ISLINGTON

NHS North Central London

ANNUAL PUBLIC HEALTH REPORT 2012

One too many?
The impact of alcohol in Islington

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Foreword

Welcome to Islington's Annual Public Health Report for 2012. In this year's report we focus on the impacts of alcohol and what needs to be done to reduce the effects of alcohol-related harm on those living, working and socialising in Islington.

As the health service prepares for unprecedented change, public health responsibilities at a local level will be moving from their current home in Primary Care Trusts to local authorities. The public health movement over generations has made some of its greatest improvements to health and wellbeing in this wider context – improvements to the environment, housing and transport have been led largely by local government. It is in this wider role that Directors of Public Health and their teams will join local authorities on 1 April 2013 and hope to bring that wider influence to bear on local policy and service development to support improvements in health.

In this context, this years Annual Public Health Report has focused on an issue that needs a multi-sector approach to improvement, something that will be supported by the new role the London Borough of Islington has in public health and through the work of the newly established Health and Wellbeing Board. The subject of this report is alcohol.

Responsible for significant use of NHS resources whether at accident and emergency departments or in general practice, welfare support, housing and social care as well as police and fire services, alcohol is costing the Borough significant amounts of money every year. Alcohol contributes to health problems, antisocial behaviour and stress for those involved with people who drink at higher than recommended levels. Some of the impacts are obvious – binge drinking and antisocial behaviour on Friday and Saturday nights for example, but much of it is not so apparent to most people. Impacts that particularly affect children and families, such as domestic violence and in some cases neglect, as well as long term health problems that occur as the result of excessive drinking, are less obvious.

The report attempts to uncover all aspects of alcohol-related harm, whether overt or hidden, individual or societal and make some suggestions for action that would help to improve outcomes for people in Islington.

I hope that the analyses contained within the report will help groups across the Borough to work together to address inequality and disadvantage associated with alcohol-related harm which is felt by those who drink too much, as well as by those who live and work with them.

I would like to thank everyone involved in the production of this report, as always, it has involved the work of many people both within the public health department and our partners. I would particularly like to mention Charlotte Ashton who, in her first year in Islington, has brought both enthusiasm and determination to her work on alcohol policy, writing chapters and ensuring everyone made their contributions in a timely and focused manner.

Finally, I hope you find the report interesting and if you have any comments or suggestions we would be keen to hear from you.

Sarah Price

Director of Public Health
Islington
October 2012

Executive summary

Alcohol: Why the focus?

Alcohol has an important and positive role in British culture and is used widely in our social and family life. It also plays an important role in our economy. The UK's alcohol drinks market is estimated to be worth more than £30 billion per year and is a significant part of Islington's thriving night time economy, contributing to employment and economic development. The vast majority of people enjoy alcohol without causing any harm to themselves or others. However alcohol is a toxic substance that can have a detrimental effect on nearly all parts of the body. Increasingly, alcohol is becoming a significant cause of personal, social and economic harm.

Although in recent years there has been an overall decline in consumption, this is not consistent across all age groups. There are economic, health and social consequences of alcohol-related harm and a strong link with deprivation. Often the negative effects of alcohol are felt by someone other than the person who has been drinking, for instance children.

Social and economic impact

- Social impacts of alcohol use are often hidden. Children and families of problem drinkers are particularly affected.
- In 2011/12, 114 adults (36%) presenting to alcohol services for the first time in Islington had contact with children, either as a parent or by living in a household with children.
- Of 1,356 domestic violence offences reported in Islington in 2011/12, 607 were identified as alcohol-related.
- Alcohol-related harm imposes significant economic costs on society. Nationally, the economic cost was estimated as at least £25.1 billion in 2008. In Islington the cost was estimated at £230 million (2007/08). Alcohol-related admissions cost the equivalent of £39 per resident in Islington in 2008/9.

Crime, anti-social behaviour and alcohol availability

- Islington has the third highest density of licensed premises in inner London, with over 1,200 licensed premises in total.
- There were over 1,900 reported alcohol-related offences in Islington in 2011/12. In addition, it is likely that there are a substantial number of unreported alcohol-related crimes.
- Alcohol-related crime most commonly occurs at night, up to midnight on Sunday to Thursday, and up to 04:00am on Saturday and Sunday, reflecting the periods when bars and nightclubs are at their busiest.

Public opinion

- Londoners' top concerns about alcohol-related harm are crime and anti-social behaviour – in a recent survey 64% of people in Islington said they were concerned or quite concerned about alcohol-related crime and violence.
- About half of Londoners surveyed said they were worried about the long-term health impacts of alcohol.

Health and health services

- Alcohol contributes to one in twenty deaths in Islington.
- Alcohol-specific death rates are highest in Islington residents under 65 years.
- Islington has the highest rate of alcohol-related admissions in London. Those living in the most deprived areas of Islington are approximately a third more likely to have an alcohol-related admission compared to those living in the more affluent areas.
- Of people admitted to hospital due to an alcohol-specific reason, over a quarter were admitted two or more times over a one year period, and 2% were admitted six or more times.
- People with alcohol misuse problems often face the additional challenges of unemployment, homelessness or housing issues, health problems and multiple drug use. In Islington, of those in alcohol treatment services, 21% report drug use and 17% a mental health problem.

How does Islington compare?

Of those who drink alcohol in Islington, estimates indicate 21% drink at increasing risk levels and 7% at high risk levels – similar to London & England.

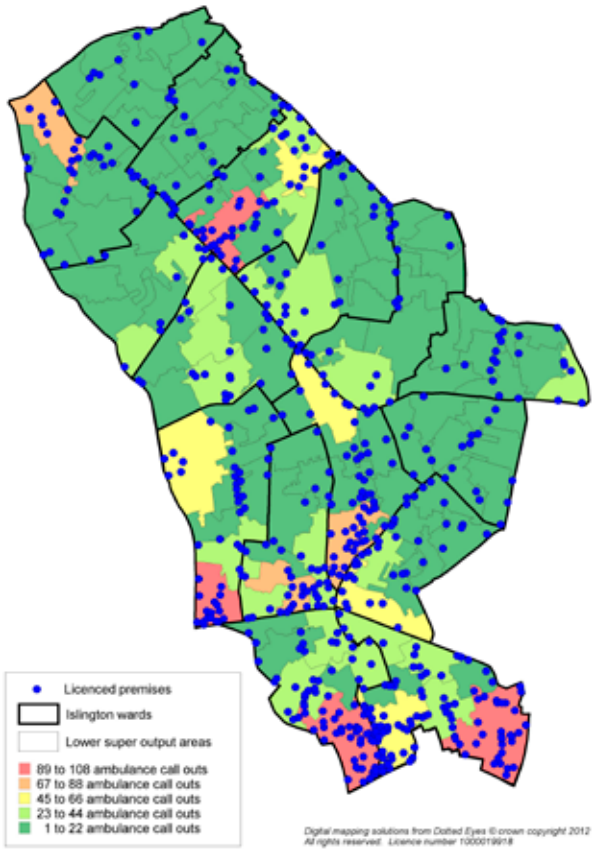
1 in 5 drinkers in Islington binge drink, higher than in London but similar to England.

Islington has one of the highest densities of licensed premises in London.

Generally, as density of licensed premises in Islington increases so does the number of ambulance callouts (shown on map) and also levels of alcohol-related crime.

The most deprived areas of the borough experience significantly higher rates of alcohol-related hospital admissions compared to less deprived areas.

Licensed premises and alcohol-related ambulance callouts across Islington, 2011/12



Highest rate of alcohol-related hospital admissions in London.[2011/12]

3rd highest rate of alcohol-specific mortality in men in London.[2008/10]

5th highest rate of alcohol attributable violent crime in London.[2011/12]

3rd highest rate of incapacity claimants whose main medical reason is alcoholism in London.[August 2011]

Taking action

Alcohol-related harm affects many different areas of everyday life, spanning multiple settings and environments. A joined up, strategic approach, which includes statutory, community and voluntary organisations, is essential to successfully reduce the significant harms associated with alcohol. The following are suggested as the top five actions for Islington:

1. Increasing awareness: Understanding of alcohol to be increased locally through the provision of clear, sensible advice around what is low risk drinking and why this is important.

2. Screening & brief intervention: Innovative approaches for the provision of identification (screening) and brief advice (IBA) and alcohol liaison models to be expanded and developed.

3. Strengthening enforcement: Recent changes in licensing regulations to be used to further strengthen the approach to managing alcohol availability locally.

4. Accessible treatment services: For those who need it, ease of access to alcohol treatment services that are fit for purpose to be improved.

5. Collaborative working: Building on work already occurring locally, to ensure there is a strong partnership approach to maximise alcohol harm reduction, including enforcement of licensing regulations, IBA and high quality treatment services.

Introduction

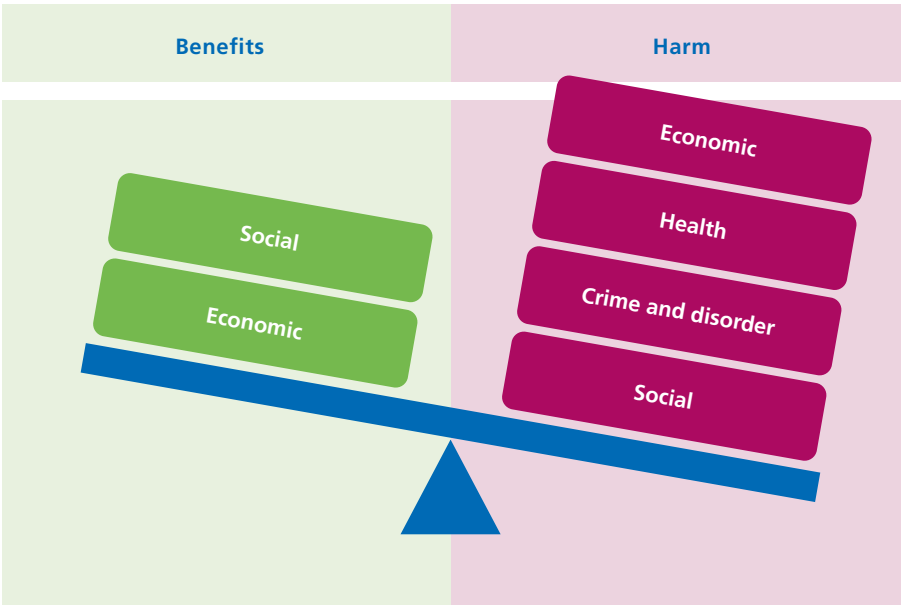
Contents

Alcohol: Why the concern?

Alcohol is the most widely used drug in the world: it has an important and positive role in British culture and is used widely in our social and family life, adding to the enjoyment of special occasions and time spent with friends[1]. It also plays an important role in our economy: the UK's alcohol drinks market is estimated to be worth more than £30 billion per year and generates tax revenue of over £13 billion per year[2]. Alcohol is an important part of Islington's thriving night time economy, which contributes to employment and economic development within the Borough. The vast majority of people enjoy alcohol without causing any harm to themselves or others. As a consequence it is important that any action taken to reduce the harmful effects of alcohol also takes account of the positive role alcohol can play within our community **(figure A)**.

Social customs and economic benefits should not be used to ignore the fact that alcohol is a toxic substance that can have a detrimental effect on nearly all parts of the body[3]. With the increased availability of alcohol over the last thirty years[4] as a result of changes in licensing, accessibility, and affordability, there has been a noticeable upward trend in consumption[5]. Increasingly, alcohol is becoming a significant cause of personal, social, and economic harm.

Figure A Weighing up the risks – benefits and harms of alcohol



Nationally, more than 10 million people drink above government guideline levels and there are a significant and increasing number in whom alcohol consumption is becoming a major cause of harm[2]. The resulting burden is felt across the NHS, public services, the local economy and the wider community.

Alcohol affects everyone in Islington in a multitude of ways. It is not necessary to be a dependent drinker to experience alcohol-related problems, and in many cases people do not realise the amount they are drinking could actually be having a detrimental effect on both themselves, those

close to them and the wider community. Reasons for this include the fact that drinking is generally socially tolerated and because many of the impacts such as liver disease and high blood pressure may not be visible until serious damage has already occurred[6]. Alcohol can therefore be considered as a cause of silent harm, and it is not necessarily the heaviest drinkers that account for most of the alcohol-related burden experienced within the population as a whole[3].

There are economic, health, and societal consequences of alcohol consumption, and a strong link with deprivation **(figure B)**. Many of these effects are felt by someone other than the drinker, for instance noise, traffic accidents and domestic violence can all be considered 'external consequences' of alcohol consumption[3].

It is against this increasing realisation of the detrimental impact of alcohol both on individuals and the population that alcohol has been chosen as the subject of Islington's 2012 Annual Public Health Report. The remainder of this introductory chapter outlines some of the impacts that alcohol has across the community, at all stages of life.

THE NATIONAL AND LOCAL IMPACT

Alcohol-related harm in Islington is significant and a particular cause for concern. Analysis produced by the North West Public Health Observatory[9], highlights how in a number of areas Islington is experiencing some of the greatest levels of alcohol-related problems in London **(figure C)**. How Islington compares against these indicators is examined in greater detail in later chapters.

Figure B The multiple effects of alcohol-related harm

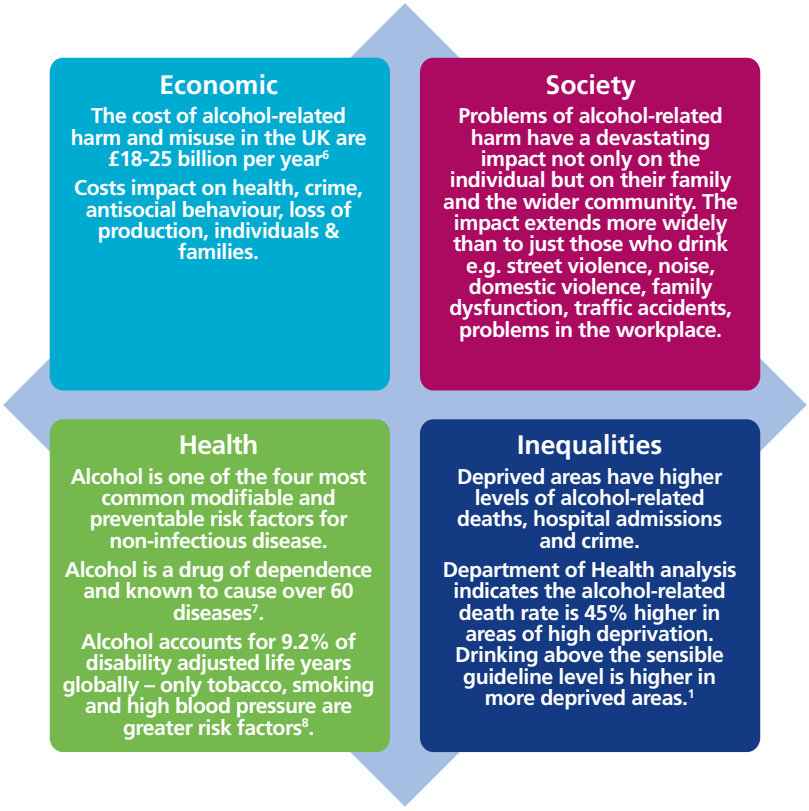


Figure C The impact of alcohol in Islington

Source: North West Public Health Observatory, 2012[9]

THE IMPORTANCE OF ALCOHOL ACROSS AGE GROUPS

The impacts of alcohol are seen across all age groups **(figure D)**. In absolute terms it is in middle age where alcohol-related deaths are greatest. However, exposure to alcohol during pregnancy can impact on brain development of the foetus and is also associated with intellectual defects that are not seen until later in childhood[3].

Alcohol can have a particularly negative effect on young people. There are concerns that a high level of alcohol consumption in those under 18 years is associated with high risk behaviour including unprotected sex and offending. It can lead to missed education, which in turn can result in the young person not reaching their full social and economic potential. The adolescent brain is particularly susceptible to alcohol[10]. Among 35 European countries, the UK has the third highest percentage of 15 year olds (24%) who have been drunk at least 10 times in the past year[10].

In the workplace harmful alcohol use and heavy episodic drinking causes problems such as absenteeism, presenteeism (lower productivity at work) and inappropriate behaviours[10].

Although alcohol consumption appears to reduce with increasing age, there is evidence that older people today maybe be heavier drinkers than previous generations. Tolerance of alcohol is significantly lower in older people, and as a result it can have a more detrimental effect. Alcohol depresses brain function, resulting in impaired coordination and memory which can result in falls and general confusion. The effect of alcohol and alcohol-related problems in older people can also obscure non-specific health problems such as gastrointestinal problems, or result in alcohol-related behaviours being misdiagnosed as dementia or depression[11].

Figure D The effects of alcohol at different ages

Report overview

The report is split into eight chapters. The subsequent chapters explore, in more detail, the various aspects of everyday life where alcohol has an effect on both the individual and the wider community.

If the impacts of alcohol-related harm are to be truly tackled, partnership work across health, policy, licensing, education and communities is essential. This is a theme that is embedded through this report.

Chapter one sets the scene, explaining some of the key terms used throughout the report. The chapter explores how nationally and internationally alcohol has been identified as a priority.

'Nationally the level of alcohol consumption has increased by around 30% since the early seventies'[4]

Chapter two reviews patterns of drinking, how these change with age and the triggers that can change alcohol consumption. The role of discussion and advice to identify increasing risk drinking and to support changes in behaviour around alcohol consumption in a range of settings (known as identification and brief advice) is discussed.

"Alcoholism is hidden because it's legal – it's swept under the carpet" Girl aged 13[12]

Chapter three investigates the social impact of alcohol, looking at a number of areas of everyday life that are affected by alcohol. For instance the impact on families, children, employment and the economy, and the effects an individual's drinking has on others. The chapter explores the evidence for what works in supporting families affected by alcohol misuse, the workplace and children and young people who misuse alcohol.

Hospital admissions attributed to alcohol in 2008/09 cost the NHS in London an estimated £264 million, or £34 for every London resident[13]

Chapter four reviews the effects of alcohol on health, assessing how alcohol misuse impacts on general practice and hospitals. The chapter also looks at alcohol-related deaths and the use of treatment services to support those who are dependent drinkers or drinking at high risk levels. The evidence of the effectiveness of different types of intervention (such as alcohol liaison workers) to support those drinking at higher risk levels, is reviewed.

The number of licensed premises (both on and off licences) in England and Wales increased by more than 20% between 1980 and 2010[14]

Chapter five examines how control and availability of alcohol impacts on the population. The number of licensed premises in Islington and compared to elsewhere is quantified. The chapter assesses whether there is any relationship between number of licensed premises and levels of hospital admissions or ambulance call-outs. The evidence for introducing a minimum price per unit and recent changes to licensing laws is discussed.

'Nationally, in around half of all violent crimes, the victims believed their attackers had been drinking, whilst 37% of domestic violence cases involve alcohol'[15]

Chapter six looks at crime and anti-social behaviour occurring as a result of alcohol. The chapter reviews the impact of violent and non-violent crime as well as the impact of alcohol on the prison population. The relationship between alcohol-related crime, alcohol-related ambulance call-outs and hospital admissions is examined. The evidence base for preventing alcohol-related offending and working with those in contact with the criminal justice system is assessed.

Chapter seven presents the case for change and recommendations going forward. It brings together the key findings from earlier chapters and makes practical recommendations for how collaborative working can be used to reduce the impact of alcohol-related harm in Islington.

SUMMARY

Making alcohol a focus for local action is vital because alcohol misuse is a major contributor to a range of health and social problems. The impacts are felt not only by those who drink at levels which put themselves at risk, but also by their families and the community as a whole. Alcohol affects people at all ages from before birth through to old age. This year's Annual Public Health Report aims to look across the range of areas where alcohol has an impact and develop recommendations to tackle the detrimental effects felt by people living, working and socialising in Islington.

References

[1] Department of Health, Home Office, Department for Education and Skills, Department for Culture, *Media and Sport. Safe. Sensible. Social. The next steps in the National Alcohol Strategy,* 2007

[2] National Audit Office. *Reducing alcohol harm: health services in England for alcohol misuse,* HC 1049 Session 2007-08, 2008

[3] Babor T, Caetano R, Casswell S et al. *Alcohol no ordinary commodity.* Oxford: Oxford University Press, 2010

[4] OECD. *OECD.StatExtracts non medical determinants of health: alcohol consumption*, http://stats.oecd.org/index.aspx?queryid=24879, 2012 (Accessed July 2012)

[5] NHS Confederation. *Too much of the hard stuff: what alcohol costs the NHS,* Briefing, Issue 193, 2010

[6] Department of Health. *Signs for Improvement – commissioning interventions to reduce alcohol-related harm*, 2009

[7] Anderson P. *The impact of alcohol on health*. In: Anderson P, Møller L, Galea G (eds.) *Alcohol in the European Union consumption, harm and policy approaches*, WHO Europe; 2012. p5-9

[8] WHO. *The world health report 2002 – reducing risks, promoting healthy life,* 2002

[9] North West Public Health Observatory. *Local Alcohol Profiles for England (LAPE) 2012* http://www.lape.org.uk/, 2012 (Accessed August 2012)

[10] Møller L and Anderson P. *Introduction*. In: Anderson P, Møller L, Galea G (eds.) *Alcohol in the European Union consumption, harm and policy approaches*, WHO Europe; 2012. p1-4

[11] Institute of Alcohol Studies, *IAS Factsheet – Alcohol and the elderly,* 2010, http://www.ias.org.uk/resources/factsheets/elderly.pdf (Accessed July 2012)

[12] Alcohol Concern. *Swept under the carpet: Children affected by parental alcohol misuse*, 2010

[13] Baker A, Lodge H, Jacobson B, Hamm J, Murage P. *Closing time: counting the cost of alcohol-attributable hospital admissions in London*, 2012, http://www.lho.org.uk/Download/Public/17713/1/Alcohol_attributable_admissions_summary_ final.pdf (Accessed July 2012)

[14] Department for Culture Media and Sport. *Alcohol, Entertainment and Late Night Refreshment Licensing, England and Wales, April 2009 – March 2010*, 2010, http://www.culture.gov.uk/publications/7456.aspx (Accessed July 2012)

[15] Directgov. *Crime Statistics, 2012*, (DirectGov, http://www.direct.gov.uk/en/CrimeJusticeAndTheLaw/Crimestatistics/DG_181520), (Accessed July 2012)

1 Setting the scene: The alcohol burden

Contents

Key messages

- Tackling alcohol-related harm is complex and the factors affecting the amount consumed and the patterns of drinking are multifaceted.
- Alcohol has been identified as a priority area both within Islington and nationally. A number of strategies are available to support reductions in alcohol-related harm including the National Alcohol Strategy published in 2012, as well as Islington's Alcohol Harm Reduction Strategy and Licensing Policy.
- Alcohol-related harms are broad ranging and associated with even moderate levels of consumption.
- Action to reduce alcohol-related harm needs to be collaborative and take a multi-component approach.
- Ensuring that messages on what high risk drinking actually means must be clearly communicated. Understanding about the alcohol content (units) of different drinks needs to be a core part of preventative work linked to alcohol harm reduction.

INTRODUCTION

Before looking at how everyday life is affected by alcohol, it is useful to understand what is meant by harmful drinking and what this means in practice. This chapter provides a summary of some of the terminology used when discussing alcohol harm and misuse. A brief overview of the key national strategies produced over the last decade is also given to help set the context so that this important issue can continue to be taken forward locally.

Box 1.1: Government guidelines on maximum alcohol consumption[1]

Men should not regularly (everyday or most days) drink more than 3-4 units per day.

Women should not regularly (everyday or most days) drink more than 2-3 units per day.

Men and women should avoid alcohol for 48 hours after a heavy drinking session.

Pregnant women or women trying to conceive should not drink alcohol at all. If they do choose to drink, to minimise the risk to the baby, they should not drink more than 1-2 units of alcohol once or twice a week and should not get drunk.

HOW MUCH IS TOO MUCH?

The Government has produced guidance on the maximum amount of alcohol someone should consume to reduce their risk of harm **(box 1.1)**[1].

Drinking above these levels on a regular basis is associated with an increased risk of harm. The recommended levels are given in a range because alcohol affects different people in different ways depending on a number of factors such as sex, weight, height and age. For instance, levels are lower for women due to their lower body weight, lower levels of body fluid, more body fat and smaller livers, which mean a given amount of alcohol has a greater impact on their body when compared to men[2].

The Chief Medical Officer has also developed advice around drinking in children[3]. This recommends that:

- An alcohol-free childhood is the healthiest and best option. However, if children drink alcohol, it should not be until at least the age of 15 years.
- If young people aged 15 to 17 years consume alcohol, it should always be with the guidance of a parent or carer or in a supervised environment. They should do so infrequently, certainly on no more than one day a week. They should never exceed recommended adult daily limits and, on days when they drink, consumption should usually be below such levels.

WHAT IS A UNIT?

National guidance is based on the number of units of alcohol people should drink, but what does this actually mean?

A unit is a simple way of expressing the amount of pure alcohol in a drink. One unit is equal to 10ml or 8g of pure alcohol. This is about the amount an average adult can process in an hour.

The factors that affect the number of units in the drink are the size of the drink and the strength of alcohol in the drink, so for instance a pint of strong lager contains three units of alcohol but a standard pint of lager has two units. **Figure 1.1** shows the number of units in some popular drinks.

Figure 1.1 What is in a drink?

Source: adapted from NHS Choices, http://www.nhs.uk/Livewell/alcohol/Pages/alcohol-units.aspx[4]

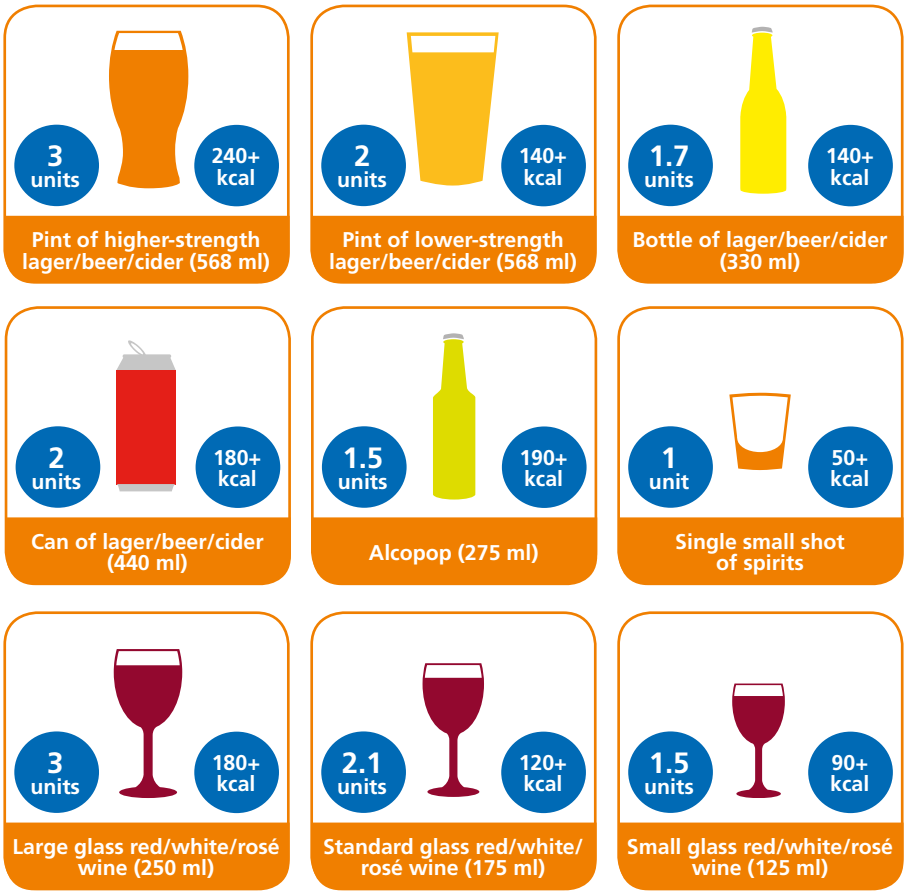


Figure 1.1 also shows the average number of calories contained in some common alcoholic drinks, and as can be seen the calories contained can be surprisingly high. For instance, a glass of wine can contain as many calories as a slice of cake. Drinking five pints of lager a week adds up to 44,200 calories over a year, equivalent to eating 221 doughnuts[4]!

However, it seems that not all those who drink alcohol fully understand either how many units their usual drink contains, or what levels of drinking can be considered as low risk. This was highlighted by an ONS survey (2010) that found although 90% of people had heard of measuring alcohol consumption in units, only 63% of people who had drunk beer in the past year knew that half a pint contained one unit **(figure 1.2)**[5].

ALCOHOL MISUSE

A range of terms are used to describe alcohol misuse. For instance, the World Health Organisation (WHO) uses the terms sensible, hazardous, and harmful. These terms were used in the UK until recently. However, there has been a shift to describing levels of drinking as low risk, increasing risk, higher risk and binge drinking **(figure 1.3)**. It is thought that these terms better reflect the risk incurred to drinkers as their consumption increases[6].

Figure 1.2 What is a unit: how good is our understanding?

Source: Opinions Survey Report No. 42 Drinking: adults' behaviour and knowledge in 2009,ONS, 2010[5]

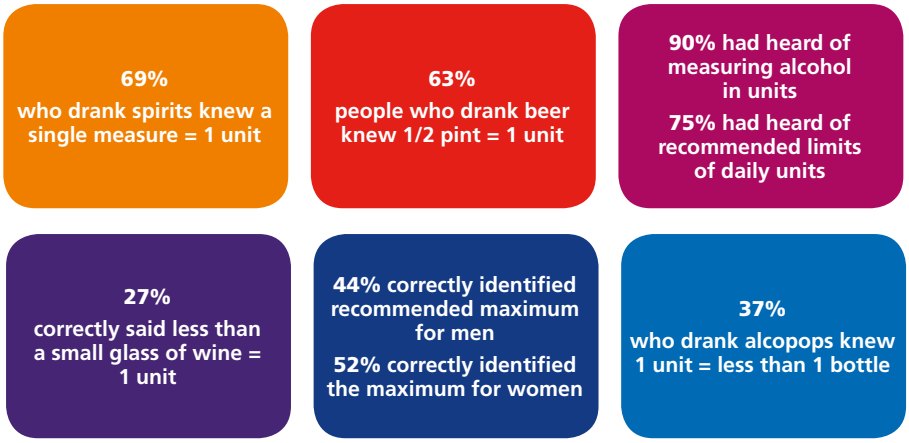
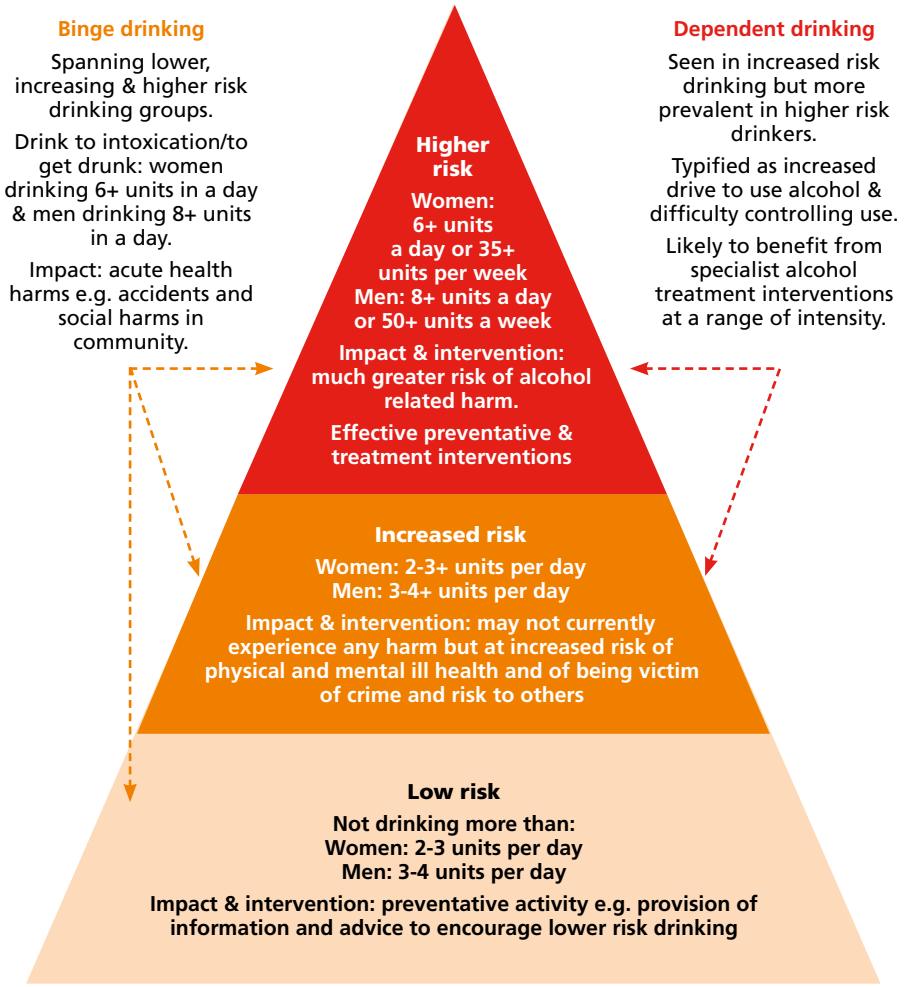


Figure 1.3 The spectrum of alcohol-related harm

Source: adapted from National Audit Office (2008)[7]



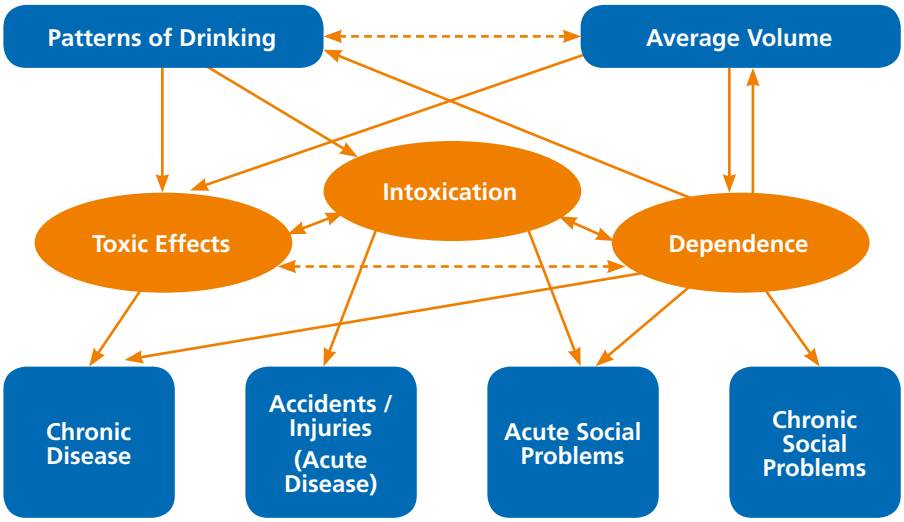
THE IMPACT OF ALCOHOL

The relationship between alcohol consumption, intoxication, dependence and resulting harm is interlinked. The impact of alcohol-related harm is associated with two separated, but linked dimensions: the amount (volume) of alcohol consumed and the pattern of drinking in terms of both the frequency of drinking and the amount consumed per drinking session[8,9,10]. This is reflected in **figure 1.4**, which highlights how different patterns of drinking can result in different problems, and consequently there is a need to look across the spectrum of alcohol-related harm. For instance, sustained heavy drinking may not result in intoxication but can cause a range of harms related to health, social situation, violence and employment, as well as leading to alcohol dependence. Whilst drinking at a low frequency but consuming a high number of drinks in one session can cause acute intoxication and lead to problems such as accidents, injury and violence. Alcohol dependence can lead to an increase in both volume and frequency of consumption over time and can have multiple impacts including both chronic and acute medical problems, alongside a number of social problems, including unemployment, absence from work and family breakdown[10].

The harm caused by alcohol is multifaceted and the impacts of alcohol can be felt at all levels of consumption — not just in those who are dependent drinkers. Indeed harm felt by someone else's drinking is common and wide ranging. At one end of the spectrum this could include being kept awake at night because of rowdy behaviour in the street, through to the more severe end where the consequences of someone else's drinking could mean being the victim of domestic violence or being a child who is neglected[11]. **Figure 1.5** highlights some of the health and social harms that are associated with alcohol.

Figure 1.4 The complex relationship between alcohol consumption, intoxication,dependence and resulting harm

Source: Babor et al. (2010)[10]



There does appear to be some protective effect of low level drinking on ischaemic heart disease. However, this is only really seen in men above forty years and post-menopausal women and the protective effect is seen at very low levels of alcohol consumption, around one to two units per day. It also seems that, in part, the protective effect is likely to be confounded by other factors, with low to moderate consumption being a proxy for better health and social capital (support networks) through which support, social norms and dissemination of information discourages individuals from risk taking health behaviours.

Consequently the proposed health benefits could be gained through other healthy behaviours[9]. The Chief Medical Officer[12] has suggested that the protective effect may have been overestimated:

'Above the age of 40 years, drinking a small amount of alcohol may reduce the risk of heart disease and stroke…… For those of any age, drinking any amount of alcohol increases the risk of cancer – there is no safe limit. Across England, alcohol results in over 13 people being admitted to hospital for every one that it prevents.' [12]

Figure 1.5 The physical and social effects of alcohol – positive and negative

Although the debate around alcohol-related harm is often focused on disease and medical conditions, the link with other social factors is considerable, and when discussing alcohol-related harm it is vital that these areas are included. The areas covered are wide ranging and include crime, family dysfunction, traffic accidents, and problems in the workplace. Often it is the social impacts of alcohol where the effects of someone else's drinking is felt most[10,13,14]. For instance, there is a range of evidence showing a link between the workplace and alcohol. Alcohol, particularly heavy drinking, increases the risk of unemployment, and for those in work, it may cause absenteeism and performance issues. These issues are discussed in more detail in Chapter 3.

ALCOHOL AS A STRATEGIC PRIORITY

Both nationally and internationally alcohol has been identified as a priority area for action over the last decade. A number of initiatives and objectives have been developed to reduce alcohol-related harm.

