Alcohol

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Executive summary

Introduction

Addressing the harm caused by alcohol is crucial to the improvement of public health and health inequalities. Reducing alcohol-related harm is one of the seven public health priorities and is considered key to achieving the National Health Service's Five Year Forward View.

The misuse of alcohol can take a range of forms and affects citizens across the range of demographics in Nottingham. Both short and longer-term health harms resulting from the misuse of alcohol and especially dependence on alcohol are responded to by the city's commissioned alcohol treatment model alongside primary and secondary care services. This Joint Strategic Needs Assessment (JSNA) identifies that, while solid progress has been made in improving the functioning of the commissioned model, there remains a substantial degree of need among the population. Where alcohol misuse intersects with other social and health issues there are also further public health concerns to be addressed.

This JSNA chapter focuses on alcohol use in adults. A chapter on substance misuse in young people is also available.

Unmet need and gaps

- Almost twice as much alcohol is consumed in the home in the UK, whilst alcohol consumption outside the home has reduced by 50% over the last decade.
- More men than women drink at increasing and higher risk level and binge drink both locally and nationally.
- Drinking alcohol during pregnancy can increase the risk of miscarriage, foetal Alcohol Syndrome (FAS), Foetal Alcohol Spectrum Disorders (FASD), Alcohol Related Birth Defects (ARBD) and Alcohol Related Neurodevelopment Disorder (ARND), learning disability.
- Alcohol hospital admissions and alcohol mortality are more common in men.

- National data suggests the proportion of increasing and higher risk is greatest in the 45-64 year age range whereas local data suggest it is greatest amongst 16-24 year olds.
- National and local data indicates that drinking at higher risk levels is more common amongst people from Lesbian, gay, bisexual and transgender (LGBT) groups than the general population.
- National and local data indicates that drinking at higher risk levels and binge drinking in greatest in people of White British and White (not British) ethnicities.
- Increased deprivation is associated with increased alcohol-related mortality, but groups of higher deprivation report lower levels of consumption.
- Alcohol use is positively associated with mental illness and 45% of people dependent on alcohol have mental health problems.
- Local survey data does not show a positive correlation between alcohol consumption risk category and poor mental wellbeing.
- Area 4 of the city (Arboretum, Radford & Park, Dunkirk & Lenton) has the highest proportion of people reporting they drink at increasing and higher risk levels and binge drinking.
- The rate of alcohol related hospital admissions in the city has increasing since 2009/10 and is now higher than the national, regional and core cities group. This increase is driven by an increase in alcohol specific admissions.
- Wards with the highest rates of hospital specific admissions are Bulwell, Dales, Arboretum, Basford and Berridge wards.
- Alcohol-related ASB accounts for 18% of all ASB calls to the Police and peaks during summer months.
  The alcohol related violent crime has reduced between 2008/9 and 2012/13 however, in the latest reporting period Nottingham had the highest rate compared to the ONS comparator local authorities.
- Almost half of alcohol-related crime occurs in the city centre and the north of the city is also over-represented. However, when considering alcohol-related violence against the person only, crimes are much more evenly spread across the city.
- Women are underrepresented in the local drug treatment system.
- There is an apparent gap in engaging 20-24 year old clients who are underrepresented in treatment services.
- Fear, stigma and mental health and failure to recognise a problem were the most commonly cited issues that might prevent someone from accessing treatment services.
- The links between alcohol consumption and deprivation requires further exploration.

Recommendations for consideration by commissioners

- Ensure that alcohol treatment services are designed to reflect the fact that alcohol consumption within the home exceeds alcohol consumption outside of the home.
- Interventions should be commissioned to reduce the impact of alcohol related harm during pregnancy.
- Ensure interventions which aim to reduce increasing and high risk drinking and binge drinking are targeted at groups with the highest prevalence. This includes men, young people, White British and White (Not British) and LGBT groups.
- Target upstream interventions, including restrictions on the supply of alcohol, towards areas with increased levels of deprivation in order to reduce the elevated risk of harm demonstrated within the alcohol harm paradox.

- Interventions to reduce drinking at highest levels should ensure equity of access from Area 4 of the city (Arboretum, Radford & Park, Dunkirk & Lenton). Interventions to reduce alcohol-specific hospital admissions should be targeted at areas with the highest rates which are Bulwell, Dales, Arboretum, Basford and Berridge wards.
- Local Authority and Clinical Commissioning Group commissioners should work together to ensure that there are robust referral pathways between substance misuse services and psychological therapy, mental health and dual diagnosis services.
- Alcohol treatment services should ensure equity of access by 20-24 year old clients and women who are underrepresented in the current treatment model.

What do we know?

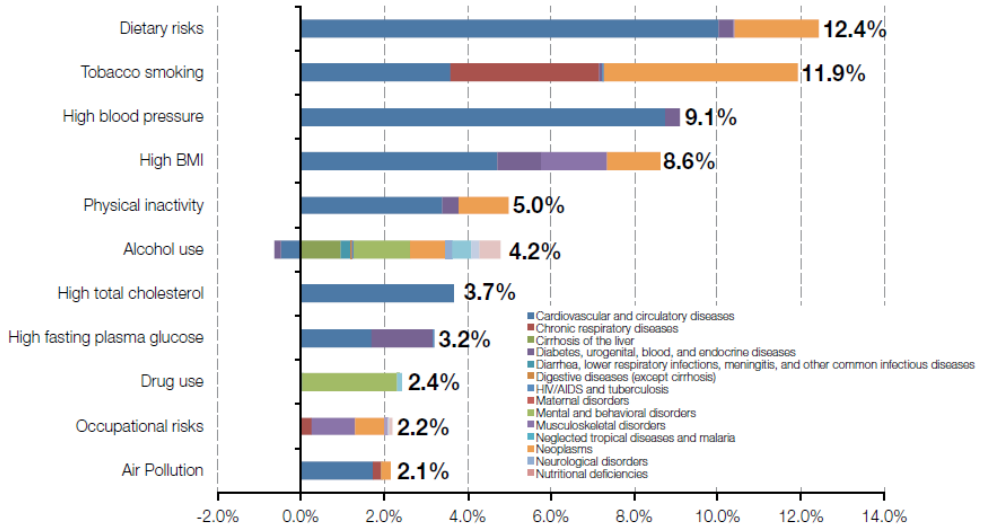
1) Who is at risk and why?

Overall impact of alcohol consumption

Harm caused by the consumption of alcohol is one of the main contributing factors of premature death and disability. Alcohol consumption contributes to more than 60 diseases and conditions including cardiovascular disease, liver diseases and cancer (World Health Organisation, 2009). Alcohol misuse costs the National Health Service an estimated £3.5 billion per year and has an estimated cost to society of £21 billion per year (Public Health England, 2014a). Alcohol can be considered a contributing factor to almost 50% of the measures included within the Public Health Outcomes Framework for England which makes addressing the harm caused by alcohol crucial to improving public health and health inequalities (Smith & Foster, 2014).

Alcohol use represents 10% of the burden of disease and death in the UK which places it in the top three lifestyle risk factors after smoking and obesity (Alcohol Concern, 2015a). Figure 1 demonstrates the burden of disease posed by alcohol consumption and other risk factors including smoking and lack of exercise. Alcohol use accounts for 4.2% of the national burden of disease in the UK and more specifically, liver cirrhosis, other digestive diseases and mental and behavioral disorders. Alcohol is also shown to have a positive impact upon the burden of disease through its effect on cardiovascular and respiratory diseases and diabetes, urogenital, blood and endocrine diseases.

Figure 1 UK disability adjusted life years, both genders all ages 2010 Public Health England (2014d)



Alcohol use exists across a broad spectrum of demographic profiles and yet research has identified higher levels of prevalence within certain populations.

Alcohol consumption risk categories

Alcohol consumption is categorised into four groups:

- lower-risk
- increasing-risk
- higher-risk
- binge drinking

Whilst the former three groups are mutually exclusive, people who binge drink may also be categorised as increasing risk or higher risk drinkers.

The four categories of alcohol consumption together with the corresponding units and risks that escalate as consumption increases are summarised in table 1.

Table 1 Alcohol consumption categories (NHS (2014), Drinkaware (2015a) and Public Health England (2014e)).

Risk Category	Units[a] (men)	Units[a] (women)	Escalating Risks
Lower	≤ 21 (per week)	≤ 14 (per week)	Not advisable when pregnant, going to drive, operate machinery, swim or do strenuous physical activity.
Binge	≥ 8 (regularly)	≥ 6 (regularly)	Increased risk of accident and negative effect on mood and memory. Can lead to antisocial, aggressive and violent behaviour.
Increasing	22 – 50 (per week)	15 – 35 (per week)	Fatigue, depression, weight gain, poor sleep and sexual problems. Increased blood pressure.
Higher	≥ 51 (per week)	≥ 36 (per week)	Cancer of the mouth, liver cirrhosis, high blood pressure, irregular heartbeat and breast cancer (in women).

[a]*One pint of beer equates to approximately 2-3 units.*

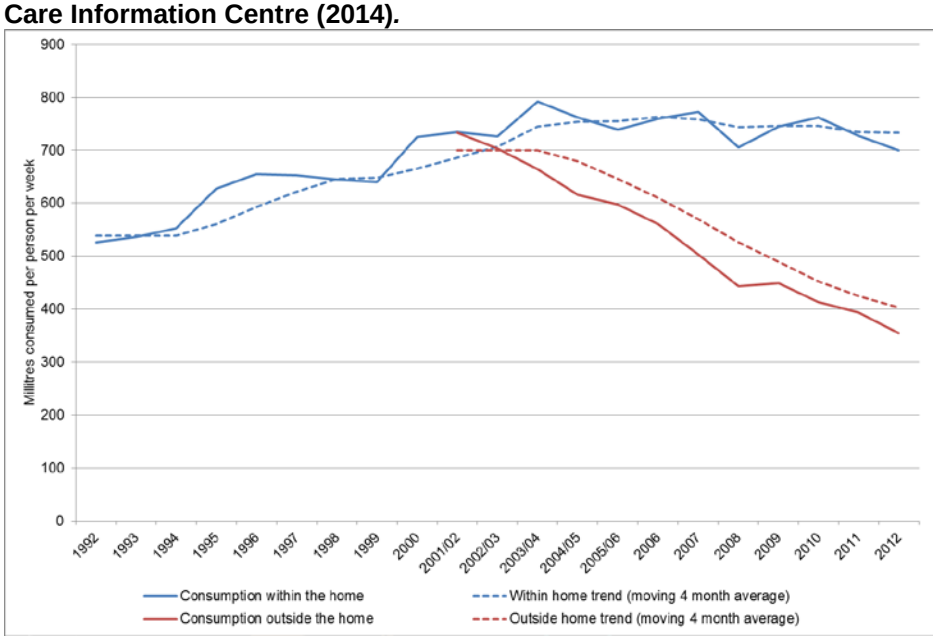
Alcohol dependence exists as a further categorisation of alcohol consumption and pertains to a cluster of behavioural, cognitive and physiological factors that typically include a strong desire to drink alcohol and difficulties in controlling its use. An alcohol dependent person may persist in drinking, despite harmful consequences, and give alcohol a higher priority than other activities and obligations (National Institute for Health and Care Excellence, 2010). Dependent drinkers may also be increasing risk, higher risk or binge drinkers. In 2013/14, 89,265 people across England accessed specialist treatment for alcohol misuse (Public Health England, 2014c).

Lower-risk drinkers are the group for which the risk of health damage as a direct result of drinking is lowest, with the exception of abstaining from alcohol altogether. Although the probability of harm for lower-risk drinkers is comparatively small, drinking to lower-risk levels is not advisable for people who are pregnant (or attempting to conceive), going to drive, operate machinery and/ or partake in strenuous activity. Significant proportions of increasing-risk drinkers and binge drinkers exist in England. Increasing-risk drinkers, binge drinkers and higher-risk drinkers are more likely to damage their health compared to those who abstain from alcohol altogether. People within these groups have a greater probability of experiencing adverse health consequences including cancer of the mouth neck and throat, breast cancer in women, liver cirrhosis and high blood pressure (NHS, 2014 & Drinkaware, 2015a).

Alcohol Consumption in the Home

Consumption of alcohol within the home is considered a problematic issue in the United Kingdom and might be considered particularly challenging because of the hidden aspect of this behaviour. Figure 2 shows millilitres of alcohol consumed per person per week inside and outside the home environment. Almost twice as much alcohol is consumed at home and, whilst alcohol consumption outside the home has reduced by 50% (2012 compared to 2002-03), the reduction in drinking at home is significantly smaller (-4%, 2012 compared to 2002-03).

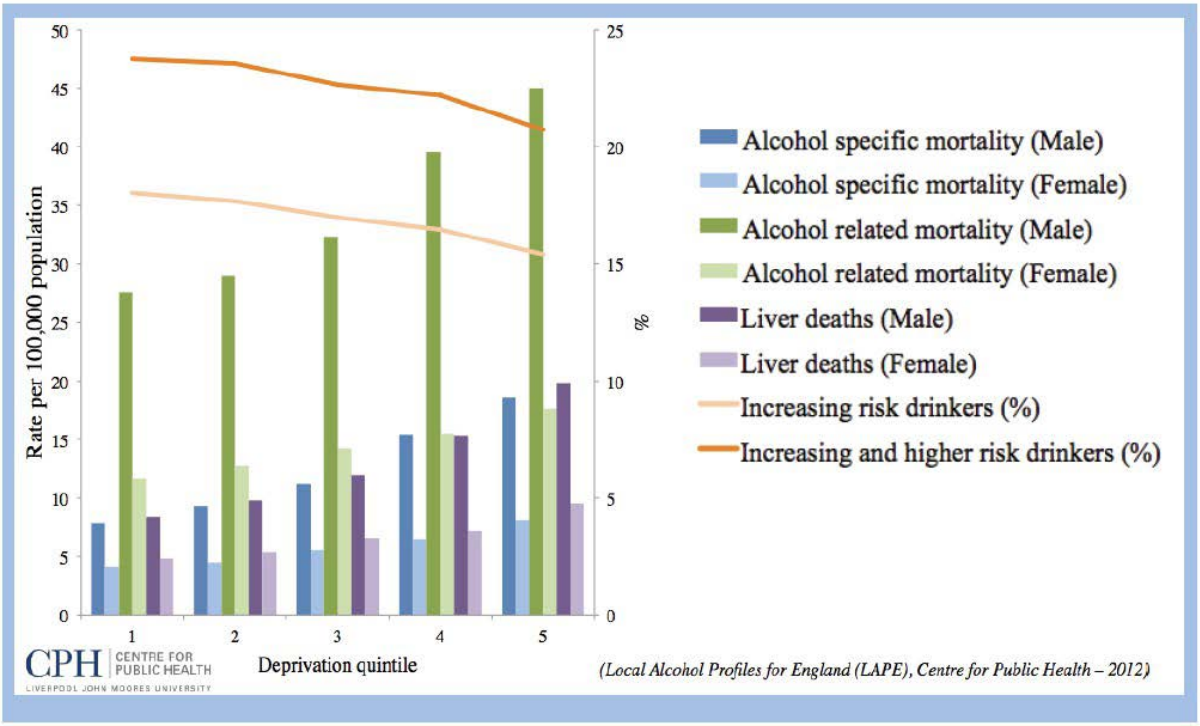
Figure 2 Household consumption of alcoholic drinks in the United Kingdom (Health & Social Care Information Centre (2014).



Alcohol Consumption and Deprivation

Despite the fact that groups of higher deprivation report lower levels of consumption, increased deprivation is associated with increased alcohol-related mortality (Anderson & Baumberg, 2006). This effect, known widely as the alcohol harm paradox, is illustrated below in Figure 3 which shows that levels of increasing risk and higher risk drinking declines as deprivation increases, yet alcohol-related mortality goes in the opposite direction.

