Alcohol Health Needs Assessment

Southampton City

2015

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Alcohol Health Needs Assessment
Southampton City, 2016

Executive Summary

This needs assessment has adopted a life course approach to examining the impact of alcohol on the health of the population. This takes us from cradle to grave and explores the points at which alcohol can cause harm. New alcohol guidelines have been released by Public Health England in January 2016, just as this report is being finalised. These highlight the risks of drinking alcohol in excess, and promote a clearer and more standardised form of guidance for the public. The new guideline defines one “threshold” for both men and women, and steers pregnant women away from any alcohol use at all. Being released during “Dry January” a campaigning period when abstinence is encouraged, may help to promote the new guideline, but there is still a long way to go before the general public and healthcare professionals become more health literate when it comes to minimising the harms caused by alcohol.

The distribution of alcohol related health and social problems in Southampton is described in the needs assessment, with a number of maps and bar-charts enabling comparison with other areas, and the picture across England. The impact of alcohol in Southampton broadly reflects the England average, but when we drill down to the wards in the city or localities, we do see areas where alcohol harm, and the hospital admissions that result, are significantly higher. These areas are among the most deprived parts of the city. The new “Better Care cluster 4” locality in the centre of town is worst affected when compared to the other 5 localities, and this population generates the highest level of hospital admissions in Southampton. These high rates of hospital admission do make significant demands on the hospital and also create a major cost pressure on the local health system. Costs to the local health economy run at many millions each year.

The report examines the condition known as fetal alcohol syndrome. This poorly understood “spectrum” condition can have serious impact on children and infants, and is entirely preventable. Our understanding of the potential harm caused by alcohol during pregnancy is now such that guidelines recommend avoiding it completely. If we want to give children in the city the very best start in life, then this is an area we really must try to tackle more proactively than before. Promotion of the latest alcohol guideline deserves a robust and concerted effort to get the message across to young adults who are about to become pregnant, whether planned or not.

The prevalence of liver disease, and the many other health problems associated with alcohol, vary between General Practices across the city, and the report examines the attitudes and varied approach to alcohol risk management by GPs in the city. Alcoholic liver cirrhosis, perhaps the best known illness caused by alcohol, probably accounts for 75% of the deaths from liver disease. At a national level, the rise in deaths in the under 65s due to cirrhosis over the last 15-20 years is alarming and contrasts with a steep decline across Europe. There is clearly a lot of preventable harm caused by alcohol in England, and this highlights the need for a robust and effective programme to reduce alcohol harm in the city, and across the UK as a whole. With earlier onset cirrhosis reported by liver specialists – concerns are increasing over high alcohol consumption during teenage and early adulthood.

Understanding the scale of the problem in the city and the very substantial numbers drinking at hazardous or harmful levels is another challenge. The report uses modelled estimates to
scale the problem and that helps us to think about the number and reach of public health interventions needed to reduce harm. Brief interventions, assessing risk and offering advice on alcohol use make a difference – with an effect size comparable to many treatments in wide use today. However, despite commissioning this type of intervention, and training hospital and community staff in its use, we do not know the number or reach of this intervention across the city communities. This needs to improve, so we can target and sustain an effective programme of brief interventions across the varied communities in the city.

The last sections of the report focus more on the specialist alcohol services in the city and how they are working to reduce the risk and help local people to deal with alcohol problems. The specialists are based in separate acute hospital and community substance misuse services (which adopt an integrated approach to both alcohol and drug misuse). Some aspects of service performance give rise for concern, while the accuracy of data on service outcomes may only partially tell us what is happening due to incomplete data capture. The overall numbers engaging in treatment, and those returning for further treatment following relapse leave room for improvement. Local commissioners are working with local services to improve service outcomes and to build recovery capital among the city residents.

Research also has a part to play in alcohol needs assessment, and the city has a number of active studies under way. These offer wider opportunities to identify and manage alcohol risk differently. Current activities include the “LOCATE” study in 10 General Practices in the city, and “ADAM” a multicentre study exploring more assertive management protocols to encourage clients to become more engaged in their treatment. A further study, called the HALO project, is being launched by the Home Office presently, exploring the relationship between outlet density, licensing decisions, and health impact. This project targets three cities on the South Coast (Brighton, Portsmouth and Southampton) with several other English cities.

Southampton has problems related to alcohol that are as challenging as the national picture, and in parts of the city, alcohol related harms to health are significantly worse than the national average. Visitors to the city will see some striking examples of alcohol excess during the night time economy, but increasingly during the daytime, the visibility of street drinkers, homelessness and begging is also apparent. The local patterns of alcohol use disorders are mirrored, by high levels of alcohol related violence, domestic violence, physical assaults, and sexual assaults.

In terms of needs assessment, the view overall is of a city with high alcohol use, high need, high demand for healthcare, and high harms at the level of community safety. The supply of alcohol services is presently struggling to engage higher numbers of clients and falling below what we would expect in terms of successful completions of treatment. This complex and entrenched problem, mirrored in other parts off the country, will need continued and determined action across health, social care, and community safety partnerships for the foreseeable future. The new alcohol guideline, novel research opportunities, and improvements in the performance of local alcohol services may help to tackle some of the problem, but the only way for this degree of harm to be reduced is by widespread changes in attitudes and behaviours linked to alcohol, and that requires a change in social attitude and engagement across whole communities to adopt a more responsible attitude to alcohol use.

Dr Bob Coates, 28 January 2016
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Southampton Alcohol Health Needs Assessment – Headlines

1. Alcohol consumption in Southampton broadly mirrors the national picture

2. Modelled estimates suggest 30,000 Southampton residents are likely to drink alcohol at increasing risk and over 10,000 more at higher risk of physical and mental harm

3. The number of alcohol dependent higher-risk drinkers in Southampton is not known. It may be higher than the national average based on the higher than national average alcohol-specific and alcohol-related indicators of harm in the city

4. More men in Southampton are dying because of alcohol than the national average, this figure has been consistent for the last 7 years; between 2011-13 there were 94 deaths specifically due to alcohol in Southampton; 77 in males and 17 in females

5. More men and women are admitted to hospital due to conditions directly caused by alcohol and more men with conditions related to alcohol compared to the national average; You are more likely to be admitted due to alcohol if you live in a deprived part of the city; highest rates of admissions occur if you live in Bargate or Bevois.

6. More under 18 year olds are admitted to hospital due to conditions directly caused by alcohol compared to the national average

7. Over 10% of Southampton General Emergency Department workload is related to alcohol work. A snapshot of all the patients on the acute medical ward on a Monday morning revealed that 18% were drinking at levels associated with hazardous or harmful alcohol use.

8. Drinking prevalence in pregnancy is probably under estimated and engagement with specialist alcohol services is poor; only 4 known cases of alcohol use in pregnancy were recorded by maternity services in 2014/15. Only 2 of these attended specialist services

9. The majority of young people engaged with specialist services use other drugs in addition to alcohol. 77 young people aged 11-24 attended specialist services in 2014/15 where alcohol was cited as a problematic substance; risks to young people drinking alcohol include sexual health

10. The majority of GPs surveyed in Southampton felt alcohol is an important cause of physical and mental harm. Less felt well placed to deal with it and a third cited lack of time as the biggest barrier to proper identification and brief advice

11. Alcohol treatment services were recommissioned in November 2014. There are several indicators that suggest performance has declined since the Southampton Drug and Alcohol Recovery Partnership went live, evidenced by a reduction in numbers in treatment, falling successful completion rates and increasing re-presentations.

12. Males and females entering treatment in Southampton are about twice as likely to be drinking in excess of 1000 units per month compared to the national average, suggesting a more challenging caseload compared to the national average

13. Commissioners locally are working to develop a new alcohol pathway which will create stronger links between hospital and specialist treatment services in the community

14. There is a perceived high prevalence of street drinking in Southampton; this entrenched behaviour appears linked to poor mental health and a different model of engagement may be needed in this group
15. Alcohol as part of a dual diagnosis with mental illness represents an additional tier of complexity for diagnosis and treatment. Engaging and supporting such clients in treatment will be an essential element of a cross-organisational alcohol pathway; it is essential that those with a dual diagnosis are not lost in the system.

16. Alcohol is consumed regularly by older adults; the exact prevalence of consumption is unknown in Southampton. A significant number of alcohol-specific and alcohol-related admissions occur in the over 65 age group and a higher proportion is likely to be associated with mental health morbidity.

17. Licensing is a statutory obligation of the council; powers to improve long-term health outcomes via licensing considerations are limited but the creative use of the alcohol licensing policy and cumulative impact zones may help to reduce alcohol-related harm.

18. The ICE bus makes a significant quantifiable and unquantifiable contribution to alcohol harm reduction for the individual and for the city infrastructure during the key hours of the night time economy.

19. Street Pastors are an integral part of the City Watch Partnership and continue to make a significant quantifiable and unquantifiable contribution to alcohol harm reduction during the key hours of the night time economy.
1.0 Introduction and national context

1.1 Introduction

Health needs assessment explores the population health impact of a condition, analyses risk factors, the supply of services, and treatments for that problem. The assessment is designed as a vehicle for making improvements, investment, disinvestment, and service changes to tackle the problem more effectively and efficiently. For this purpose I am using the term “need” to mean the ability of the population to benefit from effective intervention (which is essentially a health economist’s definition of need).

This alcohol needs assessment has been carried out in parallel with the 2015 community safety profile for the city, and aims to inform our understanding of the relationship between alcohol, population health, and safety in the city. We will cross reference between the two documents and encourage readers who have an interest to review both publications. The Safe City Strategic Assessment can be accessed here:

An alcohol needs assessment is unusual in so far as alcohol is a risk factor for a complex range of physical, behavioural, and social problems, whereas normally a needs assessment focuses on a distinct disease or a defined type of service. The complex relationship between alcohol use and health means we have to look at the problem in diverse ways, using quite different types of health and social care data. Our preference is to take a life-course approach, encompassing the impact of alcohol on pregnancy and the new-born, through to its effects in later years.

1.2 A national and regional perspective

The UK is among the top 10-15% of countries in the world when it comes to alcohol consumption per head of population, and it is perhaps not surprising we experience some poor health and social care outcomes as a result1. The pattern of use is not evenly distributed; some communities adopt abstinence, others consume a disproportionate amount, measuring

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1 Health First: an evidence-based alcohol strategy for the UK. March 1st 2013 University of Stirling ISBN 978-1-908063-12-0
in hundreds of units a week at the extreme in some individuals. Regular daily intake can have very different impacts on health and behaviour than binge drinking, which is a distinct feature of alcohol abuse in the UK. At high intake over a protracted period an individual can develop a dependency on alcohol and experience a range of symptoms if supply of alcohol is interrupted.

The negative health impacts at population level occur as a result of sustained higher risk intake of alcohol where dependency symptoms may not occur, and which impact on a much larger proportion of people. Over extended periods this pattern of intake causes chronic health problems ranging from liver cirrhosis, various forms of brain and nerve damage, to an alcoholic form of cardiomyopathy (dilation and failure of heart muscle). There may be little in the way of symptoms or signs that such a hazardous intake is occurring, and both patients and their relatives can be surprised at the level of harm and the degree of organ damage that has occurred.

Other complications of frequent alcohol use may include raised incidence of cancers (e.g. oesophageal, breast and colon cancer), raised blood pressure, cardiovascular disease, including stroke, and osteoporosis. Alcohol can also impact on a wide range of mental health problems, including memory problems and dementia. Persistently high alcohol intake is a well-known cause of premature death. Data from Wessex estimates the average age for death among dependent and high risk drinkers seen in the medical admissions units in the county to be 57 years (49-64) compared to the mean age of death at 81.5 years (81-82) among the general medical admissions (Source Wessex AHSN).

Research commissioned by Alcohol Research UK in 2015 investigated the strong relationship between alcohol and socioeconomic deprivation. This tried to improve understanding of the reasons for lower socioeconomic status (SES) being associated with a two-fold greater risk of alcohol related death compared to individuals in higher SES classifications. They found:

- Relative to high SES, low SES is associated with an increased risk of head and neck cancers, strokes, hypertension, liver disease and pre-term birth. These findings are independent of a number of other known risk factors for these conditions such as diet and smoking.

- In general, although people in different SES groups did not differ in the number of units drunk or the frequency of use across the week, there are important differences in ‘binge drinking’, beverage choice, and patterns of heavy drinking. Compared with more affluent groups, people in lower SES groups tended to binge more, and individuals with lower educational qualifications tended to drink more and binge more frequently.

- There was strong evidence of underreporting of alcohol use in general population surveys of alcohol use, but this differs by alcohol risk rather than SES. The use of alternative survey methodologies captures a greater amount of population alcohol use. This also leads to more people being classified as at increasing and higher risk from their alcohol use, which has important health policy implications.

The NHS has been quantifying the impact of alcohol on health of the population and measuring the effect of alcohol on demand for healthcare over the last decade. The negative consequences of alcohol have been known for centuries, but there has been increasing concern about the growing impact on population health in the UK, and the scale of harm is
greater than initially thought. The picture in Southampton, while broadly reflecting the national position, has worrying indicators that point to even greater harms to some parts of the city population, and also reflects the concerns about the interaction between alcohol misuse and deprivation.

Figure 1 shows the national trend in death rates caused by alcohol between 1992 and 2011. Among men mortality from this cause has doubled over this period, while among women the increase has been less dramatic, but still increased. The picture is even more worrying in people under 65 years because they generally have experienced a fall in mortality due to a wide range of serious diseases, while deaths related to liver disease have increased relentlessly, especially from 1992 onward.

Figure 2 below comes from a WHO report on alcohol\(^2\). It highlights two divergent trends – with most serious conditions declining as a cause of death before age 65, but in stark contrast to the much steeper rise in liver disease over the same period. The majority of this increase is due to alcohol related liver diseases, which accounts for approximately 75% of the liver disease. This has been called a serious “wake-up” call by experts and leaders in the field of hepatology. The case studies used to illustrate the problem offer some sharp insight: with examples of young adults presenting in their third decade (sometime in early 20’s) with end stage alcoholic liver damage - the type of presentation that would have been expected two decades later on in the past, in adults aged 50 or 60yrs. This points to a much earlier onset of persistent drinking at a high risk level, starting in early adolescence.

