Health Needs Assessment On Alcohol in Surrey

August 2008

Contents

Executive Summary 4
1. Introduction 7
2. Background 8
2.1. What is alcohol misuse? 8
Box 2: How much alcohol is in 1 unit of a drink? 9
Source: Know Your Limits Campaign – www.units.nhs.uk 9
2.2. Why tackle alcohol misuse? 9
3. Aims and Objectives 13
4. Methods 14
4.1. Limitations 16
5. Population Profile of Surrey 17
5.1. Inequalities 17
6. Alcohol Misuse: What is the scale of alcohol misuse in Surrey? 20
6.1. Prevalence of Alcohol Misuse 20
6.1.1. Alcohol Misuse, by Age-groups 24
6.1.1.1. Underage (under-18 years) 24
6.1.1.2. Young Adults (18-24 year olds) 26
6.1.1.3. 25-44 year olds 26
6.1.1.4. Older people (over-65 years) 26
6.1.2. Alcohol misuse, by Gender 26
6.1.3. Alcohol Misuse in Prisons 27
6.1.4. Alcohol misuse with Dual diagnosis 28
6.2. Health Impacts of Alcohol Misuse 29
6.2.1. Alcohol-related Hospital Admissions 29
6.2.2. Alcohol-related Mortality Rate 32
6.2.3. Alcohol-Specific Hospital Admissions 34
6.2.4. Alcohol-Specific Mortality Rate 34
6.3. Social Impact of Alcohol Misuse 36
6.4. Economic Impact of Alcohol Misuse 40
7. Alcohol Misuse Services: What works and what is available in Surrey? 42
7.1. Alcohol Misuse: What works for Alcohol Misuse 42
7.1.1. Prevention and Education 42
7.1.2. Early identification and harm minimisation 42
7.1.3. Interventions: Treatment and Rehabilitation 43
7.1.4. Enforcement of legislation 46
7.2. Alcohol Misuse: What is available in Surrey? 47
7.2.1. Tier 1: Screening Brief advice, and Referral 48
7.2.2. Tier 2: Open Access Support, Assessment and Referral 49
7.2.3. Tier 3: Community-based treatment services 49
7.2.4. Tier 4: Inpatient and/or residential care planned treatment 50
7.2.5. Numbers attending Services 50
7.2.6. Waiting times for Alcohol Services 51
7.2.7. Commissioning of Alcohol Services in Surrey 51
7.3 Prisons 51
7.4 Young People 52
7.5 Enforcement of legislation 54
8. Gaps and Priorities 56
8.1. Intelligence on Alcohol Misuse in Surrey 56
8.2. Service Issues for Alcohol Misuse 56

8.2.1. Commissioning of Services 56
8.2.2. Education and Prevention 56
8.2.3. Early Identification and harm minimisation 57
8.2.4. Treatment and Rehabilitation 58
8.2.5. Enforcement 58
8.2.6. Equity of alcohol misuse services 58
9. Conclusion 60
Acknowledgements 62
Appendix I 63
Appendix II 65
Appendix III 64

Executive Summary

Alcohol in the UK has always been strongly linked to its culture both negatively and positively. However, there has been increasing concern in recent years about the adverse effect that alcohol can have on individuals, families and society as a whole. Such concern led to the publication of a national strategy in 2004 *'Alcohol Harm Reduction Strategy for England'* and more recently a 'next steps' document *'Safe. Sensible. Social'* in 2007, which seeks to take the original strategy forward. This document also served as a stimulus for action in Surrey and highlighted the need for greater understanding about alcohol use in the County.

Through this needs assessment we have sought to identify the key issues in relation to alcohol misuse specifically, with a view to using this information, coupled with the results of a large consultation exercise *'The Surrey Big Drink Debate'* to enable us to develop an extensive Surrey wide alcohol strategy.

Chapters 1 & 2 – Introduction and Background

Alcohol misuse is a general term used to describe any drinking behaviour, which has the potential to cause harm or threatens to damage the health and well-being of the user and those around them. Alcohol misuse would therefore include any level of risk from hazardous drinking through to alcohol dependence.

Excessive drinking is harmful to health and largely preventable; it is associated with:

- 180,000+ hospital admissions per year
- 15,000-20,000 deaths per year

The main health consequences of excessive drinking are:

- Liver disease
- Cancer
- Stroke
- Hypertension
- Acute intoxication
- Deaths from injuries

In addition to the health risks, there are major financial costs associated with alcohol misuse:

- Up to £1.7 billion a year in healthcare costs alone
- Around £20 billion a year in direct and indirect costs

Reducing alcohol misuse at population level can bring a cost saving that is five times greater than the money spent on it by public services. The development of local alcohol strategies is now a national priority.

Chapters 3 & 4 – Aims and Methods

This AHNA sought to examine:

- The scale of alcohol misuse in Surrey
- Existing services and interventions
- Evidence of what works
- Recommendations of Models of Care for Alcohol Misusers (MoCAM)[1]
- Stakeholder views on gaps and priorities for alcohol misuse services

Chapter 5 - Population profile of Surrey

Surrey is a large County with a population of over one million people. This population is projected to rise over the coming decade with notable increases in the number of older people (65+) living here. This may have a significant impact on service planning as older people are more likely to experience long term illnesses and if this is coupled with prolonged alcohol misuse, these illnesses may require more intensive treatment over a sustained period of time.

Other key sections of the population, which may have particular needs in relation to alcohol in Surrey include:

- Under 18s
- Young adults
- Those aged 25-44 years
- Prisoners

- Those with associated psychiatric problem or substance misuse.

Chapter 6 - What is the scale of alcohol misuse in Surrey?
This Alcohol Health Needs Assessment estimated that a substantial number of people in Surrey drink above the recommended daily safe limits. There are estimated to be:

- 213,407 hazardous drinkers
- 34,532 harmful drinkers
- 168,473 binge drinkers
- 35,419 moderate to severely dependent drinkers
- 36,232 people with psychiatric illness along with alcohol misuse
- 580 prisoners with harmful drinking levels

Runnymede has the highest levels of hazardous drinking in the country. Runnymede, Surrey Heath and Guildford have the highest hazardous drinking levels in Surrey. For harmful drinking and binge drinking, Runnymede, Guildford and Spelthorne have the highest levels in Surrey.

There is evidence that alcohol consumption among young people, particularly among those aged under 18 is rising. Hazardous / harmful drinking and alcohol dependence are found commonly among middle-aged or older age groups, while binge drinking affects 16-24 years old mostly.

It is estimated that 254 men and 206 women die every year in Surrey as a result of alcohol misuse

The scale of the problem in relation to alcohol misuse varies according to where people live, therefore the health needs around alcohol misuse differ by borough and by type of area i.e. rural or town centre location.

There is inequality in the distribution of health indicators of alcohol misuse across the boroughs and Surrey localities:

- Elmbridge, Epsom & Ewell and Guildford rank high for alcohol-related deaths from causes including stomach cancer, accidents, suicides and undetermined injury
- Spelthorne, Woking and Waverley have the highest alcohol-specific mortality rates among men
- Epsom & Ewell, Mole Valley and Reigate & Banstead have the highest alcohol-specific mortality rates among women

Women in Reigate and Banstead had significantly lower alcohol specific hospital admission rates, but the third highest mortality rates. This may indicate that women in this area are not accessing services early enough to get the treatment they need and therefore may have advanced stages of a particular disease when intervention is no longer viable. This aspect may require some careful analysis of the factors that influence the way services are provided and how they are utilised by the local population.

Key issues identified include:

- Approximately 50% of alcohol-related admissions present as an emergency - two in five cases of violent assault attending the A & E of Royal Surrey County Hospital were linked to alcohol use
- Mental and behavioural disorders due to alcohol misuse are the most commonly reported diagnosis for hospital admissions
- There is some evidence to link alcohol misuse to deprivation as a linear correlation was found between alcohol-related diagnosis per 1000 population in Surrey and Index of Multiple Deprivation (2007) Average SOA Score

The relationship between alcohol misuse and social indicators is complex. Nationally, alcohol misuse contributes to:

- Around half of all violent crimes are alcohol related[2]
- Around a third of all domestic violence incidents are alcohol related[2]
- 37% of all assaults are alcohol related[16]

In Surrey, there are 20,000 children affected by parental alcohol problems. More than a third of violent offences reported to Surrey Police have alcohol misuse recorded in relation to the incident. Such incidents usually occur in known hotspots around town centres and the highest number of violent incidents take place on pub premises.

Alcohol misuse is a major factor contributing to economic and productivity loss in workplaces from sickness and other absenteeism.

Chapter 7 - Alcohol Misuse Services

Evidence about what works in reducing alcohol misuse indicates that:

- Prevention and treatment programmes work to reduce alcohol misuse
- Consistent safe drinking messages and educational campaigns can help inform people and raise their awareness of the harmful effects of alcohol misuse
- Offering a brief interventions to hazardous drinkers in Surrey could prevent future alcohol dependency.
- Psychosocial therapies and support have shown effectiveness in preventing relapse of alcohol misuse among dependent drinkers
- Acamprosate, a medication, is best given together with psychological interventions to achieve maximum benefits

The Department of Health has recommended a fully integrated and comprehensive service model integrated with the existing health and drugs services at primary, secondary and tertiary levels. A multi-sectoral partnership approach for service development has been recommended by the Models of Care for Alcohol Misusers (MoCAM).[1]

In Surrey, Tier 1 and 2 alcohol services in primary care are currently lacking in resources, capacity and training. A number of statutory and non statutory agencies provide care at tier 2, 3 and 4, yet there appears to be a substantial 'gap' between the numbers of dependent drinkers and specialist treatment available for severe drinkers.

Chapter 8 - Gaps and Priorities

There are a lack of services at primary care level. The development of an alcohol Locally Enhanced Service (LES) would be highly beneficial in identifying hazardous, harmful and dependent drinkers in order to ensure appropriate advice, information and referral to specialist services takes place.

The needs of those with alcohol as a primary problem and those with psychological needs should be dealt with as a major priority. Preventing hazardous drinkers from becoming harmful or dependent should also be a priority for investment.

There is a need to address alcohol misuse from a platform that has multi-sectoral and multiagency involvement. The Joint Commissioning Group for substance misuse may be a useful starting point to build and take forward a single alcohol misuse agenda for Surrey.

Chapter 10 – Recommendations

This AHNA has highlighted the need to focus on 6 key action areas and has resulted in 19 recommendations, which can be seen in detail in Appendix III on page 64:

1. **Information issues**
2. **Commissioning of Services**
3. **Education and Prevention**
4. **Early Identification and harm minimisation**
5. **Treatment and Rehabilitation**
6. **Enforcement**

The recommendations will be addressed in a separate document outlining those that will be addressed in the forthcoming strategy and those where work will be started in 2008/09.

1. Introduction

Surrey is one of the largest counties in Britain, with a population of over one million people. It is a largely affluent county, but this apparent prosperity masks areas of real need in Surrey, which can often be neglected and has lead to some quite marked health inequalities across the county.

The adverse effects of alcohol misuse on the social and economic aspects of life in England are widely recognised. The government's *Alcohol Harm Reduction Strategy for England* (2004)[2] and *Safe Sensible Social, The Next Steps in the National Alcohol Strategy* (2007)[3] outlined national priorities for reducing alcohol misuse. There is now a clear imperative for local government and PCTs (who have lead responsibility) to reduce the harm from and cost of dealing with alcohol misuse through a strategic and partnership approach. This report aims to assess the health needs associated with alcohol misuse in Surrey and will be used to inform a county wide Alcohol Strategy due to be completed in March 2009.

2. Background

Over 90% of the adult population drink. For many individuals, alcohol is associated with socialising, relaxation and pleasure. Evidence has shown that in moderation alcohol can provide health benefits by lowering the risk of death from coronary heart disease and stroke for those over the age of 40. In addition, alcohol plays an important role in our economy with the drinks market accounting for more than £30 billion a year and is estimated to be linked to around a million jobs.[2]

Most people drink alcohol sensibly but for those who drink in excessive amounts, the resulting damage to the person, their family and society as a whole can be significant.[3]

2.1. What is alcohol misuse?

Alcohol misuse is a general term used to describe any drinking behaviour, which has the potential to cause harm or threatens to damage the health and well-being of the user and those around them. Alcohol misuse would therefore include any level of risk from hazardous drinking through to alcohol dependence (see box 1).

Box 1: Categories of Alcohol Use:

Sensible (low risk) drinking is drinking alcohol within limits that do not pose any risk of harm to the person or others (i.e. staying within the current guidelines on alcohol consumption)

Hazardous (increasing risk) drinking is drinking above recognised sensible levels, but not yet experiencing harm (measured by consumption of between 22 and 50 units per week for males and between 15 and 35 units per week for females)

Harmful (high risk) drinking is drinking above recognised sensible levels and experiencing harm, such as an alcohol-related accident, acute alcohol poisoning, hypertension, cirrhosis (measured by consumption of over 50 units per week for males and over 35 units per week for females)

Binge drinking is drinking over double the daily recognised sensible levels in any one day (over eight units a day for men and over six units a day for women)

Alcohol dependence refers to drinking behaviour characterised by an inner drive to consume alcohol, continued drinking despite harm and commonly withdrawal symptoms on stopping drinking

Alcohol Health needs Assessment Research Project (2005)[4]

Alcohol dependence is measured using a screening questionnaire called the Alcohol Unit Disorder Identification Test (AUDIT; see Appendix I). An AUDIT score of 10 and above would indicate alcohol dependence.[5]

The current government advice[3] on daily limits for safe drinking is as follows:

- Adult women should not regularly drink more than 2–3 units of alcohol a day;
- Adult men should not regularly drink more than 3–4 units of alcohol a day;
- Pregnant women or those trying to conceive should not drink or drink not more than 1-2 units of alcohol once or twice a week.

The number of units in an alcoholic beverage would depend on the size of the drink and the type / strength of the alcohol within it. The absolute alcohol by volume (abv) in many drinks has increased over the years making it more and more difficult for individuals to determine the number of units they are consuming (see box 2).

Box 2: How much alcohol is in 1 unit of a drink?

One unit of alcohol contains 8 grams of pure alcohol (ethanol), which is equal to 10 ml of pure alcohol.

The equation that is used to calculate the number of units in a drink is:

$$\text{Units in a drink} = \frac{\text{Volume of drink in ml} \times \text{drink strength - \% abv}}{1000}$$

Beer, Lager & Cider	Bottle (330ml)	Can (440ml)	Pint (568ml)	Litre
5% abv	1.7 units	2.2 units	2.8 units	5 units
Alcopops 5%	1 bottle (275ml)	-	-	-
5% abv	1.4 units	-	-	-
Spirits (38 - 40%)	Small measure (25ml)	Large measure (35ml)	Small double measure (50ml)	Large double measure (70ml)
38-40% abv (Gin, rum, vodka & whisky)	1 unit	1.4 units	1.9 - 2 units	2.7 - 2.8 units
Wine & Champagne (red, white, rose or sparkling)	Small glass (125ml)	Standard glass (175ml)	Large glass (250ml)	Bottle (750ml)
12%	1.5 units	2.1 units	3 units	9 units
13%	1.6 units	2.3 units	3.3 units	9.8 units
14%	1.75 units	2.5 units	3.5 units	10.5 units

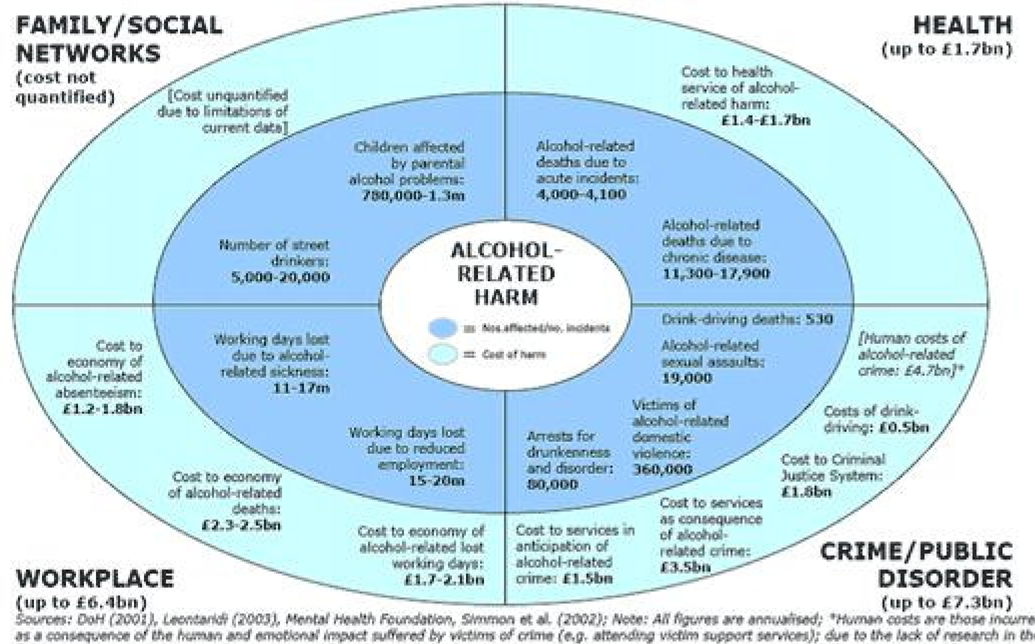
Source: Know Your Limits Campaign – www.units.nhs.uk

2.2. Why tackle alcohol misuse?

Excessive drinking is harmful to the health and wellbeing of individuals and the wider community in which they live. Whilst the health effects of alcohol misuse are largely felt by the individual alone, the social problems that arise affect everyone.

Excessive drinking costs the UK around £20 billion a year in costs incurred in dealing with the health and social impact of alcohol and indirectly through lost of productivity due to sickness absence, disability and premature death.[6] These costs do not take into account the human costs of alcohol in terms of its impact on families and children (figure 1).

Figure 1:



Source: BMJ Health Intelligence

Nationally, alcohol misuse results in:

- 180,000+ hospital admissions each year, which are due to alcohol related illness or injury – rising
- 15,000-20,000 premature deaths each year are associated with alcohol misuse
- In 2005, 4,160 people died from alcoholic liver disease – almost doubling in 10 years

Further national estimates reveal that every pound (£ 1) spent towards preventing and reducing alcohol misuse brings a five times greater saving (£5) to the public service expenditure.[1]

The main health consequences of alcohol misuse are:

- **Liver disease** – has increased substantially over the last ten years. Alcohol related liver disease accounts for 33,000 hospital admissions and over 4,500 deaths each year
- **Cancer** – after smoking, alcohol is the next most important factor in terms of the risk of developing cancer. It is a proven cause of cancer and is responsible for nearly 5,000 cancer deaths a year in the UK[7]
- **Stroke** – chronic excessive alcohol consumption increases the risk of both haemorrhagic and ischaemic stroke
- **Hypertension** – The incidence of hypertension is approximately double in people who regularly drink more than 6 units of alcohol per day.[6] Hypertension accounts for around 3,000 deaths a year in the UK
- **Acute intoxication** – tends to occur from binge drinking and refers to disturbances in the levels of consciousness, cognition, perception, mood or social behaviour. Intoxication was responsible for 23,000 hospital admissions in 2000-2001[7]
- **Deaths from injuries** – Alcohol is linked to around 14% of all deaths from injuries every year

Table 1 below outlines the full impact of alcohol misuse on individuals and others.

Table 1: Consequences of Alcohol Misuse

Physical	Gastritis
	Pancreatitis – acute & chronic
	Oesophageal varices & haemorrhage
	Hepatitis – acute & chronic
	Oesophageal, gastric, liver & colon cancers
	Laryngeal & oropharyngeal cancer
	Breast & prostate cancer
	Cholelithiasis

	Obesity
	Myopathy
	Neuropathy
	Cardiovascular disease: cardiomegaly, arrhythmias, angina, hypertension & stroke
	Road traffic accidents – injuries & deaths
	Occupational injuries
	Poisoning
	Hypothermia
Mental	Depression & Anxiety
	Dependence
	Psychosis
	Self harm
	Suicide
Foetal	Miscarriages & abortions
	Low birth weight
	Foetal alcohol syndrome
Social	Street, petty & knife crimes, Violent behaviours, Unsafe neighbourhoods
	Child neglect & abuse, Rape
	Family breakdown & Domestic Violence
	Loss of employment; Debt
Environmental	Noisy neighbourhoods, litter
Economic	Loss of workplace productivity, working days lost, sickness absenteeism

Importantly, much of the harm from alcohol misuse is preventable. The damaging effects of alcohol misuse can affect the work of several public services. Hence a partnership approach has been recommended to reduce alcohol misuse at population level.

Given this background it is expected that the Surrey Safer and Stronger Community Partnership Board (SSCPB) may be in a position to deliver effective solutions for this multifaceted problem. The Alcohol Health Needs Assessment (AHNA) for Surrey was thus carried out to inform a strategic overview of alcohol misuse locally.

As a result of the harm associated with alcohol, the Department of Health incorporated a target for alcohol in its most recent performance indicator set, vital signs. This target has also been picked up in the most recent Local Area Agreement (LAA) highlighting the commitment to tackle this issue in partnership.

The Vital Signs target for alcohol is around alcohol related hospital admissions, specifically:

Rate of hospital admissions for alcohol related harm per 100,000 population.

The rate is calculated using Hospital Episode Statistics data on alcohol related diseases where there is a finished episode of care and population estimates.[1,2] PCTs were instructed to ensure that there was a decreasing or negative percentage change from the level recorded in the previous financial year and the current financial year.

Surrey PCT has submitted the flowing trajectory (table 2), based on the baseline information recorded in table 3. 2005/06 was the baseline for the trajectories, but you can see that actual admissions have increased substantially since 2002, flattening out in 2005/06, meaning that reducing the % change is going to be extremely challenging.

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[1] **Alcohol Specific mortality or admissions** = Conditions that are wholly related to alcohol (e.g. alcoholic liver disease or alcohol overdose).

[2] **Alcohol related (or attributable) mortality or admissions** = Alcohol-specific conditions plus conditions that are caused by alcohol in some, but not all, cases (e.g. stomach cancer and unintentional injury). For these, different attributable fractions are used to determine the proportion related to alcohol.

Table 2

VSC26 **Rate of hospital admissions for alcohol related harm**

Read the definitions in the Vital Signs technical note before completing the table

		2008_09	2009_10	2010_11
VSC26_01	2001 Census based mid-year population estimates for the respective calendar years	1,090,251	1,094,702	1,099,197
VSC26_02	Rate of hospital admissions for alcohol related harm per 100,000 population	1,242	1,274	1,296

Table 3

Year	2002	2003	2004	2005	2006	2007	2008	2009	2010
Actual Trend	668	727	899	1046	1054				
Proposed Trajectory						1174	1242	1274	1296
% Change					11.1%	7.8%	5.8%	2.6%	1.7%

Based on the current trend of hospital admissions, we would have to prevent (see also table 4):

- **715 admissions in 2008/09**
- **1563 admissions in 2009/10**
- **2521 admissions in 2010/11**

Table 4: Projected actual numbers of admissions due to alcohol related conditions

	2008	2009	2010
Linear Trend of Actual	14,377	15,577	16,777
Compromise	13,662	14,014	14,256
Number need to prevent to achieve target	715	1,563	2,521

3. Aims and Objectives

This Alcohol Health Needs Assessment (AHNA) aims to identify the health needs of people living in Surrey, in relation to alcohol misuse.