Figure 3 The social gradient of alcohol harm and levels of increasing and higher risk drinkers *(Institute of Alcohol Studies)*

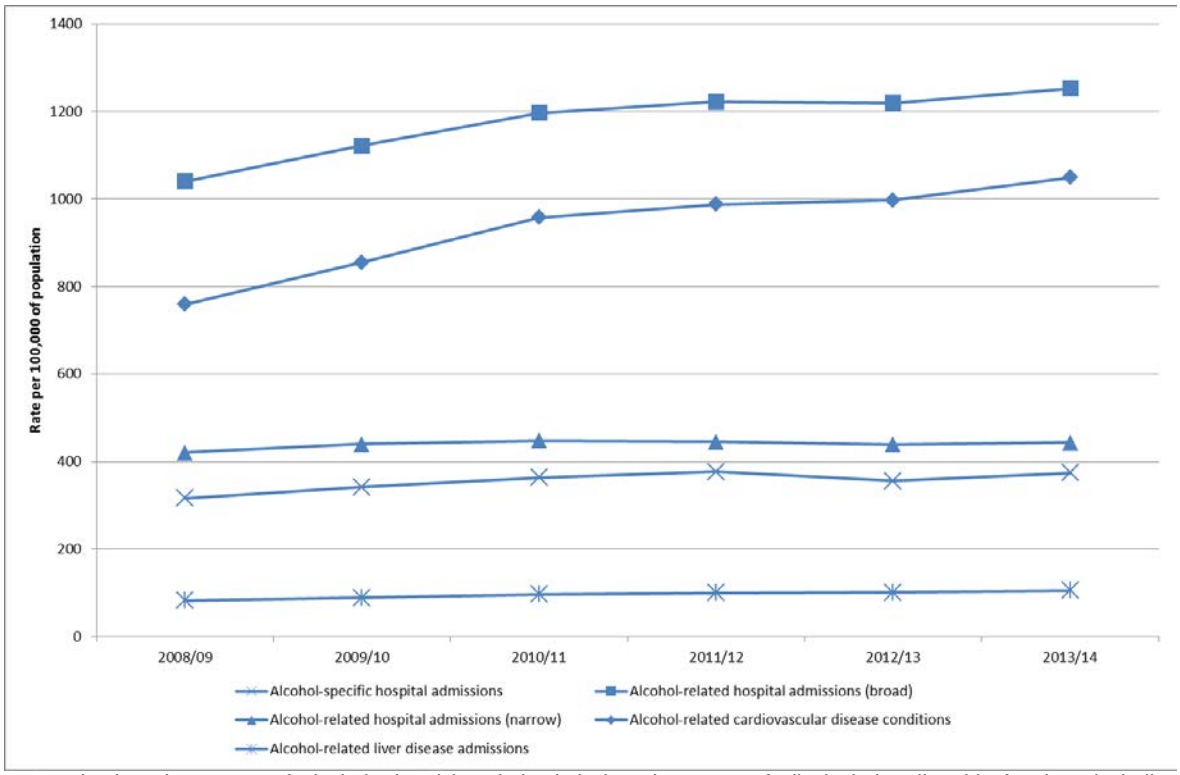


Researchers and theorists have identified a number of possible explanations for the alcohol harm paradox; as yet the cause is not fully understood. The Institute of Alcohol Studies recommends that 'upstream' public health interventions, including restrictions on supply, are prioritised over 'change' interventions such as education campaigns because the former method helps reduce health inequalities whereas the latter method is more likely to exacerbate them.

Hospital Admissions

The number of alcohol-related hospital admissions in England is approximately one million per year and this figure has been increasing consistently (Public Health England, 2014b). Figure 4 shows that the majority of alcohol-related hospital admissions have experienced increases. The greatest of those increases have been observed in the broad measure of alcohol-related hospital admissions and alcohol-related cardiovascular disease conditions).

Figure 4 Alcohol-related hospital admissions (per 100,000 of the population) in England (Public Health England, 2014c)



Note: The broad measure of alcohol-related hospital admissions is a sum of all alcohol-attributable fractions including all primary codes and secondary codes. Whereas the narrow measure is a sum of the alcohol-attributable fractions of primary codes and, if the primary code for the admission does not have an alcohol-attributable fraction but there is an external cause code as a secondary code that does have an alcohol-attributable fraction, this fraction is included.

Mortality

Alcohol-related mortality in England has remained relatively high notwithstanding a minor reduction from a rate of 47.8 (per 100,000 of the population) in 2006-08 to 45.3 in 2011-13. The rate of alcohol-specific mortality has also remained static at approximately 12 deaths per 100,000 of the population. In contrast the rate of mortality in people aged under 75 from liver disease and liver disease that was considered preventable has risen by almost 14% (from 16-18 deaths for under 75 liver disease and from 14-16 deaths for under 75 liver disease considered preventable, Public Health England, 2014c).

Health Consequences of Alcohol Use

Physical Health

Weight Gain

According to the NHS (2014b), on average wine drinkers consume approximately 2,000kcal from alcohol each month. Five pints of lager each week equates to 44,200kcal per year which is equivalent to 221 doughnuts. Exceeding recommended daily guidelines for alcohol consumption on a regular basis is proven to lead to weight gain.

Sleep Disturbance

Alcohol is a diuretic which means that people often have to get up in the night to use the toilet if they have consumed more alcohol than usual. Furthermore, alcohol interferes with sleep patterns by reducing the amount of rapid eye movement sleep, leading to feelings of exhaustion (Drinkaware, 2013a).

Sexual Problems

In addition to the damage alcohol can cause in people who are planning to have children (including taking longer to conceive, menstrual and fertility problems), alcohol consumption can also cause impotence (Drinkaware, 2015c).

Increased Blood Pressure (Hypertension)

Alcohol is a contributory factor in the development of hypertension (a form of sustained high blood pressure). Hypertension increases the risk of stroke, heart disease, vascular dementia and chronic kidney disease if untreated and costs the NHS more than £2 billion every year. Consuming more than three alcoholic drinks a day increases the chance of developing hypertension by up to 75% (Alcohol Concern, 2015b).

Cancer

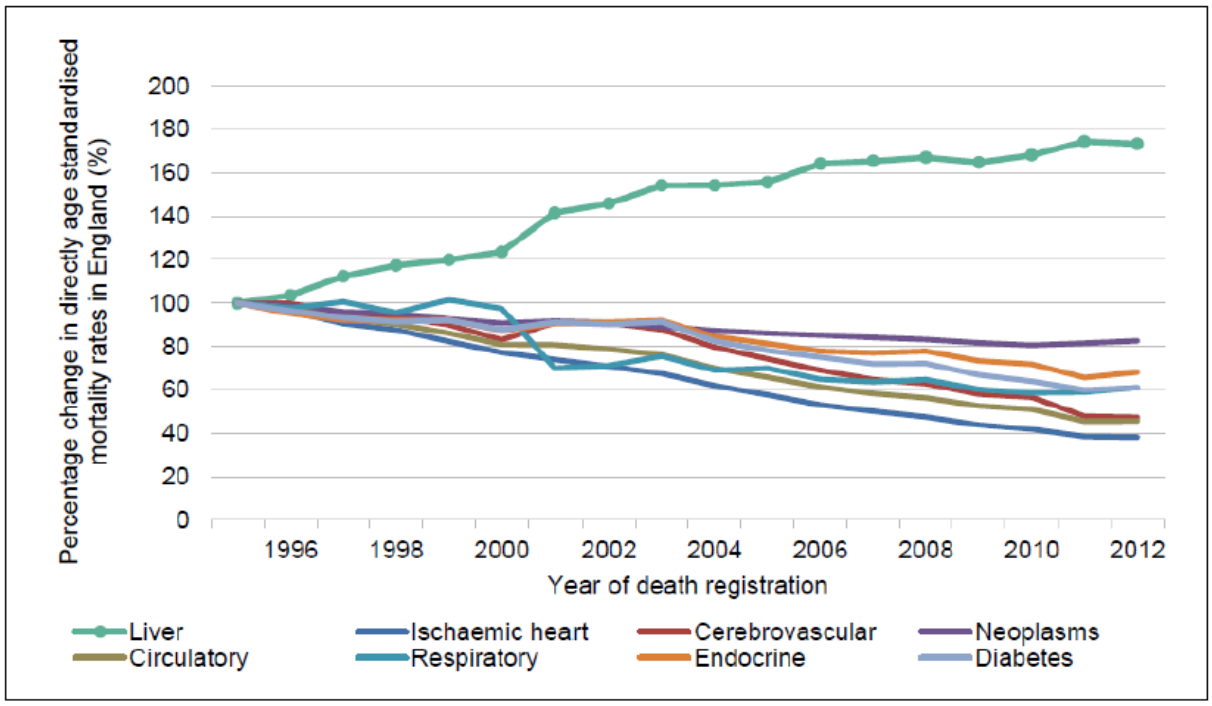
Alcohol is a known cause of seven types of cancer including cancer of the liver, bowel, breast, mouth, throat, esophagus and larynx. Alcohol is attributable to approximately 4% of cancer cases in the UK (Drinkaware, 2013b).

In 2011, alcohol was responsible for 3,000 breast cancer cases in the UK which account for 6% of all diagnoses. Every drink consumed per day increases the breast cancer risk in women by 7-12% (Alcohol Concern, 2015c).

Liver Disease

Excess alcohol consumption can lead to the build-up of fat in the liver which is called alcoholic fatty liver disease. Continued alcohol misuse can lead to alcohol hepatitis which is inflammation of liver tissue. Cirrhosis, the final stage of liver disease, is caused by scarred liver tissue which is largely irreversible and has a significant impact on life expectancy (NHS, 2013). Figure 5 shows that mortality from liver disease is increasing in England whilst mortality from other conditions, including diabetes, is reducing (Public Health England, 2014f).

Figure 5 Percentage change in mortality rates (England, 1995-2012) (Public Health England (2014f)



Drinking in Pregnancy

Alcohol is classed as a Teratogen which causes harm to the foetus by interrupting the correct coding of amino acids which leads to the development of abnormal proteins and ultimately damages the frontal lobe of the brain. The function of the frontal lobe of the brain is responsible for the development of sensory processes and the development of fine motor skills.

A number of risks are associated with drinking alcohol during pregnancy, including:

- Increased risk of miscarriage.
- Risk of Foetal Alcohol Syndrome (FAS) whose features include: growth deficiency for height and weight, a distinct pattern of facial features and physical characteristics and central nervous system dysfunction.
- Risk of Foetal Alcohol Spectrum Disorders (FASD), Alcohol Related Birth Defects (ARBD) and Alcohol Related Neurodevelopment Disorder (ARND) – which do not show the full characteristics of FAS and develop at lower levels of drinking.
- Increased risk of learning disability (without either of the above conditions).

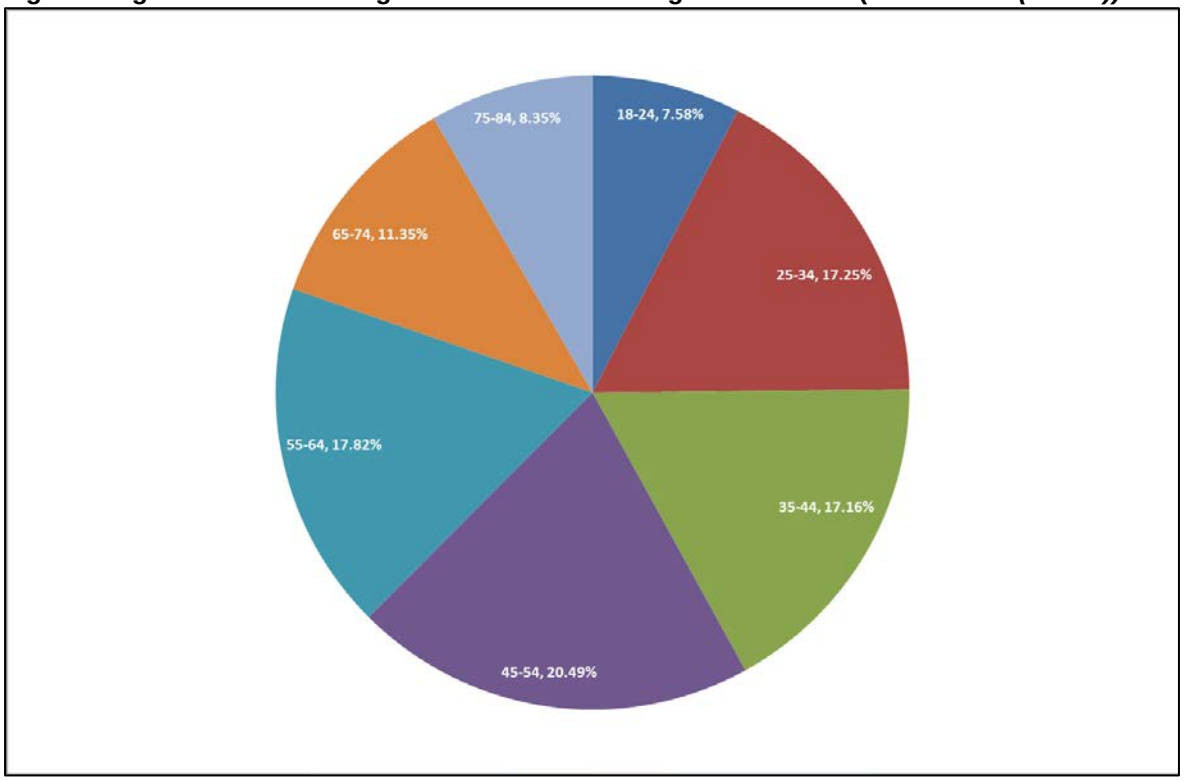
Mental health

Mental health problems directly affect 25% of the population during any given year (Singleton, Bumpstead, O'Brien, Lee & Meltzer, 2001) which was equivalent to 76,420 Nottingham citizens in 2013-14 (according to population statistics reported in the 2011 Census). For people dependent on alcohol, the prevalence of mental health problems is significantly increased to 45% (Coulthard, Farrell, Singleton & Meltzer, 2002). Whilst alcohol is known to have a negative effect on mood and memory (NHS, 2014a) and therefore might contribute to the manifestation of mental ill health, there is also evidence to suggest that alcohol is used to self-medicate existing mental health conditions (Mental Health Foundation, 2014).

Age

Higher-risk and increasing-risk drinkers exist nationally across all adult age groups. Nationally, the highest rates of increasing and higher-risk drinking exist in people aged 45-54 and 55-64, as shown in Figure 6. Over 75% of increasing-risk and higher-risk drinkers are over 35.

Figure 6 Age breakdown of higher risk and increasing risk drinkers (*Drinkaware (2015b)*)



Gender

Approximately 62% of increasing risk and higher risk drinkers are male (Drinkaware, 2015b).

Table 2 Rate (per 100,000 of population) of alcohol admissions and mortality in men and women in England (*Public Health England (2014c)*)

Measure	Men	Women
Alcohol-specific hospital admissions (2013/14)	515	241
Alcohol-related hospital admissions (broad, 2013/14)	1715	859
Alcohol-related hospital admissions (narrow, 2013/14)	594	310
Alcohol-specific mortality (2011-2013)	16.6	7.5
Alcohol-related mortality (2013)	65.4	28.4

Ethnicity

A review of UK literature concerning ethnicity and alcohol consumption (Hurcombe, Bayley & Goodman, 2010) concluded that people from white backgrounds have lower rates of abstinence and higher levels of drinking compared to most black and minority ethnic groups. Whilst abstinence is generally high among South Asians, alcohol consumption is greater for those Pakistani and Muslim men who do drink compared to other minority ethnic and religious groups. Increased drinking in Indian women, Chinese men and young Sikh women may represent an emerging trend.

Lesbian, Gay Bisexual and Transgender

Lesbian, gay, bisexual and transgender (LGBT) people have significantly higher rates of drug and alcohol use. It is estimated that binge drinking is twice as common in LGB communities compared to the general population. LGBT communities have also proven less likely to partake in health interventions and screening programmes which them at a higher level of need for targeted support and intervention (Williams et al., 2013).

2) Size of the issue locally

Local Prevalence and Demographic Inequalities in alcohol consumption risk stratification

Overall population

Local alcohol consumption data for citizens aged 16 and over is available through the Nottingham City Citizens' Survey. The survey asks participants whether they drink alcohol. If they do drink alcohol, participants are asked to recall what they drank over the last 7 days. Alcohol units and then alcohol risk category are calculated from the types of alcoholic beverage participants say they consume.

Data from the combined results of the 2012-2014 surveys indicates that the following proportion and number of adults drink alcohol (table 3). This is much lower than the national reported figure which may in part be explained by the city's relatively higher proportion if citizen from ethnic groups who tends to not drink or drink less alcohol than the general population. It may also indicate underreporting of alcohol consumption in the Citizen Survey for the reason described below.
Around 9 and out 10 people in the city drink at lower risk levels but nearly 2 out of ten binge drink and 1 out of 10 drink at level which have a greater risk for their health.

Table 3 Proportion and estimated number of citizens aged 16 and over drinking alcohol in the city (Citizens Survey 2012-2014)

Category	Proportion	95% Confidence interval	Estimated number of citizens (,000's) aged 16 years and over (2014, mid-year estimates)
Drink alcohol	59%	58.1-60.6%	150,000
Of which:			
Lower-risk	90.8%	89.9-91.6%	136,000
Increasing-risk	8.2%	6.1-7.6%	12,000
Higher-risk	2.4%	2.0-2.9%	4,000
Binge drink	17.4%	16.3-18.5%	44,000

There are also synthetic estimates of alcohol consumption in all local authorities including Nottingham published by Public Health England (Public Health England, 2014c). These suggest that approximately:

- 80% of the population drink alcohol
- 24% binge drink
- 74% are lower-risk drinkers
- 19% are increasing-risk drinkers
- 7% are higher-risk drinkers
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There are an estimated 10,687 dependent drinkers in Nottingham (Department of Health, 2010).

