Alcohol

# Summary

## Introduction

Alcohol is a prominent commodity in our communities, with an increase in the number of premises licensed to sell alcohol, particularly shops, since 2005 [1]. For many it is associated with positive activities. However, 10 million or more people drink at levels which increase their risk of health harms, and alcohol consumption is a leading factor for ill-health. Among those aged 15 to 49 in England it is the leading cause for ill-health, early mortality and disability [2].

Increased affordability of alcohol in the 1980s and 1990s, a shift to higher strength products and an increase in consumption by women has led to an increase in sales in England and Wales of 42% since 1980. Most alcohol is now bought from shops and drunk at home [1].

Many indicators of alcohol-related harm have seen an upward trend over recent years. Alcohol related hospital admissions and mortality are increasing. This is particularly apparent in the most deprived third of the population. More working years of life are lost in England as a result of alcohol-related deaths than from cancer of the lung, bronchus, trachea, colon, rectum, brain, pancreas, skin, ovary, kidney, stomach, bladder and prostate, combined [2].

The annual economic burden of alcohol is estimated as being between 1.3% and 2.7% of annual GDP [2]. There is a considerable body of international literature showing that policy and treatment for alcohol issues is both effective and cost-effective [3].

This needs analysis considers alcohol issues in adults only.

## Key issues and gaps

* Compared to the South East, Medway has high levels of hospital admissions for alcohol conditions and high levels of alcohol related mortality.
* Hospital admissions for alcohol related liver disease, mental and behavioural disorders and alcohol related conditions, are rising in Men.
* Males between 40 and 64 years are showing a rapid rise in alcohol related hospital admissions where an alcohol-specific illness is the main reason for admission.
* Females between 40 and 64 are also showing a growth in hospital admissions where an alcohol-specific illness is the main reason for admission.
* Overall mortality caused by deaths from alcohol-specific conditions for persons of all ages, is worse than the South East.
* There is a need for effective strategies to address alcohol misuse in hard to reach groups, such as the Eastern European community and the homeless.
* The provision of community rehabilitation and post treatment support needs to be improved.
* There is a need for improved mental health support for those in treatment.
* There is a need for a coherent and comprehensive approach to street drinking.

## Recommendations for commissioning

Commissioning of the substance misuse and treatment service, which includes alcohol treatment services, was completed in 2018. Once the service is embedded a Health Impact Assessment should be conducted to identify remaining or new gaps.

# Who is at risk and why?

## Alcohol and health harms

The context of alcohol use and misuse as a public health issue is due to the complex relationships between alcohol and a range of issues. Alcohol has been identified as being a causal factor in more than 200 medical conditions[4], including:

* A range of cancers, including mouth, throat, stomach, liver and breast cancer[4][2].
* Cirrhosis of the liver[4][2].
* Heart disease[4][2].
* Mental Health issues, including depression[4][2].
* Stroke[4][2].
* Pancreatitis[4][2].
* Liver disease[4][2].

It is also an influence on a range of issues linked to the wider determinants of health, such as

* Crime and disorder[5][6].
* Relationship and family problems[5][6].
* Homelessness[5][6].
* Unemployment[5][6].
* Domestic abuse[5][6].
* Child safeguarding and child sexual exploitation[4][7].
* Adult safeguarding[4].

All major body systems are affected by alcohol consumption. The effects vary according to a number of factors including age, gender, body mass index (BMI), pattern and volume of alcohol consumption and the length of time someone has been consuming alcohol[2].

## General population

In 2016, among adults aged 16 years and above, 56.9% of respondents drank alcohol in the week before being interviewed for the Opinions and Lifestyle Survey, the lowest level seen since our time series began in 2005 (64.2%). This equates to around 29 million people in the population of Great Britain[8]. In 2014, over 10 million adults were regularly drinking more than the recommended maximum of 14 units of alcohol each week. Of these, 1.9 million were drinking at high-risk levels, defined as drinking more than 35 units per week for women and more than 50 units per week for men[2].

