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**Alcohol is placing an unsustainable burden on the NHS**

*The nation's growing addiction to alcohol is putting an immense strain on health services, especially in hospitals, costing the NHS over £2.7 billion each year. This burden is no longer sustainable. The role of the NHS should not just be about treating the consequences of alcohol related-harm but also about active prevention, early intervention, and working in partnership with services in local communities to raise awareness"*

Professor Ian Gilmore, President of The Royal College of Physicians, January 2010

**Until it reaches a critical stage most liver disease has virtually no symptoms.**

*I've seen patients who've been admitted with pretty catastrophic bleeding from stomach and oesophagus with no prior warning of a problem of their liver.*

*"Others may present with jaundice or swelling of the abdomen because there's a lot of fluid in the abdomen.*

*"All these three things are signs of quite advanced liver disease and can come out of the blue."*

Dr Jonathan Mitchell, Consultant Hepatologist, November 2007

**Chronic liver disease is now occurring in young people as well as older people**

*"When I became a liver specialist 30 years ago, alcoholic liver disease was something we only saw in middle-aged and older people. Now we're seeing people in their twenties with end-stage liver disease".*

Professor Ian Gilmore, President of The Royal College of Physicians, March 2009

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**Lynfield Mount (Bradford Community Care NHS Trust)**

**Probation Services**

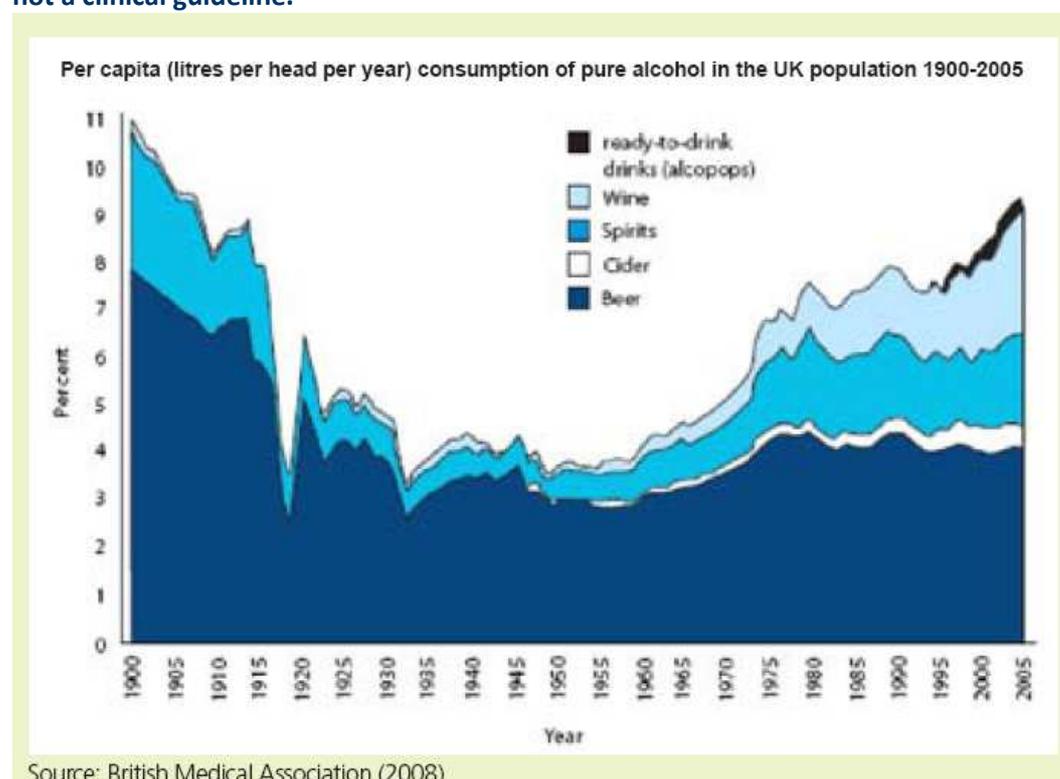
# Alcohol Health Needs Assessment for Bradford and Airedale

## Background

Currently in the UK nearly 90% of adults drink, the majority of whom do so without significant problems. However alcohol is a toxic substance that can lead to intoxication and become a drug of dependence. Alcohol misuse causes harm and misery to many. It can devastate families, and fuels violence and criminal damage, particularly in city centres. There is a strong correlation between alcohol and domestic violence. There is very clear evidence that cheaper alcohol correlates to increased consumption and greater alcohol-related harm. Alcohol is currently cheaper than ever before in real terms. If it becomes less affordable relative to people's income, some of the 48% of Bradford residents who have a drink on most days of the week may begin to change their habits.

Alcohol fulfils an important social role in the UK but has a significant potential for harm. The amount we drink has varied considerably over the last 100 years. From a peak at the beginning of the last century, overall consumption dropped until the 1950s (most dramatically during First World War and the recession of the 1930s). Since then consumption has increased steadily with an increasing market share of wine, cider and Alcopops.

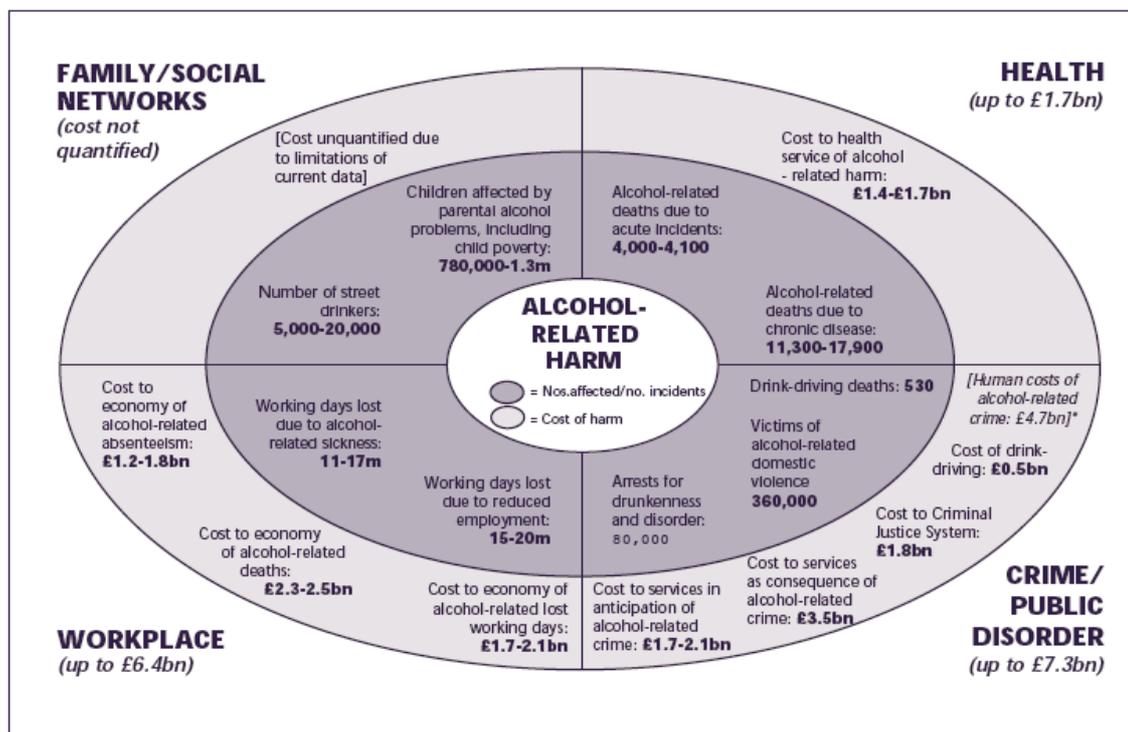
**This Alcohol Health Equity audit aims to describe patterns of harmful, hazardous and dependent drinking in Bradford. It then maps the different types of treatment services and analyses access to these services with respect to population needs. Inequity within specific population groups or locations and recommendations for alcohol service development are made. Although evidence from NICE guidelines is referenced within this document this is not a clinical guideline.**



## The burden of alcohol

### Societal

The misuse of alcohol causes or contributes to a large volume of mortality, chronic ill-health, violent crime and anti-social behaviour and places a considerable burden on the NHS. The annual cost to the NHS was estimated at £2.7 billion at 2006 - 2007 prices with alcohol accounting for 6% of all hospital admissions. Pro-rata this is £27 million in Bradford and Airedale but our high rate of alcohol-related hospital admissions suggests a higher local cost.



Source: DH 2008. The cost of alcohol harm to the NHS in England - An update to the Cabinet Office (2003) study. Crown Copyright. The total health bill of £1.7bn in this diagram differs from the figure quoted in the text above (£2.7bn) as it refers to an earlier estimate.

Workdays lost (sickness absence) through alcohol misuse (both binge drinking hangovers and chronic alcohol problems) in the Bradford district is estimated to be within the range 80,000-216,000 days lost each year.

### Personal

Drinking in moderation can confer health benefits, as modest alcohol consumption (1 unit a day) has a protective effect against coronary heart disease and stroke amongst men over 40, and post-menopausal women. Of most concern to public health is the number of people drinking excessively. The Department of Health recommends that men should not drink more than 3 to 4 units a day or 21 units a week. The amounts for women are lower (2 to 3 units a day, or 14 units a week) because of women's smaller size, different physiology and slower metabolising of alcohol. At least two alcohol free days a week are recommended for both genders. Drinking in excess of the recommended limits is referred to as hazardous or harmful drinking. Drinking more than double the recommended limits is considered to be harmful or higher risk drinking, and includes many who are dependent on alcohol.

Drinking above the recommended limits of alcohol means you are at greater risk of having physical, psychological and social problems as a result.

#### Physical:

- liver disease such as fatty liver, alcoholic hepatitis or alcoholic cirrhosis
- high blood pressure and other heart problems such as coronary heart disease and stroke
- cancer of the liver, stomach, colon, rectum, lung, pancreas, larynx (voice box) and oesophagus (food pipe)
- a serious alcohol withdrawal symptom called delirium tremens, which includes shaking, sweating, diarrhoea and seizures; this requires urgent medical attention as it can be life threatening.
- accidental injury or death

#### Psychological:

- high levels of anxiety and depression, which are often a cause of drinking in the first place, can become worse as a result of drinking
- delirium tremens, which can also cause you to feel agitated, confused, paranoid and experience hallucinations
- sleeplessness
- suicidal feelings
- problems with your sex life
- memory loss

#### Social:

- the breakdown of relationships with family and friends
- poor performance in your job
- financial problems
- breaking the law, such as driving when over the alcohol limit
- aggressive, violent or argumentative behaviour

## **The impact of the recession**

Evidence shows that the psychological stress of recession and unemployment can increase the likelihood of binge drinking. From local lifestyle surveys we know that a fifth of the adult population admit to binge drinking on at least a weekly basis. We could see an increase in this figure as the recession takes hold.

On a more positive note, there is also some evidence that as people's incomes reduce, regular drinking can decrease. Demand for alcohol is income elastic. This accounts for the dip in UK per capita alcohol consumption during the economic depression of the 1930s.

Demand for alcohol is, however, also price elastic. Manufacturers may adopt a wide range of strategies to keep the price of alcohol (relative to falling incomes) constant so as to maintain demand and minimise any fall in sales. Lobbying and alcohol pricing concerns are discussed in more detail in the appendices.

## Local policy context

Alcohol misuse is a contributor to health inequalities. Months of life lost in areas of high unemployment and low income are four times greater than in wealthier and often more rural areas. Of increasing concern is the national trend of a lowering in the age of onset of liver disease and increasing harmful drinking amongst young women. The high numbers of alcohol related deaths amongst men and high rates of hospital admissions locally have focussed the attention of various local strategies and plans firmly on alcohol harm reduction.

The Bradford and Airedale tPCT Strategic Plan 'Achieving the best health for all', the Big Plan (Bradford District's sustainable communities strategy) and the Joint Strategic Needs Assessment for Bradford District all prioritise reducing alcohol related harm. The Big Plan is in itself a key strategy for reducing health inequalities and focuses on the need to reduce the damage to health caused by the use and misuse of alcohol, tobacco and illegal drugs. This is a shared priority of the Health and Well Being and Children's Partnerships. The Local Area Agreement includes as one of its 35 most important targets for the District; Substance misuse by young people (NI115). The aim of including this target is to focus attention on reducing the proportion of young people using illicit drugs, alcohol or volatile substances.

The district's Alcohol Harm Reduction Strategy identifies ten aims and 35 approaches to tackling the problems of drug misuse in the district. The 10 aims are:

- To reduce the number of people who drink alcohol above recommended limits, thus reducing the adverse health impact of alcohol.
- To reduce alcohol-related crime, disorder, intimidation, nuisance and anti-social behaviour, and ensure that everyone can enjoy all areas of the Bradford district without fear of alcohol-related violence and intimidation.
- To reduce the prevalence of harmful drinking by children and young people under 18.
- To develop a comprehensive range of effective treatment, support, rehabilitation and reintegration services for alcohol misusers, with easy access and clear care pathways.
- To reduce the harm caused by alcohol misuse within families and relationships, including domestic abuse and the "hidden harms" caused to the children of alcohol-misusing parents.
- To reduce the number of babies born with a disorder in the Foetal Alcohol Spectrum Disorder range, and to decrease the risk of related problems experienced by children born with one of these disorders.
- To reduce alcohol-related accidents and fires, thus reducing avoidable premature death, disability and less serious injuries.
- To reduce the economic costs of alcohol misuse.
- To ensure that information and services are accessible and welcoming to all sections of Bradford's diverse population.
- To record and analyse the data necessary to measure our progress.

Actions towards achieving these aims are included in the Implementation plans of the Alcohol Strategy Implementation Group. These are monitored on a six-monthly cycle, and have been reviewed and revised for 2010-2011.

Future demand on health services caused by alcohol misuse are recognised within the above-mentioned strategic plans and the tPCT strategic plan prioritises reducing health

inequalities and developing tiered models of alcohol services that screen and treat those in need. The tPCT has prioritised re-design of the alcohol pathway accordingly.

## **National and local targets**

### **Children and Young People (<16yrs)**

- The key national targets for substance and alcohol misuse are:
- PSA 25: Reduce the harm caused by alcohol and drugs.
- NI115: Substance misuse by young people. This aims to reduce the proportion of young people using illicit drugs, alcohol or volatile substances.
- SA 14 and PSA 25 targets are monitored locally by:
  - Measuring the increase in admissions of young people to specialist treatment provision.
  - Measuring the number of young people who receive drug and alcohol awareness
- education and preventative interventions.

NI 115 has been adopted as one of the 35 National Indicators for Bradford district.

### **Adults**

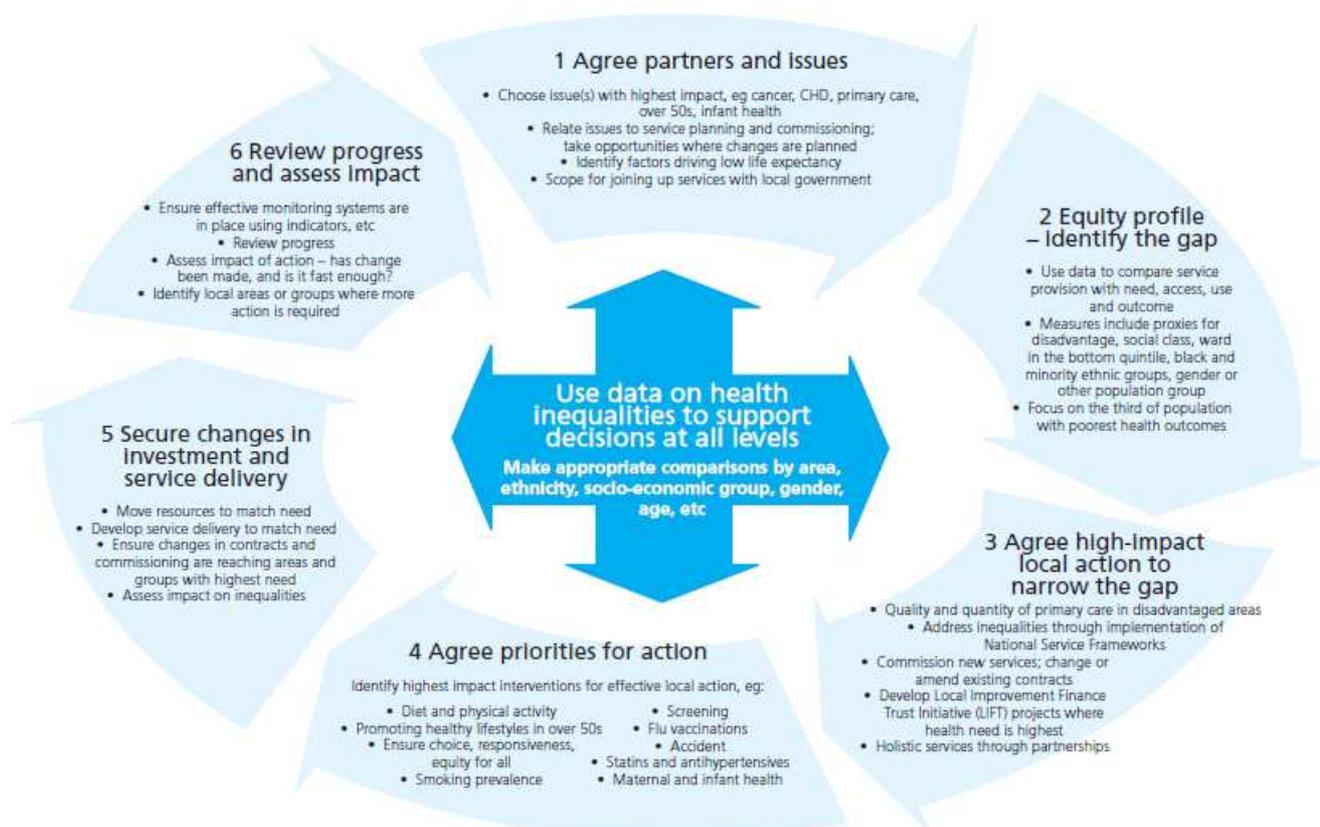
- Vital Signs Indicator: Rate of hospital admissions per 100,000 population for alcohol related harm (NHS Operating Framework).
- NI41: Perceptions of drunk and rowdy behaviour as a problem in your local area
- NI20: Assault with injury crime rate (proxy target for alcohol related violence)

# Aims of the Health Needs Assessment

## Why are we undertaking a Health Equity Audit?

To understand health equity audit (HEA) it is important to be clear about two terms – equity and audit. Equity concerns how fairly resources are distributed throughout a group of people (a population). Audit is concerned with systematically understanding a situation (often quantitatively) and then identifying and taking action. A HEA uses data about the health outcomes of a population (e.g. hospital admissions due to alcohol poisoning), their lifestyle (e.g. alcohol consumption), their use of services (e.g. treatment for alcohol dependency) and the distribution of those same services. Qualitative data from focus groups about services and treatment issues may also be used. Once all this information has been assembled appropriate comparisons can be made between communities, ethnic and socio-economic groups, gender and age-group.

