Croydon
Joint Strategic
Needs Assessment (JSNA)

2013/14

A rapid assessment of population alcohol needs in Croydon

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Note on data cut off period

The majority of service data presented cover the financial years 2011- 2013, unless otherwise stated. The data in this chapter was the most recent published data as at January 2014. Readers should note that more up-to-date data may have been subsequently published, and are advised to refer to the source shown under figures or listed in the appendices for the chapter for the latest information

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1 INTRODUCTION

This is the first key topic chapter of the 2013/14 Joint Strategic Needs Assessment (JSNA) in Croydon. JSNA is a process aiming to identify both the assets and the needs in relation to health and wellbeing topics such as alcohol.

The aim of **this rapid JSNA chapter** is to provide an overall summary of the **prevalence of alcohol problems** and the **harm caused by alcohol in Croydon**. An evidence based assessment of gaps in Croydon's current approach to tackling alcohol issues is also included. This **evidence has informed the suggested recommendations** for future action listed at the end of the chapter.

A large percentage of the UK population consumes alcohol sensibly. Unlike smoking, there are safe levels of alcohol usage and for many, drinking alcohol can be a pleasurable and a positive experience. However, there are many issues associated with alcohol. For example excessive consumption is now considered to be England's **second biggest cause of premature deaths**, after smoking and is a factor in violent crime.[1]

Overall, the evidence suggests that as consumption increases so does the risk of developing an alcohol-related problem. Harmful drinking not only affects the individual, it also has a **negative impact on families and communities.**

Encouraging a sensible drinking culture and reducing alcohol-related harm therefore has wider benefits to Croydon's population.

Other key topic chapters being undertaken in Croydon 2013/14 JSNA are:

- Key Topic 2: Healthy Weight
- Key Topic 3: Domestic Violence
- Key Topic 4: Homelessness.

There are clear links between each of these chapters, which will be highlighted where appropriate.

[1] Public Health England (2014) Understanding Alcohol-related Admissions

1.1 Why addressing alcohol-related harm is important

Alcohol misuse can lead to **many harmful consequences for the individual drinker, their family and friends.** The UK is among the heaviest alcohol consuming countries in Europe. The vast majority of the UK adult population consumes alcohol. Alcohol is **45% more affordable than it was in 1980**. As alcohol has become increasingly affordable, **consumption has increased by an estimated 121%** between 1950 and 2000.[2]

The impact of alcohol misuse is costly and widespread. Action to reduce alcohol-related harm impacts on a wide range of areas: **health, crime, domestic violence, sickness absence and lost productivity**, as highlighted below:

- Alcohol kills people early and is a cause of **health inequalities.** Compared with those living in most affluent areas, people in the most deprived fifth of the country are 3-5 times more likely to die of an alcohol-specific cause.[3]

- Alcohol misuse is a major cause of ill health in England, contributing to a range of serious health problems and injuries. In many cases these are preventable. Alcohol is a **risk factor for a number of cancers**, and the more alcohol consumed, the higher the risk.[4] Nationally, 15,479 people died from alcohol-related causes in 2010, up 30% since 2001.

- Alcohol misuse **harms families and communities** and is associated with domestic violence and marital breakdown**. 27% of serious case reviews** mention alcohol misuse and **children who have parents who misuse alcohol can have physiological, physical and behavioural problems**. [5]

- Alcohol may be a contributory factor in up to one million assaults and is associated with 125,000 instances of **domestic violence** and is often a contributory factor to **marital breakdown.** [6] More than two in five (44%) **violent crimes** are committed under the influence of alcohol.[7]

- Nationally in Accident and Emergency Departments **(A&E), 70% of attendances in the early hours and 40% of weekend attendances are caused by alcohol**[8]

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[2] Alcohol Harm Reduction Strategy for England 2004. London. Cabinet Office
[3] Association of Public Health Observatories 2007. Indications of public health in the English regions 8: alcohol
[4] Cancer Research UK
[5] *New learning from serious case reviews: a two year report for 2009-2011* (Department for Education, 2013)
[6]Domestic violence and marital breakdown, Physical, psychological, and behavioural problems for children of parents with alcohol problems: Gmel, G Rehm, J (2003): *Harmful alcohol use.* Alcohol Research and Health 27, 52–62 & Rossow, I (2000): *Suicide, violence and child abuse: review of the impact of alcohol consumption on social problems.* Contemporary drug problems 27, 397–434
6 Croydon 2012/13 JSNA key dataset indicator 195
[8] Deluca, P (2010) Survey finds only 15% of emergency departments have formal alcohol intervention and treatment policies for trauma patients Evidence Based Nursing Vol.3 No.4

- **Alcohol is associated with risky behaviour** in children and young people including offending and unprotected sex.[9]
- Alcohol is a cause of sickness absence and **lost productivity** - in the UK, up to 14 million working days are lost annually through absences caused by drinking.

1.2 The financial costs of alcohol misuse

The overall costs of alcohol have been estimated to be £21billion overall in England. This comprises of:

- NHS in England – £3.5 billion per year[10]
- Crime in England – £11 billion per year[11]
- Lost productivity in the UK – £7.3 billion per year[12][13]

For Croydon, based on its population size, this is equivalent to an estimated £144 million per year. Of this, half is alcohol-related crime (£72 million) one third is lost productivity (£48 million) and the rest is NHS costs (£24 million). This figure does not include the associated costs to families and communities.

There are **evidence based cost effective interventions** that can reduce alcohol misuse and alcohol-related harm. Therefore, **investment** in alcohol interventions, particularly before drinking becomes problematic, **can save money and improve the health and well-being of the population.**

Tackling alcohol misuse can **save money** at a local level[14]:

- For every £1 invested in **specialist alcohol treatment services**, £5 is saved on health, welfare and crime costs.
- Specialist alcohol treatment can deliver savings of nearly £1,138 per dependent drinker treated and **reduce hospital admissions**.
- Every **5000 patients screened** in Primary Care may prevent **67 A&E visits** and **61 hospital admissions** (cost £25,000, saves £90,000).[15]
- One alcohol liaison nurse can **prevent 97 A&E visits and 57 hospital admissions** (cost £60,000, saves £90,000)[16]

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[9] Chief Medical Officer for England, 2009Guidance on the consumption of alcohol by children and young people: Supplementary Report,
[10] At 2009/10 costs.
[11] At 2010/11 costs.
[12] At 2009/10 costs.
[13] Costs given in the Department of Health's written evidence to the Health Select Committee 2012. http://www.publications.parliament.uk/pa/cm201213/cmselect/cmhealth/132/132we02.htm
[14] [1]Alcohol Concern, Making alcohol a health priority - Opportunities to reduce alcohol harms and rising costs, 2011, p23-24
[15] TrEAT trial. Fleming MF, Mundt MP, French MT, Manwell LB, Stauffacher EA, Barry KL. Brief physician advice for problem drinkers: long-term efficacy and benefit-cost analysis. Alc Clin Exp Res 2002;26:36-43
[16] Alcohol: Can the NHS Afford It? (Royal College of Physicians, 2001) and an unpublished report of a comparison between two hospitals. Owens L. Chapter Six Making a Difference: Interventions by an Alcohol Specialist Nurse, and Owens L. Chapter 6 Efficacy of Brief interventions for dependent drinkers. A prospective cohort study.

1.3 Alcohol policy and strategy context

There are a number of alcohol strategy and policy documents and much guidance from the National Institute for Health and Care Excellence (NICE). These documents provide the national response on how to minimise the health and social harm from the misuse of alcohol. A comprehensive list is set out in **Appendix 2**.

High level national initiatives such as working closer with the drinks industry to promote responsible drinking inform much of the government's approach. However, there are **many actions that can be taken at a local level** to reduce alcohol-related harm, such as support for individuals to make informed choices about responsible drinking and reducing the numbers of people drinking to excess.

It is recommended that a combination of interventions aimed at the **whole population** and individuals are most effective in reducing alcohol-related harm. An example of a population approach could be ensuring a town centre has a mixed night-time economy that provides alternative choices to alcohol based activities. Population-level approaches can reach people who may not be in contact with services, and those who have been advised to reduce their intake by creating an environment that supports lower risk drinking. They can help **create an environment where lower-risk drinking behaviour is the norm.**

Interventions aimed at **individuals** can help make people aware of the potential risks they are taking (or harm they may be doing) at an early stage. This is important as an individual is more likely to change their behaviour if their drinking is addressed before it becomes very problematic. **Early intervention** can therefore prevent extensive damage to a person's health and other associated problems.

Public Health England suggests four main ways to tackling alcohol in populations and individuals.[17]

1. **Improve awareness** of alcohol harm among young people and delay the age of first use
2. For people who do drink, **make lower risk drinking the norm** and an easy choice to make
3. **Target** those people and groups most at risk
4. Respond to and **reduce the harm** experienced by those who have already developed problems.

1.3.1 Croydon local strategy

Croydon tackles alcohol issues through partnership working across organisations and through a range of initiatives. Key partnerships include:

[17] Alcohol and drugs – prevention, recovery and treatment – why invest? 2014 Public Health England

- The Safer Croydon Partnership
- The Drug and Alcohol Action Team (DAAT)
- The Croydon Healthy Behaviour Change Alliance
- Be Healthy Subgroup of the Children and Families Partnership Board
- The Clinical commissioning group (CCG) and Integrated Commissioning Unit (ICU)
- The Health and Wellbeing board

Key local documents include: *(weblinked to relevant local documents where available)

- Croydon's community strategy
- The Joint Health and Wellbeing strategy
- DAAT documents and strategy/action plan
- Safer Croydon strategy/action plan
- CCG commissioning intentions
- Croydon's Licensing Policy

1.3.2 Public Health Outcomes Framework (PHOF) alcohol targets

Croydon's overarching goals in the Health and Wellbeing strategy are to increase healthy life expectancy and to reduce differences in life expectancy between communities[18].

Indicators in the new Public Health Outcomes Framework specifically relevant to alcohol are:

- Reducing alcohol-related hospital admissions
- Mortality from liver disease
- Successful completion of drug treatment
- People entering prison with substance dependence issues who are previously not known to community treatment
- Take up of the NHS Health Check programme by those eligible (which will include screening for alcohol misuse from 2013).

However, reducing harm due to alcohol can help improve many of the other PHOF indicators. **Appendix 4** visually highlights the impact that addressing alcohol-related harm can contribute to PHOF outcomes.

[18] Health and Wellbeing strategy 2013-2018

2 METHODOLOGY

The JSNA process has been informed by a reference group made up of stakeholders from across different organisations who have provided data and expert opinion (see acknowledgements). Other key partnership groups in Croydon have also fed information into the process and commented on drafts.

This JSNA chapter refers to relevant local documents and strategies rather than duplicating information, particularly around detailed service provision information. Where it is deemed that more information or data should be collected or analysed to understand an issue better this has been proposed as a recommendation.

A range of evidence from a variety of sources has been gathered to understand the picture of alcohol-related harm in Croydon including:

- **National statistics** e.g. What does national data tells us about the prevalence of alcohol misuse among different groups of the population and how does this relate to Croydon's demographic composition?

- **Local statistics and comparisons with other areas** e.g. What does local available data tells us about the extent of alcohol misuse in our population and how do we compare with our statistical neighbours?

- **National guidance** What does the evidence say about best practice and effective approaches to reducing alcohol-related harm?

- **Local opinion** e.g. What do local stakeholders feel needs to be done about alcohol-related harm in Croydon? We did not undertake consultation for this rapid JSNA. However, the findings of previous consultations and engagement events from the last three years have been included where relevant.

2.1 Limitations of the data

Due to data access issues it was not possible to analyse GP data, Accident and Emergency or hospital admissions data in detail, for this JNSA. The exception is published QOF indicators related to alcohol, which are readily available.

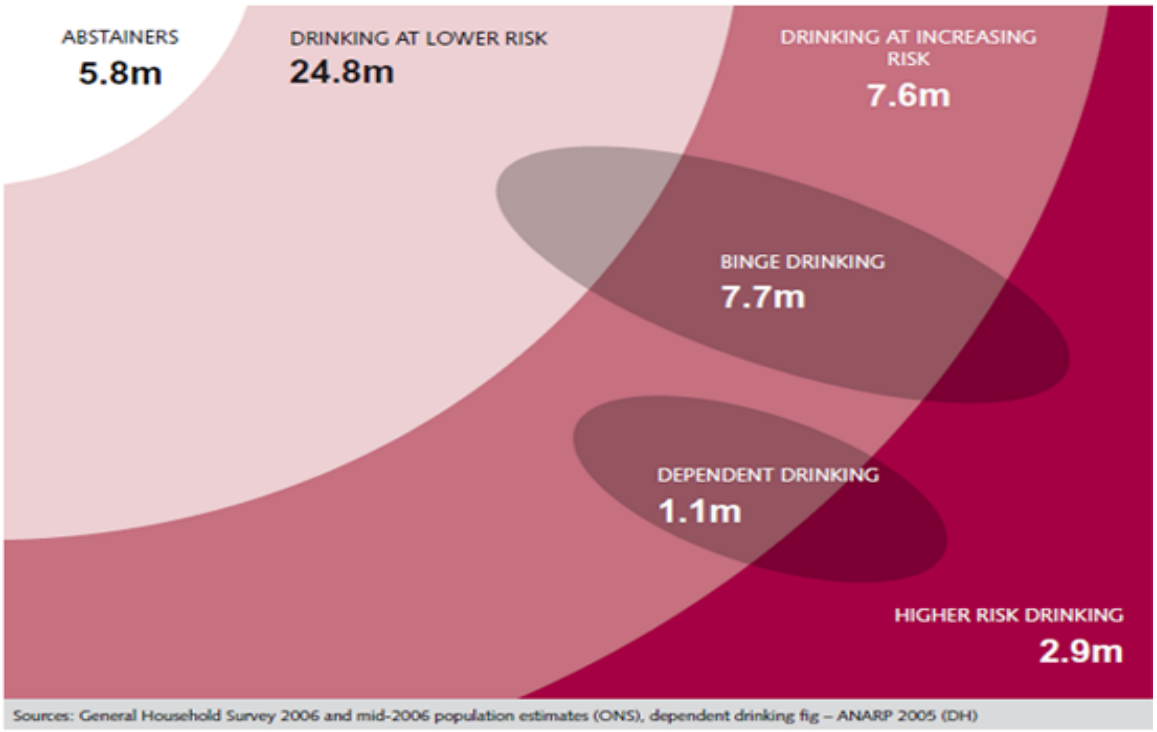
It is notoriously hard to accurately assess or measure levels of drinking in populations. Studies have shown that self-reported alcohol consumption only accounts for between 40 and 60 per cent of alcohol sales. However, rates can highlight patterns of alcohol consumption in populations and identify higher risk groups. There are also data limitations with regard to under recording and under identification of alcohol issues by practitioners. Therefore, readers are advised to be aware that alcohol needs assessments and particularly consumption rates can never be completely accurate.

