

Royal Borough of Greenwich: joint strategic needs assessment for prevention and treatment of harmful drinking

30 April 2015

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1 Executive summary

Alcohol has a large impact on health and wellbeing in Greenwich. It causes dependence, liver disease, cancers, cardiovascular conditions, digestive conditions, injuries and many other health problems. It is also associated with many social issues, including emotional and relationship problems, violence, antisocial behaviour and loss of productivity.

There is no local data on drinking in Greenwich, but estimates suggest that 43,000 adults drink above safe limits (25% of adults) and 27,000 (14% of adults) binge drink. These rates are typical for an outer London Borough. Around 1,000 adults in Greenwich may be moderately or severely dependent and require specialist services. National survey data shows that drinking is highest among men, people in late middle age, White British people and people in less deprived groups.

In 2012/13, alcohol caused around 4,000 hospital episodes for Greenwich residents (6% of the total). The impact of alcohol due to chronic disease is highest in the most deprived parts of the borough (Woolwich Riverside, Woolwich Common and Glyndon). The impact due to injury and crime is highest in town centres with high densities of licensed premises (Greenwich, the O2, Woolwich and Eltham).

Although national survey data suggests that drinking is reducing, particularly among young people, alcohol remains one of the main causes of poor health, early death and many social problems. Due to the long time over which many chronic alcohol-related diseases develop, alcohol-related hospital admissions are likely to continue increasing even while drinking levels reduce.

Strengths of services in Greenwich to prevent harmful drinking and treat people with alcohol-related diseases are:

- The Alcohol Liaison Team at Queen Elizabeth Hospital, which provides screening and brief interventions for a large proportion of patients seen in A&E.
- A coherent hierarchy of specialist services, with services for people at each level of severity. Although this needs assessment did not include a review of the quality of these services, engagement with service managers and nationally reported data suggests that capacity and outcomes are good.
- A large quantity of screening conducted in a variety of settings, including health checks, GP surgeries and acute care.

Areas for development include:

- Referrals paths from health and social care to specialist services.
- The capacity of non-specialist health and social care staff (particularly in primary care) to deliver screening and brief interventions.
- Joint strategy development, with scope for refreshing and strengthening forums for local partners involved in prevention and treatment of harmful drinking.

15 potential improvements have been identified in section 5, for consideration by key partners including the Public Health team at Royal Borough of Greenwich, the commissioning team at Royal Borough of Greenwich (Drugs, Alcohol and Mental Health Integrated Commissioning team), Greenwich CCG and local treatment providers.

2 What do we know about it?

2.1 Summary

Large numbers of Greenwich residents drink in potentially harmful ways. An estimated 43,000 (25% of adults) drink above weekly 'safe' limits and an estimated 27,000 (14% of adults) binge drink. These rates are typical for an outer London Borough. Around 1,000 adults in Greenwich may be moderately or severely dependent and require specialist services. People who drink the most are men, those in wealthier groups, white people and those in middle age. The greatest burden on services is caused by large numbers of people drinking hazardously, rather than people with alcohol dependence disorders.

Alcohol has large impacts on health and wellbeing. 1.5% of deaths are directly linked to alcohol. 6% of hospital admissions in Greenwich can be attributed to alcohol, with patients presenting with acute intoxication, dependence, liver disease, cancers, cardiovascular conditions, digestive conditions and injuries. Alcohol is also associated with mental health problems, relationship breakdown, violence and antisocial behaviour. Around half of violent crime may be related to alcohol. Alcohol is considered the sixth biggest risk factor contributing to the burden of disease in Western Europe (after smoking, hypertension, obesity, physical inactivity and high blood sugar).¹

The rate of alcohol-related deaths, hospital episodes and ambulance call-outs peak in late middle age, which coincides with the highest overall volumes of drinking. However, alcohol-related conditions are caused by the accumulated toxic effect of alcohol over many years. A 50-year old presenting with alcoholic liver disease is likely to have drunk heavily for decades.

There are no indicators suggesting unusual impacts of alcohol in Greenwich. Rates of alcohol-related illness and crime are comparable to the rest of London. The impacts of drinking can be considered in two groups:

- Impacts related to public drunkenness and the night-time economy. These are most common in the town centres of Greenwich West, the O2, Woolwich and Eltham, where there are high densities of licensed premises. There are high rates of alcohol-related ambulance call-outs for younger people and high rates of alcohol-related crime.
- Health impacts related to longer term drinking. These are most common in the most deprived areas of Woolwich Common, Woolwich Riverside and Glyndon. These areas have the highest rates of alcohol-related hospital admissions, despite people in these areas being likely to drink less.

National survey data suggest that alcohol consumption is reducing, particularly among adolescents and younger adults. Drinking in pubs, bars and restaurants is also reducing, with the majority of alcohol now consumed at home. Mortality and hospital episodes related to alcohol have started to reduce, except among older people. Similarly, rates of alcohol-related crime have reduced in recent years.

2.2 Drinking in Greenwich

Main points:

- There is no accurate local data on drinking, but estimates suggest 43,000 drink above recommended safe limits, 27,000 binge drink and 1,000 are moderately or severely dependent.
- National survey data suggests that drinking is reducing, particularly among younger groups.
- National survey data suggests that men, white people, wealthier people and people in late middle age drink most.
- Drinking among adolescents is reducing rapidly, but those who do drink are likely to drink more.

Prevalence of drinking in Greenwich

There are various ways to define drinking behaviour.

- **Overall volume and 'risk' level**, measured in units (1 unit = 10ml of pure alcohol) over a period. 'Lower risk' drinking is less than 21 units per week for men and less than 14 units per week for women. 'Increasing risk' drinking is 21-50 units per week for men and 14-35 units per week for women. Those drinking above these thresholds are 'higher risk'.²
- **Binge drinking** is drinking a large amount in one episode. It is usually defined as 8+ units in one day for men and 6+ units for women.
- **Hazardous/harmful drinking.** 'Hazardous' drinking is a pattern of alcohol consumption that increases someone's risk of harm. 'Harmful' drinking is a pattern that is causing mental or physical harm. These are not diagnostic terms, but are sometimes identified using screening tools such as AUDIT.
- **Dependence.** A psychiatric diagnosis³ of a strong desire to drink and difficulty controlling drinking. People with alcohol dependence prioritise drinking over other activities and obligations. Dependence can be 'mild', 'moderate' or 'severe'. As a rule of thumb, those with mild dependence usually do not need assisted withdrawal, those with moderate dependence need community-managed assisted withdrawal and those with severe dependence may need residential rehab.⁴

Estimates in the Local Alcohol Profiles for England suggest that Greenwich has a similar rate of hazardous and harmful drinking as London and England, with 25% of adults drinking above the 'safe' weekly limit (see table 1). The estimates also suggest a similar rate of binge drinking to London, with 14% of adults 'engaging in binge drinking' (27,000 adults in Greenwich).⁵

There are no local estimates of hazardous/harmful drinking or alcohol dependence. National data from the Adult Psychiatric Morbidity Survey suggests that 24% of adults drink in hazardous or harmful ways, and 0.5% of adults have moderate or severe alcohol dependence.⁶ 5.4% have mild alcohol dependence and are not likely to require specialist services. A estimate made for the National Alcohol Needs Assessment suggested that 3.6% of the adult population is dependent on alcohol.⁷ This includes mild dependence and is therefore not predictive of need for specialist services. Table 2 shows these estimates applied to Greenwich, suggesting that approximately 1,000 are moderately or severely dependent. These are not highly reliable estimates, particularly because drinking varies by age and ethnicity and Greenwich's population is younger and has a higher proportion of minority ethnic groups than England.

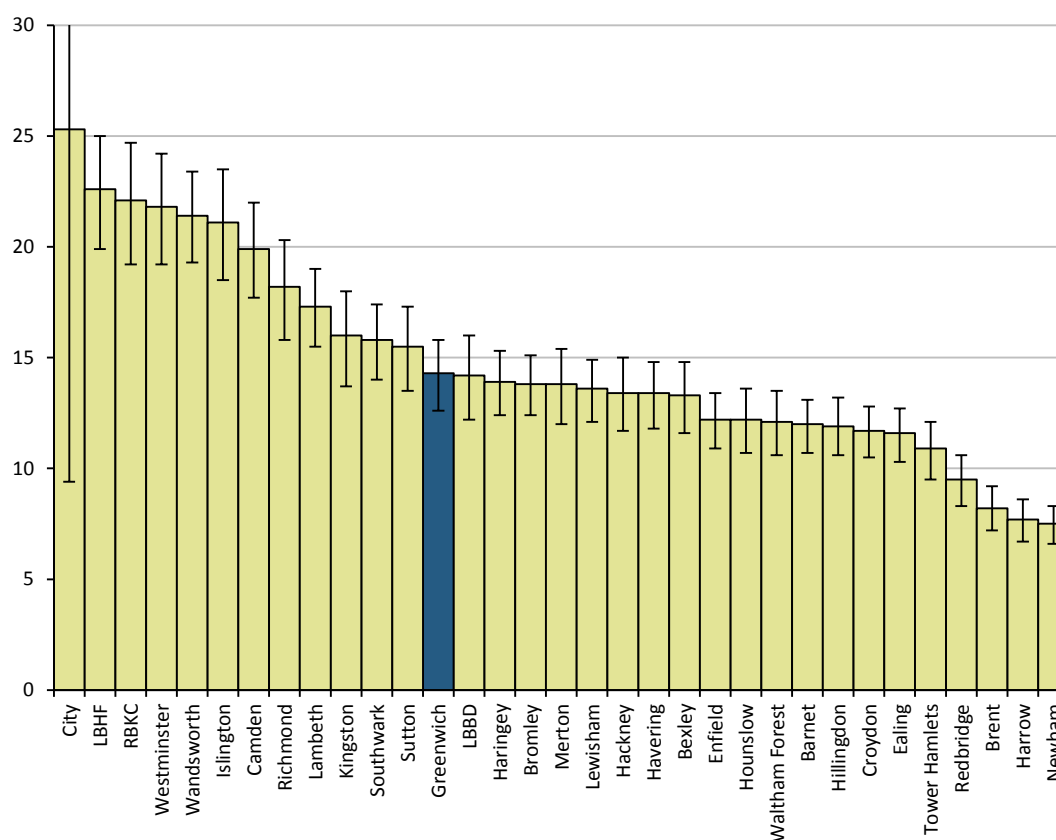
Table 1: Estimates of population by drinking risk group, 2011⁸

Risk group	Average units / week: men	Average units / week: women	Number in Greenwich	% of adults aged 16+		
				Greenwich	London	England
Abstainers	0	0	35,842	20%	25%	15%
Lower	<21	<14	97,171	55%	52%	61%
Increasing	21-49	14-34	29,871	17%	16%	18%
Higher	50+	35+	13,372	8%	8%	6%

Table 2: Estimates of Greenwich population by hazardous/harmful and dependence status, based on Adult Psychiatric Morbidity Survey⁶

AUDIT	SADQ-C	Category	% of adults aged 16+, England (APMS)	
			England (APMS)	Applied to Greenwich
AUDIT		0-7: not hazardous	75.8%	150,978
		8-15: hazardous	20.4%	40,633
		16-40: harmful	3.8%	7,569
SADQ-C		0-3: not dependent	94.1%	187,427
		4-19: mild dependence	5.4%	10,756
		20-34: moderate dependence	0.4%	797
		35-60: severe dependence	0.1%	199

Figure 1: % of the population aged 16+ that binge drink, modelled estimate, 2006-08⁵



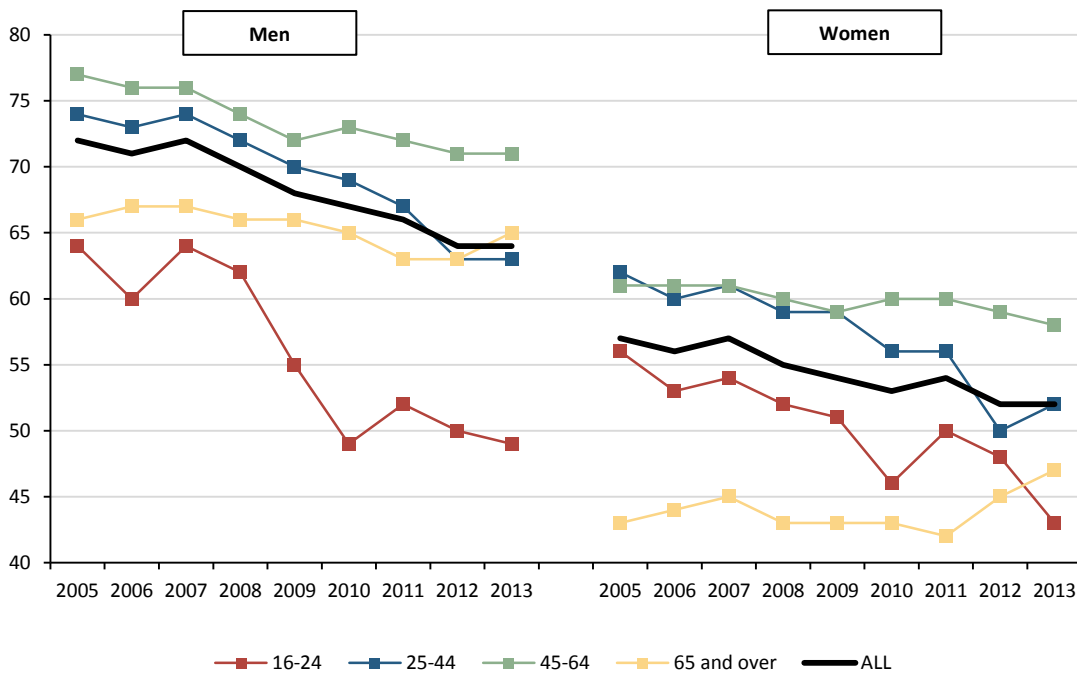
Source: LAPE – Local Alcohol Profiles for England

Trends

Drinking in the UK reduced from 11 litres of pure alcohol per person in 1900 to 3.5 litres in 1930. It began to increase again around 1960, with a sustained increase to 9.5 litres in 2004. Between 2004 and 2009, drinking reduced to 8.2 litres per person per year.⁹

This recent reduction is reflected in self-report surveys. Between 2005 and 2013, the ONS Opinions and Lifestyle Survey showed a reduction in the proportion of men drinking in the past week from 72% to 64%, and from 57% to 52% for women.¹⁰ The reduction is largest in younger groups, with no clear reduction in the oldest groups. Alcohol services in Greenwich anecdotally report less frequent drinking and fewer alcohol disorders among young people.

