Camden’s Alcohol Harm Reduction Strategy 2007/10
Following a recommendation by the Camden Health Scrutiny Panel in 2006, an Alcohol Harm Reduction Strategy has been developed in partnership by Camden Primary Care Trust and Camden Council (LBC). A range of service users, carers, service providers and strategic groups involved in addressing the problems of alcohol misuse has helped shape the Strategy. The initial consultation exercise revealed a range of important suggestions, which have been reflected in this document. These suggestions centred on the need to:

- Identify clear actions
- Clearly prioritise areas of intervention in acknowledgement of the scale of the problem and limited resources available
- Ensure better co-ordination between alcohol treatment services
- Include updated health data

We are very grateful for the range of helpful comments we have received which have been an important part in the production of this strategy.
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References
1 Executive Summary

1.1 The need for a local alcohol strategy

Alcohol misuse is a substantial problem for Camden. Both adults and young people in Camden appear to be heavier drinkers (drinking above maximum recommended limits) compared to London as a whole.

Alcohol misuse is associated with a range of cross cutting harms. In relation to health and social care systems Camden has a high level of alcohol related harm when compared to London and England as a whole. Camden has a high rate of alcohol related hospital admissions, a high and increasing rate of ambulance call outs and a high rate of mortality and premature mortality for men as a result of alcohol misuse.¹

Alcohol related violence constitutes to a large proportion of the borough’s violent offences and alcohol related harm also arises from domestic violence and drink driving. Alcohol contributes to a range of mental and physical health problems including depression, anxiety, liver disease, cancers, and fertility problems. A raft of social problems such as family breakdown, child neglect, risky sexual behaviour and sickness from work are also associated with alcohol misuse.

This strategy is based on research evidence, available best practice and consensus of key stakeholders about how to address alcohol-related harm most effectively in Camden. It reflects the main recommendations of key local and national strategies and policy, including, but not limited to:

Local reports and strategies
• Camden’s Alcohol Misuse Scrutiny Panel Report (2006)
• Camden’s new five-year sustainable community strategy “Camden Together”
• Camden PCT Annual Public Health Reports 2005/6 & 2006/7.

National policy and guidance
• Choosing Health: Making Healthy Choices Easier (2004)
• Models of Care for Alcohol Misusers (MoCAM) (2006)
• Review of Effectiveness of Treatment for Alcohol Problems (2006)

1.2 Key aims and objectives

The strategy builds on existing work to reduce alcohol misuse and sets the framework for reducing the problems associated with alcohol misuse in Camden over the next three years. It will ensure that the Council and PCT work with other partners to tackle the wide range of harms linked to alcohol misuse.
The key strategic goals aim to:

- Improve the quality of life for residents whose lives are affected by alcohol related disorder and protect children and young people from alcohol related harm
- Reduce alcohol related crime and anti social behaviour
- Support generic front line agencies which encounter children, young people and adults who misuse alcohol to identify, screen and refer individuals to appropriate support
- Improve service delivery among alcohol specific agencies and improve the consistency and quality of performance information
- Reduce demand on higher levels of care, particularly acute health services

The strategy is clustered around four strategic goals:

i) To reduce the impact of alcohol misuse on the communities of Camden through working across all sectors: licensed premises, criminal justice, street services, education, communities, health and social care to minimise the harm caused by alcohol misuse to individuals, families and the community.

Key objectives include tackling alcohol-related violence and disorder; working with licensed premises locally to reduce the harms caused by alcohol misuse; reducing the impact of alcohol misuse among key groups such as Camden’s homeless and street population through integrating enforcement options with appropriate treatment and support service interventions. Other key areas include improving data collection and targeting resources where they are most needed and improving communication and involvement of all partners in addressing alcohol misuse and its impact on the community.

ii) To reduce the harms to health caused by alcohol misuse in Camden through broadening interventions beyond specialised alcohol treatment services to help people to avoid misusing alcohol and to identify alcohol problems early, before more serious health damage arises. The key aim is to highlight alcohol misuse as a serious public health issue by targeting agencies, which encounter people who are at risk of, or may already be, drinking above maximum recommended levels.

This will include the expansion of screening and ‘brief interventions’ which are short, evidenced-based, cost-effective advice and information sessions, which can reduce drinking levels. Camden already has a programme in GP surgeries and Accident and Emergency Departments at both the borough’s acute hospitals: the Royal Free and University College London Hospital. These programmes will be closely monitored and if appropriate expanded into other areas.

iii) To increase access to a range of timely, effective treatments to ensure that specialised treatment services are able to address the needs of the Camden population.

Key objectives will include providing a range of evidence based treatment interventions with a particular focus on increasing and publicising the availability of detoxification and
relapse prevention; improving accessibility to treatment through increasing intervention
capture points, clarifying admissions criteria and referral mechanisms, and developing
care pathways. It will also propose developing a common performance framework to
ensure greater consistency of service delivery and a better understanding of clients’
outcomes.

The strategy also recognises that alcohol dependency is a chronic condition, and that
existing aftercare provision must be rationalised and expanded to prevent relapse and
promote social integration.

iv) To reduce underage drinking, heavy drinking and alcohol-related harm among
young people. Key objectives will include increasing and improving alcohol misuse
prevention programmes, focusing on education and information and conducting
targeted screening and early intervention, providing services which ensure that the
range of needs which young people have are dealt with in a co-ordinated way.

The strategy also includes objectives to improve efforts to safeguard children by
identifying and supporting children of parents who misuse alcohol and by ensuring
that parents receive the interventions they need.

1.3 Strategic framework for implementation

The implementation of this strategy will be accountable to Camden’s Drug and Alcohol
Action Team (DAAT).

An Alcohol Strategy Partnership group will steer and review the implementation of the
alcohol strategy for 12 months from April 2008 until March 2009. This group will be
comprised of a wide range of stakeholders including the police, fire, homeless hostels,
primary care, treatment services for adults and young people as well as service user
representation from the Alcohol Services Liaison Group and User Involvement Network.
In addition this group’s membership will have representation from 4 key sub-steering
groups that have the remit to oversee the day-to-day delivery of the 4 key goals of the
strategy.
2 Background

2.1 Introduction

Alcohol misuse has a number of cross cutting implications to individuals, communities and wider public levels. This section will look at the extent of the alcohol misuse problem in Camden and what we are currently doing to improve it.

Alcohol misuse accounts for almost 10% of the UK disease burden (surpassed only by tobacco and high blood pressure, to which alcohol can also be a contributing factor). It is implicated in about 22,000 deaths per year in England, and rates are rising.\(^8\) It is associated with range of conditions such as alcoholic liver disease, some cancers, high blood pressure, coronary heart disease, stroke, depression and anxiety among others.

Nationally 1.2 million violent crimes per annum are associated with alcohol (around half of all such crimes) and it is a factor in 60-70% of homicides, 75% of stabbings, 70% of beatings, 50% of fights and domestic assaults. 6% of road casualties and 17% of road deaths occurred when the driver was over the legal limit for driving.\(^8\)

Employers and employees are affected by alcohol misuse, which results in a reduction in productivity and increases in sickness absence, accidents, risks of unemployment, and the escalation of recruitment costs to replace and train staff. Alcohol related output loss has been estimated to cost the UK economy up to £6.4bn every year\(^8\) as demonstrated in Figure 1 (opposite).

Alcohol can impair the lives of individuals and families, affect the social environment and generate financial burdens on health, social care and criminal justice systems. Figure 1 (opposite) presents the nature and range of cross cutting harms and estimated costs of the problem nationally. The total cost of alcohol-related harms has more recently been estimated by the National Social Marketing Centre to be £55.1bn a year (2007).