3 DATA FINDINGS

3.1 Prevalence of alcohol misuse in Croydon

Nationally, it is estimated that **26% of the population** aged 16 to 64 have an alcohol use disorder (38% of men and 16% of women) that consists of **increasing, higher risk or dependent drinking.** Overall, the prevalence of alcohol dependence, where people feel they cannot function without alcohol, is 3.6%, (6% of men and 2% of women). For **alcohol level and unit definitions** see **Appendix 1**.

Figure 1: National levels of alcohol misuse



Source: Alcohol Needs Assessment Research Programme (ANARP), 2004

Estimates of the proportions of abstainers, lower risk (sensible), increasing risk (hazardous) and higher risk (harmful) drinkers in Croydon and London are shown in Table 1.

Just **over 50,000 adults in Croydon** are estimated to be drinking at increasing and higher risk levels. **1 in 4 (25%) people who consume <u>any</u> alcohol in Croydon drink at increasing or higher risk levels**. This is lower than the London average of 31%.[19]

About **1 in 6 people in Croydon are drinking above national guidelines.** This population group is at risk of suffering alcohol harm, as their exposure to alcohol has long-term consequences for their health and well-being.

[19] North West Public Health Observatory, Topography of Drinking Behaviours in England, 2011

An estimated **1 in 9 adults** or 11.7% (C.I. 10.6% - 12.9%)[20] are **binge drinkers** in Croydon, a figure that is slightly lower than the London average of 14.3% (C.I. 12.5% - 16.3%) and significantly lower than the England average of 20.1% (C.I. 19.4% - 20.8%).[21]

There is considerable overlap between binge drinkers and those who drink at hazardous, harmful or dependent levels and this is shown in Figure 1. Evidence suggests that young adults under the age of 25 years often binge drink.[22] However, many older people also binge drink and even people who are classified as lower risk drinkers can also binge drink.

Binge-drinking increases the risk of accidents and being a victim of violence; usually through decreased physical capacity and compromised decision-making. It also increases **the likelihood of perpetrating violence** through reduced inhibition and increased aggression.

In Croydon, just over 1 in 4 adults (28.5%) are abstainers, slightly higher than the London average of 24.5%, possibly reflecting the diversity of communities and cultures living in Croydon.

Table 1: Comparison of alcohol consumption in Croydon and London

		People aged 16 years and over		
Drinking Category	**Definitions (average weekly unit consumption)**	**London %**	**Croydon %**	**Croydon Numbers**
Abstainers	**Men: 0** **Women: 0**	**24.5**	**28.5**	**82,116**
Lower risk (sensible)	**Men: >0 and <=21** **Women: >0 and <=14**	**52.1**	**53.7**	**154,724**
Increasing risk (hazardous)	**Men: >21 units and <=50** **Women: >14 units and <=35**	**15.8**	**12.8**	**36,880**
Higher risk (harmful)	**Men: >50** **Women: > 35 units**	**7.6**	**5.0**	**14,406**

Source: North West Public Health Observatory, Topography of Drinking Behaviours in England, consumption estimates applied to ONS mid-2012 population estimates for Croydon

[20] C.I. is the 95% confidence interval
[21] Local Alcohol Profiles, Croydon (2012)
[22] The 2004 Alcohol Harm Reduction Strategy for England

Nationally, it is estimated that nearly half (45%) of children aged 11 to 15 have drunk alcohol in the previous year.[23] Croydon has limited data on young peoples' drinking habits and behaviour.

The National Alcohol Treatment Data System showed that from April 2012 – March 2013 Croydon had 652 people with primary alcohol-related issues in treatment, with 188 successfully completing treatment.

Treating dependent drinkers is extremely costly, compared with prevention and early intervention. Most commissioned services in Croydon are aimed at dependent drinkers. **A very small proportion of Croydon's population are actually dependent drinkers**, compared with those drinking at increasing (hazardous) and higher (harmful) risk (51, 862).

There is extremely low identification of alcohol problems in primary care. Although an estimated 18% (51,862) of adults are thought to drink at increasing / higher risk levels (see Table 1) **only 1% (3,727)** of Croydon's total registered population is **recorded** as having alcohol misuse problems[24]. This may indicate that **primary care practitioners are not routinely screening** or enquiring about alcohol consumption, which could enable identification of potential problems at an early stage.

3.2 Alcohol consumption estimates by age, gender, ethnicity and deprivation

Patterns of alcohol consumption vary by many characteristics including age, sex, ethnicity and deprivation. Certain population factors can increase or decrease the levels of alcohol consumption and the impact of harm associated.

3.2.1 By Age and Gender

The impact of the population age profile and alcohol consumption is quite complex. **Generally, a large young population 18-35 year olds will increase levels of alcohol consumption.** However, it is people aged 35-60 years of age who are most likely to be diagnosed with alcohol problems. The population who are most likely to have alcohol-related admissions are those in the 45-74 age groups.

Generally evidence shows that males are twice as likely to misuse alcohol or become dependent compared to women.[25] However, nationally alcohol use and misuse is increasing amongst women and the number of **women drinking above the recommended guidelines has risen by over half in the last 25 years.**

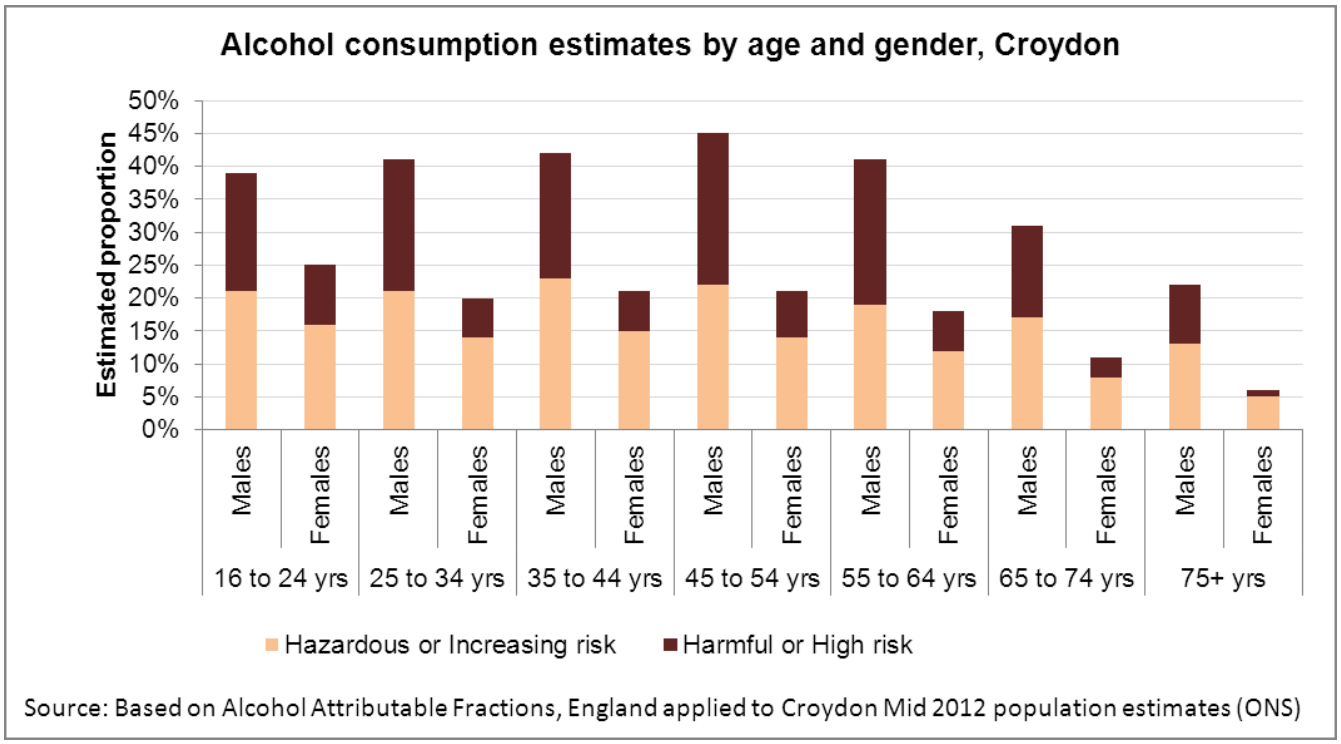
Figure 2 shows alcohol consumption estimates by age and gender in Croydon. This figure clearly shows that at every age, the proportion of men drinking at hazardous /

[23] Institute of Alcohol Studies (2013) Children, adolescents and underage drinking Factsheet 5
[24] Croydon GP data as at 31st March 2012
[25] Schuckit, M. (2009) Alcohol-use disorders, The Lancet, Vol 373, Issue 9662, pp.492-501.

harmful levels is considerably higher than for women. **Approximately 20% of Croydon men in every age group up until age 65 are drinking at a harmful or high risk.** Even in the older age groups approximately 10% of men are drinking at a harmful or high risk.

Croydon's consumption patterns are similar to those seen nationally. In Croydon, GP recorded age-sex standardised rates of alcohol misuse and dependence are almost three times as high for males as for females.[33] Although alcohol consumption drops at older ages, **about a third (32%) of people drinking at increasing and high risk levels are aged over 50**[26].

Figure 2: Alcohol consumption estimates by age and gender, Croydon



Source: Alcohol Attributable Fractions, England rates applied to Croydon Mid-2012 population estimates.

3.2.2 Alcohol and Young people aged under 18

The Department of Health recommends **no alcohol consumption below the age of 15.** [27] Although the proportion of young people drinking is reported to have declined in recent years, it is noted that those who do drink are consuming more alcohol, more often. The UK has the third highest proportion of 15 year olds (24%) who have been drunk 10 times or more over the past year.

[26] Jones L et al (2008) Alcohol-attributable fractions for England. Alcohol-attributable mortality and hospital admissions. NWPHO

[27] Donaldson, Liam, (Sir) (December 2009), 'Guidance on the consumption of alcohol by children and young people. A report by the Chief Medical Officer', Department of Health, pp. 13–29

High levels of alcohol consumption have been associated with a range of **high risk taking behaviours** including offending and unprotected sex. By delaying the start in drinking young people are less likely to engage in health risk behaviours

The national TellUs survey (2010) was carried out on 566 secondary school pupils in Croydon and found **that 39% of respondents had ever had an alcohol drink and 30% of respondents been drunk in the previous four weeks.**

A survey was also carried out in 2010 [28] to explore prevalence of alcohol misuse and risky sexual behaviour amongst for **15 – 16 year olds in Croydon.** It aimed to highlight knowledge, attitudes and behaviours relating to alcohol and sexual health issues. In summary, the main findings were:

- **Girls appeared to be drinking more frequently** and getting drunk more often than boys.
- Knowledge about alcohol was generally very poor and there was **very low awareness about 'units' of alcohol.**
- Respondents said they would be **more likely to engage in riskier sexual behaviour** if they were drunk compared to being sober.

Croydon Children and Families Partnership: Children's services needs analysis (January 2012) contains limited data about substance misuse and young people. Their analysis shows that of the 84 young people in treatment during 2010/2011, 3 were using class A substances, 11 other stimulants, 7 cannabis and alcohol, 57 cannabis only and 6 alcohol only. As the partnership have noted it is likely that the low numbers of young people receiving treatment is likely to reflect that drug and alcohol problems are not being identified/referred for treatment rather than the level of need.

For further information please refer to Croydon Children and Young People's Plan 2013-16

3.2.3 Young adults

Recent national studies identified that around **two-thirds of 17-30 year olds arrested claimed to have 'pre-loaded'** (drunk to excess at home) before a night out[29].

Preloading has important implications for preventing harm because it means that individuals are arriving at pubs, bars and nightclubs already under the influence of alcohol, and in some cases are likely to be intoxicated. **Pre-loaders are two and a half times more likely to be involved in violence than other drinkers,** according to a small scale study**.**[30]

[28] Croydon Young People's (15-16 years) perspectives on alcohol and sexual health
[29] Barton, A. and Husk, K. Controlling pre-loaders: alcohol-related violence in an English night time economy. Drugs and alcohol today.
[30] Hughes K. Anderson Z. Morleo M. and Bellis M.A. (2008): Alcohol, nightlife and violence: the relative contributions of drinking before and during nights out to negative health and criminal justice outcomes, *Addiction*, 103(1), 60-65

There is a perception by some local bar owners that pre-loading is a problem in Croydon and is a possible cause of the high ambulance call outs (see section 5.3).[31] We do not have any accurate data or information to confirm this opinion about preloading in Croydon.