The main objectives for this project were to:

1. Describe the scale and consequences of alcohol misuse in Surrey.
2. Describe the existing services in relation to the recommendations of Models of Care for Alcohol Misusers (MoCAM, 2006)[1] and evidence-based practice.
3. Obtain stakeholder view of the gaps and priorities for service development.
4. Make recommendations to the local alcohol strategy group in this regard.

4. Methods

The Alcohol Health Needs Assessment (AHNA) was based on the following information:

- prevalence of alcohol misuse and related problems in Surrey
- existing services for alcohol misuse in Surrey
- published evidence on interventions and good practice for tackling alcohol misuse
- stakeholders' views about perceived gaps and priorities for alcohol misuse services

The main sources of information used for the project are shown in the table 5.

Table 5: Sources of Information for the AHNA Surrey

Level	Title	Publisher
NATIONAL	General Household Survey, 2006	Office of National Statistics (ONS)
	Review of Effectiveness of treatments for Alcohol Problems, 2006	National Treatment Agency (NTA)
	Models of Care for Alcohol Misusers (MoCAM), 2006	Department of Health (DH)
	Alcohol Needs Assessment Research Project (ANARP), 2005	Department of Health (DH)
	Health Survey for England, 2004	Department of Health (DH)
REGIONAL	Local Alcohol Profiles for England, 2007	North West Public Health Observatory (NWPHO)
	Choosing Health in the South East, 2005	South East Public Health Observatory (SEPHO)
LOCAL	Commissioning Minimum Dataset, 2007	Surrey Primary Care Trust (PCT)
	Clearnet database, 2007	Surrey Primary Care Trust (PCT)
	Force Violence Sanitised Campaign 2007	Surrey Police
	Tackling Underage Sales of Alcohol campaign (TUSAC) for Surrey, 2007	Surrey County Council (SCC)
	Safer and Stronger Communities Partnership Board Report, 2007	Safer and Stronger Communities Partnership Board (SSCPB)
	Statistical Assessment of the Impact of Alcohol Misuse on Surrey, 2006	Surrey Drugs and Alcohol Action Team (DAAT)
	Surrey Drug & Alcohol Action Team Alcohol audit, 2006	Surrey Drugs and Alcohol Action Team (DAAT)
	Alcohol Prevalence in Surrey, 2005	Surrey Drugs and Alcohol Action Team (DAAT)
	Alcohol Related Crime & Disorder in Surrey, 2003	Surrey Community Safety Unit (SCSU)
	Local Alcohol audits, Local Strategic Partnership (LSP) Reports	Acute Trusts, Local strategic Partnerships (LSPs)

For the purpose of this report, the prevalence of alcohol misuse was primarily based on the General Household Survey (2006)[8] findings which were extrapolated to the mid-2004 population of Surrey to estimate the numbers of hazardous, harmful and dependent drinkers in Surrey. The survey uses standardised methodology, valid tools and takes place at regular intervals. The findings are generalisable to the population of England because it is based on a large, representative sample.

The Surrey DAAT (2005, 2006) and SEPHO (2005) have also used the national surveys to obtain local estimates for alcohol misuse.

The GHS[8] does not provide information on the sampling error, which affects the calculation of confidence intervals. The confidence interval for the numbers of hazardous, harmful and binge drinkers in Surrey was calculated by calculating the sampling error for proportions.

The information on commissioning arrangements was sought from Surrey Primary Care Trust (PCT) and Surrey Drugs and Alcohol Action Team (DAAT) as these are the main commissioners of alcohol misuse services in the county. At the same time the service providers (statutory and non-statutory) were also approached to describe their structure, existing resources, funding arrangements, referral pathways, activity and monitoring data.

A literature search was carried out to look for published evidence at national, regional and local levels to identify what works in the context of reducing alcohol misuse. The search strategy focussed on using Google, Scholar Google, Pubmed, Cochrane and internet sites of organisations such as the Department of Health, National Treatment Agency, Home Office, Alcohol Concern, Alcohol Anonymous and Prison Reform Trust. The needs assessments carried out in other parts of England were also reviewed through direct contact with Primary Care Trusts (PCTs) and internet search where direct contact was not readily available.

Face-to-face interviews, telephone and electronic communications were used to get stakeholder views on gaps and priorities for action. The commissioner and provider agencies that participated in the process are listed below (list 1).

List 1: Agencies contributing to the AHNA in Surrey

1. Surrey County Council (SCC)
2. Surrey Stronger and Safe Communities Partnership Board (SSSCPB)
3 Surrey Drugs and Alcohol Action Team (Surrey DAAT)
4. Surrey Primary Care Trust (PCT)
5. Surrey Police, Guildford
6. Surrey Probation Services
7. General Practitioners, (GP) Guildford & Chertsey
8. Accident and Emergency (A&E), Epsom
9. Her Majesty's Prison Health Service (HMPS): Highdown and Send Prisons
10. Rehabilitation for Addicted Prisoners Trust (RAPt)
11. Acorn
12. Windmill
13. Respond
14. Surrey Alcohol and Drugs Advisory Service (SADAS)
15. Surrey Alcohol Brief Intervention Service (SABIS)

4.1. Limitations

The ability to make comparisons and draw common themes from the available data is limited for this project. There appeared to be a discrepancy in the information from different sources, which could be due to the differences in the instruments used, time-periods reported on and changes in definitions over time. Changes to survey instruments over time do not allow for reporting of accurate trends as the way behaviour is measured over one time frame is different from the methodology followed over another time frame.

The General Household Survey, carried out annually since 1971, gives information on adult (16+ years) drinking behaviour. The Health Survey for England, commissioned by the Department of Health since 1991, also asks about use of alcohol. These two sources provide estimates of the prevalence of people drinking above safe daily limits. However, as there is self-reporting involved which depends on the recall of the respondent, findings are likely to be an under or over estimate of the real picture.

There have been other changes that affect the measurement of prevalence of alcohol misuse nationally, regionally or locally. The recommended safe drinking limits changed from a weekly measure of units to a daily measure of units in 1995.[3] These changes and variations make it difficult to compare prevalence over different points in time.

Recently the North West Public Health Observatory (2007) published local area alcohol profiles for England using data from a variety of sources, including the alcohol industry which reported on trades and sales of alcohol. The methodology used provides synthetic estimates through complex modelling of information from a number of sources and as such, this may be a closer estimate of the real picture.

It is fair, however to conclude that despite variations and limitations, a picture of local alcohol needs for Surrey can be reasonably obtained by triangulating information from different quarters to serve as a baseline. Further assessments carried out locally could be part of future alcohol needs assessments.

5. Population Profile of Surrey[9]

Surrey has over one million people living in eleven boroughs, which together form the North West, South East and South West areas of Surrey PCT (table 6). Table 3 outlines the number of people in each locality for mid-2004 and 2007.

Table 6: Resident Population in Surrey by localities (mid-2004 & 2007)

Locality	Boroughs	Population (2004)	Population (2007)
North West	**Runnymede**	78,500	79,400
	Spelthorne	88,400	87,300
	Elmbridge	127,500	135,000
	Woking	89,600	91,100
South West	**Surrey Heath**	81,100	82,200
	Guildford	130,700	133,600
	Waverley	116,300	116,600
South East	**Epsom & Ewell**	68,000	69,400
	Reigate & Banstead	126,900	128,500
	Tandridge	79,300	80,000
	Mole Valley	80,900	81,600
Total		1,067,200	1,084, 800

Source: Office of National Statistics: National resident population projections (2004, 2007)

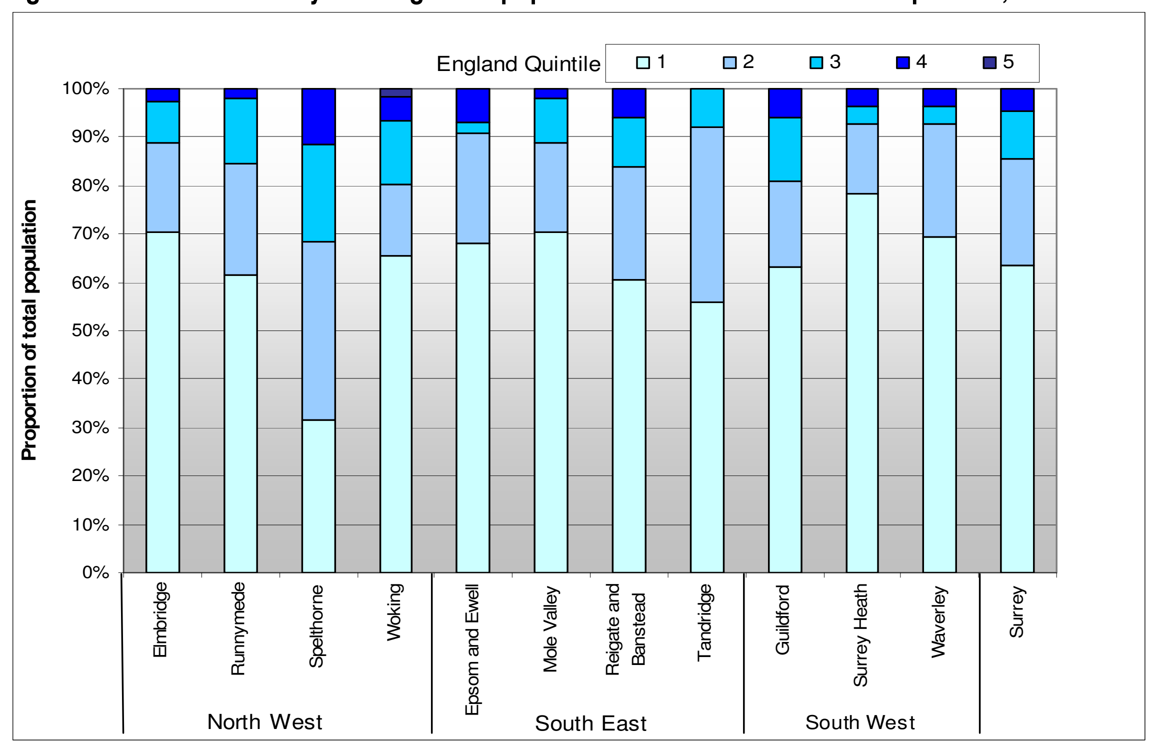
The mid-2007 population is the latest projected estimate of Surrey's population, citing an overall increase of 15,000. The North West locality has the largest population and the South West locality has the smallest. Elmbridge is the largest local authority, which together with Guildford and Reigate & Banstead constitutes more than a third of the population resident in Surrey.

5.1. Inequalities

The County has a diverse environment with a mix of rural and urban areas. While overall the population is affluent in comparison to the national average, there are masked pockets of deprivation and inequalities present across Surrey.

The Index of Multiple Deprivation (IMD) is a national index that identifies the spread of relative deprivation by local authority, electoral ward and "super output areas". The LA boroughs across the whole of England have been ranked according to this index. Using the IMD 2007, Spelthorne appears to have the largest proportion of the population living in areas that are ranked among the most deprived quintile in England. Woking, Epsom & Ewell and Reigate and Banstead follow next with a greater proportion of people living in low-income households (Figure 2).

Fig 2: Distribution of Surrey and England's population in relation to IMD score quintiles, 2007



Source: Ministry for Communities and Local Government

Young people (U18s), young adults (18-24 years), those aged 25-44 years, older people (65+) and the prison population are subgroups with specific needs in the context of alcohol misuse. Their needs merit special consideration in order to achieve horizontal[3] as well as vertical equity[4] across the county for alcohol services.

Guildford, Waverley and Elmbridge have the highest population of young people (15-19 years old). In general, there are greater numbers of older people (65+ years) living in Surrey than in England. This population group is projected to grow by 17% in 2011. With more people living for longer the effects of chronic alcohol misuse may become more manifest and more prevalent. This in turn may impact on the planning of health and social care services significantly. Currently, the highest proportion of older people (65+ years) lives in Waverley.

The greatest numbers of hazardous, harmful and binge drinkers are in the 25-44 year old age group. The working age population is significant and is perhaps where action needs to take place in order to prevent alcohol related harm long term.

Ethnic groups in Surrey have increased as a proportion of the total population. It was 3% in 1991 and rose to 5% in 2001. There was a further increase to an estimated 6.8% of the Surrey population in 2004. These ethnic groups have a lower prevalence of hazardous/harmful alcohol use, but the prevalence of alcohol dependence is similar to that of the white population[4]. The use of alcohol services by those belonging to ethnic minorities may differ according to their attitude and preferences, so it is important to consider this when planning equal access and opportunity for services users.

There are five prisons in Surrey (table 7) with a total operational capacity for 1137 male and 1026 female inmates. In prisons, alcohol misuse has been reported to be high amongst both male and female sentenced or remand prisoners[10]. Hence the needs of the prison population in Surrey requires a discrete focus.

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[3] Horizontal Equity = Equal service provision for the same needs.
[4] Vertical Equity=Service provision on the basis of needs. This may require treating differently the population groups with different levels of need.

Table 7: Profile of Surrey Prisons

Surrey Prisons	Gender	Operational capacity[5] (number of inmates)
High Down, Sutton	Male	747
Downview, Sutton	Female	358
Bronzefield, Ashford	Female	450
Coldingley, Woking	Male	390
Send, Woking	Female	218

Source: HM Prison Service (www.hmps.gov.uk), 2007

[5] The operational capacity of a prison is the total number of prisoners that an establishment can hold taking into account control, security and the proper operation of the planned regime.

6. Alcohol Misuse: What is the scale of alcohol misuse in Surrey?

This section reports on the prevalence of alcohol misuse amongst the adult population of Surrey. It then examines the scale of the problem:

- by age group
- by gender
- by prison population
- by mental health and/or substance misuse problems

The impact of alcohol misuse on the health, social and economic aspects of life is reported next based on information obtained from national, regional and local sources, where available.

6.1. Prevalence of Alcohol Misuse

The prevalence of alcohol misuse in a population is expressed as the proportion of people reporting hazardous, harmful, binge drinking or alcohol dependence levels of consumption. The findings of the GHS[8] were extrapolated to the mid-2004 population of Surrey to give us the absolute numbers of drinkers at each level.

The GHS[8] gives the percentage of men who report drinking >21 units per week and women drinking >14 units in England. These were used as a proxy measure for hazardous drinking. Likewise the percentage of men drinking >50 units and women drinking >35 units per week was used as a proxy measure for harmful drinking. The extent of binge drinking was measured as the percentage of people who reported drinking more than twice the recommended daily limit in a single session (men >8 units; women >6 units).

Using the GHS 2006 findings there are an estimated:

- 224,642 hazardous drinkers
- 61,688 harmful drinkers
- 168,473 binge drinkers

in Surrey (table 8, 9 and 10).

Table 8: Prevalence of Hazardous Drinking in Surrey, by gender and age group

Hazardous drinking [Men > 21 units weekly; women >14 units weekly]						
Age-Groups	**England (% drinking to hazardous levels)**		**Adult Population of Surrey (mid-2004)**		**Number of hazardous drinkers in Surrey**	
	Men	**Women**	**Men**	**Women**	**Men (CI)**	**Women (CI)**
16-24	30%	24%	54,995	53,915	**16,499** (CI 14,376 -18,621)	**12,940** (CI 11,176- 14,703)
25-44	33%	23%	167,055	158,156	**55,128** (CI 51,408 – 58,848)	**36,376** (CI 33,520-39,232)
45-64	34%	21%	145,012	136,326	**49,304** (CI 46,177 – 52,431)	**28,628** (CI 26,249-31,008)
65+	21%	10%	75,603	98,943	**15,877** (CI 14,153 – 17,600)	**9,894** (CI8,352-11,437)
TOTAL	31%	20%	442,665	447,340	**136,806** (CI 128,601-39,515)	**87,836** (CI 82,750-91,529)

Source: Office of National Statistics (2004; 2006)

Table 9: Prevalence of Harmful Drinking in Surrey, by gender and age group

Harmful drinking [Men > 50 units weekly; women > 35 units weekly]						
Age-Groups	**England (% drinking to harmful levels)**		**Adult Population of Surrey (mid-2004)**		**Number of harmful drinkers in Surrey**	
	Men	**Women**	**Men**	**Women**	**Men (CI)**	**Women (CI)**
16-24	9	7	54,995	53,915	**4,950** (CI 3,624 – 6,275)	**3,774** (CI 2,720-4,828)
25-44	9	6	167,055	158,156	**15,035** (CI 12,771-17,299)	**9,489** (CI 7,878-11,101)
45-64	10	6	145,012	136,326	**14,501** (CI 12,521 -16,481)	**8,180** (CI 6,792-9,567)
65+	5	2	75,603	98,943	**3,780** (CI 2,858 - 4,702)	**1,979** (CI 1,259 – 2,699)
TOTAL	8	5	442,665	447,340	**38,266** (CI 34,009- 40,607)	**23,422** (CI 20,780 – 25,699)

Source: Office of National Statistics (2004; 2006)

Table 10: Prevalence of binge drinking in Surrey, by gender and age group

Binge drinking [Men > 8 units in a single day; women > 6 units in a single day]						
Age Groups	**England Population (% binge drinking)**		**Adult Population of Surrey (mid-2004)**		**Number of binge drinkers in Surrey**	
	Men	**Women**	**Men**	**Women**	**Men (CI)**	**Women (CI)**
16-24	30%	25%	54,995	53,915	**16,354** (CI 14,227 – 18,480)	**13,483** (CI 11,694-15,273)
25-44	31%	21%	167,055	158,156	**51,117** (CI 47,468 – 54,766)	**33,109** (CI 30,349 – 35,869)
45-64	21%	12%	145,012	136,326	**30,554** (CI 27,861 – 33,246)	**16,714** (CI 14,798 – 18,630)
65+	7%	2%	75,603	98,943	**5,026** (CI 3,972 – 6,080)	**2,117** (CI 1,373 – 2,861)
TOTAL	23%	15%	442,665	447,340	**103,050** (CI 95,891-105,862)	**65,423** (CI 61,762 – 69,607)

Source: Office of National Statistics (2004; 2006)

ANARP[4] found that 6% of men and 2% of women are dependent drinkers. This applied to Surrey indicates the number of dependent drinkers to be 26,469 men and 8,950 women. There are therefore an estimated 35,419 alcohol dependent drinkers in Surrey.

It is expected that drinking patterns in Surrey are similar to those reported for the South East. Drinkers in the South East are more likely to be regular drinkers compared to England as a whole; 29% of men and 19% of women consume alcohol on five or more days a week. In 2004, 74% of men and 59% of women over 16 reported drinking alcohol on at least one day in the previous week. 24% of men drunk on 5 or more days, compared to 13% of women. In the South East 26% of men and 16% of women drank alcohol on 5 or more days in the previous week. In 2005, binge drinking was said to affect 17% of men and 6% of women in the South East[11].

In 2007 the North West Public Health Observatory (NWPHO) published synthetic estimates of drinking behaviour in England by local authority / borough. They combined the information from a number of different sources to determine the estimates outlined below[12](table 11).

Table 11: Synthetic estimates of harmful and hazardous drinkers in Surrey, 2007

	Number (CI)	% of Surrey Population (CI)
Hazardous Drinking	213,407 (196,122 -230,691)	25.0% (22.9% - 27.0%)
Harmful Drinking	34,532 (30,955 - 38,110)	4.0% (3.6% - 4.5%)

Source: North West Public Health Observatory; 2007

Whilst the prevalence of hazardous drinking in Surrey, reported by NWPHO, was not vastly different to that obtained by extrapolating the GHS findings to the Surrey population (224,642 through GHS compared to 213,407 through NWPHO), the figures for harmful drinking were quite different (61,688 through GHS compared to 34,352 through NWPHO). The GHS figures were almost double those in the NWPHO report. Given that the NWPHO prevalence rates are more locally derived, it would make sense to go with these figures as they may better reflect the local situation.

Alcohol misuse is not uniformly distributed among different social classes. The NWPHO report raised concerns about alcohol misuse among 'middle class wine drinkers' in Surrey who consume alcohol mainly within the confines of their own home. This group are almost hidden as they are less likely to come in contact with public services through GPs, A&E or Surrey police. They are therefore more likely to present when the damage is more serious and less amenable to interventions.

The NWPHO report also produced a ranking of local authority areas by the alcohol indicators. Seven of the 11 Surrey boroughs were among the top ten in the country for hazardous drinking. Runnymede and Surrey Heath had the highest rates of hazardous drinking, while Guildford and Runnymede had the highest rates of harmful and binge drinking (table 12). Interestingly, Spelthorne had the 3rd lowest hazardous drinking levels in Surrey, but the 3rd highest harmful drinking levels, perhaps indicating that whilst less people are drinking above sensible levels, when they do drink they are drinking at levels likely to cause harm.

Table 12: Ranking of LA Boroughs in Surrey, by rates of drinking Behaviour, 2007*

Borough	Hazardous Drinking - National Ranking $ (Surrey Ranking)	Harmful Drinking National Ranking $ (Surrey Ranking)	Binge Drinking National Ranking$ (Surrey Ranking)
Runnymede	1 (1)	195 (2)	168 (2)
Surrey Heath	3 (2)	305 (10)	250 (5)
Guildford	4 (3)	191 (1)	134 (1)
Mole Valley	6 (4)	301 (9)	309 (10)
Elmbridge	8 (5)	269 (5)	266 (7)
Waverley	9 (6)	282 (8)	299 (9)
Woking	10 (7)	264 (4)	236 (4)
Epsom & Ewell	15 (8)	275 (6)	323 (11)
Spelthorne	26 (9)	241 (3)	214 (3)

Reigate & Banstead	31 (10)	279 (7)	253 (6)
Tandridge	35 (11)	325 (11)	284 (8)

Note: *Ranking is arranged in descending order of alcohol misuse, with LA boroughs with greater prevalence of alcohol misuse being placed at the top.
$ There are 354 LA boroughs in the whole of England. NWPHO (2007) produced rankings of all 354 boroughs on the basis of various indicators of alcohol misuse.

6.2.6. Alcohol Misuse, by Age-groups

6.1.1.1. Underage (under-18 years)

It is an offence for a person to supply alcohol to anyone under 18 anywhere and to sell alcohol to anyone under 18; it is also an offence for an under 18 year old to buy alcohol and to knowingly consume alcohol on relevant premises. Young people aged 16-17 years are allowed to drink alcohol with a meal on licensed premises if accompanied by an adult (see Appendix II).

Whilst the percentage of young people aged 11-15 years who have never had a proper alcoholic drink has increased from 38% in 1988 to 46% in 2006 and the percentage of young people who have had a drink in the last week has decreased from 26% in 2001 to 21% in 2006, the level of alcohol consumption of those that do drink has increased from 5 units in 1990 to 11 units in 2006.[13] This raises concern about the health risks that children are being exposed to due to alcohol misuse, particularly since the livers of children are unlikely to have attained sufficient maturity to metabolise large amounts of alcohol.

The case for tackling underage drinking requires involvement of both parents as well as retailers. In 2006, the most common sources for 11-15 yrs olds to access alcohol from were parents (23%), friends (26%) bought on their behalf (20%) taken from home (14%). Stealing was rare with only 6% ever stealing from home and 2% stealing from external sources. Beer, lager, cider or alcopops are the most frequently consumed forms of alcohol by children and young people.[13]

There is little information on the extent or nature of drinking among young people in Surrey. The DAAT Young People's Needs Assessment (2007) identified that there are few studies that reported on the prevalence of problematic alcohol misuse amongst Under 19 year olds, even though this group had discreet needs and issues compared to the adult population. Smoking, Drinking and Drug Use in Young People[15] gives prevalence data on 11-15 year olds, but does not extend to 16-19 year olds.