## Men

31% of men in England drink alcohol in a way that presents increasing risk or potential harm to their health and wellbeing[4]. Gender and inequality gaps show that disproportionate levels of harm are impacting on men[9]. Among men, the prevalence of drinking more than 14 units a week increases with age and is most common among men aged 65 to 74 years. Thirty-nine per cent of men this age drink at this level[2].

## Women

16% of women in England drink alcohol in a way that presents increasing risk or potential harm to their health and wellbeing[4]. Among women, the proportion who drink more than 14 units a week declines between the ages of 25 and 44 years, and is highest among women aged 55 to 64 years with 21% of women this age drinking at this level[2].

## Unborn Children

During pregnancy alcohol can pass across the placenta to the foetus which is unable to process the alcohol in the same way as an adult. Drinking heavily can lead to Foetal Alcohol Syndrome (FAS), which is typified by restricted growth, facial abnormalities, learning and behavioural disorders. Data that would indicate incidence and prevalence are not routinely collected although numbers are likely to be low at a population level.

## Age

Among those aged 15 to 49 in England, alcohol is now the leading risk factor for ill-health, early mortality and disability and the fifth leading risk factor for ill-health across all age groups[2]. Young people aged 16 to 24 years in Great Britain are less likely to drink than any other age group; when they do drink, consumption on their heaviest drinking day tends to be higher than other ages[8].

## Socio economic factors

The highest earners, those earning £40,000 and above annually, are more likely to be frequent drinkers and “binge” on their heaviest drinking day when compared with the lowest earners[8]. (Binge drinkers are defined as women who drink more than 6 units and men more than 8 units on their heaviest drinking day in the previous week.)

While those from lower socioeconomic groups report lower levels of average consumption, they experience greater or similar levels of alcohol-related harm. They are more likely to die or suffer from a disease relating to their alcohol use. In England rates of alcohol-specific and related mortality increase in line with higher levels of deprivation and alcohol-related liver disease is strongly related to the socioeconomic gradient. This gives rise to what has been termed the ‘alcohol harm paradox’ whereby disadvantaged populations who drink the same or lower levels of alcohol, experience greater alcohol-related harm than more affluent populations. There are a number of hypotheses which try to explain this issue, although the reasons are not fully understood. Possible factors may be:

* Different drinking patterns in different socioeconomic groups[2].
* Lower resilience and/or compounding effects with other risk factors or health conditions for those in lower socioeconomic groups[2].
* Differential access to health services between socioeconomic groups[2].

## Ethnicity

The proportion of adults who do not drink varies between ethnic groups[2].

Asian groups are most likely to abstain from alcohol, particularly Asian women. About 40% of Black people do not drink compared to between 10 and 15% of White ethnic groups.

# The level of need in the population

Local alcohol health data is available through the Public Health England (PHE) Fingertips[9].

There are two types of measure; broad and narrow. ‘Broad’ is an indication of the number of admissions to hospital where the primary diagnosis or any of the secondary diagnoses have alcohol as a contributory factor[9]. ‘Narrow’ shows the number of admissions where an alcohol-related illness was the main reason for admission or was identified as an external cause[10].

## Key indicators

Compared to the South East, Medway has high levels of hospital admissions for alcohol related and alcohol specific conditions, alcohol related mortality and alcohol specific mortaltiy[9].

## Hospital admissions for cardiovascular disease

Coronary heart disease is the single most common cause of premature death in the UK. There is an increasing trend in Medway for the rate of alcohol related cardiovascular disease[9].

## Hospital admissions for liver disease

Alcohol is the most common cause of liver disease in England. Alcohol-related liver disease accounts for over a third of liver disease deaths. The overall trend for alcohol related liver disease admission episodes in Medway is increasing, and is high compared to the South East region. The data shows a significant increase between 2013/14 to 2015/16 for males in this catagory[9].

