

Southwark

Alcohol Health Needs Assessment

January 2011

Kate Harvey
Public Health Specialty Registrar



Contents

Executive Summary_____	3
1. Introduction_____	6
2. Alcohol use in Southwark_____	9
3. Health impacts of alcohol use in Southwark_____	17
4. Social and economic impacts of alcohol use in Southwark_____	25
5. Effective interventions_____	31
6. Services provided for adult alcohol use in Southwark_____	35
7. Assessing current service provision_____	39
8. Recommendations_____	48
Appendix 1_____	49
Appendix 2_____	52
Appendix 3_____	54
Appendix 4_____	60
References_____	65

Acknowledgements

Many individuals have contributed to the needs assessment process. The author would like to thank all those who gave up their time to advise and support the needs assessment. Special thanks to Jacob Wheeler, Tony Lawlor, Melvin Hartley, Paul Collins, Francis Diffley, Julie Cuthbert, Alex Trouton, Karen Phillips and Gillian Holdsworth.

Executive Summary

The Alcohol Needs Assessment quantifies the prevalence of alcohol related behaviours, the impact of alcohol on health in Southwark and assesses the services provided to reduce alcohol related harm. The assessment has been conducted alongside the Adult Drug and the Young People's Substance Misuse Needs Assessments and will be used to guide Southwark drug and alcohol action team commissioning plans, the Southwark alcohol action plan, the work of the Alcohol Steering Group and future Southwark public health activity to minimise alcohol related harm.

Alcohol related harm is of particular public health importance at this time due to the significant mortality and morbidity associated with alcohol use (locally, alcohol related harm reduces life expectancy by 10.9 months for men and 4.2 months for women) and the high cost of treating alcohol related conditions (estimated at over 2.7 billion a year in England). Nationally, there is an increasing emphasis on alcohol related harm with increasing flexibility in the delivery of drug and alcohol services and a local service reconfiguration that offers the opportunity to increase alcohol service provision. Alcohol is growing increasingly affordable relative to disposable income and ways of addressing this through population measures to address pricing are being discussed nationally, although action may need to be at a local level.

Alcohol related harm in Southwark

It is estimated that 45% of the Southwark population drink more than the recommended daily alcohol intake on one or more days of the week. Rates of drinking are particularly high amongst those with a housing need, those with diagnosed mental health problems and those known to the probation system. National data suggests that rates of drinking are particularly high in those of white ethnicity, under 65s and those employed in managerial and professional roles although the impacts of alcohol related harm may affect less affluent drinkers more significantly. The potential to achieve changes in drinking behaviour are greatest in clearly defined sections of the Southwark population, as detailed by the Department of Health Social Marketing Segmentation Tool.

75 deaths in Southwark in 2008 were attributable to alcohol and the borough experiences particularly high rates of male mortality from chronic liver disease when compared to both England and London.

3262 hospital admissions in Southwark in 2008 were related to alcohol. Alcohol specific admission data from 2009/2010 suggests that rates of admission are particularly high amongst residents of Nunhead, Livesey, East Walworth and Cathedrals wards. Estimates suggest that the cost of alcohol related admissions to A&E alone is almost £5 million a year.

Alcohol has a significant impact on a number of social and economic factors in Southwark with 3101 crimes (including domestic violence) recorded between April 09 and Sept 10 and the involvement of alcohol in an estimated 30% of child care proceedings. The economic cost of alcohol includes loss of work due to absence, loss of productivity and also the inability to work and Southwark has particularly high rates of Incapacity Benefit (IB) or Severe Disability Living Allowance (SDA) due to alcoholism when compared to England and London.

Evidence based action to reduce alcohol misuse

A range of interventions have been found to be effective, and cost effective, in reducing alcohol misuse, working both at the population and individual level, including screening for alcohol use using a validated tool and the provision of brief advice in a variety of settings.

There is no single 'best buy' package of interventions but suggested factors promoting effectiveness are:

- Service user choice
- A broad range of interventions on offer at a range of levels
- Involvement of families and other close contacts

Services to reduce alcohol misuse in Southwark

In Southwark in 2009 there were an estimated 37,881 people (18 and over) drinking at increasing risk levels, 12,168 people (18 and over) drinking at higher risk and 6199 dependent drinkers (18 and over). Services are provided by a wide range of organisations

The number of people recruited into treatment in Southwark (measured by assessments for tier 3 and 4 alcohol treatment) is similar to the expected demand, as modelled from the estimated prevalence of dependent drinking Southwark of 2.7%. There is less community detoxification than would be expected and more short term vs long term residential detoxification. Treatment rates are highest amongst the white Irish population in Southwark, with lower rates than would be expected amongst the white British population although this may be due to their treatment in other drug services. Women in treatment for primary alcohol problems were less likely to be in residential treatment than men (16.2% of women vs 23.1% of men were in residential treatment).

In terms of service effectiveness, there are low rates of planned exit for community prescribing (i.e. community detoxification services with follow-up support) with only 27% of clients leaving treatment in a mutually agreed planned way. Anecdotally, it has been reported that this is due to high rates of drop out from the follow-up support. Of the non-residential treatment modalities, structured day programmes achieve the highest rate of planned exits (70.4%).

Individuals who misuse alcohol are disproportionately likely to come into contact with some services, including the Criminal Justice System and Children's Services but referrals from these sources are rare.

Recommendations

A number of alcohol specific recommendations for NHS Southwark, London Borough of Southwark and the Southwark drug and alcohol action team have emerged from the needs assessment process:

Population level action:

1. Advocate for the introduction of a minimum pricing scheme for alcohol

NHS and NHS commissioned services:

2. Continue to develop Primary Care screening and brief advice (potentially through a Locally Enhanced Service), and continue to develop community services including shared care and the Primary Care alcohol hubs
3. Link with KCH and GSTT to contribute to their workplans around alcohol screening and treatment in A&E and across the Acute sector
4. Plan to ensure that community services will have the capacity to meet any additional referrals generated by extended screening and brief interventions in other agencies
5. Work with treatment services to ensure that family support is available in treatment services both to improve effectiveness and to minimise barriers to women accessing services
6. Investigate and address high rates of unplanned exits in community detoxification services
7. Work with treatment services to ensure that clients receive appropriate referrals into services to address wider social needs including housing, and employment
8. Include aftercare in the service remodel to ensure that sufficient services are available locally

Work with other agencies:

9. Encourage a range of agencies to use identification and brief advice to contribute to a range of health and non-health outcomes (police, probation, workplaces, acute trusts etc), including potential use of DIP to address the alcohol needs of arrested individuals
10. Link commissioned and non-commissioned services to ensure appropriate referrals and smooth flow of individuals between services (e.g. from Acute Trusts and probation into community services)
11. Continue to work closely with police, community safety and other partners to support the ongoing work to reduce alcohol related crime and violence in Southwark. This should include advocating for and individual level support to reduce alcohol related reoffending (through DIP or other means) alongside work on saturation areas and feedback to trade.

1. Introduction

- The 'Alcohol Health Needs Assessment' is being conducted alongside the 'Adult Drug and Children and 'Young People's Substance Misuse' needs assessments.
- The needs assessment aims to quantify the prevalence of alcohol related behaviours, the impact of alcohol on health in Southwark and assess the services provided to reduce alcohol related harm.
- This is being performed against a backdrop of:
 - Increasing affordability of alcohol relative to disposable income
 - Increasing consumption of alcohol within the home
 - An increasing national emphasis on alcohol related harm
 - Local population growth
 - A reconfiguration of the local services in Southwark

Two thirds of the population drink alcohol on a regular basis¹. In Southwark this resulted in 75 deaths in 2008 and about 3262 hospital admissions. The 'collateral damage' caused by drinking has gained increasing attention since the term was coined by Liam Donaldson, Chief Medical Officer, in 2008². Such damage from 'passive drinking' includes the anti-social behaviour, crime and violence associated with drinking and the night time economy and the impact that alcohol has on families, work and school. This has been recently supported by a harm analysis study in the UK that found alcohol to be the most harmful drug overall, partly due to the high harm caused to others by alcohol use³.

This Health Needs Assessment aims to support alcohol harm reduction activities in Southwark by addressing the following points:

- A summary of how many people in Southwark are drinking at increasing and higher risk levels
- Quantification of how drinking alcohol affects peoples' health in Southwark (including deaths, hospital care and the treatment of alcohol use)
- The broader social and economic impacts of drinking alcohol in Southwark, i.e. the 'collateral damage' (including crime and disorder, impacts on families and risk taking behaviour)
- The evidence based actions that are recommended to reduce the harm caused by alcohol and address health and social inequalities arising from alcohol
- The local gaps in practice and priorities for action

There are three main ways of approaching health needs assessment⁴:

1. An epidemiological approach describes the size of the problem and service use
2. A corporate approach aims to summarise the issue from the view of service users and professionals
3. A comparative approach considers observed practice against guidelines or examples.

As is common in health needs assessment, this report will incorporate all three approaches. The process was overseen by a needs assessment steering group (involving public health and the drug and alcohol action team) and the following events were held to gather wider contribution to the process:

- Data workshop (see Appendix 2)
- Expert group (see Appendix 3)
- Three Service user focus groups (see Appendices 4 and 5)

1.1 The national context

Alcohol related harm has been estimated to cost around £20 billion in England and Wales⁵, covering costs related to crime and disorder, the loss of work productivity and direct health costs to the NHS (the latter of these has more recently been estimated to total about £2.7 billion⁶ based on 06/07 prices). Alcohol problems affect both males and females, all social classes and all age groups.

Current UK Government recommendations⁷ advise that:

- Adult women should not regularly drink more than 2–3 units of alcohol a day
- Adult men should not regularly drink more than 3–4 units of alcohol a day; and
- Pregnant women or women trying to conceive should avoid drinking alcohol. If they do choose to drink, to protect the baby they should not drink more than 1–2 units of alcohol once or twice a week and should not get drunk.

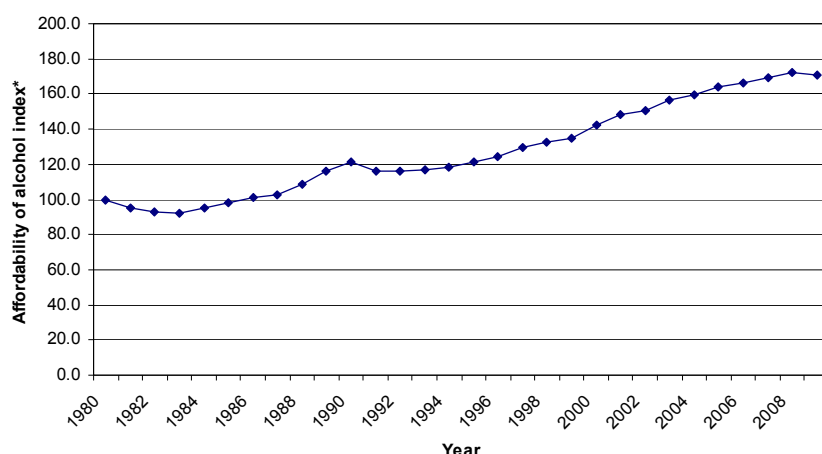
The 2004 National strategy to tackle alcohol related harm, 'Safe Sensible Social' covers health, alcohol-related crime and harm to children and young people due to alcohol. Key themes that have guided national policy and action in this area include:

1. Supporting people to make informed healthy choices (mass media and social marketing campaigns have run alongside partnerships with industry to improve unit and health information on labelling)
2. Creating an environment in which the healthier/responsible choice is the easiest choice (working with retailers and investigating the impact of pricing on alcohol consumption)
3. Providing support and advice for those most at risk of alcohol harm (developing medical student and GP skills in identifying potentially harmful drinking and provide brief interventions in a range of settings)
4. Effectively prioritised and delivered action on alcohol misuse (supporting PCTs in their commissioning and the use of appropriate targets)

The 2010 Drug Strategy, 'Reducing Demand, Restricting Supply, Building Recovery: supporting people to live a drug-free life', considers specialist treatment for severe alcohol dependency to be similar to treatment to drug dependency and therefore addresses both issues together⁸.

These policies have been developed against a backdrop of increasing affordability of alcohol over time compared to the price of other goods⁹ (see Figure 1, below). If someone were to spend the same proportion of their disposable income on alcohol in 2009 they would get roughly 70% more alcohol for their money.

Figure 1: Affordability of alcohol since 1980



* Affordability of alcohol index compares the relative changes in the price of alcohol with changes in households' disposable incomes since 1980 (a value greater than 100 shows that alcohol is more affordable than it was in 1980).

Source: NHS Information Centre 2010¹⁰

Despite recommendations by the Chief Medical Officer and the National Institute of Health and Clinical Excellence to set a minimum price per unit¹¹ this has not yet been done in England.

Other changes in alcohol consumption in the UK include a decrease in alcohol consumption outside of the home and an increase in alcohol consumption within the home. Total alcohol consumption in England has remained fairly steady since 2000¹².

1.2 The local context

This Needs Assessment is being developed to support the work of the Southwark Alcohol Steering Group, NHS Southwark and the Safer Southwark Partnership. Findings will be used to guide the re-development of an Alcohol Strategy and will provide those working in this field with a data resource.

Southwark has an estimated resident population of 285,600¹³. Like many London boroughs Southwark has a predominately young adult population compared to that of England. Approximately 43% of the Southwark population are aged 25 - 44 years old compared to 28% in England (and 72% of working age compared to 62% nationally).

The population of Southwark is growing and the resident population is expected to increase by more than a fifth to 355,200 by 2030¹⁴. Alongside this, there are significant developments that will have an impact on alcohol use and the night time economy including the Shard Development in Borough which will bring additional workers to the area and result in additional licensed premises.

2. Alcohol Use in Southwark

- In Southwark there are an estimated 35,265 to 42,459 people at increased risk, 11,026 to 13,918 people at higher risk and 35,030 to 53,133 people binge drinking (2009).
- There are an estimated 6348 dependent drinkers in Southwark.
- 2006 Health Survey for England estimates suggest that 45% of Southwark residents drink more than the recommended daily alcohol intake on one or more days of the week.
- Information on alcohol use in specific populations shows that rates of drinking are high amongst those with a housing need, those with diagnosed mental health problems and those known to the probation system.
- Alongside this, national survey data suggests that we can expect those of white ethnicity, men, under 65s and those employed in managerial and professional roles to drink more.
- Market segmentation can be used to breakdown the population into different categories of drinkers in order to target interventions appropriately. Care must be taken, however, when doing this as this technique can overestimate the population at increased or higher risk.

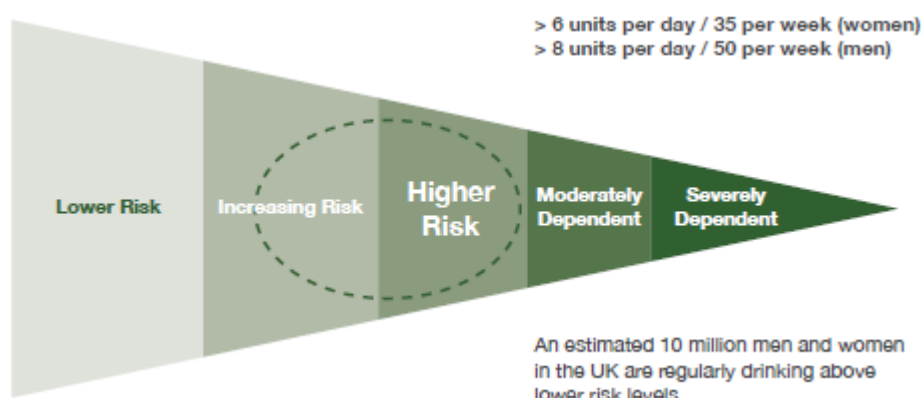
2.1 Measurement definitions

Government recommendations are that adult men should not regularly drink more than 3-4 units of alcohol a day and adult women should not regularly drink more than 2-3 units a day¹⁵. It is also recommended that pregnant women do not drink and, if they decide to drink, limit themselves to 1-2 units a week and avoid getting drunk¹⁶.

Whilst a range of sources collect information on how much people drink, e.g. the number of units drunk in an average week and the amount drunk on the heaviest drinking day in the last week, there is little precise measure of consumption against the recommendations.

A further categorisation relates to clinical groupings of alcohol consumption. Hazardous or increasing risk drinking is defined as a pattern of drinking which brings about the risk of physical or psychological harm and harmful or higher risk drinking is defined as a pattern of drinking which is likely to cause physical or psychological harm. Substance dependence is defined by the International Classification of Diseases and related health problems (ICD-10) as a cluster of behavioural, cognitive and physiological phenomena that can develop after repeated substance use. This is shown on the diagram below.

Figure 2: Moving in and out of higher risk drinking



Taken from Alcohol Social Marketing Toolkit¹⁷

Synthetic estimates of the numbers needing services at each level can be created using the 'Rush Model'¹⁸ (see section 7).

2.2 Drinking behaviour in Southwark

Mid 2005 synthetic estimates of drinking behaviour (Local Alcohol Profiles, NPHO) suggest a lower proportion of the Southwark population was engaging in increased risk drinking in 2005 compared to England as a whole¹⁹. This data is based on the application of national rates to local population details and must therefore be interpreted with caution. This assumes that the rates of increasing, higher risk and binge drinking have not changed since 2005.