The maximum recommended levels of alcohol consumption as advised by the Department of Health are shown in Figure 2 (opposite).

Binge drinking is classified as drinking more than 8 units of alcohol for men and 6 for women in a single session.

As a population we are drinking more and are drinking more often. The national Alcohol Needs Assessment Research Project for England (ANARP) found that 26% of the adult population in England (aged 16 – 64) has an alcohol use disorder, which is equivalent to approximately 8.2 million people. Among these, 7.1 million are hazardous or harmful users (including 4.6 million binge drinkers) and 1.1 million are alcohol dependent, see Figure 3 (overleaf). While it is recognised that older people are also at risk of the harms associated with alcohol misuse, data for older people was not collected.
Figure 1: Harms and estimated costs of alcohol misuse

<table>
<thead>
<tr>
<th>Category</th>
<th>Harm Details</th>
<th>Cost (up to)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FAMILY / SOCIAL NETWORKS</strong></td>
<td>(cost not quantified)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of street drinkers: 5,000-20,000m</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children affected by parental alcohol problems including child poverty:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>780,000-1.3m</td>
<td></td>
</tr>
<tr>
<td><strong>WORKPLACE</strong></td>
<td>(up to £6.4bn)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Working days lost due to alcohol-related sickness: 11-17m</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Working days lost due to reduced employment: 15-20m</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Alcohol-related deaths due to acute incidents: 4,300-4,100m</td>
<td></td>
</tr>
<tr>
<td><strong>HEALTH</strong></td>
<td>(up to £1.7bn)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Alcohol-related deaths due to chronic diseases: 11,300-17,900</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children affected by parental alcohol problems including child poverty:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>780,000-1.3m</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cost to health services of alcohol-related harm: £1.4-£1.7bn</td>
<td></td>
</tr>
<tr>
<td><strong>CRIME/PUBLIC DISORDER</strong></td>
<td>(up to £7.3bn)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Victims of alcohol-related domestic violence: 360,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Alcohol-related deaths due to chronic diseases: 11,300-17,900</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cost to services as consequences of alcohol-related crime: £3.5bn</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cost to Criminal Justice System: £3.5bn</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cost of drink-driving: £0.5bn</td>
<td></td>
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<tr>
<td></td>
<td>Cost to services in anticipation of alcohol-related crime: £1.7-£2.1bn</td>
<td></td>
</tr>
</tbody>
</table>

Source: Prime Minister’s Strategy Unit (Alcohol Harm Reduction Strategy for England), 2004

Figure 2: Maximum recommended levels of alcohol consumption

- A maximum of 2-3 units per day for women and no more than 14 units per week.
- A maximum of 3-4 units per day for men and no more than 21 units per week.
- Pregnant women should avoid alcohol all the time and never consume more than 1-2 units once or twice a week.

In addition it is advised that you do not drink alcohol 48 hours after heavy drinking (only as a short term measure).

NB. A unit of alcohol is 10ml or 8g of pure alcohol. The number of units in a drink depends on what you are drinking - how strong it is and how much there is. Units can be calculated by multiplying the volume (ml) by the % alcohol by volume and dividing by 1000.

One unit = 1/2 pint of ordinary strength (3.5%) beer or larger
Two units = A small (175ml) glass of medium strength (12%) wine
Figure 3: Categories of alcohol use

**Hazardous Drinkers**
Hazardous Drinkers are drinking at levels above the sensible drinking limits either in terms of regular excessive drinking or sporadic episodes of heavy drinking (binge drinking). They have so far avoided significant alcohol related problems, but are putting their health at risk.

**Harmful Drinkers**
Harmful drinkers are drinking above the sensible limits, typically at levels higher than most hazardous drinkers. They already show evidence of alcohol related physical or mental harm.

**Dependant Drinkers**
Dependant drinkers have an increased drive to use alcohol and have difficulty controlling its use despite negative consequences. More severe drinkers can be classified into mild, moderate or severe dependence.

From the evidence presented above and throughout this strategy it can be reasoned that there is a strong case for local action on alcohol related harm.

Historically, there have been no priorities or targets for alcohol at national level, and so local responses (where they exist) have often not been strategically planned or developed in a coordinated way.

In March 2004 the Government published a National Alcohol Harm Reduction Strategy for England (AHRSE). The strategy was the first attempt by any British government to address alcohol in a co-ordinated manner the main areas of alcohol related harm, which it identifies as health and crime. It identifies four key ways to tackle alcohol related harm, through:

- Improved, and better-targeted, education and communication
- Better identification and treatment of alcohol problems
- Better co-ordination and enforcement of existing powers against crime and disorder
- Encouraging the industry to continue promoting responsible drinking and to continue to take a role in reducing alcohol-related harm


In addition to AHRSE, a range of national alcohol related policies and guidance have been published in recent years. They aim to quantify the extent of the problem and set the framework for addressing alcohol related harm. These include:

- Choosing Health, Making Healthy Choices Easier; 2004

1. **Hazardous Drinkers**
2. **Harmful Drinkers**
3. **Dependant Drinkers**

   - Drinking at levels above the sensible limits.
   - Show evidence of alcohol related physical or mental harm.
   - Increased drive to use alcohol with difficulty controlling its use.

   - Health and crime as main areas of alcohol related harm.
   - Four key ways to tackle alcohol related harm:
     1. Improved, targeted education and communication.
     4. Encouraging the industry to promote responsible drinking.

   - Updated strategy made it compulsory for CDRPs to produce alcohol strategies by April 2008.

   - National policies and guidance published to quantify the extent of the problem and set framework for addressing alcohol related harm.

   - Examples:
2.2 Alcohol related harm: local profile

People in Camden appear to be heavier drinkers compared to London as a whole. A higher percentage of people in Camden are drinking above the maximum recommended limits compared to London. By extrapolating the findings from the North West Public Health Observatory’s local alcohol profile\(^1\) to Camden’s adult GP registered population (197,282 individuals aged between 15-74) Camden has approximately:

- 45,000 hazardous drinkers
- 11,000 harmful and dependent drinkers

Research by North West Public Health Observatory\(^1\) has estimated the prevalence of binge drinking to be 15.27% in the registered population of Camden (around 30,125 GP registered patients aged between 15-74 years).

A full picture of the extent of alcohol misuse and the implications within Camden is presented in Appendix 2 (page 31). From this information it can be summarised that Camden has:

- A high level of alcohol related and specific morbidity and mortality, resulting in many months of life being lost
- A high and increasing rate of alcohol related and specific hospital admissions,
- A high and increasing rate of alcohol related ambulance call outs
- A high level of alcohol related crime and violence
- A significant problem with the direct and indirect impact of alcohol misuse on children and young people
- A large homeless population with substance misuse (including alcohol) problems
- A high mental health need. Many people with mental illness also have an alcohol problem

2.3 Current responses to local alcohol related harm

Alcohol treatment and support is currently funded via mainstream health and social care budgets, short-term Local Area Agreement (LAA) funding (until March 2008) and the Young People’s Substance Misuse Grant.

2.3.1 Tackling crime and disorder and the wider impact of alcohol misuse

Safer Communities is one of four strands of the LAA and key objectives include tackling priority crime in Camden, including alcohol related crime. Crime and disorder related initiatives (including alcohol related crime and disorder) are delivered within the

For further details of all of these documents please see Appendix 1 (page 29).
strategic framework of the Safer Camden Strategy 2005-08\textsuperscript{15}. The Community Safety Team, the Safer Streets Team, the Metropolitan Police and Camden’s Licensing Team deliver a range of initiatives to reduce alcohol related harm, such as a Borough wide Controlled Drinking Zone (CDZ). Figure 4 below lists existing national legislation and measures to tackle alcohol misuse.