The Tell Us 2 survey is a schools based survey, which looks at a range of issues affecting children and young people aged between 12 and 16 years. The survey is carried out nationally, but results are available at a Surrey level. Table 13 below outlines the results of the first survey carried out in 2007.

Table 13: Tell Us 2 Survey Results, 2007

	Surrey	National
Number reporting having ever had an alcoholic drink	45%	48%
Number reporting getting drunk once or twice in the last month	10%	12%
Number reporting getting drunk three or more times in the last month	6%	7%
Number preferring not to say / can't remember / don't know	5%	5%

Alongside the data on prevalence:

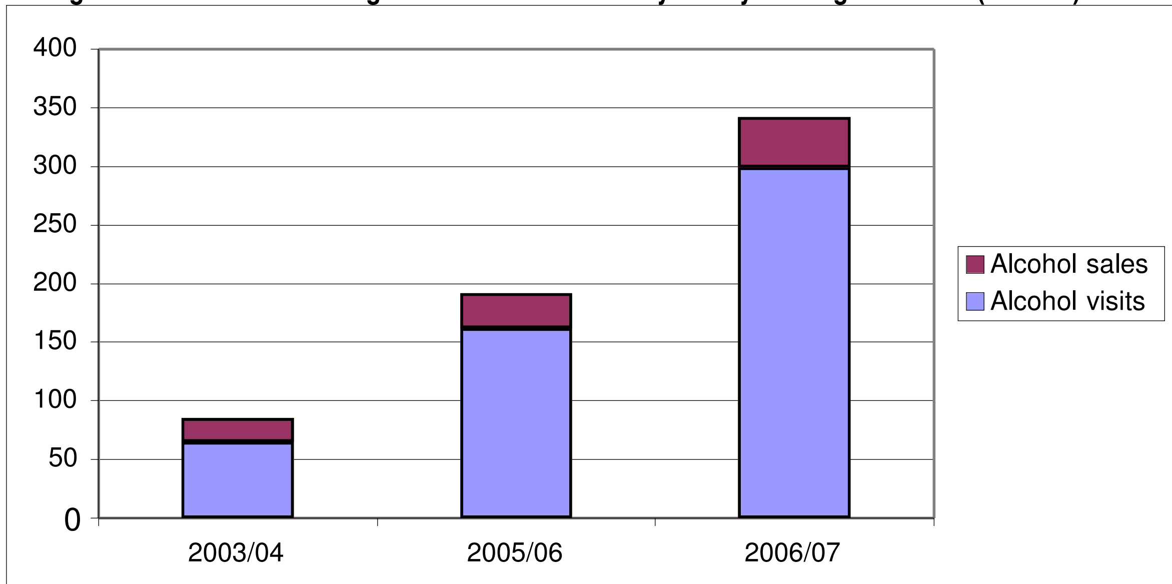
- 23% of Surrey school children felt that they needed more information on alcohol (compared to 27% nationally) and 29% felt they needed more information on drugs (compared to 31% nationally)
- 77% of Surrey school children felt that information on alcohol was good enough (compared to 73% nationally) and 71% felt that the information they received on drugs was good enough (compared to 69% nationally)

Given that this is the first year that the Tell Us 2 survey has been delivered it is difficult to draw any firm conclusions from this data. In addition, the data gives us little insight in to the demand for substance misuse services.

Surrey DAAT's young people's needs assessment stated that the majority of young people in contact with substance misuse services were either primary cannabis (41%) or alcohol users (45%); a further 40% identified alcohol as their 2nd or 3rd drug of choice.

Surrey Trading Standards have increased surveillance of underage alcohol sales since 2003. Although the number of visits by surveillance teams using underage test purchasers increased greatly from 2003/4 to 2006/7, the proportion of such visits that actually resulted in a sale decreased from 31% to 14%. (Surrey County Council 2007; see figure 3). Nationally, only 12% of young people indicated that they tried to buy alcohol from a shop or pub, perhaps highlighting the fact that whilst it is positive that successful test purchases have declined, more needs to be done around ease of access to alcohol through parents, family and friends which may be contributing more to the rise in the consumption of alcohol by young people.

Figure 3: Number of Underage sales and Test visits by Surrey Trading standards (2003-06)



Source: Surrey County Council, 2007

6.1.1.2. Young Adults (18-24 year olds)

For young adults; it is less about chronic dependence and more about binge drinking / drinking above sensible limits and the risks attached to such behaviour.

Young adults who binge drink are more likely to admit to committing criminal or disorderly behaviours during or after drinking than other regular drinkers of the same age (63% of binge drinkers compared to 34% of other regular drinkers).[3] Young adults account for a third (30%) of all offences and a quarter of all violent offences (24%) reported in the last year. The likelihood of getting involved in an argument, fight or damaging someone's belongings during or after drinking increased with how often an individual got drunk.[3]

6.1.1.3. 25-44 year olds

The greatest number of hazardous and harmful drinkers can be found in the 25-44 year age group. In order to impact on alcohol related / specific mortality this is likely to be where efforts need to be made in terms of prevention and ensuring access to treatment services as appropriate. There are estimated to be 91,504 hazardous drinkers in this age and 24,524 harmful drinkers, constituting around 1% of the total population of Surrey.

6.1.1.4. Older people (over-65 years)

Alcohol misuse declines with age[4], however the chronic health damage from prolonged alcohol misuse is more likely to manifest as we get older. Alcohol-related health problems tend to present in people in their 40s and 50s, but so far local studies in Surrey have not looked separately at the 65+ age group specifically in the context of alcohol misuse. By 2011 this age group will constitute 17.2% of the population of Surrey. Hence it is important to consider the needs of this age group specifically when planning services for alcohol misuse[9].

6.2.6. Alcohol misuse, by Gender

In England alcohol misuse is greater among men than women[4]. This is reflected in the regional pattern.[14] However, Surrey Community Safety Unit (2003) reported that the number of women drinking above recommended levels in Surrey had increased by 50% i.e. from 10% in 1988 to 15% in 1998.

Figures 4 and 5 present the mean weekly alcohol consumption by men and women of Surrey and Sussex as compared to the South East and England as a whole, over two-year rolling periods from 1994-2002. It appears here that while the weekly consumption of alcohol in men has not shown any significant change from1994/96 to 2000/02 that for women in Surrey and Sussex has increased significantly compared to that for England and the South East as a whole. However, overall consumption levels currently remain within sensible limits at around 9 units per week. This may need to be monitored regularly in case levels exceed sensible limits in the future.

Figure 4: Trends in mean weekly alcohol consumption for men, 1994-2002

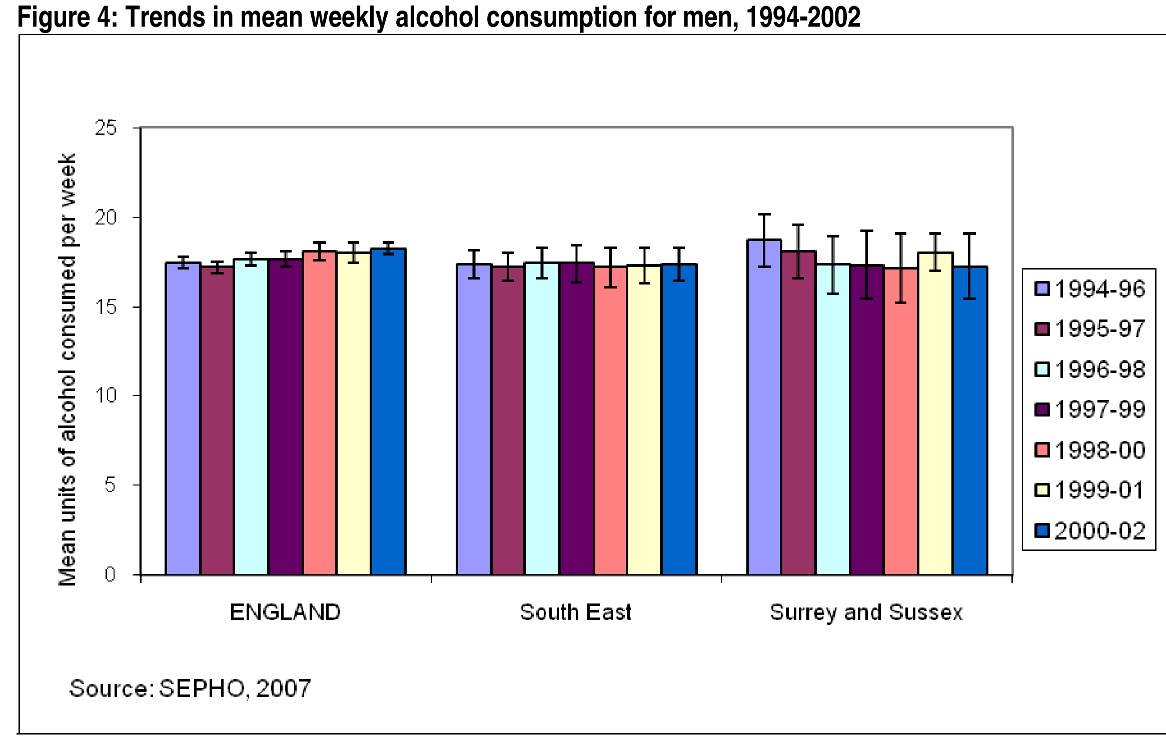
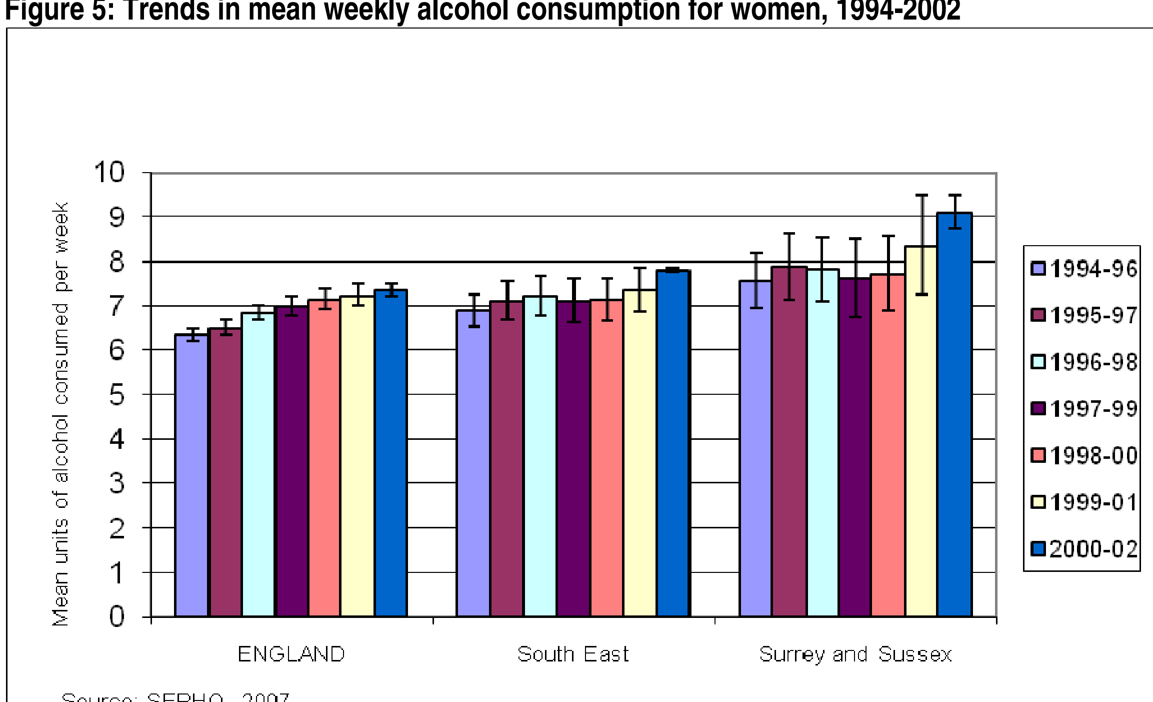


Figure 5: Trends in mean weekly alcohol consumption for women, 1994-2002



6.2.6. Alcohol Misuse in Prisons

Prisoners have extremely high rates of harmful and hazardous drinking, as measured by the Alcohol Use Disorder Identification Test (AUDIT). Nationally, it was reported that 63% of sentenced and 58% of remanded males; and 39% of sentenced and 36% of remanded female had an AUDIT score of more than 8 (indicating hazardous or harmful drinking)[15]. This survey also found that nearly a third of male prisoners and a fifth of female prisoners had an AUDIT score of 16 or above (indicating severe alcohol problems). Thus in comparison to the prevalence of alcohol misuse in the general population (6% of men and 2% of women), the alcohol

misuse needs of the prison population is high. Alcohol misuse is associated with nearly a third of suicides that occur in prisons[16].

There is limited information on the extent of alcohol misuse in Surrey's prisons. Overall two-thirds of the 74,000 prisoners in England and Wales are hazardous drinkers[18]. The findings from this national study when extrapolated to the operational capacity of Surrey prisons gives an estimate of 716 male and 400 female prisoners that are likely to be hazardous drinkers. Likewise 375 male and 205 female prisoners are estimated to be harmful drinkers.

Rehabilitation for Addicted Prisoners Trust (RAPt) reported 3,200 alcohol related arrests were made over one year in Surrey (RAPt 2007). High Down prison reported that in 2006/7, there were approximately 250 inmates identified as having alcohol misuse problems alone. This is likely to be an underestimate of the true problem.

6.2.6. Alcohol misuse with Dual diagnosis

Alcohol misuse is said to occur with a dual diagnosis when it occurs together with substance misuse or mental health problems.

Alcohol misuse is often recorded as a dual diagnosis in people who are being treated for substance misuse. A prospective cohort study which looked at 1075 people recruited to drug treatment programmes found that about a third of the participants had 'problematic or highly problematic patterns of drinking' and 8 per cent were drinking on average 42 units almost every day[17].

The odds of having a psychiatric problem in an alcohol dependent person are twice that of a person who does not have any drinking problems[18]. Surveys of psychiatric inpatients have shown that alcohol misuse problems coexist with serious mental health problems, in particular with acute psychiatric illnesses[19].

The findings of the 2000 ONS psychiatric morbidity survey[21] were extrapolated to the Surrey population to assess the prevalence of harmful drinking together with a psychiatric condition among people living in Surrey (table 13 and 14). It is estimated that there are 26,560 men and 8,947 women in Surrey who have harmful drinking together with a dual diagnosis of a psychiatric problem.

Table 13: Men drinking at harmful levels in the ONS Psychiatric survey 2000

Age	Prevalence (% having an AUDIT score 16+)	Study sample	95% CI (LL-UL)	Surrey population	Estimated number of harmful drinkers in Surrey
16-24	11.2	383	8.0-14.4	54,995	6,159 (4,400-7,919)
25-44	6.6	1,531	5.4-7.8	167,055	11,026 (9,021-13,030)
45-64	2.8	1,389	1.9-3.7	145,012	4,060 (2,755-5365
65 +	1.6	530	0.5-2.7	75,603	1,210 (378-2,041)
Total	6.0	3,833	5.2-6.8	442,665	26,560 (23,018-30,101)

Table 14: Women drinking at harmful levels in ONS Psychiatric Survey 2000

Age	Prevalence (% having an AUDIT score 16+)	Study sample	95% CI (LL-UL)	Surrey population	Estimated number of harmful drinkers In Surrey
16-24	5.0	409	2.9-7.1	53,915	2,696 (1,564-3,829)
25-44	1.5	1,987	1.0-2.0	158,156	2,372 (1,582 -3,163)
45-64	0.5	1,588	0.15-0.85	136,326	682 (204-1,159)
65 +	0.0	721	n/a	98,943	n/a
Total	2.0	4,705	1.6-2.4	447,340	8,947 (7,157-10,736)

In summary, there are significant numbers of people in Surrey who are likely to be currently drinking above sensible drinking guidelines for alcohol, indicating that there may be a high need for appropriate alcohol services across the county (see table 15 below).

Table 15: Number of people in Surrey likely to benefit from Alcohol Services

Category	Number
Hazardous drinkers:	213,407
Harmful drinkers:	34,532
Moderate to severely dependent:	35,419
Binge Drinkers:	168,473
Psychiatric illness:	35,507
Harmful drinkers in Prisons	580

6.2. Health Impacts of Alcohol Misuse

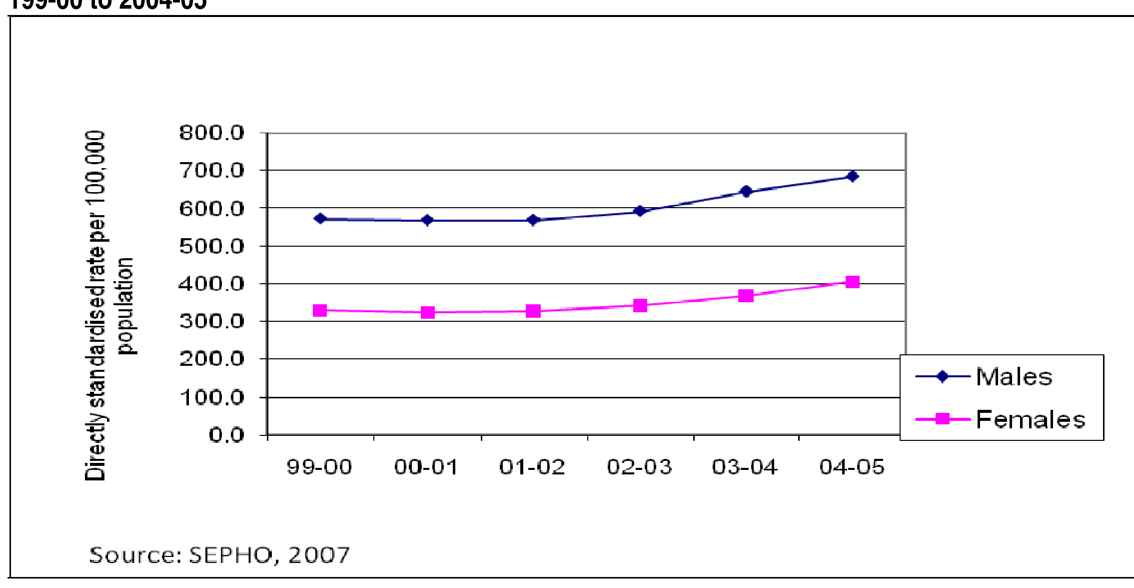
Alcohol misuse produces adverse health outcomes for both chronic and binge drinkers. A recent paper by the British Medical Association reported that excessive alcohol misuse is related to 60 medical disorders. These can result in significant ill health and premature death. There is a dose response relationship between alcohol misuse and related ill health i.e. the more a person drinks the more likely they are to suffer from ill-health as a result[20].

The key indicators used to measure the adverse health impacts of alcohol misuse are alcohol-related hospital admissions, alcohol-related mortality, alcohol-specific hospital admissions and alcohol-specific mortality. Alcohol-related conditions are those in which alcohol consumption is a contributory factor for varying proportions of cases (e.g. stomach cancer and unintentional injury).[12] Alcohol-specific conditions are those in which alcohol consumption is a contributory factor for all cases (e.g. alcoholic liver disease or alcohol overdose). The information on alcohol-related and specific hospital admissions or deaths can be obtained from routine data sources.

6.2.6. Alcohol-related Hospital Admissions

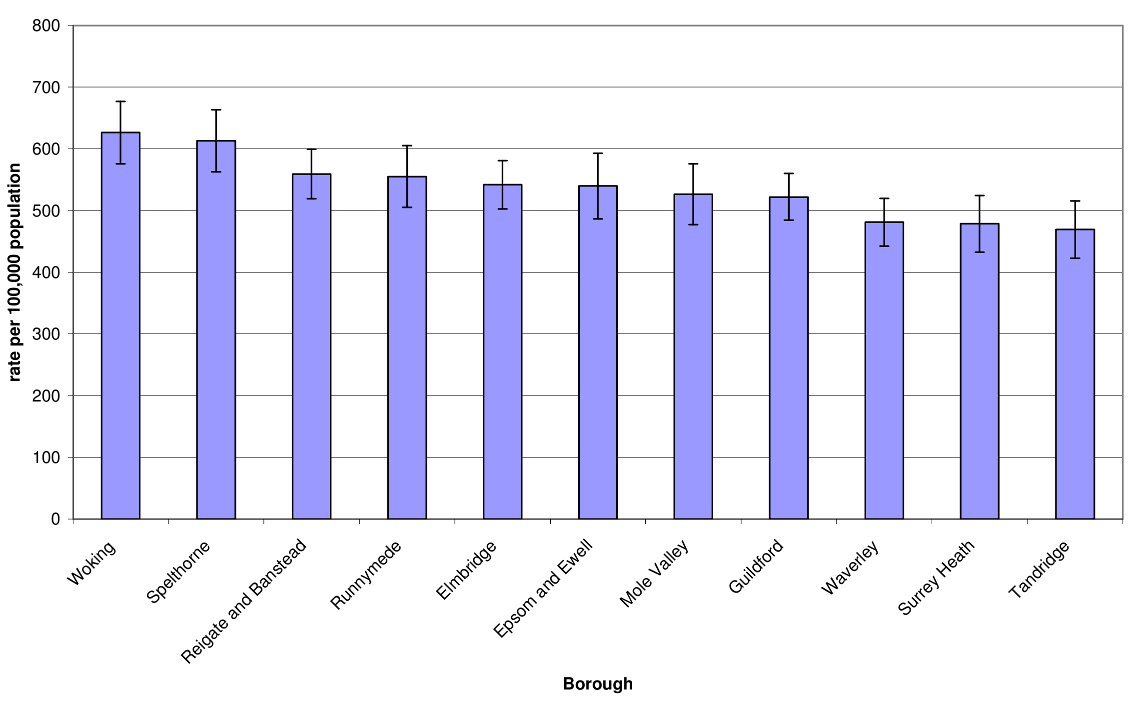
In South East England the directly standardised rates of hospital admission attributable to alcohol misuse have increased for both genders from 1999/00 to 2004/05, with men rising slightly more sharply than women (figure 6).[16]

Figure 6: Trends in alcohol attributable hospital admission rates per 100,000 in South East England, 199-00 to 2004-05



In Surrey, Woking and Spelthorne had the highest alcohol attributable hospital admission rates in 2004-2005 and were significantly higher than Guildford, Waverley, Surrey Heath and Tandridge (figure 7).