Figure 3: Mid-2005 synthetic estimates of drinking behaviour in Southwark (16 years and over)

	Southwark		London %	England %
	%	People*		
Increased risk (95% confidence interval)	16.53 (15.00-18.06)	35,265 to 42,459	18.77 (17.33-20.14)	20.10 (18.42-21.77)
Higher risk (95% confidence interval)	5.30 (4.69-5.92)	11,026 to 13,918	5.10 (4.53 – 5.67)	5.03 (4.50-5.57)
Binge drinking (95% confidence interval)	18.44 (14.9-22.6)	35,030 to 53,133	14.3 (12.5-16.3)	20.1 (19.4-20.8)
Dependent **	2.7	6348	-	3.8

*Calculated using ONS mid-2009 population estimate of 235,100 persons aged 16 and over

** Local dependency estimates provided by National Treatment Agency

Source: ONS²⁰ and NPHO Local Alcohol Profiles for England¹⁹

More local representative, but again slightly out of date, information about drinking behaviour relative to the Government's guidelines comes from the London boost of the Health Survey for England. Whilst surveys are known to suffer from under-reporting of alcohol misuse²¹, under-representation from some groups including homeless or those in institutions and a lower response rate from problem drinkers they still provide the most accurate local data available.

Figure 4: Alcohol use on the heaviest day in the past week in Southwark

Southwark (2006)	Southwark		London
	%	Persons*	%
Did not drink in the past week	37.8 (30.2-45.3)	82446 to 123669	43.6 (41.5-45.7)
Up to 4 units (men) or 3 units (women)	17.2 (10.4-24.0)	28392 to 65520	20.7 (19.5-22.0)
Between 4-8 units (men) or 3-6 units (women)	17.0 (13.7-20.3)	37401 to 55419	16.3 (15.2-17.4)
More than 8 units (men) or 6 units (women)	28.0 (19.0-36.9)	51870 to 100737	19.3 (17.8-20.9)

* Range calculated from the 95% confidence interval of the % drinking at this level applied to the appropriate ONS mid-2006 population estimates (273 000 persons)

Source: LHO^{Error! Bookmark not defined.} and ONS²²

It can be seen that drinking behaviour in Southwark does not differ significantly from the London average. The HSE did not find any significant difference between male and female drinking behaviour in Southwark although London and national data suggests that there is a higher prevalence of problem drinking amongst men than women.

2.3 Alcohol use in defined populations

Further information is available on alcohol use in defined populations.

2.3.1 Alcohol use measured by GPs

A Directed Enhanced Service is currently in place to incentivise GPs to screen new patients for alcohol use using a validated tool (either FAST or AUDIT is promoted in Southwark). Existing patients were screened for their alcohol use during the 2008/2009 period through the Locally Enhanced Service although this is not currently in place. In 09/10 only 48.6% of new registrations in Southwark were screened using a validated tool.

GPs record the number of harmful/hazardous drinkers or dependent drinkers and have found a much lower prevalence that would be expected.

Figure 5: Alcohol Use Screening in New GP Registrations (2009/10)

	2009/2010	
	Number	% (prevalence)
New registrations (age 16+)	33904	-
Screened (FAST, AUDIT C or AUDIT)	16492	-
Harmful or hazardous drinkers	531	3.22
Dependent drinkers	317	1.92

* % of those screened

2.3.2 Alcohol use amongst those known to the criminal justice system

Alcohol use amongst offending populations is known to be high and the 2010 Ministry of Justice Green Paper recognises that treatment for alcohol misuse is often the first step in reforming offenders²³.

Police

51% of arrests are dealt with at the police station. It has been estimated that 31% of this population have a problem involving alcohol misuse²⁴. In Southwark there were 15,703 arrests in 2009/2010²⁵, suggesting an estimated 4868 individuals with a problem associated with alcohol.

Prisons

63% of sentenced male prisoners and 39% of female sentenced prisoners admit to hazardous drinking prior to entering prison, with half of these having a severe alcohol dependency²⁶.

Prisoners from Southwark are placed in a range of prisons across the country and their alcohol needs are addressed by the CARAT (counselling, assessment, referral, advice and throughcare) teams.

Probation

The impact of alcohol use on offending behaviour (criminogenic need) is recorded by the probation system. This only considers alcohol use in terms of its contribution to current and past offending behaviour and does not use a validated tool but may provide some indication of the needs of this population group although prevalence is likely to be underestimated.

It is estimated that 32% of the probation assessments between October 2009 and September 2010 identified a criminogenic need related to alcohol use. Amongst the group of offenders with alcohol needs (533 individuals) it was more likely to identify mental health issues and accommodation problems than in offenders with no recognised criminogenic need linked to alcohol²⁷. During the 2009/2010 period, Southwark issued 104 Alcohol Treatment Requirements (ATRs) to individuals on probation. Individuals are screened using the AUDIT tool and treatment plans are made by a service that Equinox provides on behalf of the London Probation Trust.

2.3.3 Alcohol use in those with a housing need

39% of clients in homeless projects are suggested to have an alcohol need, rising to 56% in day centres 54% in Direct Access hostels²⁸.

Amongst rough sleepers, it is suggested that at least 25% are dependant on alcohol, with 63% reporting drug or alcohol use to be one of the reasons they first became homeless²⁹. Amongst rough sleepers drug and alcohol use and dependency is associated with being homeless for a longer time.

Hostels regularly identify and support those misusing alcohol. Other housing services hold little information about alcohol need and identify only a small proportion of the population with an alcohol need. Between April 2009 and March 2010, only 7% of those in contact with the Southwark Resettlement Team were identified as having an alcohol need (3% of all clients had a primary alcohol need, 3% had a secondary alcohol need). Within resettled premises, only 28 individuals were identified as having a support need for alcohol.

2.3.4 Dual diagnosis (co-existing mental and substance misuse disorder)

Cheryl Kiping (Consultant Nurse Dual Diagnosis, South London and Maudsley NHS Foundation Trust) has provided the following information on the alcohol needs amongst those with mental health problems. It is clear that alcohol use is a significant problem for many people with mental health problems. Of those with a 'dual diagnosis' (co-existing mental and substance misuse disorder) evidence consistently indicates that alcohol is the substance most commonly used.

Alcohol is strongly associated with a range of mental health problems, in particular depression and anxiety and mental health risks, especially self harm and suicide, with up to 41% of suicides being attributable to alcohol.

Studies have found that between 26% and 49% of mental health service users meet the criteria for harmful or hazardous drinking, with 9% to 15% being dependent on alcohol^{30, 31}. Local studies have suggested that 41% of mental health patients drink excessively (Camberwell based mental health service users)³², with prevalence higher in inpatient psychiatric wards and forensic services than in community mental health services³³.

Although some people in contact with mental health services can and do access specialist alcohol treatment, many are unwilling or unable to do so. Local snapshots and case audits have identified between 19% and 31% of caseloads have been identified with problematic alcohol use³⁴. It was identified that some care coordinators did not know about their patients' alcohol use.

The Mental Health Service for Older Adults found that in 2002/2003 13% of older adults (over 65) with a diagnosis of depression also had a diagnosis of alcohol dependence³⁵.

Challenges relating to dual diagnosis service provision have been identified by the Consultant Nurse in Dual Diagnosis as:

- A lack of focus on alcohol/dual diagnosis in pre-registration training of staff in all disciplines (a threat to the implementation of NICE guidance), compounded by the effect of disinvestment on training and supervision

- The view of some mental health staff that assessment and management of alcohol misuse as 'extra work' that should be the responsibility of alcohol services
- Mental health service users who do not view their alcohol use as problematic and do not want to access services
- The potential for service users to 'fall between the gaps' in the care pathway if reduced capacity affects acceptance criteria of different agencies
- Lack of clarity in care pathways for dual diagnosis clients, potentially compounded by NICE Guidance that recommends treating alcohol use before depression and anxiety
- Lack of mental health expertise amongst general alcohol service staff (no longer supported by dual diagnosis staff)
- Challenges for inpatient ward staff managing clients who become intoxicated (e.g. self-harm, violence, suicide risk)

There is work underway in the South London and Maudsley Foundation NHS Trust to advocate for the integration of identification (AUDIT) and brief intervention into core mental health services, with further training and sharing of best practice.

2.5 What do we know about people drinking alcohol in Southwark?

Little data is available to describe who in Southwark is at increasing or higher risk from their drinking behaviour. National data suggests that people drinking more than the recommended levels are more likely to be:

- Men (37% of men exceeded the recommended amount on at least one day of the past week compared to 26% women)³⁶
- Of white ethnicity (most other ethnic groups have higher rates of abstinence and lower rates of frequent and heavy drinking although there are exceptions to this, e.g. Sikh male populations have high rates of heavy drinking)³⁷. It is important to remember that there are often large variations within these populations.
- Under 65 (over 65s men were half as likely, and women a third as likely, to consume over the recommended daily amount at least once in the past week)
- Employed in Managerial and Professional roles and not in routine and manual roles (a difference that is particularly pronounced for women)³⁶
- Earning higher household incomes

Alcohol harm is not solely related to the amount of alcohol consumed and it has been suggested that more affluent drinkers do not suffer the same alcohol related morbidity and mortality as more deprived drinkers.

Social marketing techniques can be used to segment local populations based on their drinking behaviour and other characteristics into discrete groups that can be targeted in order to achieve change in drinking behaviour. Using the Alcohol Learning Centre market segmentation tool³⁸, eight segments describe increasing and higher risk drinkers. The segments that the Department of Health identifies as being of primary importance to focus on are 10, 12 and 13, with segments 8 and 9 being of secondary importance. Pen portraits of the primary segments are given below.

Segment 10

Segment 10 includes high numbers of pensioners, who are generally in poor health with conditions that include asthma, angina and heart problems. They have high acute hospital admissions. They often live alone and in local authority flats. As well as drinking beer and spirits, they are likely to smoke. They tend to read tabloids.

Segment 12

Segment 12 includes people with a broad range of ages, who are likely to live in terraces, often in former industrial areas. They generally have the worst levels of overall health, with asthma, cholesterol and heart conditions as well as high acute hospital admissions. They are likely to smoke and drink beer and lager, at home and in pubs. They tend to read tabloids.

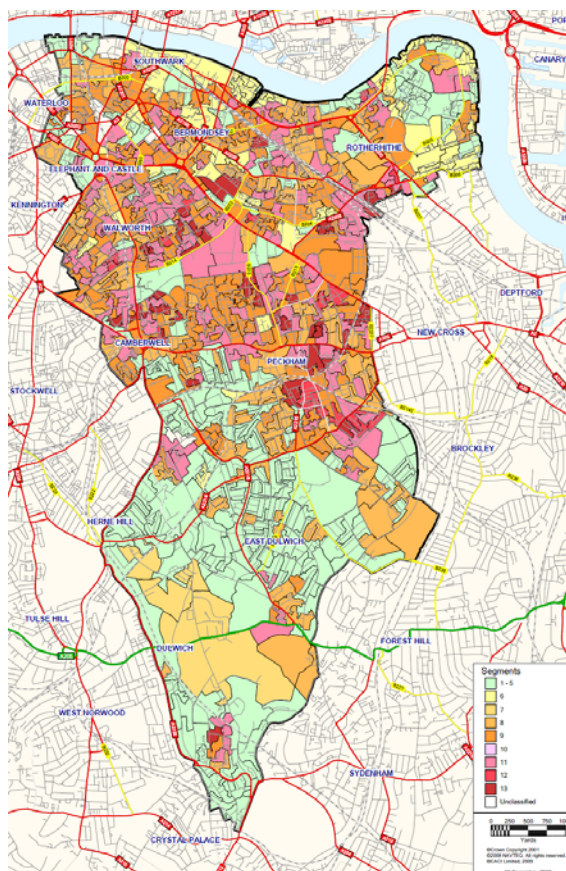
Segment 13

Segment 13 includes young people in their 20s who have a very high rate of acute admissions. They are likely to live alone in local authority flats or hostels, be unemployed and some are single parents. They are likely to drink large amounts of both beer and spirits and to smoke. They tend to read tabloids.

Taken from www.alcohollearningcentre.org.uk

The location of the segments in Southwark is shown on the map below. It can be seen that the majority of the population thought to be of Primary Importance are located in the North of the Borough but that segments are widely dispersed.

Figure 6: Social marketing drinking segmentation



Source: Alcohol Learning Centre Market Segmentation A3 Map

This map indicates postcodes where the potential to influence drinking behaviour is high – this is not purely based on drinking behaviour but also includes assessment of responsiveness to marketing and media. For this reason, whilst the postcodes identified as priority areas are likely to reflect populations with higher propensity to problem drinking the maps should not be used to guide service configuration or commissioning. The segmentation uses HealthACORN, 2006/7 alcohol attributable hospital admissions data from the North West Public Health Observatory and 2009 TGI data.

It is also possible to consider which individuals are experiencing alcohol related harm. This work is currently underway in Southwark.

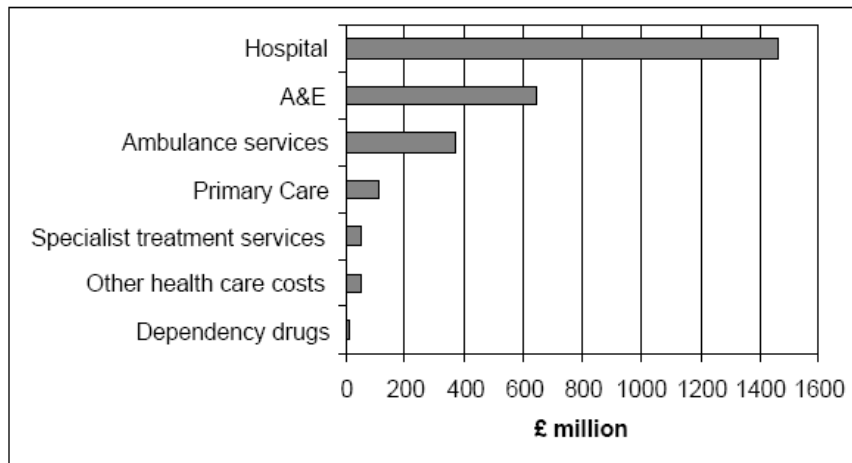
3. Health Impacts of Alcohol Use in Southwark

- Alcohol has a significant impact on the health of residents in Southwark. If all alcohol related deaths were prevented, life expectancy at birth in the Borough would increase by 10.9 months for men and 4.2 months for women.
- In 2008, 75 deaths in Southwark were attributable to alcohol. This represents a mortality rate similar to both the regional and national rates.
- Southwark experiences particularly high rates of male mortality from chronic liver disease when compared to both England and London.
- In 2008, there were 3262 alcohol related hospital admissions. This represents a significant cost to Southwark although the rate compares favourably with England and London averages.
- Alcohol specific hospital admissions can provide more information about who is experiencing alcohol related harm. Individuals being admitted for alcohol specific causes were more likely to be male (77% of admissions) and were predominantly white (70% of admissions), with most of these being white British. Rates of admission are particularly high in residents of Nunhead, Livesey, East Walworth and Cathedrals wards.
- Locally, it is difficult to assess the direct contribution of alcohol to the A&E consultation rate. Nationally, it is estimated that 12% of A&E visits are directly due to alcohol consumption. For Southwark residents, this would represent 2364 emergency admissions at a cost of approximately £4,871,143.
- 5.1% of all ambulance calls in 09/10 (2908 calls) were related to alcohol.

Alcohol has been shown to be causally related to over 60 different acute and chronic medical conditions, including cancer cardiovascular disease and obesity. Alcohol is a significant cause of morbidity and mortality but alcohol misuse is often masked by other conditions (e.g. gastrointestinal problems and insomnia), misdiagnosed or otherwise under-diagnosed.

The cost of treating alcohol related conditions in England has been estimated to be over £2.7 billion, with the highest costs being for hospital and A&E care (see below)³⁹.