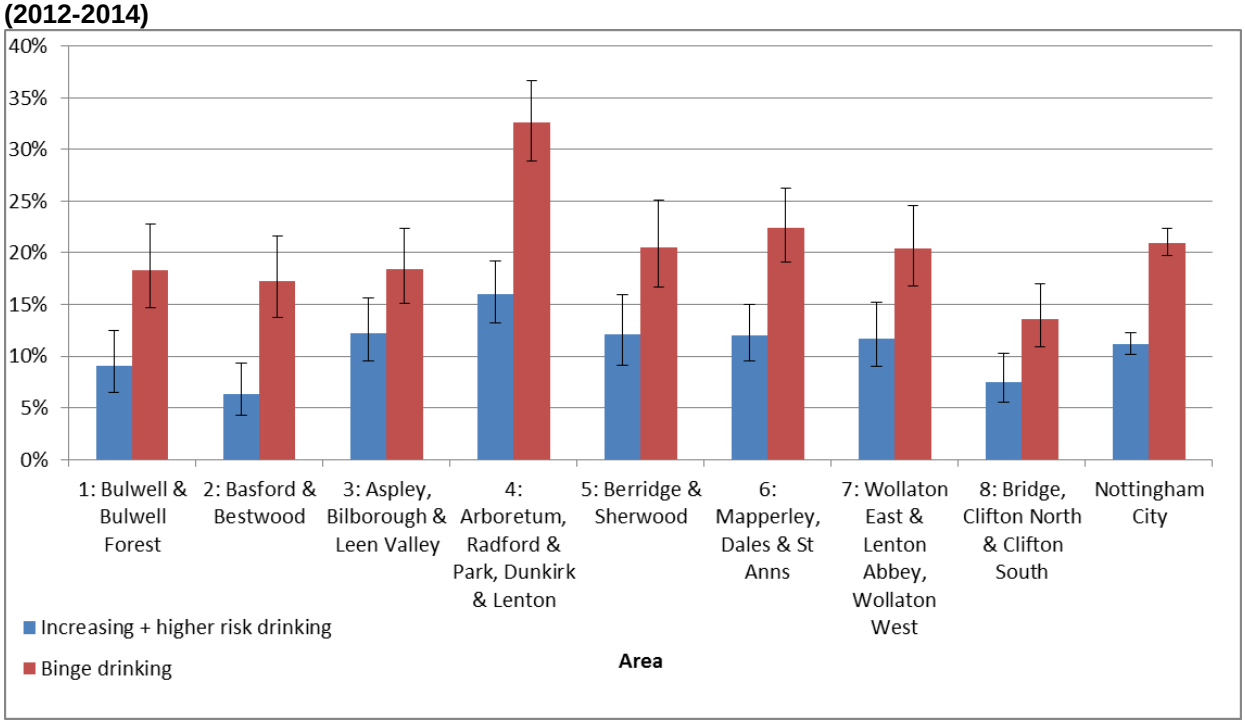
The disparity between the Citizen Survey results and the synthetic estimates may be due to the following:

- Information bias within the Citizen Survey: as misclassification bias due to the alcohol beverage recall questionnaire used, recall bias as the questionnaire uses a 7 day recall approach and, under reporting or social desirability bias due to the fact that drinking at higher levels is socially undesirable.
- Information bias within the synthetic estimates – these estimates are based upon 2008.
- National survey data which will be subject to its own information and selection bias. This data is then statistically modelled based on the Nottingham population

Local Area (Area Committee & Care Delivery Group)

Analysis at local area level indicates some geographical variation in citizens that drink alcohol at higher risk levels and consume at binge drinking levels. Ward level analysis in not included as the sample size in the citizen survey means that ward level estimates are not very precise. Area 4 in particular has a proportion of drinkers significantly higher than the city average under both of these definitions. (Figure 7).

Figure 7 Percentage of Citizens drinking at high risk levels and binge drinking by local area (2012-2014)



Gender

Using the citizen survey 2012-2014 data, significantly more women drink at lower risk levels (92.4%, 95% CI 91.2-93.4%), than men (89.2%, 95% CI 87.8-90.4%). And significantly more men drink at increasing and higher risk levels (11.0%, 95% CI 9.6-12.2%) than women (8.0, 95% CI 6.6-8.8%). Binge drinking behaviour is also significantly higher in men (19.2%, 95% CI 17.7%-21.0) than women (15.5%, 95% CI 14.0-17.1%).

Age

The age band with the greatest proportion of alcohol drinkers who drink at increasing and higher risk levels and binge drink is the 16-24 year age band. This age group has a significantly greater proportion than the city average (figure 8). Binge drinking decreases with age but Increasing and higher risk drinking decreases from and 25 years but then peaks again amongst 45 to 64 year olds.

The Citizen survey sample size does not enable analysis of drinking risk category by ethnic group. Analysis of the White British and other ethnic groups indicates that White British participants have significantly higher proportion of increasing and higher risk drinkers (figure 9).

Figure 8 Increasing and high risk drinking and binge drinking by age band (Citizen Survey 2012-2014)

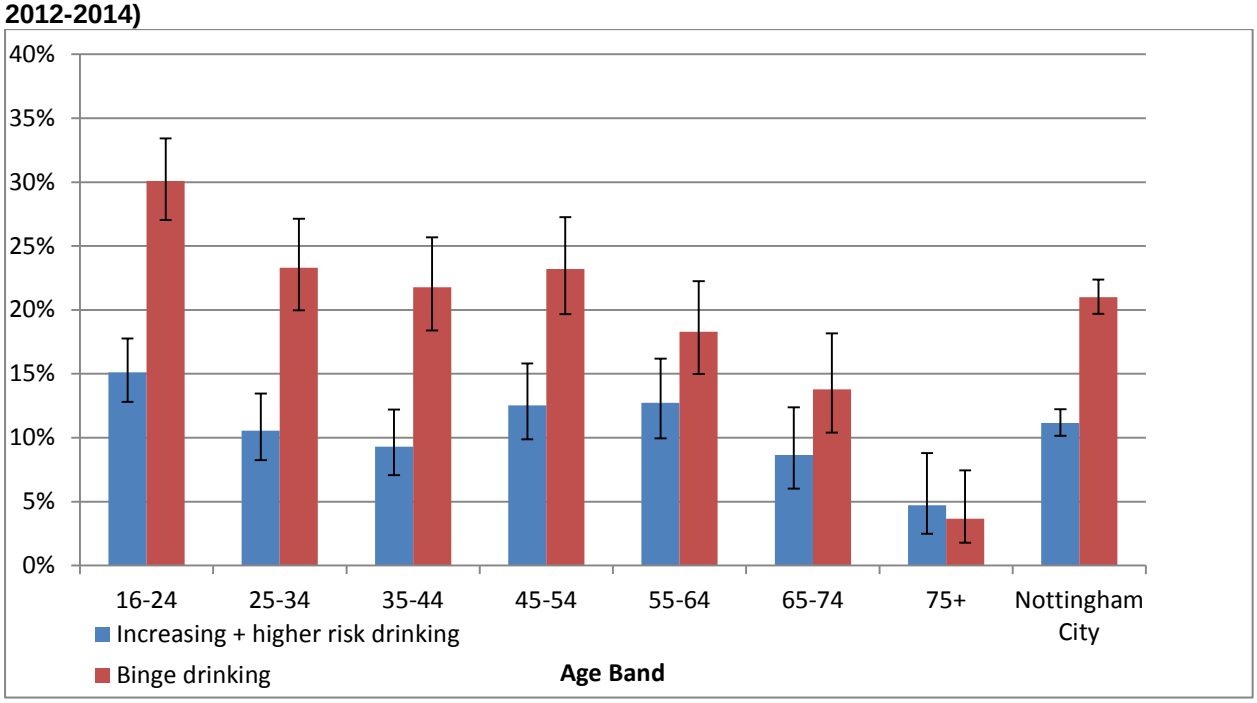


Figure 9 Percentage of alcohol drinkers at increasing-risk and higher-risk drinkers within ethnic grouping (Citizens' Survey 2012-14)

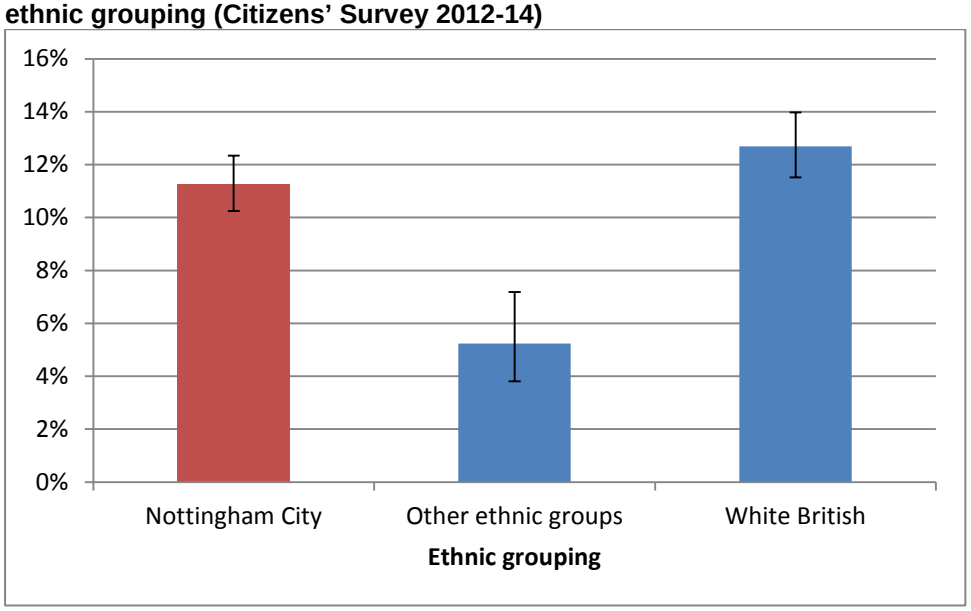
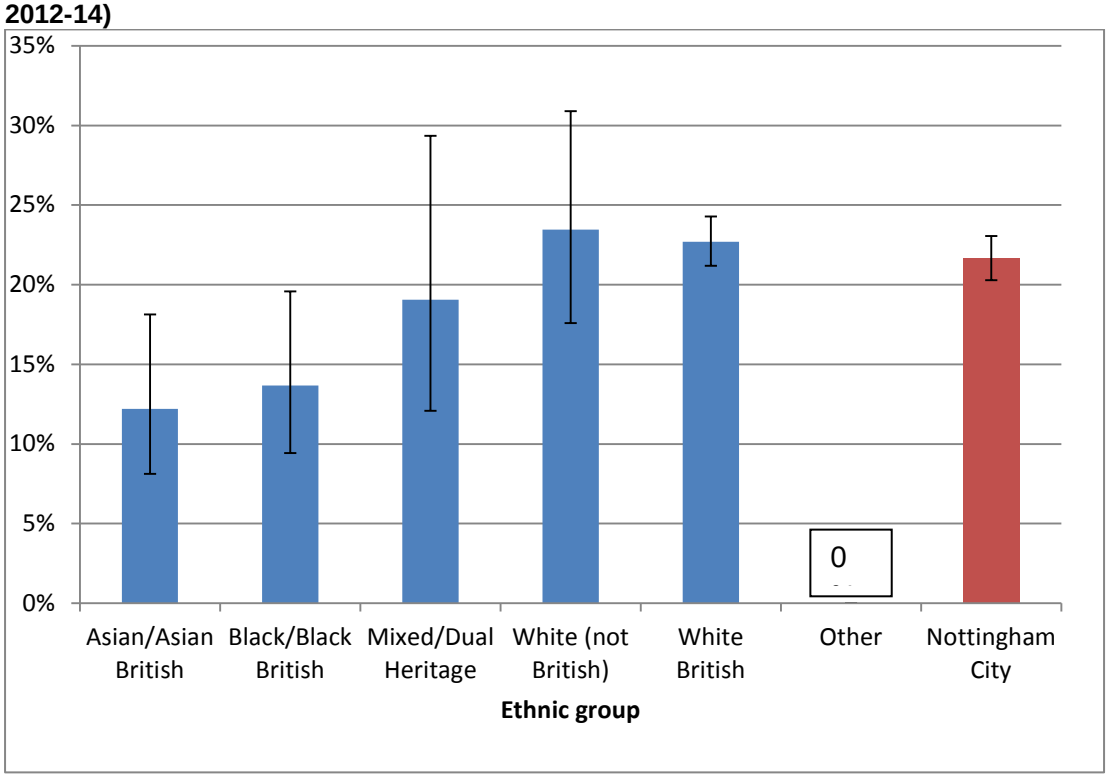


Figure 10 indicates that no ethnic group has a proportion of binge drinkers significantly higher than the city average but the proportion is highest amongst the white (not British) group (23.5%).

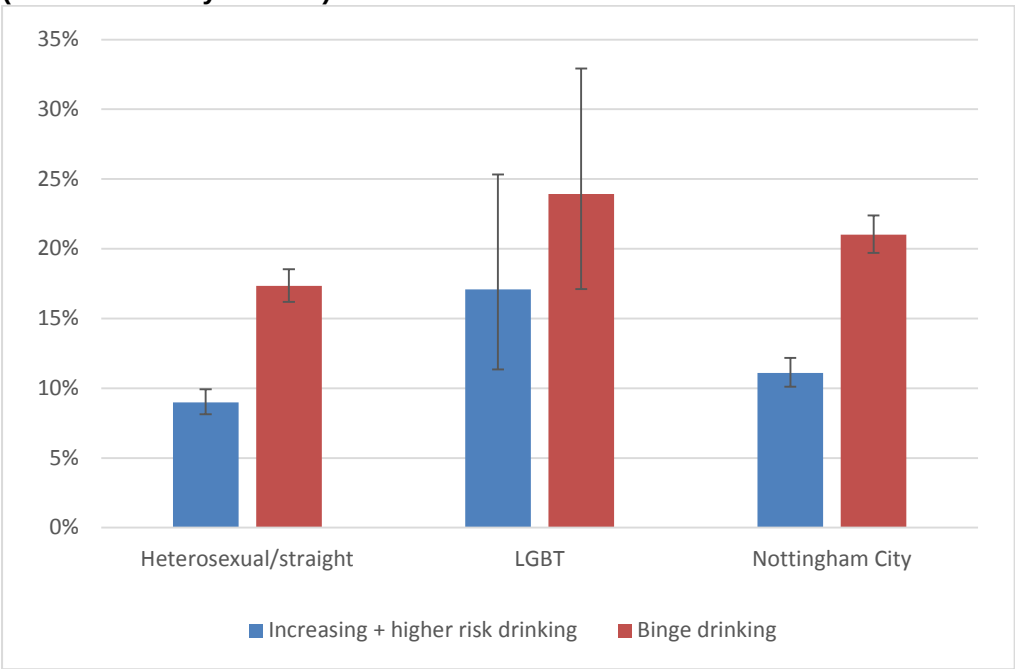
Figure 10 Percentage of alcohol drinkers who binge drinkers by ethnic group (Citizens' Survey 2012-14)



Sexual Orientation

The Citizen survey sample size does not enable analysis of drinking risk category by sexual orientation. Figure 11 shows that the Citizen Survey data indicates that the proportion of LGBT people who binge drink and drink at increasing and higher risk levels is higher than the general population. Due to the relatively small number of survey respondents from LGBT groups it is not possible to determine if this difference is statistical significant or whether there are differences within the LGBT group.

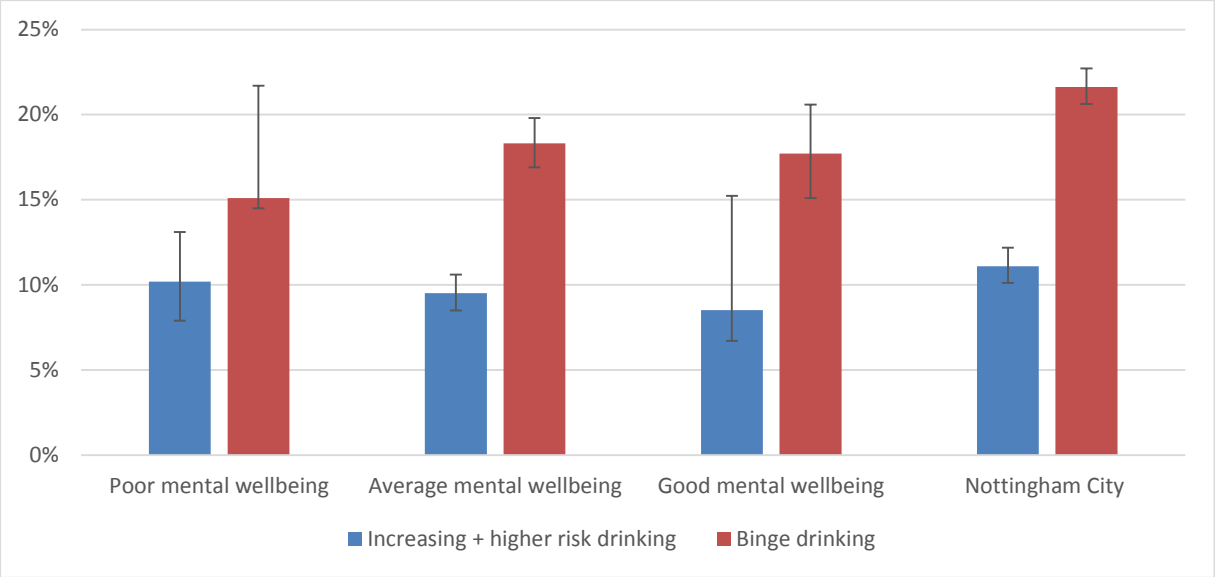
Figure 11 Percentage of increasing-risk and higher-risk drinkers by sexual orientation (Citizens' Survey 2012-14)



Mental Wellbeing

The Citizen Survey uses the WEMWBS mental wellbeing score to measure mental wellbeing which is then categorised as in figure 12. Figure 12 shows that there is no correlation between mental wellbeing category and increasing alcohol consumption.