3.2.4 Ethnicity

Nationally black and minority ethnic groups have a considerably lower prevalence of hazardous/harmful alcohol use, but a similar prevalence of alcohol dependence compared with the white population.[32]

Rates of both overall **alcohol misuse and dependence are 2-3 times higher in Croydon's White British** registered population than for other ethnic groups.[33]

Given Croydon's high proportion of black and minority ethnic groups we might expect to find a similar picture to the national one regarding alcohol dependence. This may indicate that our BME population are not being screened or diagnosed with alcohol problems. Further data analysis would be needed to follow up this theory.

3.2.5 Deprivation

Research generally finds that people from lower income households are more likely to drink more heavily when they do consume alcohol, but people living in higher income households drink alcohol more frequently[34]. However, compared with those living in more affluent areas, people in the most deprived fifth of the country are[35]:

- two to three times more likely to die of causes influenced, in part, by alcohol
- three to five times more likely to die of an alcohol-specific cause
- two to five times more likely to be admitted to hospital because of an alcohol-use disorder

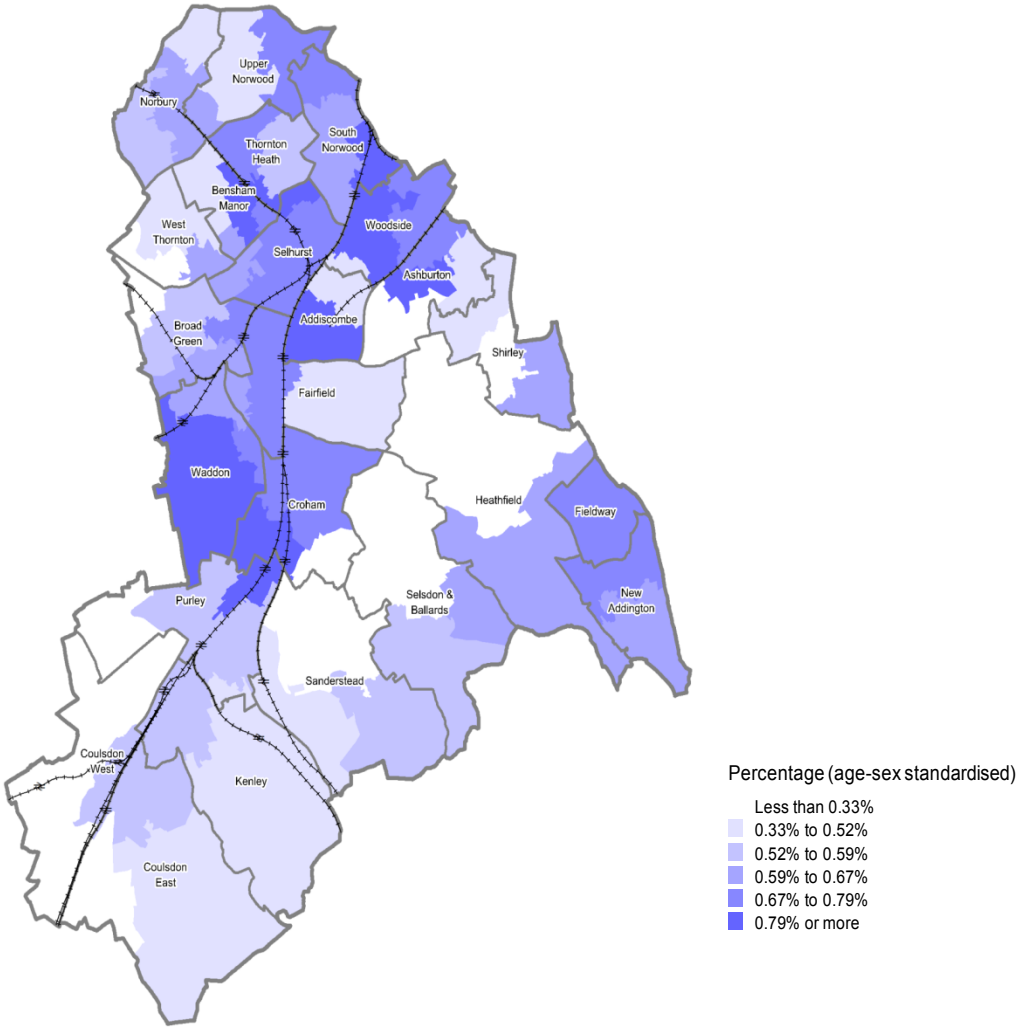
Research is inconclusive as to why people living in more deprived areas experience more alcohol-related harm and there are various hypotheses. [36]

Rates of GP diagnosed alcohol dependence are over 2.5 times higher in people living in the most deprived quintile compared to those living in the least deprived quintile. For rates of GP diagnosed alcohol misuse problem (a broader category), the deprivation gradient is less steep. Rates in the most deprived quintile are approximately 1.5 times higher than in the least deprived quintile.[37]

[31] Croydon Guardian (September 6, 2013) Special report: Binge drinking in Croydon a 'real concern'
[32] Alcohol Needs Assessment Research Programme (ANARP), 2004
[33] Croydon General Practice data, as at March 2012
[34] Huckle T, You RQ, Casswell S. Socio-economic status predicts drinking patterns but not alcohol-related consequences independently. Addiction 2010;105:1192–202.
[35] Association of Public Health Observatories 2007. Indications of public health in the English regions 8: alcohol
[36] Karriker-Jaffe KJ 2011Areas of disadvantage: a systematic review of effects of area-level socioeconomic status on substance use outcomes. Drug Alcohol Rev;30:84–95
[37] Croydon General Practice data, as at March 2012

Croydon is getting more deprived (as highlighted in the 2012/13 JSNA); therefore there is a risk that numbers of people affected by alcohol-related harm could increase in our population.

Map 1: GP recorded prevalence of alcohol dependence (age-sex standardised), map of Croydon middle super output areas 31 Mar 2012



Source: Data from Croydon general practices

4 VULNERABLE GROUPS IN CROYDON AND ALCOHOL-RELATED HARM

This section will outline the **main population groups** that are at higher risk of experiencing alcohol-related harm. For more detailed information on relative risk, including those **groups with protected characteristics**, see appendix 2.

These groups are **likely to need additional support to change their drinking behaviour.** It is critical to ensure that relevant and easily accessible services and interventions are available to these groups.

It is also important to note that 'at risk' drinkers are not a static group. Many will dip in and out of risky drinking patterns throughout their lifetime.

4.1 Homeless people and rough sleepers

Alcohol misuse is one of the most prominent causes and effects of homelessness.

The **prevalence of alcohol use disorders in homeless people and rough sleepers** has been reported to be between **38 and 50% in the UK.** Homeless people are particularly vulnerable to health related harm associated with alcohol including damage to liver, heart and stomach, high blood pressure, double incontinence, fits, mental health problems, depression, blackouts and memory loss.[38]

In Croydon, 2362 households were accommodated in temporary accommodation (September 2013), which is an increase from 2086 in 2012. Croydon is estimated to **have 25 rough sleepers on a typical night in February 2014,** which is an increasing trend from the previous year (22).

Trends show that homelessness in Croydon is increasing and has been since 2010 with increased numbers of households presenting as homeless, accepted as homeless and provided with temporary accommodation over the past three years.

Rough sleepers tend to drink high strength cheap alcohol. **One typical three litre bottle of white cider contains the maximum recommended number of weekly units for a man.**

It is widely recognised that having access to suitable housing and support can play a key role in helping people to tackle their alcohol problems. **A lack of housing and support can reduce treatment effectiveness.** Individuals with alcohol problems need a supportive base to stabilise their lives, in order to progress into detoxification or rehabilitation, during aftercare and resettlement.

It is out of the scope of this JSNA to explore the appropriateness of the housing situation in Croydon for alcohol misusers.

[38] Alcohol Concern White Cider and street drinkers: Recommendations to reduce harm

4.2 Street drinking

Street drinking has been identified as an issue within Croydon, with individuals and groups congregating in public areas. Street drinking in Croydon's town centre is perceived to be problem by over one in four consumers and almost three in four businesses.[39]

Street drinkers are **very often marginalised by society** and are largely hidden from view, mostly unemployed, often (but not always) homeless and are often parted from their families. Street drinkers are likely to have **complex needs** such as severe alcohol dependencies and histories of serious physical or mental health problems. A further problem is that many entrenched street drinkers are **resistant to the notion of treatment,** even though they are aware of local services.

Croydon has a number of **designated public place order areas (DPPO).** The DPPOs are designed to ban drinking in public spaces that have experienced alcohol-related disorder or nuisance. DPPOs can reduce the visibility of street drinking and anti-social behaviour, **but they can also have unintended consequences.** For example, DPPOs can make it more difficult for outreach workers to support street drinkers, which could **inadvertently worsen their health.** Another consequence of this approach has been to displace some street drinkers from the city centre into adjoining residential areas. It is essential that carefully **co-ordinated support packages** accompany any **enforcement interventions** with this **vulnerable** group of people.

Addressing issues associated with **street drinking such as anti-social behaviour, begging and sleeping rough has involved the use of lots of resources**. Safer Croydon and Croydon's Business Improvement District have been working to tackle these issues.

During the summer months (2013) **a multi-agency operation** (Loch Derg) saw a significant reduction in the number of individuals drinking and begging in Croydon town centre, with several individuals prosecuted and others accessed treatment services. Some of the outcomes from Operation Loch Derg included; **32 arrests, 347 alcohol seizures and 34 fixed penalty notices issued**. Compared with the same period from the previous year there was **a 6% reduction in theft, 9% reduction in shoplifting and 8% reduction in robbery.**Croydon Police continue to identify persistent offenders. Those who persist with their behaviour will be targeted for further action, with ASBO applications for the worst offenders.

For more information about Safer Croydon's initiatives see Safer Croydon Community Safety Partnership 2011/14

4.3 Victims of domestic violence

Within the home, domestic violence is often linked to alcohol consumption. In England and Wales in 2009/10, **37% of the victims of domestic violence** perceived their

[39] Croydon Town Centre Annual Town Centre BID Business and Consumer Survey 2013

attackers to have been under the influence of alcohol, and a Home Office study of male **domestic violence offenders in England found that 49% had a history of alcohol abuse.**

In Croydon the number of incidents of domestic violence reported to the police has increased over the last year and it is likely that a number of offences were perpetrated by individuals who had been drinking.

Many women use alcohol or other drugs to help them cope with the abuse**. Women experiencing domestic violence are up to fifteen times more likely to misuse alcohol than women generally.**[40] Due to the recognised association between alcohol and domestic violence, national guidance recommends that **adults at risk of domestic violence should be screened for alcohol-related harm** (see section 6.2 for more information on screening).

One of the key topics for an in-depth JSNA for 2013/14 will be focusing on Domestic Violence and is due for publication in summer 2014.

4.4 Individuals with mental health conditions

Alcohol consumption and mental ill health are closely linked. Alcohol is often a cause of mental health problems, but mental ill health can also lead to problem drinking. A 2002 study of substance misuse and mental illness found that **85% of users of alcohol services were experiencing mental health problems.**[41]

Evidence shows that people who consume high amounts of alcohol are vulnerable to higher levels of mental ill health and it can be a contributory factor in some mental illnesses, such as depression. Many depressive syndromes improve markedly within a short period (days or weeks) of abstinence. [42]

Alcohol can also exacerbate previous mental illness, for example, individuals who suffer from schizophrenia can suffer a relapse after drinking alcohol.

The 2012/13 JSNA chapters on mental health and wellbeing, depression and schizophrenia showed **that levels of mental illness are increasing in Croydon**. There is a need to screen, assess for alcohol issues and intervene early with people who have mental health problems.

4.5 Children and young people

The majority of young people who seek help for problems with alcohol have other emotional or social problems, such as self-harming, offending and family issues. They

[40] www.womensaid.org.uk
[41] Comorbidity of substance misuse and mental illness in community mental health and substance misuse services (2002) COSMIC study: Department of Health. http://dmri.lshtm.ac.uk/docs/weaver_es.pdf
[42] Brown and Schuckit (1988): Changes in depression among abstinent alcoholics. *Journal of Studies on Alcohol*, 49: 412–7 Dackis *et al* (1986): Evaluating Depression in Alcoholics. *Psychiatry Research*, 17(2): 105–9 Willenbring (1986): Measurement of Depression in Alcoholics. *Journal of Studies on Alcohol*, 49: 412–7 Davidson K M (1995): Diagnosis of depression in alcohol dependence: changes in prevalence with drinking status. *British Journal of Psychiatry*, 166: 199–204.

are also less likely to be in education, employment or training.[43] Studies have shown that young people from more than one vulnerable group are more at risk of drug or alcohol misuse[44]

The groups at particular risk are:

- Young offenders
- Looked after children
- Care leavers
- Children affected by parental substance misuse
- Homeless young people
- Young people at risk from sexual exploitation
- Excludees and persistent truants

Responses to children and young people's drug and alcohol misuse can broadly be divided into three categories:

- Universal prevention – accessible to all children and young people and delivered, for example, through schools or by GPs

- Targeted prevention – for young people who are considered to be vulnerable or who have been identified as having needs that require some low intensity intervention and monitoring (such as social inclusion programmes)

- Specialist treatment – accessible to young people with identified substance misuse needs that cannot be met by universal or targeted provision (such as mental health services, specialist schools, in-patient services, substance misuse treatment services).