Health equity audits identify how fairly services or other resources are distributed in relation to health needs. The aim is not to recommend an equal distribution of resources but, rather, relative to health need. HEA should help prioritise action that leads to a distribution of services and resources relative to need. This should allow health services and other agencies to take positive decisions on investment, service planning, commissioning and delivery of services. The HEA cycle is not complete until something changes that is likely to reduce inequalities demonstrably. Once the six stages of an HEA have been completed (see diagram) progress towards health equity, or equal resources for equal need, may be achieved.



PCTs have a mandatory requirement to use HEA to inform service planning requirement. This was first set out in the NHS Priorities and planning framework 2003–2006 [DH, 2002] and has since been reinforced in further guidance. HEA was placed firmly within the national focus on health inequalities in ‘tackling health inequalities: a programme for action’ [DH,2003]. Health equity audit is now an essential part of the process for reducing health inequalities and an essential tool in achieving the DH’s national public service agreement (PSA) target of reducing inequalities in health outcomes by 10% by 2010. The significance in the HEA process is that it helps to address local, rather than national, health inequalities by focussing on local inequity.

## **Aims and objectives**

**The aims of this alcohol health needs assessment are to:**

- **Describe patterns of harmful drinking in Bradford**
- **Map alcohol treatment services and describe access to these services**
- **Identify inequity of access within specific population groups or locations**
- **Make recommendations for alcohol service development**

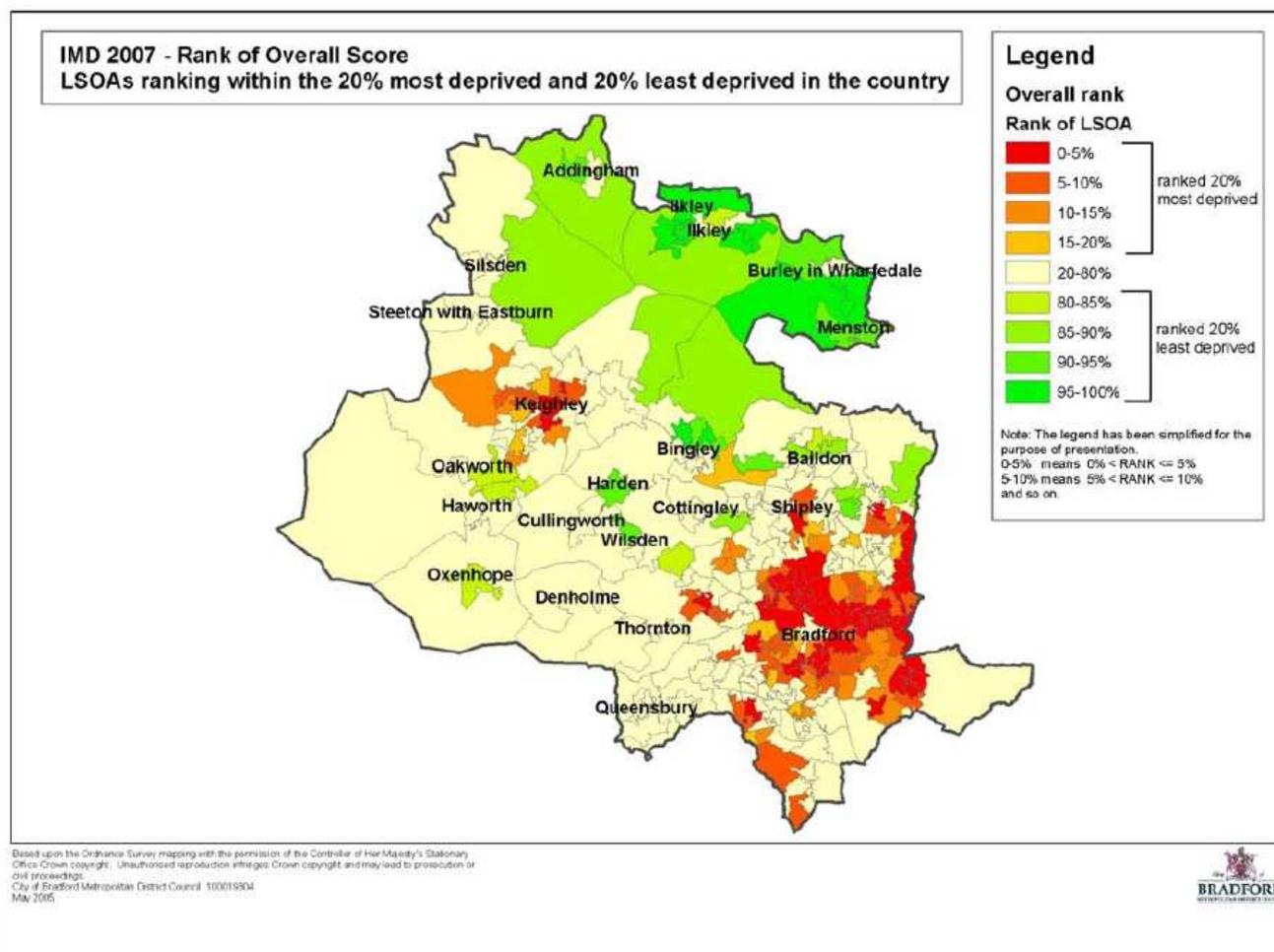
The objectives are defined as follows:

1. Place local drinking patterns in context through comparison against national rates
2. Use data from local lifestyle surveys to describe drinking patterns
3. Identify hotspots of harmful drinking
4. Gather data from all service providers for a complete picture of service uptake and associated costs
5. Describe the treatment journey (alcohol pathway) by service tier
6. Map current services against current demand and potential demand (unmet need)
7. Determine gaps in the current alcohol treatment services
8. Conduct a literature review of the most recent evidence about clinical and cost effectiveness of alcohol services
9. Identify value for money services that could affect high impact change in drinking and treatment locally

## Local Population

Bradford is a metropolitan district with a population of nearly half a million people. The latest population estimates show that 502,000 live in the District, of which 48% are male and 52% are female. Bradford consists of large expanses of rural and moorland areas; a number of discreet towns, including Bingley, Ilkley, Keighley and Shipley; many villages each with their own character, needs and differences; and the large urban city of Bradford itself, with high levels of poverty, deprivation and health and social needs.

### Bradford's least and most deprived areas (Lower Super Output Areas) 2007



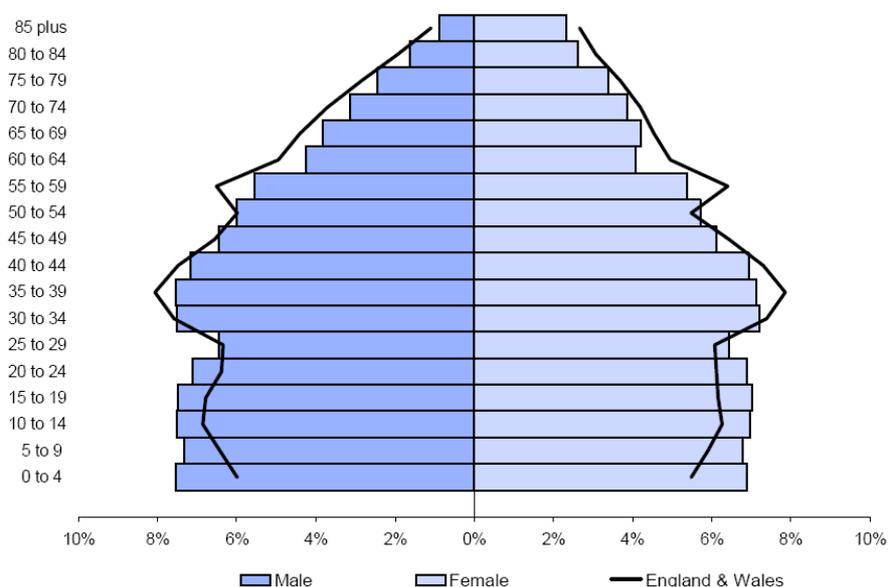
Deprivation is closely correlated with many health outcomes, including obesity. 43% of Bradford's population live in the most deprived 20% of areas in England - more than double the expected proportion of people living in the most deprived areas compared to England & Wales. The worst deprivation is concentrated in areas of Central, East and South Bradford and parts of Keighley. However Bradford also has some of the most affluent areas of the country (for example Wharfedale and Ilkley Wards), exemplifying the inequalities that exist within the District as well as compared with the country as a whole.

Bradford, unlike other Metropolitan Districts in the country, has a growing youth population. Bradford District has a diverse population with the majority of the ethnic minority population in the District residing in the inner city areas of Bradford and Keighley.

### Bradford has a young population relative to England & Wales

Age range	Bradford	England and Wales
Under 16	23.4	20.2
16 to 19	5.6	4.9
20 to 29	13.4	12.6
30 to 59	38.7	41.5
60 to 74	12.2	13.3
75 and over	6.8	7.6
Average age	36.4	38.6

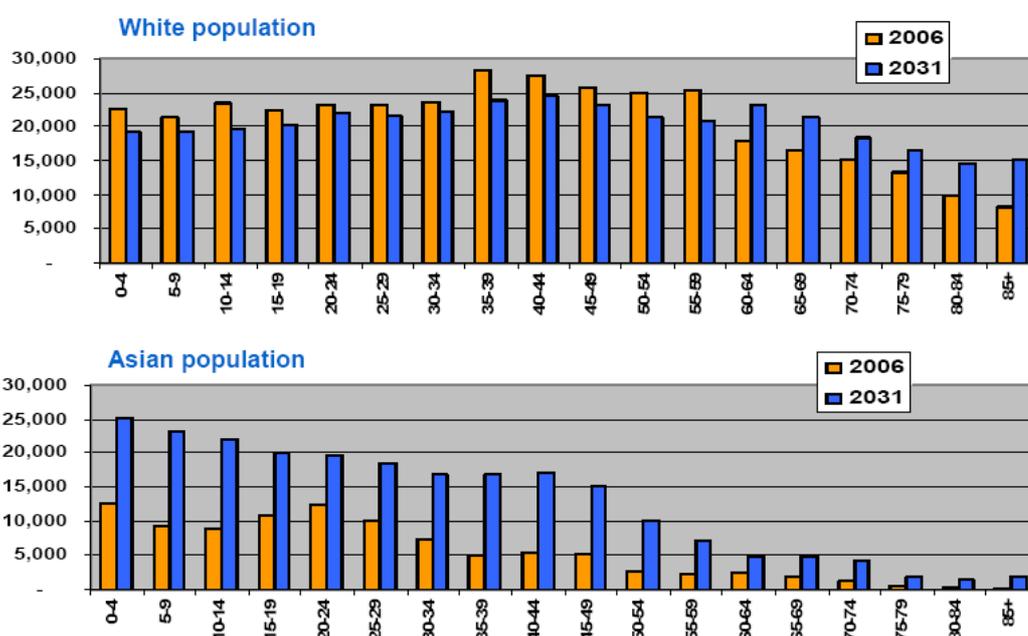
### Bradford's population structure compared to the UK average



Percentage of resident population in ethnic groups:	Bradford	England
White	78.3	90.9
of which White Irish	0.7	1.3
Mixed	1.5	1.3
Asian or Asian British	18.9	4.6
Indian	2.7	2.1
Pakistani	14.5	1.4
Bangladeshi	1.1	0.6
Other Asian	0.6	0.5
Black or Black British	0.9	2.1
Caribbean	0.6	1.1
African	0.2	1
Other Black	0.1	0.2
Chinese or Other Ethnic Group	0.4	0.9

Minority ethnic communities currently make up approximately 22% of the total current population. This proportion is forecast to increase to 26% by 2011. The total population of the District is forecast to grow by 20% by 2030, from approximately half a million to 600,000. 85% of this growth is projected to occur in the local South Asian population. Bradford District population compared to England and Wales. Bradford has an ethnically diverse population Bradford with a lower white population, a higher Asian/Asian British population when compared to England. The main ethnic grouping is white with 79% of the population, followed by Pakastani at 14.5% the majority of whom are Muslims. Bradford also has a lower Black/Black British/Caribbean population compared to England and Wales.

### Projected change in the age distribution of the White and Asian population of the District: 2006 & 2031



## Drinking patterns

### Children and Young People (<16yrs)

The commercial supply of alcohol to under-18 year-olds is illegal due to the increased immediate and long term health risks associated with drinking by those with not-fully-mature bodies. However, alcohol is a poorly regulated and heavily marketed drug (Advisory Council on the Misuse of Drugs 2006). It is strongly associated with anti-social behaviour and violence amongst adolescents. Children and young people aged 11–15 who regularly smoke or drink are much more likely than non-smokers and non-drinkers to use other drugs (Advisory Council on the Misuse of Drugs 2006). In addition, in 2003 in the UK, 8% of young people aged 15–16 reported having unprotected sex after drinking alcohol (11% females, 6% males).

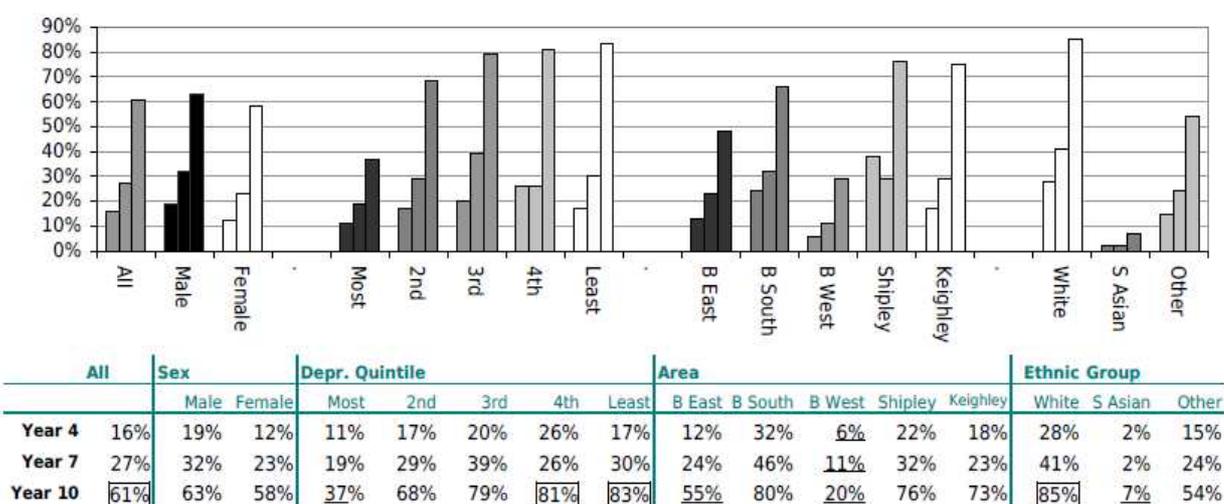
Nationally the number of children and young people aged 11–15 who drink alcohol has fallen since 2001. However, those who do drink alcohol consume more and more often than

in previous years (HM Government 2007). For example, in 2006 21% of those aged 11–15 who had drunk alcohol in the previous week consumed an average 11.4 units, a rise from 5.3 units in 1990. Drinking prevalence increases with age with 3% of pupils aged 11 drinking alcohol in the previous week compared with 41% of those aged 15 [The Information Centre for Health and Social Care, 2007].

### Local picture

In 2009 Bradford and Airedale tPCT commissioned a survey of the lifestyle of children and young people in Bradford District [SHEU, 2010]. Along with other important lifestyle factors, this survey recorded details of alcohol consumption by over 10,000 children in Years 4 (8/9yrs), Year 7 (11/12yrs) and Year 10 (14/15yrs). The results showed that as young people get older they were more likely to say that they had tried alcohol. By Year 10 over 60% of pupils have drunk an alcoholic drink.

Percentage of pupils who have ever drunk alcohol, by year group and by sex, deprivation quintile, area, and ethnicity. (chart columns show years 4,7 and 10 in order).



There were very marked differences by ethnic groups with regard to consumption. Most young people in Year 10 from White backgrounds had tried alcohol (85%), while less than 10% of South Asian youngsters in the same age group report trying alcohol. The difference between these two broad ethnic classifications explains most of the differences seen between areas.

As part of the survey, pupils in secondary schools were invited to identify from where they obtained their alcohol. The most common source for the few Year 7 drinkers was “I got my alcohol from my parents to drink with them.” Young people in Year 10 who drank last week were most likely to have obtained their alcohol by being given it by parents or carers to drink with them at home (17% of year 10 children); the next most common source was a friend who purchased alcohol for them (10%). Males were more likely than females to say that their alcohol was given to them by parents/carers to drink at home. Females were more likely than males to have been given alcohol by a friend, or to have had alcohol bought for them by a friend, or by a stranger.

Percentage of pupils who obtained alcohol from different sources, **Year 10** only, by sex, deprivation quintile, area, and ethnicity.

	All	Sex		Depr. Quintile					Area					Ethnic Group		
		Male	Female	Most	2nd	3rd	4th	Least	B East	B South	B West	Shipley	Keighley	White	S Asian	Other
Drink at home	17%	19%	15%	9%	20%	26%	30%	23%	15%	21%	6%	24%	21%	26%	2%	11%
Given/friends	7%	5%	8%	2%	8%	11%	8%	11%	6%	7%	3%	10%	9%	10%	1%	4%
Took/stole	3%	3%	3%	1%	2%	3%	2%	6%	2%	3%	1%	4%	3%	4%	0%	2%
Off-licence	5%	5%	5%	3%	6%	6%	4%	4%	4%	7%	1%	7%	5%	7%	1%	5%
Supermarket	1%	2%	1%	1%	2%	1%	1%	2%	1%	3%	0%	1%	1%	2%	0%	1%
Stranger - Off	7%	6%	8%	4%	10%	8%	5%	6%	8%	11%	1%	5%	9%	10%	0%	6%
Stranger - Super	2%	2%	3%	1%	2%	3%	2%	3%	2%	5%	0%	2%	4%	3%	0%	3%
Friend purchase	10%	9%	11%	6%	12%	13%	11%	15%	9%	11%	3%	15%	14%	15%	1%	9%
Pub	2%	2%	2%	1%	4%	2%	2%	2%	2%	3%	1%	2%	4%	3%	0%	2%
Club	1%	1%	1%	1%	2%	1%	2%	2%	1%	3%	1%	2%	2%	2%	0%	2%

## Adults

The national Alcohol Needs Assessment Research Project [ANARP, 05] in 2005 used a 3 way classification for describing alcohol use; hazardous alcohol use, harmful alcohol use and alcohol dependence. These categories are defined as follows:

**Hazardous drinking:** People drinking above recognised 'sensible' levels but not yet experiencing harm. Hazardous drinking of between 22 and 50 units per week for men and between 15 and 35 units per week for women.