\(^2\) Health First: an evidence-based alcohol strategy for the UK. March 1st 2013 University of Stirling ISBN 978-1-908063-12-0
A lot of action has to rest with central government and national organisations when it comes to the supply of alcohol to the nation. The drinks industry, advertising, marketing strategies, and pricing policy all have a key part to play in alcohol harm – by essentially influencing the supply of easily affordable alcohol. Government policy on taxation, and especially minimum unit pricing, could also play a major role in reducing harm\(^2\). Many in public health argue that these issues are the most important when it comes to reducing harm to communities and individuals. As these go beyond the local scope of needs assessment, I will say no more, except to challenge the status quo, which clearly points toward a system that is balanced more in favour of increasing harm from alcohol than a setting in which responsible behaviours are encouraged and harm is reduced.

### 1.4 Population level intervention

Most alcohol fuelled problems link to hazardous and harmful drinking, not pure alcohol dependence. A very low proportion of people drinking more than recommended low levels of intake seek any kind of help, professional or otherwise. Many of these individuals will have some kind of contact with a health or social care professional, presenting an opportunity to identify risky drinking and to respond. Evidence shows that opportunistic early identification and structured brief advice provided by GPs or other health professionals can reduce alcohol consumption and related problems. This can occur in primary and secondary care settings. If used widely, brief interventions could reduce the burden of disease, reduce costs to the NHS and impact positively on society more widely. People who need support because they are more dependent on alcohol need to be referred to more specialist alcohol services for comprehensive assessment and treatment.
1.5  General Practice and Primary Care

The role of the GP and Pharmacists in working with patients and screening for alcohol use and abuse is important. Practice varies in the UK, with some GPs being more proactive about screening and risk management than others. Recent guidance from NICE (Technology Appraisal Nalmefene) has encouraged more active approaches to risk assessment, and behaviour change for binge drinkers, augmented by prescribing. Some GPs get involved in treatment for dependent drinkers, and help with withdrawal and community detoxification. But this is not the rule. Most problem drinkers will be referred by GPs to community alcohol services, or if in recovery, to abstinence groups. Innovative ways to screen for early alcohol related liver disease have been developed in Southampton and are currently being investigated in a local research study (the Locate study). The role of pharmacy teams in identifying risky alcohol consumption and helping with alcohol use disorders needs to be explored more.

1.6  Hospital services

Commissioned by the NHS, multidisciplinary alcohol care teams have been shown to reduce alcohol admissions and readmissions to hospital, and help to develop expertise and training capability in the acute setting, where many alcohol related problems present. This type of treatment team require excellent links and seamless pathways into community alcohol treatment services. However, use of community alcohol services may attract stigma, and this can discourage attendance, and in practice only a small proportion of alcohol patients engage with and complete alcohol treatment. Communities need to work with alcohol services to reduce the stigma associated with their use, and to help remove barriers to accessing treatment and support. Specialist liver services tend to be based in regional hospitals, while liver transplant services (for people with end-stage liver failure) are organised nationally. A staggering 33,290 hospital admissions occur each year in Wessex alone for alcohol related health problems, while the national figure is over 1 million admissions annually. In many of these admissions there is a need for robust education and structured advice on behaviour change in relation to alcohol, and other behavioural factors.

1.7  Community Services

Specialist alcohol services are mainly based in the community, and are commissioned from public health grant funding. Over the years, charities and not for profit organisations have become involved in service delivery, and the NHS now provides a falling proportion of these services. Their focus currently is on treatment completion and maintaining abstinence, while in some clients the focus is more on reducing harm. Psychosocial and mental health needs should be addressed carefully alongside the alcohol related problems. Building an effective treatment system that has effective pathways of care and referral routes is important. In particular timely and proactive intervention is needed to ensure optimal engagement in treatment. Many hospital patients, for example, never get to follow-up appointments or engagement with community services following a hospital admission.
1.8 Children and Maternity Services

Alcohol use in pregnancy, and in particular binge-drinking, can have very serious consequences for the mother and baby. Policy has been to limit intake to one or two units of alcohol per week during pregnancy, but recently the advice has tightened up against any alcohol use at all. Fetal alcohol spectrum (FAS) is a complex combination of behavioural, cognitive, and sometimes facial abnormalities that affect babies of mothers who have continued to drink during pregnancy. As binge drinking during teenage has become more prevalent among younger women over the last decade in the UK, there is growing concern about FAS. The effects can range from a subtle developmental problem noted after several years, more serious disability apparent from birth.

1.9 Summary

Overall, the impact of alcohol on the health of the population in UK has been negative, and increasing in its impact over the last 10-15 years. The same applies broadly to Southampton. The NHS spends millions on treatment, hospital admissions, and prevention. There is an inequalities impact with the greatest harm affecting the most deprived individuals and communities, but harms do occur across the whole population also. Detection of alcohol problems, and early intervention presents an ongoing challenge to communities and clinicians.

1.10 Note on the Southampton Alcohol Health Needs Assessment

Whilst a large number of stakeholders have been engaged in the production of this report only routine population level data have been used. The exception of this was a survey of GP alcohol-related work which was purposefully constructed for the assessment. The report is themed around the life-course and divided into sections as shown in figure 3 below.

Figure 3: Southampton Alcohol Needs Assessment Report
2.0 Terms used in this report

**Harmful drinking** is defined as a pattern of alcohol consumption causing mental or physical health problems directly related to alcohol.

**Hazardous drinking** is a non-diagnostic term for a pattern of alcohol consumption that increases someone's risk of harm. This can be mental and physical harm or social consequences.

**Alcohol dependence** is characterised by craving, tolerance, a preoccupation with alcohol and continued drinking in spite of harmful consequences.

**Higher-risk drinking** is regularly consuming over 50 alcohol units per week (adult men) or over 35 units per week (adult women).

**Increasing-risk drinking** is regularly consuming between 22 and 50 units per week (adult men) or between 15 and 35 units per week (adult women).

**Lower-risk drinking** is regularly consuming 21 units per week or less (adult men) or 14 units per week or less (adult women). It is also known as 'sensible' or 'responsible' drinking.

3.0 Alcohol Consumption in Southampton

Alcohol consumption is usually classified by the number of alcohol units taken during a typical day or week. One unit equates to 10 ml of pure alcohol. Because alcoholic drinks come in different strengths and sizes, units are a way to tell how strong the drink is. When a healthcare worker is assessing someone’s alcohol intake they will attempt to convert the number, size and type of drinks consumed into a total daily or weekly unit measure. They may also use a validated alcohol identification tool such as AUDIT (Appendix B), or the abbreviated version AUDIT-C (Appendix C).

There are a number of online tools to allow people to assess their own alcohol consumption such a tool on the Drink Aware website:

https://www.drinkaware.co.uk/understand-your-drinking/unit-calculator

Risk of harm to health is classified based on the number of units consumed. The table below shows the current governmental guidance on daily and weekly alcohol units and risk.

*Table 1: Daily and weekly alcohol units and health risk*

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<td>2-3</td>
<td>14 or less</td>
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<td>&gt;3 and &lt;6</td>
<td>&gt;14 and &lt;35</td>
<td>&gt;4 and &lt;8</td>
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<td>35 or more</td>
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The true extent of alcohol consumption for the whole of England is difficult to ascertain. Results from the Health Survey for England (HSE) 2013 are shown in figure 4 below. A total of 8,795 adults were interviewed for the 2013 survey. The risk classification is based on the weekly unit consumption in line with the guidance above.
What this shows is that a greater proportion of men are drinking at increasing or higher risk compared to women. Women also have a greater proportion of abstainers and slightly greater proportion of lower risk drinkers.

Under reporting is a common issue when assessing alcohol consumption. Evidence for this comes from the disparity between extrapolation of drinking levels from national surveys like the HSE which falls well short of the number of units of alcohol sold each year in England.

There have been no recent surveys in the Southampton population to ascertain prevalence of drinking. Synthetic estimates from 2011 (where statistical modelling is used to estimate prevalence) for Southampton are shown in figure 5 below. The model uses data from the General Lifestyle Survey (2008), levels of hospital admissions resulting from alcohol consumption, population demographics (age, sex, and ethnicity), levels of deaths relating to alcohol and levels of deprivation.

---

3 Topography of Drinking Behaviours in England, North West Public Health Laboratory, 2011
As with all synthetic estimates a number of assumptions will have been made in the modelling. However the prevalence of drinking risk appears to be similar to the national picture. If approximately 6% of the population are higher risk drinkers, only a small proportion of these are known to, or under the care, of specialised alcohol services.

Based on the 2014 midyear population estimate of 245,300 and the 2011 census population data age distribution, over 10000 adults are likely to be drinking at the higher risk levels in Southampton. Clearly not all of these individuals would need or benefit from specialist alcohol services who helped 416 adults in 2014-15 (see section 6.7). Even amongst those with alcohol dependency only a small proportion will be under the care of specialist treatment services. Nationally this figure is estimated to be only 6% of the 1 million people dependent on alcohol. However all these individuals would benefit from reducing the risk associated with their alcohol consumption highlighting the importance of screening alcohol risk in different settings and offering a level of intervention proportionate to the risk.

The proportion of adults drinking at levels associated with increasing risk equates to over 30,000 people in Southampton. This represents a further huge potential for preventing future harm by using brief interventions. Figure 6 below conceptually displays the risk prevalence across the population. Preventing people moving up the pyramid at all levels of risk is important.
4.0 Starting Well

4.1 Alcohol and Pregnancy

With special thanks to Dr Jenny Barker, Specialty Registrar in Public Health, Southampton City Council, for contributing this section

Alcohol is known to be harmful in pregnancy. No amount of alcohol is known to be safe. The local women’s hospital in Southampton, Princess Anne Hospital, has a policy of recommending no alcohol in pregnancy. The national guidance from the Chief Medical Officer (CMO) is also not to drink alcohol in pregnancy, but goes on to recommend that if you are going to drink in pregnancy, to limit intake to 1 or 2 units once or twice a week. Such national messages may appear confusing, not only in the suggestion that perhaps a little alcohol may be safe in pregnancy, but in the difficulty people have in understanding units of alcohol or identifying the number of units present in a particular drink.

Prevalence of drinking alcohol in pregnancy in England is not accurately known due to gross under reporting. This may partly be due to the way in which the question is asked. At maternity booking appointments with midwives, questioning around current alcohol use may return a negative answer in individuals who have stopped drinking as soon as they became aware of their pregnancy. This may fail to capture the pre-conceptual drinking behaviour, including binge drinking, which may also confer some degree of risk. Other women may fail to disclose alcohol use in pregnancy for fear of becoming stigmatised.

The data that has been collected nationally suggests that around 9.37% of pregnant women continue to drink alcohol\(^a\). In the Screening for Pregnancy Endpoints (SCOPE) study, 33% of

\(^a\) UK Office of National Statistics 2013
the 651 UK participants described at least one episode of binge drinking during pregnancy, the majority of which had occurred during the first trimester⁵.

4.1.1 Fetal Alcohol Spectrum Disorders

Children born to women who drink above the recommended alcohol limit during pregnancy are at risk of a number of problems after birth. These problems include difficulties with learning, concentration, decision-making, planning and memory, not growing well, being born underweight or being born with abnormal facial features.⁶ The problems vary depending on how much alcohol is consumed and at what stage of pregnancy. Fetal alcohol spectrum disorders (FASD) is the term used to describe the range of clinical syndromes that can occur. These disorders include fetal alcohol syndrome (FAS) in which people have all of the defects mentioned above, but also other conditions in which there is much more subtle damage. There is no cure for FASD and the effects are life-long. Disabilities associated with FASD are shown in figure 7 below. Data on FAS/FASD is not routinely collected in the UK. However, evidence from the US suggests that some form of FASD occurs in approximately 1% of all births⁷.

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**Figure 7: Disabilities associated with FASD**

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⁸ Centre for Addiction and Mental Health, Toronto, Canada
It is not easy to tell if a person has FASD as they may only start showing difficulties as they get older. This puts people with FASD at risk of further problems (including education, mental health problems and substance abuse). Early diagnosis is important to make sure that people with the disorder have access to the help and support that they need, as well as to provide support to other family members. This may include treatment for alcohol dependence in the mother and contraceptive advice to reduce the risk of future alcohol exposed pregnancies. Of concern, the incidence of FAS in younger siblings of children with a diagnosis of FAS is very high - around 771 per 1,000⁹. FASD has a high cost, both to the affected individual and to society in general.

It is not clear if there is a safe level of alcohol to drink during pregnancy. Not all women who drink alcohol during pregnancy are at risk of having a child with FASD. The risk is higher in women who regularly ‘binge’ drink large quantities of alcohol, particularly if they have a smaller body mass index. The numbers of children with FASD are particularly high in rural parts of South Africa and Australia with high levels of socioeconomic deprivation, where binge drinking is common.

FASD prevention involves reducing the risk of alcohol exposed pregnancies by educating women about risky alcohol consumption and effective contraception, screening for alcohol use during antenatal visits, and offering targeted help for people most at risk.

4.1.2 Alcohol in pregnancy in Southampton

There were 3,306 live births in Southampton in 2014. The local maternity service identifies around four cases of isolated alcohol dependence in pregnancy each year. Those identified as at risk are managed by a consultant obstetrician, have additional scans and blood tests, and are offered referral to the community drug and alcohol treatment team. There were only two new presentations to the Southampton specialist alcohol treatment services for women who were pregnant in 2014-15 according to the National Drug Treatment Monitoring System (NDTMS). This suggests that levels of engagement amongst pregnant women with the service is generally poor. Midwives in Southampton are not trained in Identification and Brief Advice (IBA) for alcohol and feel that a signposting role is more appropriate due to competing priorities.

If the global prevalence data for FAS and FASD is applied to the Southampton population, we could expect to see anything between one and seven children born with FAS each year. The prevalence of children born with FASD would be much higher - around 33 per year.