4.6 Children of parents with alcohol problems

Young people's drinking behaviour can be strongly influenced by parental drinking and **children with parents who are problem drinkers are four times more likely to develop alcohol problems themselves.[45]**

An estimated 3.4 million children live with at least one parent who binge drinks[46] and, in England, an estimated 79,291 babies under one year old live with a parent who is a problem drinker.[47] Nationally, 2.6 million children are thought to be **living with parents**

[43] NTA, 2011
[44] DfES:2005; The NHS Information Centre, 2011.
[45] NICE CG115, 2011
[46] Manning, V., Best, D.W., Faulkner, N., Titherington, E. (2009) New estimates of the number of children living with substance misusing parents: results from UK national household surveys. BMC Public Health 9: p 377. doi: 10.1186/1471-2458-9-377
[47] Cuthbert, C., Rayns, G. and Stanley, K. (2011) All Babies Count: Prevention and protection for vulnerable babies. London: NSPCC.

who are drinking hazardously [48] - based on Croydon's population**, this equates to 18,000 children in Croydon.**

Children are especially vulnerable to violence and the wider effects of alcohol in the home. In 2008/09, a fifth (21%) of all young callers to Childline were worried about drinking by a parent or other significant person.[49] They described experiences of neglect, violence, isolation and fear.

4.7 Pregnant women

The Department of Health recommends that pregnant women, or women trying for a baby, should avoid alcohol altogether. The National Institute for Health and Clinical Excellence (NICE) **advises that the risks of miscarriage in the first three months** of pregnancy mean that it is particularly important for women not to drink alcohol at all during that period,

If women do choose to drink, to minimise risk to the baby, the government's advice is to not have more than one to two units of alcohol once or twice a week, and not to get drunk. Miscarriage, stillbirth, premature birth, small birth weight, and Foetal Alcohol Spectrum Disorder (FASD) are all associated with a mother's binge drinking which means consuming more than six units on one occasion whilst pregnant.

4.8 Drinking alcohol at home

Nationally, **less alcohol is now consumed on licensed premises than in the home**. In Croydon, over the last seven years more people are purchasing alcohol from supermarkets and shops. Croydon has seen a 12% increase in the number of off licences and a 20% decrease in the number of pubs. This indicates a significant shift in sales of alcohol from the "on" trade to the "off trade" and highlights a change in drinking behaviour in Croydon's population.[50]

Evidence shows that **drinking in the home is becoming an increasing problem** and is the most frequent place where people consume alcohol, particularly adults and older people.[51] Whilst licenced premises are regulated and landlords can stop serving alcohol to those deemed to be drunk, **home drinking is unregulated** in this sense. Home drinkers tend to pour larger measures of drinks than pubs.

[48] Manning, V et al (2009) New estimates of the number of children living with substance misusing parents: results from UK national household surveys BMC Public Health 2009, 9:377 in Guide to Alcohol for Councillors, Alcohol Concern 2013.
[49] Mariathasan, J., Hutchinson, D. (2010) Children talking to ChildLine about parental alcohol and drug misuse. ChildLine Casenotes series. London: NSPCC.
[50] Croydon Council's Licencing Policy 2013
[51] Plant MA & Plant ML (2006) Binge Britain: alcohol and the national response. Oxford: Oxford University Press.

Alcohol-related violence in the home (including child abuse and domestic violence) is often due to alcohol consumed at home. Much of this violence is unlikely to be reported to the police. [52]

Home drinkers may be at risk of longer term alcohol-related ill health and of developing increased alcohol dependency.[53] This changing pattern of behaviour means that we need to ensure the debate about alcohol is balanced in Croydon and does not only focus on 'problematic' drinking in public spaces. **There is a need to engage and target home drinkers** in sensible drinking messages.

[52] Walby S and Allen J. 2004. Domestic violence, sexual assault and stalking: findings from the British Crime Survey. Home Office Research Study 276. London: Home Office

[53] Alcohol academy (2010) Home drinking, out of sight out of mind. Draft paper

5 CROYDON ALCOHOL-RELATED OUTCOMES

This section will outline the **main published alcohol-related outcomes,** focusing on relevant indicators from Croydon's key dataset.

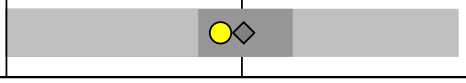
1. Alcohol-related crime
2. Hospital stays for alcohol-related admissions
3. Deaths attributable to alcohol (for both male and females)
4. Successful completion of alcohol treatment

Supplementary information is also given where it is available.

The Croydon Key Dataset brings together comparative data for a wealth of indicators of relevance to health and wellbeing. The full version of the key dataset can be found on the Croydon Observatory http://www.croydonobservatory.org.

Croydon's key dataset contains five indicators for alcohol, of which, four (213 - 216) have data available for the previous one and three years and one (217) is a new indicator this year. **For each of the four indicators where trend data is available, Croydon's ranking has been consistently deteriorating relative to England as a whole (Figure 3)**

Figure 3: Croydon Alcohol indicators

Indicator	Croydon	London	England	England Range	1 Year Trend	3 Year Trend
213 Alcohol related recorded crimes (rate per 100,000 population)	10.8	11.1	7.0		◄	◄
214 Hospital stays for alcohol attributable conditions (rate per 100,000 population)	1992	1985	1974		◄	◄
215 Deaths attributable to alcohol (men) (rate per 100,000 population)	35.2	34.2	35.5		◄	◄
216 Deaths attributable to alcohol (women) (rate per 100,000 population)	13.6	13.0	14.7		◄	◄
217 Successful completion of alcohol treatment (planned exits as a % of those exiting treatment)	55.0%	58.0%	57.7%		no data	no data

Source: Croydon's key dataset (2013/14)

5.1 Hospital Data

Alcohol-related harm is costly for hospitals. It is estimated that the annual cost of alcohol- related harm to the NHS in England is £3.5 billion. Almost three quarters of the costs were incurred as hospital- based care.

Conditions such as alcoholic liver disease where alcohol is the sole cause are known as **alcohol-specific or wholly alcohol-attributable** conditions e.g. liver disease or methanol poisoning. For other conditions, where alcohol has a proven relationship, but it is not the only cause they are known as **partially attributable** conditions e.g. heart failure or stroke. [54]

Alcohol is a **causal factor** in more than 60 medical conditions, including: mouth, throat, stomach, liver and breast cancers, high blood pressure, cirrhosis of the liver, and depression

Nationally, between 2002/13 and 2011/12, alcohol-related hospital admissions more than doubled. There were 1.2 million alcohol-related hospital admissions in England in the year 2011/12, a 135% increase since 2002/03. [55]

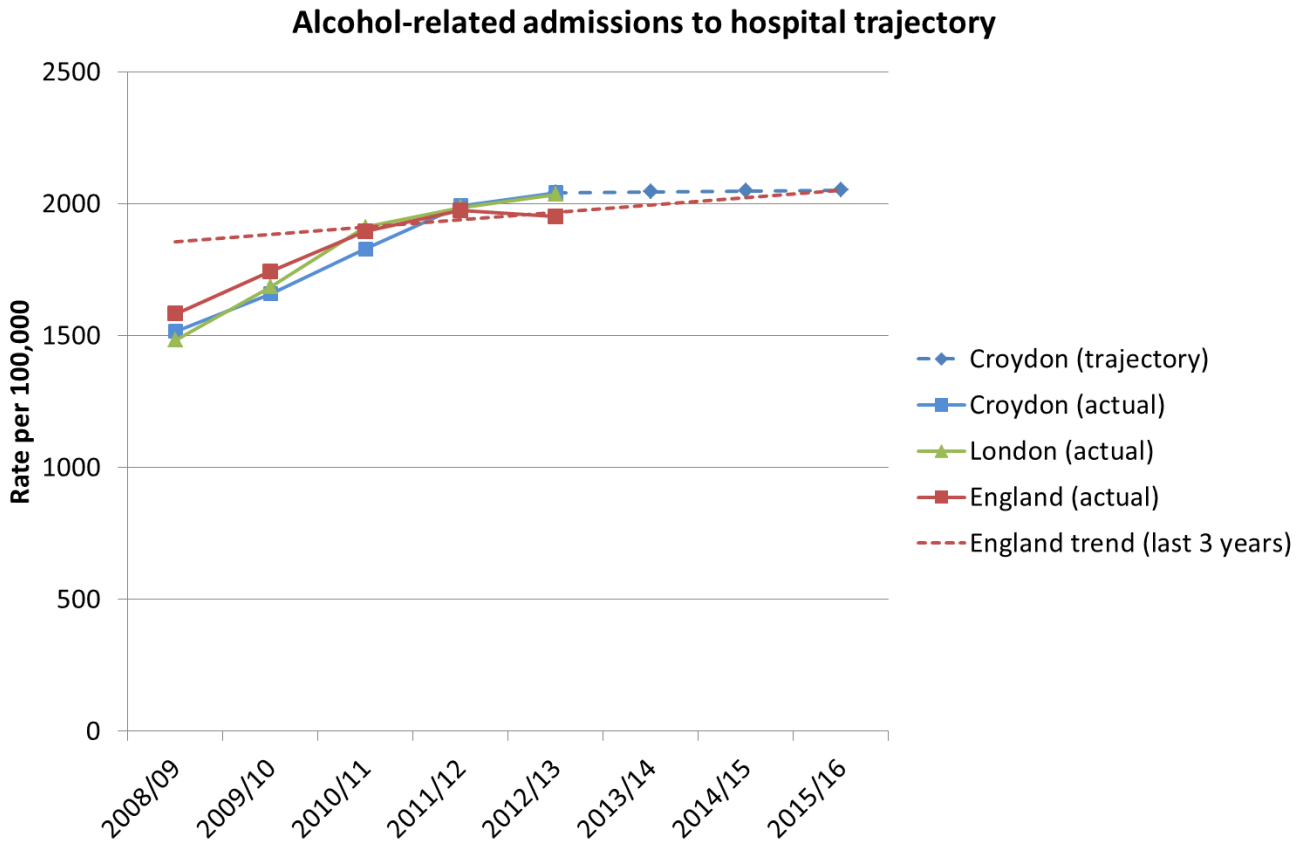
Croydon's alcohol-related hospital admission **rates are similar to rates in London, although slightly higher than England.** The trajectory for alcohol-related admissions is shown in **Figure 4**.

Croydon's crude rate for under 18s admitted to hospital due to alcohol specific conditions was 39.8 per 100,000 population in 2012. [56] **This figure is significantly better than the national figure (55.8 per 100,000 population)** However, this figure does not include Accident and Emergency attendance where many young people are often seen with alcohol-related issues, treated and then go home.

It is important to note that **the consequences of high levels of alcohol intake can take a number of years to become visible**. The fact that Croydon's trends are getting worse may reflect a change in drinking patterns and behaviour in our population, which may need further exploration and suggests that **we are storing up problems for the future**.

[54] Public Health England (2014) Understanding Alcohol-related Hospital Admissions
[55] Alcohol Statistics 2013, Health and Social Care Information Centre
[56] Local Area Alcohol Profile 2012

Figure 4: Alcohol-related admission to hospital trajectory



Source: Local Alcohol Profiles for England

5.2 Mortality

Nationally, 3.1% of all deaths are wholly attributable to alcohol. Compared to women, **men are at more than double the risk** (4.4% in males and 2% in females). Some age groups have very high risks; among males, 26.6% of all deaths in 16-24 year olds nationally were estimated to be attributable to alcohol consumption.[57]

As Figure 3 shows Croydon's ranking for deaths attributable to alcohol data has been consistently deteriorating relative to England as a whole. Croydon had 2365 deaths in 2011. Applying national rates to Croydon, an estimated **73 deaths can be attributed to alcohol in 2011.**

5.3 London Ambulance Service data

As of 2012/13 **Croydon ranked 5th highest among the London boroughs** in terms of the number of ambulance call outs for alcohol-related illness, with two thirds of these for men.[58]

[57] Jones L et al (2008) Alcohol-attributable fractions for England. Alcohol-attributable mortality and hospital admissions. NWPHO.
[58] SafeStats, London Ambulance Data for 2002/03 to 2012/13

Over the last three years the number of alcohol-related ambulance call outs in Croydon has **increased** from **1947 calls in 2010-11** to 2194 calls in 2011-12 and **2493 calls in 2012-13.**

Among Croydon's electoral wards, **Fairfield, Broad Green and Selhurst** have the highest numbers of ambulance call outs for alcohol-related illness. The ambulance call out rate in **Fairfield ward is over five times the Croydon average.** The number of Fairfield call outs is likely to be due to a combination of the high density of pubs and nightclubs in the city centre and the location a housing support scheme for people with substance misuse problems.

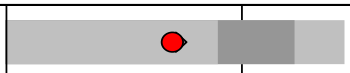
The ambulance call outs as a result of pubs means that many of those people being picked up will not necessarily be Croydon residents, but may be visitors from out of the borough.

When rates of ambulance call outs are analysed, a slightly different picture emerges. In 2012-13 there were 6.8 ambulance call outs for alcohol-related incidents per 1000 population in Croydon. This ranks Croydon 14th out of 33 London boroughs for the rate of ambulance call outs per 1000 population in the last year.

5.4 Alcohol-related crime

Alcohol-related crime is a significant indicator because of the impact it can have on local communities. There are many factors where alcohol has an effect on community safety. These include the night time economy, violent crime, domestic abuse, sexual violence, street drinking, anti-social behaviour and licensing issues.