Figure 7: Annual estimated cost of alcohol to the NHS (2006-2007)⁴⁰



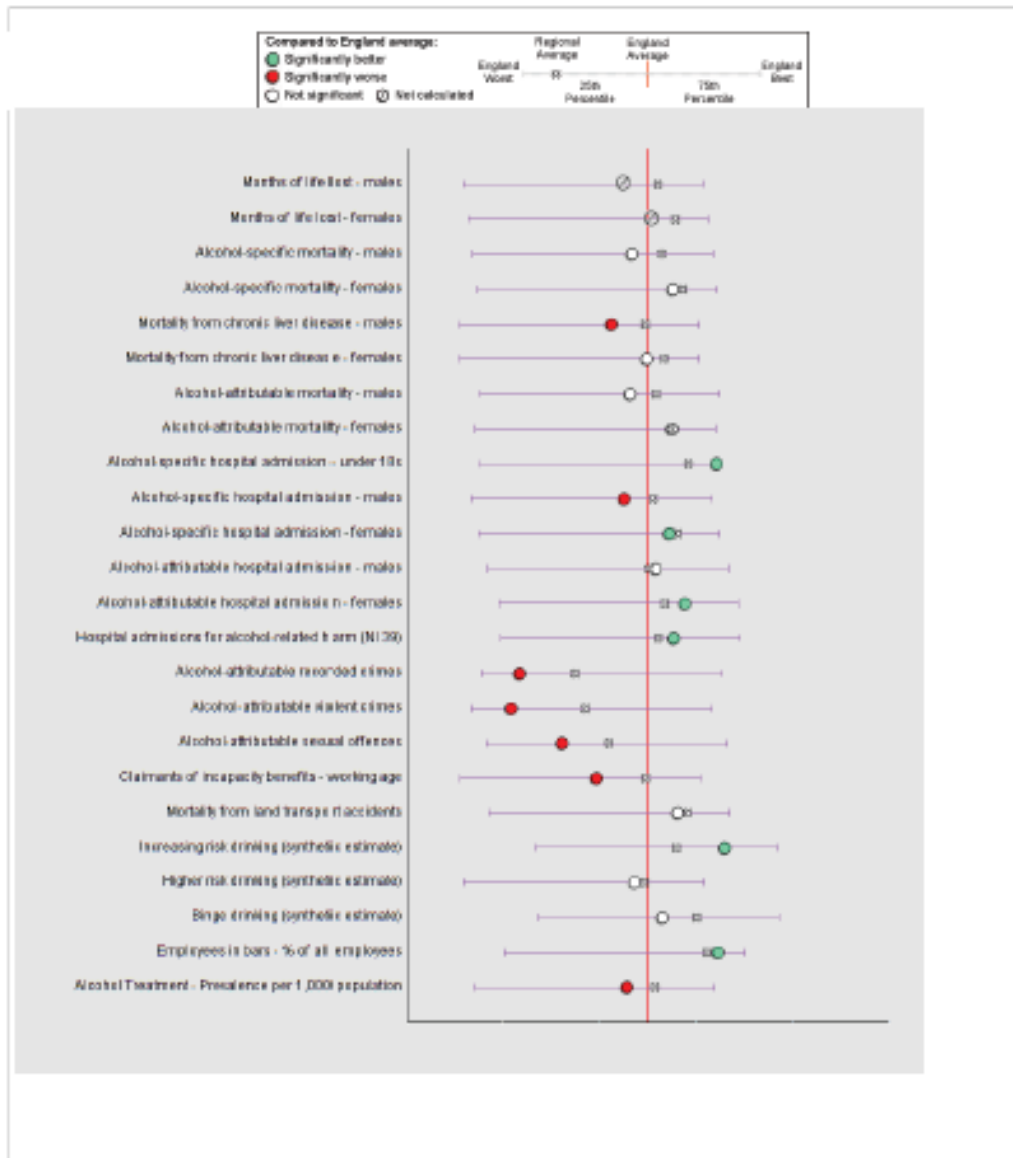
Source: Health Improvement Analytic Team 2008³⁹

3.1 Health impacts of alcohol misuse in Southwark

The chart below compares the Southwark health impacts from alcohol to the average English and London experiences. Southwark has particularly high rates of alcohol related crime compared to the London and England averages and this is explored in more detail in Chapter 4.

A number of individual areas of health impact are explored in more depth in this chapter including alcohol attributable mortality, hospital admissions and A&E calls.

Figure 8: Profile of alcohol related harm for Southwark (compared to England and London)



Source: NWPHO

3.2 Alcohol related deaths in Southwark

3.2.1 Alcohol attributable mortality

75 deaths in Southwark in 2008 were attributable to alcohol (60 male deaths and 15 female deaths)⁴¹. This represents an age standardised mortality rate of 41.2 per 100,000 population for men and 12.7 per 100,000 for women (neither rate differs significantly from the London and England averages) and includes both those causes of death directly caused by alcohol and also a proportion of the deaths sometimes related to alcohol.

Alcohol attributable mortality in Southwark has remaining roughly constant since 2004. Nationally, there was a decrease in alcohol attributable mortality in 2009 that

has been attributed to the impact of the recession⁴². This is expected to reverse once the financial climate improves.

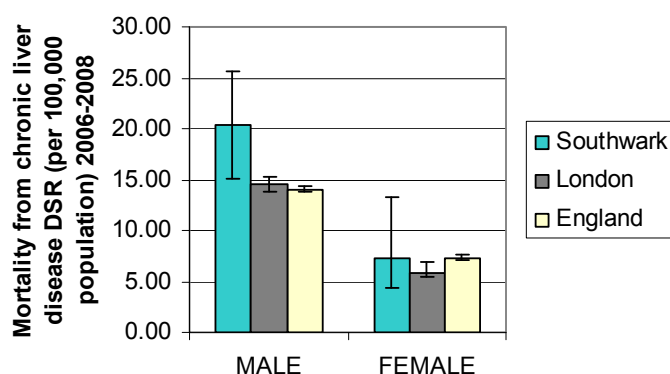
3.2.2 The impact of alcohol on life expectancy in Southwark

If all alcohol attributable deaths in those under 75 were prevented, life expectancy in Southwark would increase by 10.9 months for men and 4.2 months for women.

3.2.3 Mortality from chronic liver disease

Mortality from chronic liver disease is particularly high for men in Southwark compared to both London and England, as shown on the graph below. Women have much lower mortality from liver disease than men and experience similar rates to both London and England.

Figure 9: Mortality from chronic liver disease (06-08)



Error bars show 95% confidence intervals

DSR = Directly age standardised rate (i.e. controlling for age structures of the populations)

Source: NWPFO

3.3 Alcohol related hospital activity in Southwark

As for mortality, hospital admissions due to alcohol use include conditions caused solely by alcohol use (e.g. mental and behavioural disorders due to the use of alcohol or ethanol poisoning) and also conditions that are only partially caused by alcohol use.

The main causes of alcohol related admission in Southwark for 2007/2008 (compiled by London Health Observatory and not available for 08/09) are shown below:

Figure 10: Alcohol related admission in Southwark (2007/2008)

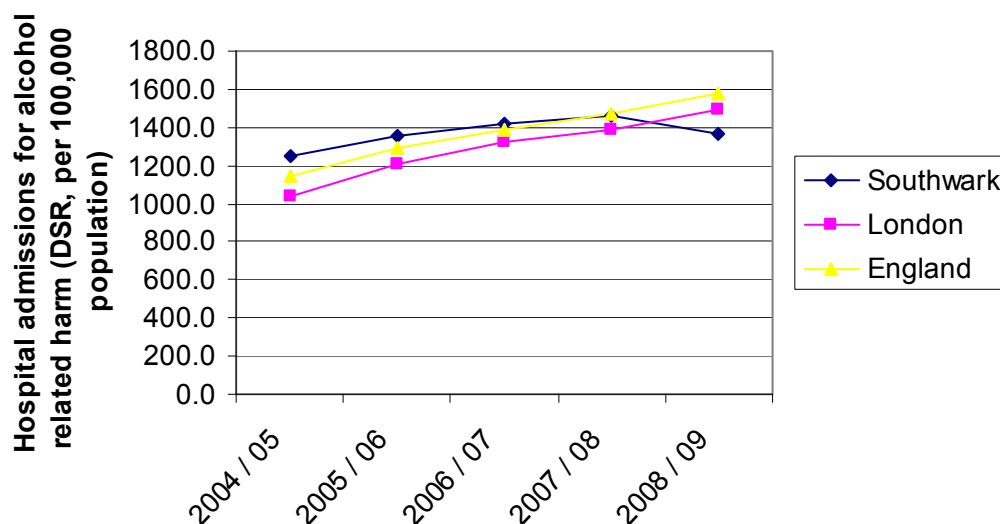
Dominant Diagnosis	Number of admissions (07/08)
Mental and behavioural disorders due to the use of alcohol	997
Hypertensive diseases	865
Cardiac arrhythmias	386
Epilepsy and status epilepticus	303
Alcoholic liver disease	158
Fall injuries	84
Chronic hepatitis/liver cirrhosis	76
Intentional self-harm/event of undetermined intent	70
Assault	65
Oesophageal varices	56
Spontaneous abortion	50
Ethanol poisoning	37
Malignant neoplasm of the breast	29
Malignant neoplasm of lip, oral cavity and pharynx	24
Chronic pancreatitis (alcohol induced)	23
Acute and chronic pancreatitis	23

Source: London Health Observatory⁴³

3.3.1 Alcohol related admissions (NI36 – admissions for alcohol related harm)

In 2008/2009 there were 3262 hospital admissions for alcohol related harm in Southwark. This represents a rate that is significantly lower than both London and England averages (1361.5 per 100,000 population vs 1489.9 and 1582.4 per 100,000 respectively). This is due to recent reductions in the rate of hospital admissions in comparison to England and London increases.

Figure 11: Alcohol related admissions (02/03 to 07/08)



Source: NWPHO⁴¹Error! Bookmark not defined.

3.3.2 Non-A&E alcohol related hospital admissions in Southwark

1415 men and 790 women were admitted to hospital (excluding A&E admissions) in Southwark with alcohol attributable conditions in 2008/2009. Male admission rates are similar to England and London averages, but Female admission rates are significantly lower than both England and London.

Southwark has particularly high rates of age standardised admissions for alcohol specific conditions amongst males, at 485 per 100,000 populations (vs 398 per 100,000 for London and 379 per 100,000 for England).

3.3.3 Alcohol related A&E activity in Southwark

Whilst data collection in A&E has been improved recently, coding problems with submitted data and lack of data from Kings A&E means that it is not possible to assess the local burden of A&E admissions due to alcohol. Nationally, it is estimated that 12% of A&E admissions are directly related to alcohol⁴⁴.

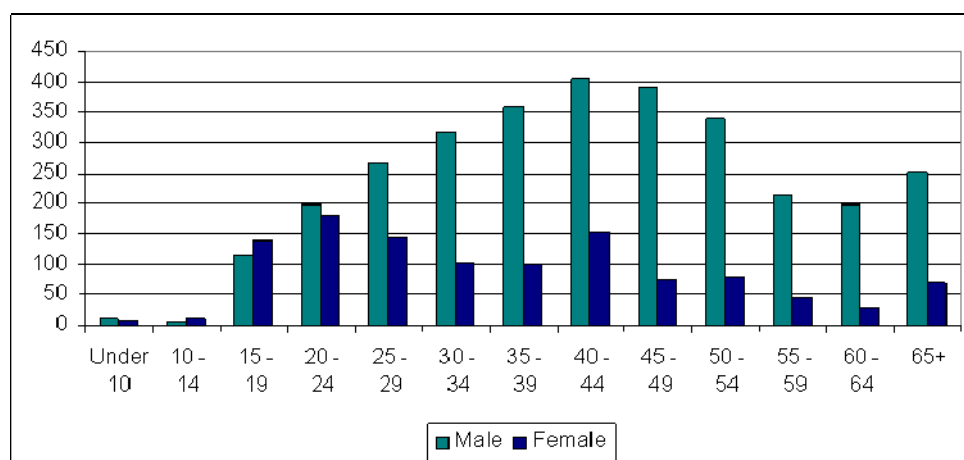
In Southwark there were 19,698 emergency admissions in 2009/2010 (patients aged 18 and over only). Applying National estimates, 12% of these admissions are directly related to alcohol representing 2364 emergency admissions at a cost of approximately £4,871,143⁴⁵.

There is still very poor data held on alcohol consumption prior to A&E visit and a recent audit at Kings suggests that an alcohol history was only recorded for 8% of patients⁴⁶.

3.3.4 Alcohol related ambulance service use in Southwark

Between April 2009 and March 2010 there were 2908 alcohol related ambulance calls in Southwark (5.1% of all calls). Examining the calls by gender and age it can be seen that males represent the bulk of the alcohol related calls, particularly amongst adults aged 30-50. This is consistent with the high levels of alcohol related male violent crime observed in Southwark (see Chapter 4).

Figure 12: London Ambulance Service alcohol related calls (April 09 – Sept 10)



Source: LAS

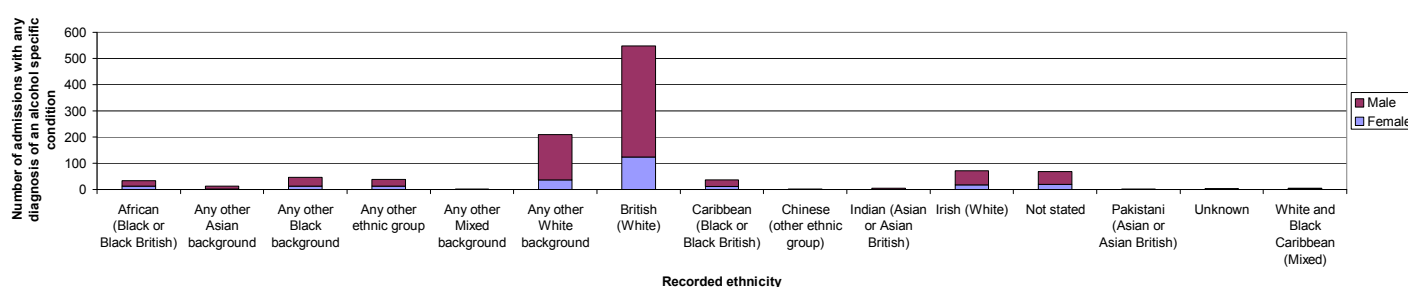
3.3.5 Who is admitted to hospital for alcohol specific causes?

Local data on alcohol specific admissions gives a picture of who is experiencing harm from alcohol use in Southwark.

Alcohol specific admissions are here defined as admissions that mention alcohol specific conditions in any of the diagnosis codes, as used by the North West Public Health Observatory.

In 2009/2010 there were more male admissions than female admissions (77% of admissions were for males). As shown on Figure 13, most admitted individuals were white (70%) with the majority of these being white British.

Figure 13: Alcohol specific admissions by ethnicity and gender (Southwark registered population, 09/10)



Source: HES

The alcohol specific admission rates per 1000 population in Southwark show that the white population in Southwark experience the highest rate of admissions. Other

Figure 14: Alcohol specific admission rates by ethnicity 2009/2010

	Admissions (2009/2010)	Population (000s) (2007)	Admission rate per 1000 population
White	829	152.1	5.45
Other	40	11	3.64
Black or Black British	117	41	2.85
Asian or Asian British	19	14.8	1.28
Mixed	7	6.4	1.09
TOTAL	1084	225.2	4.81

Source: ONS and HES

The admissions are drawn from a range of postcodes and, when grouping admissions by Ward and comparing admission rates (relative to Ward populations) it can be seen that there is a large variation, with Nunhead, Livesey, East Walworth and Cathedrals Wards having the highest admission rates.

Figure 15: Ward level admission rates for alcohol specific conditions (any diagnosis recorded) in Southwark (09/10)

Ward	2009 Population	Admissions (09/10)	Admissions per 1000 population
Nunhead	12005	72	6.00
Livesey	13654	77	5.64
East Walworth	13117	64	4.88
Cathedrals	15851	76	4.79
Brunswick Park	12281	56	4.56
Faraday	13488	55	4.08
Newington	14424	56	3.88
Camberwell Green	13868	52	3.75
South Bermondsey	12824	45	3.51
Peckham Rye	12896	43	3.33
Rotherhithe	12938	42	3.25
Grange	14803	47	3.17
The Lane	14473	42	2.90
Riverside	13475	39	2.89
Peckham	12066	31	2.57
Surrey Docks	12818	31	2.42
East Dulwich	11893	28	2.35
Chaucer	16132	36	2.23
Village	11019	22	2.00
South Camberwell	12230	21	1.72
College	11221	10	0.89

Source: GLA population estimates (2009) and HES

4. Social and Economic Impacts of Alcohol Use in Southwark

- The social and economic costs of alcohol in Southwark include:
 - Crime, including domestic violence (alcohol was related to 3101 crimes, April 09 to Sept 10)
 - Alcohol misuse has a significant impact on families, children and young people and Southwark Children's Services estimated that alcohol is involved in 30% of local care proceedings
 - Sexual health and unplanned conceptions
 - Accidents including road traffic accidents and fires.
- Economic costs of alcohol include loss of productivity and absence from work.
- Individuals who misuse alcohol are disproportionately likely to come into contact with some services, including the Criminal Justice System, Children's Services.
- Individuals who drink alcohol at increasing or higher risk levels, or are dependent on alcohol, are more likely to take unplanned absence from work.
- In Southwark, there are much higher rates of claiming Incapacity Benefit (IB) or Severe Disability Living Allowance (SDA) due to alcoholism than across England or London. In 2009, 400 individuals in Southwark were claiming IB / SDA due to alcoholism.

European estimates place the social cost of alcohol at between 1% and 3% of GDP, figures that exceed Government expenditure on social security and welfare and total roughly 25% of healthcare expenditure⁴⁷.

This section will consider the broader impact of alcohol use in terms of crime and disorder, domestic violence, impacts on children and young people, fires and road traffic accidents and impacts on work and productivity.

4.1 Crime and disorder

Alcohol is a major factor in many kinds of crime and the costs of alcohol related crime and disorder was estimated to cost £7.3billion in England in 2004⁴⁸. Police Superintendents suggest that alcohol is a factor in half of all crime⁴⁹ and an All Party Group of MPs was advised by the British Medical Association⁵⁰ that alcohol is a factor in:

- 60-70% of homicides
- 75% of stabbings
- 70% of beatings
- 50% of fights and domestic assaults

Alcohol misuse can also perpetuate offending behaviour and it is recognised that tackling these problems is often the first step in helping an offender to reform⁵¹.

Police figures may seriously underestimate the numbers of alcohol related crime as it has been estimated that less than a quarter of assaults recorded in emergency departments are reported to police⁵². Work is currently underway in Southwark to improve the availability of data on alcohol use in assaults presenting to emergency departments.

Public perceptions of crime can be measured by CAD calls as these are made by members of the public when they have a crime issue that they wish to be resolved. From 2009/2010 to 2010/2011 to date there has been a 37.5% decrease in alcohol related CAD calls with particular decreases in Cathedral Ward (North West corner of the Borough) and The Lanes Ward (Central Southwark).

Continuing hot spots have been identified as:

1. Clink Street and surrounds (70 calls)
2. Peckham High Street (102 calls).

4.1.1 Alcohol related crime (excluding domestic violence)

Data from the Metropolitan Police suggests that 5.3% of all crime in Southwark was flagged as alcohol related⁵³ between April 09 and Sept 10.

