6 Improving lifestyles

6.1. Alcohol

Alcohol misuse: the scale of the problem

Almost one-third of the adult male population and one-fifth of the adult female population regularly drink more alcoholic drinks than the government recommends. For almost 3 million people in England, alcohol consumption is a major cause of ill health and over 1 million people are dependent on alcohol.[65] There were 8,758 deaths due to alcohol in the UK in 2006.

Recently, alcohol use and misuse have received a great deal of coverage in the media. The Chief Medical Officer highlighted the issue of young people drinking alcohol. He suggested that under-16s should not be allowed to drink alcohol and that a minimum price should be set for alcoholic drinks, based on a price per unit.[66] These public health measures are designed to address the problem of alcohol misuse in society.

Alcohol misuse is costly both for the individual and for society. Alcohol can also have a detrimental effect on health if used to excess. Some common diseases associated with alcohol are cirrhosis of the liver, cancers and heart disease.

Society bears the direct costs of alcohol misuse via the NHS. This cost is estimated at almost £3 billion per year. The wider costs of alcohol misuse are due to the effects on crime and disorder and sickness from work. The total annual cost of alcohol misuse has been estimated to be up to £25 billion.[67] Haringey Drug and Alcohol Action Team take the lead for the local Alcohol Harm Reduction Strategy. This document, available from www.haringey.gov.uk, outlines activities to reduce alcohol problems in Haringey.

Local analysis for 2002-2008 shows that across all ethnic groups the main cause of alcohol related hospital admissions was hypertensive disease. It is well documented that the prevalence of hypertension is very high among black people compared to Caucasians . This is significant bearing in mind the diverse make up of Haringey which could contribute to the high rates of hospital admissions for hypertension.

Alcohol misuse in Haringey

In 2007/08 the directly standardised rate of deaths due to alcohol in Haringey was 3.5 per 100,000 population for females and 15.8 per 100,000 for males. These are both below the London average. There were 1,820 alcohol-related ambulance calls in Haringey in 2008 and the rate of admission for alcohol-related harm was 1,404 per 100,000 population (directly age and sex standardised) in 2007/08.[68]

Table 7: Alcohol units

Type of alcoholic drink	Volume containing 1 unit
Beer	½ pint (285ml)
Wine	1 small glass (125ml)
Spirits	1 measure (25ml)
Sherry	1 glass (50ml)

Table 8: The detrimental effects of alcohol

Condition	Men (increased risk)	Women (increased risk)
Hypertension	4 times	2 times
Stroke	2 times	4 times
Coronary heart disease	1.7 times	1.3 times
Pancreatitis	3 times	2 times
Liver disease	13 times	13 times

Key messages:

- Alcohol misuse is costly both for the individual and for society and has risen significantly in Haringey over the last five years.
- In Haringey drug use problems are concentrated in the east of the borough. Local evidence shows that Haringey drug treatment agencies are successful in reaching a large number of clients from Black and Minority Ethnic groups.
- Smoking is currently the principal avoidable cause of premature death in the UK. There are marked inequalities in smoking between ethnic groups, with major gender differences within the groups.
- Participation in regular physical activity can help to prevent and treat over 20 long-term conditions or disorders. Participation in physical activity is less likely in some Black and Minority Ethnic groups.

Although below the London average, there is cause for concern about the level of alcohol misuse in Haringey. As Figure 25 shows, the rate of wholly alcohol-attributable hospital admissions in Haringey has risen sharply over the last five years.

Barriers to getting help with alcohol misuse

In an ethnically diverse borough like Haringey there are potentially numerous barriers to accessing support for alcohol related issues. These barriers can include language, stigma, childcare issues, concerns over confidentiality and lack of gender specific services. Some communities, such as asylum seekers or refugees may find it difficult to trust government-funded services.