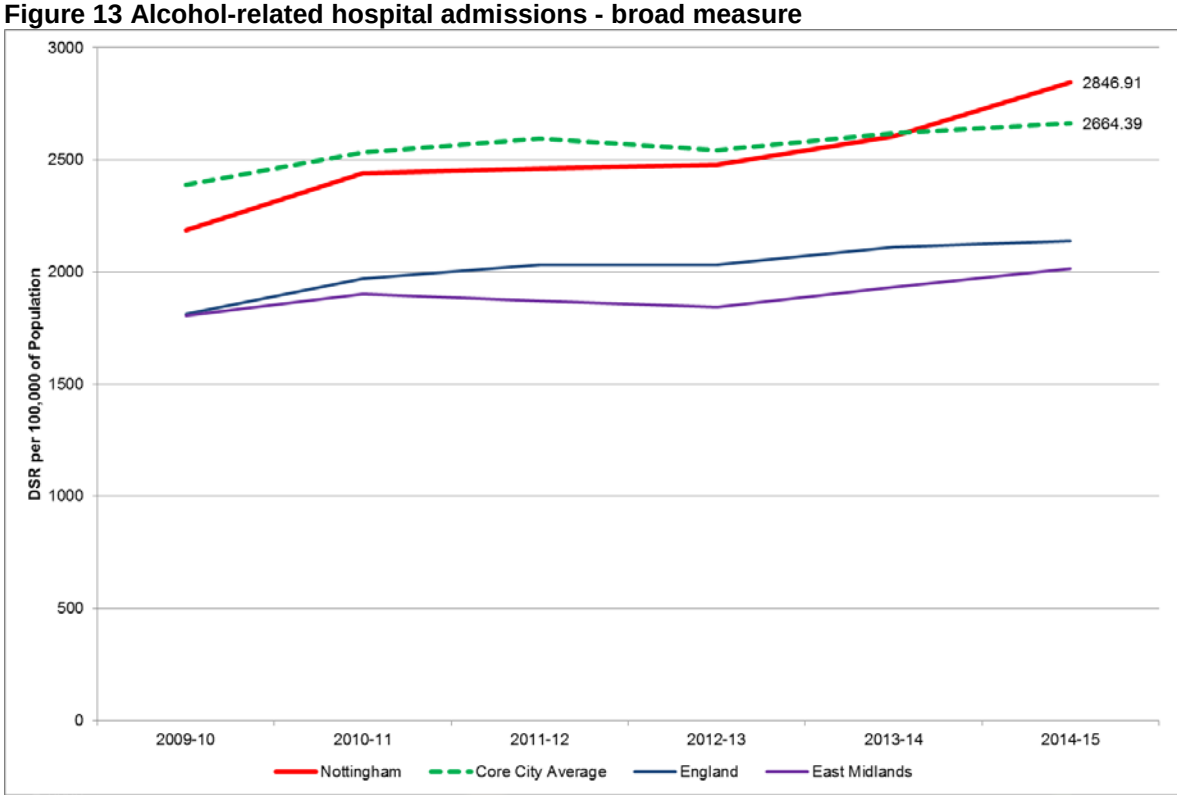
Figure 12 Percentage of increasing-risk and higher-risk drinkers by mental wellbeing category (Citizens' Survey 2012-14)



Alcohol-Related Hospital Admissions – broad measure

The broad measure of alcohol-related hospital admissions in Nottingham has increased over the previous five years by 17% (2014/15 compared to 2010/11) and in 2014/15 Nottingham's rate was higher than the average for the core cities (Figure 13).

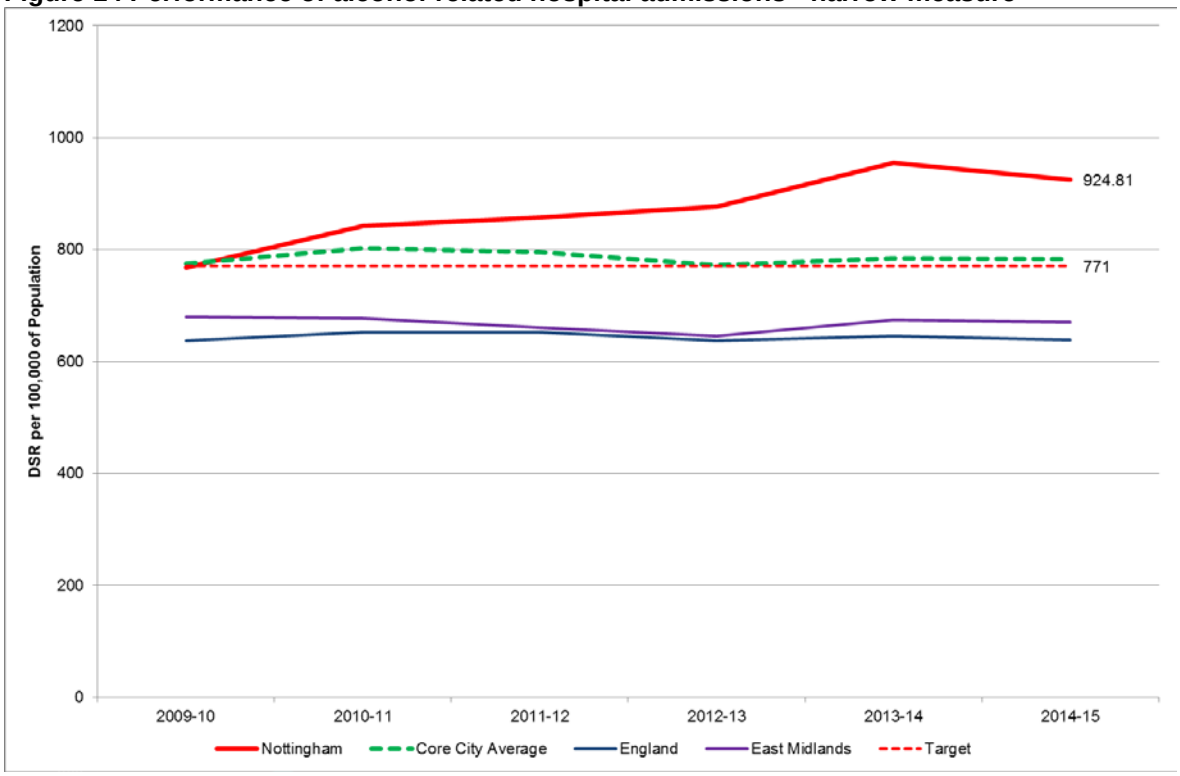
Figure 13 Alcohol-related hospital admissions - broad measure



Alcohol-Related Hospital Admissions – narrow measure

Nottingham's rate of alcohol related hospital admissions is also significantly higher than the regional, national and core cities group using the narrow measure. This is the figure used to measure Nottingham's performance in the Nottingham Plan to 2020.

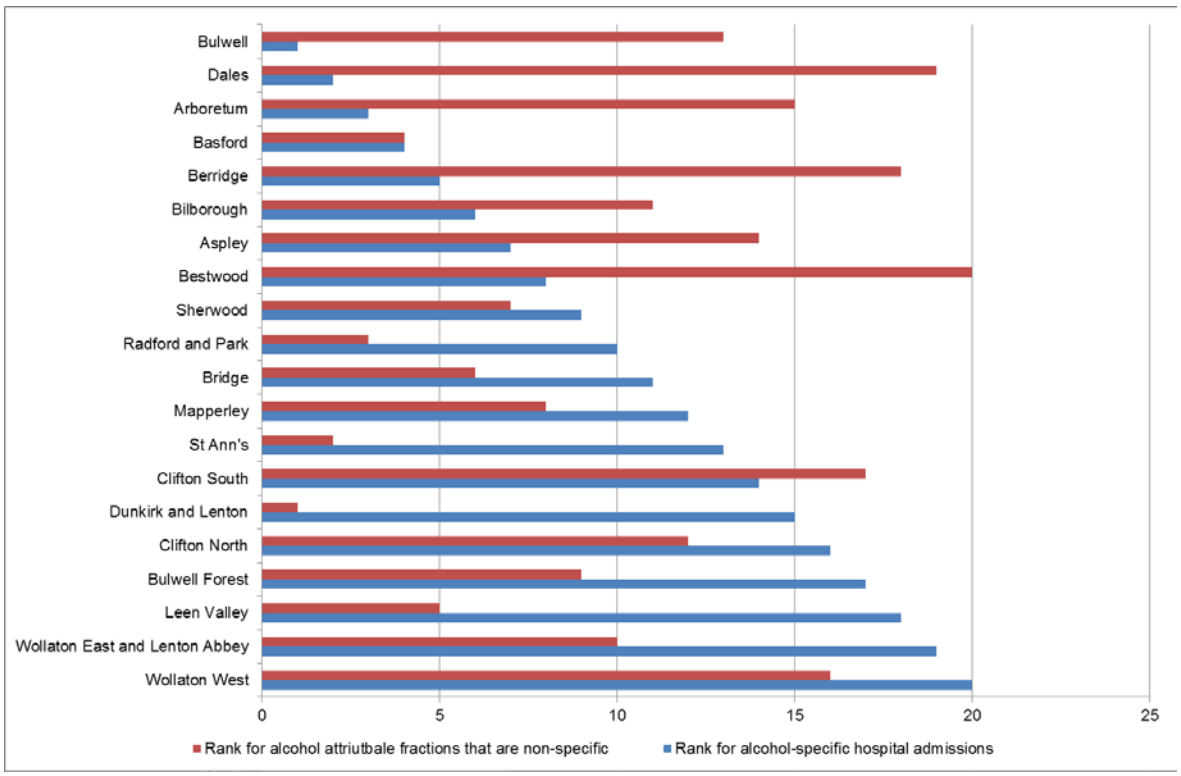
Figure 14 Performance of alcohol-related hospital admissions - narrow measure



Analysis on alcohol-related hospital admissions using Secondary Care Users Service data revealed that the increase in alcohol-related hospital admissions is driven by an increase in hospital-specific admissions (admissions with an alcohol attributable fraction of 1); the proportion of alcohol-related hospital admissions that were alcohol specific has increased from 8.1% in 2009/10 to 9.7% in 2012/13. Figure 15 shows that whilst the number of alcohol-specific admissions per patient has remained stable, the number of patients has increased. This suggests that the continued increase in alcohol-related hospital admissions is a result of more people at risk of alcohol-specific harm as opposed to a constant cohort of citizens at increasingly greater risk.

Figure 15 shows the number of alcohol-specific hospital admissions (in blue) and alcohol attributable fractions (in red) ranked by ward, where a rank of 1 equates to the highest number and 20 equates to the lowest number. This evidence suggests that the top five wards that should be primarily focused upon for interventions to reduce alcohol-specific hospital admissions are Bulwell, Dales, Arboretum, Basford and Berridge.

Figure 15 City wards ranked by alcohol-specific hospital admissions and alcohol attributable fractions (2009/10-2012/13)



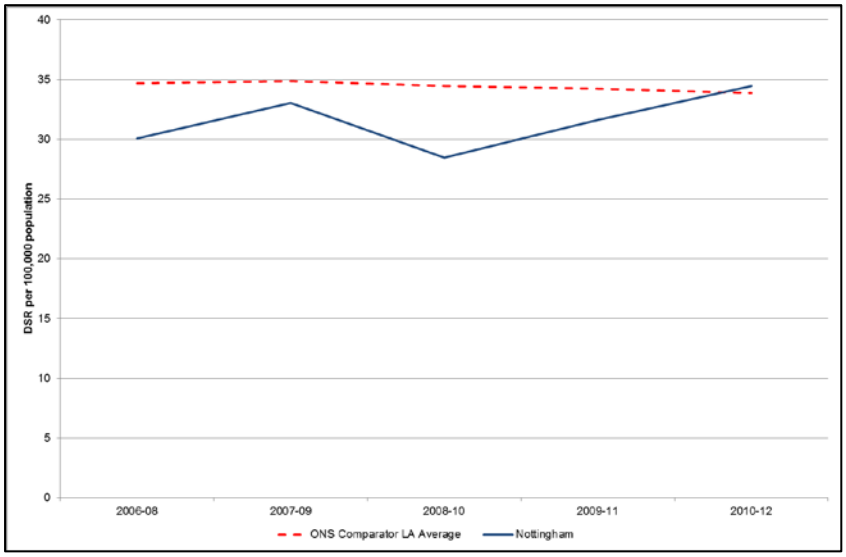
Alcohol Mortality

Alcohol mortality by local authority is published annually by the Office for National Statistics (ONS) and is disaggregated into alcohol-specific mortality and alcohol-related mortality.

Alcohol-specific mortality

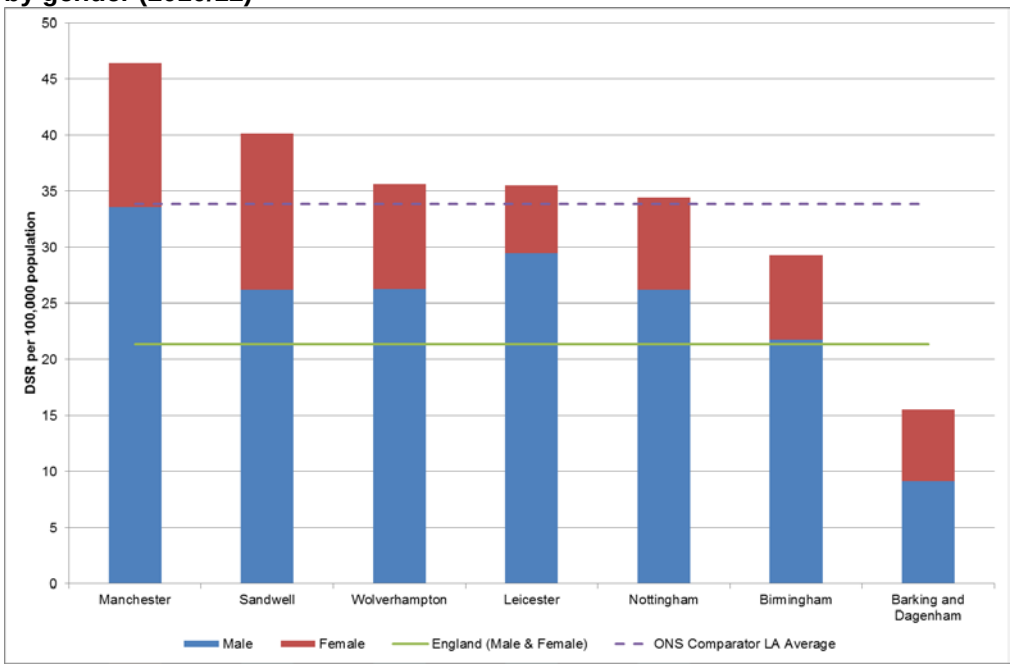
The directly standardised rate (DSR) per 100,000 of the population of alcohol-specific mortality in Nottingham has increased by 15% over the last five reporting periods (2006/08-2010/12). Figure 16 shows the rate of alcohol-specific mortality in Nottingham (represented by the dark blue line) compared to the respective rate of Nottingham's ONS comparator local authorities and the average of all eight cities (represented by the dashed red line). Nottingham's rate of alcohol-specific mortality has remained below the average until the latest reporting period.

Figure 16 Alcohol-specific mortality rate in Nottingham and ONS comparator local authorities (2006-2012)



Alcohol specific mortality is more common in men than women; the male to female ratio in Nottingham in the last reporting period was 13:4. Figure 17 shows the rate of alcohol-specific mortality for the latest reporting period (2010/12) for Nottingham and its ONS comparator local authorities.