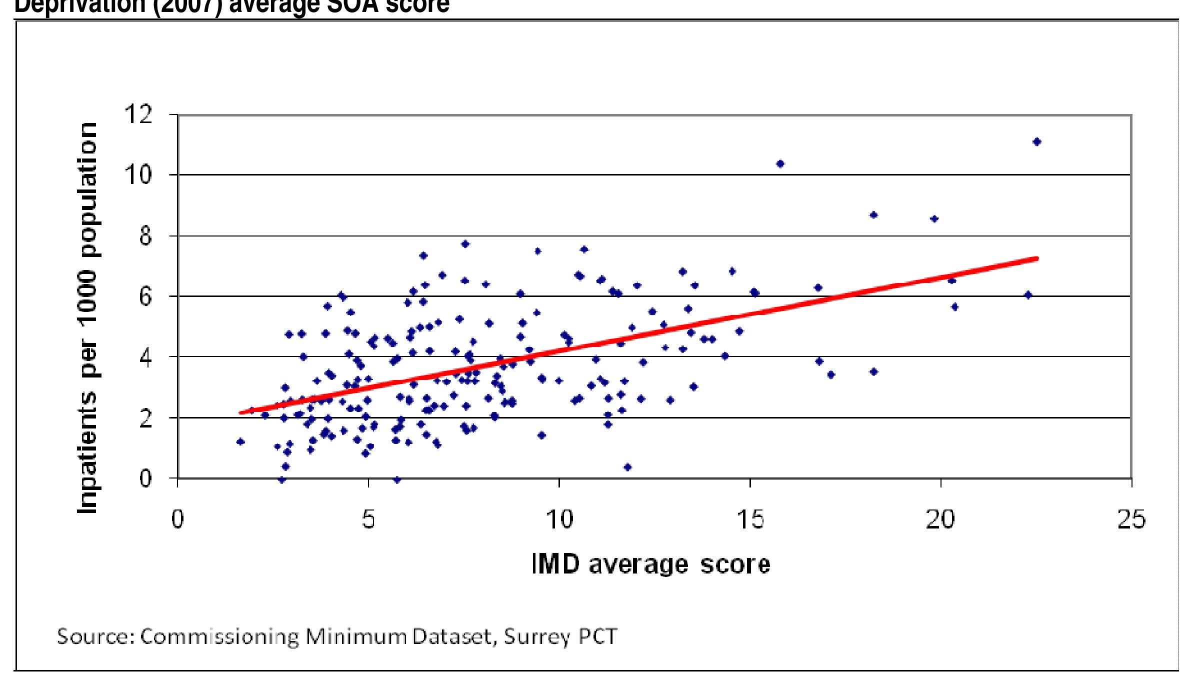
Figure 7:



Source: SEPHO, 2007

There appears to be a linear correlation between the number of inpatients with an alcohol-related diagnosis per 1000 population in Surrey and the Index of Multiple Deprivation (2007) Average SOA Score (figure 8).

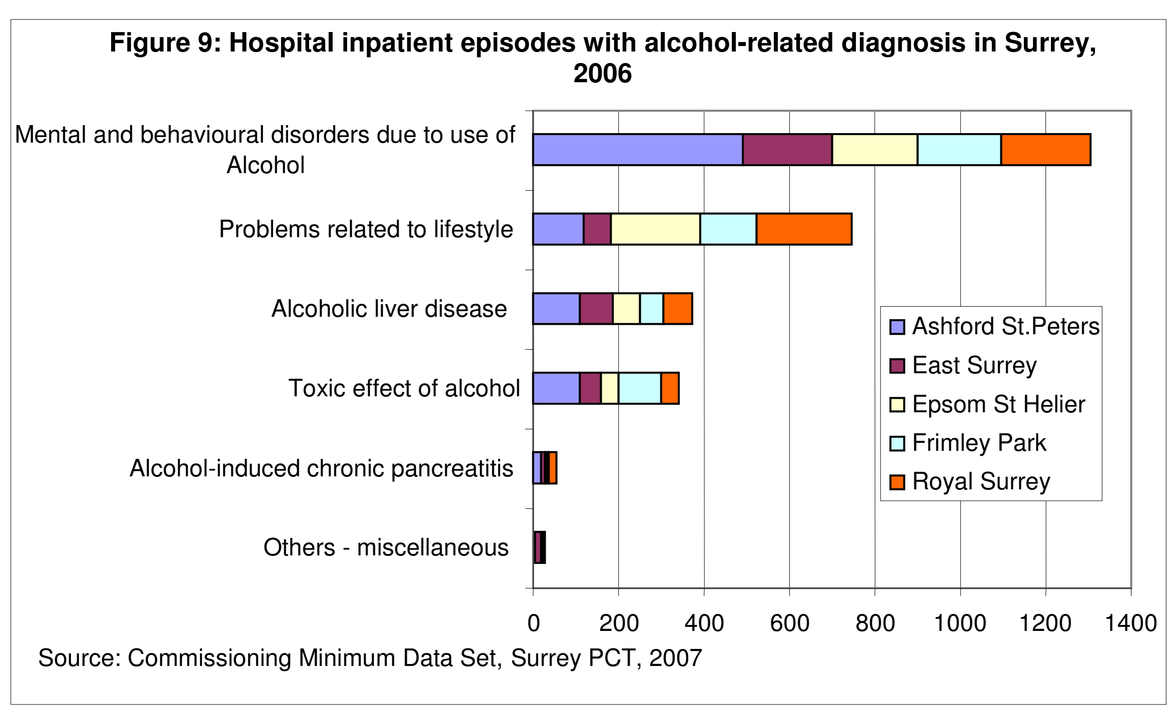
Figure 8: Number of inpatients per 1000 LA Ward population in Surrey and the Index of Multiple Deprivation (2007) average SOA score



Source: Commissioning Minimum Dataset, Surrey PCT

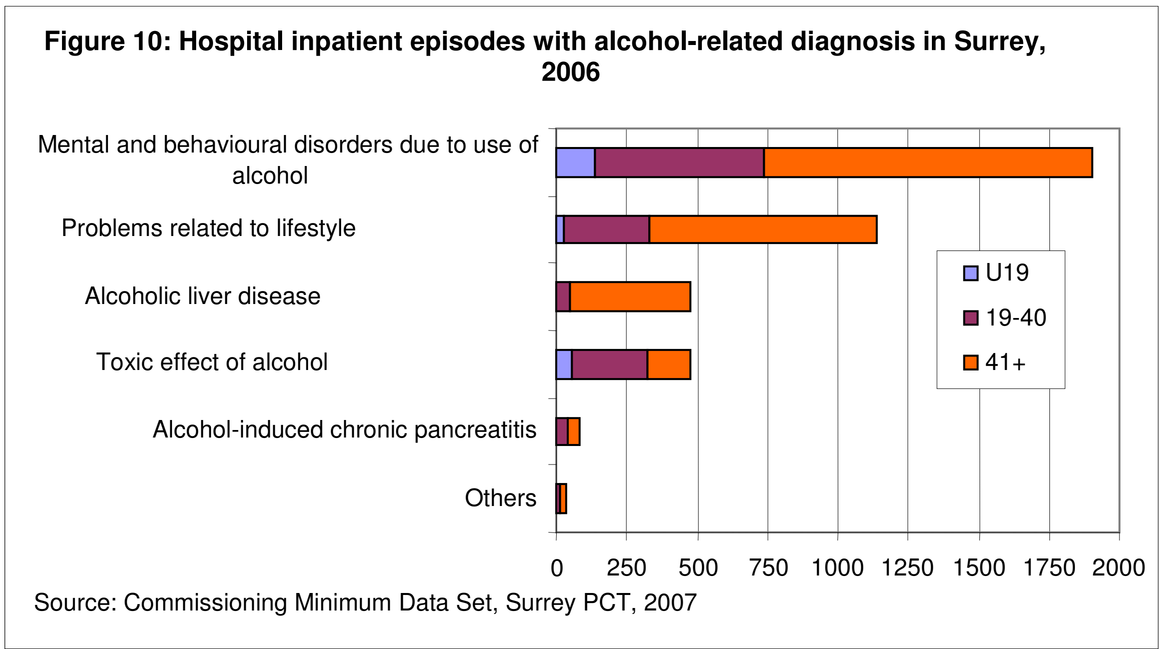
The examination of hospital episodes information on inpatients with an alcohol-related diagnosis showed that in Surrey the most commonly affected age group is 41+ years and the most commonly reported diagnosis is mental and behavioural disorders. In addition, most admissions take place in St Peters and Ashford Hospital Trust (figures 9 and 10).

Figure 9: Hospital inpatient episodes with alcohol-related diagnosis in Surrey, 2006



Source: Commissioning Minimum Data Set, Surrey PCT, 2007

Figure 10: Hospital inpatient episodes with alcohol-related diagnosis in Surrey, 2006



Source: Commissioning Minimum Data Set, Surrey PCT, 2007

A vast majority of alcohol-related admissions present to Acute Trusts as emergencies rather than planned admissions. Accident and Emergency (A & E) units can receive patients either due to their alcohol-related medical condition or injuries and accidents related to alcohol misuse. One in 6 people who attended A & E for treatment were reported to have an alcohol-related injury or problem, which rises to 8 out of 10 during peak times. 1 in 16 of all hospital admissions are said to be alcohol related[21]. In Surrey, an audit carried out in the A & E of Royal Surrey County Hospital showed that two out of five cases of violent assault attending were linked to alcohol use[22].

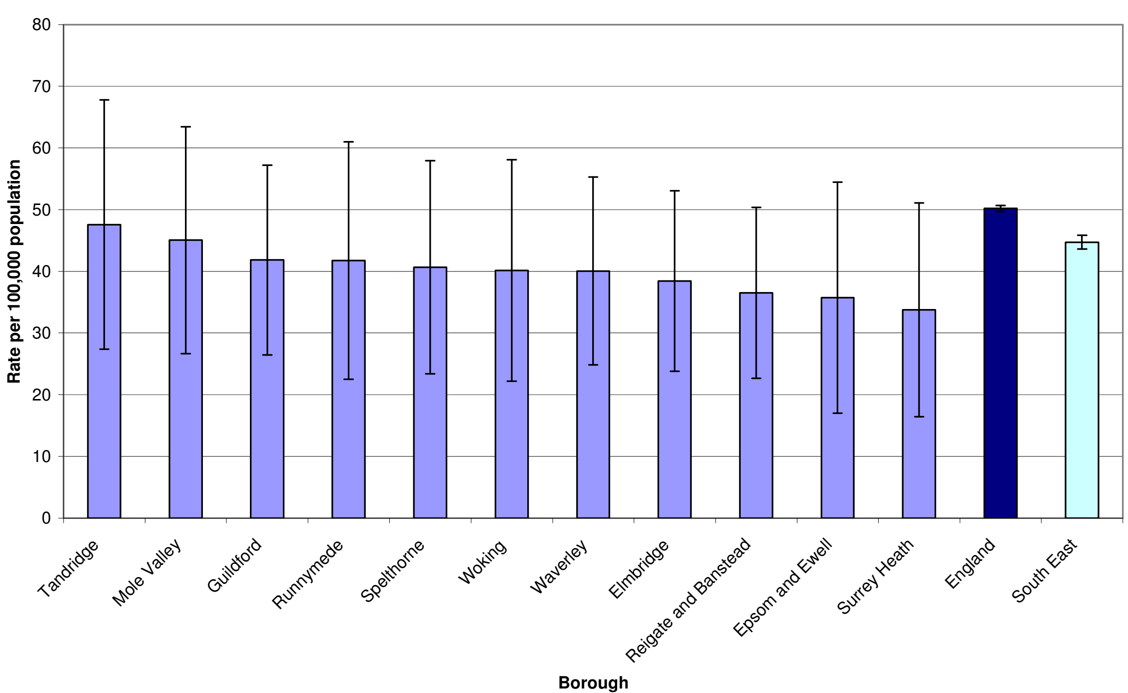
Nationally it has been reported that 1 in 5 patients presenting to general practice settings for health problems drink alcohol to harmful or hazardous levels[23]. However, there is limited information available about the impact of alcohol misuse in primary care locally.

6.2.6. Alcohol-related Mortality Rate

Alcohol-related deaths in the South East have doubled in the last fifteen years. Men account for two-thirds of the total number of deaths attributable to alcohol and alcohol-related death rates in men (17.9 deaths per 100,000 populations) are more than double that of females (8.3 deaths per 100,000).[16] The NWPHO (2007) report indicated that in 2005 there were 255 deaths among men and 211 deaths among women in Surrey that were attributable to alcohol-related causes.

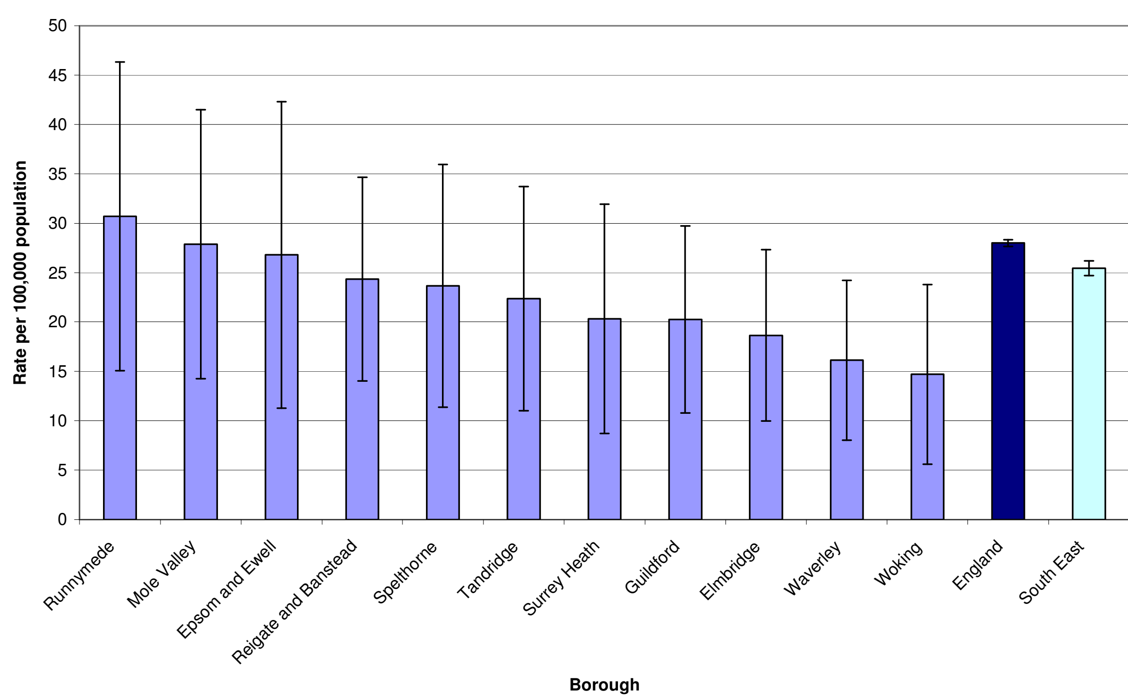
Across Surrey there is variation in the rate of deaths attributable to alcohol, with males in Tandridge having the highest rate of alcohol related mortality (47.56 per 100,000 – figure 11), although none of the boroughs were significantly differently to each other or England and the South East. For women the highest rates were found in Runnymede (30.69 per 100,000 – figure 12). Similarly no borough was significantly different to another, although Woking and Waverley were significantly lower than England and the South East.

Figure 11:



Source: NWPHO, 2007

Figure 12:



Source: NWPHO, 2007

The Standardised Mortality Ratios (SMR) for alcohol-related conditions such as oesophageal cancer, stomach cancer, accidents, suicides and undetermined injury were also looked at. The SMR was lower than 100 for all these conditions, implying that alcohol-related deaths are lower than would be expected relative to the general population, England. The ranking of Surrey boroughs on the basis of SMR for these conditions is shown below in table 16.

Table 16: Standardised Mortality (SMR) for alcohol related conditions in Surrey, by boroughs, 2004-06

Rank in Surrey	Oesophageal Cancer	Stomach Cancer	Accidents	Suicide & undetermined injury
1	Woking	Elmbridge	Elmbridge	Elmbridge
2	Guildford	Epsom & Ewell	Epsom & Ewell	Epsom & Ewell
3	Reigate & Banstead	Guildford	Guildford	Guildford
4	Mole Valley	Mole Valley	Mole Valley	Mole Valley
5	Runnymede	Reigate & Banstead	Reigate & Banstead	Reigate & Banstead
6	Epsom & Ewell	Runnymede	Runnymede	Runnymede
7	Surrey Heath	Spelthorne	Spelthorne	Spelthorne
8	Waverley	Surrey Heath	Surrey Heath	Surrey Heath
9	Spelthorne	Tandridge	Tandridge	Tandridge

10	Tandridge	Waverley	Waverley	Waverley
11	Elmbridge	Woking	Woking	Woking

Source: National Centre for Health Outcomes Development (www.nchod.nhs.uk)

It is difficult to draw out any significance in variation of the SMR of the conditions reported above; however the ranking of the boroughs was remarkably similar for three out the four alcohol-related conditions that were looked at. The boroughs of Elmbridge, Epsom & Ewell and Guildford ranked as the top three with the highest SMR for deaths due to stomach cancer, accidents, and suicides & undetermined injury.

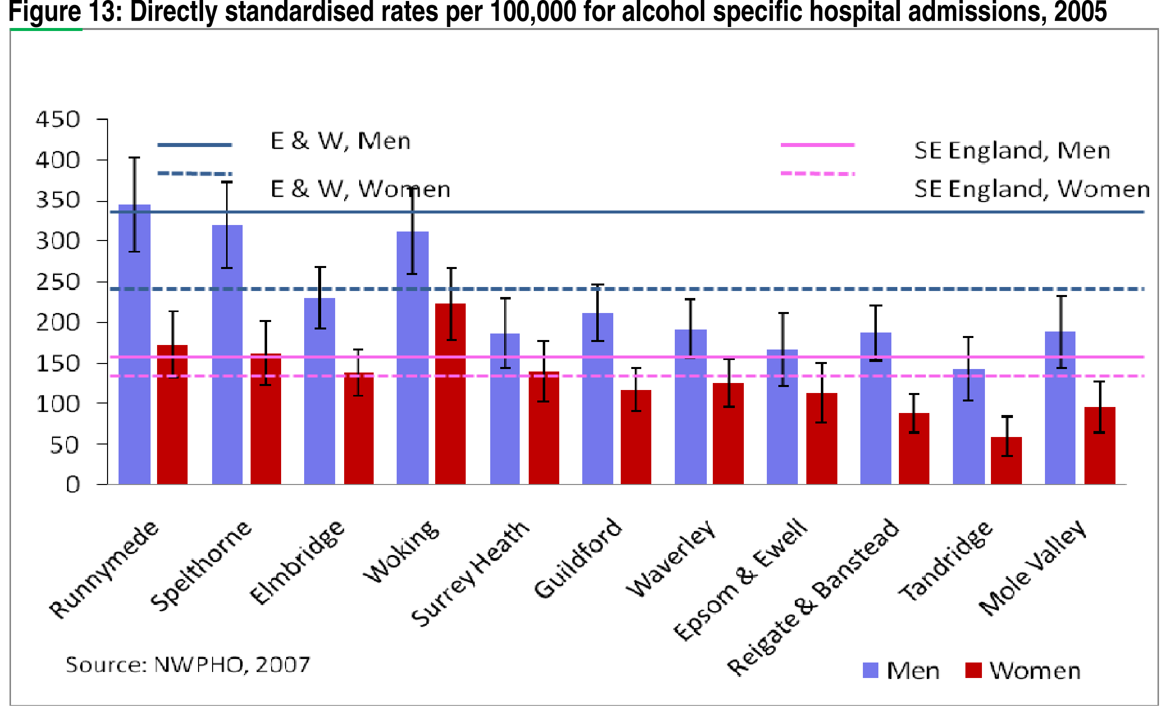
6.2.6. Alcohol-Specific Hospital Admissions

The NWPHO (2007) has looked at the directly standardised rates (DSR) per 100,000 for alcohol-specific hospital admissions in 2005 (figure 13). The DSR for alcohol-specific hospital admissions per 100,000 for men was significantly lower than that for England in most boroughs. However, the rates for men were significantly higher than that for the South East Region in Runnymede, Spelthorne, Elmbridge, Woking and Guildford.

In general there appeared to be inequality in the DSR per 100,000 for alcohol-specific admissions between the North West and South East localities of Surrey.

There was also a significant gender difference in the rates for the boroughs of Runnymede, Spelthorne, Elmbridge, Guildford, Reigate and Banstead, Tandridge and Mole Valley. The DSR of alcohol-specific admission per 100,000 women was significantly lower than that of men for women in Runnymede, Spelthorne, Elmbridge, Guildford, Reigate & Banstead and Tandridge. The DSR per 100,000 women was significantly less than that for England and the South East Region in the South East Locality of the County (Reigate & Banstead, Tandridge and Mole Valley).

Figure 13: Directly standardised rates per 100,000 for alcohol specific hospital admissions, 2005

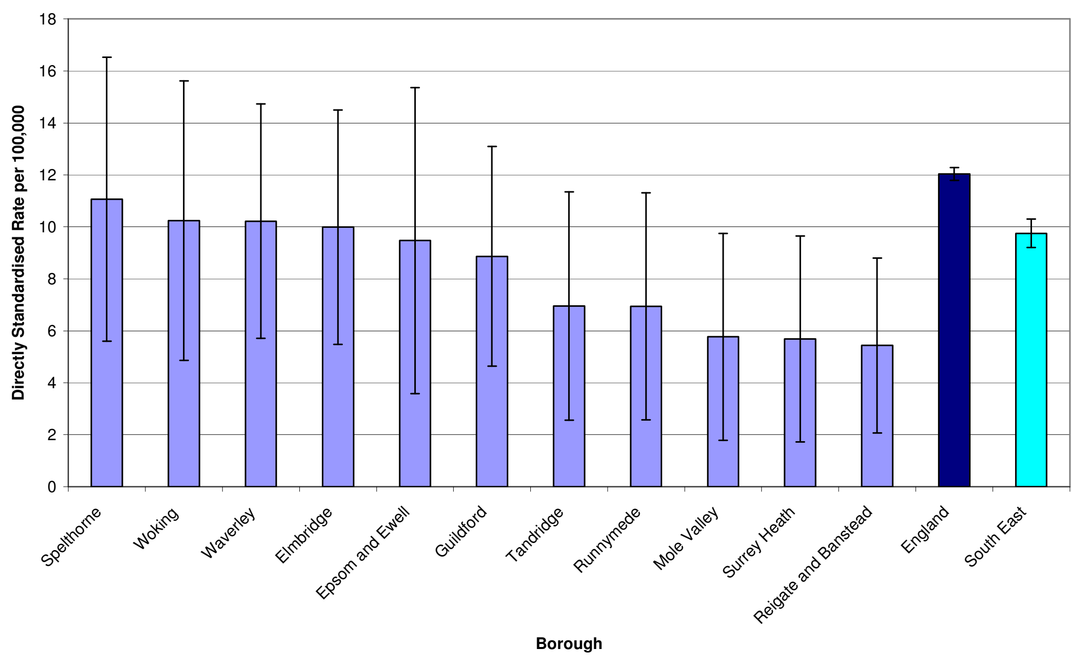


6.2.6. Alcohol-Specific Mortality Rate

NWPHO(2007) also published alcohol-specific mortality rates per 100,000 for men and women by borough in Surrey 2003-2005 (figures 14 and 15). The data should be viewed with caution as the absolute numbers are very small and the confidence intervals are therefore wide. Men in Spelthorne have the highest alcohol specific

mortality rate, but it is not significantly different from England or the South East. Men in Reigate and Banstead have significantly lower alcohol specific mortality rates compared to England and the South East. Women in Epsom and Ewell have the highest alcohol specific mortality rates, but again this is not significantly different to that of England and the South East. Women in both Surrey Heath and Waverley have significantly lower rates compared to England and the South East.