**Harmful drinking:** People drinking above 'sensible' levels and experiencing harm. Harmful drinking of more than 50 units per week for men and more than 35 units per week for women.

**Alcohol dependence:** People drinking above 'sensible' levels and experiencing harm and symptoms of dependence. Although these people are likely to be drinking at harmful levels, dependence cannot be determined purely from alcohol intake. Rather, dependence constitutes a combination of signs and symptoms including:

- a strong compulsion to drink alcohol
- the need to drink every day or on regular days
- feeling that you can't stop drinking once you have started
- a growing tolerance to alcohol - needing larger quantities to get the same effect
- neglecting other interests and increasingly prioritising drinking alcohol
- spending more and more time drinking and recovering from the effects of alcohol
- drinking first thing in the morning
- withdrawal symptoms including anxiety and tremor
- inability to cut down despite a deterioration in psychological or physical health, and personal relationships / life circumstance

Self administered alcohol use disorder identification tests can be used on individuals to identify hazardous or harmful drinking. Similarly alcohol dependence can be assessed by the self-completed SADQ-C (Severity of Alcohol Dependence Questionnaire). For this health equity audit we do not have population wide surveys that use these questionnaire based tools. We have therefore estimated the numbers of people falling into the hazardous and harmful groups using data from the Bradford and Airedale adult lifestyle survey of 2007/2008. It is not possible from the questions asked as part of the lifestyle survey to classify respondents as dependent drinkers. However, synthetic estimates do exist from the Ready Reckoner tool and from the Adult Psychiatric Morbidity Survey (2007). \*\*According to local experts, these estimates of dependency are better expressed as a confidence interval estimate of between 3-6% until better local data is available.

The Bradford and Airedale lifestyle survey collected data about alcohol consumption (including frequency and number of units consumed) for a representative sample of 6,000 adults in Bradford and Airedale. Health survey questionnaire are reasonably effective and accurate for measuring excessive alcohol use [Cutler, 88]. However we found that when using survey data about units consumed this produced unrealistically low numbers of harmful and hazardous drinkers in Bradford, when compared to other sources (e.g. Ready Reckoner, Psychiatric Morbidity Survey, HSE Synthetic estimates). We therefore used lifestyle data about the number of days drinking alcohol and binge drinking to make local estimates. This produced more believable figures (see table below).

### Sources of estimated drinking prevalence in Bradford District (aged 16+)

	<b>Bradford Lifestyle Survey (2007/2008) Used in this report</b>	Ready Reckoner v5 (estimate for Bradford 2010)	Adult psychiatric Morbidity Survey (2007)
Hazardous drinking	<b>21%</b>	22%	24%
Harmful drinking	<b>4%</b>	7%	4%
Alcohol dependence	<b>N/A**</b>	6%**	6%**

The reason for making estimates based on the lifestyle survey was to demonstrate an effective estimation method that we could then go on and use for stratification of harmful/hazardous drinkers by age-group, sex and locality (ward). This stratification was not available from other sources. The Bradford Lifestyle Survey estimates are used for the remaining of this document.

**Our estimates are that there are ~92,000 people in Bradford District drinking at hazardous levels that may damage their health. This places nearly a fifth of the population at risk of adverse health effects.**

**Approximately 17,000 drink at harmful levels that will result in physical or psychological harm. Many people drinking at harmful levels will also be alcohol dependent.**

**Estimated numbers of hazardous and harmful drinkers by age and sex for Bradford and Airedale (2008) [source: Bradford and Airedale Lifestyle Survey 2007/2008]**

Age Range	Men		Women		Adults	
	Hazardous (inc Harmful)	Harmful	Hazardous (inc Harmful)	Harmful	Hazardous (inc Harmful)	Harmful
18-24	10,155	1,693	8,701	452	18,856	2,145
25-34	21,387	1,277	4,823	492	26,211	1,769
35-44	11,142	3,436	5,787	1,191	16,929	4,628
45-54	11,190	3,000	4,517	1,255	15,707	4,255
55-64	6,270	2,090	2,135	769	8,406	2,859
65-74	3,098	818	1,201	277	4,299	1,095
75+	1,167	412	238	119	1,405	531
<b>Total</b>	<b>64,410</b>	<b>12,726</b>	<b>27,402</b>	<b>4,555</b>	<b>91,812</b>	<b>17,281</b>

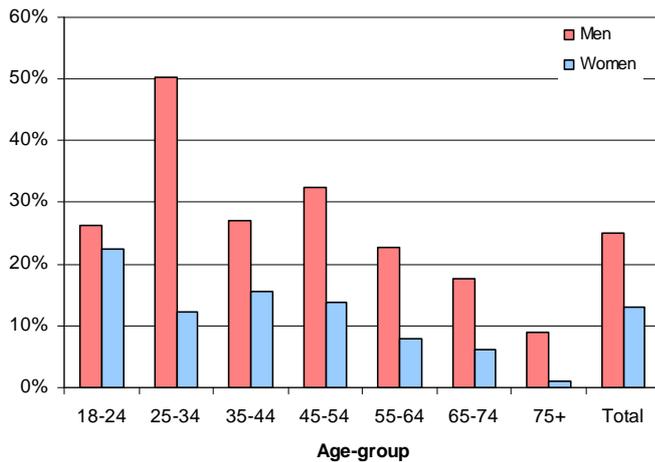
**Prevalence of hazardous and harmful drinkers by age and sex for Bradford and Airedale (2008) [source: Bradford and Airedale Lifestyle Survey 2007/2008]**

Age Range	Men		Women		Adults	
	Hazardous (inc Harmful)	Harmful	Hazardous (inc Harmful)	Harmful	Hazardous (inc Harmful)	Harmful
18-24	26%	4%	23%	1%	24%	2%
25-34	50%	3%	12%	1%	28%	2%
35-44	27%	8%	16%	3%	21%	6%
45-54	32%	9%	14%	4%	24%	6%
55-64	23%	8%	8%	3%	15%	5%
65-74	18%	5%	6%	1%	13%	3%
75+	9%	3%	1%	1%	5%	2%
<b>Total</b>	<b>30%</b>	<b>6%</b>	<b>13%</b>	<b>2%</b>	<b>21%</b>	<b>4%</b>

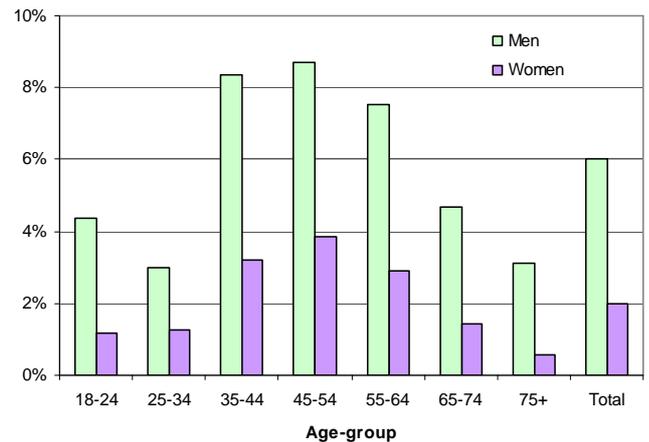
There are approximately 92,000 adults in Bradford District drinking at hazardous levels including 17,000 drinking at harmful levels. Approximately one in three men and one in seven women drink at hazardous levels. This proportion rises to 50% for men between 25-34. Within the 18-24 year group the proportion of men and women drinking at hazardous levels are similar. This is particularly concerning for young women as alcohol-related liver disease occurs in women sooner, after approximately 14 years of drinking hazardous levels compared with 20 years in men. In addition, female organs and tissues are more vulnerable to the toxic effects of alcohol. The effects of alcohol last longer in the blood with women which puts them at particular risk if binge drinking and 'keeping up' with male alcohol consumption. In all other age groups the proportion drinking at higher hazardous and harmful levels is higher for men.

Data from the lifestyle surveys shows negligible drinking within the Pakistani sub-group. Of over 800 people of Pakistani origin surveyed as part of the Bradford District lifestyle survey 1% reported that they drink alcohol once or more a week. This compares to 71% within the white group, 16% within the Indian and 0% within Bangladeshi sub-group.

**Proportion of hazardous drinkers in each age-sex cohort**



**Proportion of harmful drinkers in each age-sex cohort**



The results of the 2007/2008 lifestyle survey indicate that the prevalence of hazardous drinking (those drinking above the recommended limit) is highest in Baildon, Eccleshill and Clayton and Fairweather wards and generally lowest in Wharfedale within the Northern at edge of the District. The higher prevalence of harmful drinkers (that will contain many alcohol dependent drinkers) is within Toller and Great Horton wards. Toller ward has a relatively high South Asian population (76%) and would not be expected to be a hot-spot. The ward based prevalence figures, however, must be interpreted with caution. They are based on much lower numbers of survey responders than for the District profile and are subject to greater statistical instability. Further work is ongoing to look at the profile of drinkers in these two wards to explore the impact of age and ethnicity on these findings.

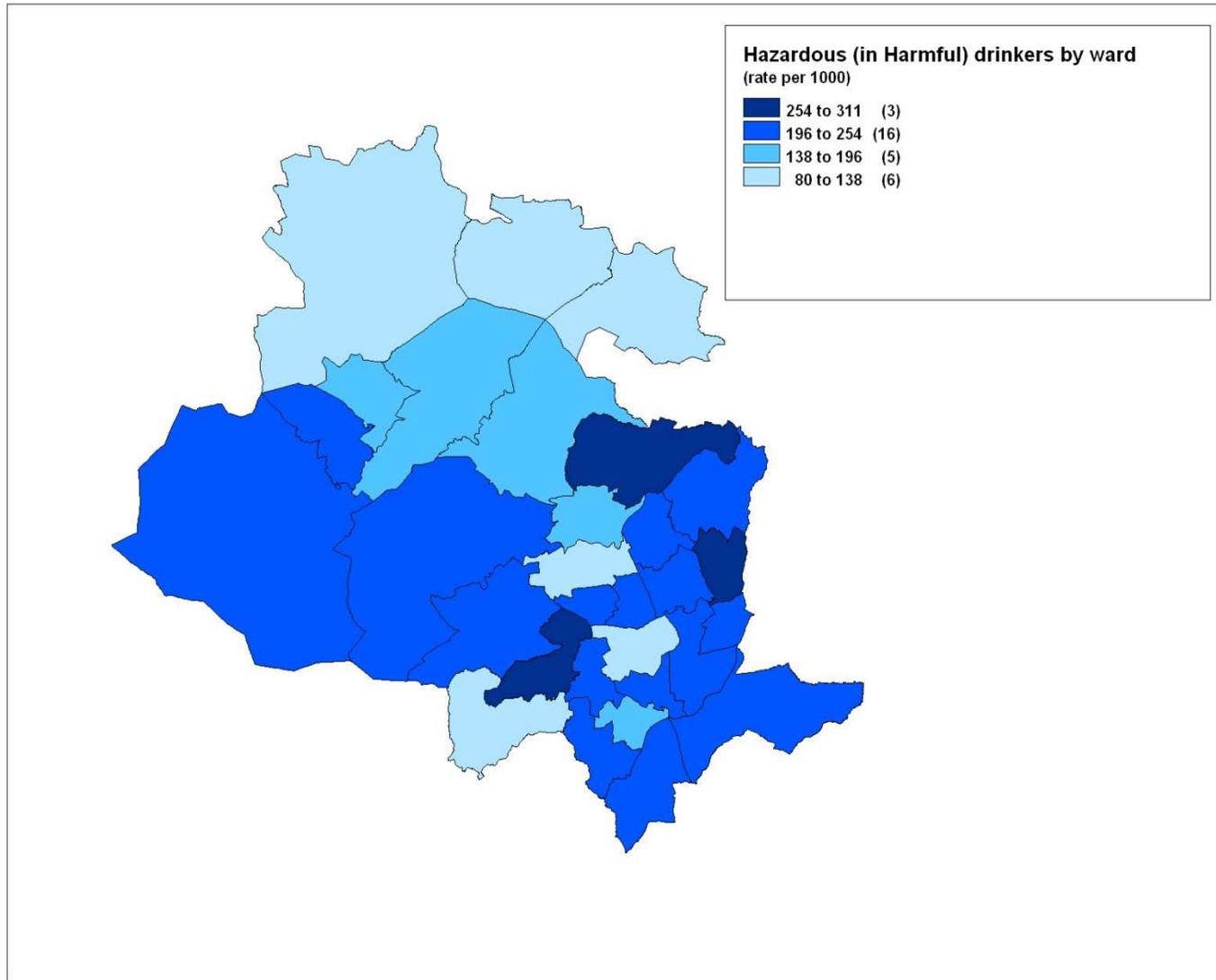
It must be recognised that although these maps show variability in drinking habits they do indicate that there are people drinking at hazardous and harmful levels in every ward in the District and so services that screen for alcohol problems must be universal and contain many different access points. It is also acknowledged that people will tend to underestimate their alcohol consumption, as recent research by Alcohol Concern [Bellis et.al 2009] has highlighted.

## Bradford District wards



**Estimated numbers of people drinking at hazardous levels or harmful levels by ward (rate per 1,000)**

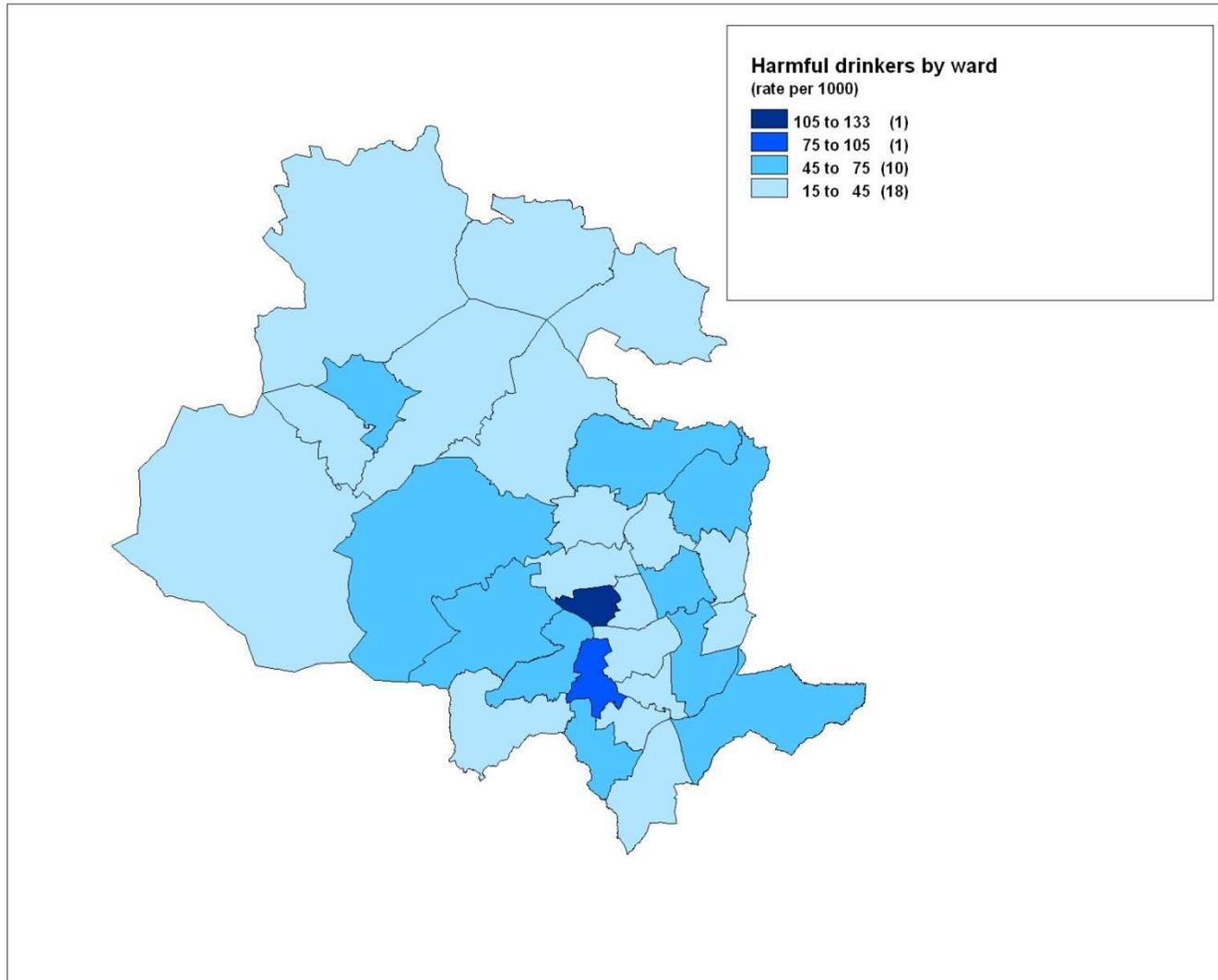
*Drinking above 22 units per week for men and 15 units per week for women.*



Source: Estimated from Bradford and Airedale Lifestyle Survey (2007/2008)

