

## **PREFACE**

### **Thomas Nashe's Menagerie**

The first is Ape drunke, and leapes and sings and hollowes, and daunceth for the heavens; the second is Lion drunke, and he flings the pots about the house, calls his Hostesse W---, breaks the glass windowes with his dagger, and is apt to quarrell with any man that speaks to him; the third is Swine drunke, heavy, lumpish and sleepe, and cries for a little more drinke, and a few more cloathes; the fourth is Sheepe drunke, wise in his own conceit, when he cannot bring forth a right word; the fifth is Mawdlen drunke, when a fellow will weepe for kindness in the middle of his Ale, and kisse you saying 'By God, Captaine, I love thee, goe thy waies, thou dost not think so often of me as I do of thee. I would (if it pleased God) could I not love thee so well as I do', and then he puts his finger in his ere, and cries; the sixth is Martin drunke, when a man is drunke and drinks himself sober ere he stirre; the Seventh is Goate drunke, when in his drunkenness he hath no mind but on lechery; the eighth is Foxe drunke, when he is craftie drunke, as many of the Dutch men bee who will never bargaine but when they are drunke.

Thomas Nashe (1567 - 1601)

From *Pierce Penilesse* published in London while Nashe was at the Croydon home of Archbishop Whitgift.

There has been much recent local media attention given to alcohol use in the Croydon which paints a picture of drunken revelry in the town centre little different to the 16<sup>th</sup> century observations of Thomas Nashe. However, this only draws attention to the more obvious results of the use of alcohol. The following report shows how alcohol can have implications for all aspects of life and work across Croydon and many of the problems associated with alcohol use are caused by the non-dependent drinker rather than those who are dependent drinkers. If the problems caused by alcohol use are to be tackled, then joint commissioning, joint purchasing and shared work between specialist and generic workers in Croydon is imperative.

## **EXECUTIVE SUMMARY**

### **OBJECTIVES OF THE STUDY**

The aim of this research was to explore the impact of alcohol misuse in Croydon. The specific objectives were:

- a) to obtain baseline data on the scale and nature of alcohol misuse in Croydon
- b) detail alcohol-related service provision in Croydon
- c) to survey the extent and nature of alcohol-related use of Accident and Emergency services.
- d) to survey the extent and nature of alcohol-related acute admissions to Mayday Hospital
- e) the extent and nature of alcohol-related offending in Croydon
- f) explore the frequency and role of alcohol misuse locally in relation to:
  - Housing issues
  - Domestic violence issues
  - Racist Behaviour
  - Sexual health and unplanned pregnancies
  - Drink driving
  - Antisocial behaviour
- g) provide recommendations for future approaches, interventions and research.

### **MAIN FINDINGS**

#### **The alcohol drinking environment in Croydon**

The number of licenses issued in Croydon have doubled in the last five years with the capacity for drinkers in central Croydon on a typical weekend increasing from 8,000 to 18,000 over the same period.

#### **The at risk population in Croydon**

Estimates suggest that between 56,000 and 63,000 people are drinking above recommended safe drinking levels in Croydon.

25% of 14 year olds and nearly 80% of 17-18 year olds report being drunk in the previous week.

#### **Dependent drinkers**

Estimates of the number of dependent drinkers between the ages of 16-64 in Croydon range from 9,800 to 11,700 people.

#### **Treatment use**

Figures collected from helping agencies in Croydon suggest that whilst most treatment users are in the 30-50 year old age range, younger problem drinkers are being seen at the agencies. Around 10% of those approaching Croydon Alcohol Counselling Services and Oaks Resource Centre were from ethnic minority groups.

## **Mayday Hospital**

Questionnaire surveys carried out at Mayday Hospital for this study suggested that 29% of those attending Accident and Emergency and 14% of acute admissions were drinking at harmful or hazardous levels.

## **Alcohol-related offences**

Up to 20% of arrests during the study period were alcohol-related. Alcohol and cannabis were the main drugs used by those approaching the local arrest referral scheme. Alcohol was recorded as the leading factor in 29% of the Probation service caseload, ahead of illegal drug use and family relationship as factors.

## **Other alcohol-related issues**

In the absence of local statistics, key informant interviews suggested that alcohol plays an important role in the incidence of domestic violence and unplanned pregnancies. Interviews indicated that there were gaps in housing provision for those with alcohol-related problems.

## **RECOMMENDATIONS**

### **Co-ordination and communication.**

The lack of communication between alcohol services was notable in Croydon. It is essential that the alcohol helping agencies explore communication mechanisms with a view to establishing responsive alerting systems and improved co-ordination in the collection, assimilation and dissemination of information. It is recommended that a co-ordinator be appointed to facilitate this process and to plan future service development.

### **Information**

Information describing sources of help for alcohol problems in Croydon should be readily available and widely disseminated with clearly identified modes of communication and referral. These should be made available in several forms and languages. To this end a booklet should be commissioned and the information should also be published on the Internet. Feedback on the services provided should be sought and encouraged.

### **Existing resources and future developments**

Currently there is limited data collection and audit. Both are essential if the effectiveness of services is to be improved and developed. Resources to achieve this should be made available including personnel, training, IT support, hardware and software. The reduction in existing services has been compounded by the lack of a government alcohol strategy. New service developments should be considered including a drop-in centre, easier access to existing services, support for those pursuing abstinence, services for women and children, provision for those continuing to drink and detoxification services which are not hospital-based. A co-ordinated Croydon-wide alcohol strategy should be developed and funded, anticipating the much-delayed Government strategy.

## **The NHS**

### **Primary Health**

Primary health care personnel are in a unique position to identify and manage individuals with alcohol related problems. Training and support should be provided to enable them to fully exploit this opportunity and mechanisms established for closer working with specialist services.

### **Mayday Hospital**

A substantial number of people attending Mayday are drinking alcohol at hazardous levels. A hospital-wide strategy for detecting and responding to alcohol problems should be pursued and an alcohol liaison worker employed to work between the hospital, psychiatric liaison and specialist alcohol services.

### **Adult mental health**

Closer working between general adult psychiatry and specialist alcohol services is essential to improve the treatment of dual diagnosis clients. Specialist training in alcohol problems should be provided for community psychiatric teams. Mutual support and communication should be established and protocols for joint working developed.

### **Crime**

Co-ordination between the arrest referral scheme and alcohol services should be improved. The Home Office has recently published an action plan to deal with alcohol-related crime and has a number of recommendations that should be explored in Croydon.

### **Ethnic communities**

The uptake of alcohol services by ethnic communities is less than would be expected from the sizes of the populations concerned. Research should be commissioned to explore the reasons and to identify approaches to improve access.

### **Research**

A number of areas that warrant further investigation have been identified in Croydon. These include the impact of waiting lists on treatment outcomes, the role of substance misuse in domestic violence, the role of GPs in dealing with substance misuse and brief interventions in a hospital setting. Research funding should be identified to support further projects.

<b>Introduction</b>	<b>7</b>
<b>Why we should be concerned about alcohol</b>	<b>10</b>
<b>Government Policy and alcohol</b>	<b>12</b>
<b>Description of the local population</b>	<b>16</b>
<b>Safe levels of drinking</b>	<b>14</b>
<b>Definition of terms</b>	<b>17</b>
<b>The alcohol drinking environment in Croydon</b>	<b>20</b>
<b>What works</b>	<b>21</b>
<b>Croydon in context: national statistics on alcohol</b>	<b>24</b>
<b>Helping agencies available to Croydon</b>	<b>35</b>
<b>Use of Croydon’s helping services</b>	<b>38</b>
<b>Alcohol Education in Croydon</b>	<b>42</b>
<b>Alcohol-related problems at Mayday AandE</b>	<b>44</b>
<b>Alcohol-related acute admissions at Mayday</b>	<b>47</b>
<b>Alcohol-related offences in Croydon</b>	<b>48</b>
<b>The frequency and role of alcohol in relation to local issues</b>	<b>51</b>
<b>Recent developments in Croydon</b>	<b>55</b>
<b>The Way forward</b>	<b>56</b>
<b>References</b>	<b>62</b>
<b>Key informants for the project</b>	<b>65</b>

## **INTRODUCTION**

### **Background to the research**

This research was commissioned by the Croydon Drug Action Team to help inform the future planning and purchase of drug and alcohol services in the borough. The research is also intended to provide directions for future research and explore the opportunities for further co-ordination and effective interventions.

## **METHODOLOGY**

The aim of this research was to explore the impact of alcohol misuse in Croydon. The specific objectives were

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  - Antisocial behaviour
- g) provide recommendations for future approaches, interventions and research.

### **Research strategy**

An epidemiologically-based research strategy was used in this study taking both quantitative and qualitative approaches with reviews of secondary data sets where available. The extent and nature of alcohol-related problems presenting to Mayday Accident and Emergency and acute admissions were surveyed by questionnaires based on the widely used and validated Alcohol Use Disorders Identification Test (AUDIT). Statistics on local alcohol-related offending were collated from data supplied by Croydon Police. National statistics on alcohol were obtained from Alcohol Concern and the Hospital Episodes Unit and web-site of the Department of Health.

Key informants in Croydon were interviewed for approximately one hour using a semi-structured questionnaire. The questionnaire had the following questions:

- What is the aim of your organisation?
- What is your responsibility within the organisation?
- How does alcohol and/or drug use impact on your work?
- Do you have a specific user group?
- How does your user group access your service?
- Are there any difficulties for people accessing your service?
- Do you provide a service for your users where alcohol or drug use is an issue?
- Have you or your colleagues been specifically trained to work with alcohol and/or drug users?
- Are there any guidelines for working with alcohol and/or drug users?
- Are there any restrictions in the service you provide to this group?
- Are your activities co-ordinated with alcohol and drug-related agencies in Croydon?
- How effective do you think this co-ordination is?
- Do you record any of those using your service with drug and alcohol-related problems in your notes?
- Do you have any methods of evaluating the effectiveness of the services you provide?
- In your experience is alcohol and drug use a large problem in Croydon?
- What difficulties do you recognise for providing for the needs of alcohol and drug users in Croydon?

### **The Alcohol Focus Group**

Guidance and support concerning the conduct of the research was provided by the Alcohol Focus Group. The main aim of the Group is to promote responsible and sensible drinking in the borough of Croydon. Specifically its remit is to:

identify priorities

evaluate gaps or overlaps or duplication in service

share and promote modes of good practice

disseminate ideas on research and initiatives in the alcohol field

prompt the dialogue on Croydon's strategic direction with the DAT.

The Chairperson of the Alcohol Focus Group, the late Dr Clifford Floyd, was the prime mover behind this report. This research project is the result of his vision, enthusiasm and compassion for those experiencing problems with their alcohol use. The project would have been far harder to carry out without his guidance, wisdom and deep knowledge of Croydon.