## Admission episodes for mental and behavioural disorders due to use of alcohol condition

Overall for both narrow and broad measures for this data Medway has a constant upward trend, and is generally similar to the South East region. However for males in both categories there has been a sharp increase from 2014/15 to 2015/16. Medway now has worse rates when compared to the South East region for males[9].

## Admissions episodes for alcohol related conditions (narrow) by age and gender

Medway data for admission episodes for alcohol related conditions (narrow) has shown a rapid rise between 2014/15 to 2015/16 for males between 40 and 64 years following a period of constant to decreasing numbers. Females in this age group have shown a smaller growth over the same period of 2014/15 to 2015/16[9].

## Hospital admissions due to alcohol specific conditions

Medway has been largely constant over the last few years for hospital admissions where the primary diagnosis or any of the secondary diagnoses, are alcohol specific conditions, but has shown a rapid rise for males between the period of 2014/15 to 2015/16[9].

## Alcohol specific mortality

Overall, alcohol specific mortality, which refers to deaths from alcohol-specific conditions for persons of all ages, has shown a steady downward trend in Medway from 2006/08 to 2014/16. However, the rate of male specific mortality is greater than the rest of the South East region[9].

## Mortality from chronic liver disease

While the rate for mortality in males from chronic liver disease in Medway decreased between 2013/15 and 2014/16, it is still significantly greater than the South East region[9].

## Alcohol related mortality

There has been an increasing trend in alcohol related mortality in males of all ages, with rates significantly higher in 2015 to 2016 when compared to the South East region[9].

## Alcohol consumption

The proportion of drinkers in Medway who can be categorised as engaging in increasing risk and higher risk drinking or possible dependence is 26.6%. 16.3% of drinkers consume alcohol on more than 4 or more days a week. 15.5% of drinkers binge drink[11].

# Current services in relation to need

Community based specialist treatment for people who misuse alcohol has been available in Medway for over 10 years. Commissioning intentions have reflected national drug strategy changes, including a drive towards promoting and sustaining the recovery of adults from dependent and problematic substance misuse.

## Alcohol Treatment Services

Adult alcohol treatment services are provided in Medway, with locations in Chatham and Gillingham. Services are available for anyone over the age of 18. Referrals can be made via professionals, such as GPs, as well as self referrals.

For the period 01/10/2016 to 30/09/2017, 224 adults were in treatment with 117 successful completions[12].

## Don’t Bottle It Up

Don’t Bottle It Up[13] is a web based alcohol intervention promoted by Medway Public Health. Between October 2016 and October 2017 there were over 3275 visits to the website, with 1399 of these going on to complete the AUDIT self assessment tool[14].

## Intervention and Brief Advice (IBA)

IBA is an alcohol brief intervention which typically involves using a validated screening tool to identify ‘risky’ drinking, and then the delivery of short, structured ‘brief advice’ aimed at encouraging a risky drinker to reduce their consumption to lower risk levels[15].

IBA training has been given to a variety of people in different settings including:

* Health professionals, such as pharmacies, GP’s, dentists and stroke services.
* Partners, such as community wardens and KFRS.
* Medway Champions.
* Older adult groups.

## Projects

* Blue Light Project - a national initiative to develop alternative approaches and care pathways for treatment resistant drinkers who place a burden on public services[16].
* Public Health participation in the alcohol licensing process.

# Projected service use and outcomes in 3–5 years and 5–10 years

**Table 1:** Medway population projections 2012 - 2026 (ONS sub-national population projections). Note: Figures are in thousands

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Year** | **15 - 24** | **25 - 34** | **35 - 49** | **50 - 64** | **65 +** |
| 2018 | 36.4 | 40.7 | 55.3 | 53.0 | 45.4 |
| 2022 | 36.3 | 41.9 | 55.6 | 56.1 | 49.4 |
| 2026 | 38.2 | 41.0 | 59.0 | 56.1 | 54.5 |

The key indicators of hospital admissions for alcohol related and alcohol specific conditions and alcohol related mortality all show an increasing trend in Medway[9] but the contributing reasons are complex.