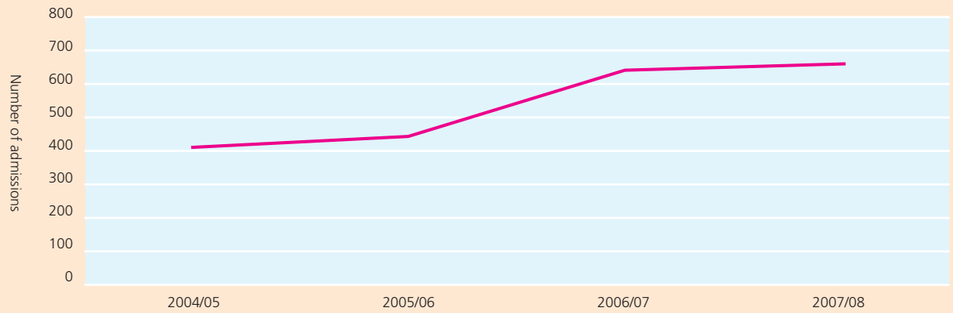
Haringey DAAT continue to attempt to reduce and/or remove these issues in a number of ways. For example, creating woman only sessions in treatment services and providing translation services. Haringey DAAT have recently received funding from the Migration Impact Fund (Government Office for London) to research the needs of street drinkers in Haringey.

However it is difficult to establish which groups are more affected by alcohol misuse and the extent they access services. The definitions of different ethnic groups are very broad, for example, the term 'white other' could refer to someone from Iran as easily as it could refer to someone from Slovenia.

Alcohol services

There are many different treatments available for people concerned with their levels of alcohol consumption. These include services concentrating on medication and counselling. People worried about their drinking or that of anyone close to them, can contact their GP or the Haringey Advisory Group on Alcohol (HAGA), 590 Seven Sisters Road, Tottenham, N15 6HR. Tel. 020 8800 6999; web: www.haga.co.uk.

Figure 25: The rate of wholly alcohol-attributable hospital admissions in Haringey, 2004/05–2007/08



Source: Hospital episode Statistics, 2004–2008

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6.2. Substance misuse

The extent of problem drug use in Haringey

There are approximately 2,700 problem drug users in Haringey.[69] Problem drug use can impact on many areas of an individual's health and social functioning. Links have been shown between problem drug use and mental health, unemployment, crime, family breakdown and homelessness.

In Haringey, drug use problems are concentrated in the east of the borough, with crack use being most prevalent in the north-east. This may be a reflection of the fact that the east of the borough is more densely populated and more deprived.

Drug use and ethnicity

Although the current prevalence data does not specify ethnic group, local evidence shows that Haringey drug treatment agencies are successful in reaching a large number of clients from Black and Minority Ethnic groups.[70] In 2008, there were 1,028 problem drug users in treatment in Haringey.[71] Nearly half (41%) of these individuals classed their ethnic group as non-White.

The London average is 33% (see Table 9). Some Black and Minority Ethnic groups are over-represented both in drug treatment statistics and in the criminal justice system for drug-related offences.[72]

Local data shows that during the 2007/08 financial year White British, Black Caribbean and White Other were the largest ethnicity groups (37%, 15% and 15% respectively)[74] that presented for treatment at drug services. Black Caribbean, Other Black and any other ethnic categories were over-represented in the treatment population in comparison to the total Haringey population.[75] Over 50 different nationalities were represented in treatment in 2007/08.[76] This is a reflection of the diversity within the borough.

In order to avoid stigmatising certain ethnic groups, care needs to be taken when drawing conclusions about illicit drug use or type of crime on the basis of ethnicity or nationality information in isolation. For any intervention to be effective with problem drug use, the focus should be on using a multi-agency approach to tackle the complex issues that surround an individual's use of drugs.