In 2010, the WHO published a global strategy[8] to reduce the harmful use of alcohol. The objectives of this strategy were to raise awareness of the magnitude and nature of harm; strengthen the knowledge base; increase partnership working and coordination; and improve systems for monitoring and surveillance. A number of target areas were identified to support these objectives. Locally there is a need to ensure these areas are embedded into approaches to tackling alcohol-related harm:

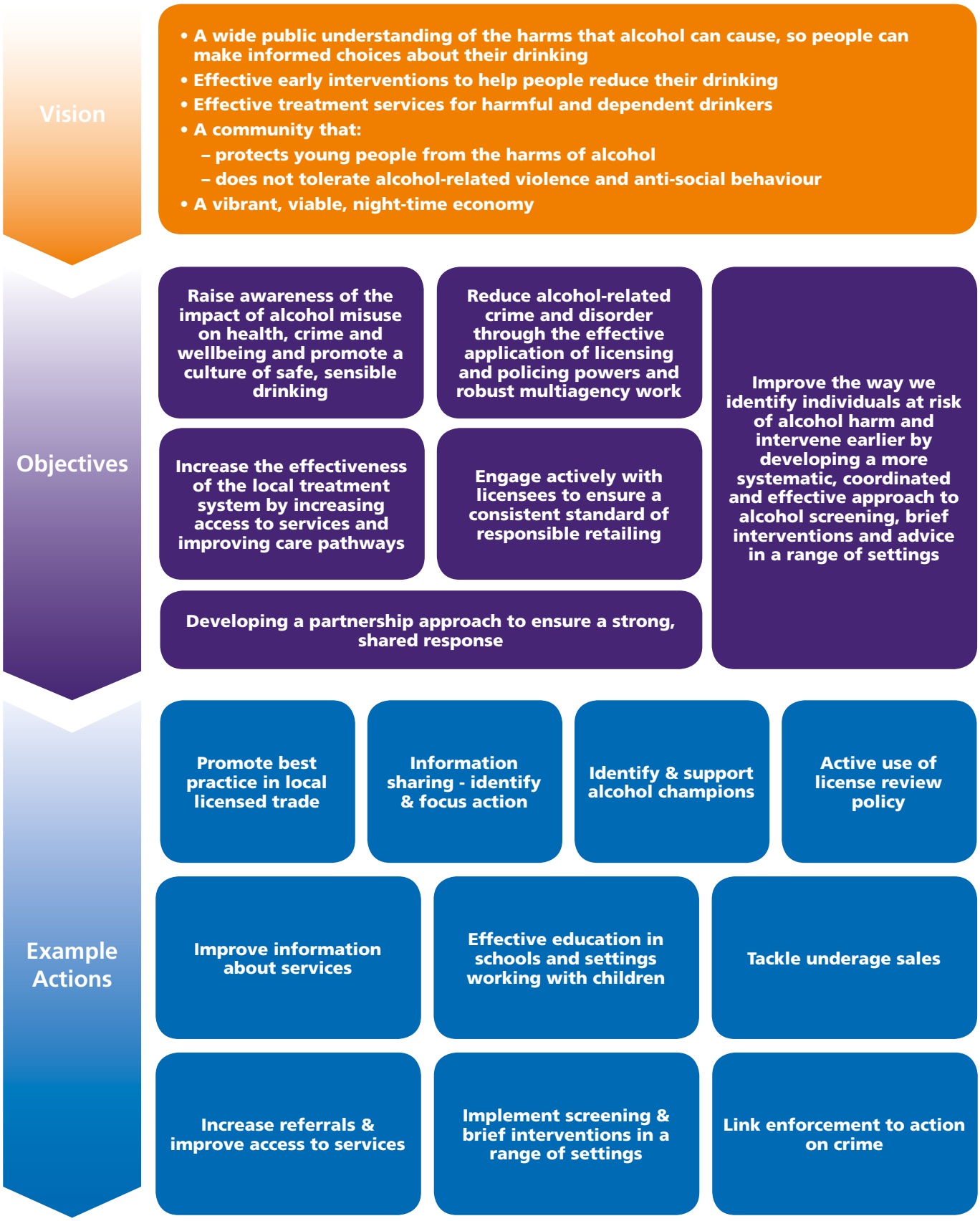
- Leadership, awareness and commitment
- Health services' response
- Community action
- Drink driving policies and countermeasures
- Availability of alcohol
- Marketing of alcoholic beverages
- Pricing polices
- Reducing the negative consequences of drinking and alcohol intoxication
- Reducing the public health impact of illicit alcohol and informally produced alcohol
- Monitoring and surveillance

Nationally an alcohol harm reduction strategy was published in 2004[15]. This strategy set out a cross-government approach to alcohol harm reduction, emphasising the importance of partnership working, and

Figure 1.6 High impact changes to reduce alcohol-related harm
Department of Health, 2009: Signs for Improvement[6]

Work in partnership	• NHS & partners prioritise alcohol • Investigate local alcohol-related needs • Agree joint vision & collaborative working
Control impact of alcohol misuse in the community	• Use existing laws, regulations and controls to minimise alcohol-related harm • Manage the night-time economy to reduce alcohol-related harm
Influence change through advocacy	• High profile champions to provide leadership within partner organisations
Improve effectiveness & capacity of specialist treatment	• Evidence based effective treatment and increased treatment opportunities for dependent drinkers • Review care pathways, access times and blockages into treatment
Appoint Alcohol Health Worker	• Dedicated Alcohol Health Worker providing a focus for medical management of patients with alcohol problems in hospital, liaison with community alcohol services, education and support for health workers, case finding and delivery of brief advice
Provide more help to encourage people to drink less	• Identification and brief advice: opportunistic screening followed by simple alcohol advice • Directed at patients drinking at increasing or higher risk levels who are not typically complaining about or seeking help for alcohol problem
Amplify national social marketing priorities	• Marketing to inform public about alcohol and influencing those drinking at higher risk to reduce their use of alcohol to within lower risk levels

Figure 1.7 Islington's Alcohol Harm Reduction Strategy, 2011-2014



included a series of measures aimed at facilitating a long term change in attitudes to irresponsible drinking including:

- Providing better information to consumers about the dangers of alcohol misuse and ensuring messages are easy to understand and apply;
- Improving health and treatment services;
- Combating alcohol-related crime and disorder in city centres by working with the police, the local authority and alcohol premises to ensure existing laws to decrease alcohol-related crime and disorder are enforced;
- Working with the alcohol industry to prevent irresponsible product marketing and advertising.

The strategy was updated in 2007 with the publication of the document 'Safe.Sensible.Social'[11]. This focused on minimising harm to health, violence, and antisocial behaviour associated with alcohol, whilst ensuring alcohol can be enjoyed safely and responsibly. It aimed to deliver improvements in three areas:

- Ensuring laws and licensing powers are used widely and effectively to tackle alcohol-fuelled crime, protect young people and bear down on irresponsibly managed premises;
- Sharpen the focus on the minority of drinkers who cause or experience the most harm to themselves, their communities and their families, with a particular focus on those aged under 18 who drink, and 18-24 year old who are binge drinkers and harmful drinkers;
- Work collaboratively to develop an environment that actively promotes sensible drinking, including investment in better information and communication.

Following on from 'Safe.Sensible.Social'[11] the Department of Health identified nine high impact[6] changes that were likely to make the greatest difference in tackling alcohol-related harm. Described in **figure 1.6**, these provide a good framework for developing a local approach to reducing alcohol-related harm. The high impact changes need to be applied together, as the proposed actions will have less effect if applied in isolation. The recommendations made throughout this report will take this model into account.

In 2012 the Coalition Government published a strategy outlining the Government's approach for alcohol. This identified the following priority areas[16]:

- Ending availability of cheap alcohol and irresponsible promotions and introduction of a minimum unit price for alcohol;
- Ensuring local areas have the power to tackle alcohol-related problems locally;
- Working with industry to support changes to individual drinking behaviour;
- Supporting individuals to make informed choices about health and responsible drinking.

The Police Reform and Social Responsibility Act 2011[17] also comes into force during 2012. This Act sets out a new approach to tackling crime and disorder caused by alcohol and the resulting health and social harms, and is discussed in more detail in Chapter 5.

To support the delivery of the national objectives outlined in The National Harm Reduction Strategy[15] and Safe.Sensible.Social[11], whilst taking account of the specific local needs, Islington published a multi-partner alcohol harm reduction strategy in 2011[18]. This sets out Islington's vision and actions to support this **(figure 1.7)**.

Additionally there is an Islington Licensing Policy[19], with the purpose of:

- Informing licence applicants of the way in which the Licensing Authority will make licensing decisions;
- Setting out how licensed premises are likely to be permitted to operate;
- Informing residents and businesses of the way in which the Licensing Authority will make licensing decisions and how their needs and concerns will be dealt with.

The policy, which is discussed in more detail in later chapters, takes into account a range of areas including management of anti-social behaviour, noise, harm reduction, promoting cultural diversity, safer travel, standards of management, licensing hours, venue location, and impact on children and enforcement.

SUMMARY

Tackling alcohol-related harm is complex. A range of factors affect the amount someone drinks. The harm caused by alcohol is multifaceted and the impacts of alcohol can be felt at all levels of consumption – not just in those who are dependent drinkers. Indeed harm felt by someone else's drinking is common and wide ranging, and this is an issue discussed in subsequent chapters.

Reducing alcohol-related harm has been identified as a national and local priority. A number of initiatives and objectives have been developed to reduce alcohol-related harm. The recommendations made within this Annual Public Health Report will take account of the actions and guidance outlined in these documents and, in doing so, make sure the report can be used to inform, develop and support a shared approach to alcohol harm reduction in Islington.

References

[1] NHS. *Alcohol Units.* 2012, http://www.nhs.uk/Livewell/alcohol/Pages/alcohol-units.aspx, (accessed July 2012)

[2] Science and Technology Committee. *Eleventh Report Alcohol Guidelines*, 2011 http://www.publications.parliament.uk/pa/cm201012/cmselect/cmsctech/1536/153602.htm, (accessed July 2012)

[3] Donaldson L. *Guidance on the consumption of alcohol by children and young people. A report by the Chief Medical Officer, Department of Health,* 2009

[4] NHS Choices. *Calories in alcohol,* 2010. http://www.nhs.uk/Livewell/alcohol/Pages/calories-inalcohol. aspx. (Accessed July 2012)

[5] Lader D and Steel M. *Opinions Survey Report No. 42 Drinking: adults' behaviour and knowledge in 2009*, Office for National Statistics, 2010

[6] Department of Health. *Signs for improvement – commissioning interventions to reduce alcohol-related harm*, 2009

[7] National Audit Office. *Reducing alcohol harm: health services in England for alcohol misuse*, HC 1049 Session 2007-08, 2008

[8] World Health Organisation. *Global strategy to reduce the harmful use of alcohol.* WHO, 2010

[9] Anderson P. *The impact of alcohol on health.* In: Anderson P, Møller L, Galea G (eds.) *Alcohol in the European Union consumption, harm and policy approaches,* WHO Europe; 2012. p5-9

[10] Babor T, Caetano R, Casswell et al. *Alcohol no ordinary commodity,* Oxford University Press, 2010

[11] Department of Health, Home Office, Department for Education and Skills, Department for Culture, Media and Sport. *Safe. Sensible. Social. The next steps in the National Alcohol Strategy,* 2007

[12] Donaldson L. *150 years of the Annual Report of the Chief Medical Officer: On the state of public health 2008.* Department of Health, 2009

[13] Shield K, Kehoe T, Gmel G et al. *Societal burden of alcohol* In: Anderson P, Møller L, Galea G (eds.) *Alcohol in the European Union consumption, harm and policy approaches,* WHO Europe; 2012. p10-28

[14] Anderson P. *Alcohol and the workplace* In: Anderson P, Møller L, Galea G (eds.) *Alcohol in the European Union consumption, harm and policy approaches,* WHO Europe; 2012. p69-82

[15] Cabinet Office. *Alcohol harm reduction strategy for England,* 2004

[16] Home Department. *The Government's alcohol strategy.* Cm8336, HM Government, 2012

[17] Great Britain. *Police Reform and Social Responsibility Act 2011*. London: The Stationery Office

[18] NHS Islington and Partners. *Islington alcohol harm reduction strategy 2011-14*, 2011

[19] Licensing Service London Borough of Islington. *Licensing policy 2011-14,* 2011

2 Patterns of drinking

Contents

Key messages

- Long term, the trend is for increased alcohol consumption in both men and women, although more recent evidence indicates a slight decline in consumption. The longer term increase in consumption has been linked to greater affordability, access, and societal and lifestyle changes.
- In Islington, estimates indicate around a fifth of the population drink at increasing risk levels and a further 7% drink at higher risk levels, similar to London and England.
- Around a fifth of people in Islington are thought to binge drink, significantly higher than London, but similar to England.
- Average alcohol consumption is higher in more affluent groups, but rates of higher risk and dependent drinking are higher in more deprived groups and associated with greater levels of harm.
- Identification and brief advice (IBA) has been shown to be effective in supporting individuals with increasing risk and higher risk drinking to reduce their level of consumption. In Islington, IBA is occurring within primary care, as part of NHS health checks and in accident and emergency where hospitals have been incentivised to increase the use of this intervention. However, there remains scope to increase provision within Islington.
- To improve awareness, the public need to be provided with consistent messages, tailored to key groups, on the health risks of alcohol consumption and sensible drinking limits.
- Ensuring health care staff are equipped with the skills to identify 'hidden' drinkers, including older people who may have been admitted because of injury caused by drink, is important in tackling alcohol-related harm.

WHY FOCUS ON THIS AREA?

Alcohol is the third leading risk factor for disease and mortality in Europe[1]. Even relatively low levels of alcohol consumption can cause harm, but over a third of Londoners drink alcohol in a way that can harm them, their families and communities; and the trend is for this level of harm to increase[2]. Factors influencing patterns of consumption include affordability and accessibility of alcohol, as well as societal and lifestyle factors. There are important differences in

drinking patterns associated with gender, age, income, ethnicity and religious belief. Although average alcohol consumption is higher in more affluent groups, harms are higher among the more deprived[1]. Islington, with a particularly large young adult population, has a higher level of binge drinkers than the London average, but also a significant proportion of abstainers linked to factors such as ethnicity and faith.

HOW MUCH ARE PEOPLE DRINKING?

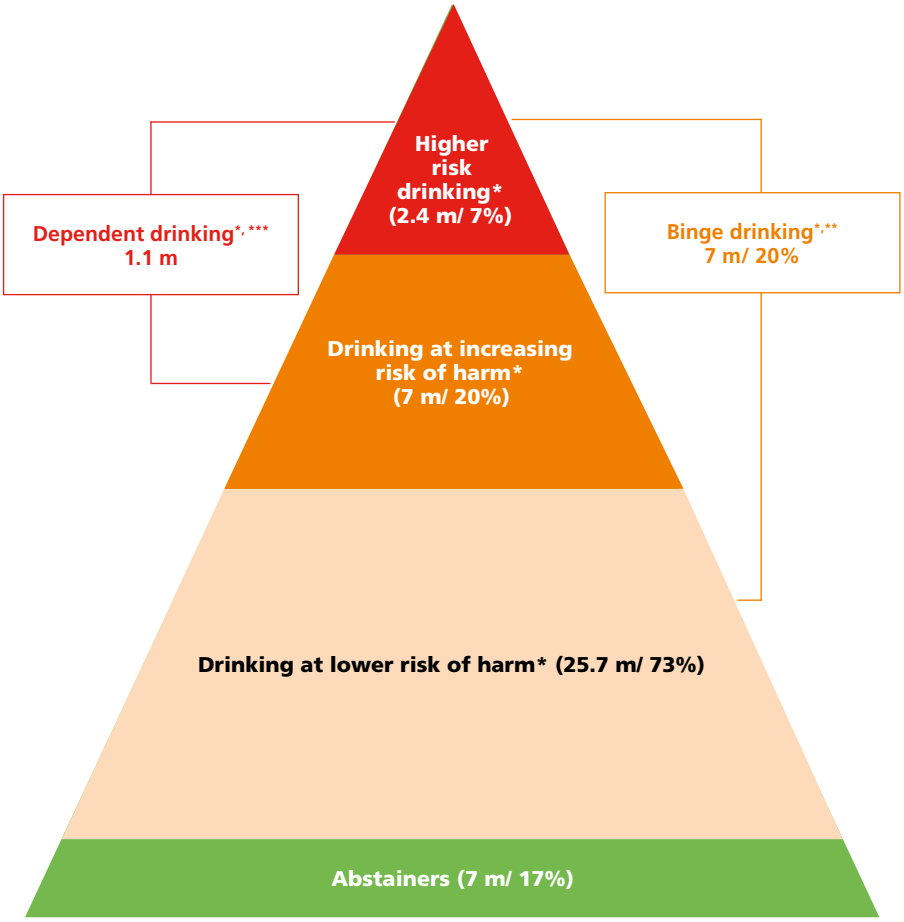
Patterns of alcohol consumption: National

The majority of the adult population in England (33 million) abstain or drink alcohol at levels with low risk of harm **(figure 2.1)**. However, there are an estimated 9.4 million people drinking at levels that put them at an increased or high risk of harm, including 1.1 million dependent drinkers. Seven million people are described as binge drinkers. Trends in alcohol consumption show a long term increase since the 1950s. This appears to have peaked in 2004 with a small decline in subsequent years. However, annual per person consumption has remained consistently above 7 litres per person since the early 1980s and is one of the higher average per person consumptions in the world[3,4].

The General Lifestyle Survey collects data on levels of alcohol consumption in the population[7]. The survey reports that, on average, men consume substantially more units of alcohol than women. In recent years there appears to have been a general decline in weekly alcohol consumption in both men and women across all age groups,

Figure 2.1 Drinking patterns in England

Source: Signs for improvement, Department of Health[5] *Refer to chapter 1 for more details of the spectrum of alcohol-related harm. Percentages in brackets relate to the drinking population, whereas for abstainers the percentage relates to the whole adult population. Mid-2009 estimates. **2007-2008 estimate applied to mid-2009 population figure; ***Source: ANARP, 2005[6]



with the largest reduction among the 16-24 year olds. However, trends over the last two decades suggest there has been an increase in alcohol consumption in women[8]. In 2010, among both men and women, average weekly consumption appears to be greatest in those aged 45-64 years; lowest consumption in both sexes is in those 65 years and over **(figures 2.2a and 2.2b)**.

Average alcohol consumption is lower among older people than other adults, but can be associated with a range of problems and receives less media attention than younger age groups. The contribution of alcohol to age-related problems, such as memory problems, confusion and falls, may be overlooked or ignored by professionals. Alcohol overuse in older people may also have potentially harmful interactions with prescription medicines[9].

Binge drinking – the consumption of large quantities of alcohol at a single session resulting in intoxication – carries particular health and social risks including ischaemic heart disease, accident/ trauma and sudden death[1]. Most common in younger age groups,

binge drinking is often associated with 'pre-loading', a pattern of drinking a large amount of alcohol at home before going out to bars and night clubs. In a study of 18-35 year olds, those drinking prior to attending city nightlife venues (e.g. drinking at home) reported significantly higher total alcohol consumption during a night out than those not drinking until reaching bars and nightclubs. Individuals drinking before going out were over four times more likely to report drinking more than 20 units on a usual night out and were 2.5 times more likely to have been involved in a fight in the city's nightlife during the previous 12 months[10].

Drinking patterns vary by socio-economic group. As gross household weekly income rises, so does the amount and frequency of alcohol consumption **(figure 2.3)**[11]. However, higher risk and dependent drinking is more common in lower socio-economic groups and rates of alcohol-attributable hospital admissions are significantly higher (also see Chapter 4). Some socially and economically deprived groups, including rough sleepers and some migrant and black and minority ethnic (BME) groups, suffer disproportionate harm from alcohol linked to the inequity they face in other areas of their lives[12].

Alcohol consumption is lower in many BME communities than in the White English population, although rates of dependent drinking have been found to be similar in white, black and some other minority ethnic groups[6]. In general, men and women from Black Caribbean, Black African and Black British communities consume less alcohol; there are low rates of consumption among the Chinese; and South Asian communities have the lowest rates of alcohol use. However, there are high rates among some drinkers in these groups. Higher rates of abstention and lower consumption within these communities are linked to factors including family influences and religious belief, with Muslim identity for example strongly linked to abstinence. These factors may apply differentially to women than men and may disguise hidden drinking[13].

Figure 2.2a Men Mean alcohol consumption (units) in the previous week, Great Britain, 2006-2010, by age group

Source: Information Centre 2012 (General Lifestyle Survey 2010)
*change to the method used for calculating the number of units drunk

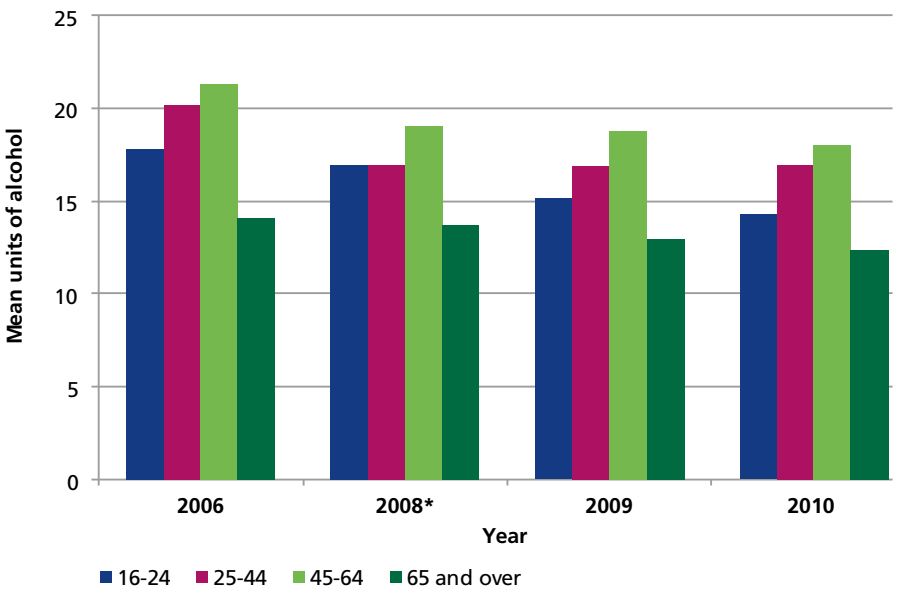
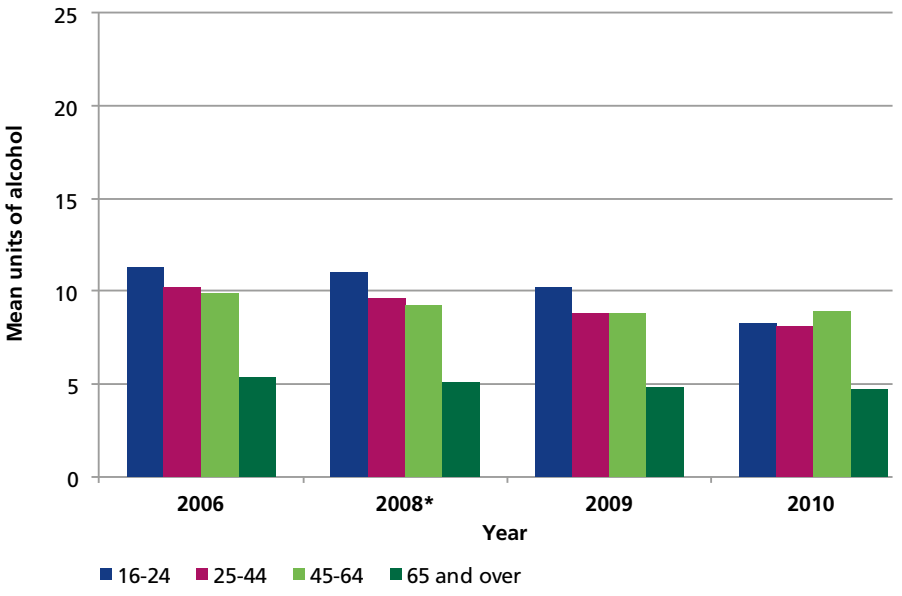


Figure 2.2b Women Mean alcohol consumption (units) in the previous week, Great Britain, 2006-2010, by age group

Source: Information Centre 2012 (General Lifestyle Survey 2010)
*change to the method used for calculating the number of units drunk



However, there are higher rates of consumption or evidence of harm in some other BME communities. The frequency and amount of alcohol consumption in both Irish men and women is higher than for the White English; and men and women in the Irish and Scottish communities and Indian men have higher rates of alcohol-related deaths[13].

There is evidence that the pattern of consumption is beginning to change in some BME groups[13]. Second generation communities may be more likely to drink and increased drinking is seen in women from Indian and Sikh communities. Factors such as education, income and inter-ethnic friendships also influence drinking patterns.

Patterns of alcohol consumption: London and Islington

In London, drinking on a daily basis increases with age. The 18-24 years age group has the highest percentage of abstainers in London **(figure 2.4)**[14]. This could potentially be attributed to those London boroughs where a large proportion of young people belong to BME groups whose religious or cultural values may be amongst reasons for not drinking alcohol. However, the proportion of people in Islington who do drink alcohol is higher than the London average.

Estimates for Islington show that the majority of Islington drinkers are drinking at lower risk levels (72%) and a fifth (21%) are drinking at increasing risk levels (higher than recommended levels), similar to London and England averages[15].

Figure 2.3 Percentage of adults drinking on five or more days in the previous week by socio-economic classification and gender, England 2010

Source: General Lifestyle Survey 2010, Office for National Statistics (ONS)

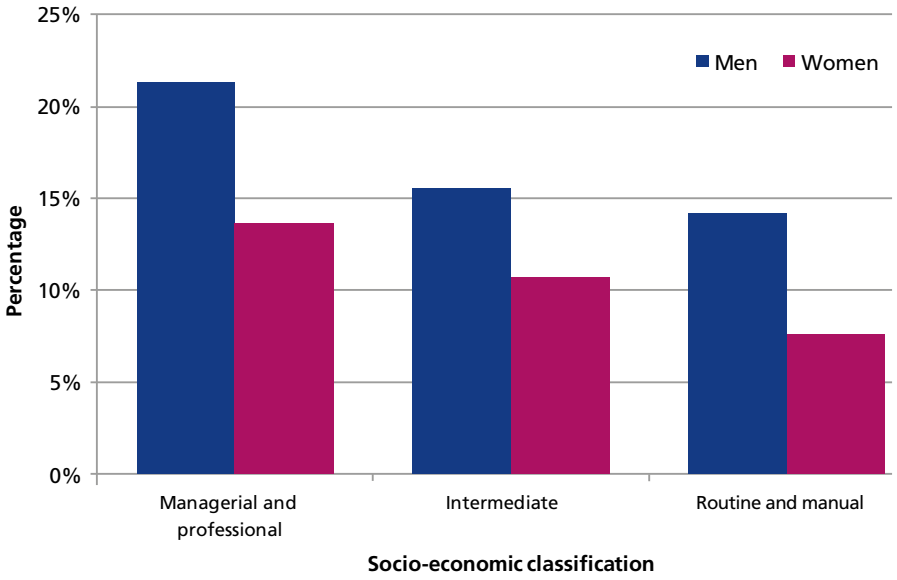
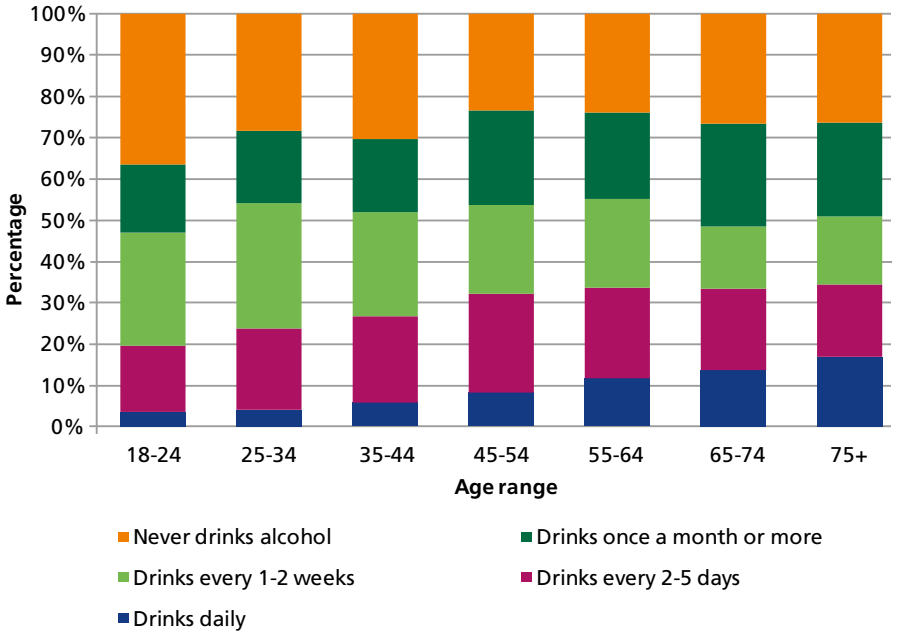


Figure 2.4 Breakdown of alcohol consumption, by age group, London, 2012

Source: General Lifestyle Survey 2010, Office for National Statistics (ONS



About 7% of Islington's drinking population engage in higher risk drinking, similar to London and England averages. Around a fifth (21%) of Islington's drinking population engage in binge drinking, levels that are significantly higher than the London average, but similar to the England average **(figure 2.5)**.

Analysis of primary care data shows that 73% of adults registered with an Islington GP in 2011 had their alcohol status recorded at some point. Among patients with status recorded, 37% stated they were a non-drinker, 56% low risk, 6% increased risk and 1% higher risk **(figure 2.6)**[16]. This is a lower proportion of people at risk of alcohol-related harm than would be expected based on national estimates. It may be that the level of alcohol consumption is being under-reported or that patients at higher risk are less likely to report their alcohol consumption.

Figure 2.5 Percentage of the drinking population aged 16 years and over who report engaging in binge drinking, by London borough, 2008

Source: Local Alcohol Profiles for England (LAPE), 2007-2008 synthetic estimate

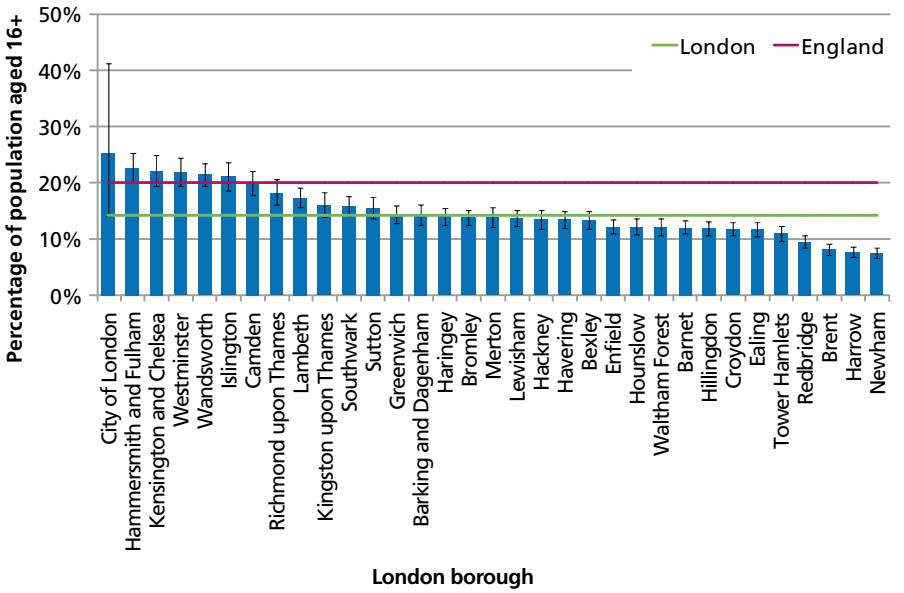


Figure 2.6 Breakdown of alcohol consumption status, Islington registered population aged 18 and over with alcohol consumption recorded in the previous 15 months, March 2011

Source: Islington's GP PH dataset, 2011

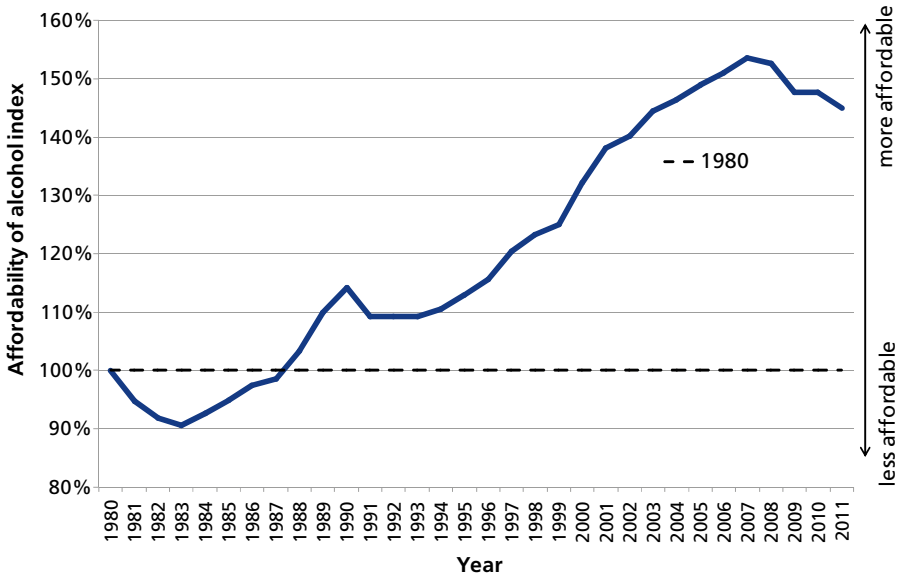
REASONS FOR INCREASED DRINKING

Affordability of alcohol

One of the factors contributing to an increase in drinking amongst all age groups is the rise in households' disposable income and the affordability of alcohol. Compared to 1980, alcohol is now 45% more affordable[7] **(figure 2.7)**. Greater accessibility and availability of alcohol, linked to changes in licensing, have also contributed.

As well as an increase in the affordability and accessibility of alcohol, there are other factors which affect the drinking patterns of certain groups, linked to wider societal and lifestyle changes. For instance in older people, increased affluence, social isolation, a younger outlook and ill health have all been indicated as factors leading to increased alcohol consumption[9,17]. Increased consumption in women may be linked to greater gender equity[8]. Women are also more likely to drink supermarket purchased wine[17], in which alcohol content has increased. Media attention on 'binge drinking' in younger women means that middle aged and older women may not recognise when they are drinking in a way that may cause them harm[17].

Figure 2.7 Alcohol affordability index: 1980 (=100%) to 2011
Source: Health and Social Care Information Centre, 2012



WHAT WORKS?

Identification and Brief Advice (IBA)

The process of identifying people who may have alcohol issues and then taking action is known as identification and brief advice (IBA). IBA involves two steps: the "screening" which seeks to assess whether or not an individual is an "at risk" drinker; and the intervention or "brief advice" which is a very short counselling session between an individual and the person who initiated the screening.

IBA is aimed at individuals who are at risk through drinking above the recommended guidelines, but not typically seeking help for an alcohol problem. Identification is through the use of validated screening tools, such as the Alcohol Use Disorders Identification Test (or AUDIT), described in **box 2.1**.

There is strong evidence that IBA reduces alcohol consumption, mortality, morbidity, alcohol-related injuries, alcohol-related social consequences, and health care resource use[18]. One in eight people will reduce their level of drinking after a brief intervention[19,20]. This compares very well to smoking where one in twenty given brief advice will reduce their level of smoking[5].

Studies of IBA with patients in A&E departments showed reductions in subsequent visits to A&E over the following 12 months[21] and continued reduction in alcohol consumption[22]. Department of Health *Guidance for Commissioners 2009*[5] estimates that one nurse delivering brief interventions in A&E could prevent about 40 admissions each year, more than offsetting the costs of the post.

Results from a systematic review of 29 controlled trials of IBA in primary care found that one year or more after a brief intervention, people drank on average 4-5 fewer units of alcohol than people who did not receive IBA. Levels of binge drinking and heavy drinking were also reduced[4]. Primary care is well placed to deliver IBA, but financial incentives, training and ongoing specialist support are important in effective implementation[23,24].

Evidence indicates performing IBA in non-health care locations including criminal justice settings, probation offices, prisons and police custody suites is also acceptable, feasible and effective[25].

NICE guidance recommends that IBA should be offered opportunistically by all health and social care, criminal justice, community and voluntary sector professionals in both NHS and non-NHS settings who regularly come into contact with people who may be at risk of harm from the amount of alcohol they drink. Staff should be trained to ensure they are competent performing IBA[26]. IBA is occurring within a number of settings in Islington **(box 2.2)**.

Box 2.1: What is AUDIT?

AUDIT was designed by the World Health Organisation[24] as a simple screening tool to pick up the early signs of hazardous and harmful drinking and identify mild dependence, therefore identifying individuals at increased or high risk for health harms. If identified as "at risk", a short conversation about alcohol can lead to reduced drinking and improved health. The test was designed to be used internationally and was validated in a study using patients from six countries. Questions 1-3 deal with alcohol consumption, 4-6 relate to alcohol dependence and 7-10 consider alcohol-related problems. A score of 8 or more in men (7 in women) indicates a strong likelihood of hazardous or harmful alcohol consumption. A score of 20 or more is suggestive of alcohol dependence.

A shorter, quicker version of AUDIT, called AUDIT-C has also been developed and shown to be effective. This uses the first 3 questions of the 10 question AUDIT instrument. In men a score of 4 or more is considered positive, while in women a score of 3 or more identifies possible risky drinking.

	Scoring system				
Questions	**0**	**1**	**2**	**3**	**4**
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week
2. How many units of alcohol do you drink on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 9	10+
3. How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year
10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year

Source: Babor T, Higgins-Biddle J, Saunders J et al. The Alcohol Use Disorders Identification Test, 2001. WHO. http://whqlibdoc.who.int/hq/2001/who_msd_msb_01.6a.pdf

Box 2.2: IBA in Islington

Alcohol Directly Enhanced Service

A Directly Enhanced Service (DES) is an additional service or activity provided by GP practices that has been negotiated nationally in which practices can choose whether to participate. The alcohol DES was introduced nationally in 2008/09 to screen all new GP registrations aged 16 years and over, and deliver brief advice to patients identified as drinking at increasing and higher risk levels.

Screening can be carried out using the AUDIT-C or Fast Alcohol Screen Test (FAST) questionnaires. If a patient is identified as positive on one of these questionnaires, the remaining questions of the ten-item AUDIT questionnaire are used to determine hazardous, harmful or dependent drinking. Those patients identified as drinking at hazardous or harmful levels should then receive a brief intervention about alcohol. Dependent drinkers should be referred to local specialist services.

Since the alcohol DES is not compulsory, not all GP practices take part. In 2008/09 ten GP practices in Islington took part; however by 2010/11, 76% (28/37) practices in Islington were participating. Data returned by the practices in 2010/11 showed that 13,529 newly registered patients were screened using the AUDIT-C or FAST questionnaires; 8% (1,140) went on to receive the full AUDIT questionnaire, indicating a high likelihood of drinking at above recommended levels of alcohol consumption.

NHS Health Checks

The aim of the Islington 'NHS Health Check' programme is to identify people at high risk of developing heart disease, stroke, diabetes and chronic kidney disease and to support people to reduce their risk. As part of the health check, the AUDIT-C questionnaire is used to screen for increasing and higher risk alcohol use and to pick up alcohol problems early. Local data show that, between August 2011 and April 2012, 35% (863/3,359) of those screened had drinking patterns requiring further investigation.

CQUIN

The Commissioning for Quality and Innovation (CQUIN) payment framework enables commissioners to reward excellence by linking a proportion of health care providers' (e.g. hospitals) income to the achievement of local quality improvement goals. The NHS North Central London CQUIN framework includes alcohol reduction as one of its six core CQUINs. It should therefore be embedded in all applicable contracts and as part of this scheme hospitals receive incentives for providing IBA in Accident and Emergency (A&E) settings.

Awareness Raising and Education

Advice on sensible drinking limits can play an important role in alcohol education. People require clear, concise and consistent messages explaining the health risks of alcohol consumption. Evidence suggests that specifically targeted education measures are likely to be more effective than broad-based approaches[27]. The information needs to be disseminated widely and tailored to key groups[28]. Formats for delivering alcohol education include:

- **Mass media and information campaigns:** Although they are generally viewed as ineffective in changing behaviour when implemented in isolation[29], there is evidence that such campaigns may be helpful in raising awareness about certain issues[30].
- **School-based education about alcohol:** This is another area where there is debate around effectiveness in changing behaviour, although some initiatives show positive outcomes[31].
- **Targeted efforts that address particular groups of individuals:** These include programmes for young people, problem drinkers, or other "at-risk" populations[32].
- **Specific interventions** to deal with drinking patterns that may be especially problematic, such as "binge" drinking or drinking and driving[33].
- **Warning labels** that address possible health risks, drinking and driving, or drinking during pregnancy. These are found on containers of beverage alcohol in a number of countries. While labels may raise awareness among some individuals, when used by themselves, they have been largely ineffective in changing behaviour[34].
- **Alcohol education** integrated into general health education and provided through physicians, nurses, and other health or social workers[35].

Two examples of how Islington is raising awareness and ensuring easy access to advice and support are discussed in **box 2.3**.

Box 2.3: Raising the issue of alcohol and direct access to services – Islington Community Alcohol Services (ICAS)

Direct access to services

The Direct Access Service aims to prevent alcohol-related harm and promote recovery by addressing the diverse range of individual and community needs in relation to alcohol. A wide range of support is available, from health advice for the general public, right through to more targeted individual treatment for dependent drinkers.

People can access the service either by self-referral or referral by a professional or carer. Immediate access is available through drop in sessions on week days. A women-only session is also available. The service provides general information and advice as well as immediate support as appropriate. This may include referral to a GP, hospital or homelessness service. Ongoing open access services are used to strengthen engagement and reduce harm. A daily programme of groups is available, including alcohol and drug education, relapse prevention and complementary therapies.

Between July 2011 and June 2012, 500 people were referred to Islington Community Alcohol Service. The service exceeded its referral targets and received an 'excellent' rating following an audit.

A number of service developments are planned to ensure an even greater impact on alcohol-related harm. This includes an increase in the provision of health promotion advice and identification and brief advice in community settings. Links with other services including probation services will also be expanded to ensure that the diverse needs of these client groups are met.

Training in Brief Alcohol Advice

'Raising the Issue' training aims to equip a range of frontline staff with the basic skills, knowledge and confidence to recognise potential alcohol misuse and provide brief advice about alcohol needs in their day-to-day work with the public. The training and resources are provided free of charge to a range of services in Islington e.g. social care, housing, community and voluntary sector, and criminal justice.

Learning outcomes for staff attending 'Raising the Issue' training include an increased understanding of the signs, symptoms and harms associated with differing levels of alcohol use. Staff are also equipped with the confidence, skills and resources to recognise and raise alcohol as an issue; provide brief advice for problem alcohol use; and refer to other sources of information and support including specialist services, primary care and self-help options, where appropriate.

During 2011/12, 158 people received 'Raising the Issue' training in Islington. The training has been evaluated as very successful in meeting the learning outcomes described above.

In 2012/13, the service aims to train a further 240 staff, targeting groups of staff that were underrepresented in the previous year, including community organisations and employment services. More targeted health promotion will also be provided at community health events and in community settings including supermarkets, in a bid to raise awareness of recommended guidelines, unit content of drinks and health risks.

SUMMARY

This chapter investigated how much Islington residents are drinking and compared this to regional and national drinking patterns. It also discussed reasons for increased alcohol consumption and summarised the evidence and case studies around interventions to decrease alcohol-related harm.

Trends in alcohol consumption show a long term trend of increased consumption since the 1950s. There are important differences in drinking patterns associated with gender, age, income, ethnicity and religious belief. Over the last few decades, the increased affordability of alcohol, and changes to society and lifestyle, has contributed to an increase in alcohol consumption.

Whilst the majority of Islington drinkers consume alcohol at lower risk levels, one fifth of the population are drinking at increasing risk levels and 7% engage in higher risk drinking patterns. Average alcohol consumption is higher in more affluent groups, but rates of higher risk and dependent drinking are higher in more deprived groups and associated with greater levels of harm. BME groups tend to consume less alcohol. Around one fifth of Islington's population binge drink and this drinking pattern is more common in younger age groups.