Excluding domestic violence (see Section 4.2.2 for this data), 4.4% of crime was flagged as being related to alcohol in Southwark (2009/2010), a figure that varied by crime type as shown below. Violence, sexual offences and 'other notifiable offences' are the most likely crime types to be related to alcohol in Southwark.

Figure 16: The proportion of reported crimes related to alcohol in Southwark (excluding domestic violence) April 09 – Sept 10

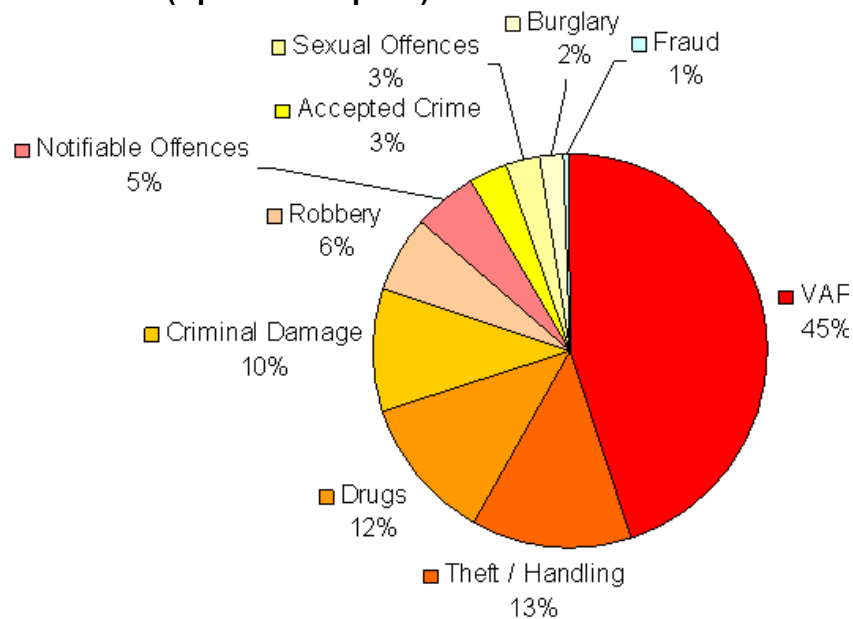
Non DV crimes

Major crime type	Alcohol involved	No alcohol	% alcohol related	Grand Total
Burglary	42	4728	0.9	4770
Criminal Damage	221	4094	5.1	4315
Drugs	267	6663	3.9	6930
Fraud or Forgery	13	1755	0.7	1768
Other Accepted Crime	67	1380	4.6	1447
Other Notifiable Offences	117	785	13.0	902
Robbery	142	2759	4.9	2901
Sexual Offences	65	445	12.7	510
Theft and Handling	288	17930	1.6	18218
Violence Against the Person	1005	8146	11.0	9151
Grand Total	2227	48685	4.4	50912

Source: Community Safety Partnership Service

The breakdown of the 2227 alcohol related crimes reported in Southwark between April 09 and Sept 10 is shown below. Violence accounts for almost half of all reported alcohol related crime.

Figure 17: Alcohol related reported crime (non-domestic violence) in Southwark (April 09 – Sept 10)



VAP = Violence Against the Person

Source: Community Safety Partnership Service

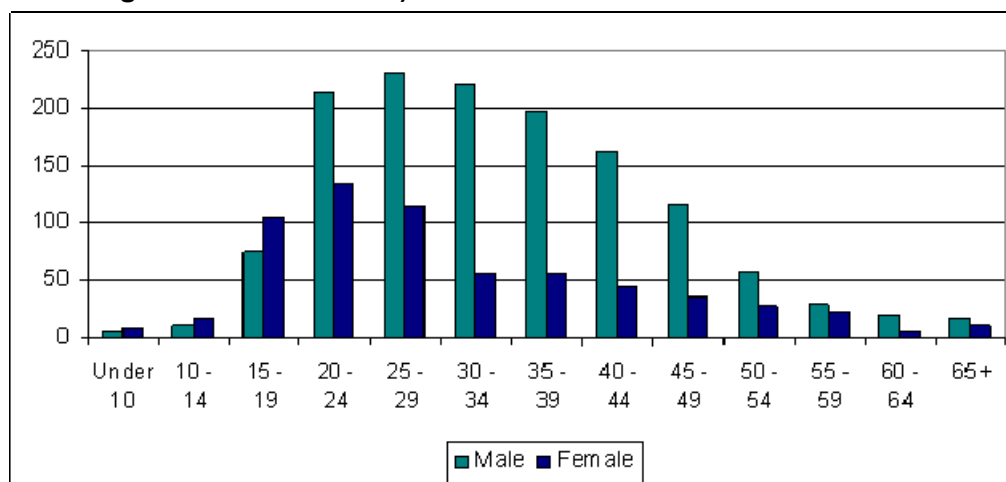
Suspected offenders of reported alcohol related crime (excluding domestic violence) in Southwark (April 09 – Sept 10) were most likely to be:

- Lone suspected offenders (78%, although 17% offended in a small group)
- Over 18 (the peak age of suspects was 20-24)
- Male (most strikingly, at the peak age of 20-24 there were almost six times as many male suspects as female suspects)

1897 individuals were reported as victims of alcohol related crime (excluding domestic violence) in Southwark between April 09 and Sept 10. Victims were most likely to be:

- Alone at the time of the incident (76.9% of victims) although 15% of victims were in a pair at the time of the incident
- Female if under age 20
- Male is over age 20 (most strikingly in the 30-34 year old age group, more than 4 times as many men as women were reported to be victims of crime, as shown on the chart below)

Figure 18: Age and gender of recorded crime in Southwark (April 09 – Sept 10; excluding domestic violence)



Source: Community Safety Partnership Service

4.2 Impacts on family relationships, children and young people

4.2.1 Parenting and child protection

Nationally, it has been estimated that between 780,000 and 1.3 million children are affected by parental alcohol problems⁵⁴. Southwark Childrens' Services estimate that 30% of care proceedings involve alcohol.

4.2.2 Domestic violence

The links between domestic violence and alcohol (or more general substance misuse) are multiple and complex⁵⁵ and relate to both the perpetrator and the victim. Perpetrators have reported that substance use increases during bouts of violence and note substance misuse issues pre-dating violence⁵⁶. Victims reporting substance misuse issues report that they began their problematic substance use following experience of domestic violence, often reporting that the link involved dulling both the physical and emotional pain. As such, it is suggested that women experiencing domestic violence are up to 15 times more likely to misuse alcohol⁵⁷.

7639 domestic violence crimes were reported in Southwark in between April 09 and Sept 10 although this will greatly underestimate the true incidence as it is estimated that only a third of domestic violence incidents are reported. Of reported incidents in this time period, 11.4% were flagged as being related to alcohol.

Violence and 'other accepted crime' (usually a domestic argument where no crimes are alleged or apparent) are the most common domestic crime types, as shown in the table below.

Figure 19: The proportion of reported domestic violence crimes in Southwark related to alcohol (April 09 – Sept 10)

DV crimes

Major crime type	Alcohol involved	No alcohol	% alcohol related	Grand Total
Burglary	0	16	0.0	16
Criminal Damage	65	295	18.1	360
Drugs	3	2	60.0	5
Fraud or Forgery	0	12	0.0	12
Other Accepted Crime	283	3697	7.1	3980
Other Notifiable Offences	19	116	14.1	135
Robbery	1	14	6.7	15
Sexual Offences	13	39	25.0	52
Theft and Handling	6	59	9.2	65
Violence Against the Person	484	2515	16.1	2999
Grand Total	874	6765	11.4	7639

Source: Community Safety Partnership Service

1268 individuals were recorded as victims of domestic abuse in Southwark between April 09 and Sept 10.

4.3 Sexual health and unplanned pregnancies

Alcohol is commonly reported as a contributing factor in sex without a condom, regretted sexual activity and sex with someone who would not normally be found attractive⁵⁸. A link between alcohol consumption and both sexually transmitted infections⁵⁹ and also teenage pregnancy⁶⁰ has been suggested.

Whilst there has been a 27.4% reduction on the 1998 baseline rate of teenage conceptions, rates remain high and Southwark has the third highest rate across London and the seventh highest nationally (63.3 conceptions per 1000 amongst 15-18 year olds). 60-70% of teenage conceptions end in terminations⁶¹.

4.4 Fires and Road Traffic Accidents

In 2009 there were 975 collisions involving one or more driver. Of these, alcohol was recorded as a contributory factor in 19 accidents (2%). Positive breath tests were only received in 13 of these incidents⁶².

The consumption of alcohol has long been suspected to be related to increased risk of fire in the home (usually due to cooking, careless handling or disposal of lit materials and falling asleep).

Across London, alcohol is suspected as a contributing factor in 5.3% of fires in homes (totalling 569 fires) since November 2008 when the National Incident Recording System was introduced⁶³. Toxicology tests find alcohol in the blood of fatal domestic fire victims at a higher rate than this (up to about 25% of victims) but in the past 10 years there have been few fatalities in Southwark with positive toxicology results for blood alcohol (only 4 since 2000).

4.5 Work, Absence and Worklessness

Alcohol related loss of productivity involves:

- Alcohol related absence
- The inability to work
- Premature deaths amongst people of economically active age

In total, alcohol related output losses to the UK economy are estimated to be up to £6.4bn a year⁶⁴.

4.5.1 Alcohol and the workplace

It has been estimated that up to 17 million working days are lost in England through alcohol related absence, costing the UK economy about £1.5bn.

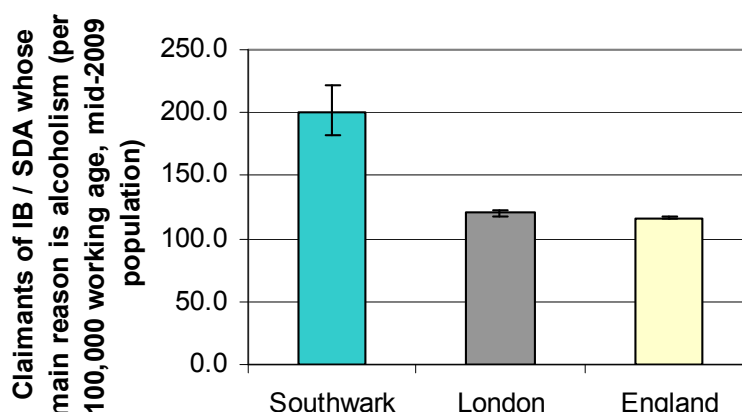
Alcohol is also related to productivity when at work and with a third of employees report having been to work with a hangover, and 15% report having been drunk at work, this may have a significant impact on productivity⁶⁵.

4.5.2 Alcohol and the inability to work

Recent research from the Department for Work and Pensions has, for the first time, provided estimates of the number of dependent drinkers receiving a range of benefits in 2008. Dependency is defined by a score of 20 or more on the AUDIT screening tool. The study estimates that 4% of all people in receipt of the Disability Living Allowance (DLA), Incapacity Benefit, Income Support or Job Seekers Allowance are dependent drinkers. Men are most at risk and the peak age for alcohol related problems is 54-44⁶⁶.

In Southwark, the rate of claiming Incapacity Benefit or Severe Disability Allowance due to alcoholism was much higher than the London and England averages, as shown on the graph below.

Figure 20: Rates of IB / SDA claimants per 100,000 working age mid-2008 population (August 2009)



400 individuals were registered as claiming Incapacity Benefit or Severe Disability Allowance due to alcoholism in August 2009.

5. Effective Interventions

- A range of interventions have been found to be effective, and cost effective, in reducing alcohol misuse, working both at the population and individual level.
- Screening in a variety of settings for alcohol use is important if the treatment base is to be broadened to include problem drinkers before they become help seekers. It is important to use a validated tool as relying on informal methods may miss the majority of increasing risk drinkers who have no obvious signs of alcohol related harm.
- There is no single 'best buy' package of interventions but suggested factors promoting effectiveness are:
 - Service user choice
 - A broad range of interventions on offer at a range of levels
 - Involvement of families and other close contacts
- Detailed evidence based Clinical Guidance in the management of harmful drinking and alcohol dependence has been provided by NICE. This should be followed by all services and monitored regularly.

Treatment for alcohol misuse is cost effective from a national perspective and for every £1 spent £5 is saved elsewhere^{67, 68}. For the purposes of this document, the evidence of effectiveness for services will be broken down into:

1. Preventing harmful drinking
2. Identifying harmful drinkers
3. Reducing and targeting harmful drinking
4. Alcohol withdrawal and dependency

Reviewing the effectiveness of services requires clear definition of the goals and outcome measures. Traditionally, services have aimed to improve an individual's quality of life but there may be a move nationally to consider abstinence as the primary outcome measure of success⁶⁹. This review will consider both quality of life and abstinence outcome measures according to the evidence available.

The evidence base for services for ethnically diverse areas suggests that all services should be competent to meet the ethnic and cultural needs of local populations. There is a trade off between providing specific services for different groups and offering choice through a range of generic services so it may be more useful to find new ways of engaging with ethnic minorities as opposed to separate services. Women (apart from women who have been abused) generally do well in mainstream services provided co-morbidity needs are addressed.

5.1 Preventing harmful drinking

NICE recommends population level approaches as a more effective, and more cost effective, way of reducing alcohol associated harm⁷⁰. Full details can be found in the public health guidance, *Alcohol-use disorders: preventing the development of harmful and hazardous drinking*.

Such population level action is suggested to involve:

- Making alcohol less affordable (e.g. a minimum price per unit)
- Managing availability of alcohol so that it is less easy to buy (both through licensing and reviewing personal import allowances)
- Regulating advertising of alcohol (with a particular emphasis on children and young people).

5.2 Identifying harmful drinkers

Screening in a variety of settings for alcohol use is important if the treatment base is to be broadened to include problem drinkers before they become help seekers. It is important to use a validated tool as relying on informal methods may miss the majority of increasing risk drinkers who have no obvious signs of alcohol related harm.

NICE highlights the importance of ensuring that any organisation that regularly comes into contact with individuals at risk of harmful drinking screens for alcohol use. They specifically name health and social care, criminal justice and the community/voluntary sector in both NHS and non-NHS settings. Where population wide screening is not possible it is suggested that targeted screening, including particular patient groups or new GP registrations, is an alternative to general screening^{67,70}. Screening by trained individuals in all NHS commissioned services that come into contact with those at risk of alcohol misuse is recommended in NICE clinical guidelines.

A wide range of screening tools are available for use, some of which were originally developed for specific situations (e.g. AUDIT for primary care, FAST for emergency departments) and various adaptations of these tools have been made since. When selecting a tool it is important to consider the time available for screening and the likely prevalence of different levels of need (e.g. dependency vs increasing risk drinking). The AUDIT is, however, suggested to be the tool of choice in community settings although initial SIPS results suggest that FAST may be superior in primary healthcare settings⁷¹.

5.3 Reducing and treating harmful drinking

5.3.1 Brief interventions

NICE recommends providing brief interventions following identification of those at increased risk from their drinking. These interventions are generally either structured brief advice or extended brief interventions.

It is recommended that staff use recognized, evidence based packs with a short guide on how to deliver a brief intervention, a validated screening questionnaire, a visual presentation (to compare the person's drinking levels with the average), practical advice on how to reduce alcohol consumption, a self-help leaflet and possibly a poster for display in waiting rooms. Brief interventions have been shown to be cost effective although most of the research comes from a primary care setting.

Brief advice based on the FRAMES approach (feedback, responsibility, advice, menu, empathy, self-efficacy) is recommended. The advice should cover the potential harm caused by their level of drinking, reasons for changing the behaviour, including the health and wellbeing benefits, the barriers to change, outline practical strategies to help reduce alcohol consumption and lead to a set of goals.

For those not responding to brief intervention or advice, it is recommended that up to four extended brief interventions (20-30 minutes, based on a motivational interviewing approach) are provided, with referral for clients who need more specialist services. Such clients include those who show signs of moderate or severe alcohol-dependence, those who have failed to benefit from structured brief advice and an extended brief intervention and wish to receive further help for an alcohol problem or those who show signs of severe alcohol-related impairment or have a related co-morbid condition (for example, liver disease or alcohol-related mental health problems).

5.3.2 Further support

The National Treatment Agency (NTA) suggests that it is best to offer extensive treatments (over a long period of time) rather than intensive treatments (resource intensive in a short period of time) due to the variation in the course of alcohol problems over time. This is particularly true for individuals with chronic and severe alcohol related problems.

To ensure the effectiveness of any activities it is essential that properly trained and competent staff deliver the interventions, following manuals or guidelines as outlined in the research base.

In terms of individual treatments, there is no one 'best value package' but rather a range of interventions, some of which have a specific application but most of which are generally effective. There are a range of different treatment options offering a range of approaches that deliver equally good outcomes. Such approaches include intensive socially based therapies, less intensive motivationally based treatments, 12 step facilitation treatments, cognitive behavioural coping skills therapy, behavioural self control training and marital and family therapies. Service user choice in treatment improves outcomes.

Inclusion of friends and family in treatment^{67,72}, specifically suggested to involve:

1. Making the role played by the social environment as central and important as that played by individual factors
2. Broadening the base of treatment to see family as a legitimate unit for intervention, allowing the family member or other individual to become the focus of help either within a family-based intervention or as a service user themselves
3. Recognising a broader set of positive outcomes from treatment in addition to reductions in alcohol use (e.g. effects on family and the wider social context).

Some of these clients may be experiencing some degree of alcohol dependency.