Figure 5: Croydon violence related indicators

Indicator	Croydon	London	England	England Range	1 Year Trend	3 Year Trend
15 Violence against the person offences (rate per 1,000 population)	15.3	15.1	10.5		–	◄
16 Sexual violence offences (rate per 1,000 population)	1.27	1.16	0.93		–	–
17 Emergency admissions for violence (rate per 100,000 population)	70.8	71.9	67.7		no data	no data

Source: Croydon's key dataset (2013/14).

The alcohol-related crime indicator shown in

Figure **5** is **used nationally to compare local authorities' performance** and is the only indicator that is currently available. Attributable fractions are used to estimate the number of crimes that are attributable to alcohol consumption (see Table 2). It is **estimated** based on the proportion of selected crime types that are attributable to alcohol nationally.

Figure 5 shows that Croydon's rate of violence and sexual violence offences are higher than rates in England and London[59] and these offences increased year on year between 2007/08 and 2010/11[60]

Croydon reports a rate of 10.8 (alcohol-related recorded crime per 100,000 population) which is similar to the London figure of 11.1 and statistically significantly higher than the England figure of 7.0. **Croydon's rate has become relatively worse over the last three years**.[61] Croydon has an increasing trend particularly in alcohol-related sexual offences. [62]

Figure 5 shows that alcohol-related crime rates in **Croydon are significantly worse** than the **England** average. Out of 326 local authority areas in England, Croydon is ranked 298 for all alcohol-related crimes (where 1 is the best and 326 the worst). **Croydon is in the worst 50 boroughs for both alcohol-related violent crimes and for alcohol-related sexual offences**[63]

From April 2013, **the Metropolitan police have begun to record crime that is alcohol-related by flagging offences**. Once more data has been collated this may provide an opportunity to compare **more accurate local Croydon data** against the alcohol-attributable fractions for crime and give a richer picture.

Table 2: Alcohol-attributable fractions for crime

Crime category	Alcohol-attributable fraction*
Violence against the person	0.37
Sexual offences	0.13
Robbery	0.12
Burglary	0.17
Theft of motor vehicle	0.13
Theft from a motor vehicle	0.13

*An alcohol-attributable fraction is the attributable fraction due to alcohol; i.e. 1 = 100%, 0.25 = 25% of cases are attributable to alcohol.

Source: Local Alcohol Profiles for England 2012

5.5 Probation data and alcohol

A third (33%) of all adult offenders on Croydon's probation system have alcohol identified in their offending.[64]

Croydon will be introducing an Alcohol Abstinence Monitoring Requirement from May 2014. Legislation has been introduced to monitor offenders who commit alcohol-related crime by sentencing them to a Community Order with a requirement to either wear a

[59] Croydon Key dataset 2013/14,
[60] Croydon Local Alcohol Profile 2013
[61] Croydon 2012/13 JSNA – Key dataset indicator 195
[62] Croydon Alcohol Profiles, LAPE 2012
[63] Croydon Local Alcohol Profiles (2013)
[64] Croydon Alcohol Strategy Action Plan 2013-2015

tag or be tested for alcohol. If alcohol is found in their system they can be breached and returned to court.

Dependent drinkers are required to undertake an Alcohol Treatment Requirement which requires them to have treatment. This initiative is done in partnership with the Croydon Recovery Team and currently has a successful completion of 95%.

6 CROYDON'S CURRENT APPROACH TO REDUCING ALCOHOL-RELATED HARM AND GAPS

National guidance suggests that organisations **across health, social care and in the voluntary and community sector must work in partnership** to tackle alcohol issues effectively. In particular, those partners involved with **health and wellbeing boards should take the lead.**

The structure for this section sets out the national **evidence based recommendations** that all boroughs can implement to **reduce the harm caused by alcohol**. Croydon's gaps against the evidence base will then be discussed.[65]

Table 3 shows the three strands to this section **1) Strategy and Policy, 2) Prevention and Screening and 3) Addressing alcohol-related problems.** Under each main strand are the evidence based interventions suggested.

Table 3: NICE Alcohol public health briefing and web links: Evidence based recommendations to reduce alcohol-related harm

Strategy and policy	Prevention and screening	Addressing alcohol-related problems
Advertising, marketing, availability and price Further info: see licensing on Alcohol-use disorders' pathway.	**Screening children** Further info: Prevention and screening for young people	**Prevention and screening for people with existing problems** Further info: Prevention and screening for adults
Education programmes and schools partnerships Further info: see school partnerships Alcohol-use disorders' pathways and School-based interventions on alcohol	**Screening young people and adults** Further info: Alcohol-use disorders: preventing the development of hazardous and harmful drinking.	**Assessment of higher risk drinking alcohol dependence** Further info: Alcohol dependence and harmful alcohol use
Licensing and enforcement Further info: see licensing on Alcohol-use disorders' pathway.	**Providing advice for people at risk of an alcohol-related problem** Further info: see behaviour change guidance.	**Interventions for higher risk and alcohol dependence** Further info: Alcohol-use disorders: physical complications

Source: National Institute for Health and Clinical Excellence (NICE) – Alcohol local government public health briefing (PHb6 2012)

[65] NICE (2012) Local Government Briefing PHB6

6.1 Strategy and policy

The National Institute for Health and Care Excellence (NICE) recommends that Local Authorities and their partners **have clear strategies and policies** in place to address alcohol issues in a co-ordinated way.

In Croydon there is a considerable amount of good work happening across partnerships to tackle different alcohol-related issues e.g. treatment, enforcement and education. However they tend to operate independently. **Currently Croydon does not have a Borough wide strategic approach** to encourage a sensible drinking culture and reduce alcohol-related harm.

6.1.1 Advertising, availability and price

One of the most effective ways to reduce the harm from alcohol is to reduce the affordability, availability and attractiveness of alcohol products.

Alcohol is very readily available across the Borough. Croydon has a high number of licensed premises (1,200 +), 300 of which are pubs and night clubs. The remainder are primarily off licences, members clubs (sports & social clubs) and convenience stores.

Limiting availability of alcohol is well evidenced to reduce harm. Limiting availability is most effective **in reducing binge drinking and alcohol-related crime**[66] and drinking by young people through[67]:

- Reducing the density of premises that sell alcohol
- Enforcing the refusal to serve drunk customers
- Restricting late night trading
- Enforcing the law on age of purchase

Making alcohol less affordable (based on a minimum price per unit) is a highly effective way of reducing alcohol-related harm. However, the government has recently put on hold the introduction of a national minimum unit price.

Croydon's licensing department is looking into the feasibility of **introducing a local voluntary scheme** where off licences would take the decision not to sell cheap beer and cider products above a certain alcohol content or alcohol by volume (ABV). These schemes are not intended to be anti-alcohol, but **recognise the significant harm that super-strength beer, lager and cider can cause**, particularly to street drinkers and other vulnerable groups. Similar schemes in other areas of the country e.g. Ipswich has **demonstrated a reduction in crime, disorder and anti-social behaviour.**

[66] Interventions on Control of Alcohol Price, Promotion and Availability for Prevention of Alcohol Use Disorders in Adults and Young People, University of Sheffield review for the NICE Public Health Programme Development Group, 2009

[67] Anderson P, Baumberg B. Alcohol in Europe: a public health perspective: report to the European Commission, Institute of Alcohol Studies, 2006

6.1.2 Education programmes and schools partnerships

Appropriate education programmes can help children and young people develop healthier attitudes towards alcohol and understand the harm that it may cause. **Educational programmes should start early, before the child reaches 13,** because it is important to establish a strong message in the early years of a child's life.

NICE[68] recommends taking a **whole schools approach** to ensure that children and young people's strategic partnerships focus on:

- encouraging children **not to drink alcohol**
- **delaying the age** at which young people start drinking
- **reducing the harm** it can cause among those who do drink.

For children who are thought to be drinking harmful amounts of alcohol, the action is to provide brief advice and direct referrals to appropriate services if required.

Community-based programmes should educate parents and children together about alcohol and the harm it can cause (programmes for parents only are effective, but less so than when children are also involved).

An essential part of education programmes includes training of professionals to increase their knowledge and confidence around alcohol misuse, identification and support for children and young people. Education programmes should:

- increase knowledge of the potential damage alcohol use may cause, physically, mentally and socially (including the legal consequences)
- provide the opportunity to explore attitudes to, and perceptions of, alcohol use
- help develop decision-making, assertiveness, coping and verbal/non-verbal skills
- help develop self-esteem
- increase awareness of how the media, advertisements, role models and the views of parents, peers and society can influence alcohol consumption

Currently there is **no standardised programme of alcohol education in Croydon schools.** In order to obtain a Croydon Healthy Schools award, schools are required to evidence what they are doing address risk taking behaviours and specifically drug/alcohol education schools. It has been noted that the non-statutory nature of Personal Social Health and Economic Education (PHSE) together with the competing priorities demanding schools' attention, means that **there has not been a great focus on drugs/alcohol education in the borough in the last few years**.

[68] NICE (2007) PH7 School-based interventions on alcohol

A small minority of schools involve outside voluntary agencies such as Croydon Drop-in in their alcohol education and prevention work. The quality of PSHE and therefore **alcohol education programmes is variable across schools in the Borough.**

Croydon's Public Health department runs an Alcohol and Sexual Health Risk-Taking workshop that aims to increase participants' awareness of the serious consequences of consuming too much alcohol, in relation to unplanned pregnancy and STI's. However, this has not been delivered regularly in the last year due to capacity issues.

There is an intelligence gap around Croydon young people's views and behaviour about alcohol. However, there are imminent plans for a survey which will include questions on alcohol awareness and attitudes that will be distributed to secondary schools and pupil referral units.

6.1.3 Licensing and enforcement

All licence applications must comply with four licensing objectives, namely:

- the prevention of crime and disorder
- public safety
- the prevention of public nuisance
- the protection of children from harm

Croydon has a robust licensing policy. The 2003 Licensing Act requires that the Council carries out its various licensing functions and promote the following four licensing objectives:

- the prevention of crime and disorder
- public safety
- the prevention of public nuisance
- the protection of children from harm

Currently as determined by national government there is no direct Public Health licensing objective. The Licensing Team works in partnership with other responsible authorities like the police, trading standards and noise pollution teams, to oversee enforcement work across the borough, which includes:

- Monitoring all licensed premises. Those linked to regular outbreaks of alcohol-related crime and disorder risk being closed.
- Tackling anti-social behaviour that may cause significant harm to individuals and communities

The Licencing Act also allows local authorities to amend their written statement of licensing policy to include **Cumulative Impact Zones (CIZs).** This policy can be put in place in areas where unacceptable levels of crime, disorder or public nuisance have been identified. There is then a presumption that in the CIZ applications for new

premises licences, club premises or variations to existing licences would normally be refused, following relevant representations, unless the applicant can demonstrate that there will be no negative cumulative impact on one or more of the licensing objectives

Croydon Council has recently designated **four CIZs** limiting the number of new retail shops entitled to sell alcohol in these four main thoroughfares.

The Safer Croydon Partnership works to reduce crime and anti-social behaviour. It also has a role around:

- Enforcing the Designated Public Place Orders across the borough
- Promoting activity to reduce drug and alcohol-related crime and anti-social behaviour e.g. town centre initiatives to reduce street drinking and begging.
- Working closely with the Westminster Drug Project to engage with vulnerable individuals such as street drinkers and provide support and access to treatment services.

As indicated in section 5.4 the most recent Local Alcohol Area Profile for England estimates that Croydon has a high level of alcohol-related crime and that trends are getting worse. Currently, there is limited accurate local information about the precise nature of alcohol-related crime or anti-social behaviour i.e. which offences are related to alcohol and who are the perpetrators. This makes it more difficult to target resources and appropriate interventions. However, there will soon be one year's data from the Metropolitan police initiative to flag alcohol-related incidents. This may give a more detailed local picture for future targeting and response.

Research also shows that the **majority of violent assaults are not reported to the police, but many people present to emergency departments with their injuries. Health workers** on the frontline often come into contact with people who have been directly affected by **alcohol-related violence.** The Cardiff Model is a model of good practice which outlines how Accident and Emergency Departments can contribute to violence prevention by working closely with community safety partnerships[69] [70]. This model **uses anonymised information** obtained from A&E patients about the precise location of violence, weapon use, assailants and day/time of violence. Evaluation has shown that this model **enhances the effectiveness of targeted policing and local authority effort, and significantly reduces serious violence** recorded by the police and violence-related hospital admissions. Using the Cardiff model can also help to identify domestic violence and child protection issues. This type of partnership working is **not currently happening in Croydon**, but partners are exploring how they might improve data sharing arrangements. This could help prevent violence by targeting

[69] Warburton Al, Shepherd JP (2006). Tackling alcohol-related violence in city centres: effect of emergency medicine and police intervention. Emergency Medicine Journal 23:12-17.
[70] Alcohol Learning Centre – Alcohol Learning Resources
http://www.alcohollearningcentre.org.uk/LocalInitiatives/projects/projectDetail/?cid=6476

resources more effectively and **reduce the alcohol-related burden on emergency services.**

For more detailed information about licensing and enforcement please refer to: Safer Croydon Community Strategy and Croydon's 2013 Licensing Policy.

6.2 Prevention and screening

As highlighted in section 3, Croydon has approximately 52,000 people who are currently drinking at increasing or higher risk levels. **Screening** is an evidence based method of **identifying people before their drinking becomes problematic or they become alcohol dependent**. It is possible to support these people to **change their drinking behaviour** by providing **intervention and brief advice** (IBA).

