

Alcohol Consumption and Misuse: Factsheet

Tower Hamlets Joint Strategic Needs Assessment 2010-2011

Executive Summary

- This factsheet covers alcohol misuse among adults (aged 18 years and over) along a continuum which characterises consumption patterns by the volume/frequency of alcohol consumed and the differential impact on related health and social outcomes from hazardous or harmful drinking to dependence. Excess alcohol consumption is associated with a wide range of health and social related harms including increased risk of injury and accidents, heart disease, liver disease, teenage pregnancy, accidents, violence and crime.
 - Although rates of alcohol consumption are low in Tower Hamlets due to a large abstinent population¹, high risk drinking amongst the population who do drink is common; among the white population, 4 in 10 are classified as harmful drinkers compared to 2 in 10 nationally² and the most recent alcohol related admissions data from 2010/11 suggests that the rate of hospital admissions (directly or indirectly) attributable to alcohol was 2289.6 - higher than the London (1911.7) and England (1,895) figures³.
- The 2012-2015 Substance Misuse Strategy (encompassing alcohol and drugs) has recently been launched to combat alcohol related harm across the Tower Hamlets partnership. The work plan associated is undergoing ratification but encompasses actions across the 3 central tenets of the strategy i) behaviour change and prevention ii) treatment iii) enforcement and regulation. A range of different services (provided by both statutory and voluntary sectors) are available in Tower Hamlets in accordance with the evidence base and depending on individual presenting need.
- It is recommended that:
 - The Tower Hamlets Substance Misuse Strategy is robustly implemented through the persistent support and buy in of all partner organisations
 - A mapping and review exercise of the alcohol identification and treatment pathway is conducted to characterise patients seen against need and identify strengths/weaknesses of the current system. Within this:
 - The hospital response to alcohol related admissions/A&E attendances is strengthened⁴
 - A more formal strategy for the identification and brief advice is coordinated to include a review of the alcohol NIS in primary care
 - A strategic partnership alcohol communications campaign is developed

¹ North West Public Health Observatory *Topography of drinking behaviours in England* report, 2011.

² Dr I. Basnett, NHS Tower Hamlets Director of Public Health: Annual Report of the Joint Director of Public Health 2009-10

³ This total includes alcohol-specific conditions (i.e. those that are wholly attributable to alcohol e.g. alcoholic liver cancer) plus conditions that are caused by alcohol in some, but not all, cases (e.g. stomach cancer and unintentional injury). For these latter conditions, different (nationally derived) attributable fractions are used to determine the proportion related to alcohol for males and females. A list of alcohol-attributable conditions with their ICD-10 codes can be found at:

<http://www.nwph.net/nwpho/publications/AlcoholAttributableFractions.pdf> - Tower Hamlets sees a significant rate of hospital admissions for conditions including diabetes or coronary heart disease which, in Tower Hamlets at least, are less likely to be alcohol related, given the consumption profile, and are more likely to be explained by poor diet or a sedentary lifestyle. The reliability of such nationally derived fractions as applied to the Tower Hamlets population, is thus questionable. However, this is the only currently nationally recognized technique used to provide a more complete picture of the true scale of alcohol related harm and no other more reliable indicator exists currently.

⁴ Tower Hamlets has recently submitted a response to the North West Public Health Observatory on *Estimating Consultation on the methods used to estimate alcohol-related hospital admissions for England*.

- A clinical special interest group (SIG) is formed to strengthen clinician involvement in service development and local scientific/medical learning of relevance to the field of alcohol related harm.

1. Alcohol related harm

This factsheet covers alcohol consumption and related harm in adults aged 18 years and over.

Alcohol is a legal drug sanctioned overall by cultural and social norms in the UK. However, some cultures and/or religions e.g. Islam do not approve of the consumption of alcohol. Alcohol is a central nervous system depressant, although in smaller amounts it can have a mild stimulant effect affecting control of judgment and leading to loss of inhibition. The main psychoactive ingredient in alcoholic beverages is ethyl alcohol, produced through the fermentation of sugar by yeast. Within 10 minutes of swallowing, alcohol starts to enter the blood stream through the stomach and small intestine.