### **Structure of the report**

The first part of the report seeks to put the alcohol situation in Croydon into a national context and provides a summary of the effects of alcohol, displays important national statistical information about alcohol, outlines Government plans and shows that many Drug Action Teams across London are already incorporating alcohol into their work. The second part is the core of the report and brings together quantitative and qualitative information about alcohol use and problems in Croydon. The final section suggests some ways forward, building on the good work around alcohol currently carried out in the borough.

## **WHY WE SHOULD BE CONCERNED ABOUT ALCOHOL**

Alcohol has been called our "favourite drug" (Royal College of Psychiatrists 1986) and many people who drink alcohol enjoy it and cause no harm to themselves or others. However, whether people drink sensibly or not can have a profound effect on their physical and mental health and

that of others (UK Department of Health 1998). Alcohol impairs judgement, reduces inhibitions and slows reflexes in proportion to blood alcohol levels. Large doses may reduce inhibitions to the extent that people can become aggressive, argumentative and violent which are typical signs of drunkenness.

### **Accidents**

The major risk of alcohol intoxication is that it can produce cognitive and psychomotor impairment, particularly on memory and planning. This impairment can increase the risks of various kinds of accident in leisure activities, driving and other forms of transportation and activities in the workplace and the home. Alcohol has been estimated to be a factor in 20-30% of all accidents and Department of Transport figures have shown that 30% of pedestrian accidents are associated with alcohol consumption (UK Department of Transport 1993). A Scottish study found that young men aged 20-29 were the highest risk group of intoxicated pedestrians sustaining traffic injuries as a result of impairment of judgement (Bradbury 1991).

### **Risk Behaviour**

Alcohol also increases the likelihood of engaging in risky behaviour such as dangerous driving and unsafe sex practices. There is evidence that alcohol use is related to high risk sexual behaviour amongst homosexual males, that heavy drinking adolescent teenagers are nearly three times less likely to use condoms than non-drinkers, and that heavy drinking is related to the number of sexual partners. In addition alcohol intoxication is implicated in suicide and self-harm (Raistrick et al 1999).

### **Heavy Chronic Use**

Heavy chronic use of alcohol can produce a dependence syndrome in which drinkers have difficulties in stopping or controlling their use. The abrupt cessation of alcohol use amongst severely dependent drinkers produces a well-defined withdrawal syndrome which can prove fatal in a small number of cases. Such abrupt withdrawal can lead to anxiety and tremors and more rarely paranoid feelings, hallucinations and fits.

Heavy alcohol use can produce psychotic symptoms in some individuals, either during acute intoxication or during withdrawal. Chronic heavy use may also indirectly cause brain injury, the Wernicke-Korsakoff syndrome, marked by symptoms of severe memory defect and an impaired ability to plan and organise. Continued heavy drinking in the absence of vitamin supplementation may lead to severe irreversible cognitive impairments.

Alcohol use is now seen as a contributory cause of cancer in various tissues and organs of the digestive system and of female breast cancer. Alcohol use is a major cause of liver cirrhosis and other liver diseases such as hepatitis and heavy drinking is also implicated in gastritis, high blood pressure, stroke, cardiac arrhythmias, cardiomyopathy, pancreatitis and polyneuropathy. There is also evidence that substantial doses of alcohol taken during pregnancy can produce a fetal alcohol syndrome (Hall et al 1998). Continual drinking above 30 units per week may cause serious immune deficiency leading to increased susceptibility to infections. American research has found that the prevalence of hepatitis C in people who misuse alcohol is 20-25% compared to 10% in normal drinkers (Paton 2000).

### **The Protective Effect of Alcohol**

Studies have shown non-drinkers have higher rates of morbidity and mortality than light-to-moderate drinkers and that heavy drinkers have an increased risk. This protective effect of moderate drinking is evident in men and women but is stronger in men over 40 years of age and post-menopausal women (Raistrick et al 1999).

## **GOVERNMENT POLICY AND ALCOHOL**

Targets for reducing the levels of drinking in the UK were set out in the White Paper *Health of the Nation*. This White Paper was a statement of the government's strategy for health in England and selected 5 'key areas' for action and also set national targets for improvement in health within these areas. The first key area, coronary heart disease and stroke had the following target

in relation to alcohol

*To reduce the proportion of men drinking more than 21 units of alcohol per week from 28% in 1990 to 18% by 2005 and the proportion of women drinking more than 14 units of alcohol per week from 11% in 1990 to 7% by 2005. (UK. Department of Health 1992)*

It became clear that this target was not being reached and the UK government declared its intention to introduce a national strategic approach to alcohol in 1998:

*The government is preparing a new strategy on alcohol to set out a practical framework for a responsible approach (UK. Department of Health 1998).*

In the 1999 White Paper *Saving Lives: Our Healthier Nation* the Government outlined the broad aims of the proposed strategy:

- *To encourage people who drink to do so sensibly in line with our guidance, so as to avoid alcohol-related problems*
- *To protect individuals and communities from anti-social and criminal behaviour related to alcohol misuse*
- *To provide services of proven effectiveness that enable people to overcome their alcohol misuse problems*

*An effective strategy to tackle alcohol misuse needs the co-operation of all those concerned with alcohol: health and social services, schools, the alcohol industry, law enforcement agencies, Government and the general public (UK. Department of Health 1999).*

Yvette Cooper, the Minister for Public Health gave further information on the proposed National Strategy when addressing a meeting of the All Party Parliamentary Group on Alcohol in July of this year. A draft copy of the strategy was expected in the Autumn and the minister noted that there was a need for a national strategy as the extent of drinking and changing patterns of drinking, in particular women's drinking, was having a significant impact on health and crime. The minister said that the National Strategy will focus on the role of alcohol misuse in the following areas:

- Binge drinking
- Young people
- Extreme dependence

The response to alcohol problems would be in the context of existing Department of Health priorities, cancer, heart disease, mental health, teenage pregnancy and health inequalities and alcohol was recognised as a risk factor in each of these areas.

The Government's commitment to an alcohol strategy is reflected in the NHS National Plan published in July 2000.

Although the National Alcohol Strategy has yet to be published, there is a proposal that the planned National Treatment Agency should include alcohol as well as other drugs in its remit. Already over half of the DATs in England and Wales have addressed alcohol and other DATs across London have taken the initiative in incorporating alcohol into their work. The following table shows the place of alcohol in the DAT templates (the formal reporting mechanism of the DATs' plans and activities) and day-to-day work.

### What's happening with alcohol at London Drug Action Teams

Drug Action Team	Alcohol in template	Alcohol covered	Notes
Barking and Havering	Yes	Yes	Works with alcohol services and alcohol reps sit on DRG
Barnet	Yes	Yes	-
Bexley	Yes	Yes	-
Brent	Yes	No	-
Bromley	No	No	-
Camden and Islington	No	No	-
City	No	No	Alcohol services attend the DTG
Ealing	Yes	No	-
Enfield	Yes	Yes	Implementing a substance misuse (rather than drugs misuse) strategy
Greenwich	No	No	-
Hackney	Yes	Yes	Implementing a substance misuse (rather than drugs misuse) strategy
Hammersmith and Fulham	Yes	Yes	Developing an alcohol strategy
Haringey	Yes	Yes	Implementing a substance misuse

			(rather than a drugs strategy). Now termed a DAAT
Harrow	No	No	-
Hillingdon	Yes	Yes	Developing an alcohol strategy
Hounslow	Yes	-	-
Kensington and Chelsea	Yes	Yes	-
Kingston	Yes	-	-
Lambeth Southwark and Lewisham		No	Are considering incorporating alcohol
Merton	-	-	-
Newham	Yes	Yes	Have someone from the alcohol services on the DAT board
Redbridge and Waltham Forest	Yes	Yes	Intends to include alcohol formally within its infrastructure
Richmond	Yes	Yes	-
Sutton	-	-	-
Tower Hamlets	Yes	Yes	Developing an alcohol strategy and has someone from the alcohol services on the DAT board
Wandsworth	-	-	-
Westminster	No	No	-

### **Preparing locally for the National Strategy**

Alcohol Concern recommends that alcohol needs be seen as a “must do” in relation to national and local priority areas and advises that those involved in local alcohol policy should ensure that the local Health Improvement Plans (HimPs) for the next year identify the role of alcohol misuse in existing priority areas. Taking action at this stage will help the Health Authorities to meet the challenge of the National Alcohol Strategy when it emerges.

## **DESCRIPTION OF THE LOCAL POPULATION**

The level of services required with Croydon is related to the size of its population and the health and social factors within its population.

### **Demography**

Croydon has the largest population of the 32 London boroughs. The total population in 2000 is estimated to be 338,000 and is expected to increase to 344,000 by 2006. The main changes are expected to be a fall in the people aged 30-44 and increases in the 45-64 year-olds and the numbers of older people.

Croydon has a large and growing minority ethnic community and a significant number of refugees and asylum seekers, with the overall ethnic minority population currently forming 23% of borough total. The most recent London Research Centre population projections suggest a 13% rise in the number of people from minority ethnic communities between 2000 and 2006, with the fastest growing groups expected to include the Bangladeshi community (expected to increase by 26%), black “others” (21%) and Black African and Pakistani communities (18% each).

### **Deprivation**

Croydon is placed 88th out of a total of 360 local authorities in the latest 1998 Government Index of Local Deprivation. Croydon has higher levels of deprivation than many of its immediate neighbours and other outer London boroughs. The Jarman Underprivileged Area Score is related to socio-economic deprivation, with a higher score predicting more severe deprivation. Croydon has a score 10 points above the national average of zero. A number of wards in Croydon score over 25 and the Fieldway ward scores nearly 32 points. A number of wards also score higher than the national average for risk factors of mental illness on the Mental Illness Needs Index. Deprivation is concentrated in several wards across the borough, particularly in the North and the large council estates of the South East of the borough.

### **Homelessness**

The main indicators of homelessness in Croydon have shown a steep upward trend in 1999/2000. The number of homeless households approaching the Council rose by nearly 20% to 5,900. 1,219 households were accepted as priority homeless during the year, a 40% increase on the previous year. The number of single homeless has also increased with 1,820 approaches to the Council in 1999/2000. 20% of these advice seekers have no fixed abode.

## **SAFE LEVELS OF DRINKING**

Most people drink alcohol without problems. It is difficult to define safe levels of drinking for a number of reasons. The effects of alcohol on an individual can vary according to gender, metabolism, physique and level of tolerance. In addition the attempt to define safe levels of drinking may omit or neglect occasions or patterns of drinking which may be harmful such as drink-driving and 'binge' drinking. Despite these problems the following classification of levels of drinking were arrived at by the Royal Colleges of Psychiatrists, Physicians and General Practitioners in 1986/7 and used to define sensible drinking limits in the Government's 1992 White Paper, the *Health of the nation*.