5.4 Alcohol withdrawal and dependency

5.4.1 Planned care

The evidence on the management of alcohol use disorders (harmful drinking and alcohol dependence) has been reviewed in detail by NICE⁷³. In the clinical guidance *Alcohol-use disorders: diagnosis and clinical management of alcohol related physical complications*. Evidence based recommendations for the delivery of care are provided in depth and a brief summary is provided in Appendix 1.

5.4.2 Unplanned Withdrawal

Advice on managing unplanned medical withdrawal suggests admission for those who are in acute withdrawal and with, or at high risk of developing, alcohol withdrawal seizures or delirium tremens or are under 16 years old. A lower threshold for admission is suggested for people who are vulnerable (for example, those who are frail, have cognitive impairment or multiple co-morbidities, lack social support, have learning difficulties or are 16 or 17 years)⁷⁴.

For people who are alcohol dependent but not admitted to hospital it is suggested that professionals should offer advice to avoid a sudden reduction in alcohol intake and information about how to contact local alcohol support services⁷⁵.

Recommendations on treatment for alcohol withdrawal suggest that clinicians should:

- Offer pharmacotherapy to treat the symptoms of acute alcohol withdrawal as recommended
- Ensure that people with decompensated liver disease who are being treated for acute alcohol withdrawal are offered advice from a healthcare professional experienced in the management of patients with liver disease and
- Provide information for other patients being treated for acute alcohol withdrawal about how to contact local alcohol support services.

More specific guidelines exist for dosing and the management of a number of specific conditions including pancreatitis, alcohol related hepatitis, liver disease and Wernick's encephalopathy.

6. Services Provided for Adult Alcohol Use in Southwark

- Individuals misusing alcohol in Southwark have access to a range of services, operating through a range of organisations.
- NHS Southwark commissions services to treat adults with a primary alcohol need on behalf of the Drug and Alcohol Action Team (DAAT). Services funded by the DAAT include alcohol primary care hub activities including extended brief advice and community detoxification, community support programmes through Foundation 66, specialist alcohol treatment within South London and Maudsley (SLaM) specifically the Community Drug and Alcohol Teams, specialist out-patient clinics and inpatient detoxification units as well as residential rehabilitation programmes through a range of providers. Some of the other substance misuse services also provide support for individuals with an alcohol need – this will be expanded through the service remodel.
- Services funded through other routes include primary care (Directed Enhanced Services) activity (IBA), services within Kings College Hospital Trust, Guys and St Thomas' Hospital Trust, Criminal Justice (police, probation, CARAT teams) and a range of voluntary sector organisations.
- Taking a stepped care approach to the provision of care, an individual should be offered the least intrusive and least expensive intervention that is likely to be effective and only offering a more intensive alternative if treatment fails.
- It is essential that the full range of services available is well understood by all those involved in alcohol misuse prevention and treatment to avoid confusion and the unintended loss of people to the treatment system.

Southwark Services

The Drug and Alcohol Action Team (DAAT) funds some services to treat adults with a primary alcohol need through the pooled treatment budgets and supplementary PCT and council funding.

NHS Southwark commissions services to treat adults with a primary alcohol need on behalf of the Drug and Alcohol Action Team (DAAT). The DAAT funds some services to treat adults with a primary alcohol need through the Substance Misuse Pooled Treatment Budget as well as supplementary PCT and council funding.

In 2010/2011 5.3% (£506,071) of the total adult substance misuse service spend was allocated for primary alcohol misuse services. Many of the drug services will also support clients with their adjunctive alcohol use, further adding to the resource available.

These alcohol specific services include:

- Tier 1: - Alcohol strategy work
- Tier 2: - Foundation 66 direct access walk in
 - St Mungos assertive outreach
- Tier 3: - Foundation 66 counselling and structured day programme
 - Primary care hub activities
 (including extended brief advice and community detoxification)
 - Specialist treatment within South London and Maudsley, SLaM
 (specifically the Community Drug and Alcohol Teams,
 specialist out-patient clinics and inpatient detoxification units)
 - Residential rehabilitation programmes

Services funded through other routes include Directed Enhanced Services within General Practice as well as services within Kings College Hospital Trust, Guys and St Thomas' Hospital Trust, Criminal Justice (police, probation, CARAT teams) and a range of voluntary sector organisations.

A map of services provided within Southwark is shown in Figure 20.

Figure 21: Southwark Alcohol Services (DAAT and non-DAAT Funded)

	Service	Client Group
Tier 1 Non-substance misuse specific services	Social Services	Universal
	GPs / Primary Care / CMHTs / Other	Universal
	Generic Health Services	Universal
	Housing / Employment	Universal
	A&E	Universal
	Criminal Justice System	Universal
Tier 2 Services offering drop-in harm reduction interventions	Foundation 66 Elephant & Castle Shopfront	Primary Alcohol Users with or without any other substance use
	Hospital Liaison & Assessment Service (Kings College Hospital and Guy's & St Thomas' Hospital)	Any drug user; poly or single use including Alcohol
	Blenheim CDP Outreach Bus	Any drug user; poly or single use with or without Alcohol as non-primary drug
	Primary Care Alcohol Hubs	Alcohol users (with or without other drugs)
	St Mungos Outreach Service	Any DIP drug user (poly or single use including Alcohol) or Any Primary Alcohol user (with or without any other substance use)
	Three Boroughs Drug & Alcohol Team	
Tier 3 Services offering community-based specialised substance misuse assessment & treatment	SLaM Community Drug & Alcohol Team	Any drug user; poly or single use including Alcohol
	Blenheim CDP KAPPA Service	Any drug user; poly or single use including non-primary Alcohol
	Foundation 66 Counselling Service	Poly drug users with Primary Alcohol
	Foundation 66 Day Programme	Primary Alcohol Users with or without any other substance use
	Blenheim CDP Rise Day Programme	Any drug user; poly or single use including Alcohol
	CRi REACH Day Programme	Any drug user under a DRR order; poly or single use including non-primary Alcohol
	Blenheim CDP Evolve Crack Service	Any stimulant user; poly or single use including non-primary Alcohol
	Primary Care Alcohol Hubs	Alcohol users (with or without other drugs)
Tier 4 Services offering residential substance misuse treatment	Equinox Brook Drive	Any drug user; poly or single use including Alcohol
	SLaM Inpatient Services	Any drug user; poly or single use including Alcohol
	Social Services Care Management Team	Any drug user; poly or single use including Alcohol

Aftercare / Holistic / Wrap-around Services	Red Kite Employment, Training and Education	Any drug user; poly or single use including Alcohol
	Thamesreach Aftercare Accommodation	Any drug user; poly or single use including Alcohol
	Service User Council	Any drug user with experience of the Treatment system
	CRi Peer Advocacy Service	Any drug user with experience of the Treatment system

7. Current Service Provision Relative to Need

- Amongst individuals in treatment for alcohol use, 34.1% used a second substance, with cannabis being the most common substance, followed by cocaine.
- The number of assessments for alcohol treatment (Tier 3 and 4) performed in Southwark is similar to the number predicted by the Rush Model (based on an estimated prevalence of dependent drinking in Southwark of 2.7%).
- Local service provision in 2009/2010 involved less community detox and more short term residential detoxification (with less long term residential detox) than predicted.
- Treatment rates are highest amongst the white Irish population in Southwark, with lower rates than would be expected amongst the white British population.
- Women in treatment for primary alcohol problems were less likely to be in residential treatment than men (16.2% of women vs 23.1% of men were in residential treatment).
- The most common source of referrals into alcohol treatment is health and mental health services (43%), followed by substance misuse services (19%). Few referrals come from the criminal justice system (3%) and family services (1%) although these sectors will be in contact with clients with a high prevalence of alcohol misuse.
- There are low rates of planned exit for community prescribing (i.e. community detoxification services), with only 27% of clients leaving treatment in a mutually agreed planned way.
- Of the non-residential treatment modalities, structured day programmes achieve the highest rate of planned exits (70.4%).

It is important to distinguish between the different measures used when considering alcohol service provision.

Need refers to the capacity to benefit from alcohol services – i.e. how many people are drinking at increasing or higher risk levels and how many dependent drinkers are there.

Dependent drinkers who should be treated in a given year can be estimated as a proportion of the total number of all dependent drinkers. This does not represent the expressed demand or numbers in treatment.

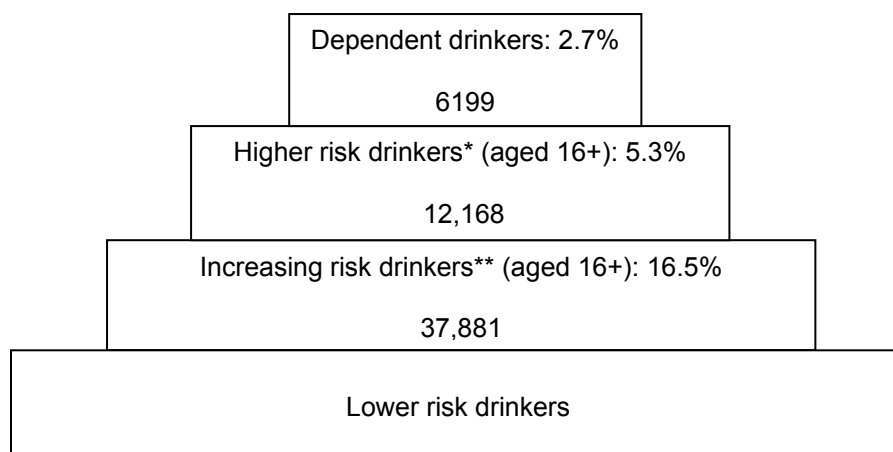
Treatment provision quantifies the services actually provided (this may be similar to demand although not everyone presenting may be appropriate for treatment).

7.1 Need

7.1.1 Drinking behaviour

The figures below summarise alcohol related health behaviour in the Southwark population aged 18 and over. This can be used to predict the adult alcohol service need.

Figure 22: Southwark alcohol related risk and dependency estimates (aged 18 and over)



* Men drinking over 50 and women drinking over 35 units a week

** Men drinking 22-49 and women drinking 15-34 units a week

All figures calculated based on extrapolated mid-2009 population estimate for Southwark (229,580 persons)

7.1.2 Hospital admissions

Hospital admissions data has identified the Wards with particularly high rates of alcohol specific hospital admissions (admissions with any diagnosis of an alcohol specific disorder) – see Section 3.3.5.

7.2 Predicted annual service use for dependent drinkers

It is suggested that 10%-20% of dependent drinkers should be treated in a given year. The Department of Health has suggested that 10% is used in England and Wales⁷⁶ which suggests that for Southwark (with an estimated 6199 dependent drinkers) 620 dependent drinkers required treatment in 2009.

The Rush model assumes that:

- 55% of patients require outpatient treatment
- 30% require day treatment
- 10% require short term residential treatment and
- 5% require long term residential treatment

In terms of aftercare, it is estimated that:

- 75% of outpatients
- 80% of day treatment
- 85% of short term residential and
- 70% of long term residential patients require aftercare

Applying this model to the local prevalence of depended drinking (2.7%, i.e. 6199 dependent drinkers), it can be estimated that in Southwark in 2009:

Tier 3 Services:

373 people required assessment

42 people required community detoxification

157 people required counselling or outpatient treatment (incl 20% drop out)

86 people required day treatment (incl 20% drop out)

Tier 4 Services:

29 people required short term residential treatment (detox) (incl 20% drop out)

14 people required long term residential treatment (rehab) (incl 20% drop out)

243 people required aftercare

7.3 Services provided for primary alcohol users in Southwark (2009/2010)

It is not possible to gather complete data on service provision across all tiers of alcohol services. Data is particularly sparse in terms of lower tier provision, with no reliable data on the provision of brief interventions in primary care.

Data on St Mungos assertive outreach for 09/10 is currently being sourced.

Data on Foundation 66 Tier 2 and aftercare provision cannot be separated as it is reported as combined activity figures.

In 2009/2010, 690 clients were in treatment. There were 399 new presentations to Tier 3 and 4 alcohol services and 364 total exits. The number of new presentations to alcohol services has fallen since 08/09. The total number of people in treatment for a primary alcohol problem, however, has increased as fewer people are being discharged.

The total number of new presentations that we have accurate data for during the year is shown in more detail below compared to the Rush Model service estimates. The number of assessments is taken as the number of new presentations.

Figure 23: Service provision in Southwark (observed vs expected)

	Expected (Rush Model Estimates) (2009)	Observed New Presentations (2009/2010)
TIER 1:	-	-
TIER 2:	-	-
TIER 3:		
Assessment	373	351
Community detox	42	15*
Counselling/outpatient	157	264**
Day treatment	86	22***
TIER 4:		
Short term residential	29	41
Long term residential	14	7
AFTERCARE:	243	281 [□]

* community prescribing

** structured psychosocial intervention or other structured treatment

*** structured day programme

□ Includes both Tier 2 and aftercare provision

Source: NDTMS Quarterly Report Q4 2009/2010

Initial interpretation of the service use data suggests that:

- The number of assessments performed is roughly similar to that predicted
- A smaller number of community detoxifications are occurring than are predicted
- There may be more counselling and outpatient service provision than predicted (although some of this may actually be day treatment), and conversely there may be less day treatment provision (although again this may be due to confusion between categories).
- There is more short term residential treatment being provided than predicted, with less long term residential treatment than predicted.

7.4 Access to services

When profiling service users for the 2009/2010 period it can be seen that treatment rates are highest for the White Irish population in Southwark, as shown on Figure 24. Treatment rates for the white British population are lower than would be expected given the high rate of hospital admissions for this group but the small numbers being considered mean that this data should be interpreted with caution and significance testing is necessary to aid interpretation.

The lower than expected treatment rate for the white British population in Southwark may also be due to the relatively high treatment rates for other drug amongst this group and it is necessary to compare this data to other drug treatment rates.

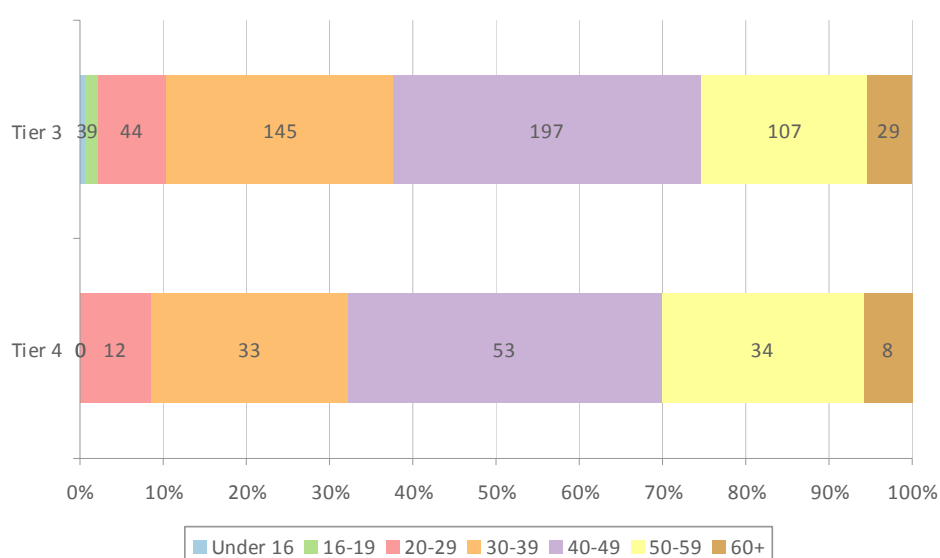
Figure 24: Treatment rates by ethnicity in Southwark (2009/2010)

Ethnicity	In treatment (09/10)	Population ages 18 and over	Treatment rate per 1000 population
White Irish	56	5,280	10.61
White & Black Caribbean	19	2,525	7.52
Other Black	23	3,673	6.26
Other	18	3,903	4.61
Other Asian	9	2,296	3.92
White British	472	120,759	3.91
Caribbean	28	14,693	1.91
Other White	42	22,728	1.85
Other Mixed	5	2,755	1.81
White & Black African	3	1,837	1.63
African	21	28,009	0.75
Pakistani	1	1,607	0.62
Indian	1	7,347	0.14
White & Asian	0	1,837	0.00
Bangladeshi	0	3,903	0.00
Chinese	0	6,658	0.00

Source: Data provided by DAAT analyst from NDTMS (Ethnicity proportions applied to ONS mid-2009 over 18 population estimate for Southwark)

The age of clients in treatment (shown separately for tier 3 and tier 4 treatment) is shown below. As would be expected, individuals in residential treatment (tier 4) are generally older than those in lower tier treatment.

Figure 25: Age profile of clients in tier 3 and 4 treatment (2009/2010) (age at mid-point of treatment)



Source: Data provided by DAAT analysts from NTA needs assessment data

Modality of service use varied with gender, with women being less likely to be in residential treatment than men (only 16.2% of the women in alcohol treatment in 2009/10 were in residential or inpatient treatment, compared to 23.1% of men)ⁱ. This may be due to the reluctance of women to access more intensive services due to impacts on the family with potential care proceedings for children – an issue raised in the service user consultation.

Amongst clients in treatment for primary alcohol use, 34.1% used a second substance. Cannabis was the most common second substance used (14.2% of clients) with cocaine (6.9%), heroin (3.9%) and crack (3.9%) being next.

Service user consultation suggests that barriers to accessing services may exist for:

- Women with children (due to fear and potentially lack of understanding of care proceedings)
- Homeless (due to delays waiting to find secure housing before accessing treatment)

Drug services were viewed as being easier to access than alcohol services, with particular problems accessing residential services being expressed. It was also recognised that accessing services straight from hospital was common, particularly when clients were at crisis point.