Factors that may contribute to a reduction in hospital admission episodes are:

* The ONS figures suggest that 15-24 year olds in Medway will actually decrease over the next ten years and then gradually increase again. Alcohol consumption trends among young people have shown they are drinking less frequently compared with a decade ago[17], and coupled with the decreasing population of this cohort, this may result in a decrease in interventions.
* Changes to treatment and recovery services, aimed at supporting substance misusers through the treatment phase and into a sustainable recovery may reduce the number of people re presenting to treatment services.
* Increase in IBA interventions within the hospital setting in response to updated CQUIN indicators[18], due to start in 2018, identifying increasing risk and higher risk drinkers, will support and encourage healthier behaviour, with the intention of reducing alcohol harms.
* Decrease of the availability of alcohol due to the adoption of a more strategic Statement of Licencing Policy, including a Cumulative Impact Policy in those geographical areas of greatest alcohol related harms.
* Factors that may contribute to an increase in attendances
* Middle aged groups (40 - 64 years), particularly males, who are showing an increasing trend in all key indicators, are projected to grow at a faster rate than younger groups[9]. This older group may experience an increasing incidence of alcohol related harms in line with this trend, with increased associated hospital admission episodes.
* Increase in IBA interventions within the hospital setting in response to updated CQUIN indicators[18], identifying dependent drinkers with subsequent referrals to treatment services, may increase the number of those seeking treatment and recovery services.

# Evidence of what works

PHE and NICE recommends a variety of measures to address alcohol related harm[2][6]:

* Taxation and price regulation.
* Regulating marketing.
* Regulating availability.
* Providing information and education.
* Managing the drinking environment.
* Brief interventions and treatment.

## National measures

* Policies that reduce the affordability of alcohol are the most effective, and cost-effective, approaches to prevention and health improvement[2].
* Taxation and price regulation policies affect consumer demand. Minimum unit pricing (MUP) is highly targeted, ensuring any resulting price increases are passed on to the consumer. Combining an increase in taxation alongside MUP is estimated to lead to substantial gains in alcohol-related health, reductions in crime and work absence costs. This reduction is greater than that achieved by MUP in isolation[2].
* Marketing bans are highly effective and cost effective. Complete bans are more effective and cost-effective than partial bans[2].
* Lower legal alcohol limits for young drivers are effective and cost-effective at reducing casualties and fatalities[2].

## Local measures

* Reducing the hours during which alcohol is available can reduce alcohol-related harm. When enforced and targeted at the most densely populated areas this policy is cost-effective[2].
* Regulating the availability of alcohol by reducing the density of licensed premises may reduce inequalities in specific areas with high levels of alcohol-related harm[2].
* Community programmes that are coordinated and implemented through multi-agency partnerships are effective and cost-effective[2].
* Enforcing legislation for reducing road traffic crashes, casualties and fatalities. Enforcement, using breath testing is cost-effective[2].
* Identification and brief advice is effective at addressing alcohol consumption for at risk drinkers, with specialist treatment for those who have harmful drinking patterns and are dependent. These show good returns on investment. Their success depends on large-scale implementation, dedicated treatment, staffing and funding streams[2].
* Effective treatment and recovery services[2].

# User Views

In 2016/17 Medway Public Health commissioned an audit of local substance misuse needs, including a consultation with service users, treatment providers and partner agencies. 81 people with current or recent substance misuse issues, including alcohol dependence, were consulted, as well as 33 professionals working with both service providers and partner agencies[19].

In 2016/17 a consultation was undertaken with members of the public concerning their perception of alcohol harms linked to licensed premises in support of the licensing policy process. There were a total of 57 responses[20].