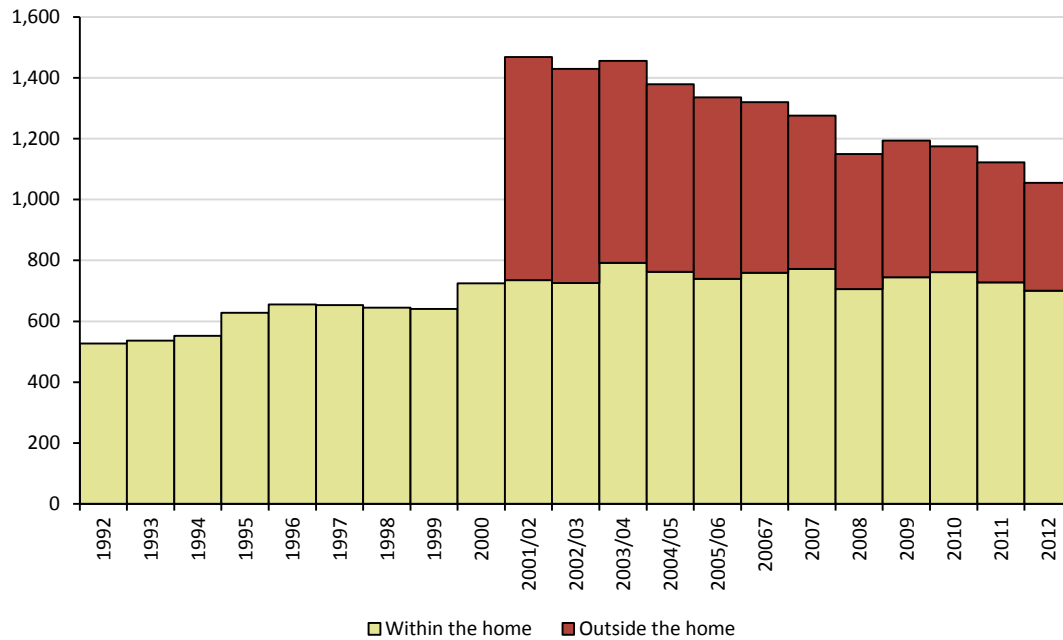
Figure 2: % of respondents drinking in the past week, by age group and sex, Great Britain¹⁰



Source: ONS, Opinions & Lifestyle Survey

As well as a reduction in drinking among younger groups, there has been a large reduction in drinking outside the home. Between 1992 and 2003, the average volume drunk at home increased by about 50% and then maintained its level up to 2012. From 2003 to 2012, drinking outside the home halved. Now, about two-thirds of drinking is at home.

Figure 3: Average volume of alcohol drunk per person per week, ml (data for drinking outside the home only available from 2001/02)¹¹



Source: Various ONS surveys (most recently the Integrated Household Survey)

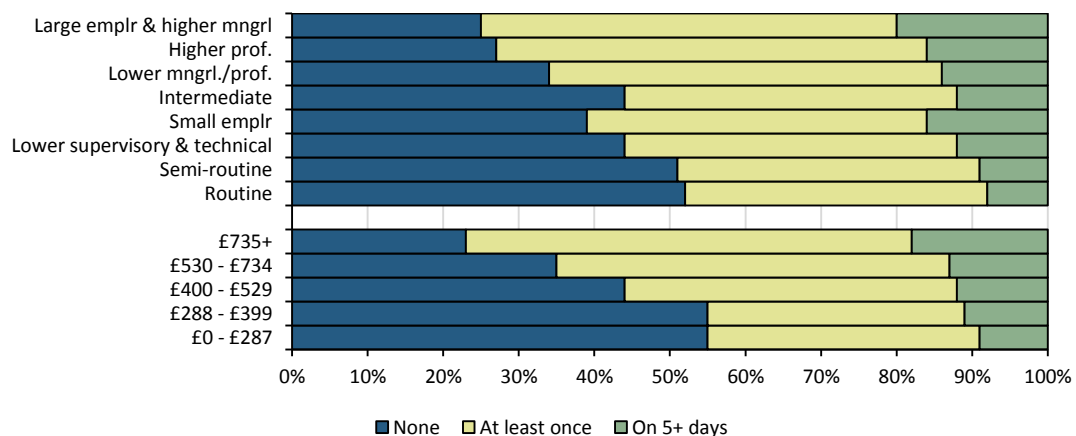
Demographic patterns

Men, white people, people in managerial and professional occupations and people on higher incomes (see appendix 1) drink most. The sex difference is now very small for younger groups, while in older groups men drink substantially more.

The London Boost of HSE (2006) showed that 57% of those in the most deprived quintile of LSOAs in London did not drink at all, and 15% drank at the higher risk level; while in the least deprived quintile, 28% did not drink at all and 22% drank at the higher risk level.¹²

The pattern of alcohol consumption is partly explained by ethnicity, because minority ethnic groups drink less on average than white people, and also make up a larger proportion of more deprived areas. However, the social gradient of drinking remains very strong when 'White British' people are considered in isolation.

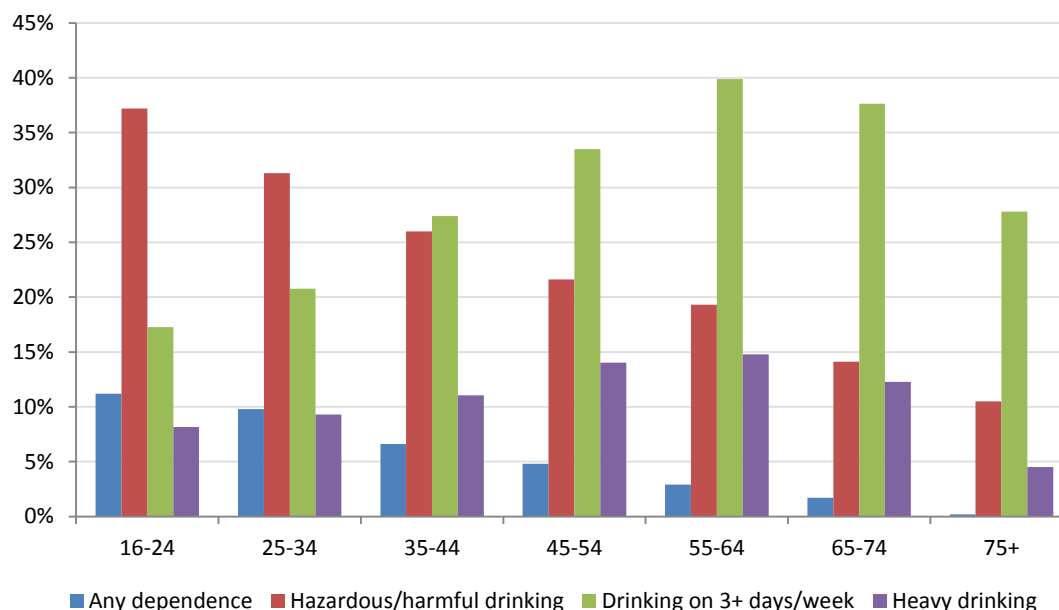
Figure 4: Drinking in the past week by occupation and equivalised household income, 2011¹³



Source: ONS General Lifestyle Survey

The Adult Psychiatric Morbidity Survey suggests that harmful and dependent drinking are highest among men and white people,⁶ consistent with drinking frequency and volume. However, prevalence of harmful and dependent drinking is highest among young people, even though older groups drink the largest overall volume. Survey data suggest that young people drink less regularly but drink more in each episode, and are more likely to develop dependence.

Figure 5: Prevalence of hazardous/harmful drinking, dependent drinking, frequent and heavy weekly drinking by age group, England



Sources: Harmful and dependent drinking from APMS.⁶ Harmful drinking is 8+ on AUDIT; dependent drinking is 4+ on SADQ-C (the majority of which are mild dependence). Drinking on 3+ days/week and 'heavy drinking' (defined as 21+ units/week for women and 35+ units/week for men) are calculated from Health Survey for England (2012). A similar pattern is visible for those drinking 35+/50+ units.

Young people

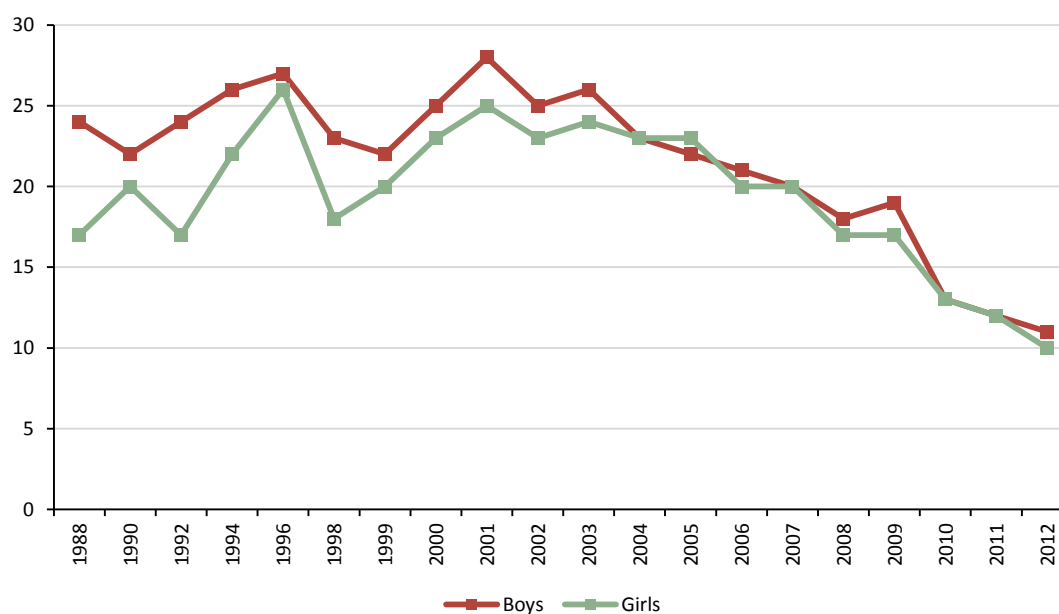
Surveys suggest a much lower prevalence of drinking among young people than adults. Nationally, 10% of pupils in years 7-11 drank in the past week in 2012,¹⁴ compared to 58% of adults.¹⁵ Drinking increases with age, with 1% of 11-year olds and 16% of 15 year-olds drinking at least once per week.

Drinking among young people is less prevalent in London than elsewhere. 7% of young people in London drank in the past week in 2012, compared to 10% across England. This may reflect the larger proportion of minority ethnic groups in London, who are less likely to drink at all ages.

The prevalence of drinking among young adults aged 16-24 has reduced rapidly in recent years (see figure 2). This trend is more pronounced among adolescents. The proportion drinking in the past week halved between 2007 and 2012 from 20% to 10%.

However, a large proportion of young people who drink alcohol have been drunk recently. Of the 22% of young people who drank in the past four weeks, half had been drunk. The Tellus4 survey in 2010 found that 15% of all pupils in years 6, 8 and 10 had been drunk in the past four weeks, with 5% drunk three or more times.¹⁶

Figure 6: percentage of pupils in England drinking in the past week, pupils aged 11-15¹⁴



Source: HSCIC, *Smoking, drinking and drug use among young people in England* (an annual cross-sectional survey)

2.3 Impact on health and wellbeing

Main points:

- Alcohol consumption increases risk of many diseases, including cardiovascular disease, liver disease and many cancers, with those drinking more at higher risk.
- Alcohol also causes many other social problems, and is responsible for half of violent crime.
- Alcohol is strongly associated with mental health problems. It is likely that causality works in both directions.
- 6% of hospital admissions in Greenwich can be attributed to alcohol. The rate of alcohol-attributable admissions is highest in the most deprived areas of Glyndon, Woolwich Riverside and Woolwich Common.
- At least 5% of ambulance call-outs in Greenwich are related to alcohol. The rate of alcohol-related call-outs is highest in town centres of Greenwich West and Peninsula (the O2 arena).

How alcohol impacts health

Alcohol affects physiology and behaviour in a wide range of ways. The impacts can be grouped into three areas: the effects of intoxication or being drunk, the toxic effects of alcohol on the body, and the effects of alcohol addiction.

Figure 7: key health impacts of alcohol consumption¹⁷

Intoxication	Toxicity	Addiction and dependence
<ul style="list-style-type: none"> •Anti-social behaviour •Sexual risk taking •Injury •Violence, including domestic violence •Acute physiological impacts, including cardiac arrhythmias and stroke 	<ul style="list-style-type: none"> •Liver – cirrhosis, hepatitis •Digestive system – gastritis, ulceration, pancreatitis •Cancer – risk factor for many cancers, especially mouth/larynx/oesophagus •Circulatory system – drinking causes hypertension and increases risk of heart disease and heart attack. Possible protective effect in older people 	<ul style="list-style-type: none"> •Psychological dependence •Physical dependence •Lack of nutrition •Impact on employment •Impact on relationships •Anxiety, depression, psychosis and other psychiatric disorders

The dose-response relationship between alcohol consumption and health outcomes varies by age and outcome. Various studies suggest that light alcohol consumption protects against cardiovascular disease in groups who are at risk (mainly older people), as it raises levels of high-density lipoprotein ('good cholesterol') in the bloodstream. Light drinking may also be protective against many cancers.¹⁸ In men under 35 and women under 65, all-cause mortality is lowest among people who do not drink. Above these ages, light drinkers appear to have lower all-cause mortality than abstainers and heavy drinkers.¹⁹

While there are biological mechanisms that could explain the apparent beneficial effects of light drinking for older people, they may also be the result of methodological weaknesses in the literature:

- Light drinkers are less deprived and have healthier lifestyles and better access to healthcare than abstainers. Studies may not have fully controlled for these differences.
- The 'sick quitter' or 'sick abstainer' effect. Many people abstain from alcohol due to ill health, which may explain their poorer health outcomes.

