licensing policies, possibly resulting in a limit to the number of licensed premises in a given area.

There is evidence for a relationship between exposure to alcohol advertising and the onset of drinking among young people. In addition, there is evidence that those young people that do drink are likely to increase consumption in response to advertising. An advertising ban similar to that on advertising smoking has been suggested, but there is inconclusive evidence for this at present (25). Nonetheless NICE is considering the use of a ban on advertising and marketing, including television, radio, and cinema and sports sponsorship. The Committee on Advertising Practice (CAP) and Broadcast Committee on Advertising Practice (BCAP) have reviewed the advertising codes following the release of the Sheffield report on the effects of alcohol price and promotion. They have stated that they do not believe changes are required at present, but they have recently consulted on this position (20).

HEALTH PROMOTION AND BRIEF INTERVENTION

There is evidence that appointments made for other health problems are not appropriate times to discuss alcohol use. However, health promotion is discussed at other visits such as new patient registrations and well-person clinics and these are considered appropriate arenas to discuss alcohol as part of general lifestyle issues (25).

The Draft NICE guidance on preventing hazardous or harmful drinking recommends structured brief advice for those identified as misusing alcohol using a screening questionnaire. This can be followed by motivational counselling for those who have failed to benefit from structured brief advice or are felt to require more than brief advice (25). Further details of these are in the section below.

EARLY PARENTAL SUPPORT
The Prime Minister’s Strategy Unit highlighted in 2004 that poor parenting can contribute to problems with alcohol in later life (26). It also highlighted the effects of parental alcohol misuse on the family. Support for young parents has been suggested as one way of helping to integrate health promotion, social support and education. This can be achieved by Children’ Centres and by 2010 every community will be served by a Sure Start Children’s Centre.
SCHOOL INITIATIVES AND PREVENTION OF ALCOHOL MISUSE IN YOUNG PEOPLE

NICE recommended in its guidance for schools that alcohol education should be made integral to the school curriculum and tailored to the different age groups and learning needs (27). A whole school approach should be used when dealing with schools. This should include children and their parents and staff. The school should consult with families about alcohol initiatives.

If young people are thought to be drinking to harmful levels, they should be assessed using the Common Assessment Framework (CAF) and offered on-to-one advice and referral to a specialist service. These children should have their ability to consent to alcohol-related interventions routinely assessed.

The draft NICE guidance on the prevention of hazardous and harmful drinking suggests young people aged 16 and 17 should be assessed using a validated alcohol screening questionnaire. This needs to be done in a manner sensitive to the age of the person and their culture.

DETECTING ALCOHOL MISUSE AND BRIEF INTERVENTION

It can be difficult to identify someone who has an alcohol misuse problem. Alcohol problems are associated with stigma and many healthcare professionals find it difficult to raise the subject with the person in front of them. There are a number of well-evaluated instruments to aid people to assess alcohol use, such as the Paddington Alcohol Test (PAT test) and the Alcohol Use Disorders Identification Test (28). Blood tests can also be used, but their interpretation depends very much on the circumstances. Blood alcohol can be useful in accident and emergency settings, and liver enzymes such as γ-glutamyl transferase can be useful in in-patient care. However, liver enzymes are affected by a raft of medical conditions and drug interactions and are not very useful in primary care (28).

Brief Intervention is the most commonly used model for early intervention for problematic drinking. There is good evidence for benefit from brief intervention provided by healthcare workers who are not alcohol specialists and while there is not such strong evidence, brief intervention should be able to be provided by a variety of people, including healthcare workers, probation and police staff (25). Patients are asked about alcohol consumption and their level of risk is assessed by the healthcare worker by, for example, questionnaire. Those that require intervention are given information on alcohol use and harms, identification of high risk situations for drinking and individual coping strategies and a personal plan to reduce drinking are developed. Brief intervention usually takes between 5 and 15 minutes for a GP.

The National Treatment Agency’s (NTA) review of the effectiveness of treatment for alcohol problems (16) showed that opportunistic brief interventions in primary care for hazardous or harmful drinkers are effective in reducing alcohol consumption to low risk levels. This demonstrates that brief interventions could have a large impact on public health. However, the review also found that the majority of healthcare professionals had not incorporated any identification and advice for hazardous and harmful drinkers, in particular GPs were not identifying most hazardous and harmful drinkers presenting to their practices. Primary care
offers an exceptional opportunity for early intervention, helping people to reduce their drinking.

Brief intervention has now been shown to be effective for up to 2 years post-intervention and even as long as 4 years (29). However, reservations have been expressed as to whether brief intervention is suitable for women and a Cochrane review did not demonstrate a clear benefit for women receiving brief intervention (30). In addition, there is limited evidence on the effectiveness of screening and brief interventions for young people (25). The draft NICE guidance on the prevention or hazardous or harmful drinking suggests that lower screening thresholds may need to be considered for women, young people, people aged 65 and over and black and minority ethnic groups. More research is needed to evaluate if screening and brief intervention is effective in women and young people.

TREATING ALCOHOL MISUSE

Best practice on commissioning and providing alcohol services in England are based on MoCAM, the Models of Care for Alcohol Misusers, published in 2006 by the Department of Health and the National Treatment Agency for Substance Misuse (15). This is a four-tiered model of interventions forming an integrated treatment system for adults based on stepped care, i.e. the progression from tier 1 to tier 2 is based on need and prior treatment.

Using MOCAM, commissioners should estimate the numbers of people by type of misuser, and calculate likely demand. The interventions/services are then commissioned according to these data, with some flexibility as you cannot be too prescriptive about the type of treatment that should be given to someone with a particular type of alcohol misuse problem. There are two main types of intervention: targeted and opportunistic screening/brief interventions for hazardous and harmful drinkers; and assessment and co-ordinated care-planned treatment for moderately and severely dependent drinkers or those with complex problems associated with their alcohol use e.g. dual diagnosis.

In 2008, PCTs reported an average spending of 600,000 on services for the prevention and reduction of alcohol-related harm (21).

Specialist services are primarily designed to treat harmful and dependent drinkers. The availability of specialist services varies greatly around the UK. These services include walk-in clinics, home-based detoxification programmes, residential rehabilitation, in-patient detoxification in the acute sector and structured psychological interventions. These services might be commissioned by the drug and alcohol team (DAAT) or the PCT or by both in partnership. There was until recently no standard model for the commissioning arrangements (21), however Signs for Improvement should have addressed this problem (31). Estimates for the need for specialist treatment were published by the Alcohol Needs Assessment Research Project (ANARP) (Department of Health 2005), which found that only approximately 1 in 18 dependent drinkers were accessing specialist alcohol treatment in England per annum (17). This compares unfavourably with access to treatment for other drug problems (55% of misusers gain access to treatment each year) and against international comparators such as North America where access is considered low even though 1 in 10 people have access to treatment.
Where people are referred for treatment, almost 30% of individuals do not take up the service offered. This could be due to the drinker not being ready for treatment, lack of confidence in whether the treatment will work, or due to waiting times, which can be quite lengthy.
Table 1  Tier 1 Services for Alcohol Misuse

<table>
<thead>
<tr>
<th>Definition</th>
<th>Provision of: identification of hazardous and harmful drinkers and those who drink in excess of the sensible drinking limits; information on low risk drinking; ‘brief advice to reduce alcohol-related harm; and referral of those with alcohol dependence or harm for more intensive interventions.</th>
</tr>
</thead>
</table>
| Provided interventions | • Targeted screening for those drinking in excess of Guidelines on Safer Drinking (DH)  
• Provision of brief advice to hazardous drinkers  
• Referral of those requiring more than brief advice for services in higher tiers  
• Partnership or “shared care” with staff from higher tiers, e.g. joint care of individuals attending Tier 1 services requiring alcohol treatment. |
| Examples of agencies delivering Tier 1 provision | Tier 1 provision can be delivered by a very wide range of agencies whose main focus is not alcohol treatment, such as: primary healthcare services; acute hospitals, e.g. A&E departments; psychiatric services; social service departments; homelessness services; antenatal clinics; general hospital wards; police, e.g. custody cells; probation services; prison service; education and vocational services; and occupational health services. |

Based on MOCAM  (Department of Health/National Treatment Agency for Substance Misuse 2006)
### Table 2  Tier 2 Services for Alcohol Misuse

**Tier 2 Provision of open access support to reduce alcohol-related harm, assessment and referral services**

<table>
<thead>
<tr>
<th>Definition</th>
<th>Provision of open access facilities and outreach that provide: alcohol-specific advice, information and support; brief interventions to help alcohol misusers reduce alcohol related harm; and assessment and referral of those with more serious alcohol-related problems for care-planned treatment.</th>
</tr>
</thead>
</table>
| Provided interventions | Tier 1 interventions plus:  
- Open access facilities and outreach targeting alcohol misusers which provide: alcohol-specific information  
- advice and support brief support to reduce alcohol-related harm alcohol-specific assessment and referral of those requiring more structured alcohol treatment partnership or “shared care” with staff from Tier 3 and 4a provision, or joint care of individuals attending other services providing Tier 1 provision mutual aid groups, e.g. Alcoholics Anonymous  
- triage assessment may be agreed as part of locally agreed arrangements |

*Based on MOCAM (Department of Health/ National Treatment Agency for Substance Misuse 2006)*
## Table 3  Tier 3 Services for Alcohol Misuse

<table>
<thead>
<tr>
<th>Definition</th>
<th>Provision of community based specialised alcohol misuse assessment, care-planned treatment, and care co-ordination when required.</th>
</tr>
</thead>
</table>
| Provided interventions | All Tier 2 provision plus:  
- comprehensive substance misuse assessment;  
- care planning;  
- care co-ordination a range of evidence-based psychosocial therapies and support within a care plan to address alcohol misuse  
- a range of evidence-based interventions for assisted alcohol withdrawal (detoxification) and pharmacotherapies to address alcohol misuse provision of information, advice and training and “shared care” to others delivering Tier 1 and Tier 2 provision. |
| Examples of agencies delivering Tier 3 provision | Statutory, independent or voluntary community-based services providing care-planned alcohol treatment, General medical services, and other generalist services, with the required additional specialised expertise and resources to provide care-planned alcohol treatment. Specialist alcohol services with the expertise to address the treatment needs of the more severe or complex dependent drinkers. |

Based on MOCAM (Department of Health/National Treatment Agency for Substance Misuse 2006)
Table 4  Tier 4 services for Alcohol Misuse

<table>
<thead>
<tr>
<th>Tier 4: Provision of residential/inpatient care-planned treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition</strong></td>
</tr>
<tr>
<td><strong>Provided interventions</strong></td>
</tr>
</tbody>
</table>
  • comprehensive substance misuse assessment  
  • care planning  
  • care co-ordination  
  • a range of evidence-based psychosocial therapies and support to address alcohol misuse  
  • a range of evidence-based assisted alcohol withdrawal (detoxification) and pharmacotherapy to address alcohol misuse  
  • provision of information, advice and training and “shared care” to others delivering Tier 1 and Tier 2 services. |
| **Agencies delivering** |  
  **- Tier 4a provision** | Specialist statutory, independent or voluntary sector residential inpatient facilities for assisted alcohol withdrawal (detoxification) and possibly rehabilitation alcohol residential rehabilitation units. |
  **- Tier 4b provision** | Highly specialist non-alcohol specific residential or inpatient services, which have patients or clients with high levels of alcohol-related morbidity who may require care plans and support to facilitate their access to alcohol specific provision across the Tiers. Examples include: specialist liver disease units, specialist psychiatric wards, forensic units, A&E wards, residential provision for the homeless. |

Based on MOCAM (Department of Health/National Treatment Agency for Substance Misuse 2006)
Burden of Disease

Physical Health

Alcohol is associated with the cause of over 60 medical conditions and is a significant cause of morbidity and premature death (3). Men who regularly drink more than 8 units a day and women who drink more than 6 units a day raise their risk of having various diseases; these include high blood pressure, stroke, coronary heart disease, pancreatitis and liver disease (31).

Alcohol is associated with a number of cancers, liver disease, acute toxicity and hypertension. Alcoholic liver disease is the most common alcohol-related cause of death and this increased 20% between 2001 and 2005. Although many people are aware of the link between alcohol and liver cirrhosis, they are not aware of the other diseases associated with alcohol consumption and do not realize that comparatively low consumption can put them at higher risk of some diseases, e.g. A consumption of 7 units per week increases the risk of breast cancer (32).

Alcohol is also known to have a protective effect against certain diseases such as heart disease and the relationship between alcohol and cerebrovascular disease follows a classic
‘J-curve’. At lower levels of consumption, alcohol protects against the risk of death compared with abstention, but at higher levels of consumption, the relative risk of death from cerebrovascular disease increases with increasing alcohol consumption (33).

Table 5 – Increased risks of ill-health due to harmful drinking

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>MEN (INCREASED RISK)</th>
<th>WOMEN (INCREASED RISK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>4 times</td>
<td>2 times</td>
</tr>
<tr>
<td>Stroke</td>
<td>2 times</td>
<td>4 times</td>
</tr>
<tr>
<td>Coronary Heart Disease</td>
<td>1.7 times</td>
<td>1.3 times</td>
</tr>
<tr>
<td>Pancreatitis</td>
<td>3 times</td>
<td>2 times</td>
</tr>
<tr>
<td>Liver disease</td>
<td>13 times</td>
<td>13 times</td>
</tr>
</tbody>
</table>


The National Alcohol Harm Reduction Strategy (17) found that over half of all violent crimes, 22000 premature deaths, 70% of all peak-time admissions to emergency departments and 1000 suicides per annum were directly related to alcohol.

The increase in rates of alcohol-related hospital admissions from 2003-2007 led the Department of Health to include a Vital Signs indicator (VSC26) in the NHS targets from April 2008. This target is for the reduction of alcohol-related admissions and is the same target as NI39 for local authorities.

**PHYSICAL INJURY**

Alcohol is a major cause of accidents and injury. It has been cited as the single most important form of contributory behaviour for domestic accidents resulting in death, resulting in an estimated 400 alcohol-related deaths due to home accidents each year (13).

Estimates of the proportion of deaths due to drinking range from 35-63% of deaths due to falls to 21-47% of deaths due to drowning and 12-61% of deaths due to burns (34). In 1983 a study of accident and emergency attendances demonstrated that 50% of injuries from assault were associated with alcohol levels about 80mg/100ml (the legal drink-drive limit) (34). Two decades later, it was noted in Choosing health (8) that around one-third of all accident and emergency department attendances are alcohol-related.

A 2006 report presented evidence that in almost one third of fatalities due to fire, the victim was under the influence of alcohol. This was echoed by a 2008 report from London Fire Brigade which stated that alcohol was a factor in 31% of fatal accidental fires in London homes and concluded that people were dying despite having working smoke alarms, as they were unable to react due to alcohol impairment (34).

In 2006, 6% of road casualties and 17% of road fatalities were due to alcohol intoxication (11) (12). There was a fall in the number of drink drive accidents from 9280 in 2007 to 8640 in 2008. However, this was accompanied by a 3% increase in fatal accidents in the same time period. These accidents resulted in 430 fatalities in 2008 and 12,600 injuries, 1630 of which were serious (35). The Chief Medical Officer for England has recently called for a zero
alcohol limit for young drivers and both the Royal Society for the Prevention of Accidents (RoSPA) and British Medical Association (BMA) have called for the drink driving limit to be reduced from 80mg/100ml blood alcohol to 50mg/100ml blood alcohol (5) (23) (36).

MENTAL HEALTH

Dual Diagnosis refers to the diagnosis of a mental health problem alongside a substance misuse problem. This includes drugs and alcohol. Dual diagnosis is important because people with a dual diagnosis have and increase risk of suicide, homelessness, family problems and are more likely to have contact with the criminal justice system (37) (38).

In Haringey the Dual Diagnosis Unit at St. Ann’s Hospital provides care for people with a dual diagnosis, whether their substance misuse involves alcohol or another drug. The Unit has a ‘hub and spoke’ model, with a consultant psychiatrist, a manager and a senior mental health specialist based at St. Ann’s and specialist workers working in community mental health teams, across health services and in the probation service. The Dual Diagnosis Unit is funded by NHS Haringey (the PCT) and Haringey DAAT team.

In 2008 the unit saw 57 patients whose primary substance misuse problem was with alcohol. This is from an overall caseload of approximately 175 patients. The DAAT monies are from the pooled treatment budget and thus are provided for the prevention and treatment of problematic use of illegal drugs, rather than alcohol. However the Unit does not turn people away and is able to offer people with a dual diagnosis and alcohol misuse problem treatment, including in-patient treatment if necessary.

CRIME AND DISORDER

Alcohol use is often associated with antisocial and aggressive behaviour in both domestic and public settings. The British Crime Survey 2008/9 noted that 47% of victims of violence described their attacker as being under the influence of alcohol. Based on the 2008/9 British Crime Survey, there were almost 1 million incidents where the victim believed the offender was under the influence of alcohol. There has been an increase from 1995 to the present in alcohol-related incidents. This is at the same time that the number of drug-related incidents has remained relatively stable (Home Office 2009). Half of all incidents of alcohol-related violence in England and Wales take place in or around pubs and clubs. Insufficient transport services and poor street lighting also increase the likelihood of violence (39).

Crime has fallen steadily over the past 3 years in Haringey, but some crimes such as serious violence are increasing and are higher than in many other London boroughs. However, there have been changes to the way that violent crime is counted and this may account for the rise in serious violence reports (40).

Youths, young adults, and people of African-Caribbean descent are more likely to be victims of crime; and young men, people of African-Caribbean descent and unemployed people are more likely to be offenders. Crime and disorder are higher in the east of the borough, particularly Noel Park, Bruce Grove and Northumberland Park.
Most offences tend to be committed in the evening, particularly violent and sexual offences that tend to be committed on weekend evenings. There was a correlation between the location of licensed premises and violent and sexual offences in the year ending August 2008 (40).