Units are a simplified way of stating a drink's alcohol content, usually expressed by the standard measure ABV (alcohol blood volume). ABV is a measure of the amount of pure alcohol as a percentage of the total volume of liquid in a drink. One unit equals 10ml or 8g of pure alcohol, which is around the amount of alcohol the average adult can process in an hour. This means that on consumption of one unit and within an hour there should be little or no alcohol left in the blood of an adult (although this will vary from person to person). One standard glass (175ml) of wine contains approximately 2.1 units (12.5 ABV), a pint of average strength lager contains approximately 2 units (3.6 ABV) and a single measure of spirits (gin, vodka, rum, whisky etc) contains 1.4 units. The NHS recommends that men should not regularly drink more than 3-4 units of alcohol a day and women should not regularly drink more than 2-3 units of alcohol per day (where *regularly* means drinking this amount daily or almost every day).

Alcohol intake can be understood along a continuum which characterises consumption patterns by the volume/frequency of alcohol consumed and the differential impact on related health and social outcomes. Individuals may have varied consumption patterns throughout their lives moving between drinking categories.

Hazardous drinking - A pattern of alcohol consumption that increases someone's risk of harm i.e. exceeding recommended units but not yet experiencing the physical/mental sequelae.

Harmful drinking - A pattern of alcohol consumption that is causing mental or physical damage.

Binge drinking – Understood as consuming 8 or more units of alcohol in a single session for men and 6 or more for women although tolerance and speed of drinking varies from person to person.

Dependence - A cluster of behavioural, cognitive and physiological factors that typically include a strong desire to drink alcohol and difficulties in controlling its use. Someone who is alcohol-dependent may persist in drinking, despite harmful consequences. They will also give alcohol a higher priority than other activities and obligations⁵.

Excess alcohol consumption can lead to a wide range of health related harms. The short-term negative health effects of hazardous drinking can include impaired senses, mood or personality changes, loss of consciousness and an increased risk of injury and accidents, while regular alcohol consumption can lead to heart disease, stroke, liver disease, stomach damage and certain types of cancer⁶. Alcohol consumption can also be linked with risky sexual activity, teenage pregnancy and sexually transmitted infections⁷. It is estimated that up to 35% of all emergency department attendances and ambulance costs are alcohol-related⁸. In England in 2010/11, 1,173,386 alcohol related hospital admissions were seen, an increase of 11% on the 2008/09 figure, where there

⁵ Please refer to: 'Diagnostic and statistical manual of mental disorders' (DSM-IV) (American Psychiatric Association 2000) and 'International statistical classification of diseases and related health problems – 10th revision' (ICD-10) (World Health Organization 2007)

⁶ NHS Choices website. 'The risks of drinking too much' – accessed 4.4.11

⁷ North West Public Health Observatory (2007) Indications of public health in the English Regions 8: alcohol. Liverpool: Association of Public Health Observatories

⁸ Prime Minister's Strategy Unit (2003) Strategy unit alcohol harm reduction project: interim analytical report. London: Cabinet Office

were 1,056,962 such admissions and over double the number in 2002/03 when there were around 510,780 admissions⁹. Consumption of excess alcohol can also lead to premature death. The most recent data suggests that in 2009/10 across England 6,584 deaths were directly related to alcohol with the most common cause of death being alcoholic liver disease.

Wider social harms associated with alcohol consumption include accidents, violence and crime, poor performance at work, unemployment, homelessness or social isolation. The most recent available data suggests that in 2006/07, alcohol was associated with over 500,000 recorded crimes in England¹⁰. It may also be a contributory factor in up to one million assaults and is associated with 125,000 instances of domestic violence¹¹. Up to 17 million working days are lost annually through absences caused by drinking – and up to 20 million are lost through loss of employment or reduced employment opportunities¹². It costs the NHS in England alone up to £2.7 billion a year to treat the chronic and acute effects of drinking¹³. Alcohol-related harm is estimated to cost society more generally between £17.7 billion and £25.1 billion per year¹⁴.

Alcohol-related problems also have a significant contribution to social and health inequalities¹⁵. The adverse effects of alcohol are exacerbated among those from lower socioeconomic groups, as they are more likely to experience its negative consequences; of particular significance to Tower Hamlets. This is not necessarily as a result of drinking themselves, but can be due to other people's drinking. In addition, factors such as a poor diet and a general lack of money mean that people in lower socioeconomic groups who do drink heavily cannot protect themselves as well as those in more affluent groups against the negative health and social consequences¹⁶. Compared with those living in more affluent areas, people in the most deprived fifth of the country are:

- two to three times more likely to die of causes influenced, in part, by alcohol
- three to five times more likely to die of an alcohol-specific cause
- two to five times more likely to be admitted to hospital because of an alcohol-use disorder¹⁷.