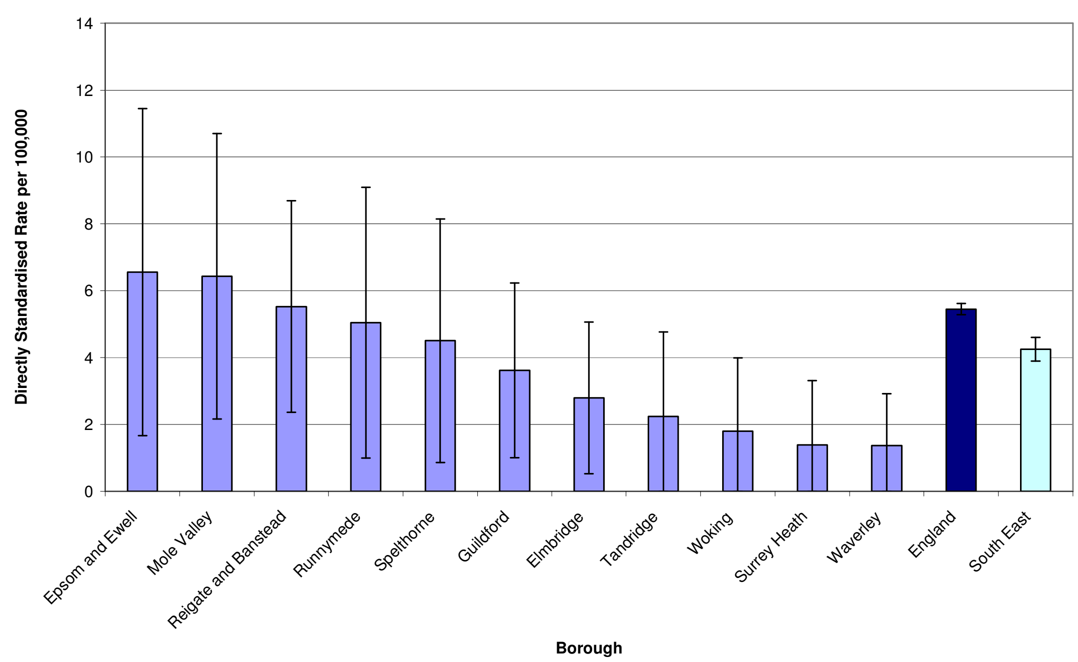
Figure 14:



Source: NWPHO, 2007

Figure: 15:

Alcohol Specific Mortality in Females by Borough, 2003-2005

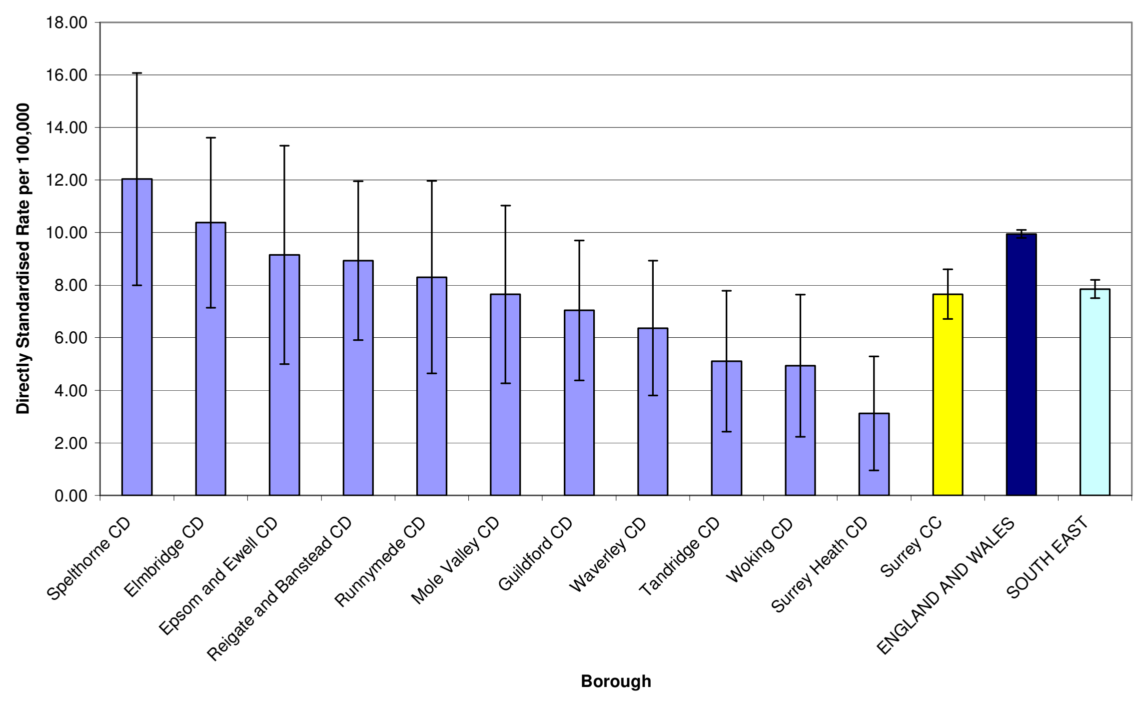


Source: NWPHO, 2007

Interestingly when we compare alcohol specific hospital admissions by gender with alcohol specific mortality by gender we see that whilst men in Runnymede have the highest alcohol specific admission rate; they have the 4th lowest mortality rate in Surrey. Similarly women in Woking have the highest alcohol specific admission rate, but the 3rd lowest mortality rates. This may indicate that in these areas, people are accessing services early enough to prevent death. Conversely, whilst women in Reigate and Banstead have significantly lower alcohol specific hospital admissions rates, mortality rates were the 3rd highest. This may indicate that women in this area are not accessing services early enough to get the treatment they need and therefore may have advanced stages of a particular disease when intervention is no longer viable. This aspect may require some careful analysis of the factors that influence the way services are provided and how they are utilised by the local population.

Chronic liver disease is one of the most significant alcohol specific diseases. Spelthorne has the highest mortality rate for chronic liver disease in Surrey; it is also higher than the Surrey, England and South East averages, but not significantly. Surrey Heath's mortality rate is significantly lower than Surrey, England and the South East (figure 16).

Figure: 16



Source: NCHOD

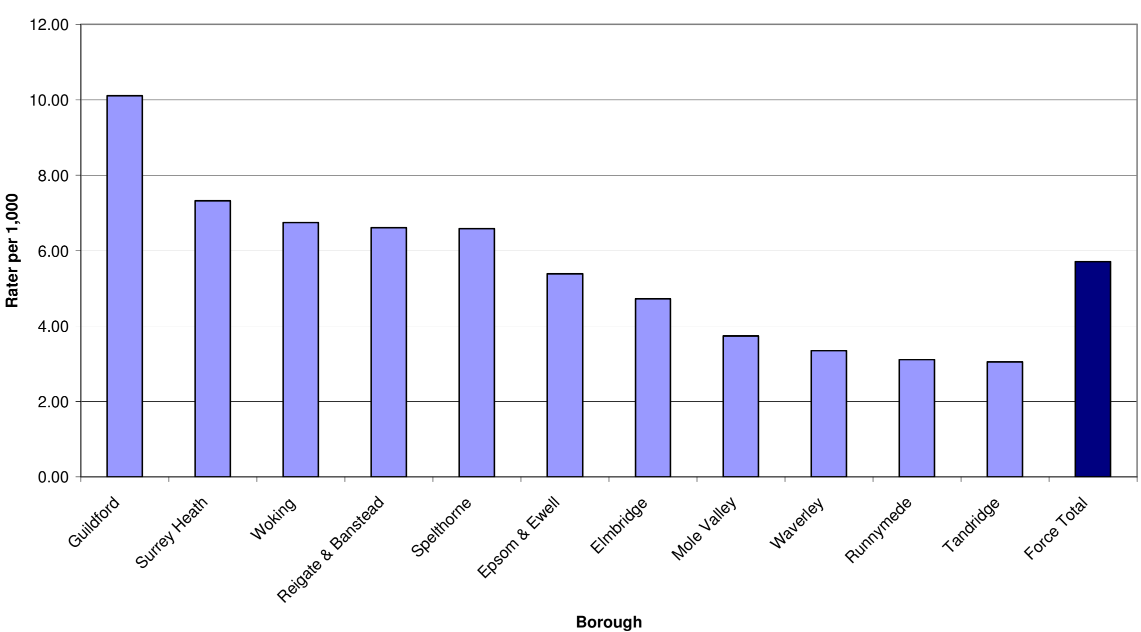
6.3. Social Impact of Alcohol Misuse

Alcohol misuse is strongly linked to crime and anti-social behaviour:

- Around half of all violent crimes are alcohol related[2]
- Around a third of all domestic violence incidents are alcohol related[2]
- 37% of all assaults are alcohol related[16]

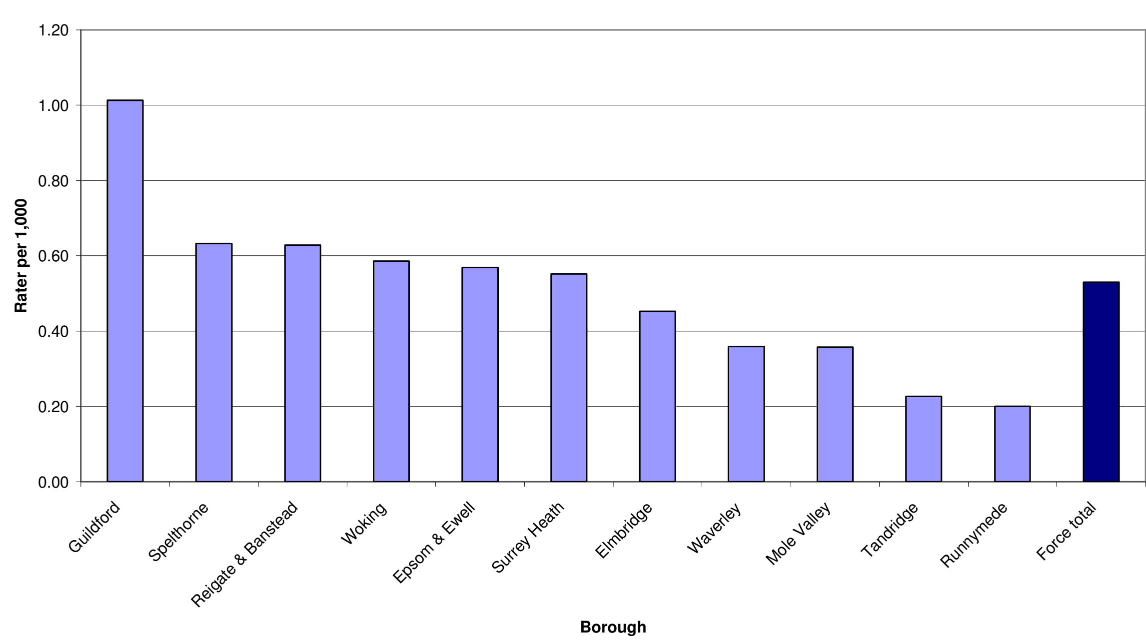
Crime & Disorder:
According to provisional figures from Surrey Police, Guildford has the highest rate of intoxicant violence in Surrey (figure 17a). Guildford also has the highest rate of licensed premises violence in Surrey (figure 17b).[6]

Figure 17a:



Source: Surrey Police, 2008

Figure 17b:



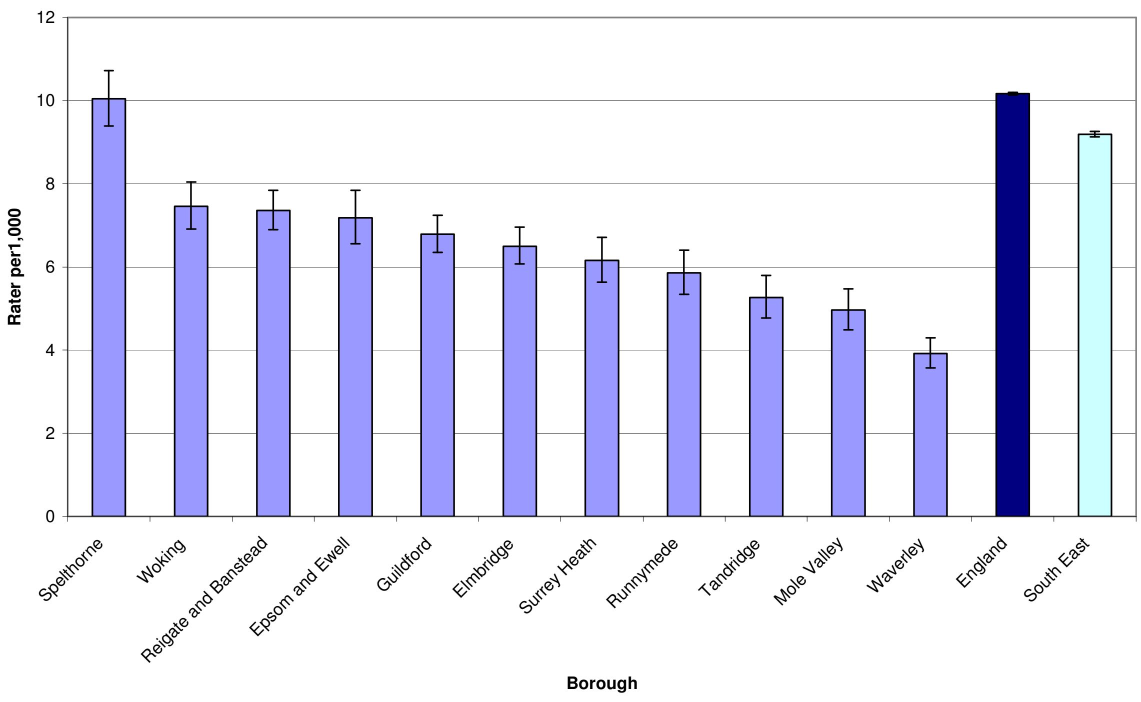
Source: Surrey Police, 2008

[6] This data must be viewed with caution as a 'tick box' qualifier is used to determine those offences that are alcohol related and that occur on licensed premises. There are no guidelines about the definition of alcohol related crime so the use of the qualifier in this context is down to individual police officer's judgement.

The data also indicated that there was a 41% increase in the number of intoxicant violent crimes in Guildford in 2007/08 compared to 2006/07 (948 in 2006/07 compared to 1337 in 2007/08). 6 out of the 11 boroughs saw increases in the number and rate of intoxicant violence in 2007/08 compared to 2006/07.). 3 out of the 11 boroughs saw increases in the number and rate of licensed premises violence in 2007/08 compared to 2006/07.

According to the NWPHO report, alcohol-related crime for all boroughs in Surrey, except Spelthorne, is significantly lower than that for England and the South East (figure 18). Spelthorne has the highest alcohol related crime rate and is just below the national average and above the South East average; it has a significantly higher rate compared to other boroughs in Surrey.[16]

Figure 18:

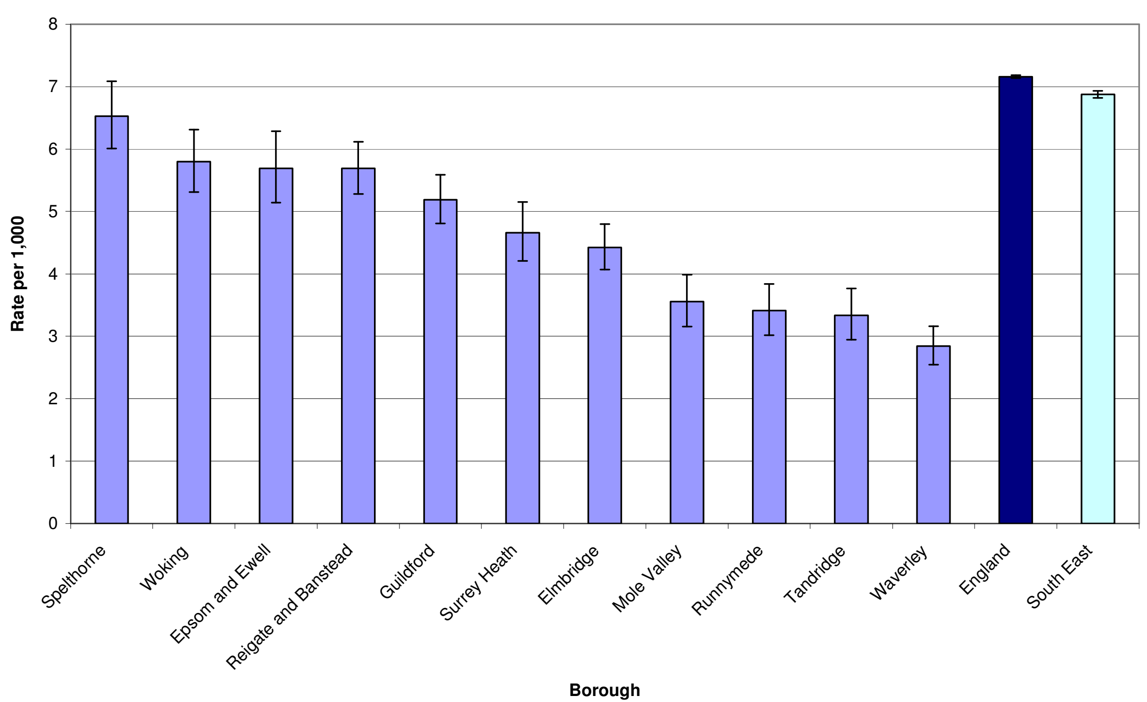


Source: NWPHO, 2007

A similar picture emerges for violent crimes attributable to alcohol, with all boroughs being below England and the South East and significantly so with the exception of Spelthorne (figure 19). Spelthorne has a significantly higher rate of alcohol related violent crime compared to other boroughs in Surrey.

In the NWPHO report Guildford, Spelthorne, Woking and Reigate & Banstead emerged as the boroughs with the largest social impact of alcohol misuse in terms of recorded crime attributable to alcohol, violent crime attributable to alcohol and sexual offences attributable to alcohol.

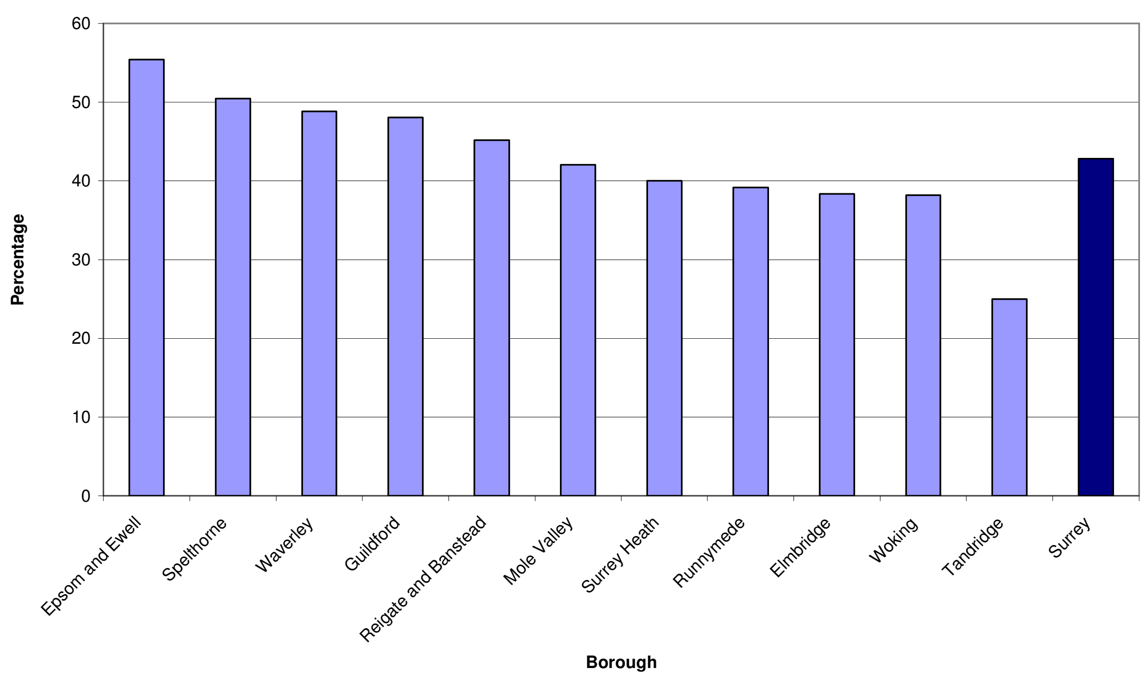
Figure 19:



Source: NWPHO, 2007

According to the Audit Commission's area profiles[24], over 50% of people in Epsom & Ewell and Spelthorne feel that people being rowdy or drunk in public places is a very big or fairly big problem in their local area (figure 20). Interestingly Waverley has the lowest reported alcohol attributable crime and violent crime rates, but a large proportion of the population (49%) feels that alcohol may be a problem in their area.

Figure 20:



Source: Audit Commission

For Alcohol Related Penalty Notices for Disorder (PNDs) as a percentage of the total by police authority, all ages, in 2004, Surrey was below the South East average but above the average for England[25].About half of Persistent Prolific Offenders (PPOs) are said to have an alcohol problem[26].

A&E Attendances:
Surrey Police (2004) examined data on A & E attendances following violent incidents in Surrey. This audit report indicated that more than a third of the violent offences that resulted in hospital treatment cited alcohol as a factor in the incident. Most of the violent incidents that present to A & E or the Police occur in known hotspots around town centres[27].

Licensing of Premises:
The licensing of premises can fall in to one of two categories:

- Off-license – can sell alcohol, but consumption is not allowed on site
- On-license – alcohol served and consumed on site

There are 7.3 off-licences and 17.6 on-licences per 10,000 population in Surrey compared to 8.7 off-licences and 21.2 on-licences per 10,000 populations in England and Wales. The average number of premises where alcohol is sold in Surrey is less than the national average. However, the available evidence suggests that it is the location and quality of these premises, rather than their number that relates to alcohol related violent behaviour (Surrey County Council, 2007).

Marital / Family Problems:
Other social damages that occur in association with alcohol misuse are divorce, child abuse/ negligence and domestic violence. The British Crime Survey indicates that 44 per cent of domestic violence victims believed their attacker to have been under the influence of alcohol[28]. Marriages where one or both partners have a drink problem are twice as likely to end in divorce as those not affected by alcohol.

Nationally about 780,000 to 1.3 million children are said to be affected by parental alcohol misuse.[6] Surrey DAAT carried out an analysis of alcohol need in 2006, which reported that there are an estimated 20,000 children affected by parental alcohol problems and 100 street drinkers in Surrey.

The relationship between alcohol misuse and social indicators is complex as they are invariably inextricably linked with deprivation and other socio-economic factors, which are often significant.

6.4. Economic Impact of Alcohol Misuse

The alcohol industry has an important economic role to play in many European countries. Alcohol contributes significantly to the local and national economy by being associated with substantial governmental tax receipts, consumer expenditure and jobs.

The British Institute of Innkeeping have indicated that an average Pub injects £73,000 into the local economy every year; 900,000 people are employed and 1 in 5 new jobs are created in the hospitality industry. Excise duty & VAT raised in the UK Drinks industry amounts to £22 Billion annually.