Heavy episodic drinking (binge drinking) also increases health risks. Most studies focus on the total volume consumed, but there is evidence that binge drinking is more strongly associated than sustained drinking with hypertension²⁰ and cardiovascular disease,²¹ and a recently cohort study found that binge drinkers have double the risk of death over a 20 year period than moderate regular drinkers.²²

Alcohol is a significant contributor to at least 60 health conditions, including dependence, circulatory and digestive diseases, liver disease, cancers and mental illnesses. The increased risk of alcohol consumption for selected diseases is shown in table 3, based on a meta-analysis conducted in 2003.

Table 3: Relative risk of selected diseases from alcohol consumption²³

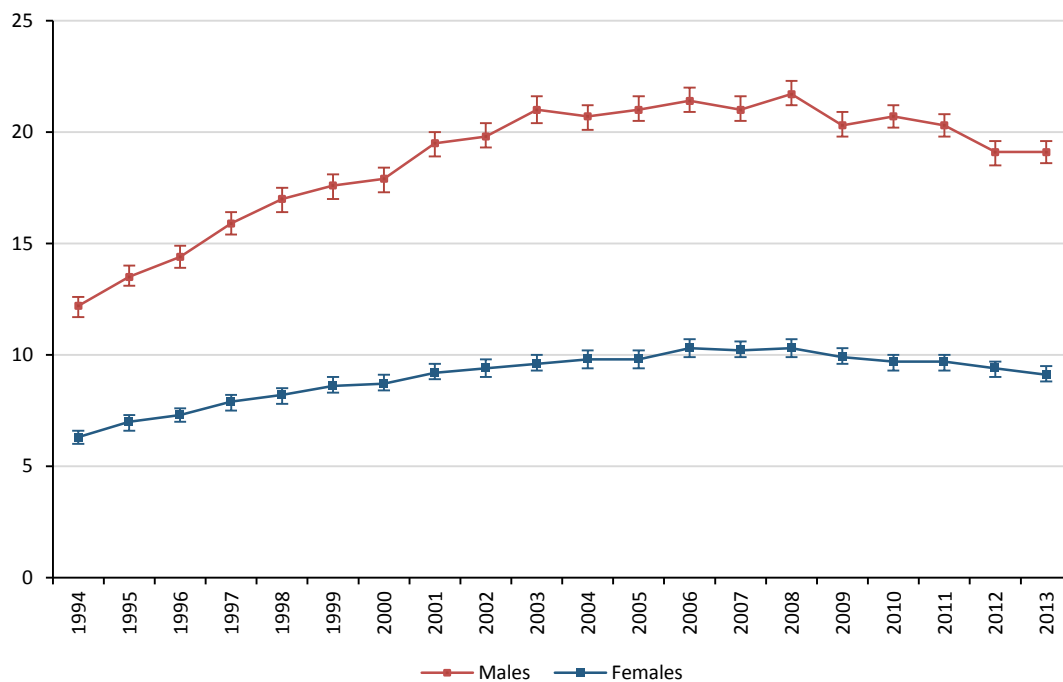
Condition	3 units/day	8 units/day	12 units/day
Breast cancer	1.25	1.55	2.41
Ischemic stroke	0.90	1.17	4.37
Hemorrhagic stroke	1.19	1.82	4.70
Liver cirrhosis	2.90	7.13	26.52
Injuries and violence	1.12	1.26	1.58

Deaths caused by alcohol

The ONS records deaths that are directly related to alcohol.²⁴ Rates are highest in men aged 55-69. There were 8,416 alcohol-related deaths in the UK in 2013, which is 1.5% of the 544,286 deaths.*

Alcohol-related death rates in England and Wales almost doubled from 1994 to 2008 and then reduced by 10% to 2013. The reductions in death rates were greatest among young people, while rates continue to increase for the oldest group. In Greenwich, alcohol-related deaths appear to be reducing for both men and women, but there are only five years of data readily available in the Local Alcohol Profiles for England.

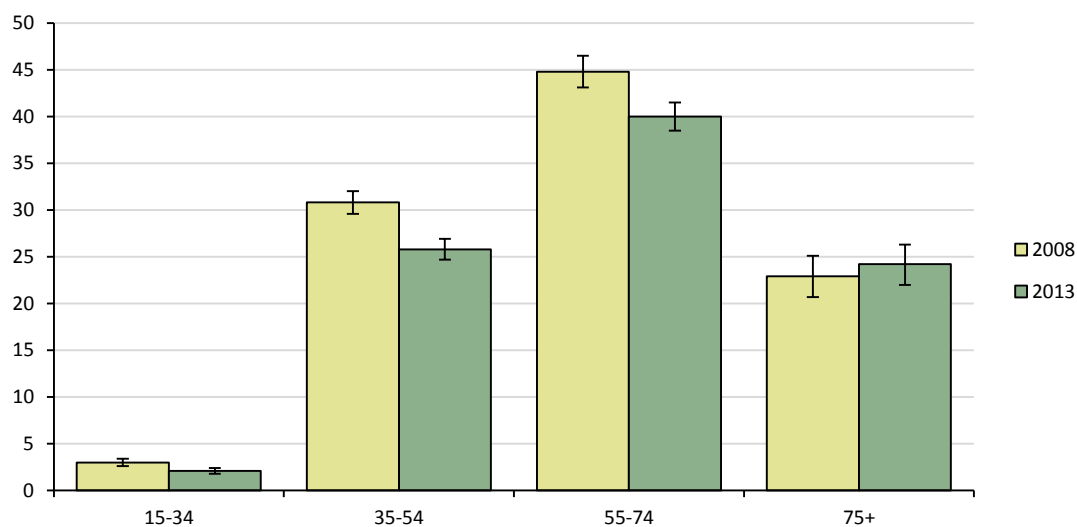
Figure 8: Alcohol-related deaths per 100k (with 95% confidence limits), England and Wales²⁴



Source: ONS, *Alcohol-related deaths in the UK*

* There were 506,790 deaths in England (ONS, Deaths registered in England and Wales, <http://www.ons.gov.uk/ons/re/vsob1/death-reg-sum-tables/2013/sb-deaths-first-release--2013.html>), 54,700 deaths in Scotland (National Records of Scotland, <http://www.nrscotland.gov.uk/news/2014/births-deaths-other-preliminary-2013>) and 14,968 deaths in Northern Ireland (Northern Ireland Statistics and Research Agency, <http://www.nisra.gov.uk/demography/default.asp10.htm>).

Figure 9: Alcohol related deaths per 100k by age group (with 95% confidence limits), England and Wales²⁴



Source: ONS, Alcohol-related deaths in the UK

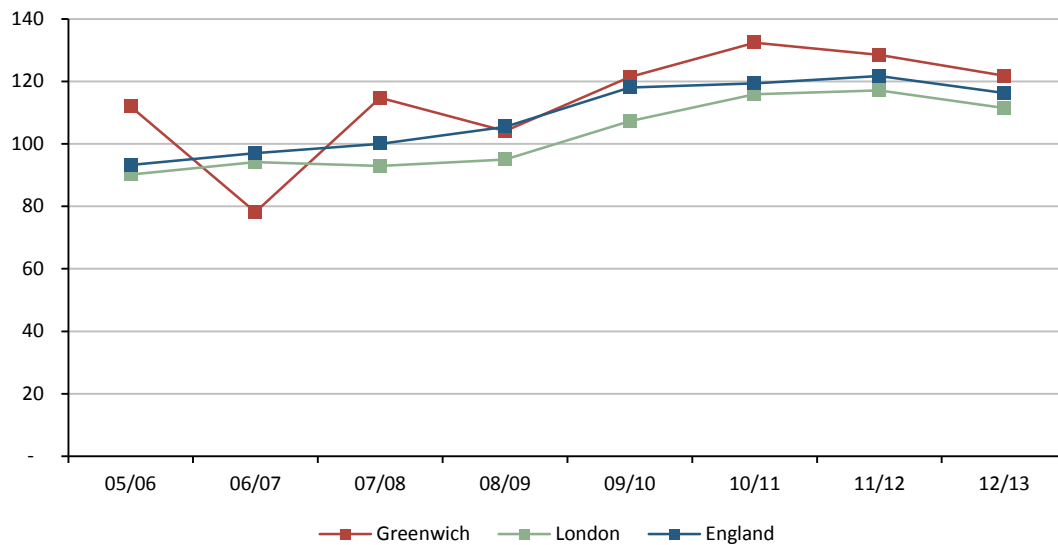
Hospital episodes caused by alcohol

Out of the 15m hospital episodes in England in 2012/13, 297k (2%) were given primary or secondary diagnoses that are considered 'wholly attributable to alcohol',¹¹ such as acute intoxication and alcoholic cirrhosis of the liver. Other diagnoses, including some cancers, cardiac arrhythmias and injuries, are considered partially attributable to alcohol. Fractions based on epidemiological research have been developed by Public Health England to estimate the proportion of these admissions that are attributable to alcohol.²⁵ These calculations suggest that a further 712k admissions (5%) can be attributed to alcohol. This suggests that the majority of the impact of alcohol on hospital services is caused by conditions for which alcohol increases the risk, rather than alcohol dependence or specifically alcohol-related diseases.

Using the same methodology, a total of 4,041 admissions (6% of 72,012 total admissions in 2012/13²⁶) in Greenwich are estimated to be attributable to alcohol,⁵ or 1,980 per 100k (directly standardised to the European standard population). This is a similar rate to London, at 1,970 per 100k. The most common alcohol-related diagnoses are 'mental and behavioural disorders due to use of alcohol' (which includes acute intoxication and withdrawal syndrome) and breast and colorectal cancer. While alcohol causes a small proportion of these cancers, it still causes a large absolute number due to their high prevalence (see appendix 3).

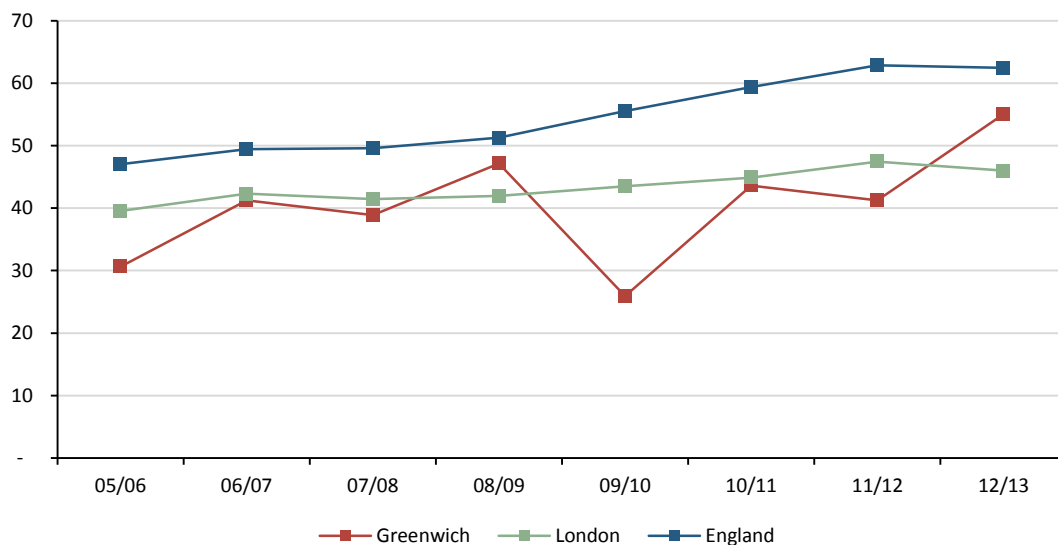
Analysis of two key wholly attributable diagnoses, 'mental and behavioural disorders due to use of alcohol' and 'alcoholic liver disease' (which together account for 59% of admissions in England that are 'wholly attributable to alcohol') suggests that Greenwich has a similar rate and trend in alcohol-related service use to London and England. Consistent with the national reduction in drinking in recent years, admissions for 'mental and behavioural disorders due to use of alcohol' (which tend to be more acute episodes) have started to reduce. Admissions for 'alcoholic liver disease' continue to increase, reflecting the continued long term increase in all liver disease.²⁷ There can be up to 30 years between first onset of liver disease and presentation to medical services, which, combined with increases in independent liver risk factors such as hepatitis viral infections²⁸ and obesity, is likely to mean that alcoholic liver disease will continue to increase for decades even as drinking decreases.

Figure 10: Hospital admissions with primary diagnosis of 'mental and behavioural disorders due to use of alcohol' (F10) per 100k, unstandardised



Source: Analysis of Hospital Episode Statistics. Based on populations from Census 2011.

Figure 11: Hospital admissions with primary diagnosis of 'alcoholic liver disease' (K70) per 100k, unstandardised



Source: Analysis of Hospital Episode Statistics. Based on populations from Census 2011.

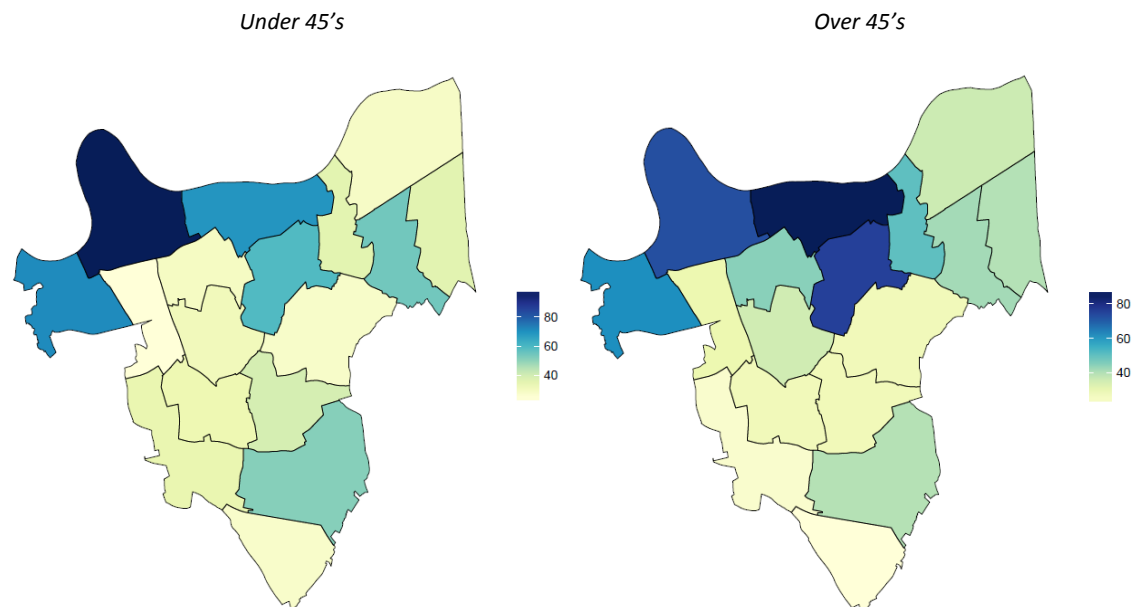
Ambulance call-outs

Ambulance call-outs are flagged if they are considered alcohol-related. The London Ambulance Service believes that this flag underreports alcohol-related incidents. Incidents given the flag are likely to relate to conditions or injuries related to drunkenness rather than long-term alcohol consumption.