**Figure 4: Existing legislation and measures to tackle alcohol misuse**

- Fixed Penalty Notices and Penalty Notices for Disorders which deal with minor environmental offences (such as dropping litter) and more serious offences (such as being drunk and disorderly) and can be issued by police officers or other accredited people
- Anti-social behaviour orders (introduced in 2003)
- CDZs (introduced under the Criminal Justice & Police Act 2001) to allow local authorities to designate controlled drinking areas, where the police are given the power to confiscate alcohol in public places.
- Licensing Act (2003) which aims to reform UK licensing laws via the prevention of crime and disorder, public safety and the prevention of public nuisance
- Violent Crime Reduction Act (2006) has powers that include alcohol disorder zones, drinking banning orders, reviews of licensed premises and alcohol related dispersal powers.

Other local activities include the ‘Safer Travel at Night’ scheme (a London-wide campaign that aims to raise awareness about the dangers of using unlicensed minicabs), which is currently developing a proposal for a marshalled taxi rank, which would not only provide additional safe travel but also help reduce crime and disorder in Camden Town.

The Best Bar None scheme piloted in 2006 in Camden Town and Holborn has been rolled out to pubs, clubs and bars across the borough. The national scheme aims to reduce the risk of alcohol related disorder by encouraging high standards in the licensed trade and is recognised as a best practice scheme by the Home Office.

Seasonal enforcement campaigns are also undertaken to increase personal safety at peak times such as Christmas and during the summer. Camden’s Street Population Teams assist homeless people (including those with serious problematic drinking issues) with their housing and other needs, using enforcement where appropriate.

In addition, there is a range of groups that target alcohol related crime and anti social behaviour such as The Violent Crime Group (VCOG) Camden Town Operational Group (CTOG) and the Domestic Violence Working Group.

2.3.2 Tackling harms to health

Camden PCT and its partners are involved in a number of initiatives to reduce the harm to health caused by alcohol, mainly through providing education and information,
screening and brief interventions.

The health promotion department carried out an alcohol awareness campaign that provided hints to promote sensible drinking to those drinking in Camden and focused on the sensible number of units to consume in one sitting and what constitutes a unit. in Camden in December 2006 and January 2007 and will continue to ensure sensible drinking is within its work programme. The Healthy Schools team based at Camden Council provides training to teachers around teaching about drugs and alcohol and the Personal Social and Health Education Programme taught throughout schools now contains explicit lessons around alcohol.

A primary care development worker is now employed within the public health directorate at Camden PCT. This post is working with general practices, training healthcare staff how to screen for alcohol misuse and offering brief interventions for alcohol problems (see Figure 5. below) Selected patients attending A&E at University College Hospital and Royal Free Hospital are now screened by clinical staff for alcohol misuse and where appropriate referred onto a specialist alcohol worker based at both sites.

**Figure 5: Brief interventions**

Brief interventions are short advice and information sessions lasting no more than a few minutes. A large body of evidence shows that they can reduce weekly drinking between 13% and 34%, resulting in 2.9 to 8.7 fewer average drinks per week with a significant positive effect on alcohol use.\(^\text{12}\)

Harmful drinkers can benefit from extended brief interventions, which take 20-30 minutes, possibly over repeat sessions.

### 2.3.3 Adult treatment and support

Camden Substance Misuse and Adult Social Care commissioners (joint commissioners across Camden Council and Camden PCT) fund a range of alcohol treatment and support services spanning the recommendations of MoCAM tiers.\(^\text{11}\) These include open access services, one-to-one and group working; specialist provision, inpatient detoxification, and community based aftercare. *Table 1* overleaf shows the number of clients treated in 2005/06 by alcohol services in Camden, for a detailed description of the services please see *Appendix 4 (page 39)*. Please note that 2006/07 data was not available at the time of publication.

In addition, the Supporting People programme offers vulnerable people the opportunity to improve their quality of life by providing a stable environment, which enables greater independence. It delivers high quality and strategically planned housing-related services, which are cost effective and reliable, and complement existing care services. Supporting People is a working partnership of local government, service users and support agencies and funds accommodation based support to assist people through the recovery process.
Table 1: Service delivery in existing Camden alcohol services

<table>
<thead>
<tr>
<th>Provider</th>
<th>Estimated number of clients treated during 2005/06</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tier 2</td>
</tr>
<tr>
<td>Specialised day service at the Spectrum Centre</td>
<td>200</td>
</tr>
<tr>
<td>Alcohol Recovery Project – ARP (including Women’s Alcohol Service)</td>
<td>436</td>
</tr>
<tr>
<td>St Mungos – 9 St Pancras Way</td>
<td>25</td>
</tr>
<tr>
<td>Alcohol Advisory Service for Camden and Islington - AASCI (including GP satellites)</td>
<td>347</td>
</tr>
<tr>
<td>Camden Alcoholics Support Association - CASA</td>
<td>50</td>
</tr>
<tr>
<td>Residential detoxification (Rugby House)</td>
<td>100</td>
</tr>
<tr>
<td>Residential Treatment (including continuous drinkers)</td>
<td>61</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>711</strong></td>
</tr>
</tbody>
</table>

In addition, alcohol detoxifications also take place in both acute hospitals in Camden at the Royal Free Hospital and University College Hospital. A small number of patients are admitted electively for detoxification from alcohol. However, in most cases patients are admitted with either an alcohol related or non-alcohol related problem but because of their alcohol related dependency will require detoxification during their stay in hospital.

2.3.4 Children and young people

Camden Young People’s Substance Misuse commissioner funds a range of services such as schools drug education lessons; targeted health promotion work; a specialised substance misuse service which provides one-to-one and group work sessions, psychiatric and psychological interventions. The training of frontline staff working with children and young people is currently in progress to identify alcohol misuse among young people and refer to specialist agencies where necessary. Initiatives are also underway to support the “Hidden Harm” agenda (the harm experienced by many children and young people living in substance misusing households) by developing appropriate links and parenting programmes between Camden’s Children, Schools and Families Directorate and provider services.

Alcohol treatment services for young people in Camden are delivered primarily by the substance misuse service, FWD (Forward – part of the Children, Schools and Families Directorate of London Borough of Camden). In 2006/07 FWD supported 53 young people who reported problematic alcohol use.
3 Local priorities to tackle alcohol related harm

Sections 1 and 2 have identified the current issues around alcohol misuse in Camden and what is currently in place to reduce alcohol related harm. This section will identify where gaps exist and then set out where Camden’s priorities lie, outlining why an alcohol harm reduction strategy is needed.

3.1 Gaps - Key issues with existing arrangements

Gaps in service provision have been identified through mapping existing arrangements outlined in Section 2.3 (page 11) to the evidence base and national policy and guidance (see Appendix 1 on page 29). These shortfalls are discussed below.

Tackling crime and disorder and the wider impact of alcohol misuse

There needs to be a more systematic and co-ordinated approach to addressing alcohol related crime and disorder and a consistent application of legislation.

Alcohol is not systematically recorded as being a contributory factor in crime or anti social behaviour incidents. However it is possible to analyse the data by searching for “violence against the person offences” where the details of the offence included the phrases drunk, drinking, beer, street drinker, wine, licensed premise, landlord, licensee, public house, PH, intoxication and alcohol. This method is not without flaws, as it will include offences that are not related to alcohol and other alcohol related offences will be missed, but it is currently the most accurate way of identifying offences. While it is possible to estimate alcohol related crimes, these estimations must be used with care.

Health Promotion

Health campaign work needs to be co-ordinated between the PCT Health Promotion Team and Community Safety to ensure messages are consistent and all target groups are reached.