GPs were seen as having a crucial role in terms of provision of services and referral into more specialist treatment although problems were cited included lack of consistency between GPs, GP awareness of services on offer, waiting times and refusal to prescribe to support community detoxification. Using nurses to provide the services with less of a wait was suggested.

The lack of services at weekends was mentioned.

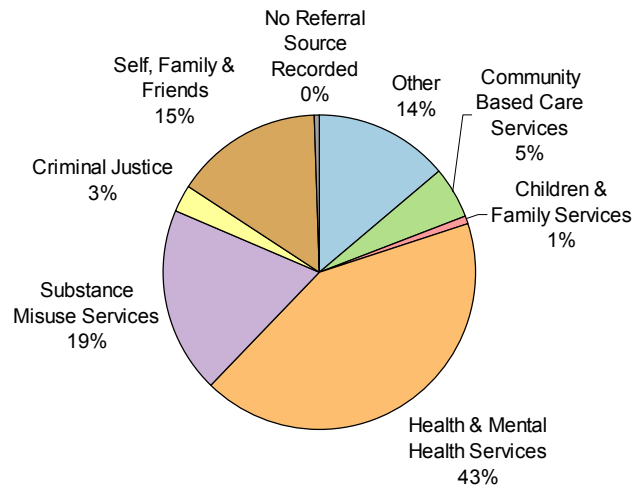
Ongoing aftercare, including drop in options, was viewed as being very important but often lacking.

7.5 Referral Sources

The most common source of new referrals into alcohol services (based on the 860 referrals recorded by NDTMS is health and mental health services (43%) followed by substance misuse services (19%). Few referrals are recorded from criminal justice (3%) and children and family services (1%). This is shown on the figure below.

ⁱ Source: NDTMS Quarterly Report, Q4 2009/2010

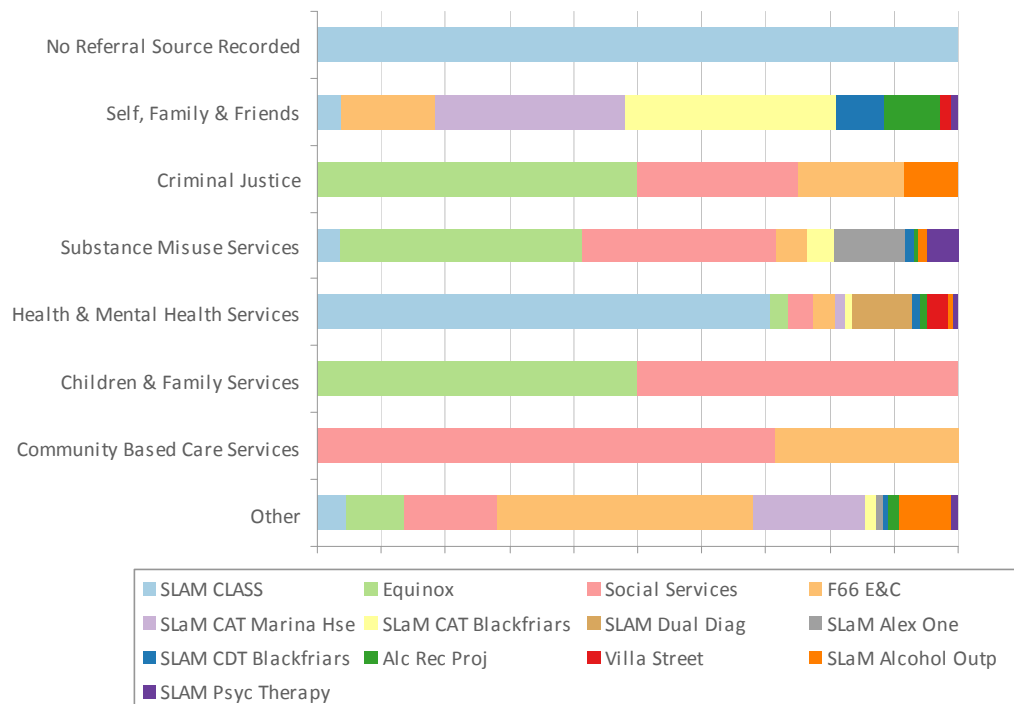
Figure 26: Alcohol treatment referral source (09/10)



Source: NDTMS (data provided by DAAT Data Analyst)

Criminal justice and children and family services tend to refer into Equinox or social services, as shown on the chart below.

Figure 27: Alcohol treatment referral source by provider (09/10)



7.6 Effectiveness of services

Effectiveness of alcohol services is measured as the client leaving treatment in a mutually agreed planned way. The effectiveness of different modalities of treatment provision is shown below. This considers all clients leaving treatment in the 2009/2010 period, regardless of the date that they entered treatment.

Figure 28: Service effectiveness by modality (2009/2010)

	Inpatient treatment	Residential rehabilitation	Community prescribing	Structured psycho-social	Structured day prog	Other structured
Interventions ended (n)	103	45	37	197	28	207
% with exit status recorded	99%	100%	100%	99%	96%	98%
% mutually agreed planned exit	81.4%	82.2%	27.0%	50.0%	70.4%	46.0%
% unplanned exit	13.7%	8.9%	56.8%	48.0%	29.6%	52.0%
% treatment withdrawn	4.9%	8.9%	16.2%	2.0%	0.0%	2.0%

Source: NDTMS Quarterly Report (Q4, 2009/2010)

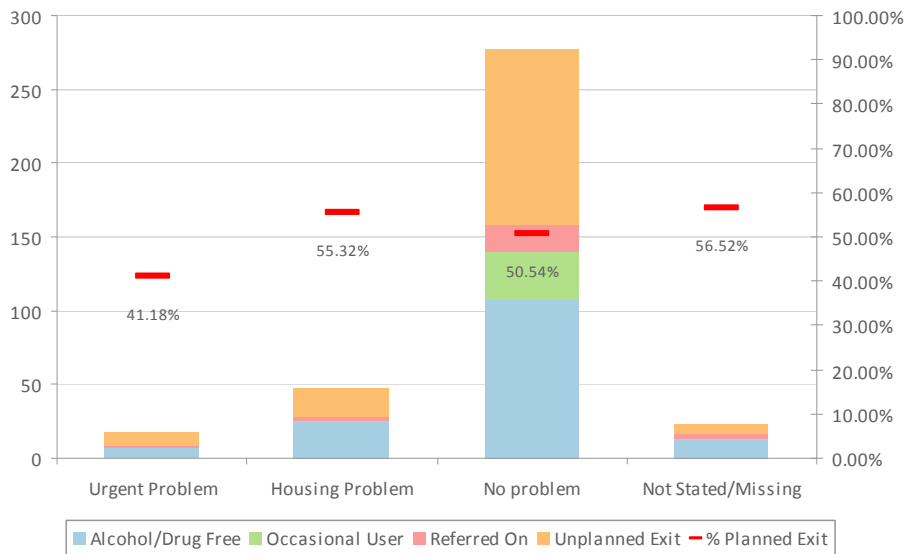
This data suggests that:

- There are low rates of planned exit for community prescribing (i.e. community detoxification services with follow-up care and support, with only 27% of clients leaving treatment in a mutually agreed planned way. Anecdotally, it has been reported that this is due to successful completion of the community detox with lower success rate for the follow up support.
- The numbers of community detoxes, however, are low with only 37 in 2009/2010
- The non-residential treatment modality that achieves the highest rate of planned exits is the structured day programmes (70.4%)

The planned exit rate for treatment provided in 2009/2010 does not vary with client accommodation status, as shown on Figure 29 below. The relatively small numbers suggest of clients with housing problems, however, mean that this data should be interpreted with caution.

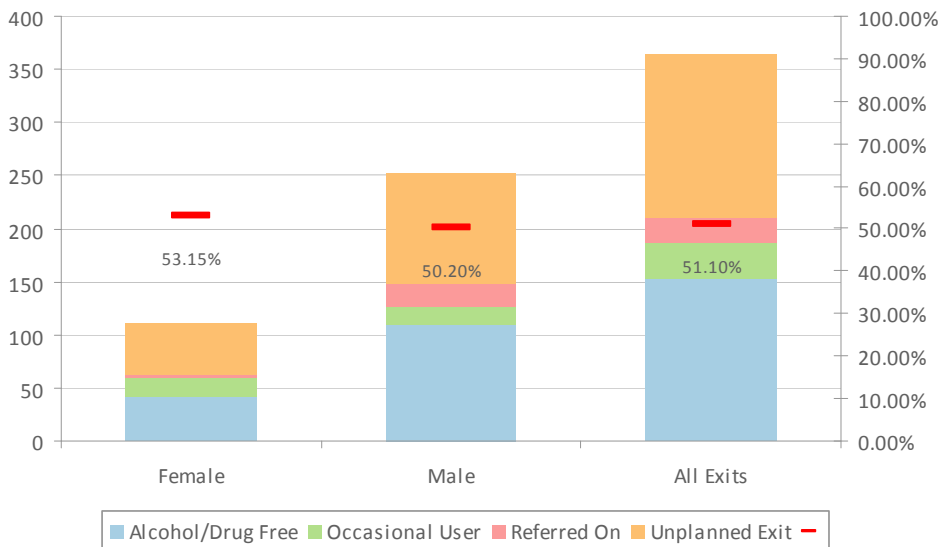
Analysis of the planned exit rate by age also suggests that rates of planned exit are similar across different age groups although again, there are relatively small numbers of clients in treatment at some ages.

Figure 29: Effectiveness of services by client accommodation status



Analysis of the rates of planned exit by gender suggest that there is a slightly higher rate of planned exit for women than for men, as shown below.

Figure 27: Effectiveness of Services by Gender



8. Recommendations

A number of alcohol specific recommendations for NHS Southwark, London Borough of Southwark and the Southwark drug and alcohol action team have emerged from the needs assessment process:

Population level action:

1. Advocate for the introduction of a minimum pricing scheme for alcohol

NHS and NHS commissioned services:

2. Continue to develop Primary Care screening and brief advice (potentially through a Locally Enhanced Service), and continue to develop community services including shared care and the Primary Care alcohol hubs
3. Link with KCH and GSTT to contribute to their workplans around alcohol screening and treatment in A&E and across the Acute sector
4. Plan to ensure that community services will have the capacity to meet any additional referrals generated by extended screening and brief interventions in other agencies
5. Work with treatment services to ensure that family support is available in treatment services both to improve effectiveness and to minimise barriers to women accessing services
6. Investigate and address high rates of unplanned exits in community detoxification services
7. Work with treatment services to ensure that clients receive appropriate referrals into services to address wider social needs including housing, and employment
8. Include aftercare in the service remodel to ensure that sufficient services are available locally

Work with other agencies:

9. Encourage a range of agencies to use identification and brief advice to contribute to a range of health and non-health outcomes (police, probation, workplaces, acute trusts etc), including potential use of DIP to address the alcohol needs of arrested individuals
10. Link commissioned and non-commissioned services to ensure appropriate referrals and smooth flow of individuals between services (e.g. from Acute Trusts and probation into community services)
11. Continue to work closely with police, community safety and other partners to support the ongoing work to reduce alcohol related crime and violence in Southwark. This should include advocating for and individual level support to reduce alcohol related reoffending (through DIP or other means) alongside work on saturation areas and feedback to trade.

Appendix 1:

Evidence Based Recommendations for the Management of Alcohol Use Disorders (Harmful Drinking and Alcohol Dependence)

The recommendations provided by NICE⁷⁷ include the following key points. These are heavily summarised so for more detail the full document should be referred to.

Care coordination and case management

- Care coordination as part of the routine care of all service users in specialist alcohol services (throughout care, including aftercare)
- Case management in Tier 3 services for people who are dependent and at risk of dropping out of treatment or with a history of poor engagement (throughout care, including aftercare), including engagement with family or significant others and other agencies involved in care

Goals of treatment

- The use of abstinence as a goal for those with alcohol dependence and those with severe co-morbidities, but without refusing treatment to clients who refuse to abstain and chose to moderate
- The use of moderation as a goal for those with harmful drinking or mild dependence without significant co-morbidity (and with adequate social support) unless the client has a strong preference for abstinence
- A harm reduction programme of care for those with severe alcohol dependence or harmful alcohol use with significant co-morbidities who refuse to work towards abstinence
- Recognition that abstinence may be a court requirement for some clients

Identification, assessment and ongoing measurement

- Assessment of risk and need by trained staff, using validated tools, to inform care planning
- Assessment and management of assisted withdrawal by staff competent in the diagnosis and assessment of alcohol dependence and withdrawal symptoms and use of appropriate drug regimes
- Brief triage, comprehensive assessment and assessment of co-morbid psychiatric problems as appropriate (with ongoing psychiatric assessment as treatment for alcohol misuse can result in psychiatric improvements)
- Use of breath alcohol, blood tests and cognitive functioning tests on an individual rather than routine basis

Assisted alcohol withdrawal

- For service users drinking >15 units per day, or scoring >20 on AUDIT, consider assessing for a community-based assisted withdrawal (varying according to the severity of dependence, social support and co-morbidities but with monitoring every other day at least) or specialist alcohol withdrawal if there are safety concerns
- Inpatient or residential assisted withdrawal if a service user meets one or more of:
 - o Drinks over 30 units of alcohol per day
 - o Has a score of more than 30 on the SADQ
 - o Has a history of epilepsy, or experience of withdrawal-related seizures or delirium tremens during previous assisted withdrawal programmes
 - o Need concurrent withdrawal from alcohol and benzodiazepines
 - o Regularly drink between 15 and 20 units of alcohol per day and have: significant psychiatric or physical comorbidities (for example, chronic severe depression, psychosis, malnutrition, congestive cardiac failure, unstable angina, chronic liver disease) or a significant learning disability or cognitive impairment.

- A lower threshold for inpatient or residential assisted withdrawal should be considered for homeless people, older people, pregnant women.

Drug regimens for assisted withdrawal

- In community-based assisted withdrawal programmes, fixed-dose medication regimens should be used (starting with a standard dose that is not based on the level of alcohol withdrawal)
- In inpatient or residential settings fixed dose or symptom-triggered medication regimens can be used.
- All medication should be prescribed, dosed and administered according to guidelines
- For clients already using benzodiazapines, doses should be increased accordingly and inpatient withdrawal regimes should last for at least 2-3 weeks

Interventions to promote abstinence and relapse prevention

- Initial assessments for all people misusing alcohol should include motivational interventions
- Interventions promoting abstinence in community-based settings should be offered to all people who misuse alcohol
- More intensive structured community-based interventions should be offered to people with moderate and severe alcohol dependence who have very limited social support (for example, they are living alone or have very little contact with family or friends), complex physical or psychiatric co-morbidities or have not responded to initial community-based interventions
- Residential rehabilitation for a maximum of 3 months should be considered for people with alcohol dependence who are homeless
- All people seeking help for alcohol misuse should be given information on the value and availability of community support networks and self-help groups (for example, Alcoholics Anonymous or SMART Recovery) and helped to participate in community support networks and self-help groups by encouraging them to go to meetings and arranging support so that they can attend

Interventions for harmful drinking and mild alcohol dependence

- Harmful drinkers and people with mild alcohol dependence should be offered a psychological intervention focused specifically on alcohol-related cognitions, behaviour, problems and social networks
- Harmful drinkers and people with mild alcohol dependence who have a regular partner who is willing to participate in treatment should be offered behavioural couples therapy
- Harmful drinkers and people with mild alcohol dependence who have not responded to psychological interventions alone, or who have specifically requested a pharmacological intervention, should be considered for the use of acamprosate or oral naltrexone in combination with an individual psychological intervention or behavioural couples therapy
- When the needs of families and carers of people who misuse alcohol have been identified, guided self-help should be offered
- If the families and carers of people who misuse alcohol have not benefited, or are not likely to benefit, from guided self-help and/or support groups and continue to have significant problems family meetings should be considered

Interventions for moderate and severe alcohol dependence after successful withdrawal

- Acamprosate or oral naltrexone in combination with an individual psychological intervention or behavioural couples therapy should be considered for people with moderate and severe alcohol dependence who have completed a successful withdrawal
- Disulfiram in combination with a psychological intervention should be considered for people with moderate and severe alcohol dependence who have completed a successful withdrawal if the individual has a goal of abstinence but acamprosate and oral naltrexone are not suitable or if the individual would prefer disulfiram and understands the relative risks of taking the drug

- Benzodiazapenes should only be used for managing alcohol withdrawal (not for ongoing treatment for alcohol dependence), antidepressants and GHB should not be used
- If using acamprosate, treatment should be started as soon as possible after assisted withdrawal and continue for up to 6 months or longer for those benefiting (use should be stopped if drinking persists 4-6 weeks after starting the drug)
- If using oral naltrexone, treatment should be started after assisted withdrawal and continue for up to 6 months, or longer for those benefiting (again, use should be stopped if drinking persists 4-6 weeks after starting the drug)
- If using disulfiram, treatment should be started at least 24 hours after the last alcoholic drink consumed

Other recommendations for managing withdrawal

- For people who misuse alcohol and have comorbid depression or anxiety disorders, the alcohol misuse should be treated first as this may lead to significant improvement in the depression and anxiety
- Those who misuse alcohol and have a significant comorbid mental disorder, and those assessed to be at high risk of suicide, should be referred to a psychiatrist to make sure that effective assessment, treatment and risk-management plans are in place
- For comorbid alcohol and nicotine dependence, encourage service users to stop smoking according to NICE guidance⁷⁸
- Follow NICE guidance⁷⁹ on thiamine for people at high risk of developing, or with suspected, Wernicke's encephalopathy. In addition, offer parenteral thiamine followed by oral thiamine should be offered to people who are entering planned assisted alcohol withdrawal in specialist inpatient alcohol services or prison settings and who are malnourished or at risk of malnourishment (for example, people who are homeless) or have decompensated liver disease.
- People with Wernicke-Korsakoff syndrome should be offered long-term placement in supported independent living for those with mild cognitive impairment or supported 24-hour care for those with moderate or severe cognitive impairment