Alcohol-related call-outs have increased substantially in Greenwich, more than doubling from 816 in 2001/2 to 1,928 in 2013/14. A similar increase occurred in the rest of South East London. This increase is likely to reflect changes in recording rather than the true number of alcohol-related call-outs, particularly given that the majority of the increase in all six boroughs in South East London occurred between 2003/4 and 2004/5.

The rate of alcohol-related call-outs for people under 45 is strongly associated with the density of licensed premises, with highest rates in the town centres of Greenwich West and Peninsula, and to a lesser extent Eltham South and Woolwich Riverside. The rate of alcohol-related call-outs for people over 45 is more strongly associated with deprivation (see appendix 4), with high rates in Woolwich Common, Woolwich Riverside and Glyndon. The call-out data does not allow straightforward analysis of conditions of patients, but it is likely that call-outs for younger patients relate to acute intoxication and injury, while call-outs for older people more commonly relate to acute alcohol-related conditions such as cardiac arrhythmias.

Figure 12: Alcohol-related ambulance call-outs for under-45s, per 1,000, 2009/10 – 2013/14



Source: data provided by London Ambulance Service. Populations from Census 2011. Figures show wards.

Alcohol and mental health

There are high rates of comorbidity between alcohol disorders and common mental illness. Data from four large population-based studies in Europe and the US showed a two to threefold increase in the lifetime prevalence of affective disorders (anxiety and depression) among people with alcohol abuse or dependence.²⁹ An international meta-analysis from 2011 suggests that the presence of either alcohol use disorder or major depressive disorder doubles the odds of the other.³⁰ The associations remain after controlling for possible confounders, such as genetic factors that may increase likelihood of both alcohol use and mental illness.

The cause of this relationship is not clear. Alcohol consumption may lead to mental health problems, or people with mental health problems may be using alcohol to self-medicate.

Longitudinal studies of alcohol consumption and mental health outcomes have conflicting results. Some older studies suggest that people who drink larger amount of alcohol are more likely to develop mental health problems. Recent studies with larger samples and better controlling of confounding variables have not found this. An 18-month follow-up study of participants in the 2000 UK Adult Psychiatric Morbidity Survey found that individuals who drank above government guidelines had comparable odds of anxiety and depression to those who drank within the guidelines.³¹ The study also found that mild anxiety and depression at baseline were associated with alcohol dependence at

follow-up. Similarly, a longitudinal study in Canada found that people who drank more or less than five drinks per day at baseline had similar incidence of major depression after two years.³² Analysis of the National Comorbidity Survey in the US suggests that alcohol disorders are associated with other psychiatric disorders, and the other disorders tend to come first.³³ Taken together, this evidence may suggest that the association between alcohol and mental illness is driven by self-medication.

This reflects the views of local service users (see section 4.9), who reported that they became dependent because they could not face relationship, debt or mental health problems. Preventative measures that reduce incidence of mental illness may also reduce alcohol dependence.

However, a narrative review of causal explanations for the association between alcohol and mental illness identified several studies suggesting that alcohol use causes depression,³⁰ and estimated that 10% of major depression is caused by alcohol. Both directions of causality are highly plausible, and some people are likely to experience a vicious cycle between alcohol use and mental illness.

Other social issues caused by alcohol

Alcohol is one of the main causes of violent crime and antisocial behaviour. Although the prevalence of these issues across England appears to be reducing, the social impact of alcohol-related violent crime and antisocial behaviour remains high.

2,340 alcohol-related recorded crimes were recorded in Greenwich in 2012/13, which is 31% lower than in 2008/09⁵. Of these, 1,684 were violent crimes, which have reduced by 23% since 2008/09 and 41 were sexual crimes, which is not enough volume to show a trend. This reduction may reflect a reduction in drinking behaviour and/or general reductions in crime. A review of the role of alcohol in all crimes in Greenwich, based on full notes for each crime, will be conducted by Royal Borough of Greenwich's Community Safety Team in April 2015.

According to the British Crime Survey 2011/12, 47% of victims of violent crime in England and Wales believed the offender to be under the influence of alcohol. While this proportion has stayed constant since 1995, the number of violent crimes roughly halved.³⁴ 10% of all adults in 2013/14 experienced or witnessed alcohol-related antisocial behaviour (drunkenness in public and associated problems).³⁵

Alcohol-related crime is concentrated in town centres of Greenwich West, the O2, Woolwich, Plumstead and Eltham.³⁶

Demographic and geographic patterns

The demographic pattern of hospital admissions for key alcohol-related diagnoses in Greenwich and other parts of London is as follows (see appendix 2):

- Men have double the rate of alcohol-related hospital admissions than women. This is consistent with higher rates of drinking among men.
- White British people have higher rates of admissions than BAME groups. This is consistent with higher rates of drinking among White British people.
- The rate of admissions peaks in people aged 40-59. This is consistent with higher rates of drinking in this group.
- Admission rates are higher in areas of higher deprivation. This contrasts with lower rates of drinking among poorer groups.

The rate of alcohol-related admissions (standardised by age) in most parts of Greenwich is lower than in England, with only the borough's three most deprived wards (Glyndon, Woolwich Riverside and Woolwich Common) having significantly higher rates.

Figure 13: Index of hospital admissions attributable to alcohol, April 2008 – March 2013 (100 = same rate as England, based on age profile of ward)³⁷

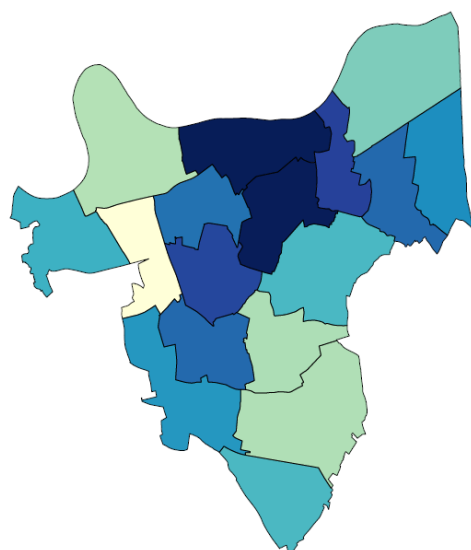
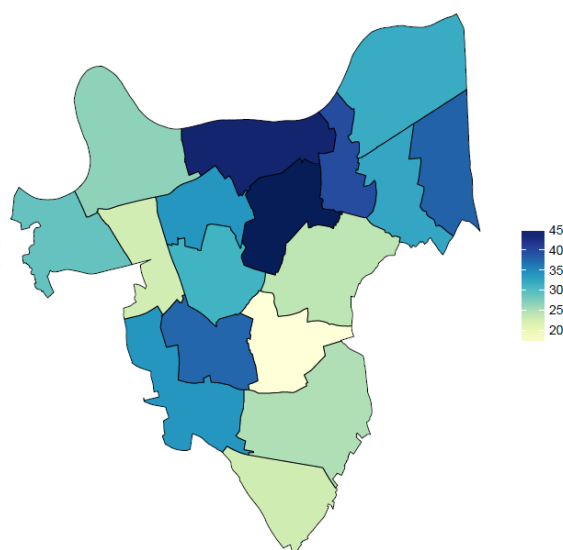


Figure 14: Average IMD 2010 score of ward (higher = more deprived. National range = 2-74)³⁸



Source: Public Health England. *Small Area Indicators for Joint Strategic Needs Assessment*. Populations from Census 2011. Figures show wards.

There is no clear explanation for the higher rates of admissions in deprived areas despite lower levels of drinking. This is a national phenomenon, which has been called the ‘alcohol harm paradox’. There may be more harmful drinkers in poorer groups due to a greater polarisation of drinking (with more abstainers and more very harmful drinkers), or poorer groups may be more susceptible to harm due to comorbidities, risk factors (such as obesity) or lower levels of help seeking. Possible explanations have been recently reviewed.³⁹

Impact of alcohol on young people

The Chief Medical Officer’s *Guidance on the consumption of alcohol by children and young people*⁴⁰ provides evidence that drinking at an early age has potentially serious short and long term health impacts, and recommends no drinking before age 15. Early age drinking (before age 14) is associated with alcohol problems later in life,⁴¹ injuries, violence, mental health issues and physical health risks. Alcohol is unlikely to offer any health benefits to young people.

There is also evidence of behaviour-related impacts. For example, a school-based cross sectional study from North-West England suggests that among 15-16 year-olds who binge drink 2+ times per week, 60% have been in a fight when drunk and 30% have regretted sex after drinking.⁴²

Any ‘early age’ drinking is common among young people, with 37% of 13 year-olds having ever had an alcoholic drink,¹⁴ but frequent or heavy drinking appears rare, with 4% drinking at least once per week.

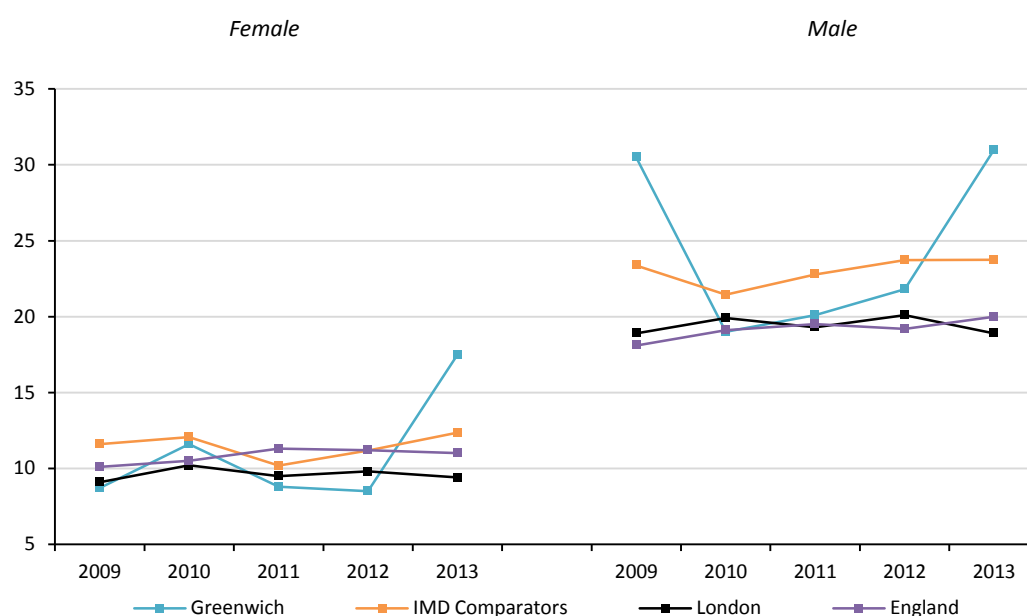
Alcohol-specific hospital admissions begin to rise at age 12, but remain very low for adolescents compared to adults (see analysis of admissions for key alcohol-related diagnoses in appendix 2). The rate of alcohol-specific hospital stays in Greenwich for under-18’s are lower than London, at 21/100k of population, compared to 30/100k for London.⁴³

Alcohol and liver disease in Greenwich

Indicators in the CCG Outcome Framework suggest high rates of under-75 mortality from liver disease in 2013 (the most recent year available). The rate in Greenwich is higher than in England, London or Greenwich's IMD comparator group (Lambeth, Lewisham, Southwark, Hammersmith & Fulham, Haringey and Brent) for both men and women. The increase in 2013 for women looks particularly large. In addition, the rate of hospital admissions for alcoholic liver disease among Greenwich residents doubled between 2009/10 and 2012/13 (see figure 11).

Rates of liver disease are increasing throughout the England, with death rates increasing by 400% between 1970 and 2014 (though there has been a small reduction in recent years).⁴⁴ The reason is not known, but alcohol consumption, obesity and viral hepatitis are considered possible drivers. Commissioners and service providers in Greenwich have expressed concern that liver disease indicators from 2013 may reflect high alcohol consumption in the borough.

Figure 15: Directly age and sex standardised mortality rate from liver disease for people aged under 75, per 100,000 registered patients

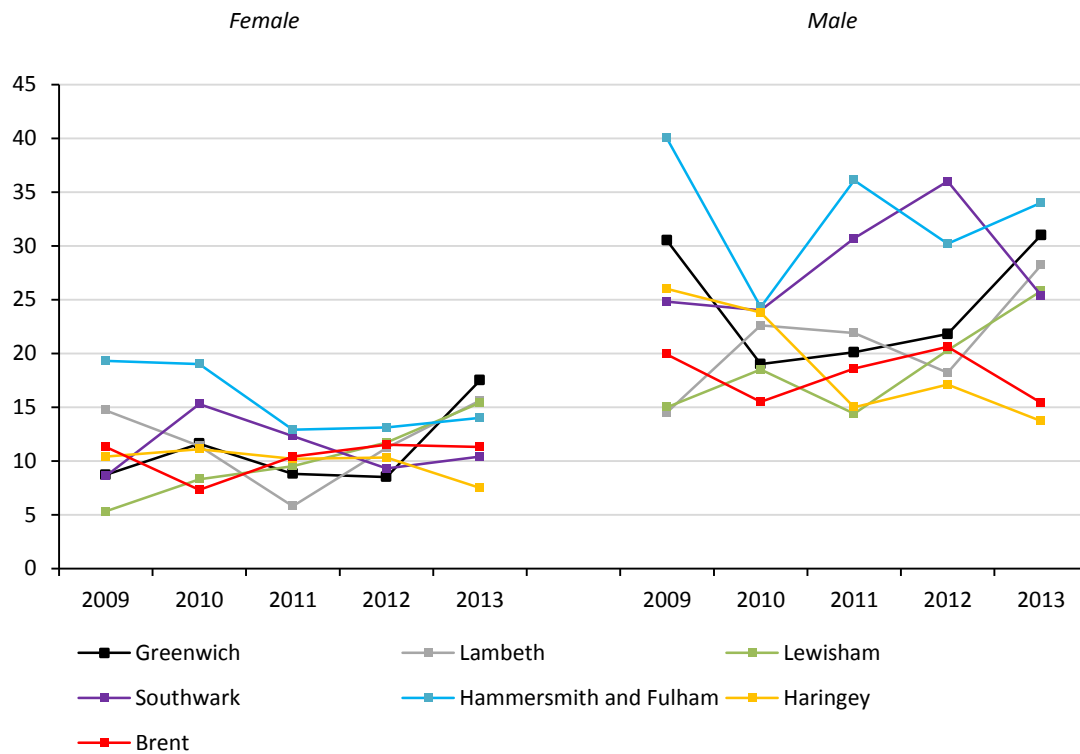


Source: NHS England, CCG Outcome Indicators

However, due to the small absolute numbers of people presenting at hospital or dying from liver disease, rates at a local level are volatile. When a longer time period is considered, the rate of hospital admissions for alcohol liver disease in Greenwich looks less concerning, with a similar rate to London between 2005/06 and 2012/13 (see figure 11). Greenwich's IMD comparators have similar volatility in rates of under-75 mortality from liver disease (see figure 16).

