Contents

4 Alcohol

4.1 Introduction

Alcohol is an accepted part of many cultures as a means of relaxation and celebration and can have a positive impact on social and community life. The alcohol industry provides employment through production, retail and the night-time economy. However, as a widely available intoxicant and potentially addictive substance, it lends itself to misuse and has associated health risks.

This section will focus on alcohol consumption at increasing risk level, including binge drinking (see definitions in Box 1). High risk and dependent drinking are covered in the 'Mental health and substance misuse' JSNA chapter.

Current guidance from the government's Chief Medical Officer (CMO) on safe and risky levels of alcohol consumption are summarised in Box 2. These revised guidelines suggest that there is no safe level of alcohol consumption.

Box 1: Definitions used in this section[1]

There are two key sources which measure drinking levels: Local Alcohol Profiles England (LAPE) and Alcohol Use Disorders Identification Test Consumption (AUDIT-C).

Please note: both sources use classifications based on the *previous* CMO alcohol guidelines (and not those in Box 2) and will, therefore, underestimate the number the number and proportion of people drinking at increasing (and high) risk levels.

LAPE provides estimates on drinking behaviours in each local authority, based on data from a national survey. [1] LAPE distinguishes between 'increasing' and 'high' risk, and provides an estimate of binge drinking. Category definitions are being revised in light of new guidance.

Risk levels by alcohol units consumed on a regular basis	Lower Risk	Increasing Risk	Higher Risk	Binge
Men	3-4 units/day or 21/week	4-8 units/day or 21-50/week	> 8 units/day or 50/week	>8 units
Women	2-3 units/day or 14/week	3-6 units/day or 22-35/week	> 6 units / day or 35/week	>6 units

AUDIT-C calculates levels of risk differently, and groups together 'increasing' and 'high' risk into 'higher' risk drinkers. Scores from the three questions are summed to give a total score between 0 and 12 - a score of five or more indicates increasing or higher risk drinking. The final question also provides implied estimates of binge drinking.

AUDIT-C is a validated tool that is used to screen for alcohol-related problems. It is quick and easy to use as part of a questionnaire and is widely used in primary care across the UK and many other countries. A range of studies have confirmed the validity and efficiency of AUDIT (a longer version of the tool) and AUDIT-C in the identification of harmful use, abuse, and dependence on alcohol. [2]

	Score				
	0	1	2	3	4
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week
How many units of alcohol do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily/ almost daily

Box 2: Current CMO guidelines on alcohol consumption [3] [4]

In January 2016, the CMO published revised guidelines in relation to alcohol risk.

The new guidelines state that:

- lower-risk drinking is now defined as less than 14 units a week for both men and women, spread over at least 3 days a week
- there is no safe level of consumption.
- a good way to cut down on alcohol is to have several drink-free days each week.

The CMO is presently consulting on risk levels, but the previous definition implies that the revised 'increasing risk' level would be 15–35 units per week for men and women.

It is worth noting that people tend to under-report the amount of alcohol they consume, so measures reliant on self-reporting (as described in this section) are likely to underestimate population levels of drinking. Heavy drinking and non-routine drinking patterns, in particular, may be associated with greater under-reporting, and so estimates of drinking above recommended levels are likely to be disproportionately under-estimated. [5]

With these caveats in mind, trends since 2005 show that there has been an overall decline in drinking frequency in the UK, which has been most marked for men and women up to age 44. [6]

Increasing risk and binge drinking is a public health issue for a variety of reasons. A recent report identified alcohol to be the third leading risk factor for death and disability after smoking and obesity. [7] [8] Alcohol has been identified as a causal factor in more than 60 medical conditions, including: [7]

- mouth, throat, stomach, liver and breast cancers
- pancreatitis
- heart disease & stroke
- liver disease.

Alcohol misuse is also strongly linked to mental health problems, including depression and serious mental illness (for more detail see 'Mental health and substance misuse' JSNA chapter). The national confidential inquiry into suicide and homicide by people with mental illness found that there was a history of alcohol misuse in almost half (45%) of suicides in this group during the period 2002 to 2011. [9]

There are specific risks for young people in terms of alcohol consumption. Alcohol consumption during any stage of childhood can be harmful for child development, and heavy drinking in young people carries risks in relation to liver, bone, growth and endocrine development.[2] Alcohol use during the teenage years, and especially

[1] For more information, see https://www.alcohollearningcentre.org.uk/

[2] The glands of the endocrine system and the hormones they release are instrumental in regulating mood, growth and development, tissue function, and metabolism, as well as sexual function and reproductive processes

before age 14, is related to a wide range of health and social problems, including alcohol-related injuries, involvement in crime, and suicidal thoughts and attempts (or suicide 'ideation'). Drinking at an early age is also associated with having more sexual partners, unwanted pregnancy, using drugs, not being in education, employment or training, and other risky behaviours. [10] [11]

Alcohol misuse also places particular pressure on health services. For example, in 2013/14, there were over a million hospital admissions for alcohol-related ill-health in the UK, an increase of 64% since 2005. [12] In addition, an estimated 35% of accident and emergency (A&E) attendances are alcohol-related (rising to 70% at weekend peak-times), and 22-35% of GP visits are alcohol-related. [12]

Drinking alcohol during pregnancy can also have a medical impact on the unborn child. The effects include a greater risk of miscarriage, low birthweight and premature birth. Drinking heavily throughout pregnancy can cause foetal alcohol syndrome (FAS), which is associated with poor foetal growth, facial abnormalities and learning and behavioural difficulties. [13]

Finally, alcohol is a significant factor in violent crime, with almost half (47%) of victims perceiving their attacker to be under the influence of alcohol. More violent crimes are recorded between 9pm and 3am on Fridays and Saturdays than at other times in the week. [14] Please see 'Society and environment' JSNA chapter for further discussion of the health impacts of crime.

4.2 Causes and risk factors

In cultural terms, characterisations of the British drinking culture as one of excess are too simplistic. Frequent but moderate drinking is more common than is often acknowledged in policy debate. However, increasing risk drinking behaviours are found across a range of settings and contexts, including home drinking among older couples, and social gatherings of family and friends. [15]

Increasing risk drinking is more common in people aged 26-64, men, those in employment (especially managerial/professional occupations) and those on higher incomes. [6] [16] Binge drinking is more common in males, and also in younger adults (aged 16-44) - although recent trends suggest that binge drinking in younger adults may be declining. [17] [6]

Older age is a growing risk factor for alcohol-related harm. For example, the only group which has shown an increase in drinking frequency in recent years is women over the age of 65; and people aged 45-64 on average drink more regularly than younger groups aged under 45. [6]

Evidence has also shown that lesbian and bisexual women aged 20–34 years reported higher weekly alcohol consumption and less abstinence compared with heterosexual women. [18] Among young gay and bisexual men, no differences are identified in alcohol-related behaviours in comparison with heterosexual young men. [18]

Cultural and religious practices may play a role in alcohol consumption among different ethnic groups, with many people from Asian or Chinese backgrounds more likely to report that they are abstinent. [19] There can also be a genetic element in drinking patterns, as around 36% of those from north east Asian backgrounds are likely to have less of the enzyme alcohol dehydrogenase so may metabolise alcohol more slowly. [20]

Section 4.4 describes local socio-demographic differences in drinking behaviours in more detail.

Causal factors in relation to the drinking patterns of children and young people are complex, but parental attitudes to alcohol can affect the age at which children and young people start drinking, as well as the pattern of their alcohol use. Weak parental bonds, and both permissive and over-protective approaches to alcohol, may lead to higher levels of misuse by children. [21] In addition, peer influence has been linked to drinking behaviour in young adults. [22] Evidence also suggests that alcohol marketing exposure has a long term effect on adolescents drinking behaviours. [23]

4.3 Local data and unmet need

Two main sources of data are used in this section to describe local patterns of alcohol consumption – LAPE modelled estimates and results from the 2015 Hackney resident health and wellbeing survey (involving a sample size of 1,009 residents age 16+), which included a set of questions based on the AUDIT-C tool. [24] [25]

As mentioned in Box 1, LAPE uses number of units only and distinguishes between ‘increasing’ and ‘high’ risk, while AUDIT-C groups these categories together into ‘high risk’ and uses other information as well as number of units.