### **Classification of levels of drinking (in units per week)**

Unit=1/2 pint of ordinary beer or lager, 1 single measure of spirits, 1 glass of wine

	Sensible	Excessive	Heavy
Men	0-21	22+	51+
Women	0-14	15+	36+

Regular consumption of alcohol above recommended "sensible" levels is thought to increase levels of harm to the individual in terms of health, such as the occurrence of liver cirrhosis and alcohol-related social problems. Regular "heavy" consumption is associated with an increased risk of psychological and physical dependence on alcohol and alcohol-related disease.

However, it is important to note that alcohol-related problems are not confined to those who drink excessively or those with alcohol dependence and indeed, although heavy drinkers experience high rates of alcohol-related problems, they only make a small contribution to the overall level of such problems. Most alcohol-related problems occur in light to moderate drinking category, although such drinkers themselves have low rates of problems.

The 1995 Government report *Sensible drinking report* used daily rather than weekly sensible drinking benchmarks of 3-4 units for men and 2-3 units for women. Government advice was that men who drank more than 4 or more units a day and women who drank more than 2-3 units a day were running progressive health risks. However, most survey data on alcohol use in the UK is based on the weekly rather than the daily benchmarks.

## DEFINITION OF TERMS USED IN THIS REPORT

### Alcohol misuse

Alcohol misuse can be defined as a level or pattern of drinking which is likely to damage the physical and psychological health or social adjustment of the individual drinker, or others directly affected by his or her drinking. (Edwards and Unnithan 1994). This can include:

- drinking consistently in excess of the Department of Health's sensible drinking benchmarks
- circumstances where drinking may aggravate an existing condition or situation or is potentially dangerous
- driving when above the legal blood alcohol limit
- drinking in such a way as to endanger the drinker or other people, or to cause nuisance to others

## **Alcohol Dependence**

The International Classification of Diseases, 10th edition provides a checklist of six symptoms under the syndrome of alcohol dependence and three or more of these symptoms should have occurred in the past year for a diagnosis of dependence

- a strong desire or sense of compulsion to take the substance
- difficulties controlling substance-taking behaviour in terms of its onset, termination or levels of use
- a physiological withdrawal state; substance abuse to relieve or avoid withdrawal symptoms
- evidence of tolerance such that increased doses are required in order to achieve effects originally produced by lower doses
- progressive neglect of alternative pleasures or interests because of substance use, increased amount of time necessary to obtain or take the substance or to recover from its effects
- persisting with substance use despite clear evidence of overtly harmful consequences.

## **CLASSIFICATION OF ALCOHOL DRINKERS**

Drinkers of alcohol have been classified in three categories

### **Category 1: the ‘at Risk’ drinker**

This category includes anyone drinking over sensible limits who has not developed any alcohol-related problems or dependence. These drinkers may experience alcohol-related harm as a result of their pattern of drinking such as binge drinking or drinking combined with driving.

### **Category 2: the problem drinker: excessive drinking associated with alcohol-related problems but without established dependence.**

This category of drinker includes those with both acute problems such as pancreatitis or an alcohol-related traffic accident or chronic problems such as cirrhosis, hypertension, alcohol-related brain impairment.

### **Category 3: the dependent drinker: excessive drinking with problems and dependence**

Dependent individuals all of whom have alcohol-related problems as well.

### **THE ALCOHOL DRINKING ENVIRONMENT IN CROYDON.**

The variety of places at which people can drink alcohol in Croydon ranges from homes to socially designated and public areas. There has been a notable increase in the number of alcohol licenses granted in the borough in recent years with the number of licenses having doubled in the last five years.

Capacity figures for licensed premises in Croydon on a typical weekend are:

Public houses/clubs with 11 o'clock licenses	3,200 people
Public houses/clubs with 12 o'clock licenses	600 people
Public houses /clubs with 1 o'clock licenses	3,600 people
Public houses/clubs with 2 o'clock licenses	9,350 people

Restaurants with 11 o'clock licenses	1,350
Restaurants with 12 o'clock licenses	1,200

Most of these premises are in or near the town centre and those premises with 1 o'clock and 2 o'clock licenses are in the town centre. The total capacity is around 18,000, which compares to a figure of 8,000 five years ago.

Information from the police suggests that at the moment any public order problems related to alcohol use in the town centre are presently under control. Currently 27 police officers are on patrol throughout the whole borough of Croydon on Thursday, Friday and Saturday nights between 11pm and 7am. This contingent is supplemented by a Rowdyism patrol of a sergeant and 6 PCs on duty between 7pm and 3am on the same nights.

## **WHAT WORKS? EVIDENCE FOR THE EFFECTIVENESS OF SERVICES AND INTERVENTIONS.**

There is now abundant evidence that treatment works and there is demonstrable evidence of benefit in investing in treatment for alcohol problems (Proudfoot and Teeson 2000).

Services for alcohol-related problems have grown and diversified in the last 30 years. Croydon is no exception in having a mix of statutory, voluntary and private services. Alcohol Concern has identified the elements for core services for alcohol-related problems: outreach work; screening for alcohol problems; brief interventions; longer term specialist treatment which includes detoxification and counselling services in day care and residential settings; self-help support groups and support for the families of problem drinkers (Alcohol Concern 1999).

### **Screening and brief interventions.**

Problem drinkers are seen by health and other professionals during the course of their day-to-day work. Such settings include the GP surgery, the hospital ward and AandE department and the community psychiatric wards. Other professionals include social workers, probation officers,

police forensic examiners and occupational health physicians and nurses. As the studies undertaken for this report indicate, individuals drinking at hazardous and harmful levels are not easy to identify and may not realise that their drinking pattern has the potential to cause them harm. Screening should be adopted at places where such individuals present.

A brief intervention comprises an assessment of alcohol intake, provision of information on harmful and hazardous drinking and clear advice for the individual on how to cut down or stop drinking. The content of a brief intervention can vary from a minimal advice session with leaflet or can include provision of self-help manuals, advice about local and national support services and how the individual's drinking compares to that of the general population.

The research evidence suggests that well-planned brief interventions with follow-up can help motivate people to cut down their drinking to sensible limits but probably will not help alcohol-dependent patients. There is also evidence that providing face-to-face training and continuing specialist telephone support for the primary health workers can significantly increase the implementation of screening and intervention programmes at a cost of £6 per intervention.

### **Primary care For Category 1 and 2 drinkers**

With up to 20% of people consulting their GP drinking more than the recommended upper limits, primary healthcare seems an appropriate setting for the detection of harmful and hazardous levels of drinking. Heavy drinkers consult their GPs twice as often as light drinkers (Deehan et al 1998). Research on brief interventions in this setting has suggested that intervention by GPs could reduce the alcohol consumption of 250,000 men and 67,500 women in the UK who are currently drinking to excess to moderate levels of drinking (Wallace 1988).

Practice nurses can play a pivotal role. A 1996 national study found that the practice nurses were identifying harmful and hazardous drinkers at the same rate as GPs but at an earlier stage in their drinking careers (Deehan et al 1996).

Importantly the GP's knowledge of the patient and their family makes the GP a crucial link in the network of medical, psychological and social support each patient will need (Drug and Therapeutics 2000).

### **General hospital**

The present study has found that 15% of patients were drinking at harmful or hazardous levels. Other studies have shown that many of such patients are unlikely to be detected unless specifically assessed (Canning et al 1998). There is suggestive evidence that brief interventions are effective in this setting (Chick et al 1985). In some areas specialist alcohol liaison approaches have been adopted which aim to promote early intervention through a combination of advice, feedback and motivational support.

The present study also found harmful and hazardous levels of drinking amongst AandE attendees. One study found that up to 3 sessions of counselling from a trained assistant nurse was effective. Brief interventions in this setting should be integrated with intervention policies of the hospital as a whole (Marshall, 2000).

### **Specialist treatment. For category 2 and 3 drinkers**

Many patients who wish to stop drinking have not developed the alcohol dependence syndrome and will not develop withdrawal symptoms. If withdrawal symptoms seem likely, detoxification or “assisted withdrawal” aims to minimise severe discomfort through appropriate drug treatment and to prevent the occurrence of seizures or delirium tremens. Many patients can be detoxified at home and hospital admissions should be considered for patients with: a history of withdrawal seizures or delirium tremens; recent failed detoxification at home; acute physical illness; polysubstance abuse; or risk of suicide (UK Alcohol Forum 2000).

### **Rehabilitation hostels**

These places are usually aimed at people with significant social problems as well as substance-related problems. There is little research evidence to support their effectiveness but clearly they may provide a route out of a cycle of interrelated problems and move the client toward better long-term adjustments.

### **Alcoholics Anonymous**

Alcoholics Anonymous makes a significant contribution to the recovery from alcohol dependence for many people. Many treatment programmes incorporate Twelve-Step principles and recommend AA attendance this is rarely done systematically in the UK. A recent study undertaken by the National Addiction Centre looking at alcohol users discharged from alcohol treatment services found that those who attended AA weekly or more frequently showed benefits in achieving lower drinking levels, with fewer drinking days, smaller amounts of alcohol consumed and lower percentage of drinking days. Weekly attenders also used more of the available treatment services (Best et al 2000).

## CROYDON IN CONTEXT: NATIONAL STATISTICS ON ALCOHOL

**Table 1: Great Britain. Alcohol consumption: proportion of men exceeding 21 units per week**

Age	1988	1990	1992	1994	1996	1998
16-24	31	31	32	29	35	36
25-44	34	33	31	30	30	27
45-64	24	25	25	27	26	30
65+	13	14	15	17	18	16
Total	26	27	26	27	27	27

**Table 2: Great Britain. Alcohol consumption: percentage of women exceeding 14 units per week**

Age	1988	1990	1992	1994	1996	1998
16-24	15	16	17	19	22	25
25-44	14	13	14	15	16	16
45-64	9	10	11	12	13	16
65+	4	5	5	7	7	6
Total	10	11	11	13	14	15

Source: Office for National Statistics. Living in Britain: results from the 1998 General Household Survey.

### Commentary

The proportion of men exceeding 21 units per week has remained largely unchanged since 1988, 27% had done so compared to 26% in 1988. However there has been changes within age groups. There was a decrease from 34% to 27% amongst the 25-44 age group in this period but increases in the 16-24 and 45-64 age groups, the proportions increasing from 31% to 36% and 24% to 30% respectively.

The proportion of women exceeding 14 units per week had increased from 10% to 15% during this same period and the pattern holds across all age groups.

### Estimating the at risk population in Croydon

Synthetic estimation is a straightforward method that can be used to identify the numbers at risk of alcohol-related problems in a locality. The method uses existing prevalence data sets for parts of the population and combines this with population data from the target area. In this instance data sets on mean weekly number of units from the General Household Survey can be combined with mid-1998 population estimates for Croydon. It must be noted that the synthetic estimate method assumes that Croydon's population matches the national sample used in the Household

Survey and should be borne in mind when interpreting the following figures.