Crime and Disorder Reduction Partnerships (CDRPs) are bodies set up to co-ordinate the activities of many bodies such as criminal justice, education and local authorities to reduce crime in an area. PCTs are statutory partners in these partnerships (40).

VIOLENT CRIME

ASSAULTS - CRIME RELATED HOSPITAL ATTENDANCES AND ADMISSIONS

Crime-related hospital admissions and A&E attendances are significantly higher in males aged 20-44 years, who accounted for almost half of attendances. One quarter of admissions were in males aged 19 and under. African-Caribbean males are over-represented in the admissions data and tend to come from the East of the Borough. Alcohol is a significant problem in the admissions group, whereas assault is significant in A&E attendances (although a number of these assaults will be related to alcohol). Other White and Other ethnic groups are over-represented in the crime-related A&E attendances. Some of this may be due to these groups having no other access to healthcare, i.e. they may not be registered with a GP.

During the period July 2007 to June 2008, there were 176 admissions resulting from assault, including 37 admissions for stabbings and 1 admission for gun crime. There were 1636 attendances in A&E due to assault and 126 of these were due to stabbing and 5 were due to gun crime.

Alcohol-related hospital admissions and A&E attendances are significantly higher than those due to illicit drugs (41).

London Borough of Haringey commissioned an analysis of alcohol-related violence using data from December 2008 to March 2009. During this time period, there were 8,832 confirmed crimes in the borough. 312 Actual Bodily Harm (ABH) and Grievous Bodily Harm (GBH) offences were reported during this time and it was established that 42 incidents were associated with alcohol.

There was no clear geographic clustering, although there was some evidence of clusters around Bruce Grove and Haringey Ladder. A temporal analysis showed that the peak time for offences was between midnight and 4 am, followed by 4pm to 8pm. It is interesting that Crouch End and Muswell Hill did appear to have a problem with alcohol-related incidents despite a high concentration of licensed premises.

Sexual assault is also often associated with alcohol. More than half of those convicted of rape had been drinking before they committed the crime (39).
DOMESTIC VIOLENCE

Domestic violence is associated with alcohol use and a third of incidents of domestic violence occur when the perpetrator has been drinking. Almost a fifth of women in the UK and one tenth of men aged 16-59 have been the victim of physical domestic violence (39). In the British Crime Survey (42), 38% of victims of domestic violence believed their attacker to be under the influence of alcohol. Alcohol-related domestic violence also has an impact on children who can develop mental health problems and might misuse alcohol themselves in later life.

Hearthstone Domestic Violence Advice and Support Centre opened full-time in 2004. Between July 2007 and June 2008, there were 1349 referrals to hearthstone, a 57% increase on the previous year suggesting a greater awareness of the service. Police referrals accounted for 12% and social services referrals accounted for 4%. The majority of visits are drop-ins (73%), rather than appointments and this was particularly pronounced in the first-time visitors.

Of those referred, there were 695 individuals during 2007/08, 674 of whom were women. Women with children accounted for 63% of visits and less than 1% were from lesbian, gay, bisexual or transgender individuals, a low percentage given the population of Haringey. There were a range of ethnicities, most commonly Black British or African-Caribbean (37%), followed by White British (17%), White Other (13%), Asian British (8%) and Turkish (6%) (41).

Drugs and/or alcohol were known to be a factor in nearly 24% of referrals. The majority of these were due to the perpetrator using alcohol and/or drugs.

In the analysis of alcohol-related violence reported above, 23 of the incidents linked to alcohol (55%) were flagged as domestic violence. There were no significant geographical hotspots for these offences. The majority of victims (20/23) were female. Although it appears that there are a small number of alcohol-related domestic violence incidents reported in Haringey, it should be remembered that the vast majority of domestic violence is not reported to the police. The 23 incidents reported between December 2008 and March 2009 were likely to be the ‘tip of the iceberg’.

SELF-HARM AND SUICIDE

Alcohol plays a significant role in self-harm and suicide. It has been estimated that 15-25% of all suicides in England and Wales are associated with alcohol (39) (43) and that 65% of suicide attempts are related to alcohol [Dept Health. Health of the nation key are handbook: mental health. HMSO. London. 1993]. Alcohol misuse may increase the risk of suicide and a study in Northern Ireland found that the risk of suicide was eight times higher in people misusing alcohol compared with those not currently misusing alcohol (44).

There is a complex relationship between alcohol, suicide and mental illness. A study in Northern Ireland found that 89% of suicides among alcohol dependants were associated with at least one other mental disorder (44).

There were 94 suicides in Haringey in the period 2004-2008.

ANTISOCIAL BEHAVIOUR
Anti-social behaviour is a concern for many people and in particular there are concerns about young people consuming alcohol which can lead to antisocial behaviour. Extra resource was made available by Government this year to co-ordinate activities to deal with alcohol-related anti-social behaviour in the summer holidays. Haringey benefited from these monies which funded activities and projects over the summer and allowed extra police patrols on Friday and Saturday nights. Further investment is also being made to ensure that there are places available for young people to visit on Friday and Saturday nights.

There are now a number of actions that can be taken to tackle alcohol-related problems. These include anti-social behaviour orders (ASBOS), anti-social behaviour contracts and alcohol arrest referral schemes.

The number of serious calls to the anti-social behaviour action team in Haringey has been increasing and in 2007/8 and 28% of these calls were youth-related (despite the fact that the most common age range for anti-social behaviour is 42-49.) One third of calls (33%) related to the victim’s home and almost one quarter (24%) related to the suspect’s home.

Of the calls for anti-social behaviour in this time period, 45 calls were due to alcohol-related issues (Haringey Community Safety Team 2008).

ACQUISITIVE CRIME

There is no evidence of a significant effect of alcohol on levels of acquisitive crime. Anecdotal information from sources in the local authority and local alcohol worker suggests that there have been incidents where street drinkers were robbed of their belongings and Polish street drinkers being targeted in Haringey. However there are no official data to back these claims.

PROBATION SERVICES AND YOUTH OFFENDING

When someone is convicted of a crime they are likely to be placed on probation, either as part of a community sentence or as part of their parole requirements. If someone breaks the terms of their probation they could be incarcerated. Probation officers work with offenders to reduce the chance that they might commit further crimes. They monitor your activities and let the court know of any problems they observe. They can help offenders get help for their alcohol problem where this is relevant.

Probation officers are often involved in the provision of alcohol services such as education or brief advice and should be trained and competent to the relevant standard, i.e. Drugs and Alcohol National Occupational Standards (DANOS).

The National Probation Service is divided into 42 regional probation areas in England and Wales. Each regional office is responsible for the people who are on probation in their area. London Probation provides a range of programmes for offenders and offenders can be required to attend one of these programmes as part of their community order.
Alcohol treatment requirements (ATRs) were introduced in the Criminal Justice Act 2003 and can be made a component of a Community Order (CO) or Suspended Sentence Order (SSO). As part of a CO, an ATR can be imposed for 6-36 months and as part of an SSO it can be imposed for up to 24 months. The court does not have to be satisfied that alcohol caused or contributed to the offence to impose an ATR, but does have to be satisfied that the offender is dependent on alcohol (including hazardous or harmful drinking) and that this requires treatment and that the treatment is available.

An alcohol service specification has recently been developed for probation services, but this is only applicable to the new probation trusts. In addition, the National Offender Management Service (NOMS), has developed a strategy for alcohol-related interventions. Gaps in local provision are addressed by Regional Offender Managers working in partnership with Crime and Disorder Reduction Partnerships (CDRPS) and the local DAAT team.

London Probation provides the following evidence-based programmes designed to reduce re-offending. These include programmes for addressing domestic violence, anger management, and life skills. There are a number of schemes designed for those offenders that might have a problem with alcohol. These include the Drink Impaired Drivers (DID) and Addressing Substance Related Offending (ASRO). ASRO is a highly structured programme with both probation staff and specialist drug and alcohol workers. Drink drivers can take part in DID which confronts offenders with facts about drink-driving and helps offenders develop problem-solving skills. Drink-drivers are also eligible to take part in Steer Clear, a course of groupwork which looks at alcohol, poor decision making and risk-taking behaviour. Haringey residents can take this course locally and if the course is completed within a set time-frame, participants are eligible for a reduction in their license ban [http://www.london-probation.org.uk/how_we_work/offending_behaviour_programmes.aspx; http://www.london-probation.org.uk/how_we_work/offending_behaviour_programmes/steer_clear.aspx].

A review of the National Probations Service’s work with alcohol-misusing offenders (McSweeney Tim 2009) reported that English probation areas were offering a broad range of alcohol-related interventions, but that there was an unmet need within caseloads. The authors suggest that this should be addressed by sharing emerging best practice, identifying effective strategies for ensuring more offenders commence and complete programmes, and increasing the range, capacity and finding of the probation services alcohol-related work. The report also highlighted the lack of peer-reviewed research on best practice in dealing with offenders with alcohol misuse issues.

In Haringey, alcohol assessments for the Courts are provided by a specialist alcohol worker prior to sentencing using OASYS, the offender assessment system. Brief intervention and advice is provided by Phoenix Futures and referrals can be made to HAGA. In prisons, incarceration is often seen as a form of detox, but this can lead to people being released from prison and returning immediately to their problem drinking, as the root of the problem has not been addressed. One issue that was raised by Haringey Probation Services was the number of people who do not speak English. For these people the programmes that the service usually refers to are often not appropriate and the client has to be seen on a 1:1 basis.
It is widely accepted that young people in contact with youth offending teams are at a higher risk of substance misuse. This may be due to the fact that some of the factors linked with offending behaviour such as truancy, exclusion from school and adverse life events are also linked to the likelihood of developing a substance abuse problem (45) (46).

Youth offending increased 11% in Haringey from July 2007 to June 2008 and repeat offenders were responsible for almost three quarters of all offences committed. The most common offence committed by young people was violence against the person (41).

There are two Youth Offending Service posts that help young people with substance misuse problems. They screen all young offenders and those at high risk of offending, using the Substance Abuse Subtle Screening Inventory (SASSI) and refer them appropriately.
CHILDREN, YOUNG PEOPLE AND FAMILIES

MATERNITY

Alcohol passes freely across the placenta to the unborn child and excessive consumption of alcohol by pregnant women can lead to miscarriage, low birth weight and foetal alcohol syndrome. Foetal alcohol syndrome is characterised by reduced birth weight, small head size, learning difficulties and a particular set of facial features.

The level of drinking that is harmful to the foetus is unclear. There are many confounding factors contributing to the difficulty in finding a safe limit for maternal drinking while pregnant.

In 2003 NICE stated that women should limit their alcohol consumption to no more than one standard unit per day [NICE CG62]. In 2008, these recommendations were updated. The recommendations conclude that alcohol consumption should be discussed with pregnant women at their first contact with a professional for antenatal care and that women should be advised to avoid drinking in the first 3 months of pregnancy due to the possible association with an increased risk of miscarriage, advised to drink no more than 1-2 units of alcohol and to avoid binge drinking (defined as more than 7.5 units in a single occasion) [NICE CG62].

YOUNG PEOPLE AND ALCOHOL

Although the number of young people aged 11-15 that have never had an alcoholic drink is rising, there are concerns about those young people that do drink alcohol. The early onset of drinking has implications for the health of young people and their likelihood of developing problematic drinking in later life.

The Youth Alcohol Action Plan was launched in June 2008, aiming to reduce levels of alcohol consumption and alcohol-related harms. This document set out the plans of the Government to develop guidelines regarding young people and alcohol, reduce alcohol consumption by young people and create a new offence of persistent possession of alcohol in a public place. A three-month consultation was held in England and early 2009 on Children Young People and Alcohol. This covered the guidance recently issued by the Chief Medical Officer (CMO) and advice and information for young people and parents. The responses to this consultation were generally in favour of the CMO guidance although there were concerns that parents rather than legislation should dictate when young people start to drink alcohol. This is a view that was echoed in a women’s workshop in Haringey where many women, especially women who were not born in the UK, felt that the family should be in control of teaching young people to drink responsibly.

The Haringey Children’s Trust programme issues a questionnaire to schoolchildren in the borough as part of the borough’s Children and Young Peoples Plan. This Health Related Behaviour Survey in 2009 was completed by over 1800 young people aged 9-15. In Haringey 91% of pupils in Year 6 (10-11 years) reported that they did not drink. Eight per cent of boys and 3% of girls reported that they had an alcoholic drink in the week prior to completing the
questionnaire. Beer was consumed by 15 of pupils and wine by 2%. In addition 1% said they had drunk spirits in the week preceding the survey (47).

To explore young people’s views on alcohol, a focus group was held with members of Haringey Youth Council and 2 questionnaires were circulated, one to secondary school pupils and one to young people leaving care (16-17 year olds). The intention was to try and reach a wide variety of young people. The schools questionnaire received a poor response rate and the date for response has been extended so the results will not be reported here.

There were some interesting results from the focus group. Young people regard gin as an old man’s drink, but enjoy Alcopops due to their sweetness and the colour. polish vodka was also mentioned because it is cheap and accessible. This resonates with views reported in the work of Warwick et al for the Thomas Coram Research Unit (48).

Young people are attracted to the drinks that can get you intoxicated in the least time. This was the case for young people from year 8 onwards and the young people in the focus group thought that people were starting to drink younger. There were also special ‘methods’ to make sure that you became drunk faster, e.g. Young people mentioned drinking while spinning and drinking through the eyes (a practice that can cause serious health problems (49). There was a perception that young people progressed from alcopops to cider with alcopops and then on to vodka.

Young people thought the issues of drugs and alcohol should be tackled separately. They did not think of alcohol as a ‘drug’ and young people did not think that ‘drugs’ were a huge problem. They thought that alcohol was a much bigger problem in young people, although they saw the effects of alcohol as minor compared to ‘hardcore drugs’.

The leaving care questionnaire revealed that young people feel they can talk amongst themselves about drugs and alcohol problems and would feel comfortable to advise a friend to go and seek help. This was echoed by the focus group. One of the main barriers to accessing help for alcohol misuse was the fear of someone else finding out and amongst the leaving care group there seemed to be a lack of understanding about confidentiality. The Youth Council group also reported that there was stigma associated with problematic drinking.

The people that young people would turn to in the event of them developing an alcohol problem were quite varied. Some stated that they would not want to talk to a professional or a parent. However, one young girl mentioned that she would talk to her mom and that all her friends can talk to her mom as well about such issues. Childline was mentioned by a number of the young people. No one mentioned contacting their GP and when the focus group was asked if they would do, they stated that they do not contact GP very often and would not do so to discuss alcohol. At school, young people would speak to mentor or someone you could approach like a mentor or teacher and some of the leaving care team stated that they would talk to a person advisor or key worker.

ACCESS TO ALCOHOL

In England you need to be aged 18 or over to buy alcohol, from a shop or in a bar, for consumption. In Haringey, trading standards regularly hold test purchase exercises and
prosecute offenders, i.e. shops that sell alcohol to under-18s. However, members of Haringey Youth Council reported that it was easy to buy alcoholic drinks and that certain shop keepers are willing to sell alcohol to young people. This ties in with the work of the Thomas Coram Research Unit (Warwick I 2009) where young people reported few problems accessing alcohol.

The Local Better Regulation Office (LBRO) investigated licensing with a series of licensing case studies and found that young people trying to buy alcohol is prevalent, with refusals often resulting in verbal abuse and intimidation of staff. The Think 21 campaign which aims to encourage retailers to challenge people who appear to be under-age and ask for photographic ID has been well received by retailers and generally retailers accept test purchase exercises. This research however, demonstrated that there is not a full appreciation of the powers available to trading standards officers and the penalties for under-age sales. Most licensees believed that they would be given fixed penalty notices and did not think that they were likely to be taken to court.

ALCOHOL AND EDUCATION

Most young people receive information on alcohol and other substances via Personal Social Health and Economic (PSHE) education. There was evidence in the qualitative work that this was, indeed, needed. Amongst young people there was confusion about whether girls had a higher tolerance to alcohol than boys and thus could drink more without health consequences and there were dangerous practices such as drinking through the eyes. The Government is due to make PSHE compulsory for all young people and will be revising the drug and alcohol guidance for schools. The new guidance will have a greater emphasis on alcohol.

A study by Edinburgh University demonstrated a statistically significant association between truancy and alcohol use (45) and an analysis of fixed-term exclusions for substance misuse carried out for London Borough Haringey reported 26 fixed term exclusions for substance misuse, including 5 exclusions for alcohol use in 2008-09.

When asked when alcohol becomes a problem, young people stated ‘when it affects other people’. They thought that some people don’t realise until it is too late and don’t listen to other people telling them they have a problem. Young people reported that they perceived a need for guidance from school or authorities on where the boundaries were with drugs and alcohol.

BARRIERS TO YOUNG PEOPLE ACCESSING SERVICES FOR ALCOHOL MISUSE

In both the focus group and the questionnaire, young people referred to the stigma of alcohol misuse and how the embarrassment and shame of realising that they had a substance misuse problem might prevent them accessing services. They reported that they thought it was important that any help was non-judgmental and no labels were involved. They felt the hardest thing is to admit there is a problem.
Young people reported that they would worry about wasting their time visiting services that might not be effective, as they do not receive feedback on the use of services and the outcomes.

Most young people stated that they wanted comfort and privacy in a service for alcohol misuse. They wanted clean surroundings, patient and professional workers. 4YP, the Haringey service which provides information and advice on sex and relationships was mentioned as a model. 4YP provides a bus, clinics and drop-in sessions and these were considered a good model for alcohol services, particularly the 4YP bus which could go to schools and acted as a ‘one-stop shop’. Young people related that they found the 4YP advisers to be accessible and non-judgemental.

**YOUNG PEOPLE, ALCOHOL AND SEXUAL BEHAVIOUR**

Teenagers who drink excessively are more likely to participate in risky behaviours, including risky sexual behaviour. In a cross-sectional study of Scottish young people, 40% of 13 and 14 year olds reported being drunk or ‘stoned’ when they experienced first sexual intercourse and one in seven 16-24 year olds have had unprotected sex after binge drinking. One in five has had sex they later regretted after binge drinking (13).