However, in Southampton, the specialist substance misuse midwife and the neonatal team estimate that there are very low levels of FAS locally. It is possible that some of the more subtle indicators of FASD may go unrecognised until later in the child’s development. In other cases some of the features of FAS/FASD may mimic specific genetic disorders which require exclusion before FAS can be considered. Since there is no nationally data collected on FASD, so it is impossible to say how many people may have FASD locally or indeed whether any local children have ever been given FASD as a specific diagnosis.

⁹ Abel EL. Fetal alcohol syndrome in families. Neurotoxicol Teratol 1988;10(1):1-
Local information suggests that a high number of women use the local genitourinary services following unprotected sexual intercourse related to binge drinking. Southampton also has a higher than average number of teenage pregnancies. Given that only around 55% of pregnancies are planned (16.2% are unplanned and 29% ambivalent)\textsuperscript{10}, there is a concern that women may be binge drinking and exposing the foetus to dangerously high levels of alcohol during the first trimester before the pregnancy becomes obvious. The impact of this is not clear as trials have mainly commented on sustained binge drinking.

The number of looked after children in Southampton is also high compared to comparator cities. There were 586 looked after children in Southampton in March 2015. If the international estimates following active case ascertainment in looked after children are accurate (FAS prevalence of 60/1000, 95% CI 38-85, FASD prevalence 169/1000, 95% CI 109-238)\textsuperscript{11}, a substantial number of these children may have diagnoses of FAS/FASD.

Missed FASD diagnoses may have implications not only for the individuals involved but also for service providers, commissioners and policy writers. Until the prevalence of this condition is quantified, it will be very difficult to map local need and plan services. However the complexities associated with making a diagnosis of FASD suggest it may remain an elusive phenomenon to quantify and strategies targeted at increasing awareness of the potential harm alcohol can have pre-conceptually and during pregnancy, may remain the best course of action.

Ensuring robust identification of alcohol use at antenatal booking appointments also remains important in order to target enhanced obstetric care and specialist alcohol services for those found to be drinking harmfully. Several trials have been carried out looking at how to best identify and manage women who are drinking harmful levels of alcohol during pregnancy, as well as how to reduce the risk of alcohol exposed pregnancies in women who are not currently pregnant but have risky alcohol consumption and unreliable contraception. These studies have had varying amounts of success.

### 5.0 Growing Well

#### 5.1 Alcohol and young people

As with adults, specialist services for young people (classified as under 24 years of age) with harmful drinking or alcohol dependence use represents the tip of the iceberg of likely harm in the population as a whole. An idea of prevalence of drinking in younger people who are not in contact with young people’s specialist substance misuse services can be obtained from the ‘Smoking, drinking and drug use amongst young people in England survey’. The 2014 report can be found in full at the following link:


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The proportion of 11 to 15 year olds who have ever had an alcoholic drink has been declining since 2003 as shown in figure 8 below.

Boys and girls are equally likely to have ever tried alcohol but the prevalence increases with age as shown in figure 9 below. This is not surprising since experimental and risk taking behaviour increases through adolescence and adult supervision diminishes. Factors associated with drinking alcohol in the last week included smoking, drug taking, truancy and family influences.
Other findings from the survey include that the majority of pupils who drank in the last week, did so on only one day and the average consumption was 9.8 units. Six percent of pupils reported that they had been drunk in the last four weeks.

Young people drinking alcohol are at increased risk of a number of short and long-term health problems. An analysis of data from the 1970 British birth cohort study\textsuperscript{12} found that 17% of adolescent binge drinkers were dependent on alcohol at age 30, 43% exceeded the recommended weekly limits and 24% were taking illicit drugs, compared to 11, 30 and 16% respectively of those who did not binge drink as adolescents.

Regular, heavy alcohol consumption and binge drinking in young people are associated with physical health problems, anti-social behaviour, violence, accidents, suicide, injuries and road traffic accidents. Alcohol consumption can also have a major impact on school performance.

5.1.1 Alcohol and young people in Southampton

There is no reason to believe that drinking prevalence amongst children aged 11-15 is any different in Southampton compared to the national picture. In fact it could be slightly higher. Southampton has a significantly higher under 18 alcohol-specific admissions\textsuperscript{13} rate compared to the England average as shown in figure 10 and also significantly higher than comparator cities. The graph shows the crude rate per 100,000 population under 18 – a total of 125 under 18’s were admitted with alcohol-specific conditions between 2011/12 and 2013/14. Locally under-18 alcohol-specific admissions may be significantly higher due to a policy in which alcohol intoxication in this age group is treated as self-harm with a policy to admit. However, this still represents a considerable burden of harm to the individuals, demands on the service and a stark reminder of opportunity to address drinking in this age group before behaviours become entrenched. It is also highlights the importance of making it more difficult for young people to obtain alcohol.

Education is a key in helping to reduce the harms of alcohol in young people, reduce the prevalence of binge drinking and try to prevent drinking becoming entrenched. The National Institute for Health and Care Excellence (NICE) suggest the content of teaching materials and methods of identifying harmful alcohol intake is left to the discretion of practitioners adapting to the age group with which they work\textsuperscript{14}. It emphasises alcohol education being part of the national science curriculum and the personal, social, health and economic education (PSHE) whilst adopting a whole school approach is also recommended.

Signposting parents or carers for help with parenting skills is a further recommendation.

Where school children are known to be drinking they should be offered brief one-to-one advice on harmful effects of alcohol, how to reduce risk and where to find further help. Referral to external services can also be made in specific circumstances. Child protection, consent and confidentiality best practice should be followed at all times.

\textsuperscript{13} For a detailed explanation of alcohol-specific admissions please see section x
\textsuperscript{14} Alcohol: school-based interventions (PH7) November 2007
NICE goes on to recommend partnership working between schools and extended school services to include children's services (including the Children's Trust/children and young people's strategic partnership), clinical commissioning groups, drug and alcohol action teams, crime disorder reduction partnerships, youth services, drug and alcohol services, the police and organisations in the voluntary and community sectors. This would include public health services within the local authority.

In Southampton once such partnership working exists between the charity ‘No Limits’ (see section 6.6) and the majority of schools in the city in a project called ‘Buzz’. Buzz is aimed at 14-16 year olds living or studying in Southampton and engaging them in discussions about alcohol and other substances. There is an emphasis on exploring ways they can enjoy themselves without substances by participating in alternative activities and helping them to make healthy choices.

**Figure 10: Alcohol-specific admissions under 18, Southampton, 2011-2014**

Some young people drink at levels which bring them into contact with specialist alcohol treatment services. Alcohol misuse represents 50% of the workload for the combined drugs and alcohol service for young people which is similar to the national level of 52%. In total there were 77 young people attending specialist services due to alcohol problems in 2014/15 of whom 41 were under 18 years of age. The majority of these will be using alcohol.
and other drugs. The age distribution is shown in figure 11 below. The largest proportion of young people are accessing alcohol services in the 18-24 year age grouping. The joined up working between young people’s services and adult services are a key opportunity to ensure smooth transition when needed.

![Age distribution of young people in Southampton specialised alcohol services](image)

*Figure 11: Age distribution of young people in specialised alcohol services in Southampton*

In those in treatment under the age of 18, 66% of females and 40% of males cite alcohol as a problematic substance. The majority of young people (73%) attending services only do so for less than 3 months. This is generally shorter than adult services because the substance misuse is not such an entrenched behaviour. Psychosocial interventions represent the bulk of the work undertaken with young people. These are a range of talking therapies designed to encourage behaviour change.

Approximately 77% of exits from the service are planned and less than 1% of those leaving in a planned way re-present within 6 months to either the same service or the adult service.

5.1.2 Alcohol, teenagers and sexual health

In the 2011 European School Survey Project on Alcohol and Other Drugs (2009), 13% of UK 15-16 year old respondents had sexual intercourse as a result of alcohol in the preceding 12 months and 10% regretted it. Young people get drunk for a number of reasons. It may be their individual choice, due to coercion and peer pressure, or it may be a result of someone ‘spiking’ their drink. As a consequence of being drunk they may lose willpower or inhibitions and have sex. This may be unprotected and/or against their will. Continued use of alcohol can lead to an increased number of sexual partners and a risk of sexually transmitted infections (STIs).

Data is not systematically collected about use of alcohol by sexual health services in Southampton to allow mapping to the incidence of STIs or teenage pregnancy. A study done by a team at Southampton University showed that identification and giving standard
information alone (a leaflet) was as good as structured brief advice in helping people change their sexual and alcohol behaviour\textsuperscript{15}.

Pharmacies in the city who provide emergency hormonal contraception over-the-counter, and there is currently no mechanism for recording whether alcohol has been implicated in the request.

5.1.3 Alcohol and University Students

Southampton has two large Universities hosting over 30,000 students in the city. There are approximately 24,000 students at the University of Southampton and 11,000 at the Southampton Solent University. Many students enjoy alcohol as part of their social experience, and for many, university marks the first time they have enjoyed independence combined with the ability to purchase and consume alcohol legally.

There are no recent surveys in Southampton to quantify the prevalence of drinking amongst the student population. However an online survey of 1679 UK university students carried out by a youth media agency called ‘Student Beans’ suggested that the average weekly consumption of alcohol by those surveyed in Southampton University was 11 units – well within the recommended lower risk drinking levels and ranking Southampton 23 out of 50 universities (he University of York was ranked 1\textsuperscript{st} at 19 units). However no data was available for the range of units consumed, the actual numbers sampled, or whether those sampled were representative of the wider student population in Southampton.

Studies at other universities suggest that prevalence of drinking in universities is high. For example a study at seven UK universities\textsuperscript{16} (Gloucestershire, Bath Spa, Oxford Brookes, Chester, Plymouth, Swansea and Ulster) which included over 3,500 students, suggested that the majority of students (65% females, 76% males) had an episode of binge drinking (5 or more drinks in one session) in the previous two-week period. In the survey the CAGE questionnaire\textsuperscript{17} was also used to assess problem drinking (CAGE score of ≥2) and alcohol dependence (CAGE score of ≥3). Problem drinking was prevalent in 20% of females and 29% of males and possible alcohol dependence in 8% of females and 16% of males. In this student population higher alcohol consumption was associated with being male and having perceived insufficient income; living away from home, being 1\textsuperscript{st} or 2\textsuperscript{nd} year students, having no intimate partner and lower academic achievement were also associated with some of the higher consumption indicators.


\textsuperscript{17} CAGE is an acronym of four questions and is a screening test for problem drinking and potential alcohol problems:

a) Have you ever felt you needed to Cut down on your drinking?
b) Have people Annoyed you by criticizing your drinking?
c) Have you ever felt Guilty about drinking?
d) Have you ever felt you needed a drink first thing in the morning (Eye-opener) to steady your nerves or to get rid of a hangover?
Some qualitative research at the University of Southampton found that the majority of students included in the study binge drank, did not associate this behaviour with binging and did not believe they needed to reduce intake\textsuperscript{18}. Factors that influenced drinking behaviour were peer pressure, peer drinking and the abundance of drinking events. The study also highlighted that many of the university strategies to reduce harms associated with alcohol focus on the social consequences as opposed to the health issues.

University students strongly associate alcohol with socialising and perhaps feel removed or immune from the long-term harms associated with excessive consumption. Fresher events for new university intakes need to be carefully managed in order to reduce the immediate social harms to students attending Southampton universities. Partnership working between the licensing department, the council safer communities team (ICE bus) and the universities can help to reduce the short-term risks. The longer-term health risks may be addressed by alcohol-harm reduction campaigns, perhaps by tapping into nationally available materials. Identification and brief advice has limited evidence of benefit in reducing alcohol consumption in individuals within the student population and other innovative approaches may be needed to address the longer-term health risks.

6.0 Living Well

6.1 Alcohol and mortality

Alcohol can be directly or indirectly implicated in mortality. When someone dies due to a condition wholly attributable to alcohol (attributable fraction = 1), such as acute intoxication or alcoholic liver cirrhosis, it is termed alcohol-specific mortality. By definition these conditions should not arise in the absence of alcohol. Conversely, when someone dies due to a condition where alcohol can be a causative factor, but where it is not implicated in every case, the condition is given an attributable fraction. The larger the attributable fractions, the greater contribution alcohol makes in the condition. For example, the attributable fraction for death from oesophageal cancer in males, aged 45-54, is 0.63, and for death by drowning in females, aged 16-24, is 0.18. Attributable fractions allow alcohol-related mortality rates to be calculated which can provide an overarching impression of alcohol-related harm. Alcohol-specific mortality provides a more direct impression of mortality caused by alcohol.

6.1.1 Alcohol-specific mortality

The following conditions in table 2 have been given an attributable fraction equal to 1 and used to calculated alcohol-specific mortality.

<table>
<thead>
<tr>
<th>Table 1: Conditions with an alcohol attributable fraction of 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol-induced pseudo-Cushing’s syndrome</td>
</tr>
<tr>
<td>Mental and behavioural disorders due to use of alcohol</td>
</tr>
<tr>
<td>Degeneration of nervous system due to alcohol</td>
</tr>
<tr>
<td>Alcoholic polyneuropathy</td>
</tr>
<tr>
<td>Alcoholic myopathy</td>
</tr>
<tr>
<td>Alcoholic cardiomyopathy</td>
</tr>
</tbody>
</table>

\textsuperscript{18} Amy Taylor and Penelope Nestel. 2014. The need and opportunities to manage binge drinking among undergraduates at an English university. *Education and Health* 32(4), 130-135
Alcoholic gastritis
Alcoholic liver disease
Alcohol-induced acute pancreatitis
Alcohol-induced chronic pancreatitis
Fetal alcohol syndrome (dysmorphic)
Excess alcohol blood levels
Ethanol poisoning
Methanol poisoning
Toxic effect of alcohol, unspecified
Accidental poisoning by and exposure to alcohol
Intentional self-poisoning by and exposure to alcohol
Poisoning by and exposure to alcohol, undetermined intent
Evidence of alcohol involvement determined by blood alcohol level
Evidence of alcohol involvement determined by level of intoxication

There were 94 alcohol-specific deaths specifically due to alcohol in adults in Southampton between 2011-13, 77 in males and 17 in females. Alcohol-specific mortality in Southampton compared to ONS statistical and geographical neighbours is shown in figure 10 below. Alcohol-specific mortality rate per 100,000 persons in Southampton is significantly higher than the England average. This is true for males and females combined and for males separately. Female alcohol-specific mortality is slightly lower than the England average but not significantly so. These are directly age-standardised rates which generates a rate that would apply if a standard population had the same age-specific rates as Southampton which allows comparison with areas with different age group distributions. This is important to give a more accurate idea of how Southampton compares to the national rate and other comparator cities.