Appendix 2:

Notes from Needs Assessment Data Workshop

19th November 2010

Attendees:

Jonathon Joseph	Homeless Services and Resettlement
Clare Ansdell	Probation
Jacob Wheeler	Southwark DAAT Partnership
Bernie Casey	National Treatment Agency
Melvin Hartley	Southwark DAAT Partnership
Paul Collins	Southwark DAAT Partnership
Kate Harvey	Southwark PCT

1. Probation Data:

- Contacts are Robin Lattimer, Dezlee Dennis, Hermione Wright
- OASIS assessment performed on everyone in the supervised cohort and those receiving pre-sentencing reports (about 19,000 individuals plus about the same number in custody) – sometimes OASIS is repeated at different points e.g. pre-sentencing, at breach, review etc
- OASIS includes good information on substance misuse although alcohol has rarely been analysed in the past
- Fields of interest include:
 - In treatment?
 - Treatment naïve?
 - Demographics
 - Polydrug use
 - Alcohol use
 - Type of offense
- Can access a full data set if required (request from Robin Lattimer)
- Data on those with supervision orders <12 months will be on Diamond's system

Actions: CA to provide a blank OASIS to JW
PC, KH and JW to request data (provide spec)
PC and KH to investigate data from Diamond

2. Housing Data:

- Contact is Jonathan Joseph (resettlement)
- Resettlement team only hold data on alcohol and drug use when they impact on an individual's ability to hold a tenancy (based on self disclosure – no screening tool used)
- Only 'alcohol' or 'drug' use (no details)
- Individuals are referred for treatment if their need is severe (but timing rarely right as individuals are in crisis) – no earlier intervention
- Database holds information on about 2500 people (about half of single individuals are recorded as having substance misuse problems)
- Supports individuals once they have lost their home through their time in supported accommodation, treatment etc for up to two years
- Tenancy Services work with Council Tenants who are in arrears to help
- May have data on impact of substances?
- Housing register unlikely to hold useful information

Actions: PC and KH to source data from JJ
PC and KH to investigate tenancy services data

3. NDTMS

- Contact is JW
- Can look at those entering treatment, outcome, time in treatment, re-presentations and referral route
- Can analyse client groups (e.g. criminal justice clients)

Actions: PC and KH to request data from JW

4. Primary Care Data

- Contacts are Pat Roberts (PCT) or Frances Diffley (GP)
- Can look at variation by Practice
- Some lead GPs take specialist patients
- Shared care – can get data from Jacob
- KH has data on the LES and DES

Actions: PC and KH to investigate and request further data

5. NTA value for money tool

- Available from mid-Dec to look at scenario planning

6. Policy scanning

- Name documents

7. Midwife data

- KH to investigate

**Actions: KH to investigate
PC and KH to analyse**

8. Other options

- Case Studies
- LASS data
- A&E data

Actions: PC and KH to investigate

Appendix 3:

Notes from Needs Assessment Expert Group

Needs Assessment Expert Group Meeting 7 th January 2011 Tooley Street	
Name	Organisation
Gina Warilow	Foundation 66
Dionne Dennie	Foundation 66
Jenny Corless	SLAM
Jo Delaforce	Haven
Dionne Cameron	DAAT LBS
Carolyn Hart Taylor	DAAT LBS
Irina Andrade	CRI
Edward Dean	JCP
Jake Wheeler	Data Manager
Becca Walker	PCT
Tony Lawlor	PCT
Alberto P	BCDP
Sisa Madaka	SLAM CAHMS
Chris Saunders	Children's Services
Michelle Harris	Children's Services
Monika Ciurej	Children's Services
Jenny Brennan	Children's Services Youth Offending
Julie Cuthbert	NHS Southwark
Maria Moore	Foundation 66
Marilyn Major	SLAM
Colin Maclean	BCDP/Southwark DIP
Sarah Day	DAAT LBS
Alison Campbell	BCDP
Liz Legge	BCDP Rise Day Prog
Iain Gray	DAAT LBS
James Bell	SLAM

Introductions

PC and TL opened the meeting with house keeping information followed with a request for each attendee to introduce themselves and explain their role to the group. TL then explained the structure of the workshops.

The aim was to present the preliminary findings out of which a document would be produced.

The group were informed that they would be put into workshop groups to discuss what is working well, what is not working and identifying what the barriers are.

A definition of what a needs assessment was given: triangulate, qualitative and quantitative data.

The new needs assessment is going to be about local prevention as well as provision and where gaps in the service provision exist the Expert Group's meeting aims to identify ways of providing an improved service.

PC informed the group that he has been liaising with various groups and stakeholders to get relevant information. He informed the group that February 2011 would be the timescale for the final version of the Needs Assessment document.

In response to being asked why a needs assessment document is being carried out this year, PC explained that it is a different world now and that a national strategy would now include

drugs and alcohol. It would cover abstinence, personal responsibility, early intervention, and a key issue would be public health in England.

Definition

The current definition of what constitutes a problem drug user is changing. Southwark has significant issues with alcohol and cannabis use. Future funding of alcohol and drug treatment will be based on successful treatment, linked to exiting, so it is now about how people leave the service and if it is in a planned way and whether they are abstinent.

In terms of finances it is likely that some of our partners will face pressure so it is going to be a challenging period. We have to think about what we do with families but also the children in those families.

KH gave a summary of the problem stating that Southwark is no different to other boroughs apart from having higher levels of people drinking. This information was gathered by KH looking at social marketing data where statistics show that more people are dying who also fall under the categories of being in need of housing, are rough sleepers, are known to the criminal justice service and who may have mental health problems.

KH then showed the group hospital data that she has been using to get a better idea of the current situation. She ran through the admissions to the accident and emergency department and death statistics. The data revealed that Southwark has a higher level of people with liver disease, more people absent from work and more people experiencing incapacity or disability. A higher percentage of this was related to alcohol.

It was suggested that a broad range of interventions is now needed. In terms of current service provision we need to look at numbers going into and out of treatment and the problem with links between services.

KH asked the group if they had come across other services that could be utilised for screening. In response it was found that Job Centres have done work in this area and referred people to services. Haven the centre for supporting those who have been raped or sexually assaulted provided data on alcohol related rape which is 47% higher than other boroughs.

IG informed the group that in terms of access to services, satellite services within hostels had been positive because many people in hostels who are in need of support are not in treatment.

Alcohol screening

- Primary Care Alcohol Hub: In terms of gaps in the service it was felt that some people were not aware of what a Primary Care alcohol hub is.
- GP's do screen new patients for alcohol use and will do a brief interview themselves or refer them for assessment to alcohol hubs.
- Nurses are available in pharmacy's to provide screening.
- Foundation 66 provides screening.

It was felt that early intervention is the most effective and that service provider staff members need to be aware of all the various services available and need to integrate. The PCT website has been re-launched to give clearer information about services.

Aftercare needs to be flexible for people's needs.

Data

Tops data was used and it revealed that cannabis was commonly used in Southwark; PDU's are mainly using it on a daily basis.

Crack and opiates are commonly used daily. The Tops data also revealed that this lifestyle was linked to health and social care aspects such as being at risk of losing their tenancy.

PC explained that the profile of someone could influence whether they would access services. For instance we have to consider if someone would access services if they are currently working. So we need to look beyond the drug use and at the wider picture. At present there is a fairly consistent level of drug use taking place in Southwark. There is a 28% penetration rate across London

Southwark has one of the of the lowest penetration rates in London but it has reduced. The data came from different data sets and was then compared to get estimates, which is done by looking at the socio economic makeup.

JW then compared needs assessment information and exiting treatment. From the data he could determine what a client's most likely exit would be, those who tended to be referred on, those who would drop out or disengage. This was done by looking at criteria such as age, ethnic origin, gender etc.

Although the data suggested those in treatment would exit treatment in a planned way, group members disagreed.

In terms of the service users view of services

PC ran a couple of service user groups screening people with lots of cannabis use. It was clear that there was a problem with parents using cannabis while their children were present resulting in them thinking it was normal behaviour.

Service users felt that there was a lack of support for families unless they had reached crisis point. This view was especially felt by women. Also discussed was the effect of this working life and children's schooling. Parents were not aware of their rights within services and they felt that there needed to be more information about services available. People still remain in fear of accessing social services because of fear that children will be removed, rather than getting any support. The general feeling was that organisations need to be honest in accepting that some people are not aware of the service that they provide.

In terms of multiple services, there is a problem with people getting stuck within services and struggling to get treatment intervention.

Young People's Substance Misuse Preliminary Findings

Period **2009-10** People in treatment

Treatment for young people is different to adults because young people's needs are different. For young people brief intervention, approximately four sessions, is good as they do not keep coming back week after week.

National Treatment Agency can be referred to for more information on this area.

Current Performance

Youth Outreach Service (YOS)

Self referrals account for a couple and are increasing. Age of young person in treatment in Southwark ranges from 13-15 but no under 13's. Note after secondary school young people tend not to listen and instead become influenced by their peers, so early intervention is essential.

Workshop feedback

Group 1

Specialist Interventions and care through to recovery

What works well

- Day programmes-longer period of time provides structure with an outcome.
- User reaches stages which are celebrated and people then feel that they are moving forward.
- Counselling service, focusing on holistic needs and cognitive focus.
- Relapse prevention at day programme, stand alone group, peer support.
- Day programme can be a referral pathway to rehab
- Community detox
- Satellite services for adults and young people, (e.g. gang postcode issues)
- GP shared care and GP referrals into alcohol dependent services.
- Monitoring data (some services do not monitor as effectively)
- Volunteering as a form of meaningful activity
- Service user led services
- Working with theatre groups, so using artistic means to help support recovery.

What doesn't work well

What are other structured interventions that can support recovery (e.g. for after completing a day programme)

- Rehab
- Permission to record data means that data may not be accurate
- Liaison with services –problems around TOPS sharing information
- Focus on recovery is lacking in services currently harm minimalisation culture
- Need more services to support recovery. Lots in start and middle but hardly anything at the end of treatment journey.
- Need more focus on addressing holistic needs of users, e.g. the benefits, accommodation etc.
- Difficult to access counselling services
- Need more activities to fill time, some services aren't sensitive towards drug alcohol services
- ITEP work isn't enough. Service users can't maintain this when worker is not there.
- Working with continuous drinkers.
- Problem with talking about drugs and/or alcohol all day as this may make people want to use, so need other meaningful activities.
- Joined up planning with parental substance misuse and children's services planning.
- Tiers don't work for YP
- Lack of out of hours services e.g. evenings and weekends

Top priorities

- Middle to end of pathway-preparation for the end
- Focus on families and early prevention to prevent young people continuing onto adult services.

Group 2

Specialist interventions and care through to recovery

- Revisit YP and alcohol DIP assessment in the station-missing an opportunity at this stage
- Family, we should be thinking more about the whole situation
- YOT has a drugs worker so need to get specialist knowledge to the young people.
- Conflict regarding DUST and assessment etc.
- First contact is critical
- Good skills of staff
- FIP
- TAC –Team Around the Child
- Satellites
- When do you need a specialist?
- Training Assessment tool

Group 3

Exiting treatment relapse prevention and aftercare.

What works well

- Partnership holistic approach
- More in depth work in terms of aftercare
- Peer mentors to assist regarding transitions
- 12 step fellowships
- Peer support groups
- Training for peer mentors
- Counselling and psychology
- Family interventions

What doesn't work well

- Restricting appointments for aftercare to working hours
- Restricting access to aftercare
- Better co-ordination around exiting treatment
- Interagency approach
- Poor communications
- Discrimination against people with addiction difficulties
- Disconnected- systems-lack of continuity
- Multi agency work needed as part of aftercare
- Limited options for aftercare
- Time-services focused on working hours
- When exiting treatment more support is needed
- Regarding unplanned exits childcare is major issue

Top priorities

- Training for social services regarding service users
- Partnership aftercare
- Wider range of aftercare services
- Evening and weekend access
- Appropriate housing

Group 4

Identification-outreach difficult

Engagement –comes from service user not service, so how to motivate engagement.

SM illegal –society says must engage

Difficulty with cla

Diclosure

Adults/parents-conflict with services

Lack of knowledge

Of care services

Of SM services

Transition YP –adult

MH assessment only available after 6 months alcohol abstinence

Role legitimacy

Hand holding

Role Model

What works well?

Foundation 66

Outreach-other areas e.g. Insight

Holistic approach

Models of good practice in schools

Health huts

KAPPA

Brief assessments (needle exchange) etc.

YOS, SLAM

What doesn't work well

Schools –evidence base (Nat)

Provision of support to revolving door

Haven –connectivity links to services are not good

Accident and emergency do not make it a priority

Top Priorities

Sustained effort –e.g. hospital, A and E

Liaison

Finance consideration-what has maximum impact regarding model

Communication strategy

All in PCT strategy

Appendix 4:

Southwark Drug and Alcohol Service User Council Focus Group

24th November 2010

1. Southwark Profile

Key drug issues identified locally included:

- Alcohol also involving older middle aged people who have been on drugs for a long period of time (30/35 years old upwards)
- Alcohol – people meet up daily and sit outside drinking (e.g. Camberwell Green)
- “Active addiction” of Class A drugs and alcohol is seen around Camberwell/Dulwich and Camberwell Green
- Cannabis and alcohol in London Bridge, particularly with teenagers (of all ethnicity) drinking in public
- Cannabis was recognised as a major emerging problem *“The biggest problem I see is cannabis. Weed. Skunk... And it seems to be young boys, the odd girl... but young boys in groups and anti-social behaviour and drinking and puffing seems to go together”* *“nearly everyone smokes puff”* *“the cannabis thing it’s just taken off”* *“it’s all about image and status with young people and a lot of these young people... have had parents in addiction and their parents haven’t provided for them so they’ve grown up really quickly and started to get into the same lifestyle... it’s all image, they want this and they want that..”*
- Not many new people using Class A drugs *“there still is people but I don’t think there’s so many”* *“A lot of people on class A drugs are people who’ve been on it a long time”* *“I don’t think there’s so many people now as there was 15 years ago starting on Class As”*
- Dealing hot spots (for Class A drugs) identified included East Street, Camberwell Green, East Street, Wharf Road
- Dealers are also using MacDonalDs and Bookies *“using MacDonalDs... I’ve seen a lot of activity in MacDonalDs”* *“the dealers are going up to the toilets and meeting people there. They’re shutting them in the toilets”* *“and using Bookies a lot now”* *“you go past any Bookies you’ll see a load standing outside these days. And you see the same faces from morning to night, all day until it closes”*

The impacts of substance misuse that the group discussed included:

- Antisocial behaviour *“people don’t really care anymore, that’s the impact”*
- Impact on families:
 - Families where parents have substance misuse often have young people who use drugs or drink
 - Parental addiction affect children
 - Young person addiction affects the whole family

“If a young person’s getting involved in drugs it impacts on the whole family” *“it’s not just the person who’s going through the addiction, the whole family goes through it with you”*

Factors related to the start of substance misuse included:

- Family substance misuse (normalising substance misuse and meaning that children grow up quickly) *“there’s a lot of families that use with their kids”* *“especially the cannabis”*
- Failure of “the system” to support children with family addiction, abuse, family breakdown

- Starting using alcohol and cannabis then moving on to other substances (speed, cocaine, crack, heroin)
- Peer pressure (especially with cannabis) and material requirements (clothes etc)

It was noted that dealers were getting younger and drugs were becoming more easily available.