In an online survey for the Family Planning Association, 37% of over 1000 people aged 18-30 surveyed said they had had sex with a new partner without using a condom. 40% of these said alcohol was a factor in what had happened. In this same survey, 38% of respondents said they had taken part in sexual activity with someone and regretted it later. Of these, 70% reported that alcohol had a great deal or a fair amount to do with their behaviour and 73% of the respondents that had had sex with someone they normally wouldn’t find attractive (8%) gave alcohol as a factor.

This online survey, performed by Ipsos MORI, found that in those that had not used a condom with a new partner and believed that alcohol was a factor in this decision (15% of total respondents), one in eight reported that they or the person they had sex with became pregnant (unplanned) and that 7% had contracted a sexually transmitted infection (STI) (50).

*Figure 5* Ipsos MORI online survey results. Percentage of respondents reporting alcohol was a factor in their decision/behaviour.
Source: Family Planning Association 2009
ALCOHOL AND VULNERABLE ADULTS

Little work has been conducted on alcohol and drug use in people with learning disabilities, partly due to the fact that there is no consensus on terminology. Some people refer to learning difficulty or intellectual disability rather than learning disability. There is a gap in the evidence when considering prevalence, but research suggests that people with learning disabilities drink less and abstain more, but this may be due to people with learning disabilities having more limited lifestyle choices. The effects of alcohol on people with learning disabilities may be more profound given that they might be on medication that could interact with alcohol, may be more likely to develop long-term health problems such as cardiovascular (CVD) disease which are exacerbated by alcohol and might be at a greater risk of exploitation (51).

Although most media attention is focused on young people and alcohol, alcohol misuse in older people has been highlighted recently by Age Concern, Alcohol Concern and academics in the field. As our bodies age we become more sensitive to the effects of alcohol and the Government guidelines on the number of units that equate to sensible drinking might not apply to older people. Indeed, in the USA, there is a different recommendation for people older the 65 years (52). Older people tend to drink less than younger people, but 1 in 6 older men and 1 in 15 older women have harmful levels of drinking and alcohol use disorders are often misdiagnosed or undetected (53) (52). As older people are more likely to be taking medication there is also a greater likelihood of drug interactions with alcohol. Older people are sometimes at higher risk of developing problematic drinking behaviours due to their life circumstances. For instance, bereavement, social isolation and boredom can put people at higher risk.

There are few studies of treatment or alcohol misuse in older people, but it has been demonstrated that elderly people are at least as likely to benefit from treatment as young people (54).

The ageing population means that the number of elderly people with alcohol use disorders will increase in the coming years and this may be exacerbated by the current economic climate and increasing levels of poverty in elderly people who no longer work. Further work will be required to ensure that the health service identifies and treats elderly people with problematic drinking.

CHILD ABUSE/NEGLECT AND LOOKED AFTER CHILDREN

The effects of drinking on children and families can start even before birth. However, the problems do not end there and up to 1.3 million children are estimated to be affected by parental alcohol problems. This can lead to relationship breakdowns, family neglect and even child abuse. It has been estimated that 30-60% of child protection cases involve alcohol (40).

In Haringey 2979 young people were referred to Haringey’s Children and Young People Social Care services in the period April 2008 to March 2009. During this period, 41 children and young people were referred due to needs associated with alcohol and 267 with needs related to domestic violence.
It has been widely accepted that young people who have grown up in state care are particularly vulnerable to developing substance misuse problems. In the 2008/9 financial year, 312 people started to be looked after by the local authority. 245 young people left the care of the local authority in this time. In addition there is a group of young people who have run away from home and these are considered especially vulnerable. Research carried out for the Home Office found a small minority of young people (although this was almost 10%) who drank every day and drank an average five drinks or more in a session. One quarter (25%) of young people making the transition between care and independent living reported that their alcohol consumption had increased due to boredom, loneliness or depression, or to help cut down on their use of illegal drugs (Ward J 2003).

To address these issues the local authority has a designated team that deals with young people leaving care (and unaccompanied asylum seekers). This team assesses the risks to young people using a tool called DUST (Drug Use Screening Tool) leaving care and can refer to appropriate services.

In 2007/8 HAGA worked with 317 children and young people via its children and families service, COSMIC. COSMIC offers a drop-in service and a telephone advice and counselling service. The service works with young people that have a problem themselves or with young people affected by a loved one’s substance misuse, offers a creche to allow people to access their support groups and arranges daytrips for young people (22).

**ALCOHOL CONSUMPTION**

Excessive drinking is a major cause of morbidity and mortality world-wide. In 2002, harmful use of alcohol was estimated to cause about 2.3 million premature deaths worldwide and be responsible for 4.4% of the global disease burden, even after the protective effects of low and moderate alcohol consumption had been considered [http://www.who.int/features/qa/66/en/index.html].

Worldwide, the years of life lost and the reduction in productive life due to excessive drinking is second only to tobacco smoking and high blood pressure.

2.9 million (7%) of the adult population in Britain are thought to be alcohol dependent and 5.9 million people in Britain are estimated to engage in binge drinking (8 or more units per day for men and 6 or more units per day for women) (55). 8.2 million people are estimated to have an alcohol use disorder (17).

The number of NHS hospital admissions in England of adults aged 16 and over with a primary or secondary diagnosis specifically related to alcohol more than doubled from 89,280 in 1995/96 to 187,640 in 2005/06 and the number of NHS hospital admissions of children under 16 with a primary or secondary diagnosis specifically related to alcohol rose from 3,870 in 1995/96 to 5,280 in 2005/06 (British Medical Association 2008). In 2007/8 there were 863,000 NHS hospital admissions in England with either a primary or secondary diagnosis wholly or partly related to alcohol (31).
In 2007 London had a higher than average percentage of both men and women that did not drink in the previous week (See figure 7). This is probably, in part, due to the ethnic mix of the London population (see figure 8). 

Source: Department of Health 2009
In the London Boost of the Health Survey for England (56) reported a high number of residents (40%) stating that they had not drunk alcohol in the past week. This is close to the London average (43%) and probably reflects the high BME population in Haringey. The rate of non-drinking was much higher in females and males and more likely in the 55+ age range.

However, over a quarter of Haringey residents (28%) reported binge drinking in the past week. This was the second highest rate for London and much higher than the average for London (19%). This is not completely in accordance with the modelled data for 2003-2005. This could be due to the data being modelled on regular binge drinkers compared to those in the London Boost data that had binged in the preceding week. However, there is a possibility that these data point to a marked increase in binge drinking in the borough and this should probably be investigated further.
Figure 9: Reported Consumption of Alcohol on the Heaviest Day of Drinking in the Previous Week in Haringey, 2006 (%)

Source: London Health Observatory

Figure 10: Reported Consumption of Alcohol on the Heaviest Day of Drinking in the Previous Week by Gender for Haringey, 2006 (%)

Source: London Health Observatory
Figure 11  Reported Consumption of Alcohol on the Heaviest Day of Drinking in the Previous Week by Age for Haringey, 2006 (%)

Source: London Health Observatory

Figure 12  Modeled estimate of binge drinking in London 2003-5

Source: Commissioning Support for London
ALCOHOL-RELATED HARM IN HARINGEY

AMBULANCE SERVICES

The emergency services deal with a huge number of calls due to alcohol. In particular the ambulance services are affected by a high number of calls due to people who are intoxicated, are ill or have been injured due to alcohol. In London there were 59708 alcohol-related calls in 2008. 1820 of these were in Haringey. The number of alcohol-related calls in Haringey has remained fairly constant in recent years at 3% of the alcohol-related calls in London (See table 3). Ambulance call-outs related to alcohol are significantly lower than those due to illicit drugs.

Table 6  Alcohol-related calls to London Ambulance Service

<table>
<thead>
<tr>
<th>Year</th>
<th>London</th>
<th>Haringey</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>51519</td>
<td>1559</td>
<td>3.03</td>
</tr>
<tr>
<td>2006</td>
<td>55734</td>
<td>1787</td>
<td>3.21</td>
</tr>
<tr>
<td>2007</td>
<td>61627</td>
<td>1901</td>
<td>3.09</td>
</tr>
<tr>
<td>2008</td>
<td>59708</td>
<td>1820</td>
<td>3.05</td>
</tr>
</tbody>
</table>

Source: London Ambulance Service

MORTALITY AND MORBIDITY DUE TO ALCOHOL

Mortality due to alcohol-specific causes, (that is conditions that are caused by alcohol in some, but not all cases, such as stomach cancer), is higher than the English average for males in Haringey and ranks 6th in London. Mortality due to alcohol-specific causes was significantly better in women compared to the average for England (North West Public Health Observatory 2009). Mortality due to liver disease in males, however, is significantly higher than the English average. Haringey is the fourth worst borough in London for this measure. Haringey is also significantly worse than the England average for Alcohol-related recorded crimes and alcohol-related violent crime (57).

HOSPITAL ADMISSIONS

Reasons for alcohol related hospital admissions for Haringey residents

There are 3 categories of alcohol related admissions (Jones L 2008) these are: wholly attributable, partially attributable - chronic, and partially attributable - acute. All wholly attributable admissions contribute completely to Vital Signs Indicator VSC26, while partially attributable admissions contribute only a proportion to the total, determined by an alcohol attribution fraction specific to the diagnosis, gender and age group (See Appendix B).

There has been an increase in the number of wholly attributable hospital admissions in the years 2004/5 to 2007/8 among Haringey residents. The number of such admissions is high for London, but approximately average for England (See figure 14).

Overall nine major diagnostic groups accounted for nearly 90% of all alcohol-attributable hospital admissions in Haringey residents over the period 2004/5 to 2007/8. These were: Hypertensive diseases; mental and behavioural disorders due to use of alcohol; cardiac
arrhythmias; epilepsy; cirrhosis of the liver; breast cancer; fall injuries; assault; intentional self-harm.
Approximately 24% of the total admissions attributed to alcohol were wholly attributable to alcohol. The most common reason for admission was mental and behavioural disorder due to use of alcohol, followed by alcohol poisoning. In this category, the condition with the greatest increase in admissions was toxic effect of alcohol, unspecified, which rose by 400% over the time period 2004/5 to 2007/8.

Figure 13: Alcohol related admissions rates per 100,000 population 2007-8

Source: Commissioning Support for London

Figure 14: Wholly attributable hospital admissions - Haringey residents 2004/5-2007/8

Source: Secondary Uses Service data, NHS
Of the partially attributable-chronic category, the greatest number of estimated admissions was due to hypertensive diseases, followed by cardiac arrhythmias and epilepsy. The greatest increase was seen in Gastro-Oesophageal laceration-haemorrhage syndrome, which increased by 150%. However, this was an increase in a small number of cases (1.9 to 4.7), especially compared to the increase in hypertensive disease which increased 103% from 481.1 to 977.3.

**Figure 15** Increase in selected partially attributable chronic admissions 2004/5 to 2007/8

The largest increase in partially attributable-acute admissions was in inhalation or ingestion of food causing obstruction of the respiratory tract (choking) followed by intentional self-harm. The number of choking cases estimated to be partially due to alcohol was small (0.3-1.0), but the number of intentional self-harm incidents thought to be due, in part, to alcohol was more considerable (25.3-55.2). The greatest number of admissions in this category was due to fall injuries and assaults. There was a modest increase (5%) in the number of fall injuries, but the number of assaults actually reduced between 2004/5 and 2007/8.

**Figure 16** Change in partially attributable – acute hospital admissions of Haringey residents 2004/5 to 2007/8

*Source: Secondary Uses Service data, NHS*
Partially attributable – chronic admissions accounted for approximately 66% of the calculated total alcohol attributable admissions in any one year.

Of interest in these data are the hypertensive diseases (high blood pressure and associated conditions). These were the largest diagnostic group and the estimated numbers increased by 103%, more than any other category of partially attributable chronic admissions. The cardiac arrhythmias were the next largest group and this category still showed a sizeable increase of 63%. Epilepsy cases showed a slower growth at 39%, but were still a sizeable number of admissions at an estimated 212 admissions in 2007/8.

Interestingly liver cirrhosis and breast cancer, both diseases associated with alcohol consumption, increased less than average for the chronic group.

The large number of calculated partially attributable admissions due to hypertensive disease and cardiac arrhythmias might be a reflection of the high rates of these diseases in Haringey. Haringey has a diverse population and both diseases are higher in BME populations compared to the general population (Lip GYH 2007). Relative to white European populations, people of African origin, both Caribbeans and West Africans, have a high incidence of stroke and end-stage renal failure, whereas coronary heart disease (CHD) is less common – around half the rate found in the general population for men and two-thirds of the rate for women. Also, the hypertensive and cardiac diseases tend to be associated with increasing age and so the increase in admissions may be, in part, due to an ageing population.

The clinical codes for hypertensive diseases do not distinguish whether the disease is due to alcohol or other causes, so there is unfortunately no way of using the data available from the North West Public Health Observatory to tease out whether the high admission rates in Haringey due to hypertensive diseases are a reflection of the ethnicity of the population, socio-economic factors or indeed, alcohol (58). The only way to determine this would be by auditing patient records to determine whether they have a clinical code for alcohol misuse or another contributory cause of hypertension.
Figure 17 - Modelled estimates of prevalence of hypertension (% population) for 2009 by ethnic group (Haringey)

![Figure 17 - Modelled estimates of prevalence of hypertension (% population) for 2009 by ethnic group (Haringey)](image)

Source: Commissioning Support for London 2009

Figure 18 - Modelled estimates of CHD prevalence by ethnic group

![Figure 18 - Modelled estimates of CHD prevalence by ethnic group](image)

Source: Commissioning Support for London 2009

Figure 19 - Four year trend in admissions by attribution

![Figure 19 - Four year trend in admissions by attribution](image)
Source: Secondary Uses Service data, NHS

Over the four years from 2004/5 to 2007/8, the maximum number of admissions varied from 13 for wholly attributable conditions (average 2.28 admissions per patient), 16 for partially attributable – acute (1.35 admissions per patient) and 73 for the partially attributable-chronic (2.47 admissions per patient).

* Attribution at first (known) admission. A small proportion of patients change attribution on subsequent admission

Partially attributable admissions are a synthetic – they are calculated from the total admissions. Further information on this is available in Jones et al. (59).

Patterns of frequent or repeat admissions

The admissions data above does not distinguish between people that were admitted just once and those that are admitted a number of times for conditions associated with alcohol.

An analysis of admissions in Haringey demonstrated that there are a number of people being readmitted a number of times. Of 4210 individuals who first appeared in the records in 2004/05, 684 (16%) returned in 2005/06, 569 (14%) in the next year and 502 (12%) in the following. These data suggest that patients continue to be readmitted for years.

Figure 20- repeat admissions to hospital for alcohol attributable causes among Haringey residents
Source: Secondary Uses Service data, NHS
The pattern of readmission varies according to the extent of alcohol attribution, i.e. wholly, partially-acute and partially-chronic.

**Figure 21** Repeat admissions to hospital for wholly alcohol attributable causes among Haringey residents

![Figure 21](image1.png)

**Source:** Secondary Uses Service data, NHS

**Figure 22** Repeat admissions to hospital for partially alcohol attributable causes among Haringey residents

![Figure 22](image2.png)

**Source:** Secondary Uses Service data, NHS

The proportion of 2004/05 chronic diagnosis cases returning reduced from 18 to 14% over the period. Chronic cases showed the highest return rate among the three attribution groups.
Figure 23 - the increase in high volume diagnoses 2004/5 to 2007/8

Source: Secondary Uses Service data, NHS

Figure 24 Increase in diagnoses with multiple admissions per patient

Source: Secondary Uses Service data, NHS

The diagnoses with the highest readmission rates are relatively uncommon partially attributable conditions and therefore contribute little to the vital signs target, VSC 26.
EQUITY PROFILE

An equity profile examines use of/access to a service across various dimensions and compares this against expectations derived from known (epidemiological) studies. In other words it compares the actual use or access of a service to what would be expected for a given population. There can be problems with this approach because of problems calculating what should be expected for the population.

In what follows, access to service for all alcohol attributable cases has been examined for ‘equivalent’ cases i.e. the number of cases that would be expected, based on modelling. This obviously doesn’t apply to wholly-attributable cases.

AGE AND GENDER

Table 7 - ‘Equivalent’ attributable cases of alcohol attributable harm per 1000 population 2004/05 to 2006/07

<table>
<thead>
<tr>
<th>GENDER</th>
<th>16-24</th>
<th>25-44</th>
<th>45-64</th>
<th>65-74</th>
<th>75-84</th>
<th>85+</th>
<th>ALL AGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>22.6</td>
<td>18.5</td>
<td>57.8</td>
<td>111.1</td>
<td>133.1</td>
<td>186.3</td>
<td>38.1</td>
</tr>
<tr>
<td>Female</td>
<td>16.8</td>
<td>12.4</td>
<td>23.5</td>
<td>37.8</td>
<td>50.2</td>
<td>80.5</td>
<td>19.8</td>
</tr>
<tr>
<td>Persons</td>
<td>19.5</td>
<td>15.4</td>
<td>39.6</td>
<td>72.1</td>
<td>85.5</td>
<td>112.9</td>
<td>28.6</td>
</tr>
</tbody>
</table>

Source: Secondary Uses Service data, NHS

Male rates for all attributable cases were higher than female, with a reduction for both genders from 16-24 to 25-44 years and a steady increase thereafter. The relative gender difference was widest for the 65-74 year age group.