Figure 17 Alcohol-specific mortality rate in Nottingham and ONS comparator local authorities by gender (2010/12)

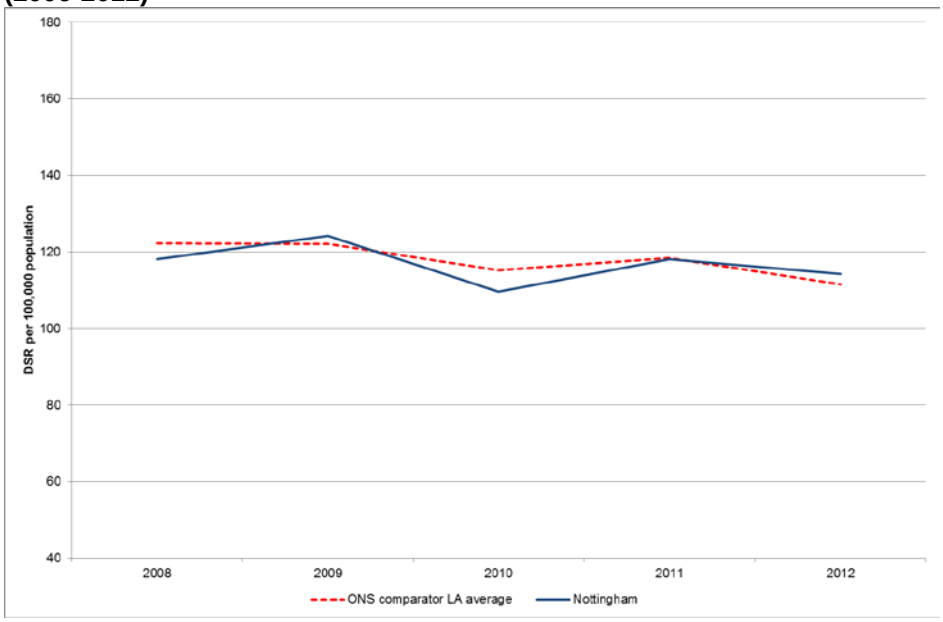


Alcohol-related mortality

Whilst the DSR of alcohol-specific mortality in Nottingham has increased, the DSR of alcohol-related mortality has been comparatively static over the same time periods. A reduction of 3% was observed in the alcohol-related mortality DSR in 2010-12 compared to 2006-08. Nottingham's rate has remained similar to the ONS local authority comparators

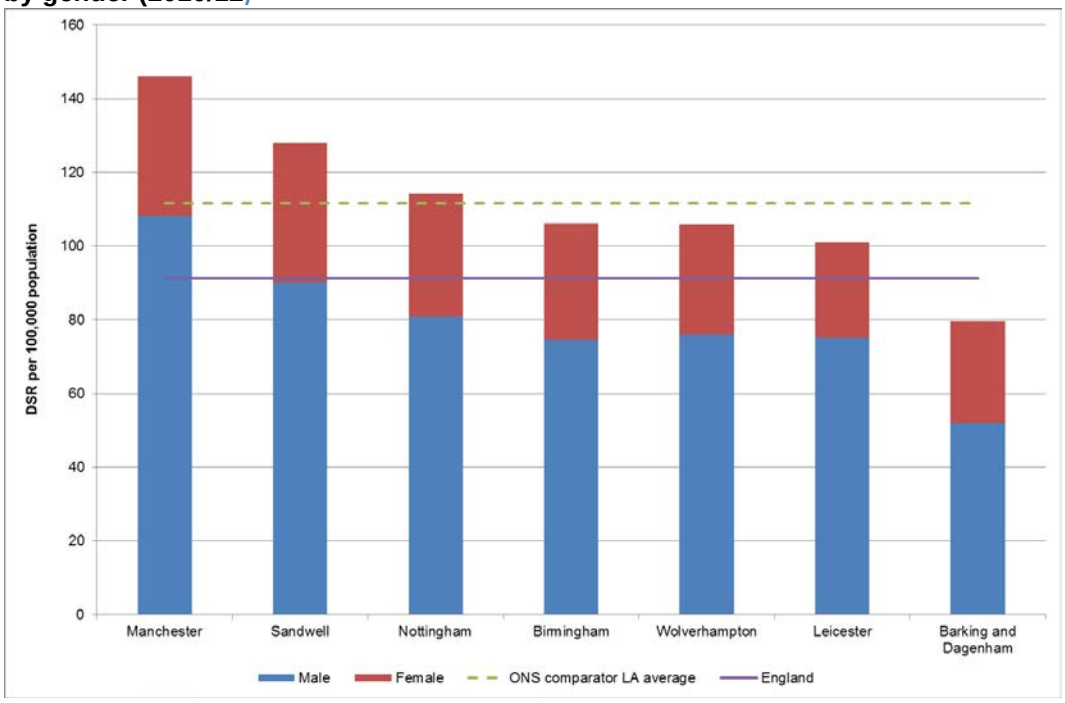
average over the previous five reporting periods, although, as shown in Figure 18, Nottingham's position has moved from slightly below the average to slightly above it.

Figure 18 Alcohol-related mortality rate in Nottingham and ONS comparator local authorities (2006-2012)



Alcohol-related mortality, as with alcohol-specific mortality, is more common in men compared to women. In 2010-12, the latest reporting period, the male to female ratio was 81:33. Figure 19 shows rate of alcohol-related mortality for the latest reporting period (2010/12) for Nottingham and its ONS comparator local authorities.

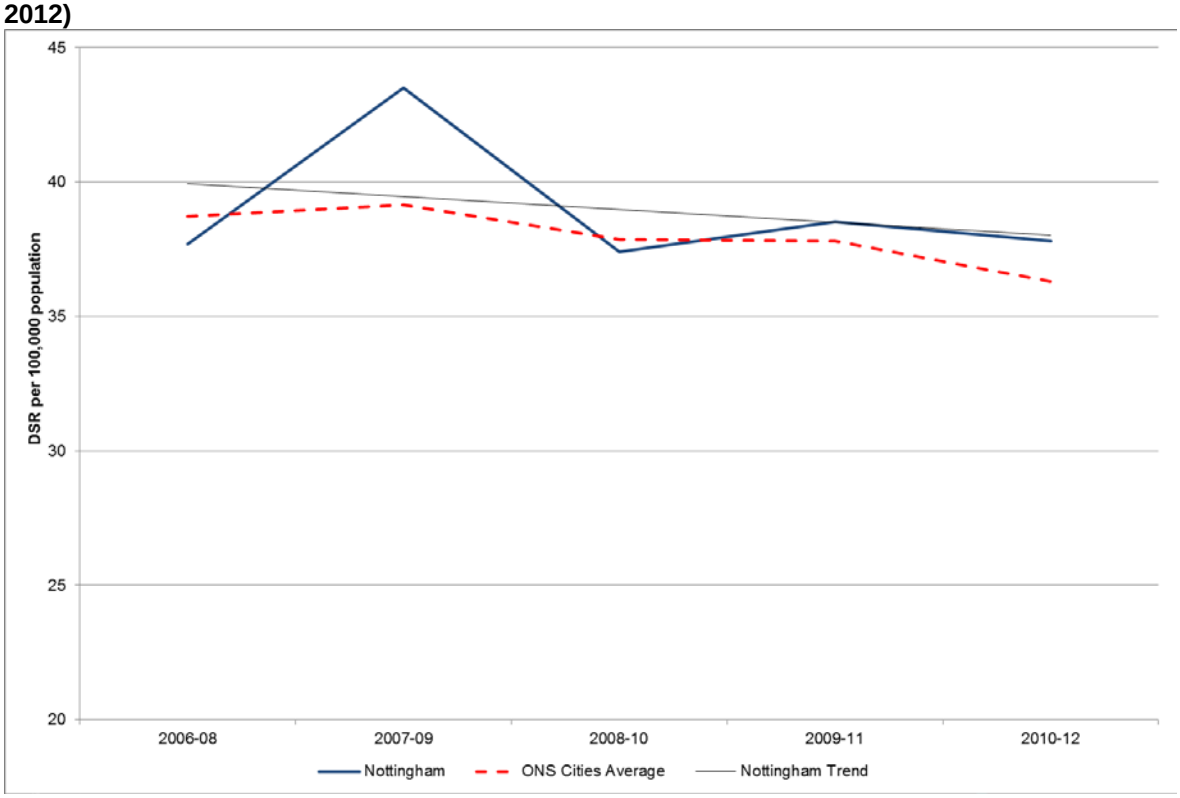
Figure 19 Alcohol-related mortality rate in Nottingham and ONS comparator local authorities by gender (2010/12)



Mortality from Liver Disease

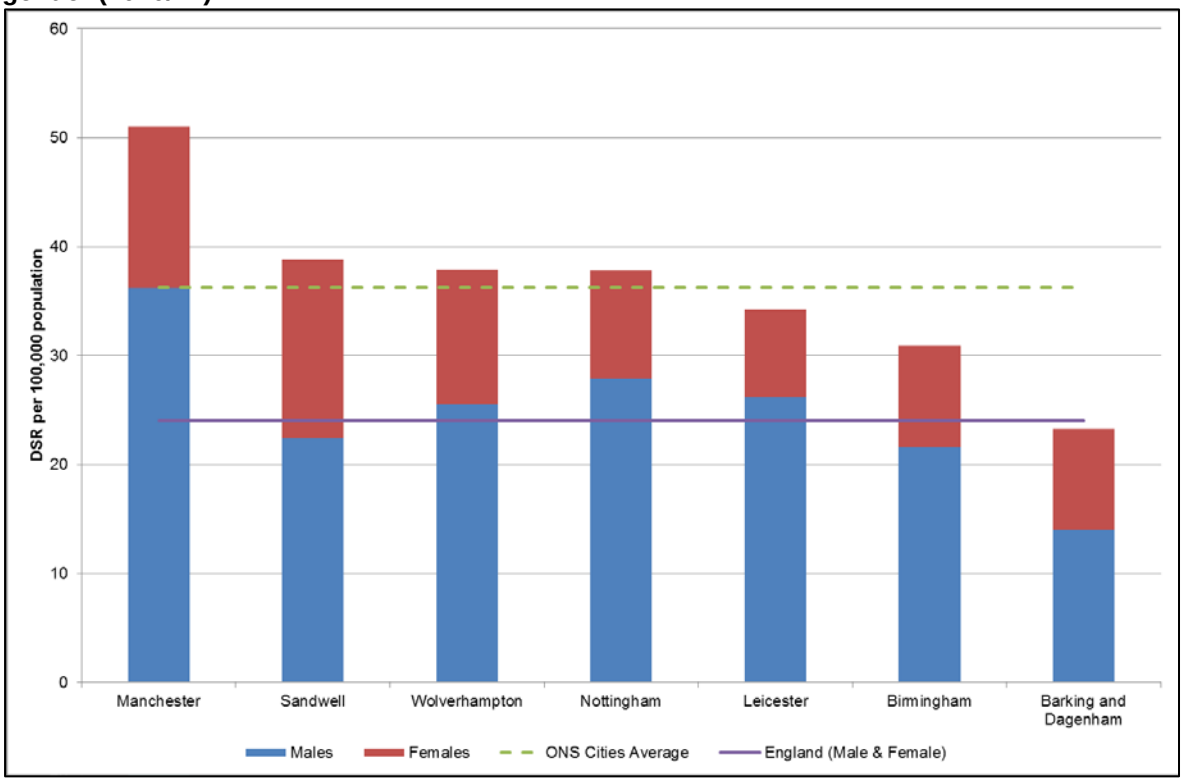
Mortality from liver disease by local authority is reported by the Office for National Statistics. In Nottingham, liver disease is at a very similar DSR in 2010-12 (37.8) compared to 2006-08 (37.7), although there was an increase in 2007-09. This evidence suggests that the increase in alcohol-specific mortality is not driven by liver disease. Figure 20 shows the DSR of liver disease mortality trend in Nottingham (represented by the dark blue line), its ONS comparator local authorities and the average of all eight local authorities (represented by the dashed red line). Notwithstanding similar rates of liver disease in Nottingham in 2010-12 compared to 2006-08, Nottingham's performance is worse than the ONS comparator local authority average, which has reduced over time.

Figure 20 Liver disease mortality in Nottingham and ONS comparator local authorities (2006-2012)



Similarly to alcohol mortality in general, liver disease mortality is more common in men than women across Nottingham and its ONS comparator local authorities, as is shown in Figure 21. In the latest reporting period of 2010-12, the male to female ratio was 3:1.

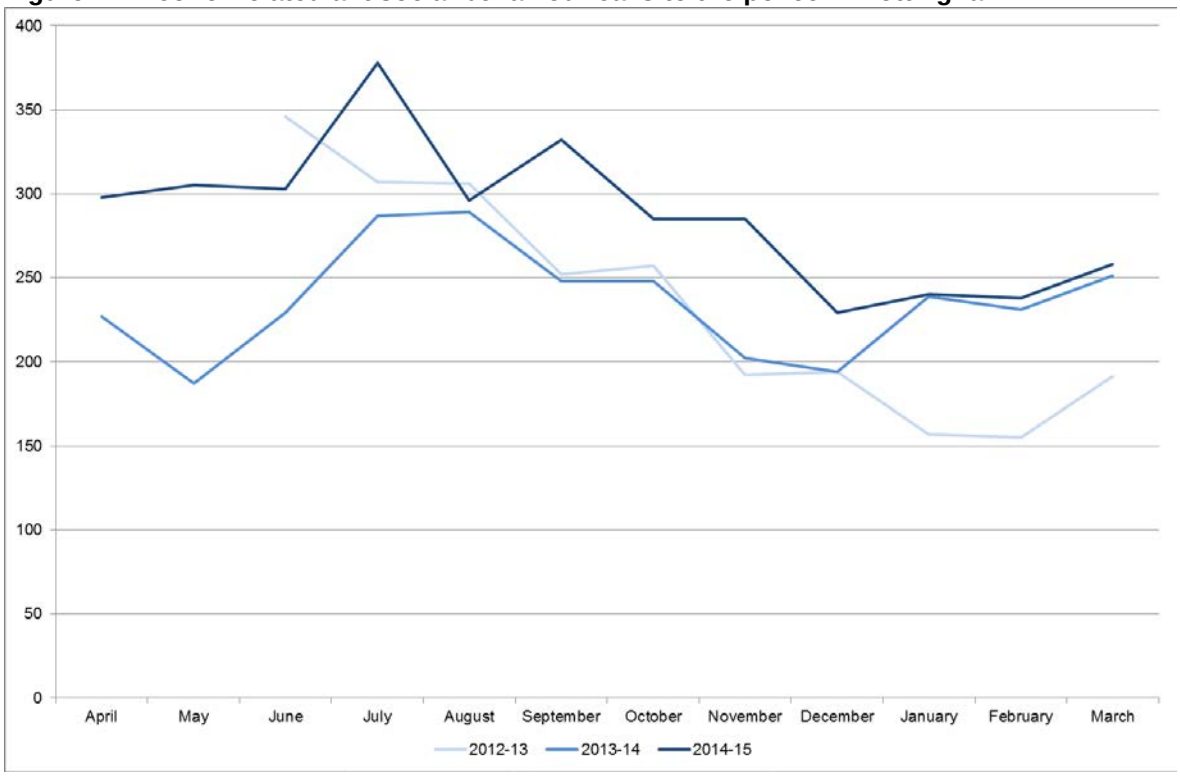
Figure 21 Liver disease mortality in Nottingham and ONS comparator local authorities by gender (2010/12)



Alcohol-Related Anti-Social Behaviour

Alcohol-related anti-social behaviour (ASB) is identified using a marker and/ or where the call details match a list of alcohol-related key words. Alcohol-related ASB accounted for 18% of all ASB calls to the Police in Nottingham during the two years ending May 2015. Figure 22 shows that alcohol-related ASB peaks during summer months and that the level was particularly high in July 2014, although changes to the way in which ASB is recorded makes the historical assessment of ASB on a like-for-like basis problematic.