**Table 3: estimate of people in Croydon drinking above safe drinking levels in Croydon**

Age	% drinking above 21/14 units - General Household Survey	95% Confidence Intervals	Estimated range of number drinking above 14/21 units in Croydon
15-24	30.5	28.2-32.9	12,274 – 14,320
25-44	21.5	20.4-22.6	22,920 – 25,391
45-64	23	21.8-24.3	16,064 – 17,905
65+	11	9.9-12.1	4872 - 5,955
Total			56,130 - 63,571

### **Estimating the alcohol dependent population in Croydon**

The synthetic estimation in this instance uses a data set from the Office of Population Censuses and Surveys (OPCS), now the Office for National Statistics (ONS), Psychiatric Morbidity Survey of private households combined with mid-1998 population estimates for Croydon. The ONS survey collected data from 10,000 adults living in private households in Great Britain and was conducted between April and September 1993. Alcohol dependence was assessed from answers to a self-completion questionnaire of 12 questions which focused on the three components of dependence: loss of control, symptomatic behaviour and binge drinking.

**Table 4: Alcohol dependence of people living in private households aged 16-64 years Great**

**Britain, 1993.**

Rate per thousand population in last twelve months

Age	All	Men	Women
All aged 16-64	47	75	21
16-19	90	113	68
20-24	110	176	45
25-29	72	115	28
30-34	50	85	16
35-39	40	57	24
40-44	27	53	4
45-49	21	35	7
50-54	28	42	14
55-59	4	8	1
60-64	7	12	1

Source: Meltzer, H. et al The prevalence of psychiatric morbidity among adults living in private households in Great Britain (Office of Population Censuses and Surveys Psychiatric Morbidity in Great Britain, Report 1).

**Table 5: Estimation of alcohol-dependent drinkers in Croydon using data from the ONS psychiatric morbidity survey**

Age	% of age band dependent on alcohol in Psychiatric Morbidity Survey	95% Confidence Intervals	Estimated range for number of alcohol dependent in age band in Croydon
16-24	10	9.1-10.9	3928-4705
25-34	6.1	6.0-6.2	3582-3702
35-44	3.4	3.3-3.5	1737-1842
45-54	2.5	2.2-2.8	945-1202
55-64	0.6	0.5-0.7	155-217
All	4.7	4.3-5.1	9864-11700

**Commentary**

The national survey showed that alcohol dependence was higher amongst men than women with an annual rate of 75 per thousand amongst men, compared with 21 per thousand amongst

women. For both men and women alcohol dependence was more prevalent in younger age groups and the prevalence was highest among those aged 16-24.

**Table 6: NHS hospital admissions where there was either a primary, or secondary, diagnosis of selected alcohol-related diseases. England 1995/96**

Diagnosis	All persons	Males	Females
<b>Primary diagnosis</b>			
F10 Mental and behavioural disorders due to alcohol	32,500	22,600	9,700
F10.0 Acute intoxication	8,200	5,400	2,800
F10.1 Harmful use	2,900	1,900	900
F10.2 Dependence syndrome	15,700	11,000	4,600
F10.3 Withdrawal state	2,900	2,300	600
F10.4 Withdrawal state with delirium	1,000	800	200
F10.5 Psychotic disorder	600	400	200
F10.6 Amnesic syndrome	300	200	100
F10.7 Residual and late-onset psychotic disorders	200	200	100
F10.8 Other mental and behavioural disorders	100	-	-
F10.9 Unspecified mental and behavioural disorders	700	500	200
K70 Alcoholic liver disease	7,100	4,700	2,400
T51 Toxic effect of alcohol	2,200	1,300	900

### Primary and secondary diagnosis

F10	Mental and behavioral disorders due to alcohol	72,500	52,200	19,700
F10.0	Acute intoxication	22,100	16,100	5,800
F10.1	Harmful use	11,000	7,500	3,300
F10.2	Dependence syndrome	31,300	22,500	8,700
F10.3	Withdrawal state	4,900	3,700	1,000
F10.4	Withdrawal state with delirium	1,400	1,100	300
F10.5	Psychotic disorder	800	600	200
F10.6	Amnesic syndrome	500	400	100
F10.7	Residual and late-onset psychotic disorders	500	300	200
F10.8	Other mental and behavioural disorders	100	100	-
F10.9	Unspecified mental and behavioral disorders	1,300	800	400
K70	Alcoholic liver disease	14,400	9,600	4,600
T51	Toxic effect of alcohol	13,600	7,300	6,200

Patients admitted with a primary diagnosis of one of the alcohol-related diseases shown are included in both at "Primary diagnosis" and "Primary and secondary diagnosis".

Source: Department of Health Hospital Episode Statistics

**Table 7: NHS hospital admissions where there was either a primary, or secondary, diagnosis of selected alcohol-related diseases. England 1998**

Diagnosis Code	Primary diagnosis	Primary and secondary diagnosis
F10.0 Acute intoxication	8200	23259
F10.1 Harmful use	2633	14363
F10.2 Dependence syndrome	11942	32821
F10.3 Withdrawal state	3964	6636
F10.4 Withdrawal state with delirium	950	1399
F10.5 Psychotic disorder	540	739
F10.6 Amnesic syndrome	256	555
F10.7 Residual and other late-onset disorders	226	479
F10.8 Other mental and behavioural disorders	56	116
F10.9 Unspecified mental and behavioural disorders	665	1227
K70 Alcoholic liver disease	9148	20034
T51 Toxic effect of alcohol	1552	16698

Source: Department of Health Hospital Episodes Database.

**Table 8: Hospital episode figures for Croydon with Primary or Secondary Diagnosis of**

## alcohol-related diseases

	1996-1997	1997-1998	1998-1999	1999-2000
Males	399	517	489	421
Females	125	161	158	156
Total	524	678	647	577

### Commentary

In 1995/96 there were 32,500 NHS hospital admissions with a primary diagnosis of “mental and behavioural disorders due to alcohol”. Men had more than twice the number of admissions with this primary diagnosis as compared to women. This contrast is also reflected in the Croydon episode statistics. The more recent unpublished 1997 figures from the Department of Health show that there had been a fall in the number of admissions with a primary diagnosis of “mental and behavioural disorders due to alcohol” to 29,400 admissions, particularly amongst those diagnosed as being alcohol dependent.

## ALCOHOL AS A CAUSE OF DEATH

The number of deaths resulting from alcohol-specific diseases has risen steadily in England and Wales from 3,603 in 1990 to 4,733 in 1997.

**Table 9: Deaths from selected causes linked to alcohol consumption, England and Wales, 1997.**

Cause of death	Total
Alcoholic psychoses	18
Alcoholic dependence syndrome	326
Non-dependent abuse of alcohol	150
Alcoholic cardiomyopathy	132
Chronic liver disease	4,107

and cirrhosis

Toxic effect of alcohol 174

### Commentary

These figures reflect the common view of alcohol-related deaths which focuses on chronic physical diseases such as cirrhosis of the liver and are seen to affect the middle-aged or elderly sections of the population. However as the recent Advisory Council on the Misuse of Drugs report on reducing drug-reduced deaths points out, alcohol is a significant cause of death among young people (ACMD 2000). The mechanisms involved poisoning by alcohol overdose, inhalation of vomit, alcohol-induced lowering of blood sugar and deaths by road traffic accident and other types of accident and violence.

When the number of deaths in which alcohol is implicated, rather than the sole cause is considered, the number of alcohol-related deaths is far higher and has been estimated to be between 25,000 to 40,000 deaths per year (Alcohol Concern 1999). These deaths include a wide range of diseases where alcohol is a contributory cause such as cancer and vascular disease and acute deaths due to cardiac arrhythmia, stroke, acute pancreatitis and gastro-intestinal bleeding.

The Standardised Mortality Rate (SMR) for Chronic Liver Disease and Cirrhosis, conditions related to alcohol use, can be used to put Croydon in context. The SMR is used to compare mortality rates in different population groupings because it takes into account the differences in the age structure of the population. The national standard for England and Wales is 100 so if a Health Authority area has an SMR greater than 100 then that Health Authority has a mortality rate higher than the average for England and Wales. For the period 1997-1999 Croydon Health Authority recorded 82 mortality cases and has an SMR of 105, with Confidence Intervals of 84 at the lower range and 131 at the upper. Confidence Intervals give a range in which there is a 95% chance of the true value lying. This SMR is not significantly different to the SMRs for England and Wales or London as a whole. Eight other London Health Authorities have SMRs which are significantly higher including Camden with an SMR of 240 (UK. Department of Health 2000).

## ALCOHOL AND DRIVING

**Table 11: Estimates of casualties in road accidents where at least one of the drivers or riders involved was over the legal limit, by mode of road user and age group, 1997.**

	Total	Pedestrians	Cyclists	Motor-cyclists	Car Occupants	Other
Children	970	120	30	10	780	30

Adults 16-59	1 4,830	450	100	830	12,780	650
Elderly	790	80	10	20	650	30
All ages (1)	16,800	670	150	870	14,400	720

1. Includes age not known

Source: Department of Environment, Transport and Regions: Road accidents - Great Britain 1998 - the Casualty Report

### Commentary

Road accident casualty figures demonstrate that the majority of car occupant casualties in drink-related accidents were not drinking over the limit and driving themselves. More car passengers were casualties than drunk car drivers and almost as many were killed or seriously injured. It is also estimated that there were also over seven hundred pedestrian casualties and nearly two hundred cyclist casualties in these accidents (UK. DETR 1999). Information regarding drink driving and fatal road traffic accidents in Croydon is not available, as this is not a statistic recorded on the Accident Investigation Unit.

**Table 12: Roadside screening breath tests: by outcome: England and Wales 1996-1998**

thousands

Outcome	1996	1997	1998(provisional)
Positive/refused	101	104	95
Negative	680	696	720

Source: Department of Environment, Transport and Regions: Road accidents - Great Britain 1998 - the Casualty Report

**Table 13: Screening breath tests in Croydon**

Out-come	Jun 99	Jul 99	Aug 99	Sep 99	Oct 99	Nov 99	Dec 99	Jan 00	Feb 00	Mar 00	Apr 00	May 00
Posi-tive and refus-ed	29	22	4	15	16	24	21	24	24	24	22	29
Neg-ative	85	69	76	61	56	1	1	1	0	0	0	3

## Commentary

The number of screening breath tests carried out in England and Wales has almost doubled since 1988. The recent national figures for tests show that 12-13% of those screened tested positively or refused the test. The recent figures for Croydon show that over 40% of those screened tested positively or refused the test through June 1999-May 2000.

## ALCOHOL USE AND SCHOOLCHILDREN

**Table 14: Percentage of pupils who drank last week, by age and gender, England.**

	1990	1992	1994	1996	1998
	15 years	15 years	15 years		42
<b>Boys</b>	<b>Girls</b>	<b>All</b>			
Total	Total	Total		22	20
11 years	11 years	11 years		8	4
12 years	12 years	12 years		9	6
13 years	13 years	13 years		17	19
14 years	14 years	14 years		32	32

21	24	26	27	23
6	8	8	7	4
8	13	10	12	14
18	15	22	27	16
32	32	34	37	28
40	49	52	50	48
	17	22	26	18
	5	4	6	2
	7	9	9	6
	11	16	22	14
	25	26	35	29
	40	48	55	40
	21	24	27	21
	6	6	7	3
	10	9	11	10
	13	19	24	15
	29	30	36	29
	45	50	53	44

Source: ONS Smoking, drinking and drug use among young teenagers in 1998. Volume 1: England.