Mortality from chronic liver disease, for which alcohol is one of many possible causes, mirrors alcohol-specific mortality in being significantly higher than the England average for males and females combined and for males separately. Female chronic liver disease mortality is slightly lower than the England average but not significantly so. In Southampton, alcohol accounts for 75% of the deaths from liver disease.

6.1.1.1 Southampton compared to statistical neighbours

The Office for National Statistics (ONS) have recently updated their list of ‘statistical neighbours’ based on data from the 2011 census. Southampton is in a group called ‘business centres’ with similar demographics (socio-economic, ethnicity and gender profiles). Within this list are 11 other unitary authorities which can offer further useful bench marking for the Southampton picture. As can be seen from figure 12, Southampton has an alcohol-specific mortality that is statistically similar to all its comparator statistical neighbours other than Liverpool which has a significantly higher alcohol-specific mortality.
The time trend for alcohol-specific mortality between 2006 and 2013 is shown in figure 13 below. This shows no statistical significant trend which means rates of alcohol-specific mortality have remained stable over that time period. Whilst this suggests the situation has not worsened, it has not improved from the baseline of being significantly higher than the England average.

Sources: Local Alcohol Profiles, Public Health England

Figure 12: Alcohol-specific Mortality 2011-13

Figure 13: Alcohol-specific mortality time trend
6.1.2 Alcohol-related mortality

The concept of attributable fractions has been described above. Alcohol-related mortality includes all the cases of alcohol-specific mortality and those in which alcohol is known to play a part. The full list of alcohol-attributable fractions used in the Local Alcohol Profiles for England (LAPE) data set can be found by accessing the LAPE user guide:


Alcohol-related mortality in Southampton mirrors the differences with the England average seen in the alcohol-specific mortality but these have not reached statistical significance. This can be seen in figure 14 below. There were 95 deaths related to alcohol in 2013, 71 in males and 24 in females.

A time-trend for alcohol-related mortality is shown in figure 15 for rates between 2008 and 2013. Much like alcohol-specific mortality this has remained stable over that time period.

Figure 14: Alcohol-related mortality in Southampton 2013
Alcohol dependent drinkers engaged with alcohol treatment services represent the tip of the iceberg of alcohol harm within the population. The unseen harm may represent a much greater proportion of the population. As discussed in the section on drinking prevalence, surveys suggest that 13% of women and 18% of men are drinking at levels suggesting increasing risk. It could be argued that general practice offers an ideal setting to deliver effective evidence-based ‘Identification and brief advice’ (IBA) for this group before their drinking manifests as symptomatic harm. Additionally general practice offers an ideal setting for identifying those with higher risk drinking and alcohol dependence and ensuring they are referred appropriately to specialised alcohol services.

The most-up-to-date source of information on discussion of drinking with health professionals comes from the ONS opinion survey of 2009. This was the last year that the survey covered alcohol. Respondents were asked whether in the last year they had discussions about their drinking with their General Practitioner, or someone else at the surgery, another doctor or any other medical professional.

One in ten male drinkers (10%) and one in fourteen female drinkers (7%) had such discussions in the last year, the majority of these with their GP. This was similar to data from the same survey in 2000, when this question was first asked, in the proportions having such discussions. Heavier drinkers (greater than 21 units (men) or 14 units (women)) were more likely to have discussions about alcohol. There was no statistical significant difference in which age groups were having the discussions.

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Figure 15: Alcohol-related mortality time trend

6.2 Alcohol & General Practice

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18 Between 21 and 50 units per week for men and between 14 and 35 units per week for women
19 Alcohol-use disorders: prevention (PH24)
6.2.1 Alcohol and General Practice in Southampton

As part of the alcohol needs assessment for Southampton an email survey was distributed to all Southampton GPs via the clinical commissioning group (CCG). The anonymous survey was designed to be completed in 1-2 minutes maximum and had 6 multiple choice questions and opportunity for free text. The survey can be found in appendix A. Thirty GPs responded.

The vast majority of GPs (93%) believed that alcohol is an important contributor to mental and physical harm and therefore an important part of General Practice work, but the proportion of these same GPs that believed that GPs were well placed to contribute towards the prevention of alcohol harm dropped to only 70%. One GP felt that alcohol was a societal issue and not an important part of general practice work. This same respondent also believed that GPs do not have time to assess alcohol consumption and give brief advice. This view was held by about a fifth of all respondents. An additional four GPs mentioned time as a limiting factor for alcohol work in each of four free-text comments shown in table 3 below.

### Table 3: GP views on alcohol work in general practice

<table>
<thead>
<tr>
<th>Free-text GP survey comments about GP views on alcohol work in general practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcoholics are often help seeking, help refusers &amp; GPs have limited time to do anything really meaningful for them</td>
</tr>
<tr>
<td>GPs can contribute to cases where high risk identified, but not on a more widespread level due to time constraints</td>
</tr>
<tr>
<td>The time and resources for GPs to do more than signpost are limited</td>
</tr>
<tr>
<td>GP’s are well placed but have very little time to implement intervention</td>
</tr>
</tbody>
</table>

Together this suggests that 33% of GP respondents felt time was a major limiting factor in addressing alcohol harm with their patients.

About half of GPs would take every relevant opportunity to raise the issue of alcohol consumption with their patients, whether this was because the patient had signs of intoxication or withdrawal, presented with a condition in which alcohol could be a factor, the patient (or relative) raised it as an issue or when there was an opportunity to address lifestyle factors. The other half of GPs chose one of those opportunities as shown in figure 16 below.
Approximately a fifth of GPs said they used the AUDIT tool (Appendices B and C) or another recognised tool to identify alcohol harm in their patients. A larger proportion of GPs (43%) did not use a recognised tool, but rather tried to calculate the weekly alcohol units their patient was consuming, and presumably compare this to the governmental recommended lower risk guidelines to feedback to the patient. Other GPs (33%) used their own autonomous questioning to establish if their patient had a problem with alcohol. This perhaps suggests a proportion of GPs are resistant to the tick box exercise of standard screening tools.

Training GPs in using recognised screening tools and in giving brief advice is an issue. Twelve GPs (40%) had been trained in IBA, three of which had done so as part of the RCGP Certificate in the ‘Management of Alcohol Problems in Primary Care’. Eighteen GPs had not been trained in IBA. Two did not believe they needed to be trained in order to advise about alcohol, nine felt they would never have time to do this, and seven said they would be interested if training was locally available. Two of those interested in the IBA training had previously cited that time was an issue in GPs ability to address alcohol harm. Perhaps they saw training as improving their ability to efficiently identify and manage alcohol harm.

For those trained in IBA, whether they actually used their training in the real world was dependent on whether they had enough time during a consultation. Only six GPs would use an alcohol screening tool template on their IT system to record the episode. Over half of all GP respondents would simply read code\textsuperscript{22} something related to alcohol and one GP would read code an episode of IBA. The remaining 10% of GP respondents free-texted an entry into the history section of the record. This has implications for capturing alcohol data where read coding offers a greater ability to search for records for audit purposes. However, variety within GP IT systems and lack of consistency in the use of built in templates (which

\textsuperscript{22} Read codes are the standard clinical terminology system used in General Practice in the United Kingdom
ultimately can store information as read codes) and which read codes are used, may further complicate future data collection on alcohol work in general practice.

The GP’s who completed the survey cite a lack of time rather than a lack of willingness in screening and management of alcohol risk. This highlights the importance of using the simplest system for identifying alcohol risk and ensuring GPs are trained in how to give brief advice since this could help them become more time-effective when addressing alcohol issues. An emphasis on the benefit to their own future workload may also help GPs engage with Identification and Brief Advice.

6.3 Alcohol and University Hospital Southampton Emergency Department

A significant proportion of attendances at the Emergency Department (ED) of University Hospital Southampton (UHS) are related to alcohol. The most recent alcohol-related workload is unknown due to a change in the way attendances were recorded. During the period 2009-11 the discharging clinician was required to record on the computer system whether the attendance of a patient was in any way alcohol-related as part of the patient discharge protocol. The data is shown in table 4 below.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Attendances</th>
<th>Alcohol Related Attendance</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>86,390</td>
<td>11,156</td>
<td>12.9%</td>
</tr>
<tr>
<td>2010</td>
<td>88,522</td>
<td>11,110</td>
<td>12.5%</td>
</tr>
<tr>
<td>2011</td>
<td>92,831</td>
<td>10,358</td>
<td>11.2%</td>
</tr>
</tbody>
</table>

As can be seen from this table, over one in every ten attendances to the ED were in some form or another alcohol-related. This represents a huge burden to the ED. This would include anything from acute intoxication or decompensated liver failure to an alcohol-related injury or assault.

This discharge data field requirement was ‘switched off’ in 2012 when other data collection requirements were introduced. One of the changes was the attempt to classify drinking prevalence in each person attending the ED. The intention was that this would be done using an AUDIT-C questionnaire (see appendix C). However, this is a much more complex enquiry for a clinician than ticking a box if alcohol was related to the reason for attendance, and therefore the data quality is likely to be poor. Under self-reporting of alcohol units is a common issue and is likely to reflect in the data. An entry was a mandatory requirement for the discharge process but this could have been ‘alcohol consumption not known’ when a patient was incapacitated or if the clinician had forgotten to ask about alcohol. Table 5 below shows the alcohol risk levels identified.
The proportions of different risk groups identified in the ED differ from the modelled population estimates which suggest that 14-18% of people are in the ‘increasing risk’ group. This suggests either that a smaller proportion of ‘increasing risk’ drinkers have cause to attend the ED compared to the wider population or more likely highlights the difficulty in assessing alcohol consumption accurately in the ED.

There are two conditions in which alcohol would be the principle reason for attendance. These are consistently recorded on the discharge IT system and would be classified as either ‘Alcohol intoxication’ or ‘Toxic effect of alcohol’. Figure 17 below shows the number of patients coded with either of these in the period 2009-14.

![Chart showing number of patients attending ED coded as 'Acute Intoxication of Alcohol' or 'Toxic Effects of Alcohol' 2009-14](image-17)

This chart suggests a trend of increasing number of patients attending the ED specifically due to acute toxic effects of alcohol over the time period 2009 to 2014 and mirrors the trend for increasing alcohol-specific admissions to UHS discussed in the next section. However these are unadjusted crude numbers rather than rates and changing baseline population should also be considered as a factor.
6.4 Alcohol and hospital admissions

Alcohol can be directly or indirectly implicated in hospital admissions. When someone is admitted due to a condition wholly attributable to alcohol (attributable fraction = 1), such as acute intoxication or alcoholic liver cirrhosis, it is termed an alcohol-specific admission. By definition these conditions should not arise in the absence of alcohol. Conversely, when someone is admitted due to a condition where alcohol can be a causative factor, but where it is not implicated in every case, the condition is given an attributable fraction. The larger the attributable fractions, the greater contribution alcohol makes in the condition. For example, the attributable fraction for pneumonia in a 35-44 female is 0.08 and for hypertensive disease in males above age 75 is 0.15. Attributable fractions allow alcohol-attributable admission rates to be calculated which can provide an overarching impression of alcohol-related harm. Alcohol-specific admissions provides a more direct impression of admissions caused by alcohol.

6.4.1 Alcohol-specific admissions

The conditions which have been given an attributable fraction equal to 1 are the same used to calculated alcohol-specific mortality which can found in section 6.1.

Alcohol-specific admissions in Southampton are significantly higher than the England average as can be seen in figure 18 below. This is true for males and females combined and separately. These are directly age-standardised rates which generates a rate that would apply if a standard population had the same age-specific rates as Southampton which allows comparison with areas with different age group distributions. This is important to give a more accurate idea of how Southampton compares to the national rate and other comparator cities.

6.4.1.1 Southampton compared to statistical neighbours

The Office for National Statistics (ONS) updated list of ‘statistical neighbours’ was briefly discussed in section 6.1.2. As can be seen from figure 18, Southampton has an alcohol-specific hospital admission rate that is statistically similar to many of its comparator statistical neighbours. It is significantly lower than Liverpool and Salford but significantly higher than Birmingham, Sheffield and Leeds.

The time trend graph for alcohol-specific admissions in figure 19 shows that between 2010/11 and 2011/12 there was a statistically significant increase which has since stabilised at the higher level. This was true for both males and females (data not shown). This trend appears to have mirrored a slight increase over time in the national average number of alcohol-specific admissions. This is no indication that this is a phenomenon associated with coding or data collection and is more likely the real consequences of a greater prevalence of higher risk drinking in the population.

A separate indicator exists for alcohol-specific admissions in the under-18 year age group. This has been discussed separately in section 5.1 on alcohol and young people.
Figure 18: Alcohol-specific hospital admissions in Southampton 2013/14

Figure 19: Alcohol-specific admissions time trend
6.4.1.2 Alcohol-specific hospital admissions by ward

Alcohol-specific hospital admissions by electoral ward are shown in figure 20 below. This shows that Bitterne, Freemantle, Swaything, Bargate and Bevois have alcohol-specific admissions significantly above the Southampton average. Again these are age-standardised rates to take account of the different population structure of each area. The central ward of Bevois has notably an alcohol-specific admission of twice the city average.