In order to get the true context of the economic impact of alcohol use, it is important to compare the benefits or economic contributions of the alcohol industry with the costs incurred by alcohol misuse on public services spending in dealing with its health and societal impacts including workplace productivity[29].

Alcohol misuse incurs costs to the society and industry through the health service, crime/public disorder, unemployment, workplace production and disruption of family/ social networks.[2] Nationally the total cost of dealing with alcohol misuse was quantified to be up to £20 billion.

There is limited information on the costs and contribution of alcohol use to the local economy in Surrey. The Surrey DAAT (2006) reported that more than a third of the annual spend on A& E services and ambulance call outs in Surrey were associated with alcohol misuse. Table 17 below presents the estimated costs of dealing with health, social and criminal effects of alcohol misuse in Surrey.

Table 17: Economic impacts of alcohol misuse

Effect	**National Economic Impact (per annum)**	**Extrapolated Impact on the Economy of Surrey** (per annum)
Cost to economy of alcohol related deaths	£2.3-2.5 billion	£51 million
Cost to economy of alcohol related absenteeism	£1.2-1.8 billion	£32 million
Cost to economy of alcohol related lost working days	£1.7-2.1 billion	£40 million
Working days lost due to alcohol related sickness	11-17 million	300,000 days lost
Working days lost due to reduced employment	15-20 million	377,000 days lost
Human costs of alcohol related crime	£4.7 billion	£101 million
Costs of drink-driving	£0.5 billion	£10.7 million
Costs to Criminal Justice System	£1.8 billion	£38 million
Costs to services as consequence of alcohol-related crime	£3.5 billion	£75 million
Costs to services in anticipation of alcohol-related crime	£1.5 billion	£32 million
Drink-driving deaths	530 per annum	11 death
Alcohol-related sexual assaults	19,000 per annum	400 assaults
Victims of alcohol-related domestic violence	360,000 per annum	7,758 victims
Arrests for drunkenness and disorder	80,000 per annum	1,724 arrests

Source: Surrey DAAT, 2006

7. Alcohol Misuse Services: What works and what is available in Surrey?

7.1. Alcohol Misuse: What works for Alcohol Misuse

An outline of what is known to work in relation to reducing the incidence and impact of alcohol misuse at population level is produced here and has been grouped in relation to the following key strands of action:

- Prevention & education
- Early identification & harm minimisation
- Treatment & rehabilitation
- Enforcement.

7.2.6. Prevention and Education

There is currently a lack of review-level evidence for interventions that work in the primary prevention of alcohol misuse among young people. However; it is likely that reducing excessive consumption of alcohol in children and young people in particular will in turn bring about a positive change in the burden of alcohol related and alcohol specific problems for health and social services in the long run.

The various health promotion interventions that have been used in the UK to reduce alcohol misuse are mass media campaigns, public service messages and school-based educational programmes. These are effective at increasing knowledge and modifying attitudes, but have limited effect on drinking behaviour in the long term[22].

A Cochrane review by Foxcroft et al.[32] reported that no firm conclusions about the effectiveness of prevention interventions in the short or medium term were possible. However, longer term the Strengthening Families Program (SFP) showed promise as an effective intervention. The Number Needed to Treat[7] (NNT) with SFP was 9 over a 4 year period for the three alcohol initiation behaviours - alcohol use, alcohol use without permission and first drunkenness. This means that to prevent 1 person from starting to use alcohol; or use alcohol without permission; or get drunk for the first time you would need to have had 9 people on the SFP programme over a 4 year period. One study in this review also highlighted the potential value of culturally focused skills training over a longer term (NNT=17 over three-and-a-half years for 4+ drinks in the last week)[30].

Most school-based interventions to educate and prevent alcohol misuse among young people increase the knowledge but have little impact on their attitudes or behaviour. Good family relations and a supportive family environment are strongly linked to lower levels of drinking[31].

7.2.6. Early identification and harm minimisation

Screening for alcohol misuse is the first step towards reducing harm. Early identification is important for engaging the client with the service and reducing harm through brief advice, information, structured counselling and treatment.

The identification of a drinking problem is most likely to occur in the health sector or via the criminal justice system due to the increased likelihood of damage to health or contact with the police as a result of alcohol related crime and disorder.

A detailed interview conducted with the client is considered to be the gold standard in screening and performs best in terms of accurately identifying those individuals with alcohol misuse problems. However, this can be

[7] Numbers Needed to Treat (NNT) is a measure of how many patients would need to be treated with an intervention, in order for ONE of them to show the desired effect.

highly time consuming so a range of questionnaires have been developed and assessed against the 'gold standard' for screening alcohol misuse. These include questionnaires like the four-item 'cut down, annoy, guilty and 'eye opener' (CAGE), the Alcohol Use Disorders Identification Test (AUDIT) [32, 5] , Alcohol Use Disorders Identification Test Consumption (AUDIT-C), AUDIT Piccinelli (AUDIT-PC), the five-shot questionnaire, Fast Alcohol Screening Test (FAST), Brief Michigan Alcoholism Screening Test (BMAST) and the Paddington Alcohol Test (PAT).

The relative sensitivities of the screening tests were as follows: AUDIT 93%, CAGE 79% and BMAST 35%. AUDIT was the most sensitive test for those drinking above 14 and 21units, but CAGE and BMAST were not. The British Journal of General Practice (2001) reported that, except for the CAGE, all questionnaires performed much better than laboratory tests. The five shot questionnaire has a better specificity among female patients in a general practice[33].

It has been recommended that the CAGE questionnaire which has been more popular among the GPs due to its simple four question structure should be replaced by the AUDIT-C questionnaire which has a simple three question format, greater effectiveness but performs less well among females[34]. The full AUDIT questionnaire is extensive and therefore can be time consuming, so it may be difficult to implement its use in routine General Practice in the time span of a clinical consultation.

A comparison of alcohol screening instruments among under-aged drinkers treated in emergency departments concludes that AUDIT performs best as a screening tool[35]. The FAST tool is a shorter version of AUDIT for use in busy A&E and hospitals to detect hazardous drinking. PAT is another test which has been developed for use in A & E.

A review carried out in Scotland (2007) recommended FAST in A&E settings and CAGE plus or FAST in community settings to be the appropriate screening tools for detecting people with alcohol dependence that may need detoxification[36].

The screening tools used and assessment of alcohol misuse varies between healthcare and other public services. For example, the prison service uses the AUDIT tool and the probation service identifies, assesses and deals with alcohol misuse through its Offender Assessment System (OASys). There is limited evidence that compares the effectiveness of these screening tools across services.

7.2.6. Interventions: Treatment and Rehabilitation

The interventions that are used to treat alcohol misuse have been ranked in order of their relative effectiveness by the Messa Grande project[37] in the United States (Table 18). This list includes some therapies like naltrexone (opioid antagonist) which is not licensed in the United Kingdom.

Table 18: Ranking of interventions against Alcohol Misuse

Interventions	Ranks
Brief intervention	1
Motivational enhancement	2
GABA agonist	3
Opiate antagonist	4
Social skills training	5
Community reinforcement	6
Behaviour contracting	7
Behavioural marital therapy	8
Case management	9
Self-monitoring	10
Cognitive therapy	11
Client-centred counselling	12.5
Disulfiram	12.5
Aversion therapy, apnoeic	14.5
Covert sensitization	14.5

Aversion therapy, nausea	16.5
Acupuncture	16.5
Self-help	18
Self-control training	19
Minnesota model	20.5
Exercise	20.5
Stress management	22
Family therapy	23
Twelve-Step facilitation	24.5
Aversion therapy, electric	24.5
Antidepressant, SSRI	26
Lithium	27
Functional analysis	29
Marital therapy, other	28
Hypnosis	30
Psychedelic medication	31
Calcium carbimide	32
Serotonin antagonist	33
Anti-anxiety medication	34
Relapse prevention	35
Metronidazole	36
Antidepressant, non-SSRI	37
Milieu therapy	38
Alcoholic anonymous	39.5
Video self-confrontation	39.5
Standard treatment	41
Relaxation training	42
Confrontational counselling	43
Psychotherapy	44
General alcoholism counselling	45
Educational lectures, films, groups	46

In the United Kingdom the research evidence on effectiveness of most of these interventions has been analysed and reported by the Health Development Agency (HDA; 2005)[38], NHS Scotland [318, 39] and the National Treatment Agency (NTA: 2006)[40].

The HDA[40] looked at interventions to address alcohol across three key themes and found the following evidence around interventions to support these key themes (table 19).

Table 19:

Key Theme	**Evidence**
▪ Interventions to reduce alcohol impaired driving	There is review level evidence to support: ▪ lower blood alcohol concentration (BAC) laws ▪ raising the drinking age limit to 21 years ▪ selective breath testing ▪ sobriety checkpoints ▪ random breath testing ▪ ignition interlock devices ▪ face-to-face server training together with strong and active management support
▪ Healthcare settings	There is review level evidence that: ▪ There is conflicting evidence for the effectiveness of GP based lifestyle advice interventions to reduce heavy drinking ▪ A cognitive behavioural intervention by a GP is no more effective than one being given by a

	nurse practitioner of brief advice ▪ A behavioural change programme is no more effective than brief advice, assessment of drinking behaviour only, or follow up measurement only on alcohol consumption or alcohol related problems ▪ Heavy drinkers receiving brief interventions are twice as likely to moderate their drinking 6-12 months on ▪ Brief interventions can reduce weekly consumption by between 13% and 34% ▪ Brief interventions are equally effective in men and women for hazardous alcohol consumption in primary care settings ▪ Brief interventions are effective in opportunistic samples ▪ It may be possible to increase the engagement of GPs in screening and giving advice for hazardous and harmful alcohol consumption ▪ Self-help materials can help reduce drinking above safe limits. These are particularly helpful in those who have either identified themselves as needing help for drinking or those who were screened to be at-risk
▪ Children and Young People	There is currently a lack of review level evidence for the effectiveness of interventions in reducing alcohol misuse in young people.

The brief interventions may be very brief (single session; up to 5 minutes duration), brief (single session; 10-15 minutes), or extended (several brief interventions over several sessions). The overall benefit of these interventions was quantified to be of the order of NNT (numbers needed to treat) of 10 in hazardous drinkers over a one year period. In other words, 10 people with hazardous drinking would need to be treated with brief interventions to prevent one person from becoming a harmful drinker or alcohol dependent over a one year period.

NHS Scotland carried out an assessment of the evidence in support of interventions that prevent relapse in alcohol dependents between 2001 and 2003. This was updated in 2006. The NTA also reviewed interventions for screening, harm minimisation, treatment and rehabilitation of those with drinking problems.

The effectiveness of brief interventions has not been assessed in those who are alcohol dependent. The NTA reported that while brief interventions given by generic workers in any setting may influence the behaviour of those drinking to hazardous/ harmful levels, those with alcohol dependence could only benefit from that delivered intensively by specialist workers.[41]

The Health technology board for NHS Scotland (2006) found that psychosocial measures like coping skills and social skills training, behavioural self-control training, motivational enhancement therapy and marital/family therapy prevent relapse of excessive drinking in 1 out of every 7 alcohol dependents treated.

NHS Scotland (2007) recommended that people with moderate alcohol dependence be effectively and safely detoxified in community/home/outpatient settings. Outpatient and home detoxification settings are clinically effective and less costly than inpatient settings. However, inpatient settings with close monitoring by specialists are essential for people with severe alcohol dependence[38].

Benzodiazepines are the best choice of drugs in treating detoxification. Chlordiazepoxide is preferred for treating uncomplicated detoxification due to its reduced potential for dependency[36]. Of the two other drug

therapies for detoxification: acamprosate and disulfiram, the former was found to be an effective adjunct to psychosocial interventions in the prevention of relapse. The number needed to treat with acamprosate and psychosocial interventions to prevent one person from relapsing back to alcohol dependence and a harmful pattern of drinking was of the order of 12 for one year. Disulfiram was said to be of benefit in preventing relapse when given under supervision.

The NTA (2006) emphasised the value of a stepped care approach within a service model which is integrated with existing systems of community and specialist health and social care. This appeared to be a rational approach in the presence of finite resources. It also pointed out that the delivery of interventions and their effectiveness is dependent on the availability of a trained and competent practitioner.

There is as yet no evidence on the effectiveness of interventions that target alcohol misuse in specific socio-economic, ethnic or vulnerable groups. More research is needed to determine the effectiveness of screening and brief interventions in different settings and with different populations.

7.2.6. Enforcement of legislation

Under the Licensing Act of 2003 it is a criminal offence:

- to sell alcohol to anyone aged less than 18 years
- to sell sweets containing alcohol including liqueur chocolates to children less than 16 years
- for a person under 18 to sell alcohol unless the sale is specifically authorised by someone who is over 18 - the person making the sale, the Designated Premises Supervisor, personal licence holders and the company operating the business may be held liable for this offence.

These are criminal offences which may incur a level 5 penalty of up to £5000 and removal/ suspension of the license to sell alcohol.

The Licensing Act 2003 now permits 24-hour opening in England and Wales. Active enforcement of laws regulating licensing hours and prohibiting the sale of alcohol to the intoxicated or underage, increases compliance with legislation.

The BMA Board of Science (2008) reported that a high density of alcohol outlets is associated with increased alcohol sales, drunkenness, violence and other alcohol-related problems. A lower density of outlets was considered to be a deterrent for consumers when there is increased time and inconvenience in purchasing it. The layout, design and internal physical characteristics of licensed premises are also important considerations for strategies to reduce alcohol-related crime and disorders[22].

Local interventions on licensing are an effective way of reducing harmful drinking and underage drinking through its effect on trade and sales of alcohol. Some such initiatives useful in enforcing safe and sensible drinking behaviour and reducing alcohol-related incidents are:

- Pubwatch schemes
- Award scheme for responsible licensees
- Door staff registration schemes
- Challenge 21
- Staggered closing times in areas with high density of drinking outlets
- Eliminate the use of discounted drinking especially “happy hours”
- Increase use of plastic bottles and toughened glasses
- Using local bye laws to ban consumption in public places and create designated alcohol free zones;
- Taxi Marshall Schemes
- Improve transport links out of town and city centres to reduce congestion
- Develop and promote a responsible licensees forum

The evidence does not support any of these initiatives more or less than the other. Close working with the private sector and engagement with the alcohol industry is essential to ensure that local initiatives are selected

with a consensus approach, in a resource-efficient manner. An evaluation of these initiatives in meeting desirable outcomes should be carried out and reported to the strategic partners.

Other interventions that have been recommended at national level are:
- prohibiting price promotions
- establishing minimum price levels
- prohibiting celebrity sponsorship to promote sales or advertising during sporting events or before 9 pm on TV and radio

Careful review of these strategies can help identify innovative ways of influencing behaviour change in the local population. These however require a greater impetus and drive from the centre.

Preventive measures taken together with the alcohol industry and trade can be effective in preventing alcohol misuse in the general population. These could be reducing the cost of soft and low alcohol drinks and stopping drinks promotions. Workplace alcohol policies can also potentially promote a sensible drinking culture within the organisation especially when support to employees with drinking problems is available[39].

7.2. Alcohol Misuse: What is available in Surrey?

7.2.1 Services for Adults

The Models of Care for Alcohol Misusers (2006)[1] report recommended a comprehensive four-tier service model for adult alcohol misuse. The report identified that alcohol misuse services are best delivered by joint planning and commissioning, in integration with the existing statutory and non statutory services. Using this approach the scope of alcohol misuse services can be presented as in figure 21 below.

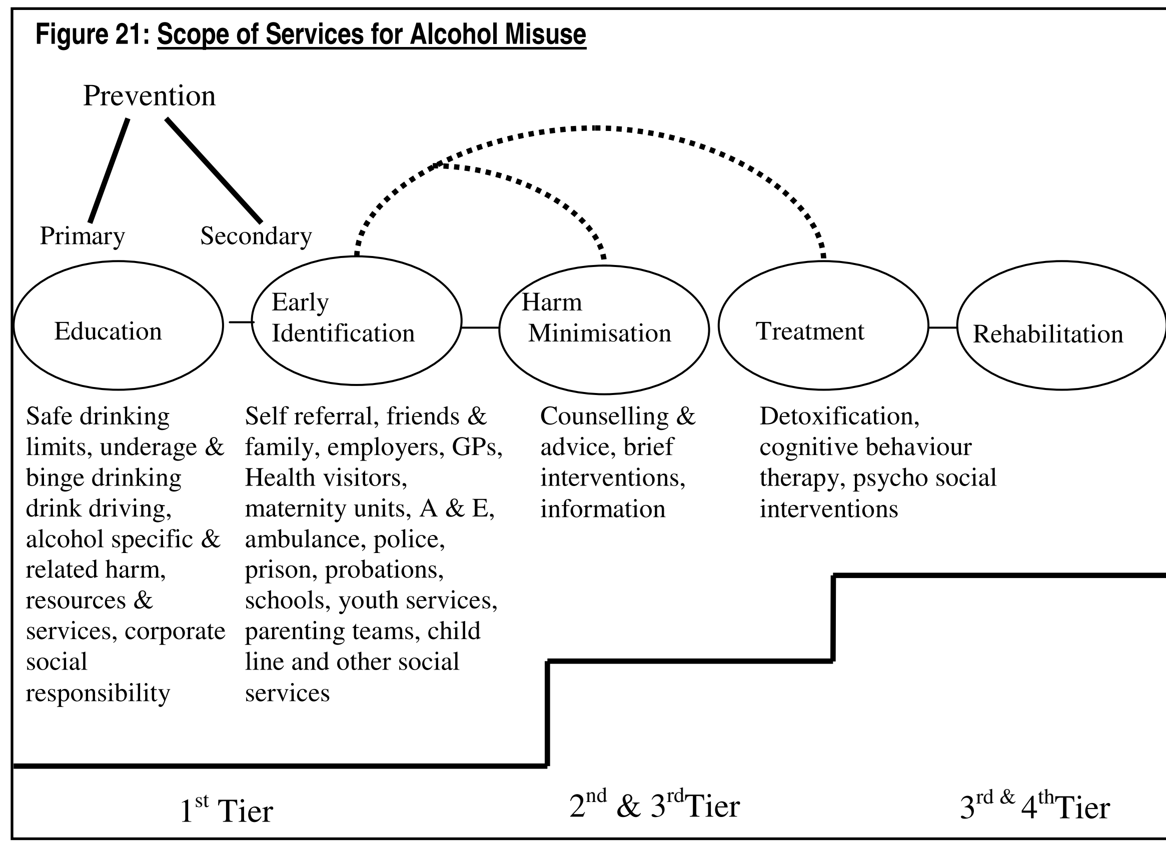


Figure 21: Scope of Services for Alcohol Misuse

The model shown in figure 22 allows a stepped care approach to be taken when dealing with alcohol misuse. The level of risk for an individual is assessed and various interventions for prevention and education, early

identification and harm minimisation, treatment and rehabilitation are provided within this tiered framework of service provision (table 20).

Table 20: Four Tier Model of Alcohol Services

Tier	Setting	Interventions	Level of Risk
1	Mainstream Services e.g. Primary Care, Police, Probation, Prisons, Young offenders Team (YOT)	Information & brief advice, targeted screening referral, shared care.	Low risk Hazardous
2	Mainstream Services or Specialist unit/teams from Drugs and Alcohol Advisory services.	Open access or outreach, brief interventions, assessment and referral, shared care	Harmful
3	Community based specialist alcohol treatment	Comprehensive assessment care, planned treatment, Assisted withdrawal, psychosocial treatments.	
4	Residential specialist alcohol treatment	Residential rehabilitation inpatient treatment, assisted withdrawal and psychosocial treatments.	Dependent Severely dependent

population at risk

Source: National Treatment Agency 2006

The following section describes the existing services for alcohol misuse in Surrey. Most people with alcohol misuse problems can be managed in tiers 1, 2 and 3; those with alcohol dependence are likely to require residential specialist alcohol treatment services (tier 4). It would be pertinent to mention that in Surrey the tiers do not necessarily fit neatly in to the model described above, in that there is a degree of blurring across the lines where some tier 2 services may also offer what would traditionally be described as tier 3 services, for example. However, it is useful to break down the services in Surrey in this way to give an indication of what is available to those with alcohol problems.

7.2.5. Tier 1: Screening Brief advice, and Referral

The health service is an important setting where problem drinkers are likely to present. Most people visit their GP at least once a year and alcohol misusers are likely to present to general practice more often than non alcohol misusers. Previously unidentified alcohol misusers may also present to the A&E, Police, Probation Service and Prisons.

Health Service

GP practices in Surrey do not routinely screen for alcohol misuse and there is no established protocol for screening in every A & E department. The practice usually depends on the individual professionals and varies across the county.

Information about individual alcohol intake is obtained and recorded during new patient checks upon registration with a GP, however not all patients attend these checks. Hypertensive patients, those with heart disease and diabetes are asked about their alcohol intake every year. Most GPs ask patients about their alcohol use opportunistically, about every 3-5 years. This information however is not formally collected in a register and unless this is done, it will be difficult to assess local prevalence of alcohol misuse in primary care in a precise manner.

There is variation in the tool that is used to screen alcohol misuse in primary care. There is limited local experience with the use of a standardised instrument like AUDIT in primary care. Some GPs reported familiarity with the CAGE questionnaire and expressed reservations about the usefulness of AUDIT in their clinical experience. Currently, patients who report high levels of alcohol intake are advised to reduce their

intake. The advice may be supported with information leaflets. If a patient clearly has a drinking problem, they are offered consultation at one of the Community Drugs and Alcohol Services or with Voluntary Organisations operating in Surrey.

Social workers in Surrey use the Scott Wheel Family Health Needs Assessment Tool at the six week post natal check, when drinking problems are addressed through the section that relates to "smoking, drugs, alcohol". The parents self assess their drinking behaviour and alcohol misuse can be identified through this along with other social problems like domestic violence and parenting issues.

7.2.7. Tier 2: Open Access Support, Assessment and Referral

Tier 2 services are more open access and provide the following types of interventions - assessment, brief interventions and referral to more specialist tier 3 services.

At present in Surrey, the following tier 2 services are available:

- **Surrey Drugs and Alcohol Advisory Service (SADAS)** – provide open access, support, counselling services and referral to tier 3 service provision
- **OMNI** – provide services for those with dual diagnosis (mental health and substance misuse)
- **Telephone helpline** – this is primarily for drugs, but the trained personnel answering calls will support those calling with issues relating to alcohol
- **Alcohol Outreach** – a small project in the Guildford and Waverley area only. They deal specifically with alcohol and use outreach to engage with community members and enable those with alcohol misuse problems to get access to the treatment they may need. SADAS have been funded by Surrey PCT to run this project; it is the only service in Surrey that deals with alcohol only
- **Surrey Alcohol Brief Intervention Service (SABIS)** - this is a Surrey-wide Alcohol Brief Intervention Programme, which has been operational since 2007 and is linked to the criminal justice system. It is provided by the Rehabilitation for Addicted Prisoners Trust (RaPt). SABIS is for adults whose offending behaviour is linked to alcohol use. Alcohol users referred to the service are triaged, given alcohol education and harm minimisation advice and referred on where appropriate

SABIS was originally set up as a result of Surrey's 11 borough councils highlighting alcohol related anti-social behaviour as a key problem. It was thought that an alcohol service linked to the criminal justice system would provide an opportunity to work with those entering the system as a result of involvement in an alcohol related crime. There are 4 referral routes into SABIS - Police divisional anti-social behaviour units, Probation, Arrest Referral Service (based at police station & court) and the local Community Incidents Action Groups (CIAGs). The service is currently under review as the number of referrals is below what was expected.