Ensuring health care staff are equipped with the skills to identify 'hidden' drinkers is important in tackling alcohol-related harm. Evidence-based and evaluated IBA and awareness raising and education interventions are delivered in a number of settings across Islington. There remains scope to increase the provision of IBA within Islington.

References

[1] Møller L and Anderson P. Introduction. In: Anderson P, Møller L, Galea G (eds.) *Alcohol in the European Union consumption, harm and policy approaches.* WHO Europe, 2012. p1-4

[2] London Health Improvement Board. *Alcohol Proposals for Action in 2012/13.* January 2012. Available from: http://www.lhib.org.uk. (Accessed 3 July 2012).

[3] British Medical Association Board of Science. *Alcohol misuse: tackling the UK epidemic.* BMA, 2008. Available from: http://findings.org.uk/count/downloads/download.php?file=Roycroft_G_1.txt. (Accessed 4 September 2012).

[4] World Health Organisation. *Global status report on alcohol and health.* WHO, 2011. Available from: http://www.who.int/. (Accessed 26 June 2012).

[5] Department of Health. *Signs for Improvement: Commissioning interventions to reduce alcohol-related harm.* DH, 2009. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_102813. (Accessed 28 June 2012).

[6] Department of Health, University of London. St George's Division of Mental Health. Section of Addictive Behaviour, Kable Limited, MORI Social Research Institute. Alcohol Needs Assessment Research Project (ANARP): *The 2004 national alcohol needs assessment for England, 2004.* http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidan ce/DH_4122341 (Accessed: 31 August 2012).

[7] Health and Social Care Information Centre. *Statistics on Alcohol: England, 2012.* Available from: http://www.ic.nhs.uk/statistics-and-data-collections/health-andlifestyles/ alcohol/statistics-on-alcohol-england-2012-[ns]. (Accessed 26 June 2012).

[8] Bloomfield K, Allamani A, Beck F, Bergmark KH, Csemy L, Eisenbach-Stangi I, Elekes Z, Gmerl G, Kerr-Corea F, Knibbe R, Makela P, Monteiro M, Medina Mora M, Nordlund S, Obot I, Plant M, Rahav G and Mendoza M. *Gender, Culture and Alcohol Problems: A Multinational Study.* Project Final Report. GENACIS. [Online] 2005. Available from: www.genacis.org/. (Accessed 25 June 2012).

[9] Alcohol Concern *Cymru Briefing. Hidden Harm? Alcohol and older people in Wales.* May 2011. Available from: http://www.alcoholconcern.org.uk/publications. (Accessed 22 June 2012).

[10] Hughes K, Anderson Z, Morleo M and Bellis MA. *Alcohol, nightlife and violence: the relative contributions of drinking before and during nights out to negative health and criminal justice outcomes.* Addiction. [Online] 2008;103(1):60-65. Available from: http://onlinelibrary.wiley.com/doi/10.1111/j.1360-0443.2007.02030.x/abstract. (Accessed 10 August 2012).

[11] The Marmot Review. *Fair Society, Healthy Lives: Strategic review of health inequalities in England post-2010.* The Marmot Review. February 2010. Available from: http://www.instituteofhealthequity.org/. (Accessed 4 September 2012).

[12] London Health Improvement Board. *Taking Action on Alcohol in London: The case for action.* 24th October 2011. Available from: http://www.lhib.org.uk. (Accessed 10 August 2012).

[13] Hurtcombe R, Bayley M, Goodmam A. *Ethnicity and alcohol: a review of the UK literature.* Joseph Rowntree Foundation. 2010. http://www.jrf.org.uk/sites/files/jrf/ethnicity-alcoholliterature-review-summary.pdf (Accessed 31 August 2012).

[14] London Health Observatory. *Question Time: A survey of attitudes and perceptions towards alcohol consumption in London. 2012.* Available from: http://www.lho.org.uk/lho_topics/health_topics/lifestyle_and_behaviour/londondrinkdebate.aspx. (Accessed 28 June 2012).

[15] North West Public Health Observatory. *Local Alcohol Profiles for England (LAPE) 2012.* Available from: http://www.lape.org.uk/. (Accessed August 2012).

[16] NHS Islington Public Health Intelligence. *Islington GP dataset, 2011.*

[17] Smith L, Foxcroft D. *Drinking in the UK: An exploration of trends.* Joseph Rowntree Foundation, Oxford Brookes University, 2009. Available from: http://www.jrf.org.uk/publications/drinking-in-the-uk. (Accessed 19 June 2012).

[18] Alcohol Learning Centre. *Clarifying brief interventions.* 2010. Available from: http://www.alcohollearningcentre.org.uk/. (Accessed 18 July 2012).

[19] Moyer A, Finney J, Swearingen C, and Vergun P. *Brief Interventions for alcohol problems:a meta-analytic review of controlled investigations in treatment-seeking and non-treatment seeking populations,* Addiction 2002; 97:279-292.

[20] Kaner EF, Dickinson HO, Beyer FR, Campbell F, Schlesinger C, Heather N, Saunders JB, Burnand B, Pienaar ED. *Effectiveness of brief alcohol interventions in primary care populations.* Cochrane Database of Systematic Reviews 2007, Issue 2.

[21] Crawford MJ, Patton R, Touquet R, Drummond C, Byford S, Barrett B. et al. *Screening and referral for brief intervention of alcohol-misusing patients in an Emergency Department: a pragmatic randomised controlled trial.* The Lancet 2001; 364:1334-1339.

[22] Barrett B, Byford B, Crawford MJ. *Cost effectiveness of screening and referral to an alcohol health worker.* Drug and Alcohol Dependence, May 2005.

[23] McGovern R, Kaner E, Deluca P. *Alcohol screening and brief intervention in primary health care.* Institute of Psychiatry, King's College London, 2012.

[24] Babor T, Higgins-Biddle J. *Brief intervention for hazardous and harmful drinking: a manual for use in primary care.* WHO 2001. Available at: http://www.icap.org/PolicyTools/ICAPBlueBook/BlueBookModules/1AlcoholEducation/tabid/1 62/Default.aspx.

[25] Coulton S, Newbury-Birch D, Cassidy P, Dale V, Deluca P, Gilvarry E, et al. *Screening for Alcohol Use in Criminal Justice Settings: An Exploratory Study* Alcohol and Alcoholism 2012; 47(4):423-427.

[26] National Institute for Health and Clinical Excellence. *Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence.* NICE clinical guideline 115, 2011 http://guidance.nice.org.uk/CG115 (Accessed 4 September 2012).

[27] ICAP International Centre for Alcohol Policies. *Alcohol Education.* [Online]. Available from: http://www.icap.org/PolicyTools/ICAPBlueBook/BlueBookModules/1AlcoholEducation/tabid/1 62/Default.aspx (Accessed 9 August 2012).

[28] Royal College of Physicians. *Science & Technology Select Committee: Inquiry on alcohol guidelines, Royal College of Physician's written evidence.* September 2011. Available from: http://www.rcplondon.ac.uk/sites/default/files/rcp_evidence_to_the_inquiry_on_alcohol_guidelines_1.pdf. (Accessed 4 September 2012).

[29] Babor TF, Caetano R, Casswell S, Edwards G et al. *Alcohol: No Ordinary Commodity – Research and Public Policy.* Oxford: Oxford University Press, 2010.

[30] Yang Z & Schaninger CM. *Parenting strategies as influences of teen drinking via self esteem: An important area for family policy.* Journal of Macromarketing, 2010;30: 331–341.

[31] Foxcroft DR & Tsertsvadze A. *Universal school-based prevention programs for alcohol misuse in young people.* Cochrane Database of Systematic Reviews, 2011; 5.

[32] Koning IM, van den Eijnden RJ, Verdurmen JE, Engels RC & Vollebergh WA. *Long-term effects of a parent and student intervention on alcohol use in adolescents: A cluster randomized controlled trial.* American Journal of Preventive Medicine, 2011;40:541–547.

[33] Donohue B, Allen DN, Maurer A, Ozols J & DeStefano G. *A controlled evaluation of two prevention programs in reducing alcohol use among college students at low and high risk for alcohol related problems.* Journal of Alcohol and Drug Education, 2004;48: 13–33.

[34] Agostinelli G & Grube JW. *Alcohol counter-advertising and the media: A review of recent research.* Alcohol Research and Health, 2002;26: 15–21.

[35] Kumpfer KL, Whiteside HO, Greene JA & Allen KC. *Effectiveness outcomes of four age versions of the Strengthening Families Program in statewide field sites.* Group Dynamics: Theory, Research, and Practice, 2010;14: 211–229.

3 Social impact

Contents

Key facts

- The UK's alcohol drinks market is estimated to be worth more than £30 billion per year. Alcohol-related harm costs the country more than £25 billion a year, with further un-estimated but substantial costs for individuals and families.
- It is estimated that 2.6 million children in the UK are living with parents who are drinking hazardously. In Islington in 2011/12, 114 adults (36% of all new cases) presenting to alcohol services for the first time had contact with children, either as a parent or living in the same house.
- Studies indicate that alcohol is a very common feature of domestic violence. One study of offenders on probation or referred for pre-sentence reports charged with domestic violence offences found alcohol use was a feature in the majority of cases (62%), and almost half of the sample (48%) were alcohol dependent. Of 1,356 domestic violence offences reported in Islington in 2011/12, 607 were identified as alcohol-related, of which 258 were alcohol-related violence against the person offences.
- Nationally the proportion of 11–15 year olds who drink regularly has fallen (from 28% in 2001 to 21% in 2006) but the average weekly consumption among those who do drink has increased significantly. Survey data suggests fewer young people in Islington drink alcohol compared to the national average, but those who do, drink more heavily.
- Alcohol impacts on the workplace, as individuals who are dependent drinkers experience greater levels of sick leave than those drinking at lower levels; whilst up to 25% of workplace accidents and around 60% of fatal accidents at work are thought to be linked to alcohol.
- In 2011, Islington had the third highest rate in London of working age persons claiming incapacity benefits due to alcoholism, significantly higher than the London and England averages.
- The availability of data around the social impacts of alcohol is limited. Understanding the full effects requires improving collection of data to quantify the social impact alcohol is having on families and communities.

WHY FOCUS ON THIS AREA?

There are multiple social and economic consequences of alcohol consumption. These affect not only the individual who drinks, but families, the workplace and society as a whole. As a consequence increasing attention is being paid to the harm alcohol causes to people other than the drinker, sometimes referred to as 'social harm' or 'passive drinking'[1, 2, 3].

Although there are economic benefits of alcohol, there are also substantial costs which are felt across a number of areas including health, crime, the workplace and social networks. Quantifying the economic cost of alcohol is an important component of understanding the wider picture of alcohol-related harm and is discussed in this chapter.

Sustained recovery has been linked to the resources available to support the individual. The National Drug Strategy[4] has suggested three types of resources that can aid recovery, which are summarised below, and the factors contributing to these will be discussed during this chapter:

- Social resource: relationships with family, partners, children and friends, both the support received from these as well as the resulting obligations
- Physical resource: financial and material resource needed to provide a stable environment
- Human resource: the skills and employment opportunities available to the individual

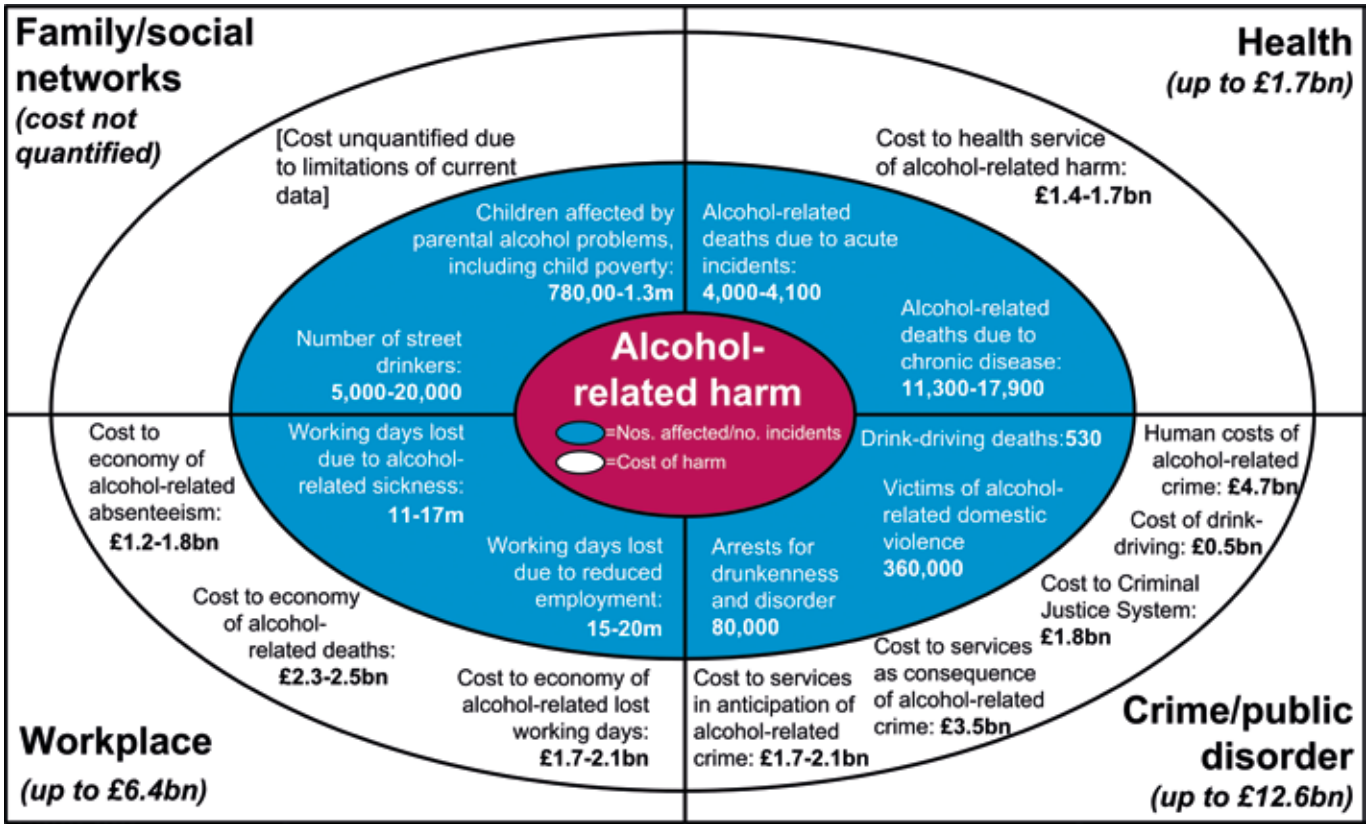
The social harm associated with alcohol consumption is not as easily measured as some other harm; however it is acknowledged that the impacts can be substantial. Children and young people are often the most severely affected by another individual's alcohol use since they can do little to protect themselves from the direct or indirect consequences of parental drinking[5]. It is because of this vulnerability, and the fact that evidence shows children of alcohol misusers are more likely to experience behavioural problems and poor outcomes at school, that children and families are the focus of this chapter.

ECONOMIC IMPACTS OF ALCOHOL

Alcohol is an important component of the entertainment and night time economy and an important source of employment both nationally and within Islington. The UK's alcohol drinks market is estimated to be worth more than £30 billion per year. Alcohol is also subject to both excise duty and VAT, generating tax revenue of over £13 billion per year[6].

Within Islington, food and drink retail businesses account for around

Figure 3.1 The national costs of alcohol-related harm (2004)
Source: Cabinet Office. Alcohol harm reduction strategy for England, 2004[3]



4% of businesses and nearly all have an off-licence for alcohol. Alongside this, restaurants, bars and hotels account for a further 13% of Islington's total businesses[7].

However, the benefits need to be weighed against the financial costs of alcohol-related harm. Analysis from 2004 indicated that alcohol-related harm costs the country at least £20 billion, with further unestimated costs for individuals and families **(see figure 3.1)**[3]. The 2004 Cabinet Office estimates were updated in 2008 and put the total annual cost of alcohol misuse to the UK economy at up to £25.1 billion[8]. Although the analysis was unable to put a figure on social costs, a recent report quantifying costs in Scotland suggest that 41.2% of the total cost of alcohol-related harm is linked to wider societal costs[9]. Applying this to the UK would suggest the societal cost of alcohol could be around £17.6 billion a year.

The estimated costs associated with alcohol misuse in Islington is £230 million (2007/08), made up from costs to health services, criminal justice and workplaces[10]. Inpatient admissions alone were estimated to cost £7.4 million in 2008/9, an average of £39 for every resident in the borough[11].

The economic costs are clearly wide ranging and it is important to understand the factors contributing to these. This chapter explores the social and workplace impacts of alcohol in more detail, whilst subsequent chapters examine the impact of alcohol on health and crime.

CHILDREN AFFECTED BY SOMEONE ELSE'S ALCOHOL USE

It is estimated that 2.6 million children in the UK are living with parents who are drinking hazardously and 705,000 children are living with dependent drinkers[12]. The World Health Organisation highlight parental substance misuse as an issue, stating:

'The negative effects of excessive drinking on non-drinking family members, and particularly on children, remain a concern and have to be considered a pertinent public health issue'[13]

Research undertaken by the Scottish Health Action on Alcohol Problems (SHAAP) and the NSPCC's ChildLine in Scotland, provides clear insight into the physical and psychological harms children can suffer from parental alcohol misuse[14]. In this study children provided accounts of multiple negative impacts associated with harmful parental drinking including severe emotional distress, physical abuse and violence and a general lack of care, support and protection. Physical abuse ranged from one-off slaps to being punched and kicked regularly, usually occurring when the parent was drunk or had been drinking[15]. Alcohol can result in distorted roles within the family, with children having to take on a range of roles including carer when looking after a drunken parent and protector and mediator when family conflict occurs. There are also long-term effects on children growing up in an environment affected by alcohol-related harm and estimates suggest they are five times more likely to develop alcohol-related problems than those with non-alcoholic parents[16].

Estimating the size and extent of the negative impacts of parental alcohol misuse on children in Islington is difficult since children may not be in contact with health or social services until problems escalate and even then, parental alcohol misuse is not always recognised or recorded. In Islington in 2011/12, 114 adults (36% of all new cases) presenting to alcohol services for the first time had contact with children, either as a parent or living in the same house **(figure 3.2)**[17]. Ensuring treatment services cater for a child affected by someone else's drinking is an important component of a holistic alcohol treatment pathway; approaches to enabling this are discussed in the 'what works' section of this chapter. Locally, the CASA Family Service helps children, young people and families who are having difficulties because of parental use of alcohol or other drugs **(box 3.1)**.

Parental alcohol misuse is often a contributory factor in child protection cases. Nationally, parental alcohol misuse is estimated to be a factor in around a quarter of known cases of child abuse[18]. The way in which data around child protection cases is recorded in Islington makes quantification of the impact of alcohol in these cases difficult. However information is collected around contributory factors discussed at child protection case conferences. Although a child may be the subject of a number of case conferences or a number of children from one family may be discussed at one conference, this data still gives a good indication of the impact of alcohol on this particularly vulnerable group of children. In 2011/12 there were a total of 240 case conferences

in Islington; alcohol was a contributory factor in 18% of these, and one of the top four contributory factors discussed. Domestic violence, drugs, and adult mental health were the other major contributing factors **(figure 3.3)**[19].

National guidance, "Working Together to Safeguard Children"[20], recommends the establishment of interagency protocols for coordinating assessment and support between adult alcohol services and children's services, as well as collaboration with other agencies, such as health, maternity, social care, courts and the prison/probation services. Islington's Interagency Protocol for working with children and families affected by parental alcohol and drug misuse was launched in November 2010. The aims are to:

- increase the number of parents with substance misuse problems accessing treatment and receiving family focused care
- increase the number of families whose cases are jointly worked across children's social care and adult treatment
- increase the number of children of drug or alcohol users receiving support
- increase the timely removal of children not safely cared for at home
- increase the professional competence across all sectors in identifying and responding to parental substance misuse
- decrease the number of children looked after due to parental substance misuse
- decrease the number of children with a child protection plan affected by parental substance misuse

Figure 3.2 Parental status of individuals using alcohol treatment services in Islington, all new presentations, 2011/12.

Source: Islington Public Health Intelligence. Islington alcohol and substance misuse needs assessment, 2012.[8]

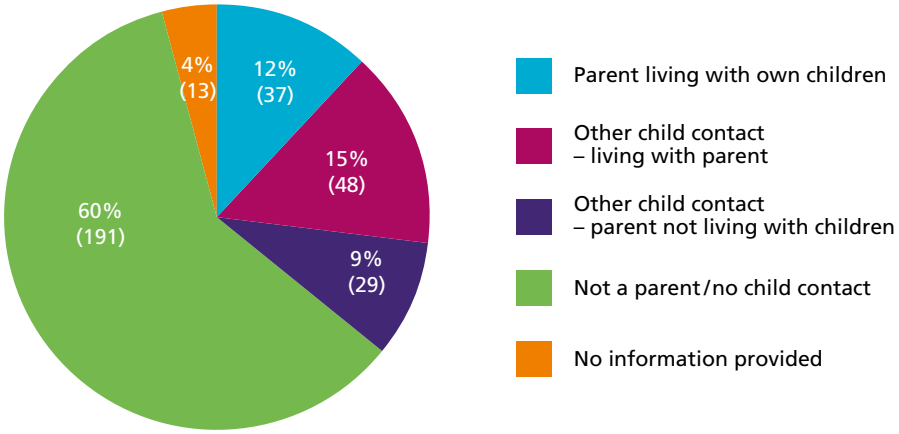
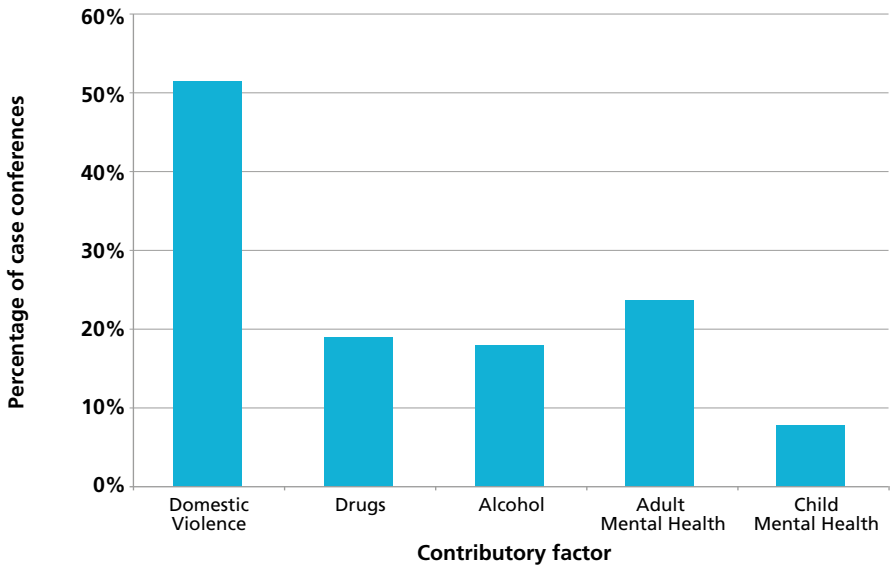


Figure 3.3 Percentage of Child Protection conferences in which different contributory factors included, 2008-2010

Source: Islington Public Health. Area Children's Young People Partnership (ACYPP) health data profile 2011



It is important that services coming into contact with children and families are in a position to support and signpost individuals affected by alcohol misuse. Islington's 16 Sure Start Children's Centres offer a range of activities and services for children and their families to give every child the best start in life and are an ideal setting for providing information, advice and support to parents with alcohol misuse problems. Islington's Children's Centre Alcohol and Substance Misuse Policy[21] outlines safeguarding procedures relating to alcohol or substance misuse and the role of the Children's Centre in supporting families alcohol or substance misuse issues.

Box 3.1: Community alcohol support for families and friends

CASA, Islington's Community Alcohol Service, provides a comprehensive range of support for any Islington resident who is concerned about their own or someone else's drinking.

Families, Partners and Friends (FPF) Service

This service provides support to adults aged 18 years and over who are family members, partners and friends/carers of alcohol and substance misusers. The advice provided covers the impacts on the individual affected as well as providing them with skills to support the alcohol misuser going through recovery. Those accessing the service present with high levels of stress, mental and physical health problems related to the drinkers' alcohol misuse, relationship problems with the drinker, family, work and social isolation problems, domestic violence and child protection issues. CASA also find there is a significant degree of ignorance and misunderstanding about alcohol dependency and treatment.

People can self-refer or be referred by a professional. In 2011/12, 70 individuals were referred to the service, with an average of 30 clients being supported at any one time. The service includes one-to-one support and counselling over the phone or in person, an out-of-hours 24-hour helpline and a weekly support group. CASA will also liaise and link in with other agencies as required, such as domestic violence services, social services, and other family services.

CASA Family Service

The CASA Family Service helps children, young people and families who are having difficulties because of parental use of alcohol or other drugs. The service aims to help parents provide a safer and more secure environment for everyone in the family, especially children and young people.

Self referrals, professional or family referrals are accepted. The service tries to see people as quickly as possible, aiming to offer appointments within 10 days. In 2011/12 the service worked with 72 families, and provided training on alcohol-related family issues to 50 professional colleagues across other Islington agencies.

Specifically, the Family Service offers: direct therapeutic work with families; group work with children, young people and families; parenting programmes; a young carers project; outreach to universal services with a focus on early intervention and prevention; and consultation and training for Children's Services staff.

The Islington Healthy Children's Centre Programme to promote better health and wellbeing includes five standards related to alcohol and substance misuse:

1. The Children's Centre works in partnership with specialist agencies to provide access to support groups and individual support to pregnant women and their partners, parents and carers with substance misuse problems
2. Staff are aware of the importance of supporting parents with substance misuse problems, have good knowledge of specialist services, and how to refer into these
3. Parents with drug and alcohol problems are actively encouraged to become involved in Children's Centre activities
4. Parenting programmes include information about substance misuse and hidden harm
5. The Children's Centre has a policy to outline safeguarding procedures relating to substance misuse and the role of the Children's Centre in supporting families with parental substance misuse issues

DOMESTIC VIOLENCE

Although there are no national figures on the prevalence of domestic abuse in the alcohol treatment population, studies indicate that alcohol is a very common feature of domestic violence. One study among offenders on probation or referred for pre-sentence reports charged with domestic violence offences found alcohol use was a feature in the majority of cases (62%) and almost half of the sample (48%) were alcohol dependent[22]. Evidence shows alcohol use amongst perpetrators of domestic violence, particularly heavy drinking, is more likely to result in serious injury to their partners than if they had been sober[23]. Drinking also increases the risk of becoming a victim of domestic violence, although research has found that alcohol is also used by victims as a coping mechanism[9].

Of 1,356 domestic violence offences reported in Islington in 2011/12, 607 were identified as alcohol-related, of which 258 were alcohol-related violence against the person offences. Islington's Domestic Violence Strategy[24] sets out a series of objectives and actions to reduce domestic violence in the borough, a number of which relate directly to alcohol misuse. Key among these are:

- Improving the response to survivors of domestic violence with multiple needs, including alcohol misuse:
  - Improving joint working between substance and alcohol misuse services
  - Increasing awareness of the Stella project: a UK wide project that encourages a collaborative approach to manage alcohol and drug related domestic violence. The project has produced toolkits, resources and offers training including guidance for those working with perpetrators
  - Ensuring effective risk assessment tools and referral pathways are in place
- Improving the response to perpetrators of domestic violence with multiple needs, including alcohol misuse, by working with relevant agencies to combine the skills and knowledge of staff. This includes work to:
  - Promote specialist training on the response to perpetrators of domestic violence
  - Explore the potential for creating a pilot programme for working with perpetrators of domestic violence who are also currently misusing substances, including alcohol

YOUNG PEOPLE DRINKING ALCOHOL

"It is important to teach about alcohol because they (pupils) experiment with alcohol and it's so widely available – it's insidious; (it's important for them) to know the dangers; also in the context that some of them have parents who drink heavily... I think it's pretty vital, don't you?"

PSHEE Coordinator, Islington Arts and Media School

As well as the affect of someone else's drinking on children and young people, alcohol consumption among young people can have a particularly detrimental effect on their health, development and ability to reach their full potential, as well impacting on the life of their family and community. Higher levels of alcohol consumption in young people are associated with a wide range of risks, including unprotected sex, offending behaviour and street violence.

Nationally, the proportion of 11–15 year olds who drink regularly has fallen (from 28% in 2001 to 21% in 2006) but the average weekly consumption among those who do drink has increased significantly[25].

The 2008 Ofsted Tellus survey suggests that overall fewer young people in Islington drink compared to the national average, but those who do, drink more heavily.

A survey in January 2012 found a third of Islington residents report they do not feel safe outside in their local area because of young people drinking in public spaces[26]. One multi-agency initiative to address the issue of youth drinking and the subsequent impact on the wider community was the Islington Community Alcohol Partnership (CAP). Discussed in Chapter 5, this approach has had success in reducing sales of alcohol to minors and a reduction in antisocial behaviour related to alcohol consumption.

It is important that alcohol awareness is included within the education of children and young people. In Islington alcohol education is delivered through the PSHEE (Personal, Social, Health and Economic Education) curriculum and the awareness raising starts early (in primary schools) and develops throughout a child's education. It is designed to equip children and young people with age appropriate knowledge and skills and enable them to explore others' attitudes and consider their own.

Following consultation in 2009/10 with Year 9 pupils (aged 13-14 years)

on levels of alcohol use among young people and the education and advice they would find useful about alcohol[27], new school-based approaches were tested with 70 workshops involving a total of 1,430 year 8 and 9 (aged 12-14 years) pupils from 14 schools in Islington. Following the lessons, about two-thirds agreed or strongly agreed they could resist negative pressure, including peer pressure. Most could suggest ways to reduce the risks of drinking, including, "taking sips instead of all in one go", "drinking with people you trust", as well as "not drinking too much". The majority of pupils were able to suggest how and where to get support if they, or a friend, had a problem with alcohol.

Children and young people may themselves misuse alcohol, and providing support and treatment services which are age specific is important. In Islington this is provided through Islington's Young People's Drug and Alcohol Service (IYPDAS). This service provides free and confidential advice and treatment for young people up to the age of 18 who have substance misuse issues. IYPDAS offers a range of individually tailored interventions, joint work with other services and onward referral as required. In 2011-12 the IYPDAS received a total of 134 referrals for young people with substance misuse issues. Of these, 110 engaged in comprehensive substance use assessments and were supported within structured, care planned treatment, plus an additional 24 received an advice and information only service. Of the 110 young people IYPDAS supported, the majority were male (69%), and 87% were aged 15 to 17. The primary referral source was the Youth Offending Service (62% of referrals). The primary substance used was cannabis (71% of referrals), while the secondary substance used was alcohol in 64% of cases.

EMPLOYMENT AND ALCOHOL

Another impact of alcohol misuse and dependency is loss of productivity, which can result in additional financial pressure on families and can be a key factor in inter-generational poverty and worklessness[4].

Alcohol is linked to both problems in the workplace and subsequent unemployment. The effects on workplace performance include:

- Absences: individuals who are dependent drinkers experience greater levels of sick leave than those drinking at lower levels
- Accidents: In the UK up to 25% of workplace accidents and around 60% of fatal accidents at work are thought to be linked to alcohol[1]
- Productivity: performance is affected by alcohol and this can have detrimental effects on relations with co-workers

Consequently, the inclusion of advice and support to workplaces around the management of alcohol problems and alcohol in the work place policy should be seen as an important component of alcohol harm reduction which is likely to have positive effects both on those in the workplace and the wider social network including the family of the individual drinking. Later in this chapter effectiveness of approaches to alcohol awareness in the workplace are discussed.

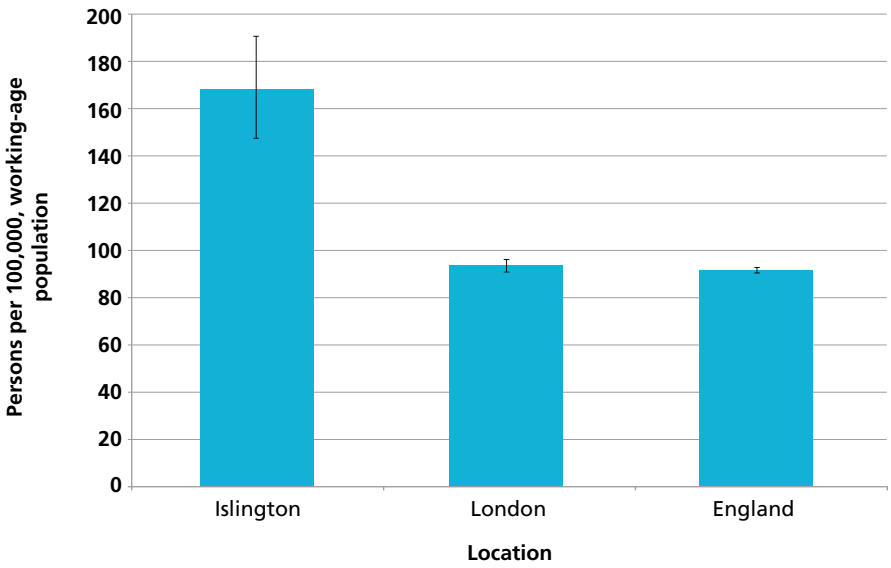
The impact of poor workplace performance can be repeated dismissals ultimately leading to long-term unemployment.

An evidence review of the health impacts of unemployment on individuals and their families in the UK found this was associated with higher rates of family breakdown as well as detrimental effects on the health of the whole family. There is also some evidence that alcohol consumption can often increase after the onset of unemployment[28].

In 2011, Islington had the third highest rate in London of working age persons claiming incapacity benefits due to alcoholism, significantly higher than the London and England averages **(figure 3.4)**[29].

Figure 3.4 Crude rate of claimants of Incapacity Benefit or Severe Disablement Allowance whose main medical reason is alcoholism for Islington, London and England: Persons per 100,000, working-age population (Aug 2011)

Source: Local Alcohol Profiles for England, 2012



WHAT WORKS

Involving families in treatment

NICE guidance supports the involvement of families in treatment. It is important that families and carers have their own needs identified, are offered information and support and are encouraged to be involved in the treatment and care of people who misuse alcohol to help support and maintain positive change[30].

The evidence about what approaches work best when working with the whole family to reduce alcohol-related harm is relatively limited. A review suggested three main approaches to involving families in treatment of those with alcohol misuse problems[31,32]:

1. Family members encouraging the individual with an alcohol-related problem to seek treatment and making changes to family and social life so as to encourage changes in behaviour. This appears to increase the likelihood that users will access treatment services.
2. Involving family members in the treatment of the misuser and assessing wider issues such as improving relationships and addressing behaviours that facilitate drinking. Studies using this approach have shown improved outcomes in the individual with an alcohol-related problem.
3. Providing support to family members affected by someone else's drinking. There is emerging evidence that this not only improves outcomes for the individual who is drinking but also helps the family to develop better ways of coping and resilience

Peer support can be a useful resource to families. It can be offered in families own homes or environments and can reduce families anxieties about accessing formal services[33].

Family focused approach

The 'Think Family' approach was developed by the Department for Education to improve and coordinate support offered to vulnerable children and adults within the same family[34]. National policy promotes the 'whole family approach' for management of alcohol and substance misuse, which can be important in 'breaking the intergenerational patterns of dependency'. Support packages tailored and coordinated to families with multiple needs is a potentially effective approach to improving outcomes.

A number of approaches have been used to provide intensive family focused support in the UK. They involve integrated and holistic care that brings together adult and children's services[35]. Addressing substance and alcohol misuse is a core component of the model and outcomes from this approach are promising. For instance in one programme among 530 families identified as having problems with drinking or alcoholism, 57% reported alcohol to no longer be an issue on completion of the support programme; children showed improved educational attendance and there was a reduction in the number of young people with caring responsibilities[36,37].

Another approach where preliminary findings indicate effectiveness is the Family Drug and Alcohol Court, which aims to improve child outcomes by addressing the complex difficulties experienced by parents. A specialist multi-disciplinary team works with the court to develop and coordinate a care plan that addresses the families problems and supports parents to engage and stay engaged with treatment services. There are regular

court reviews to enable monitoring and problem solving. The pilot found improved outcomes for both children and parents compared to ordinary care proceedings, with a higher proportion of users engaging in treatment, stopping substance misuse and parents being reunited with children. Both parents and professionals found the approach was better than ordinary care proceedings[38].

Supporting children and young people misusing alcohol

Schools are an important setting. NICE recommends alcohol education should be an integral part of the school curriculum, tailored to different age groups and learning needs. School interventions on alcohol use should be integrated with community interventions. Families should be consulted and involved with initiatives to reduce alcohol use and partnership working incorporated. If a child is thought to be drinking harmful amounts of alcohol they should be offered one-to-one advice or should be referred to an external service[39].

The National Drug Strategy states young people in whom drug or alcohol misuse has already started to cause harm or who are at risk of becoming dependent require rapid access to specialist support aimed to address substance misuse but also the wider issues affecting them. NICE recommends that children and young people with significant comorbidities or limited social support requiring specialist services for alcohol use should be offered coordinated programmes of care, including family or systems therapy, to meet their needs. This requires substance misuse services, youth offending, mental health and other children's services to come together to ensure appropriate support packages are in place. The focus should be on preventing an increase in use and harm and stopping the young person becoming an alcohol or drug dependent adult.

Alcohol and the workplace

The evidence for effective workplace intervention to reduce alcohol-related harm is limited[40]. However the workplace has been identified as a useful location for promoting health, including alcohol harm reduction. One effective approach could be a wider well-being at work initiative, including policies which make workplaces alcohol free, which may help to reduce alcohol-related work place accidents and injuries as well as developing a healthier relationship with alcohol that impacts on friends and families[41]. Other interventions include[38]:

- Brief Interventions: High quality evidence is limited, but available evidence suggests brief intervention approaches can be successfully applied in a workplace setting.
- Employee assistance programmes: These generally identify employees with alcohol-related problems and refer them on to treatment. Although evaluations are limited, self referral and easy access to support programmes are important, and should be accessible via or in the workplace.
- Web-based interventions: These appear to be acceptable to staff, have good levels of use among a range of groups and impact on drinking behaviour.

Certain industries where exposure to alcohol or where the risk associated with alcohol-related harm is greater have been suggested as areas for specific focus, for instance bar and restaurant staff, construction workers and seafarers[41].

One study involving restaurant employees illustrates how prevention and early intervention, aimed at young people in an at-risk industry, can impact on heavy drinking. The study provided workshops using discussion and practical exercises designed to address stress management and encourage peer referral to counselling and was associated with a reduction in heavy alcohol use[42]. Mandatory screening programmes targeted at employees in high risk situations such as those working in transport have been found to be effective[41].

Supporting people back into work as part of alcohol treatment services is also important. This should focus on building up skills and self-esteem of individuals; including training, volunteering and work trials as part of a stepped process back into paid employment and have close links to employment programmes[4].

SUMMARY

Although there are economic benefits of alcohol, there are also substantial costs which are felt across a number of areas including health, crime, the workplace and social networks. The social harm caused by alcohol is not easily measured; however it is acknowledged that the impacts of alcohol can be substantial.

Alcohol misuse does not just affect the drinker but also impacts on those around them. For children the effects of alcohol misuse can include physical abuse of the child and alcohol is often a contributory factor in child protection cases. Alcohol is also a common feature of domestic violence. It is important that treatment services take account of the wider impacts of alcohol misuse on families and children as well as treating the drinkers themselves. Local alcohol services provide support to Islington residents who are concerned about their own or someone else's drinking. Services include those that provide advice to people who are family members, friends or carers of people who misuse alcohol and those that help children, young people and families who are having difficulties because of parental use of alcohol.

Alcohol consumption among young people can have a particularly detrimental effect. Higher levels of alcohol consumption in young people are associated with a wide range of risks, including unprotected sex, offending behaviour and street violence.

Both nationally and locally there is a need to improve the availability of data to better understand and quantify the social impact alcohol is having on families and communities.

References

[1] World Health Organisation. *Global status report on alcohol.* WHO 2004 http://www.who.int/substance_abuse/publications/globalstatusreportalcohol2004_socproblems.pdf

[2] HM Government. *The Government's alcohol strategy.* CM8336. London: The Stationery Office, 2012

[3] Cabinet Office. *Alcohol harm reduction strategy for England,* 2004

[4] HM Government. *Drug strategy 2010 Reducing Demand, Restricting Supply, Building Recovery:Supporting People to Live a Drug Free Life.* London: The Stationery Office, 2010

[5] World Health Organisation *Expert Committee on problems related to alcohol consumption.* Technical report series 944, 2007

[6] National Audit Office. *Reducing alcohol harm: health services in England for alcohol misuse,* HC 1049 Session 2007-08, 2008

[7] London Borough of Islington. *Islington Alcohol Harm Reduction Strategy 2011 – 2014.* 2010

[8] Department of Health. *The cost of alcohol harm to the NHS in England.* London: Department of Health 2008

[9] York Health Economics Consortium, University of York. *The societal cost of alcohol misuse in Scotland for 2007.* 2010. http://www.scotland.gov.uk/Resource/Doc/297819/0092744.pdf, accessed 3rd September 2012.