2. Prevention

- Lack of prevention work with children and young people
- Should get ex-users into schools
- Youth clubs help
- Leaflets could be put in schools, GP surgeries, pharmacies, churches, supermarkets – these need to be specifically about drugs

3. Access into Treatment

- People only access services when they know they have a problem
- Often you have to be in crisis to get support (people have to put themselves in crisis, e.g. become homeless or get arrested)
- Barriers exist in particular for women due to the knowledge that treatment will start the social services process (there was support for this process but it was recognised as a barrier to women accessing treatment)
- Women need an individual social worker to guide them through social services issues and ensure that women are well informed (it is good to have social workers for children but many women do not know their rights and it was reported that some women had put their children up for adoption in situations where this was not necessary due to lack of understanding of the process)
- Few referrals were made from schools and social services
- Is it always necessary for individuals to take part in a day programme before accessing residential rehabilitation? Those most in need of residential programmes would be unable to attend a day programme as they are at crisis point

4. Treatment Service Provision and Quality

- Lack of alcohol treatment services (alcohol is often seen as less of a problem than drugs due to social acceptability and its legal status)
- Need for automatic referral service upon hospital admission for alcohol related cause (as with suicide and psychological support)
- Lack of drug services for young people and parents (some parents are not familiar with substance misuse)
- Services do not tackle substance misuse being passed on within families (e.g. children growing up with parents with substance misuse)
- Lots of services provided for teenage mums and pregnant women (both a good and bad thing)
- Women with infants in foster care find it hard to get support to stay busy
- Support for teenagers needs to be structured (e.g. YOT orders are good)
- Initial contact with services was seen as good
- More could be done to help those who were struggling (more key worker sessions or information on treatment alternatives)
- Social services have poor understanding of drug use and can make people feel uncomfortable
- Social services need to support the client as well as children

- Social service support around relapse could help support women in re-contacting services to seek help if they fear they are at risk of relapse
- The cuts may affect services, especially as it is already difficult to access peripheral services (e.g. holistic massage)
- Care plans are good as they are a joint effort and goals are flexible, shared and positive
- Shared care planning could incorporate social services and other agencies to ensure that there was understanding across the agencies and now conflicting advice and information/decisions
- Need more groups (rolling/drop in groups rather than 12 week programmes to help people become more comfortable in the environment without having to commit or feel pressured)
- Events or groups on offer are promoted during assessment and also by some staff and via a timetable poster in services
- Harm reduction is good as it does impact risk taking behaviour and some “wet hostels” are needed

5. Leaving Treatment

- Clients need ongoing structure and key worker links after the Care Plan was achieved
- Equally, treatment is a process that happens at individual client paces and cannot be rushed
- Treatment is often not seen as a process by providers (i.e. no exit plan was set and the emphasis is often on maintenance, e.g. using pharmacological treatment) and key workers can be shocked when clients suggested that they might want to work towards leaving treatment
- Too many people are “parked up” on prescriptions and the prescribing service does not always link with the reduction service to promote abstinence
- Long term outcomes are related to internal stability, growth, self esteem and goal setting
- Relapse prevention could be supported with multi-agency work to support all client needs, early interventions when at risk of relapse, continued aftercare support (left open), easier access into other support, ensuring that services will not be withdrawn immediately on relapse (e.g. residential treatment), more groups to build self-esteem and provide activity/distraction, relapse prevention being provided as standard (rarely done at present)
- Support during relapse is required to minimise the impact
- People need “something to do after treatment”
- There is a need for legal and housing support
- To access follow-up services clients often have to be clean for 2 weeks – is this always necessary?
- There are good links into volunteering, training etc but it is difficult to get back into work (and some barriers for training exist – e.g. some courses for specific populations including those with English as a second language)
- There is a lack of awareness of wider opportunities and voluntary sector organisations
- Apprenticeships within drug and alcohol services could build the workforce and offer employment opportunities
- More workshops in treatment places could be run by ex-service users, peer education programmes could be set up, apprenticeships are good

Appendix 5:

Alcohol Service User Focus Groups

Focus Group 1: 10th December 2010 (5 participants)

Southwark Need:

- Alcohol use is very visible in Southwark as people tend to congregate in parks
- Hostels have a real drinking and drug taking “fraternity”

Preventing People Drinking Excessively:

- Need to increase prices
- Should ban very high content alcoholic drinks
- It would be easier if alcohol was less widely available
- It would be useful to get advice and signposting in GP surgeries, parks, through police and wardens, housing and social services
- The social acceptability of alcohol encourages excessive drinking

Access to Services:

- People hear about alcohol services through GPs, word of mouth, outreach work
- More access points would help to improve treatment uptake (accessing alcohol treatment through any treatment facility was seen as “great”, especially if this enabled provision of a 7 days a week service “*you’ve got the weekend and then what do you do? They cut your drip*”)
- Barriers to access include homelessness (can link to time delays), lack of funding and bureaucracy
- It is easier to access drug treatment than alcohol treatment, particularly through Drug Rehabilitation Orders – there was a suggestion that money could be diverted from drug treatment into alcohol treatment

What Works Well?

- The services are staffed well and are supportive
- Individual motivation, when present, is the key determinant of success
- Foundation 66 is viewed positively

What Needs Improvement?

- Access into residential services, in some cases straight from GPs to prevent delay
- Having a medical part to community treatments would help
- Delays in housing can limit treatment “*3 weeks are quite long if you’re taking brown every day*”
- Delays between assessment and first appointments can mean that people get lost
- Wardens and police often enforce and move people on without offering any support or signposting into services

Ongoing Care and Aftercare:

- Confidence and success is enhanced by voluntary work, courses, mentor and peer advocacy work – lots of post-treatment clients were suggested to volunteer for Crisis Christmas work
- Recognition of achievements (e.g. certificates etc) help
- Lambeth aftercare service contacts people proactively – this helps

Focus Group 2: 14th December 2010 (12 Participants)

Preventing People Drinking Excessively:

- Price – alcohol is too cheap

- Advertising affects drinking behaviour
- Availability – alcohol is available “*on every corner*”, “*24 hours a day*” (e.g. the same shops that top up electricity keys all sell alcohol)
- No prevention campaigns really?
- GPs are not always helpful
- Wider awareness of warning signs of dangerous alcohol use and risks would help (e.g. in schools or individually through brief advice)

Access to Services:

- Access straight from hospital is common (including hospital detox following a crisis)
- There can be barriers to accessing community detox through GPs (e.g. GPs may not refer appropriately, services may not support alcohol addiction)
- It would help to be able to access brief services through nurses as well as GPs to avoid having to wait for so long
- Community detox can be accessed through Foundation 66
- Alcohol units are not widely known – it could be useful to be able to self refer to these
- More access points could help BUT it is important to ensure that everyone knows how/where to refer to avoid “*passing the buck*”

What Works Well?

- Brief intervention workers (but not if funded by cutting other services)
- Walk in services are good

What Needs Improvement?

- GPs are not always able to provide services themselves (e.g. prescribing)
- There is little consistency with GPs (hard to get same GP or same day appointment)
- Getting a care coordinator can take time
- Family support and support for the parents when combining treatment and social services processes would help, possibly with liaison workers to support whole family planning and strategies

Ongoing Care and Aftercare:

- Aftercare workers can be hard to get
- Confidence and success are enhanced by longer aftercare, “*somewhere to go*” as boredom is a problem, social support/group activities, AA (but not always liked), access to exercise facilities, specific groups or activities targeted at individuals after treatment
- The Sanctuary Club at Vauxhall offers a drop in facility

References

- ¹ Health Survey for England 2008: *National Adult Trend Tables*. HSE Dec 2009. Taken from www.ic.nhs.uk [October 2010]
- ² Chief Medical Officer. *150 Years of the Annual Report of the Chief Medical Officer*. Department of Health http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/DH_096206 [October 2010]
- ³ Nutt, D.J., King, L.A., Philips, L.D. on behalf of the Independent Scientific Committee on Drugs. Drug Harms in the UK: a multicriteria decision analysis. *The Lancet* 376 Nov 2010; P1558-1565
- ⁴ Stevens A, Raftery J. *Health Care Needs Assessment: the epidemiologically based needs assessment reviews*. Oxford: Radcliffe Medical Press; 1994
- ⁵ Cabinet Office Strategy Unit. *Alcohol Harm Reduction Strategy*. 2004
- ⁶ Health Improvement Analytic Team, Department of Health. *The Cost of Alcohol Harm to the NHS in England. An Update to the Cabinet Office Study 2003*. July 2008
- ⁷ Department of Health and Home Office. *Safe. Sensible. Social. The next steps in the national alcohol strategy*. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_075218 [October 2010]
- ⁸ The Home Office. *Reducing Demand, Restricting Supply, Building Recovery: supporting people to live a drug-free life*. 2010
- ⁹ NHS Information Centre and National Statistics. *Statistics on Alcohol in England 2010*. The Health and Social Care Information Centre. <http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/alcohol/statistics-on-alcohol-england-2010> [October 2010]
- ¹⁰ NHS Information Centre and National Statistics. *Statistics on Alcohol in England 2010 Data Tables*. The Health and Social Care Information Centre. <http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/alcohol/statistics-on-alcohol-england-2010> [October 2010]
- ¹¹ National Institute for Health and Clinical Excellence. *Alcohol Use Disorders: Preventing the development of harmful drinking*. June 2010 www.nice.org.uk
- ¹² Office for National Statistics. *General Lifestyle Survey 2008: Smoking and drinking among adults*. ONS. 2008
- ¹³ Office for National Statistics. *Mid-Year Population Estimates 2009*. <http://www.statistics.gov.uk/statbase/Product.asp?vlnk=15106> [October 2010]
- ¹⁴ Office for National Statistics. *Population Projections*. www.statistics.gov.uk [October 2010]
- ¹⁵ See http://www.dh.gov.uk/publichealth/healthimprovement/alcoholmisuse/DH_085385
- ¹⁶ Department of Health and Home Office. *Safe. Sensible. Social. The next steps in the national alcohol strategy*. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_075218 [October 2010]
- ¹⁷ NHS. *Alcohol Social Marketing for England: further tools, support and guidance*. http://www.alcohollearningcentre.org.uk/library/Resources/SocialMarketing/Toolkit_2010/Alcohol_Toolkit_Interactive.pdf [January 2011]
- ¹⁸ Rush, B. A Systems Approach to Estimating the Required Capacity of Alcohol Treatment Services. *British Journal of Addiction* 1990, 85, 45-59
- ¹⁹ NWPHO. *Local Alcohol Profiles for England 2010 PCT Datapack*. <http://www.nwph.net/alcohol/lape/> [October 2010]
- ²⁰ ONS Mid-1009 Population Estimates <http://www.statistics.gov.uk/statbase/product.asp?vlnk=15106>
- ²¹ University of Sheffield. **Prevention and Early Identification of Alcohol Use Disorders in Adults and Young People. 2010**. Taken from www.ias.org.uk [December 2010]
- ²² ONS Mid-2006 Population Estimates. <http://www.statistics.gov.uk/statbase/Product.asp?vlnk=15106> [October 2010]
- ²³ Ministry of Justice. *Breaking the Cycle: effective punishment, rehabilitation and sentencing of offenders*. 2010
- ²⁴ McKinnon, I et al. 'Health screening in police custody'. *Journal of Forensic and Legal Medicine* 17 (2010) 209-212

-
- ²⁵ London Criminal Justice Online.
<http://lcjb.cjsonline.gov.uk/area23/library/JSNA/PDOLArrestData1.xls>
- ²⁶ Criminal Justice Alliance. Criminal Justice Areas for Action. June 2010
- ²⁷ OASys data. Provided by The London Probation Trust.
- ²⁸ Homelessness Link. SNAP Survey 2009.
- ²⁹ Fountain, J. and Howes, S. Rough Sleeping, Substance Misuse and Service Provision in London. 2001. NAC
- ³⁰ Weaver, T. Charkets, V. Maffen P. Et al (2003). Co-morbidity of Substance Misuse and Mental Illness in Community Mental Health and Substance Misuse Services. *British Journal of Psychiatry* 183, 304-313
- ³¹ Barnby, B. Drummond, C. McLeod, A et al (2003). Substance Misuse in Psychiatric Inpatients: a comparison of screening questionnaire survey with case notes. *British Medical Journal* 327: 783-784
- ³² Menezes, P. Johnson, S. Thornicroft, G et al (1996). Drug and Alcohol Problems Among Individuals with Severe Mental Illness in South London. *British Journal of Psychiatry*, 168, 612-619
- ³³ Strathdee, G. Manning, V. Best, D. (2002). *Dual Diagnosis in a Primary Care Group: a step by step epidemiological needs assessment and design of a training and service model*. Unpublished report for Department of Health
- ³⁴ Kipping, C. *Alcohol and Mental Health Paper*. January 2011
- ³⁵ Southwark Dual Diagnosis Needs Assessment
- ³⁶ Office for National Statistics. *General Lifestyle Survey 2008: Smoking and drinking among adults*. ONS. 2008
- ³⁷ Joseph Rowntree Foundation. *Ethnicity and Alcohol: a review of the UK literature*.
www.jrf.org.uk
- ³⁸ Alcohol Learning Centre website. www.alcohollearningcentre.org.uk
- ³⁹ Health Improvement Analytic Team, Department of Health. *The Cost of Alcohol Harm to the NHS in England. An Update to the Cabinet Office Study 2003*. July 2008
- ⁴⁰ Duggal, A. *Haringey PCT Alcohol Needs Assessment 2008*. Reproduced with permission of the author
- ⁴¹ NWPHO. LAPE Data Pack for Southwark.
- ⁴² Office for National Statistics. 2011. <http://www.statistics.gov.uk/cci/nugget.asp?id=1091> [January 2011]
- ⁴³ London Health Observatory. Alcohol Attributable Admissions by LA Report Datapack. http://www.lho.org.uk/Download/Public/16115/1/Alcohol_attributable_admissions_by_LA_report_datapack.xls [January 2011]
- ⁴⁴ NICE. Alcohol Use Disorders: preventing the development of hazardous and harmful drinking. 2010. London: NICE
- ⁴⁵ Data provided by NHS Southwark Performance and Information Team
- ⁴⁶ Bell, J. Hunter, R. Morinan, G. Webzell, I. Wilson-Jones, C. O'Grady, J. What are the Alcohol Problems in General Hospitals? (draft paper)
- ⁴⁷ E.Gutjahr & G.Gmel in Klingemann & Gmel (Eds). Mapping the Social Consequences of Alcohol Consumption. 2001. WHO
- ⁴⁸ Alcohol Harm Reduction Strategy for England – Prime Minister's Strategy Unit, 2004
- ⁴⁹ Report from The Crime and Society Foundation, October 2004, [hosted by the Centre for Crime and Justice Studies, University of London, King's College] as cited in IAS. Alcohol Crime Factsheet 1. 2010 www.ias.org.uk [November 2010]
- ⁵⁰ Alcohol and Crime: Breaking the Link. All-Party Group on Alcohol Misuse, July 1995. as cited in IAS. Alcohol Crime Factsheet 1. 2010 www.ias.org.uk [November 2010]
- ⁵¹ The Home Office. Breaking the Cycle: effective punishment, rehabilitation and sentencing of offenders. 2010
- ⁵² Crime in England and Wales 2003/2004, Home Office, July 2004. as cited in IAS. Alcohol Crime Factsheet 1. 2010 www.ias.org.uk [November 2010]
- ⁵³ Data provided by Community Safety Partnership Service
- ⁵⁴ Strategy Unit. 2004. *Alcohol Harm Reduction Strategy for England*. London: Strategy Unit.
- ⁵⁵ LDAN. LDAN Briefing on Domestic Violence
- ⁵⁶ Humphreys, C., Thiara, R.K., Regan, L. Domestic violence and substance use: overlapping issues in separate services? 2005. University of Warwick and London Metropolitan University.

-
- Taken from http://www2.warwick.ac.uk/fac/soc/shss/swell/research/final_report.pdf
[December 2010]
- ⁵⁷ Womens Aid.
<http://www.womensaid.org.uk/domesticviolencearticles.asp?section=00010001002200280001&itemid=958>
- ⁵⁸ Ipsos MORI. Alcohol and Sexual Health. 2009. Taken from <http://www.ipsos-mori.com/researchpublications/researcharchive/poll.aspx?oltemId=2472> [December 2010]
- ⁵⁹ Cook, R.L., Clark, D. B., Is There an Association Between Alcohol Consumption and Sexually Transmitted Diseases? A Systematic Review. *Sexually Transmitted Diseases*, March 2005, Vol. 32, No. 3, p.156–164
- ⁶⁰ Alcohol Policy UK www.alcoholpolicy.net/2007/06/teenage_pregnan.html [January 2011]
- ⁶¹ Data provided by NHS Southwark public health department
- ⁶² Data provided by London Borough of Southwark Road Safety Team. December 2010
- ⁶³ London Fire Brigade. Topic Report – Alcohol as an Influencing Factor in Fires. 2009
- ⁶⁴ Strategy Unit. 2004. *Alcohol Harm Reduction Strategy for England*. London: Strategy Unit.
- ⁶⁵ Findings from a report compiled from research carried out by Vanson Bourne and YouGov and commissioned by Norwich Union Healthcare in 2007. As cited by IAS. Alcohol and Work Factsheet. Taken from www.ias.org.uk [December 2010]
- ⁶⁶ Hay, G. Bauld, L. *Population Estimates of Alcohol Misusers Who Access DWP Benefits*. DWP Working Paper No 94
- ⁶⁷ National Treatment Agency. Review of the Effectiveness of Treatment for Alcohol Problems. 2003
- ⁶⁸ UKATT. Cost effectiveness of treatment for alcohol problems: findings of the randomised UK alcohol treatment trial (UKATT). *BMJ Online*
- ⁶⁹ The Home Office. Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life. 2010
- ⁷⁰ NICE. Public Health Guidance 24: Alcohol Use Disorders: Preventing Harmful Drinking. 2010
- ⁷¹ Coulton, S. Early Results from SIPS: Screening for brief intervention. Presentation (University of Kent)
- ⁷² Copello, A. and Orford, J. Addiction and the Family: is it time for services to take notice of the evidence. *Addiction*. 97, 1361-1363
- ⁷³ NICE. Alcohol Use Disorders: Harmful drinking and alcohol dependence. Full guideline final draft November 2010
- ⁷⁴ Reoux JP, Miller K. Routine hospital alcohol detoxification practice compared to symptom triggered management with an Objective Withdrawal Scale (CIWA-Ar). *American Journal on Addictions*. 2000; 9(2):135-144.)
- ⁷⁵ National Clinical Guideline Centre for Acute and Chronic Conditions. Clinical Guideline 100 - Alcohol Use Disorders: diagnosis and clinical management of alcohol-related physical complications. 2010.
- ⁷⁶ Alcohol Learning Centre.
<http://www.alcohollearningcentre.org.uk/Topics/Browse/Commissioning/Data/?parent=5113&child=5134> [January 2011]
- ⁷⁷ NICE. Alcohol Use Disorders: Harmful drinking and alcohol dependence. Full guideline final draft November 2010
- ⁷⁸ NICE. PH1 Brief interventions and referral for smoking cessation: guidance. March 2006
- ⁷⁹ NICE. CG100 Alcohol use disorders - clinical management: understanding NICE guidance. 2010