There is reduced capacity within the heath promotion team to deliver specialist ongoing alcohol health promotion. Screening and brief interventions training needs to be extended beyond primary care staff to other members of the wider public health workforce such as school nurses Health Trainers and probation staff etc.

There is a need to evaluate the impact of having alcohol workers in A&E, with a view to seeking mainstream funding if the value can be demonstrated.

Increasing screening of alcohol problems is likely to increase demand for treatment services – it will be necessary to ensure that this demand can be met through adequate treatment services.

Alcohol treatment provision

Available funding for treatment is not adequate to meet the need estimated in Section 2.2 (page 11) (prevalence of hazardous, harmful and dependent drinkers). Adult services depend on substantial additional, non-statutory funding and many services currently operate deficits.
There are low rates of formal identification, treatment and referral of patients with alcohol use disorders by general practitioners (GPs).

Camden generalist agencies (such as sexual health services, housing services etc) do not use formal screening tools to identify alcohol misuse (although alcohol misuse is part of the assessment framework used by Social Work teams).

When the estimated level of need is compared to the actual numbers accessing alcohol services it is apparent that there are significant levels of unmet need with regard to alcohol treatment. Nationally only an estimated 5.6% of the alcohol dependent population access treatment services, owing to under developed local treatment systems and lack of referral pathways.14

Alcohol care pathways are under-developed and there is no clear performance management framework in place. There are also some service gaps, notably in relation to specialist community-based prescribing treatment necessary to treat withdrawal symptoms, promote abstinence and prevent relapse.

**Children and young people**

The Children and Young People’s Substance Misuse grant, the main source of funding for alcohol misuse in children, is low and faces possible reductions.

The application of alcohol screening tools among general agencies is inconsistent.

There is an absence of protocols between children services and adult treatment services and in addition an absence of appropriate interventions to promote parenting skills and safeguard children.

### 3.2 Priorities, strategic aims and objectives

**Why a strategy is needed for Camden?**

Alcohol misuse is a substantial and growing problem for Camden to a greater extent than for many other places, it:

- Impairs the health and quality of life of our residents
- Is associated with crime and anti-social behaviour
- Creates pressures on our local health, social care and enforcement systems
- Affects our local economy by causing sickness from work.

The strategy reflects research evidence, available best practice and the general consensus from key stakeholders on how to most effectively address alcohol related harm in Camden. The strategy also builds on and supports several local initiatives:

- Camden’s new five-year sustainable community strategy “Camden Together”5 which sets out the vision for Camden: to be a borough of opportunity with a connected community where people live active, healthy lives
- Camden PCT’s Annual Public Health Reports6,7 emphasise the collective action necessary to improve the health of the Camden population. In 2005/06 a chapter
was dedicated to reducing harm and encouraging sensible drinking and included recommendations for improving schools work around alcohol, and evaluating and considering expanding the A&E alcohol work and recommendations were also made in 2006/07.

- The 2006 Camden Overview and Scrutiny Panel report “Alcohol Misuse” which reviewed alcohol misuse and health and welfare recommended the development of a local alcohol strategy.

- Local Area Agreements (LAA) are three year agreements that set out the priorities for a local area agreed between central government, and local authorities. One of the aims of Camden’s LAA is to “reduce alcohol related harm and encourage sensible drinking” although no targets have been set around this locally.

- The Comprehensive Spending Review 2007 does include a new Public Service Agreement to “reduce the harm caused by alcohol and drugs” and therefore all local authorities will be monitored on indicators such as alcohol-harm related hospital admission rates and perceptions of drunk or rowdy behaviour as a problem (even if these indicators are not chosen as a priority area locally).

- The strategy will also be delivered in co-ordination with several local programmes of work such as Safer Camden, Safeguarding Children and adult social care strategies.

This strategy will set the strategic framework for reducing the problems associated with alcohol misuse in Camden over the next three years. It will ensure that the Council and PCT work with other partners to tackle the wide range of harms linked to the misuse of alcohol. It aims to:

- Make widely available information, advice and practical support to people to prevent themselves from being drawn into alcohol misuse.

- To give ready access to early identification of problem drinking from community and service sources, to make widely available information about and support to use simple effective self management measures.

- Use our treatment resources to provide an effective care pathway into evidence based treatments and effective after care.

- Work across all sectors – licensed premises, criminal justice, street services, education, communities, health and social care to minimise the harm caused by alcohol misuse to individuals, families and the community.

**Unifying principles**

- Improving the quality of life for residents whose lives are affected by alcohol related disorder and protect children and young people from alcohol related harm.

- Reducing alcohol related crime and anti-social behaviour.

- Supporting generic front line agencies which encounter children, young people and adults who misuse alcohol to screen, identify and offer a brief intervention or refer individuals to appropriate support services.

- Improving service delivery among alcohol specific agencies and improve the consistency and quality of performance information.

- Long term reduction in demand on higher levels of care, particularly acute health services.
4 Implementation of the strategy

4.1 Strategic framework for implementing the alcohol strategy

Goal one: To reduce the impact of alcohol misuse on the communities of Camden

Goal one sets out work across all sectors – licensed premises, criminal justice, street services, education, communities, health and social care to minimise the harm caused by alcohol misuse to individuals, families and the community.

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<th>OBJECTIVE</th>
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<tr>
<td>1.1 To tackle alcohol related violence and disorder.</td>
<td>Camden has a high level of alcohol related crime. Therefore there is a need to reduce the negative impact on the safety and quality of life of Camden residents and people who visit the borough.</td>
</tr>
<tr>
<td>1.2 Working with the licensed premises locally to reduce the harms caused by alcohol misuse (including under-age drinking).</td>
<td>National policy promotes partnership working with the alcohol industry to minimise alcohol related harm. The level of management of licensed premises varies and must be improved via measures such as good behaviour policies attached to license reviews or enhanced enforcement where improvements are not made. Local research has highlighted concerns about the levels of young people able to purchase alcohol from off-licences.</td>
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<tr>
<td>1.3 To support and empower survivors of domestic violence.</td>
<td>The risk of suffering abuse rises with increasing levels of drinking. Nearly half of domestic violence offenders are under the influence of alcohol at the time of abuse. A ‘whole systems’ approach is needed, that will support alcohol and other agencies to manage and reduce domestic violence, helping survivors understand and cope with the issues and perpetrators change their behaviour.</td>
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<td>1.4 To reduce the impact of alcohol on the homeless and street population of Camden by integrating treatment and support interventions with appropriate enforcement options.</td>
<td>Camden has a large homeless population many of whom have alcohol problems. Treatment, social care systems and enforcement must work together to address the needs of this group to ensure that appropriate services are in place.</td>
</tr>
<tr>
<td>1.5 Attendance by health and treatment professionals at the Violent Crime Operational Group and Camden Town Operational Group.</td>
<td>Much of the work done within these groups is alcohol focussed and there needs to be senior level health input to advise on relevant health and treatment services. Currently this work is predominantly enforcement orientated. (NB. The structure for delivery is currently under review within the Community Safety Partnership and these groups may change in early 2008/09.)</td>
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</table>
| 1.6 To gather data on the extent of alcohol related accidents and undertake co-ordinated action, with particular focus on:  
  • Interventions to reduce drink driving especially among younger age groups  
  • Public safety campaigns to reduce house fires. | Preventable accidents caused by drink driving and alcohol related house fires are an important priority as highlighted in national policy.8 |
| 1.7 To improve the identification and targeting of alcohol related “hotspots” (i.e. centres of public disorder). | To ensure resources and interventions are situated where they are most needed. |
| 1.8 To improve communication and involvement of the community and all partners in addressing alcohol misuse and impacts on the community. | The harms from alcohol impact across all sectors of society and require secondary action. |
Goal two: To reduce the harms to health caused by alcohol misuse in Camden