![Alcohol-specific hospital admissions - Southampton Electoral Wards: 2012/13 to 2014/15 (pooled)](image)

Sources: Inpatient SUS, Mid Year Population Estimates (The Office for National Statistics)

Figure 20: Alcohol-specific hospital admissions 2012-2014 pooled by ward

6.4.1.3 Alcohol-specific hospital admissions and deprivation

Apart from being central wards where a lot of the night-time economic activity takes place, these wards also contain a high proportion of the most deprived small area populations in the city. There is an association between alcohol-specific hospital admission and deprivation as shown in figure 21 below. This association is the same whether using local deprivation quintiles (as in figure 21) or national deprivation quintiles.
6.4.1.4 Alcohol-specific hospital admissions and Better Care Clusters

The government has assigned money for use in integrating health and social care to try and improve the experience of people needing such joined up help by putting them at the centre of the service. This is called the ‘Better Care Fund’. In order to deliver the service the Southampton geography has been divided into 6 clusters. Figure 22 below shows a map relating clusters to wards and figure 23 shows alcohol-specific admission rates by cluster.
6.4.1.5 Alcohol-specific hospital admissions by ICD-10 diagnosis

The breakdown of alcohol-specific admissions by diagnosis is shown in table 6 below. Where there are no admissions shown for a particular diagnosis this could mean there were no admissions or less than 5 in total meaning data is suppressed. The majority of alcohol-specific admissions appear to be due to mental and behavioural disorders due to harmful use, acute intoxication, dependence syndrome, toxic effects or withdrawal. It is not clear how the first four diagnoses will be differentiated.

<table>
<thead>
<tr>
<th>ICD Diagnosis</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>F101 - Mental and behavioural disorders due to use of alcohol: harmful use</td>
<td>1662</td>
</tr>
<tr>
<td>F100 - Mental and behavioural disorders due to use of alcohol: acute intoxication</td>
<td>1075</td>
</tr>
<tr>
<td>F102 - Mental and behavioural disorders due to use of alcohol: dependence syndrome</td>
<td>813</td>
</tr>
<tr>
<td>T510 - Toxic effect: Ethanol</td>
<td>603</td>
</tr>
<tr>
<td>F103 - Mental and behavioural disorders due to use of alcohol: withdrawal state</td>
<td>387</td>
</tr>
<tr>
<td>K703 - Alcoholic cirrhosis of the liver</td>
<td>255</td>
</tr>
<tr>
<td>K709 - Alcoholic liver disease, unspecified</td>
<td>244</td>
</tr>
<tr>
<td>K860 - Alcohol-induced chronic pancreatitis</td>
<td>98</td>
</tr>
<tr>
<td>T519 - Toxic effect: Alcohol, unspecified</td>
<td>85</td>
</tr>
<tr>
<td>K292 - Alcoholic gastritis</td>
<td>66</td>
</tr>
<tr>
<td>K852 - Alcohol-induced acute pancreatitis</td>
<td>54</td>
</tr>
<tr>
<td>K701 - Alcoholic hepatitis</td>
<td>41</td>
</tr>
<tr>
<td>K700 - Alcoholic fatty liver</td>
<td>24</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>F104</td>
<td>Mental and behavioural disorders due to use of alcohol: withdrawal state with delirium</td>
</tr>
<tr>
<td>F106</td>
<td>Mental and behavioural disorders due to use of alcohol: amnesic syndrome</td>
</tr>
<tr>
<td>F109</td>
<td>Mental and behavioural disorders due to use of alcohol: unspecified mental and behavioural disorder</td>
</tr>
<tr>
<td>F105</td>
<td>Mental and behavioural disorders due to use of alcohol: psychotic disorder</td>
</tr>
<tr>
<td>Y919</td>
<td>Alcohol involvement, not otherwise specified</td>
</tr>
<tr>
<td>F107</td>
<td>Mental and behavioural disorders due to use of alcohol: residual and late on-set psychotic disorder</td>
</tr>
<tr>
<td>F108</td>
<td>Mental and behavioural disorders due to use of alcohol: other mental and behavioural disorders</td>
</tr>
<tr>
<td>G312</td>
<td>Degeneration of nervous system due to alcohol</td>
</tr>
<tr>
<td>G621</td>
<td>Alcoholic polyneuropathy</td>
</tr>
<tr>
<td>K702</td>
<td>Alcoholic fibrosis and sclerosis of the liver</td>
</tr>
<tr>
<td>Q860</td>
<td>Fetal alcohol syndrome (dysmorphic)</td>
</tr>
<tr>
<td>R780</td>
<td>Finding of alcohol in blood</td>
</tr>
<tr>
<td>T511</td>
<td>Toxic effect: Methanol</td>
</tr>
<tr>
<td>X459</td>
<td>Accidental poisoning by and exposure to alcohol</td>
</tr>
<tr>
<td>Y154</td>
<td>Poisoning by and exposure to alcohol, undetermined intent</td>
</tr>
</tbody>
</table>

### 6.4.2 Alcohol-related admissions

The concept of attributable fractions has been described above. Alcohol-related hospital admissions includes all the cases of alcohol-specific hospital admissions and those in which alcohol is known to play a part. The full list of alcohol-attributable fractions used in the Local Alcohol Profiles for England (LAPE) data set can be found by accessing the LAPE user guide:


Alcohol-related hospital admissions in Southampton mirrors the differences with the England average seen in the alcohol-specific hospital admissions with a statistically significant higher rate for all persons and males separately, but not significantly for females separately. This can be seen in figure 24 below. There were 2750 alcohol-related admissions in 2013/14.

A time-trend for alcohol-related hospital admissions is shown in figure 25 below for rates between 2008 and 2014. Much like alcohol-specific admissions this shows an increasing trend from 2008 to 2012 since stabilising at the higher level. It is not surprising that alcohol-related admissions follow the same trend as alcohol-specific admissions.
**Figure 24: Alcohol-related hospital admissions 2013/14 Broad Definitions**

**Figure 25: Alcohol-related admissions Southampton 2008-2014 Time Trend**
Both these sets of data have used the broad definition of alcohol-related. This is an indication of the totality of alcohol health harm in the local adult population. A narrow measure is also separately reported which encompasses where an alcohol-related illness was the main reason for admission or identified as an external cause. Using the narrow definition, Southampton has a statistically significant higher rate of alcohol-related admissions for all persons and separately for males and females (data not shown).

6.5 University Hospital Southampton Alcohol Care Team

The Alcohol Care Team has been working in University Hospital Southampton for the last five years. It consists of a small team of specialist nurses based in University Hospital Southampton. The team is commissioned by the City Council Integrated Commissioning Unit (ICU) with the aim of optimising the care of inpatients with alcohol related harm. The team also interface between secondary care and drug and alcohol teams to ensure patients are appropriately followed up and tries to reduce the number of unnecessary readmissions associated with a number of alcohol dependent individuals. The team also have a training role for other staff within the hospital and have trained approximately 200 staff since April 2015.

They accept referrals from within the hospital wards or via the clinical decisions unit (CDU) which is part of the Emergency Department (ED) where patients may be monitored prior to either being discharged from the ED or admitted into the hospital. Approximately half of the patients which the team engages with are as a result of these referrals. The other half of suitable patients are discovered by daily visits to the CDU, Acute Medical Unit, and the gastroenterology and hepatology wards. The team generally aim to see only the higher risk patients (those reaching a score of 5-8 on the Audit-C questionnaire (Appendix C)), whereas those who could benefit from a brief intervention would ideally have this carried out by a ward nurse.

The team have previously performed an audit of medical records on the Acute Medical Ward and discovered that alcohol was only recorded in the clinical history in 50% of admissions23. This suggests that identification of alcohol harm, the precursor for a brief intervention when appropriate, is suboptimal within secondary care.

The Alcohol Care Team kindly performed a snapshot identification exercise on the Acute Medical Unit on a Monday morning in the middle of September. The team performed a full AUDIT questionnaire (Appendix C) for any patient in whom it was appropriate to assess at the time of their visit. A total of 46 suitable patients out of 55 occupied beds were assessed with the full AUDIT score. A score of 8 or more is associated with hazardous drinking or harmful alcohol use. On this occasion 8 out of 45 individuals (18%) reached AUDIT scores of 8 or more. Figure 26 below shows the distribution of AUDIT scores in the snapshot sample.

No other activity data has been available at the time of writing this report. However, the Alcohol Care Team is working closely with the ICU in developing a robust alcohol care pathway as explained further in section 6.7.

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23 Anecdotal, data not seen
6.6 Alcohol Services in Southampton

There are four tiers of alcohol treatment shown in table 7 below.

### Table 7: Tiers of alcohol treatment services

<table>
<thead>
<tr>
<th>Tier</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1</td>
<td>Non-substance misuse specific services providing minimal interventions for alcohol misuse</td>
</tr>
<tr>
<td>Tier 2</td>
<td>Open access alcohol treatment services</td>
</tr>
<tr>
<td>Tier 3</td>
<td>Structured community-based treatment services</td>
</tr>
<tr>
<td>Tier 4a</td>
<td>Residential alcohol misuse specific services</td>
</tr>
<tr>
<td>Tier 4b</td>
<td>Highly specialist non-substance misuse specific services</td>
</tr>
</tbody>
</table>

Tier 2, 3 and 4 alcohol services are currently commissioned by the public health team at Southampton City Council in conjunction with the integrated commissioning unit (ICU) and funded by the public health grant. Currently the service is combined with drug services. This was a result of the re-commissioning of services which went live in November 2014.

Current provision is split between specialised services for young people, 24 years of age and under, and adult services for anyone over the age of 25. The services sit under an umbrella partnership known as the ‘Southampton Drug and Alcohol Recovery Partnership’ consisting of the different provider organisations.

Figure 28 below represents the current partnership working.
Southampton’s Integrated Drug and Alcohol Service

24 and Under

Young Persons Substance Misuse Service (No Limits)
Advice, Information, Brief and Extended Interventions
Assessment, Recovery Plan, Care Co-ordination and Support

25 and Over

Assessment, Review and Monitoring (CRI)
Advice, Information, Brief Interventions, Assessment, Recovery Plan, Care Co-ordination and Support

Delivery Service (Solent – SSJ – No Limits)
Keyworking, Groups, Prescribing

Other Interventions
Detox, Rehab, Other Personalised Treatment

Figure 28: Southampton Alcohol and Drug Recovery Partnership
A third sector organisation in Southampton called ‘No Limits’\(^{24}\) is currently commissioned to provide alcohol services for young people. This service is known as DASH (Drug Alcohol Support and Health). The equivalent service for those over 25 years of age is ARMS (Assessment and Review Monitoring) which is provided by the charity CRI\(^{25}\) (Crime Reduction Initiatives). Solent NHS Trust provide part of the delivery wing of the service in conjunction with the Society of St James\(^{26}\) and No Limits.

6.6.1 Alcohol detoxification

Detoxification\(^{27}\) for alcohol dependence and rehabilitation is an intervention that is sometimes required. There is no formal commissioning arrangements for inpatient detoxification in University Hospital Southampton (UHS). Anecdotally, detoxification at UHS is believed to take place – possibly when a patient has been admitted for an accompanying alcohol complication or co-morbidity. In the community, ARMS is able to make spot purchasing of inpatient detoxification from local providers such as Baytrees in Portsmouth, run by Solent NHS Trust. Baytrees describe themselves as a ‘recovery focused inpatient detox centre’. A second provider, ‘Ana’, in Farlington, near Portsmouth, is a private rehabilitation centre which offers detoxification and treatment for alcohol dependence. Day detoxification was previously available from the Royal South Hants Hospital in Southampton but this was decommissioned at the end of 2014.

GPs may assist the withdrawal of patients from alcohol by prescribing certain medication. There is no data to suggest how often this is done and how successful it is. One of the ways of understanding the work GPs do is by looking at drugs they prescribe. For alcohol withdrawal/detoxification many of the drugs have other uses making it impossible to know why they were prescribed. One drug that tends to be only prescribed in alcohol withdrawal is Chlordiazepoxide. There were 282 prescriptions issued for this drug between April 2014 and March 2015 suggesting a fair amount of community prescribing for withdrawal is taking place.

There is no current inpatient detoxification available for individuals under the age of 18. Whilst this is rarely necessary the lack of provision anecdotally put a 17 year old individual at risk because they ended up going through alcohol withdrawal in an unsupported home environment.

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\(^{24}\) No Limits is a charity which offers free and confidential information, advice, counselling, support and advocacy for children and young people under 26 who live in Southampton and Hampshire. All services are confidential and free to young people. The organisation relies on the support of volunteers, local partnerships and dedicated staff who help thousands of young people a year.

\(^{25}\) Criminal Reduction Initiatives (CRI) is a leading charity providing free treatment and support to vulnerable people facing addiction, homelessness and domestic abuse.

\(^{26}\) Society of St James is a Hampshire-based homelessness charity, providing accommodation and support to over 2500 people each year and provides a life changing, personalised substance misuse recovery service for people living in Southampton.

\(^{27}\) Alcohol detoxification is an important preliminary step in the management of alcoholism. It is a medically supervised period of alcohol withdrawal. During this period, a doctor may administer medications to control symptoms, and the individual is monitored by health professionals to ensure his or her safety.
6.7. Alcohol Treatment

This part of the report focuses on adults in treatment services in Southampton for alcohol only misuse. This represents only 54% of all clients receiving alcohol treatment. Clients also are categorised by combination of alcohol misuse with opiates (7%), non-opiates (18%) or both (20%). Crack, cocaine and cannabis are the most commonly cited drugs used alongside alcohol. Combination addiction demographics and outcomes will not be considered further as part of this report. However it should be noted that such clients are particularly complex and may require additional support.

6.7.1 Demographics of people in adult treatment services in Southampton

Gender, age and ethnicity

There were 416 adults in treatment in Southampton in 2014-15 and 263 of these (63%) were adults starting treatment. The proportion of males and females in treatment for Southampton and a comparison with England is shown in figure 29 below. It can be seen from this chart that a much higher proportion of males are in alcohol treatment compared to females which mirrors the national trend but with a slightly higher proportion of males in Southampton compared to the national picture.