1. What is the local picture?

Although rates of alcohol consumption are relatively low in Tower Hamlets due to a large abstinent population, high risk drinking amongst the population who do drink is common. The Tower Hamlets Health and Lifestyle Survey (2009/10) found the following¹⁸:

- 1 in 2 adults have not had an alcoholic drink in the last year but in the white population, 4 in 10 are classified as harmful drinkers compared to 2 in 10 nationally¹⁹
- Of those who do drink, 43% have harmful or hazardous drinking patterns
- Younger residents are more likely to drink than older residents and are also more likely to drink in a harmful

⁹ The NHS Information Centre, Lifestyles Statistics (2011) Statistics on alcohol: England 2011. London: The Health and Social Care Information Centre

¹⁰ Department of Health (2007)

¹¹ Department of Health (2009) 150 years of the annual report of the Chief Medical Officer: on the state of public health 2008. London: Department of Health

¹² Prime Minister's Strategy Unit (2003) Strategy unit alcohol harm reduction project: interim analytical report. London: Cabinet Office

¹³ Department of Health (2008b) The cost of alcohol harm to the NHS in England: An update to the Cabinet Office (2003) study. London: Department of Health

¹⁴ Department of Health (2008a) Safe, sensible, social – consultation on further action. London: Department of Health

¹⁵ Health Profile of England 2008, Department of Health (2009)

¹⁶ NICE Guidelines (June, 2010) Alcohol-use disorders preventing the development of hazardous and harmful drinking

¹⁷ Ibid

¹⁸ Tower Hamlets Health and Lifestyle Survey (2009).

¹⁹ Dr I. Basnett, NHS Tower Hamlets Director of Public Health: Annual Report of the Joint Director of Public Health 2009-10

or hazardous way than older residents

- Men are more likely to drink than women (54% vs 45%) and are more likely to drink at hazardous or harmful levels (24% vs 19%)
- In the white ethnic group, 40% are classified harmful drinkers or at possible risk of harm compared to 20% nationally
- Migrants (defined as respondents who had changed address in the previous year) are significantly more likely to be drinkers than non-migrants (68% vs 46%) and to have patterns of 'risky drinking' (35% vs 19%). This remains the case when the analysis is restricted to the white population. 51% of migrants drink at hazardous or harmful levels compared to 34% of non-white migrants. The highest levels are seen in migrants of white ethnicity from outside the borough but within the UK (60%)
- Hazardous and harmful drinking is more common among people who are employed than those who are unemployed (30% and 9% respectively) and among those who are educated (GCSEs or above) compared to those with no qualifications (27% and 9% respectively among all residents and 44% and 19% in the white population)
- Alcohol consumption is unusual in that it is against the social gradient, i.e. consumption is highest in the most affluent groups. However, alcohol-related harm (and hence alcohol-related admissions) is with the social gradient, i.e. harm is greatest in the least affluent groups. Given the levels of deprivation in the borough, admission rates might be expected to be higher but this is confounded by the relatively low alcohol consumption rates among the Muslim (predominantly Bangladeshi population) of the borough.

Other sources indicate that:

- 10.9% of the Tower Hamlets adult population are estimated to binge drink; substantially less than the London and National population (London 14.3% and England 20.1%)²⁰
- The 2004 National Alcohol Needs Research Project (ANARP)²¹ concluded that the overall national prevalence of alcohol dependence was 3.6% which when crudely applied to Tower Hamlets population projections for 2012 (GLA population 2012 round population projections indicate a total of 191,650 over 18 year olds) suggests a total of in the region of 6,900 dependent drinkers locally. 2008 data suggests that the number of higher risk drinkers²² in Tower Hamlets could be as much as 14.1%²³ of the total population of drinkers (the 3rd highest in London after Harrow and Hounslow).
- Most recent alcohol related admissions data from 2010/11 suggests that the directly standardised rate of hospital admissions (directly or indirectly) attributable to alcohol was 2289.6 (less than neighbouring Newham at 2760.2 but higher than Hackney at 2158.4 admissions per 100,000 population. The Tower Hamlets admission rate is also higher than the London (1911.7) and England (1,895) figures²⁴.