**Table 15: Croydon: Percentage of children who have drunk alcohol in the past week**

Age	11 years	12 years	13 years	14 years	15 years	16 years
Boys	3	12	11	17	42	39
Girls	1	5	8	19	21	31

Source: Tobacco, alcohol and drug use among Croydon schoolchildren, 1998.

### Commentary

Before 1998 there had been a marked increase in the frequency of drinking amongst young teenagers, rising from 21% in 1990 to 27% in 1996. In 1998 there was a fall to 21% although it is not possible to identify this as a new trend. Drinking amongst Croydon's young teenagers is less frequent, particularly amongst the girls, with 14% of the 11-15 year-olds drinking in the last week compared to the national figure of 21%.

Drinking as recorded in the national survey most often took place in the home, with 58% saying this was where they usually drank. This compared with 23% saying they drank at parties, 12% saying they usually drank in pubs and 10% in clubs or discos.

## **HELPING AGENCIES AVAILABLE TO CROYDON RESIDENTS**

### **Oaks Resource Centre**

843 London Road  
Thornton Heath  
Surrey  
CR7 6JH  
Tel. 020 8700 8600

Status: statutory

Services offered: Detoxification: Home/Community programme; In-patient/Residential  
Information and advice  
Individual counselling using a cognitive-behavioural approach  
Group work  
Day centre  
Aftercare/follow-up: structured programme

Expected outcomes: abstinence or controlled drinking

Waiting list for detoxification: 2 weeks; for the treatment programme 4 weeks.

### **Croydon Social Services Drug Misuse Team**

Room 8.19

Taberner House

Croydon

CR9 2BA

Tel. 020 8686 4433 ext 2574

Status: Statutory

Services offered: provides Community Care assessments and longer term rehabilitative  
treatment

### **Keystone House**

9 Akabusi Close

Davidson Road

Croydon

Surrey

CR0 6YL

Tel. 020 8662 1171

Status: non-profit independent

Services offered: Information and advice

Aftercare/follow-up: structured programme; Halfway houses

### **Youth Drug Project@ Off the Record**

72 Queens Road

Croydon

CR0 2PR

Tel 020 8296 9655

E-mail: youthdrugproject\_otr@hotmail.com

Services offered: Information and advice for young people under 25

Counselling on drug and alcohol-related issues

Information and advice to families, friends and professionals  
Talks/training  
Consultancy

### **Croydon Alcohol Counselling Service**

28 Wellesley Road  
Croydon  
CR0 2AD  
Tel 020 8667 9500

Status: voluntary (Registered Charity)

Services offered: Information and advice

Telephone counselling

Individual counselling

Outreach activities

Established referral route for detoxification

Expected outcomes: abstinence or controlled drinking

Waiting list for assessment: 5-10 working days; up to 2 months.

### **Hayes Grove Priory**

Prestons Road  
Hayes  
Bromley  
Kent  
BR2 7AS  
Tel: 020 8462 7722

Status: private

Services offered: free assessment and report to referrer

detoxification

abstinence-based therapy programme

aftercare programme

one-to-one counselling

Expected outcomes: abstinence

### **Richmond Fellowship**

Trelawn  
30 Russell Hill  
Purley  
Croydon  
CR8 2JA  
Tel: 020 8660 4586

Status: non-profit independent

Services offered : Abstinence-based therapeutic community

Information and advice

Individual counselling

Group work

Day programme for ex-residents

Structured programmes

Dual diagnosis service

Expected outcomes: abstinence

### **Alcoholics Anonymous**

Tel: 0845 769 7555

Services offered: a recovery programme for those who want to stop drinking alcohol and stay stopped. AA will put callers in touch with a local person willing to take them to an AA meeting.

### **Women in Recovery**

Contact 020 8683 4977 for meeting details

Services offered: fortnightly meetings at 7.30-9.30pm for women who have gone through treatment and need support in an alcohol- and drug-free environment

### **Drinkline National Helpline**

Tel. 0800 917 8282

Services offered: provides telephone advice, information and support.

## **USE OF CROYDON'S HELPING SERVICES**

### **Referrals to the Oaks Resource Centre April 1999-March 2000**

Referral by	10-20	20-30	30-40	40-50	50-60	60-70	70-80	80-90	Total
1	1	7	14	20	9	3			54
2		12	42	35	29	7	1		126
3	2	12	23	9	10	4			60
4	4	50	108	80	52	15	5	1	315

5	1	2	6	7	3	1			20
6	2	34	72	56	30	6	1	2	203
7	1	1							2
9		2	7	2					11
11		1	5	1					7
14			1						1
15		1			1				2
17		1	3	2	3				9
18	1	6	4	4	3				18
19			1						1
20					1				1
Total	12	129	286	216	141	36	7	3	832

### Key

1B&M Hosp Staff  
2B&M Com Staff  
3Tertiary  
4GP  
5Other Medical  
6Self or relation

7Paramedic  
8Educational ser  
9Social Service  
10 Health Visitors  
11CPN  
12 -

13Police  
14Prison/courts  
15Solicitor  
16Guardian  
17Other medical  
18Probation

19Employer  
20Emergency serv

### Ethnic breakdown of clients attending the Oaks August 2000- Mid-February 2001

Month	White	Black Carib	Black Afr	Black other	Chinese	Indian	Pakistani	Bangladeshi	Other
August	62	3	-	-	-	6	-	-	-
Sept	54	1	1	-	-	3	-	-	-
Oct	40	1	-	-	-	4	-	-	-
Nov	39	2	-	-	1	-	-	-	-
Dec	19	1	-	-	-	1	-	-	-
Jan	41	2	-	1	-	2	-	-	-
Feb	14	2	-	-	-	1	-	-	-

Total	269	12	1	1	1	17	-	-	-
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#### Activity data for the in-patient beds at Alex One at Bethlem Royal Hospital 1.4.99-31.3.00

Total admissions	Gender	Average length of stay	% detox completed
115	85 Male 30 Female	13 days	83

Average time from referral to admission	Repeat admissions	Extended stay	Dual diagnosis	Dual dependence
8 days	21	17	28 (28%)	6 (5%)

4% of the admissions were Black-Caribbean and 2% Asian

#### Use of Croydon Alcohol Counselling Services September 1999 - August 2000

Month	Nos of advice calls	Nos of info calls	Assessments Given	No of clients seen
September 1999	n/a	n/a	11	42
October 1999	11	20	9	34
November 1999	10	25	10	43
December 1999	10	20	9	28
January 2000	4	28	8	42
February 2000	6	30	12	39
March 2000	5	23	13	36
April 2000	4	18	5	32
May 2000	4	18	7	32
June 2000	8	21	15	41
July 2000	4	18	11	36
August 2000	4	11	8	41

CACS carried out 120 assessments in this period. 11 of those assessed were from ethnic communities and nearly 60% of the total between the ages of 36 to 45.

### Use of Keystone House 1998-2000

#### Programme and second stage annexes

#### Keystone House

Year	Beds	Adm	Relapses	2 <sup>nd</sup> stage	Ind Acc	Current
2000	9	18	7	2	0	9
1999	9	27	11	9	7	
1998	9	21	11	4	7	

#### 2nd Stage

Year	Beds	Adm	Relapses	Ind Acc	Current
2000	14	21	7	4	10
1999	5	6	1	5	
1998	5	6	1	5	

#### Key

Year Calendar year

Beds Total bedspace capacity

Adm Total admissions in calendar year

Relapses Total relapses in calendar year

2nd stage Total number of residents moved from Keystone House to 2nd stage accommodation in calendar year

Ind acc Total number of residents moved to independent accommodation in calendar year

Current Total number of current residents

### **Social Services Drug Misuse Team**

The team had 300 referrals, including alcohol-related referrals in 1999 and 180 in first 6 months of 2000

### **Off the Record**

The youth counselling agency were able to provide data on clients who discussed alcohol and drug-related issues when presenting at the agency.

1.4.98-31.3.99 134 clients seen: 13 with alcohol-related issues, 7 with drug and alcohol-related issues

1.4.99-31.3.00 130 clients seen: 13 with alcohol-related issues, 5 with drug and alcohol-related issues

### **Summary**

The age data collected from the different specialist agencies suggest that those coming to treatment are predominantly in the 30-50 age range. However, there are indications that younger clients are attending services with, for example, 4 out of the current Trelawn intake of 9 under 25.

## **ALCOHOL EDUCATION IN CROYDON**

Croydon has a comprehensive and well managed approach to alcohol education in the borough.

### **Alcohol education in schools**

Alcohol is an integral but not an isolated part of the school curriculum. The Department for Education and Employment guidelines on drug education and the Croydon procedural and curricular guidelines for substance use and misuse education recommend that schools cover alcohol at every key stage. Alcohol education is not treated separately from illegal drugs, tobacco, medicines or any other substance and ideally should be covered under the one catch-all subject of substance use and misuse. The lessons not only provide information on the effects of the substances including alcohol but also cover life skills which enable children and adolescents make their own informed decisions, life skills that are appropriate for all areas of life as well as substance use and misuse. Each school can decide the content of its drug education programme.

There is a statutory requirement to cover the following in the science curriculum

Key stage 1 (5-7 year olds) - the role of drugs as medicines

Key stage 2 (7-11 year olds) - that tobacco, alcohol and other drugs can have harmful effects

Key stage 3 (11-14 year olds) - that the abuse of alcohol, solvents, tobacco and other drugs affects health and that the body's natural defence may be enhanced by immunisation and medicines and how smoking affects lung structure and gas exchange

Key stage 4 (14-16 year olds) - the effects of solvents, tobacco, alcohol and other drugs on body functions

Croydon's Drug Education Officer aims to persuade the schools to extend their programmes to cover the suggested curriculum in the local procedural and curricular guidelines.

In addition there are a number of extra agencies that assist schools in delivering information about alcohol in the classroom.

The Youth and Schools Unit of the Police's Involvement Programme covers alcohol and tobacco at year 5 (9/10yrs old), illegal and legal substances at year 6 (10/11yrs old) and alcohol at year 11 (15/16yrs old). Only at year 11 is alcohol dealt with as a substance in its own right.

Life Education Centres incorporate education about legal and illegal substances including alcohol in an approach that tries to teach young people to have respect for their bodies so that young people can be given the skills to take responsibility for their lives and enable them to make informed decisions about their lives. This programme is currently carried out in primary schools

Drug and Alcohol Foundation carry out a lot of work in Croydon secondary schools. Their programme covers legal and illegal substances at the same time. The lessons are flexible and encourage the young people to actively participate.