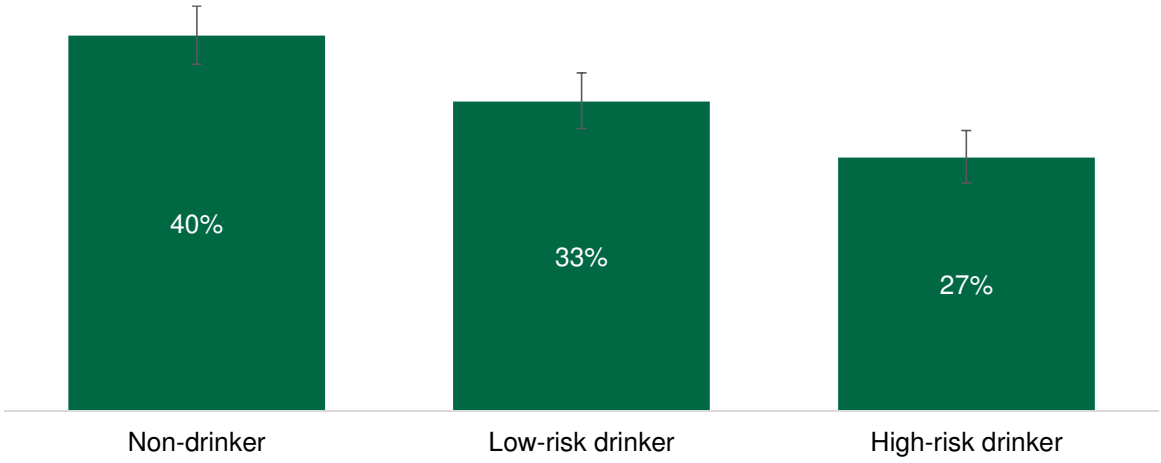
When reviewing the data presented in this section it is important to note, as highlighted in the introduction (Box 1), that both the LAPE and AUDIT-C data are likely to underestimate the number and proportion of people drinking at increasing (and high) risk levels based on the latest guidelines.

4.3.1 Local data on drinking patterns

Based on the results of the Hackney resident health and wellbeing survey, 40% of Hackney residents say they do not drink, a third (33%) of residents are estimated to be low risk drinkers and a quarter (27%) to be high risk drinkers (Figure 1). [25] All results are statistically significant.

As described in Box 1, AUDIT-C defines ‘high’ risk as a score of 5 and above. The modal (i.e. most common) AUDIT-C score in the survey was 3-4. Among high risk drinkers (i.e. with a score of 5 or above), most people reported drinking towards the lower end of this threshold – a score of 5, 6 or 7.

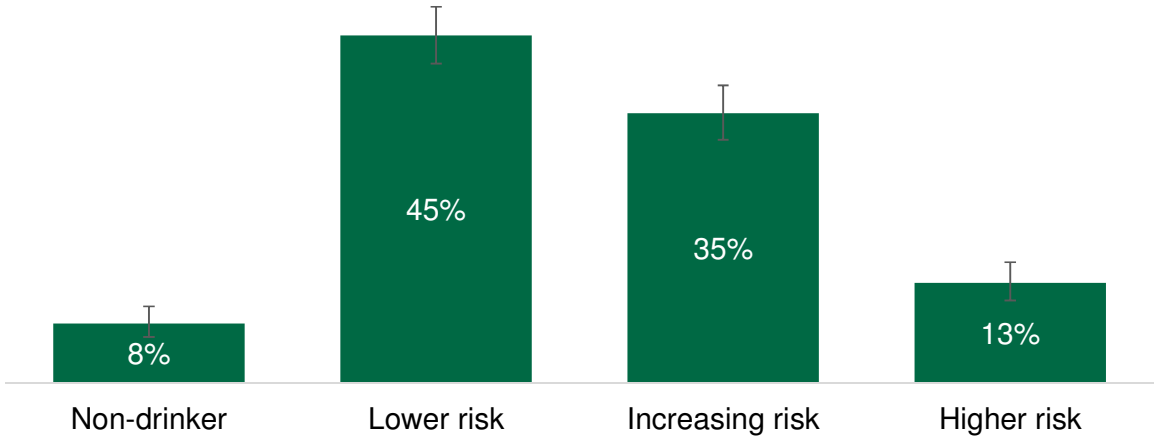
Figure 1: Reported drinking behaviour of adult Hackney residents based on AUDIT-C score (age 16+, 2015)



Source: Hackney resident health and wellbeing survey (2015)
Notes: Based on a sub-sample size of 960

Local data from the City of London is based on a survey carried out in 2011 among people who work, visit, study and live in the City of London (involving a sample size of 712). [26] It is therefore based on a very different sample to the Hackney survey and cannot be said to be representative of all City residents. This 'City drinkers' survey used full AUDIT scores (derived from a longer version of the AUDIT-C tool), which gives an estimate of the proportion of lower risk, increasing risk and higher risk drinkers. Results from this survey presented in Figure 2 show that over a third (35%) of respondents in the City of London reported levels of drinking at increasing risk and 13% at higher risk.

Figure 2: Reported drinking behaviour of City of London survey respondents based on AUDIT score (2012)

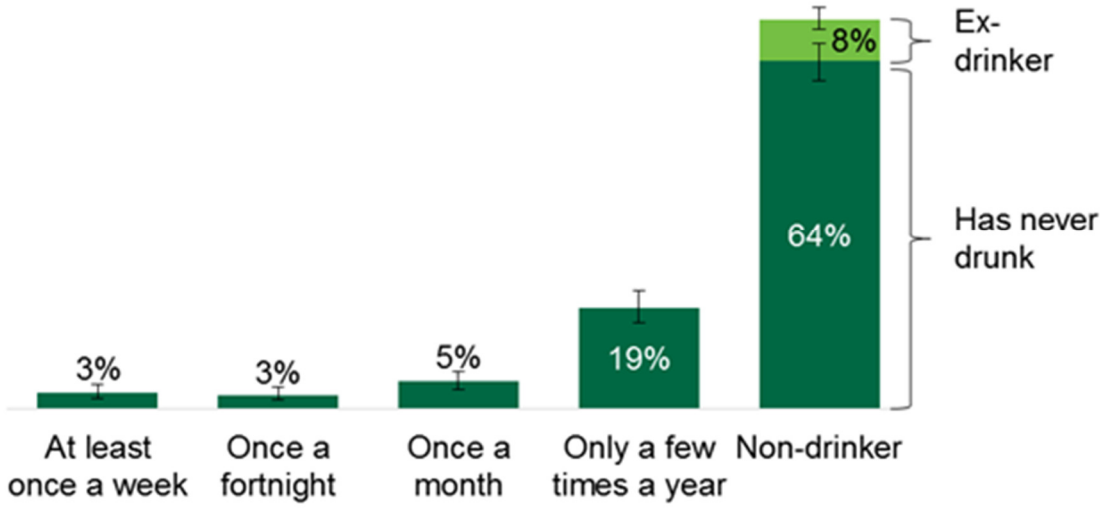


Source: City Drinkers Insight Summary Report (2012).
Notes: Sample includes people who work, visit study and reside in the City of London. It is not designed to be representative of the City resident population.

Data are also available specifically on the drinking behaviours of local young people (age 15), from the national What About YOUth (WAY) survey. As shown in Figure 3, the majority (71%) of young people aged 15 responding to this survey in Hackney

and the City of London (combined) report that they do not drink and 19% say they drink only a few times a year.

Figure 3: Reported drinking behaviour in 15 year olds in the City of London and Hackney (2014/15)



Source: What About YOUth (WAY) survey (2014/15).
Notes: Numbers may not sum to total due to rounding.

4.3.2 National estimates of drinking behaviour

In addition to local data collected via surveys, estimates of drinking behaviour in resident adults (age 16+) are available via the LAPE resource, which enables comparisons to be made between different areas (see Section 4.5). [24] This includes specific estimates of 'increasing risk' drinkers. As noted previously, this source uses a different definition to identify these 'increasing risk' drinkers (see Box 1) and so direct comparisons are not possible.

Figure 4 presents estimates of drinking behaviour among residents age 16+ in the City of London and Hackney. These data suggest that 22% of City of London adult residents and 14% of Hackney adult residents are increasing risk drinkers; and 7-8% are higher risk drinkers. These proportions equate to approximately 1,600 City of London and 23,000 Hackney adult residents drinking at increasing risk levels, and around 12,000 (Hackney) and almost 600 (City) drinking at higher risk levels (see Table 1). However, the wide confidence intervals suggest that there is significant statistical uncertainty around some of these estimates.

Figure 4: LAPE estimates of drinking behaviour in the local adult resident population of Hackney and the City (age 16+, 2011)

Source: Local Alcohol Profiles England (LAPE) (2011)

Table 1: Estimated number of adult resident drinkers in Hackney and the City, by behaviour group (age 16+, 2011)

	Abstain	Lower risk	Increasing risk	Higher risk
City of London	1,400	3,661	1,622	574
Hackney	53,979	74,618	23,054	11,680

Source: Local Alcohol Profiles England (LAPE) (2011)

LAPE also provide estimates of binge drinking. Figure 5 shows that an estimated 13% of Hackney adult residents binge drink, which is significantly lower than the estimated 25% of City of London adult residents.

Figure 5: Estimated proportion of adult resident population of Hackney and the City who binge drink (age 16+, 2013)

Source: Local Alcohol Profiles England (LAPE) (2013). Modelled estimates based on Health Survey for England (2007-08).
Notes: Binge drinking in adults is defined separately for men and women. Men are defined as having indulged in binge drinking if they had consumed 8 or more units of alcohol on the heaviest drinking day in the previous seven days; for women the cut-off was 6 or more units of alcohol.