Alcohol misuse is a serious public health issue, which affects a large proportion of the population of Camden. Interventions need to be broadened beyond treatment services to help people to avoid misusing alcohol and to identify alcohol problems early, before more serious health damage arises. Evidence suggests that brief interventions are highly cost effective and can lead to a reduction in health service use as well as having clear benefits for individuals.12

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<td><strong>2.1 To prevent people from being drawn into alcohol misuse through the provision of clear, accessible information.</strong></td>
<td>Many people are unaware of their alcohol consumption and the problems that result from excessive alcohol consumption. The absence of unit labelling and the plethora of different strengths of drink and containers makes it very difficult for people to calculate consumption.</td>
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<td><strong>2.2 Scope and develop an effective targeted health promotion programme using social marketing techniques to reduce alcohol misuse and its related harms.</strong></td>
<td>There is a growing evidence base that social marketing techniques can be successful in promoting healthy behaviours. Health promotion campaigns can reduce the numbers of hazardous and harmful drinkers and therefore reduce the alcohol related burden experienced by individuals as well as the adverse effects of alcohol experienced by the community, the health system, the criminal justice system and the local economy (through days off sick).</td>
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<td><strong>2.3 To promote alcohol misuse as a serious public health issue within PCT priority setting, commissioning and resource allocation and through the Director of Public Health’s Annual Report.</strong></td>
<td>An assessment of health needs has demonstrated that Camden has a significant problem with alcohol. Camden PCT commissions and provides services to improve the health of the Camden population and reduce inequalities. It is also a major local employer, and along with its partners, has a critical role to play in supporting the implementation of the national and local alcohol strategies.</td>
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<td><strong>2.4 To commission more health promotion alcohol specialist work to promote the sensible drinking message through supporting workplace interventions, working with Camden licensees, co-ordinating health promotion campaigns, supporting schools work, and promoting self-help materials.</strong></td>
<td>A focused and informed approach to tackling alcohol misuse could maximise the impact health promotion has on people’s behaviour. A specialist post would co-ordinate and target efforts across all partner organisations.</td>
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<td><strong>2.5 To support Camden employers to develop/update and implement alcohol policies, which includes:</strong></td>
<td>Alcohol misuse is a major issue affecting employers and employees through reduction in productivity, sickness absence, accidents, risks of unemployment, and the escalation of recruitment costs to replace staff.8</td>
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<td>• Training for managers in identifying alcohol problems at work</td>
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<td>• Providing employees with alcohol problems with information, advice and referral for treatment and support</td>
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<td>• Using the workplace to stage regular health promotion events to change workplace cultures in relation to excessive drinking.</td>
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<td><strong>2.6 To increase the level of screening and brief interventions for alcohol misuse in the community through training and support of more healthcare staff (including health visitors, district nurses, school nurses, health trainers, and non-healthcare staff such as teachers, youth and community workers, social care and probation staff). Such work should be targeted on areas of known high need to reduce health inequalities.</strong></td>
<td>It is important to build capacity by training and supporting generalist agencies to screen for alcohol misuse. Primary care, in particular, should be the main ‘capture point’ for alcohol misuse interventions.</td>
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<td><strong>2.7 To monitor the impact of screening and brief interventions in A&amp;E and consider expansion into other secondary care settings.</strong></td>
<td>There is evidence to support the effectiveness of brief interventions in A&amp;E departments.12</td>
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<td>It is important to evaluate our current service to determine effectiveness at a local level.</td>
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Goal three: To increase access to a range of timely, effective treatment and support

The objectives of this section are based on the key principles of Models of Care for Alcohol Misusers \(^\text{11}\) and take into account the needs of the Camden population with alcohol misuse disorders to access and benefit from a range of specialist treatment services.

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| 3.1 To carry out a health needs assessment of alcohol misuse in Camden to:  
  - Inform the development of integrated care pathways  
  - Inform the development and implementation of a standardised screening, triage and assessment and risk assessment framework  
  - To ensure the provision of follow on care/referral for specialist services is clear and consistent. | Commissioning and Health services should be based on an assessment of local needs.  
MoCAM \(^\text{11}\) promotes the use of the stepped care model, which is defined as ‘the least intrusive and expensive intervention that is likely to be effective as the first line of treatment’. With the expansion of screening for alcohol problems, it is important to ensure that clear routes into further care are developed. Clarity regarding the type and range of services available and the eligibility profile of clients will facilitate more appropriate client referrals. |
| 3.2 To provide a range of evidence based treatment interventions: with a particular focus on increasing then publicising the availability of detoxification and relapse prevention therapies  
  - Conducting a baseline survey of GPs to determine current practice in relation to alcohol related work  
  - Developing consistent protocols and treatment packages  
  - Reviewing the service model of specialist providers. | Camden has a 11,000 harmful and dependent drinkers, a proportion of whom need medical detoxification in conjunction with psychosocial support. This can be provided in home, in the community or in inpatient settings. |
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| 3.3 To increase access to alcohol treatment and ensure treatment is based on need by:  
  • Increasing the number of intervention “capture points”, including out of hours coverage  
  • Clarifying admissions criteria and referral mechanisms  
  • Ensuring appropriate support for carers  
  • Improving care planning and co-ordination. | To increase access to treatment for people who misuse alcohol and people who care for them across the borough of Camden and to ensure that clients have access to seamless packages of care from alcohol and other services as needed. |
| 3.4 To ensure treatment is evidence based. | Treatment interventions must be aligned with recommended practice outlined in guidance such as the Review of the Effectiveness of Treatment for Alcohol Problems to ensure the best client outcomes. |
| 3.5 To develop a common performance framework across all treatment services. | Currently there is a lack of robust service performance data. A common framework is needed to increase the quality and consistency of performance data covering domains such as demographic information, waiting times, referral rates and outcome measures. |
| 3.6 Provide consistent departure planning, aftercare and support (including reviewing eligibility criteria and access to Supporting People funded services). | Alcohol dependence is recognised as a commonly relapsing condition. It is important to rationalise and expand existing aftercare provision to prevent relapse and promote social re-integration. |
Goal four: To reduce underage drinking, heavy drinking and alcohol related harm among young people

On average, young Londoners aged 11-15 drink less often than young people in England, however local research has identified that drinking rates among Camden youth were higher than London averages. Camden is committed to ensuring that all children and young people achieve their ful potential and that children are skilled and equipped to make responsible choices about their own drinking behaviour and are protected from the impact of parental alcohol misuse, crime and antisocial behaviour.