Based on these three indicators, Greenwich may have had significantly worse rates of liver disease in 2013, but this is likely to reflect expected volatility in local-level indicators rather than a longer-term trend.

Figure 16: Directly age and sex standardised mortality rate from liver disease for people aged under 75, per 100,000 registered patients



Source: NHS England, CCG Outcome Indicators

2.4 Impact on local services

The cost of alcohol to local services is hard to calculate, due to the large number of direct and indirect ways that alcohol affects health and wellbeing. As shown above, alcohol causes at least:

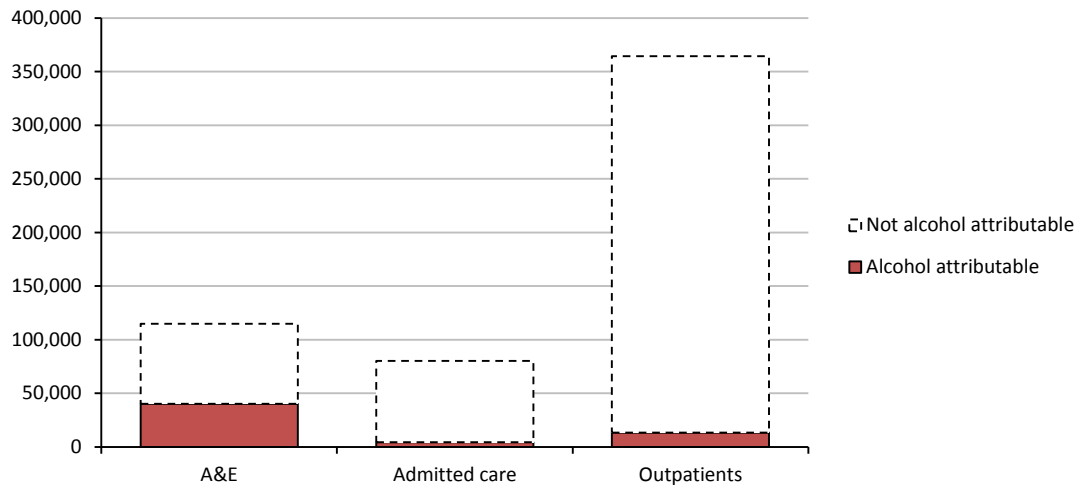
- 1.5% of deaths
- 6% of Greenwich's 72,000 annual hospital admissions
- 5% of Greenwich's 32,000 annual ambulance call-outs
- Half of violent crime

NICE estimated that in 2008/09 alcohol related harm cost the NHS in England £2.9bn (with the majority of costs from hospital admissions, A&E visits and ambulance services).² A crude pro-rate of this cost to Greenwich's population (using the ONS 2013 mid-year estimates) suggests that alcohol-related disease may cost the NHS in Greenwich in the region of £14m.

The costs of alcohol-related crime and antisocial behaviour in England were estimated at £8.0bn, which would correspond to £39m in Greenwich using the same pro-rate.

Considering all forms of hospital care, we can estimate that 10% of all hospital episodes are caused by alcohol: 35% of A&E attendances, 6% of admitted care and 4% of outpatient appointments.

Figure 17: Number of hospital episodes for residents of the Royal Borough of Greenwich, 2013/14



Sources: **A&E:** The number of A&E attendances is taken from HES. Surveys of A&E staff suggest that 35% of attendances are alcohol-attributable.⁴⁵⁻⁴⁷ **Admitted care:** LAPE estimated that 4041 admissions in Greenwich in 2012/13 were alcohol-attributable.⁵ HES gives 72012 total hospital episodes in 2012/13. This proportion (5.6%) was applied to the number of hospital admissions in 13/14, taken from HES. **Outpatients:** Alcohol Concern estimated that 12135 attendances in 2012/13 in Greenwich were attributable to alcohol.⁴⁸ HES gives 112592 outpatient attendances in 2012/13. This proportion (3.7%) was applied to the number of attendances in 2013/14, taken from HES.

3 What works?

3.1 Summary

There is consistent evidence that reducing the availability and increasing the price of alcohol reduces harm. Licensing is therefore an important part of prevention.

There is little evidence for the effectiveness of public education activities, such as information on safe drinking levels or the health risks of drinking. Existing studies suggest that information-based campaigns are likely to be ineffective. A limited number of studies also suggest that education programmes in specific settings, such as schools and workplaces, are also likely to be ineffective.

Internet-based screening and brief advice (where individuals self-complete screening questionnaires and receive online advice) provided to the general population may be effective. Websites set up in the UK and elsewhere have been used by large numbers of hazardous drinkers.

There is extensive evidence that screening and brief advice provided by professionals in health care settings reduces harm and produces cost-effective improvements in health. NICE therefore recommends that health professionals in primary and secondary care settings be trained to deliver this service.

There is good case study based evidence that alcohol liaison teams and assertive outreach teams in hospitals can reduce demand on acute care and provide overall savings.

The effectiveness of specialist services has not been considered in this document. However, there is convincing evidence that existing interventions for patients with alcohol dependence are effective and cost effective.^{4,49}

3.2 Licensing and availability

Main points:

- There is consistent evidence that the price, availability and marketing of alcohol are related to harm from alcohol.
- Some public health departments have made successful representations against new licenses based on the density of licensed premises and rate of harm from alcohol.
- Minimum unit pricing is an effective and progressive method of reducing harmful drinking.

There is consistent evidence that the price, availability and marketing of alcohol are related to harm from alcohol.

There is a clear ecological correlation in Greenwich between the density of licensed premises in wards and the rate of alcohol-related crime³⁶ and ambulance call-outs (particularly for young people) (see appendix 4). A similar analysis in Islington shows the same pattern,⁵⁰ and international research^{51,52} shows that outlet density is correlated with alcohol consumption and harm in many countries.

Although there is limited evidence of the causal relationship between licensed premises and alcohol-related harm, longitudinal studies and natural experiments suggest that increases in the number of outlets (particularly leading to 'bunching' of several premises) lead to increased binge drinking and alcohol-related violence.⁵¹ This evidence, combined with the consistent correlations between outlet density and harm from alcohol, leads most to conclude that reducing availability of alcohol is an effective measure to reduce alcohol harm. The NICE guidance 'alcohol-use disorders: preventing

harmful drinking'²⁴⁰ recommends that local authorities identify areas that have high densities of licensed premises and high rates of harm from alcohol, and limit new premises in these areas.

Some public health departments in London have identified LSOAs or postcodes where alcohol has a high impact, based on density of licensed premises and rates of alcohol-related ambulance call-outs and hospital episodes.⁵³ They consider making a representation against licensing applications in these areas, sometimes consulting with local hostels, treatment centres and other partners to evaluate the potential impact of the new premises. This approach appears to be successful, with a high rate of successful representations. Boroughs using this approach include Islington and Lambeth, which both have higher rates of alcohol-related harm than Greenwich.

There is strong evidence that minimum unit pricing reduces drinking among harmful drinkers, with health benefits concentrated in lower socio-economic groups, and is more effective than a ban on below-cost sales.^{54,55} However, local partners are not able to regulate the price of alcohol and interventions at this level must be established by the government. There is limited research into the effectiveness of promoting lower strength drinks.⁵⁶

3.3 Education and community outreach

Main points:

- There is little evidence for the effectiveness of educational interventions.
- Website-based screening and brief interventions are popular and may be effective.

Population-level interventions are important because (a) many dependent people do not seek help until late in their drinking career, if at all. The Adult Psychiatric Morbidity Survey suggests only 9% of dependent men and 26% of dependent women are currently receiving medication or counselling for a mental or emotional problem⁶, so early intervention is important and (b) the largest aggregate public health impact of alcohol is caused by common hazardous drinking (rather than severe harmful and dependent drinking).

Despite the importance of engaging with the general population, there is little evidence for the effectiveness of interventions. Preventative interventions are hard to evaluate, due to the difficulty of establishing control groups and isolating the effects from secular changes. There is some evidence that public information campaigns, (such as those raising awareness of safe drinking limits) are generally ineffective.⁵⁷ The government still considers public education to be important and NICE guidance 'alcohol-use disorders: preventing harmful drinking'² recommends that local bodies 'amplify' national campaigns such as 'Dry January'.

Screening and brief interventions delivered online to the general population may be effective. For example, the website <http://www.downyourdrink.org.uk/>, developed by UCL, provides a screening questionnaire and an interactive 'psychological intervention'. An RCT of this website⁵⁸ found that users reduced their alcohol consumption from 6 units per week to 3 units per week after one year, but a similar reduction was observed in controls, who received a screening questionnaire without the psychological intervention. The screening questionnaire alone is likely to have some effect,⁵⁹ and the users are likely to choose to use the website because they are already motivated to reduce their drinking. Attrition from website interventions is high, with 17% of risky drinkers completing in one study.⁶⁰ An international meta-analysis of similar interventions⁶¹ found a significant beneficial effect, with users drinking 3 units less than controls after one year. Although the effectiveness of online screening and brief intervention has not been robustly demonstrated, the studies show that hazardous drinkers use these websites in large numbers, and the websites appear to form part of the user's journey to healthier drinking levels.

NICE is due to publish guidance on 'preventing harmful alcohol use in the community' in December 2014.

3.4 Primary care

Main points:

- There is extensive evidence that screening and brief interventions provided in primary care is an effective way to reduce alcohol consumption among hazardous and harmful drinkers.

A Cochrane Review conducted in 2007 pooled results from RCTs and showed that after one year those receiving an intervention drank 5 units less per week than those not receiving an intervention.⁶² Longer interventions do not appear to offer additional benefit.^{62,63}

The NICE guidance 'alcohol-use disorders: preventing harmful drinking'² recommend that NHS services should develop skills and resources to carry out screening and brief interventions wherever there is concern about alcohol use. Drinkers who are identified as dependent, or are unresponsive to the brief intervention, should be referred to specialist services.

3.5 Secondary care

Main points:

- Case studies suggest that alcohol liaison services reduce costs of acute care.
- Case studies suggest that assertive outreach services reduce hospital admissions.

Evaluations of 'alcohol liaison services' suggest that they can reduce demand for acute care. For example, a team of nurses in the Royal Bolton Hospital that assesses alcohol-related admissions, provides brief interventions and develops care plans, cost £165k and saved 2,000 bed days per year.⁶⁴ This is a return of £3.85 for every £1 invested. A study of a similar service in St Mary's hospital (Paddington) found that for every two patients provided with an alcohol intervention in hospital, the number of patients attending A&E the following year was reduced by one.⁶⁵

Assertive outreach services identify patients who have frequent alcohol-related admissions. A team with a small caseload works proactively with these patients to reduce alcohol consumption. An evaluation of an assertive outreach service at Salford Royal Hospital, working with the 'top 30' patients, showed that A&E attendances reduced by 59% after the intervention.⁶⁶ Early findings from a pilot RCT of assertive outreach compared with a less intensive outreach service ('care as usual') in South London showed that clients receiving early outreach were abstinent on c.75% of days 6 months after the intervention, compared to c.60% of days for patients receiving care as usual.⁶⁷

A recent review by Public Health England recommended that every district general hospital should have an alcohol care team that can provide screening and brief advice, more extensive interventions, care planning, medically assisted detox, discharge planning and referral to community services.⁶⁸

3.6 Young people

Evidence suggests that information and education programmes in schools do not lead to sustained changes in behaviour.⁴⁹ However, the NICE guidance 'school-based interventions on alcohol'⁶⁹ recommends that alcohol education is included in the PHSE curriculum, and the national Alcohol Strategy⁷⁰ includes strengthening of alcohol education in PHSE.

There is consistent evidence that enforcing the minimum age of purchase reduces harm from alcohol among young people.⁴⁹

4 What do we know about local services?

4.1 Summary

The main preventative work in Greenwich is conducted via licensing of premises that sell alcohol. This work includes mapping of 'saturation zones' (where there is a high density of premises) and the 'reducing the strength' campaign, which encourages off-licenses to stop selling high strength beer and cider. The Public Health team has recently become a 'responsible authority' under the Licensing Act 2003, but has not yet developed a system for responding to licensing applications.

There is little educational work currently underway locally. The main information that drinkers receive is from national campaigns such as Drink Aware.

Screening is done in various settings, including health checks, GP surgeries and the Queen Elizabeth Hospital. Together with a number of smaller projects, this activity delivers a large volume of screening, potentially exceeding 40,000 screens per year if GPs screen all new patients. The quality of brief interventions and referrals in the Alcohol Liaison Team is likely to be high, but may be variable in other settings.