![Proportion of males and females in alcohol treatment 2014-15](image)

Despite there being many more males in treatment than females, the age distribution between the genders is very similar as shown in figure 30 for Southampton and figure 31 for England below.
Nationally in 2014-15, 87% of clients in alcohol treatment were white British. Other white was the next most common ethnicity, (3%) compared to 5% of the English population. No other ethnic group accounted for more than 2% of the total cohort. The ethnicity of clients in Southampton alcohol treatment is not currently accessible for the NDTMS database. Country of origin reports are generated annually. The last one for 2013/14 is shown below in figure 32 below.
6.7.2 Drinking levels of clients entering treatment

In Southampton 83% of adults in alcohol treatment services were drinking at higher levels of risk in the 28 days prior to entering treatment. For those of which the data on alcohol units was complete, the range of units consumed in the 28 days prior to entering treatment is shown in figure 33 below for males and females in Southampton and England.

![Figure 33: Alcohol units consumed in the 28 days prior to entering treatment](image)

This shows that in Southampton, a higher proportion of both males and females had drunk 800-999 and over 1000 units of alcohol in the 28 days prior to entering treatment, compared to the national figures. An example of what 1000 units equates to 25 litre bottles of vodka or 250 cans of Carlsberg Special Brew. This suggests that Southampton alcohol treatment services may be seeing a higher proportion of more heavily dependent drinkers and this may reflect on outcomes of treatment or length of time in treatment.

6.7.3 Safeguarding

Sixty percent of adults in alcohol-only treatment have no children. Fifteen percent are parents living with their children and 24% are parents who do not live with their children. A higher proportion of females than males are parents either living with or without their children.

6.7.4 Employment and housing

Only 12% of clients entering treatment for alcohol misuse are in regular employment. The majority of the clients are unemployed, disabled or on long term sickness. Less than 1% are in education. The majority (83%) do not have a housing issue but 3% have no fixed abode and 11% have a non-urgent housing problem.
6.7.5 Treatment

The anatomy of current alcohol treatment services in Southampton have been described in the section 6.6. This also describes how the recommissioning process led to a marked change in the structure of treatment services in November 2014. A number of measures are recorded by the National Drug Treatment Monitoring System (NDTMS) which is managed by Public Health England (PHE) in order to measure how treatment services are performing.

Due to changes in methodology it is not possible to compare some treatment outcomes prior to April 2014 with outcomes since. As previously described in this report, the estimated prevalence of drinking behaviour in Southampton of suggests that 5%, or over 10,000 adults in the city drink at a higher risk level. Clearly not all higher risk drinkers need specialised treatment services. Nationally there are believed to be 1 million people dependent on alcohol of which only 6% are believed to have treatment in any one year\(^{28}\). Currently there is no national model that estimates the prevalence of alcohol dependence reliably at a local level. However the department of health have commissioned Sheffield University to develop a model. There are no current bench marks for how many clients each local population should have in treatment or starting treatment. However one method of comparison is with a locality’s own performance in the previous years or compared to the national or local comparator populations.

Figure 34 below conceptually explains alcohol treatment outcome measures and they are described in table 8. Number in treatment is one of the measures of performance of alcohol and drug treatment services and is partly a measure of capacity as well as throughput.

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\(^{28}\) NICE Alcohol-use disorders guidance 2011
Table 8: Treatment outcome definitions

<table>
<thead>
<tr>
<th>Measure</th>
<th>Reporting Time Period</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number in treatment</td>
<td>Rolling 12 month period</td>
<td>Number of individuals in contact with structured treatment for the most recent 12 months</td>
</tr>
<tr>
<td>New Presentations to treatment</td>
<td>Year to date</td>
<td>The total number of individuals who started a new treatment journey in the year to date</td>
</tr>
<tr>
<td>Total exits</td>
<td>Year to date</td>
<td>The total number of individuals who exited from the treatment system in the year to date</td>
</tr>
<tr>
<td>Effective Treatment</td>
<td>Rolling 12 months (set 3 months back)</td>
<td>The number of individuals in contact with structured treatment, during the period in question, who are recorded as having begun a treatment intervention and who fulfil either of the following criteria; - they were retained for 12 weeks or more from their triaged date - they successfully exited from treatment (i.e. exit reason of treatment completed drug/alcohol free or treatment completed occasional user) This measure is set 3 months back to allow for all individuals to be followed up for the full 12 weeks</td>
</tr>
<tr>
<td>Successful Treatment</td>
<td>Varies</td>
<td>Proportion of successful completions as a proportion of all treatment where success if defined as the individual no longer having a need for structured treatment, having achieved all the care plan goals and having overcome dependent use of the substances that bought them into treatment.</td>
</tr>
<tr>
<td>Re-presentation</td>
<td>Varies</td>
<td>Proportion who successfully completed treatment in the first 6 months of the latest 12 month period and re-presented within 6 months</td>
</tr>
</tbody>
</table>

6.7.6 Alcohol treatment performance

6.7.6.1 Number in treatment

Figure 35 below shows the number of persons in Southampton in alcohol treatment. As described in table 8 above this is a rolling total for the preceding 12 month period. NDTMS do not publish data in the month of July due to updates to their systems. There appears to be a downward trend in numbers within treatment. The change in colour in the graph represents when the new treatment partnership began operations in Nov 2014. They will have inherited the clients from the existing treatment services. Figure 36 combines the rolling 12 months number of persons over a six month period (May to September) over a two year period. This clearly demonstrates a drop in numbers in treatment more marked in the recent months. This could indicate a genuine drop in number of clients the service is delivering treatment to or that some interventions are not being recorded as treatment.
6.7.6.2 New Presentations

A lower number of new presentations to the service could explain the lower numbers in treatment. Most recent data suggests there were approximately 60% less new presentations in the period April 2015 to September 2015 compared to the same period in 2014. This is shown in figures 38 and 39 below. It is not immediately clear why there are fewer new presentations for treatment. It is possible that some important interventions are being given and incorrectly classified as a client being in treatment. However it could also indicate a problem with the coordination of services or the recording of data.
6.7.6.3 Exits from treatment

The following two figures 40 and 41 below show exits from treatment. Exits occur for a number of reasons the most ideal being successful treatment. In the year to date, 53 clients
left the service. Of these 22 (42%) were alcohol free and 9 (17%) were occasional users – both of which are considered successful outcomes. The remaining 41% were a mixture of client deaths (2%), drop outs (25%), failure to commence treatment (2%), treatment withdrawn by provider (6%) or client transfer into custody (6%). Comparing a six month period over two years of data in figure 41, it can be seen that there is a lower number of exists this year compared to last year. This may be because the pool of clients from which exits will occur has become smaller as described above.

Figure 40: Exits from alcohol treatment in Southampton 2014-15

Figure 41: Exits from alcohol treatment services in Southampton 2014-15
6.7.6.4 Length of time in treatment

NICE Clinical Guidance on alcohol use disorders suggest that harmful drinkers and those with mild alcohol dependence might benefit from a package of care lasting three months, those with moderate dependence a six month package, and those with severe dependence a 12 month package. There is however a balance between the time needed for successful treatment and a client not moving through the system effectively. Figure 42 below shows the distribution of length of time in treatment for Southampton and compared to the national picture. It appears that a higher proportion of clients spend less than one month in treatment compared to the national picture and a greater proportion over 12 months in treatment.

![Length of time in treatment 2014-15](image)

**Figure 42: Length of time in alcohol treatment Southampton and England 2014-15**

6.7.6.5 Successful treatment and re-presentation

Trends in successful completions of treatment and re-presentations as defined above are shown in figure 43 below. This shows a significant drop in successful completions over time. This is also shown in figure 44 below which uses a baseline period of 1/4/14 to 31/3/15 to compare the 12 months from 1/11/14 to 31/10/15. This suggests there are approximately half the number of successful treatments as a proportion of all in treatment since November 2014 compared to baseline (23.8 % compared to 42.6%). The national average is 39.1%.

Re-presentations would ideally be at a low level although it can be argued that a client re-engaging with the treatment services is a positive step. If a client enters treatment for an alternative substance they are also classified as a re-presentation which may also effect the figures. The trend seen in figure 43 shows that alcohol re-presentations dipped towards the beginning of 2015 and have gradually turned towards baseline. Compared to the baseline period of 1/4/14 to 31/3/15 where re-presentation for alcohol services occurred in 6.7% of clients the latest data suggest since 1/11/14 to 31/10/15 the rate is 14.3%, which is higher than the national average of 10.6%. This is shown in figure 45 below.
Figure 43: Successful completion and re-presentation performance of Southampton alcohol treatment services

Figure 44: Proportion of successful completion of all in treatment in Southampton
The above data demonstrates some of the complexity of alcohol treatment services. There are indications that the performance of alcohol treatment services since the recommissioning of providers has declined. This may be a mixture of changing working practices, coordination of care, classification of treatment and data recording. Significant work has been done by the Integrated Commissioning Unit (ICU) within Southampton City Council in conjunction with Public Health England and the Southampton Drug and Alcohol Recovery Partnership in order to address these issues. For example a key alcohol care pathway is being developed which will facilitate alcohol dependent patients being passed from the Alcohol Care Team at University Hospital Southampton into community treatment services with an emphasis on person-centred care and optimising engagement. The ICU is also working with providers to ensure that all their unstructured treatment is correctly captured to address some of the issues discussed above. Services have also produced improvement plans which are monitored by the ICU who are also attending regular provider meetings to ensure improvements.

### 6.8 Alcohol and Street Drinking

In 2014, Public Health Southampton commissioned a project for Southampton Health Promotion Service to create a community street drinking profile in the Central and Shirley areas of Southampton. The project involved engaging with a number of key stakeholders including Homeless Healthcare (NHS), Police, EU Welcome, Newtown Residents Association, Nautilus, Street Pastors and Southampton Street Hostel to understand their perspectives on the street drinking community.

It is not possible to gain precise data on the prevalence of street drinking in Southampton. The street drinking community is fairly transient and no routine data is collected. However, stakeholder opinion is that there is a high prevalence of street drinking in the city.
Health Promotion Services conducted three community walks around the Southampton Central Area to observe hot spots of street drinking. The red dots on the following maps in figure 46 and 47 below represent the locations where street drinking was observed.

Figure 46: Street Drinking Observations Central Areas in Southampton

Figure 47: Street Drinking Observations around Royal South Hants Hospital Southampton
Twenty-one street drinkers were interviewed as part of the profiling; 18 conducted on the streets and three conducted in Southampton Street Hostel. None of the participants were sleeping on the streets and accommodation cited varied between hostels (7), private rented (6), council property (4) and a friend’s place (4). The ages of participants are shown in table 9 below.

Table 9: Street drinking survey age of participants

<table>
<thead>
<tr>
<th>Age Bracket</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-30</td>
<td>5</td>
</tr>
<tr>
<td>31-40</td>
<td>8</td>
</tr>
<tr>
<td>41-50</td>
<td>6</td>
</tr>
<tr>
<td>51-60</td>
<td>2</td>
</tr>
</tbody>
</table>

Key findings from these semi-structured interviews were:

- Alcohol consumption ranged from 31-52 units per day, mainly from high strength lager or cider rather than spirits
- Participants expressed mental health or drug-use as precipitating their heavy alcohol use
- Several participants described a sense of community from time spent drinking together
- 95% of participants had tried to give up alcohol at some stage
- The most common cited barriers to change were being around other drinkers, lack of prescribed drugs to help abstinence and boredom.
- 52% of participants were happy with the services available and some of the others thought more services should be available but could not define how this might look
- 43% of participants hoped for more access to prescribed abstinence drugs
- Several participants expressed an interest in paid employment to create a better life for themselves but believed themselves to be unemployable
- All participants were registered with a GP
- There were a total of 65 visits to the Emergency Department (ED) amongst the group as a whole over the last year (18 out of 21 participants); the most common number of ED visits was 3 (range 0-6)
- Some participants described concern that the controlled drinking zone pushed them into more dangerous areas of the city where there is less police presence
- Police confiscating alcohol was cited as a concern by some participants; this was also a concern raised by some stakeholders due to the risks associated with acute withdrawal of alcohol

Seven interviews were conducted with local businesses. Out of twelve convenience stores selling alcohol only three agreed to be interviewed. It was postulated that the low uptake rate may have been due to a suspicion of motives behind the project or a genuine lack of concern about street drinking. Those that did take part did not wish to have their business named.

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\[29\] It was postulated in the report that boredom may have been given as a response when the underlying motivation/reason was different eg. mental health, when speaking to a professional worker
The key findings from the convenience store interviews were:

- Two of three shops felt there was a problem with street drinking; one did not
- Those two shops worried that street drinkers put other customers off coming in their stores
- All three shops felt that street drinkers were regular customers who provided income
- None of the stores would consider removing high strength alcohol from their shelves citing that competing premises would benefit; there would have to be a blanket agreement from all premises

Four other types of store were also interviewed, a hairdressers, hotel chain, café and a bank

The key finding from these interviews were:

- There was a perception that street drinkers were aggressive, violent and a danger to society
- The local presence of street drinking made the area unsafe
- The café and hotel were inconvenienced by street drinkers using their toilets and to wash, and this was hard for staff to deal with
- People were put off from using the cash points outside the bank by street drinkers begging close by
- Two businesses commented on the mismatch between a promotion of a night time economy and the discouragement of drinking in others

As a whole it appears that there is a significant but unquantifiable street drinking presence in Southampton. This appears to be beneficial for some businesses selling alcohol and detrimental for others where street drinkers are perceived as bad for business or dangerous. The association with poor mental health and alcohol consumption is well recognised. Voluntary agreements between licensing and the off-trade to avoid selling individual cans to street drinkers may help to mitigate some of the harm; national policy on minimal unit pricing may also help to reduce the volume of consumption in this group. However the latter seems like an unlikely policy move at this time. The typical daily alcohol consumption is at a highly damaging level and this group of drinkers are likely to experience a significant volume of alcohol-related ill health including liver disease and premature mortality. The frequent attendances at ED exemplify this. It is encouraging that all street drinkers interviewed were registered with a GP. A different model of engagement incorporating mental health expertise and in environments where alcohol is not so prevalent may help some of these individuals; the sense for belonging they get from being around their ‘street drinking family’ may be a barrier to this.