²⁰ Percentage of adults that binge drink (2011) taken from Small Area Indicators for Joint Strategic Needs Assessment. Developed by Association of Public Health Observatories for Department of Health (2010)

²¹ Alcohol Needs Research Assessment. The 2004 national alcohol needs assessment for England. Department of Health (2005)

²² Higher risk is defined by: Men who drink regularly over 8 units per day or over 50 units per week and women who regularly drink over 6 units per day and over 35 units per week.

²³ North West Public Health Observatory Topography of drinking behaviours in England report, 2011.

²⁴ This total includes alcohol-specific conditions (i.e. those that are wholly attributable to alcohol e.g. alcoholic liver cancer) plus conditions that are caused by alcohol in some, but not all, cases (e.g. stomach cancer and unintentional injury). For these latter conditions, different (nationally derived) attributable fractions are used to determine the proportion related to alcohol for males and females. A list of alcohol-attributable conditions with their ICD-10 codes can be found at: <http://www.nwph.net/nwpho/publications/AlcoholAttributableFractions.pdf> - Tower Hamlets sees a significant rate of hospital admissions for conditions including diabetes or coronary heart disease which, in Tower Hamlets at least, are less likely to be alcohol related, given the consumption profile, and are more likely to be explained by poor diet or a sedentary lifestyle. The reliability of such nationally derived fractions as applied to the Tower Hamlets population, is thus questionable. However, this is the only currently nationally recognized technique used to provide a more complete picture of the true scale of alcohol related harm and no other more reliable indicator exists currently.

- In Tower Hamlets the most recent available data suggests that between 2008 and 2010 deaths specifically relating to alcohol were seen at a rate of 13.9 among men, compared to 10.7 in London (and 13.16 in England) and 3.56 among local women compared to rates of 4.03 across London (6.04 in England)²⁵.
- Alcohol related crime in Tower Hamlets is seen at a rate of 12.64 compared to a regional average of 11.1 and is marked as significantly worse than the England average (7.0)²⁶.

²⁵ Taken from North West Public Health Observatory, Alcohol Health Profiles 2011 <http://www.lape.org.uk/data.html>

²⁶ Ibid.

2. What are the effective interventions?

National Strategy

In March 2012, the Coalition Government presented The Government's Alcohol Strategy which set out a series of national and local recommendations for action to tackle alcohol related harm. Such actions include:

- Reducing the availability of cheap alcohol through the introduction of a minimum unit price
- Tightening controls over the way alcohol is marketed and advertised e.g. reviewing commitments within the Mandatory Code for Alcohol and working with the Responsibility Deal to ensure responsible sales and marketing of alcohol
- Granting greater power to licensing authorities to make it easier for them to refuse, revoke or impose conditions on a license
- Maximising penalties for premises who persistently sell to minors or drunks
- Empowering hospitals to take action against A&E alcohol related violence
- Commissioning the delivery of alcohol screening and brief advice by health professionals and recruitment of alcohol nurse specialists in hospitals for those with alcohol related presentations or needs
- Supporting delivery in schools of education and early intervention in young people affected by alcohol
- Reviewing guidance on alcohol to improve public understanding of personal risk.

Prevention/Promotion and Early Detection

In June 2010, the National Institute for Health and Clinical Excellence (NICE) released public health guidance to support the [prevention of development of hazardous and harmful drinking](#) at a policy and local practice level.

Policy recommendations include:

- a) reviewing policies on pricing to reduce the affordability of alcohol
- b) making it less easy to buy alcohol, by reducing the number of outlets selling it in a given area and the days and hours when it can be sold
- c) protecting children and young people by strengthening current regulations relating to marketing of alcohol products

Practice recommendations are:

- a) a series of references to strengthening the response from licensing authorities by making better use of local intelligence and resources to limit the number of new licensed premises and tackle underage sales
- b) implement screening (using validated tools e.g. AUDIT, SAS-Q, PAT etc appropriate to the setting and target audience) and brief interventions (using a FRAMES approach) for those at risk and those already affected by alcohol related harm i.e. hazardous and harmful drinkers and make provision for appropriately resourced tiers 2-4 services recommended in Models of Care for alcohol misusers²⁷
- c) consider extended interventions for those who do not respond to brief advice/interventions and consider a referral to specialist services for those who show signs of dependence or do not respond to brief advice/extended advice.