Specialist services are delivered by teams that treat both drug and alcohol users. Lifeline BaSIS was commissioned in 2014 to deliver a service for non-dependent drinkers, which was not previously available in Greenwich. There is now a coherent hierarchy of specialist services, with Aspire treating dependent drinkers and The Beresford Project treating complex dependent drinkers. Data from the NDTMS suggests that specialist services in Greenwich are treating a similar number of alcohol users to the London average and achieving similar recovery rates. Referral routes from health checks, primary care and social services may need some improvement, with few referrals recorded by specialist services.

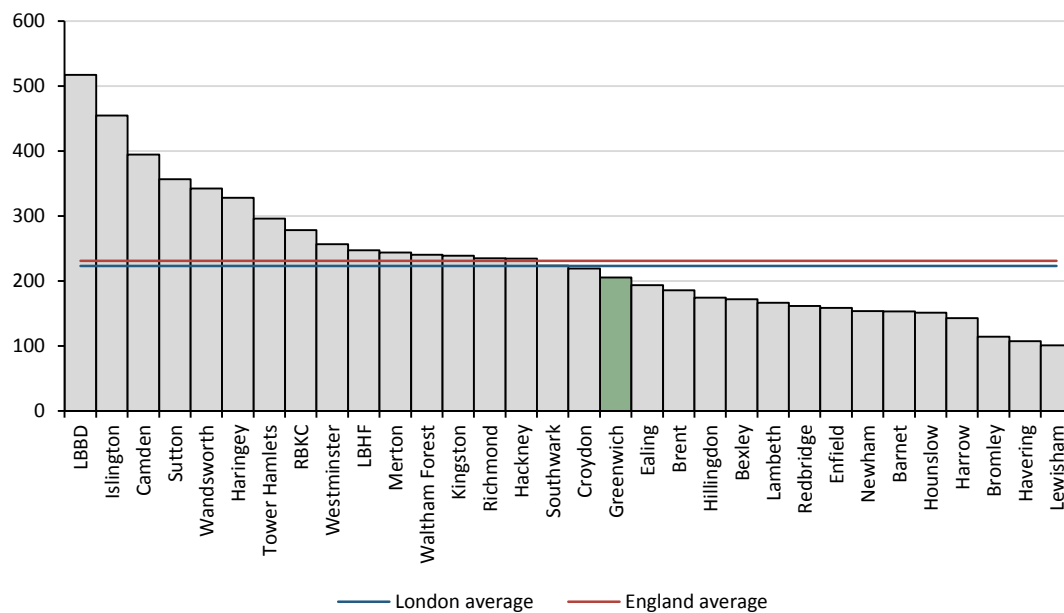
All specialist services report difficulty engaging with some groups, with Nepalese and Somali groups mentioned by managers in all services as being underrepresented. In survey conducted at a 'health event' for the Nepalese community run by the Royal Borough of Greenwich, 28/69 (40%) drank alcohol, which is significantly lower than 73% of the general population.¹⁰ Based on qualitative comments, it appears that 3-5 out of 69 drank large quantities. A GP at a surgery in Greenwich with a large proportion of Nepalese patients reported that few drink compared to other ethnic groups, but a small number drink heavily. The survey and anecdotal reports suggest that low service use among the Nepalese community is due to a combination of lower drinking rates and lower propensity to access services.

Partners involved in prevention and treatment of harmful drinking meet at a 'Joint Commissioning Group for Drugs and Alcohol', but some report that joint oversight of alcohol services may need strengthening.

4.2 Overview of services and volumes

Data from the National Drug Treatment Monitoring System (NDTMS) shows 415 Greenwich residents presenting to drug and alcohol services with alcohol as a primary substance in 2013/14. This is 205/100k residents aged over 15 (Census 2011), which is a similar rate to London and England. The rate of presentations for alcohol treatment varies widely between boroughs and does not appear to be associated with rates of drinking or harm from alcohol. It is therefore likely to reflect differences in service models, rates of identification of dependent drinkers or differences in reporting.

Figure 18: Number of residents entering treatment for primary alcohol use per 100k residents aged 15+, 2013/14



Source: NDTMS

Table 4: public health and clinical alcohol services in Greenwich

Tier	Service	Description	Volume	Cost
1	Screening of newly registered patients at GP practices	Directly Enhanced Service ALC001 requires GPs to screen all new patients aged 16+ with FAST or AUDIT-C	No data currently reported. Data will be available in Q3 2014/15. Full compliance would mean c.26,000 screens per year.	£2.38 * quantity
	Screening pilot in GP surgeries	Offered to patients in the waiting room in three GP surgeries	1,476 screened in 2-3 months	
	Health checks	General health check for residents aged 40-74, including AUDIT-C	2013/14 13,788 offered; 7,527 completed	
	Pub health checks	Small project undertaking opportunistic health checks including alcohol screen in pubs		
	QEH alcohol liaison service	Screening, brief interventions and signposting delivered by nurse-led team, mainly in A&E.	c.7,000 done in 12/13.	
2	Recovery College	Commissioned by CCG. Self referral and referral from other services. Free courses for people recovering from addiction		
	Enterprises	10 enterprises to assist recovery		
	Self-help / support groups	Regular self help groups run by independent charities, including Alcoholics Anonymous, Adfam, Smart Recovery		
	Lifeline BaSIS	Community-based short interventions (up to 12 weeks) for non-dependent drinkers	Estimated for 2014/15: 222 starting treatment and 185 complete. Also brief interventions at community events (676 at off-site events between April and December 2014)	

3	Aspire (CRi)	Community alcohol interventions for dependent drinkers Post detox service	Estimated for 2014/15: 208 entering treatment; 78 successful completions (prorated from 1/4/14 – 31/12/14). 46 in treatment at 31/12/14.	
	KCA	Service for young people. Works across tiers		
	Beresford Project (SLaM)	Medically assisted community interventions, including clients with more complex needs	Estimated for 2014/15: 70 referrals, 32 discharges alcohol free (prorated from approx. 9 months).	
4	Residential rehab	Framework agreement	Estimated 58 clients in 2014/15	£113k
	Inpatient detox	Framework agreement	Estimated 41 clients in 2014/15	£146k

4.3 Licensed premises and licensing

Licensing in Greenwich has three main approaches to reducing harm.

- The use of saturation zones (areas with high densities of licensed premises, where applicants must demonstrate that their premises will not add to the cumulative impact of alcohol), which have been identified as Greenwich, Trafalgar Road, Plumstead High St, Eltham Town Centre and Woolwich.³⁶
- ‘Reducing the Strength’. The licensing team works with off-licenses to make voluntary amendments to their licensing agreements in which they cannot sell beer, lager or cider above 6.5% ABV. 30 off-licenses in Woolwich have been invited to take part and 24 have signed up. The programme is based on a model developed by Ipswich Borough Council. Police in Ipswich attribute a 50% reduction in antisocial behaviour related to street drinking to it.⁷¹ Similar programmes are being set up in other London Boroughs. In a newspaper report, an off-license manager in Woolwich said: *“We used to have drunk customers coming in, intimidating our staff, and actually urinating in the shop. When we stopped selling high-strength lager there was an immediate change, and the staff say they now feel a lot safer. I encourage anyone who has not yet signed up to do so.”*⁷²
- Enforcement of licensing conditions.

In April 2013 the Director of Public Health became a ‘responsible authority’ under the Licensing Act 2003, meaning that they are responsible for the local authority’s public health response to licensing applications. Public Health England has developed guidance on how public health departments exercise this function.⁵³ This includes:

- Contributing to the development of the Statement of Licensing Policy.
- Contributing health and demographic data to identification of cumulative impact zones.
- Making representations for applications where information held in public health can provide evidence for the potential impact of the premise on crime and disorder, public safety, public nuisance or the protection of children.

Some public health departments in London have adopted an approach developed by the Safer Sociable London Partnership. This involves evaluating the health impact of alcohol in small areas (e.g. LSOAs), based on data such as the rate of alcohol-related ambulated call-outs, hospital episodes and the density of licensed premises. The public health team considers making a representation if an application is made in an area where alcohol appears to have a high impact on health.

The public health team in the Royal Borough of Greenwich is contributing to the development a new Statement of Licensing Policy, but has not yet developed a system for responding to licensing applications.

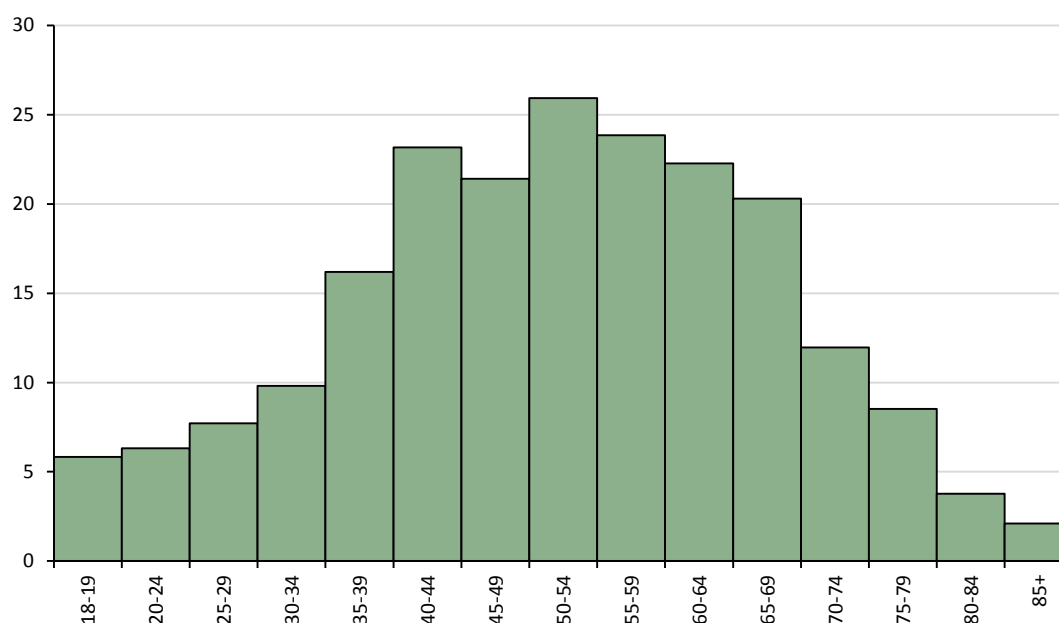
4.4 Tier 1 services

Non-substance misuse specific services providing minimal interventions for alcohol misuse

Health Checks is a rolling programme for people aged 40-74 who are residents or registered at GP surgeries in Greenwich. A proportion of this group are invited each year to a session at a GP surgery, to be screened for their risk of common non-communicable diseases. Health checks include the 3-item AUDIT-C to screen for increasing or higher risk drinking. 7,527 AUDIT-C screens were conducted as part of Greenwich's Health Check programme in 2013/14. 24% of those conducted in 'community settings' (i.e. excluding GP surgeries) were positive. Individuals receiving a positive result should receive a brief intervention, a consultation with their GP or referral to specialist services. Delivery of these forms of support appears to be limited. For example, only six referrals to specialist services were recorded in 2013/14.

The Alcohol Liaison Team at Queen Elizabeth Hospital is a nurse-led team that provides screening, brief interventions and signposting for patients at the hospital; mainly in A&E. It was set up in September 2012. Interventions last around 10 minutes. An evaluation of the first year of the project showed that 6,838 screens were performed, with 93% of patients approached agreeing to screening. 15% of individuals screened were FAST-positive (FAST is a 4-item subset of AUDIT developed for use in clinical settings). The rate of positives peaks in late middle age, which is the age group reporting the largest volume of drinking in population surveys (see appendix 1) and showing the highest rate of alcohol-related hospital admissions (see appendix 2). 33% of screen-positives were signposted to specialist services (but the rate of uptake of these referrals is not known). People aged 50-59 are most likely to be FAST-positive, which is consistent with surveys that show people in late middle age drink the most on average.

Figure 19: Number of screen-positives in QEH alcohol liaison service per 1,000 emergency attendances, by age group, 2012/13



Source: numerator = number of screen-positives recorded by QEH ALT in 2012/13. Denominator = HES: number of A&E attendances by people registered with Greenwich GPs in 2012/13

Screening in primary care. The Royal Borough of Greenwich commissioned a pilot of screening and brief interventions in waiting rooms at three GP surgeries. 1,476 AUDIT-C screens were done between May and August 2014. 14% were screen-positive. As with the Alcohol Liaison Team at Queen

Elizabeth Hospital, there was much higher variation between raters in the prevalence of screen-positives than is typically found in research settings.

NHS England requires all GP surgeries to screen new patients for hazardous or harmful alcohol consumption using FAST or AUDIT-C, under a Direct Enhanced Service.⁷³ The local office of NHS England Immunisations Team reported that data for compliance will be collected from Q3 2014/15. Full compliance is likely to result in around 26,000 screens per year.* GP registration forms in Greenwich normally include FAST or AUDIT-C based questions, suggesting that new patients are being screened. Typically 20%-30% of patients presenting in primary care are hazardous or harmful drinkers,^{63,75} which suggests that screening of all new patients could identify 6,500 people who drink too much each year.

Data from Lifeline BaSIS and CRI shows that few patients are referred from GPs. Patients who are referred often do not attend.

In addition to screening conducted as part of health checks and in GP surgeries, various small-scale projects that include alcohol screening have recently been undertaken. These include (i) health checks conducted in pubs in late 2014 and early 2015, and (ii) 516 AUDIT-C screens undertaken by Lifeline BaSIS at Freshers' events at the University of Greenwich.

Educational work. There is very little educational work underway, with no recent local information campaigns to reduce harmful drinking. The Greenwich Healthy Living website includes information about alcohol. Greenwich residents are exposed to national campaigns such as Drink Aware (<http://www.drinkaware.co.uk/>) and Change4Life (<http://www.nhs.uk/Change4Life/Pages/drink-less-alcohol.aspx>).

4.5 Tier 2 services

Open access alcohol treatment services

Self-help and mutual aid groups such as Adfam and Alcoholics Anonymous are run in various locations in the borough. They are charitably funded. The Adfam and AA websites show that there are 25 self-help groups in Greenwich, mostly run on a weekly basis. The groups are run in Woolwich and the west of the borough, and there may be a gap in availability of self-help groups in the central, southern and eastern parts of the borough (see figure 20). The number of people using these groups is not known.