[10] *Business Case for Prevention.* NHS Islington 2008

[11] London Health Observatory. *Closing time. Counting the cost of alcohol-attributable hospital admissions in London.* LHO, 2012

[12] Manning V. et al. *New estimates on the number of children living with substance-misusing parents: Results from UK national household surveys.* Journal of Public Health, 2009; 9 (1):377-389

[13] Kingermann H. *Alcohol and its social consquences – the forgotten dimension.* World Health Organisation. 2001

[14] NSPCC *Memorandum of Evidence to the Health Committee inquiry into alcohol* (Health Committee, 2009) http://www.nspcc.org.uk/Inform/policyandpublicaffairs/consultations/2009/health_select_committee_inquiry_into_alcohol_wdf67342.pdf (Accessed 24th August 2012)

[15] Tunard J. *Research in practice parental problem drinking and its impact on children,* 2002

[16] Pickens RW, Svikis DS, Cgue M and Lykken, DT. *Heterogeneity in the inheritance of alcoholism: a study of male and female twins.* Archives of General Psychiatry 1991; 48: 19–28

[17] Islington Public Health Intelligence. *Islington alcohol and substance misuse needs assessment,* 2012.

[18] Alcohol Concern. *Supporting children affected by parental alcohol misuse: A Toolkit.* www.alcoholandfamilies.org.uk (accessed 04 September 2012).

[19] Islington Public Health. *Area Children's Young People Partnership (ACYPP) health data profile 2011.* NHS North Central London and Islington Public Health. 2011

[20] HM Government. *Working together to safeguard children: a guide to interagency working to safeguard and promote the welfare of children,* London: The Stationery Office. 2006

[21] Children's Centre. *Alcohol and Substance Misuse Policy Islington council.* http://www.islington.gov.uk/publicrecords/documents/EducationandLearning/Rtf/eyfst/Substance-Misuse-template-policy.rtf. (Accessed 29th August 2012).

[22] Gilchrist E, Johnson R, Takriti R, et al. *Domestic violence offenders: characteristics and offending related needs.* Home Office. 2003

[23] Brecklin L. *The role of alcohol use in the injury outcomes of intimate assaults, Journal of Family Violence,* 2002;17(3),185-196

[24] Safer Islington Partnership. *Domestic Violence Strategy 2009-2012.* Islington Council. 2012

[25] Department for Children, Schools and Families, Home Office & Department of Health. *Youth Alcohol Action Plan.* London: The Stationery Office, 2008.

[26] Bagwell S, Witting A, Parry-Crooke G. *Evaluation of the Islington Community Alcohol Project: Final Report.* The Cities Institute: London Metropolitan University. February 2012 http://www.citiesinstitute.org/fms/MRSite/Research/cities/Publications2012/CAP%20Final%20Report.pdf (Accessed 29th August 2012)

[27] Killough J. *Report on the alcohol education project.* Healthy School Islington. 2010.

[28] Wilson SH, and Walker GM. *'Unemployment and Health: A Review'.* Public Health, 1993. 107: 153-162

[29] *Local Alcohol Profiles for England, 2012* www.lape.org.uk (accessed 24th August 2012)

[30] National Institute for Health and Clinical Excellence. *Alcohol dependence and harmful use quality standard 2011.* Available from: http://www.nice.org.uk/guidance/qualitystandards/alcoholdependence/home.jsp (accessed 18th June 2012)

[31] Copello, AG, Velleman RDB, Templeton LJ. *Family interventions in the treatment of alcohol and drug problems.* Drug and Alcohol Review 2005;24:369-385

[32] Copello AG, Templeton L, Velleman R. *Family interventions for drug and alcohol misuse: is there a best practice?* Curr Opin Psychiatry. 2006;19(3):271-6.

[33] Adfam. *A partnership approach – supporting families with multiple needs.* 2011. http://www.adfam.org.uk/docs/adfam_partnership_2011.pdf (accessed 18th June 2012)

[34] Department for Education. *Think family toolkit improving support for families at risk.* 2009 available from: https://www.education.gov.uk/publications/eOrderingDownload/Think-Family.pdf (accessed 6th August 2012)

[35] National Treatment Agency. *Supporting information for the development of joint local protocols between drug and alcohol partnerships, children and family services.* 2011 http://www.nta.nhs.uk/uploads/supportinginformation.pdf (accessed 18th June 2012)

[36] Kendall, S., Rodger, J. and Palmer, H *Redesigning provision for families with multiple problems: early impact and evidence of local approaches.* Research Report DFE-RR046. Department for Education, 2010

[37] Dixon J. Schneider V, Lloyd C, Reeves A et al. *Monitoring and evaluation of family interventions.* Research Report DFE-RR044. Department for Education, 2010

[38] Harwin J, Ryan M and Tunnard J, et al. *The Family Drug and Alcohol Court (FDAC) Evaluation Project Final Report. Brunel University.* 2011, http://www.brunel.ac.uk/__data/assets/pdf_file/0017/91340/fdac_final_report.pdf (accessed 8th September 2012)

[39] National Institute for Health and Clinical Evidence. *School based interventions on alcohol.* NICE public health guidance 7, 2007

[40] Cercarelli R, Allsop S, Evans M & Velander F. *Reducing alcohol-related harm in the workplace* (An evidence review: full report), Victorian Health Promotion Foundation, Australia, 2012

[41] Scientific Opinion of the Science Group of the European Alcohol and Health Forum. *Alcohol, work and productivity.* 2011. http://ec.europa.eu/health/alcohol/docs/science_02_en.pdf (accessed 5th September 2012)

[42] Broome, K.M & Bennett, J.B. 2011. *Reducing heavy alcohol consumption in young restaurant workers.* Journal of Studies on Alcohol and Drugs, 72, 117-124.

4 Alcohol-related harm

Contents

Key messages

- In London, Islington men have the highest death rate from conditions wholly related to alcohol consumption and Islington women also have one of the highest rates. This equates to approximately 17 deaths a year.
- People with increased alcohol consumption are at risk of developing a number of long term conditions. For example they are 2 to 4 times more likely to develop high blood pressure and stroke and 13 times more likely to develop liver disease.
- Alcohol contributes (though may not be the only cause) to one in twenty deaths in Islington residents. This includes 22% (14) of all deaths from digestive diseases (which covers chronic liver disease) and 3% (11) of all deaths from cancer.
- People with higher and increased alcohol consumption are more likely to smoke or be ex-smokers. Approaches to supporting people to stop smoking and reduce alcohol consumption may therefore be required within this population.
- Alcohol has a key part to play in hospital admissions in Islington. Rates for both alcohol-specific and alcohol-related admissions in men are higher than the average for London. The main causes of admissions include high blood pressure and mental and behavioural disorders due to alcohol consumption.
- Ambulance call-outs due to alcohol consumption increase over the weekend in Islington, especially Saturday evenings. Half (1,186) of all call-outs related to alcohol consumption, result in the person being taken to hospital. Fifty percent of all call-outs to women were to those aged 30 years and under compared to 32% of men in that age group (2011/12).
- The number of people in alcohol treatment services and new presentations to these services has declined (832 and 589 respectively) over the period 2009/10 to 2011/12. Over the same time period the proportion of people successfully completing their treatment has increased from 30% to 54% which compares to 58% nationally.
- Approximately a third of Islington alcohol clients report being faced with additional challenges, including unemployment, homelessness and housing issues, that may impact on successful treatment. This is a similar proportion to those seen nationally and highlights the complexity of people's needs.
- The evidence suggests that a multi-component approach is required for the effective treatment of alcohol misuse. This starts with the identification and screening of people to assess their level of alcohol consumption and ranges through to community and residential treatment services.

WHY FOCUS ON THIS AREA?

Excessive drinking is a major cause of ill-health and death world-wide. In 2002, harmful use of alcohol was estimated to cause about 2.3 million early deaths world-wide and was responsible for 4.4% of the global disease burden, even after the protective effects of low and moderate alcohol consumption had been considered[1]. At lower levels of consumption alcohol may protect against the risk of death compared with not drinking at all but this changes with higher consumption[2]. Men who regularly drink more than eight units a day and women who drink more than six units a day raise their risk of a number of diseases[3].

The National Alcohol Harm Reduction Strategy[4] found that every year, in England over half of all violent crimes, 22,000 early deaths, 70% of all peak-time admissions to emergency departments and 1,000 suicides were directly related to alcohol. Alcohol consumption is a major factor in a large proportion of accidents and injury. It has also been cited as the single most important form of contributory behaviour for domestic accidents resulting in death, with an estimated 400 alcohol-related deaths due to home accidents each year in England[5].

Box 4.1: Understanding alcohol attributable fractions.

The contribution of alcohol to illness or death from a disease in a population can be quantified by Alcohol Attributable Fractions (AAF). AAFs represent the extent to which disease or death in a population could be reduced if exposure to alcohol were reduced to no alcohol consumption.

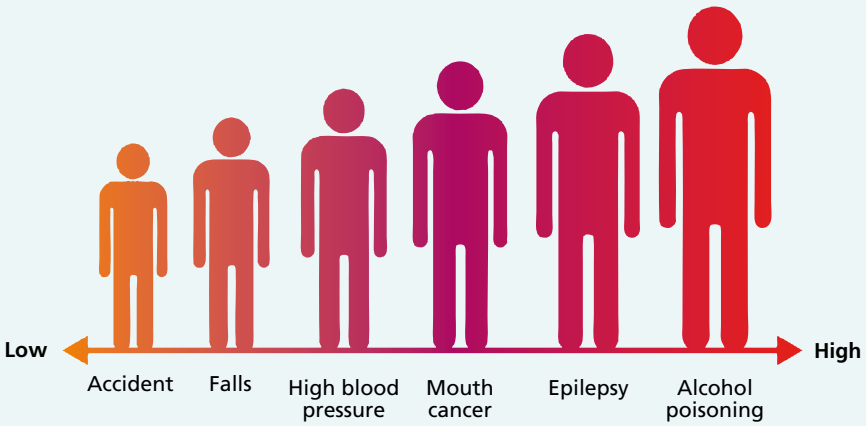
AAFs can therefore help to show whether a death or hospital admission is wholly (alcohol-specific) or partly linked to the consumption of alcohol. Alcohol-specific conditions include those where alcohol is entirely responsible for the development of the disease or death, for example alcoholic liver cirrhosis and poisoning from alcohol. A death or admission that is wholly caused by alcohol is given the value of 1.0, an example of which is alcohol poisoning **(figure 4.1).**

Alcohol-related conditions include all alcohol-specific conditions plus those where alcohol contributes to a lesser degree to the disease. A death or admission that is partly caused by alcohol is given a value of greater than zero and less than 1.0. For example, **figure 4.1** illustrates the lower and higher contribution alcohol can have on a number of conditions including high blood pressure and mouth cancer.

The calculation of AAFs is based upon the most recent population estimates of alcohol consumption and the risk of disease or death from alcohol, published in current epidemiological literature. AAFs aim to help quantify the possible contribution that alcohol may play in causing disease and death. Their calculation assumes causal associations between alcohol and disease or death and should therefore be interpreted with some caution.

Figure 4.1 Contribution of alcohol to the development of alcohol-related conditions

Source: Adapted using Alcohol Attributable Fractions from the North West Public Health Observatory[6]



DEATHS LINKED TO ALCOHOL

The annual risk of death from alcohol-related diseases in adults increases gradually with consumption from 7-8% more risk in those drinking 10-50 grams or 1-6 units a day to 9-10% increased risk in those drinking 60-90 grams or 7.5-11 units a day[7]. In 2009 there were 6,584 deaths in England related to alcohol consumption. Of these alcohol-related deaths, 63% (4,154) died from alcoholic liver disease[8].

The rate of deaths in Islington that are related to alcohol consumption are higher than the average for London and England. When compared to other London Boroughs, Islington ranks highest for alcohol-related death rates in men and fourth highest for women **(figure 4.2a and 4.2b)**.

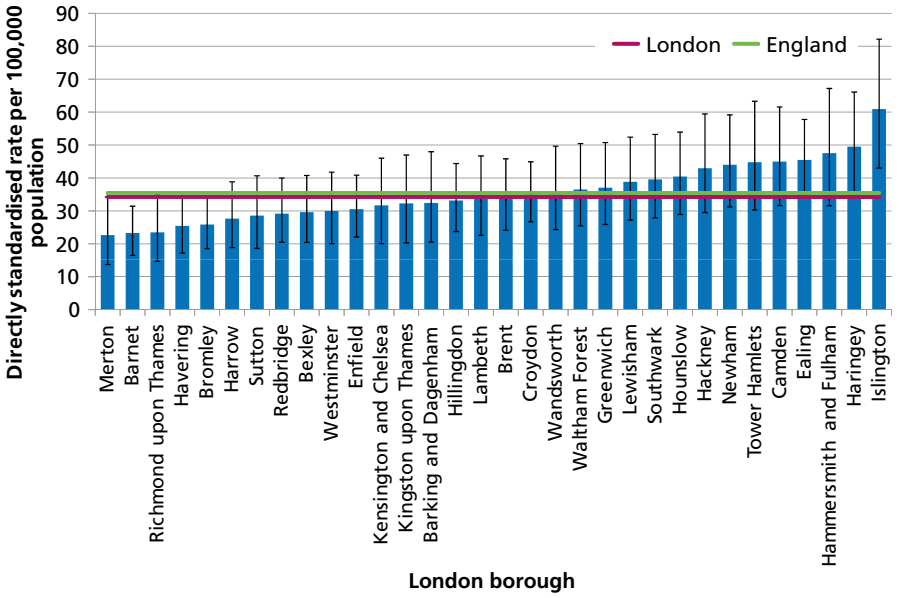
Although in recent years Islington's alcohol-specific death rate appears to be declining in men, the overall trend is that it remains higher than that seen across London and England **(figure 4.3)**.

On average each year (calculated over a three year period 2008-2010), Islington has 55 alcohol-related deaths of which 17 are alcohol-specific. Contributing to one in twenty deaths in Islington **(figure 4.4)** and includes those deaths in which alcohol is wholly responsible and those where it has played a lesser role. These are deaths that could potentially be avoided if Islington residents did not consume alcohol.

There is variation in the proportion and number of alcohol-related and specific deaths across Islington's population. Men are more likely to die from alcohol-specific and alcohol-related diseases than women.

Figure 4.2a Men Directly standardised rate of alcohol-related deaths in men, Islington, London and England per 100,000 population (2010)

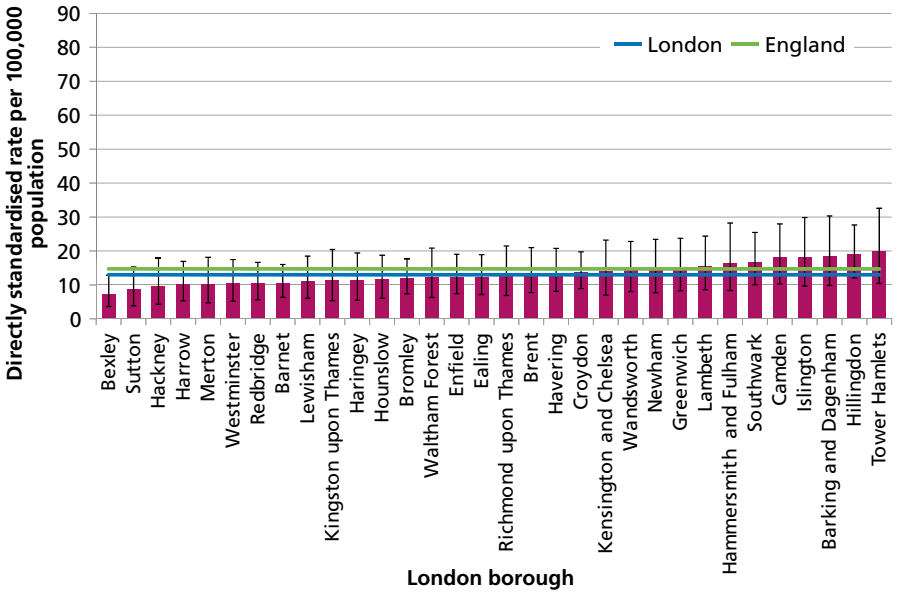
Source: Local Alcohol Profile for England. 2012



Note: City of London has been excluded due to small numbers

Figure 4.2b Women Directly standardised rate of alcohol-related deaths in women, Islington, London and England per 100,000 population (2010)

Source: Local Alcohol Profile for England. 2012



Note: City of London has been excluded due to small numbers

There is a higher rate and number of alcohol-related deaths in those less than 65 years **(figure 4.5)**. After 75 years, more women than men die of alcohol-related conditions but this is likely to reflect overall patterns observed within the population, with women living longer than men.

Looking by cause of death, alcohol consumption can impact on sudden accident related deaths including those from residential fires. The London Fire Brigade reports that alcohol is a factor in 31% of fatal accidental residential fires[9].

In addition, 22% (14) of all deaths from digestive diseases (which covers chronic liver disease) and 3% (11) of all deaths from cancer, are related to alcohol.

Deprivation is a key factor in poor health outcomes due to alcohol consumption in London and England. Alcohol-related deaths are more likely to occur in those from more deprived areas compared to those that are affluent. However, this pattern is not seen within Islington which probably reflects the relatively small numbers of deaths (statistically) that occur each year, making drawing any statistical conclusions for the local population difficult.

Figure 4.3 Directly standardised rate of alcohol-specific deaths in men and women, Islington, London and England per 100,000 population (2003-2005 to 2008-2010)

Source: Local Alcohol Profile for England. 2012

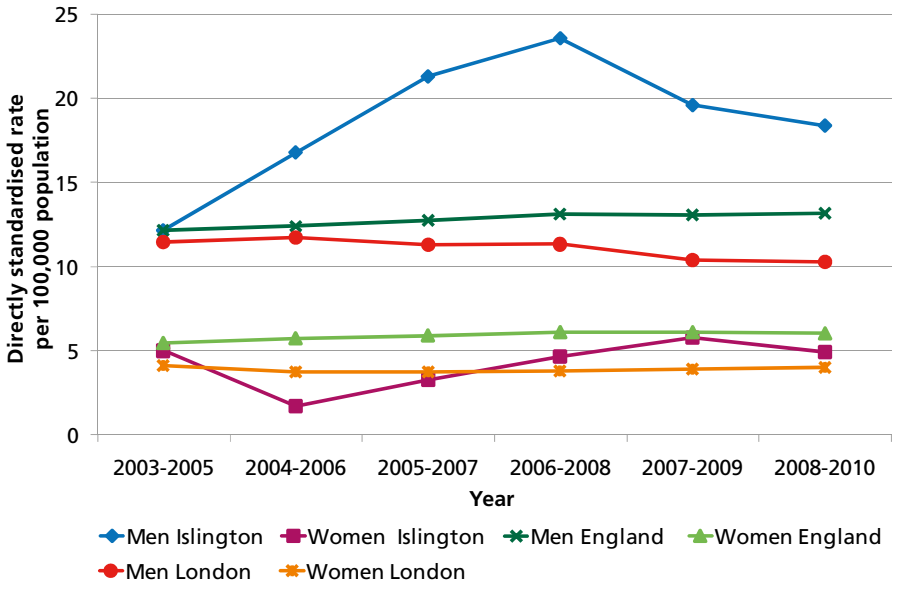
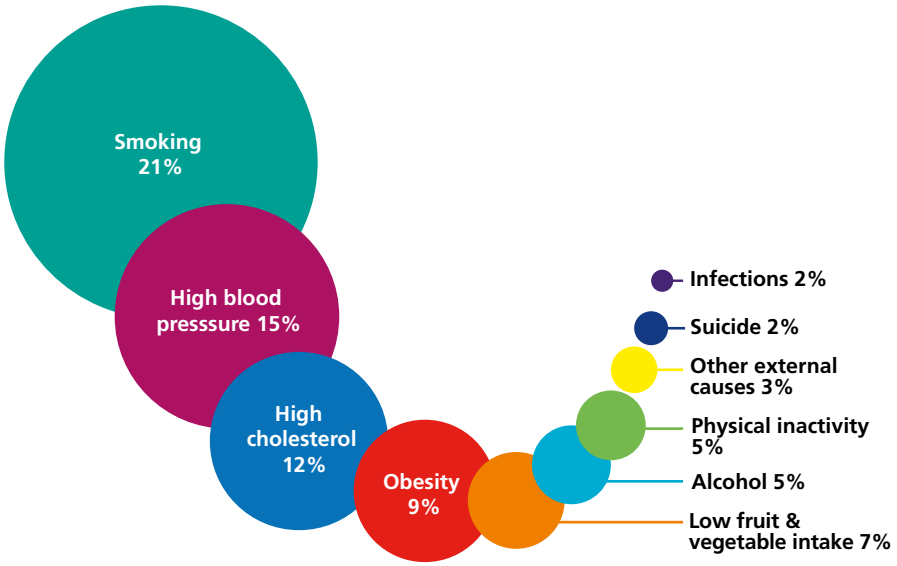


Figure 4.4 Risk factors contributing to deaths in Islington, Islington resident population, 2008-10

Source: ONS mortality files 2008-10; NWPH Observatory alcohol attributable fractions; The World Health Report 2002; Statistics on Smoking, NHS Information Centre 2006



ALCOHOL'S CONTRIBUTION TO LONG TERM CONDITIONS

Smoking, obesity, alcohol consumption, physical inactivity and poor diet are all important modifiable risk factors that can impact on health outcomes, including long term conditions. The higher risk of developing a number of long term conditions from increased alcohol consumption is outlined in **table 4.1**. The 2011 Annual Public Health Report illustrated that many people have multiple modifiable risk factors. Focusing on alcohol, it is possible to see that people with an increased risk through higher and increased alcohol consumption are more likely to smoke or be ex-smokers than those who drink less or are non-drinkers **(figure 4.6)**: for example, more than half of higher risk drinkers smoke compared to just over 20% of non-drinkers.

Figure 4.5 Percentage of alcohol-related deaths by age group, and number by age and sex, Islington resident population, all ages, 2008-2010

Source: ONS mortality files 2008-10

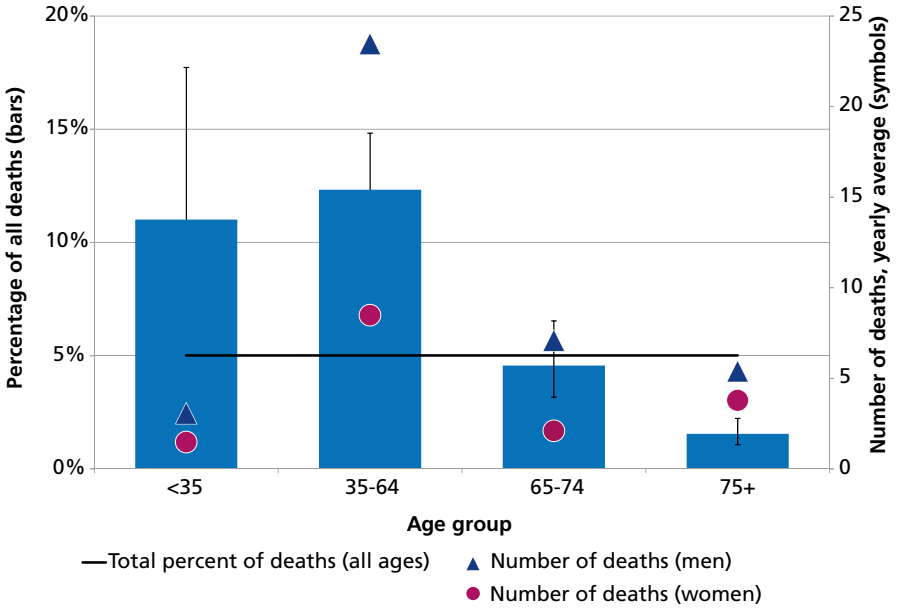


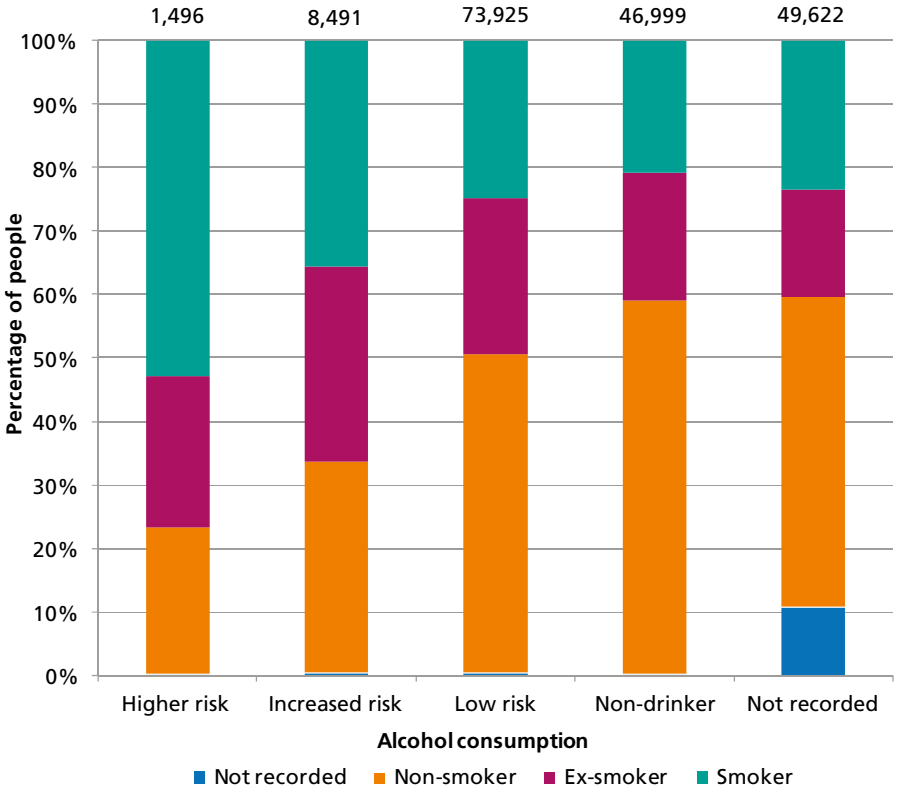
Table 4.1 Increased risks of ill-health to harmful drinkers

Source: Anderson P. the scale of alcohol-related harm Department of Health. 2007[10]

Condition	Men (increased risk)	Women (increased risk)
High Blood Pressure	4 times	Double
Stroke	Double	4 times
Coronary Heart Disease	1.7 times	1.3 times
Pancreatitis	3 times	Double
Liver disease	13 times	13 times

Figure 4.6 Breakdown of alcohol consumption by smoking status (where recorded), Islington GP registered population aged 18 and over, March 2011

Source: Islington GP dataset. 2010/11



IMPACT OF ALCOHOL ON HEALTH SERVICES

Alcohol-related admissions in Islington

It is estimated that, in 2008/09, there were just under 111,000 hospital admissions (emergency and planned) in London related to alcohol consumption, six percent of all hospital admissions[11]. In Islington 14,030 admissions were coded for a condition wholly or partly due to alcohol. Once alcohol attributable fractions were applied this equates to 9% of all (46,253) hospital admissions. The majority (91%) of admissions, coded for alcohol, were for conditions partially related to alcohol compared to those wholly related **(figure 4.7)**. With the AAFs applied, this equates to a total of 4,256 hospital admissions which could be avoided each year in Islington if alcohol consumption was reduced to zero, reducing the impact of alcohol on health services.

Islington's alcohol-related admissions rate is the highest in London[12]. There are differences by gender **(figure 4.8)** and age **(figure 4.9)** with men and those aged over 65 years of age more likely to be admitted. The increase in alcohol-related admissions with age is likely to reflect the development of long term conditions for which alcohol can be a risk factor **(table 4.1)**.

Figure 4.7 Alcohol and hospital admissions in Islington's resident population, 2011/12

Source: SUS, 2011/12
Note: the number of individuals admitted for alcohol-specific conditions may be lower than the total number of admissions as one person may be admitted more than once

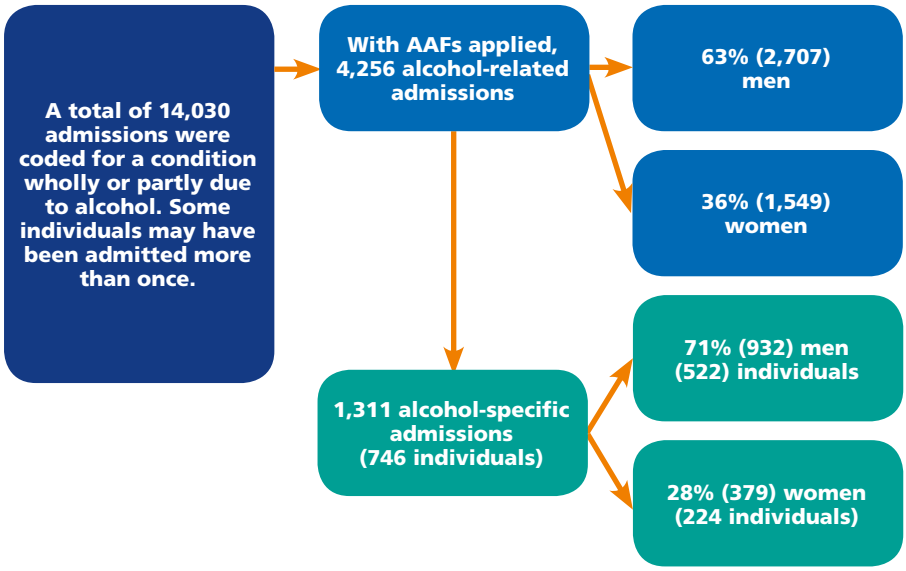
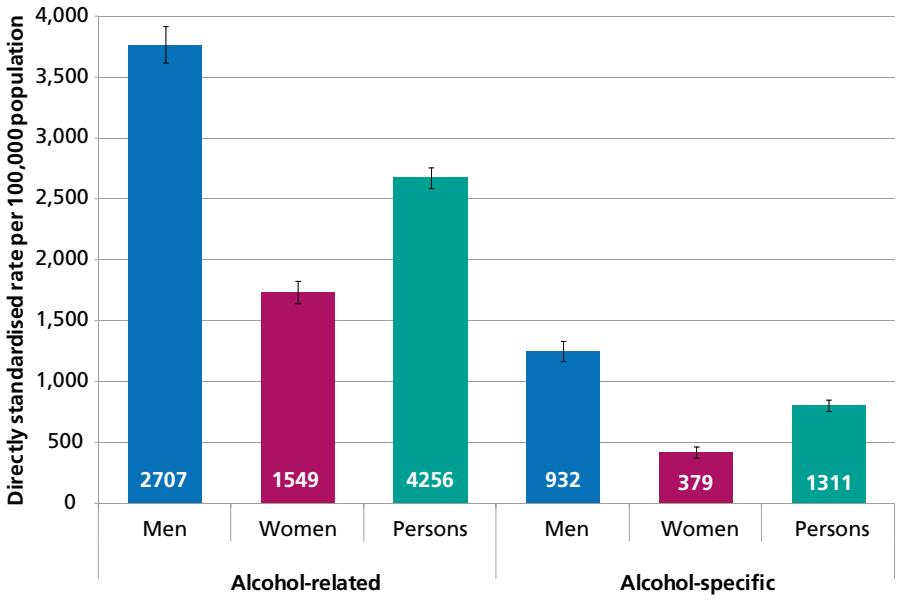


Figure 4.8 Directly standardised rates of alcohol-related and alcohol-specific admissions, per 100,000 population, all ages, by sex, Islington's resident population, 2011/12

Source: SUS 2011/12 (admissions); ONS 2010 Mid Year Estimate (population)
Note that some people will have more than one alcohol-related admission within the year



Differences in alcohol-related admissions to hospital appear to be influenced by the level of deprivation in Islington. Those living in the most deprived areas (bottom three deprivation quintiles) are approximately a third more likely to have an alcohol-related admission compared to those living in the more affluent areas (top two deprivation quintiles) **(figure 4.10)**.

Nine of Islington's wards have a similarly high rate of alcohol-related admissions compared to the average, providing some insight into the burden from alcohol on local health services in these areas **(figure 4.11)**. In contrast, Bunhill and Highbury East have lower rates.

Figure 4.12 shows that the main cause of alcohol-related admissions in Islington is from conditions related to high blood pressure (hypertensive disease), reflecting the prevalence of this condition generally within the population. Although most causes of admission, including alcoholic liver disease and alcohol poisoning, are similar in men and women, a few differences are seen. For example there was a higher proportion of admissions in 2011/12 for mental and behavioural disorders due to the use of alcohol in men (27%) compared to women (16%).

In 2011/12 the majority of alcohol-related admissions were seen by hospitals through emergency routes (61%) compared to planned procedures or appointments (38%). Of those seen through emergency routes, 33% were for mental health and behavioural disorders related to alcohol and may reflect those consuming higher levels of alcohol and binge drinking as described in chapter two.

Figure 4.9 Age-specific rates of alcohol-related admissions, per 100,000 population, Islington's resident population, 2011/12

Source: SUS 2011/12 (admissions); ONS 2010 Mid Year Estimate (population)
Note that some people will have more than one alcohol-related admission within the year

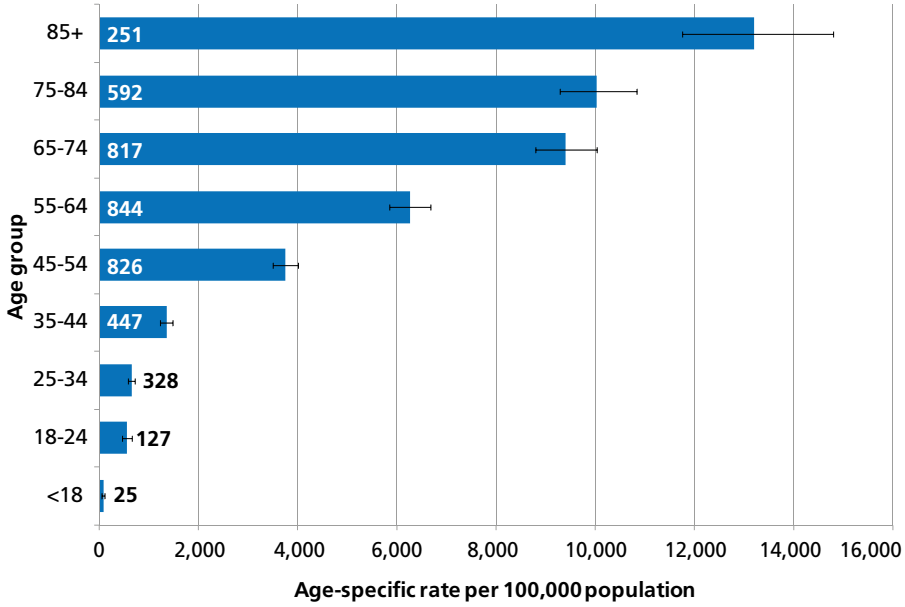


Figure 4.10 Directly standardised rates of alcohol-attributable admissions, per 100,000 population, by deprivation quintile, Islington's resident population, 2011/12

Source: SUS 2011/12 (admissions); ONS 2010 Mid Year Estimate (population); IMD 2010
Note that some people will have more than one alcohol-related admission within the year

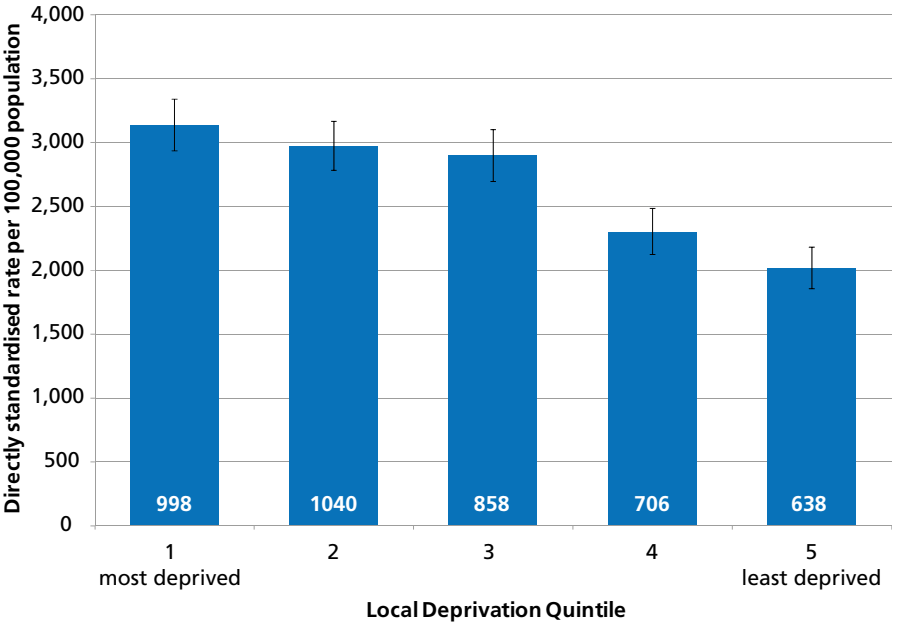


Figure 4.11 Directly standardised rates of alcohol-attributable admissions, per 100,000 population, by ward, Islington's resident population, 2011/12

Source: SUS 2011/12 (admissions); ONS 2010 Mid Year Estimate (population)
Note that some people will have more than one alcohol-related admission within the year

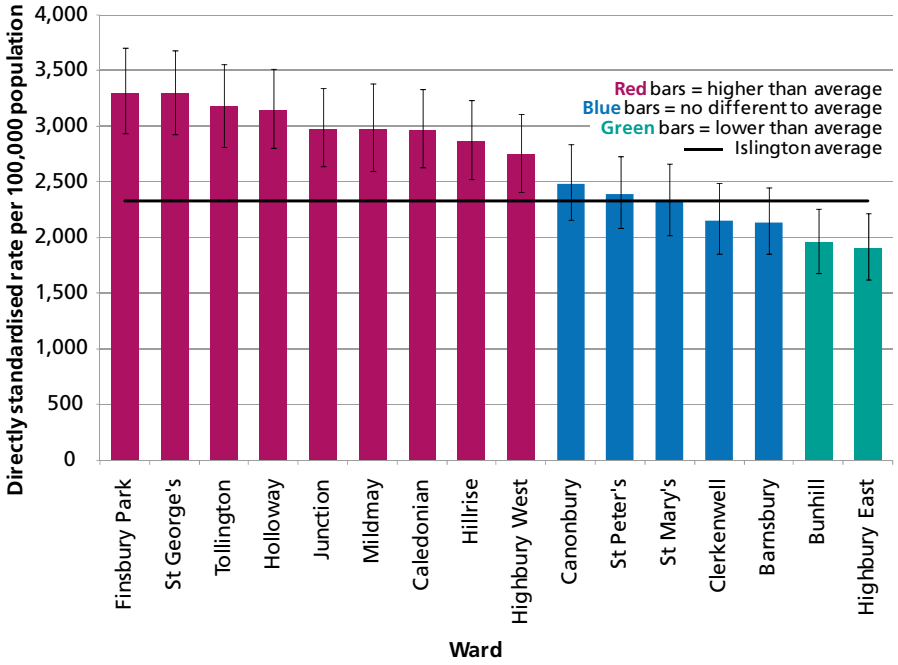
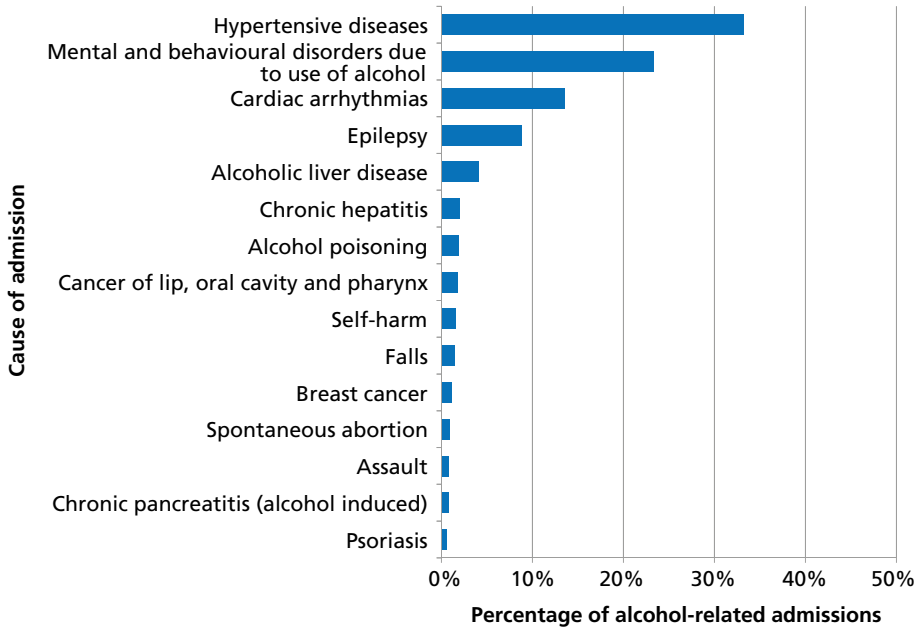


Figure 4.12 Main causes of alcohol-related admissions, Islington's resident population, 2011/12

Source: SUS 2011/12 (admissions)
Note that some people will have more than one alcohol-related admission within the year



Alcohol-specific admissions in Islington

There were 1,311 alcohol-specific hospital admissions in Islington, in 2011/12, which could have been avoided if there was a reduction in alcohol consumption in the borough. The pattern by age for alcohol-specific admissions differs to that for alcohol-related admissions in that the rates do not steadily increase with age, but instead peak between the ages of 55-74 and then decline **(figure 4.13)**. There is also a larger proportion of alcohol-specific admissions in men (71%) than women (29%) reflecting differences in high levels of alcohol consumption between these two groups **(figure 4.14)**.