4.3.3 Alcohol-related ambulance call-outs and hospital admissions

Immediate consequences of higher risk drinking include accidents and anti-social behaviour. Table 2 shows the number (and rates where available) of alcohol-related ambulance attendances and hospital admissions in Hackney and the City of London. Please note that the population on which these data are based differs across the indicators:

- ambulance attendances and attendances for alcohol-related assault include residents and non-residents attending Homerton hospital
- alcohol-related hospital admissions cover admissions of Hackney or City of London residents only.

Table 2: Number (and rates) of alcohol-related ambulance attendances and hospital admissions in Hackney and the City

Ambulance attendances and hospital admissions	City	Hackney
Alcohol-related ambulance attendances (2014/15)	960	2,416
Alcohol-related hospital admissions for under 18s (2012-15)	32 (18 per 100,000)	
Alcohol-related unintentional injuries admissions (2014/15)	5 (89 per 100,000)	310 (157 per 100,000)
Alcohol-related mental and behavioural disorder admissions (2014/15)	n/a	260 (124 per 100,000)
Homerton hospital A&E attendances for alcohol-related assault (2014/15)	210	

Source: London Ambulance Service, SafeStats (2016); Local Alcohol Profiles England (LAPE), Hospital Episode Statistics (HES); Homerton hospital accident and emergency (A&E) (2016). Data represents all ages unless otherwise specified.
Notes: Alcohol-related incidents are defined where an alcohol-related illness is recorded or where a reference to alcohol has been found in a search of the various free-text fields recorded by the ambulance service.
Hospital admissions for unintentional injuries includes admissions to hospital where the secondary diagnoses is an alcohol-attributable unintentional injuries code. Children aged less than 16 years were only included for alcohol-specific conditions and for low birth weight. For other conditions, alcohol-attributable fractions were not available for children. Directly age standardised rate per 100,000 population European standard population.
Hospital admissions for mental and behavioural disorders includes admissions to hospital where the primary diagnosis is an alcohol-attributable mental and behavioural disorders due to use of alcohol code. Children aged less than 16 years were only included for alcohol-specific conditions and for low birth weight. For other conditions, alcohol-attributable fractions were not available for children. Directly age standardised rate per 100,000 population European standard population.

4.3.4 Unmet Need

As well as AUDIT-C, the Hackney resident health and wellbeing survey also asked a question about adult residents' perceptions of their drinking habits. Table 3 shows that, again, a large proportion say they do not drink in response to this question (38%), while one third perceive themselves to be 'sensible' drinkers (33%). However, there is a discrepancy between how Hackney residents perceive their own drinking behaviour and their corresponding AUDIT-C score.

Figure 6 compares perceived drinking behaviour to the AUDIT-C results derived from responses to this local survey. The data show that while just 14% of survey respondents perceived that they drink above safe limits, 27% were actually defined as higher risk drinkers according to the AUDIT-C scores.

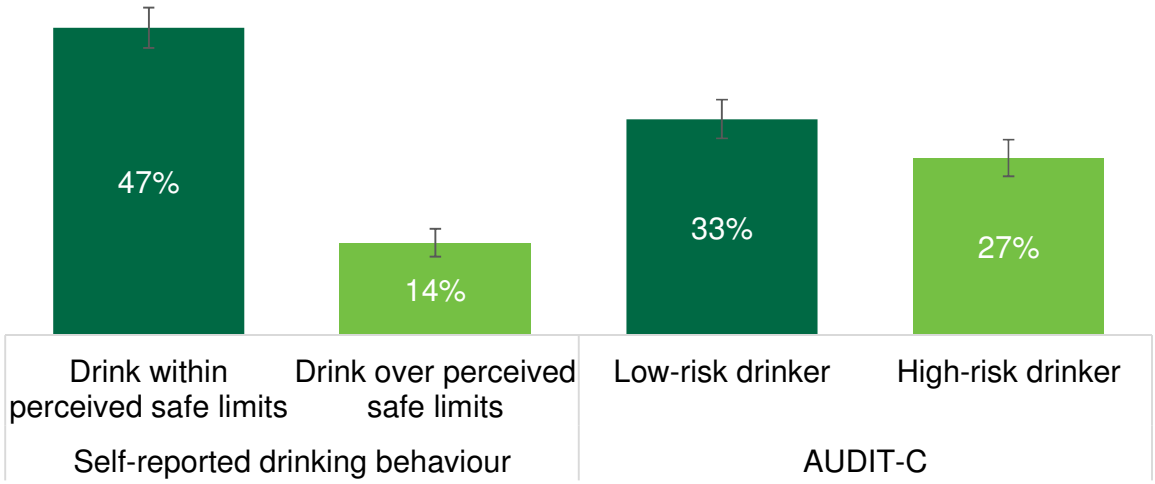
Almost all respondents (91%) who reported that they 'don't drink to excess' and two thirds (68%) of those who reported drinking 'more or less within the limits of what is good for me' were classified as high risk drinkers according to AUDIT-C.

Table 3: Perceptions of drinking behaviour among Hackney adult residents (age 16+, 2015)

Which of the following statements best describes your drinking habits?	
I do not drink alcohol	38%
I am a sensible drinker and drink well within the accepted safe limits	33%
I drink more or less within the limits of what is good for me	13%
I don't drink to excess, but I probably drink a little more than is really good for me	11%
I frequently drink quite a bit more than what is supposed to be 'safe'	3%

Source: Hackney resident health and wellbeing survey (2015)

Figure 6: Perceptions of drinking behaviour among Hackney adult residents (age 16+, 2015)



Source: Hackney resident health and wellbeing survey (2015)
Notes: AUDIT-C based on a sub-sample size of 960

Data on the drinking behaviour of adults living locally are also available via GP records. However, only half (52%) of GP patients age 15+ in Hackney and the City have an AUDIT-C score recorded. Of these, a lower proportion are identified to be 'high risk' drinkers (19%) than in the Hackney resident health and wellbeing survey (27%). While it is not possible to directly compare these results, based as they are on different population groups who responded to AUDIT-C questions in very different settings, this may suggest potential unmet need in terms of identification of increasing risk drinkers locally.

4.4 Inequalities

Local data available through resident surveys show wide variation in drinking behaviours in different population groups. In many cases, comparable data are not available for the City of London, but where possible it has been included.

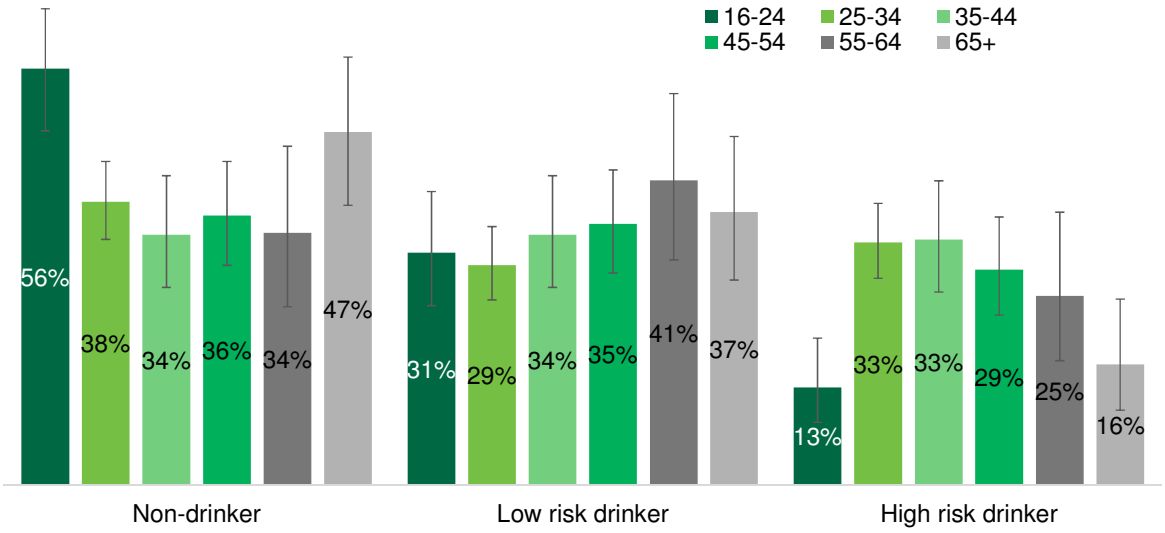
It is worth noting the very wide confidence intervals on some of the data presented, which is due to small subgroups within the overall survey samples. This means that, in some cases, it is not possible to draw firm conclusions about variation in the behaviours of different population groups locally.

4.4.1 Age

National evidence suggests that older people on average drink more regularly than younger people, although binge drinking is more common in younger age groups (see Section 4.2).