**Estimated prevalence (%) of people drinking at harmful levels**

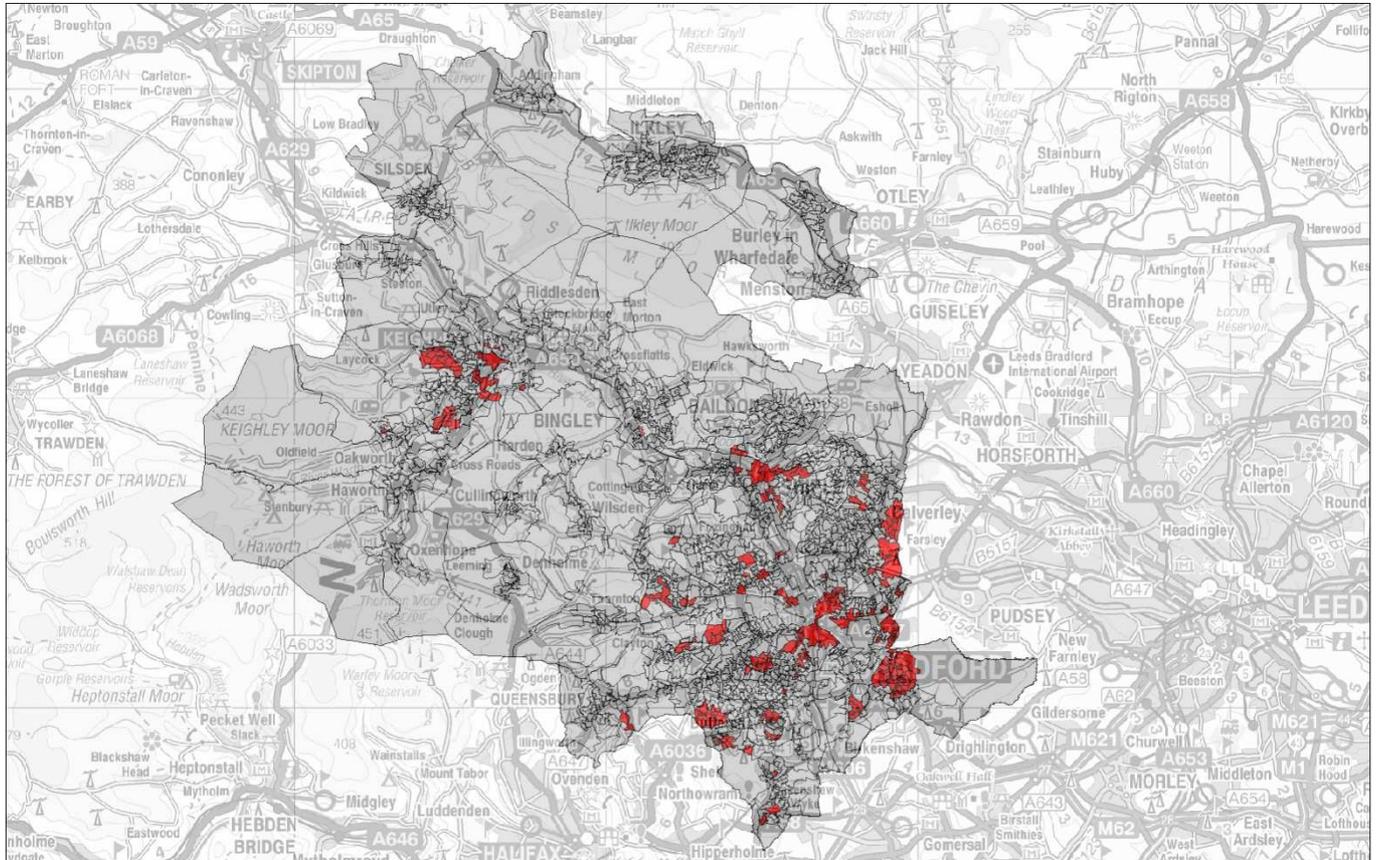
*People drinking above 'sensible' levels and experiencing harm. Harmful drinking of more than 50 units per week for men and more than 35 units per week for women.*



Source: Estimated from Bradford and Airedale Lifestyle Survey (2007/2008)

High risk areas for alcohol and smoking exist in parts of Keighley, the Eastern edge of Bradford, the Holmewood and Buttershaw estates, parts of Shipley and Wrose and other very localised segments within the District. The level of detail of the map below (to super output area) means it can be used to inform social marketing campaigns and localised service development.

**Primary high risk areas with high numbers of people who drink above recommended levels of alcohol and also smoke**



Source: Alcohol learning centre (Alcohol segmentation programme)

Primary high risk areas are a combination of segments 10, 12, 13 from the Alcohol segmentation programme.

**Segment 10:** Segment 10 includes high numbers of pensioners, who are generally in poor health with conditions that include asthma, angina and heart problems. They have high acute hospital admissions. They often live alone and in local authority flats. As well as drinking beer and spirits, they are likely to smoke. They tend to read tabloids.

**Segment 12:** Segment 12 includes people with a broad range of ages, who are likely to live in terraces, often in former industrial areas. They generally have the worst levels of overall health, with asthma, cholesterol and heart conditions as well as high acute hospital admissions. They are likely to smoke and drink beer and lager, at home and in pubs. They tend to read tabloids.

**Segment 13:** Segment 13 includes young people in their 20s who have a very high rate of acute admissions. They are likely to live alone in local authority flats or hostels, be unemployed and some are single parents. They are likely to drink large amounts of both beer and spirits and to smoke. They tend to read tabloids.

- **Whilst those from BME communities have considerably lower prevalence of hazardous/harmful drinking compared with the white population, national evidence suggests that there may be a hidden prevalence of dependent drinking. In the last decade there has been an increase in alcohol consumption in South Asian Young people with second-generations more likely to drink than first-generations within BME groups.**

There is a range of barriers that can hinder the identification of alcohol misuse in older people:

#### Societal Myths

Health Practitioners' awareness and attitudes

Denial by the person

Similarities between the symptoms of alcoholism and those of other conditions

Unreliability of self reports

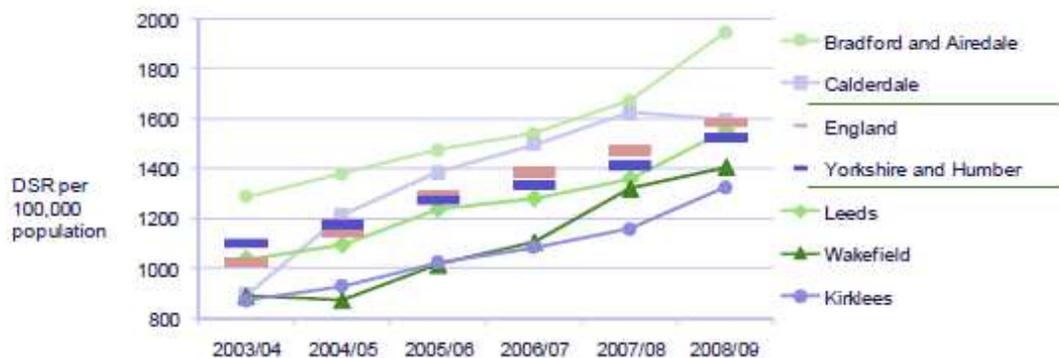
Screening instruments that are not designed to be used with elderly people

The impact of alcohol also increases as people reach old age because their alcohol tolerance diminishes and alcohols interaction with prescription drugs can increase risks such as falling, confusion or memory problems.

## Hospital admissions

In Bradford District Alcohol-attributable hospital admissions for both men and women are significantly above the regional and national averages. North West Public Health Observatory have produced local estimates of alcohol-related harm showing that alcohol attributable deaths are responsible for reducing population level life expectancy by 11 months for men and 5 months for women (<http://www.nwph.net/alcohol/lape/>) (Appendix C).

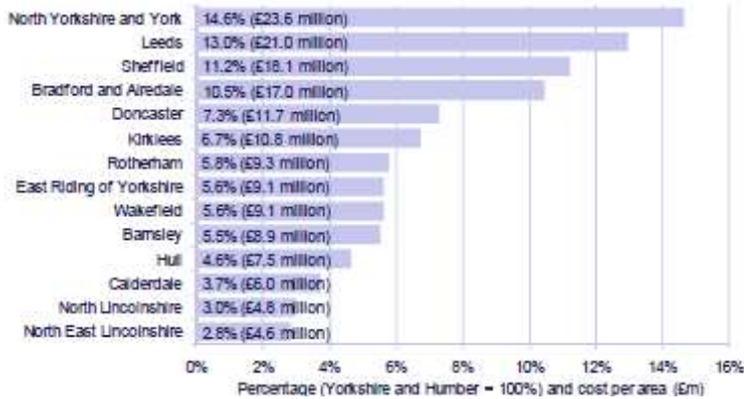
Hospital Admissions For Alcohol Related Harm Across the Region (Source: YHPHO)



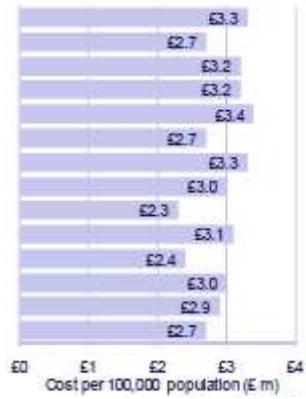
Recent work by the Yorkshire and Humber Public Health Observatory has shown that hospital admissions for alcohol related harm in Bradford, expressed as a rate per 100,000 population, are the worst in West Yorkshire and have been so since 2003. Since 2007 this rate has increased at a steeper rate than elsewhere in the West Yorkshire.

It is estimated that 6% of all admissions (nationally) are alcohol-related. The National Audit Office have highlighted that the health consequences of alcohol misuse have risen sharply in recent years with hospital admissions for the three main alcohol-related conditions having doubled in the 11 years between 1995-96 and 2006/07. Approximately 40% of all A&E attendees have a raised blood alcohol level. Cases of alcohol related liver disease are increasing significantly and the age for onset is decreasing; this trend shows every sign of continuing. It is important that the cost implications of alcohol related harm and admissions are considered in this context. Currently Bradford and Airedale is ranked 4<sup>th</sup> in the region in terms of expenditure on alcohol related hospital admissions, with 10.5% of total costs being spent in this area (£17 million). This amounts to £3.2 million per 100,000 people.

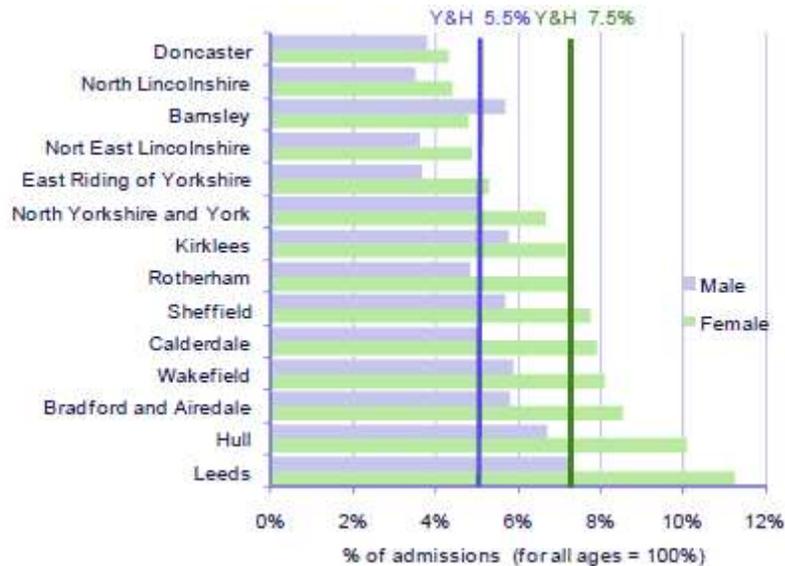
**Cost of alcohol-related hospital admissions as a percentage of total cost for Y&H, by area, 2008/09**



**Cost per 100,000 population, by area, 2008/09**



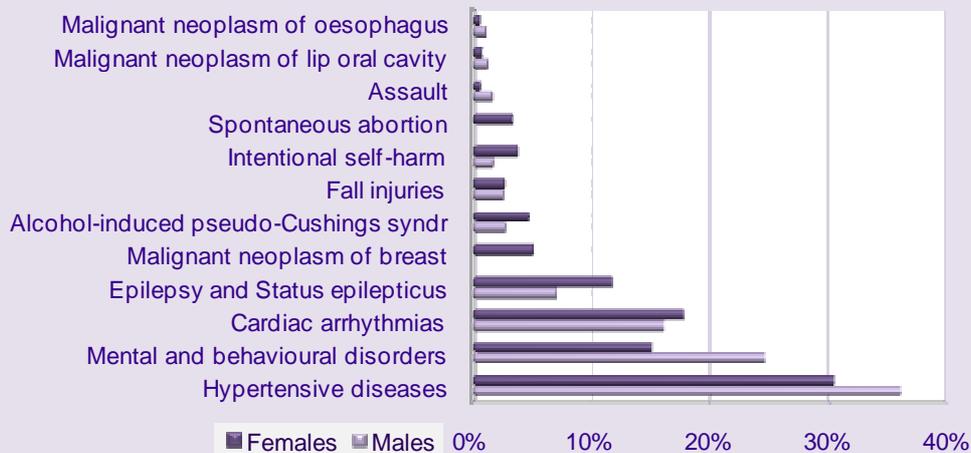
Admissions for younger people (15-24yrs) as a proportion of total admissions are higher in Bradford and Airedale than the regional average for both males and females. Admissions proportions for young women are consistently higher for females than males, with the exception of Barnsley. This gender difference is particularly pronounced in Bradford and Airedale.



**Alcohol related admissions, top 10 conditions by gender, all Persons**

**% of all alcohol related conditions, 2008/09**

Two additional conditions in Females group



Source: Hospital Episode Statistics (HES), The NHS IC for health and social care

Produced by YHPHO

Source : Strategy Unit (2003) Alcohol Harm Reduction Project – Interim Analytical Report (Crown Copyright)

For the population of Yorkshire and Humber region (see preceding chart) hypertensive disease, mental disorders and cardiac arrhythmias and epilepsy are amongst the main alcohol related admissions.

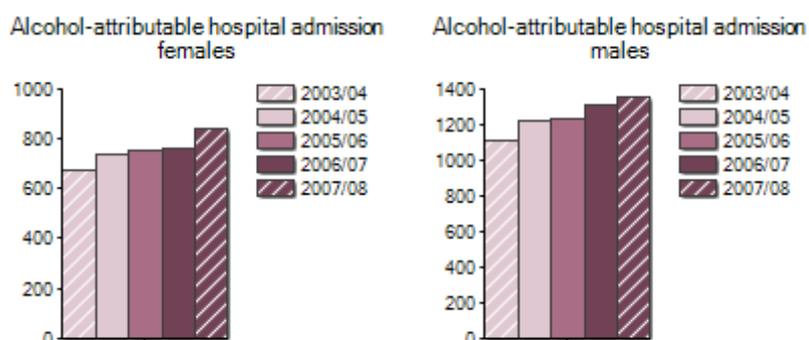
**The number of people admitted to Bradford Royal Infirmary per month with alcohol in the discharge code for the period Sep 07–Aug 08**

Month	Number	Month	Number
Sep-2007	132	Mar-08	145
Oct-07	129	Apr-08	120
Nov-07	137	May-08	144
Dec-07	121	Jun-08	139
Jan-08	104	Jul-08	183
Feb-08	127	Aug-08	192
		<b>TOTAL</b>	<b>1,673</b>

There are 90,000 (adult) attendees annually to Bradford Royal Infirmary (BRI) A&E department. In May 2008 the department conducted a patient alcohol screening survey to determine levels of alcohol use. The study showed that 36% patients were drinking at least at a hazardous level. This shows that there may potentially be as many as 32,000 attendances where alcohol is a contributing factor.

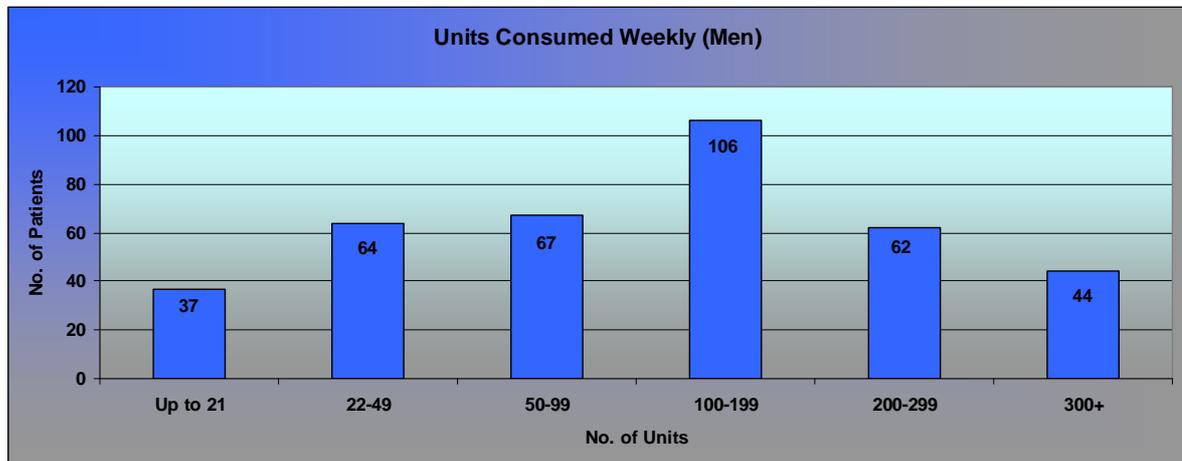
Although nationally alcohol consumption has remained stable for men, during the last decade it has increased for women. Alcohol attributable hospital admissions rose between 2003 and 2008 for men and women in Bradford District.