Lifeline BaSIS offers a service for drinkers who are not dependent. The majority of service users are self-referred, with some referred from GP surgeries and CRI (the service for less complex dependent drinkers). Support can be a single brief intervention, a course of up to six sessions of 1:1 support alongside group activities, or a course of nine sessions of 1:1 support alongside group activities. Lifeline BaSIS is based in Woolwich, and is planning to open outreach offices in the south of the borough. An estimated 185 clients will complete treatment in 2014/15.

4.6 Tier 3 services

Structured community-based treatment services

Aspire is a service in Woolwich for dependent drinkers, run by the charity CRI and funded by Royal Borough of Greenwich. Most clients self-refer, and some are referred from GPs and other specialist

* Data from Exeter extracted in 2011 shows a GP-registered population of 268,082 in 2010 and 34,716 new registrations in 2010-11 (13% turnover).⁷⁴ The ONS mid-year population estimate for Greenwich in 2013 showed 264,008 persons, of whom 200,318 were aged 18+ (75%) - <http://data.london.gov.uk/dataset/ons-mid-year-population-estimates-custom-age-tables>. The estimate of new adult registrations per year is therefore 34,716 * 75% = 25,941.

services. Clients are triaged using AUDIT. Non-dependent drinkers are referred to Lifeline BaSIS, and very complex cases are referred to The Beresford Project. Clients typically follow a 10-week programme, which consists of 4 weeks in pre-detox (when clients are seen once per week), 1 week in detox (every day), and 5 weeks in post-detox (three times per week). Some interventions are extended by inpatient or residential detox, which may be provided if agreed by the DAMIC funding panel. In 2014/15 there will be an estimated 208 clients in treatment for alcohol at Aspire, with 78 completing successfully.

The Beresford Project is a service in Woolwich for complex dependent drinkers, run by SLaM NHS Foundation Trust and funded by Royal Borough of Greenwich. It is a referral-only service, with most clients referred from Aspire. Clients are often in contact with multiple health and social care services and have very complex needs. Interventions are typically six to nine months but can last more than a year. In 2014/15 there will be an estimated 70 referrals for clients with a primary alcohol problem and 32 alcohol-free discharges.

4.7 Tier 4 services

Residential alcohol misuse specific services and highly specialist non-substance misuse specific services

Residential detox and rehab are provided by around 50 independent care homes managed in a framework agreement funded by the Royal Borough of Greenwich. In 2014/15, there will be an estimated 49 clients accessing detox for alcohol and 9 clients for drugs and alcohol, costing a total of £113,000. There will be an estimated 35 clients accessing rehab for alcohol and 7 clients for drugs and alcohol, costing a total of £145,000. These services form part of the recovery pathway for some dependent alcohol users at CRI and the Beresford Project.

Table 5: residential detox and rehab service volumes, 2014/15

	Detox: 11 months			Detox: estimated full year		Rehab: 11 months			Rehab: estimated full year	
	# clients	Cost (£k)	Per client (£k)	# clients	Cost (£k)	# clients	Cost (£k)	Per client (£k)	# clients	Cost (£k)
Alcohol only	45	82	1.8	49	89	32	111	3.5	35	121
Drugs & alc.	8	21	2.7	9	23	6	22	3.7	7	24
TOTAL	53	104	2.0	58	113	38	133	3.5	41	145

Figure 20: Location of specialist alcohol services in Greenwich



4.8 Co-ordination and oversight

The main partners involved in preventing harm from alcohol and delivering alcohol-related services are:

Table 6: local partners in prevention and treatment of harmful drinking

Partner	Role
Public Health & Wellbeing department, Royal Borough of Greenwich	<ul style="list-style-type: none"> • Provides public health funding to DAMIC • Delivers preventative programmes (e.g. health checks) • Provides population-level advice to other partners
Drugs, Alcohol and Mental Health Integrated Commissioning (DAMIC) team, Royal Borough of Greenwich	<ul style="list-style-type: none"> • Commissions specialist services
Greenwich CCG	<ul style="list-style-type: none"> • Commissions healthcare (including hospital services) for people with alcohol-related diseases • Provides links to GPs
Beresford Project (SLaM)	<ul style="list-style-type: none"> • Delivers specialist treatment for people with complex alcohol dependence
Aspire (CRi)	<ul style="list-style-type: none"> • Delivers specialist treatment for people with alcohol dependence
Lifeline BaSIS	<ul style="list-style-type: none"> • Delivers specialist treatment for people who are not dependent
Queen Elizabeth Hospital	<ul style="list-style-type: none"> • Delivers acute healthcare for people with alcohol-related diseases • Runs the Alcohol Liaison Team

Some of these partners meet at a local forum called the Joint Commissioning Group for Drugs and Alcohol. However, partners engaged during development of the JSNA felt that joint co-ordination and oversight of alcohol services could be strengthened.

4.9 Perspectives of service users

A focus group with ten users of specialist alcohol services was conducted in 2015. All participants were post-detox and attending a support group at CRI-Aspire.

In terms of feedback on the quality of the service, the group:

- Reported very high levels of satisfaction with the service. It was considered non-judgemental and motivational.
- Felt that the service “enabled” recovery. Although already motivated to stop drinking, the service users felt they could not have stopped by themselves.
- Were not concerned about the location of the service (in Woolwich), even though some had to travel half an hour or more.
- Felt that the post-detox phase should be longer, as attending the group provides structure and support and reduces the likelihood of relapse.
- Reported that ‘referral’ tends to mean a professional providing the details of the service (so that the individual can self-refer), with no members of the group accessing the service via formal referral.

When asked about interventions that may have prevented dependence, the group suggested:

- Raising awareness of specialist services among the general population. Some members of the group reported drinking for 20+ years without being aware of local services, and were eventually referred by the police, hospital, social services or another public service. The group’s prior perception was that alcohol services are for people in extreme crisis “who are literally falling apart... you have to crash and burn before you get help”. Some reported that they would have accessed services earlier if they had understood services better.
- Raising awareness of alcohol among GPs. Several members of the group reported negative experiences with GPs who did not take alcohol problems seriously. The group suggested that GPs should more regularly ask patients about their drinking, particularly if they have alcohol-related conditions. Some also reported that GPs had poor awareness of the detox and recovery process.
- More education at an early age. The group said that they hadn’t understood the signs of dependence and the potential health impacts of alcohol until it was “too late”. They felt that if they had learned about alcohol at school, they might not have drunk as much.
- Less marketing of alcohol. The group felt that there should be more restrictions on the marketing of alcohol, with some suggesting a similar approach to tobacco (e.g. placing alcohol behind a screen in shops).
- More acceptance and social support from peers and colleagues. Most members of the group reported that they used alcohol as a coping mechanism because they were not able to face relationship and family issues, debt and mental illness.

These views may not be representative of all dependent drinkers, and also do not provide insight into perspectives of drinkers who are not dependent. While dependent drinkers tend to be the most harmful drinkers, alcohol dependence is relatively rare.

5 Potential improvements

Based on the evidence base presented in section 3 and the services currently delivered in Greenwich, the following potential improvements have been suggested.

There are limited funds for additional investment in prevention or treatment. This means that improvements will need to be prioritised. Understanding and realising potential savings from investment in primary and secondary prevention are also important. Alcohol causes many preventable diseases and the burden on health and social care is large (see section 2.4). The evidence outlined in section 3 suggests that increasing screening and brief interventions in primary and secondary care is likely to be cost effective and reduce demand for healthcare (particularly in hospitals).

Table 7: potential improvements

	#	Potential improvement
Outreach and expanding provision	1	Discuss geographical spread of support groups with providers and consider whether support can/should be provided to open new groups in the central and east parts of the borough
	2	Consider development of an assertive outreach team in Queen Elizabeth Hospital, to work with the existing Alcohol Liaison Team
	3	Consider implementation or promotion of an online screening and brief advice tool (such as http://www.downyourdrink.org.uk/), and link to the Greenwich Community Directory
	4	Review national campaigns for alcohol harm reduction (e.g. Dry January) and consider how they can be amplified in Greenwich
	5	Consider outreach to communities identified by specialist services as 'hard to reach' – particularly Nepalese and Somali communities
Screening, referral and care pathways	6	Review support for 'screen positives' in the alcohol section of health checks. How can they be provided with brief interventions, referred and followed up more effectively?
	7	Provide training to workers in health and social care to provide brief interventions and referrals, as part of the Making Every Opportunity Count programme. Where possible focus on groups that experience most harm, particularly those in more deprived groups and people with mental health problems.
	8	Support Lifeline to increase referrals from primary care and expand its engagement with GPs
	9	Check GPs' implementation of the Direct Enhanced Service for screening new patients for hazardous and harmful drinking, when data becomes available in Q3 2014/15
	10	Monitor demand for specialist services, as work to increase awareness and referrals may increase demand
Addressing supply	11	Develop a system for the RBG Public Health team to respond to licensing applications, learning from the model developed by the Safer Sociable London Partnership
Governance, strategy and data	12	Strengthen forums for local partners involved in prevention and treatment of harmful drinking to develop joint strategies
	13	Develop a clear system for reporting volumes, spend and outcomes from specialist services, with success metrics
	14	Engage with Queen Elizabeth Hospital to develop a more consistent approach to using the alcohol 'flag' for hospital admissions
	15	Monitor PHOF indicators related to liver disease (including under-75 mortality from liver disease and hospital admissions for alcoholic liver disease) and investigate if rates remain high in 2014

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7 Appendix 1: analysis of Health Survey for England

Figure 21: Percentage of individuals in England binge drinking (8+ units for men on heaviest day in past 7 days; 6+ units for women), 2008-13, with 95% CIs. EHI = equivalised household income quintile

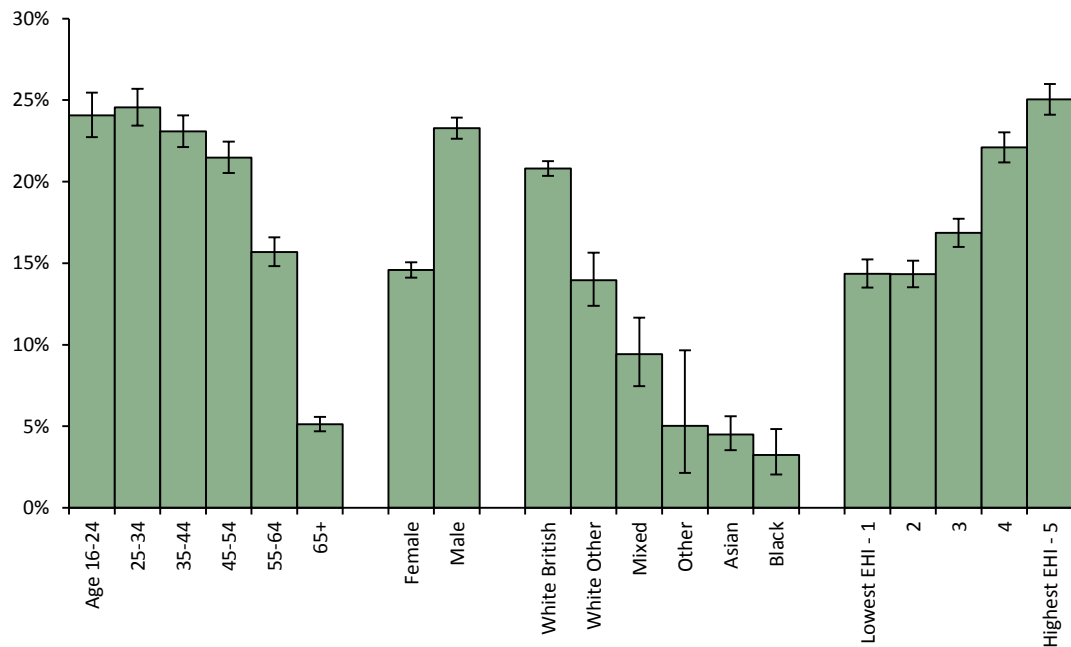
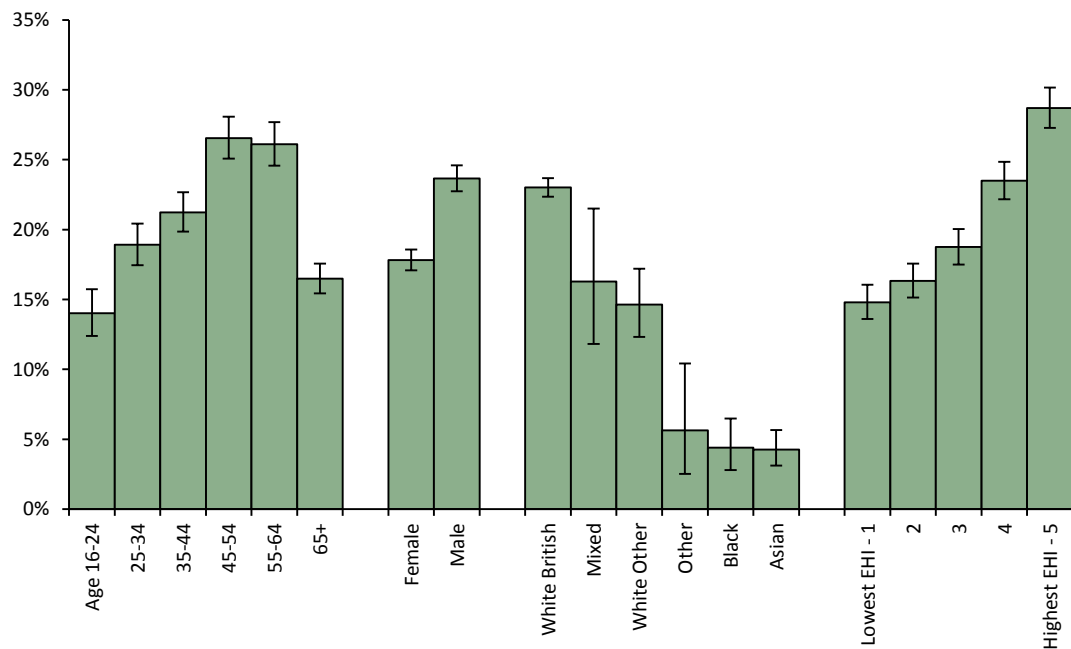


Figure 22: Percentage of individuals in England drinking above safe limits (21+ units for men in the past 7 days; 14+ units for women), 2011-13, with 95% CIs. EHI = equivalised household income quintile



Data were obtained from the UK Data Service. Analysis was conducted using Health Survey for England post-stratification survey weights.