Locally, there are also marked differences in drinking patterns across age groups, according to responses to the Hackney resident health and wellbeing survey. As shown in Figure 7, those aged 25-34 are more likely to be drinking at high risk levels than younger adults or those aged 65 and above. Survey respondents aged 25-44 were also less likely to say they don't drink compared to younger adults. Table 4 reports self-perceptions of drinking behaviour by these same age groups.

Figure 7: Reported drinking behaviour of Hackney adult residents based on AUDIT-C score, by age (2015)



Source: Hackney resident health and wellbeing survey (2015)
Notes: Based on a sub-sample size of 960.

Table 4: Perceptions of drinking behaviour among Hackney adult residents, by age (2015)

Self-reported drinking behaviour	16-24	25-34	35-44	45-54	55-64	65+
Non-drinker	54%	36%	33%	34%	32%	44%
Drink within perceived safe limits	41%	46%	51%	48%	49%	45%
Drink over perceived safe limits	5%	17%	16%	16%	17%	11%

Source: Hackney resident health and wellbeing survey (2015)

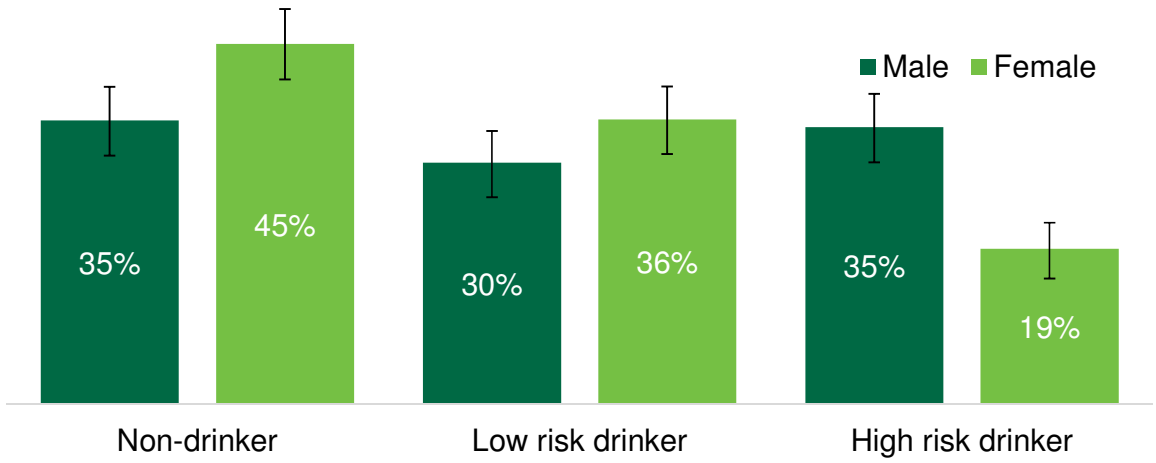
Nationally, fewer 15-16 year-olds drink now than previously, but those who do drink tend to start younger, drink more, and have more positive expectations of alcohol compared with their European or US peers. [27] Recent evidence has also shown a sharp rise in alcohol-related teenage poisoning in the UK over the last 20 years. [28]

4.4.2 Gender

As alluded to in Section 4.2, there are clear differences in drinking behaviours by gender. According to the Hackney resident health and wellbeing survey, men in Hackney are more likely to be high risk drinkers than women, based on calculated survey AUDIT-C scores (Figure 8). Men are also more likely to report that they drink over perceived safe levels (Table 5). Female drinkers were more likely to say they are non-drinkers on average.

Despite these gender differences in alcohol consumption patterns, self-reported awareness of the national recommendations for safe alcohol consumption is exactly the same for men and women in this survey (Table 6).

Figure 8: Reported drinking behaviour of Hackney adult residents based on AUDIT-C score, by gender (age 16+, 2015)



Source: Hackney resident health and wellbeing survey (2015)
Notes: Based on a sub-sample size of 960

Table 5: Perceptions of drinking behaviour among Hackney adult residents, by gender (age 16+, 2015)

Self-reported drinking behaviour	Men	Women
Non-drinker	34%	43%
Drink within perceived safe limits	47%	47%
Drink over perceived safe limits	19%	10%

Source: Hackney resident health and wellbeing survey (2015)

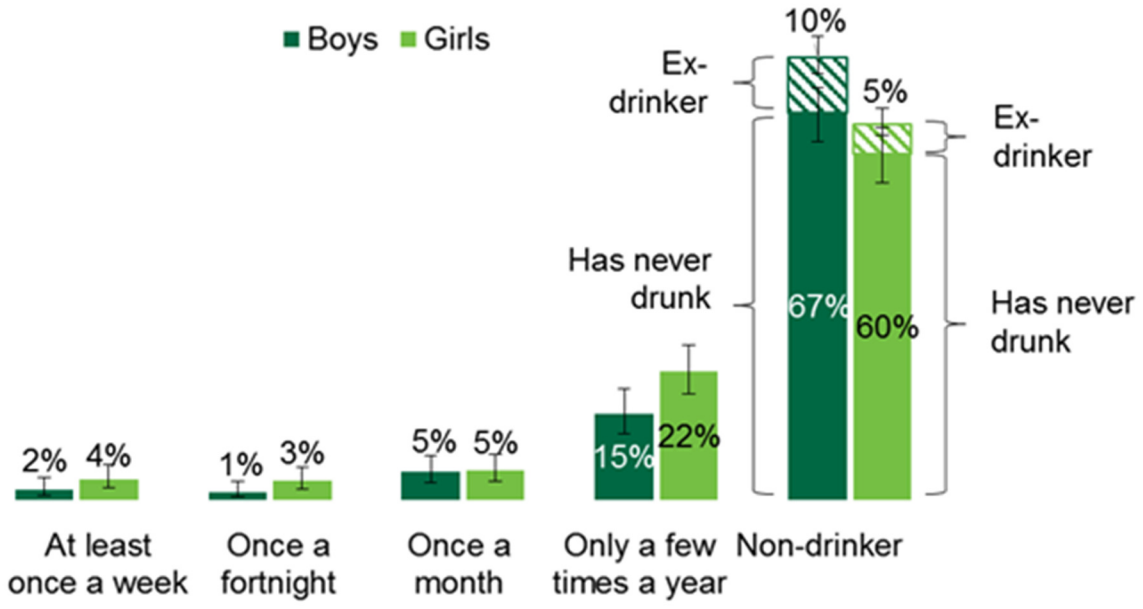
Table 6: Self-reported awareness of CMO alcohol guidelines among Hackney adult residents, by gender (age 16+, 2015)

Awareness of alcohol recommendations	Men	Women
Yes – aware	59%	59%
No – not aware	39%	39%
Don't know	2%	2%

Source: Hackney resident health and wellbeing survey (2015)
Notes: Based on a sample size of 416 male respondents and 593 female respondents.
Please note: at the time of the survey, the previous CMO guidelines were in place and responses related to knowledge of these prior recommendations.

According the WAY survey, patterns around gender and alcohol consumption are quite different for young people in Hackney and the City, as shown in Figure 9 below. Girls aged 15 are *less* likely than boys to say they are non-drinkers.

Figure 9: Reported drinking behaviour in 15 year olds in the City of London and Hackney, by gender (2014/15)

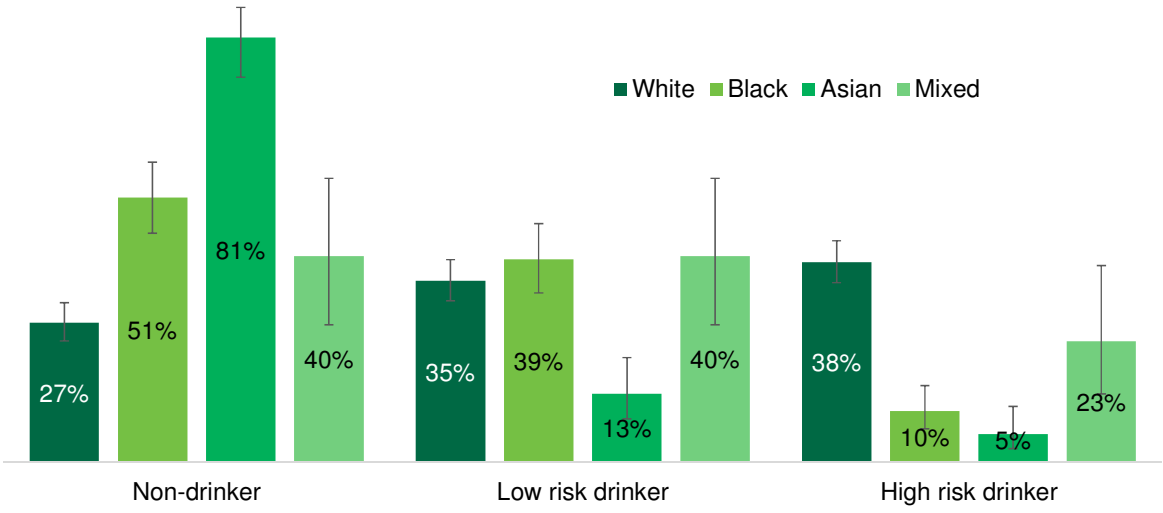


Source: What About YOUth (WAY) survey (2014/15)
Notes: Numbers may not sum to total due to rounding.