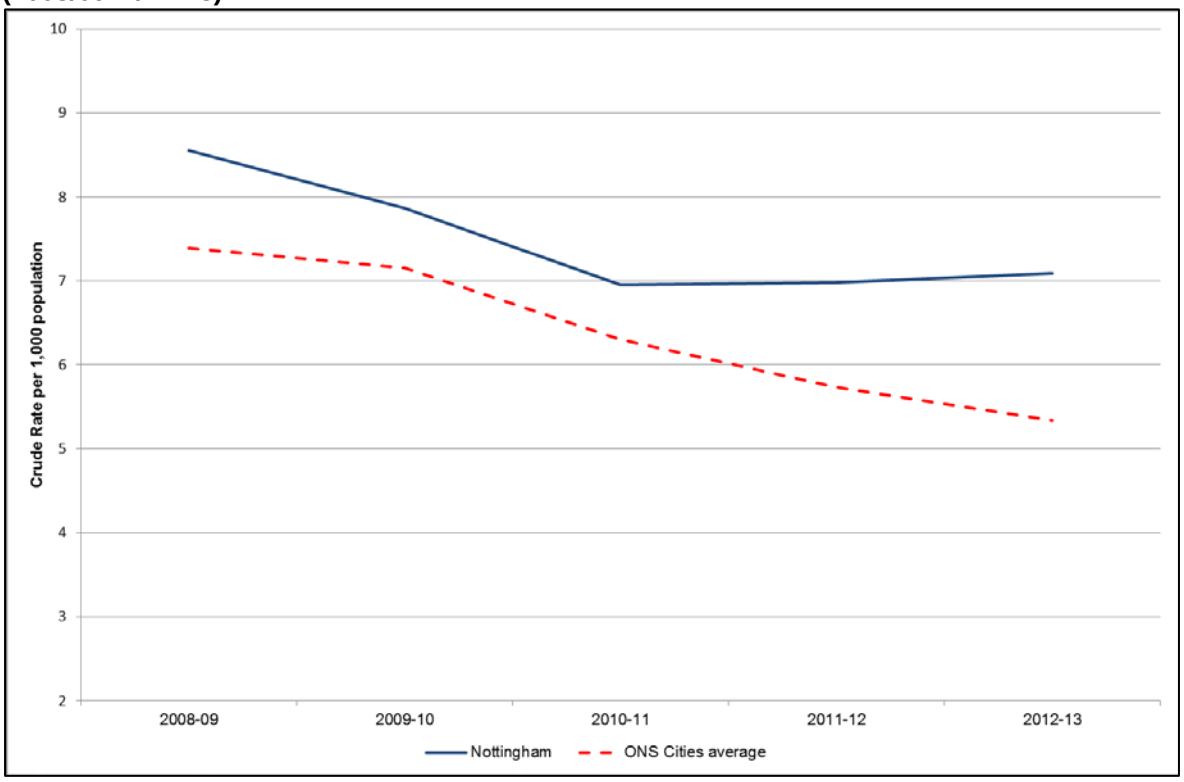
Figure 22 Alcohol-related antisocial behaviour calls to the police in Nottingham



Alcohol-Related Violence

Alcohol-related violent crime is published annually by the Office for National Statistics. Figure 23 shows that, in Nottingham, the rate of violent crime per 1,000 of the population has reduced in 2012-13 compared to five years previous however, in the latest reporting period Nottingham had the highest rate compared to the ONS comparator local authorities.

Figure 23 Alcohol related violent crime in Nottingham and its ONS comparator local authorities (2008/09-2012-13)



Men are disproportionately represented as offenders of alcohol-related crime. Over the last 12 months, 82% of alcohol-related crime offenders, where an offender was identified, were male. The most common offender age group is people aged 18-25 years. Of the alcohol-related crime that occurred in the last year, more than a quarter (27%, 433 crimes) were carried out by men aged between 18 and 25.

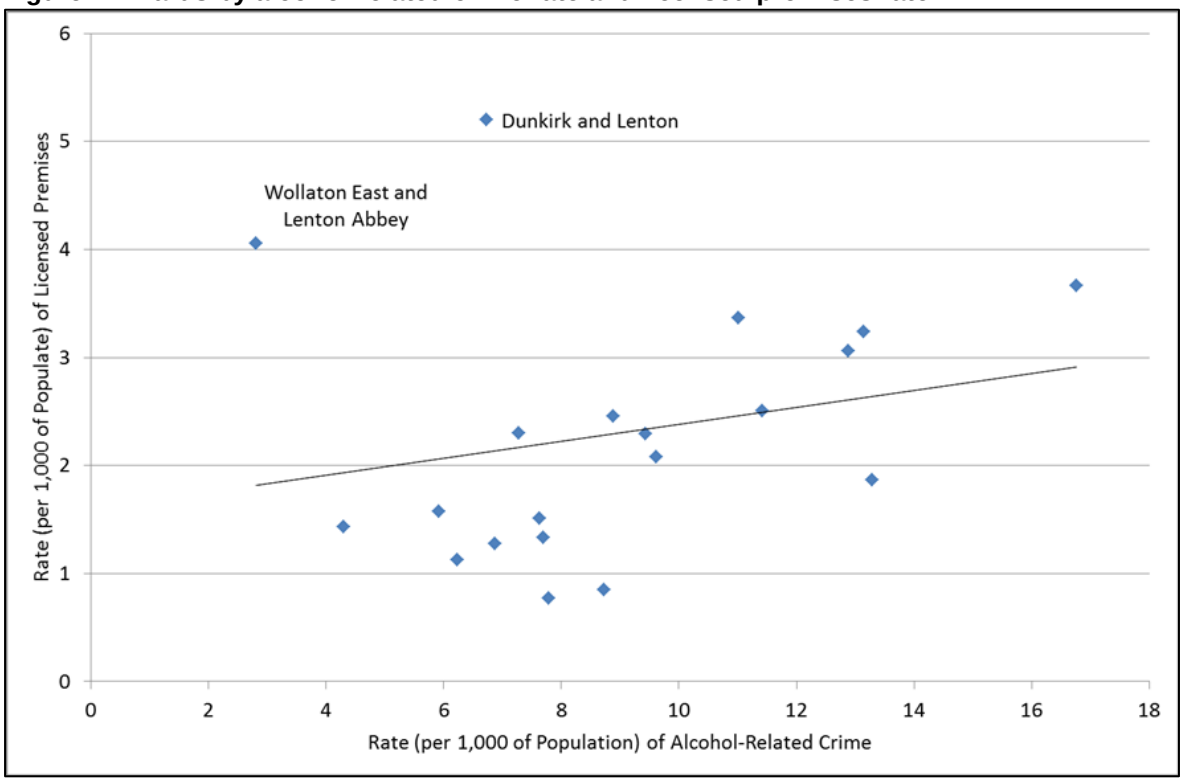
A similar profile for victim age for offenders exists for victims in that the 18-25 year old cohort is considerably overrepresented. However, gender for victims is evenly split, whereas men were much more prevalent offenders. The fact that the 18-25 year old cohort has emerged as a target group, both for offenders and victims, is in line with the results from the Citizens' Survey which showed this age group, together with citizens aged 55-64, to be the most overrepresented for problem-drinking behaviour.

Access to Alcohol

Almost half of alcohol-related crime occurs in the City Centre and the north of the city is also over-represented. However, when considering alcohol-related Violence Against the Person only, crimes are much more evenly spread across the city.

The highest density (per 1,000 or population) of licensed premises exists in the city centre and this is also the area with the highest rate of alcohol-related crime. Figure 24 shows that there is a significant positive correlation between the density of licensed premises and rate of alcohol-related crime when the city centre is treated as a separate area ($r=0.975$, $n=21$, $p=0.00$). A slight positive trend also exists between the density of licensed premises and alcohol-related crime in the city wards not including the city centre ($r=0.226$, $n=20$, $p=0.169$). The two wards that do not follow the trend are Wollaton East & Lenton Abbey and Dunkirk & Lenton.

Figure 24 Wards by alcohol-related crime rate and licensed premises rate



3) Targets and performance

The Nottingham Plan to 2020 contains the following target:

- To reduce alcohol related hospital admissions

The target for Nottingham is to achieve a rate of 771 alcohol-related hospital admissions (using the narrow measure) per 100,000 of population, which was the core cities average rate in 2012/13. As is shown in Figure 14, Nottingham is considerably off target, ending 2014/15 with a rate of 924.81 per 100,000 of the population. This is considerably higher than the core cities average, the East Midlands rate and the England rate. In 2008/09, Nottingham was mid-table in terms of its rank within the core cities, however since 2012/13, Nottingham has moved to the top of the table with the highest level of alcohol-related hospital admissions of the core cities. Notwithstanding this performance picture, some progress has been made in Nottingham with a reduction of 3.3% in 2014/15 compared to the previous year.

The Health & Wellbeing Strategy 2013-16 contains the following targets pertaining to alcohol:

- Reduce proportion of adults drinking at harmful levels by 33%;
- Reduce alcohol-related crime;
- Reduce alcohol-related antisocial behaviour;
- Reduce adult binge drinking;
- Fewer alcohol-related deaths

Details on the performance of alcohol-related crime, anti-social behaviour, alcohol-related mortality and alcohol-related hospital admissions have been included in this chapter under the section entitled ‘Size of the Issue Locally’.

As measured by the Nottingham Citizens' survey, the proportion of adults drinking at increasing or higher risk levels reduced from a baseline of 12% in 2012 to 9% in 2014. The proportion of binge drinkers also decreased from 23.7% to 18.7%.

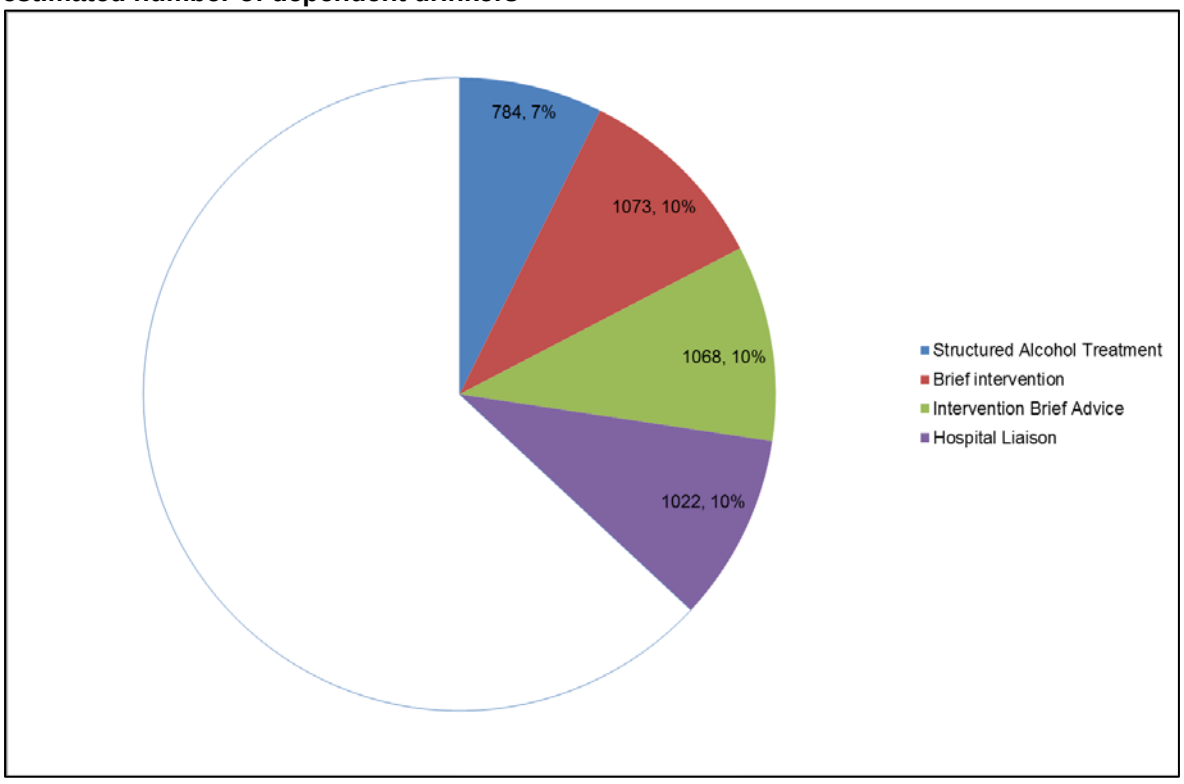
4) Current activity, service provision and assets

Treatment Penetration

Analysis of treatment penetration into the substance misusing population in Nottingham is a key measure of treatment impact because it assesses the extent to which alcohol services are meeting the need of those who have the capacity to benefit from it. The Department of Health has commissioned a project to determine the number of individuals who would benefit from some level of intervention at national and local levels so that a consistent method for assessing penetration can be developed (Public Health England, 2014g). In the meantime, a local snapshot has been developed pertaining to the estimated number of clients who accessed alcohol-related interventions in 2014-15 as a proportion of the estimated number of dependent drinkers in Nottingham, the results of which are shown in Figure 25. It is not currently possible to draw comparisons between Nottingham's penetration rate and that of its comparators because the information was sourced directly from the local treatment provider in Nottingham.

It is estimated that there are 10,687 dependent drinkers in Nottingham, 17.3% of whom (1,857 individuals) accessed structured treatment or a brief intervention in 2014-15. If the total number of individuals who accessed an alcohol intervention of any kind in 2014-15 is taken into account, the penetration rate is increased to 36.9% (3,947 individuals) however; it is likely that there is a certain amount of client duplication using this methodology. It should be noted that both of these rates do not include clients who accessed treatment prior to 2014-15. It is not currently possible to quantify this cohort however, if these clients were included, the penetration rate would be higher.

Figure 25 Clients who accessed alcohol interventions in 2014-15 as a proportion of the estimated number of dependent drinkers



Activity, Provision and Assets

Identification and brief advice

Identification and brief advice (IBA) is a simple, evidence based way to identify people who may be drinking too much and offer simple brief advice to reduce alcohol consumption. Nottingham City GPs have been incentivised to screen patients aged 16 and over who are likely to be misusing alcohol and for offering brief advice to patients found to be drinking at increasing-risk or higher-risk levels. 1501 claims were received during 2014/15. In April 2015, contracts to deliver this service were extended via a direct award process while practices not previously delivering the service were invited to apply for accreditation. Currently, there are 29 GP practices in the city contracted to deliver this service.

The new providers of Criminal Justice substance misuse interventions are starting to deliver IBA in the Bridewell custody suite and are also working on the process of delivering alcohol interventions for those who have alcohol informed offending.

HMP Nottingham screens all new receptions for alcohol issues and will offer IBA and full treatment for all those who are identified as needing it.

Treatment Services

Nottingham City Council commissions six treatment services for alcohol. All six services were subject to re-tendering in 2014 following the transfer of contracts from the Nottingham City Clinical Commissioning Group to the City Council. The new contracts were awarded in November 2014. All six contracts are now delivered by Framework Housing Association's Last Orders service. A new model of service provision is being commissioned in 2015/16 as part of a wider project to redesign and re-commission substance misuse treatment services in the city to better align services and deliver further efficiencies.

a) Access, engagement and brief treatment clinics

Alcohol Clinical Assessment and Triage Service (ACATS)

ACATS provides a nurse-led single point of access for anyone concerned about their alcohol use. This provides rapid clinical assessment and triage on a walk-in basis. Those requiring additional support will be offered a treatment appointment with either the recovery or specialist treatment service. The service also provides brief treatment clinics in primary care settings for those preferring to access the service in their locality. The service provides training in alcohol awareness and identification and brief advice to 1,200 primary care and front line community staff each year, and delivers health promotion activities to promote safe drinking.

Hospital Alcohol Liaison Service (HALT)

HALT works with and trains hospital staff within the Emergency Department and relevant in-patient wards and out-patient departments to identify patients drinking at increasing and higher risk levels and provide brief advice to those patients. The service will also work with hospital staff to identify in-patients who are alcohol dependent and provide medical detoxification and treatment where appropriate. The service will provide a direct link into community treatment to ensure continuity of treatment upon discharge from hospital.

b) Intensive case management

The intensive case management service (ICMS) identifies patients who use secondary care services to a high volume as a result of their dependency on alcohol and provides intensive support and case management in order to help them to engage with treatment and reduce the number of hospital admissions, ambulance call outs and attendances at the Emergency Department.

c) Non-specialist alcohol dependency service (Last Orders Recovery Service)
Non-specialist structured treatment for those mildly dependent on alcohol. The service provides individual and group based psychosocial interventions as well as a range of interventions to support full recovery.

d) Specialist alcohol treatment
Specialist treatment for those moderately or severely dependent on alcohol that may include complex needs (including secondary illicit drug use, moderate to severe psychiatric or physical co-morbidities, significant social issues and pregnancy). The service provides pharmacologically assisted alcohol detoxification, psychosocial interventions, pharmacotherapy for relapse prevention and recovery support.

e) Step facilitation
The service offers an intensive abstinence-based group support programme based on step facilitation principles.

Safe, Responsible, Healthy: Nottingham's Approach to Alcohol 2012 -2015
The 2012 partnership alcohol strategy structured its approach around three core themes: prevention, treatment and enforcement. A wide range of successful approaches have been developed or sustained over this time, with Nottingham having been recognised as an area of best practice in the field (Nottingham was designated as an 'Alcohol Mentor Area' by the Home Office under the LAAA programme).

City-Wide 'Street Drinking Ban'
In March 2013 the Designated Public Place Orders (DPPOs) in place in parts of the city were expanded to cover the whole of Nottingham. It is now a requirement to relinquish alcohol upon request to an authorised officer anywhere in the city. These terms have migrated to the new arrangements for Public Space Protection Orders (PSPOs) under the terms of the *Anti-Social Behaviour, Crime and Policing Act 2014.*

Super Strength Free Campaign
In 2013 Nottingham expanded its approach to addressing cheap, strong beers and ciders through its Super Strength Free campaign. A voluntary scheme whereby off licences can chose to withdraw high impact drinks from sale. Three quarters of city centre alcohol retailers signed-up to the scheme.