Public Health continues to commission work around street drinking into 2015/16. Further discussion between stakeholders following the production of the street drinking report will take place in order to develop interventions to support stakeholders and /or the street drinking community in the city
6.9 Alcohol as part of a dual diagnosis

Dual diagnosis is a term used to describe a patient who is suffering with a diagnosable mental illness and also from a diagnosable substance misuse disorder. Alcohol is one of society’s major public health issues and mental illness is another. The relationship between the two is well recognised. Mechanisms such as changes to neurotransmitter functioning due to alcohol in the brain are thought to cause depression. Poor mental health can also lead to the alcohol drinking behaviour in the first place or be a side effect of the harm which alcohol causes to relationships and employment. Comorbid mental health disorders commonly include depression, anxiety disorders and drug misuse, some of which may remit with abstinence from alcohol but others may persist and need specific treatment.

It can be difficult for health professionals to properly assess someone’s mental health when they present with alcohol dependence as the two conditions can be intricately entwined. Equally assessing someone’s alcohol use can be challenging when someone is experiencing mental health issues. There is a concern from a number of stakeholders in Southampton that a number of alcohol dependent individuals may fall between the services offered by mental health professionals and specialist substance misuse services. There may be a number of reasons including the perception that someone acutely intoxicated cannot be helped.

In Southampton a quarter of clients attending specialised alcohol treatment services are also receiving care from mental health services. This is shown in figure 48 below. It should be noted that this statistic refers to previously diagnosed mental health at first assessment. Significant undiagnosed mental health issues may not become apparent until further into assessment or treatment.

![Figure 48: Clients currently receiving care from mental health services for reasons other than alcohol misuse in Southampton and England](image)

It has not been possible to obtain data on dual diagnosis from mental health services for the purposes of this report. Cross-organisational collaboration and communication is essential.
to ensure that patients with the complexity of dual-diagnoses are not lost in the current system. The alcohol-care team at UHS is also integral to this and the new alcohol-treatment pathway being developed should strengthen the communication between organisations relevant to mental health and optimise engagement of clients.

7.0 Ageing Well

7.1 Alcohol and Older Adults

Alcohol consumption in older adults in Southampton is difficult to specifically quantify in the absence of specific population surveys. Alcohol will affect the older person in a number of ways. There may be entrenched behaviour that continues throughout adulthood or new increased consumption due to bereavement and loneliness. NICE recommend reducing alcohol consumption as a modifiable risk factor to reduce the risk of dementia\(^\text{30}\).

The most recent national data on drinking prevalence (2013) in those over 65 years of age is taken from the Opinions and Lifestyle Survey\(^\text{31}\) and is shown in figure 49 below. Drinking prevalence and severity of drinking is greater in men than women. People over the age of 65 are more likely than any other age group to drink on more than 5 days in the preceding week\(^\text{2}\).

![Drinking prevalence England aged over 65 years](image)

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30 Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset, NICE 2015
31 Adult Drinking Habits in Great Britain, 2013, ONS
Despite this regularity of consumption, the proportion of those drinking at each higher level of risk on the heaviest day of drinking is much less than any other age group as shown in figures 50, 51 and 52 below.

There is some evidence that today’s older populations may be relatively heavier drinkers than previous generations due to formative years of increasing affordability, availability, and social acceptability. This coupled with a greater proportion of elderly people due to increasing life expectancy.

![Figure 50: Proportion of age group drinking > 4/3 units on heaviest day in preceding week](image1)

![Figure 51: Proportion of age group drinking > 8/6 units on heaviest day in preceding week](image2)

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32 Older people and alcohol factsheet, Institute of Alcohol Studies, 2013
7.1.1 Alcohol-specific hospital admissions and the older person

The background to alcohol-specific hospital admissions were described in detail in section 6.4.1 of this report. Such admissions affect every age group. Figure 53 below shows the age-specific alcohol-specific hospital admission rates for Southampton. In absolute terms in 2012-14 there were 334 admissions in the over 75-year age group in Southampton in total. This can be seen in table 10 below.

![Figure 52: Proportion of age group drinking > 4/3 units on heaviest day in preceding week](image)

![Figure 53: Alcohol-specific admissions by age group Southampton 2012-15](image)

<table>
<thead>
<tr>
<th>Alcohol-specific admissions to UHS from Southampton Residents (numbers)</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age Group</strong></td>
<td><strong>Male</strong></td>
<td><strong>Female</strong></td>
<td><strong>Total</strong></td>
</tr>
<tr>
<td>[75-79]</td>
<td>134</td>
<td>35</td>
<td>169</td>
</tr>
<tr>
<td>[80-84]</td>
<td>79</td>
<td>30</td>
<td>109</td>
</tr>
<tr>
<td>[85-89]</td>
<td>26</td>
<td>18</td>
<td>44</td>
</tr>
<tr>
<td>[90+]</td>
<td>12</td>
<td>*</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>251</td>
<td>83</td>
<td>334</td>
</tr>
</tbody>
</table>

*numbers less than 5 are not shown

Sources: Inpatient SUS, Mid Year Population Estimates - The Office for National Statistics
7.1.3 Alcohol-related hospital admissions and the older person

The background to alcohol-related hospital admissions were described in detail in section 6.4.2 of this report. Such admissions affect every age group. Figure 54 below shows alcohol-related hospital admission rates per 1000 population by age group and gender. There is a trend for an increasing age-specific alcohol-related hospital admission for men through all age groups whereas for women this increasing age-specific rate appears to peak at age 60-65 and then declines.

Table 11 shows actual numbers of alcohol-related admission. This totalled 17,994 in the over-70 age group in Southampton, between 2012 and 2015, and represents a significant alcohol-related burden to both the individuals and the health services. Admissions in this age groups is also going to have a significant impact on social care demands.

| Alcohol-related hospital admissions to UHS from Southampton Residents (numbers) |
|---------------------------------|-------------|-------------|-------------|
| Age Group           | Male        | Female      | Total       |
| [75-79]             | 497.5       | 108.9       | 606.4       |
| [80-84]             | 437.5       | 90.5        | 528.0       |
| [85-89]             | 255.2       | 72.6        | 327.8       |
| [90+]               | 130.7       | 50.3        | 181.0       |
| Total               | 1320.9      | 322.3       | 1643.2      |

7.1.3 Alcohol and mental health in the older person

A briefing report produced for Alcohol Concern in 2012 suggested that for people aged 60 and over in England, hospital admissions for mental and behavioural disorders associated
with alcohol use outnumber those with alcohol related liver disease and the number of older people between the ages of 60 and 74 admitted to hospitals in England with mental and behavioural disorders associated with alcohol use has risen by over 50% more than in the 15-59 age group over the past 10 years (a 94% increase in the 15-59 age group from 27,477 to 53,258 and a 150% increase in the 60-74 age group from 3,247 to 8,120)\textsuperscript{33}. Additionally, those aged over 75-years of age experience longer period of hospitalisation as a consequence.

The overall findings cannot be explained purely by a rising population of older people given that the population of people aged 65 and above in England and Wales increased by 11% between 2001 and 2011.

### 8.0 Staying Safe

#### 8.1 Alcohol and Licensing

Provision of alcohol for consumption on and off premises is regulated by local authority licensing, planning and trading standards departments. There are currently 698 licensed premises in Southampton – approximately 1 premises for every 250 residents. About 34% of the licensed premises are for off-sales only. A map of current licensed premises in Southampton is shown in figure 55 below.

\begin{figure}[ht]
\centering
\includegraphics[width=\textwidth]{figure55.png}
\caption{Licensed premises in Southampton city}
\end{figure}

\textsuperscript{33} Trends in alcohol related admissions for older people with mental health problems: 2002 to 2012
In the last 10 years there have only been 35 licences or certificates revoked and 39 applications refused. The revoked numbers are probably an accurate reflection of failing the licensing objectives, but the refused include every type of transaction showing as refused, not just new licences or full variations.

Local powers are limited under a framework of legal and policy objectives which focuses on the balance of individual liberties and economics against the immediate harms of acute alcohol intoxication\(^3^4\). The current licensing objectives (as defined by the Licensing Act 2003) are listed in table 12 below and do not currently include a public health objective. This is contrast to Scotland which has included this. The Police Reform and Social Responsibility Act 2011 added health leads as responsible authorities in the licensing process for the first time. However using local powers to prevent long-term health related harm due to higher risk drinking is much more difficult in the absence of a health or public health objective despite the majority of harm coming from chronic conditions.

### Table 12: Licensing objectives in England & Wales

<table>
<thead>
<tr>
<th>Licensing objectives in England and Wales as defined by the Licensing Act 2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention of crime and disorder: based on police advice concerning, preventing crime and maintaining order.</td>
</tr>
<tr>
<td>Public safety: physical safety of people using a premises, immediate harms, e.g. accidents, injuries, unconsciousness.</td>
</tr>
<tr>
<td>Prevention of public nuisance: noise nuisance, light pollution, noxious smells, litter and where an 'effect is prejudicial to health'.</td>
</tr>
<tr>
<td>Protection of children from harm: moral, psychological and physical harm, including underage sale of alcohol.</td>
</tr>
</tbody>
</table>

One of the main problems is attributing alcohol-related harm to specific premises. For example it would be impossible to link routine health data to harm caused by a particular corner shop or nightclub. Licensing police statements are required every 5 years and Southampton is about to publish its latest edition. Special policies can be implemented to address area-wide impacts of alcohol consumption. These are known as cumulative impact zones (CIZ) and are areas where the provision of alcohol is saturated and any new premises must therefore evidence that they would not negatively impact any of the licensing objectives. The onus in the case of the CIZ is on the applicant. This is in contrast to the usual licensing application, the assumption of which is that the license will be granted. Southampton’s current CIZ is shown in figure 56 below.

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Additional powers which can be applied locally include early morning restriction orders and late night levies (LNLs). A LNL was agreed in Southampton last year and was introduced in April 2015. Licensed premises selling alcohol between 00:01 and 06:00 hours, pay an annual fee as a contribution towards the cost of late-night policing, anti-social behaviour and street cleansing.

8.1.1 Test purchasing

The perception from the licensing department is that the off-trade premises are more likely to default on one of their licensing objectives. One important area is the illegal sale of alcohol to any person under the age of 18.
Test purchasing is organised by police or trading standards in order to determine whether premises are abiding by the law. In Southampton there appears a trend in which the number of test purchases have gone down but the odds\textsuperscript{35} of refusal have also reduced. This trend is displayed in figure 57 below. Much of the decline in test purchasing numbers is due to changes in budgets. Premises tend to be targeted when the police have intelligence suggesting underage sales have taken place. It is possible that better targeting of premises likely to fail the test is now taking place.

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figures/figure57.png}
\caption{Underage test purchases Southampton 2010-15}
\end{figure}

Underage selling is the commonest reason for a license to be revoked in the off-trade. After an initial failed test-purchase the person selling to the minor is fined £100 and the premises is given a warning. If a further default occurs within three months then the license is reviewed.

In the on-trade the commonest reason for a license to be revoked is violent incidents within premises. Alcohol-related violence is a considerable issue in Southampton, mostly associated with binge-drinking and the night time economy. Further details can be found in the Southampton Safe City Strategic Assessment found here:


\textsuperscript{35} Odds in this context refers to the chances of refusal versus the chances of sales
In summary there are limitations in the current licensing objectives to address the total health burden of alcohol in Southampton. The CIZ and LNL are tools which can be used to limit the damage that alcohol creates in the city. Creative use of CIZ’s and local licensing policy statements may enhance the damage-limiting powers of the current system. Case studies from elsewhere support the benefit of local initiatives, for example where they have specified minimum unit pricing as a condition of the license within a particular premises within a CIZ36.

8.2 Alcohol and the Southampton ICE bus

The ICE bus or ‘In Case of Emergency’ bus is an innovative initiative to reduce the burden of alcohol-related attendances at University Hospital Southampton Emergency Department during the peak hours (1000 to 0400 hrs) of the Night Time Economy in Southampton City Centre. It was implemented in 2009 and since then has offered an important service offering welfare support and acute medical care to vulnerable people during most Saturday nights in the city. The service is run from a single decker bus which is driven to a central location, usually opposite the Cenotaph.

The service is coordinated by Southampton City Council Safer Communities Team in partnership with South Central Ambulance Service (SCAS). SCAS provide Emergency Care Practitioners (ECP’s) and Emergency Care Assistants (ECA’s) to deliver medical interventions on site using a specially designed treatment area on the bus. Southampton City Council organise the welfare support, driver and shift leader element of the service through a mix of paid workers and volunteers.

An evaluation conducted a year after the ICE bus was instigated found:

- Reduced number of presentations to UHS Emergency Department
- Reduced number of journeys needed by ambulance to hospital
- Improved efficiency and effectiveness of Police enabling officers to focus on their core duties

The review found that the annual total cost for providing the service based on 54 shifts was £53,708, but that direct total savings equated to £123,128 saving a combined £69,420 in combined avoidance of ED attendances, ambulance call outs and police involvement. Figure 58 shows the 2010 ICE bus usage and cost savings. A number of indirect savings which are impossible to measure were also proposed to occur from ICE bus presence. These included the estimated 64% of ICE bus attendees who would not have any intervention elsewhere if it were not for the service. The service offers a preventative element in reducing vulnerability and the risk of becoming a victim of crime. The service offers a safe haven for people who have become separated from friends, or those that are refused taxi entry because of their alcohol use.

Most recent data suggest from April 2014 to March 2015 suggests an increase in ICE bus usage compared to the previous year but lower than in 2010 when the economic analysis was performed. The ICE bus was operational for 57 nights and dealt with 347 clients. This was an increase of 11% in clients compared to 2013/2014. Figure 59 below shows how client numbers have changed over time in relation to the number of nights of service which has remained fairly constant.