There is variation in alcohol-specific admissions by deprivation, with those living in the three most deprived quintiles twice as likely as those in the two least deprived quintiles to be admitted for conditions wholly related to alcohol consumption. This highlights the impact of alcohol consumption among socially deprived populations on health services. Alcohol-specific admissions are highest in St George's ward, the reasons for which require further investigation **(figure 4.15)**.

The main causes of alcohol-specific admissions **(figure 4.16)** were for mental and behavioural disorders due to the use of alcohol (76%), alcoholic liver disease (13%) and alcohol poisoning (6%). Mental and behavioural disorders due to the use of alcohol was the most common cause for both men and women (79% and 67%, respectively) and similar proportions of both men and women were admitted due to alcoholic liver disease. A higher proportion of women (14%) were admitted due to alcohol poisoning

Figure 4.13 Age-specific rates of alcohol-specific admissions, per 100,000 population, Islington's resident population, 2011/12

Source: SUS 2011/12 (admissions) ONS 2010 Mid Year Estimates (population)
Note that some people will have more than one alcohol-specific admission within the year

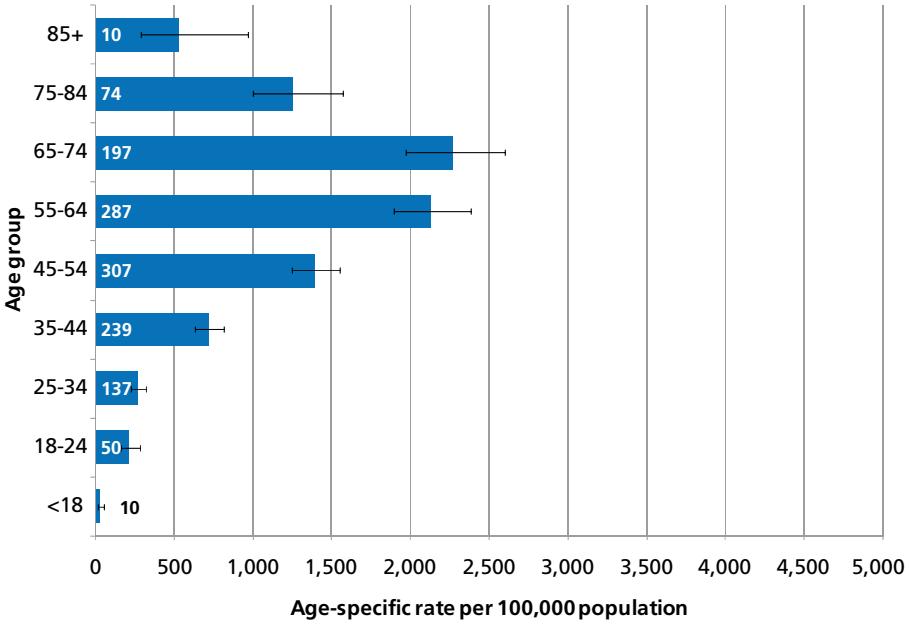
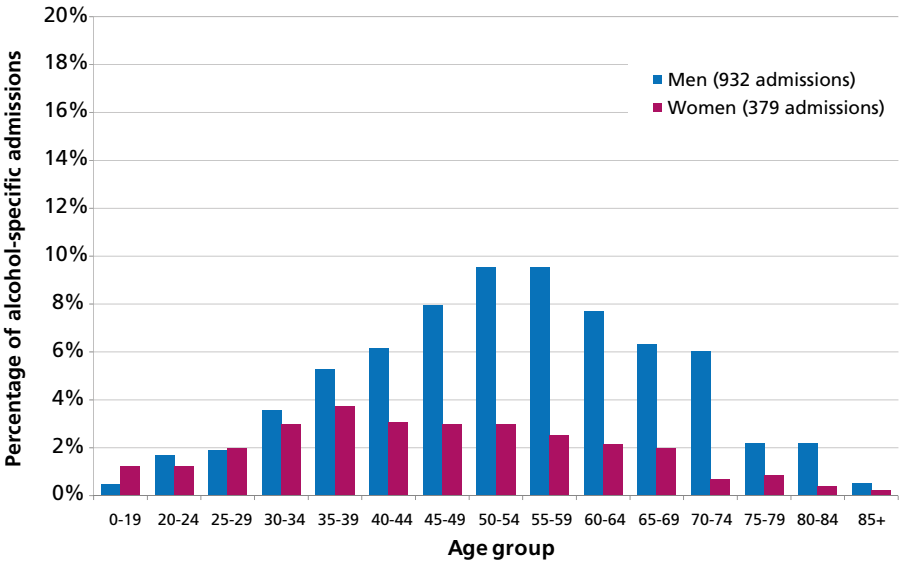


Figure 4.14 Alcohol-specific admissions, by age and sex, Islington's resident population, 2011/12

Source: SUS 2011/12
Note that some people will have more than one alcohol-specific admission within the year.
Age groups below 20 years have been aggregated due to small numbers.



compared to men (3%), possibly reflecting differences in drinking behaviour between these groups.

The majority (85%) of alcohol-specific admissions were by emergency routes, possibly reflecting the main cause (mental and behavioural disorders due to the use of alcohol) of admission through this route and drinking patterns within the population. Sixty-eight percent (509) of individuals were admitted once, 26% (190) two-three times and 2% (15) six times or more.

Figure 4.15 Directly standardised rates of alcohol-specific admissions, per 100,000 population, by ward, Islington's resident population, 2011/12

Source: SUS 2011/12 (admissions); ONS 2010 Mid Year Estimate (population)
Note that some people will have more than one alcohol-specific admission within the year

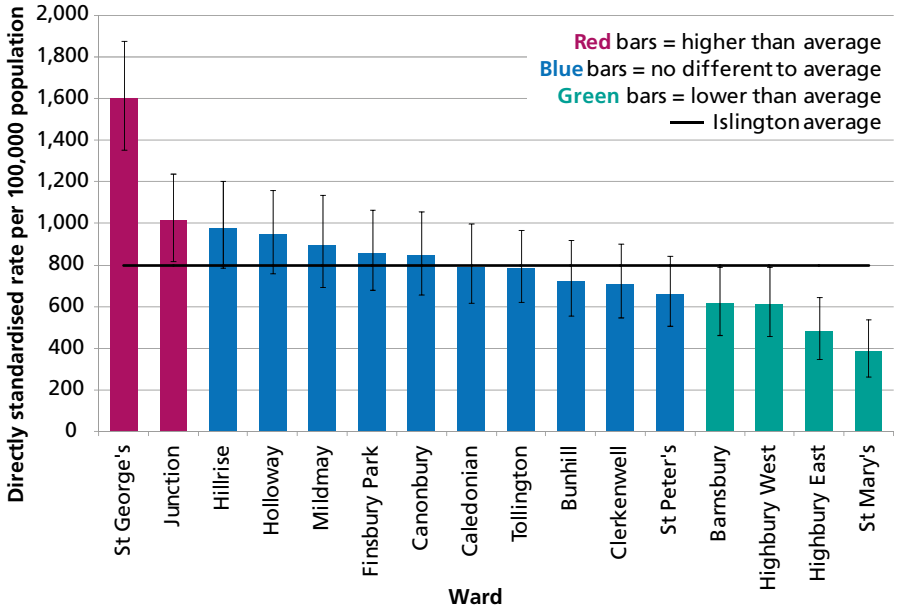
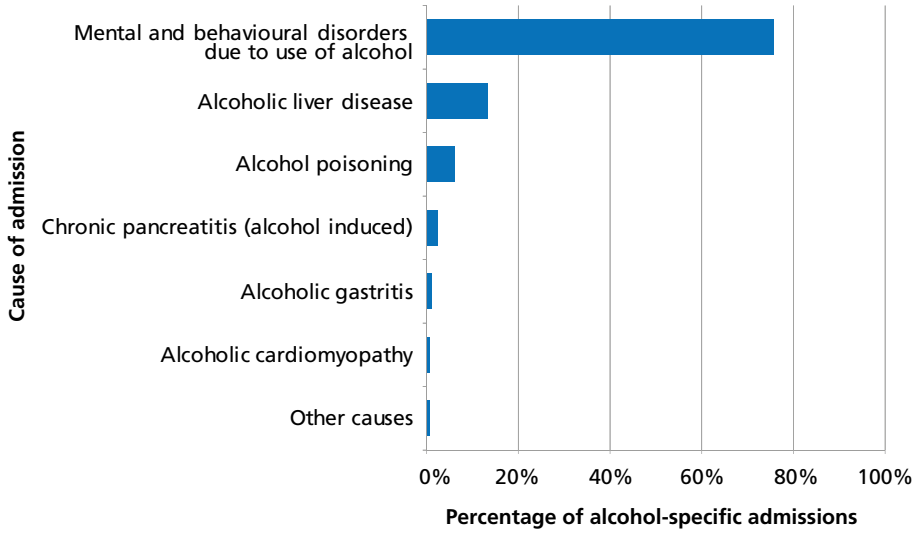


Figure 4.16 Alcohol-specific admissions by cause, Islington's resident population, 2010/11

Source: SUS 2011/12 (admissions)
Note that some people will have more than one alcohol-specific admission within the year



A&E attendances

Estimates suggest that in London alcohol-related harm accounts for 35% of all A&E attendances and up to 70% of all attendances at peak times (midnight to 5am at weekends)[13]. Whether alcohol was involved in an A&E attendance is not routinely recorded locally, consequently the data available on A&E attendances in Islington appear to underestimate the local impact of alcohol-related harm in A&E.

Hospital bed days

In London during the period 2008/09, 76 per 100,000 hospital bed days were estimated to have been used for reasons linked to alcohol; twenty-nine percent of which were for alcohol-specific conditions and 71% for alcohol-related conditions. This is compared to Islington where 85 per 100,000 (15,436) bed days were linked to alcohol; 37% (5,703) from alcohol-specific admissions and 66% (10,288) from alcohol-related admissions[11].

Ambulance activity

Data is recorded by the London Ambulance Service (LAS) for any alcohol-related illness responses. This, combined with cases where a reference to alcohol is made in the free-text records, provides information about the alcohol-related calls in Islington. The data and information discussed in this section differs from that presented previously in that it refers to anyone involved in a call-out in Islington. This reflects where the call was made, not where the individual lives and therefore includes people who may live outside the borough.

There were 2,465 alcohol-related calls for the LAS in Islington in 2011/12. **Figure 4.17** shows the

Figure 4.17 Day and time of alcohol-related London Ambulance Service calls in Islington, 2011/12

Source: London Ambulance Service, 2011/12 SafeStats (www.safestats.org.uk)

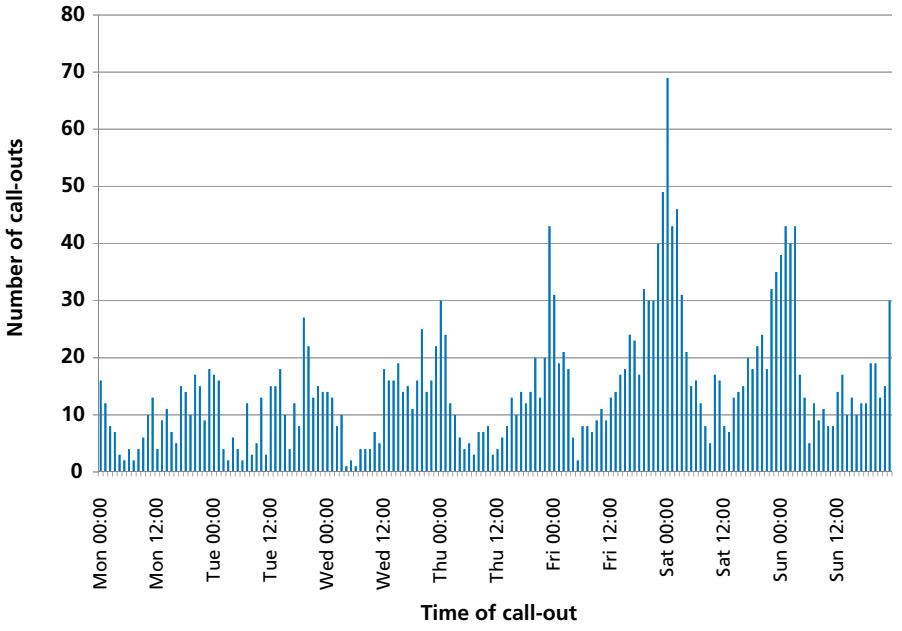
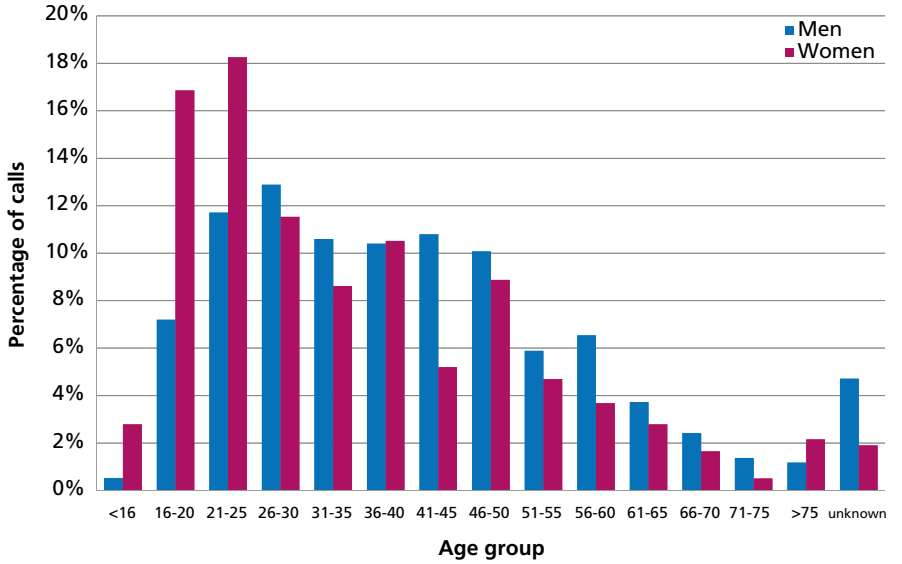


Figure 4.18 Age and gender of alcohol-related calls made to the London Ambulance Service in Islington, 2011/12

Source: London Ambulance Service, 2011/12 SafeStats (www.safestats.org.uk)



total number of alcohol-related calls for the LAS within Islington broken down by day of the week and time across 2011/12. Calls are generally at their lowest from approximately 3am to 3pm, with peaks between 6pm and midnight on weekdays. There is a clear increase in alcohol-related calls on Saturdays and Sundays, with the greatest number of calls from 10pm Saturday evening until 4am on Sunday morning. This is likely to be related to the peak times for social drinking in the general population and Islington's night-time economy which draws on a large number of people from outside the borough. The relationship between alcohol-related call-outs and licensing and crime are discussed in chapters in five and six.

A larger proportion of the total alcohol-related LAS call-outs were to men (66%) compared to women, 34% **(figure 4.18)**. However, 50% (413/830) of all call-outs to women were to those aged 30 and under. The proportion of men receiving alcohol-related call-outs in that age group was 32% (508/1,612).

Higher rates of LAS alcohol-related call-outs have been observed in Finsbury Park, Bunhill and Clerkenwell wards. However the data is not specific to Islington residents and may represent individuals socialising in these areas and subsequently requiring LAS involvement.

Just over half the alcohol-related call-outs received by the LAS in 2011/12 resulted in the individual being taken to hospital (where recorded) **(figure 4.19)**. Eighty two percent (975/1,186) of which were seen by either University College London Hospital or the Whittington Hospital.

Figure 4.19 Outcome of alcohol-related London Ambulance Service calls in Islington, 2011/12

Source: London Ambulance Service, 2011/12 SafeStats (www.safestats.org.uk)

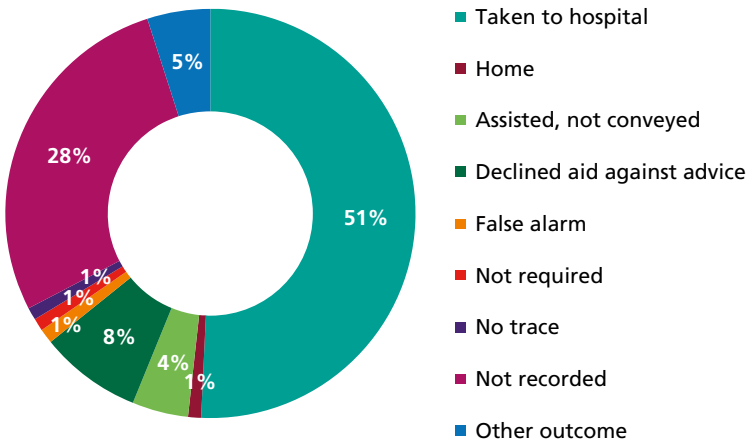
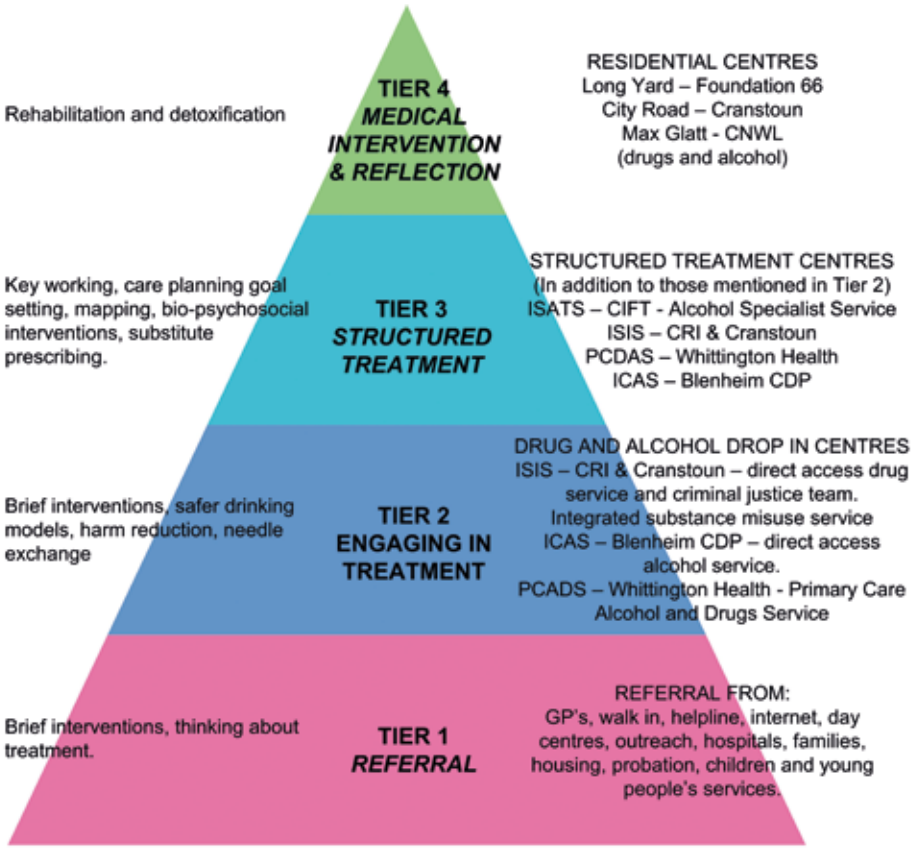


Figure 4.20 Alcohol tiered treatment service



ALCOHOL TREATMENT SERVICES IN ISLINGTON

There are a number of alcohol treatment services within Islington as well as voluntary agencies providing support to those with an alcohol need. These are split across four tiers as described in **figure 4.20**. In addition 28 GP practices offer interventions around alcohol.

Numbers in alcohol treatment services in Islington decreased between 2009/10 and 2010/11, from 832 to 800 and there has been a further reduction in numbers in 2011/12 to 589. This is coupled with a reduction in the number of new presentations to alcohol treatment services across the previous three years **(figure 4.21)**, particularly within 2011/12. A reorganisation of alcohol services and decrease in finances within this time period may account for some of the pattern observed. Overall, more men (60%, 356) than women (40%, 233) currently receive treatment for alcohol misuse in Islington and there are larger proportions of men in all age groups **(figure 4.22)**.

In 2010/11, over a third (35%) of all Islington alcohol clients had been in contact with services for less than three months, and 20% had been in contact with services for 12 months or more **(figure 4.23)**. Seventy four percent of clients in 2010/11 had just one treatment journey in Islington, but 20% had had another treatment journey prior to their current one with two percent of clients having had three or more prior treatment journeys. The cyclical nature of patients returning to treatment highlights the difficulties associated alcohol misuse and importance of focusing on recovery.

Figure 4.21 Numbers in alcohol treatment with alcohol as the primary drug, Islington 2009/10-2011/12

Source: National Drug Treatment Monitoring System 2011/12

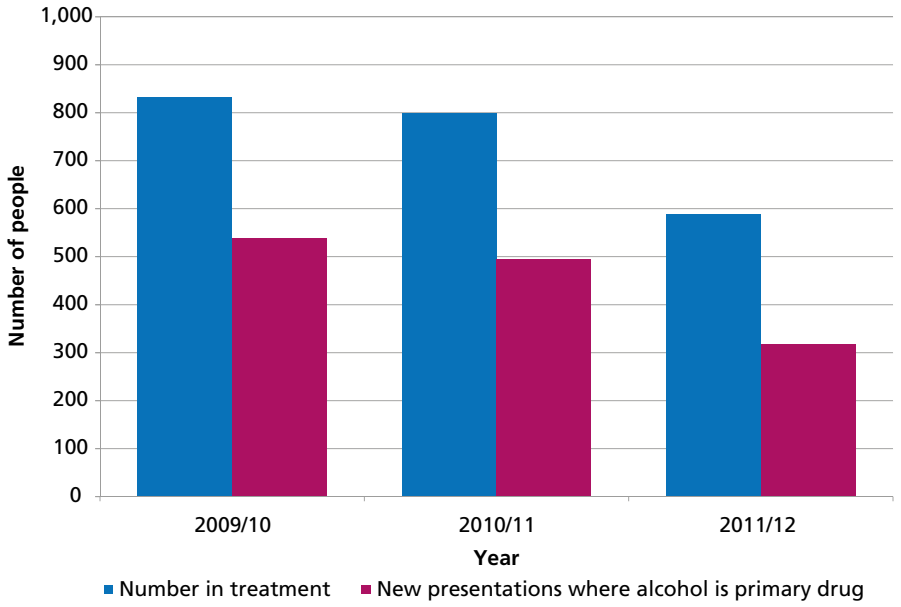
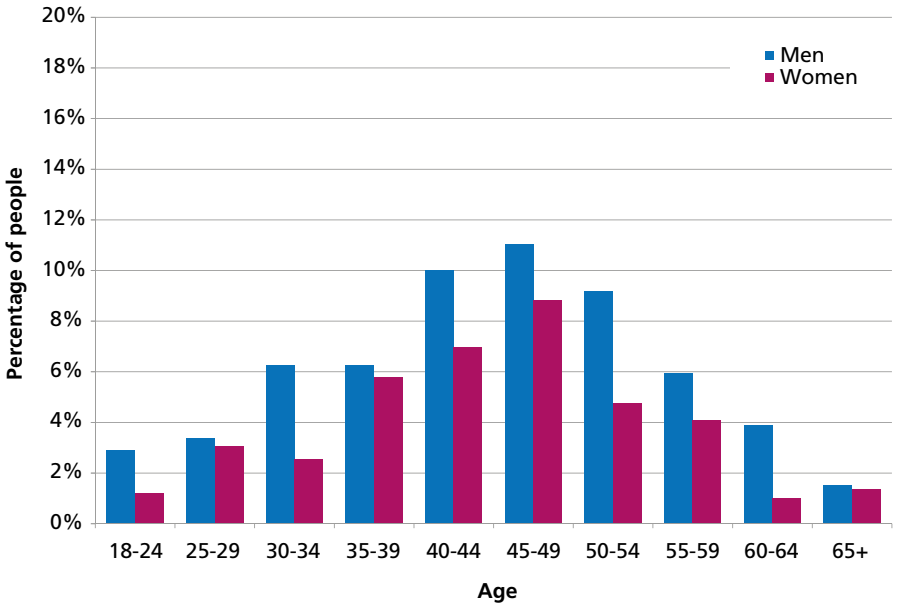


Figure 4.22 Percentage of all those in alcohol treatment services in Islington, by age and sex, 2011/12

Source: National Drug Treatment Monitoring System. 2011/12



Exits from alcohol treatment services can be classified as: *successful* or *planned* completions whereby a client is free from or an occasional user of alcohol, or as an *unplanned* exit, where clients have dropped out of treatment services. In addition, exit reasons termed *referrals* on or *transfers* to other service providers can also include clients who have not had a successful, planned treatment exit.

In Islington the successful completions/planned exits as a proportion of all exits has increased from 30% (124) in 2009/10 to 54% (353) in 2011/12 **(figure 4.24)**. This is comparable to national achievement, where 58% of exits are planned.

People with alcohol misuse problems also often face added complexities of unemployment, homelessness or housing issues, health problems and multiple drug use. Approximately a third of Islington clients will have at least one additional factor (complexity item), and eight percent will have four or more factors that will influence successful treatment outcomes. Unemployment, drug misuse, dual diagnosis and housing are some of the main complexities faced by Islington's alcohol misuse clients **(figure 4.25)**.

Alcohol users may require help to remain in their existing housing, to prevent homelessness, or to prepare for independence when moving on from supported housing. There can be a delay in people accessing or in the availability of appropriate housing which can be detrimental to accessing treatment and successful recovery.

According to the complexity index, a larger proportion of Islington clients referred from the criminal

Figure 4.23 Percentage of clients in contact with alcohol treatment services in Islington by length of time, 2010/11

Source: National Drug Treatment Monitoring System 2011/12

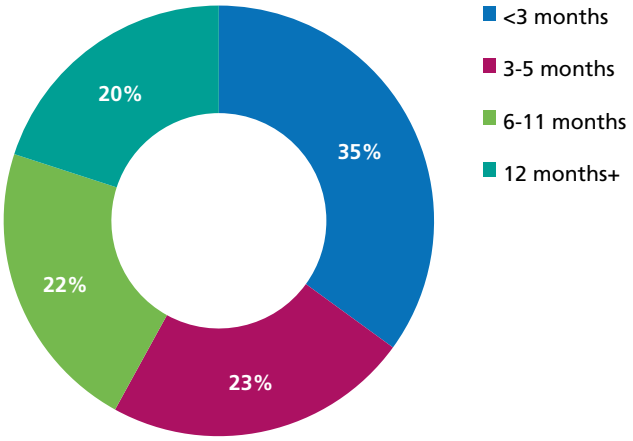


Figure 4.24 Alcohol treatment outcomes, Islington, 2009/10-2011/12

Source: National Drug Treatment Monitoring System. 2011/12

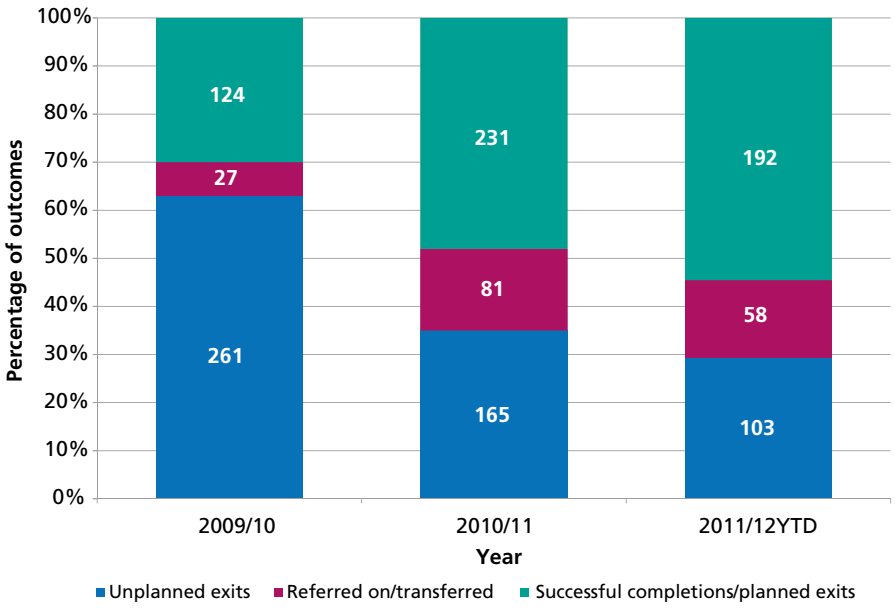
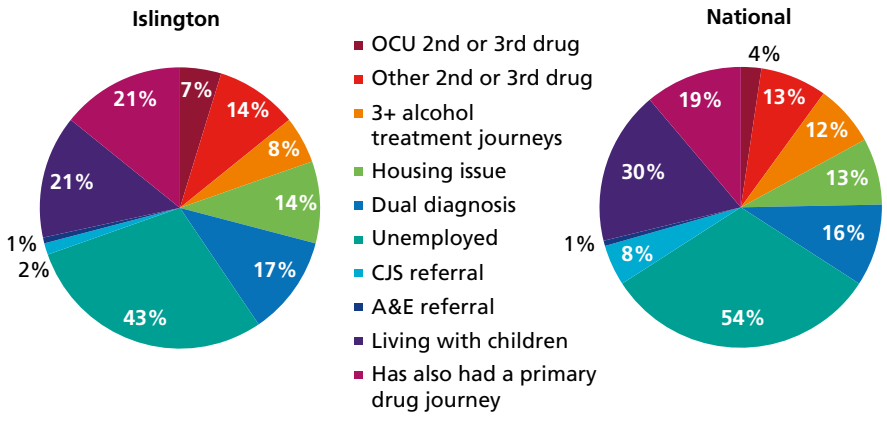


Figure 4.25 Percentage of Islington and National alcohol treatment service clients by complexity item, 2011/12

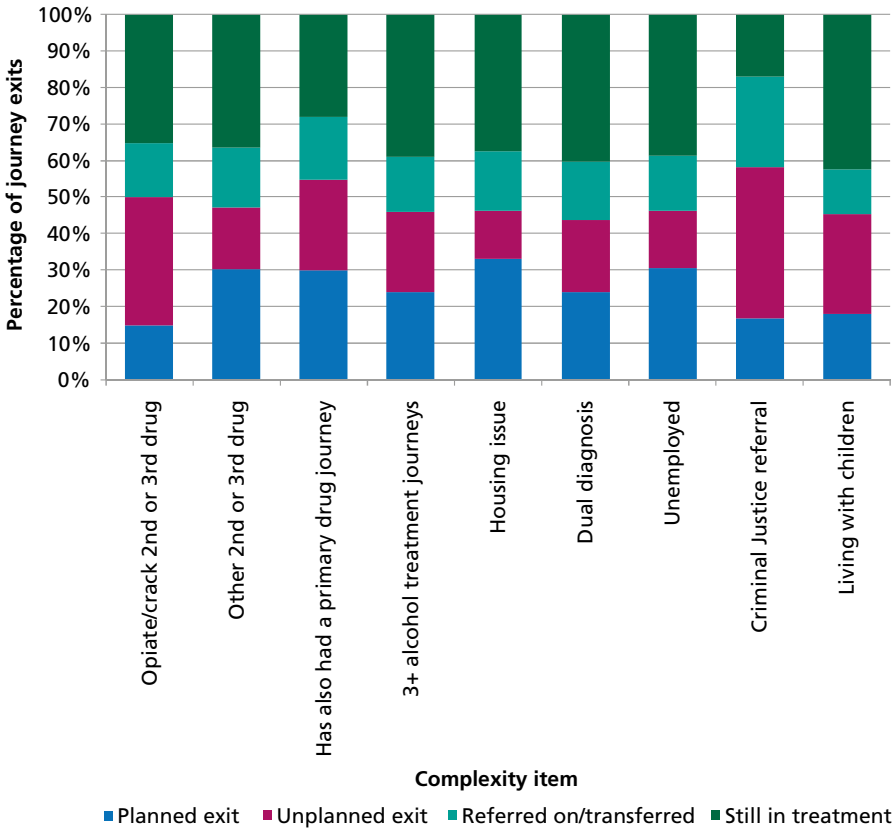
Source: National Drug Treatment Monitoring System. 2011/12



justice system (CJS) or those that use opiates or crack (OCU) as a second or third drug are more likely to have an unplanned exit than those with other complexity issues **(figure 4.26)**. The relationship between wider societal factors (illustrated by the complexity index) and alcohol misuse highlights the importance of services providing a holistic treatment approach. Further discussion on the impact of societal factors on alcohol misuse is provided in chapter 3.

Figure 4.26 Journey exits for alcohol users by complexity item, Islington, 2010/112

Source: National Drug Treatment Monitoring System. 2011/12



WHAT WORKS?

Alcohol treatment services

In 2006 the National Treatment Agency published Models of Care for Alcohol Misusers (MoCAM)[14]. The framework highlights a stepped approach to the treatment of alcohol misuse though a range of interventions available in four tiers **(figure 4.20)**. Tier one includes screening and brief interventions to identify and reduce harmful drinking delivered by a range of staff in various settings. Tier two interventions include alcohol-specific advice information and support, extended brief interventions and triage assessment, and referral to "care planned" treatment within tier three. Tier three provides community based specialist alcohol assessment and structured psychological or pharmacological interventions. Tier four interventions include residential specialised treatments. MoCAM therefore sets out a comprehensive model which is built around a treatment journey.

There are two national guidelines from the National Institute for Clinical Excellence that outline effective alcohol treatment services. The first guideline (CG115[15])

Table 4.2 Summary of approaches for the treatment and management of alcohol misuse

Intervention	Summary of effectiveness of approach
Screening and brief intervention (The process of identifying people who may have alcohol issues and then taking action)	A cost effective approach for moderate and high risk drinkers, but referral to a specialist service is necessary for dependent drinkers
Case management (The assessment, planning, coordination and monitoring of care)	Used in the management of harmful and dependent drinkers has some benefit in prolonging time to lapse, days of heavy drinking, and increase in aftercare attendance.
Stepped Care (A stepped care recovery model seeks to treat service users at the lowest appropriate service tier in the first instance, only 'stepping up' to intensive/ specialist services as clinically required)	A system which: a. Provides to the majority the least costly and least restrictive brief intervention that will be effective b. Has a system of built in monitoring to identify those who have not benefitted from the initial intervention c. Has the referral system and capacity to provide more intensive intervention Evidence has shown that there may be a small effect in favour of stepped care for moderate risk drinkers with limited effect of this approach for more harmful and dependent drinkers.

sets out effective methods for improving access to treatment and best practice for treatment itself. A summary of the main interventions is provided in table 4.2.

The second guidance from NICE (PH24[16]) focuses on effective interventions in preventing the development of harmful and hazardous drinking and identifies how government policies on alcohol pricing, its availability and how it is marketed could be used to combat harm. It summarises that policy changes are likely to be more effective in reducing alcohol-related harm among the population as a whole than actions undertaken by local health professionals and that particular focus should be given to licensing and resources for identifying and helping people with alcohol-related problems.

Reduction in hospital admissions

Focusing on effective interventions to help with reducing hospital admissions highlights the possible role of Hospital Liaison Workers and use of brief interventions in this task.

Research has identified how brief interventions with men aged over 35 who regularly drink over 50 units could reduce alcohol-related admissions nationally by 13,000 over three years[10]. The Department of Health has estimated that providing alcohol identification and brief advice to all new General Practice registrants could avert 10,000 to 15,000 alcohol-related admissions nationally over a three year period.

Evidence indicates that hospital-based alcohol harm reduction frameworks, supported in delivery

Box 4.2: Primary Care Alcohol & Drug Service (Alcohol Liaison Provision - Whittington Hospital)

The Primary Care Alcohol and Drug Service (PCADS) is for patients of the Whittington Hospital or Islington GPs, who are experiencing problems associated with their use of alcohol or drugs. In addition to provision of outreach clinics within GP practices and Islington substance misuse services, PCADS also provides an alcohol hospital liaison service at the Whittington hospital.

The aims of PCADS treatment interventions are to reduce the harms caused by substance misuse and, wherever possible, enable service users to achieve drug abstinence and/or cease problem alcohol consumption. The service works with local partner agencies to improve service user opportunities for social re-integration and maintaining a sustained recovery.

PCADS uses a range of approaches to identify and manage people with an alcohol problem:

Screening / health promotion and harm reduction advice	Alcohol and drug misuse assessment
Detox and maintenance pharmacotherapy	Relapse prevention support
Psychological therapies	Family and carer advice
Care co-ordination	

Service data records 263 hospital liaison alcohol assessments from April 2011 to April 2012 (average 20 per month). In addition the total alcohol liaison nurse contacts recorded for the same period is 535.

The majority of referrals to the alcohol liaison nurse have originated from inpatient sites and have been characterised by individuals presenting with 'harmful' levels of alcohol consumption where pharmacological inpatient detoxification has often been initiated. As patients are not seen prior to being admitted opportunities to introduce earlier harm reduction interventions may have been missed.

In order to identify and provide support to people with poor drinking habits who attend hospital through the Emergency Department or Urgent Care Centre, local hospital trusts are being incentivised to screen adults, provide alcohol awareness information and make appropriate referrals to community alcohol services.

Future work will focus on redesigning the current role of the alcohol liaison nurse and the development of an ambulatory detox pathway to reduce the amount of time spent in hospital.

by specialist alcohol nurse liaison teams, have the potential to reduce cost and improve health. The Royal College of Physicians recommend that every acute hospital has an alcohol health worker or an alcohol liaison nurse to manage patients with alcohol problems, deliver specialist interventions within the hospital and liaise with community services[17]. The reported impact of hospital liaison workers are:

- Reduced length of hospital stay
- Reduced necessity for hospital attendance and admission
- Accident and emergency attendance reduced
- Hospital admissions reduced
- Decrease in alcohol consumption

There are a range of models for alcohol liaison services including multi-disciplinary approaches where patients with alcohol-related liver disease are seen in joint clinics by a gastroenterologist, psychiatrist and psychiatric liaison nurse, an approach used at the Royal Bolton Hospital[18]. Other methods for delivering this service include alcohol nurse specialist teams that target problem drinkers who are frequent attendees within hospitals, in particular accident and emergency departments. Some areas, for example Middlesbrough[19], use the voluntary sector to provide a service which places an alcohol health worker in an acute hospital setting to aid liaison between the hospital and community services.

SUMMARY

Alcohol consumption impacts on both the health of the individual and in turn health services, through admissions to hospital and ambulance related activity. Islington has some of the highest rates for admissions to hospital and deaths due to alcohol consumption. Although the number of deaths in Islington wholly due to alcohol consumption are relatively small these, as well as a number of deaths partly due to alcohol, are potentially preventable through interventions to reduced alcohol-related harm.

Alcohol consumption does not only affect death and hospital admissions but also has a clear impact on the use of the ambulance service. Whilst this is not all due to Islington residents it highlights the effect of the borough's night-time economy on local health services.

There are a range of services in Islington to help alcohol misusers reduce their alcohol consumption. However, while the proportion of successful treatment outcomes has increased, the number of people accessing these services has declined over time, despite data indicating there is a continuing need for these services. This period corresponded with a reorganisation of community alcohol services in Islington and some clients may have been lost to services during this period.

Individuals that misuse alcohol are often faced with a range of other factors that may affect their ability to reduce consumption. Unemployment and housing are two factors that can impact on someone's ability to successfully enter and complete alcohol treatment. Those that also misuse drugs and/or have been referred to treatment through the criminal justice system are less likely to experience a successful treatment outcome.