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<tr>
<td><strong>4.1 To carry out a health needs assessment of alcohol misuse in children and young people in Camden to:</strong>&lt;br&gt;• Inform the development of integrated care pathways&lt;br&gt;• Inform the development and implementation of a standardised screening, triage and assessment and risk assessment framework&lt;br&gt;• To ensure the provision of follow on care/referral for specialist services is clear and consistent.</td>
<td>It is important to understand level of need for service and current service provision.&lt;br&gt;Clarity regarding the type and range of services available and the eligibility profile of clients will facilitate more appropriate referrals ensuring need is being met.</td>
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<td><strong>4.2 Increase and improve alcohol education and information available to children and young people in schools and non-school settings especially around binge drinking, and to measure effectiveness of such programmes.</strong></td>
<td>There is a lack of review level evidence for the effectiveness in reducing alcohol misuse in young people and research has shown there is widespread confusion amongst young people around the sensible drinking message.&lt;br&gt;The DFES (2004) recommends that the aim of alcohol education should be to reduce the risks associated with pupils’ own and others’ drinking by taking a harm reduction approach for education to minimise the adverse outcomes of excessive drinking. Recently, NICE has produced guidance on interventions in schools and other agencies working with children and young people to prevent and reduce alcohol use among children and young people.</td>
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<td><strong>4.3 Increase targeted prevention, screening and early intervention with socially excluded/vulnerable young people and their parents/carers.</strong></td>
<td>Socially excluded young people are likely to have higher levels of alcohol misuse. Better integration between young people’s substance misuse services and other generic young people’s services is needed to improve early identification of alcohol problems and timely action.</td>
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<td><strong>4.4 To offer effective care co-ordination with a smooth transition between young people service and adult services.</strong></td>
<td>Young people may have a range of problems, which require effective co-ordination. Seamless transitional arrangements are essential between young people and adult services as young people can fall through the net at this stage.</td>
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| **4.5 Ensure earlier identification and intervention for children affected by parental alcohol misuse:**  
• Development of clear protocols for adult treatment agencies in relation to children living with alcohol misusing parents.  
• Development of a specialist substance misuse health visiting post to ensure that the children of alcohol misusing parents are able to access relevant services. | Safeguarding children is an issue for all agencies, not just children’s services. 60% -70% of care proceedings initiated by social care are because of parental substance misuse. |
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| 4.6 Support for parents who misuse substances (including alcohol) via:  
  - Systematically incorporating parenting programmes into adult alcohol services  
  - Prioritising efforts to ensure alcohol-dependent parents receive the interventions they need  
  - Exploring the possibility of attaching social/family support workers to adult treatment services. | Parents have a critical role in positive child development.  
Poor parenting can have serious consequences on a child’s mental and physical well-being and increases the risks of involvement in anti-social behaviour and substance misuse.  
NICE recommendations indicate that long term family based structured interventions are effective in improving parenting skills and thus reducing the risk the child’s involvement in anti-social behaviour and substance misuse. |
| 4.7 Increase the knowledge and skills of front line workers who deal with children, young people and families in relation to the impact of parental alcohol misuse (including core social care training). | To broaden the base of alcohol misuse interventions to ensure that the problem is identified and tackled appropriately. |
| 4.8 To pilot and evaluate a Family Drug and Alcohol Court Programme which brings together care proceedings and services dealing with parents who have drink and drug problems. | This American intervention model has been effective in getting parents to engage with and remain in substance misuse services leading to more children being able to remain at or return home.  
It is hoped the scheme will:  
  - Help parents to engage with and stay in substance misuse services more readily so that more children can return home  
  - Enable parents who want to change to get help quickly  
  - Enable permanent alternative families to be found for children if parents don’t engage and their children are unable to return home  
  - Lead to fewer lengthy and expensive court proceedings. |
How the strategy will be delivered and monitored

Camden Drug and Alcohol Action team (DAAT) holds overall responsibility for the multi-agency strategy to address alcohol and drug related problems and oversees expenditure for drug and alcohol treatment services.

This strategy is based on the best available information and data at the time of publication, however, findings from the detailed health needs assessments will inform future recommendations and this strategy will be updated accordingly. This strategy will be delivered within existing budgets, with recommendations made for mainstream funding where appropriate. An Alcohol Strategy Development Officer (currently funded via Local Area Agreement funding) will have day-to-day responsibility to ensure the strategy is delivered.

Governance arrangements

The implementation of this strategy will be reported via the DAAT (the former Drug Action Team which has recently expanded to include alcohol within its remit). New sub groups will also be formed as below:

An Alcohol Strategy Partnership Group made up of a wide range of stakeholders including the police, fire, homeless hostels, primary & secondary care, treatment services and service users will meet quarterly to steer and review the implementation of the alcohol strategy through the development and roll out of the strategy action plan.

This group will have representation from 4 key sub-steering groups that have the remit to oversee the day to day delivery of the 4 key goals of the strategy:

• **Primary Care Group** which will develop and co-ordinate the work programme focussing on delivering screening and treatment in primary care

• **Alcohol Treatment Group** that has responsibility for the implementation of Models of Care (This group covering Camden and Islington is already in existence. It will be re-formed as a Camden only forum)

• **Alcohol and Young People Group** which will ensure the delivery of the those elements of the strategy relating to young people

• **Community Impact Group**, which will ensure the delivery of the strategy in relation to community safety, criminal behaviour and reducing the impact of alcohol misuse on the environment.

In addition to the routine meetings of the steering and working groups set out above, there will also be an annual meeting of the Camden Alcohol Network. This new network will not only bring together all the steering and working groups but also a wider group of stakeholders such as licensees and councillors. The annual event will provide an opportunity for all stakeholders to network and share learning with one another and also inform future plans. Camden’s Alcohol Harm Reduction Strategy will be launched at the first meeting of Camden Alcohol Network in Spring 2008.

*Figure 6* overleaf displays the governance structure for this strategy.
Figure 6 - Proposed Governance Structure

Drugs and Alcohol Action Team (DAAT)

Alcohol Strategy Partnership Group
(To be active for the first 12 months of implementing the strategy)

Effective Treatment (Alcohol Treatment Group)
Young People
Primary Care (Primary Care Alcohol Steering Group)
Community Impact (VCOG and CTOG)

VCOG = Violent Crime Operational Group
CTOG = Camden Town Operational Group
Appendices

Appendix 1 - Summary of National Alcohol Harm Reduction Policy and Guidance

Choosing Health, Making Healthy Choices Easier; 2004
Set out the need to support the public to make healthier and more informed health choices by promoting early identification of alcohol related issues (focussing on hospital accident and emergency departments), improvement of alcohol treatment services and partnership work with the alcohol industry.

Alcohol Needs Assessment Research Project; 2004
Found high levels of alcohol misuse and consequent alcohol harm. The report highlighted that only an estimated 5.6% of the people needing treatment actually receive it owing to under developed local treatment systems and lack of referral pathways. The report also recommended that General Practice should be the main ‘capture point’ for alcohol misuse.

Models of Care for Alcohol Misusers (MoCAM); 2006
Provides a national framework for the commissioning of adult treatment for alcohol misuse in England. It recommends that treatment interventions should be available for people with a range of drinking patterns (see diagram overleaf) and is based on a four tiered framework (see Appendix 4 on page 39) of provision ranging from screening, early identification and brief interventions (short evidence based advice and information sessions, see overleaf) through to structured care-planned treatment.

Review of the Effectiveness of Treatment for Alcohol Problems; 2006
Examined the evidence base for treatments available for people with alcohol problems, ranging from simple advice to intensive specialist treatment (see Figure 7 overleaf) and suggested that providing alcohol treatment to 10% of the dependent drinkers in the UK would reduce public sector costs by between £109 million and £156 million each year (or for every £1 spent on treatment, £5 is saved).

Next steps in the National Alcohol Strategy: Safe, Sensible, Social; 2007
Reviews progress since the publication of the Alcohol Harm Reduction Strategy for England and outlines further national and local action to achieve long term-reductions in alcohol related ill health and crime and a commitment to sharpen criminal justice interventions for drunken behaviour, reduce alcohol related harm among young people, and provide better information and communication. The document puts particular emphasis on young people who drink alcohol, 18 – 24 year old binge drinkers (who are responsible for the majority of alcohol related crime and disorder) and harmful drinkers (many of whom don’t realise that their drinking patterns are damaging their physical and mental health).
Figure 7: Effective interventions for alcohol misuse

Alcohol Problems

- Hazardous Drinking
- Harmful Drinking
- Moderately dependent drinking
- Severely dependent drinking

Interventions:
- More intensive specialist treatment
- Less-intensive treatment in generalist or specialist settings
- Extended brief intervention in generalist settings
- Simple brief interventions in generalist settings
- Public health programmes - primary prevention
Appendix 2 - Alcohol misuse and alcohol related harm

Epidemiology of alcohol misuse

Drinking patterns and health inequalities in the UK.