High quality care and treatment of adults affected by alcohol misuse

To achieve the best possible outcomes, adults affected by alcohol misuse should:

- Have timely access to high quality services as defined by [National Institute for Health and Clinical Excellence](#) (NICE) clinical guidance CG115 and CG100; Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence and Alcohol-use disorders: diagnosis and clinical management of alcohol-related physical complications (covering acute unplanned alcohol withdrawal including delirium tremens, alcohol-related liver damage, alcohol-related pancreatitis and management of Wernicke's encephalopathy)
- Receive the most appropriate treatment for their condition, which is delivered to a high standard as well as being cost effective. An NTA (National Treatment Agency) review²⁸ of the effectiveness of treatment for alcohol problems concluded that:

²⁷ Department of Health (2006) Models of care for alcohol misusers (MOCAM). London: Department of Health.

²⁸ Raistrick D, Heather N, Godfrey C (2006) Review of the effectiveness of treatment for alcohol problems. National Treatment Agency

- treatment for alcohol problems is cost effective; for every £1 spent on treatment, £5 is saved elsewhere e.g. health, social care and criminal justice systems
- interventions of all kinds are only effective if delivered in accordance with their current descriptions of best practice and carried out by a competent practitioner
- stepped care is a rational approach to developing an integrated service model that makes best use of resources.

3. What is being done locally to address this issue?

A new substance misuse strategy (the first local strategy to encompass both alcohol and drugs) for 2012-2015 has recently been launched (July 2012). The strategy is based on three 'central pillars' of action: i) prevention and behaviour change, ii) treatment, and iii) enforcement and regulation. These 3 areas encompass the holistic approach taken in Partnership across the borough by the full range of statutory and voluntary partners and which aims to help individuals to choose not to abuse alcohol or drugs, encourage those who do so to engage in treatment, and to target and punish those who sell illegal substances in the borough. The Strategy draft action plan details the range of commitments made by the Tower Hamlets partners (including London Borough of Tower Hamlets Council, the NHS, Police and voluntary sector agencies, among others) to tackle alcohol related harm proactively and includes amongst its suite of commitments: delivery of a comprehensive alcohol harm communications strategy, expansion of screening and brief interventions (including in probation services) and continued delivery of evidence based structured education to children and young people on the subject of alcohol related harm.

Alcohol Awareness Week, a (national) annually occurring campaign, provides the platform for a local focus on alcohol related harm. The principal objective of the week is to raise awareness of services and sources of advice and support locally. Typically a range of events are held across both statutory services and in the community to maximise the reach of locally appropriate messages. The advent of the new Substance Misuse Strategy heralds an opportunity to expand provision of such campaigns and to ensure these are joined up and consistent across the partnership.

A range of different services are currently commissioned by Tower Hamlets DAAT (Drug and Alcohol Action Team) on behalf of London Borough of Tower Hamlets Council and North East London and the City NHS. Such services provide an escalating level of care and intervention depending on the identified need of the presenting individual. Services are described below:

- Four Health Trainer organisations across the borough provide advice and support to members of the public regarding healthy lifestyles, including alcohol consumption. Health Trainers are lay members of the community who have received specific training in the delivery of low level/threshold advice and support packages across a range of different health and social themes.
- A dedicated substance misuse (including alcohol) specialist midwife based at the Royal London Hospital provides support to pregnant women and their families affected by alcohol (and/or more specifically by foetal alcohol syndrome), support throughout the pregnancy, management of the affected foetus and post-partum support to mother and child.
- An alcohol network improved service (NIS) across 33 primary care practices delivers a stepped package of care which commences with the stratification of the patient's risk and alcohol related need using the AUDIT-C tool²⁹. Depending on the AUDIT-C score, the patient may then be offered a brief intervention or be a potential candidate for detoxification which is most usually delivered in partnership (and in the context of the shared care scheme) between the primary care GP and the Tower Hamlets Community Alcohol Team (THCAT).
- THCAT are commissioned to deliver an integrated system ranging from education and brief intervention for non-problematic drinkers to community detoxification and pathways into residential treatment for

²⁹ <http://www.alcohollearningcentre.org.uk/Topics/Browse/BriefAdvice/?parent=4444&child=4898> – accessed 20/09/2011

dependent drinkers. Clients can be referred by a range of providers including GPs, statutory drug services, self/relative, social services, arrest referral/DIP team, probation etc. THCAT provide comprehensive assessment, community detoxification or pathways into residential detox, counselling for up to 12 weeks, one-to-one key work sessions, brief interventions, structured groups, peer support etc.