References

[1] World Health Organisation, http://www.who.int/features/qa/66/en/index.html

[2] Appleby, Eric. *Alcohol use: Consumption and costs.* Alex Paton and Robin Touquet. ABC of Alcohol. Oxford: Blackwell Publishing Ltd, 2007

[3] Department of Health. *Signs for improvement: Commissioning interventions to reduce alcohol-related harm.* London: Department of Health, 2009

[4] Cabinet Office. *Alcohol harm reduction strategy for England,* 2004

[5] Department of Health. *Alcohol Needs Assessment Research Project (ANARP) The 2004 national alcohol needs assessment for England.* London: Department of Health, 2005

[6] North West Public Health Observatory. *Alcohol- attributable fractions for England.* Alcohol-attributable mortality and hospital admissions. 2008

[7] Institute of Alcohol Studies. *Binge Drinking: Medical and Social consequences:* Institute of Alcohol Studies, 2007

[8] The NHS Information Centre, *Statistics on Alcohol: England. 2011*

[9] *Topic Report – Alcohol as an influencing factor in fires,* London Fire Brigade Information Management, September 2010

[10] Anderson P. *the scale of alcohol-related harm.* Unpublished. Department of Health. 2007

[11] London Health Observatory. *Closing time. Counting the cost of alcohol-attributable hospital admissions in London.* London. 2012

[12] North West Public Health Observatory. *Local Alcohol Profiles for England.* Islington. 2012

[13] London Health Improvement Board. *Taking action on alcohol in London the case for action.* London. 2012

[14] Department of Health. Models of care for alcohol misusers (MoCAM) DH 2006

[15] National Institute for Health and Clinical Excellence. *Alcohol dependence and harmful alcohol use.* NICE Clinical Guidance 115. 2011

[16] National Institute for Health and Clinical Excellence. *Alcohol-use disorders - preventing harmful drinking.* NICE Public Health Guidance 24. 2010

[17] *Alcohol - can the NHS afford it? Recommendations for a coherent alcohol strategy for hospitals* Report of a working party of the Royal College of Physicians 2001

[18] Moriarty KJ. *Alcohol Related Disease: Meeting the Challenge of Improved Quality of care and Better Use of Resources.* A Joint Position Paper on behalf of British Society of Gastroenterology, Alcohol Health Alliance UK and British Association for the Study of the Liver. 2010

[19] Alcohol Learning Centre. *Local initiatives. Projects (online).* Available from http://www.alcohollearningcentre.org.uk/LocalInitiatives/projects/projectDetail/?cid=6376 (accessed August 2012)

5 Control and availability of alcohol

Contents

Key messages

- The borough of Islington has the third highest density of licensed premises in London.
- There is a relationship between the number of licensed premises and the number of alcohol-related ambulance callouts, with more ambulance callouts in areas of Islington with a higher density of licensed premises.
- Islington Council is the borough licensing authority and sets high management standards for all licensed premises with a number of schemes and initiatives in place, including Pubwatch, Best Bar None, the Licensing Charter and the Purple Flag Award.
- To manage the night-time economy, Islington Council applies licensing restrictions and conditions to areas of the borough with large numbers of licensed premises. These include the south Clerkenwell area, the area surrounding the Emirates Stadium on match days, the Angel Town Centre and the Kings Cross area.
- The Council's Trading Standards department regularly conducts test purchasing exercises on underage sales with licensed retailers. Of the 251 test purchase exercises carried out between April 2010 and August 2012, 71 (28%) resulted in a sale.
- Illicit alcohol (counterfeit, non duty paid and stolen) is widely available across small retailers in Islington and London. The biggest problems are found with branded spirits, particularly vodka, and cheap Italian wine.
- Between April 2010 and August 2012, 46 premises were reviewed, with 15 licences revoked, 22 licences suspended and 9 licences with extra conditions added for offences related to illegal alcohol and underage sales.
- Evidence suggests that a number of approaches are required to promote alcohol-related public safety and safer levels of alcohol consumption. These range from legislative changes around minimum pricing and taxation and opportunities in the Police Reform and Social Responsibility Act, as well as local multi-agency approaches between Islington Council, the Police, the local community and licensees.

WHY THE FOCUS ON THIS AREA?

Availability of and access to alcohol has an important influence on levels of alcohol consumption. Generally speaking, changes in the availability of alcohol tend to be reflected sooner or later in changes in levels of alcohol consumption and alcohol-related harm[1]. Alcohol is widely available through commercial (bars, restaurants, shops) and social sources (friends, family, peers). Commercial environments are covered by regulations and conditions set out in national and local licensing policies. This includes regulating the places, times and context where customers can access alcohol. For young people and particularly underage drinkers, social sources of alcohol are more important, particularly as access to alcohol through commercial sources is more difficult.

Interventions that have the greatest impact on controlling the availability of alcohol are regulating physical availability and altering the drinking context[1]. Regulating physical availability includes taxation and pricing, ensuring minimum legal purchase age, restricting hours and days of sale, ensuring a server legal liability (where the person serving alcohol takes responsibility for ensuring that the customer is not intoxicated or underage) and restricting the number (or density) of alcohol outlets in an area. Interventions shown to have the greatest impact on changing the drinking context include high standards in outlet management, including policies not to serve intoxicated patrons, training of bar staff and managers, design and layout of outlets, and rigorous enforcement of on-premises regulations and legal requirements. Voluntary codes of practice used by bars and pubs and promoting alcohol-free activities are thought to have little if any effect[1].

LICENSING

The Licensing Act of 2003 established a single integrated national scheme for licensing premises which are used for the sale or supply of alcohol, provision of regulated entertainment, or provision of late night refreshment. Islington Council is the authority responsible for issuing licences for people / organisations who want to sell alcohol in Islington. The four licensing objectives they judge applications against are:

- the prevention of crime and disorder;
- public safety;
- the prevention of public nuisance;
- the protection of children from harm.

The new Police Reform and Social Responsibility Act 2011[2] gives local councils and police greater powers around a range of licensing activities, particularly in tackling problem premises **(see box 5.1)**.

Box 5.1: Police Reform and Social Responsibility Act 2011

New measures in the Act include:

- Doubling the fine for persistent underage sales to £20,000.
- Introducing a late night levy to help cover the cost of policing the late night economy.
- Increasing the flexibility of early morning alcohol restriction orders.
- Lowering the evidential threshold on licensing authorities. Previously authorities had to demonstrate decisions were 'necessary' to promote licensing objectives, the amendment means decisions need to be 'appropriate'. This should give authorities greater power to tackle irresponsible premises.
- Removing the vicinity test for licensing representations, so that any person or organisation can make a relevant representation in relation to a premises, regardless of their geographic proximity. This will allow wider local community involvement.
- Reforming the system of temporary event notices (TENs). A TEN is a notification to the licensing authority that an individual intends to carry out licensable activities for a period not exceeding 96 hours. The changes will extend the right to object to a notice to environmental health (currently only police can object); allow objections to be based on all licensing objectives (not just crime and disorder); extend the time period objections can be made within; and relax the statutory limits on maximum duration of a TEN to a maximum of 168 hours [3].
- Suspension of premises licences due to non-payment of annual fees.

The measures come into force during 2012 and councils will need to decide how to use these to best effect to meet local needs. One of the measures includes making health bodies responsible authorities, meaning they will also be able to make relevant representations around licensing applications.

Islington's licensing policy

All businesses or individuals licensed to sell alcohol must comply with the licensing conditions set out in the Islington licensing policy. The current policy, based on the powers in the 2003 Act, sets out the required standards of outlet management, the specific licensing policies and area specific issues relevant to Islington[4].

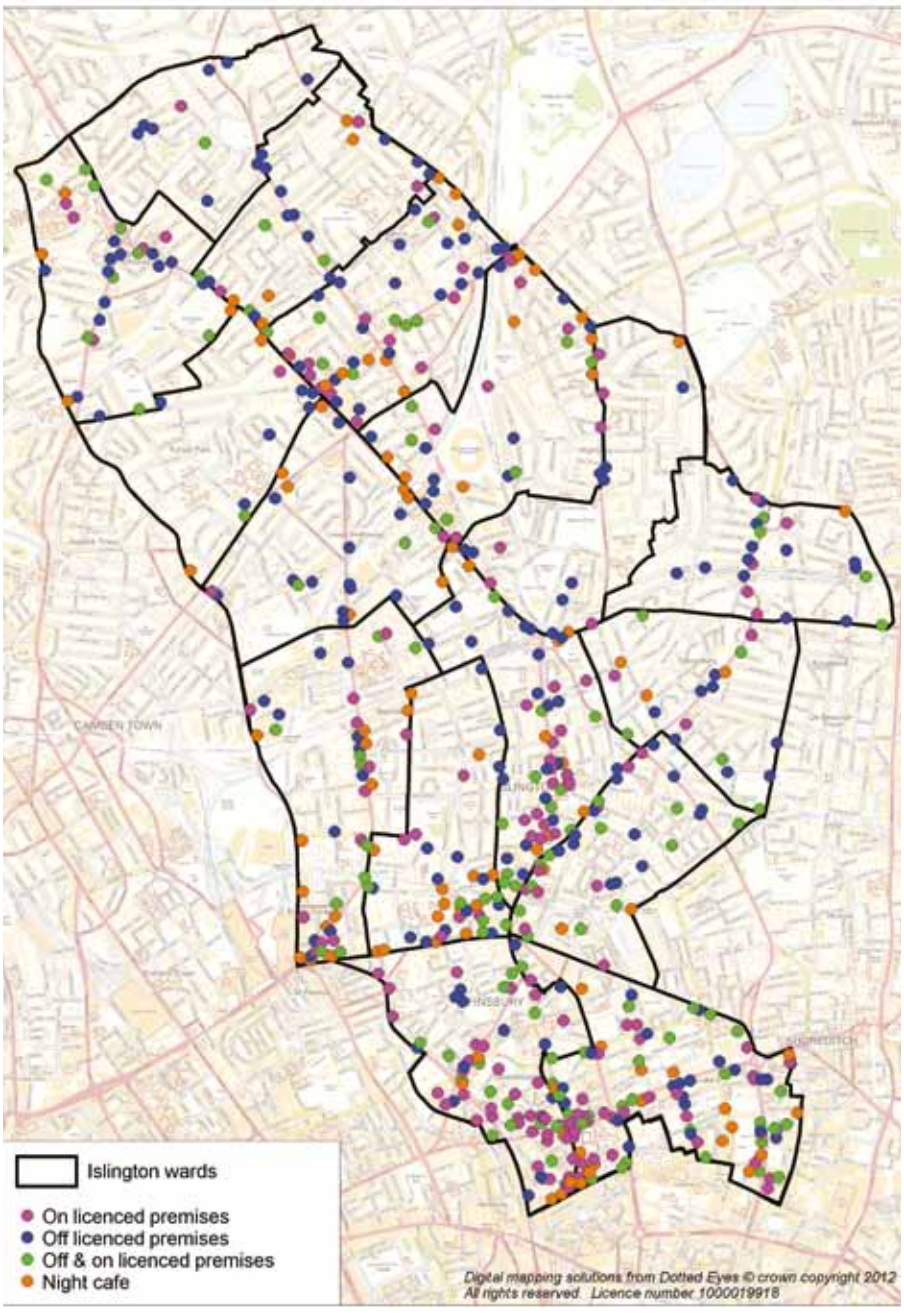
Density of licensed premises in Islington

Higher densities of alcohol outlets are associated with increased binge drinking and higher levels of alcohol-related harm[5]. Islington has the third highest density of licensed premises in inner London, with an average of 0.8 licensed premises per hectare, only exceeded by the City of London (2.5 licensed premises per hectare) and Westminster (1.4)[6]. The location of licensed premises in Islington are shown in **map 5.1**.

Density of licensed premises and alcohol-related ambulance callouts

There is a clear relationship between the number of licensed premises in an area and the number of alcohol-related ambulance callouts in Islington, with more ambulance callouts in areas with higher density of licensed premises **(figure 5.1)**. **Map 5.2** shows the distribution of licensed premises and alcohol-

Map 5.1 Licensed premises by type, Islington, June 2012



Note:
On licensed premises are those that sell alcohol for consumption on the premises (e.g. bars). **Off licensed** premises are those that sell alcohol for consumption elsewhere (e.g. shops). **Night cafes** are premises that sell late night refreshments (hot food or drink, for consumption on or off the premises between 11pm and 5am the next morning). Some venues registered as night cafes also have an on licence.

related ambulance callouts across Islington. Consistent with the analysis in **figure 5.1**, higher numbers of callouts tend to be in the areas with larger numbers of licensed premises. A similar pattern is seen between the number of licensed premises and alcohol-related crime, this is discussed in chapter 6.

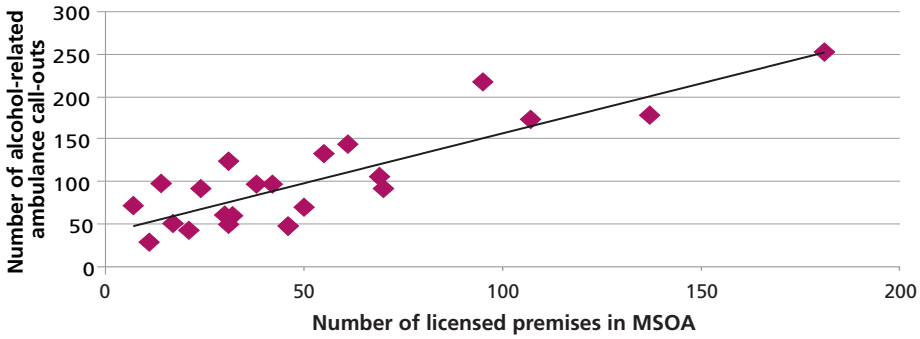
STANDARDS OF OUTLET MANAGEMENT

Given the density of licensed premises, the expected management standards set out in local licensing in Islington are high. There are a number of schemes and initiatives to raise the management standards for premises. This includes schemes like Pubwatch, Best Bar None, the Licensing Charter and Purple Flag Award[7] **(box 5.2)**.

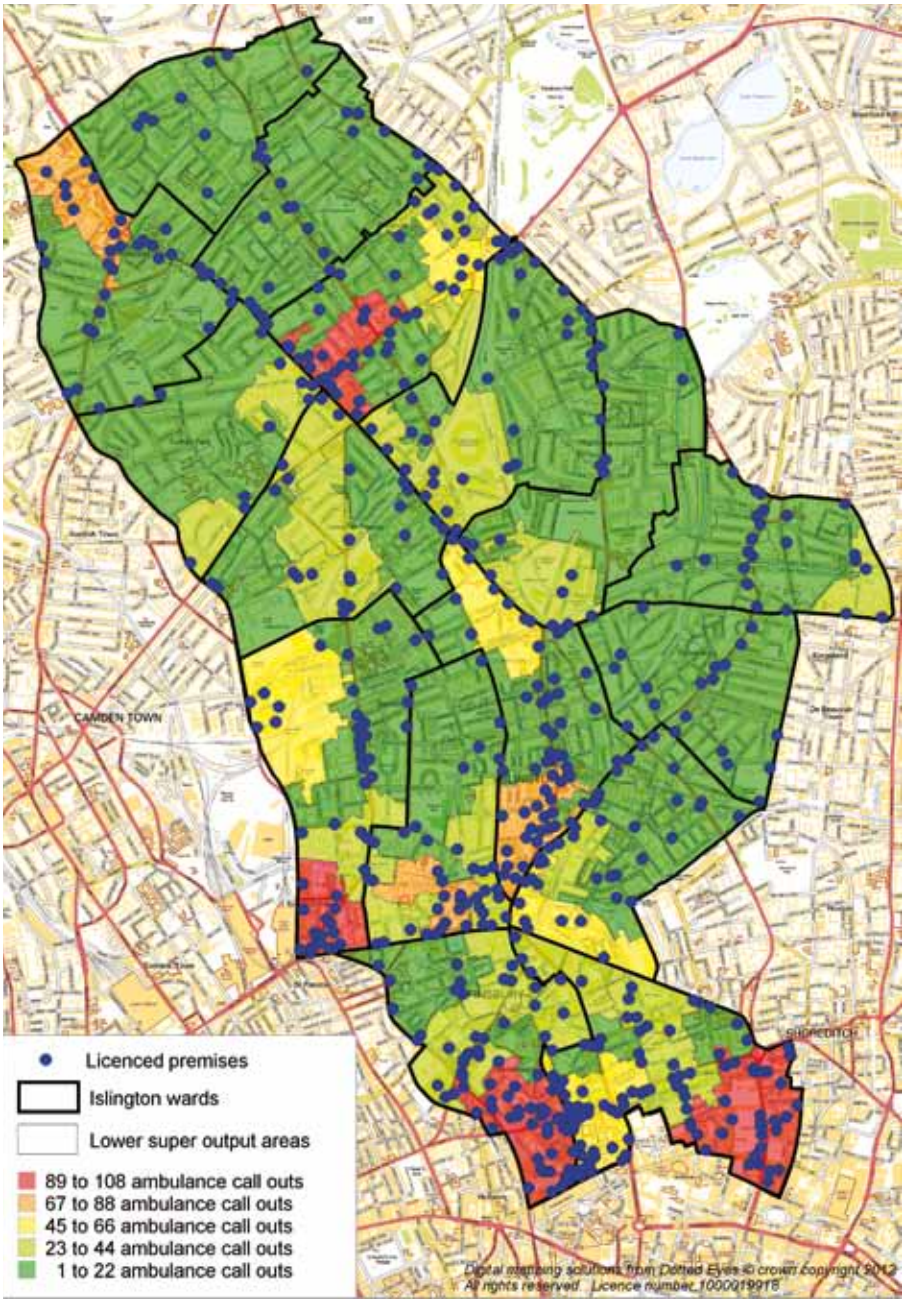
Pubwatch is an Islington wide network where licensees regularly meet with the licensing team, the police and other relevant authorities. This scheme provides a network for licensed premises to share information and disseminate best practice*.

Best Bar None (BBN)[8] is a national award scheme supported by the Home Office and aimed at promoting responsible management and operation of alcohol licensed premises. The overall aim is to reduce the harmful effects of drinking as well as alcohol-related crime and disorder by building a positive relationship between the licensed trade, police and local authorities. It sets standards for premises, licensees and bar staff as well as enforcement and regulation agencies, to improve knowledge and skills necessary to manage licensed premises responsibly.

Figure 5.1 Numbers of licensed premises and alcohol-related callouts across Islington's Middle Super Output Areas (MSOA), 2011/12.
Source: London Ambulance Service, provided through, and in agreement with GLA SafeStats (www.safestats.org.uk)



Map 5.2 Location of licensed premises and alcohol-related ambulance callouts across Islington's Lower Super Output Areas (LSOA), 2011/12.



*Islington Pubwatch schemes: Archway, Arsenal (pubs in the vicinity of Emirates Stadium), Caledonian Road/King's Cross, Central (Angel, Chapel Market, Essex Road, Liverpool Road and Upper Street areas), Club watch (late night dance venues), Clerkenwell Gay and Lesbian Pubwatch, Stroud Green.

Box 5.2: Promoting a responsible drinking environment in the Clerkenwell area

Over the past ten years, the Clerkenwell area in the south of Islington has seen an increase in the intensity of the night-time economy, with 10% of Islington's "on licensed" venues located within this small geographical area. It also has one of the highest concentrations of late licensed premises and as a consequence sees the influx of thousands of people in the evening and at weekends. Residents, Councillors and local businesses report that this impacts on the local environment and quality of life experienced by local people. In response, a special policy relating to cumulative impact in the south Clerkenwell area **(see map 5.3)** has been implemented along with other measures to promote a safe environment in the area, e.g. The Clerkenwell Charter and Purple Flag scheme.

The cumulative impact special policy ensures that any new licence applications that are likely to add to the existing cumulative impact will normally be refused. This policy also creates a local understanding between the Council, licensees and residents that high quality standards of outlet management must be maintained to minimise the negative impacts of the night time economy on the local area.

The Clerkenwell Licensing Charter initiative for late night premises was developed in 2008, to help manage the impact of the night time economy on residents and authorities. A number of issues had been raised by residents about antisocial behaviour associated with late night entertainment. This included noise from customers both inside and outside premises, loud music, customers leaving early in the morning and noise from 'bottling out', where staff empty bottles into bins and move bins around after the premises have closed.

Other issues raised were litter associated with premises (flyers, food rubbish overflowing from bins, bottles / broken glass and cigarette butts) and drunken and nuisance behaviour (urination / vomiting in the street and on doorsteps, blocking pavements and making roads inaccessible, screaming, shouting and fighting).

In response to complaints from residents, the Charter set out a range of socially responsible actions that licensees should follow, with the three overarching aims of:

- Encouraging their customers and staff to respect the local neighbourhood.
- Promoting the highest standards of management inside and outside of their premises.
- Ensuring their premises are safe to use.

All premises in the area are encouraged to join and be actively involved in the Charter with just over half of premises in the Clerkenwell area currently signed up. Lessons learned are being used to inform future actions across other areas of the Borough with a significant night time economy, for instance Angel.

Purple Flag

In June 2010, Clerkenwell was awarded Purple Flag status in recognition of the proactive management of the area for the benefit of residents, businesses and the night time economy.

The Purple Flag acknowledges that while the bar and pub industry can be the mainstay of cities at night, they need to be supported by a diverse range of other activities that will attract families with young children and older people. This includes arts & culture, leisure, food & dining, education, and events, as well as good transport links and a safe environment. Clerkenwell is one of only four places in London to achieve the Purple Flag kitemark – Covent Garden, Leicester Square and Victoria (all in the City of Westminster) are the other London locations with a Purple Flag.

Approximately 30 venues in Islington currently have the award, with an additional number meeting the standard and therefore eligible to apply for the BBN award this year. This scheme is run every two years in Islington and plans are to run it again.

Location, cumulative impact and saturation

Having one of the highest densities of licensed premises in the country can sometimes result in conflicts between residents, businesses and late night premises in Islington. To minimise impact on residents, the Council considers location of the premises, type of licence, cumulative impact upon the area, and potential areas of saturation (areas where no further licensed premises can be accommodated). The Council can apply restrictions to licensing hours or impose stricter conditions, particularly where there is evidence of poor management, residential complaints and evidence of antisocial behaviour related to the premises. The Council is currently considering the cumulative effect of the large number of premises providing licensable activities in the Angel, Upper Street and Essex Road areas following views from residents and local businesses. As well as the cumulative impact policy in south Clerkenwell, conditions are also attached to licensing in a number of parts of Islington, each reflecting the particular issues of the area:

- the area surrounding the Emirates Stadium on match days;
- the Angel Town Centre;
- King's Cross area;
- Bunhill.

ENFORCEMENT

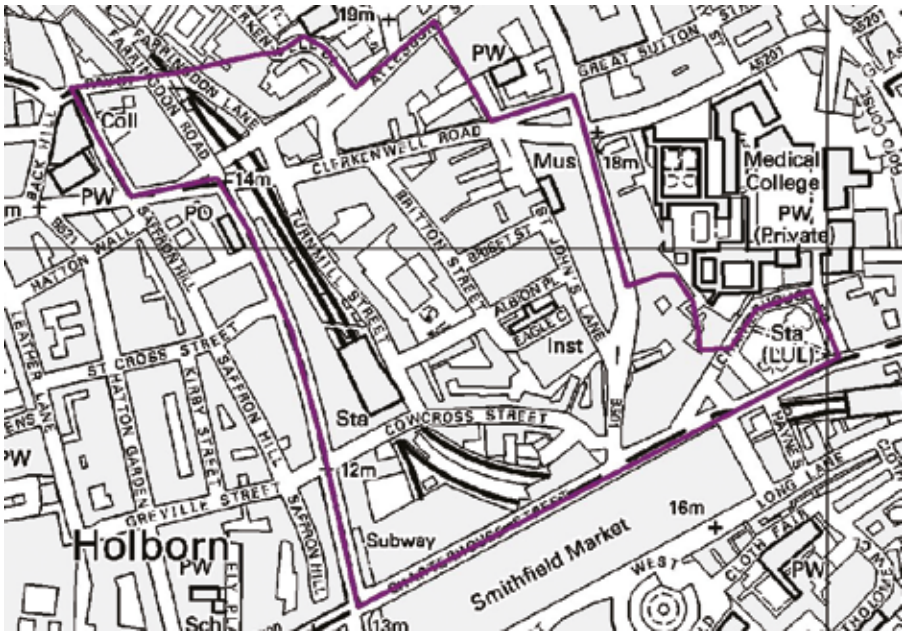
All licensed premises are required to comply with their specific licensing conditions to meet the four licensing objectives described earlier. The majority of Islington licensees comply with the objectives and work in collaboration with the licensing team to ensure the conditions are met. Suspension and closure notices are issued as a last resort to premises that breach their licensing conditions, following previous warnings.

Underage sales and proxy sales

The Council's Trading Standards department regularly conducts test purchasing exercises on underage sales with local licensed retailers. Test purchase exercises are carried out by young people (under 18) who make attempts to purchase alcohol. Of the 251 test purchase exercises carried out between April 2010 and August 2012, 71 (28%) resulted in a sale. Initiatives used locally to work with licensed premises around the importance of checking the age of customers have been shown to have a positive impact. For instance, following the Community Alcohol Project **(see box 5.3)**, which provided targeted support to retailers about licensing law, no test purchase exercises conducted resulted in a sale.

Proxy sales (when a person over 18 purchases alcohol on behalf of a minor) are often difficult for retailers to identify. To raise awareness about proxy sales, trading standards provide retailers with information, resources (posters and leaflets) and training about the law and how to manage difficult customers. Islington has also used awareness campaigns to inform members of the public about the law and penalties if caught buying alcohol for young people **(figure 5.2)**.

Map 5.3 Map showing the boundary of the Farringdon Area of Clerkenwell Cumulative Impact Area
Purple line denotes areas where Cumulative Impact Area applies, see **box 5.2** for details.



Illicit alcohol (counterfeit and non duty paid and stolen)

Illicit alcohol (counterfeit alcohol or genuine alcohol but where duty has not been paid, or where alcohol is stolen) is widely available across London, and is mainly an issue found in smaller retailers[9]. Trading Standards in partnership with Her Majesty's Revenue and Customs (HMRC) often conduct spot checks on premises to detect illicit alcohol. Since April 2010, the majority of smaller retailers checked were found to be selling alcohol where the appropriate duty had not been paid (non duty paid and stolen alcohol) with a smaller number selling counterfeit alcohol. The biggest problems are found with branded spirits, particularly vodka, and cheap Italian wine. In response, Trading Standards have developed guidance for retailers on how to identify illicit alcohol products[10]. To avoid buying non duty paid products, retailers are advised to only deal with reputable traders and ensure they get proper invoices **(figure 5.3)**.

Information is provided to retailers about how to recognise illicit alcohol, including instructions on recognising the standard UK Duty stamp **(figure 5.4)**. It is an offence for retailers to sell stock without this stamp unless they can demonstrate that the goods predate the introduction of the scheme. The pink stamp will glow green, yellow or white under ultra violet (UV) light, whereas illegal stamps do not react at all. Poor print quality and labels stuck over the stamp are also clear indicators that the product may be counterfeit and therefore illegal. Businesses found selling smuggled goods are likely to be prosecuted and / or have their alcohol licence reviewed and then revoked or suspended.

Figure 5.2 Raising awareness about proxy sales

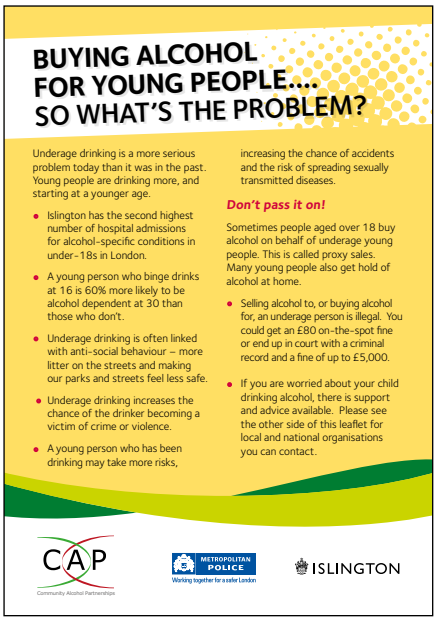


Figure 5.3 Retailer poster about illegal products

Figure 5.4 Representation of a UK Duty stamp
Source: UK Duty Stamps Scheme. www.hmrc.gov.uk

Between April 2010 and August 2012, 46 premises have been reviewed, with 15 licences revoked, 22 licences suspended and 9 licences where extra conditions were added for offences related to illegal alcohol and underage sales.

Box 5.3: Islington Community Alcohol Project (CAP)

The Islington Community Alcohol Partnership (CAP) was a multi-agency response to address local concerns about alcohol-related crime and antisocial behaviour amongst young people in Caledonian and Holloway wards.

The nine month pilot started in April 2011 and involved alcohol-related education in schools using drama and other activities for young people to provide an alternative to drinking alcohol and "hanging around on the street". The project also included direct work with local licensed retailers about sales to minors and counterfeit alcohol, and a supportive neighbourhood police presence.

An evaluation of the pilot found:

- Young people reported a better understanding of the risks associated with alcohol consumption
- Levels of reported antisocial behaviour and crime had reduced during the project, with residents claiming to have greater confidence in the ability of the police and other public services to tackle the problems
- A strengthened relationship between trading standards, police and local retailers, with retailers reporting more confidence in identifying underage customers, proxy sales and illicit goods
- Results from test purchasing exercises with local licensed retailers involved in the pilot showed that following the CAP, no retailer sold alcohol to underage customers, where as before the CAP almost 30% of all test purchases were successful. Following the success of this programme, plans are underway to embed the programme in the pilot wards and to extend it to other areas of the Borough experiencing similar problems.

WHAT WORKS

Minimum pricing and taxation

An increase in the minimum price of alcohol is likely to be among the most effective ways of reducing alcohol consumption. Recent reviews found alcohol demand is price responsive, and suggests that a 10% increase in affordability of alcohol would result in a 3.2% increase in consumption[11]. Efforts to prevent cheap alcohol sales must cover both on and off licensed retailers. In England it has been estimated that setting a minimum alcohol price of 50p per unit for all retailers would reduce violent crime by 2.1% and hospital admissions by 7.4% in the first year[12].

Studies have shown that tax increases have reduced alcohol-related harms across a range of outcomes including cirrhosis mortality, suicide rates, alcohol-related mortality, and road / work-place accidents, criminal activity, violent crime, and criminal damage/ property offences[11, 12]. Alcohol duty is rising in the UK by 2% above retail inflation each year to 2014-5. Higher amounts of alcohol duties are being applied to cider and beer to align duty more closely to alcohol strength.

Policies which result in low alcohol products being sold at low prices and high alcohol products sold at very high prices are likely to reduce the total amount of alcohol consumed and so reduce alcohol-related harm.

Alcohol Strategy

The 2012 Government Alcohol Strategy[13] sets out a policy to introduce a new minimum unit price (MUP) for alcohol to make it illegal for shops to sell alcohol for less than a set price per unit. The strategy requires local services and business to address alcohol-related issues in their area, tackling excessive drinking and enforcing responsible behaviour. Local agencies will have the powers and tools to restrict late night alcohol sales and introduce a levy for businesses selling alcohol to contribute towards the cost of policing. The density of premises licensed to sell alcohol can also be controlled. The alcohol industry is being encouraged to end irresponsible practices and continue

their commitment through the Responsibility Deal to foster a culture of responsible drinking, although evidence shows that other interventions are required to promote responsible industry behaviour. Individuals will be helped to change by being given the information and support they need, e.g. a national review of alcohol guidelines to support adults make informed decisions about their drinking is proposed. There are plans to develop social marketing campaigns to communicate health harms of drinking at above lower risk guidelines.

Changes to licensing

When the licensing system is used to restrict the number of outlets, alcohol harm and public order problems are reduced. Restricting physical availability of alcohol can reduce total volume consumed as well as alcohol-related problems. Studies assessing the effectiveness of limiting the density of alcohol outlets showed greater alcohol outlet density to be associated with increased alcohol consumption and harms including injury, violence, crime and medical harm. Small numbers of concentrated problematic nightlife venues often cause a large proportion of alcohol-related harm, violence and injuries in city centres[14]. Restrictions on times when alcohol can be sold has been used in the past to reduce the availability of alcohol. A review of the impact of the extension in alcohol sales times in England and Wales found a shift in the timing of violence to later in the night with an increase in offences and violent crimes reported between 3am and 6am. There was no clear picture of whether alcohol-related demands on A&E services and alcohol-related admissions had risen as a result, some hospitals saw a fall in alcohol-related attendances, others reported an increase[11].

The Police Reform and Social Responsibility Act 2011[2] has taken forward proposals to rebalance the Licensing Act 2003 to give local authorities and the police much stronger powers to remove licences from, or refuse to grant licences to, any premises that are causing problems in the local area.

Examples of promising interventions

Measures that have been implemented to reduce harm in drinking environments and shown to have had some effect include[15]:

- enforcement activities to prevent underage drinking through test purchasing;
- policy interventions including programmes to reduce drink driving, risk assessment, provision of manuals and information, promoting an alcohol prevention strategy at licensed premises, promoting responsible service in respect of minors and drunk patrons;
- community interventions with multi-agency partnerships implementing a range of measures;
- educational interventions to reduce binge drinking, involving a brief intervention using the AUDIT questionnaire (see chapter 2 for information on AUDIT) and a blood alcohol test.

In general, studies found that training of individuals serving alcohol, as well as policy interventions backed up by enforcement and community partnerships, have the potential to reduce alcohol-related problems[16]. These are discussed further in chapter 6.

Types of drinking

Research suggests the association between consumption of particular types of alcohol and alcohol-related harm in general does not vary much between types of drink (e.g. wine or beer). However, excessive drinking of spirits (e.g. vodka, whiskey) is more likely to be associated with alcohol poisoning, alcohol overdose death, and higher overall alcohol consumption implying that spirits are worth discouraging through higher pricing[17].

SUMMARY

Islington has one of the highest densities of licensed premises in London. There is a significant link between density of licensed premises and alcohol-related ambulance callouts and crime (as discussed in chapter 6), particularly in a number of hotspot areas in the Borough. There are a range of effective interventions and area-based licensing requirements in operation in Islington, although these initiatives have often been implemented on a relatively small scale or as pilots. Levels of alcohol-related harm in Islington are high and there is scope to build on and expand the effective practice already occurring.

Multi-agency action is important in licensing and enforcement, particularly for developing and implementing preventive and proactive initiatives. Islington Council has a long history of good partnership working with a number of local and regional agencies to promote public safety in relation to alcohol. While the Council acknowledges that although licensing is not the primary mechanism for controlling antisocial behaviour away from licensed premises, tighter controls over licensing decisions is part of the Council's holistic approach to the management of the evening and night-time economies in the borough.

Working with licensed premises through initiatives such as Pubwatch, Purple Flag and the CAP is likely to contribute towards effectively reducing alcohol-related harm and promoting public safety. New measures in the Police Reform and Social Responsibility Act provide further opportunities to address alcohol-related problem areas / premises and a review of how these new powers can be integrated into local policy will contribute towards management of the Islington night-time economy.

References

[1] Institute of Alcohol Studies. *Alcohol Control Studies, Fact Sheet.* http://www.ias.org.uk/resources/factsheets/policies.pdf (accessed 23 June 2012)

[2] *The Police Reform and Social Responsibility Act 2011. Chapter 13.* 2011 http://www.legislation.gov.uk/ukpga/2011/13/contents (accessed 25 July 2012)

[3] Home Office. *Police Reform and Social Responsibility Bill* – March 2011 – Temporary Event Notices. Date unknown. http://www.homeoffice.gov.uk/publications/alcoholdrugs/alcohol/alcohol-proposals-factsheet/tens?view=Binary, (accessed 1 September 2012)

[4] *Islington Licensing Policy (2012-14)* https://www.islington.gov.uk/publicrecords/documents/LeisureandCulture/Pdf/Licensing_policy_2011-14.pdf (accessed 23 June 2012)

[5] *Reducing Harm in Drinking Environments*, EU Fact Sheet. 2009 http://www.cph.org.uk/showPublication.aspx?pubid=547 (accessed 20 June 2012)

[6] The Chartered Institute of Public Finance & Accountancy. *Regulatory Services Statistics Actuals,* 2010-2011. www.cipfa.org

[7] Purple Flag. http://www.purpleflag.org.uk/about-purple-flag.html (accessed 31 July 2012)

[8] Best Bar None http://www.bbnuk.com (accessed 27 June 2012)

[9] Her Majesty's Revenue and Customs (2012) *Alcohol Fraud Legislative measures to tackle existing and emerging threats to the UK alcohol duty regime.* Consultation document. 26 March 2012 - 25 June 2012. http://customs.hmrc.gov.uk/channelsPortalWebApp/channelsPortalWebApp.portal?_nfpb=true&_pageLabel=pageLibrary_ConsultationDocuments&propertyType=document&columns=1 &id=HMCE_PROD1_031982 (accessed 26 July 2012)

[10] Islington Council, Trading Standards Department. http://www.islington.gov.uk/services/business-licensing/regulations/trading_standards/trading_standards_advice/Pages/default.aspx (accessed 7 September 2012)

[11] *The likely impacts of increasing alcohol price: a summary review of the evidence base.* Home Office, 2011. http://www.homeoffice.gov.uk/publications/alcoholdrugs/ alcohol/impacts-alcohol-price-review?view=Binary (accessed 2 July 2012)

[12] Meir P, Booth A, Stockwell T, Sutton A, Wilkinson A, Wong R. *Independent review of the effects of alcohol pricing and promotion.* Department of Health, 2008.

[13] HM Government. *The Government's alcohol strategy.* CM8336, London: The Stationery Office, 2012.

[14] Bryden A et al. *A systematic review of the influence on alcohol use of community level availability and marketing of alcohol.* Health and Place 2012; 18(2):349-357.

[15] Osterberger E. *Availability of Alcohol.* In: Anderson P, Møller L, Galea G (eds.) *Alcohol in the European Union consumption, harm and policy approaches,* WHO Europe; 2012. p83-88.

[16] Bolier L, Voorham L, Monshouwer K et al. *Alcohol and drug prevention in nightlife settings: a review of experimental studies.* Susbtance Use & Misuse 2011; 46(13): 1569-1591.

[17] Makela P, Mustonen H, and Osterberg E. *Does beverage type matter?* Nordic Studies on Alcohol and Drugs. 2007; 24: 617-31.

6 Alcohol-related crime and anti-social behaviour

Contents

Key messages

- Alcohol is a major cause of criminal and anti-social activity in Islington. About 2,000 alcohol-related offences are reported each year in Islington, including more than 900 violent offences. But it is likely that only about half of alcohol-related crimes are reported.
- Alcohol-related harm is perceived to be a problem by Islington residents.
- Increasing density of licensed premises is associated with higher rates of alcohol-related crime in Islington. 'Hotspot' areas include the Angel and Essex Road, Clerkenwell and Bunhill, and near King's Cross.
- Licensing and regulation have an important role in reducing crime and anti-social behaviour linked to alcohol (see chapter 5) and this needs to work hand-in-hand with policing and other partners.
- There are important opportunities to prevent or reduce alcohol-related offending and re-offending through community, policing and criminal justice actions, and multi-agency approaches. This needs to be underpinned by good intelligence and data sharing. Data are already shared effectively within Islington, and reviewing how this can be further developed will be beneficial, for instance including health data.

WHY FOCUS ON THIS AREA?

Alcohol is associated with a wide range of criminal and anti-social behaviours (ASB), particularly public drunkenness and street drinking, violence, domestic violence, injury, victimisation, and deaths and casualties linked to road traffic accidents. About ten percent of all reported crimes are recorded as alcohol-related, but this is likely to underestimate the impact of alcohol on crime. The British Crime Survey estimates that only about 40% of alcohol-related assaults are reported to the police[1].

The National Institute of Health and Clinical Excellence estimates that alcohol-related crime costs £8bn per year[2], which includes security and insurance, damaged and stolen property and other costs to victims, as well as policing, courts, prisons and probation. This figure does not include health service costs arising from alcohol-related crime.

There are particular links to the night time economy, with over half of alcohol-related violent incidents taking place in or around bars and clubs[3] and the trend of "pre-loading" (drinking at home before going out to a bar or club) increasing the risk of alcohol-related violence and disorder[4].

Alcohol misuse is particularly prevalent among prison populations

and increases the risk of re-offending on release[5]. This is acknowledged as a key risk factor in predicting violent re-offending[6].

Crime and ASB associated with alcohol therefore place a significant burden across a range of public services, businesses and local people and communities. Impacts are felt across physical, mental and sexual health, and can have devastating effects on victims, families and communities[7]. Tackling alcohol-related crime and ASB requires multi-agency action, which in Islington is coordinated by the Safer Islington Partnership.