Table 9: Treatment population and ethnicity breakdown by region, 2008 [73]

Overall ethnic group	Mixed %	Asian %	Black %	White %	Other %
Haringey	7%	5%	25%	56%	4%
London	6%	9%	15%	64%	3%
National	3%	4%	4%	83%	1%

Source: National Treatment Agency for Substance Misuse

Drug misuse services in Haringey

In 2007/08 the Healthcare Commission reviewed drug misuse services in Haringey with a specific focus on diversity. Haringey Drug and Alcohol Action Team* (DAAT) and our local drug treatment agencies were awarded a score of 4, which means services were rated as excellent. The Healthcare Commission concluded that Haringey did especially well on:

- Needs assessment and planning that identifies and responds to the needs of diverse populations
- Ensuring that services are planned and provided with consideration and respect for the views of service users and other services.

Haringey DAAT also continues to commission culturally competent agencies such as BUBIC (Bringing Unity into the Community) and Eban. BUBIC is a community support service run by former drug users, most of whom are non-White British. Eban offers specialist treatment for crack and other stimulant users. We plan to continue to develop our drug misuse services with improvements, including:

- Ensuring that better translation services are available to all drug treatment and support agencies by facilitating a skills audit and skills exchange
- Commissioning trainees from diverse communities to develop the workforce
- Facilitating training for staff on cultural competence with the aim of diversifying the workforce when recruiting, for example, by a volunteer scheme.

6.3. Smoking

Smoking as the principal avoidable cause of premature death

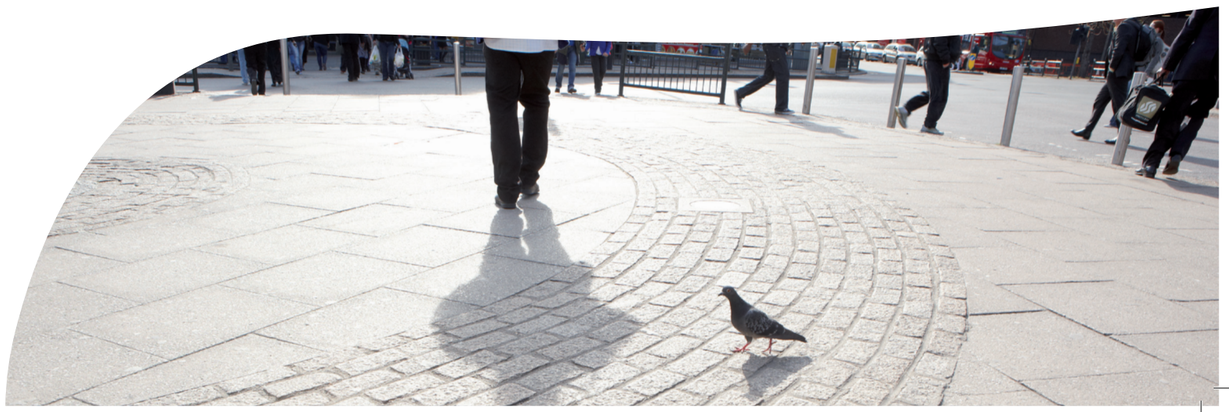
Smoking is a major cause of illness and premature death in England, and also contributes substantially to the inequality in health across the country. It is currently the principal avoidable cause of premature death and ill health in England. Hence, reducing the number of smokers is a key priority in improving the health of the population in Haringey and other deprived boroughs where smoking rates tend to be higher.

Smoking rates in Haringey

Currently there is no data on tobacco prevalence across the borough at ward level and among different population groups. However, modelled prevalence suggests that current smoking prevalence in Haringey is about 28.3% compared to 23.3% in London and 24.1% in England as a whole. Highest smoking prevalence of between 29 and 33% was estimated in Noel Park, Tottenham Green, Northumberland Park, Tottenham Hale and White Hart Lane.[77]

Every year in Haringey, there are 260 deaths related to smoking, which represents about 19% of total deaths in borough and 1,120 hospital admissions, at a cost of over £2.5 million in at 2004.[78]

* The DAAT represents and delivers the work of the Drug and Alcohol Partnership in Haringey.