Brief advice for increasing and high risk drinkers is a **short, structured conversation to motivate and support people** to think about and/or plan a change in their drinking behaviour. The majority of these at risk drinkers can benefit from simple, brief advice delivered by mainstream professionals with no alcohol specialism. Through a short training session a range of frontline staff from across sectors may be trained to give IBA at 'opportune moments', e.g. pharmacy staff, probation, A&E staff, housing officers, or welfare rights staff. Brief Advice following screening has been well researched and evaluated. Evidence estimates that 1 in 8 appropriate recipients of brief advice make changes to their drinking behaviour and it **can help people reduce their alcohol consumption by up to 20%.** [71]

In addition to adults who may benefit from **screening** and IBA, NICE also recommends that **children and young people aged 10–15 years** who are thought to be at risk of drinking alcohol should be screened.

It is recommended that local authorities should work with clinical commissioning groups and health and wellbeing boards to **prioritise activities to prevent alcohol-related illnesses as an 'invest to save' measure.** They should provide joined-up alcohol screening; referral and advice services (see appendix 4 for further details).

Current and past Croydon screening programmes include:

- A programme of screening brief intervention training for GPs, practice nurses and staff in Accident & Emergency settings (St George's brief interventions project 2007)
- Probation, offender managers and custody suite screening training through Croydon DAAT
- A&E alcohol liaison nurses delivering screening in Croydon University Hospital

NICE recommends that GPs should routinely carry out screening. Every **5000 patients screened** in Primary Care may prevent **67 A&E visits** and **61 hospital admissions**

[71] Moyer et al (2002) Brief interventions for alcohol problems: a meta-analytic review of controlled investigations in treatment-seeking and non-treatment-seeking populations. Addiction: 97(3): 279-92

(costs £25,000, saves £90,000).[72] As far as possible **screening should be standard practice with all patients,** in addition to targeting population groups who are deemed vulnerable (as identified in section 4), For example, discussions should take place during new patient registrations, when screening for other conditions, and when managing chronic disease or carrying out a medicine review. As noted earlier, **there is extremely low identification of alcohol problems in primary care.** This indicative of missed opportunities to identify people before their drinking escalates to problematic levels. Screening in primary care can be carried out by a **range of staff including GPs, nurses, pharmacists and health care assistants.** NICE cost analysis guidance suggests it is more effective for practice nurses to carry out screening.[73]

There are currently **very low levels of alcohol screening** by other key practitioners such as social workers, school nurses, targeted youth workers and other professionals who work with **children and young people in Croydon.** Opportunities to identify potential alcohol misuse or emerging issues of concern may be missed.

Croydon's **current approach** to prevention and screening **is patchy and un-coordinated.** Screening work to date in Croydon has **had little evaluation or monitoring** to assess if it is effective or if screening is actually being implemented in the different settings.

6.3 Addressing alcohol-related problems

Alcohol dependence is a long-term condition, which may involve recurring relapses even after good quality treatment. Sufferers typically also experience **multiple health problems and are heavy users of health services.** Treating alcohol dependence, where successful, has been shown to prevent future illnesses and reduce health service use.

Of the 1 million people aged between 16 and 65 who are **alcohol dependent** in England, **only about 6% per year receive treatment.[74]** Reasons for this include the often long period between developing alcohol dependence and seeking help.Tthe fact that **alcohol misuse is under-identified by health and social care professionals,** leading to missed opportunities to provide effective interventions.

NICE recommends that for all people who misuse alcohol, a **motivational intervention** should be carried out as part of the initial assessment. The intervention should contain the key elements of motivational interviewing including: helping people to recognise problems or potential problems related to their drinking, helping to resolve ambivalence and **encourage positive change and belief in the ability to change,** and adopting a persuasive and supportive rather than an argumentative and confrontational position.

[72] TrEAT trial. Fleming MF, Mundt MP, French MT, Manwell LB, Stauffacher EA, Barry KL. Brief physician advice for problem drinkers: long-term efficacy and benefit-cost analysis. Alc Clin Exp Res 2002;26:36-43
[73]NICE guidance costing report (2010) Alcohol-use disorders: preventing harmful drinking. Implementing
[74] NICE guidance (2011) CG115 Alcohol dependence and harmful alcohol use

Croydon's alcohol treatment services for adults over 18 are currently commissioned by **Croydon's Drug and Alcohol Action Team (DAAT).** Croydon DAAT is the multi-agency partnership that is led by Croydon Council and includes the Clinical Commissioning Group, Public Health, police, probation, Job Centre Plus, Service User representation. Croydon DAAT is in the **process of procuring an innovative, recovery orientated treatment system for drug and alcohol users, their family and carers**. The DAAT have a duty to ensure that commissioned services are accessible to and appropriate for everyone and this JSNA provides an opportunity to **target and invest based on the evidence of need.** The intention of the procurement exercise is to shift the balance to include appropriate alcohol interventions, treatment and support as historically the focus has been very much on drug treatment.

Croydon Early Intervention Support Service (EISS) within Children, Families and Learners have responsibility for commissioning child and adolescent drug and alcohol treatment services. **Croydon EISS are in the process of procuring a new children and young people drug and alcohol misuse service** which will introduce greater focus on early intervention provision as well as maintaining provision of treatment services.

For detailed information on the DAAT plans for treatment services please email Shirley.Johnstone@croydon.gov.uk.

7 CONCLUSIONS

This rapid assessment shows that like the national picture, **Croydon's relationship with alcohol is complex.** The majority of adults who consume alcohol in Croydon are not dependent on alcohol. Only **a very small minority of Croydon's population** match the public image of the "alcoholic" and are **dependent on alcohol.** Most adults who drink alcohol live fully functioning lives; have jobs, families and positions of respect in the community. However, **a large number** (50,000+) of these **people are drinking at levels that place them at greater risk of alcohol-related harm**. The consequences of high levels of alcohol intake can take a number of years to become visible, therefore it is essential to raise awareness of alcohol-related harm through **prevention and early intervention** methods.

To summarise the main findings:

- **1 in 6 adults in Croydon are drinking above national guidelines equating to over 50,000 adults.** This population group is at risk of suffering alcohol harm, as their exposure to alcohol has long-term consequences for their health and well-being.

- **Cost of alcohol-related harm is high.** The **cost** of tackling alcohol issues is estimated to be **£144 million** per year in **Croydon**. Of this, half is related to alcohol-related crime, one third is lost productivity and the rest is NHS costs.

- **Intelligence about prevention is limited.** There is some information about alcohol misuse and attitudes and behaviour among **children and young people.** There is extremely limited prevention and education work currently happening in schools or community settings, **which needs to be reviewed.**

- **People who consume alcohol in Croydon are drinking at increasing or higher risk levels.** 1 in 4 (25%) prevalence of increasing risk (harmful) and higher risk (hazardous) drinking patterns in Croydon is similar to rates in England and London. An estimated **1 in 9 adults** or 11.7% **are binge drinkers** in Croydon.

- More people are likely to be **drinking alcohol in the home, often to excess.** In the last seven years Croydon has seen a 12% increase in the number of off licences and a **20% decrease in the number of pubs.**

- **Men are at higher risk of harm than women**. Approximately **20% of Croydon men in every age group up until age 65 are drinking at a harmful or high**

risk. Even in the older age groups approximately 10% of men are drinking at a harmful or high risk.

- Nationally alcohol use and misuse is increasing amongst women and the number of **women drinking above the recommended guidelines has risen by over half in the last 25 years.**

- GP data shows that rates of both overall **alcohol misuse and dependence** are 2-3 times higher in **Croydon's White British population** than for other ethnic groups. This is different to the national picture where there is no difference in alcohol dependence between ethnic groups. This may indicate inequalities for BME screening of alcohol dependence in Croydon.

- **Alcohol harm in increasing both nationally and in Croydon.** The consequences of high levels of alcohol intake can take a number of years to become visible. The fact that Croydon's trends are getting worse, relative to England may reflect **a change in drinking patterns and behaviour in our population, which may need further exploration and suggests we are storing up problems for the future.**

    - Nationally, between 2012/13 and 2011/12, alcohol-related hospital admissions more than doubled. Three year trends show that **alcohol-related hospital admission rates** are lower in Croydon compared with rates in London or across England, but **are increasing**. The data currently held does not provide demographic data such as age, gender or geographical origin.

    - **Alcohol-related crime is getting worse**, relative to England and has been over a 3 year period. Alcohol-related crime is closely linked to **domestic violence** which has **also seen higher levels of reported offences in Croydon**.[75]

    - Croydon's ranking for **deaths attributable to alcohol** has been **consistently deteriorating** relative to England as a whole. In 2011 an estimated 73 deaths were wholly attributable to alcohol

    - Croydon has a **high number of alcohol-related ambulance call outs** compared with other London boroughs. Over the last three years the number of alcohol-related ambulance call outs in Croydon has **increased** from 1947 calls in 2010-11 to **2493 calls in 2012-13.**

- There is an **extremely low identification of alcohol-related problems** in primary care, which may indicate that screening is not happening consistently. Although an **estimated 18% (51,862)** of adults are thought to drink at increasing/high risk levels **only 1% (3,727)** of Croydon's population is recorded as having alcohol misuse problems.

[75] JSNA domestic violence chapter 2013/14 (to be published summer 2014)

- **Some older people continue to be at risk of harm.** All age groups in Croydon have high levels of people consuming at rates that can cause harm. Although alcohol consumption drops at older ages, **about a third (32%) of people drinking at increasing and high risk levels are aged over 50** in Croydon.

- **Vulnerable groups** including homeless people, people with mental health problems, women experiencing domestic violence in Croydon's population should be **targeted** for alcohol prevention, early identification and screening inventions. Some good work is happening, but **existing screening programmes in Croydon are not coordinated or systematic in their approach.**

- As is the case nationally, there is a **relationship between deprivation** and **alcohol dependence** and alcohol misuse in Croydon. Rates of GP diagnosed alcohol dependence are over **2.5 times higher in people living in the most deprived quintile** compared to those living in the least deprived quintile

- Most commissioned adult alcohol services in Croydon focus primarily on **costly specialist services** for **dependent users** of alcohol. These services are not equipped to meet the needs of the much larger groups of increasing risk 'hazardous' and higher risk 'harmful' drinkers (51,862).

8 RECOMMENDATIONS

The following recommendations are evidence based and will enable the **most efficient use of resources** to **improve the health** of Croydon's population and reduces costs in the short, medium and long term by reducing the harm caused by alcohol.

The recommendations have been grouped into three themes;

- Strategy,
- Prevention and screening,
- Data, intelligence and outcomes.

8.1 Strategy

Croydon does not have a borough-wide strategic approach to encouraging a sensible drinking culture and reducing alcohol-related harm. An evidence based strategy will help partners to focus limited resources in the right place and **make efficiency savings where possible.**

1. **The Health and Wellbeing Board** should ensure that partners develop a comprehensive borough-wide **alcohol strategy** that is driven by the Local Strategic partnership. The strategy should prioritise **public health and community safety**. The strategy should include a ladder of interventions based on evidence of what works, matched with a **suitable investment** across all age groups and **address health inequalities**.

2. Leadership is required from senior management across partner organisations to ensure there is effective **joined up working and coordination of effort** between key partnerships. This will enable the most **efficient use of resources** and **improve the health** of Croydon's population. Partners need to sign up to an **agreed vision** of how Croydon aims to address alcohol-related harm and promote a sensible approach to drinking **in the short, medium and longer term.**

8.2 Prevention and screening

In the past Croydon has invested a large amount of money into commissioned treatment services for those with severe problems with alcohol. It is essential to have a more balanced approach moving forward. All partners in Croydon should prioritise investing in **preventative and early identification services and interventions.** Taking this approach could prevent alcohol-related harm, **improve health** and **save money in the longer term.**

1. Expand **awareness and early intervention training** for universal and targeted services to **increase the identification** of emerging and problematic alcohol misuse issues in children and young people.

2. **Review the quality and level of alcohol education programmes** across the borough for families, children and young people, both in schools and community settings.

3. **Prioritise reaching the large numbers of Croydon's population** drinking at increasing, higher risk and binge drinking. Strengthen the impact of existing **Alcohol Identification and Brief Intervention** (IBA) work by introducing a co-ordinated programme of work in different settings across the Borough, with inbuilt evaluation.

4. **All health and social care professionals** should be trained to be able to routinely provide IBA to their clients, particularly those from vulnerable groups. **Improve identification and recording of alcohol misuse in primary care.** Primary care professionals should screen adults using a validated alcohol questionnaire and offer a brief intervention if appropriate. Ensure that Croydon's new **Health Check** service maximises the opportunity to **provide brief interventions** to reduce harmful drinking to a large number of population.

5. **Provide more help to encourage people to drink less.** Alcohol awareness campaigns should be fully commissioned and provide **appropriate tailored messages/information** for different **vulnerable groups.** Across the wider population, messages should consider the fact that a high percentage of drinking now takes place in the home and that **drinking behaviour may be changing in Croydon.** Develop an appropriate evaluation framework for activity aimed at reducing alcohol consumption by **assessing both short-term and long-term effectiveness.**

6. Continue to prioritise work to tackle street drinking and offer appropriate support and treatment to this group. **Work with licensees** that sell **cheap high-strength lagers and ciders** to encourage responsible retail sales.

8.3 Data, intelligence and outcomes

In order to assess if Croydon's approach, interventions or services are **making a difference to outcomes**, timely data and relevance intelligence needs to be regularly scrutinised.