Visits from outside agencies are followed up in the schools using their own work. Schools are recommended to have a programme for a six week/half term block of one lesson per week every other year. This would involve teacher and outside agency input. A gap identified by the Drug Education Officer is that, unlike smoking and illegal drugs, there are no specific alcohol educators available for schools. This gap is being actively investigated.

As part of a series of leaflets for parents in Croydon, a leaflet on alcohol has been distributed to every parent of a Croydon school pupil in Year 6 (10/11yrs old) and Year 9 (13/14yrs old). The leaflet was produced by a multi-agency team comprising Croydon LEA, Health Promotion, Police, Croydon Alcohol Counselling Service (CACCS), Croydon Social Services & Parents. The leaflets have also been distributed throughout the libraries, GP surgeries and pharmacies in the borough.

### **Adult alcohol education**

The Senior Health Promotion Specialist has lead responsibility for advice and consultancy and for facilitating and co-ordinating planned programmes, responsive to the needs of adults in the community across the borough. Most programmes are planned and implemented through

interagency collaborative working with key players in the statutory and voluntary agencies, pooling skills and resources for quality and appropriateness. The programmes are wide-ranging and ongoing and include focused work on the following:

- campaigns to promote sensible and responsible drinking in line with the government guidelines on the daily benchmarks for men and women through notice board displays and exhibitions in the Whitgift Centre and NHS premises including GP surgeries and community groups
- binge drinking especially among young adults
- social impact on families, including domestic violence
- impact of alcohol on physical and mental health
- drink drive, working with and supporting the local authority's Road Safety Officer and the Traffic Police to reduce the incidence of drink-related road accidents
- the provision of a wide range of up-to-date resources for professionals/agencies and members of the public, including leaflets, posters, videos and teaching packs
- providing advice, consultancy and training for key personnel to improve their knowledge and skills in carrying out alcohol-related health promotion work
- undertaking policy-related initiatives and identifying gaps in service provision. Amongst recently identified issues are alcohol use among women, elderly people and pregnant women

## **ALCOHOL-RELATED PROBLEMS AT MAYDAY ACCIDENT AND EMERGENCY**

### **Methodology**

Over a four week period in July to August anonymous self-completion questionnaires were given to all ambulant persons attending the Mayday Accident and Emergency (AandE). The AandE was attended in 8 hour shifts over a month in order to provide estimates for all times of the week. There were 300 adult walk-in patients and 260 of these were completed a questionnaire.

A short questionnaire taking only several minutes to complete was used to encourage compliance. The questionnaire sought information on whether alcohol was used before and after the accident and included the 10-question Alcohol Use Disorders Identification Test (AUDIT) to measure patterns of alcohol use. Persons between the age of 18 and 85 were handed the

questionnaire. Those who could not understand the purpose of the questionnaire or who were in too much pain or distress were not approached. On completion the completed questionnaire was put in a box in the AandE waiting room.

In addition time was spent in the treatment area to count and observe alcohol-related cases arriving by ambulance over late Friday and Saturday night shifts which were expected to be the busiest times for alcohol-related problems in the unit. A checklist of behavioural signs of intoxication drawn from police sources and nurse information were used to identify alcohol-related incidents.

## **Results**

13% of the sample reported consuming alcohol before their attending the AandE.

If the respondents scored 8 or above out of a possible score of 40 on the AUDIT, this is interpreted as indicating a hazardous level of alcohol intake. 29% of the sample scored 8 or higher.

Of the 9 cases arriving at AandE by car or ambulance on the Friday night between 11pm and 2am, 5 were alcohol-related.

Of the 7 cases arriving at the AandE by car or ambulance on the Saturday night between 11pm and 4am, 5 of the cases were alcohol-related.

## **The Study in context**

Recent figures from Alcohol Concern suggest that 1 in 6 people attending AandE departments have alcohol-related injuries or problems which rise to 8 out of 10 at peak periods. This study was based on staff perceptions rather than a quantitative study and more appropriate comparative studies have been carried out in Liverpool and, more recently, at St. Mary's in London. The St. Mary's study in two London AandE departments found that 26% of the ambulant patients scored over 8 on the AUDIT scale (Thom et al 1999), a similar finding to this Croydon study.

A working party of the Royal College of Physicians has investigated ways of reducing the burden of alcohol misuse on hospital services and reported in February 2001. The working party's remit was to:

- identify the current impact of alcohol misuse on health care delivery, particularly in acute hospital services
- examine how well present hospital services are equipped to identify both alcohol-related illness and coincidental problem drinkers, and to explore how well such drinkers are currently managed
- Recommend, from evidence of research and good practice how current hospital resources could best be targeted to reduce the burden of alcohol on the NHS

Amongst the recommendations of the working party are:

- A screening strategy for early detection of harmful/coincidental hazardous drinkers administered as part of routine admission procedures through lifestyle questionnaires
- Early assessment of dependence severity by appropriately trained staff
- Widely available and audited protocols for the pharmacotherapy of detoxification
- Readily available 'acute response' from liaison or specialised alcohol psychiatry services for the management of more complex patients undergoing alcohol withdrawal
- Assessment of the need for referral to on-going support services by appropriately trained staff with knowledge of local services
- Provision of brief interventions for coincidental hazardous drinkers
- Provision of general staff education
- Occupational policies for alcohol for all hospital health care workers, for example with respect to drinking at work
- Close liaison with general practitioners on discharge (Royal College of Physicians 2001)

## **ALCOHOL-RELATED ACUTE ADMISSIONS TO MAYDAY HOSPITAL**

### **Methodology**

200 consecutive admissions to Mayday Hospital at the end of August and the beginning of September were assessed using a brief lifestyle questionnaire. The questionnaire sought information on smoking, medicine and illegal drug use. Information on alcohol use was gathered using the 10-question AUDIT. The questionnaire took approximately 5 minutes to complete. The sample consisted of those admissions between the ages of 18 and 85. Those in too much pain or distress or unable to understand the purpose of the questionnaire were excluded. The sample was drawn from the complete range of specialities: Surgery, Trauma, Geriatric, Orthopaedic and Medical, with 36% of the sample from Surgery wards and 30% from Medical wards.

### **Results**

If respondents score 8 or over out of a possible score of 40 on the AUDIT, this is interpreted as indicating a hazardous level of alcohol intake.

14% of the admissions scored 8 or higher. The highest percentage of high AUDIT scores were found amongst trauma patients at 23.5% of this group, followed by 21.7% of those in the medical

wards and 9.6% of those in the surgery wards.

### **The study in context**

The most recent comparative study was carried out in King's College Hospital between January 1995 and January 1997 and the results mirror those of the present study with 15% of the King's sample of acute admissions misusing alcohol.

### **Alcohol and the GP workload**

The most recent study of alcohol and drug use amongst patients attending the GP surgeries in Croydon was carried out in 1996. All GPs in Croydon were sent an eight-page postal questionnaire on their work and attitudes to alcohol- and drug-using patients. A response rate of 52% was achieved. These GPs reported working with 3.5 patients drinking above recommended guidelines in the previous week (Deehan et al 1998).

### **Alcohol and dual diagnosis in Croydon**

Dual diagnosis or comorbidity defines the co-existence of alcohol misuse or alcohol dependence problem and one or more additional mental or behavioural disorders. On October 13th 1999 a research team from the Community Psychiatry Department of the Institute of Psychiatry (PRISM) carried out a spot survey amongst the inpatients in the mental health wards in Croydon. 117 patients were in the group studied and 17% of the sample said that alcohol was a principal factor, alone or in combination with illicit drug use, in their reason for admission (Wright et al 2001).

In one study in 1998 61 patients with psychotic illnesses who have been in contact with mental health services in Croydon were randomly selected for interview with 40 cases responding. Prevalence rates for dual diagnosis were 33%, for any substance misuse 20%, for alcohol misuse only, 8% for drug misuse only and 8% for both alcohol and drug misuse. The Dual Diagnosis patients were found to have spent on average over twice as long in hospital as other psychotic inpatients over the previous 2 years (Wright et al 2000).

A current PRISM research project is currently evaluating an integrated approach to dual diagnosis which involves the training of Community Psychiatric Nurses in Community Mental Health Teams in Lambeth, Southwark and Lewisham Health Authority and Croydon. 1,560 patients have been screened and 1,271 identified as having a severe mental illness. 233 (18%) of these 1,271 have been dual diagnosed. 160 were interviewed and 37 of these were from Croydon, drawn from the Central, Mid-Central, West-Central, East-Central and North-West sectors. 71.4% had had a drink in the last 30 days and 25% were drinking daily. Compared to the LSL sample those in Croydon were drinking less overall but drinking more often.

### **Commentary**

Severely mentally ill patients have high rates of alcohol and drug-related mental and behavioural problems. Patients with a dual diagnosis are above average users of the emergency and inpatient services and have higher rates of offending, imprisonment and dangerous behaviour. There is

also an association between homelessness and dual diagnosis. Although it is difficult to estimate the size and nature of dual diagnosis in the population, it has been estimated using a range of sources that in a population of 500,000 there will be nearly 6000 problem drinkers with comorbid mental health problems (Rorstad and Checinski 1996).

## **ALCOHOL-RELATED OFFENCES IN CROYDON**

### **Data Source**

Croydon Police's Management Information Unit supplied data on the number of arrests during the period of the study. They were able to provide data on offences where alcohol was directly involved and where alcohol was recorded in the arrest notes for other offences.

### **Croydon Borough Alcohol-Related Arrests**

<b>Offence</b>	<b>May 2000</b>	<b>June 2000</b>	<b>July 2000</b>
Drunk and disorderly	41	45	52
Drunk and incapable	15	16	24
Drunk in a public place	3	16	15
Drink Driving	44	42	71
Drunk in charge of a child	0	0	0

<b>Total</b>	103	119	162
<b>Total arrests</b>	969	904	958

### Reported offences where alcohol had been consumed

Minor category description	August 2000	September 2000	Total
GBH	0	1	1
ABH	3	2	5
Common assault	3	3	6
Harassment	1	3	4
Fraud and forgery	0	1	1
Criminal damage to a building	2	0	2
Other criminal damage	1	0	1
Other theft	3	0	3
Other notifiable crime	2	0	2
<b>Total</b>	15	10	25

### Alcohol and the Forensic Medical Examiner

Methodology: taken from interview material with Dr. Farhan as part of a National Addiction Centre study of the work of the Forensic Medical Examiners

Dr Farhan is based mainly at Croydon police station but covers other stations as well. He sees a lot of people coming into the stations drunk at night, especially on Friday and Saturday and estimates that 10-15% of his workload involves drunken detainees.

### Commentary

The arrest figures show a variation in the number of alcohol-related arrests ranging from 10% of all arrests in May to 17% in July. The observations of the Forensic Medical Examiner parallel the findings of an observational study carried out in South Norwood Police Station in 1993-1994 which found that 16% of detainees were suffering from the effects of alcohol ( Phillips et al

1998).