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Smoking and ethnicity

Available data suggests that there are marked inequalities in smoking between ethnic groups with major gender differences within the groups. In general, the gap between the smoking rate of the general population and that of minority groups in each sex has closed between 1999 and 2004. The rates of smoking in groups with rates above that of the general population, such as Bangladeshi men, Irish men, Black Caribbean men and Irish women, are falling and those with rates below the general population, namely Chinese men, Indian men, Bangladeshi women, Pakistani women, Indian women and Chinese women, are rising.[79]

A national survey published in 2004 found that Bangladeshi men were 43% more likely to smoke compared to the general population. Other groups with higher smoking rates were Irish, Pakistani and Black Caribbean men who were 30%, 8% and 2% respectively more likely to smoke than the general male population. Smoking prevalence was found to be lower in Chinese men and Indian men than the general male population.

Smoking prevalence is lower among women in most minority ethnic groups than the general female population when age was taken into consideration. Compared to the general female population, Bangladeshi, Pakistani, Indian, Chinese, Irish and Black Caribbean women were found to be more likely to smoke. A quarter of Bangladeshi women also chew tobacco.

A report of prevalence of current smoking for major ethnic groups found that respondents from the Black African, Indian, Pakistani, Bangladeshi and Chinese Minority Ethnic groups were less likely to be current smokers than England as a whole, whereas Irish respondents were more likely to be current smokers.

Tobacco control activities

In 2007, NHS Haringey commissioned research on tobacco control activities in Haringey. Data on deprivation, ethnicity, housing condition, health status, income and employment were aggregated to identify postcodes and wards that are likely to have the highest smoking prevalence. These areas were matched against numbers of residents who accessed quit smoking services and were successful quitters at four weeks post attempt. The results suggest that in general the best quitting performance is being achieved in areas and ethnic groups for which the problems are generally not the worst.[80]

6.4. Physical activity

The importance of physical activity to health

Participation in regular physical activity can help to prevent and treat over 20 long-term conditions or disorders, including coronary heart disease stroke, obesity, some cancers, mental health and type II diabetes. The risk of premature death among physically active adults is reduced by 20–30%, and the risk of developing major long-term conditions, such as coronary heart disease, stroke, diabetes and cancers, is reduced by up to 50%.[81]

The vast majority of the adult population in the UK are not active at levels to confer health benefits. The current recommendations for adults for general health are that every adult should achieve a total of a minimum of 30 minutes a day of at least moderate intensity physical activity on five or more days of the week. Children and young people should be physically active to at least a moderate intensity for a total of at least 60 minutes every day.[82]

Haringey recognises the important role of physical activity for improving health and has identified physical activity as a local priority in its overall plan, known as the Local Area Agreement. The Local Area Agreement target is to increase physical activity participation from 22.9% to 26.9% over a three-year period by 2010. No single approach and no single organisation will be able to solve the issue of physical inactivity in Haringey. A multi-pronged approach is needed, which will involve a range of partners, including schools, the NHS, leisure and sports services, the media, and town and transport planners.

National and local data

The national results of the Active People Survey 2007/08 revealed that 21.3% of adults (aged 16 and over) participate in physical activity three times a week for 30 minutes at a moderate intensity, indicating an increase of 0.32% over the past two years.[83] However, London rates fall below these figures at 20.2%, indicating a decrease of 1.1% over the past two years.

A new approach to health and well-being

In January 2009, Haringey formed a Community Sport and Physical Activity Network as part of Sport England's delivery system for sport and physical activity. The core aim of this network is to facilitate the effective strategic co-ordination of sports and physical activity planning and provision to enable all people to have the opportunity to participate in high quality sport and physical activity and therefore reduce health inequalities. The work of this network has a specific focus on improving participation rates among people from ethnically diverse backgrounds.

A similar trend is evident in Haringey, where participation rates have decreased from 22.9% in 2006/07 to 19.8% in 2007/08, although this decrease does not represent a statistically significant change.

Physical activity and ethnicity

Participation in physical activity is less likely in some Black and Minority Ethnic groups. National participation rates among White adults have increased over the past two years from 21.2% to 21.7%%, while participation among non-White adults has decreased from 18.6% to 17.6%.[84]