**Persons admitted to hospital due to alcohol-attributable conditions (all ages, male/female), directly standardised rate per 100,000 population**

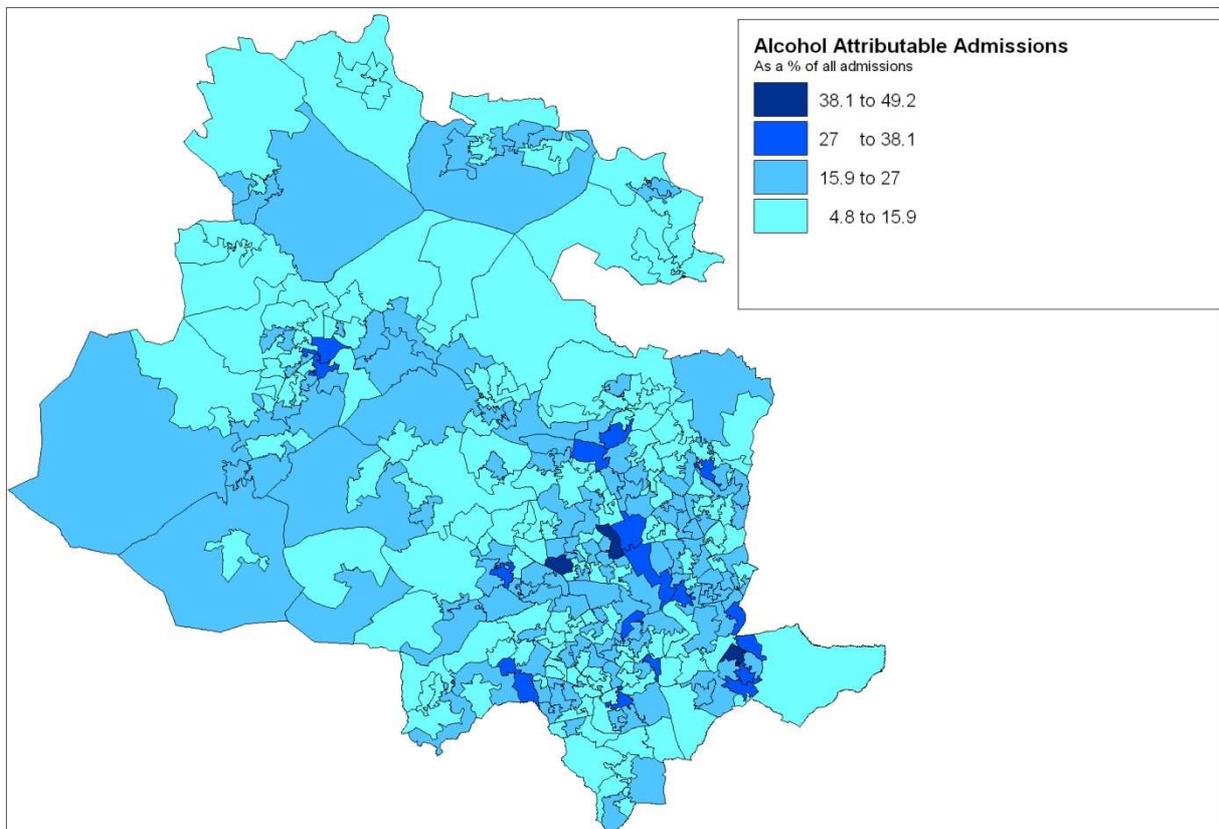


Source: LAPE

**The number of units consumed weekly by men admitted to Bradford Royal Infirmary for alcohol related reasons**



**Alcohol attributable admissions as a percentage of total admissions by lower super output area (2008/2009)**



There are local hotspots where over a quarter of all hospital admissions are alcohol attributable; in Holme Wood, central parts of Keighley and Shipley and a strip of Bradford extending from just north of the city centre, through Bolton and Undercliffe to Barkerend and Bowling. The likelihood of being admitted to hospital for alcohol-related harm increases as deprivation increases for all ethnic groups [Tiffany, 2010]. Although local admissions by ethnic

group have not been explored here national research [Tiffany, 2010] indicates that for some ethnic groups (particularly mixed and Asians in the under thirties age bracket) rates are higher in females than males. Also that within the most deprived national quintile, Pakistani and Bangladeshi groups account for high proportion of alcohol-related admissions.

# Interventions - summary of evidence

<b>Brief Interventions</b>	<p>Recommendations from the <b>Staying Healthy Pathway</b> in Healthy Ambitions include improving the screening and identification of people with alcohol use problems and commissioning brief interventions to “industrialise” their use across NHS services. The cost-effectiveness of brief interventions is estimated at approx £1,300 per year of ill-health or premature death averted (Alcohol Related Harm WHO 2009). Key settings include:</p> <p>In primary Care:</p> <ul style="list-style-type: none"><li>• new registrants; Commission identification and brief advice as per the Directed Enhanced Service (DES) for all newly registered patients.</li><li>• at risk groups; Consider extending coverage through a Local Enhanced Service (LES) in primary care to additional at risk groups such as all men aged 35-54 or those patients on existing QOF registers.</li></ul> <p>And in hospital settings:</p> <ul style="list-style-type: none"><li>• Interventions and brief advice in A&amp;E and specialist units (e.g. fracture clinics): Commission a specialist alcohol nurse linked to every accident and emergency unit where there is apparent local need. (Department of Health (2009) Signs for Improvement. Crown Copyright)</li></ul>
<b>Tiered Services</b>	<p>Healthy Ambitions states that PCTs should commission a range of tiered services to cope with people who present with different levels of dependency and ensure simple referral routes are accessible from screening points. The Department of Health’s <i>Signs for Improvement</i>, recommends the following High Impact Changes as having the greatest impact on health commissioned outcomes: Improve the effectiveness and capacity of specialist treatment; Ensure the provision and uptake of evidence-based specialist treatment for at least 15% of estimated dependent drinkers in the PCT area; Appoint alcohol Health Worker(s) - commission an adequate number of Alcohol Health workers or Alcohol Liaison Nurses to work across the acute hospitals.</p>
<b>Other</b>	<p><b>Amplify national social marketing priorities:</b> Commission local social marketing activity which builds on the evidence, strategy and tools provided by the national social marketing Department of Health (2009) Signs for Improvement. Crown Copyright</p>

Source: NHS Yorkshire and the Humber Qipp resource pack: May 2010 (STAYING HEALTHY)

## Adults

NICE undertook an assessment of the clinical and cost-effectiveness of:

- measures to detect alcohol misuse amongst adults and young people
- brief interventions to manage alcohol misuse among adults and young people
- wider interventions to improve management of England’s alcohol market including pricing policies, restrictions on advertising and measures surrounding alcohol outlet density and licensing hours [NICE, 2009].

The results are summarised below along with further relevant evidence.

### *Screening and brief interventions in Primary care and hospital settings*

The table below covers a variety of settings and assumptions and assumes a 10 year screening programme over the whole of England. Costs and savings are shown for healthcare services from reduced prevalence of alcohol-related conditions due to reduced consumption (excluding crime and workplace costs) so QALY gains relate to health conditions only. The incremental cost-effectiveness ratio (ICER) compares the intervention to a ‘do nothing’ scenario of no

intervention in any setting. The net benefit calculation assumes a NICE threshold of £20,000 per QALY and a 30 year time horizon. Scenarios have been considered in which consumption levels are assumed to rebound to baseline in 3 years (as opposed to the 7 year baseline assumption).

### Screening and brief intervention (SBI) results: overall population

Scenario	Setting <sup>1</sup>	Screening tool and M/F threshold	Screening staff <sup>2</sup>	BI tool (duration; effect; rebound)	BI staff <sup>3</sup>	Net NHS/PSS cost (£m)	QALY gain ('000s)	ICER v do nothing <sup>4</sup>	Netten £m <sup>4</sup>	Screened <sup>5</sup>	Coverage <sup>6</sup>	Sensitivity <sup>7</sup>	Specificity <sup>7</sup>	PPV <sup>7</sup>	NPV <sup>7</sup>
SBI1	GP reg	AUDIT 8	P nurse	25m; 12%; 7y	P nurse	-45.5	30.9	Dom	664	39%	36%	88%	85%	68%	95%
SBI2	GP reg	AUDIT-C 3	P nurse	5m; 12%; 7y	P nurse	-112.2	30.8	Dom	728	39%	36%	88%	86%	68%	95%
SBI3	GP reg	FAST 3	P nurse	5m; 12%; 7y	P nurse	-112.8	29.1	Dom	695	39%	33%	81%	88%	71%	93%
SBI4	GP con	AUDIT 8	GP	25m; 12%; 7y	GP	742.1	110.5	£6,716	1,468	96%	79%	84%	88%	70%	95%
SBI5	GP con	AUDIT-C 3	GP	5m; 12%; 7y	GP	4.2	110.8	£38	2,212	96%	79%	84%	88%	69%	95%
SBI6	GP con	FAST 3	GP	5m; 12%; 7y	GP	-121.5	102.7	Dom	2,176	96%	71%	76%	91%	74%	92%
SBI7	GP reg	AUDIT-C 3	P nurse	5m; 6%; 7y	P nurse	-7.3	15.4	Dom	315	39%	36%	88%	86%	68%	95%
SBI8	GP reg	FAST 3	P nurse	5m; 6%; 7y	P nurse	-16	14.6	Dom	308	39%	33%	81%	88%	71%	93%
SBI9	GP con	AUDIT 8	GP	25m; 12%; 3y	GP	1135.3	49.2	£23,075	-151	96%	79%	84%	88%	70%	95%
SBI10	GP reg	AUDIT-C 3	P nurse	5m; 6%; 3y	P nurse	50.7	7	£7,243	89	39%	36%	88%	86%	68%	95%
SBI11	GP con	AUDIT-C 3	GP	5m; 6%; 3y	GP	553.3	24.8	£22,310	-57	96%	79%	84%	88%	69%	95%
SBI12	GP reg	AUDIT 8/6	P nurse	25m; 12%; 7y	P nurse	-38	32.5	Dom	688	39%	39%	95%	78%	60%	98%
SBI13	GP reg	AUDIT-C 4/3	P nurse	5m; 12%; 7y	P nurse	-112.7	30.7	Dom	727	39%	36%	87%	85%	67%	95%
SBI14	A&E	FAST 3	S nurse	50m; 19%; 2y	ANS	134.3	12.9	£10,411	124	78%	18%	78%	87%	72%	91%
SBI15	A&E	FAST 3	S nurse	25m; 12%; 7yr	ANS	-32.7	26.8	Dom	569	78%	18%	78%	87%	72%	91%

Table 3.1: Screening and brief intervention results: overall population

Notes: (1) reg = registration, con = consultation; (2) P/S = practice/staff nurse, ANS = alcohol nurse specialist; (3) Dom = dominates; (4) λ=£20,000; (5) % of total population screened; (6) % of hazardous and harmful drinkers given BI; (7) Ability of screening strategy to detect hazardous and harmful drinkers.

Three baseline scenarios were considered for Screening and Brief Interventions (SBI) at the next GP registration:

- (SBI1) screening using the full AUDIT, followed by a 25 minute intervention
- (SBI2) screening using AUDIT-C, followed by a 5 minute intervention (this is similar to the DES configuration)
- (SBI3) screening using FAST, followed by a 5 minute intervention.

Three baseline scenarios are also considered for next GP appointment:

- (SBI4) screening using the full AUDIT, followed by a 25 minute intervention
- (SBI5) screening using AUDIT-C, followed by a 5 minute intervention (this is similar to the DES configuration)
- (SBI6) screening using FAST, followed by a 5 minute intervention.

A single baseline scenario is considered for the A&E setting:

- (SBI14) a pre-screen similar to that used in the PAT, screening with FAST, followed by a 50 minute intervention (inclusive of staff administrative time).

The Alcohol Use Disorders Identification Test (AUDIT) is a simple way to screen and identify people who are at risk of developing alcohol problems. It identifies the preliminary signs of hazardous drinking and mild dependence and is considered a sensitive tool across all ethnic and gender groups. The FAST alcohol screening test was developed to be used in busy medical offices and emergency rooms to screen patients for hazardous drinking, and is quicker to administer than the AUDIT test.

SBI at the next available GP registration for a patient (SBI1-3) assume that a Practice Nurse undertakes both the screening and, if appropriate, the brief intervention. **Using AUDIT or FAST**

**screening tools the estimated costs of delivering SBI are outweighed by the financial savings due to the reduced burden of illness.**

SBI at next GP consultation assume that a General Practitioner undertakes both the screening and, where indicated, brief intervention. If a 25 minute intervention time is assumed then the estimated costs of implementation are larger than healthcare costs avoided, i.e. there is a net cost overall (ICER of £6,700 per QALY gained - considered cost-effective under the NICE technology assessment framework). With 5 minute interventions intervention costs are lower and cost-effectiveness improves.

The outcome is less CE than a next GP registration SBI because; GP staff costs are higher than those of a Practice Nurse, males who incur the majority of alcohol-related health harm tend to consult less frequently than females, and patients consult their GP much more frequently than they change their GP so costs are higher.

**Brief advice from general practitioners (GPs) has been shown to be effective and efficient in reducing alcohol abuse and the use of medical services in the long run [Fleming, 2002].**

However evidence does not strongly support the cost effectiveness of nurse led interventions in primary care [Lock, 2006].

Within A&E departments screening of, particularly the adult population, suffers from low uptake rates (assumed take-up rate of 30% in individuals screened positive). A greater proportion of hazardous and harmful drinkers are assumed to attend A&E. **Evidence is somewhat inconclusive [Emmen, 2004] but generally supports the view that hospital based interventions reduce alcohol consumption [Barrett, 2006] and is cost effective when compared to standard care.** The effectiveness analysis showed that referral to AHWs led to a reduction in the number of alcohol units consumed per week in comparison with standard care. Referral to alcohol health workers (AHWs) for the management of alcohol misuse among individuals presenting to the accident and emergency department (AED) was a cost-effective strategy in comparison with standard care.

**Screening in primary/ secondary care is generally cost saving and highly cost effective. Screening is particularly cost effective for men who generally drink more. Uptake tends to be lower in secondary care but more cost effective possible because a higher proportion of drinkers classified as harmful or dependent are screened than in primary care settings.**

#### ***Detoxification programmes – mixture of in-patient, community, social care package***

Detoxification programmes for people dependent on alcohol improve clinical outcomes but are expensive and may not be cost effective depending on which threshold is used by societies or governments. The cost per QALY gained in a Dutch study [Parrot, 2006] was above the threshold imposed by NICE (£20-30k per QALY). However, it must be considered that in order for the cost effectiveness of such programmes to be successfully evaluated, there is a need for a robust estimate of the prevalence of alcohol dependent drinkers. This estimate is difficult to obtain.

Corry [2004] examined alcohol detoxification and relapse prevention by "optimal care" (as advocated in the literature) and current care. Current care was defined as self-reported contact with any health professional (e.g. general practitioner, psychiatrist, psychologist, social worker, nurse, community mental health worker, drug and alcohol counsellor, or any other counsellor). Optimal care (involving the greater use of psychological treatments) was advocated for the treatment of both harmful use of alcohol and alcohol dependence. Optimal care) was both cheaper and more effective than current care for treatment of harmful use of alcohol and treatment of alcohol dependence.

Adam, *et. al* (2010), investigated the differences between alcohol dependent inpatients who seek alcohol treatment and those who do not seek alcohol specific but general hospital treatment, and to investigate problem drinking 12 months after hospitalization. Two samples of alcohol dependent inpatients were recruited:  $N = 571$  at general hospitals and  $N = 473$  at psychiatric alcohol detoxification units, and were followed-up 12 months later. Multivariate logistic regression analyses revealed that higher age, living alone, being employed, previous help-seeking, increased severity of dependence, increased adverse consequences from drinking and increased motivation were significant predictors of receiving alcohol detoxification vs. general hospital treatment. A composite assessment of motivation to change and to seek help was the strongest predictor of positive outcome 12 months later. Alcohol dependent individuals who receive detoxification in psychiatric care have a more severe alcohol problem and fewer social resources than those treated in general hospitals. As a result of this research, Adam *et.al* (2010) recommend that Interventions targeted at enhancing motivation to change and to seek help should be part of routine general hospital care and of detoxification treatment in psychiatric care.

### **UKATT**

The UKATT study compared two treatment options for alcohol problems [UKATT, 2005]. The treatment options were motivational enhancement therapy and social behaviour and network therapy, which is a new social treatment option. Social behaviour and network therapy, comprising up to eight 50-minute sessions, helps patients to build social networks to support change in their drinking and associated behaviours. Motivational enhancement therapy, comprising up to three 50-minute sessions, combines counselling in the motivational style with objective individual feedback from earlier assessment.

‘The novel social behaviour and network therapy did not differ significantly in cost-effectiveness from the proved motivational enhancement therapy.’ The authors suggested that as both treatment options appear to have been cost-effective and equally effective, they could be adopted into practice according to particular characteristics of local settings.

### **Alcohol control** [SCHaRR, 2009]

**Alcohol pricing** polices are cost saving and bring about big reductions in alcohol consumption particularly amongst middle age drinkers with chronic disease. Across the board increases in the price of alcohol leads to a fall in crime, positive health impact on the unemployed and reduction in societal costs. Young drinkers aged 18-24 are particularly affected by policies that raise prices in pubs and bars.

A 10% cross the board increase in alcohol prices could expect to bring about a 4.2% reduction in alcohol consumption and lead to an estimated drop of 15 deaths, 500 hospital admissions, 640 crimes and 2,900 work day absences per year in Bradford Disitrc.

**Bans on promotion and advertising:** There is little research to suggest that restrictions on advertising reduces alcohol consumption and binge drinking. Published evidence on public health promotions suggests a small or insignificant effects on consumption. However, advertisements and promotions contribute to the normalisation of alcohol as a fun product.

**Limiting outlet density:** Most of the published evidence for outlet density signals a clear positive relationship between increased outlet density and alcohol consumption. However, Bradford’s city centre has fewer outlets for alcohol than cities of equivalent size. The impact, in terms of alcohol consumption, of limiting outlet density is much smaller than minimum pricing policies.

**Limiting licensing hours:** Evidence is limited on the effects of changes in licensing hours on consumption but shows that there is little change in alcohol consumption, level of harm go relatively unchanged, and crime and accidents shift to later times in the evening and night.

## Children and Young People

For Children and young people in schools, guidance is as follows [NICE, 2010]:

- Ensure alcohol education is an integral part of the national science, PSHE and PSHE education curricula, in line with Department for Children, Schools and Families (DCSF) guidance.
- Ensure alcohol education is tailored for different age groups and takes different learning needs into account. It should aim to encourage children not to drink, delay the age at which young people start drinking and reduce the harm it can cause among those who do drink.
- Introduce a 'whole school' approach to alcohol, in line with DCSF guidance, involving staff, parents and pupils.
- Where appropriate, offer parents or carers information about where they can get help to develop their parenting skills.

*Maintain and develop partnerships to:*

- Support alcohol education in schools as part of the national science, PSHE and PSHE education curricula
- Ensure school interventions on alcohol use are integrated with community activities introduced as part of the 'Children and young people's plan'
- Find ways to consult with families (parents or carers, children and young people) about initiatives to reduce alcohol use and to involve them in those initiatives
- Monitor and evaluate partnership working and incorporate good practice into planning.