1. **Continue to monitor and analyse alcohol-related trends, particularly health inequalities and vulnerable groups.** Carry out further cost analysis related to alcohol trends and cost effectiveness of interventions. Develop a co-ordinated and meaningful approach to collation of data, analysis and dissemination across partners. **Ensure that data is used appropriately to inform commissioning, target service provision and validate impact.**

2. Improve our understanding of the **prevalence of alcohol misuse** among our population, particularly among vulnerable groups and **children and young people** through **focus groups and surveys**. Ensure that data analysis of the imminent survey to secondary schools and pupil referral units is carried out. **The findings should be widely publicised** to professionals, children and young people and their parents and inform future services and interventions.

3. Obtain and **analyse detailed data on hospital related admissions and A&E data** to assess people with wholly attributable and partially attributable alcohol-related conditions, **against demographic data such as age, gender and geographical origin.** This will enable the right mix of targeted interventions to be introduced and appropriate services to be commissioned.

4. Obtain senior leadership **commitment to introduce a 'Cardiff model'** approach to violence prevention and data sharing in Croydon. Pull together and analyse the data on alcohol-related offences from police, probation, health services and other key partners to **increase our understanding of the local picture and the types of alcohol-related crime,** groups perpetrating and those affected in Croydon.

Appendix 1: Alcohol definitions

For clarity the definitions that have been used in this JSNA are:

Alcohol-related harm is the physical or mental harm caused either entirely or partly by alcohol. If it is entirely as a result of alcohol, it is known as 'alcohol-specific'. If it is only partly caused by alcohol it is described as 'alcohol-attributable.'

Alcohol misuse according to the NHS there are three main types of alcohol misuse, hazardous, harmful and dependent (see Table 10).

Alcohol Units. Most people have heard of units of alcohol and the sensible drinking message. However, evidence shows that people do not always understand what constitutes a unit; it is difficult to keep track of units (principally because the more a person drinks the less reliable their recollection is). Therefore many people could be drinking more than they think and results in less accurate assessments of the levels of drinking in a population.

One alcohol unit is measured as **10ml or 8g** of pure alcohol.

Current UK daily alcohol guidelines are that recommended in daily and weekly amounts are:

For men: three to four units per day (30-40g), up to a maximum of 21 units per week. This is equal to 1½ pints of beer per day.

For women: two to three units per day (20-30g), up to a maximum of 14 units per week. This is equal to one (175ml) glass of wine a day.

Both men and women are advised to have at **least two alcohol free days a week**

Table 4: Understanding units in different alcoholic drinks

Alcoholic beverages	Units
1 pint of high strength beer/lager (5%)	3 units
1 pint of lower strength beer/larger	2 units
1 small glass of wine (125ml)	1.5 units
1 standard glass of wine (175ml)	2 units
1 large glass of wine (250ml)	3 units
1 bottle of standard white/red wine	10 units
1 single small shot of spirit e.g. vodka	1 unit

Table 5: Definitions of types of drinkers

Types of drinkers	Definition
Hazardous drinkers/increasing risk drinkers	People who regularly drink more than the recommended daily unit allowance, but less than the harmful/ higher risk levels. It is also possible to drink hazardously by binge drinking.
Harmful/higher risk drinkers	Men who **regularly** drink more than 8 units a day (e.g. 3 pints a day) or more than 50 units a week. Women who **regularly** drink more than 6 units a day (e.g. 2 large glasses of wine a day) or more than 35 units of alcohol a week. The risk of liver disease is increased by 13 times. Risk of coronary heart disease is increased by 1.7 times for men and 1.3 times for women.
Dependent drinkers/alcohol dependence	Being dependent on alcohol means that a person feels that they are unable to function without alcohol, and the consumption of alcohol becomes an important, or sometimes the most important, factor in their life
Binge drinkers	Consuming 8 or more units in a single session for men and 6 or more for women
Sensible/drinking at lower risk	Drinking within the national guidelines
Abstainers	Do not consume alcohol

'Regularly' means drinking this amount every day or most days of the week.

Appendix 2: Evidence of what works to reduce alcohol-related harm

There is a body of evidence around effectiveness in alcohol interventions including new guidance published by the National Institute for Health and Clinical Excellence:

NICE Local government public health briefings PHB 6 (2012)

This briefing summarises how local authorities and their partners can reduce the harm caused by alcohol.

NICE public health guidance 24 (2010)
Alcohol-use disorders: preventing the development of hazardous and harmful drinking. This guidance covers the prevention and early identification of alcohol-use disorders among adults and adolescents. Its recommendations cover:

- licensing practices
- supporting children and young people aged 10-15
- appropriate screening and treatment for 16-17 year olds
- appropriate screening and treatment for adults

NICE clinical guideline 100 (2010)
Alcohol-use disorders: diagnosis and clinical management of alcohol-related physical complications. This guidance covers key areas in the investigation and management of the following alcohol-related conditions in adults and young people (aged 10 years and older):
• Acute alcohol withdrawal, including seizures and delirium tremens;
• Wernicke's encephalopathy;
• Liver disease;
• Acute and chronic pancreatitis.

NICE clinical guideline 115 (2011)
Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. This guidance covers principles of care, identification and assessment and interventions for alcohol misuse.

NICE Quality Standard for Alcohol (2011)
The alcohol dependence and harmful alcohol use quality standard defines clinical best practice within this area. It covers the care of children (aged 10-15 years), young people (aged 16-17 years) and adults (aged 18 years and over) drinking in a harmful way and those with alcohol dependence in all NHS-funded settings. It also includes opportunistic screening and brief interventions for hazardous and harmful drinkers.

Review of the effectiveness of treatment for alcohol problems *Raistrick et al 2006*
This outlines the evidence base for screening, brief interventions, less-intensive alcohol treatments, specialist treatment, detoxification and self-help.

NICE guidance PH7 for alcohol
This guidance on school based interventions on alcohol describes the role of schools in education and brief advice to prevent alcohol misuse.

NICE clinical guideline (CG110) Pregnancy and complex social factors, focusses on the antenatal care of women with particular needs one of which is the misuse of alcohol and/or drugs. It describes how access to care can be improved, how contact with antenatal carers can be maintained, the additional support and consultations that are

required and the additional information that should be offered to pregnant women with complex social factors.

NICE public health guidance (PH3) makes recommendation on prevention of sexually transmitted infections (STI's) and under 18 conceptions. It focusses on behaviours that increase the risk of STIs including misuse of alcohol and/or substances

Other key guidance documents include:

The Government's Alcohol Strategy 2012
This strategy focuses on promoting responsible drinking, closer working with the drinks industry and support for individuals to make informed choices about responsible drinking and reducing the numbers of people drinking to excess.

Health First – an evidence based alcohol strategy for the UK (2013)
This report has been produced by an independent group of experts

Models of Care for Alcohol Misusers (DH 2006)
This provides best practice guidance for health organisations in delivering an integrated local treatment system and sets out a tiered approach for alcohol interventions

Signs for improvement: Commissioning interventions to reduce alcohol-related harm (DH 2009) This publication describes how organisations should be commissioning interventions to reduce alcohol-related harm. It includes some evidence base for the 7 high impact changes

Managing the Night-Time Economy
This document provides a best practice guide for managing the night time economy, with emphasis on an integrated approach to night time economy management.

The Purple Flag accreditation scheme sets out quality standards for managing the night time economy based on good practice.

Cardiff Model – Effective NHS Contributions to Violence Prevention outlines how Emergency Departments can contribute to violence prevention by working closely with community safety partnerships based on a model developed in Cardiff A&E.

Appendix 3: Vulnerable groups to alcohol-related harm and the relative risks [76]

A relative risk or estimate of likelihood of increased risk of drinking has been entered into the third column where this is stated in the literature. This does not mean however that for categories where there is no value entered that there is no increased risk of drinking alcohol in those groups rather that there is no evidence available.

Group	Relative risk	Evidence review
Age		
Young people	4 fold increase in alcohol dependence in adulthood if started drinking before 13 years.	Alcohol consumption before the age of 13 years, for example, is associated with a four-fold increased risk of alcohol dependence in adulthood (Dawson *et al.*, 2008; Hingson & Zha, 2009 cited in NICE CG115, 2011). For men, the highest prevalence of alcohol dependence is those aged between 25 years and 34 years (16.8%), whereas for women it is most common in those between aged 16 years and 24 years (9.8%) (Adult Psychiatric Morbidity Survey, 2007 cited in NICE Commissioning Guide, 2011) The number of children and young people aged 11–15 who drink alcohol has fallen since 2001. However, those who do drink alcohol consume more – and more often (HM Government 2007, cited in NICE PH7, 2007). In 2006, 21% of those aged 11–15 who had drunk alcohol in the previous week consumed an average 11.4 units – up from 5.3 units in 1990. Drinking prevalence increased with age: 3% of pupils aged 11 had drunk alcohol in the previous week compared with 41% of those aged 15 (The Information Centre for Health and Social Care 2007 cited in NICE PH7, 2007).).
Older adults	Overall decline in drinking on over 50's except: • Affluent RR 1.09 • Highly	A US study on drinking behaviour after the age of 50 suggested that overall, alcohol consumption declined. However, rates of decline differed appreciably among sample persons, and for a minority, alcohol consumption increased. Persons with increasing consumption over time were more likely to be affluent (relative-risk ratio [RRR] = 1.09, 95% CI [1.05, 1.12]), highly educated (RRR = 1.20, 95% CI [1.09, 1.31]), White (RRR = 3.54, 95% CI [1.01,

[76] Including those with protected characteristics

Group	Relative risk	Evidence review
	educated RR1.20 • White RR 3.54	12.39]), unmarried, less religious, and in excellent to good health. A history of problem drinking before baseline was associated with increases in alcohol use, whereas the reverse was true for persons with histories of few or no drinking problems. (Platt et al, 2010, USA) The proportion of older people drinking above the government's recommended levels has recently been increasing in the UK. The proportion of men aged 65 to 74 years who drank more than four units per day in the past week increased from 18 to 30% between 1998 and 2008 In women of the same age, the increase in drinking more than three units per day was from 6 to 14%.(Fuller *et al.*, 2009 cited in NICE CG115, 2011). In a study in the Netherlands on the association of health behaviours with retirement, the involuntarily retired had lower risk of decreased alcohol use (RR = 0.47, 95% CI: 0.29–0.73) (Henkens et al, 2008, Netherlands)
Early age binge drinking	Hazardous or harmful binge drinking most common in under 25 years	The 2004 Alcohol Harm Reduction Strategy for England identified that hazardous or harmful binge drinking is most common in young adults under the age of 25 years
Students	Drinking more prevalent in apprentices who perceived this was the norm in their peer group.	In a study in Germany on associations of normative misconceptions and drinking behaviours, alcohol use disorders were more prevalent in male apprentices who overestimated drinking quantity in their reference group than in those who correctly estimated or underestimated drinking quantity in their reference group; however, this difference was not found in female apprentices. The direction of the gender differences observed in this study is reversed in comparison with previous research, which has found women to have a higher (Borsari and Carey, 2003) or a similar degree of misperceptions (McAlaney and McMahon, 2007) compared with men. The results of this study suggest that social norm interventions might be promising to reduce problem drinking in apprentices. Particularly subgroups of apprentices with the strongest normative is perceptions might benefit from this intervention approach, in this study these are male apprentices with high alcohol consumption. The results also indicate increasing normative misperceptions in the

Group	Relative risk	Evidence review
		group of apprentices aged 21 years and older and increasing misperceptions concerning drinking quantity with increasing school education. (Haug et al, 2011, Germany) A US study suggests students may have a higher risk of heavy drinking associated with specific events or dates e.g. New Years Eve, Spring Break, Graduation, 21st birthday. (Neighbors et al, 2011, USA)
Ethnic groups	Ethnic minority groups lower prevalence of hazardous and harmful drinking compared with the white population (ratio of 1:1.7) but alcohol dependence equal in prevalence (ratio of 1:1.1). Under representation in access to treatment though.	Based on the UK Psychiatric Morbidity Survey, the ANARP study found that people from ethnic minority groups as a whole had a lower prevalence of hazardous and harmful drinking compared with the white population (ratio of 1:1.7) whereas alcohol dependence was approximately equal in prevalence (ratio of 1:1.1) (Drummond *et al.*, 2005). However this study was unable to compare different ethnic minority groups. Using the assumption that alcohol dependence is equal in prevalence the National Treatment Agency and Department of Health, 2010 suggest some under-representation in access to treatment. Studies in England have tended to find overrepresentation of Indian-, Scottish- and Irish-born people and under-representation in those of African Caribbean or Pakistani origin (Harrison & Luck, 1997 cited in NICE CG115, 2011).). This may partly be due to differences in prevalence rates of alcohol misuse, but differences in culturally-related beliefs and help-seeking as well as availability of interpreters or treatment personnel from appropriate ethnic minority groups may also account for some of these differences (Drummond, 2009 cited in NICE CG115, 2011).
Gender Male/Female/ transgender individuals	Males RR 2.4 for heavy drinking Males double the risk of alcohol attributable	In a US study estimating demographic influences on heavy drinking a higher probability of heavy drinking associated with male gender - RR 2.4 (CI 95%) (Karlamangla et al, 2005 USA) Men had more than double the risk of alcohol attributable deaths compared with women (Jones *et al.*, 2008 cited in