4.4.3 Ethnicity

Local survey data also show notable variation in drinking behaviour across different ethnic groups, as illustrated in Figure 10. In the Hackney resident health and wellbeing survey, high risk drinkers were most likely to be from White backgrounds, while non-drinking was particularly common among Asian and Black respondents compared to White respondents, which may reflect religious or cultural practices (as described in Section 4.2). Data are not available for more detailed analysis within each of these broad ethnic groups.

Figure 10: Reported drinking behaviour of Hackney adult residents based on AUDIT-C score, by broad ethnic group (age 16+, 2015)



Source: Hackney resident health and wellbeing survey (2015)
Notes: Based on a sub-sample size of 960

These patterns are also observed in perceptions of drinking behaviour, with residents from White backgrounds more likely than those from Black and Asian backgrounds to report that they drink over perceived safe limits (Table 7).

Correspondingly, national evidence shows that, in terms of drinking patterns by ethnic group for those who are underage, young people from White ethnic backgrounds are more likely to drink than those in other ethnic groups. [29]

Table 7: Perceptions of drinking behaviour among Hackney adult residents, by broad ethnic group (age 16+, 2015)

Self-reported drinking behaviour	White	Black	Asian	Mixed
Non-drinker	26%	47%	78%	35%
Drink within perceived safe limits	53%	47%	19%	54%
Drink over perceived safe limits	22%	5%	1%	10%

Source: Hackney resident health and wellbeing survey (2015)

4.4.4 Socio-economic disadvantage

Section 4.2 reported that people in professional jobs and on higher incomes are more likely to be drinking at 'increasing risk' levels. Data from the Hackney resident health and wellbeing survey are consistent with these findings, showing that high risk drinking (based on calculated AUDIT-C scores) is less common among adults living in the most deprived areas locally[3] – 19% in those living in the most deprived areas[4] compared with 27% overall.

National evidence suggests that, despite lower alcohol consumption levels compared with those living in more affluent areas, people living in the most deprived areas are: [30]

- 2–3 times more likely to die, in part, as a result of alcohol
- 3–5 times more likely to die of an alcohol-specific cause
- 2–5 times more likely to be admitted to hospital because of an alcohol-use disorder.

The reasons for these patterns are complex, but research shows that while people in lower socio-economic groups drink on fewer occasions, they consume more per occasion. This suggests that the greater alcohol-related mortality risk observed in lower socio-economic groups may, in part, be explained by higher levels of intoxication per occasion. [15]

Even at similar levels of alcohol consumption, deprived communities experience more alcohol-related harms than affluent areas. This 'alcohol harm paradox' has been variously attributed to higher alcohol-related worklessness in deprived communities, poorer resilience and healthcare provision, and a higher prevalence of binge drinking. Moreover, alcohol-related ill health is exacerbated by excessive drinking in combination with other harmful behaviours that are more prevalent in deprived communities – such as smoking, inactivity and poor diet. [31] There is also some evidence that the alcohol harm paradox seen among adults is also present for children and young people living in the most deprived communities. [29]

4.5 Comparisons with other areas & over time

Public Health England (PHE) produces the Local Alcohol Profiles for England[5] - a free, online tool that allows users to compare local and national figures on a number of different indicators. A selection of indicators are described throughout this section.

[3] Based on the 2015 Index of Multiple Deprivation. Lower Super Output Areas (LSOA) are areas where approximately 1500 residents live. Almost 90% of Hackney LSOAs are the 30% most deprived LSOAs in the country. The Index of Multiple Deprivation ranks and scores LSOAs on various measurements of deprivation. Hackney does not have any LSOAs in the 40% least deprived areas in the country. See London Borough of Hackney Deprivation Briefing for more detail of different measures of deprivation based on IMD2015 - http://hackney.gov.uk/Assets/Documents/Deprivation.pdf

[4] Residents living in the most deprived LSOAs according to national deprivation deciles.

[5] https://fingertips.phe.org.uk/profile/local-alcohol-profiles

4.5.1 Drinking patterns

The comparisons presented here are of drinking behaviour among adult residents (16+) living in different local authority areas, based on LAPE modelled estimates. These estimates are presented with a high degree of uncertainty as they are experimental data based on hospital admissions, population demographics, deaths related to alcohol and national survey data.

Please note: None of the differences between the local authority estimates presented in Table 8 are statistically significant and, therefore, they should be interpreted with caution.

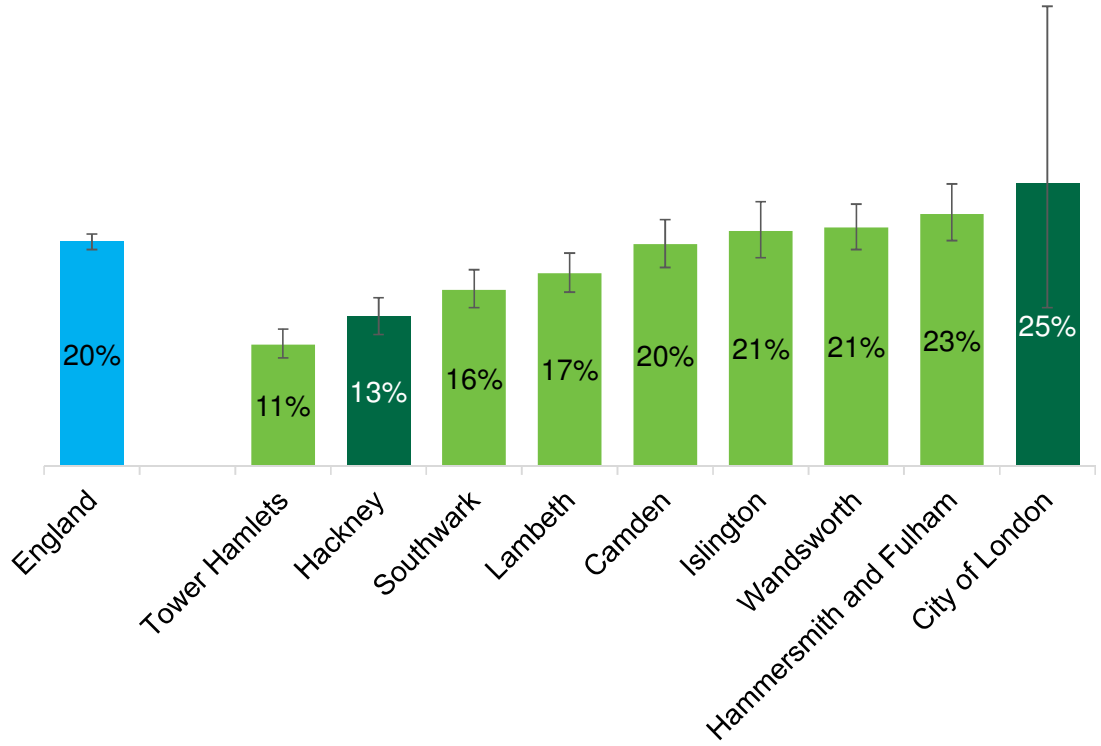
Hackney is estimated to have a lower proportion of adult residents who binge drink than England and most statistical peers (Figure 11). In the City of London, 25% of residents are estimated to binge drink, but there is significant statistical uncertainty around this estimate (as indicated by the wide confidence intervals shown).

Table 8: Local Alcohol Profiles England (LAPE) estimates of adult resident drinking behaviour (age 16+, 2011)

Estimates of drinking behaviour	Abstain	Lower Risk	Increasing Risk	Higher Risk
City of London	19%	50%	22%	8%
Hackney	33%	46%	14%	7%
Camden	25%	50%	17%	9%
Hammersmith and Fulham	21%	57%	14%	9%
Islington	25%	52%	18%	6%
Lambeth	22%	55%	17%	6%
Southwark	21%	54%	17%	9%
Tower Hamlets	34%	44%	13%	9%
Wandsworth	16%	53%	22%	9%
London	25%	52%	16%	8%

Source: Local Alcohol Profiles England (LAPE) (2011)