Figure 6.1 Types of alcohol-related crime reported in Islington, 2011/12
Source: MPS crime data, Islington Intelligence Unit, June 2012

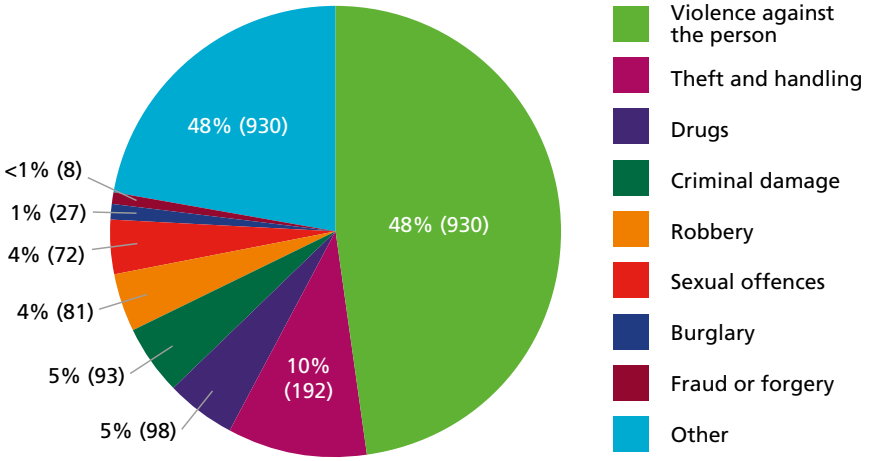
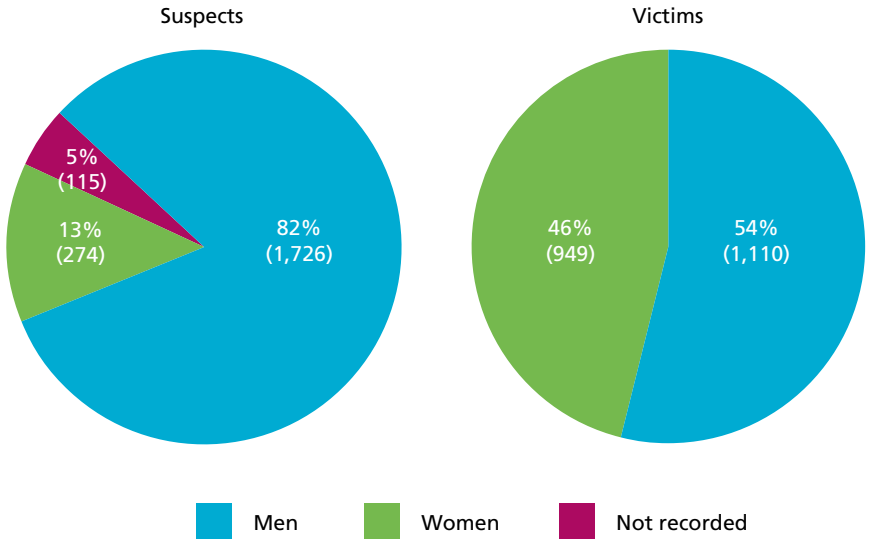


Figure 6.2 Suspects and victims of alcohol-related crime, by gender, 2011/12
Source: MPS crime data, Islington Intelligence Unit, June 2012



PERCEPTIONS OF ALCOHOL-RELATED CRIME AND ANTI-SOCIAL BEHAVIOUR

The British Crime Survey found that 53% of respondents thought alcohol was a major cause of crime, ranking third after drugs (68%), and lack of parental discipline (67%)[8]. Londoners' top concerns about alcohol-related harm are crime (72%) and ASB (58%) ahead of concerns over long-term health impacts such as liver disease (48%) and short-term health issues such as hangovers (33%)[9]. 47% of victims of violent offences and 38% of victims of domestic violence, believed the offender to be under the influence of alcohol[10].

ALCOHOL-RELATED CRIME AND ASB IN ISLINGTON

1,926 offences identified as alcohol-related were reported to police in Islington in 2011/12. 930 (48%) were violent crimes, similar to England (45%)[11], and 72 (4%) were sexual offences **(figure 6.1)**.

Many alcohol-related offences go unreported to the police. Crime survey data, which looks at unreported as well as reported crime, estimates that there were around 2,700 alcohol-related crimes in Islington in 2010/11, of which 1,880 were violent. Islington's estimated rate in 2011/12 (13.8 per 1,000 population) was higher than the London (11.1) and England (7.0) rates[12].

Alcohol-related sexual offences

Alcohol is a major factor in sexual offences, with 58% of men imprisoned for rape having consumed alcohol prior to the offence[13]. In 2011/12 there were 72 alcohol-related sexual offences reported in Islington, including 37 offences of rape. The North

London Rape Crisis Centre reports an increasing number of women presenting as victims of drug facilitated sexual assault (where drinks have been "spiked" with sedatives), with 8 presentations in Islington between December 2010 and February 2012.

Drink driving

The Metropolitan and City of London police forces undertook 86,598 roadside breath tests in London in 2010/11, of which 15% were positive or refused, compared to 12% across England as a whole. In 2009, there were 20 deaths, 90 serious injuries and 580 slight injuries resulting from drink driving across London[14]. Nationally, drink driving rates have shown a downward trend over the last decade[15]. Figures specifically for Islington are unavailable.

Suspects and victims of alcohol-related crimes

Among suspects of alcohol-related crime in Islington, the large majority are men (82%). The peak rate is in the 18-24 year old age group. About 65% are described as White, with the next largest group described as Black (22%). Men are slightly more likely to be victims than women **(figure 6.2)**, with a more pronounced gender difference in violent crime (60% males). Rates of being a victim are similar across the 18-24 to 45-54 year old age groups. 72% of victims are described as White and 15% as Black **(figures 6.2, 6.3, 6.4)**.

Alcohol-related crime most commonly occurs at night, up to midnight on Sunday to Thursday, and up to 04:00am on Saturday and Sunday, reflecting the periods when bars and nightclubs are at their busiest during weekends. Alcohol-related

Figure 6.3 Number of suspects and victims of alcohol-related crime, and rates per 1,000 population, by age, 2011/12

Source: MPS crime data, Islington Intelligence Unit, June 2012

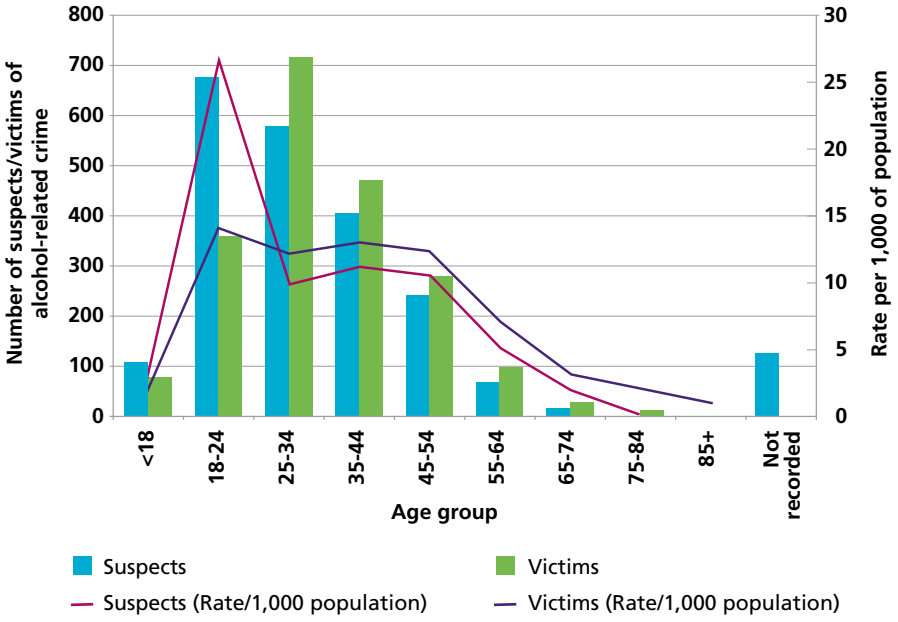
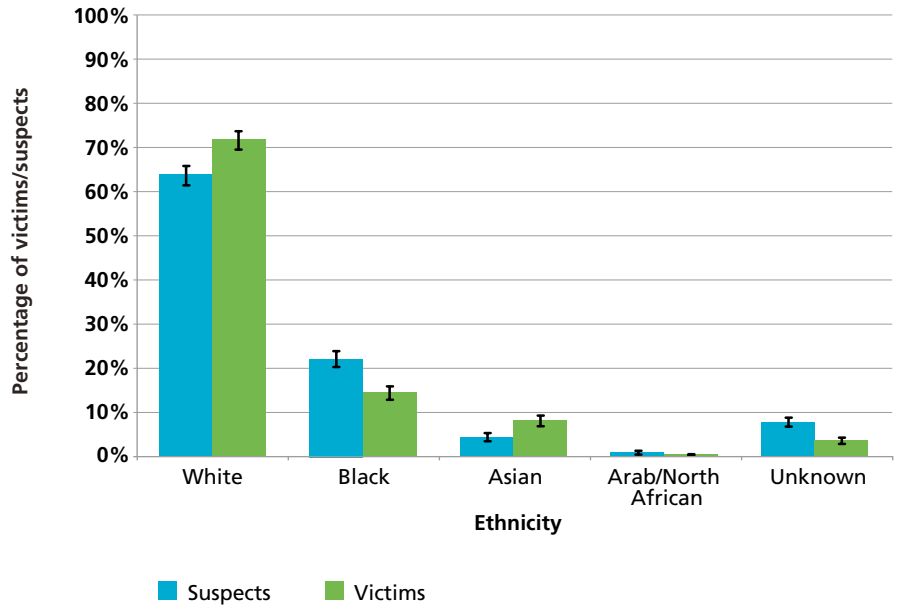


Figure 6.4 Perceived ethnicity of suspects and victims of alcohol-related crime, 2011/12

Source: MPS crime data, Islington Intelligence Unit, June 2012



ambulance callouts follow a similar pattern **(figure 6.5)**. Alcohol-related ambulance callouts are discussed in more detail in chapter 4.

Sharing datasets across different agencies is beneficial in understanding the impacts of alcohol related harm. For instance **figure 6.6** uses data on the number of licensed premises and alcohol-related harm to highlight a general link in Islington between the number of licensed premises and the number of alcohol-related crimes in an area, with number of crimes tending to increase with the number of licensed premises. The pattern is similar to that seen between the number of alcohol-related ambulance callouts and density of licensed premises as discussed in chapter 5. The type of licence (on- or off-licence) or the type of crime (violent or non-violent) makes little difference to this pattern. This challenges the local perception that alcohol-related crime is only connected to on-licensed premises.

Large numbers of licensed premises and good public transport links in the Angel/Upper Street area, King's Cross, Bunhill, and south Clerkenwell, make these areas popular entertainment destinations. However, the same combination also contributes to high levels of alcohol-related crime. Another hotspot for alcohol-related crime runs north from Highbury Corner along the Holloway Road. Seven Sisters Road, between the Nag's Head and Finsbury Park Station, is an area popular with street drinkers and also experiences high levels of alcohol-related crime.

Map 6.1 shows the areas where alcohol-related crime is high (more than twice the average number of crimes recorded per lower super output area in Islington, shown in yellow) and very high (more than four times the average, shown in red). The map also shows the density of licensed premises across Islington, and the proximity of underground and railway stations to areas that experience high levels of alcohol-related crime.

Figure 6.5 Day and hour of reported alcohol-related crime and alcohol-related ambulance callouts, 2011/12

Source: MPS crime data, Islington Intelligence Unit and: London Ambulance Service, provided through, and in agreement with GLA SafeStats (www.safestats.org.uk).

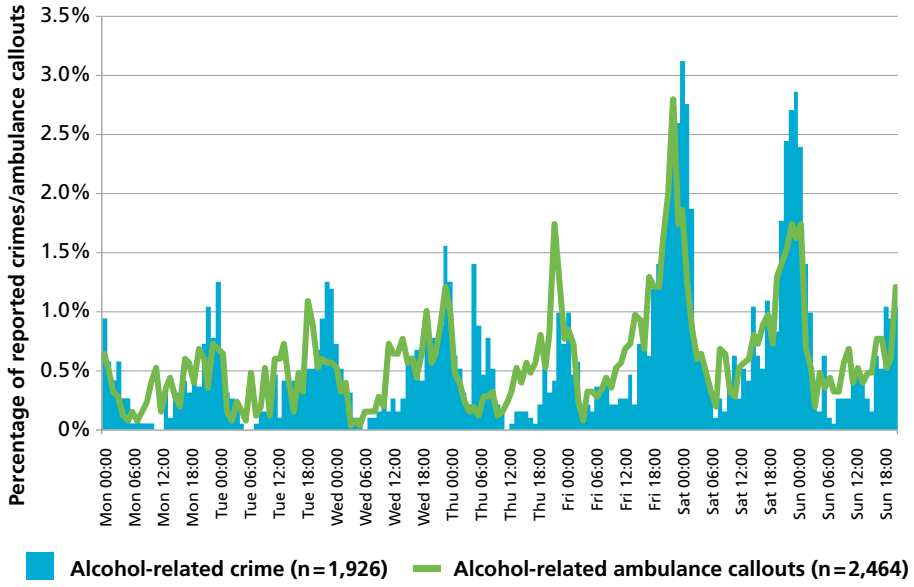
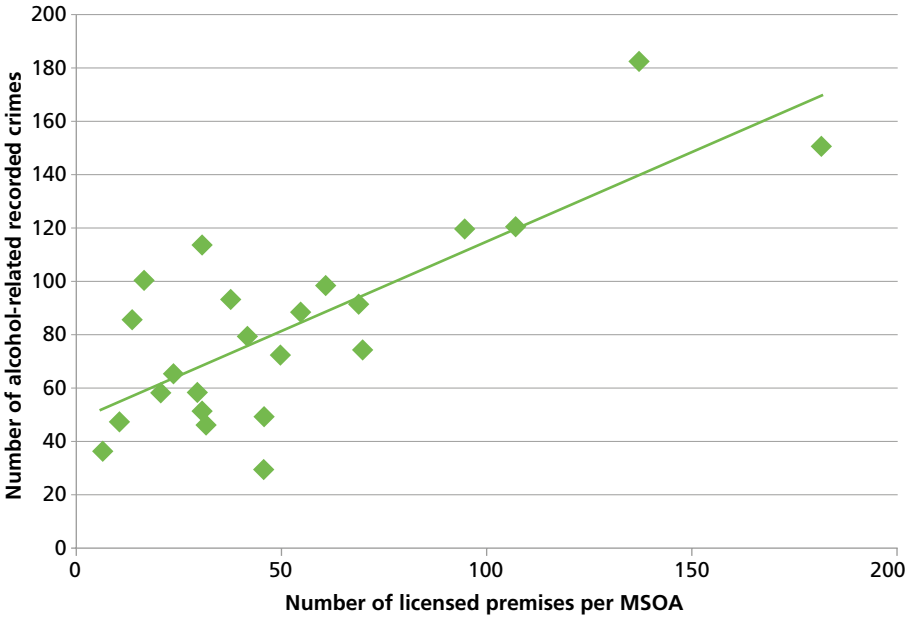


Figure 6.6 Number of licensed premises and alcohol-related crime by Middle Super Output Area (MSOA), Islington, 2011/12

Source: MPS crime data, Islington Intelligence Unit, June 2012, Islington Council licensing data.



This highlights an important link between availability of alcohol, patterns of consumption and crime and ASB, with international evidence showing reducing alcohol outlet density can reduce violence and other alcohol-related harm[16]. Chapter 5 looks in more detail at the control and availability of alcohol.

ANTI-SOCIAL BEHAVIOUR (ASB)

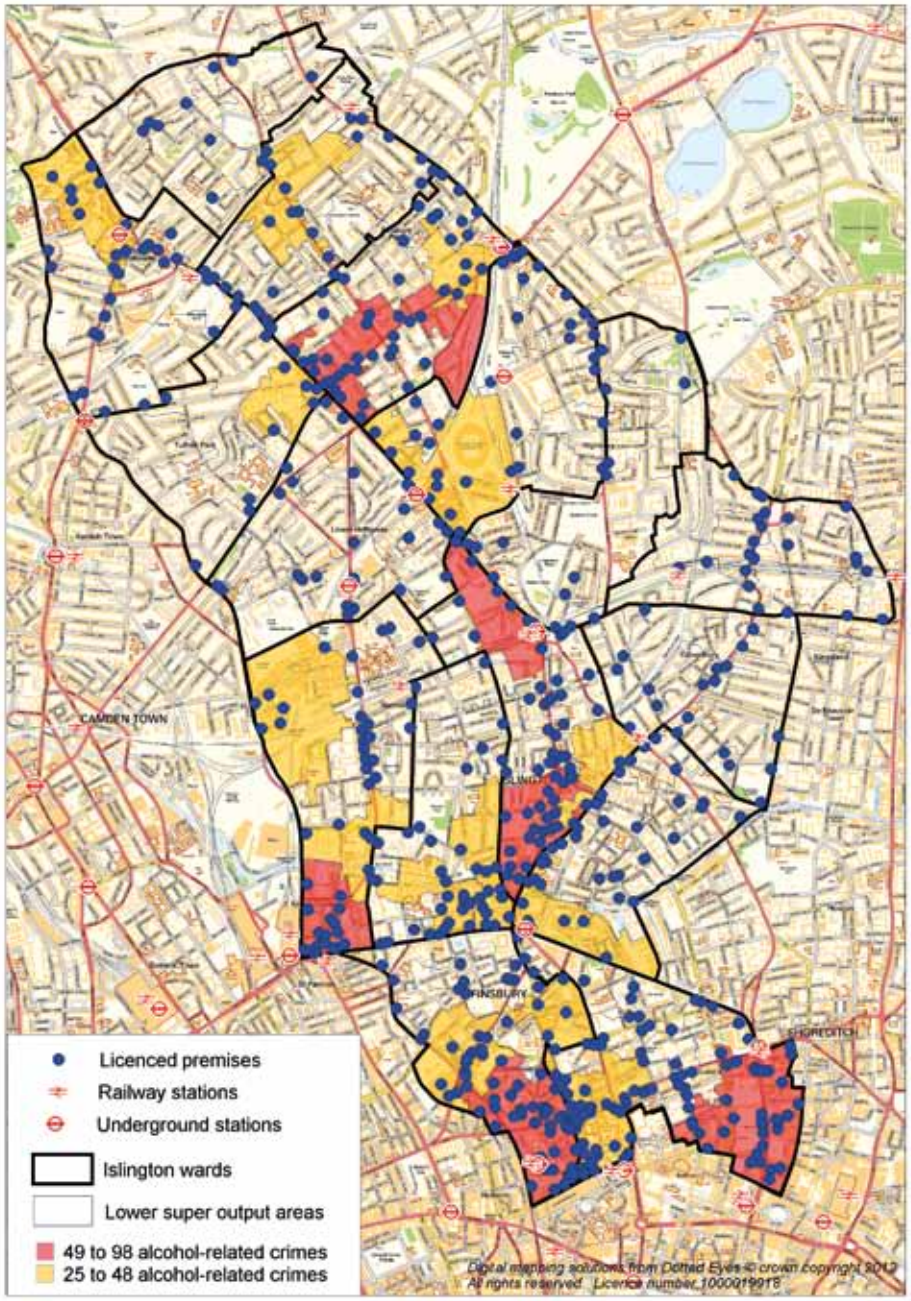
Alcohol is an important contributor to ASB, although this is less well recorded than alcohol's involvement in crime. It is often reported to the Council or a social landlord, rather than to the police. Alcohol-related ASB can substantially affect people's quality of life. It can be intimidating, cause nuisance and disorder, and degrade public spaces which can become a 'no go' area for residents and the community **(figure 6.7)**.

Islington Council's *Place Survey* shows that 42% of residents in 2009/10 thought people being rowdy or drunk in public places was a problem (compared to 38% in 2003/4), significantly more than London (36%) and England (29%)[17].

A frequent example of ASB is street drinking, particularly in the summer months, and is often associated with other forms of ASB/crime such as open drug use and violence. Because of its transient nature it is difficult to quantify the amount of street drinking occurring. However, data regarding street drinking, the movement of hotspots and street drinkers is monitored by Islington's outreach data which Community Safety, Greenspace (who manage parks and green space) and the Police feed into. Current data suggests 150 and 189 incidents of street drinking in 2010/11 and 2011/12 respectively. Outreach teams work with street drinkers to provide support before using enforcement. Other initiatives include redesigning hotspot areas to make it difficult for people to congregate for drinking.

Map 6.1 Alcohol-related crime hotspots in Islington, 2011/12

Source: MPS crime data, Islington Intelligence Unit, June 2012



Interventions to reduce ASB

Islington Council launched a new ASB service at the start of 2012. Between January and June, 4,908 complaints for ASB were recorded, including 236 for noise from music, 62 due to noise from people around licensed premises, 182 for rowdy/drunken behaviour and 7 for drinking in a public place. Other complaints may have arisen from alcohol-related ASB, but not been recorded as such. A single database for ASB reports and incidents across the Council has been introduced as part of the new service, enabling all data to be captured in one place and linked to other information, including police data. This system helps services target their efforts more effectively as well as identify hot spots areas more easily.

Figure 6.7 Public perception of anti-social behaviour

Source: British Crime Survey 2008/09.

Box 6.1: Tackling alcohol-related anti-social behaviour in Islington

Grenville Road Gardens is a small green space and children's play area in a residential street in the north of the borough. In 2009, street drinkers began to gather and drink in the park. Their increasingly loud and rowdy behaviour attracted other people thought to be involved in drugs, and they often brought large dogs into the park. Residents felt that their children could no longer use the play facilities because of the increase in drunken adults using the park as a toilet, being rowdy and abusive, and perceived drug-related activity. Fear of crime increased and confidence in the authorities decreased.

The problem was taken to the North Multi-Agency Geographical Panel in Islington (MAGPI), where a problem solving approach involving residents and agencies identified a number of interventions. An action plan to reduce the number of drinkers causing ASB in the park, increase the involvement of drinkers in treatment and support services, and reduce residents' fear of crime was put in place.

Environmental improvements were made and trees and bushes cut back to increase natural sight lines. Tenants of supported housing in the street were reminded that ASB by any of their visitors may affect their tenancy (although it later transpired that this had not been a major problem). The Safer Neighbourhood Team, Park Guard (park patrols), and Outreach Teams increased patrols and shared information. Although there was no Designated Public Place Order in force at that time, the police used existing powers to displace people causing ASB. The most prolific offenders were identified and Acceptable Behaviour Contracts negotiated, whereby individuals agreed not to urinate in public, swear or verbally abuse anyone, or gather in groups of three or more consuming alcohol.

Following the interventions, the number of incidents fell dramatically and have remained low.

Multi-Agency Geographical Panels in Islington

MAGPIs (Multi-Agency Geographical Panels in Islington) are groups of people from across the Borough that work together to tackle local nuisance, ASB, and crime. The MAGPI members discuss ways to solve problems, developing action plans **(box 6.1)**. Usually, several agencies will work together to solve one problem with multiple facets. Each panel has core members from Islington Council and other local agencies, including registered social landlords, Islington police, voluntary groups, and ward councillors.

MAGPIs are able to use a range of actions to tackle ASB, including targeting parks patrols, street outreach and sending ASB out-of-hours teams to hotspot areas, joint patrols of services and organising visual assessments to identify physical or environmental factors that contribute to ASB, and making changes or recommendations to the environment, and supporting local youth groups.

If ASB is persistent, the Council can issue ASB orders, acceptable behaviour contracts, or dispersal orders (which require groups of two or more people to leave the area and not return for 24 hours). A borough-wide "Designated Public Place Order", which gives the police the power to ask people within a defined area who are behaving in an anti-social manner, to stop drinking and hand over any alcohol in their possession, has been in place since August 2011.

Figure 6.8 Prevalence of drinking levels, alcohol arrest referrals, April to June 2012

Source: Islington Community Safety Partnership Unit

Safer Neighbourhood Task Force

The Safer Neighbourhood Task Force is a team of six officers working from 8pm to 6am Thursdays to Saturdays to deal with ASB associated with late-night clubs and pubs, as well as other forms of ASB. Licensed premises staff and licensing officers are able to contact the taskforce directly. The team also undertakes proactive crime reduction visits to licensed premises, and works alongside the MAGPIs and Safer Neighbourhood Teams.

ALCOHOL INTERVENTIONS IN THE CRIMINAL JUSTICE SYSTEM

Arrest Referral Scheme

This service is available in Islington's custody suites on a voluntary or referral basis. Substance misuse counsellors make contact with suspects held in police cells after arrest but before prosecution. The service assesses an average of 20 clients per month, and between April and June 2012, 54% of those assessed received a brief intervention or referral to alcohol services. The primary objective is a reduction in alcohol-related crime and reduced re-offending linked to alcohol consumption. At present, the service is provided by counsellors employed by the substance misuse service when capacity allows for this more proactive approach.

Figure 6.8 shows the prevalence of drinking levels among people referred to the arrest referral scheme between April and June 2012. Compared to estimated patterns of drinking among the general population in Islington, the proportions of people in the Arrest Referral Scheme drinking at harmful and dependent levels are much higher.

Alcohol treatment requirements

Courts have the power to attach an Alcohol Treatment Requirement to a community or suspended sentence, whereby the offender must agree to treatment for alcohol use for up to two years for a suspended sentence or three years for a community sentence. A dedicated worker from Islington's treatment provider (CASA) provides a weekly satellite service at the probation offices. Interventions that are offered are motivational interviewing, harm reduction advice, relapse prevention, and onward referral within the treatment system. Offenders are offered up to 12 individual sessions over a three to six month period.

Probation

The Probation Service is responsible for supervising people serving community sentences and prisoners released on parole or on licence. It uses an Integrated Offender Management Framework designed to ensure that agencies work together to improve public safety, rehabilitate offenders, and reduce re-offending. In 2011, alcohol misuse was identified in 1,027 cases (37%) managed by the Islington service (similar to the national estimated percentage[18]), often linked to offending behaviour. Social factors such as housing, education and employment are significantly associated with re-offending, and need to be addressed in conjunction with alcohol[19].

Prisons

Islington has two prisons. Pentonville is a men's prison predominantly serving prisoners on remand or awaiting sentence, with two-thirds staying at the prison for less than three months. Holloway is a women's prison for adults and young offenders with an average length of stay at the prison of 45 days.

Islington's recent Prison Needs Assessments found high levels of alcohol misuse within the prison populations. Fifteen percent of prisoners screened at reception, in both Holloway and Pentonville, reported drinking 16 or more units a day (equivalent to at least 112 units a week). Non-response and under-reporting is a problem, so the true level of need is likely to be higher. Screening of prisoners referred to the Alcohol Intervention Services found a high proportion were dependent drinkers (65% at Pentonville and 38% at Holloway) [20,21]. Among prisoners who are heavy drinkers (16 or more units a day), co-morbidity with substance use and mental health problems is high: 54% of male prisoners and 62% of women prisoners reported a current or previous mental health problem; and drug use was reported by 54% at Pentonville and 70% at Holloway. Prisoners with alcohol problems are more likely than other prisoners to come into prison with pre-existing difficulties, such as housing needs and health problems[22].

Service provision aims to support a reduction in alcohol use by prisoners through case management and clinical and psycho-social services. A prisoner reporting alcohol misuse at reception is assessed by the 'Counselling, Assessment, Referral Advice, Throughcare' (CARAT) team for assessment and referral to an alcohol programme or group sessions, among other services. First night care for alcohol users and detoxification are also provided. New Alcohol Intervention Services (AIS) were introduced at both prisons in 2011 to provide cognitive behavioural therapy to increasing and higher risk drinkers.

Drugs Intervention Programmes (DIP) support prisoners on release. Good communication between the prisons and the DIP teams both in Islington and other boroughs is important because the majority of prisoners released reside outside of Islington.

The needs assessments found prisoners and staff at both prisons had positive experiences and opinions of the CARAT team's ability to meet prisoners' needs, and high proportions of prisoners receiving alcohol treatment were motivated to stop drinking: 59% at Pentonville and 68% at Holloway. Short sentence lengths, transfers to other prisons, and high levels of alcohol dependency with concurrent substance misuse or mental health problems present particular challenges for ensuring prisoners have the full opportunity to benefit from services. 31% of male prisoners and 28% of female prisoners thought that they would have a problem with alcohol following their release, particularly dependent alcohol users[23,24]. Both prisoners and staff identified the importance of successful transition to community alcohol treatment services on release.

WHAT WORKS

Initiatives to help reduce alcohol-related crime and ASB are closely linked to regulation and enforcement. As discussed in chapter 5, evidence shows a link between alcohol pricing, consumption and criminal harm, and that increases in alcohol tax/price are associated with reductions in a range of criminal activity and offences[25].

Improving the drinking environment can help reduce crime and disorder in licensed premises. Ensuring adequate venue capacity and an appropriate ratio of customers to seating, and the presence of door security to control numbers entering and prevent entry or re-entry to drunk or disorderly individuals can reduce crime[26]. Improving premises ventilation, access to free water and safer polycarbonate glasses, good street lighting and adequate public transport can all support safer drinking environments[27]. Alcohol server interventions and staff training programmes focusing on preventing violence have demonstrated a reduction in aggression[28]. The Stockholm Prevents Alcohol and Drug Problems project combined increasing awareness and knowledge of alcohol-related harms in the community, responsible beverage server training, and enhanced enforcement. Over ten years it found an increase in refusals to serve alcohol to intoxicated people and an estimated reduction in violent crime of 29%[29]. Another project, which included training for bar staff by emergency department consultants and police, and enhanced enforcement, found that city centre assault injury prevention can be achieved through interventions targeted at high risk licensed premises[30].

In terms of policing and criminal justice, Home Office evaluations of arrest referral services found them to be of value in identifying dependent drinkers and directing them to more intensive interventions. The evaluation did not find a significant reduction in re-arrest rates, although there was some evidence of a reduction in overall alcohol consumption among the intervention groups[31].

Alcohol diversion schemes involve issuing a fixed penalty notice to a person arrested for alcohol-related offences such as being drunk and disorderly or causing criminal damage. The notice is generally given in a custody suite, and the offender is given the option of either paying the fine or attending an alcohol awareness session and accepting a smaller fine. Evaluation has shown that attendees are able to recognise that their drinking had resulted in inappropriate behaviour which invited arrest[32]. A similar scheme in Birmingham showed a reduction in re-offending at 18 months[33].

The *Screening and Intervention Programme for Sensible Drinking* (SIPS) project found the proportion of offenders in probation who were drinking at risky levels decreased as much after brief feedback as part of routine probation supervision meetings as with longer lifestyle counselling/advice. Successful implementation was associated with promotion by champions and sustained and significant support from specialist alcohol workers[34].

Systematic recording of where an assault victim's last drink was purchased or consumed has been shown to be effective in better targeting and tackling violent alcohol-related crime[35].

SUMMARY

Excess drinking is associated with a wide range of criminal and anti-social behaviour, impacting on public services, businesses, local people and communities. Islington experiences higher levels of alcohol-related crime and disorder compared to the London and England averages. There are a number of "hotspots" for alcohol-related crime in Islington, generally clustered around areas with large numbers of licensed premises. Alcohol-related crime most commonly occurs during weekend evenings and the early hours, when bars and clubs are at their busiest. A large proportion of alcohol-related crime, particularly anti-social behaviour, is likely to go unreported.

Licensing and regulation, which were discussed in chapter 5, have an important role in reducing crime and ASB linked to alcohol and this needs to work hand-in-hand with policing and other functions.

Alcohol misuse is particularly prevalent among prison populations, increasing the risk of re-offending on release[36] and is acknowledged as a key risk factor in predicting violent re-offending[22]. A number of initiatives are already occurring within the local criminal justice setting to identify and support those identified as drinking at levels likely to cause harm. Ensuring a systematic and comprehensive approach to identification, assessment and treatment of alcohol-related harm among those in contact with the criminal justice system is likely to result in social and economic benefits for the community as a whole.

References

1 *Hansard HL,* 7 Feb 2012: Column 188

2 National Institute for Health and Clinical Excellence. *Alcohol use disorders: preventing harmful drinking.* Costing report. London: NICE, 2010

3 Budd T. *Alcohol-related assault. Findings from the British Crime Survey.* Home Office Online Report 35/03, 2003.http://webarchive.nationalarchives.gov.uk/20110218135832/http://rds.homeoffice.gov.uk/rds/pdf s2/rdsolr3503.pdf (accessed 25 June 2012)

4 Hadfield P, and Newton A. *Alcohol, crime and disorder in the night-time economy.* London: Alcohol Concern, 2010.

5 Singleton N, Farrell M, and Meltzer H. *Substance misuse among prisoners in England and Wales.* London, ONS, 2003

6 Skidmore M, Engelen S, Tysoe E, Booth S, Falshaw L,. and Roberts P. *Alcohol services in prisons: an unmet need.* London: HM Inspectorate of Prisons, 2010

7 Prime Ministers Strategy Unit *Interim Analytical Report.* London: Cabinet Office, 2003

8 Walker A, Flately J, Kershaw C, and Moon D. *Crime in England and Wales 2008/09. Volume 1: Findings from the British Crime Survey and police recorded crime.* Home Office Statistical Bulletin 11/09 Volume 1, 2009

9 Murage P. et al. *Question Time. A survey of attitudes and perceptions towards alcohol consumption in London.* London Borough of Islington report. London: GLA, 2012

10 Walker, A. Flately, J., Kershaw, C. and Moon, D. *Crime in England and Wales 2008/09. Volume 1: Findings from the British Crime Survey and police recorded crime.* Home Office Statistical Bulletin 11/09 Volume 1, 2009

11 Direct.gov *Alcohol and crime, undated* http://www.direct.gov.uk/en/CrimeJusticeAndTheLaw/CrimePrevention/DG_181558 (accessed 21 June 2012)

12 North West Public Health Observatory *Local Alcohol Profiles for England, 2012.* www.lape.org.uk (accessed 24 August 2012)

13 Faculty of Public Health briefing statement: Alcohol and Violence, undated http://www.fph.org.uk/uploads/bs_alcohol_violence.pdf (accessed 24 August 2012)

14 Department for Transport. *Road Accidents and Casualties 2010 annual report.* London: DFT, 2011

[15] Home Office. *Screening breath tests and number positive or refused, by police force area, 2009 and 2010,* table BT02. London: Home Office, 2012 http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/policeresearch/ police-powers-procedures-201011/breath-tests-1011 (accessed 28 June 2012)

[16] Popova S, Giesbrecht N, Bekmuradov D, and Patra J. *Hours and Days of Sale and Density of Alcohol Outlets: Impacts on Alcohol Consumption and Damage: A Systematic Review.* Alcohol & Alcoholism 2009;44(5):500–516

[17] IPSOS/MORI *Assessing Islington's performance. Results of the Interim Place Survey 2009/10 for Islington Council and partners.* London: Islington Council, 2010

[18] Drummond, C. et al *Alcohol Needs Assessment Research Project.* London: Department of Health, 2005

[19] Social Exclusion Unit. *Reducing re-offending by ex-prisoners,* London, ODPM, 2002

[20] Harker K. *HMP/YOI Holloway Needs Assessment Substances & Alcohol.* London: NHS NCL, 2012

[21] Harker K. *HMP Pentonville Needs Assessment Substances & Alcohol.* London: NHS NCL, 2012

[22] Skidmore M, Engelen S, Tysoe E, Booth S, Falshaw L and Roberts, P. *Alcohol services in prisons:an unmet need.* London: HM Inspectorate of Prisons, 2010

[23] HM Chief Inspector of Prisons. *Report on an unannounced inspection of HMP Pentonville 24 February – 4 March 2011.* London: Ministry of Justice, 2011

[24] HM Chief Inspector of Prisons. *Report on a full unannounced inspection of HMP Holloway 15 – 23 April 2010.* London: Ministry of Justice, 2010

[25] Home Office. *The likely impacts of increasing alcohol price: a summary review of the evidence base.* London: Home Office, 2011 http://www.homeoffice.gov.uk/publications/alcoholdrugs/alcohol/impacts-alcohol-price-review?view =Binary (accessed 2 July 2012)

[26] Deehan A. *Alcohol and crime: Taking Stock. Policing and Reducing Crime Unit Crime Reduction Research Series Paper 3* London: Home Office, 1999

[27] Osterberger E. *Availability of Alcohol.* In: Anderson P, Møller L, Galea G (eds.) *Alcohol in the European Union consumption, harm and policy approaches*, WHO Europe; 2012. p83-88

[28] Graham K, Osgood D, Zibrowski E, et al. *The effect of the safer bars programme on physical aggression in bars: Results of a randomised controlled trial.* Drug and Alcohol Review 2004;23:31-41

[29] Wallin E, Norstrom T, and Andreasson S. *Alcohol prevention targeting licensed premises: A study of effects on violence.* Journal of Studies on Alcohol 2003;64:270-7

[30] Warburton A and Shepherd J. *Tackling alcohol-related violence in city centres: Effect of emergency medicine and police intervention.* Emergency Medicine Journal 2006;23:12-17

[31] Blakeborough L, and Richardson A. *Summary of findings from two evaluations of Home Office arrest referral pilot schemes.* London: Home Office, 2012

[32] McNicol I. *Evaluation of the Hertfordshire Alcohol Diversion Scheme.* Hemel Hempstead: Druglink, 2009.

[33] Kilgallon R and D'Ippolito A. *Analysis of alcohol arrest referral and penalty notice of disorder data.* Birmingham Drug and Alcohol Action Team, 2011 www.bdaat.co.uk/documents/AlcoholArrestReferralAnalysis 0311v3.doc accessed 2 July 2012

[34] McGovern R, Newbury-Birch D, Deluca P, et al. *Alcohol screening and brief intervention in probation.* Institute of Psychiatry, King's College London, 2012. www.fingings.org.uk (accessed 2 July 2012)

[35] Warburton A and Shepherd J. *Tackling alcohol-related violence in city centres: Effect of emergency medicine and police intervention.* Emergency Medicine Journal 2006; 23:12-17

[36] Singleton N, Farrell M, and Meltzer H. *Substance misuse among prisoners in England and Wales.* London, ONS, 2003

7 Case for change and recommendations

Contents

1. INTRODUCTION: THE CASE FOR ACTION

The introduction to this year's report acknowledged that alcohol can play an important and positive role in British culture, enhancing social and family life. In addition alcohol is an important part of Islington's thriving night-time economy. The vast majority of people enjoy alcohol without causing harm to themselves or others. However, alcohol is becoming an increasingly significant cause of personal, social and economic harm. The burden of alcohol-related harm is felt across the NHS, public services, the economy and local communities. This report has articulated key trends and the multiple impacts alcohol has on the population of Islington.

Consumption patterns:

- Around a fifth of people living in Islington are drinking at levels that put themselves at increased risk, a further 7% drink at higher risk levels[1].
- Around a fifth of people in Islington binge drink[1].
- National data shows a general trend of increasing consumption, as well as an increase in affordability of alcohol.[2]
- Nationally, those aged 45-64 years were the group most likely to be drinking above national low risk drinking guidelines. Average weekly consumption was also greater in this age group than in any other group[2].
- The impacts of alcohol-related harm are felt at all ages and at all levels of consumption – not just in the most obvious groups like dependent and binge drinkers associated with anti-social behaviour in town centres. Often alcohol-related harm can go unnoticed, and it is not necessarily the heaviest drinkers that account for most of the alcohol-related burden experienced within the population as a whole.

Health impacts:

- Islington has the highest rate of deaths in men linked to alcohol in London, and is significantly above the rate for England. The rate in women is not significantly different from London or England[1].
- Admissions to hospital linked to alcohol in Islington are significantly above the average for London. Admissions are also greater in people living in more deprived areas of the borough[1].
- Nationally, alcohol mortality is greatest in those aged 55-75 years[2].
- People with alcohol misuse problems often face added complexities of unemployment, homelessness or housing issues, health problems and multiple drug use. In Islington, of those in alcohol treatment services, 21% reported drug use and 17% a mental health problem[3].

Public perception:

- Londoners' top concerns about alcohol-related harm are crime and anti-social behaviour. Furthermore, 48% of those surveyed were worried about the long-term health impacts of alcohol[4].

- Over 60% of people in Islington said they were concerned or quite concerned about alcohol-related crime and violence[5].
- Information from the London Drink Debate suggests people are put off from using town centres at night due to fear of crime and anti-social behaviour[4].

Crime, anti-social behaviour and alcohol availability:

- Islington has the third highest density of licensed premises in inner London, with over 1200 licensed premises in total.
- There were over 1900 reported alcohol-related offences in Islington in 2011/12[6].
- There is a general link between the number of licensed premises and an increase in alcohol-related crimes in Islington: areas with a higher number of licensed premises also have a higher number of alcohol-related crimes.

Social:

- Young people with alcoholic parents are approximately five times more likely to develop alcohol-related problems than those with non-alcoholic parents[7].
- In Islington during 2011/12, 114 individuals who presented to alcohol services for the first time had contact with children, either as a parent or by living in a household with children.
- Islington has the third highest rate in London of working age persons claiming incapacity benefits due to alcoholism[1].

Economic:

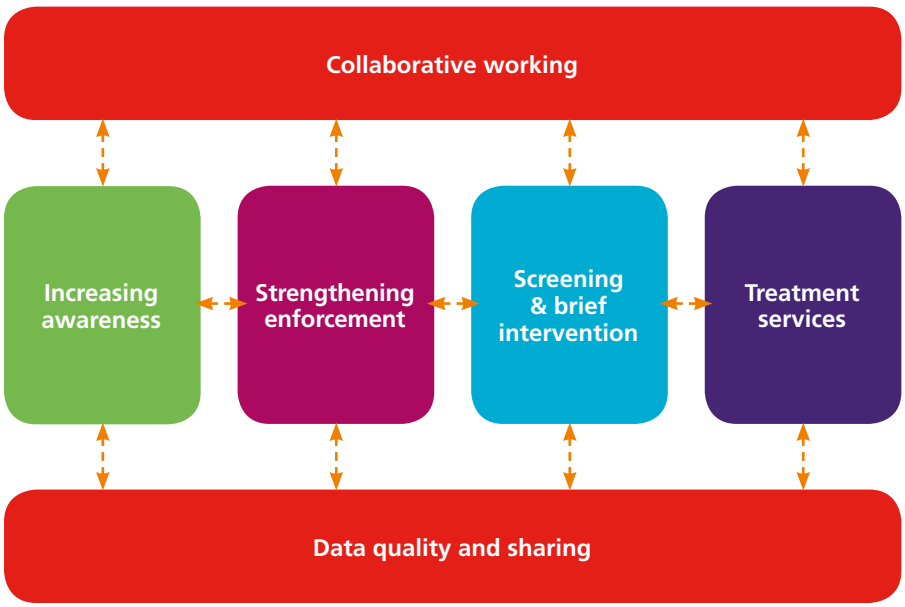
- The cost of hospital admissions related to alcohol in London has been estimated at £264 million, or £34 for every London resident. In Islington, this rises to £39 for every resident[8].
- Alcohol-related harm causes significant costs to society, such as crime and disorder, social and family breakdown and sickness, estimated as at least £25.1 billion nationally[9].