There are currently no tier 2 services available in primary care or other possible suitable locations e.g. A & E departments.

7.2.5. Tier 3: Community-based treatment services

Community Drugs and Alcohol Teams (CDAT) are the only providers of tier 3 services in Surrey. They act as a gateway in to more specialist tier 4 services. The 3 CDATs operating in Surrey are:

- Acorn
- Respond
- Windmill

They provide structured interventions e.g. key working, psychological therapies, group programmes, support for home detoxification, assessment and referral to tier 4.

CDATs are large mutli-disciplinary teams of nurses, substance misuse specialists, doctors, psychologists and social workers.

7.2.6. Tier 4: Inpatient and/or residential care planned treatment

Tier 4 services provide residential (inpatient) detoxification from drugs and alcohol and residential rehabilitation. In Surrey, Windmill House are the only providers of tier 4 services and only provide residential detoxification, they do not provide residential rehabilitation services. Those requiring residential rehabilitation services are referred to suitable establishments across the country. Windmill House is a Surrey wide 12-bedded inpatient unit based at Ashford and St Peter's Hospital Trust.

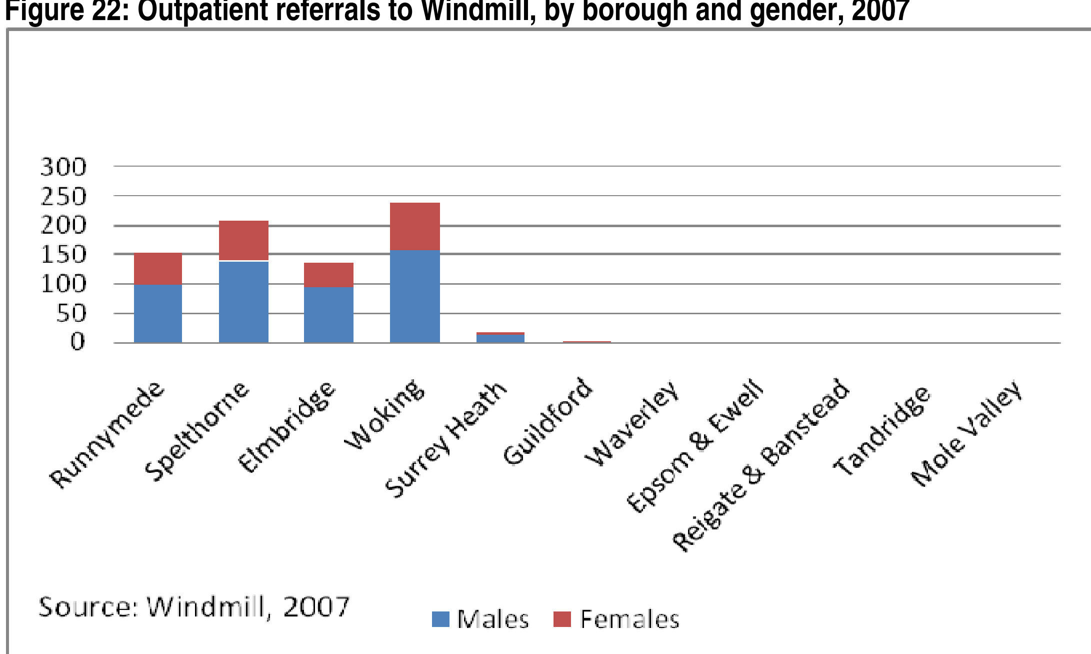
Vaughan House (English Churches Housing Group), a hostel for the homeless in Guildford, provides some specialist support for rough sleepers with alcohol problems. However, this is restricted to Guildford and is not Surrey wide; it provides a small number of detoxification beds where clients are supported by a GP that visits regularly.

7.2.7. Numbers attending Services

Information on alcohol misuse only clients attending services has not been readily available until recently. A new IT system, HALO, for collecting data from drug services is currently being established to assist organisations in transferring their data to the National Drug Treatment Monitoring System (NDTMS). Acorn and Windmill are currently up and running on the system, Respond are about to go live and SADAS will be on line with it shortly. Therefore, data on clients accessing services for reasons relating to alcohol misuse is becoming increasingly available.

Windmill received 755 outpatient referrals from Surrey boroughs in 2006 to 2007. Most referrals were from North West Surrey. Whilst Guildford has the highest percentage of harmful drinkers in Surrey; it appears to have a low number of referrals for outpatient consultation (figure 22).

Figure 22: Outpatient referrals to Windmill, by borough and gender, 2007



Of those referred to Windmill, 113 went on to receive inpatient detoxification. The majority of these were White British (90%) and male (65%). Treatment was completed by less than half (44%) of those who entered the programme.

Respond received 854 referrals for adult clients with alcohol as their primary problem. A quarter of those seen required inpatient care with the Windmill team.

7.2.8. Waiting times for Alcohol Services

Historically, substance misuse services have always been more formally managed around drugs users as there have been quite clear targets and performance indicators for this area. This has therefore resulted in fluctuating waiting times for those with alcohol misuse problems in the past.

7.2.9. Commissioning of Adult Alcohol Services in Surrey

Substance misuse services in Surrey are primarily funded through the DAAT and PCT (see table 22), although the Surrey DAAT funding is essentially ring fenced for drugs. For drug services there is a Joint Commissioning Group led by the DAAT, which is an inter-agency group overseeing the commissioning of adult drug services in Surrey. This group does not have a remit for alcohol.

At present there is no real commissioning structure for alcohol in Surrey and is a gap that needs to be addressed in order to ensure adequate services are available for those with alcohol misuse problems. An integrated commissioning structure is currently under discussion and would enable a more robust approach to the commissioning of alcohol services in line with the current structure which exists for drug services.

Table 22: Substance Misuse Services receiving funding from the Surrey DAAT, Surrey PCT and Surrey County Council (2007)

Service	Surrey DAAT Funding	Surrey PCT Funding	Surrey County Council
Windmill CDAT	£468,000	£574,000	0
Acorn CDAT	£403,000	£435,000	0
Respond CDAT	0	£1,682,000	0
Windmill House Detox	£148,000	£1,116,000	0
Residential Rehabilitation Places	0	0	£270,000
Counselling service	.£91,000	£45,000	£76,000
Omni Outreach	£95,000	£20,000 (alcohol specific)	£125,000

Source: Surrey PCT, 2008

The only alcohol-specific funding is the £ 20,000 contribution made by Surrey PCT to SADAS for its OMNI outreach service for difficult to engage alcohol clients. A clearly ring-fenced alcohol budget separate from the substance misuse budget and clear alcohol targets can assist initial and ongoing investment in alcohol misuse services. The recent addition of an LAA / Vital Signs target around alcohol related admissions may support this move in the future.

Performance and Monitoring

There is currently a lack of performance monitoring in relation to treatment services for alcohol. The DAAT monitors the performance of services in relation to drugs as they have specific targets to achieve in this area, they do not monitor performance on alcohol. However, HALO will enable the PCT and other agencies to do this and is something that will need to be fully integrated in to any new commissioning structure that is developed.

7.3 Service Provision in Prisons

The prison population has a higher prevalence of substance misuse problems compared to the general population. This includes increased rates of hazardous, harmful and dependent alcohol use prior to imprisonment. Currently there is no specific funding for alcohol treatment in Surrey prisons, which leads to constraints in the service that the Clinical Addictions and Substance Awareness Teams aspire to deliver. Any clinical care is financed from the already overburdened general healthcare budget.

On admission into prison all clients undergo general health screening for pre-existing physical, mental and substance misuse problems. This includes the use of an alcohol screening tool. If appropriate clients are referred to a substance misuse nurse for assessment who will in turn refer to the specialist substance use doctor to commence detoxification prescribing with minimal delay (often clients are demonstrating signs of withdrawal due to length of time in police custody). The initial days of medically assisted alcohol withdrawal are supervised in areas of the prison with 24 hour nursing care.

A weekly alcohol awareness group is facilitated by a substance misuse nurse; the content of which is currently being assessed for accreditation. The substance misuse nurses have the capacity to offer 1:1 sessions with patients with complex problems. The prisons have better systems for undertaking investigations than some community specialist agencies and run regular venepuncture clinics. Thus they can easily use, for example, improving results of liver function tests as a tool during relapse prevention counselling. There is excellent inter-team relationships within each prison healthcare centre and an example of this is the Mental health Inreach Team and the Clinical Addictions Team who co- manage integrated care plans for the most complex dual diagnosis patients. If the patient has a community care plan comprising the prescription of drugs to promote abstinence alongside psychosocial treatment then the prescription will be initiated in the prison and a supply given to last until it can be continued by the community prescriber.

CARAT workers assess new admissions and if alcohol use is co existent with any other substance use then are able to actively work on a care plan. If the client's sole substance problem is alcohol then CARATs would not be able to work with them proactively but do offer initial advice, provision of leaflets and addresses of relevant community agencies for the client to contact. CARATs do not keep these clients on their case load but if a prisoner asks for advice prior to release then they would be seen and informed of options regarding visiting their GP, or self referring to a particular service. The emphasis is on the individual prisoner to take action and there is no clear care pathway from the prison to the community. CARATs however do run a regular open alcohol awareness group. AA also run a weekly group. The prison does support continued contact from the client's community key worker if the prisoner was already engaged with a treatment service prior to release and prisoners can be directly admitted to a rehabilitation facility on release from custody. There is a need to develop a more consistent joined up approach as currently exists in clients released with opiate dependency.

A prison survey was conducted in 2003; it received responses from half of all prisons in England and Wales and identified only one prison that had a dedicated alcohol strategy. In December 2004 the Prison Service published its alcohol Strategy for Prisoners which focussed primarily on improving the consistency of measures to prevent future hazardous drinking across the prison estate and built on existing good practice. High Down now has a written Alcohol Strategy. The first accredited alcohol treatment programme (12 week full time course) funded with ring fenced budget has recently been established in Bullingdon Prison and its success will lead to its extension to other prisons.

7.4 Service Provision for Young People

The Health Advisory Service (HAS, 2001) recommends a four tier model for young people's substance misuse (including alcohol); this is broken down as follows:

1. Services for all young people
2. Services for vulnerable young people
3. Community based services for young people with problematic substance misuse
4. Residential services for young people with complex problems associated with substance misuse

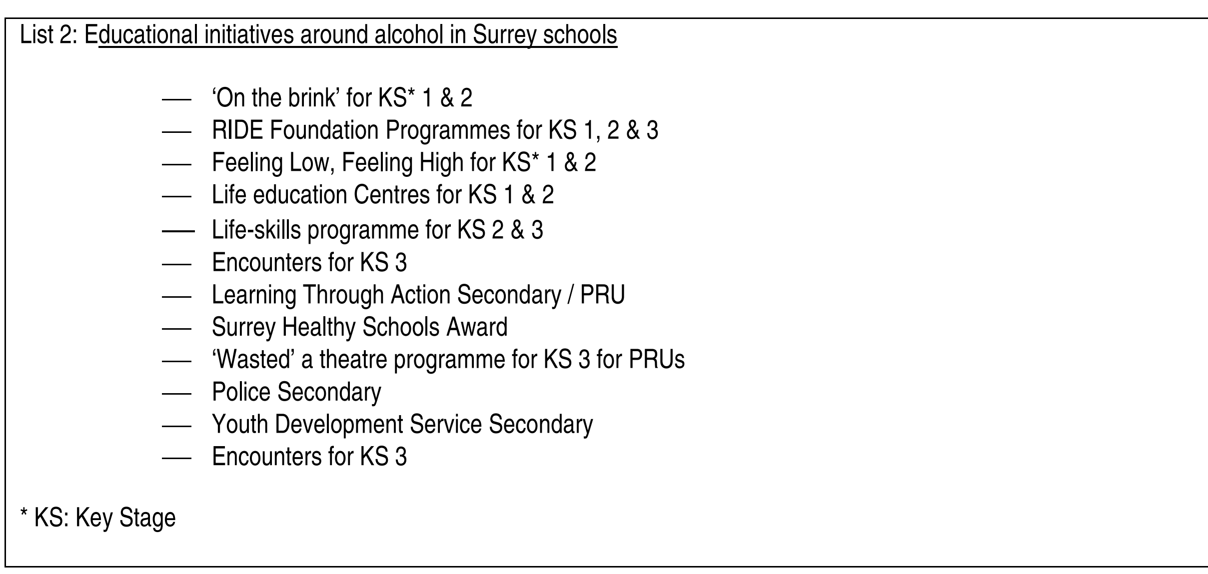
Services for all young people

All funding for young people's substance misuse services including education, prevention and treatment includes work on alcohol. The distinction that exists between illegal drugs and alcohol within the adult field does not apply to young people's services.

Schools and Young People

The vehicle for improving the quality of alcohol education in schools is the Healthy Schools Programme. This programme requires schools to fulfil a number of criteria to achieve Healthy Schools Status; this includes

criteria around the quality of Personal Social and Health Education (PSHE) of which alcohol education is a part. Schools are supported to achieve healthy schools status and as of 31st March 2008 68% of schools had achieved Healthy Schools Status and 90% were on the programme. This is line with national targets. Alongside this a number of agencies are commissioned by Borough Councils to support schools in the delivery of drug/alcohol education. These providers are listed in List 2. These seek to educate and raise awareness of issues relating to alcohol amongst children and young people.



List 2: Educational initiatives around alcohol in Surrey schools

- 'On the brink' for KS* 1 & 2
- RIDE Foundation Programmes for KS 1, 2 & 3
- Feeling Low, Feeling High for KS* 1 & 2
- Life education Centres for KS 1 & 2
- Life-skills programme for KS 2 & 3
- Encounters for KS 3
- Learning Through Action Secondary / PRU
- Surrey Healthy Schools Award
- 'Wasted' a theatre programme for KS 3 for PRUs
- Police Secondary
- Youth Development Service Secondary
- Encounters for KS 3

* KS: Key Stage

These school initiatives are complemented with the education available in the community, outside school settings. Information and advice to young people in the community is provided through mainstream services working with children and young people such as the Youth Development Service.

Services for vulnerable young people
The National Drugs Strategy identifies the following groups as vulnerable to developing problematic substance misuse:

- Children in Care
- Homeless young people
- Young Offenders
- Young people not in school
- Children of substance using parents

The DAAT needs assessment (2007) provides a summary of service provision for these groups, which includes a set of recommendations.

Treatment and support services
The approach to treatment for young people is different from adults. Alcohol services for young people are structured separately from adult services, with regards to premises and staff. At the time of publishing the services that currently offer treatment to young people with substance misuse including alcohol are outlined in table 18:

Table 18: Treatment of Alcohol Misuse in Young People in Surrey

In-volve Surrey Young People Service (SYPS)	Young people under the age of 19 living, working or at school in Surrey with problematic substance use
Youth Justice Service Substance Misuse Service	Young people in contact with the Youth Justice Service with problematic substance use
Omni-Youth, SADAS	Young people under the age of 19 living in Surrey with problematic substance use who do not engage in treatment

Rainer DAYS	Early intervention for young people (at risk of being) excluded from school for drug/alcohol related issues as well as those Leaving Care

Source: Surrey DAAT, 2007

However Surrey DAAT have just completed a tender exercise for the services provided by Involve SYPS, Omni-Youth SADAS and Rainer DAYS. Rainer has been identified to provide these services and will begin operation on 1st November 2008.

Young People's Commissioning Group
The Surrey DAAT also has a DAAT Young People's Commissioning Group. This group oversees the performance management of young people's substance misuse services as well as the development and implementation of the Young People's Substance Misuse Plan. It includes alcohol misuse among young people within its remit. The group has representation from the Families Services (County Council), Youth Justice Service, Connexions, Youth Development Service, Surrey PCT, CAMHS Partnership and Surrey Police.

The budget for young people's services for substance Misuse is separate from the Adult Pooled Treatment budget and in 2006/7 it amounted to £ 773,000. This seemingly small budget is supplemented by funds available through the Healthy Schools initiative of the County Council (about £150,000).

Unlike adults, both drugs and alcohol are integrated within the DAAT agenda for Young People.

7.5 Enforcement of legislation

The Trading Standards Service, the Police and the local licensing authorities in the Boroughs and Districts jointly enforce the Licensing Act 2003. Trading Standards is the designated 'responsible authority' under the Licensing Act 2003 and work very closely with the 11 District and Borough Council Licensing Officers.

The law gives Trading Standards Officers the power to make test purchases using children under 18. The legislation regulating the sale of age restricted goods is also enforced from within the Community Safety Team. Table 24 presents the campaigns and initiatives that have been undertaken or are in place in Surrey to facilitate enforcement of the law against alcohol misuse.

Table 24: Enforcement Initiatives in Surrey, 2007

Initiative	Brief Description
Alcohol Misuse Enforcement Campaign (AMEC)	Guildford participated in the 8-week national Alcohol Misuse Enforcement Campaign aimed at tackling alcohol-related violence and disorder. It also aimed to crack down on the illegal, irresponsible selling and consumption of alcohol which promotes irresponsible and rowdy behaviour.
Surrey Together	The joint teams of the Surrey Police and Surrey County Council focus on issues around anti social behaviour in neighbourhoods with a responsibility for ensuring that alcohol is not being sold illegally to under 18s.
Alcohol Related Penalty Notices for Disorder (PNDs)	These are issued to the public for public order offences and to licensees for selling alcohol to under 18s.
Traffic Light System	A "traffic light" system introduced in Epsom & Ewell records the severity of problems associated with individual licensed premises. This will link to the more formal licence review arrangements.
Designated Public Places Order (DPPO)	This is a joint project with Surrey County Council where Police Community Safety Officers (PCSOs) work in joint teams with youth service personal advisors and trading standards officers to work with young people at risk of offending. It also looks at anti-social behaviour zones in which police officers have power to confiscate alcohol and prohibit street drinking. On 1/2/07 there were 11 DPPOs in place in Surrey with a

	further 2 under active consideration.
Drink Impaired Drivers programme	The Drink Impaired Drivers programme is a condition of supervision orders for those convicted of drink driving.
Driver re-education courses	This is an initiative undertaken by the Surrey Probation Service
Working with the Alcohol Industry	'Pubwatch' Scheme, Challenge 21, British Institute of Innkeeping (BII), Security Industry Authority

Source: Surrey Safer Stronger Community Partnership Board, 2007

8. Gaps and Priorities

This section gives an overview of the gaps and priorities for alcohol misuse services in Surrey. The gaps and priorities were assessed on the basis of national guidelines and the views obtained from partner agencies. The user perspective did not inform this process as it was planned to seek the public's perspective on alcohol misuse through Surrey's Big Drink Debate. The key gaps and priority issues that emerged through the AHNA relate to the available intelligence about the problem, resources, capacity and equity of services.

8.1. Intelligence on Alcohol Misuse in Surrey

The intelligence on the numbers of adult alcohol misusers by age-group and gender has been mainly derived from national surveys. This may be an under or overestimation of the actual numbers needing support from alcohol services. In order to achieve effective service planning, systems that collect information on people's drinking behaviour are needed.

Whilst information on how many people come in to contact with health or social services is not formally recorded in primary care; it is likely to be a large number so this setting provides an important opportunity within which to deliver tier 1 interventions.

The practice of asking about drinking habits varies across GPs in Surrey. The old GMS contract rewarded GPs for carrying out health promotion checks every three years but this is not included in the new GMS contract; so not all practices routinely ask about alcohol use any more. The lack of a formal driver for collecting such information may be a barrier to developing robust information on alcohol misuse in primary care. This is an issue to be considered by the strategy group with input from the Professional Executive Committee (PEC) of Surrey PCT.

Alcohol misuse intelligence shared across partner agencies can assist in the development of alcohol profiles for Surrey. As such this can support the development of alcohol services with greater reliability and responsiveness to the needs of the local population. Developing shared intelligence across primary care, the criminal justice system and workplaces in Surrey can also assist in the comprehensive planning of alcohol services as per the recommendations of the Department of Health and National Treatment Agency.

8.2. Service Issues for Alcohol Misuse

8.2.6. Commissioning of Services

The Surrey DAAT is well placed to coordinate the delivery of alcohol misuse services for moderate or severe drinkers within with the existing drugs and advisory services. However, gaps in meeting the needs of those with complex psychological needs have to be planned with input from GPs and Mental Health Services in Surrey.

The DAAT does not have any targets related to alcohol misuse in relation to adult treatment. This leads to the lack of a policy driver to guide and monitor local performance in this regard. However, the Department of Health have recently introduced 'vital signs' targets, which PCTs must deliver on. For the first time there is a target relating to alcohol and specifically to reducing alcohol related admissions to hospital. The same target has also been integrated in to the Local Area Agreement highlighting that Surrey is fully behind a move to tackle alcohol. Having a formal target for alcohol can assist local action and ultimately impact significantly on performance.

There is a need for an integrated commissioning structure along the lines of the DAAT's Joint Commissioning Group to ensure alcohol services are appropriately commissioned, funded and monitored.

8.2.6. Education and Prevention

There are national media campaigns currently underway, which seek to raise awareness amongst the general population of the impact of excessive drinking on themselves and others. It endeavours to ensure consistent messages about sensible drinking are conveyed and that there is greater clarity for individuals about

understanding themselves how much alcohol they consume. The public should continue to be made aware of the harms associated with alcohol and have access to information about what is available locally through clear and accessible patient information.

There are a number of statutory and non statutory providers at tier 2 and 3. However, there seems to be a gap in the awareness of professionals about what is available locally, what the referral criteria is and what the appropriate care pathways are. More information about what professionals know and how aware they are about existing services would be beneficial. This could be achieved by conducting an audit on awareness levels in local GP practices.

In addition, a survey by the Royal College of General Practitioners showed that only 4 out of 10 GPs who participated were able to assess the number of units in five out of the six drinks shown; 7 out of 10 of GPs were unable to determine the alcohol content of all six drinks to within 30%. Nearly half of the responders recommended safe drinking limits of 28 units per week for men and 21 for women which are both over the amounts recognised officially by the government.[42] This indicates that there may be a need for training for frontline staff who may be in a position to influence drinking behaviour to ensure that the correct information and advice is given to patients. There is a need to invest more towards developing consistent safe drinking messages and train professionals to deliver these.

The existing initiatives for schools and young people should be evaluated and findings reported to the Alcohol Strategy Group. A greater and more visible engagement from schools and youth services may be helpful. Social marketing strategies and the involvement of parents, families and carers may enhance outcomes.

Those living in prisons and the homeless should be prioritised for receiving prevention advice.

The workplace provides an ideal opportunity for preventing and detecting alcohol misuse early. The workforce, through working with employers, should be engaged in education, harm minimisation and treatment.

8.2.6. Early Identification and harm minimisation

Any prevention strategy is likely to be fully effective only when the mechanisms for early identification and assessment are established. This will allow a targeted delivery of interventions such as advice and brief interventions.

Arguably, the prevention of alcohol misuse can benefit 9 out of 10 adults drinking varying amounts of alcohol, therefore the Models of Care for Alcohol Misusers[1] recommends that service planners for alcohol misuse should focus first upon the needs of the hazardous, harmful and dependent adult alcohol misusers.