Group	Relative risk	Evidence review
	deaths But women 1.6 times more likely to access treatment	NICE CG115, 2011). The UK Alcohol Needs Assessment Research Project found that, taking account of the lower prevalence of alcohol dependence in women compared with men (ratio of 1:3), they were 1.6 times more likely to access treatment (Drummond *et al.*, 2005 cited in NICE CG115, 2011).). Women are also more likely to seek help for alcohol misuse than men in the US (Schuckit, 2009 cited in NICE CG115, 2011).).
Sexual orientation	Males classified as mostly heterosexual Hazard ratio HR 1.35 and bisexual HR 1.58; reported a younger age at first consuming a whole drink than did heterosexual males. Females, mostly heterosexual HR 1.62; bisexual HR, 2.02 and lesbian HR 1.66 more likely than heterosexuals to report a younger age at consuming their first whole drink.	In a US study comparing sexual orientation differences in alcohol use behaviours, youth who report same-sex attractions regardless of how they identify themselves, including youth describing them- selves as mostly heterosexual, may be at high risk for alcohol use at relatively young ages. Males and females reporting a minority sexual orientation indicated a younger age at first consuming a whole alcoholic drink than their same gender heterosexual counterparts. After controlling for covariates, males classified as mostly heterosexual (hazard ratio [HR], 1.35; 95% confidence interval [CI], 1.09-1.56) and bisexual (HR, 1.58; 95% CI, 1.09-2.30) reported a younger age at first consuming a whole drink than did heterosexual males. Gay males also reported a younger age at first whole drink consumption than did heterosexual males, but findings were not statistically significant (HR, 1.21; 95% CI, 0.96-1.54). Among females, mostly heterosexual (HR, 1.62; 95% CI, 1.49-1.77), bisexual (HR, 2.02; 95% CI, 1.72-2.38), and lesbian (HR,1.66; 95% CI, 1.14-2.43) participants were more likely than heterosexuals to report a younger age at consuming their first whole drink. (Corliss et al, 2008, USA)
Individuals with Mental Health Conditions	RR 5.46 higher risk of alcohol dependence in	In an Australian study, participants with affective disorders (depression, dysthymia, bipolar affective disorder); (relative risk (RR) = 5.46, 95% CI 4.08–7.31 for alcohol

Group	Relative risk	Evidence review
	people with affective disorders for alcohol dependence within 5 years of onset and RR 2.77 after first 5 years. RR 3.33 in people with anxiety disorders for alcohol dependence within first 5 years of onset; RR = 3.56, after first 5 years	dependence within 5 years of onset; RR = 2.77, 95% CI 1.93–3.99 after first 5 years and anxiety disorders (agoraphobia, social phobia, panic disorder, generalised anxiety disorder, obsessive– compulsive disorder, post-traumatic stress disorder) (RR = 3.33, 95% CI 2.37–4.68 for alcohol dependence within first 5 years of onset; RR = 3.56, 95% CI 2.72–4.64 after first 5 years) were at higher risk of alcohol misuse and alcohol dependence. (Liang and Chikritzhs, 2011, Australia) People with antisocial personality disorder ASPD have a higher risk of severe alcohol dependence (Goldstein *et al.*, 2007 cited in NICE CG115, 2011).
Attention Deficit and Hyperactivity disorder (ADHD)	Young people with ADHD at highest risk of developing substance misuse disorders Adults with ADHD at higher risk of developing substance-use disorders at an earlier age.	There is a strong association between conduct disorder and substance-use disorders and this is considered to be reciprocal, with each exacerbating the expression of the other. Conduct disorder usually precedes or coincides with the onset of substance-use disorders, with conduct disorder severity found to predict substance-use severity. Significantly higher rates of attention deficit hyperactivity disorder (ADHD) have been reported in young people with substance-use disorders; data from untreated adults with ADHD indicate a higher risk of developing substance-use disorders and at an earlier age compared with treated controls as well as a more prolonged course of substance-use disorders. However, those young people with ADHD and co-occurring conduct or bipolar disorders are at highest risk of development of substance-use disorders. (NICE CG115, 2011).
Individuals with long term conditions	HR 2.3 of alcohol abuse in people having gastric bypass surgery	In a Swedish study after gastric bypass surgery there was a 2-fold increased risk of inpatient care for alcohol abuse among patients who had GBS compared with those who had restrictive surgery (hazard ratio, 2.3; 95% CI, 1.7-3.2).

Group	Relative risk	Evidence review
	compared to restrictive surgery Diagnosis of diabetes in over 50's decreases probability increased drinking by 65% (RRR = 0.35)	(Ostlund et al, 2013, Sweden) In a study on drinking behaviour after 50 years old found that being diagnosed with diabetes decreases the relative probability of being an increasing drinker by 65% (RRR = 0.35, 95% CI [0.16, 0.79]) (Platt et al, 2010, USA)
Single parents		No evidence found on this search.
Children with parental/relative alcohol misuse	Offspring of parents with alcohol dependence are four times more likely to develop alcohol dependence	NICE say that it is well established that alcohol dependence runs in families. In general, offspring of parents with alcohol dependence are four times more likely to develop alcohol dependence (NICE CG115, 2011). Parental substance misuse causes serious harm to children at every age from conception to adulthood'(Advisory Council on the Misuse of Drugs. Hidden Harm. London: Home Office; 2003 cited in NICE CG110, 2010).
Migration – asylum seekers and refugees		No evidence found on this search.
Individuals having suffered a traumatic event		No evidence found on this search.
History of abuse	54% of female and 24% of male alcohol dependents were victims of sexual abuse, mostly before the age of 16 years	One UK study found 54% of female and 24% of male alcohol dependent patients identified themselves as victims of sexual abuse, mostly before the age of 16 years (Moncrieff *et al.*, 1996, cited in NICE CG115, 2011). Further, they were more likely to have a family history of alcohol misuse, and began drinking and developed alcohol dependence earlier than those without such a history

Group	Relative risk	Evidence review
	Women using more than one illicit drug more likely to report frequent drinking 33%, RR 12.73 binge drinking 39%, RR 5.7 and drinking during pregnancy 37%, RR 2.10	A US study suggested that women who reported using more than one illicit drug were more likely to report frequent drinking (33%, relative risk [RR] 12.73, 95% confidence interval [CI] 7.9-20.4, binge drinking (39%, RR 5.7, 95% CI 4.9-7.6), and drinking during pregnancy (37%, RR 2.10, 95% CI 1.75-2.53) compared with nonusers (3%, 7%, 17%, respectively, *p* _ 0.0001). (Sharpe & Velasque, 2008. USA)
Ex-military/veterans	Strong association between combat exposure and alcohol consumption	In a US study of the relationship of combat experiences to alcohol misuse among U.S. soldiers returning from the Iraq war combat exposure has been strongly associated with alcohol consumption (Wilk et al 2010 cited in Taylor et al systematic review 2012)
Employees in retail of alcohol (those working in pubs and bars)		No evidence found on this search.
Social Exclusion &/or marginalisation		No evidence found on this search although other categories in this table may contribute to a sense of social exclusion and/or marginalisation.
Marital status	RR 1.4 of heavy drinking associated with not being married	Higher probability of heavy drinking associated with not being married – RR 1.4 (95% CI) (Karlamangla et al, 2005 USA)
Relationship problems	RR 1.6 of heavy alcohol consumption for people becoming unmarried RR 1.4-1.7 for	People becoming unmarried suggested to be at higher risk of heavy alcohol consumption RR 1.6 (CI 95%) (Karlamangla et al, 2005 USA) Living alone, being divorced/ widowed and being unemployed (relative risk ratios=1.4-1.7) associated with

Group	Relative risk	Evidence review
	people living alone, divorced/ widowed	increased use of alcohol by men (Schnuerer et al 2013)
Low self esteem		No evidence found on this search although other categories in this table may contribute to low self esteem.
Homeless people, rough sleepers	38-50% prevalence of alcohol use disorders in UK homeless population	No recent studies were found on this but NICE CG115 sites 2 older studies which found a high prevalence of alcohol misuse amongst people who are homeless. The prevalence of alcohol use disorders in this population has been reported to be between 38 and 50% in the UK (Gill *et al.*, 1996; Harrison & Luck, 1997, cited in NICE CG115, 2011))
Unemployed population	RR 1.5 heavy drinking associated with having annual income below the median. RR 1.4-1.7 for people living alone, divorced/ widowed	Higher probability of heavy drinking associated with having annual income below the median – RR 1.5 (95% CI) (Karlamangla et al, 2005 USA) Living alone, being divorced/ widowed and being unemployed (relative risk ratios=1.4-1.7) associated with increased use of alcohol by men (Schnuerer et al 2013)
Highly qualified individuals in low end jobs		No evidence found on this search.
Drinking too much on a regular basis		No evidence found on this search.
Debt/Financial problems		No evidence found on this search.
Education	RR 1.5 of heavy drinking associated with having less than a high school education	Higher probability of heavy drinking associated with having less than a high school education – RR 1.5 (95% CI) (Karlamangla et al, 2005 USA)
Socioeconomic	In most	Children who experience socioeconomic disadvantage are

Group	Relative risk	Evidence review
factors	deprived 1/5 if the UK are: 2-3 times more likely to die of alcohol-related causes, 2-5 times more likely to die of alcohol specific cause, 2-5 times more likely to be admitted to hospital with alcohol-use disorder. --- Sex-adjusted RR ¼ 2.11 of being alcohol- or drug-dependent by age 32 for children belonging	at high risk of suffering from tobacco, alcohol, or drug dependence and of having an unfavourable cardiovascular risk profile by the time they reach young adulthood. By age 32 years, children who belonged to a low socioeconomic status group were at higher risk than those who belonged to a high-SES group of being alcohol- or drug-dependent (sex-adjusted RR ¼ 2.11, 95% CI: 1.16, 3.84) (Melchior et al, 2007, New Zealand) --- Compared with those living in more affluent areas, people in the most deprived fifth of the country are: • two to three times more likely to die of causes influenced, in part, by alcohol • three to five times more likely to die of an alcohol-specific cause • two to five times more likely to be admitted to hospital because of an alcohol-use disorder (North West Public Health Observatory 2007, UK).

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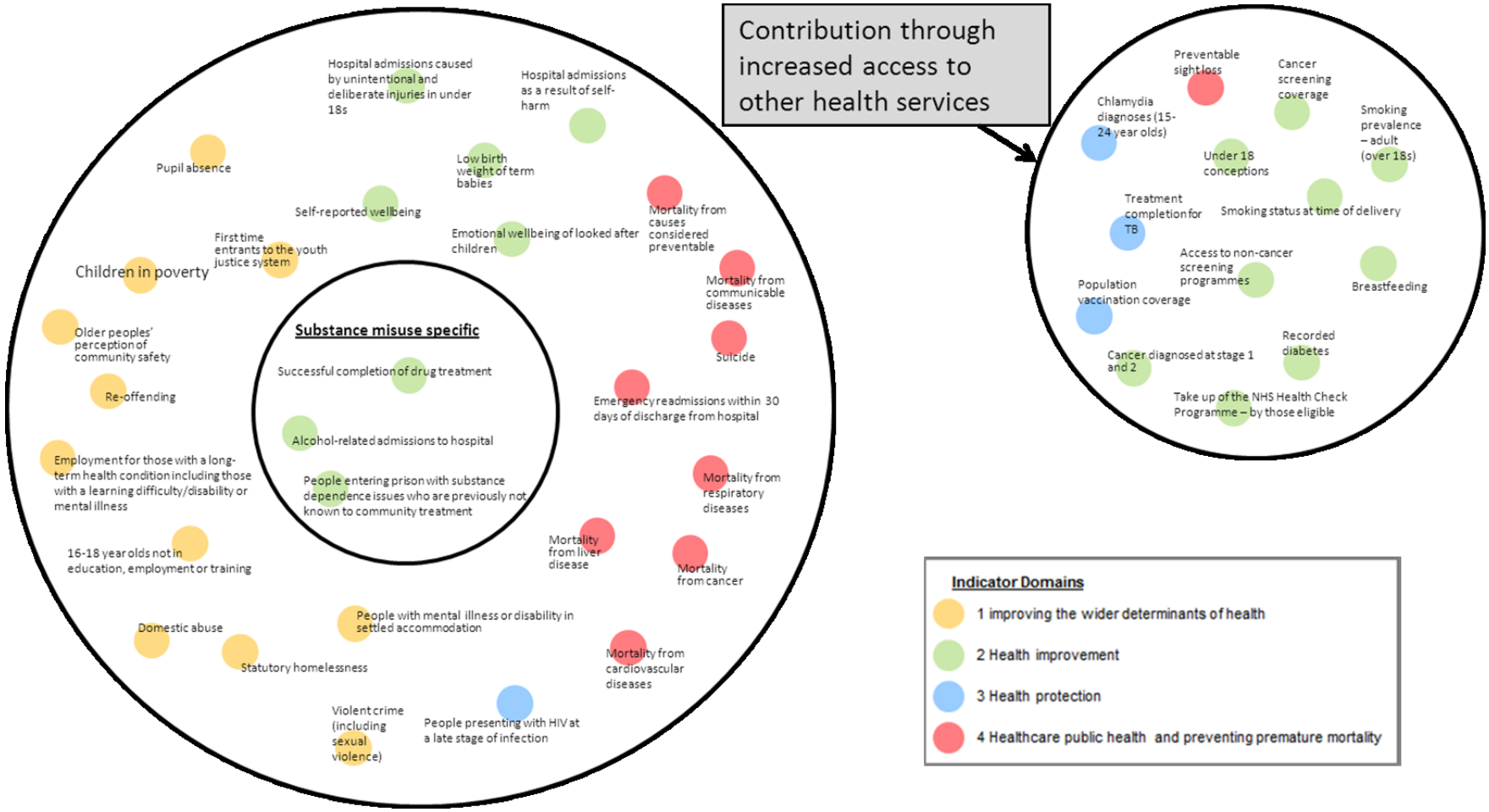
Appendix 4: How addressing alcohol harm and substance misuse can contribute to PHOF outcomes



Source: Public Health England /National Treatment agency