It is important to note that views expressed will reflect the opinions of the respondents only and may not accurately represent the views of the entire population.

## Service users

The key messages from this group were:

* There was little rehabilitation support when back in the community, although the idea of community rehabilitation was advocated[19].
* There was a lack of mental health support[19].
* There was often a feeling of box ticking to keep funding going in treatment rather than a personalised approach[19].
* Those who were Eastern European believed their nationality was a barrier to support either through language problems or a right to accommodation[19].
* Lack of accommodation for the homeless was seen as a barrier to successful treatment[19].

## Staff of treatment providers

The key messages from this group were:

* There are good links with agencies in Medway such as hospitals, the university, social services and police[19].
* Alcohol discharges from hospital needed more attention and immediate pick-up[19].
* Working individuals are a potentially neglected group and there should be more on offer to help their recovery[19].
* More emphasis is needed on aftercare[19].
* Issues such as housing threatened people’s ability to change[19].

## Partners

The key messages from this group were:

* A lack of accommodation, especially ‘dry houses’ was a barrier for change[19].
* The service provider was perceived to cater primarily for opiate users, which caused a barrier for users of other substances[19].
* Obtaining mental health support for clients could be problematic[19].
* There was a need for better transitioning support for young adults[19].
* A more holistic way of working for those in active addiction or recovery was needed[19].

## Members of the public

The key messages from this group were:

* 86% felt that licensed premises in their area contributed towards issues of crime, disorder, nuisance, safety and harm to children[20].
* Most residents experienced alcohol related issues weekly or more often[20].
* The majority of the negative impacts from customers of licensed premises occurred during the evening and night. However, there was significant street drinking, littering, intimidation and begging and nuisance during the day impacting communities[20].

# Unmet needs and service gaps

## Ethnic minorities

Those from ethnic minorities, particularly the Eastern European community, are underserved, with language and a lack of stable accommodation highlighted as barriers to treatment and recovery. Improved engagement and access to treatment services for this group would reduce inequality.

## Homeless

There is a need for outreach, especially for the homeless community, who are difficult to reach and engage in treatment and support in recovery. One of the main barriers to support is the provision of suitable accommodation.

## Street drinking

There is a need for a coherent and comprehensive approach to street drinking.

## Peer mentors

The Saturday Club, run by peer mentors, could be further promoted and strengthened, providing a greater support for the recovery community.

## Partnership working

Alcohol discharges from hospital need more attention and immediate pick-up by treatment and recovery services.

## Treatment provision

Provision of community rehabilitation and post treatment support needs to be improved.

A lack of mental health support has been highlighted.

## Males in the 40 - 64 age group

A sharp increase in admission episodes for alcohol related conditions in males aged 40 - 64 has been recorded, as well a smaller increase in females. Attention needs to be given to this specific group to address this issue.

## Area/community intervention

Geographical areas or communities which have an identified need could be prioritised, such as wards with identified high volume of alcohol related harms.

## Intervention and Brief Advice training

Further training will be given to health professionals in the hospital setting, to support proposed CQUIN indicators[18].

# Recommendations for Commissioning

Commissioning of substance misuse services, including wellbeing and recovery services was completed in 2018.

Ensure accessibility of services to all hard to reach groups following mobilisation of commissioned services.

Outreach services to engage the difficult to reach populations, such as the homeless and ethnic minority groups.

# Recommendations for needs assessment work

Assess the level of alcohol harms and barriers to engagement within migrant populations.

Assess the levels of need and service response for clients requiring both mental health and alcohol misuse services.

A substance misuse needs assessment/audit was carried out in 2016/17, which included alcohol misuse. This was carried out with the intention of informing the commissioning process for a new treatment and recovery service. An updated review would help to establish if gaps have been met and where needs still exist prior to the next commissioning process.

Complete a health impact assessment following mobilisation of substance misuse treatment and recovery services.

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