8 Appendix 2: demographic characteristics of alcohol-related hospital admissions

Figure 23: Hospital admissions for 'mental and behavioural disorders due to use of alcohol' (mainly acute intoxication, harmful use, dependence syndrome and withdrawal state) (F10) per 100,000, 2002/03 to 2012/13

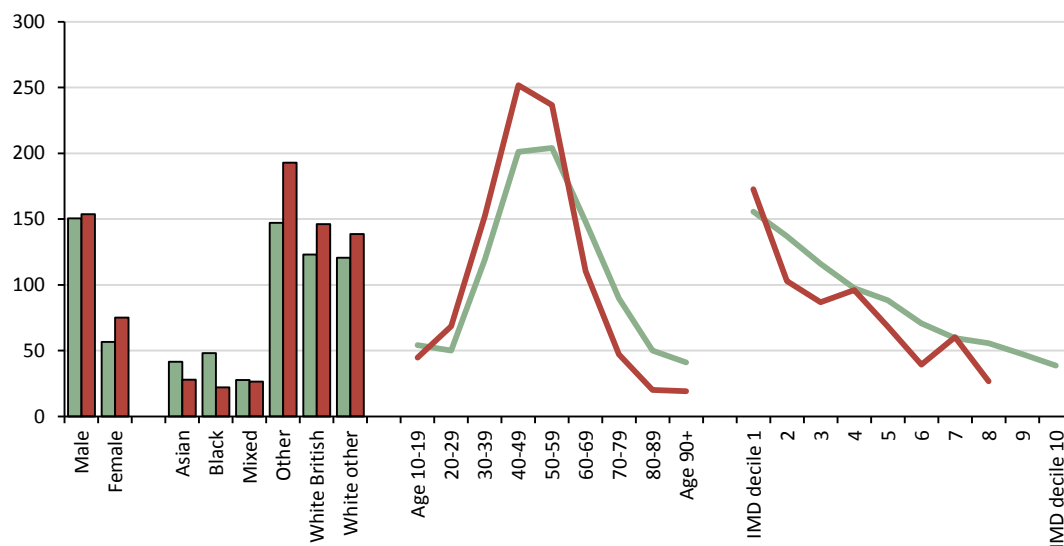
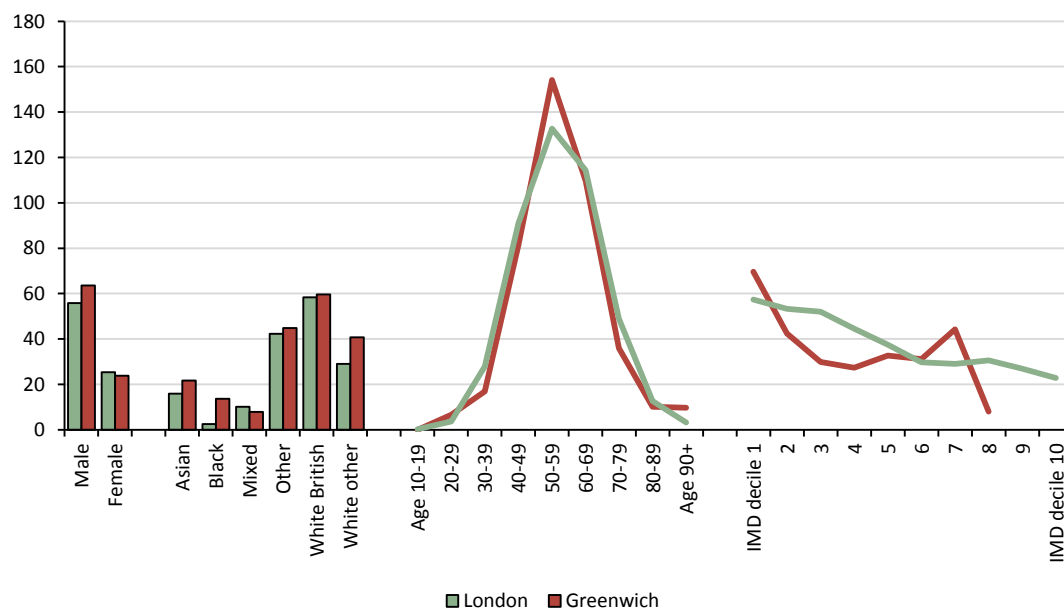


Figure 24: Hospital admissions for 'alcoholic liver disease' (K70) per 100,000, 2002/03 to 2012/13



Analysis of Hospital Episodes Statistics. Populations based on Census 2011. Significance of differences in rates of admissions between London and Greenwich were tested for demographic groups shown in the figures, with age and IMD groups simplified. Differences were considered important if they met three criteria: (a) absolute difference: the difference between London and Greenwich represents 25+ people per year, (b) significance: the difference is significant to the 95% level, using a chi-square test and assuming that the proportion of patients with multiple admissions is the same in all groups, (c) relative difference: the rate of admissions in Greenwich is greater than 125% or less than 80% of London. None of the differences met these criteria.

9 Appendix 3: alcohol-attributable hospital episodes in Greenwich

The table below draws on Hospital Episode Statistics for Greenwich and applies the 'Alcohol Attributable Fractions'²⁵ to estimate how many admissions are attributable to alcohol.

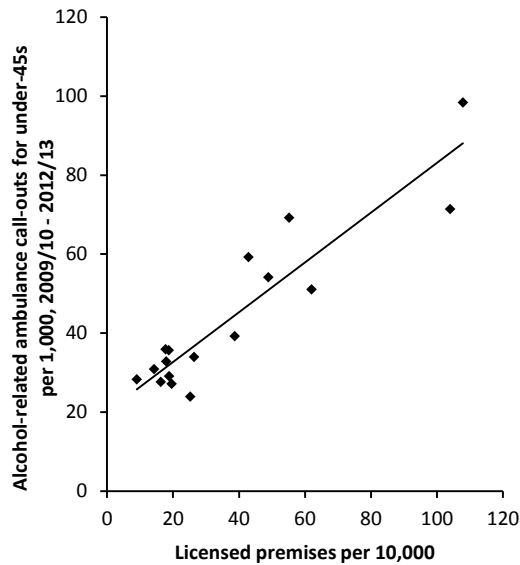
Table 8: admissions for alcohol-related diagnoses (excluding injury) in Greenwich and estimates of admissions attributable to alcohol, 2009/10 to 2012/13 combined

Reason for admission	All admissions	Admissions attributable to alcohol	Avoided admissions	% attributable to alcohol	% of alcohol-attributable admissions
Wholly attributable admissions					
Alcoholic liver disease	516	516		100%	9%
Mental and behavioural disorders due to alcohol	1,532	1,532		100%	26%
Degeneration of nervous system due to alcohol	24	24		100%	0%
Alcoholic gastritis	26	26		100%	0%
Alcoholic cardiomyopathy	9	9		100%	0%
Alcohol-induced acute pancreatitis	22	22		100%	0%
Alcohol-induced chronic pancreatitis	75	75		100%	1%
Degeneration of nervous system due to alcohol	24	24		100%	0%
Toxic effect of alcohol, unspecified	4	4		100%	0%
Ethanol poisoning	14	14		100%	0%
Tuberculosis	368	94		26%	2%
Cancer					
Lip, oral cavity and pharynx	534	217		41%	4%
Oesophagus	590	322		55%	6%
Colorectal	4,001	589		15%	10%
Liver and intrahepatic bile ducts	321	48		15%	1%
Larynx	129	47		37%	1%
Breast	6,044	823		14%	14%
Diabetes mellitus (type II)	828		85	-10%	0%
Epilepsy and Status epilepticus	974	199		20%	3%
Cardiovascular diseases					
Hypertensive diseases	729	145		20%	2%
Ischaemic heart disease	6,405		559	-9%	0%
Cardiac arrhythmias	2,246	306		14%	5%
Haemorrhagic stroke	727	28		4%	0%
Ischaemic stroke	2,247		67	-3%	0%
Oesophageal varices	180	79		44%	1%
Pneumonia	4,848	363		7%	6%
Digestive diseases					
Unspecified liver disease	195	85		44%	1%
Cholelithiasis (gall stones)	2,072		411	-20%	0%
Acute and chronic pancreatitis	185	49		26%	1%
Pregnancy and childbirth					
Spontaneous abortion	1,200	109		9%	2%
Low birth weight	1,259	63		5%	1%
TOTAL		5,812	1,122		100%

10 Appendix 4: ward-level correlations between harm and determinants in Greenwich

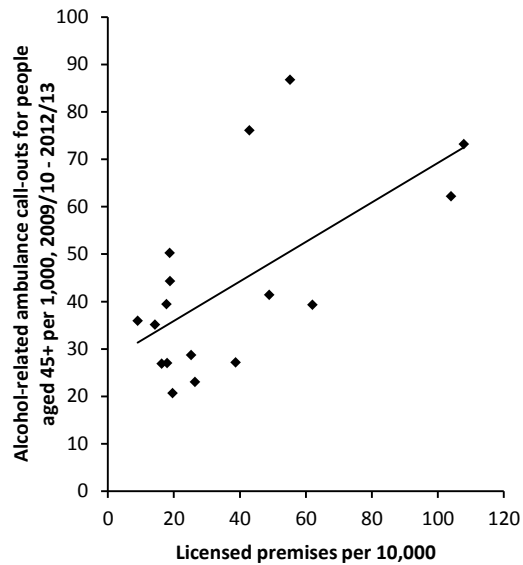
10.1 Ambulance call-outs

Figure 25: Call-outs for young people vs. licensing density



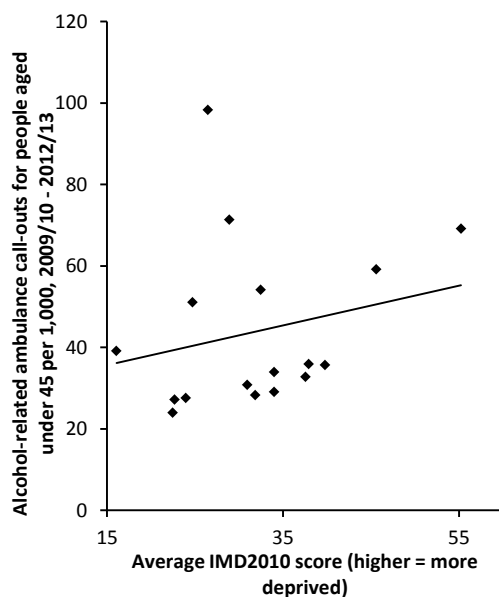
$R^2 = 0.84$, $p \sim 0$

Figure 26: Call-outs for older people vs. licensing density



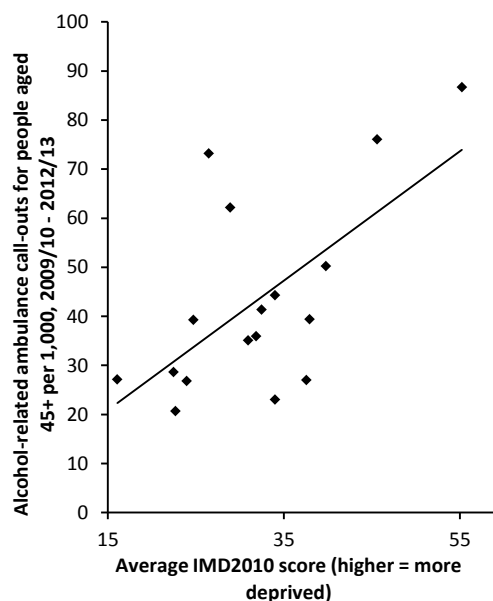
$R^2 = 0.39$, $p = 0.01$

Figure 27: Call-outs for young people vs. deprivation



$R^2 = 0.03$, $p = 0.54$

Figure 28: Call-outs for older people vs. deprivation

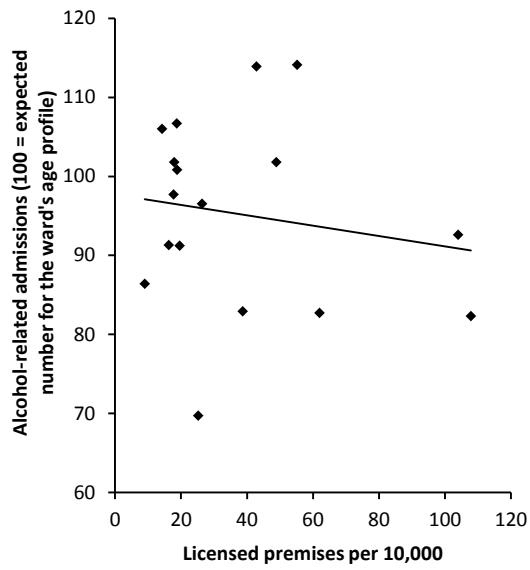


$R^2 = 0.31$, $p = 0.02$

Alcohol-related call-outs provided by London Ambulance Service. Ward populations are from Census 2011. Numbers of licensed premises from RBG Licensing. Average IMD2010 scores are from Public Health England.³⁸

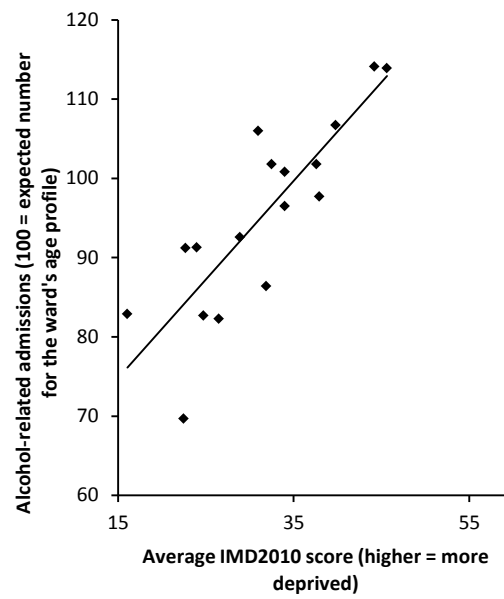
10.2 Hospital admissions

Figure 29: Hospital admissions vs. licensing density



$R^2 = 0.03$, $p = 0.53$

Figure 30: Hospital admissions vs. deprivation



$R^2 = 0.70$, $p \sim 0$

Sources as previously. Alcohol-related hospital admissions from Public Health England.³⁷