There is, therefore, a clear case for reducing the burden of alcohol-related harm in Islington. This is further supported by regional and national priorities and strategies. For instance, the London Health Improvement Board (LHIB) has identified alcohol as one of its priority areas. It suggests three key pillars for initial regional action as being: development of a London vision; ensuring alcohol is supplied responsibly and; ensuring interventions are in place to support those most at risk. The LHIB stated that:

'There is a strong case that to improve the health and well-being of Londoners' there is a need to address alcohol-related harm'[10]

Alcohol-related harm is a multi-factorial issue that spans multiple settings, environments and agencies. A joined up, strategic approach, which includes statutory, community and voluntary organisations, is essential in enabling success in reducing the significant harms associated with alcohol. Within Islington, the Safer Islington Partnership (SIP) provides this strategic partnership. This report recommends six key areas where work should be focused and it is important that the SIP is used to support and develop these. Four of the priorities focus on specific areas of alcohol harm reduction; the remaining two are overarching enablers **(figure 7.1)**. Implementation of these recommendations should dovetail with regional work around alcohol, as well as the 2012 National Alcohol Strategy.

Figure 7.1 Recommended priority areas



2. INCREASING AWARENESS

2.1 Population awareness of sensible drinking and alcohol-related harm

There is a key need to raise awareness of official guidance about drinking levels and the impacts of higher consumption. A quarter of adults are unaware of official guidance on alcohol limits, and of those who are aware, fewer than half can correctly identify the recommended levels for men[11]. Whilst messages about drink driving, supported by a range of enforcement measures and campaigns, have been highly effective, there is a need to develop effective messages around general drinking.

Addressing the social acceptability of higher alcohol consumption is important, too. A recent national survey found 83% of people who regularly drink above national guidelines felt that their drinking was not putting them at risk. Unlike smokers, whom when asked, a majority want to quit, only 18% of those who drink above recommended levels wanted to change their behaviour[11].

A 'one size fits all' approach to increasing alcohol awareness will not have the desired effect and needs to be tailored to particular population groups and audiences using a variety of methods. Awareness also needs to span across all ages from families with children through to older people.

The longer a young person waits to drink alcohol the less likely they are to experience detrimental effects of alcohol in later life. Families need to be provided with guidance and support around the impacts of alcohol on children and young people. Working closely with education providers and those coming into contact with families, such as Children's Centres, to ensure work promoting healthy lifestyles encompasses alcohol as an important component of this.

Levels of binge drinking were found to be higher in Islington than the London average and national evidence shows binge drinking is greater in young people under 25 years of age. It is important that clear consistent messages around the importance of sensible drinking are promoted to young people, including through the universities and higher education colleges in Islington.

National analysis identifies that those in middle age (45-64 years) were the group with the greatest proportion drinking at above nationally recommended levels, as well as having the greatest average weekly consumption of alcohol units[12]. This is a group not commonly identified as part of the binge drinking culture and are unlikely to be aware of the effect their drinking could be having on their health; hence a prime example of a hidden group in terms of alcohol-related harm. It is important that those aged over 40 are not forgotten and that messages relevant to this age group are clearly promoted. This work should cover advice around what low risk drinking is, screening and brief advice, and how to access treatment services. General practice is in a particularly good position to increase awareness of alcohol-related harm and sensible drinking among this age group.

2.2 Awareness of local services to support people with alcohol-related problems

A range of support materials, as well as a single point of access, is available within Islington for those needing alcohol treatment services. However, the level of awareness of these amongst both the public and frontline staff is unclear. A survey of Londoners found that only one-in-five people knew where to go for help for an alcohol-related problem[5]. It is vital that people know what services are available locally. Islington's single point of access for alcohol services needs to be further promoted through multi-media campaigns to support easy access to services.

Front line staff need to have the skills and confidence to raise the issue of alcohol-related harm. Local awareness training is available in Islington. Going forward, this training needs to be further promoted to ensure it is accessed by a range of front-line staff providing services across the borough.

Recommendations

2.1 Clear consistent messages around alcohol-related harm and sensible drinking to be developed and promoted as part of a local awareness programme.

2.2 Alcohol to be embedded in healthy lifestyle work occurring as part of the Healthy Children's Centres initiatives and with local education providers.

2.3 Single Point of Access for alcohol services to be widely promoted within the borough, and treatment pathways reviewed to ensure access to services is easy and clear – both for individuals affected and professionals coming into contact with those who could benefit from support.

2.4 Training on raising the issue of alcohol should be further promoted. Staff working in a range of frontline local services and voluntary organisations should be encouraged to attend.

3. STRENGTHENING ENFORCEMENT

Islington has a thriving night-time economy and this brings a number of benefits to the borough. However, it is vital the benefits are balanced against the harms. Successful local initiatives to minimise detrimental effects include the use of saturation zones in Clerkenwell, the Community Alcohol Partnership and the Purple Flag accreditation and Pubwatch schemes. These initiatives have often been implemented on a relatively small scale or as pilots. Islington needs to explore how best practice and lessons learned from these successes can be expanded and embedded. This may require a review of resources available to support these initiatives. It will be important to build on existing partnership strengths, as well as assess cost-effective approaches, including exploration of models for using joint budgets to fund projects. The introduction of the Late Night Levy, which enables boroughs to charge for on and off licence sales between midnight and 6am, is one possible mechanism for generating revenue to support these developments.

National changes to the Licensing Act and the Police Responsibility Act[13], as well as proposals in the 2012 Alcohol Strategy[14], will give additional powers to local authorities to tackle alcohol-related harm. Islington needs to critically review and embed these powers into local licensing and enforcement to ensure concerns around over-saturation of licensed premises and the negative impacts this is having on those who live, work and socialise in Islington are taken into account. Particular areas to review include widening the use of saturation and cumulative impact policies in places where alcohol is having a particularly detrimental effect, as well as the times in which premises are allowed to sell alcohol, including 24 hour off licences. Health services need to engage fully in this and ensure the links between density of licensed premises, alcohol availability and indicators of health related harm, such as ambulance pick-ups, inform licensing decisions.

There are also greater powers for individuals and local communities to input to local decisions[14]. The vicinity test on licensing has been removed, meaning the wider community can input into a decision to grant or revoke an alcohol license, and not just those living in the immediate vicinity. Local communities need to be made aware of the increased opportunities to have their say about local decisions.

Effective licensing and enforcement works hand-in-hand with policing and other partners involved in reducing alcohol-related harm, underpinned by good intelligence and data sharing. Data is already used effectively within Islington, and reviewing how this can be further developed will be beneficial. For instance, it can be used to identify areas where additional data is available, including health information.

Recommendations

3.1 Ensure licensing, health services and communities in Islington use new powers to make representations in relation to license applications and amendments effectively.

3.2 Review Islington's licensing policy to ensure it uses changes in national legislation to further support a robust, fair and stringent approach to licensing and enforcement in Islington which is fit for purpose, including use of cumulative impact / premises saturation policies and guidance around opening hours.

3.3 Explore approaches to expand initiatives found to successfully address alcohol-related harm to larger parts of Islington.

3.4 Review the Islington Alcohol Harm Reduction Strategy to ensure the associated joint action plan is fit for purpose and addresses local need.

4. IDENTIFICATION AND BRIEF ADVICE

Opportunistic case finding followed by delivery of simple brief advice (IBA) is highly effective in identifying and reducing alcohol-related harm in a range of health and non-health settings. For every eight people who receive advice, one will reduce their drinking to lower risk levels. This compares very well to smoking where one in twenty given brief advice and one in ten given advice and NRT change their behaviour[15]. Over time this should help to reduce A&E attendances, admissions and other associated costs of alcohol-related harm. Intervening in men aged over 35 years who regularly drink over 50 units a week could reduce alcohol-related admissions nationally by 13,000 over three years[15]. Screening and brief advice within general practice could save £58,000 for every 1,000 screened[16].

Locally, screening and brief intervention is occurring in a number of settings including primary care, A&E and the criminal justice system and is already included within NHS Health Checks. However the approach is not necessarily being used systematically, nor is the collection of data on IBA sessions or subsequent outcomes robustly recorded. There is substantial scope to embed and extend the use of IBA in Islington, particularly targeting groups who are at increased risk.

A number of approaches have been shown to successfully increase provision of IBA. Web-based self-assessment tools are being piloted, which may be attractive to people who are unlikely to go for a health check or regularly use primary care. There are also opportunities to expand the locations and settings where IBA occurs, for example dentists, as well as further embedding within general practice and those in hospitals (both as in and outpatients). Active training, support and monitoring needs to be in place, with good access to other alcohol treatment services when additional needs are identified.

Recommendations

4.1 Review approaches to data collection as part of the IBA process, including outcomes, to ensure relevant and systematic data are available to better understand patterns of use, inequalities, and effectiveness.

4.2 Expand the use of IBA across a range of venues and settings across the Borough.

4.3 Examine alternative approaches for the delivery of IBA, using web-based tools and applications.

4.4 Build on existing commissioned training provided to frontline staff on raising the issue of alcohol. Ensuring the content continues to cover the most appropriate techniques for raising the issue of alcohol and signposting to other levels of support.

4.5 Review best practice from elsewhere and assess how similar approaches could be applied locally.

5. TREATMENT SERVICES

Local service monitoring has shown a decline in the numbers accessing alcohol treatment services, following the loss of non-recurrent funding. In 2011/12, 589 people accessed treatment services, compared to 800 in 2010/11. This has been kept under review, with additional funding identified to provide support for access introduced this year, and steps taken to improve effectiveness.

There are between 6,660 and 7,940 dependent drinkers in Islington, which is equivalent to 7-8% of those in need having been seen by alcohol treatment services in 2011/12 compared with 10-12% in 2010/11[17]. Previously the Department of Health[15] had suggested PCTs should be aiming to get 15% of their dependent population into alcohol treatment services each year. This would indicate in Islington a target figure of between 999 and 1,191 individuals accessing services.

Whilst it may not be feasible locally within current resources and service capacity to achieve the 15% access figure, looking at approaches for increasing this proportion is important to improve outcomes and reduce harm. This should include clear, well-publicised and easily accessible pathways into treatment for frontline staff or patients to self-refer. As well as getting individuals into services, local performance management needs to continue to monitor levels of successful exits from treatment and ensure evidence-based approaches and good practice are shared amongst the range of providers to improve outcomes. As the chapter on social harm (chapter three) highlighted, in many cases those most affected are not the ones drinking alcohol, and it is important to ensure their needs are identified and addressed successfully too. For instance, children living in households affected by alcohol-related harm are more likely to suffer emotional distress, violence and physical abuse; partners and other family members experience increased levels of domestic violence[18].

Innovative approaches to service delivery that meet the needs of the local population also need to be explored; for instance, the use of ambulatory detox as an alternative to inpatient provision. Alcohol liaison is an example of an innovative service development which can improve access to treatment services and support coordination across a range of health and social services, as well as save costs and reduce admissions. The delivery of alcohol liaison within hospital settings should be reviewed to identify the scope to develop the offer locally.

Improving information and communication around alcohol-related hospital admissions will support multi-agency care planning, as well as supporting admission avoidance work and reducing pressure on hospital services. For instance analysis for this report found that over a quarter of people admitted to hospital with an alcohol-specific reason were admitted two or more times over a one year period and 2% (15 people) were admitted six times.

Recommendations

5.1 Review the alcohol treatment pathway to ensure it is well understood and publicised locally. The pathway needs to be easy to access and navigate, both for potential referrers and those being referred into the service. The pathway should ensure a holistic approach, including the community and voluntary sector, so that social as well as health needs are managed and supported.

5.2 Develop promotional work to raise levels of awareness of local alcohol services amongst all those coming into contact with individuals who could benefit.

5.3 Assess how approaches for using alcohol liaison services to provide intensive support to particularly vulnerable groups (such as those who have had frequent hospital admissions as a result of alcohol-specific problems) could be developed and delivered more widely across Islington.

5.4 Review local treatment provision to ensure it is fit for purpose and is used innovatively and efficiently to meet local need. This must be supported by robust evaluation of numbers accessing services and successfully completing treatment.

6. COLLABORATIVE WORKING

Two factors have emerged as common themes across all areas discussed in this year's annual report. Firstly, the need to work collaboratively and secondly, improving the quality and sharing of data related to alcohol-related harm.

The impacts of alcohol are wide-ranging and the factors contributing to harmful alcohol use are complex. Effective partnership work, involving statutory, community and voluntary organisations, contributes to a range of better outcomes, including improving health and social well-being, reducing crime and anti-social behaviour, and supporting the local economy. Locally the SIP brings together stakeholders, supported by the Islington Alcohol Harm Reduction Strategy, which provides the action plan to support delivery. The current financial climate continues to pose a real challenge to all those involved in provision of alcohol harm reduction. Working collaboratively to identify how the financial resources available can be used innovatively and cost- effectively will be even more important during the forthcoming period.

By 2013 PCTs will cease to exist and although they will be replaced by Clinical Commissioning Groups (CCGs), CCGs will not commission drug and alcohol services – although they will play an important role in wider action on alcohol harm. The responsibility instead transfers to the Director of Public Health who will be located within the local authority. This means that local authorities will take on a larger role in alcohol harm reduction. At the same time, changes in legislation around licensing and the new analysis included within this report offer an excellent opportunity to review and develop the local vision and strategy for how stakeholders can work together to effectively tackle alcohol-related harm. The Islington Health and Wellbeing Board provides the ideal means for further developing a joined up strategic approach, particularly as it has identified alcohol as a priority area for development.

Partnership working also needs to be cross-boundary. For instance, because Islington has a range of venues and is a transport hub, concerns have been raised about violence hotspots linked to transport interchanges[19]. Management of such effects are likely to need working across councils and policing areas, and will not be successfully combated by Islington alone. Similarly, the approach in other boroughs, including licensing or controlled drinking zones, can potentially have knock on effects in Islington and vice-versa. Local police and hospitals see individuals with alcohol-related problems from a range of boroughs. Working collaboratively with neighbouring boroughs to address cross-border issues is likely to result in improvements in the management of these wider impacts.

Linked to partnership work is the need for accurate and timely data to support initiatives aimed at reducing alcohol-related harm. Islington is already using data well and approaches building on this should be assessed. Good information sharing is vital if Islington is to fully understand the range, location and size of alcohol-related problems, and to support the development of shared, evidence based priorities for action.

One area where sharing of data could have a particularly positive impact is A&E data. The College of Emergency Medicine promotes an approach to sharing of non-identifiable data around violence-related injuries including information on date, exact location and type of assault[20]. This supported a sustained reduction in violence within licensed premises and street violence in Cardiff, and reduced overall A&E violence related attendance by 40%[21]. Such a scheme would also provide valuable information to strengthen health representations made in assessment of licensing changes. Other sources that would assist include: alcohol-related A&E admissions, robust monitoring of IBA work, and the need for improved recording of alcohol screening within general practice.

Recommendations

6.1 Use the Health and Wellbeing Board to strengthen collaborative working and agreeing joint priorities for alcohol harm reduction.

6.2 Work collaboratively to identify how the financial resources available can be used innovatively and cost-effectively.

6.3 Build on current approaches for sharing data and intelligence to develop a clear picture of the range, location and size of alcohol-related problems, and to support the development of shared, evidence based actions aimed at reducing alcohol-related harm.

7. CONCLUSIONS

This year's Annual Public Health Report has shown that alcohol-related harms extend across many areas of social and economic life – affecting households, communities, businesses, public services and the community and voluntary sector in Islington. As well as the more 'visible' negative effects such as binge drinking, street drinkers and anti-social behaviour, there are many hidden harms. The social and economic benefits to the Borough linked to alcohol and to the night-time economy are important, but the harms and societal costs of alcohol represent an increasing and serious challenge for public services, local residents and communities. This report highlights that although many 'visible' harms, such as binge drinking, anti-social behaviour or street drinking, often capture the headlines, there are many other less visible or hidden harms, particularly those that affect children and families and long term health. Additionally, the impact of alcohol is not felt equally across society. In particular, lower socio-economic groups consume less alcohol, but suffer greater harm. For example, the rates of alcohol-related hospital admissions are greater in people living in the most deprived areas of Islington.

With so many harms and different services affected, the key challenge highlighted is one of alignment – having a full understanding and shared perspective of the harms caused, the importance of working towards shared goals and ensuring that services and policies work together to address those needs and harms. Within Islington there is recognition that a concerted, systematic and joined up response, across statutory, community and voluntary organisations, is necessary to make sustained gains.

The following are suggested as the top five priorities Islington should strive to achieve in order to reduce the local burden of alcohol-related harm:

1. Increasing awareness:
Understanding of alcohol to be increased locally through the provision of clear, sensible advice around what is low risk drinking and why this is important.

2. Screening & brief intervention:
Innovative approaches for the provision of identification (screening) and brief advice (IBA) and alcohol liaison models to be expanded and developed.

3. Strengthening enforcement:
Recent changes in licensing regulations to be used to further strengthen the approach to managing alcohol availability locally.

4. Accessible treatment services:
For those who need it, ease of access to alcohol treatment services that are fit for purpose to be improved.

5. Collaborative working:
Building on work already occurring locally, to ensure there is a strong partnership approach to maximise alcohol harm reduction, including enforcement of licensing regulations, IBA and high quality treatment services.

This report has recognised the many examples of strong and innovative action in Islington. There is a need to ensure that the challenges presented by increasing and significant harms are tackled using a robust and systematic approach. The report has set out the scope for a more fully linked up approach that creates better coverage of effective interventions. A successful approach will not only reduce alcohol-related harm but will improve health and well-being whilst reducing inequalities, crime, disorder and offending.

References

[1] North West Public Health Observatory. *Local Alcohol Profiles for England (LAPE)* 2012 http://www.lape.org.uk/, 2012 (Accessed August 2012)

[2] The Information Centre. *Statistics on Alcohol: England, 2012,* 2012, http://www.ic.nhs.uk/pubs/alcohol12 (accessed August 2012)

[3] Islington Public Health Intelligence. *Islington alcohol and substance misuse needs assessment,* 2012.

[4] London Health Improvement Board. *Taking Action on Alcohol in London – The case for action.* London. 2012

[5] Murage P, Hamm J, Andrews M and Mackintosh D. *Question Time A survey of attitudes and perceptions towards alcohol consumption in London*, London Borough of Islington report, Regional Public Health Group, 2012

[6] Islington Intelligence Unit. *MPS crime data*, Islington Intelligence Unit, June 2012

[7] Pickens, RW, Svikis, DS, Cgue, M and Lykken, DT. *Heterogeneity in the inheritance of alcoholism: a study of male and female twins.* Archives of General Psychiatry 1991; 48: 19-28

[8] Allan Baker A. Lodge H. Jacobson B. et al. *Closing time – Counting the cost of alcohol attributable hospital admissions in London,* London Health Observatory. 2012, http://www.lho.org.uk/Download/Public/17713/1/Alcohol_attributable_admissions_summary_final.pdf (accessed August 2012)

[9] National Audit Office. *Reducing Alcohol Harm: Health services in England for alcohol misuse,* LONDON: The Stationery Office. 2008

[10] London Health Improvement Board. *Taking Action on Alcohol in London Proposals for Action,* London, 2011.

[11] Lader D and Steel M. *Opinions Survey Report No. 42 Drinking: adults' behaviour and knowledge in 2009,* Office for National Statistics, 2010

[12] The Information Centre. *Statistics on Alcohol: England,* Health and Social Care Information Centre, 2012

[13] *Great Britain. Police Reform and Social Responsibility Act 2011.* London: The Stationery Office, 2011

[14] HM Government. *The Government's alcohol strategy. CM8336.* London: The Stationery Office, 2012

[15] Department of Health. *Signs for Improvement – commissioning interventions to reduce alcohol-related harm,* 2009

[16] Department of Health, Home Office, Department for Education and Skills, Department for Culture, Media and Sport. *Safe. Sensible. Social. The next steps in the National Alcohol Strategy,* 2007

[17] *Business Case for Prevention.* NHS Islington 2008

[18] NSPCC *Memorandum of Evidence to the Health Committee inquiry into alcohol* (Health Committee, 2009) http://www.nspcc.org.uk/Inform/policyandpublicaffairs/consultations/2009/health_select_committee_inquiry_into_alcohol_wdf67342.pdf (Accessed 24th August 2012)

[19] London Borough of Islington *Overview and Scrutiny Committee. Night time economy – crime anti-social behaviour and alcohol misuse,* report of the Overview and Scrutiny Committee, 2012

[20] College of Emergency Medicine, *Guideline for information sharing to reduce community violence,* 2009

[21] Shepherd J. *Effective NHS contributions to violence prevention – the Cardiff Model.* Cardiff University, 2007

Glossary

Absenteeism The practice of regularly staying away from work or school without good reason.

Alcohol Attributable Fractions (AAF) A statistical measure used to show whether a death or hospital admission is wholly (alcohol-specific) or partly linked to the consumption of alcohol.

Alcohol 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 obligations.

Alcohol poisoning A condition in which a toxic amount of alcohol has been consumed, usually in a short period of time. The individual with alcohol poisoning may become extremely disoriented, unresponsive, or unconscious, with shallow breathing.

Alcoholic liver disease Damage to the liver caused by excess alcohol intake. Typified by three stages: 1. Fatty liver disease, 2. Alcoholic hepatitis, and 3. Cirrhosis. Progression to each type of liver disease is variable.

Alcohol-related conditions Includes all alcohol-specific conditions plus those where alcohol is implicated in some but not all cases of the condition, for example, high blood pressure, cancers and falls.

Alcohol-related crime Offences in which a police officer suspects that either the suspect or the victim of a crime was under the influence of alcohol at the time, and recorded as such on the Crime Related Incidents Database.

Alcohol-related harm Physical or mental harm caused either entirely or partly by alcohol. If it is entirely as a result of alcohol, it is known as 'alcohol-specific' harm. If it is only partly caused by alcohol it is described as 'alcohol-attributable' harm.

Alcohol-specific conditions Includes those where alcohol is implicated in all cases of the condition, for example alcoholic liver cirrhosis and poisoning from alcohol.

Alcohol-use disorders identification test (AUDIT) AUDIT is a screening tool used to identify people who may be at risk of developing alcohol problems. It covers the three domains of hazardous drinking: quantity and frequency, and dependence symptoms and other problems from alcohol use. The quantity and frequency domain is an effective brief screening tool which is known as AUDIT-C; following a positive result on AUDIT-C the full AUDIT screen should be offered to determine the severity of the person's alcohol use.

Antisocial behaviour Denotes behaviour that violates the rights of others, society, or the law.

Best Bar None A national award scheme supported by the Home Office. It promotes the responsible management and operation of alcohol licensed premises with the overall aim to reduce the harmful effects of drinking, as well as alcohol-related crime and disorder by building a positive relationship between the licensed trade, police and local authorities.

Binge drinking Binge drinking usually refers to drinking a large quantity of alcohol in a short space of time or drinking to get drunk. It is sometimes defined as women drinking 6 or more units and men drinking 8 or more units in a single session.

Case management The process of planning, coordinating, managing and reviewing the care of an individual.

Child neglect The persistent failure to meet a child's basic physical and/or psychological needs, resulting in serious impairment of health and/or development. Neglect is a serious form of maltreatment.

Child protection Child protection aims to promote, protect and fulfil children's rights to protection from abuse, neglect, exploitation and violence as expressed in the UN Convention on the Rights of the Child and other human rights, humanitarian and refugee treaties and conventions, as well as national laws.

Chronic disease Chronic diseases are conditions persisting for more than three months.

Cirrhosis The scarring of the liver as a result of continuous, long-term liver damage. It severely affects liver function and reduces life expectancy. Alcohol misuse is a leading cause of cirrhosis.

Clinical Commissioning The process whereby GPs and other clinicians assess population health and social care needs, prioritise health outcomes, procure products and health and social care services, and manage service providers.

Common Assessment Framework (CAF) The Common Assessment Framework (CAF) is an assessment that is designed to get a complete picture of a child or young person's additional needs at an early stage.

Community A group of people living, working or studying in a geographically defined area (geographical community) or who have a characteristic, cause, need or experience in common (community of interest).

Comorbidity The presence of more than one diagnosed health condition occurring in an individual at the same time.

Coronary heart disease A condition characterised by the narrowing of small blood vessels that supply blood and oxygen to the heart. CHD is also called coronary artery disease.

Cumulative impact policy Under the Licensing Act 2003, a licensing authority has the power to consider the impact of granting an additional licence to sell alcohol in an area that already has a high number of licensed premises. The impact must refer to one or more of the licensing objectives.

Dementia The significant loss of intellectual abilities, such as memory capacity, that is severe enough to interfere with social or occupational functioning.

Dependent drinking Heavy drinking, but the overriding criterion is the presence of dependence (see alcohol dependence), rather than the volume of alcohol consumed.

Depression A common mental health disorder that presents with low mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration. These problems can become chronic or recurrent and lead to substantial impairments in an individual's ability to take care of his or her everyday responsibilities.

Detoxification (alcohol) Medically assisted withdrawal from alcohol, frequently using a scheduled programme of gradually decreasing doses of a sedative or tranquilizer such as chlordiazepoxide (Librium).

Disability adjusted life year The sum of years of potential life lost due to premature death and the years of productive life lost due to disability.

Domestic violence Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

Emergency care Patients admitted without having planned for the admission ahead of time, generally via A&E.

Ethnic group A social group characterised by a distinctive social and cultural tradition, maintained within the group from generation to generation, a common history and origin, and a sense of identification with the group. Members of the group have distinctive features in their way of life, shared experiences, and often a common genetic heritage. These features may be reflected in their health and disease experience.

Harmful drinking Harmful drinking is defined as where an individual is drinking at a level that is causing physical or mental harm.

Hazardous drinking Hazardous drinking is defined as where an individual is drinking at a level that increases their risk of physical or mental harm, and sometimes social harm is included in this definition.

Health and Wellbeing Board Health and wellbeing boards are a forum for local commissioners across the NHS, public health and social care, elected representatives, and representatives of health service users. They discuss how to work together to improve the health and wellbeing outcomes of the people in their area.

Health promotion The delivery of basic health messages, e.g. around alcohol, to the general public.

Higher risk drinking Refers to a pattern of consumption where an adult man drinks over 50 units per week or an adult woman drinks over 35 units per week.

Identification and Brief Advice (IBA) Refers to opportunistic case finding (identification) followed by delivery of simple (brief) advice (IBA) to those not typically complaining about or seeking help for alcohol related problems.

Incidence The number of new events, e.g. new cases of a disease in a defined population, within a specified period of time.

Increasing risk drinking Refers to a pattern of alcohol consumption where an adult man regularly drinks between 22 and 50 units of alcohol per week or an adult woman regularly drinks between 15 and 35 units of alcohol per week.

Indirectly standardised rate (IDSR) Comparison of the actual number of events in an area with the expected number of events based on mortality rates of a reference population (e.g. England).

Ischaemic heart disease A condition of the heart where the heart muscles are damaged or do not work as efficiently due to a reduced blood supply to the heart. The decreased blood flow is most often caused by narrowing of the coronary arteries, a condition called atherosclerosis. The risk of getting this disease increases with age, and is more prevalent among smokers than non-smokers. Also at risk are people with diabetes, high blood cholesterol levels, high blood pressure (people suffering from hypertension), and individuals who have family history of the disease.

ISIS A direct access drugs service in Islington offering psychosocial and prescribing interventions. It is a consortium of providers: Crime Reduction Initiative (CRI), Cranstoun and Whittington Health.

Islington Alcohol Directly Enhanced Service (DES) A service introduced in GP practices to screen new patients aged 16 years and over for alcohol use disorders and deliver brief advice to patients identified as increasing and higher risk drinkers.

Islington Community Alcohol Partnership (CAP) A 9 month pilot programme started in April 2011 in Caledonian and Holloway wards to address local concerns about alcohol-related crime and antisocial behaviour resulting from underage drinking.

Islington Community Alcohol Service (ICAS) A service which aims to prevent alcohol-related harm by addressing the diverse range of individual and community needs in relation to alcohol. It covers the full spectrum from health advice for the general public to individual treatment for dependent drinkers.

Licensing objectives The licensing objectives establish the tests against which a licensing authority carries out its duties for the new licensing regime. In England, they are: the prevention of crime and disorder; public safety; the prevention of public nuisance; and the protection of children from harm.

Life expectancy (at birth) The average number of years that a newborn is expected to live if current mortality rates continue to apply.

Lifestyle The set of habits and customs that is influenced, modified, encouraged, or constrained by the lifelong process of socialisation. These habits and customs include use of substances such as alcohol, tobacco, tea, coffee, dietary habits, exercise, etc. which have important implications for health and are often the subject of epidemiological investigations.

Local deprivation quintile Calculated by ranking small areas within each local authority based on how deprived they are and then grouping the areas in each local authority into five groups (quintiles) with approximately equal numbers of areas in each. Quintile 1 corresponds with the 20% most deprived small areas within that local authority, whereas quintile 5 represents the least deprived group.

Long term condition An illness which cannot currently be cured but can be controlled and managed by medication, other therapies, and adoption of healthier behaviours.

Lower Super Output Area (LSOA) A LSOA is a geographical location with a minimum of 1,000 residents and 400 households, but average 1,500 residents.

Mental health A state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

Middle Super Output Area (MSOA) A MSOA is a geographical location with a population of a minimum of 5,000 up to 7,200 people.

Morbidity Any departure, subjective or objective, from a state of physiological or psychological wellbeing (i.e. illness).

Mortality Death.

Multidisciplinary approach An approach where patients are looked after by a number of different professionals providing holistic care. Patients with alcohol-related liver disease would be seen in clinics by a gastroenterologist, psychiatrist and psychiatric liaison nurse.

National Institute of Health and Clinical Excellence (NICE) Develops independent, evidence-based guidance and other products to help resolve uncertainty about which medicines, treatments, procedures and devices represent the best quality care and which offer the best value for money for the NHS. It also produces public health guidance for local authorities, the NHS and all those with a remit for improving people's health in the public, private, community and voluntary sectors.

NHS Health Checks A service provided by general practitioners and some other qualified providers which helps people to assess their risk of developing a stroke, heart attack, diabetes, chronic kidney disease and then gives personalised advice on how to reduce it. In Islington this service is available to people between the ages of 35-74 who do not have diagnosed high blood pressure, heart disease, stroke or diabetes, and who have not already had an NHS Health Check.

Office of National Statistics (ONS) survey ONS is the UK's largest independent producer of official statistics and the recognised national statistical institute of the UK. They play a leading role in the development of national and international good practice in the production of official statistics.

Outreach A method of delivering interventions in settings away from a service's usual site. The purpose of outreach may be to deliver interventions to clients not accessing site-based services or facilitate their access to site-based services.

Pancreatitis Inflammation of the pancreas, an organ important in digestion and metabolism. The most common causes are alcohol and gallstones.

Partnership A partnership (for health) is a voluntary agreement between two or more partners to work cooperatively towards a set of shared health outcomes.

Pharmacotherapy Treatment of disease through the use of drugs.

Population attributable fraction (PAF) The estimated reduction of a disease in a population that would occur if risk factor levels were reduced.

Premature mortality Deaths occurring before the age of 75. Many of these deaths are considered to be preventable.

Presenteeism The practice of coming to work despite illness, injury, anxiety, often resulting in reduced productivity.

Prevention Actions aimed at eradicating, eliminating, or minimising the impact of disease and disability, or if none of these is feasible, retarding the progress of disease and disability.

Primary care The collective term for all services which are people's first point of contact with the NHS.

Proxy sales When a person over 18 years old purchases alcohol on behalf of a person who is under 18 years old.

Public health The science and art of preventing disease, prolonging life, and promoting health through organised efforts of society.

Public Health Observatory There are 12 Public Health Observatories (PHOs) working across the five nations of England, Scotland, Wales, Northern Ireland and the Republic of Ireland. They produce information, data and intelligence on people's health and health care for practitioners, policy makers and the wider community. Their expertise lies in turning information and data into meaningful health intelligence.

Pubwatch A borough wide network where licensees regularly meet with the licensing team, the police and other relevant authorities. This scheme provides a network for licensed premises to share information and disseminate best practice.

Quality and Outcomes Framework (QOF) A voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results.

Registered population Refers to the population registered with a general practice within a defined area, e.g. a primary care trust.

Rehabilitation A range of interventions, following a period of treatment, to assist a person to return to, and cope with, day-to-day living.

Resident population A population with a usual address within the geographical boundary (e.g. in Islington).

Responsible authority Responsible authorities include the police, environmental health and child protection services, fire and rescue, trading standards, and local health authorities, as defined in the Licensing Act 2003. Responsible authorities must be notified of all licence variations and new applications and can make representations regarding them. Responsible authorities are also able to apply for a review of an existing licence where it believes one or more of the licensing objectives are being breached.

Risk factor An aspect of personal behaviour or lifestyle, an environmental exposure, or an inborn or inherited characteristic, that on the basis of epidemiological evidence, is known to be associated with health-related condition(s) considered important to prevent.

Secondary care Refers to a service provided by medical specialists who generally do not have first contact with patients. Usually, a general practitioner or other health professional will refer someone to a secondary care service.

Social harm The damage to a person's role, e.g. family life, relationships, employment, etc. as opposed to physical, mental or emotional harm experienced by an individual.

Socio-economic group A method of dividing the population into groups based on the occupation, or job, of the head of a household. People from lower socio-economic groups generally experience poorer health than those from higher groups.

Standardisation A set of techniques used to remove, as far as possible, the effects of differences in age or other confounding variables when comparing two or more populations.

Substance misuse Use of a substance for a purpose not consistent with legal or medical guidelines, as in the non-medical use of prescription medications.

Synthetic estimate An estimate for a small area where a reliable estimate for a large area is used to derive an indirect estimate for that smaller area, with an assumption that the characteristics of the smaller area are the same as those for the larger area.

Systematic review A detailed appraisal and synthesis of previously conducted research.

The Annexe Islington's drugs and alcohol service for young people.

Under-diagnosis Failure to recognise or correctly diagnose a disease or condition especially in a significant proportion of patients.

Unit In the UK, alcoholic drinks are measured in units. Each unit corresponds to approximately 8g or 10 ml of ethanol. To calculate the number of units in a drink, the volume of the drink in millilitres is multiplied by the alcohol by volume (ABV, stated on the container label) and divided by 1000:

$$\frac{\text{ml} \times \text{ABV}}{1{,}000}$$

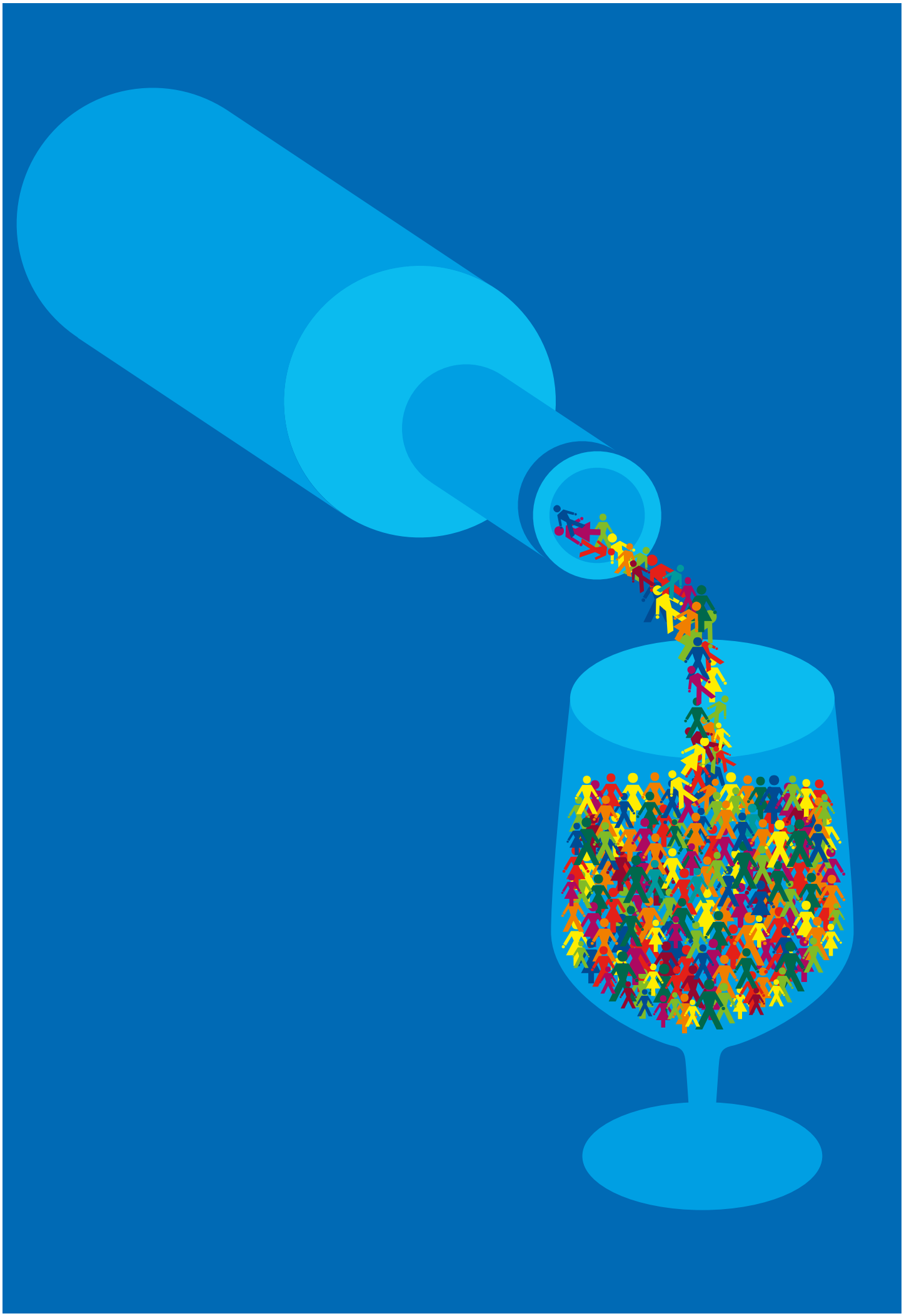
For example, a standard bottle of wine (750ml) at 13% ABV would have

$$\frac{750 \times 13}{1{,}000} = 9.75 \text{ units.}$$

Abbreviations and acronyms

Abreviation/ acronym	Full Meaning
A&E	Accident and Emergency
AAF	Alcohol Attributable Fraction
ACT	Assertive Community Treatment
AIS	Alcohol Intervention Service
ANARP	Alcohol Needs Assessment Research Project
APHR	Annual Public Health Report
ASB	Antisocial behaviour
AUDIT	Alcohol Use Disorders Identification Tool
AUDIT-C	Alcohol Use Disorders Identification Tool – Consumption
BBN	Best Bar None
bn	billion (thousand million)
CAP	Community Alcohol Partnership
CARAT	Counselling, Assessment, Referral Advice, Throughcare team
CASA	Not an acronym. CASA Social Care Ltd provides alcohol treatment services in Islington
CCG	Clinical Commissioning Group
CIFT	Camden and Islington Foundation Trust
CJS	Criminal Justice System
CNWL	Central and North West London (NHS Trust)
CQUIN	Commissioning for quality and Innovation
CRI	Crime Reduction Initiative
DES	Directly Enhanced Service
DIP	Drugs Intervention Programmes
FAST	Fast Alcohol Screening Test
FPF	Families Partners and Friends
GHS	General Household Survey
GP	General Practitioner, General Practice
HMRC	Her Majesty's Revenue and Customs
IBA	Identification and brief advice
ICAS	Islington Community Alcohol Service
IMD 2010	Index of Multiple Deprivation (2010 version)
ISATS	Islington Specialist Alcohol Treatment Service
ISIS	Not an abbreviation. ISIS provides substance misuse services in Islington.
IYPDAS	Islington Young People's Drug and Alcohol Service
LAPE	Local Alcohol Profiles for England
LAS	London Ambulance Service
LSOA	Lower Super Output Area
MAGPI	Multi-Agency Geographical Panel in Islington
MoCAM	Models of Care for Alcohol Misusers
MPS	Metropolitan Police Service
MSOA	Middle Super Output Area
MUP	Minimum Unit Price
NHS NCL	National Health Service North Central London
NICE	National Institute for Health and Clinical Excellence
NRT	Nicotine Replacement Therapy
NSPCC	National Society for the Prevention of Cruelty to Children
OCU	Opiates or Crack
ONS	Office for National Statistics
PAF	Population attributable fraction
PCADS	Primary Care Alcohol and Drug Service
PCT	Primary Care Trust
PHSEE	Personal, health, social and economic education
SHAAP	Scottish Health Action on Alcohol Problems
SIP	Safer Islington Partnership
SIPS	Screening and Intervention Programme for Sensible drinking
SP	Supporting People
Stella	Not an acronym. The Stella Project is a UK-wide domestic violence partnership.
SUS	Secondary Uses Service
TEN	Temporary Event Notice
UK	United Kingdom
UV	Ultra Violet
VAT	Value Added Tax
WHO	World Health Organisation

Notes



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