### Alcohol and the Croydon ‘Get It While You Can’ Arrest Referral Scheme

#### Use per drug of arrestees approaching the scheme

Drug	May	June	July	August	Sept	October	Total	%
Alcohol	1	8	15	14	6	7	51	20.8
Amphet amine	1	1	2	3	2	2	11	4.5
Anti- depress.				1		1	2	0.8
Benzos				3			3	1.2
Cannab.	3	15	11	12	9	8	58	23.7
Cocaine	1	2	2	2	1	1	9	3.7
Crack	1	5	1	8	6	8	29	11.8
DHC				2			2	0.8
Diazep.			1	1			2	0.8
Ecstasy		2	1	1			4	1.6
Hall		1					1	0.4
Heroin		3	7	13	10	17	50	20.4
Methad.		3	1	4	4	4	16	6.5
Not user			1				1	0.4
Opiates Other		1					1	0.4
Solvents					1		1	0.4
Temaz. DFs		1	1	1	1		4	1.6
<b>Total</b>	7	42	43	65	40	48	245	
%	2.9	17.1	17.6	26.5	16.3	19.6		

Key DHC =Dihydrocodeine Hall=Hallucinogens Temaz=Temazepam  
DFs = DF118 (Dihydrocodeine proprietary)

The arrest referral schemes are initiatives which encourage drug users in contact with the criminal justice system to come forward for programmes of advice and treatment. These initial findings from ‘Get it While You Can’ demonstrate that cannabis and alcohol are the two main drugs amongst this client group, closely followed by heroin and crack cocaine.

#### Alcohol and the probation service

Methodology: interview with Ann Williams, Borough Manager for Croydon Probation.

The interviewee observed that alcohol use was behind much of the offending coming to the attention of their service. An analysis of the key factors mentioned in reports for the courts in Croydon in 1999 showed that alcohol was the leading factor in 29% of cases, followed by drugs and family relationships, both at 26%. This amounts to 331 offenders out of a total of 1144 cases in 1999.

## **THE FREQUENCY AND ROLE OF ALCOHOL IN RELATION TO LOCAL SOCIAL ISSUES.**

### **Methodology**

In the light of the unavailability of statistical data in these areas, information was mainly collected through interviews with key informants in the borough. These interviews were carried out using a semi-structured questionnaire and took around an hour to complete. The interviews were all conducted by the main researcher on this project and in the workplaces of the interviewees.

### **Housing Issues**

Interview with Angela Chew, Croydon Housing.

The Rough Sleepers Unit of the DETR carried out their most recent survey of people sleeping rough in England in June/July 2000. Street counts were made in every area and Croydon's count of 25, although the same total for the previous year, gave it the 7th highest total in England. It is estimated that as many as 50% of rough sleepers have serious alcohol-related problems.

Figures for those with both alcohol-related problems and housing needs are difficult to quantify because the homeless have complex needs. In Croydon 12 people are housed

through Social Services who have alcohol and drug-related problems. South East London Probation also assist the housing of ex-offenders who have drug and alcohol-related problems.

However although many approach Croydon council as single homeless, those who have mental health problems receive priority and those with alcohol-related problems will receive priority only if allied to mental health problems. In addition there are nearly 300 single homeless units but many of these will not take alcohol/drug users. Although Trelawn and Keystone provide specialist provision for this group, there is still a big gap in provision in the borough.

The Alcohol Recovery Project and Hyde Housing Association are developing a wet hostel in Central Croydon to take people of any age and whether they want to give up alcohol or drugs and planned to be on stream by 2001.

### **Domestic Violence**

Findings from the British Crime Survey found a large increase in domestic violence incidents in the 1990s, rising from around 500,000 in 1991 to around one million in 1995 (Mirlees-Black et al 1996). A recent review of the research literature found that 60-70% of men assault their partners while under the influence of alcohol (Jacobs 1998). While it is difficult to prove a causal link between domestic violence and alcohol misuse and to clearly delineate the interrelationship between the two, it is clear that its role should not be ignored whilst making effective interventions in this area.

Interviews were carried out with the Croydon Domestic Violence Co-ordinator, the manager of the One Stop Service for domestic violence victims and an ex-staff member of the same service.

Interviews with clients by One Stop indicated that a high percentage of the perpetrators of violence were using alcohol and/ or drugs although it was clear their substance misuse was not the cause of violence in most cases. Alcohol and/or drug use was not routinely collected by the agency but the agency is considering doing so.

Croydon police recorded 397 cases of domestic violence in May; 378 cases in June; 400 in July; 382 in August; 371 in September.

### **Young people and alcohol**

Recent research has shown that young people are drinking more in a session and starting to drink at an earlier age (Wright 1999). The latest survey of substance misuse amongst Croydon schoolchildren found that :

- between a third and a half of children over 15 drank alcohol regularly
- a high proportion of children report being drunk in the last week, ranging from 25% of 14 year-olds to nearly 80% of 17-18 year-olds (Adcock et al 2000).

It is not possible to predict which young people will develop alcohol and other substance misuse problems but a number of high risk groups have been identified (Evans et al 1999):

Young people known to the social services

The Croydon Social Services does not keep specific information related to substance misuse in their case records. The Child Protection Advisor is currently compiling some figures for mentions of alcohol in case records.

Young homeless people

No data has been obtained for Croydon at time of writing

Young people having difficulty with formal education

The 1998 Croydon Schools survey questionnaired a sample of 176 pupils attending three Special Educational Needs schools and two Pupil Referral Units in Croydon. The lack of confidentiality and high rates of absenteeism compromise the findings of this part of the schools survey. However, the levels of drinking were similar to those found in the main schools survey with a quarter of the pupils attending the Pupil Referral Unit reporting 10 or more episodes of drunkenness in the past year (Adcock et al 2000).

Young people involved in the Youth Justice System

Interviews were carried out with the Manager of the Youth Justice Team and two members of the team. It is estimated that 3% of the 10-17 year old population in Croydon will offend although the bulk of the caseload is within the 13-17 year olds. 88% of the clients are male and 40% from ethnic communities. Anecdotal information from the clients suggests that alcohol and drug use is a substantial part of their lives.

Young people involved in prostitution

No data has been obtained for Croydon at time of writing

Young people with substance misusing parents

No data has been obtained for Croydon at time of writing.

## **Ethnic groups**

Contact was made with a number of representatives from the ethnic communities in Croydon and although these representatives were helpful it was not possible to gather data on the extent of alcohol use in these communities. Respondents outlined the difficulties of carrying out an alcohol prevalence survey amongst these communities because of the often “taboo” nature of the subject but were willing to help with any future initiatives.

Racial harassment

The housing department reported one case in the past year of problem alcohol drinker racially harassing another tenant, resulting in the former's eviction.

## **Sexual health and unplanned pregnancies**

The 1999 Social Exclusion report on teenage pregnancy highlighted the role of alcohol in teenage sex. Research undertaken by the Health Education Authority showed that after drinking alcohol one in seven 16 to 24-year-olds have had unsafe sex, one in five have had sex which they later regretted, one in ten have been unable to remember the night before and 40% think they are more likely to have casual sex. A survey of 13 and 14-year-olds found that 40% were under the influence of alcohol or illegal drugs when they experienced their first sexual intercourse (Wight 2000).

Croydon currently exceeds the national conception rate for women aged 13 to 19 and the rate of births to women under 16 is higher than the national average. These teenage pregnancy rates vary between wards and Primary Care Groups, with the South being the least deprived Primary Care Group and having the lowest rates of terminations and births to teenagers. (Sawney 2000).

## **Alcohol and pregnancy**

Drinking alcohol during pregnancy is associated with a number of harmful consequences. Low birth weight babies and premature delivery are relatively common. More serious but relatively uncommon even amongst heavy drinking pregnant women are Foetal Alcohol Syndrome abnormalities which include brain damage, pre-natal and post-natal growth retardation and facial malformations. It has been estimated that FAS occurs once per 3000 births. FAS can lead to developmental and behavioural problems as well as impede child development.

Figures for the use of alcohol by pregnant women are not routinely collected by antenatal services in Croydon but drug and alcohol use amongst this group is recognised by the antenatal services and a care plan is currently being constructed in collaboration with the Oaks Resource Centre.

## **Alcohol and the elderly**

General Household Surveys have shown an increase in the proportion of older people drinking above hazardous levels in Britain. In 1984 12% of men and 3% of women aged 65 or over were drinking above 21 pints and 14 pints respectively. In 1998 these figures had risen to 16% of the men and 6% of the women, although declining slightly from the previous year (Office of National Statistics 1999).

Older people are more vulnerable to the effects of alcohol and it is essential that those who are drinking excessively are recognised and given appropriate advice. However it is difficult to estimate the extent of this problem in Croydon. Although anecdotal evidence from such services as Home Help suggests a number of cases of heavy drinking amongst this group, there is a low rate of referrals to Old Age Psychiatry and alcohol services in Croydon. CACS recorded one user of their service over the age of 65 in 1999-2000 and the Oaks had 10 referrals over the age of 70 in the same year. The needs of this group may be overlooked and the development of services and training is required to ensure recognition and adequate support. The Public Health Directorate are currently investigating the extent of the problem and establishing guidelines for the management of old people with alcohol problems in Croydon.

## **RECENT DEVELOPMENTS IN CROYDON**

### **Moves towards formalising joint working arrangements between social services and the Oaks Resource Centre**

Discussions are underway to formalise the current close working arrangements between the Oaks Resource Centre and the Social Services Department which will improve services for alcohol problems and facilitate fast tracking and care planning.

### **The appointment of a GP liaison nurse**

The newly appointed GP liaison nurse will initially be liaising with the Primary Care Group in the North of the borough, the part of Croydon which is seen as having the greatest need.

### **Other developments at the Oaks**

The Oaks is establishing an ante-natal service for drug and alcohol users in liaison with antenatal facilities in Croydon. There will also be an afterbirth service. The Oaks is also setting up a well-users clinic. Closer working with Mayday AandE is also being pursued.

### **The appointment of a dual diagnosis worker at Trelawn**

A dual diagnosis worker has been in place at Trelawn for 6 months and initial results are good , with many of the clients staying in the programme. Joint working with the Westways Clinic which provides psychiatric input has been a successful aspect of experience so far.

### **The establishment of the Youth Drug Project at Off the Record**

Recently established, this project has plans to recruit a worker for a satellite project in New Addington.

## **THE WAY FORWARD: RECOMMENDATIONS FOR ACTION**

### **Moving alcohol issues forward in Croydon: the need for a co-ordinator**

It was clear during the conduct of the research for this report that there are a lot of initiatives under way to deal with alcohol as well as drug misuse problems in Croydon. However, these initiatives seem to falter and are not followed through. In addition many in the alcohol and substance misuse community are not aware of the good and relevant work around the borough. There is a need for capacity to co-ordinate alcohol-related activities in parallel with the various responses to drug-related problems in Croydon.