Table 8 - Cases of Wholly alcohol attributable harm diagnoses per 1000 population 2004/05 to 2006/07

<table>
<thead>
<tr>
<th>GENDER</th>
<th>16-24</th>
<th>25-44</th>
<th>45-64</th>
<th>65-74</th>
<th>75-84</th>
<th>85+</th>
<th>ALL AGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>7.3</td>
<td>7.7</td>
<td>18.3</td>
<td>17.4</td>
<td>11.9</td>
<td>18.2</td>
<td>10.8</td>
</tr>
<tr>
<td>Female</td>
<td>4.4</td>
<td>3.2</td>
<td>5.4</td>
<td>3.3</td>
<td>1.6</td>
<td>0.0</td>
<td>3.8</td>
</tr>
<tr>
<td>Persons</td>
<td>5.8</td>
<td>5.5</td>
<td>11.5</td>
<td>9.9</td>
<td>6.0</td>
<td>5.6</td>
<td>7.2</td>
</tr>
</tbody>
</table>

Source: Secondary Uses Service data, NHS

For wholly attributable diagnoses the gap between male and female rates was wider, with high male rates from 45 years onwards with the exception of 75 - 84 year olds. Much lower female rates peak in the 45 -64 year age group.

Table 9 - ‘Equivalent’ attributable cases of partially alcohol attributable chronic harm per 1000 population 2004/05 to 2006/07

<table>
<thead>
<tr>
<th>GENDER</th>
<th>16-24</th>
<th>25-44</th>
<th>45-64</th>
<th>65-74</th>
<th>75-84</th>
<th>85+</th>
<th>ALL AGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>3.0</td>
<td>5.2</td>
<td>35.2</td>
<td>91.0</td>
<td>114.7</td>
<td>153.8</td>
<td>21.2</td>
</tr>
<tr>
<td>Female</td>
<td>7.0</td>
<td>7.0</td>
<td>15.8</td>
<td>33.0</td>
<td>45.3</td>
<td>72.2</td>
<td>13.2</td>
</tr>
<tr>
<td>Persons</td>
<td>5.1</td>
<td>6.1</td>
<td>25.0</td>
<td>60.1</td>
<td>74.8</td>
<td>97.2</td>
<td>17.1</td>
</tr>
</tbody>
</table>

Source: Secondary Uses Service data, NHS
Partially attributable chronic rates increased with age for both genders and gender differences were narrower. Up to age 44 female rates were higher than male, probably as a result of the inclusion of Spontaneous Abortion (miscarriage).

Table 10 - ‘Equivalent’ cases of partially alcohol attributable acute harm per 1000 population 2004/05 to 2006/07

<table>
<thead>
<tr>
<th>GENDER</th>
<th>16-24</th>
<th>25-44</th>
<th>45-64</th>
<th>65-74</th>
<th>75-84</th>
<th>85+</th>
<th>ALL AGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>12.3</td>
<td>5.6</td>
<td>4.3</td>
<td>2.8</td>
<td>6.5</td>
<td>14.3</td>
<td>6.1</td>
</tr>
<tr>
<td>Female</td>
<td>5.4</td>
<td>2.2</td>
<td>2.3</td>
<td>1.5</td>
<td>3.4</td>
<td>8.3</td>
<td>2.8</td>
</tr>
<tr>
<td>Persons</td>
<td>8.6</td>
<td>3.9</td>
<td>3.2</td>
<td>2.1</td>
<td>4.7</td>
<td>10.2</td>
<td>4.4</td>
</tr>
</tbody>
</table>

Source: Secondary Uses Service data, NHS

Gender differences for partially attributable acute rates were wider and rates for both genders followed a U curve with a low in the 65-74 age group and higher rates in the 75+ age group

ETHNICITY

Table 11 - ‘Equivalent’ attributable cases per 1000 Population (2001 Census based) by ethnicity

<table>
<thead>
<tr>
<th>ETHNICITY</th>
<th>ALL</th>
<th>WHOLLY ATTRIBUTABLE</th>
<th>PARTIALLY - CHRONIC</th>
<th>PARTIALLY - ACUTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>British</td>
<td>24.5</td>
<td>7.5</td>
<td>14.2</td>
<td>2.8</td>
</tr>
<tr>
<td>Irish</td>
<td>40.9</td>
<td>20.6</td>
<td>17.8</td>
<td>2.5</td>
</tr>
<tr>
<td>Any other White background</td>
<td>25.1</td>
<td>4.8</td>
<td>16.2</td>
<td>4.2</td>
</tr>
<tr>
<td>White and Black Caribbean</td>
<td>7.9</td>
<td>2.2</td>
<td>3.9</td>
<td>1.8</td>
</tr>
<tr>
<td>White and Black African</td>
<td>11.6</td>
<td>1.9</td>
<td>8.3</td>
<td>1.3</td>
</tr>
<tr>
<td>White and Asian</td>
<td>3.3</td>
<td>0.4</td>
<td>2.4</td>
<td>0.4</td>
</tr>
<tr>
<td>Any other mixed background</td>
<td>13.6</td>
<td>2.9</td>
<td>8.4</td>
<td>2.4</td>
</tr>
<tr>
<td>Indian</td>
<td>27.0</td>
<td>4.5</td>
<td>21.0</td>
<td>1.4</td>
</tr>
<tr>
<td>Pakistani</td>
<td>13.7</td>
<td>0.5</td>
<td>12.0</td>
<td>1.3</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>15.8</td>
<td>0.0</td>
<td>14.7</td>
<td>1.1</td>
</tr>
<tr>
<td>Any other Asian background</td>
<td>24.2</td>
<td>3.3</td>
<td>17.8</td>
<td>3.1</td>
</tr>
<tr>
<td>Caribbean</td>
<td>28.6</td>
<td>3.8</td>
<td>21.3</td>
<td>3.4</td>
</tr>
<tr>
<td>African</td>
<td>17.1</td>
<td>1.9</td>
<td>13.3</td>
<td>1.9</td>
</tr>
<tr>
<td>Any other Black background</td>
<td>40.4</td>
<td>8.9</td>
<td>24.5</td>
<td>7.0</td>
</tr>
<tr>
<td>Chinese</td>
<td>14.9</td>
<td>0.0</td>
<td>12.1</td>
<td>2.7</td>
</tr>
<tr>
<td>Any other ethnic group</td>
<td>115.4</td>
<td>26.9</td>
<td>67.8</td>
<td>20.6</td>
</tr>
<tr>
<td>All</td>
<td>26.0</td>
<td>6.5</td>
<td>16.3</td>
<td>3.3</td>
</tr>
</tbody>
</table>

Source: Secondary Uses Service data, NHS. (Crude rates for ‘equivalent’ cases were calculated based upon 2001 ethnic minority population estimates.)

In the ‘All Alcohol Admissions’ category, the rates for any other ethnic group is very high. This is likely to be due to people not recording ethnicity correctly at time of admission and due to the poor discrimination of ethnicities in the data. For instance, it is not clear what people would class their ethnicity as if they were, for example, Kurdish or Albanian.
Apart from this group the highest ‘All Alcohol Admissions’ rate was for those classifying themselves as Irish followed closely by ‘any other Black background’. The Wholly attributable rates are highest in the any other ethnic group at 26.9 per 1000 population, followed by the Irish group at a rate of 20.6. The rates in Asian ethnicities are of interest; overall Asian ethnic groups have a low alcohol intake, partly due to religions that discourage alcohol use. However, grouping all Asian ethnicities together can be misleading, as seen in the Haringey data. In Haringey, Pakistani and Bangladeshi populations have extremely low levels of admissions due to wholly attributable causes, compared to a higher rate in the Indian population. This pattern has been reported nationally also (60). Aside from the ‘Any other ethnic group’, partially - chronic rates were highest for the ‘any other Black background’ group, followed by Caribbean and Indian, probably demonstrating the susceptibilities of these groups to hypertension and chronic heart disease.

There are no data available on ethnicity and trends in drinking. This is one of the challenges of using data from the General household survey (GHS) and Health Survey for England (HSE) surveys. Only 9% of the white, British population do not consume alcohol, whereas 48% of the black African and more than 90% of Pakistani or Bangladeshi population in Britain abstain (12). Interestingly, although overall alcohol use is increasing among ethnic minorities (60), there is a protective effect of ethnic density on current alcohol consumption above sensible drinking limits (61). It should be noted that there are problems with the instruments used for the collection of data on alcohol in ethnic minority groups and these are documented in Bhopal et al (58).

**GEOGRAPHY**

**By Ward**

Converting patient postcodes to the appropriate electoral ward standardised ‘equivalent’ case rates were calculated.

**Table 12 - Standardised* ‘Equivalent’ Attributable Case Rate per 100,000 by Electoral Ward, 2004/05 to 2007/08 Cases**

<table>
<thead>
<tr>
<th>WARD</th>
<th>ALL</th>
<th>WHOLLY ATTRIBUTABLE</th>
<th>PARTIALLY-CHRONIC</th>
<th>PARTIALLY - ACUTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alexandra</td>
<td>2,913</td>
<td>460</td>
<td>2,030</td>
<td>422</td>
</tr>
<tr>
<td>Bounds Green</td>
<td>3,700</td>
<td>772</td>
<td>2,496</td>
<td>430</td>
</tr>
<tr>
<td>Bruce Grove</td>
<td>4,266</td>
<td>854</td>
<td>2,884</td>
<td>528</td>
</tr>
<tr>
<td>Crouch End</td>
<td>3,323</td>
<td>734</td>
<td>2,178</td>
<td>411</td>
</tr>
<tr>
<td>Fortis Green</td>
<td>2,776</td>
<td>503</td>
<td>1,906</td>
<td>367</td>
</tr>
<tr>
<td>Harringay</td>
<td>4,251</td>
<td>808</td>
<td>3,005</td>
<td>438</td>
</tr>
<tr>
<td>Highgate</td>
<td>2,896</td>
<td>739</td>
<td>1,798</td>
<td>359</td>
</tr>
<tr>
<td>Hornsey</td>
<td>4,603</td>
<td>1,252</td>
<td>2,842</td>
<td>509</td>
</tr>
<tr>
<td>Muswell Hill</td>
<td>3,709</td>
<td>1,007</td>
<td>2,282</td>
<td>420</td>
</tr>
<tr>
<td>Noel Park</td>
<td>3,907</td>
<td>985</td>
<td>2,460</td>
<td>461</td>
</tr>
<tr>
<td>Northumberland Park</td>
<td>3,714</td>
<td>814</td>
<td>2,503</td>
<td>396</td>
</tr>
<tr>
<td>Seven Sisters</td>
<td>3,064</td>
<td>754</td>
<td>1,990</td>
<td>319</td>
</tr>
<tr>
<td>St Ann's</td>
<td>3,624</td>
<td>700</td>
<td>2,418</td>
<td>506</td>
</tr>
<tr>
<td>Stroud's</td>
<td>3,533</td>
<td>994</td>
<td>2,119</td>
<td>420</td>
</tr>
<tr>
<td>Tottenham Green</td>
<td>3,680</td>
<td>814</td>
<td>2,398</td>
<td>468</td>
</tr>
<tr>
<td>Tottenham Hale</td>
<td>3,764</td>
<td>902</td>
<td>2,408</td>
<td>455</td>
</tr>
</tbody>
</table>
West Green 3,383 680 2,261 441
White Hart Lane 3,236 498 2,290 449
Woodside 3,476 698 2,370 408
Total 3,653 822 2,394 437

Source: Secondary Uses Service data, NHS. *Direct age and sex standardisation using the 2007 England & Wales 5 year band population estimates

Overall rates were highest in Hornsey, followed by Bruce Grove, and lowest in Forest Green. Wholly attributable rates were highest in Hornsey, followed by Muswell Hill and Stroud Green, and lowest in Alexandra. Partially attributable – chronic rates were highest in Harringay and lowest in Highgate. Partially attributable – acute rates were highest in Bruce Grove, followed by Hornsey and St Ann’s and lowest in Seven Sisters.

By Postcode

There is a convention that the admitting hospital postcode is used when a homeless person is admitted, but this did not seem to be the case.

Table 13 - Postcodes contributing more than 8 ‘equivalent’ cases in the four years

<table>
<thead>
<tr>
<th>POSTCODE</th>
<th>ALL</th>
<th>WHOLLY ATTRIBUTABLE</th>
<th>PARTIALLY - CHRONIC</th>
<th>PARTIALLY - ACUTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>N17 9EQ</td>
<td>10.87</td>
<td>6</td>
<td>3.75</td>
<td>1.12</td>
</tr>
<tr>
<td>N17 6TG</td>
<td>9.39</td>
<td>1</td>
<td>7.52</td>
<td>0.87</td>
</tr>
<tr>
<td>N15 6NJ</td>
<td>9.02</td>
<td>7</td>
<td>1.75</td>
<td>0.27</td>
</tr>
<tr>
<td>N10 1PL</td>
<td>8.95</td>
<td></td>
<td>7.91</td>
<td>1.04</td>
</tr>
<tr>
<td>N8 7PF</td>
<td>8.72</td>
<td>4</td>
<td>2.86</td>
<td>1.86</td>
</tr>
<tr>
<td>N15 5RN</td>
<td>8.42</td>
<td></td>
<td>6.98</td>
<td>1.44</td>
</tr>
<tr>
<td>N17 0HE</td>
<td>8.26</td>
<td>3</td>
<td>4.95</td>
<td>0.31</td>
</tr>
<tr>
<td>N6 4AL</td>
<td>8.18</td>
<td>1</td>
<td>6.67</td>
<td>0.51</td>
</tr>
<tr>
<td>N10 3JH</td>
<td>8.06</td>
<td>4</td>
<td>3.36</td>
<td>0.7</td>
</tr>
<tr>
<td>N8 9QL</td>
<td>8.01</td>
<td>6</td>
<td>1.68</td>
<td>0.33</td>
</tr>
</tbody>
</table>

Source: Secondary Uses Service data, NHS

Postcode N10 1PL contains two care homes, although it seems unlikely that admissions from such a source would be alcohol related and this might be another case of chronic heart disease or hypertension skewing the data.
Table 14 Postcodes contributing more than 50 admissions in the four years

<table>
<thead>
<tr>
<th>Postcode</th>
<th>All</th>
<th>Wholly Attributable</th>
<th>Partially -Chronic</th>
<th>Partially - Acute</th>
</tr>
</thead>
<tbody>
<tr>
<td>N10 1PL</td>
<td>120</td>
<td>87</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>N8 7HS</td>
<td>86</td>
<td>78</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>N17 6NF</td>
<td>83</td>
<td>6</td>
<td>72</td>
<td>5</td>
</tr>
<tr>
<td>N15 5QA</td>
<td>78</td>
<td></td>
<td>78</td>
<td></td>
</tr>
<tr>
<td>N8 8ST</td>
<td>72</td>
<td>2</td>
<td>64</td>
<td>6</td>
</tr>
<tr>
<td>N8 0NJ</td>
<td>69</td>
<td>1</td>
<td>65</td>
<td>3</td>
</tr>
<tr>
<td>N17 9EQ</td>
<td>65</td>
<td>18</td>
<td>28</td>
<td>19</td>
</tr>
<tr>
<td>N22 7BD</td>
<td>65</td>
<td></td>
<td>61</td>
<td>4</td>
</tr>
<tr>
<td>N10 2JX</td>
<td>62</td>
<td>2</td>
<td>44</td>
<td>15</td>
</tr>
<tr>
<td>N17 6XP</td>
<td>62</td>
<td></td>
<td>57</td>
<td>5</td>
</tr>
<tr>
<td>N10 3AQ</td>
<td>59</td>
<td></td>
<td>52</td>
<td>7</td>
</tr>
<tr>
<td>N17 BLZ</td>
<td>59</td>
<td>2</td>
<td>49</td>
<td>8</td>
</tr>
<tr>
<td>N10 26A</td>
<td>57</td>
<td>1</td>
<td>51</td>
<td>5</td>
</tr>
<tr>
<td>N2 9NE</td>
<td>56</td>
<td>9</td>
<td>45</td>
<td>2</td>
</tr>
<tr>
<td>N10 3PA</td>
<td>55</td>
<td>2</td>
<td>39</td>
<td>14</td>
</tr>
<tr>
<td>N10 3JH</td>
<td>54</td>
<td>11</td>
<td>38</td>
<td>5</td>
</tr>
<tr>
<td>N15 4AZ</td>
<td>54</td>
<td>4</td>
<td>46</td>
<td>4</td>
</tr>
<tr>
<td>N17 GHE</td>
<td>54</td>
<td>7</td>
<td>41</td>
<td>6</td>
</tr>
<tr>
<td>N8 7AZ</td>
<td>54</td>
<td>2</td>
<td>46</td>
<td>6</td>
</tr>
<tr>
<td>N10 3JA</td>
<td>53</td>
<td>3</td>
<td>36</td>
<td>14</td>
</tr>
</tbody>
</table>

Source: Secondary Uses Service data, NHS
Table 15 - Correlation of the Index of Multiple Deprivation at ward level with Standardised* ‘Equivalent’ Case Rates

<table>
<thead>
<tr>
<th>Ward</th>
<th>IMD</th>
<th>All</th>
<th>Wholly Attributable</th>
<th>Partially - Chronic</th>
<th>Partially - Acute</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northumberland Park</td>
<td>54.08</td>
<td>3,714</td>
<td>814</td>
<td>2,503</td>
<td>396</td>
</tr>
<tr>
<td>White Hart Lane</td>
<td>49.14</td>
<td>3,236</td>
<td>498</td>
<td>2,290</td>
<td>449</td>
</tr>
<tr>
<td>Tottenham Green</td>
<td>46.35</td>
<td>3,680</td>
<td>814</td>
<td>2,398</td>
<td>468</td>
</tr>
<tr>
<td>Bruce Grove</td>
<td>44.69</td>
<td>4,266</td>
<td>854</td>
<td>2,884</td>
<td>528</td>
</tr>
<tr>
<td>Tottenham Hale</td>
<td>44.55</td>
<td>3,764</td>
<td>902</td>
<td>2,408</td>
<td>455</td>
</tr>
<tr>
<td>Noel Park</td>
<td>44.40</td>
<td>3,907</td>
<td>985</td>
<td>2,460</td>
<td>461</td>
</tr>
<tr>
<td>West Green</td>
<td>39.65</td>
<td>3,383</td>
<td>680</td>
<td>2,261</td>
<td>441</td>
</tr>
<tr>
<td>Seven Sisters</td>
<td>39.58</td>
<td>3,064</td>
<td>754</td>
<td>1,990</td>
<td>319</td>
</tr>
<tr>
<td>St Ann’s</td>
<td>39.38</td>
<td>3,624</td>
<td>700</td>
<td>2,418</td>
<td>506</td>
</tr>
<tr>
<td>Woodside</td>
<td>38.61</td>
<td>3,476</td>
<td>698</td>
<td>2,370</td>
<td>408</td>
</tr>
<tr>
<td>Bounds Green</td>
<td>35.53</td>
<td>3,700</td>
<td>772</td>
<td>2,498</td>
<td>430</td>
</tr>
<tr>
<td>Hornigay</td>
<td>35.04</td>
<td>4,251</td>
<td>808</td>
<td>3,005</td>
<td>438</td>
</tr>
<tr>
<td>Homsey</td>
<td>33.34</td>
<td>4,603</td>
<td>1,252</td>
<td>2,842</td>
<td>509</td>
</tr>
<tr>
<td>Stroud Green</td>
<td>27.39</td>
<td>3,533</td>
<td>994</td>
<td>2,119</td>
<td>420</td>
</tr>
<tr>
<td>Crouch End</td>
<td>19.78</td>
<td>3,323</td>
<td>734</td>
<td>2,178</td>
<td>411</td>
</tr>
<tr>
<td>Fortis Green</td>
<td>18.58</td>
<td>2,776</td>
<td>503</td>
<td>1,906</td>
<td>367</td>
</tr>
<tr>
<td>Highgate</td>
<td>18.34</td>
<td>2,896</td>
<td>739</td>
<td>1,798</td>
<td>359</td>
</tr>
<tr>
<td>Muswell Hill</td>
<td>18.06</td>
<td>3,709</td>
<td>1,007</td>
<td>2,282</td>
<td>420</td>
</tr>
<tr>
<td>Alexandra</td>
<td>17.80</td>
<td>2,913</td>
<td>460</td>
<td>2,030</td>
<td>422</td>
</tr>
</tbody>
</table>

Source: Secondary Uses Service data, NHS. *Direct age and sex standardisation using the 2007 England & Wales 5 year band population estimates. **Spearman’s rank correlation coefficient (rs) with IMD

Calculation of the correlation between deprivation and the four alcohol attribution groups shows some positive correlation for all of them, lowest for wholly attributable and highest for partially attributable – chronic.