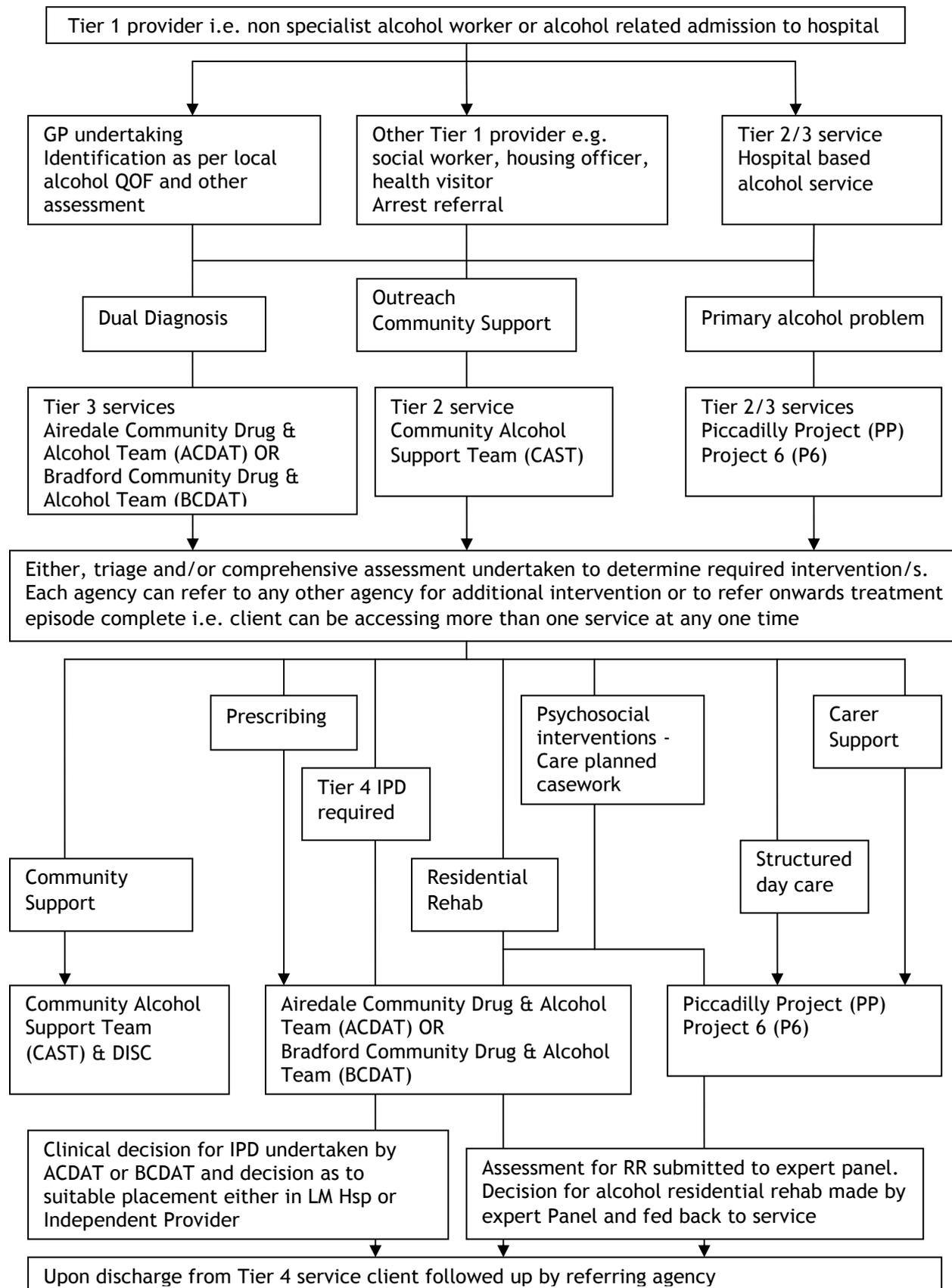
For children and young people in schools thought to be drinking harmful amounts of alcohol:

- Where appropriate, offer brief, one-to-one advice on the harmful effects of alcohol use, how to reduce the risks and where to find sources of support. Offer a follow-up consultation or make a referral to external services, where necessary.
- Where appropriate, make a direct referral to external services (without providing one-to-one advice).
- Follow best practice on child protection, consent and confidentiality. Where appropriate, involve parents or carers in the consultation and any referral to external services.

Recent evidence concerning interventions for reducing adolescent alcohol abuse indicates that a wide range of treatments are effective including, behavioural and cognitive therapies and motivational interviewing [Tripodi, 2010]. There is no clear evidence which type of treatment is most effective. However a recent systematic review of 16 relevant studies concluded that interventions focussed on the individual adolescent rather than the family have larger effects in reducing alcohol intake. In addition, behaviour oriented treatments are more likely to have longer term effects 12 months or more after treatment ends (both in individual and family settings).

# Access to alcohol services in Bradford District

Services that screen people to detect potentially hazardous and harmful drinking patterns and then treat a proportion of these people are organised into 4 service tiers.



## Service activity

The table below summarises the number of patients or clients accessing alcohol services in Bradford District. Following this there is, where possible, a description of service activity for each provider by age category, gender, ethnicity and geography. It has not been possible to stratify the data in the same way for each provider as data sources differ considerably in composition and quality. Referral between tiers and between services within the same service occurs. Consequently there will be an element of double counting within this table.

### Summary of activity for local alcohol services by service tier (Bradford and Airedale)

	<b>Organisation</b>	<b>TOTAL no. accessing services (April 09 - March 10)</b>
Tier 1	Offered intervention by GP	<b>15,421</b>
	Offenders Probation Service (screening cases)	<b>139</b>
	Alcohol Arrest Referral Pilot	<b>1,094</b>
	Screened by Ward Staff BRI	<b>987</b>
Tier 1 total		<b>17,641</b>
Tier 2	Alcohol Arrest Referral Pilot	<b>355</b>
	AA	<b>335</b>
	Alcohol Clinical Nurse Specialist BRI	<b>346</b>
	Caleb Project (no longer in business)	<b>50</b>
	CAST	<b>39</b>
	Turning Point DTTO Bradford	<b>8</b>
Tier 2 total		<b>1,134</b>
Tier 3	ACDAT	<b>131</b>
	BCDAT	<b>350</b>
	Lifeline - Piccadilly Project (an estimated 200+ per year are also in Tier 2, but exact numbers are not available)	<b>408</b>
	Project 6	<b>148</b>
Tier 3 total		<b>1,037</b>
Tier 4	TTP Detox	<b>15</b>
	Phoenix Futures Adult Service - Wirral	<b>unknown</b>
	Phoenix Futures Adult Service - Sheffield	<b>unknown</b>
	The Linwood Group	<b>unknown</b>
	Turning Point Smithfield Detox	<b>18</b>
	Abbey Gisbourne	<b>unknown</b>
Linfield Mount	<b>Unknown (but largest provider)</b>	

Source: NDTMS plus local source data (April 2009 – March 2010 unless otherwise stated)  
May include services outside the District involving local residents

Alcohol Arrest Referral Pilot data - December 15th 2008- December 31st 2009 - Tier 2 figure includes brief advice and not referral to other tier 2/3 services.

AA estimate assumes 15 unique members per AA session in Bradford District

CAST data from April 2008- March 2009. Referrals to the ACNS BRI for Brief Advice for the period Sep 08 – Aug 09

## Tier 1: Identification and Brief Advice

Provision that covers the identification of hazardous and harmful drinkers and those who drink in excess of the sensible drinking limits. It involves:

- targeted screening for hazardous drinking (those in excess of guidelines on safer drinking) and information on low risk drinking
- brief advice to reduce alcohol-related harm in hazardous drinkers
- referral of those with alcohol dependence or harm for more intensive interventions

It can be delivered by a wide range of agencies whose main focus is not alcohol treatment.

### GP Screening

The number of adults in the district drinking at hazardous levels is estimated to be over 90,000. However, under a quarter (20,000) of this number have been identified by GPs as hazardous drinkers and 76% of these have been offered a brief intervention. The proportion of patients offered brief interventions is similar across GP Alliances.

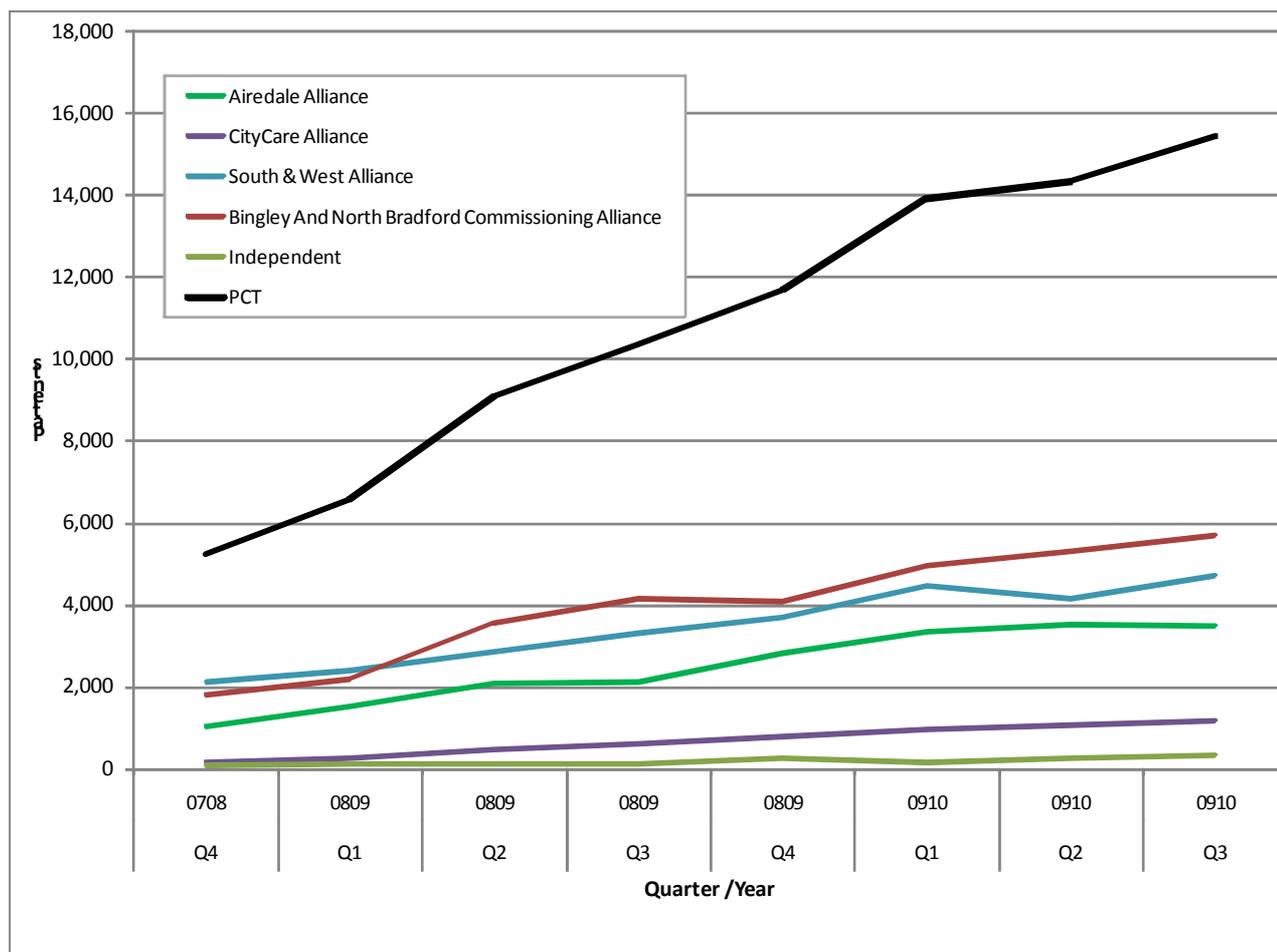
### Number of patients aged 16+ years and identified as drinking at hazardous levels (greater or equal to 14 units each week for females, 21 units each week for males) and offered a brief intervention (QoF target 2a)

Alliance	Patients identified as drinking at hazardous levels	Patients identified as drinking at hazardous levels offered brief intervention	% offered brief intervention
Airedale	4,744	3,481	73
Bingley And North Bradford	7,274	5,715	79
CityCare	1,547	1,172	76
Independent	567	349	62
South & West	6,151	4,704	76
PCT	20,283	15,421	76

Screening and brief intervention (SBI) for hazardous and harmful drinkers in a primary care setting is effective in reducing alcohol-related harm and cost-effective in terms of reducing future burden on NHS. Screening should be targeted at patients regularly drinking at excessive levels our binge drinkers (may be either harmful or hazardous drinking levels). Dependent drinkers require more structured treatment and intensive interventions available from specialist alcohol services.

CityCare Alliance has low levels of hazardous drinkers compared to its population size. This would be expected given the high South Asian population many of whom do not drink due to cultural and religious beliefs. In fact, the 10 practices in Bradford District with the highest South Asian population all belong to City alliance. Only 0.2% of the combined practice populations of these 10 surgeries have been identified as hazardous drinkers. This contrasts with between 4% and 14% South Asian clients of Pakistani population in specific alcohol services. This suggests that there are many people drinking at harmful levels within the South Asian community that are not being identified by their GPs.

**The number of patients (>16yrs) identified as drinking at hazardous levels and offered a brief intervention (2007-2010)**



***Bradford Offenders Probation Service***

This service is focused on alcohol misuse as a factor in offending behaviour (particularly crime and antisocial behaviour in City Centres) and as a community health issue. The local Probation Service in Bradford is part of a coherent and evidence based national approach to tackling alcohol misuse in offenders.

Data from the Offender Assessment system indicates that:

- 139 offenders during 08/09
- 76% male, 24% female
- 78% White, 14% Pakistani
- The majority of clients were from Central Bradford, Tong, Idle and Shipley

**Summary Tier 1: Overall three quarters of those entering OASIS are male, 78% are white and 14% are of Pakistani origin. There is very low identification and screening of South Asian hazardous drinkers in CityCare practices, even allowing for alcohol abstinence in groups of South Asian origin.**

## Tier 2: open access facilities and outreach - brief intervention - referral

Provision of open access facilities and outreach provided by specialist alcohol services or other related services. It involves:

- Alcohol-specific information, advice and support
- Brief support to reduce alcohol-related harm
- Alcohol-specific assessment and referral of those requiring more structured alcohol treatment
- Partnership or 'shared care' with staff from Tier 3 and 4 provision, or joint care of individuals attending other services providing Tier 1 provision
- Mutual aid groups, e.g. Alcoholics Anonymous
- Low threshold prescribing for assisted withdrawal

### *Alcohol Clinical Nurse Specialist Bradford Royal Infirmary (Sep 08 – Aug 09)*

There is a large gender difference in referrals with more than four times the amount of men being referred than women. Roughly equal numbers of men and women are admitted onto the medical assessment wards but it is unclear whether this referral difference reflects true need or other factors. The difference between men and women referred is smaller for younger adults but this still does not reflect true alcohol admission patterns. Only 36% of people had had previous contact with alcohol services (but 51% required detox). The service within BRI is therefore partially meeting an unmet need.

### Characteristics of the referrals to the Alcohol Clinical Nurse Specialist during a 12 month period

No. of referrals assessed	346/988
<b>Characteristics of those assessed (n=346)</b>	
Male: Female	284:62
<b>Ethnicity</b>	
British White	317
British Asian	11
British Black	n/a
Irish	n/a
Mixed	n/a
Other (<2/ category)	18
Mean Age (sd)	48 (12.9)
Range	18-76 years
<b>Type of Alcohol use</b>	
Lower Risk alcohol use M:F (% of total)	33:22 (16%)
Increasing Risk alcohol use M:F (%of total)	61:28 (26%)
Higher risk alcohol use M:F (% of total)	221:60 (81%)
No. with polysubstance use (%)	25 (7%)
No receiving detox during their admission (%)	177 (51%)
Previous involvement with alcohol or substance misuse services (%)	124(36%)
<b>Characteristics of those not assessed (n=642)</b>	
Male:Female	461:181
Mean age (sd)	38 (13.2)
Range	16-77 years

Once they have been referred to an Alcohol Nurse, men are 50% more likely to be assessed as needing further treatment.

Between Sept 2008 and April 2010 there were 220 referrals to BRI alcohol hospital liaison service for those aged over 55 years. Numbers were split equally between the 55-60 year and >60 year age-group and were highest from BANCA and South and West Alliance areas.

### ***Community Alcohol Support Team (CAST)***

- 41 clients in 2009/2010 (12 month period)
- 59% Male, 39% female
- 98% White British
- 26-29yrs – 8%, 30-50yrs – 50%, 50-59 – 37% (30-59yrs – 87%)

Informal feedback from CAST suggests there is a gap in services for people aged 55 – 64 as they are often too young for older people's services but do not fit criteria for mental health or Social Services.

### ***Alcohol arrest referral pilot***

- 1,100 arrests
- 80% male, 18% female
- 77% White, 4% Pakistani
- under 20yrs: 9%, 20-30: 33%, 31-40: 31%
- 355 referrals to other alcohol services are made from the 1,100 arrests

**Summary Tier 2: Overall three quarters of those entering Tier 2 services are male, 86% are white and 6% are of S Asian origin. Roughly one third (35%) are under 35yrs of age and 39% are 35-54yrs.**

### Tier 3: community based - specialist assessment - care planned treatment - referral

Provision of community based specialised alcohol misuse assessment, care-planned treatment, and care co-ordination when required. It is delivered by statutory, independent or voluntary community-based services providing care-planned alcohol treatment involving:

- Comprehensive substance misuse assessment
- Care planning
- Care co-ordination
- A range of evidence-based psychosocial therapies and support within a care plan to address alcohol misuse
- A range of evidence-based interventions for assisted alcohol withdrawal (detoxification) and pharmacotherapies to address alcohol misuse
- Provision of information, advice and training and “shared care” to others delivering Tier 1 and Tier 2 provision.