The impact of future initiatives will depend on the choice of one of two models of co-ordination: either making the most of existing resources or looking to increase resources to improve co-ordination. If the former route is taken it is imperative that the collection, assimilation and dissemination of information is improved in the borough. If the second route is taken with the appointment of a co-ordinator an important part of their role should be to fund raise and seek monies for improving alcohol services in Croydon. It is recommended that the second route is taken and a co-ordinator appointed to facilitate the co-ordination of activity and to plan future service development.

### **An alcohol strategy for Croydon**

With the release date for the Government's national alcohol strategy still unknown, it is crucial that work starts on devising an alcohol strategy for Croydon to address the issues raised in this report. Alcohol Concern have provided a template for a strategy with their report *Proposals for a*

*National Alcohol Strategy for England* and other Health Authorities (eg Newcastle) have developed their own strategy and may have expertise to offer.

### **Informing the community and the non-dependent drinker**

There is a need to disseminate basic information on alcohol and where to get help throughout Croydon. It is recommended that handy easy-to-read in the range of languages should be made available through such venues as libraries, the healthy living centre, hospitals, GP surgeries as well as the Croydon website. The leaflets on alcohol for parents produced by a multi-agency team in Croydon detailed in the education section above could provide a useful model to exploit.

### **Measuring the met and unmet needs; involving the alcohol user.**

This report lacks the voice of the alcohol user, which leaves a major gap in the information and perspectives it presents. The Croydon Alcohol Services Users Group folded during the course of the research for this report. Notably the members of the group felt that during the life of the group, it had not achieved any visible changes in services, but were willing to be consulted in the future if they could be assured their views made a difference.

Problem alcohol users may be a group who are poor utilisers of existing available alcohol treatment services. In addition they may be unaware themselves of their health needs. These needs may be complex and a combination of quantitative and qualitative approaches is a productive way forward to identify them. Not only should the views of current users of services be sought but the views of those who have not been in contact with services should also be collected to build up a picture of local need. In this way the extent to which the current services are meeting their target populations can be gauged (Fountain et al 2000).

It is recommended that agencies in Croydon make concerted efforts to listen to views of alcohol users, both in and out of treatment, in the planning and management of their services. It is recommended that a needs assessment involving this group should be initiated, perhaps using the methodology of the Fountain et al study cited above. At time of writing, the Oaks have instigated a project to explore clients' needs which could provide the basis of a borough-wide assessment.

### **Arrest referral schemes**

Croydon's arrest referral scheme has been successfully been running since May 2000. Figures from the scheme have shown that alcohol along with cannabis are the two main substances being reported by clients. Comments from Arrest Referral Scheme staff indicate that, whilst wishing to be active in referring on alcohol problems, the lack of appropriate facilities such as a drop-in centre, in Croydon have made this difficult.

### **Expanding needs and limited resources**

Many interviewees felt that alcohol services were being squeezed as a result of the attention given to drugs and that alcohol-related problems were widespread and under-recognised. Services were falling behind need.

The number of alcohol-related referrals has continued to rise at the Oaks Resource Centre from 745 in 1997-98, through to 845 in 1999-2000 (Oaks keyworker database). However, following reconfiguration of existing treatment resources the capacity, as defined by client caseloads, to work with alcohol related clients has declined by 20% over this period. This has resulted in the introduction of a waiting list in October 2000 for alcohol-related treatment. It is recommended that the funding for statutory services be reviewed in order to match provision and need. Interviewees identified other alcohol services they felt to be lacking in Croydon, including a drop-in centre, services for women and children and detoxification services which were not hospital-based.

### **Measuring the effectiveness of services**

It has been noted that the two questions addressed by any evaluation of effectiveness is whether the treatment involved make any difference and whether this difference may have been improved by alternative approaches. Evaluation sets out to identify what resources currently available, the demand being placed on this resources, the context and challenges in the future and mechanisms that may help to respond to these changes

The recent QuADS Organisational Standards for Alcohol and Drug Treatment Services published by SCODA(now part of Drugscope) and Alcohol Concern require that the quality of organisational practice is continually monitored and developed through target setting, review, training and resource development with monitoring playing a key role in the development of service planning and deliver, and in establishing the criteria for effective service delivery. It is an approach that should be adopted by local alcohol agencies which may usefully investigate, for example, the impact of waiting times on the effectiveness of their services.

### **Data collection for commissioning**

It has proved difficult to obtain activity data from helping agencies in a number of areas, most notably in the ethnic breakdown of clients using services. At time of writing it is clear that agencies are now making strenuous efforts to make up this shortfall and data will be available for the final report. However it is recommended that all helping agencies ensure that they have well managed activity data procedures in place to facilitate the commissioning process. It is understood that a new data package, BOMIQ, is to be installed at the Oaks which will vastly improve its data collection and retrieval.

### **Working with Primary Health**

As noted above the evidence suggests that a brief intervention of advice and target setting from a GP or other primary health care worker could have a significant beneficial effect at a low cost. This opportunity may be missed with GPs unwilling to take these opportunities because of lack of time and insufficient training. There could be a lack of awareness of services specialist services available in Croydon which could result in inappropriate referrals.

There is scope for closer working with primary healthcare personnel. Healthcare facilities provide an ideal opportunity for identifying people who are currently experiencing or at risk for problems with alcohol. A primary care protocol for drug and alcohol dependence is currently being constructed nationally and also locally in Croydon by the Public Health Directorate.

Strategies could be adopted to encourage the use of screening procedures which could include:

- group education through workshops and seminars
- training given by respected colleagues
- educational outreach to individual doctors
- performance feedback
- financial incentives

Practice nurses could be key personnel to target in this area. In addition there may be an opportunity to pursue community detoxification with pharmacists and explore shared care approaches in the health authority. It is recommended that PCGs be actively encouraged to become involved in dealing with substance misuse problems. A survey of current GP involvement to follow up one conducted in Croydon in 1995-1996 should be undertaken. This survey could determine whether alcohol is placing an increased burden on their workload, their views of current alcohol services in the borough and establish a bridge between GPs and Croydon's response to substance misuse.

### **Working with dual diagnosis patients**

It is clear from the research that many patients diagnosed as dual diagnosis are cases involving alcohol misuse. Previous attempts to establish closer co-ordination between mental health services and alcohol services have identified this 'ping pong' effect with clients falling between services and disciplines and not receiving optimum care. Croydon has been providing 'joint care' of these patients and a joint working party between psychiatric and substance misuse service providers, users and purchasers made progress in 1997 and 1998 on producing guidelines on the management of patients with co-existing psychiatric disorders and substance misuse. Ways forward would be to pursue partnerships that may include improving inter-disciplinary working between general adult psychiatry and alcohol services through more closely aligned assessment procedures, interdisciplinary training and co-case working. A CPN could monitor progress in communities and closer liaison with GPs could be pursued.

Work is currently underway in Bromley Sector 1 to involve GPs in dealing with dual diagnosis cases and is being supported by the Department of Health as a possible demonstration model project for other areas to follow. It is recommended that the needs of this group are addressed in the work of alcohol agencies in Croydon and efforts are made to establish inter-disciplinary working in the borough..

### **Working in Mayday Hospital**

The surveys undertaken for this project have demonstrated that a substantial number of people are approaching Mayday who are drinking alcohol at hazardous levels. The hospital setting provides an opportunity to screen patients for alcohol-related health needs and it is recommended that the possibilities for a hospital-wide strategy for detecting and responding to alcohol problems be pursued. There may also be an opportunity for the deployment of an alcohol liaison

nurse or counsellor in the hospital. Any such developments should be preceded by research with the hospital staff and management to measure attitudes and capacity to deal with alcohol-related problems.

### **Working with those from ethnic communities**

It is difficult to discern need for services for these groups without further information. There is a lack of national research on the drinking patterns of different ethnic communities to put Croydon into context. Figures from EACH, Ethnic Counselling in Hounslow, showed that drinking problems were emerging amongst both Hindus and Muslims, with increasing use of the service by women and the elderly. Experience with working with clients from the ethnic communities at CHOICES in Stockwell showed that language is a major barrier preventing these people approaching services and that counselling and treatment agencies must have some expertise in these languages and knowledge of cultural contexts to be attractive to them. Interviews with members of the ethnic community in Croydon made it clear that researching the needs of these groups would be difficult, but it is essential that an accurate picture of their needs is established before determining whether to set up a service specifically for them.

### **Domestic violence**

Key informant interviews highlighted the difficulty of accessing refuges for those victims of alcohol-induced domestic violence. There is a need for closer liaison between alcohol misuse and domestic violence services and it is recommended that mechanisms for interdisciplinary working be explored. This has training implications for services which will need to be addressed.

### **Linking up with The Home Office action plan to reduce alcohol-related crime**

The Home Office has recently published an action plan to deal with alcohol-related crime and has a number of recommendations that should be explored in Croydon.

### **Alcohol awareness for non-specialists**

Alcohol is impacting on the work of a number of agencies in Croydon and there is a clear need for basic alcohol awareness training for members of staff to recognise alcohol-related problems and be confident in dealing with them through appropriate action and referral.

### **Changing the culture in treatment agencies**

Commissioners and managers of alcohol treatment agencies should encourage their staff to be more pro-active in helping to develop services. Managers and staff should be encouraged to look outside the borough for examples of good practice that can enrich the work of the service.

### **Communication**

The lack of communication channels have been a notable feature of Croydon during this research, with alcohol treatment agencies unaware of recent developments in areas relevant to their work in the borough. Effective information development and a communication strategy is

essential for service development. It is recommended that the DAT and alcohol helping agencies explore communication mechanisms with a view to establishing responsive alerting systems and improved co-ordination in the collection, assimilation and dissemination of information.

### **Keeping the information up-to-date.**

It is important that the information and sources of information identified for this report are kept up to date so that an alcohol data set be maintained to inform the planning and commissioning of services in Croydon. This research has been met with much enthusiasm from workers across the borough who have all made significant contributions to the project and it is essential that the building blocks of an alcohol information base for Croydon is not lost. There is a need for a consistent monitoring system that crosses organisational boundaries that will be crucial for effective service development and strategic planning.

### **Developing a research strategy for Croydon**

A number of areas that warrant further investigation have been identified in Croydon. These include the impact of waiting lists on treatment outcomes, the role of substance misuse in domestic violence, the role of Primary Care in dealing with substance misuse and brief interventions in a hospital setting.

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## **LIST OF THOSE WHO HAVE HELPED WITH THE REPORT**

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Ray MacGuire	Youth Justice Team
Jill Maddison	Croydon Equalities Unit
Andy Opie	Health Promotion
Pat Randall	Women in Recovery
John Terry	Get It While You Can
Sam Tearle	Croydon Social Services
Lesley Tomkins	Croydon Social Services
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