It is interesting that the highest $r$ value (the correlation coefficient, which is a measure of the strength of association) is for the association between the index of multiple deprivation and partially alcohol-attributable chronic disease. This could be confounding due to link between IMD and some of the chronic conditions such as cardiovascular disease. It could also be confounded by the ethnicity of the populations in particular wards e.g. Northumberland Park and Tottenham Green have much higher black and minority ethnic populations than Highgate and Muswell Hill. Repeating the analysis at a lower geographic level might reveal stronger relationships.

Table 16 shows the result of calculating correlation coefficients against IMD at ward level for seven diagnostic groups, one wholly attributable to alcohol and six partly so.
Table 16 - Correlation of the Index of Multiple Deprivation at ward level with Standardised* ‘Equivalent’ Case Rates for selected diagnostic groups

<table>
<thead>
<tr>
<th>DIAGNOSIS</th>
<th>SPEARMANS RANK CORRELATION COEFFICIENT (R_S) OF STANDARDISED* ‘EQUIVALENT’ CASE RATE WITH IMD AT ELECTORAL WARD LEVEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental and behavioural disorders due to use of alcohol</td>
<td>0.26</td>
</tr>
<tr>
<td>Hypertensive diseases</td>
<td>0.44</td>
</tr>
<tr>
<td>Cardiac arrhythmias</td>
<td>-0.67</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>0.08</td>
</tr>
<tr>
<td>Fall injuries</td>
<td>-0.18</td>
</tr>
<tr>
<td>Assault</td>
<td>0.90</td>
</tr>
<tr>
<td>Intentional self-harm</td>
<td>0.23</td>
</tr>
</tbody>
</table>

Source: Secondary Uses Service data, NHS. *Direct age and sex standardisation using the 2007 England & Wales 5 year band population estimates

The highest correlation with deprivation was observed for Assault, the next highest for Hypertensive diseases. Mental and Behavioural disorders showed a lower correlation, close to that for Intentional self-harm.

For Epilepsy correlation was practically non-existent, while for fall and Cardiac arrhythmias it was negative.

There is a lack of trend data for different socioeconomic groups (2). To reliably compare trends across different survey years by different socio-economic groups would require secondary analysis of raw data from the respective surveys.

Alcohol related admissions are categorised as wholly attributable, partially attributable – chronic and partially attributable acute (59).
SERVICES AVAILABLE AND THEIR COST

THE COST OF ALCOHOL SERVICES IN HARINGEY

The DAAT is funded by the Home Office and Department of Health, via the Pooled Treatment Budget. Allocations are made on a formula basis that takes into account deprivation etc, so that the money goes to those areas in most need. This funding is then supplemented by the NHS.

The pooled treatment budget has increased considerably over the last few years, but it is now expected to reduce considerably, even by as much as a quarter, due to current financial conditions across the public services and the wider economy (41).

The total budget for substance misuse in Haringey is £4,589,000 for 09/10, of which £819,077 is allocated for alcohol services. This is funded from a number of grants from LB Haringey and PCT mainstream funding.

Table 17 Budget Allocation for Alcohol services in Haringey 2009-10

<table>
<thead>
<tr>
<th>ORGANIZATION</th>
<th>BUDGET ALLOCATION (£ STERLING)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCT</td>
<td>375,217</td>
</tr>
<tr>
<td>Area Based Grant (LB Haringey)</td>
<td>82,000</td>
</tr>
<tr>
<td>Migration Impact Funds grant (LB Haringey)</td>
<td>20,000</td>
</tr>
<tr>
<td>Adult Community Culture Services (LB Haringey)</td>
<td>34,1860</td>
</tr>
</tbody>
</table>

Source: Haringey DAAT

The PCT funds Home detoxification (‘detox’), the core services and counselling at HAGA. In addition it funds the A&E brief intervention, contributes to the alcohol strategy, pays for inpatient detox at Equinox and pays for a primary care worker at North Middlesex University Hospital Trust.

HAGA

Haringey Advisory Group on Alcohol (HAGA) is a charity based in Tottenham, Haringey that promotes the prevention and recognition of alcohol and substance misuse problems and treats those suffering from them. It does not promote total abstention.

HAGA receives most of its funding through the local authority, Haringey DAAT team and NHS Haringey. The organisation supports families affected by alcohol and drug problems and supports people who have alcohol and mental health problems with a view to maintaining their housing. The former is funded by the DAAT team and the latter is funded by LB Haringey. In addition, Haringey supporting people funds support from HAGA to tenants who are vulnerable because of their problematic alcohol use (22). A Young persons’ alcohol worker is funded by a Comic Relief grant and the Family Learning Project worker is funded by a lottery grant. The Outreach and Home Support team is funded by the Neighbourhood Renewal fund.
Most people access services at HAGA through self-referral or referral from other agencies. HAGA runs a Day Centre 6 days a week. People are given an initial assessment and referred to the appropriate service depending on their needs. The day centre provides group-work, workshops, individual counselling and access to support such as housing support. They can also use alternative therapies such as acupuncture. In the year 07/08 603 people were seen in the Day Treatment programme (332 males and 271 females) and telephone and drop-in services were provided to 420 Haringey residents.

HAGA has trained the majority of the borough’s GPs in brief interventions for alcohol misuse and works with North Middlesex Hospital where they have a liaison nurse who assists the wards with treating people who have been admitted and who also have alcohol misuse problems. HAGA works to reduce the pressure on secondary services by providing a home detoxification service. This carried out 175 detoxes in 07/08. 99 for men and 76 for women. Street drinkers need to be approached directly and the Outreach team from HAGA build up a relationship with street drinkers to help encourage them into treatment. The outreach team also provides support to people who are too unwell to attend other services. In 2007/8 the outreach team contacted 200 individuals and worked with 64 people, of which the vast majority (59) were male.

There is a children and families service, COSMIC, at HAGA. This provides alcohol, drug and safety awareness sessions to children and young people and provides one-to-one sessions for children affected by someone else’s substance misuse. The service covers ages 0-18 years. There is now a satellite service to other substance misuse services in Haringey. In 2007/8 COSMIC worked with 317 children and 99 adults. From January -December 2008, COSMIC saw 129 new children and young people, 36 of which were aged 13-18, none of these young people had a substance misuse problem themselves, but were assessed as at risk of developing a problem with alcohol. HAGA has a worker specifically to work, in partnership with Hearthstone (the local domestic violence project), with people affected by domestic violence.

HAGA tries to address inequalities by work focussed on particular minorities, such as its outreach work with the Turkish and Kurdish communities around Green Lanes.

HAGA also provides Kinesis Employment Training Service. This is a service to support people overcoming their alcohol or drug misuse problems and help them to return to work or gain qualifications. This service worked with 635 clients in 2007/8.

HAGA has a service user forum to help guide its services. The meetings are held weekly and minuted. The minutes are used by the DAAT team for monitoring purposes. It is an aspect of DAAT funding that there is user involvement in the running of services.

Figure 25 Number of client contacts for Haringey Advisory Group on Alcohol 2007/8
Table 18 Haringey Advisory Group on Alcohol Annual Expenditure (2007/8).

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>£ STERLING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management and administration</td>
<td>104,174</td>
</tr>
<tr>
<td>Houses</td>
<td>179,582</td>
</tr>
<tr>
<td>Probation and probation detox</td>
<td>19,357</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>36,428</td>
</tr>
<tr>
<td>Counselling</td>
<td>17,570</td>
</tr>
<tr>
<td>Outreach</td>
<td>81,166</td>
</tr>
<tr>
<td>Mental health</td>
<td>33,309</td>
</tr>
<tr>
<td>Kinesis</td>
<td>215,341</td>
</tr>
<tr>
<td>Floating support</td>
<td>135,228</td>
</tr>
<tr>
<td>Day centre</td>
<td>150,658</td>
</tr>
<tr>
<td>COSMIC</td>
<td>193,793</td>
</tr>
<tr>
<td>Detox and brief interventions pilot</td>
<td>109,128</td>
</tr>
<tr>
<td>Staff training NVQ</td>
<td>10,639</td>
</tr>
</tbody>
</table>

Source: HAGA  Annual Report 2008

Alcoholics Anonymous (AA) is a world-wide self-help organisation. Meetings are held throughout London and 19 meetings are held in Haringey on a weekly basis. One of the chief differences between AA and other services for harmful and dependent drinkers is the firm belief that abstinence is the only solution for alcohol misusers. This is at odds with the ethos and findings of Models of Care for Alcohol Misuse (MoCAM). It is not possible to obtain data from Alcoholics Anonymous, as they have a confidentiality policy that precludes the sharing of data.

PHOENIX FUTURES

Phoenix Futures is a voluntary sector organisation that provides services for people with drug and alcohol problems. They are working in partnership with Haringey Probation Services to provide treatment for alcohol misuse in offenders across North London. From July to
September 2009, Phoenix Futures offered 3533 appointments with alcohol practitioners across North London, 331 of which were in Haringey and 163 of which were taken up by offenders in Haringey.

Alcohol Treatment Requirements (ATRs) are used by the courts for those offenders that have a serious alcohol problem and require specialist treatment such as ‘detox’ or residential rehabilitation. They usually last between 6 months and 3 years and the treatment is provided for Haringey residents by Phoenix Futures (63).

The target for successful completion of ATRs in Haringey is 20 per annum. There have been difficulties with staffing recently and in the year up to September 2009, only 8 ATRs had been successfully completed. The staffing issues have now been resolved and this statistic should improve. The data for community treatment appointments presents a much better picture, with 82% of the 45 appointments booked in the borough being attended.

**PRIMARY CARE**

The majority of Haringey GPs have been trained in brief intervention by the DAAT team. This is in contrast to the national picture which suggested almost half of a sample of GPs did not feel they had adequate training to recognize alcohol-related problems in their patients (21). In Haringey the training given to GPs has been provided by HAGA, but nationally there are programmes to provide training during undergraduate years for medical students and an online training programme - available from the Alcohol Learning Centre (www.alcohollearningcentre.org.uk).

The NHS Health Check is a national programme, delivered locally by the PCT and primary care, to assess the risk of cardiovascular disease in people aged 40-74 years. Although alcohol is not a mandatory component of this assessment, identification and brief advice has been incorporated into the Haringey NHS Health Check (64).

**IN-VOLVE HARINGEY**

In-Volve Haringey is a specialist young people’s substance misuse treatment provider of tier 2 and 3 services, working with young people aged 13 to 21 in Haringey who are substance misusers or are affected by someone else’s substance misuse. Children under 12 are referred to COSMIC (HAGA) and young people aged 18-21 are supported through the transition to adult services. In-Volve offers information, advice and counselling, complementary therapies, assessment for medical interventions and access to medical interventions working as part of a multi-agency team which includes satellite workers from other services such as sexual health. In-Volve also offers family members and carers an assessment, and can involve them in the treatment of the young person where they have given their permission.

In-Volve accepts self-referrals and referrals from various agencies using the DUST screening tool and common assessment framework (CAF). The organisation is funded via funding from the Home Office via the Government Office for London and Haringey DAAT. The service budget for 2009/10 is £221,144.

In-Volve received 57 referrals, assessed 37 young people and engaged with 36 young people in 2008/9.
**DRUG ADVISORY SERVICE HARINGEY (DASH)**

DASH is a service, funded by the DAAT and PCT, which provides services for people with substance misuse problems. The service is based at St. Ann’s hospital where substitute medication is prescribed. There is also a drop-in centre at Alexandra Court in Wood Green. The service can provide access to counselling and residential and day care programmes and can provide shared care with the client’s GP where there is stable substance use.

DASH also manages the Dual Diagnosis Team at St. Ann’s Hospital and works jointly with HAGA, and Eban, the service for crack cocaine and poly-drug users.

DASH usually refers alcohol misusers to HAGA, but where it is required they can provide ambulatory detox.

**EQUINOX**

Equinox is a charity formed from a group of organisations in London, including police, probation, alcohol care and Greater London Council. The charity covers a wide area of London and some surrounding boroughs and helps over 6000 people per year with substance misuse problems, including alcohol misuse.

From 2010/11, Equinox Care, will be commissioned to provide in-patient detoxification for Haringey residents as part of an agreement with 5 boroughs: Islington, Haringey, Enfield, Barnet and Hertfordshire. There will be 18 beds and initially the service will be based in Hackney, although suitable premises are being sought within the 5 boroughs. Referral will be made from the various care teams in the borough and Haringey is contributing £200,000 to this service per annum.

**EFFECTIVENESS AND COST-EFFECTIVENESS OF ALCOHOL TREATMENT**

The National Treatment Agency of Substance Misuse published a major review of effectiveness of treatment for alcohol problems in 2006 (16). This concluded that there is a good case for investing in both brief interventions for the hazardous and harmful drinker and in the more intensive interventions for dependent drinkers and that alcohol treatment would save money across the public sector.

Pharmacotherapies are used for a narrow spectrum of symptoms and are usually used as adjunct to psychosocial therapies as they are considered insufficient treatment when given alone. Chlordiazepoxide is used as a treatment for alcohol withdrawal with diazepam as an alternative. Disulfiram is used as a sensitising agent due to the adverse effects when combined with alcohol and is used for the prevention of relapse, as are naltrexone and acamprosate. In addition, vitamin supplements are sometimes prescribed for those people with problematic drinking that might put them at risk of vitamin deficiency e.g. Wernicke’s encephalopathy (16).

There is evidence available in the report mentioned above, plus a Cochrane Systematic review (Kaner EFS 2007), to suggest that identification and brief advice are cost-effective as they reduce the need for more intensive treatment later if the person develops further alcohol misuse problems. Indeed, the NAO report ‘Reducing alcohol harm: health services in England for alcohol misuse’ quotes one study suggesting that brief interventions would yield
savings of around £2,000 per life saved and a US study has suggested that brief advice is one of the most cost-effective services in primary care (65). Although opportunistic brief interventions may be cost neutral in a hospital setting, there are public health gains. A variety of psychosocial interventions such as cognitive behavioural marital therapy and coping and social skills training have been shown to be effective and a major trial carried out in 2005 found that some types of psychosocial treatment for dependent drinkers could save the public sector £5 for every £1 spent (UKATT Research Team 2005). This is comparable with the treatment of other problem drug users. In addition to psychosocial therapies, Psychosocial therapies, and the use of acamprosate for achieving abstinence have been shown to be cost-saving whilst naltrexone costs £2076 per death averted, which is well within the cost per quality adjusted life year (QALY) required for recommendation by the National Institute for Health and Clinical Excellence (NICE). Outpatient care was found to be more cost-effective than residential or in-patient care, but it was recognised that some drinkers require more intensive residential or in-patient facilities. If residential programmes are time-limited, this results in greater cost-effectiveness (16).

Table 19 Cost-effectiveness results from a mode of Scottish Treatment (Raistrick D 2006)

<table>
<thead>
<tr>
<th>Treatment type</th>
<th>Net health cost per death averted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coping and social skills</td>
<td>-£3,073</td>
</tr>
<tr>
<td>Behavioural self-control</td>
<td>-£1,278</td>
</tr>
<tr>
<td>MET</td>
<td>-£2,069</td>
</tr>
<tr>
<td>Marital and family therapy</td>
<td>-£2,388</td>
</tr>
<tr>
<td>Acamprosate</td>
<td>-£1,122</td>
</tr>
<tr>
<td>Naltrexone</td>
<td>£2,076</td>
</tr>
<tr>
<td>Unsupervised disulfiram</td>
<td>£5,536</td>
</tr>
</tbody>
</table>

ALCOHOL SERVICES IN PRIMARY CARE

Prior to 2008, the PCT operating framework included 36 national targets, including smoking, sexual health and cardiovascular disease. However it did not include alcohol and there were no defined measures for benchmarking of PCT performance. Money was allocated to PCTs for alcohol services from 2006/7 onwards under Choosing Health. However, this money was not ring-fenced and much of it was spent on services other than alcohol.