Late Night Levy
Nottingham established a Late Night Levy (LNL) in 2014. The LNLs were established under the *Police Reform and Social Responsibility Act 2011* and allow licensing authorities with the support of local PCCs to introduce a charge to licensed premised open after midnight to contribute to the cost of night time economy (NTE) policing. The city agreed to exempt members of the Business Improvement District (BID) from the levy in recognition of the financial contribution the BID makes to NTE safety. Revenue, after costs is shared between the PCC and Nottingham City Council.

Cumulative Impact Policy Expansion
The city centre Cumulative Impact Policy (CIP or 'Saturation Zone') was established in 2011. The policy enables the increased management of alcohol retail through the automatic generation of objections to new licenses under the terms of the *Licensing Act 2003*. Analysis of the intervention was undertaken in 2014 which identified that crime had fallen at a greater rate in the CIP area than in neighbouring areas. Full Council approved the extension to the east and west in 2014 to incorporate Sneinton Market and the Castle Quarter of the city centre.

Recommissioned Community Alcohol Treatment
Core to the city's approach to tackling alcohol misuse is the provision of high quality specialist treatment services, accessible to citizens from hospital, community and primary care settings. In 2014 the Crime & Drugs Partnership Commissioning Team undertook the recommissioning of the community treatment model. Responsibility for commissioning alcohol treatment services moved to the local authority in 2013 under the terms of the *Health and Social Care Act 2012*. Provision based on the existing treatment model and pathway successfully commenced under a single provider (Framework Housing Association's Last Orders service) from November 2014. A new performance framework will monitor effectiveness and gather insight to support future commissioning activity. The commissioning process retained the Alcohol Intensive Case Management Service (AICMS) which was piloted from 2011. A comprehensive academic review of the AICMS service has been funded with results due for publication in 2015.

Recommissioned CJS Drug and Alcohol Treatment
From April 2015 alcohol has been incorporated into a single criminal justice substance misuse treatment service alongside illicit drug treatment. Following a process of review and needs assessment undertaken by the Crime & Drugs Partnership new provision was commissioned from April 2015. Framework Housing Association's Clean Slate service secured the tender. This service will deliver court ordered treatment requirements, enabling the effective management of offenders while also providing engagement in the custody suite setting.

Ending Alcohol Harm Campaign
In 2014 the city developed and launched an –inter-agency communications plan to cover all areas of alcohol policy. The Ending Alcohol Harm (EAH) campaign has three core elements: protecting and enhancing the reputation of the city; providing resources and information to partner agencies, as well as motivating behavioural change for specific groups. It is intended that the EAH identity will help to place a coherent identity to alcohol related communications for citizens, conceptually linking diverse areas of activity such as licensing, policing and treatment.

Operation Promote
Operation Promote works to reduce violence in Nottingham City centre's night time economy (NTE) using a Home Office recognised best practice approach of restricting the supply of cocaine and other stimulants. Following the successful deployment of a pilot in November and December of 2013 in which violence was reduced by 23% funding was secured for a further deployment of 20 nights per year for three years. The impact of crime recording changes following inspection by HMIC resulted in an increase in incidents being recorded as 'violent crimes'. Nevertheless over the 2014/15 deployment proactive activity by Operation Promote saw violence increase by only 5.74% on the nights it operated against a city centre NTE increase of 17%.

NTE Insight Hub
Nottingham has introduced a new approach to the utilising and sharing of data to inform NTE policing, licensing and partnership interventions. Based on 'Cardiff Model' principles of hospital and ambulance service data sharing the project will be delivered through a project team which includes police intelligence officers and analysts. The project will deliver three core products: a revised intelligence based NTE police tasking method, a single venue level matrix of risk and a demand management tool to support emergence department and EMAS planners.

Industry Partnership – Nottingham BID
Nottingham Business Improvement District (BID) funds and manages a number of interventions to assist in the effective management of the NTE. The BID manages the Purple

Flag scheme which Nottingham has secured every year since its inception in 2010; recognition of the strong partnership operating in the city centre. The Best Bar None scheme also helps to raise standards for venues while promoting good practice. Taxi marshals, street cleansing, the business radio scheme and financial support to the Street Pastors also make a strong contribution to reducing alcohol related problems in the NTE.

Michael Varnum House

Michael Varnum House is a medium to long term hostel for homeless citizens with alcohol problems. The hostel comes under the auspice of the gateway and the contract sits with Nottingham Homes. The service is provided by Framework Housing association. The CDP financially contribute to the expenses of the service as it houses some of our most needy clients.

Crisis Detox in Michael Varnum House

The previous alcohol pathway created a rather complex system of referrals into crisis detoxification and in-patient detoxification. Two services originally existed with two distinct pathways. The Woodlands in-patient detoxification unit was originally set up to house those clients preparing for long-term residential rehabilitation and was mainly aimed at drug users gradually it saw more alcohol dependent clients and offer a service to detox as in-patients those clients who could not manage to detox at home. Only the Nottinghamshire Healthcare Trust could refer clients to the Woodlands. Running parallel to the woodlands was the Priory Clinic which offered a similar service to that of the Woodlands, but only the Framework services could refer there.

In December 2014 the Priory clinic withdrew its intention to provide crisis detox, as such an interim service had to be procured at short notice, discussions took place between the providers to suggest a suitable solution and Framework offered one bed at Michael Varnum House to provide in-patient crisis detox for alcohol clients. However this has been a great success and is still being utilised. It takes great pressure off the Woodlands and bypasses waiting times.

The Woodlands

The Woodlands is a detoxification unit run by Nottinghamshire Healthcare Trust as part of a block contract held by the CCG; The CDP performance manages the service. In recent times alcohol crisis detoxification and poly substance misuse have been the most predominant reason for referral.

Quarter 1 figures for 2015 – 16 indicate that of 30 referrals

- 11 alcohol detox
- 4 alcohol and methadone stabilisation
- 1 Heroin, crack cocaine, amphetamine and alcohol detox.

This clearly indicates that alcohol plays a part in most individual's problems.

Unmet Need in Treatment

Gender

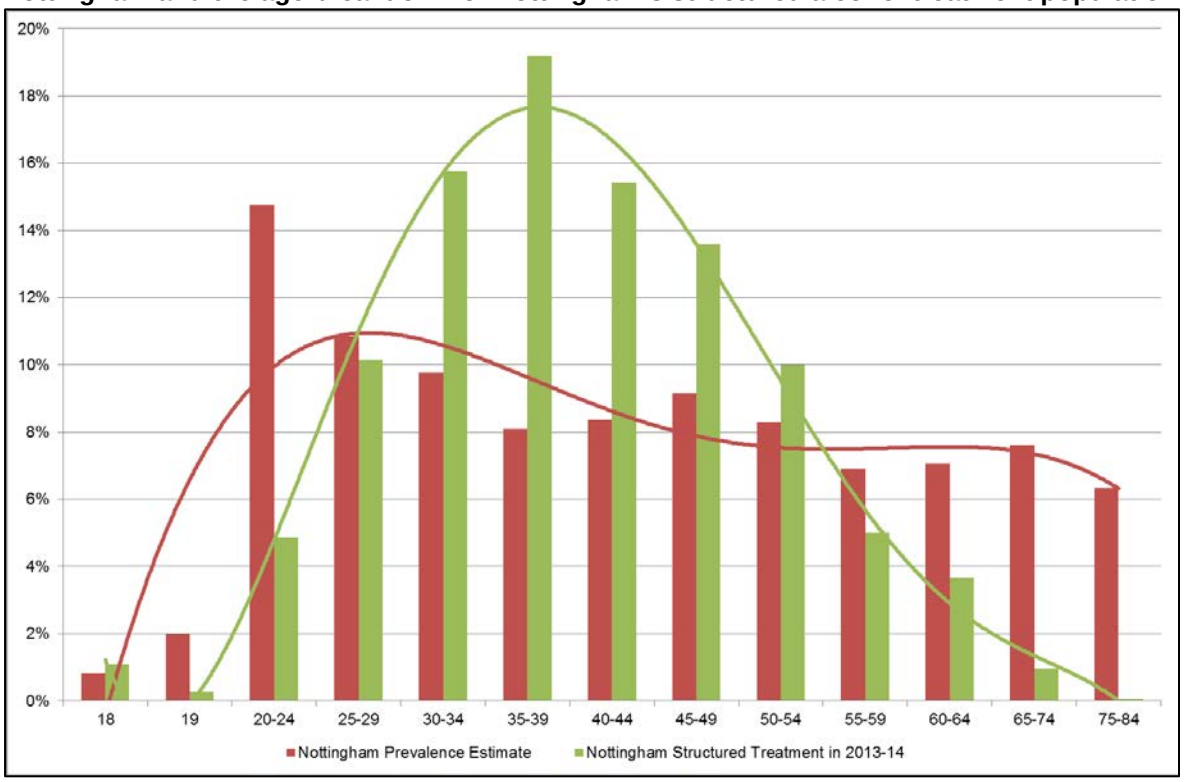
The demographic breakdown of clients accessing structured treatment interventions in Nottingham for alcohol use is 69% male and 31% female, suggesting that men may be slightly overrepresented within the treatment system. A comparison with the demographic breakdown of clients accessing structured alcohol treatment in England also shows men to be slightly overrepresented in the treatment system, although to a lesser degree than in Nottingham.

Age

Structured alcohol treatment population peaks in 35-39 year olds and the population is more heavily weighted towards clients aged 30 and over. This evidence, illustrated in Figure 26, might indicate that 20-24 year olds are underrepresented in structured alcohol treatment.

Data used to assess the demographic breakdown of the local and national treatment population is sourced from the National Drug Treatment Monitoring System (NDTMS) which does not report on unstructured treatment. Unstructured treatment is classified as treatment which consists of five or fewer sessions and does not involve a pharmacological or a psychosocial intervention. The effect of excluding demographic information on unstructured treatment may provide a partial explanation for the underrepresentation of the 20-24 demographic in alcohol treatment.

Figure 26 Age breakdown of the increasing risk and higher risk drinking estimate for Nottingham and the age breakdown of Nottingham's structured alcohol treatment population



Ethnicity

The assessment of differences in ethnicity reveals that White British structured alcohol treatment clients are slightly less prevalent in Nottingham compared to the national comparator (82% compared to 85%, respectively). The demographic profile of structured treatment clients in Nottingham and England is shown alongside estimated prevalence of increasing-risk and higher-risk drinkers in Table 4 below.

Table 4 Demographic breakdown of higher risk and increasing risk drinkers and structured alcohol only treatment populations

	Higher and Increasing Risk Drinkers		In Treatment Population[c]		
Demographic	**England[a]**	**Nottm (Estimate)[b]**	**Nottm 12/13**	**Nottm 13/14**	**England 13/14)**
Gender					
Male	61.72%	63.04%	69.19%	70.99%	66.61%
Female	38.28%	36.96%	30.81%	29.01%	33.39%
Age					
18	0.68%	0.83%	4.89%[d]	1.08%	0.95%
19	0.71%	1.99%		0.27%	0.66%
20-24	6.20%	14.76%		4.87%	5.29%
25-29	8.63%	10.84%	7.68%	10.14%	9.47%
30-34	8.62%	9.76%	11.46%	15.75%	13.75%
35-39	8.07%	8.10%	17.13%	19.20%	14.92%
40-44	9.08%	8.37%	14.57%	15.42%	16.72%
45-49	10.66%	9.15%	16.02%	13.59%	14.90%
50-54	9.83%	8.30%	13.46%	10.01%	10.73%
55-59	8.46%	6.90%	7.45%	5.00%	6.33%
60-64	9.36%	7.06%	5.23%	3.65%	3.53%
65-74	11.35%	7.61%	2.11%[d]	0.95%	2.43%
75-84	8.35%	6.34%		0.07%	0.32%
Ethnicity[e]					
White British	-	-	83.31%	82.35%	85.17%
White Irish	-	-	1.89%	1.49%	1.64%
Other White	-	-	4.23%	3.72%	3.06%
White & Black Caribbean	-	-	2.45%	3.38%	0.85%
White & Black African	-	-	0.33%	0.20%	0.24%
White & Asian	-	-	0.33%	0.47%	0.28%
Other Mixed	-	-	0.89%	0.81%	0.46%
Indian	-	-	1.33%	1.15%	1.12%
Pakistani	-	-	0.78%	0.95%	0.42%
Bangladeshi	-	-	0.00%	0.07%	0.20%
Other Asian	-	-	0.67%	0.81%	0.64%
Caribbean	-	-	1.78%	2.10%	0.93%
African	-	-	0.89%	0.54%	0.66%
Other Black	-	-	0.67%	1.01%	0.77%
Chinese	-	-	0.00%	0.00%	0.03%
Other	-	-	0.44%	0.68%	0.63%
Not stated	-	-	0.00%	0.14%	1.89%
Missing / inconsistent ethnicity code	-	-	0.00%	0.14%	1.02%

[a]https://www.drinkaware.co.uk/media/362885/drinkaware_monitor_2014_adults.pdf
[b]Based on Drinkaware data adjusted for Nottingham population
[c]Based on data from the National Drug Treatment Monitoring System which includes structured treatment only
[d]Further age breakdown unavailable due to missing data
[e]Ethnicity data unavailable

5) Evidence of what works

There is a body of evidence around effectiveness in alcohol interventions including new guidance published by the National Institute for Health and Clinical Excellence:
NICE public health guidance 24 (2010)
Alcohol-use disorders: preventing the development of hazardous and harmful drinking. This guidance covers the prevention and early identification of alcohol-use disorders among adults and adolescents. Its recommendations cover:

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

NICE clinical guideline 100 (2010)
Alcohol-use disorders: diagnosis and clinical management of alcohol-related physical complications. This guidance covers key areas in the investigation and management of the following alcohol-related conditions in adults and young people (aged 10 years and older):
• Acute alcohol withdrawal, including seizures and delirium tremens;
• Wernicke's encephalopathy;
• Liver disease;
• Acute and chronic pancreatitis.
NICE clinical guideline 115 (2011)
Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. This guidance covers principles of care, identification and assessment and interventions for alcohol misuse.
NICE Quality Standard for Alcohol (2011)
The alcohol dependence and harmful alcohol use quality standard defines clinical best practice within this area. It covers the care of children (aged 10-15 years), young people (aged 16-17 years) and adults (aged 18 years and over) drinking in a harmful way and those with alcohol dependence in all NHS-funded settings. It also includes opportunistic screening and brief interventions for hazardous and harmful drinkers.
Review of the effectiveness of treatment for alcohol problems *Raistrick et al 2006*
This outlines the evidence base for screening, brief interventions, less-intensive alcohol treatments, specialist treatment, detoxification and self help.
NICE guidance PH7 for alcohol
This guidance on school based interventions on alcohol describes the role of schools in education and brief advice to prevent alcohol misuse.
Other key guidance documents include:
Models of Care for Alcohol Misusers (DH 2006)
This provides best practice guidance for health organisations in delivering an integrated local treatment system and sets out a tiered approach for alcohol interventions
Signs for improvement: Commissioning interventions to reduce alcohol-related harm (DH 2009)
This publication describes how organisations should be commissioning interventions to reduce alcohol-related harm. It includes some evidence base for the 7 high impact changes
Alcohol Payment by Results (PbR)
Nottingham is one of four areas piloting a new approach to paying for alcohol treatment. Rather than paying in bulk for treatment under a block contract, payments made under

'Payment by Results' (PbR) are standardised dependent on diagnosis and treatment required for individuals within assigned groups.

6) What is on the horizon?