- Island Day Programme are commissioned to provide structured abstinence-based day programme for drug and alcohol users following the 12 step model for Tower Hamlets residents over the age of 18. The programme also offers one to one counselling and an aftercare programme.
- A dedicated Alcohol Nurse Specialist (ANS) service is provided through the Royal London Hospital for all adult patients whose admission or A&E attendance is alcohol related. Patients are screened for their alcohol consumption using the PAT (Paddington Alcohol Test³⁰) and, depending on the outcome, may then be offered a series of brief intervention sessions and/or referral to other specialist substance misuse services or wider social or health services. The ANS service provides support and training to hospital staff in managing patients in withdrawal or who may require detoxification as well as support to staff in identifying the full spectrum of alcohol related harm. The service has successfully developed a hospital alcohol withdrawal policy, now ratified, and a local hospital alcohol strategic group consisting of outreach workers, social work teams, inpatient staff and hostel staff provides an opportunity to raise the profile of alcohol related among generalist providers and to discuss opportunities for learning and training as well as commonly encountered problems among those alcohol related admissions.
- The Tower Hamlets outreach team's remit has recently been re-directed to focus on DIP (Drug Intervention Programme) i.e. criminal justice clients. The team typically work with the most challenging and hard to reach individuals who struggle to engage with (drug and) alcohol treatment, typically working with them on the street and wider community to support their re-integration into society and ultimate rehabilitation.
- A range of different providers are commissioned on a predominantly 'spot' or 'block' basis to provide inpatient detoxification and residential rehabilitation(i.e. Tier 4 services) in and out of borough to Tower Hamlets residents identified as in need of a residential intervention.
- A range of other services from the voluntary sector e.g. AA (Alcoholics Anonymous) provide structured and/or informal support to individuals through peer mentors, structured group or individual programmes
- Treatment agencies are alert to the possibility of alcohol related harm affecting a child or young person (so called 'hidden harm') and the potential need to pursue safeguarding protocols. Dedicated programmes are available locally which provide support to the wider family affected e.g. Breaking the Cycle and MPACT. Further information regarding the Tower Hamlets approach to hidden harm can be found in the Hidden Harm Strategy which prioritises training of staff, clear referral and management protocols and has at its heart robust partnership working.

4. What evidence is there that we are making a difference?

A range of services across the borough fulfil best practice guidance in terms of both the types of service and the nature of interventions and support delivered. To demonstrate the effectiveness of investment in this area would require more robust measures of uptake, outcomes and progress across the full range of services.

Available data is set out below:

Strategic:

- The development across the partnership of a new substance misuse strategy (encompassing both alcohol and drugs) is indicative of the significance placed on alcohol related harm and the commitment by all member organisations including the Police, probation service, local Council and NHS to proactively work together to reduce the negative impact of alcohol on the individual, family and wider community
- A training event targeting Imams and focusing on alcohol harm reduction was held in Spring 2012 resulting in over 60 Imams attendance and the identification of a need for more regular training regarding (drugs and)

³⁰ <http://www.alcohollearningcentre.org.uk/Topics/Browse/Hospitals/EmergencyMedicine/?parent=5168&child=5169> – accessed 20/09/2011

alcohol for this community group. Plans are underway to develop a sermon pack for the Imams to expand community education and support in this field

Primary care/community care:

- The most recent data from primary care suggests that during 2011/12, 30,843 individuals were screened for their alcohol consumption, a significant increase on the previous years' figures which have remained consistently between 25,000-26,000 individuals
- The latest more detailed data from 2010/11 suggested that approximately ¼ of individuals screened were classed as hazardous/harmful drinkers (less than would be expected from the Health and Lifestyle Survey) however, approximately 38% of all those screened received some form of brief advice regarding their alcohol consumption
- Data from 2010/11 suggests that 553 adult clients were seen in structured alcohol treatment services (THCAT). Numbers in treatment remain consistently high year on year