In 2008 the Department of Health provided an extra £8 million for GPs to screen new patients and increased alcohol-specific training for doctors (21). The aim was to improve the identification, assessment and intervention offered to people at greater risk of alcohol morbidity in primary care, particularly those drinking to hazardous and harmful levels; to provide quicker access to early assessment of potential alcohol related harm, early intervention and timely referral to specialist help for those who show signs of dependence; to reduce consumption levels in people who are drinking at hazardous, harmful or dependent levels and improve health outcomes of people drinking at hazardous, harmful or dependent
levels. It is intended that better value for money can be achieved through effective commissioning of primary care services for people who are drinking at hazardous, harmful or dependent levels and a further choice of interventions for these people could be provided closer to home and outside of a secondary care setting.

In Haringey there is a Directed Enhanced Service (DES) for screening and brief intervention for alcohol misuse. Practices are paid £2.33 for every patient over 16 screened using the AUDIT-C questionnaire at registration. Patients identified as positive are screened using the AUDIT questionnaire and any patients found to be drinking at harmful or hazardous levels are given a brief intervention. Dependent drinkers are referred to specialist services. As this scheme only covers new GP registrations in the borough, it is limited. There have been 113,831 new registrations in the last three years in the borough, of which 59,032 were in the 2008/09 financial year. As payment for the DES is made annually there have been very few returns and it is too soon to evaluate the cost-effectiveness of this programme in Haringey. However, one effect has been the training of healthcare staff in practices in brief intervention, which has been provided by HAGA (see below) (29). In Haringey there are no GPs with a special interest in alcohol misuse, but DASH commissions two GPs with special interest in substance misuse.

Figure 26 - Alcohol Care Pathway for Primary Care, based on the DES

Source: Department of Health
St. Mary’s Hospital, Paddington assesses all accident and emergency attendees with conditions that might be alcohol-related using a questionnaire – the Paddington Alcohol Test. Patients that score as likely to be drinking at hazardous or harmful levels are offered an appointment with an alcohol worker. This has proved to reduce the drinking of alcohol after 6 months in people who were referred to the alcohol worker and reduce re-attendance in accident and emergency (21). This model was amongst those used to develop the Screening and Intervention Programme for Sensible Drinking (SIPS). SIPS was funded by the Department of Health for 3 years and jointly led by the Institute of Psychiatry and Newcastle University. This project set out to assess alcohol screening and brief intervention in Accident and Emergency Departments, Primary Care and Criminal Justice settings. The project was designed as a cluster randomised trial and asked what the barriers to implementation were in a typical setting, what the most effective screening method is and what the most effective and cost-effective interventions are. This project is now nearing completion and the results are awaited. Early information suggests that a number of barriers have been identified, particularly around workload and discomfort with non-targetted screening.

NHS Haringey primarily commissions acute services from North Middlesex University Hospital. This hospital was part of the SIPS pilot and has an alcohol health worker based at the Hospital. This worker has successfully built relationships with the ward staff. However, interviews with HAGA staff suggest that there is still work to be done to build relationships with accident and emergency at North Middlesex and to implement an integrated identification scheme for alcohol misuse in this setting.
7. CONCLUSIONS AND RECOMMENDATIONS

Care must be taken to distinguish between needs and demands and the aim of needs assessment is to ensure that need is mapped, demand examined, service provision mapped and a gap analysis undertaken so that unmet need etc. can be identified.

Haringey has a well-established alcohol strategy group and has an alcohol strategy, unlike many PCTs in England (21). The Alcohol Strategy Board has representatives from many teams, including the DAAT team, HAGA, NHS Haringey (the PCT), police and community safety teams and is a good example of joint working between the PCT, local authority and other relevant organisations. This is a good starting point to explore improving communications between the relevant agencies and improving joint commissioning, which will be of increasing importance over the following years, given the economic climate.

A common model for service planning of alcohol services was developed by Brian Rush (3). According to the Rush model, the service planning for tier 2 and 3 services in Haringey should be based on:

- 909 people requiring assessment
- 545 people requiring community detoxification ('detox')
- 381 people requiring counselling or outpatient treatment
- 207 people requiring day treatment
- 579 people requiring aftercare
- 1133 people requiring case management

The service planning for tier 4 services in Haringey should be based on:

- 54 people requiring in-patient detox
- 69 people requiring short-term residential treatment
- 96 people requiring long-term residential treatment

The data from HAGA, the organisation providing the majority of alcohol services in Haringey indicate that that HAGA is receiving roughly the number of referrals for assessment that would be expected, but there is probably a large unmet need for community detox services and a greater number of people accessing day/outpatient services at HAGA than would be expected. These, of course, are the people requiring tier 2 and 3 services for which there is good data on cost-effectiveness and efficacy.

Recent information from projects aiming to evaluate identification and brief advice (brief intervention) would suggest that an expansion of brief intervention would be cost-effective, particularly as this preventative work would be expected to deliver a reduction in the demand for tier 2 and 3 services and the number of hospital admissions and accident and emergency attendances. However, these results would not be immediate and it is only in the long run that effects would be seen on, for example, mortality data.

Dr Foster Research Ltd was contracted by NHS Haringey and London Borough of Haringey to develop a health segmentation model for Haringey residents. This model divided Haringey’s population into 9 segments and then provided data on varying needs, access to services.
and potentially unmet needs in the borough. This was performed to inform future commissioning decisions for Haringey residents.

The model (67) highlighted a higher crude mortality rate due to alcohol-related causes in the C02 segment of the population, which they describe as very deprived black, minority and ethnic (BME) communities with healthy young families, but unhealthy lifestyles. This remains 1 standard deviation above the borough average when directly standardised. In addition, the 2002-2006 hospital admission data provide evidence that people in the C03 segment of the population have a far greater likelihood of being admitted to hospital due to alcohol-related problems. This segment is characterised as deprived BME communities with young families and above average rates of breast cancer. This is interesting, as the alcohol-related problems appear here to be in a different segment of the population compared to the mortality data. This has been interpreted as possible indicator of poor lifestyle in this segment that will lead to future issues. When the data are adjusted for age, sex and deprivation, the C03 segment still has a higher than expected admission rate for alcohol-related problems. This could suggest that there is a need for more advisory services for these populations, which are found predominantly in the eastern areas of the borough.

The A01 and C01 populations (over-indulging early career executives and deprived high impact multicultural communities respectively) also have higher than average mortality due to alcohol related causes when compared to the overall Haringey population and, again, this is still evident when the rates have been directly standardised. This would indicate that there could be a problem with alcohol in these population segments and the synthetic estimates data on alcohol problems support the conclusion that alcohol is a problem in the A01 segment. Synthetic estimates based on the Health Survey for England suggest that binge drinking is a concern amongst this population segment.

It is interesting that the synthetic estimates predict that C01 and C02 segments of the population should be fairly healthy with lower rates of binge drinking and alcohol problems. This is not reflected in the mortality data. Overall this picture suggests a need for information on alcohol and this could be addressed by the scoping phase of a social marketing project.

The years of life lost per death due to alcoholic liver disease including cirrhosis are high for A01 and A03 (privileged elderly) populations, but this could reflect the fact that A01 population segment has young and middle-aged adults. When the data are adjusted for age sex and deprivation, and compared to the expected years of life lost due to alcoholic liver disease including cirrhosis, there is obviously a problem in the A01 segment. There are a much higher number of years of life lost due to alcoholic liver disease than would be expected. There are sufficient data to suggest that the relatively affluent populations of Muswell Hill and Crouch End have a need for alcohol intervention and prevention work. This area is probably most suitable for a brief intervention scheme in primary care, possibly through children's centres, as many women with children in these areas do not work, or via extended hours GP services. A good piece of social marketing would help steer prevention efforts in this population and help assess the healthcare services used allowing these to be targeted. A01 and A03 populations predominantly live in the West of the borough.

Alcohol admissions and mortality are higher than would be expected in the C02 population segment. It has not been possible to unpick the data on this population and a further piece of work would be required to investigate which section of this population is contributing the
most to these data, especially given that there is a high BME population here and there is
evidence that high density BME populations are ‘protect’ against alcohol and tobacco (62).
There is evidence that BME populations are at higher risk of conditions such as hypertension,
and this may be exaggerating the partially attributable admissions data for Haringey. This
needs further investigation.

The C03 segment had low prevalence rates and mortality rates, but high levels of hospital
admissions for alcohol-related problems. As this is a relatively young population, it is probably
worth investigating whether this is due to admissions related to binge drinking. Binge drinking
is associated with damage to health in the long-term and a good piece of preventative
work may be required for this population which, like C02, resides predominantly in the East of
the borough. This preventative work could be informed by social marketing and possibly
delivered through the use of community pharmacy.

The Greater London Alcohol and Drug Alliance (GLADA) recently released a statement of
priorities for alcohol in the capital. These are based on 3 strategic objectives:

1. To reduce alcohol-related harm to health, through awareness-raising, early
intervention and better access to treatment and support
2. To reduce alcohol-related crime and disorder and anti-social behaviour through
continuing to improve the management of the night-time economy and tackling the
links
3. To reduce the risk of harm to children and young people as a result of their own or
others’ drinking through developing alcohol work within targeted youth support and the
Every Child Matters agenda

In line with these the following are the recommendations of this needs assessment:

Reducing alcohol-related harm to health

- Ways of improving joint commissioning between NHS Haringey, Haringey DAAT and L
  B Haringey should be explored.
- Communication and joint working arrangements between the dual diagnosis unit
  and HAGA need to be considered and a way of improving these, such as a
  memorandum of understanding, should be explored. This would improve
  communication between clinicians and the services e.g. between Mental Health
  teams and substance abuse teams and improve clinical care and hence clinical
  outcomes
- A number of nurses at HAGA that deliver home detox services have been trained to
  be nurse prescribers. However, because of current clinical governance policies, the
  nurses are not currently able to provide this service to clients. This needs to be
  resolved by NHS Haringey pharmacy team, public health team and HAGA.
- Services to treat ‘frequent flyer’ patients i.e. those who are continually re-admitted to
  hospital with alcohol-related illness should be investigated. For instance, community
  matrons could be used to help avoid hospital admissions in this group.
- Polydrug use, where alcohol is one of the drugs, needs to be investigated. The
  number of Haringey residents with this problem needs to be quantified and existing
  services mapped out to see if these are sufficient. This should include both legal and
  illicit drugs, for example alcohol and tobacco, alcohol and cocaine.
- An Equity Impact Assessment (EIA) should be prepared for alcohol services
- A programme budgeting marginal analysis (PBMA) exercise for alcohol services
  should be conducted in Haringey. This would allow the PCT to benchmark against
  other PCTs and assess services in the light of this information.
• An alcohol specialist nurse for accident and emergency should be commissioned to provide brief advice and ensure that there is a named A&E consultant with responsibility for alcohol issues. This is in line with the Paddington model and would provide clinical leadership along with clear lines of responsibility.

• Alcohol health workers or alcohol liaison nurses should be appointed to work in and across the acute sector. The care of people with alcohol-related problems should also be considered in the service designs for polisystems and urgent care.

• The cost-effectiveness of the directed enhanced service (DES) for identification and brief advice in primary care should be investigated. Consideration should be given to extending this DES to cover all at-risk groups, possibly via a local enhanced service (LES). In addition, ways of improving the use of identification and brief intervention should be investigated. This will ultimately reduce alcohol-related admissions in the borough.

• The use of using community pharmacies for health promotion around alcohol should be explored. This would help address health inequalities by reaching hard-to-reach populations such as younger men who are not registered with a GP.

• An alcohol brief intervention has been included in the NHS Health Check. This is an ideal way of screening the entire population of Haringey aged 40-74 years inclusive and should remain in the standard operating procedure for this programme.

• Efforts should be made to ensure that sufficient tier 3 and 4 services are commissioned for hazardous and harmful drinkers (particularly given that the NHS Health Check and any additional work in accident and emergency might increase referrals).

• The effectiveness and capacity of specialist treatment should be improved by ensuring that there is capacity at HAGA (or elsewhere) to provide specialist treatment for at least 15% of estimated dependent drinkers in Haringey.

• A piece of work should be commissioned to investigate whether the high number of partially alcohol-attributable admissions is due to high rates of hypertension and coronary heart disease in the borough and investigate how much of this is due to ethnicity and socioeconomic status.

• Social marketing has been acknowledged as a powerful tool for improving health. NHS Haringey should commission, with or without partners such as Haringey DAAT, a social marketing study to identify people’s views of sensible drinking, barriers to health-seeking behaviour and how best to signpost people to local services. There seems a particular need to understand the levels of alcohol use in the borough’s Irish population, given the high levels of alcohol-related harm evidenced in this report.

Reducing alcohol-related crime and disorder and anti-social behaviour:

• The information in the alcohol harm reduction strategy should be updated after the 9/10 commissioning round.

• Work should be commissioned to investigate levels of binge drinking in the borough, especially among young professionals who are at risk of exceeding guidelines without realising.

Reducing the risk of harm to children and young people:

• Targeted information should be developed for young people.

• This needs assessment has not been able to cover all areas of work on alcohol use and misuse due to the far-reaching consequences of alcohol misuse and the impact of alcohol on people’s lives. However, the work done for this assessment has highlighted a number of areas that could benefit from further consideration. These include: further work on domestic abuse and alcohol misuse; work on safeguarding - both children and vulnerable adults; work on alcohol misuse identification in maternity services and alcohol misuse in pregnant women.
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Sheena Carr  Public Health NHS Haringey
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Fiona Cook  Haringey Advisory Group on Alcohol
Mike Davis  PSHE/Citizenship and Participation manager LB Haringey
Ian Dawson  Public Health Consultant
Michael Edelstein  Public Health NHS Haringey
Terry Grant  Young Fathers Project LB Haringey
Sarah Hart  Haringey DAAT
Trevor Hubbard  London Ambulance Service
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Jin Lim  Public Health NHS Haringey
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Angela Small  Eban
Linda Somerville  Public Health NHS Haringey/Haringey DAAT
Graeme Walsh  Public Health NHS Haringey
Otis Williams  Community Safety, LB Haringey
Fiona Wright  Public Health NHS Haringey

Members of Haringey Youth Council
Clients of the Leaving Care team that took part in the questionnaire
Figure 27 – The adverse effects of alcohol consumption in the UK.

- The attributable fraction due to alcohol was not available.

Source: Association of Public Health Observatories (APHO), 2007


20. **ScHARR University of Sheffield.** Alcohol pricing and promotion effects on consumption and harm. London: Department of Health, 2008.


29. **NHSEmployers.** Clinical directed enhanced services (DESs) for GMS Contact 2009/09. s.l.: NHS Employers, May 2009.


APPENDIX A

TERM INO LO GY - THE USE OF ALC O H O L UN I TS

Units are the measure used for the alcohol content of drinks. One UK unit is 10ml or 8 grams of pure alcohol. To calculate the units in a drink, you multiply the ABV (strength) by the volume (ml) and divide the result by 1000. As this is a bit complicated, there is a calculator on the NHS Choices website. Most drinkers measure their consumption by the glass and there have been campaigns to inform the general public about the units in e.g. one medium glass of red wine, or one pint of lager.

Research from the Alcohol Education Research Council (ref) found that when people were asked to estimate the units in a glass of alcohol they had poured themselves, only 25% (check) could give an accurate estimation.

PATTERNS OF DRINKING

SENSIBLE DRINKING

There is no such thing as completely safe drinking. Any amount of alcohol carries a risk and only teetotallers have no risk of harm due to alcohol.

The current guidelines are that men should not regularly drink more than three to four units of alcohol per day and women should not regularly drink more than two or three units. Regular in this context means every day or most days of the week. The limit is given as for a day to make it clear that you should not drink a week’s units in one go – i.e. to discourage binge drinking.

Women trying to conceive and pregnant women are advised to avoid drinking or only drink one to two units of alcohol once or twice a week. Men who regularly drink more than eight units of alcohol per day and women that regularly drink more than six units per day are considered to be at risk of harm.

ALCOHOL MISUSE

Approximately 10% of people in the UK do not drink alcohol and 80% drink socially. Up to 15% of people drink more than sensible levels and these are described as misusing alcohol. The terms alcoholic and alcoholism are now no longer used due to stigma.

WHO DEFINITIONS

The WHO uses three categories of alcohol use disorders. These are

Hazardous: People drinking above the recognised sensible levels but not yet experiencing harm (Drummond C, 2004).
Harmful: People drinking above sensible levels and experiencing harm (Drummond C, 2004).

Alcohol Dependence: People drinking above sensible levels and experiencing harm and symptoms of dependence (Drummond C, 2004). This is further divided into moderately dependent drinkers, those that can be managed effectively in community settings and severely dependent drinkers, who might need to receive inpatient treatment for withdrawal and residential rehabilitation (Department of Health/National Treatment Agency for Substance Misuse 2006).

NEW NHS TERMINOLOGY

Recently, the Chief Medical Officer has requested that the NHS and Department of Health change the terminology on alcohol use (Primary care service framework). This is due to reported confusion with the sensible, hazardous and harmful terminology. The new terminology is:

Lower risk drinking: This refers to men not regularly drinking >3-4 units alcohol per day and women not regularly drinking >23 units per day

Increasing risk drinking: This refers to men regularly exceeding >3-4 units per day, but not drinking at levels incurring the highest risk. As you might expect, for women this refers to women regularly drinking in excess of 2-3 units per day, but not drinking at levels incurring the highest risk.

Higher risk drinking: This refers to men regularly exceeding 8 units per day or regularly drinking >50 units per week and women drinking >6 units per day on a regular basis or regularly drinking >35 units per week.