Over the last 50 years, alcohol consumption has been steadily rising in the UK, with around a quarter of people drinking above sensible limits. 23% are hazardous or harmful drinkers, and 4% are alcohol dependent. The level of excessive drinking in the UK is higher than most countries in the world. Binge drinking in Britain particularly prevalent compared to most of the rest of Europe.

Alcohol misuse and gender

Although men drink more heavily than women however both men and women’s drinking has been rising rapidly resulting in increases in alcohol related deaths. In 2005 the male death rate, at 17.9 deaths per 100,000 population, was more than twice the rate for females (8.3 deaths per 100,000) and males accounted for two thirds of the total number of deaths.

Alcohol misuse and age

The percentage drinking more than sensible limits is the highest in young adults (16-44 years) and tends to decline with age. Binge drinking is more common amongst young people under 25. The European Schools Project 2003 found that the proportion of UK teenagers drinking at this level is one of the highest in Europe, with girls now overtaking boys – 29% of girls and 26% of boys reported binge drinking in the previous 30 days.

Alcohol misuse and social class

A clear socioeconomic gradient for alcohol consumption is also evident in women, with women from managerial and professional households drinking more (on average 8.3 units per week in 2002) than women from a routine or manual household (who drank on average 6.5 units per week in 2002). However, this relationship is not evident in men.

Social class is a risk factor for alcohol related mortality although the relationship is more complex. Generally the problems of heavy drinking are experienced more severely by people from lower social classes. Men in manual occupations are more likely than men in non-manual occupations to die of alcohol related causes and this is most evident in 25 to 39 year olds. In younger women those in the manual classes are also most at risk from alcohol related deaths, however in older women, professionals have the highest risk of dying from alcohol related causes.

Alcohol misuse and marital status

Single men and women are more likely to drink above sensible limits than those who are married. The percentage of women reporting binge drinking is more than double the percentage of married women -19% compared with 8%.

Alcohol misuse and ethnicity

In 2004 the Health Survey for England showed that people from several black and minority ethnic groups in England (Indian, Pakistani, Bangladeshi, Black Caribbean and
Black African) were on average more likely to be non-drinkers, and less likely to drink above sensible levels or binge drink than the general population. The Irish community, however, are more likely to drink above sensible levels and to binge drink than the general population. The level of alcohol dependency is however similar between BME groups and the white population. 

Other groups of people vulnerable to the harms of alcohol include ex-prisoners, homeless people, those who suffered abuse as a child and those from a family where alcohol was misused.

**Alcohol misuse and children and young people**

On average, young people in London (aged 11-15) drink less often than young people in England. The 2000 survey of smoking, drinking and drug use amongst people in secondary schools found that 17% of boys and 14% of girls in London had drunk in the last week compared to 25% and 23% in England.

However, a local survey in Camden in 2004 of 1,491 Year 8 (12-13 year olds) and Year 10 (14-15 year olds) pupils reported that 19% had at least one alcoholic drink in the last week. More girls than boys in both age groups had consumed a drink in the last week. Older boys and girls are more likely to drink, and to drink more, than younger children. During the seven days before the survey, 1% of Year 8 boys and 4% of year 8 girls had bought alcohol from an off-licence; the figures for Year 10 are 5% for boys and 11% for girls.

**Health related harms of alcohol**

Alcohol accounts for almost 10% of the burden of disease in the UK, surpassed only by tobacco and high blood pressure. Alcohol is a major contributor to a range of health problems such as:

- Alcoholic liver disease
- Some cancers (mouth, gullet, liver, colon and breast)
- High blood pressure, coronary heart disease and stroke
- Mental health problems including depression, anxiety and suicide- up to 40% of men who try to kill themselves have an alcohol problem
- Accidents - drinking alcohol causes about 1 in 7 road deaths
- Sexual difficulties such as impotence
- Cardiomyopathy (heart muscle disease)
- Obesity (alcohol has many calories)
- Damage to an unborn baby in pregnant women
- Risky sexual behaviour, contributing to unwanted pregnancies and sexually transmitted disease (especially amongst young people)
- Death - alcohol is directly implicated in about 22,000 deaths per year in England, and rates are rising (see Figure 8 opposite).
Increase in disease burden has a direct impact on the NHS. Alcohol accounts for:

- 150,000 hospital episodes. Hospital admissions have significantly increased over the last decade.¹⁴
- Up to 70% of attendances at Accident and Emergency during peak times are related to alcohol.⁸
- A cost of 1.7 billion per annum to the health service.⁸

**Prevalence of alcohol related harm in Camden**

*Figure 9 (overleaf)*, created by North West Public Health Observatory¹ has used a statistical technique to enable a number of different indicators to be plotted on the same axis. A red circle signifies where we are significantly worse than England as a whole, a green circle where we are better. The middle line represents the England average and the cross represents the London average. *Figure 9 (overleaf)* shows that we are worse than England in a number of indicators including hospital admissions and violent crime.
Figure 9: Camden Alcohol Profile, 2007

Compared to England average:
- **Significantly better**
- **Significantly worse**
- **Not significant**
- **Not calculated**

Premature mortality due to alcohol

*Figure 10* opposite compares premature mortality (before age 75) from alcohol related conditions by calculating the months of life lost due to alcohol 2003-5. Within London, Camden males rank 7th the worst in London for months of life lost and Camden females rank 14th worst.¹
Figure 10: Months of life lost for male 2003-05

| Measure | Camden | Hammersmith and Fulham | Hackney | Hounslow | Islington | Lambeth | Lewisham | Southwark | Newham |
|---------|--------|------------------------|---------|----------|-----------|---------|----------|-----------|--------|--------|
| 0       |        |                        |         |          |           |         |          |           |        |        |
| 2       |        |                        |         |          |           |         |          |           |        |        |
| 4       |        |                        |         |          |           |         |          |           |        |        |
| 6       |        |                        |         |          |           |         |          |           |        |        |
| 8       |        |                        |         |          |           |         |          |           |        |        |
| 10      |        |                        |         |          |           |         |          |           |        |        |
| 12      |        |                        |         |          |           |         |          |           |        |        |

Figure 11: Months of life lost, 2003-05

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<th>Camden</th>
<th>Hammersmith and Fulham</th>
<th>Hackney</th>
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<th>Lambeth</th>
<th>Lewisham</th>
<th>Southwark</th>
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Source: NWPHO Local Alcohol Profiles

Mental health and suicide

Psychiatric co-morbidity is common among problem drinkers. The Mental Health Needs Index indicates that Camden has one of the highest needs for mental health services in London.

Alcohol is a key risk factor for suicide. About 30 people per year commit suicide in Camden, and the borough has the second highest suicide rate in London. For the period 2003-05 the suicide rate for Camden was 14.4 per 100,000 of the population, compared to a rate of 5.8 for England and Wales and 5.5 for London.
Hospital admissions for alcohol

Camden appears to have a much higher rate of admissions attributable to alcohol and for alcohol specific conditions than London or England for both men and women, with alcohol specific admissions for males being the highest in London and the 6th highest in the country.¹

Alcohol specific hospital admissions in London for males, 2005/06¹

Admissions related to alcohol have also been steadily and significantly increasing over the last few years in Camden. The table below shows the number of admissions where alcohol was the main cause for admission. This excludes admissions where alcohol may be a contributing factor such as a fractured pelvis following an accident as a result of intoxication with alcohol. There has been a large increase in alcohol related admissions (elective, emergency and patient transfers) between 2002/03 and 2006/07, an increase of over 50%.

Number of admission in Camden registered patients where the primary cause of admission is due to an alcohol specific cause.