Acute care/hospital:

- The ANS service was recently evaluated and data suggests that the service supported 1137 individuals (over 2066 individual patient episodes) between January 2010 and December 2011. 78% of all episodes were among white patients, 7% among Asians and 9% among other ethnic groups – more could be done to attract individuals from specific demographic groups e.g. older patients, young men and hazardous/harmful drinkers
- Between 2010/11 and 2011/12, among the top 33 A&E frequent 'alcohol related' attendees, there was a 55% reduction in the number of ANS attendances and among patients known to the Brief Intervention (BI) clinic, only 4.3% returned/ re-referred following a BI
- A series of recommendations were made following the evaluation and these should be prioritised for implementation this year.

5. What is the perspective of the public on support available to them?

A focus group of approximately 25 current clients of the Tower Hamlets community alcohol team was convened at the end of 2011 and a series of recommendations to improve services were volunteered. Among those on the detailed list and relating to perceived gaps in services and/or needs among service users were:

- The development of clear local communication campaigns were welcomed as the national guidance regarding volume and frequency of recommended or 'safe' alcohol consumption was felt to be unclear and occasionally contradictory
- Those recently engaged with treatment requested greater say regarding their treatment pathway options – towards abstinence or controlled drinking - and felt that the latter was not always advocated. Service users were also keen to see greater clarity regarding what treatment entails and what medical/clinical interventions are available
- Wider health issues associated with excess alcohol consumption were a real concern for many service users who requested more information regarding associated health problems and sources of advice and support for these
- The potential for relapse was a source of great anxiety for some service users who were keen to see additional support regarding relapse prevention therapy and outpatient counseling. Greater clarity regarding who to contact in the event of a crisis or emergency regarding care was also suggested
- Residential rehabilitation was the focus of an extensive discussion among users who wanted to know more about the requirements, thresholds for consideration, length of stay, location(s) and price – if paying privately was an option.

6. What more do we need to know?

- The extent to which unmet need correlates with met need – are any specific population groups (either demographic or alcohol related need based) under or over represented in alcohol treatment?
- Public/patient perspectives of services is captured informally and needs to be more formally structured

across the pathway to include primary care, A&E (alcohol nurse specialist), THCAT and Tier 4

- Age standardised alcohol A&E attendance rates and admission rates (using a more robust and locally appropriate methodology than attributable fractions) across all equality strands are needed. This would provide a useful profile of individuals who are potentially less likely to come into contact with either primary care, or specialist substance misuse services and enable the targeting of resources appropriately
- A refresh of the local Health and Lifestyle Survey is needed to strengthen local understanding of alcohol consumption patterns and alcohol related need
- What else can we do to reduce the prevalence of hazardous/harmful drinking among the local population, particularly among those for whom such behaviour is entrenched?

7. What are the priorities for improvement over the next 5 years?

- The implementation and continued responsiveness of the Tower Hamlets Substance Misuse Strategy through the persistent support and buy in of all partner organisations
- The mapping and review (across all equality strands) of the alcohol identification and treatment pathway and alcohol related data in Tower Hamlets to characterise patients seen against need and identify the strengths and weaknesses of the current system
- The strengthening specifically of the hospital response to alcohol related admissions/A&E attendances further to the evaluation of the Alcohol Nurse Specialist (ANS) service. Providers will need to be mindful of the predicted increase in hazardous/harmful alcohol consumption as the local demographic evolves and of the impact this is likely to have on local resources
- The development of a more formal strategy for the expansion of identification and brief advice to people at risk of alcohol related harm (which should include probation services) to include a review of the alcohol NIS in primary care to inform GP networks and CCG on progress and identify areas of key learning
- The development of greater local understanding of alcohol related harm among the general population of Tower Hamlets, including local service users, through a strategic alcohol communications campaign e.g. including Imam training, provision of locally appropriate information campaigns, research/development or social marketing where appropriate and training of frontline workers in identification and referral to specialist providers
- The implementation of a clinical special interest group (SIG) focusing on drugs and alcohol to strengthen and formalise clinician involvement in service development and local scientific/medical learning of relevance to the field of alcohol related harm.

8. Key Contacts

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