There is no widely accepted definition of binge drinking, but this term is used to describe drinking to a considerable excess of sensible levels on a single occasion, e.g. double the sensible daily levels or more in a single occasion.
PSA Delivery Agreement 25: Reduce the harm caused by alcohol and drugs

Revised June 2009
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1 Vision

1.1 The Government's vision is to produce a long-term and sustainable reduction in the harms associated with alcohol and drugs, where:

- fewer people develop drug problems; where there is early intervention to prevent and reduce the harms caused by substance misuse, particularly amongst the most at-risk children, young people and families where people who do have drug problems receive the effective treatment and support they need; where communities are relieved of drug-related crime and associated violence; and where organised criminal enterprises are prosecuted and their assets are recovered; and
- there is a safe, sensible and social drinking culture where violent and anti-social behaviour is not tolerated; where young people are prevented from experiencing poor outcomes resulting from alcohol misuse; where those who drink alcohol are aware of the risks involved; and where those that are drinking too much receive the advice and support they need.

1.2 Problem drug use and harmful alcohol use are public health and social issues which have a significant impact on society as a whole, but disproportionately affect the most deprived communities and the most vulnerable individuals. Around a third of acquisitive crimes is believed to be undertaken to fund a drug addiction and alcohol is a factor in around a half of violent crimes. Problem drug use and harmful alcohol use destroy families and contribute to a cycle of deprivation and lost opportunity. The harms are significant, wide-ranging and cost an estimated £15.4 billion for drugs* and £18-22 billion for alcohol.

1.3 This PSA will aim to reduce the harms caused by drugs and alcohol to:

- the community as a result of associated crime, disorder and anti-social behaviour;
- the health and well-being of those who use drugs or drink harmfully; and
- the development and well-being of young people and families.1

1.4 Actions will be underpinned by relevant strategies on drugs and alcohol. The current 10-year drug strategy will come to an end in April 2008 and a new strategy will be developed towards the end of this year. A new alcohol strategy was published on 5 June 2007.2

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* The economic and social costs of drug (and alcohol) use are estimated to be around £15.4 billion per year. (Source: Carlton, Tiddy, C., Cadenhead, A. and Hurst 2001.) The Harms and Costs of Drug Use in England and Wales, 2000/01 D. Carlton, M. Cadenhead, A. and Hurst 2001.1


2 Keeping these outcomes will be supported by NDS and PSAH1.

* The PSA Delivery Agreement will be updated appropriately after the strategy is published.

2 Measurement

2.1 The indicators that measure progress in reducing drug and alcohol-related harm are set out below. Further detail on each indicator in the PSA can be found in the Measurement Annex.

**Indicator 1: The number of drug users recorded as being in effective treatment**
- Drug treatment is the intervention with the most developed evidence of effectiveness and it is the key intervention to reduce drug-related crime. This indicator will also drive the reduction of the harms caused to health and well-being by frequent use of illegal drugs, but drug dependence is also directly linked to other harms that PAs seek to address. It is also the key intervention to reduce drug-related crime.

**Indicator 2: The rate of alcohol-related hospital admissions**
- This indicator will drive the reduction of the harms caused to health and well-being by frequent consumption of harmful levels of alcohol. But it will also measure the impact of prevention interventions: when they are improved, hospital admissions for specific chronic and acute conditions are expected to slow in the short, medium and long term.

**Indicator 3: The rate of drug-related offending**
- Drug use, particularly of Class A drugs, heroin and cocaine/crack (HCO), is a key driver for crime and offending. This indicator will drive the reduction of the harms caused to the community by drug-related crime and offending, and thereby contribute to an overall reduction in crime/offending.

**Indicators 4 & 5: The percentage of the public who perceive drug use or dealing/drunk and rowdy behaviour to be a problem in their area**
- Problem drug use and harmful alcohol use have a significant impact on society as a whole but disproportionately affect the most deprived communities. These indicators will drive the reduction of the harm caused to the community by alcohol and drug-related disorder, by measuring the perception of the public who perceive the use of associated crime/ASB to be a problem in their area.

2.2 In addition to the above indicators that sit solely with this PSA, there are other indicators within other PSAs that are crucial to reducing the harms outlined within this delivery agreement:
- Young people frequently using drugs, alcohol or volatile substances that sit within the PSA 14 to Increase the number of children and young people on the path to success;
- Alcohol-related violent crime and disorder, especially assault with injury: the level of serious acquisitive crime; and the level of re-offending that sit within the PSA 13 to Make communities Safer; and
- The recovery of criminal assets that sit within the PSA 24 to Deliver a more effective, transparent and responsive Criminal Justice System for victims and the public.
3 Delivery strategy

3.1 Problem drug use and harmful alcohol use are public health and social issues that are exacerbated by deprivation or personal problems experienced by individuals, and a lack of awareness about the risks involved. If not addressed effectively, there are wider consequences for the community in terms of increased crime and anti-social behaviour.

3.2 This Plan sets out cross-government action to reduce the harms caused by alcohol and drugs. These harms are significant, wide-ranging and cost an estimated £15.4 billion for drugs and £18.2 billion for alcohol.

3.3 Action will centre around three main strands, underpinned by new national alcohol and drugs strategies:

- reducing the harms caused to the development, achievement and well-being of young people and families;
- reducing the harms caused to the health and well-being of drug users and those using alcohol in harmful ways; and
- reducing the harms caused to the community as a result of associated crime, disorder and anti-social behaviour.

3.4 Actions will include:

- public health campaigns and education to raise awareness of the harms associated with alcohol and drug use and sources of support;
- a renewed effort to address substance misuse amongst young people, particularly through early intervention with those known to be most vulnerable;
- a new focus on supporting the most at-risk families who are experiencing multiple problems, where parental substance misuse is often a key factor;
- helping people who use illegal drugs or drink harmfully to live healthier lives by providing information and advice and for those that need it, treatment and support in re-establishing their lives, including the identification and referral of drug misusing offenders to treatment in prison and in the community;
- tackling crime and the key drivers of offending, reducing the disorder and anti-social behaviour associated with alcohol and drugs, tackling the supply of drugs and the irresponsible sale or promotion of alcohol; and
- giving local areas increased flexibility to plan and use resources, with light touch performance management arrangements.

3.5 Although there are some overlaps, there are also significant differences in the type and level of harm associated with alcohol and drugs and in our strategies for addressing them. Consequently, the delivery strategies for each are set out separately.
Alcohol harms

3.6 The Government’s delivery strategy for reducing the harms caused by alcohol is divided into three strands:

- first, the law and licensing powers introduced to tackle alcohol-fuelled crime and disorder, protect young people and bear down on irresponsibly managed premises need to be used widely and effectively;

- second, focusing prevention, information and support, and working with appropriate the criminal justice system and the minority of drinkers who cause the experience the most harm to themselves, their communities and their families. These are: 16-24 year old binge drinkers; young people under 18 who drink alcohol; and harmful drinkers; and

- third, collaborative work by all agencies to shape an environment that actively promotes sensible drinking. Delivery will draw on the knowledge, skills, commitment and ability of local communities, the police, local authorities, prison and probation staff, the NHS, third sector organisations, the alcohol industry, the wider business community and the media.

Prevention aimed at young people

3.7 Prevention activity aimed at young people is led by the Department for Children, Schools and Families (DCSF). Young people and their parents will be supported in making informed decisions about drinking, through authoritative, accessible guidance about what is and what is not safe and sensible in the light of the latest available evidence from the UK and abroad. In order to do this, a panel of paediatricians, psychologists and epidemiologists will be convened to compile and discuss the latest evidence on the effects of alcohol on young people’s physical and emotional health, cognitive development and brain functioning. Young people’s awareness of alcohol use will also be raised through a social marketing campaign, with work to create a culture where it is socially acceptable for young people to choose not to drink and, if they do start drinking, to do so later and more safely.

3.8 Local areas will identify those young people most at risk of failing to reach their potential because of substance misuse and provide tailored support for them. This programme is known as Targeted Youth Support.

3.9 The main delivery levers are:

- the young people’s substance misuse indicator;

- performance management of Local Strategic Partnerships by Government Offices against indicators embedded within Local Area Agreements; and

- Ofsted inspections of schools, the reports of which are publicly available.

Targeting irresponsible promotion and sales

3.10 Targeting irresponsible promotion and sales is controlled by OFCOM and the Advertising Standards Authority. Industry self-regulation bodies such as the Portman Group and the alcohol industry itself through a range of codes and standards. Evaluating and improving the effectiveness of these will form the core of action to tackle the irresponsible sales and promotion.

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1 The programme is described in more detail in the Delivering Agreement for the PS14.
2 See PS2 14.
Tackling alcohol-related crime and disorder

3.15 Sharpened criminal justice for crime and anti-social behaviour will be achieved by making much greater use of the tools and powers to tackle alcohol-related crime and disorder that were introduced through the Licensing Act and Violent Crime Reduction Act. Government will encourage concern, regional and national action to target alcohol-related offenders. This will involve a combination of penalties and health education interventions to drive home messages about risks associated with alcohol and to promote behavioural change.

3.16 As part of this, the Home Office will roll-out a new programme to help local partnerships and communities tackle alcohol-related crime, disorder and anti-social behaviour, encouraging more and stronger local partnerships and industry participation and making it compulsory for local areas to develop alcohol strategies. Government Offices will be asked to ensure strategic regional coordination of these. The Ministry of Justice will work to improve the way alcohol-related offenders are dealt with in custody and in the community and support key strategic actions by the National Offender Management Service (NOMS).

See FAQ 33.
3.17 The main delivery levers are:

- the indicator for reducing violent crime and disorder, especially assault with injury;*
- the indicator for reducing the percentage of the public who perceive drunk and
driving behaviour to be a problem in their area in this PSA;
- performance management of NCA by the Ministry of Justice;
- performance management of Local Strategic Partnerships by Government Offices
against indicators embedded within Local Area Agreements; and
- performance management of individual police authorities by the Home Office
against indicators embedded within their plans.

More help for those who want to drink less

3.18 More help for those who want to drink less by informing the public about the risks
associated with drinking alcohol through a major national communications campaign linked
to the labelling of bottles and cans to assess daily consumption, and supporting the development
of a range of new kinds of information and advice aimed at people who drink at harmful levels
and their families and friends, including telephone helplines, interactive websites and support
groups. This will run alongside other kinds of support and advice from the NHS for those who
need more intensive professional help and treatment. The Department of Health will also
establish a framework to support commissioners in planning local investment and health to
disseminate the findings of 52 trailblazers that have been established to implement
identification and brief advice in a range of health, criminal justice and community settings.

3.19 The main delivery levers are:

- reducing the trend in alcohol related hospital admissions indicator in this PSA;
- independent assessment and review by the Health Care Commission and Audit
Commission, including ongoing Health Care Commission sentinel indicators for
measuring effective local commissioning and alcohol treatment provision;
- Primary Care Trust and Partnership use of Audit Commission costing tools in the
commissioning of cost effective treatment;
- performance management of Local Strategic Partnerships (LSPs) by Government
Offices against indicators embedded within Local Area Agreements; and
- performance management of Primary Care Trusts by Strategic Health Authorities
and independent assessment by the Health Care Commission against national and
local indicators.

Drug harms

3.20 The Government’s delivery strategy for reducing drug harms can be divided into four
strands:

1. Protecting communities through robust enforcement to tackle drug supply, drug
related crime and anti-social behaviour.
2. Preventing harm to children, young people and families affected by drug misuse.
3. Delivering new approaches to drug treatment and social re-integration.

*See para 25.
3.2.1 In order to do this central government will work with Local Authorities and partnerships, including businesses and the third sector, criminal justice agencies, children and young people’s services and the NHS.

**Tackling supply of drugs**

3.2.2 The supply of drugs will be tackled at international, national and local levels. The Serious Organised Crime Agency, working closely with a range of partners and especially with the UK Border Agency (UKBA) and police forces, will build knowledge of drug supply, the harm it causes, and the effectiveness of different responses. On the basis of that knowledge, it will take action to reduce the supply of drugs to the UK. It will increase the amount of criminal assets recovered and the proportion of cases in which the proceeds of crime are pursued. Its enforcement activity will increase the risk to drug traffickers who have an impact on the UK. UKBA has a wide range of responsibilities at the UK frontier and overseas. On a risk and intelligence-led basis, UKBA will act to disrupt the importation of drugs into the UK.

3.2.3 In addition, the Foreign and Commonwealth Office (FCO) will work with other governments through its network of diplomatic posts to generate a policy and legal framework that will support our counter-narcotic activity. It will work to build the capacity of priority states, such as Afghanistan, Colombia, Venezuela and Jamaica, to implement their own strategies to target the production and trafficking of drugs and, together with the Department for International Development (DFID), will provide support to strengthen and diversify legal rural livelihoods in drug-producing states.

3.2.4 The Home Office, together with the Association of Chief Police Officers (ACPO) and the police, will promote the use of the National Intelligence Model to identify problem areas, issues and high harm causing users. These will then be targeted for intervention.

3.2.5 The main delivery levers for tackling supply are:

- the PSA indicator to reduce the percentage of the public who perceive drug use or dealing as a problem in their area;
- improved knowledge to as to be able to mount the most appropriate and effective enforcement interventions;
- performance management of individual police forces by the Home Office;
- effective use of the FCO Drugs and Crime Programme and the cross-departmental Afghan programme;
- Departmental Strategic Objectives which are mutually supportive of the aim of reducing harm and;
- effective partnership working with other countries.

**Prevention and early intervention**

3.2.6 Prevention and early intervention will be led by DCSF to prevent substance misuse amongst young people, particularly with those we know to be the most vulnerable, to ensure they are able to reach their full potential. This will be delivered through schools, Children’s Services, the
Targeted Youth Support programme and other programmes such as Positive Futures, FRANK1 and “Know Your Limits”. 1

3.27 DH, DCSF and the Home Office will also run national and local public health campaigns to provide information about the harms associated with drug misuse.

3.28 The main delivery levers for prevention are:

- the young people’s substance misuse indicators;2
- performance management of Local Strategic Partnerships by Government Offices against indicators embedded within Local Area Agreements; and
- Ofsted inspections of schools and children’s services, the reports of which are publicly available.

Provision of drug treatment

3.29 The Department of Health through local services commissioned by Primary Care Trusts with other local partners is responsible for leading on the provision of drug treatment both for high harm causing drug-misusing offenders and other drug misusers. Drug dependence is directly linked to most of the harms this PSA sets out to address and treatment is the intervention with the most developed evidence of effectiveness. We will work to ensure that there is sufficient capacity in the system, both for those referred to treatment via the Criminal Justice System (CJS) and for those who self-refer, to ensure we intervene early and appropriately with priority groups such as prisoners, young people and drug users who are parents. Treatment provision includes harm reduction, medical and psycho-social drugs treatment.

3.30 The main delivery levers are:

- the effective treatment indicator in the PSA;
- performance management of Local Strategic Partnerships by Government Offices against indicators embedded within Local Area Agreements; and
- performance management of Primary Care Trusts (PCT) by Strategic Health Authorities against indicators in local PCT delivery plans;
- National Treatment Agency (NTA) will provide assurance of local drug partnership plans via a process of annual agreement and quarterly review;
- publication of monthly treatment performance information by the National Drug Treatment Monitoring System (NDTMS);
- provision of dedicated resources via the pooled Treatment Budget allocation of funding on a per person treated basis;
- independent assessment and review by the Health Care Commission and Audit Commission, including ongoing Health Care Commission sentinel indicators for measuring effective local commissioning and drug treatment provision;
- core guidance and support including DH/NTA Models of Care/NICE guidance; and
- Primary Care Trust (PCT) and Partnership use of Audit Commission costing tools in the commissioning of cost effective treatment.

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1 See PND 13.
2 See DH 2004/06.
3.31 Effective treatment for substance misuse needs to include tailored and integrated support to address the range of complex and interrelated issues faced by each individual. These may include mental and physical ill health, poor housing and homelessness, family and relationship problems, social isolation, non-attendance or social exclusion, leaving care, worklessness, low skills and criminal or anti-social behaviour. Responsibility for delivering wider support services is shared between a range of departments including the Department of Health, Home Office, Communities and Local Government, Ministry of Justice, Department for Work and Pensions, Department for Innovation, Universities and Skills and the Department for Children, Schools and Families.

Development of support services

3.32 The development of integrated, support services for substance misusers to help individuals and families re-integrate and re-establish themselves in the community is set out in the 2008 drug strategy. Best practice in delivering integrated support will build on learning from current initiatives including the Adults Facing Chronic Exclusion pilots, the Individual Budget-Holding Lead Professional pilots and the National Offender Management Service (NOMS) Pathways.

3.33 Support services also need to recognise and reduce the wider harms caused by drugs misuse, particularly to the families, friends and the children of drug misusers.

3.34 The main delivery levers are:

- planned national roll-out of Pathways to Work by the Department for Work and Pensions;
- performance management of Local Strategic Partnerships by Government Offices against indicators embedded within Local Area Agreements;
- publication of the Comprehensive Area Assessment carried out by the Audit Commission and Local Service Inspectorate;
- the indicators on settled accommodation and employment outcomes for young adults leaving care, ex-offenders and those on community sentences; adults in contact with secondary mental health services and those with moderate to severe learning disabilities in the PSA 16 on adult social exclusion. This PSA will help to ensure that the most disadvantaged adults are offered the chance to get back on the path of a more successful life.

Tackling drug-related crime and ASI

3.35 Work to tackle crime and anti-social behaviour associated with drug use is led by the Home Office and Ministry of Justice. Through the police, Local Authorities, Crown Prosecution Service (CPS) and courts, Government will use criminal sanctions and anti-social behaviour powers to address crime and anti-social behaviour. Together with local partners including police, local authorities, CPS, courts, Youth Offending Teams, prisons, probation and health agencies we will build on the success of the Drug Interventions Programme and the Priority and other Priority Offenders Programme to break the cycle of drug-misuse and offending by intervening at every stage of the criminal justice system to move problematic drug users into appropriate drug treatment and support. NOMS will also introduce the full integrated drug treatment system in 21 prisons with enhanced clinical services in a further 32.