#### Project 6

- 148 clients in 09/10
- 65% male, 35% female
- All white (S Asians seen via outreach service)
- 76% aged 35-54yrs
- All from Keighley (Airedale)

#### Bradford District Care Trust - in-patients

- 63% male, 37% female
- 95% White, 2% Pakistani
- 30-40yrs - 24%, 40-50yrs - 34%, 50-60yrs - 23%
- Highest numbers in BD 21/22 (Keighley), BD16/18 (Bingley/Shipley), LS29 (Wharfedale)

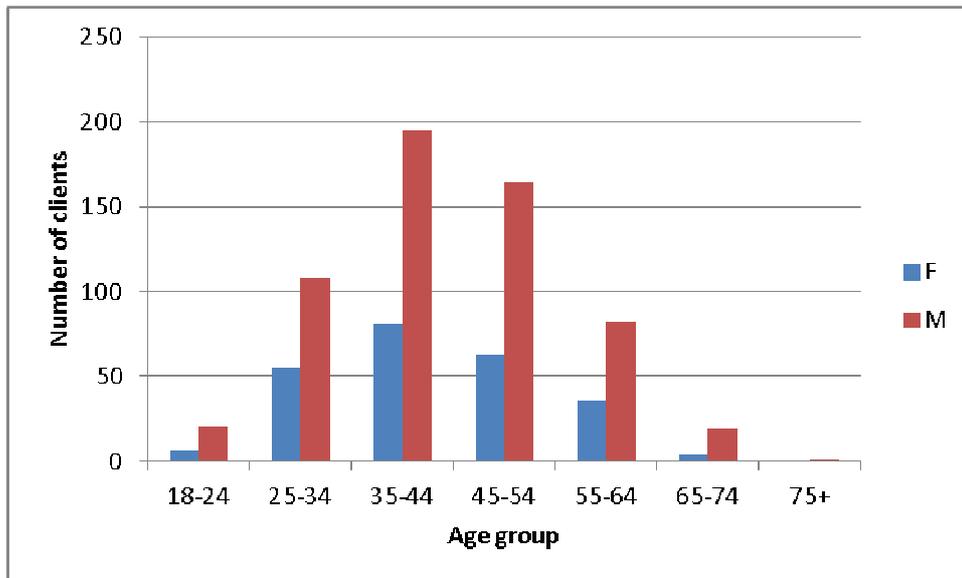
#### Piccadilly Project

##### Male/female breakdown of clients (Piccadilly project)

	Age and Sex							
	18-24	25-34	35-44	45-54	55-64	65-74	75+	Total
<b>F</b>	6	55	81	63	36	n/a	n/a	<b>245</b>
<b>M</b>	21	108	195	164	82	19	n/a	<b>590</b>
<b>Total</b>	27	163	276	227	118	23	n/a	<b>835</b>

	Age and Sex							
	18-24	25-34	35-44	45-54	55-64	65-74	75+	Total
<b>F</b>	2%	22%	33%	26%	15%	2%	0%	100%
<b>M</b>	4%	18%	33%	28%	14%	3%	0%	100%
<b>Total</b>	3%	20%	33%	27%	14%	3%	0%	100%

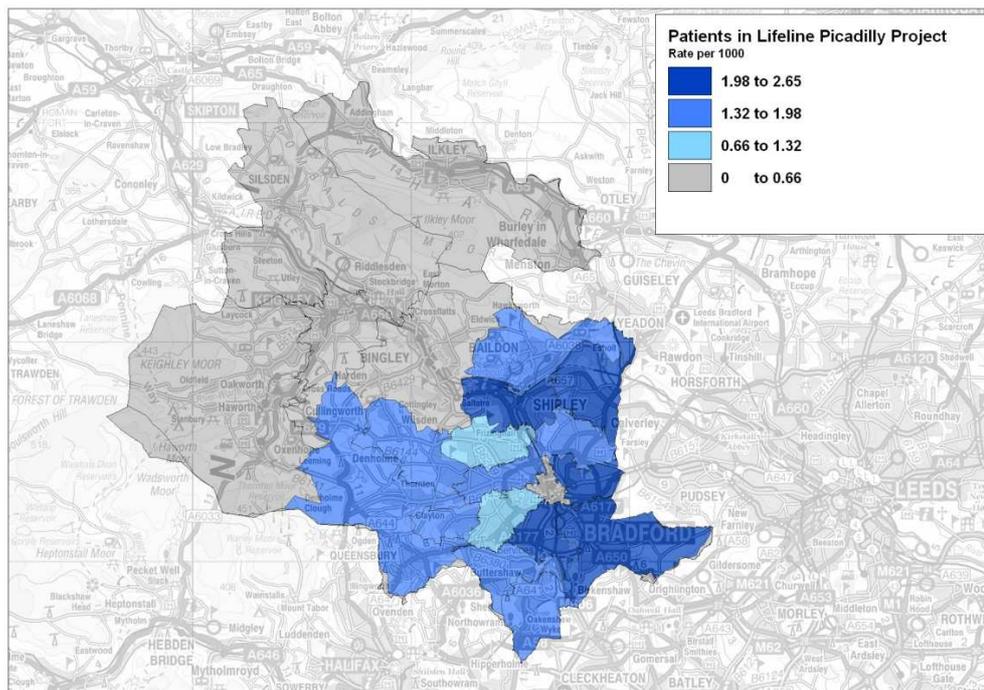
The majority of clients included in this analysis entered the service between 2008 and 2010



### Ethnic breakdown of clients using the Piccadilly project service

Ethnic Group	Frequency	Percent
Not Stated	n/a	0.5
White British	778	93.2
White Irish	n/a	n/a
Other Mixed	n/a	n/a
Asian / Asian British Indian	10	1.2
Asian / Asian British Pakistani	23	2.8
Other Asian / Asian British	n/a	n/a
Other Black / Black British	n/a	n/a
Any Other Ethnic group	14	1.7
<b>Total</b>	<b>835</b>	<b>100</b>

### Distribution of Piccadilly Project clients by ward (Bradford)



The highest number of clients are from the 35-54 year age group for men and women. In terms of ethnic background, 93% of clients are from a white background and 4% South Asian.

**Summary Tier 3: Overall two thirds of those entering Tier 3 services are male, 96% are white and 2% are of S Asian origin. Under one third (29%) of clients are under 35yrs of age and over half (53%) are 35-54yrs.**

The highest number of Piccadilly Project clients come from Shipley, Idle, East and South East Bradford. The map on the previous page shows zero or low numbers of clients from Airedale and Wharfedale as this area is covered by another service (Project 6 treatment service).

#### **Tier 4: residential / in-patient – highly specialist expertise – care plans**

Provision in a residential or inpatient setting of care-planned treatment (requiring specialist expertise in alcohol treatment). It involves:

- Comprehensive substance misuse assessment
- Care planning and care co-ordination
- A range of evidence-based psychosocial therapies and support to address alcohol misuse
- A range of evidence-based assisted alcohol withdrawal (detoxification) and pharmacotherapy to address alcohol misuse
- Provision of information, advice and training and “shared care” to others delivering Tier 1 and Tier 2 services.

It may also involve highly specialist non-alcohol specific residential or inpatient services if delivered as part of planned care package.

#### **Numbers of patients who were seen by Alcohol Clinical Nurse Specialist at BRI and were undergoing alcohol detoxification at the time**

	<b>September 2008 to August 2009 inc</b>	<b>September 2009 to August 2010 inc</b>	<b>September 2010 to 26th October 2010</b>
<b>*Total number of patients who were seen by ACNS and were receiving a detox regime at BRI</b>	<b>176</b>	<b>150</b>	<b>32</b>
<b>**Current CIWA scoring</b>		<b>32</b>	<b>35</b>
<b>Total Patients seen by Alcohol Clinical Nurse Specialists</b>	<b>347</b>	<b>534</b>	<b>156</b>

\* Only records those seen by ACNS i.e in working hours

\*\* Recording of patients who were being assessed as at risk of developing alcohol withdrawal but had not at the time of assessment received any medication.

### ***North Bradford Drug service (detox – commissioned by the district but not at BRI or Linfield***

#### ***Mount)***

- 31 in-patient alcohol detox 2009
- 62% male, 34% female
- 90% White, 10% Other
- 20-30yrs: 25%, 30-40: 31%, 40+: 44%

#### ***Oak Mount Wet House***

55 is the average age of referrals to Oak-Mount, a wet house for men with chronic alcohol dependency, who would otherwise be unable to maintain a tenancy.

#### ***Residential Homes***

3 residential homes for the elderly cater for people with alcohol dependency; the Heathers, Park View and Bronte Park. Currently they are home to 36 people with a range of issues and disabilities.

**Summary Tier 4: Of patients entering detoxification programmes 62% were male and 32% female with 90% white. One quarter of patients were under 30years old with 31% between 30 and 40yrs and the remaining 44% aged over 40 years.**

## Summary and Conclusions

The misuse of alcohol causes or contributes to a large volume of mortality, chronic ill-health, violent crime and anti-social behaviour and places a considerable burden on the NHS. The annual cost to the NHS in Bradford District is estimated to be £27 million.

Health equity audits (HEA) identify how fairly services or other resources are distributed in relation to health needs. HEA help prioritise action that lead to a distribution of services and resources relative to need.

The aims of this alcohol health equity audit for Bradford District are to:

- Describe patterns of harmful drinking in Bradford
- Map alcohol treatment services and describe access to these services
- Identify inequity of access within specific population groups or locations
- Make recommendations for alcohol service development

There follows a summary of the findings of the HEA and recommendations for service development.

### Drinking patterns

- Most young people from White backgrounds (Year 10) have tried alcohol (85%), compared to 10% of South Asian youngsters.
- Males are more likely than females to be given alcohol by parents or carers to drink at home. Females are more likely than males to have been given alcohol by a friend, or to have had alcohol bought for them by a friend or stranger.
- Within Bradford District 91,000 adults are drinking at hazardous levels and 17,000 at harmful levels (the male : female ration is 70% : 30%).
- The proportion of men and women drinking at hazardous levels (above the recommended limits) are equal within the 18-24 year group. In all other age groups the proportion drinking at hazardous or harmful levels is higher for men ( as a proportion of all males). Hazardous drinking is most prevalent in young adults (25-34 for men, 35-44 for women). Half of all men aged 25-34 are drinking to hazardous levels.
- Harmful drinking (more than twice the recommended limit) is most prevalent in the 45-54 year age-group for both sexes.
- There is negligible drinking reported within the Pakistani and other South Asian sub-groups.
- High risk areas for alcohol and smoking are Keighley, the Eastern edge of Bradford, the Holme Wood and Buttershaw estates, parts of Shipley and Wrose and other very localised segments within the District.
- The results of the 2007/2008 lifestyle survey indicate that the highest prevalence of harmful drinking (men and women) is within Toller and Great Horton wards. Toller

ward has a relatively high South Asian population so the figures must be interpreted with caution and further work is ongoing to look at the profile of these drinkers.

- We have no quantitative data about drinking patterns in the local population of asylum seekers, refugees and new economic migrants, particularly from Eastern Europe although initial meeting with services that support Eastern Europeans has identified unmet need.

## Equity audit

- Approximately 18,000 people have accessed Tier 1 services for alcohol screening or brief advice. There are a further 1,100 people per year in contact with Tier 2 services receiving brief interventions or further referral. About 1,000 people per year access Tier 3 services for specialist assessment with 70 requiring in-patient detoxification and/or highly specialised treatment (Tier 4).
- Only a fifth of the estimated number of hazardous drinkers have been screened and identified as so by GPs. Once screened three quarters of these patients are offered brief interventions. This proportion is similar across GP alliances although very low numbers are screened in some CityCare practices.
- Overall three quarters of those entering Tier 2 services are male, 86% are white and 6% are of South Asian origin. Roughly one third (35%) are under 35yrs of age and 39% are 35-54yrs.
- **Males are slightly more likely than women to be screened and enter Tier 1/2 services (22% compared to 17%). The chances of entering Tier 1/2 services increases with age. Approximately one in seven young adults drinking at hazardous levels enters these services. This rises to one in three for those over 55 years old.**

### Numbers and proportion (%) of hazardous drinkers entering Tier 1/2 services

Group	Number of hazardous drinkers	Number entering services (tiers 1 and 2)	Uptake (use-need ratio)
Males	64,410	14,081	21.9%
Females	27,402	4,694	17.1%
Young adults (<35yrs)	45,067	6,571	14.6%
35-55yrs	32,636	7,322	22.4%
>55yrs	14,110	4,882	34.6%
<b>Total</b>	<b>91,812</b>	<b>18,775</b>	<b>20.4%</b>

- Overall two thirds of those entering Tier 3 services are male, 96% are white and 2% are of South Asian origin. One quarter of clients are under 35yrs of age and over half (55%) are 35-54yrs. The majority of service users in Bradford come from Keighley, Bingley, Shipley, Idle, East and South East Bradford.
- Of patients entering detoxification programmes 62% were male and 32% female with 90% of white background. Only one third of patients are under 30years old.

- **Female harmful drinkers are more likely than males to enter Tier 3/4 services (8.5% compared to 6%). Unlike Tier 1/2 services uptake rates for Tier 3/4 decrease with age (from 8.2% for those under 35yrs to 4.4% for people >55yrs).**

#### Numbers and proportion (%) of harmful drinkers entering Tier 3/4 services

Group	Number of harmful drinkers	Number entering services (tiers 3 and 4)	Uptake (use-need ratio)
Males	12,726	720	5.7%
Females	4,555	388	8.5%
Young adults (<35yrs)	3,914	321	8.2%
35-55yrs	8,883	587	6.6%
>55yrs	4,485	199	4.4%
<b>Total</b>	<b>17,281</b>	<b>1,108</b>	<b>6.4%</b>

- It is difficult to estimate uptake rates of services for South Asian and other groups due to limited data. What data we have from lifestyle surveys shows negligible alcohol consumption within the Pakistani subgroup: of 800 people of Pakistani origin surveyed as part of the Bradford District lifestyle survey 1% reported that they drink alcohol once or more a week.
- Of the four GP Alliance CityCare has by far the lowest rate of hazardous drinkers identified by GPs. This would be expected given the high South Asian population many of whom do not drink due to culture and religious beliefs. In fact, the 10 practices in Bradford District with the highest South Asian population all belong to City alliance. Only 0.2% of the combined practice populations of these 10 surgeries have been identified as hazardous drinking.
- **However, very low rates of self-reported drinking and GP alcohol screening in the South Asian population contrasts with our service data that show 6% of those entering Tier 2 services and 2% of those entering Tier 3 services are of Pakistani origin.**
- The highest numbers of clients entering the Piccadilly Project (Tier 2/3 service covering Bradford) are from Shipley, Idle, East and South East Bradford. This appears broadly equitable, matching areas of high estimated drinking levels and high alcohol attributable hospital admissions.

**In summary, males are more likely than females to be screened and receive brief intervention for drinking at hazardous levels. Young adults (<35yrs) drinking at hazardous levels are less likely to enter these services than older adults.**

**With respect to those drinking at harmful levels (many of whom will be alcohol dependent), females are more likely to receive specialist and in-patient treatment. The proportion of this group entering these services drops with age.**

**Our data show that drinkers of South Asian (including Pakistani) origin are entering Tier 2/3 services despite negligible reported alcohol consumption and low alcohol screening within general practice.**

## Hospital Admissions

- Nationally, cases of alcohol related liver disease are increasing with the age for onset decreasing; this trend shows every sign of continuing.
- In Bradford District alcohol-attributable hospital admissions for both men and women are significantly above the regional and national averages and increasing.
- Due to alcohol related deaths the average man in the district loses 11 months of life with each women losing 5 months.
- Once admitted to hospital and referred to a specialist alcohol nurse, men are 50% more likely than women to be assessed for further specialist treatment.
- Only a third of people who are screened for alcohol problems within hospital have had previous contact with alcohol services but half are suitable for a detoxification programme. This suggests that many dependent drinkers by-pass all screening and brief intervention before ending up in hospital and that there is a significant unmet need for more specialist treatment (Tier 3/4 services).
- The current level of investment in clinical alcohol nurses and alcohol workers within Bradford Royal Infirmary is enough to slow the rise in hospital admissions. The estimated annual impact of this service by 2010 is 540 fewer A&E attendance, 260 fewer admissions and a net financial benefit of £203,000.
- Further investment in 4 more alcohol health workers in hospital and a doubling of GP screening for alcohol problems (from 4,000 to 9,000 per year) would result in a net financial benefit of £859,000 p.a by 2012. More importantly this could halt the upward rise in admissions resulting in 2,176 fewer A&E attendances and 1,093 fewer admissions per year.
- There are local hotspots where over a quarter of all hospital admissions are alcohol attributable; these being Holme Wood, central parts of Keighley and Shipley and a strip of Bradford extending from just north of the city centre, through Bolton and Undercliffe to Barkerend and Bowling.

## Recommendations

**As the country goes through a period of economic challenge, health services are reassessing their capacity to deliver efficiency whilst maximising the quality of care. These recommendations are structured to reflect this situation, and acknowledge the need to explore the redesign of structures and roles, to reflect evolving changes in the commissioning and provision of care, in particular the advent of GP commissioning.**

- The evidence base for the efficacy of Identification and Brief Advice (IBA) within a primary care setting is strong and needs to be propagated to all appropriate professionals in order to maximise its use within the district.
- The importance of offering IBA when appropriate to teenagers and younger adults needs to be reinforced within GP practices.
- A GP clinical lead for alcohol should be identified as the GP consortia emerge.
- The importance of offering IBA needs to be reinforced within GP practices working within our South Asian communities. In addition alternative access points (eg dentists, hospital visits) and outreach work are required to maximise the opportunities to for offering IBA to South Asian heritage residents.
- Bradford Safer Communities Partnership should work with their employers in Bradford district to provide their employees with access to on-line free and confidential alcohol identification and brief advice. This engagement needs to be at both the strategic and operational levels
- Appropriate action should be taken to ensure that services are able to cope with the additional number of Tier 2/3 patients who can be expected to be identified as a consequence of increased Tier 1 activity.
- Evidence indicates that Alcohol Clinical Nurse Specialists and Alcohol Health Workers within hospitals are effective and cost saving. These posts should be considered in this context when planning services, including at Airedale General Hospital which currently as no specialist service of this type.
- The Joint Commissioning Team (Substance Misuse & DIP) to work with Bradford District Care Trust to develop a robust pathway for elective detoxification at Lynfield Mount Hospital.
- Establish more robust estimates of alcohol dependency in Bradford district in order to complete the analysis of services/treatment need.
- NHS Bradford & Airedale need to develop projections of the number of harmful/hazardous/dependent drinkers in future years and the impact on alcohol attributable hospital admissions due to cancer, CVD, mental and behavioural disorders, alcohol attributable accidents/trauma and liver cirrhosis. The Bradford Public Health Observatory should be developed to provide up to date information on the national and local epidemiology of alcohol abuse and up to date evidence on the effectiveness and cost effectiveness of interventions.