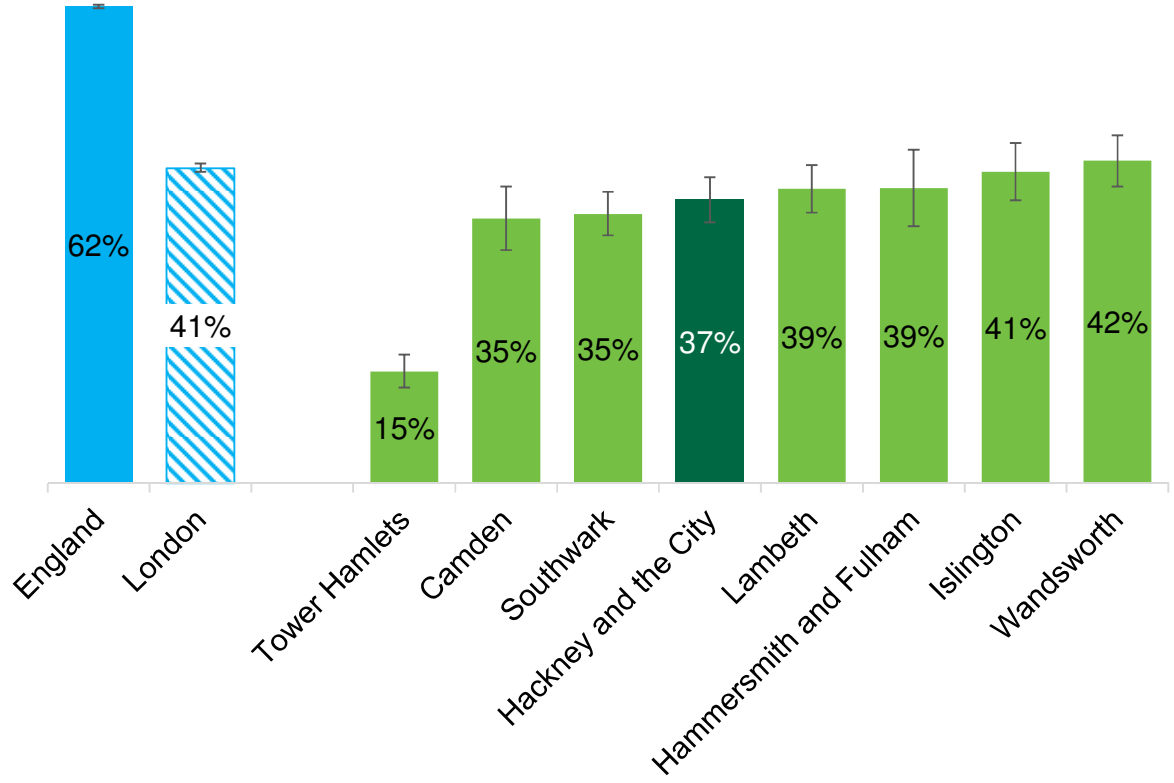
Figure 11: Estimates of the percentage of adult resident population who binge drink (age 16+, 2013)



Source: Local Alcohol Profiles England (LAPE) (2013). Modelled estimates based on Health Survey for England (2007-08).
Notes: Binge drinking in adults is defined separately for men and women. Men are defined as having indulged in binge drinking if they had consumed 8 or more units of alcohol on the heaviest drinking day in the previous seven days; for women the cut-off was 6 or more units of alcohol.

Figure 12 shows that the proportion of 15 year olds responding to the WAY survey in Hackney and the City who have ever had an alcoholic drink is similar to most of Hackney's statistical peers (apart from Tower Hamlets, where the figure is significantly lower) and lower than the London and England average.

Figure 12: Percentage of 15 year olds who report ever having had an alcoholic drink (2014/15)



Source: What About YOUth (WAY) survey (2014/15)

4.5.2 Alcohol-related A&E attendances and hospital admissions

This sub-section presents data on alcohol-related ambulance attendances and hospital admissions, which may be considered to be objective indicators of increasing levels of drinking in the local population.

Alcohol-specific conditions are those where alcohol is causally implicated in all cases; for example, alcohol-induced behavioural disorders and alcohol-related liver cirrhosis. *Alcohol-related* conditions include all alcohol-specific conditions, plus those where alcohol is causally implicated in some but not all cases of the outcome; for example, hypertensive diseases,[6] various cancers and falls.

Table 9 shows that alcohol-related ambulance attendances in Hackney and the City of London have remained steady since 2010-11.

Figure 13 shows that Hackney's rate of admissions for alcohol-related unintentional injuries has been consistently higher than the regional average in recent years. The rate of admissions for mental and behavioural disorders due to use of alcohol is also notably higher in Hackney than London (Figure 14).

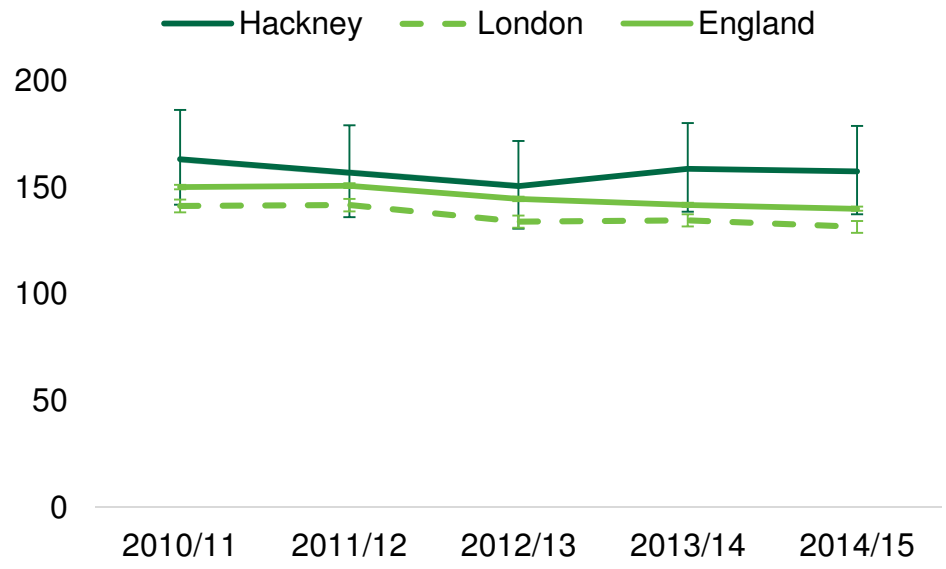
[6] A group of disorders that includes heart failure, ischemic heart disease, hypertensive heart disease, and left ventricular hypertrophy (excessive thickening of the heart muscle)

Table 9: Number of alcohol-related ambulance attendances in Hackney and the City of London

Financial Year	City of London	Hackney
2010-11	878	2,546
2011-12	866	2,432
2012-13	987	2,553
2013-14	1,032	2,769
2014/15	960	2,416

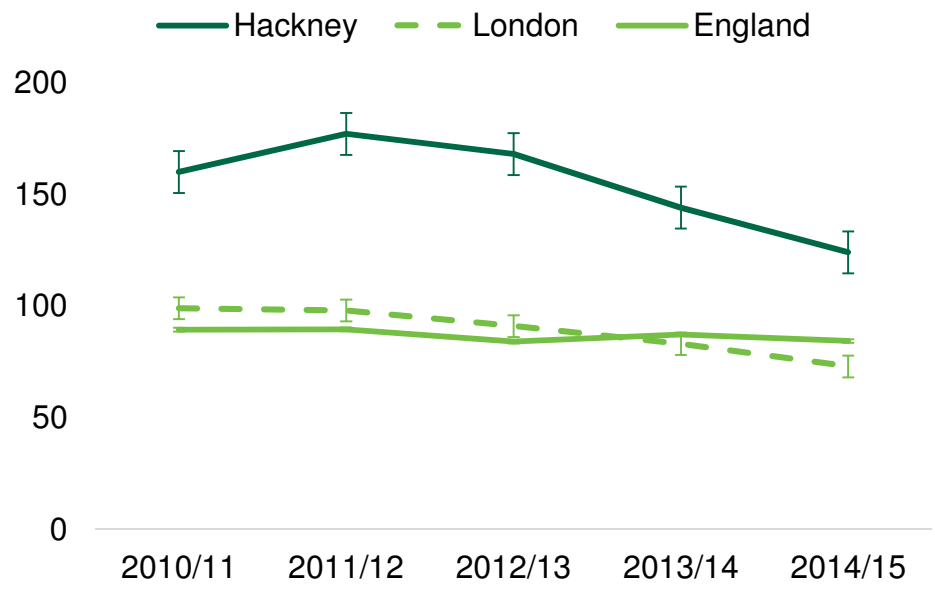
Source: London Ambulance Service, SafeStats (2016)
Notes: Data represents all ages. Alcohol-related incidents are defined where an alcohol-related illness is recorded or where a reference to alcohol has been found in a search of the various free-text fields recorded by the ambulance service.

Figure 13: Rate of admissions for alcohol-related unintentional injuries per 100,000 population (2010/11 to 2014/15)



Source: Local Alcohol Profiles England (LAPE), Hospital Episode Statistics (HES).
Notes: Includes admissions to hospital where the secondary diagnoses is an alcohol-attributable unintentional injuries code. Children aged less than 16 years were only included for alcohol-specific conditions and for low birth weight. For other conditions, alcohol-attributable fractions were not available for children. Directly age standardised rate per 100,000 population European standard population.