3.36 NOMS will increase the use of post-custodial licence conditions (for sentences of 12 months plus) to ensure continuity of treatment on release from prison. Improved links between the Drug Interventions Programme and NOMS will deliver ongoing support for drug misusers on completion of statutory supervision.
3.37 The main delivery levers for tackling crime and anti-social behaviour (ASB) are:

- the indicator for reducing drug-related offending in this PSA;
- the indicators for reducing acquisitive crime and re-offending;¹
- the indicator for reducing the percentage of the public who perceive drug use or dealing to be a problem in their area in this PSA;
- performance management of Local Strategic Partnerships by Government Offices against indicators embedded within Local Area Agreements;
- performance management of individual police forces by the Home Office against indicators embedded within their plans;
- publication of the Comprehensive Area Assessment carried out by the Audit Commission and Local Service Inspectorate; and
- local accountability to neighbourhoods through the Neighbourhood Policing initiative.

Role of wider performance management frameworks

3.38 Strong performance management is a key part of the delivery strategy. Reducing the harm caused by drugs and alcohol is reflected within the core strategic objectives and PSAs of contributing Departments and agencies. The PSA indicators will also be reflected in the Local Area Agreement indicator set, IHMS metrics, APACS Assessments of Policing and Community Safety (APACS) and NOMS and Youth Justice Board (YJB) assessments and performance measures. This approach creates a comprehensive matrix of governance and accountability that minimises reporting and monitoring burdens. The departments and agencies overseeing the framework will ensure that they interface and align with the Local Government Performance Framework for England, and other relevant frameworks such as those covering the wider criminal justice system, using consistent performance indicators and analysis throughout.

Local Government Performance Framework

3.39 The 2006 Local Government White Paper¹ set out the Government’s proposals for a new performance framework for Local Authorities (in England) working alone or in partnership with others, including a single set of national performance indicators (the National Indicator Set) and improvement targets specific to each locality agreed through local Area Agreements (LAA). Separate performance frameworks will also operate for other local delivery partners, but government departments are working together to ensure that these arrangements will align with the local government framework. The headline indicators for this PSA and other key crime and community safety measures will therefore be included in both APACS and the national indicator set as part of the local government performance framework.

Department of Health

2.40 The new Health and Social Care Outcomes and Accountability Framework is moving away from centrally driven national targets and placing the responsibility for local prioritisation with PCTs, in discussion with their local partners. Performance indicators for drugs and alcohol will form part of a set of health and social care outcome indicators which support Health’s Departmental Strategic Objectives (DSOs). PCTs will be able to select their own priorities from:

¹See 1523-25.
the set of DCO metrics, against which they will be performance managed by their Strategic Health Authorities (SHAs). Indicators which require joint PCT and Local Authority action, will be part of the local government national indicator set and if prioritised by the PCT and Local Authority within their joint strategic needs assessment, will also form part of the Local Area Agreement improvement set. If an indicator for drugs and alcohol was not prioritised, the SHA conversation with their PCT would include strong challenges where existing performance was weak.\footnote{See PS2 10.4.15.}

3.41 The new Health and Social Care Outcomes and Accountability framework as it applies to drug treatment, will be supported by accuracy of local drug partnership plans via a process of annual agreements and quarterly reviews by the National Treatment Agency for Substance Misuse (NTA). The publication of monthly performance management information through the National Drug Treatment Monitoring System (NDTMS), the provision of dedicated resources via a joint Department of Health and Ministry of Justice pooled treatment budget and independent assessment and review by the Healthcare Commission, Commission for Social Care Inspection, and the Audit Commission. For alcohol, a national alcohol treatment monitoring system is under development and independent review by the Healthcare Commission and National Audit Office under its consideration.

Assessment of Policing & Community Safety (APACS)

3.42 The Assessments of Policing and Community Safety (APACS) framework is being developed in partnership by the Home Office, the Association of Chief Police Officers (ACPO), the Association of Police Authorities (APA), Her Majesty’s Inspectorate of Constabulary (HMIC), the Local Government Association, Audit Commission and Communities and Local Government (CLG).\footnote{See http://www.police.homeoffice.gsi.gov.uk/aps/} It will provide an assessment framework for the work of the police and its partners on crime and community safety, rationalising existing central frameworks.

3.43 These new arrangements will cover policing and community safety issues in a balanced way, and will minimise data demands on the police and their partners. APACS will provide cross-cutting assessments of performance based on the PSA indicators as well as other measures that provide a more specific and balanced picture of performance, including on equality and fairness. APACS will be introduced from April 2008, with the first assessments published in 2009, reporting on the 2008-09 year.

NOMS Performance Management Framework

3.44 The NOMS Performance Management framework will provide a single assessment framework for the entire NOMS system – including commissioners, partners and providers. It is being developed in partnership by NOMS, the Ministry of Justice, HM Inspectorate of Probation and the Audit Commission. The framework will be developed iteratively as NOMS moves to a full commissioning system and introduces Probation Trusts. It will include national performance reporting and assessment (including published assessments) as well as assessments of all providers, commissioners, regional reoffending boards and other relevant partners. It will build on existing performance measures while seeking to minimise data requirements and ensuring a balanced set of measures that include quality assessments. An early version of the framework will be developed and applied in 2007/08. We aim to publish the first assessments in 2008, reporting on the 2007-08 year.
Youth Justice Board Performance Framework

3.45 The YJB’s performance management framework, developed collaboratively with service providers and aligned with the Local Government Performance Framework, will have an outcome focus and much greater emphasis will be placed on measures that support local areas, such as programme quality and completions, and post-order support. The YJB will also strengthen measures that relate to victim engagement and confidence. The YJB is exploring the possibility of sourcing data direct from case management systems, to further reduce the information burden on local areas.

3.46 The current youth justice plan and effective practice and quality assurance arrangements will be merged with an annual assessment of service provider capacity to reduce offending, which will be based on effective practice and other key processes such as performance management. The YJB will monitor and advise Youth Offending Teams (YOTs), make grants and promote emerging and effective practice. YJB regional teams will also undertake an annual risk-based validation exercise of capacity assessment, with support provided by improvement consultants wherever this is identified as necessary.

Accountability and governance

3.47 The Home Secretary is the lead Secretary of State for this PSA. The relevant Cabinet Committee’s will drive performance by regularly monitoring progress, holding Departments and programmes to account and resolving inter-departmental disputes where they arise.

3.48 The Senior Responsible Officer within Government for the PSA will be the Director of the Drugs and Alcohol Directorate, Home Office who will report to the Senior Official PSA24/25 Strategic Board on alcohol and drugs respectively, comprising all the key supporting departments. The Board will also monitor progress and review delivery regularly and report to the relevant Cabinet Committee.

3.49 Beyond this, a cross-government Inter-Departmental Ministerial Group on Substance Misuse will continue to provide Ministerial leadership and oversight. At official-level, the Alcohol Strategy Delivery Group and Drug Strategy Delivery Group will (respectively) continue to coordinate programmes of work on alcohol and drugs, reviewing performance against published commitments.

Consultation

3.50 The PSA is closely linked to the new cross-government Alcohol Strategy, published in June 2007. Discussions with a wide range of stakeholders has been an integral part of the development of the new strategy, over the past 18 months. Consultation seminars have been held with representatives from the Drinkaware Trust, the main alcohol industry associations (e.g. the British Beer & Pub Association, Wine & Spirit Trade Association, The Punters Group), ACPD; third sector (e.g. Alcohol Concern, Action on Addiction, Turning Point); health representatives (e.g. the Royal Colleges); the Devolved Administrations and various other key stakeholders.

3.51 A public consultation is planned in 2008 to assess views concerning the effectiveness of a range of current measures, which are subject to industry self-regulation. These include the labelling of bottles and cans and standards for the responsible retail and promotion of alcohol.

3.52 Development of this PSA has been closely linked to the initial thinking on the development of the new drug strategy, which was implemented from April 2008. Discussions between government departments and others had been ongoing since early 2007 and a series of regional

discussions provided the opportunity to consult with service users, providers, families, commissioners and those responsible for setting local priorities and driving delivery.


3.54 The consultation was open and wide ranging, and sought views from the public, service users, their families, front-line professionals and service providers on how we can continue to reduce drug-related harms for the benefit of individuals, families and communities.

3.55 A leaflet was also developed and was available in a wide range of locations accessed by the public.
Measurement annex

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Percentage change in the number of drug users recorded as being in effective treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data provider</td>
<td>National Drug Treatment Monitoring System (NDTMS).</td>
</tr>
<tr>
<td>Data set used</td>
<td>National Drug Treatment Monitoring System (NDTMS) core data set.</td>
</tr>
<tr>
<td>Baseline</td>
<td>2007/2008. Due to the nature of the metric construction (which requires a time lag of 12 weeks plus 21 days to occur) a baseline will not be available until September/October 2008.</td>
</tr>
<tr>
<td>Frequency of reporting</td>
<td>Annual. Monthly data available for performance monitoring.</td>
</tr>
<tr>
<td>95% per cent confidence interval at last outcome</td>
<td>Not applicable - the indicator measures recorded treatment.</td>
</tr>
<tr>
<td>Data Quality Officer</td>
<td>Treatment Information Manager, National Treatment Agency.</td>
</tr>
<tr>
<td>Minimum movement required</td>
<td>±1 percentage point.</td>
</tr>
</tbody>
</table>

Definition of key terms

- Drug users are regarded as in continuous treatment, if they move from one episode of treatment to another but where the time elapsing does not exceed 21 days from discharge at one agency to modality start date at a subsequent agency (inclusive of discharge and modality start date). Where episodes run concurrently and a modality has commenced in the later episode, Movement within the treatment system which is occurring in this way is known as the treatment journey and is defined by admission into and discharge from the treatment system as recorded on NDTMS. An example of this would be where a drug user moves from drug treatment in the community into residential rehabilitation.
- Clients are regarded as still in treatment if any episodes in their treatment journey are not recorded as discharged.
- Drug users are considered to have been successfully discharged from treatment if the reason for discharge is recorded on NDTMS as planned as this denotes active care planning and treatment goals achieved.

A.1 The measure is to improve on the 2007-08 baseline (i.e. the annualised figure for that year) the number of drug users recorded as being in effective treatment. This indicator measures the percent change in the number of drug users using crack and/or opiates in treatment in a financial year, who are still in continuous treatment, who are discharged from the treatment system after 12 weeks or if discharged before then, were successfully discharged in a care planned way as a percent change from baseline performance in 2007-08.

A.2 The indicator is measured across the local drug partnership, sometimes known as the Drug Action Team. Details of these can be found on www.me.sh.w.uk. Local drug partnerships are mapped to lead FTCTs for the purpose of HCC assessment and metric assessment in the small number of cases where there is not co-terminosity.

A.3 The indicator focuses on users of crack and/or opiate resident in the local drug partnership area who are being treated by the structured element of the treatment system, that is treatment accounting within the three and/or four as described in Models of Care (Models of Care Update 2006, MOPAC, regardless of where that treatment occurs. It includes treatment provided in other local drug partnership area and treatment provided to those under 16. It also includes clinical drug treatment in prison.

A.4 In cases where an individual has more than one admission into the drug treatment system in a financial year it counts only the most recent episode.

A.5 Admission into treatment is recorded by the National Drug Treatment Monitoring System (NDTMS), and derived from the date of triage. Further details on NDTMS can be found on www.me.sh.w.uk.
### Indicator 2: Rate of hospital admissions per 100,000 for alcohol related harm

<table>
<thead>
<tr>
<th>Data provider</th>
<th>CH Information Centre.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data set used</td>
<td>Hospital Episode Statistics (HES).</td>
</tr>
<tr>
<td>Baseline</td>
<td>2006 Hospital Episode Statistics (HES) data for alcohol related hospital admissions. To be provided in December 2007.</td>
</tr>
<tr>
<td>Frequency of reporting</td>
<td>Monthly.</td>
</tr>
<tr>
<td>95 per cent confidence interval at last outbreak</td>
<td>Not applicable - the indicators measure recorded treatment.</td>
</tr>
<tr>
<td>Data Quality Officer</td>
<td>Senior Information Analyst at the Information Centre.</td>
</tr>
<tr>
<td>Minimum movement required</td>
<td>1 percentage point reduction in the trend. for performance appraisal</td>
</tr>
</tbody>
</table>

**A6** The measure is to reduce the trend in the increase in alcohol related hospital admissions. This indicator measures the % change in the number of alcohol related admissions using Hospital Episode Statistics.

**A7** Hospital Episode Statistics (HES) are considered to be sensitive to the impact of prevention interventions. I.e. when prevention interventions are improved, hospital admission for specific chronic and acute conditions should show in the short, medium and long term. This indicator will therefore measure the impact of prevention interventions, without creating an additional burden for local healthcare organisations.

**A8** The data indicates a range of conditions some of which are more likely to show rapid changes to local action to reduce alcohol use than others (an example would be methanol poisoning). Work is currently ongoing within the Department of Health to determine which conditions are most likely to show this relationship and it is these conditions that ultimately will form the baseline.

**A9** To support the development and targeting of interventions, significant supporting analysis to assist in planning actions to reduce admissions is available from the North West Public Health Observatory (NWPHO). This includes local rates of alcohol consumption, attributable ill health and crime. The profiles are available for FCT and LA geographies.

### Indicator 3: The rate of drug related offending

<table>
<thead>
<tr>
<th>Data provider</th>
<th>Police forces, DATs, WIMS, C4IRs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data set used</td>
<td>Police National Computer (PNC) data and Drug Interventions Management Information System (DIMIS) and Offender Assessment System (OASys).</td>
</tr>
<tr>
<td>Baseline</td>
<td>Available September 2002. This is the earliest point at which complete convictions data will be available for the baseline cohort, Quarter 1 2002 (January - March 2002) is the first available baseline cohort for this FQA indicator.</td>
</tr>
<tr>
<td>Frequency of reporting</td>
<td>Annual.</td>
</tr>
<tr>
<td>95 per cent confidence interval at last outbreak</td>
<td>N/A. This indicator is based around the recording of a cohort of individuals drawn from the same quarter each year. There is no confidence interval associated with the results because although this cohort represents a sample of the population of individuals identified each year, it is not possible to say that the cohort represents a statistically valid sample of that entire population. The same quarter is used each year to ensure that year-on-year comparisons are valid, but there are therefore actual results, not samples.</td>
</tr>
<tr>
<td>Data Quality Officer</td>
<td>QDUs Data Quality Officer, Home Office.</td>
</tr>
<tr>
<td>Minimum movement required</td>
<td>Not applicable, since the results are actual results, not samples. for performance appraisal</td>
</tr>
</tbody>
</table>

### Definitions of key terms

- **Drug related offending**: The FQA aims to achieve a reduction in the rate of drug related offending defined as offending by those identified as Class A drug misusers in the course of their contact with the criminal justice system.

- **Rate of offending**: Rate of offending is defined as number of proven offences per offender recorded in the 12 months following QS identification.

The cohort of (Class A) drug misusers is likely to include:

- those who have tested positive for specified Class A drug(s) (Heroin, Cocaine/Crack) in police detention following arrest/charge (as part of the Drug Interventions Programme);

- and/or those assessed through the Drug Interventions Programme as needing further intervention (for Class A drugs); and/or those assessed through C4IRs as needing further intervention (for Class A drugs); and/or those recorded on OMAS (Offender Management Assessment System) as having problematic (Class A) drug use whilst on licence or on a community sentence.

- inclusion in the cohort will be based on first instance of identification in a given (3 month) period.
Table of Indicators:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>The percentage of the public who perceive drug use or dealing to be a problem in their area.</td>
<td>British Crime Survey.</td>
</tr>
</tbody>
</table>

Definitions of Key Terms:

- Anti-social behaviour:
  - Anti-social behaviour measure in the PSA is based on one element of the British Crime Survey (BCS) anti-social behaviour measure. The BCS measures levels of perceived anti-social behaviour from responses to seven individual anti-social behaviour strands:
  - noisy neighbours or loud parties,
  - teenagers hanging around on the streets,
  - rubbish or litter lying around,
  - vandalism, graffiti and other deliberate damage to property,
  - people using or dealing drugs,
  - people being drunk or rowdy in public places,
  - abandoned or burnt-out cars.

Perceptions of anti-social behaviour are measured using a scale based on answers to the seven questions as follows: ‘very big problem’, ‘fairly big problem’, ‘not a very big problem’ and ‘not a problem at all’.

The measure is based on respondent’s answer to the following question:

- “For the following things I read out, can you tell me how much of a problem they are in your area. By your area I mean within 15 minutes walk from here.

- (How much of a problem are...) people using or dealing drugs?”

The percentage quoted is the proportion of respondents who say that people using or dealing drugs is a ‘very’ or ‘fairly’ big problem in their local area.
Definitions of key terms

- **Anti-social behaviour:**
  The anti-social behaviour measure in the PSA is based on one element of the BCS anti-social behaviour measure. The BCS measures levels of perceived anti-social behaviour from responses to seven individual anti-social behaviour strands:
  - noisy neighbours or loud parties,
  - teenagers hanging around on the streets,
  - rubbish or litter lying around,
  - vandalism, graffiti and other deliberate damage to property,
  - people using or dealing drugs,
  - people being drunk or rowdy in public places,
  - abandoned or burnt-out cars.

Perceptions of anti-social behaviour are measured using a scale based on answers to the seven questions as follows: ‘very big problem’, ‘fairly big problem’, ‘not a very big problem’ and ‘not a problem at all’.

The measure is based on respondent’s answers to the following question:

- For the following things I need out, can you tell me how much of a problem they are in your area. By your area I mean within 15 minutes walk from here.

The percentage quoted is the proportion of respondents who say that people being drunk or rowdy in public places is a ‘very’ or ‘fairly’ big problem in their local area.
FIGURES

Figure 1 - Per Capita consumption of pure alcohol in the UK 1900-2005 (litres per person)................................. 9

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