The screening tools recommended for early identification of drinking problems are the alcohol use disorders identification test (AUDIT) and fast alcohol-screening test (FAST). These are simple and reliable ways of detecting problem drinking behaviour in harmful and hazardous categories based on cut-off scores. At present, screening for alcohol misuse using the AUDIT tool is patchy and inconsistent across primary care, prisons and criminal justice system.

There is a gap in the expertise of professionals at an organisational level to screen for and minimise harm from alcohol misuse. If the opportunity for early identification and engagement with the service at lower levels of need are missed, there is a possibility that more people will consequently present to the specialist level at tier 4 or to health and social services with greater and more complicated needs. This is likely to result in greater costs and less satisfactory treatment options. It is, therefore, a priority to train frontline services and staff in the use of AUDIT, systematic reporting of results and appropriate referral along the care pathway.

A gap is also apparent in our knowledge and understanding of how best to engage and support patients who drink well above sensible / safe limits, but would not perceive themselves to be dependent on alcohol and are therefore reluctant to use traditional alcohol treatment services.

8.2.6. Treatment and Rehabilitation

There is currently a gap in the provision of alcohol services within primary care and other areas that may offer opportunities for engaging with hazardous / harmful drinkers, for example A&E departments. The development of a primary care / A&E Locally Enhanced Service (LES) would enable the development of such services.

The main difficulty around implementing and alcohol LES is time. Many GPs believe that brief interventions, for example, are often not very brief as they can last around 30 minutes. With the usual GP consultation lasting between 10-15 minutes in which there are at least three issues to be dealt with, a further 30 minutes on top would significantly increase workloads and their ability to see more patients. GPs may therefore be limited in what they can offer patients in the form of brief interventions and it may require a significant shift in GP perceptions and understanding of brief interventions and/or identifying other members of the practice team that could deliver such interventions instead. An alternative approach may be to utilise existing staff within CDATs, for example, to go in to practices enabling GPs to refer their patients directly almost straight away. This would also provide better links to other levels of intervention that may be required.

The development of a LES would need to take in to account the possible knock on effects of the implementation of a good primary care service. Such a service is likely to increase demand for alcohol treatment and thus, tier 3 services may not have the capacity to meet such increases in demand.

The Health Care Needs Assessment for Alcohol (2005)[4] stated that a population of 500 000 would require 10-12 beds for inpatient care. This would indicate that the 12-bed detoxification unit at Windmill House does not have enough capacity for Surrey's population of over a million and would suggest that a further 10-12 beds would be required to bring it up to the recommended number. However, there is a general feeling that despite the size of Surrey's population a 12 bedded detoxification unit is sufficient to cope with demand due to the fact the affluent nature of the population means that a number of those requiring such interventions seek private treatment facilities.

8.2.6. Enforcement

The development of the enforcement arm of the local alcohol strategy could be particularly strengthened by engaging with the local alcohol industry. Working with industry to develop a 'Responsible Beverage Service' in Surrey may be one of the ways to achieve this. A 'Responsible Beverage Service' in Surrey pubs and clubs through 'server training' could enhance enforcement of legislation. It can be set up and implemented as an incentive scheme for local businesses whereby they compete to achieve it as a mark of excellence and demonstration of social responsibility.

8.2.6. Equity of alcohol misuse services

The needs of different sections of the population are not the same. For example, there is a high alcohol-specific death rate in females in Epsom & Ewell, but they have low alcohol-specific hospital admissions, which could indicate issues relating to the accessibility of services for women in Epsom & Ewell. Such an issue may result in late presentation and delayed diagnosis, thus impacting significantly on mortality figures as people are presenting with advanced or end stage disease making medical intervention difficult.

In primary care there is a lack of routine questioning and advice being given in relation to alcohol. Certain people are opportunistically asked and given advice about alcohol, but these are mainly confined to those with an alcohol related condition or young women attending for contraceptive advice. Young men in particular are being missed out at present and are, perhaps, the ones we should be prioritising with safe drinking messages and information. They are likely to require a social marketing approach to ensure the right messages are getting through in the right format for them.

The alcohol misuse needs of the prison population are particularly significant. The prevalence of alcohol misuse is much higher than in the general community but the availability of support and interventions are particularly limited. There is also a need to link the services inside prison with those in the community. This will facilitate maintenance of safe drinking once the prisoner is released.

Finally, tackling alcohol misuse requires a whole-systems approach. It also requires multi-agency involvement, funding and planning of resources on the basis of evidence with regular review of needs, resources and

services. Rather than having several small pots of money for lots of specific targets around alcohol, it may be more efficient to have a large pot of money for alcohol and use local area agreements to decide investment and priorities.

9. Conclusion

Cook (2005),[43] when assessing alcohol needs at a national level, recommended that within each locality it is important to ask three overarching questions:

1. Has a local plan on alcohol misuse been formulated? Is it being implemented and updated?
2. What mechanisms for integration exist?
3. What mechanisms currently exist to determine adequacy of multi-disciplinary, multi-sectoral training in alcohol misuse?

In Surrey the Surrey Safer and Stronger Communities Partnership Board have undertaken to tackle alcohol misuse on a county-wide basis. There is willingness within the participating agencies to review local needs and develop services with a strategic approach. Recognition that a partnership approach is beneficial already exists, but there is a need to take this willingness a step further to ensure integration of services with existing care pathways and to ensure adequate multi-disciplinary, multi-sectoral training in alcohol misuse is implemented.

A greater clarity on the prevalence of alcohol misuse based on local intelligence, resources and funds dedicated to alcohol misuse, mapping of referral pathways, service providers and development of referral protocols should be prioritised by the Alcohol Strategy Group. Workforce training and development in order to provide alcohol services across the public and voluntary sector is essential to delivery of effective interventions in an effective and equitable manner. Working with the industry is vital to achieve reductions in alcohol misuse in a sustainable manner.

At present Surrey is tackling alcohol misuse in a disjointed manner with one or two key agencies taking forward their own isolated action plans as they have seen alcohol as a priority for action e.g. Surrey police in relation to crime and Surrey PCT in relation to health issues. The development of a Surrey wide alcohol strategy is therefore crucial in ensuring that there is a more joined up approach to alcohol in Surrey and it is hoped that this needs assessment is able to provide a sound starting point for the development of such a strategy.

The introduction of a target around alcohol should enable us to focus on the topic. In order to achieve the extremely challenging target, efforts will need to focus on those with acute conditions (e.g. accidental injury, poisoning etc) and chronic alcohol related conditions, which make up approximately 62% of all alcohol related conditions.[8]

Harmful drinkers and dependent drinkers need to be targeted as they represent the greatest cost to the NHS (twice as much as normal drinkers). Targeting these groups will be the most effective and cost effective way of reducing alcohol related admissions in the short term. This will require careful targeting of harmful drinkers and adequate provision of specialist treatment for dependent drinkers.

The following key actions have been highlighted as those necessary to reduce alcohol related admissions[6]:

- Through local alcohol strategies:
  - build and sustain activity in alcohol misuse – reinvest savings in to alcohol misuse services and increase access to specialist treatment
  - Influence through advocacy – build the case for investment with local champions publicising harm and potential savings
- Development of brief intervention advice in A&E units (possibly with the use of specialist alcohol nurses)

Finally, it is important to recognise that this AHNA serves as a baseline. This needs assessment will need to be revisited at regular intervals to ensure that progress is achieved and maintained in order for us to collectively work towards achieving the very challenging LAA and vital signs target over the coming years and

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[8] David Sheehan briefing paper on the efficacy of interventions to reduce alcohol related hospital conditions (June, 2008)

ensure that people in Surrey have the opportunity to make informed decisions about alcohol and get access to the right sort of treatment when they need it.

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Appendix I

Alcohol Use Disorder Identification Test (AUDIT) questionnaire: A screening tool for alcohol use

Please circle the answer that is correct for you

1. How often do you have a drink containing alcohol?
   - Never
   - Monthly or less
   - 2-4 times a month
   - 2-3 times a week
   - 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day when drinking?
   - 1 or 2
   - 3 or 4
   - 5 or 6
   - 7 to 9
   - 10 or more

3. How often do you have six or more drinks on one occasion?
   - Never
   - Less than monthly
   - Monthly
   - Weekly
   - Daily or almost daily

4. During the past year, how often have you found that you were not able to stop drinking once you had started?
   - Never
   - Less than monthly
   - Monthly
   - Weekly
   - Daily or almost daily

5. During the past year, how often have you failed to do what was normally expected of you because of drinking?
   - Never
   - Less than monthly
   - Monthly
   - Weekly
   - Daily or almost daily

6. During the past year, how often have you needed a drink in the morning to get yourself going after a heavy drinking session?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

7. During the past year, how often have you had a feeling of guilt or remorse after drinking?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

8. During the past year, have you been unable to remember what happened the night before because you had been drinking?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

- No
- Yes, but not in the past year
- Yes, during the past year

10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested you cut down?

- No
- Yes, but not in the past year
- Yes, during the past year

Scoring the audit

Scores for each question range from 0 to 4, with the first response for each question (e.g. never) scoring 0, the second (e.g. less than monthly) scoring 1, the third (e.g. monthly) scoring 2, the fourth (e.g. weekly) scoring 3, and the last response (e.g. daily or almost daily) scoring 4. For questions 9 and 10, which only have three responses, the scoring is 0, 2 and 4 (from top to bottom).

A score of 8 or more is associated with harmful or hazardous drinking, a score of 13 or more in women, and 15 or more in men, is likely to indicate alcohol dependence.

Appendix II

The laws relating to young people and alcohol

<table>
<tr><th>Age</th><th>Legal Act</th><th>Provision</th></tr>
<tr><td>Under 5 years</td><td>--</td><td>Can consume alcohol within private homes</td></tr>
<tr><td>Under 16 years</td><td>Licensing Act 2003</td><td>It is illegal for children under 16 years to drink on any premise to which a license or temporary event notice has been given exclusively for the supply of alcohol, if they are not accompanied by an adult (aged 18 or over). This provision includes every part of the premises including terraces and beer gardens.
Children aged 16-17 years may drink beer, wine or cider at a table meal if they are accompanied by an adult.</td></tr>
<tr><td>Under 18 years</td><td>1. Licensing Act 2003

2. Confiscation of Alcohol Young Persons) Act 1997</td><td>The legal age for purchasing alcohol is 18 years.

It is an offence for any person:
To supply alcohol to children anywhere, not just on licensed premises e.g. supplying smuggled alcohol from vans or car boots.
To sell alcohol to a child unless the person charged believed he/she was 18 or over or took reasonable steps to establish the purchaser’s age i.e. asked for proof of age identification.
It is an offence for a child:
to buy or attempt to buy alcohol;
knowingly consume alcohol on relevant premises
The police have powers to confiscate alcohol from under- 18s drinking in public and to contact their parents.

When a child has been asked to test-purchase alcohol from relevant premises by a police officer or a trading standards officer, the child will not be committing an offence.</td></tr>
</table>

Source: Alcohol Concern, 2006

Appendix III - Recommendations

The recommendations presented here are based on the assessment of gaps and priorities and the perception of the problem by stakeholders in tackling alcohol misuse in Surrey.

INFORMATION ISSUES:	
Issue	**Recommendation**
▪ Prevalence data for hazardous, harmful and dependent drinkers are currently modelled estimates based on national indicators meaning that the numbers of drinkers in these categories in Surrey could be a vast under or over estimation.	1. Seek funding to enable the development of a LES for alcohol to include the development of a database or register in Primary Care to record the number of people with alcohol misuse and its severity.
▪ Robust information systems across frontline public services are currently lacking. The development of an appropriate system could support future planning, allocation of funds and evaluation of services. It is important to identify ways for confidential sharing of information to assist service development and evaluation.	2. Work with partners to re-start the A&E data collection programme, which will help support the achievement of the vital signs target and provide a good starting point for improving the planning of services in the future.
▪ Data collection on the use of alcohol services, resources and annual spend is haphazard. More robust data collection would enable commissioners to monitor alcohol services more effectively and ensure resources are invested appropriately.	3. Set up a data collection system to capture how many people access treatment in each tier and develop metrics to measure outcomes
▪ There appear to be gaps in the knowledge and awareness of existing alcohol services in Surrey amongst GPs and in primary care generally.	4. Post Surrey Big Drink Debate, use the website as an awareness raising tool for professionals to gain access to up to date information about services available etc.
COMMISSIONING OF SERVICES	
▪ There is a need to ensure services provided are effective and evidence based.	5. Use Models of Care for Alcohol Misusers (MoCAM); the NTA's review of effectiveness of treatments for alcohol misuse; and the forthcoming NTA publication on exploring the evidence for young people's substance misuse services to inform commissioning of alcohol services.
▪ The commissioning arrangements for alcohol lack proper co-ordination and integration.	6. Need to establish a proper joint commissioning system to ensure the needs of those with alcohol misuse problems are met.
▪ Psychological interventions work to improve health and social outcomes in drinkers who have severe dependency. However, there are currently long waiting times reported by the SABP Trust in accessing psychological treatments.	7. Consider commissioning more psychological sessions.
▪ Waiting times for those adults with a dual diagnosis of alcohol misuse and psychiatric problems are long.	5. Seek input from the Mental Health Commissioning Team at Surrey PCT to reduce waiting times for those with dual diagnosis of psychiatric problems. The Mental Health Commissioning teams at Surrey PCT could be in a position to invest in the development of psychological treatments.
▪ Alcohol misuse services in prisons are currently inadequate and inconsistent. There is a lack of	8. Develop an Alcohol Strategy for Prisons and / or ensure that prisons are incorporated into the

integration with community services once prisoners are released and inmates are often only seen for their alcohol misuse where drug misuse is the primary concern.	Surrey wide alcohol strategy.
PREVENTION AND EDUCATION	
▪ There is currently a lack of good patient information about alcohol services available; what to expect from them; the range of treatment options available and who provides it.	9. Develop clear and accessible patient information.
▪ Whilst the evidence around what works for young people is lacking; it indicates that a family / societal approach is likely to work.	10. Consider focusing on greater engagement with parents and families through education and support packages / interventions developed with and through families, carers, schools and other youth settings / services.
▪ There is a lack of targeted marketing locally.	11. Use social marketing to target messages to specific sectors of the population. This approach can be effective in stimulating behaviour change and / or improving uptake and outcomes of interventions. Some key target groups would include: young people, prisoners and employees.
▪ There are gaps in the knowledge base of professionals dealing with alcohol misuse clients.	12. Improve information and availability of training for professionals
EARLY IDENTIFICATION AND HARM MINIMISATION	
▪ Screening for hazardous / harmful drinkers is not currently carried out consistently by all staff in primary care and secondary care.	13. Screening and brief interventions should be offered in primary and secondary care. The WHO Alcohol Use Disorders Identification Test (AUDIT) is a valid, reliable tool that should be adopted by all agencies, including primary care, as standard. All hazardous and harmful drinkers identified by AUDIT should be offered brief interventions to reduce their alcohol drinking. Young people's services already have a screening tool which may need further dissemination.
▪ There is a lack of consistency in the screening tool used by staff to assess levels of alcohol misuse in the community.	14. The AUDIT tool should be used by all staff in all appropriate settings. This will assist in the development of a consistent approach to identification and intervention.
▪ Brief interventions in alcohol are effective. For every 10 hazardous drinkers receiving brief interventions, one will be prevented from becoming a harmful drinker. This would impact positively on tier 4 services by reducing the numbers of people requiring that level of service. The current brief intervention programme for adults is not imbedded in primary and secondary care and therefore cannot reach the numbers of people necessary to make a real difference.	15. Greater investment in prevention and harm minimisation through implementation of more brief intervention programmes in primary and secondary care in particular is required.
▪ Lack of tier 2 services for adults in primary care.	See Recommendation 1 – seek funding to develop a LES for alcohol in order to develop tier 2 services in primary care.
▪ Existing alcohol misuse services for adults have not been monitored or evaluated in the past, so there is little data on the effectiveness of current	16. Carry out an evaluation of current services and implement more robust monitoring arrangements. All services will need to be

services.	appropriately engaged in understanding their role in achieving the LAA / vital signs target around alcohol.
TREATMENT AND REHABILITATION	
▪ There is currently a lack of clarity around referral processes and care pathways for adults with alcohol problems.	17. Clear referral guidelines and care pathways should be developed and disseminated. This should be made available to staff in primary care, A & E, other hospital departments, mental health teams, police, probation, prisons and CDAT. The guidelines should state the routes into treatment, and identify criteria/ thresholds for referral to more specialist help.
▪ Service provision for those adults with alcohol misuse and dual diagnosis of mental health problems is problematic with long waiting times being reported by GPs.	18. Review service provision for this client group, to include an audit of waiting times.
ENFORCEMENT	
▪ There is a need to get the alcohol industry more heavily involved in taking a shared responsibility for reducing the harm associated with alcohol.	19. Develop a Responsible Beverage Service in Surrey.

References

[1] Department of Health. National Treatment Agency for Substance Misuse (2006) Models of Care for Alcohol Misusers. June 2006

[2] Cabinet Office. Prime Minister's Strategy Unit (2004). National Alcohol Harm Reduction Strategy for England. March 2004

[3] Department of Health, Home Office, Department for Education and Skills, Department for Culture, Media & Sports Policy HM Government. (2007). Safe. Sensible. Social. Next steps in Alcohol Strategy June 2007.

[4] Department of Health (2005). Alcohol Needs Assessment Research Project (ANARP). The 2004 national alcohol needs assessment for England.

[5] Saunders JB, Aasland OG, Babor TF et al. Development of the alcohol use disorders identification test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol consumption —II. Addiction 1993, 88: 791–803.

[6] Cabinet Office. Prime Minister's Strategy Unit (2003). Interim Analytical Report. Strategy unit, alcohol harm reduction project.

[7] BMJ Health Intelligence: http://healthintelligence.bmj.com

[8] Office of National Statistics (2006). General Household Survey.

[9] Surrey Primary Care Trust (2007). Public Health Annual Report. 2007

[10] Singleton N et al (1999). Substance Misuse among prisoners in England and Wales 1997. Office of National Statistics.

[11] Association of Public Health Observatories (2007). Indications of Public Health in the English Regions | 8: Alcohol

[12] North West Public Health Observatory 2007. Local area profiles for England. accessed on http://www.nwph.net/alcohol/lape/#

[13] The Information Centre (2007). Smoking, Drinking and Drug Use Among Young People in England in 2006.

[14] Sheehan, D (2007). Choosing Health in South East: Alcohol. South East Public Health Observatory. January 2007.

[15] Singleton N, Farrell M, Meltzer H. 1997. Substance misuse among prisoners in England and Wales. London, ONS.

[16] Prison Reform Trust (2005). Prison death toll. September 2005 accessed Jan 2008 on http://www.prisonreformtrust.org.uk/subsection.asp?id=328

[17] Gossop M, Marsden J, Stewart D. NTORS after five years. Changes in substance use, health and criminal behaviour during the five years after intake. National Addition Centre, London, 2001.

[18] Farrell M, Howes S, Bebbington P et al. (2001) Nicotine, alcohol and drug dependence and psychiatric morbidity. Results of a national survey. Br J Psych 2001. 179: 432-437.

[19] Barnaby B, Drummond C, McCloud A et al. (2003) Substance misuse in psychiatric inpatient settings: comparison of a screening questionnaire survey with case notes. Br Med J 2003; 327: 783-784.

[20] BMA Board of Science (2008) Alcohol misuse: tackling the UK epidemic. (2008) British Medical Association accessed in March 2008 on http://www.bma.org.uk/ap.nsf/AttachmentsByTitle/PDFtacklingalcoholmisuse/$FILE/Alcoholmisuse.pdf

[21] Pirmohamed M, Gilmore IT. Alcohol abuse and the burden on the NHS — time for action. J R Coll Physicians Lond 2000; 34(2): 161-162.

[22] Royal Surrey County Hospital (2004). Safer Guildford Crime and Disorder Audit

[23] Anderson, G. (1993) Management of alcohol problems: the role of the general practitioner. Alcohol & Alcoholism. Vol. 28, No. 3 pp 263-272

[24] Audit Commission (2005). Local Quality of Life Indicators: Supporting Local Communities to Become Sustainable. http://www.areaprofiles.audit-commission.gov.uk/(xnsq0i55vegomoflgwjht445)/StaticPage.aspx?info=25&menu=57

[25] Shaylor E (2007) Scoping a task to produce a Surrey Alcohol Strategy. A Report to Surrey Safer and Stronger Communities Partnership Board.

[26] Surrey Criminal Justice Board (2006) Working Together for Justice. Annual Report 2005-06

[27] Surrey Community Safety Unit (2006). Assessing the impact of licensing changes on alcohol-related crime and disorder. 14th June 2006

[28] Walker A, Kershaw C Nicholas S (2006) Crime in England and Wales 2005/06. Home Office Statistical Bulletin Home Office, London July 2006.

[29] Anderson P, Baumberg B. (2006). Alcohol in Europe. A public health perspective. A report for the European Commission. Institute of Alcohol Studies.

[30] Foxcroft, D. R., Ireland, D., Lister-Sharp, D. J., Lowe, G. and Breen, R. (2002). Primary prevention for alcohol misuse in young people. The Cochrane Database of Systematic Reviews, Issue 3.

[31] McKenzie K, Haw S (2006) NHS Health Scotland. Alcohol And Alcohol-Related Problems In Scotland: Summary And 2006 Update Of Evidence

[32] Babor T F. Higgins-Biddle J C. (2001) A U D I T The Alcohol Use Disorders Identification Test. Guidelines for Use in Primary Care. World Health Organisation. 2nd ed. Accessed in 2007 on http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf

[33] Aertgerts B, Buntinx F, Ansoms S, Fevery J. (2001) Screening properties of questionnaires and laboratory tests for the detection of alcohol abuse or dependence in a general practice population. Br J Gen Pract 2001; 51: 206-217.

[34] P Wallace (2001) Patients with alcohol problems —simple questioning is the key to effective identification and management. Editorials. Br J Gen Pract. 2001 March; 51(464): 172–173.

[35] Kelly T M, Donovan J E (2002) 37 (5): 444. (2002) Alcohol & Alcoholism 37 (5): 444. (2002)

[36] NHS Scotland (2007). Quality Improvement. Evidence Note 20. Screening tools, detoxification and vitamin supplementation for alcohol dependence

[37] Miller W R, Wilbourne P L. (2002). Mesa Grande: a methodological analysis of clinical trials of treatments for alcohol use disorders. Review. 2002 Society for the Study of Addiction to Alcohol and Other Drugs. Addiction, 97, 265–277

[38] Mulvihill C, Taylor L, Waller S et al. (2005) Prevention and reduction of alcohol misuse (second edition). London: Health Development Agency 2005.

[39] McKenzie K, Haw S (2006) NHS Health Scotland. Alcohol And Alcohol-Related Problems In Scotland: Summary And 2006 Update Of Evidence

[40] Raistrick D et al. (2006) Review of the effectiveness of treatment for alcohol problems. National Treatment Agency for Substance Misuse.

[42] Webster-Harrison P J, Barton A G, Barton S M, Anderson S D (2001) General practitioners' and practice nurses' knowledge of how much patients should and do drink. Br J Gen Pract. 2001 March; 51(464): 218–220.

[43] Cook, C. Alcohol Misuse. Health Care Needs Assessment. Epidemiology based needs assessment reviews. Accessed Jan 2008. http://hcna.radcliffe-oxford.com/alcoframe.htm