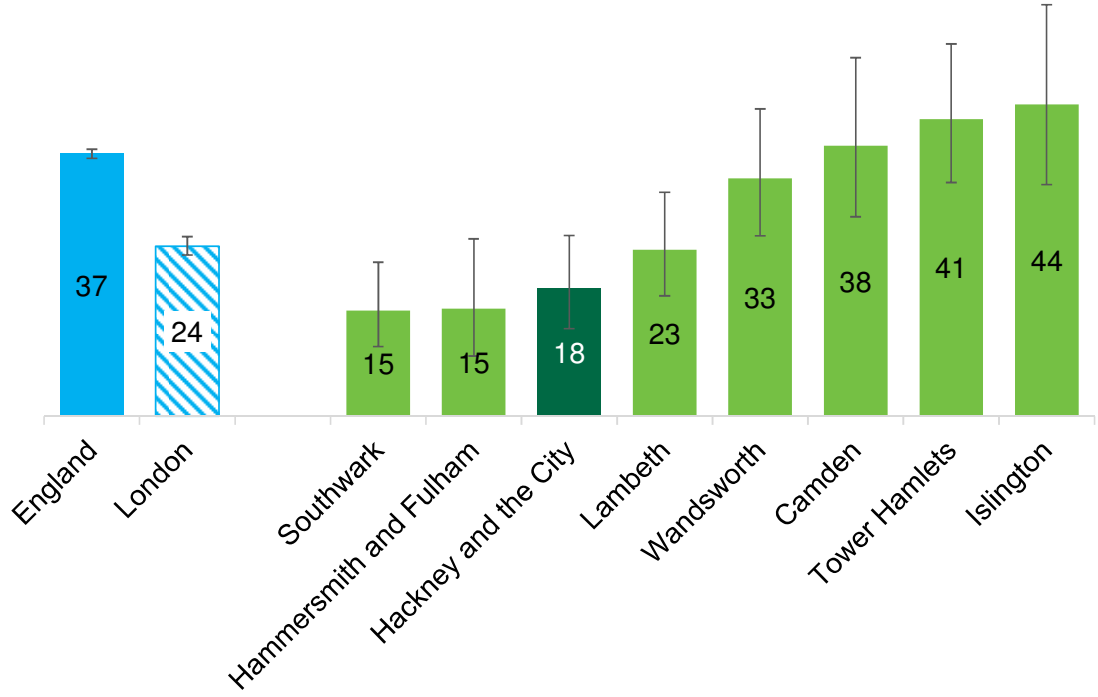
Figure 14: Rate of admissions for mental and behavioural disorders due to use of alcohol per 100,000 population (2010/11 to 2014/15)



Source: Local Alcohol Profiles England (LAPE), Hospital Episode Statistics (HES).
Notes: Admissions to hospital where the primary diagnosis is an alcohol-attributable mental and behavioural disorders due to use of alcohol code. Children aged less than 16 years were only included for alcohol-specific conditions and for low birth weight. For other conditions, alcohol-attributable fractions were not available for children. Directly age standardised rate per 100,000 population European standard population.

Figure 15 shows lower rates of alcohol-specific hospital admissions in under 18s in Hackney and the City compared to the national average and many statistical peers. Local rates are not statistically different from London but are significantly lower than the national rate.

Figure 15: Rate of admissions of persons under 18 admitted to hospital for alcohol-specific conditions per 100,000 population (2012-15)



Source: Local Alcohol Profiles England (LAPE), Hospital Episode Statistics (HES)

Table 10 reports the number of Homerton hospital A&E attendances for alcohol-related assault over the past five years.

Table 10: Number of Homerton A&E attendances for alcohol-related assault by financial year

Financial Year	Number of A&E attendances for alcohol-related assault
2010/11	169
2011/12	272
2012/13	283
2013/14	234
2014/15	210

Source: Homerton hospital A&E data (2016)

4.6 Evidence and good practice

Table 11 provides an overview of the efficacy of a range of interventions to prevent or reduce alcohol-related harm across the life course, ranging from universal interventions to those which are selective or targeted according to the level of risk or alcohol-related harm. Evidence suggests that a positive focus on encouraging lower risk drinking, rather than discouraging higher risk drinking, is more likely to be effective in encouraging healthier behaviour. [32]

When delivered alongside interventions that equip people with the skills and resilience needed to avoid developing harmful use, the provision of accurate and relevant information can help reduce harm and inform the choices people make

about alcohol. [33] This includes prevention activities delivered through a range of programmes and in a variety of settings (e.g. at home, in school, among peers, in the workplace, throughout the local community and in the media), as well as whole population approaches. [30]

Table 11: Efficacy of interventions to prevent/reduce alcohol-related harm across the life course

	Prenatal & infancy	Early Childhood	Middle Childhood	Early adolescence	Adolescence	Adulthood
Family	Prenatal and infancy visitation (selective) **		Parenting skills (universal & selective) ****			
	Interventions for pregnant women substance misusers (selective) *					
School		Early childhood education (selective) ****	Personal & social skills (universal) ***	Prevention education based on personal & social influences (universal & selective)***		
			Classroom management (universal) ***	School policies and culture (universal) **		
			Policies to keep children in school (selective) **			
			Addressing individual vulnerabilities (indicated) **			
Community				Alcohol & tobacco policies (universal) *****		
	Community-based multi-component initiatives (universal & selective) ***					
				Media campaigns (universal & selective) *		
				Mentoring (selective) *		
					Entertainment venues (universal) **	
					Workplace prevention (universal, selective & indicated) ***	
				Brief intervention (indicated) ****		

Source: UNDOC prevention standards. Public Health England [33]
Notes: Assessment of efficacy: * limited / ** adequate / ***good / **** very good / ***** excellent
Definitions: 'indicated' means aimed at people who are already using substances; 'selective' interventions serve specific sub-populations (individuals, groups, families and communities) whose risk of substance misuse is known to be higher than average; 'universal' approaches address an entire population.

4.6.1 Educational interventions

In terms of specific work with children and young people, evidence suggests that a 'whole school' approach should be adopted, covering everything from policy development and the school environment to staff training, with parents and pupils involved in developing and supporting this. [34] [35] This includes development of Personal, Social Health and Economic Education (PSHE) to cover alcohol as a 'risky behaviour', and links to social skills and influences, aiming to delay alcohol initiation for young people. As indicated in Table 11, selective interventions in early childhood are among the most effective, but universal and selective education also has good evidence of efficacy through to adolescence.

4.6.2 Screening, identification and brief advice

For adults, NICE guidance advocates screening, brief advice and motivational support to identify and respond to alcohol misuse. 'Identification and brief advice' (IBA) in primary care has been shown to be effective in encouraging people drinking at higher risk levels to cut down, through screening and giving appropriate guidance. [36]

Screening and brief advice has also been recommended by NICE as part of an 'invest to save' approach for the NHS and local authorities. [37] The brief advice component is a structured conversation, usually lasting no more than ten minutes, aimed at motivating at-risk drinkers to change their drinking behaviour or reinforcing the habits of low risk drinkers. This has very good evidence of efficacy for adolescents and adults (Table 11).

IBA-type interventions are useful in identifying non-dependent but risky drinkers, and even a single session can motivate individuals to reduce their drinking. [38] However, IBA must be aligned to context, and delivered sensitively to avoid unintended consequences. [39] It is unlikely to be effective in contexts where the recipient may perceive that their responses will affect the services they receive or where the person delivering IBA lacks credibility, cultural competence, or confidence and legitimacy. Without this, IBA may simply lead to 'false negatives', with people being unwilling to disclose risky behaviour. [40]

4.6.3 Community centred approaches

There can be value in using community-centred approaches to improve health and wellbeing, promote equity and increase people's control over their lives. Local communities have been identified as an important system in preventing alcohol-related problems and planning and implementing community prevention projects; community-centred approaches have good evidence of effectiveness across the life course (Table 11). [41] Relevant initiatives include Community Alcohol Partnerships, which have been associated with reduced harms for underage drinkers, and schemes which promote volunteering and its value for health and wellbeing. [42] [43]

4.6.4 Building resilience - personal and social skills

Resilience, or the capacity to do well in the face of adversity, is positively associated with strong social networks - i.e. family, friends and community. Alongside enhancing protective attitudes and behaviours, building resilience through reinforcing social connections can challenge alcohol misuse as a way of coping with stress. While older people are more likely to be affected by stressors such as bereavement, economic inactivity, personal/family crises or social isolation, developing personal and community resources has the potential to bring benefits across generations and reduce health inequalities. [44]

Children with access to strong family networks, as well as their own social networks, are more likely to have better mental health, fewer behavioural problems and are less likely to engage in 'risky' behaviour (including drinking alcohol). [45]

4.6.5 Workplace approaches

The workplace presents a vital opportunity to encourage and facilitate health behaviours around alcohol and other substances. The London Healthy Workplace Charter provides a framework for action to help employers build good practice in health and work in their organisation.