![Figure 59: ICE Bus client & night numbers over time (2011-15)](image)

1 Source: NHS Southampton City
2 Source: South Central Ambulance Service
3 Source: Southampton Police
The busiest time for clients attending the bus is between midnight and 2am with 38% (132) of clients visiting during this time. A further 30% (104) of clients attended during the hours of 2am – 4am.

Males outnumbered females in attending the ICE bus (see figure 60 below) which is a gender difference mirrored in the assault data collected by the community safety team in the council and is a finding that is consistent over time.

![ICE bus attendance by gender](image)

Figure 60: Gender of ICE Bus clients 2013-15

The majority of ICE Bus clients are in the 18-24 year age group. This is displayed in figure 61 below. This probably reflects the age distribution of people frequenting the night-time economy as well as the distribution of binge drinkers.
People living outside the city represent the greatest proportion of clients as can be seen in figure 62 above and this has been consistent over time. This means they could be living just outside the city limits or further afield. This perhaps suggests they are more vulnerable to problems associated with getting safely home should they be affected by the use of alcohol.

Self-referrals represent the main source of referral to the ICE bus as seen in figure 63 below. The variety of referral routes suggest the ICE bus is well recognised within the night-time economy and is an integral part of the safe city partnership.
The reasons for visiting the ICE Bus are shown in figure 64 above and the outcomes of the visit in figure 65. Alcohol represents a substantial component of the ICE bus work and the majority of the clients are deal with by the ICE Bus Emergency Care Practitioner or by the welfare and other staff on the bus. Some clients do still have to be sent to the ED – 57 were sent in 2014-15.
Alcohol and assaults

Detailed information on alcohol and crime is available as part of the Safe City Strategic Assessment available here:


The Emergency Department (ED) at University Hospital Southampton (UHS) records attendance data associated with assaults. This is collated and analysed by the Community Safety Team to help deploy resources more effectively. There were a total of 946 assaults which presented to the ED in Southampton in 2014/15. Of those, 456 were known to occur in Southampton and take place between 1800 hrs and 0900 hrs of the next day. However, there are a number of other assaults where location is unknown and the real number of assaults in Southampton in the night time economy is therefore likely to be greater. In addition, not all assaults will end in attendance to the ED. The number of assaults in 2014/15 represents a 12% reduction in number of assaults that attend ED compared to 2013/14. Alcohol was a factor in 50%, drugs in 3% and mental health in 3% of recorded cases.

The number of attending assaults by month for 2013-15 is shown in figure 57 below. This shows that there are some peaks in summer months and around Halloween and Christmas.
The Licensing Department report that Halloween is the busiest night in the year for the night time economy and coincides with the start of the University terms.

The majority of assaults take place in the central SO14 postcodes as shown in figure 58 below. For the purposes of the analysis all the venues from the city centre are included in this grouping. This is not surprising since SO14 is the focus for the night time economy and contains a high concentration of licensed premises.
Within SO14 and the city centre, figure 58 shows where the assault took place. Most assaults took place in venues as shown in figure 59 below.

Friday and Saturday nights remain as the most frequent night for assaults to take place. There has been a larger drop of 39% between 2013/14 to 2014/15 in the number of assaults.
on a Friday night compared to other nights and this may reflect the observation reported elsewhere that Friday night has become quieter. Day of assault is shown in figure 60 below.

**Figure 60: Assaults by day of week**

Figure 61 below shows the time of evening or night when the assault took place. The peak of assaults occurs between 2100 hrs and midnight. This is a time when a large number of people affected by alcohol will be leaving premises to move to other premises or returning home. This is a vulnerable time when disinhibited behaviours could include violence. However most of the assaults took place within venues suggesting the accumulative impact of alcohol as the night rolls plays a part in when assaults occur.

**Figure 61: Assaults by time of day**
The majority (76%) of victims of assaults are males and 42% between the ages of 18 and 24 years old as shown in figure 62 below. This mirrors the gender proportionality and age of the ICE bus clients and reflects the peak age group frequenting the night time economy.

Similarly the most frequent age for a female victim is 18 to 24 years old as shown in figure 63 below. A partner, ex-partner or spouse is the perpetrator in 17% of assaults to females.
Victims reported assaults to police in 59% of cases, and whilst the police did transport a number of victims to the ED, the majority of them came by ambulance as shown in figure 64 below.

This section demonstrates a high number of assaults occurred in the city in 2014/15 and 230 of these were recorded as alcohol being a factor. The reduction in recorded assaults to the ED between 2013/14 and 2014/15 is encouraging. The importance of partnership working within the City Watch and the function of the ICE bus is integral in reducing the burden of alcohol-related harm to the individual and to the infrastructure of the night time economy. Part of the Late Night Levy described in section 8.1 will help maintain a strong police presence at peak times to further try to reduce the number of assaults occurring in the city.

8.4 Alcohol and Street Pastors

Street Pastors is a third sector organisation, partly funded by a city council grant, which is part of the City Watch Partnership in Southampton. The organisation has been present nationally for the last 11 years and for the last 7 years in Southampton. Since then, teams of two or more Street Pastor volunteers patrol the city centre on a Friday and Saturday night between 1030 and 0400 hrs, when the night time economy is in full swing. They talk to everyone they meet on their patrol, especially people who appear to be in need of help. This
may be due to alcohol intoxication, drug use or other vulnerabilities. They liaise with emergency services, accompany people to the ICE bus, provide flip-flops for someone vulnerable to a high-heel related ankle injury, pick up bottles or broken glass and sometimes simply advise someone that it’s probably time they went home.

Shortly after Street Pastors began patrolling the city at night, an audit in the emergency department in University Hospital Southampton suggested a reduction of 22% in emergency attendances on the nights they patrolled.\(^{37}\)

Street Pastors collect data on every interaction they have each time they go out on a patrol. Data relevant to the alcohol needs assessment includes when they have assisted a drunk person, picked up a bottle or broken glass, handed out some flip-flops, cleared up some vomit, referred to the ICE bus or called an ambulance to a person.

Trends for each of these activities are shown in the following figures 65-70.

\(^{37}\) Anecdotal report from Street Pastors, data not seen
Figure 66: Bottles picked up

Figure 67: Broken glass picked up
Figure 68: Flip-flops provided

Figure 69: Vomit cleared

Figure 70: Referrals to ICE bus and ambulances called
What these charts show is that the number of drunk persons that Street Pastors are assisting, the amount of vomit cleared and the number of flip-flops handed out has reduced between 2010 and 2014. The narrative around these figures is explained by Street Pastors as a genuine reduction in volume of people in the night time economy. However, what this data does not suggest, but the Street Pastor experience on the street does, is that those people who are frequenting the city at night appear to be in a more serious state of drunkenness than in previous years. This is backed up by discussions with the licensing department who report that people may be favouring Saturday night to enjoy the city rather than going out on both nights of the weekend.

Street Pastors will also refer to the ICE bus and these referrals have increased since 2012 and this has been accompanied by a reduction in the number of ambulances they have needed to call. Prior to 2012 a roaming paramedic in the city centre would shepherd appropriate cases to the ICE bus for treatment but that service has been decommissioned. Discussions with Street Pastors also suggest they have become more skilled in preventive action rather than reactionary as their service has evolved since beginning in Southampton.

### 8.4.1 Ambulance call-outs by Street Pastors

Street Pastors keep a record of the location to which they have called an ambulance. Figure 71 below shows the locations of ambulance call outs by Street Pastors in central Southampton in 2013-15. A further call-out not shown in the map occurred in Oxford Street and one in the Bevois Valley. In total there were 38 ambulances called by Street Pastors. Several pins reflect the location of multiple call-outs within the central night-time economy. Unsurprisingly, the Street Pastors patrol through the busiest parts of the city, and the places where they needed to call ambulances all fall within the areas demarked as cumulative impact zones (CIZ) by the licensing team within the council, or the parks just outside these areas (see section 8.1).

Unfortunately the ambulance service have not provided any data pertaining to the total burden to their service with respect to alcohol-related call outs in the city.

Street Pastors is an integral member of the City Watch Partnership and provides an important extra street presence during the busiest times and in the busiest areas of the night time economy. In a similar way that the totality of the work that the ICE bus cannot be measured in terms of cost-effectiveness, Street Pastors have an unmeasurable benefit in the alcohol-harm reduction initiatives in the city. They carry out a diverse role as can be seen from the snapshot of work they perform, from caring for an individual’s welfare to making the streets a more pleasant and safer environment for others by cleaning up vomit and disposing of abandoned bottles and broken glass. Whilst intuitively the Street Pastors cannot be everywhere at the same time, in their absence, a considerable greater amount of alcohol-related harm would have occurred in Southampton city during the busiest times of the night time economy over the last 7 years. Street Pastors should continue to be cherished as part of the City Watch Partnership.
9.0 Recommendations

Alcoholic liver disease, and a number of the consequences of alcohol over-use, such as raised blood pressure, pre-cancerous changes in tissues, or mental health problems, can easily be missed until late in the natural history of the disease. In many cases this can be too late to reverse the damage.

*Earlier intervention is needed, and we must increase the awareness and diagnosis of alcohol related harms in the population.*

National factors can play a key part in reducing alcohol risk, and lobbying activities with the government and alcohol industry need to continue to challenge the status quo.

*This especially applies to minimum unit pricing, and potentially the strengthening of licensing laws.*

Locally we need to focus on delivery of population-wide awareness campaigns and high volume, low cost, risk assessments and brief interventions, while encouraging GPs to be proactive about assessing the potential for alcohol harm among all their patients.

The very high levels of hospital attendance give us an opportunity to work with patients to modify their drinking behaviours, and strong referral links to community services are essential to help engage patients in more structured behaviour change programmes.

*Alcohol referral pathways and carefully integrated services need to be developed locally.*
Awareness of fetal alcohol syndrome among teenagers and young adults, and the risk of alcohol use in pregnancy, needs to be addressed, especially if the binge drinking culture in the UK continues.

*School and college based education needs to raise the profile and understanding of FAS. Obstetric services need to screen and educate pregnant women about the risks of FAS and ensure prompt treatment and pregnancy counselling for women dependent on alcohol.*

Any new licensing powers need to be explored to see if they can be used to reduce harm (see Halo Project)
### Appendix A – GP Questionnaire

#### GP Alcohol Work Questionnaire (September 2015)

**Q1** Which **two** of the following best represents your views on alcohol work in General Practice?

- Alcohol is a societal issue and **NOT** an important part of General Practice work
- Alcohol is an important contributor to mental and physical harm and therefore an important part of General Practice work
- GPs are well placed to contribute towards the prevention of alcohol harm
- GPs do not have time to assess alcohol consumption and give advice
- Other: Please specify

**TICK**

**Q2** Which **one** of the following best represents when you decide to explore alcohol consumption with a patient?

- The patient comes in smelling of alcohol or showing signs of withdrawal
- The patient presents with a condition in which alcohol could be a factor
- The patient or relative raises it as an issue
- Whenever I feel I have the opportunity to address lifestyle factors
- All of the above

**Q3** Which **one** of the following best represents how you assess alcohol consumption with a patient?

- I use a recognised alcohol screening tool eg. AUDIT/AUDIT-C
- I use my own self-generated questions to establish if there is a problem
- I simply try to calculate the number of units my patient is drinking
- I don’t assess alcohol consumption
- None of the above

**Q4** Have you had training in alcohol Identification and Brief Advice? (IBA)

- Yes, as part of the RCGP Certificate in the management of alcohol problems in primary care
- Yes, but from another source
- No, GPs don’t need to be trained in advising about alcohol (Go to Q6)
- No, but I’d like to be trained if locally available (Go to Q6)
- No, it’s important but I’ll never have enough time for this (Go to Q6)
Appendix B – Full Audit Questionnaire

This is one unit of alcohol...

...and each of these is more than one unit

<table>
<thead>
<tr>
<th>AUDIT</th>
<th>Scoring system</th>
<th>Your score</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often do you have a drink containing alcohol?</td>
<td>Never, Monthly or less 2 - 4 times per month, 2 - 3 times per week, 4+ times per week</td>
<td></td>
</tr>
<tr>
<td>How many units of alcohol do you drink on a typical day when you are drinking?</td>
<td>1 - 2, 3 - 4, 5 - 6, 7 - 9, 10+</td>
<td></td>
</tr>
<tr>
<td>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?</td>
<td>Never, Less than monthly, Monthly, Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>How often during the last year have you found that you were not able to stop drinking once you had started?</td>
<td>Never, Less than monthly, Monthly, Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>How often during the last year have you failed to do what was normally expected from you because of your drinking?</td>
<td>Never, Less than monthly, Monthly, Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?</td>
<td>Never, Less than monthly, Monthly, Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>How often during the last year have you had a feeling of guilt or remorse after drinking?</td>
<td>Never, Less than monthly, Monthly, Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>Have you or somebody else been injured as a result of your drinking?</td>
<td>No, Yes, but not in the last year, Yes, during the last year</td>
<td></td>
</tr>
<tr>
<td>Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?</td>
<td>No, Yes, but not in the last year, Yes, during the last year</td>
<td></td>
</tr>
</tbody>
</table>

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence
Appendix C – AUDIT-C Questionnaire

This is one unit of alcohol...

...and each of these is more than one unit

**AUDIT – C**

<table>
<thead>
<tr>
<th>Questions</th>
<th>Scoring system</th>
<th>Your score</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often do you have a drink containing alcohol?</td>
<td>Never</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Monthly or less</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2 - 4 times per month</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>2 - 3 times per week</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4+ times per week</td>
<td>4</td>
</tr>
<tr>
<td>How many units of alcohol do you drink on a typical day when you are drinking?</td>
<td>1 - 2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>3 - 4</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>5 - 6</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>7 - 9</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Daily or almost daily</td>
<td>5</td>
</tr>
<tr>
<td>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?</td>
<td>Never</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Less than monthly</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Monthly</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Weekly</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Daily or almost daily</td>
<td>4</td>
</tr>
</tbody>
</table>

**Scoring:**
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.