<table>
<thead>
<tr>
<th>Measure</th>
<th>2002/03</th>
<th>2003/04</th>
<th>2004/05</th>
<th>2005/06</th>
<th>2006/07</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons</td>
<td>260</td>
<td>296</td>
<td>340</td>
<td>447</td>
<td>400</td>
</tr>
</tbody>
</table>
**Ambulance Call Outs for Alcohol**

London saw a fourfold increase in ambulance call outs to recorded alcohol related accidents and injuries, from 2003 compared to 2000.

Camden has a much higher rate of ambulance call outs for alcohol than London as a whole.\(^3\)

<table>
<thead>
<tr>
<th>Rate of ambulance call outs for alcohol per 100,000 2001-3</th>
<th>Camden</th>
<th>Inner London</th>
<th>London</th>
</tr>
</thead>
<tbody>
<tr>
<td>380</td>
<td>284</td>
<td>179</td>
<td></td>
</tr>
</tbody>
</table>

**Impact on crime and anti social behaviour**

Year on year alcohol related violence and crime in Camden has risen significantly. Crime increased dramatically by 48.7\% between 2003/04 and 2004/05. After a drop in alcohol related crimes in 2004/05, numbers have continued to rise in 2005/06 with 1844 crimes related to alcohol.\(^2\)

In 2005/06 the primary problematic locations for alcohol related crime were Camden Town, Ferdinand Street, Kings Cross, Tottenham Court Road and New Oxford Street. Secondary and tertiary problem areas included Kilburn, Kentish Town Road, Warren Street, Holborn and Gray’s Inn Road.\(^2\)

Alcohol related violence data identified that 10\% of all violent crimes were flagged as domestic incidents. Over one third of these have been proxy linked to alcohol. Research by Camden Safety Net (which supports women affected by domestic violence) established that 47\% of respondents reported their partner’s misused alcohol.\(^3\)

(NB. Whilst it is possible to estimate alcohol related crimes, these estimations must be used with care).

**Impact on social factors**

The interplay of alcohol and a range of social problems also serves to illustrate the extent of the problem in Camden.

There are strong links between alcohol misuse and housing problems. The borough has in the region of 6800 single homeless individuals of whom an estimated 75\% have substance misuse problems.

Substance misuse (including alcohol) is the single biggest issue dealt with by children and families social services departments in inner city areas. An estimated 3,286 Camden children are affected by parental alcohol misuse and 40 per cent of Camden’s current Looked After Children have been affected by parental substance misuse.
Appendix 3 - Specialist Alcohol Services in Camden

• **Specialised Day Service at the Spectrum Centre** offers a comprehensive group work programme as well as sessions run by external agencies on issues such as harm reduction, relapse prevention, housing benefit and health issues. The service also provides sessions where people can drink alcohol in a controlled and safe environment.

• **St Mungos – 9 St Pancras Way funded by the Home Office** (and not Camden Commissioners) this service provides alcohol detoxification for people identified through the criminal justice system.

• **Rugby House Long Yard** provides a full crisis intervention service for those who misuse alcohol. A registered Care Home, it provides a place of safety for stabilisation, a full assessment and withdrawal from alcohol as part of an overall care package. Rugby House provides “non-medicalised” care (there is no 24 medical cover) and aims to supports individual medical needs without treating each client as a patient.

• **CASA** provide a range of alcohol misuse advice, support, intervention and treatment services. The structured day programme provides intervention and treatment through therapeutic groups, one-to-one counselling, complementary therapies, and an aftercare project for individuals with an alcohol misuse problem. CASA also provide specialist services for older people in a harm reduction model to control alcohol use, a multiple needs service for individuals with drug/alcohol and mental health needs, and a carers service which supports people affected by someone else’s use of alcohol or drugs.

• **Alcohol Recovery Programme (ARP)** provide a Direct Access Service and a Women’s Access Service to alcohol misusers. The Direct Access Service includes a drop-in service, informal one-to-one support, alcohol assessments, 12 week group programmes and complementary therapies. The Women’s Access Service offers specialist advice, information and support to women who want to control or stop drinking, including domestic violence advocacy sessions, one-to-one sessions and group work.

• **Camden & Islington Alcohol Advisory Service (AASCI)** is a statutory sector multi-disciplinary team who offer assessments and care-planned treatment to alcohol misusers in Camden, including specialist care for individuals with mental health problems. The service is currently being re-modelled to operate a streamlined, referral only service offering specialised services (psychiatry, psychology, community detoxification and specialised advice). There is high demand for this service and waiting lists have operated.

• **Residential treatment** includes detoxification followed by a residential programmes (which focuses on promoting the immediate psychological adjustments necessary to live drug free) Access to residential services is managed through social care team within the Camden and Islington Mental Health and Social Camden and Islington Mental Health and Social Care. This team purchases services from around 8 residential centres all of which are based out of London.
## Appendix 4: Recommended tiers of treatment based on Models of Care for Alcohol Misuse

### Tier 1 Provision
Can be delivered by a wide range of agencies whose main focus is not alcohol treatment, such as:

- Primary healthcare services;
- Specialist psychiatric services;
- Social service departments;
- Antenatal clinics;
- Police, custody cells;
- Prison service;
- Occupational health services.

- Acute hospitals, e.g. A&E departments;
- Liver disease units,
- Homelessness services;
- General hospital wards;
- Probation services;
- Education and vocational services;

### Tier 2 Services
(open access, non care planned, alcohol specific interventions)

- Alcohol-specific information, advice & support
- Extended brief interventions & brief treatment to reduce alcohol-related harm
- Alcohol-specific assessment & referral to structured alcohol treatment
- Partnership or ‘shared care’ with staff from Tier 3 & Tier 4 or joint care with Tier 1
- Mutual aid groups
- Triage assessment, as part of local arrangements
- Provision of information, advice and training and ‘shared care’ to others.
- Triage/more in depth assessment.

### Tier 3 Services
(alcohol specialist-led services for the provision of care for severe or complex needs and to support primary care)

- Comprehensive substance misuse assessment
- Care planning and review
- Community care assessment and case management
- Evidence based prescribing interventions
- Structured day and care planned day programmes
- Liaison services (acute medical and psychiatric health services)
- Provision of information, advice and training and ‘shared care’ to others

### Tier 4 Services
(alcohol specialist inpatient treatment and residential rehabilitation)

- Comprehensive substance misuse assessment
- Care planning and review for all inpatient and residential structured treatment
- Evidence based prescribing interventions (including medically assisted alcohol withdrawal (detoxification) inpatient or residential care and prescribing interventions to reduce risk of relapse.
- Structured evidence-based psychological therapies and support to address alcohol misuse
- Provision of information, advice and training and ‘shared care’ to others.
<table>
<thead>
<tr>
<th>Reference</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Camden PCT. Collective Action; Camden’s Annual Public Health Report, 2005/06.</td>
</tr>
<tr>
<td>7</td>
<td>Camden PCT. Ashes to Ashes; Camden’s Annual Public Health Report, 2006/07.</td>
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<td>19</td>
<td>National Social Marketing Centre. It’s our health! Realising the potential of effective social marketing, 2006</td>
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<td>National Institute for Clinical Excellence (NICE). Interventions in schools to prevent</td>
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</tbody>
</table>


27 The European Schools Survey Project on Alcohol and other Drugs (ESPAD) [homepage on the internet cited 2007 Jan 21]; Available from: http://www.espad.org/


31 Office for National Statistics [homepage on the internet]. Alcohol deaths: rates in the UK continue to rise [cited 2007 Jan 21];


33 The Institute for Alcohol Studies [homepage on the internet]. UK Alcohol Reports. [Cited 2007 Jan 21]; Available from: http://www.ias.org.uk