The business benefits of having a healthy, fit and committed workforce are widely recognised. These include lower absence rates, fewer accidents, improved productivity, staff who are engaged and committed to the organisation and remain healthy as they grow older. [46]

The Charter works by recognising good practice at three tiers: 'commitment', 'achievement' and 'excellence'. The standards for alcohol and substance misuse are outlined in Table 12.

Table 12: London Healthy Workplace Charter – alcohol and substance misuse standards [46]

Level of Achievement	Requirements
Commitment Level	A working alcohol and substance misuse policy/statement is in place regarding the use of alcohol and other substances in the workplace that is clear and consistent
	Employees are provided with information about the effects of alcohol and substance misuse that is appropriate, acceptable and accessible
	Alcohol policy/ statement includes guidelines on the use of alcohol at business functions if relevant to the organisation
	Employees are supported in seeking help to treat alcohol or substance misuse issues. This includes providing sources of further information and support that are readily available
Achievement Level	Organisational code of conduct and behaviour in relation to alcohol and substances has been well established and well publicised
	New employees are made aware of how to access relevant policies, information and support services
Excellence Level	Managers at all levels are aware of the link between alcohol, substance misuse and mental health in the workplace and aware of why staff may be reluctant to come forward with related problems. Managers actively promote the use of external help and rehabilitation when approached. Employees are aware of link between alcohol, substance misuse and mental health in the workplace
	Staff representatives from various levels of the organisation are involved in the development or review of the policy which addresses alcohol and other substances

4.6.6 Alcohol policy - licensing, price, enforcement and advertising

Making changes to the environment where risky behaviour takes place has the potential to reduce harmful outcomes. [33] This includes action such as controlling alcohol sales, pricing or the density and number of outlets.[7] A recent review of evidence by Public Health England found that policies that reduce the affordability of alcohol are the most effective, and cost-effective, approaches to prevention and health improvement. [47] Implementing a minimum unit price (MUP) was found to be a highly targeted measure which improves the health of the heaviest drinkers who are experiencing the greatest amount of harm.

Stronger regulation of the licensing of alcohol outlets in a local area is associated with a greater reduction in alcohol-related harm within the population - for example, as reflected in the number of hospital admissions. [48] Conversely, increasing the hours of sale by two hours or more is associated with greater alcohol-related harm. [49]

[7] For further consideration of health and the local planning and licensing environment, see the 'Society and environment' JSNA chapter

Alcohol advertising has a positive and direct impact on alcohol consumption by young people, which indicates that work to reduce exposure to advertising is likely to impact on drinking behaviours. [50]

Some work is underway to address the alcohol environment locally in Hackney, as described in Section 4.7. However, there are some limitations in the extent to which local government can influence these wider environmental forces, especially in relation to alcohol pricing and advertising, which require national legislation to address comprehensively.

4.6.7 What might work - areas of limited evidence

Media campaigns

Media campaigns and associated population level interventions may be designed to increase alcohol awareness and reduce alcohol-related harm, by influencing people's perceptions and behaviours. One example of a national campaign is Dry January.

Use of 'new' media (e.g. through mobile phone apps) is also used to encourage people to change their drinking behaviour. For example, work by the British Liver Trust led to the development of the app Spruce that encourages users to set a weekly goal of having three or more consecutive days a week without alcohol. Such tools tend to attract those who are already motivated to reduce alcohol consumption, however.

There is only limited evidence on the effectiveness of mass media campaigns and social media as isolated interventions to reduce alcohol misuse (see Table 11). However, they may help to improve awareness and attitudes, and change social norms, as part of a wider alcohol strategy. [51] [52]

Addressing other risk factors and links with wellbeing

There may also be opportunities to promote links between lower risk drinking and wider health benefits. This may include emphasising the benefits that lowering alcohol consumption can bring by encouraging increased activity, better diet and general wellbeing; as well as raising awareness of the calorie content and financial cost of alcohol. This kind of approach emphasises the wider benefits of lower risk drinking, without framing low level alcohol consumption as an intrinsic hurdle to good health and wellbeing. [53]

Reducing stigma

Providing services in a non-stigmatising environment may promote access to support for increasing risk drinkers. For example, satellite services in GP surgeries offering extended brief interventions may reach those at risk of alcohol-related harm, but for whom mainstream treatment services are not appropriate or necessary. However, these services need to be relevant to the needs of increasing risk drinkers, rather than catering for people with chronic alcohol-related ill health. This kind of provision

also needs to be culturally sensitive and address potentially harmful alcohol use in relation to other personal and social factors. [8]

4.7 Services and support available locally

Prevention work is carried out in schools, colleges and youth hubs by the local Young People's Substance Misuse Service, which works in Hackney and with young people in the City of London. The service provides awareness sessions as part of PSHE in schools along with targeted group work, and was recently expanded to include a greater focus on prevention and early intervention. There are plans to further strengthen links with health and education services, and with Hackney's health outreach services for those aged 5-19. The service also works with young people experiencing 'hidden harm' as a result of substance misuse by a family member.

In both Hackney and the City of London, integrated substance misuse services are commissioned which, in addition to treatment services, also include the provision of preventative outreach activity. Screening is currently available in primary care, and is carried out as standard for new patient admissions, as part of the NHS Health Check for those aged 40-74 and in annual health checks for people with long-term conditions. Work is underway by City and Hackney Clinical Commissioning Group together with Homerton Hospital and substance misuse service providers to reduce hospital admissions related to alcohol, through the introduction of an ambulatory care alcohol detoxification pathway, based on successful models elsewhere. [54]

The City of London launched Business Healthy in 2013 to unite business leadership in meeting the health and wellbeing needs of City workers. Business Healthy provides an up-to-date library of resources and holds expert-led events throughout the year for City businesses. These have included events on alcohol and wellbeing at work. Hackney Council has recently been awarded London Healthy Workplace Charter status (at 'commitment' level) and the City of London Corporation has already been awarded 'achievement' under the Charter. This provides an excellent platform for the two local authorities to work with employers in the area to enable and encourage health behaviours around alcohol, making the most of the workplace as a health promoting setting.

In terms of the broader alcohol and policy environment, a range of work is underway to influence this locally. This includes the introduction in Hackney of a voluntary minimum unit price of 50p, as well as ensuring a role for public health in reviewing new licence applications and variations in existing licences for on and off sales. For further details on local licensing interventions, please see the 'Society and environment' JSNA chapter.

[8] Stigma of alcohol use in some faith communities may facilitate escalation from low to high risk drinking

Box 3: Case study - 'Nudging pubs' in Hackney

'Nudging pubs' is the culmination of a year-long study into behaviour change and licensed venues based in Dalston, carried out by Club Soda (supported by Alcohol Concern). The project was funded by Hackney Council in 2015/16 through the Healthier Hackney Fund.

The work aims to promote sensible drinking by increasing the range of non-alcoholic drinks on offer in pubs and other licensed venues. Venues stand to gain by attracting customers who want to drink less, or not at all. Increasing the social acceptability of soft drinks may also lead to more sensible drinking. Feedback from Club Soda members indicates that a major barrier to reducing alcohol consumption is the impact on people's social life.

> *"I would like to be strong enough to refuse a drink while in a drinking environment. I find my designated 'non-drinking' days involve staying at home."*
>
> *"Need to drink more low alcohol alternatives, and to decide to 'cap' my drinking before I go out. Unplanned drinking is always the worst."*
>
> *"It's rare for me not to be insulted or mocked by bar staff if I ask if they serve alcohol free beer, even if they do actually sell it."*

Training bar staff and empowering customers were seen as critical in effecting change, and the research concludes that it is possible to support bars and pubs to change their drinks offer. This, in turn, encourages positive behaviour change, as given better information about non-alcoholic options on offer by staff, customers are more likely to make healthier choices.

Continuing into 2016/17, as part of the Healthier Hackney Fund activities grants, Club Soda and their partners Blenheim are using this learning to work with venues, customers and licensing to develop new digital tools to support sensible drinking. This will include supporting venues to carry out self-assessments to rate how well they are doing at providing for their customers who want to drink less. The project will also share good practice and develop a local rewards scheme for innovation in promoting sensible drinking.

4.8 Service gaps and opportunities

Many of the services in Hackney and the City which provide support around alcohol risk are relevant to higher risk or dependent drinkers, and recovery services promote abstinence over reduced drinking. The infrastructure to promote moderation and raise awareness and reduction of alcohol-related harm for increasing risk drinkers is more limited. To support greater activity in this area, there may be a case for expanding training in IBA for more frontline workers.

There may also be potential for further work with certain sections of the community who may be at particular risk of alcohol-related harm, including older people and

lesbian, gay, bisexual, transgender and other sexual and gender minority (LGBT+) residents.

Finally, while many minority ethnic communities have lower risk levels of drinking, people within these communities who are drinking at increasing risk levels may be less likely to seek support (due to stigma and/or cultural attitudes). Working with relevant local communities, to gain a better understanding of cultural issues in relation to alcohol, may help to build capacity to prevent and address alcohol-related harm and support better access to services. [55]

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