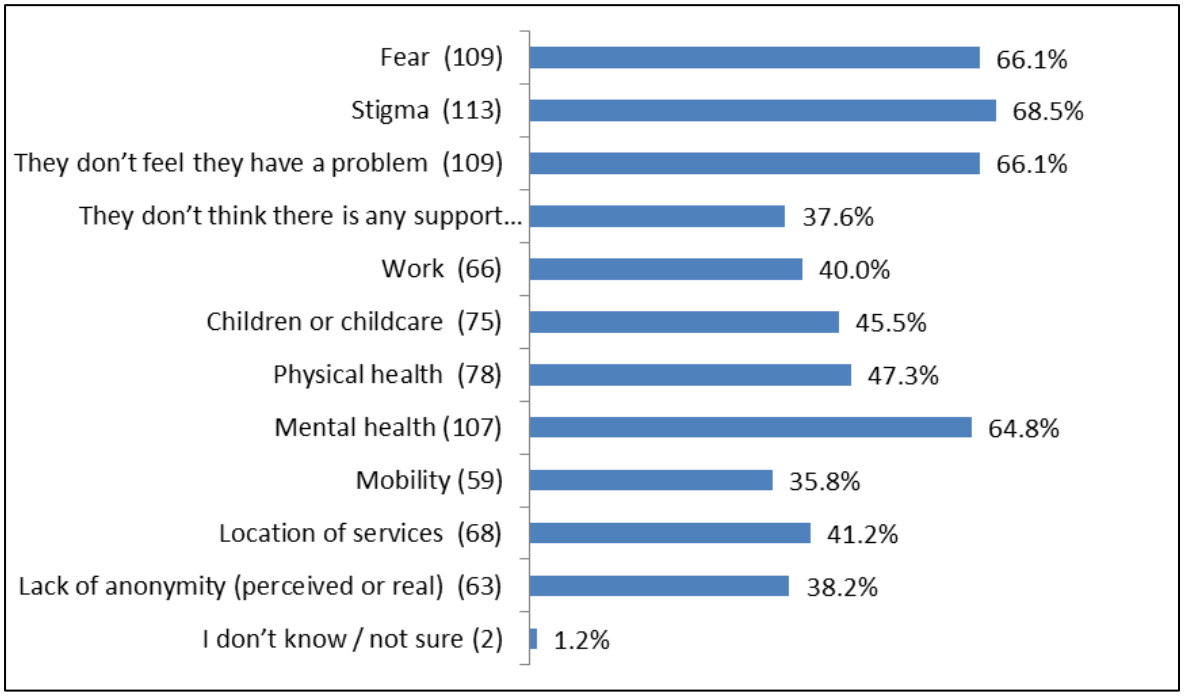
Projected Service Use

The projections of estimated service use have been calculated using the assumption that, within the next three years, the number of clients in treatment will slightly exceed those in treatment at the highest point in the past. This assumption is based on the fact that the current alcohol treatment provider is placing focus on promotional activity as a means of improving the rate of clients in treatment as a proportion of overall need. It is estimated that, during 2017-18, 900 adults will access structured alcohol treatment services in Nottingham.

7) Local Views

In July 2015, the Crime & Drugs Partnership carried out a consultation with 215 service users, service managers and staff, partner stakeholders, voluntary sector services, family and carers and the general public. The results showed that over 50% of respondents felt that substance misuse services were either very or fairly easy to access and 60% of respondents felt that it was very or fairly easy to refer someone to the correct substance misuse service for the first time. Figure 27 shows that fear, stigma and mental health and failure to recognise a problem were the most commonly cited issues that might prevent someone from accessing services.

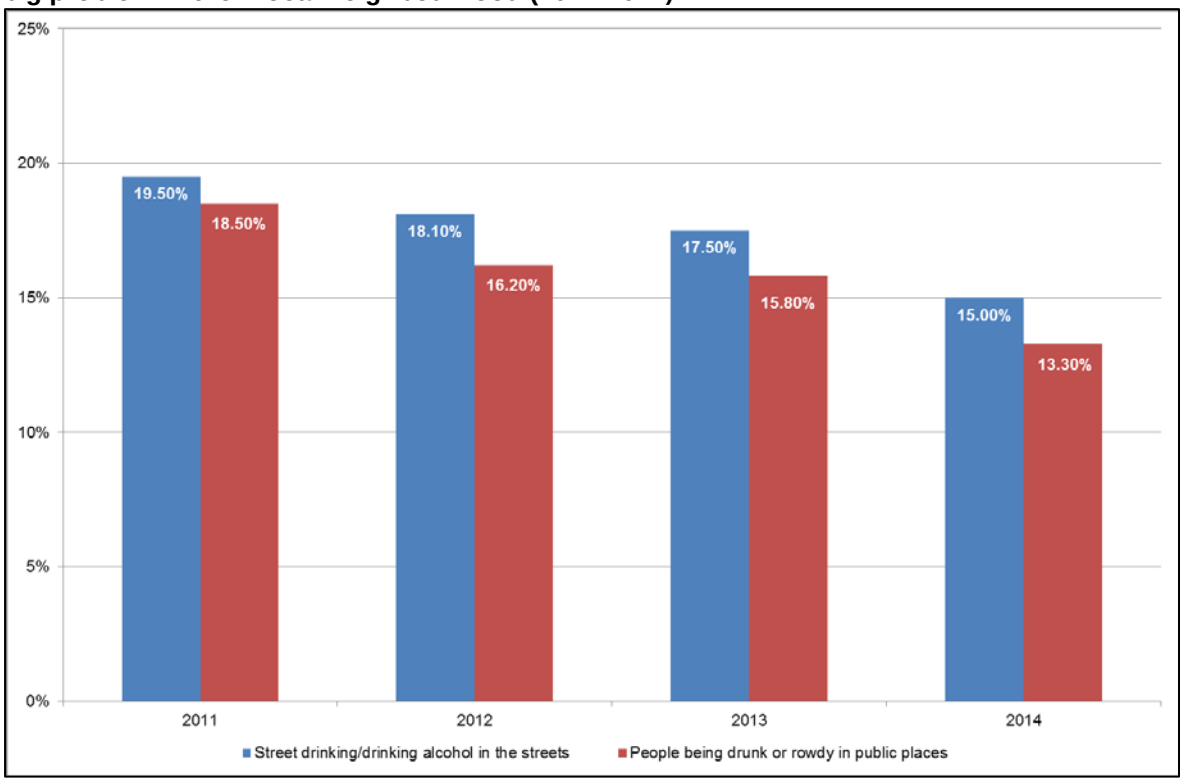
Figure 27 Response to consultation question on what might prevent people from accessing alcohol treatment



The opinions of citizens in respect of anti-social behaviour issues are sought annually via the Respect for Nottingham survey. According to the last four years of survey results, the percentage of respondents who felt that street drinking and drinking alcohol on the street in their local neighbourhood was either a fairly or very big problem reduced from 19.5% to 15%. A similar reduction was observed in the percentage of respondents who said that

people being drunk or rowdy in public places within their local neighbourhood (18.5% to 13.3%, as shown below in Figure 28).

Figure 28 Percentage of Respect Survey respondents who felt that alcohol was a fairly or very big problem in their local neighbourhood (2011-2014)



What does this tell us?

8) Unmet needs and service gaps

- Almost twice as much alcohol is consumed in the home in the UK, whilst alcohol consumption outside the home has reduced by 50% over the last decade.
- More men than women drink at increasing and higher risk level and binge drink both locally and nationally.
- Drinking alcohol during pregnancy can increase the risk of miscarriage, foetal Alcohol Syndrome (FAS), Foetal Alcohol Spectrum Disorders (FASD), Alcohol Related Birth Defects (ARBD) and Alcohol Related Neurodevelopment Disorder (ARND), learning disability.
- Alcohol hospital admissions and alcohol mortality are more common in men.
- National data suggests the proportion of increasing and higher risk is greatest in the 45-64 year age range whereas local data suggest it is greatest amongst 16-24 year olds.
- National and local data indicates that drinking at higher risk levels is more common amongst people from Lesbian, gay, bisexual and transgender (LGBT) groups than the general population.
- National and local data indicates that drinking at higher risk levels and binge drinking in greatest in people of White British and White (not British) ethnicities.

- Increased deprivation is associated with increased alcohol-related mortality, but groups of higher deprivation report lower levels of consumption.
- Alcohol use is positively associated with mental illness and 45% of people dependent on alcohol have mental health problems.
- Local survey data does not show a positive correlation between alcohol consumption risk category and poor mental wellbeing.
- Area 4 of the city (Arboretum, Radford & Park, Dunkirk & Lenton) has the highest proportion of people reporting they drink at increasing and higher risk levels and binge drinking.
- The rate of alcohol related hospital admissions in the city has increasing since 2009/10 and is now higher than the national, regional and core cities group. This increase is driven by an increase in alcohol specific admissions.
- Wards with the highest rates of hospital specific admissions are Bulwell, Dales, Arboretum, Basford and Berridge wards.
- Alcohol-related ASB accounts for 18% of all ASB calls to the Police and peaks during summer months.
  The alcohol related violent crime has reduced between 2008/9 and 2012/13 however, in the latest reporting period Nottingham had the highest rate compared to the ONS comparator local authorities.
- Almost half of alcohol-related crime occurs in the city centre and the north of the city is also over-represented. However, when considering alcohol-related violence against the person only, crimes are much more evenly spread across the city.
- Women are underrepresented in the local drug treatment system.
- There is an apparent gap in engaging 20-24 year old clients who are underrepresented in treatment services.
- Fear, stigma and mental health and failure to recognise a problem were the most commonly cited issues that might prevent someone from accessing treatment services.
- The links between alcohol consumption and deprivation requires further exploration.

9) Knowledge gaps

Alcohol consumption

Whilst the alcohol consumption Citizen Survey provides additional insight into population alcohol consumption, which most other areas do not have, it does have its limitations as described in the chapter. These particularly relate to the bias inherent in self reported alcohol consumption and limitations of precision of the survey in accurately estimating the prevalence of higher risk drinking in population sub groups. Further research would be required to describe this more accurately.

Treatment Statistics

Statistics pertaining to drug and alcohol treatment reported by Public Health England via the National Drug Treatment Monitoring System are restricted and, as a result, cannot be lawfully published prior to official release. The information contained within this chapter includes data up until 2013-14 which means that more up to date information cannot be taken into account if the findings are to be shared in a public arena. This issue represents a challenge and knowledge gap for commissioners.

What should we do next?

10) Recommendations for consideration by commissioners

- Ensure that alcohol treatment services are designed to reflect the fact that alcohol consumption within the home exceeds alcohol consumption outside of the home.
- Interventions should be commissioned to reduce the impact of alcohol related harm during pregnancy.
- Ensure interventions which aim to reduce increasing and high risk drinking and binge drinking are targeted at groups with the highest prevalence. This includes men, young people, White British and White (Not British) and LGBT groups.
- Target upstream interventions, including restrictions on the supply of alcohol, towards areas with increased levels of deprivation in order to reduce the elevated risk of harm demonstrated within the alcohol harm paradox.
- Interventions to reduce drinking at highest levels should ensure equity of access from Area 4 of the city (Arboretum, Radford & Park, Dunkirk & Lenton). Interventions to reduce alcohol-specific hospital admissions should be targeted at areas with the highest rates which are Bulwell, Dales, Arboretum, Basford and Berridge wards.
- Local Authority and Clinical Commissioning Group commissioners should work together to ensure that there are robust referral pathways between substance misuse services and psychological therapy, mental health and dual diagnosis services.
- Alcohol treatment services should ensure equity of access by 20-24 year old clients and women who are underrepresented in the current treatment model.

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References

Alcohol Concern (2015a) *Statistics on Alcohol,* Available at: https://www.alcoholconcern.org.uk/help-and-advice/statistics-on-alcohol/ [Accessed: 26 August 2015].

Alcohol Concern (2015b) *Alcohol and Hypertension Factsheet,* Available at: http://www.alcoholconcern.org.uk/wp-content/uploads/woocommerce_uploads/2015/05/Alcohol-and-Hypertension_Factsheet.pdf [Accessed 27 August 2015].

Alcohol Concern (2015c) *Alcohol and Breast Cancer Factsheet,* Available at: http://www.alcoholconcern.org.uk/wp-content/uploads/woocommerce_uploads/2015/06/Alcohol-and-Breast-Cancer_Factsheet.pdf [Accessed 27 August 2015].

Anderson. P. and Baumberg. B. (June 2006) *Alcohol in Europe, a public health perspective.* A report for the European Commission, P 99.

Coulthard, M. Farrell, M. Singleton, N. Meltzer, H. (2002) *Tobacco, Alcohol and Drug Use and Mental Health*. London: The Stationery Office. Available at:

www.statistics.gov.uk

[Accessed 13 November 2015]

Department of Health (2010) *Alcohol Ready Reckoner Briefing*, Available at: http://www.alcohollearningcentre.org.uk/Topics/Browse/Data/Datatools/?parent=5113&child=5109 [Accessed 27 August 2015].

Drinkaware (2013a) *Alcohol and sleep: Key things you need to know,* Available at: https://www.drinkaware.co.uk/media/307247/alcohol_and_sleep.pdf [Accessed 27 August 2015].

Drinkaware (2013b). *Alcohol and Cancer: Five key things you need to know,* Available at http://eb6eac5692db912ed5d9-411b8674dd3ca0f7d171c621142907c5.r53.cf1.rackcdn.com/Alcohol%20and%20cancer.pdf [Accessed 27 August 2015].

Drinkaware (2015a) *Your alcohol risk level,* Available at: http://www.drinkaware.co.uk/understand-your-drinking/is-your-drinking-a-problem/your-drinking-risk-level [Accessed: 26 August 2015].

Drinkaware (2015b) *Monitor 2014: Adults' drinking behaviour and attitudes in the UK*, London: Ipsos MORI. Available at: http://www.drinkaware.co.uk/media/362885/drinkaware_monitor_2014_adults.pdf [Accessed 26 August 2015]

Drinkaware (2015c) *Is alcohol affecting your sex life?,* Available at https://www.drinkaware.co.uk/check-the-facts/effects-on-relationships/is-alcohol-affecting-your-sex-life [Accessed 27 August 2015].

Health & Social Care Information Centre (2014) *Statistics on Alcohol, England 2014*, Leeds: Health & Social Care Information Centre. Available at: http://www.hscic.gov.uk/catalogue/PUB14184. [Accessed 27 August 2015].

Hurcombe, R., Bayley, M. and Goodman, A. (2010) *Ethnicity and Alcohol: A review of the UK literature*, York: Joseph Rowntree Foundation. Available at: http://www.jrf.org.uk/sites/files/jrf/ethnicity-alcohol-literature-review-full_0.pdf [Accessed 27 August 2015].

Mental Health Foundation (2014) *Alcohol,* Available at: http://www.mentalhealth.org.uk/help-information/mental-health-a-z/A/alcohol/ [Accessed: 27 August 2015].

NHS (2013) *Alcohol-related liver disease,* Available at: http://www.nhs.uk/conditions/liver_disease_(alcoholic)/Pages/Introduction.aspx [Accessed 27 August 2015].

NHS (2014a) *The risks of drinking too much,* Available at: *http://www.nhs.uk/Livewell/alcohol/Pages/Effectsofalcohol.aspx* [Accessed: 26 August 2015].

NHS (2014b) *Calories in alcohol*, *Available at:* *http://www.nhs.uk/Livewell/alcohol/Pages/calories-in-alcohol.aspx* [Accessed: 27 August 2015].

National Institute for Health and Care Excellence (2010) *Alcohol-use disorders: preventing harmful drinking,* Available at: *http://www.nice.org.uk/guidance/ph24/chapter/glossary#alcohol-dependence* [Accessed: 26 August 2015].

Public Health England (2014a) *Indicator Definitions and Supporting Information,* Available at: http://fingertips.phe.org.uk/search/alcohol#gid/1/pat/6/ati/102/page/6/nn//par/E12000004/are/E06000015/iid/91384/age/1/sex/4 [Accessed: 26 August 2015].

Public Health England (2014b) *Understanding alcohol-related hospital admissions,* Available at: https://publichealthmatters.blog.gov.uk/2014/01/15/understanding-alcohol-related-hospital-admissions/ [Accessed: 26 August 2015].

Public Health England (2014c) *Public Health Profiles,* Available at: http://fingertips.phe.org.uk/search/alcohol#gid/1/pat/6/ati/102/page/0/nn//par/E12000004/are/E06000015/iid/90892/age/1/sex/4 [Accessed: 26 August 2015].

Public Health England (2014d) *From evidence into action: opportunities to protect and improve the nation's health*, London: Public Health England.

Public Health England (2014e) *Local Alcohol Profiles for England*, Liverpool: Public Health England. Available at: http://www.lape.org.uk/data.html [Accessed 27 August 2015].

Public Health England (2014f). *The burden of liver disease in the East Midlands.* Available at: http://www.empho.org.uk/Download/Public/13149/1/East%20Midlands%20Liver%20Disease%20Briefing%202014.pdf [Accessed 27 August 2015].

Public Health England (2014g) *Alcohol data: JSNA Support Pack*.

Singleton N, Bumpstead R, O'Brien M, Lee A, Meltzer H. (2001) Psychiatric Morbidity Among Adults Living In Private Households 2000 London: The Stationery Office p32.

Smith, K. and Foster, J. (2014) *Alcohol, Health Inequalities and the Harm Paradox: Why some groups face greater problems despite consuming less alcohol*, London: Institute of Alcohol Studies. Available at: http://www.ias.org.uk/uploads/pdf/IAS%20reports/IAS%20report%20Alcohol%20and%20health%20inequalities%20FULL.pdf [Accessed 26 August 2015].

Williams, H., Varney, J., Taylor, J., Fish, J., Durr, P. and Elan-Cane, C. (2013) *The Lesbian, Gay, Bisexual and Trans Public Health Outcomes Framework Companion Document*, Public Health England. Available at: http://lgbt.foundation/policy-research/the-lgbt-public-health-outcomes-framework-companion-document/ [Accessed 27 August 2015].

World Health Organisation (2009) *Harmful Use of Alcohol*. Available at: http://www.who.int/nmh/publications/fact_sheet_alcohol_en.pdf [Accessed 26 August 2015].