- Alcohol health related messages and campaigns need to be more sophisticated, evidence based and targeted using local intelligence and data to maximise the opportunities of reaching specific target population groups.
- For young people of secondary school age, messages need to be reinforced about the dangers of drinking alcohol, and in particular for girls about the dangers of receiving alcoholic drinks from strangers.
- For young people in higher education, alcohol related messages and access to alcohol services need to be delivered in a wide variety of settings, as research shows that young people are resistant to alcohol related messages delivered by college and university authorities.
- In addition to mainstream service provision there need to be targeted interventions for populations and individuals with particular needs who may fall outside of mainstream service provision.
- NHS Bradford & Airedale, Bradford Council and their partners should continue to use all appropriate avenues to influence changes in alcohol pricing, promotion, and licensing policies that will contribute to a reduction in alcohol related harm.
- NHS Bradford & Airedale, Bradford Council, and their partners should seek to undermine the cultural attitude, especially amongst many teenagers and young adults, that binge drinking and drunkenness are normal, expected positive behaviour.
- The current evidence based approach to all aspects of service provision and commissioning should be embedded. This will include NICE guidance and associated tools and will incorporate robust audit and evaluation.
- Any service redesign process should include a value for money review.

# Appendices

## Appendix A - Bibliography

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## Appendix B - Data sources and further information

1. Alcohol arrest referral pilot
2. Bradford District Care Trust - in-patients
3. Bradford offenders probation service (OAsys database)
4. Community Alcohol Support Team (CAST)
5. Every Child Matters in Bradford District: A report of the Health and Lifestyle Survey for Children and Young People 2009-10.  
<http://www.bradford.nhs.uk/observatory/Docs/Documents/Every%20Child%20Matters%20Bradford%202010.pdf>
6. Hospital admissions data (NHS Bradford and Airedale)
7. Local Alcohol Profiles for England (LAPE). <http://www.nwph.net/alcohol/lape/>
8. National Drug Treatment Monitoring System (summary of service data)
9. North Bradford Drug service
10. Patients aged over 16 years identified as drinking at hazardous levels and offered a brief intervention (QoF target 2a).
11. Piccadilly Project
12. Project 6
13. Ready Reckoner v5.  
<http://www.alcohollearningcentre.org.uk/Topics/Browse/Commissioning/Data/?parent=5113&child=5109>
14. Report of the First Year of the Alcohol Clinical Nurse Specialist Post in Bradford Royal Infirmary - September 2008 - August 2009

### ***Further sources of information***

North West Public Health Observatory: Social marketing report on alcohol consumption in NW, using MOSAIC classes and geosegmentation combined with national behaviours and regional lifestyle survey data. <http://www.nwph.net/nwpho/publications/CHAMPSseg.pdf>

Alcohol attributable fractions for England report: this methodology is detailed and contains all the formulae needed to calculate AA fractions for Bradford.

<http://www.nwph.net/nwpho/Publications/AlcoholAttributableFractions.pdf>

### ***Cost effectiveness studies***

WHO report on cost effectiveness of alcohol intervention programs.

<http://www.euro.who.int/document/E82969.pdf>

BMJ Randomised control trial of interventions for alcoholism (2005) compared the cost effectiveness of social behaviour and network therapy (a new treatment for alcohol problems) with that of the proved motivational enhancement therapy.

<http://www.ncbi.nlm.nih.gov/pubmed/16150765>

Study from Australia highlighting the cost effectiveness of residential care for alcoholics.

<http://www.ingentaconnect.com/content/bsc/add/2009/00000104/00000010/art00011>

Report from Scotland detailing research into cost effectiveness of different interventions.

<http://www.scotland.gov.uk/health/alcoholproblems/docs/rfliire.pdf>

### ***Health Needs Assessments and Tools***

Contains regional data including Y&H. Gap analysis and levels of detection at primary care covered.

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4122341\\_DH\\_HNA\\_2004](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4122341_DH_HNA_2004).

Nottingham JSNA Alcohol.

<http://www.nomadplus.org.uk/secure/Intelligence/Health%20and%20social%20care/Joint%20Strategic%20Needs%20Assessment/Alcohol%20final%20April%202008.pdf>

Paper from 1990 that sets out methods for estimating required capacity of services.

[http://www.alcohollearningcentre.org.uk/library/Rush\\_article.pdf](http://www.alcohollearningcentre.org.uk/library/Rush_article.pdf)

Rush Model Spreadsheet for estimating a model for estimating the average PCT capacity of alcohol treatment systems at the local or regional level.

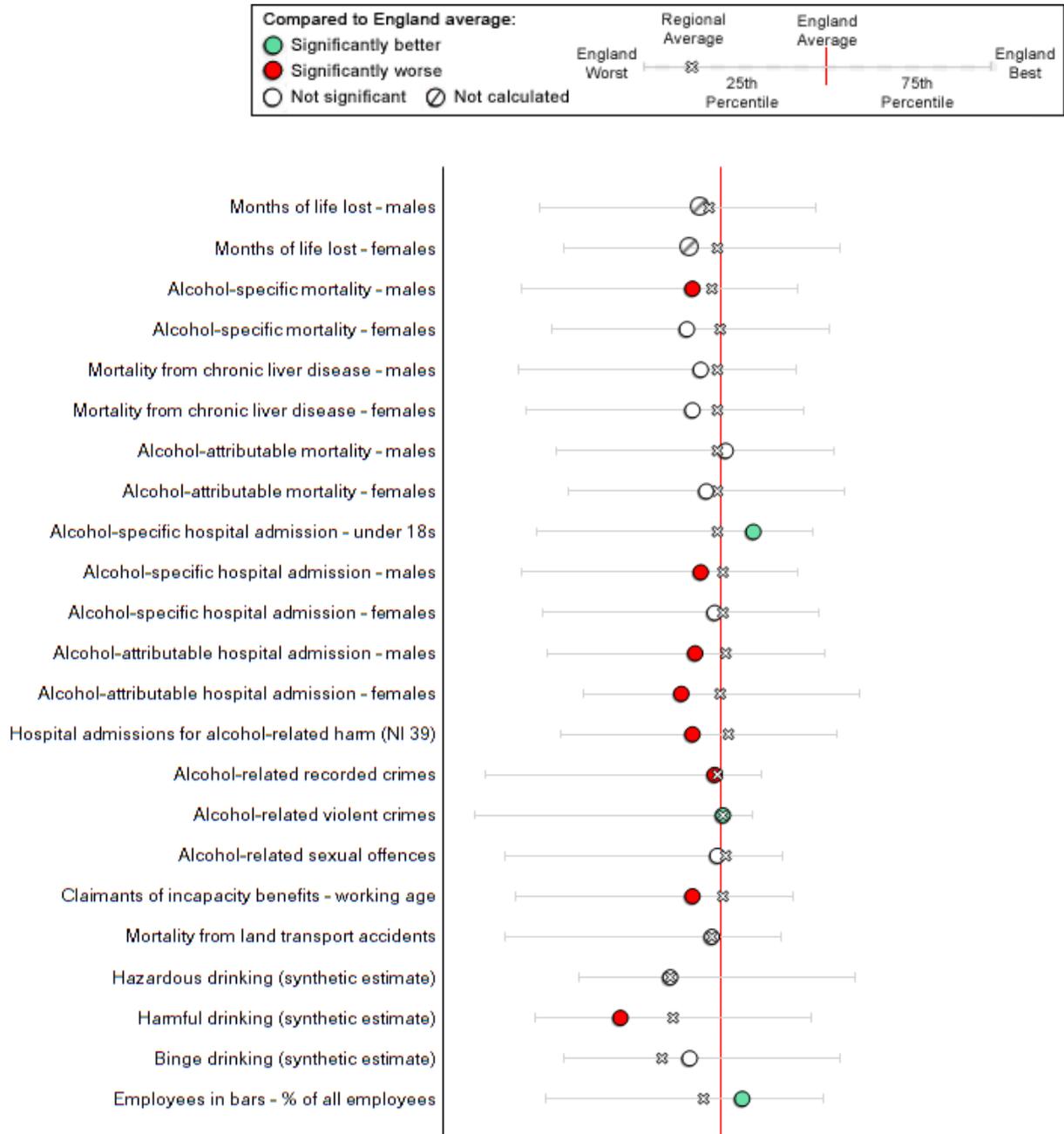
<http://www.alcohollearningcentre.org.uk/Topics/Browse/Commissioning/Data/?parent=5113&child=5134>

Essential website with a huge number of resources. <http://www.alcohollearningcentre.org.uk/>

# Appendix C - Local Alcohol Profile for Bradford

## Profile of Alcohol Related Harm

The chart shows Bradford's measure for each indicator, as well as the regional and England averages and range of all local authority values for comparison purposes



## Appendix D –ALCOHOL CONTROL – PUBLIC POLICY INITIATIVES

Central to reducing the demand for both alcohol treatment and for reducing the number of A&E presentations due to alcohol misuse, is a change in the public policy frame work surrounding alcohol. The Bradford District’s Alcohol Harm Reduction Strategy “*Drinking sensibly in Bradford*” contains six approaches designed to reduce the availability of cheap alcohol and to reduce the level of binge, hazardous and harmful drinking. These fall within two of the strategy ten aims.

### AIM A1: REDUCE CONSUMPTION

#### APPROACHES

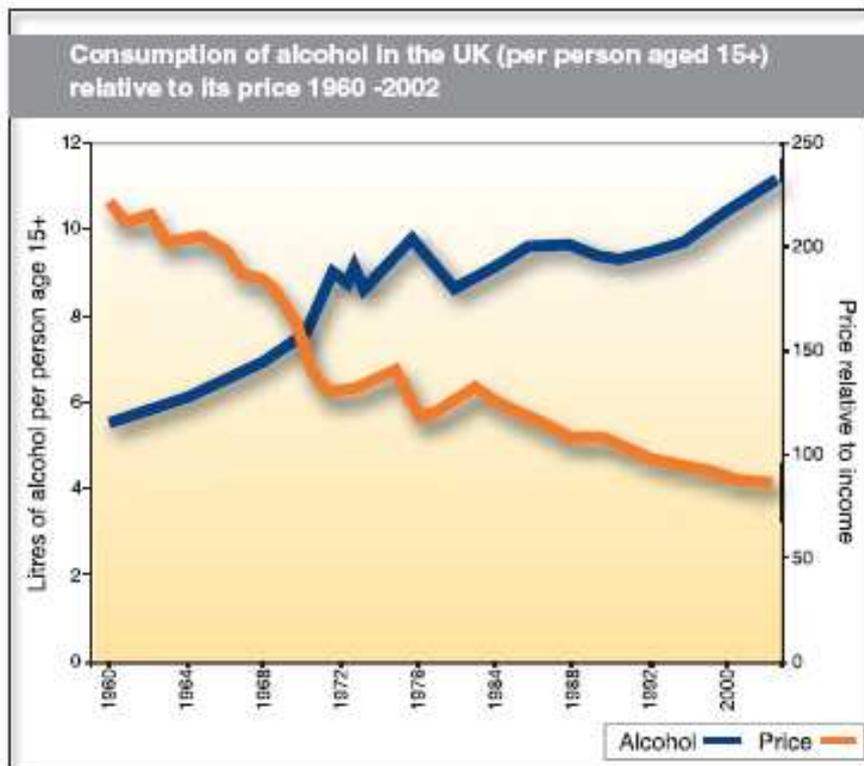
- PO7 To advocate a change in the method of calculating the duty to be imposed on alcoholic drinks to a system based on the volume of alcohol; and advocate phased increases in the duty on alcoholic drinks to make them as expensive in real terms as the equivalent type and strength of drink was prior to the beginning of the significant and continuous rise in consumption (circa 1970). Additionally, to hypothecate increased duty revenues resulting from increases in duty rates to pay for improvements in alcohol treatment, brief interventions and prevention activity.
- PO8 To advocate changes in competition law, to give the Government and local authorities power to ban irresponsible retailing practices; and amendments to the Licensing Act so that licensing authorities can take into account public health considerations.
- PO9 To engage with the on- and off-trade (including supermarkets) to develop a local code of practice designed to discourage retailing practices that promote irresponsible drinking, and to adopt measures to limit access to alcohol. If necessary, to use any powers permissible under planning, licensing and competition law to impose restrictions on outlets having price promotions on alcoholic drinks, using alcohol as a loss leader, or having aisle-end and other prominent displays of discounted alcoholic drinks.
- PO 10 To utilise all available measures to ensure that all licensed premises provide non-alcoholic and low (under 2% proof) alcoholic drinks at prices comparable to purchasing a half pint of normal strength beer.

### AIM A3: REDUCE UNDER-AGE DRINKING

#### APPROACHES

- PO20 To advocate legislative initiatives to cover mandatory unit labelling, health warnings on drink containers, and restrictions on marketing designed to eliminate those practices which glamorise alcohol, and make its use seem an essential part of social and personal success and happiness. These restrictions will apply to advertising and product placement, and include bans on promotional activities such as sports sponsorship, association with celebrity, promotional pricing campaigns (including Happy Hours, 2 for 1 etc.) and the use of alcoholic drinks as loss leaders in both the on- and off-trades.
- PO21 To advocate a responsible attitude by the mass media to alcohol use, with particular reference to media such as pop music shows, “reality TV” and soaps which are aimed at, or reach, large numbers of children and young people. In particular, we want to see an end to the glamorisation and positive condoning of binge drinking in the media.

The relationship between the price and consumption of alcoholic drinks can be clearly seen in the graph below:



Some examples of how cheap it can be to misuse alcohol are shown below:

- THE DAILY WINE DRINKER

Supermarkets promote wine at very low prices e.g. LIDL has offered six different types of red wine for £2.79 a bottle; their ABV ranged from a Californian Ruby Cabernet at 13% to a South African Shiraz Cabernet Sauvignon at no less than 14.5% (approximately 11.5 units a bottle, equivalent to 24 pence a unit). Two people sharing a bottle a night of even the 13% proof variety would consume 68 units a week between them, the borderline for higher risk drinking for a woman, at a cost of under £10 each. With two dry nights a week, each would still be drinking 24 units a week, which is 70% above the maximum recommended number of units a week for a woman i.e. 14 units, and slightly above the maximum recommended level for a man. A very drinkable bottle of wine can be bought for £4 -£5 in a supermarket, so a couple can drink hazardously at home for about £15 a week each, or less if cheaper wine is purchased. If the wine purchased is 13.5% or 14% proof, then the health risk is increased. Recent research by the Joseph Rowntree Foundation has shown that many people whose home consumption far exceeded recommended weekly limits regard their own drinking practices as unremarkable (*“Drinking Places: Where people drink and why”* Valentine G et al, JRF, 2008. )This is why the government is to run a social marketing campaign targeting those who drink harmfully, and characterised in press reports as “middle-class wine drinkers”.

- UNDER-AGE LAGER DRINKERS

One supermarket (LIDL 25.1.08) was selling a four-pack of 500ml cans of lager with 4.1% ABV for £2.29, equivalent to £1.145 per litre, or about 25p per unit of alcohol. Four cans contain some 8 units of alcohol and thus underage drinkers can intoxicate themselves very cheaply. White cider and vary strong (7.5 – 9% ABV) lagers are cheaper still.

- THE WHITE CIDER DRINKER

A bottle of 7.5% proof white cider in a discount supermarket costs around £1.99. It contains about 15 units of alcohol, making the price of a unit of alcohol about 13p. The weekly adult male harmful/higher risk threshold of 50 units costs under £8, and the weekly adult female harmful/ higher risk threshold of 35 units costs only £4.55. White cider is thus a great favourite of street drinkers, but of even greater concern is how easily and cheaply a group of teenagers sharing a bottle or two can get drunk, and possibly poison

themselves. Promotional bottles containing 3 litres for the price of two have been sold – that's under 9p per unit of alcohol.

- THE REAL ALE DRINKER

Conversely, drinking to excess in a pub is expensive.. A pint of real ale in a pub costs £2 - £3. It typically has an ABV of 3.8% to 4.5%. In other words, a unit of alcohol costs £1 - £1.20, thus a man would spend around £21 -£25 a week to drink the maximum recommended 21 units; drinking harmfully (50 units) would cost £50 - £60, and for a woman £35 - £42.

A University of Sheffield report, commissioned by the Department of Health to help Government Ministers decide future alcohol policy, shows that policies which lead to price increases reduce alcohol consumption and can have significant effects on reducing alcohol-related harm. The major findings of the University of Sheffield research are summarised in the media release reproduced below:

*1. What are the policy effects of introducing across-the-board price increases?*

Across the board price increases can have a substantial impact on reducing consumption, and consequently harm. Such price increases mean that there is less incentive for switching between different types of alcohol or drinking venues (for example by going to the pub if supermarket alcohol is getting more expensive) than in policies targeting price increases at certain products or market sectors. Pubs and supermarkets are equally affected by a general price increase, although it has been argued that supermarkets may be less likely than pubs to pass on such price rises to consumers.

- Across-the-board price increases (covering all products in the on-trade and off-trade) tend to lead to relatively larger reductions in mean consumption for the population compared to other pricing options.
- Policies targeting price changes specifically on low-priced products or certain product categories lead to smaller changes in consumption, as they only cover a part of the market.

*2. What are the policy effects of an introduction of minimum pricing?*

Minimum pricing is a policy which sets a minimum price at which a unit of alcohol can be sold. Price increases are targeted at alcohol that is sold cheaply. Cheaper alcohol tends to be bought more by harmful drinkers than moderate drinkers and studies show that it is also attractive to young people. So a minimum price policy might be seen as beneficial in that it targets the drinkers causing the most harm to both themselves and society whilst having little effect on the spending of adult moderate drinkers.

- Approximately 27% of off-trade alcohol consumption is purchased for less than 30p per unit, compared to 9% in the on-trade. 59% of off-trade consumption and 14% of on-trade consumption is purchased for less than 40p per unit.
- Increasing levels of minimum pricing show very steep increases in effectiveness. Overall reductions in consumption for 20p, 30p, 40p, 50p, 60p, 70p are: 0.1%, 0.6%, 2.6%, 6.9%, 12.8% and 18.6%.
- Minimum prices targeted at particular beverages are less effective than all-product minimum prices.
- Differential minimum pricing for on-trade and off-trade leads to more substantial reductions in consumption and harm (for example, pairing a 30p minimum price in the off-trade with an 80p on-trade minimum price gives a reduction in consumption of 2.1% compared to 0.6% for off-trade alone).

*3. What are the effects of banning off-trade price promotions – buy one get one free, 10% discounts, etc?*

Just over 50% of all alcohol purchased from supermarkets is sold on promotion, although many of the discounts are quite small. Only quite tight restrictions on the level of discount offered

would have noticeable policy impacts. For example:

- Banning only buy-one get-one free offers has very little effect on consumption and harm.
- Bans on discounts only for lower-priced alcohol (less than 30p per unit) are not effective in reducing consumption.
- A ban of discounts of greater than 20% (which would prohibit buy-one-get-one-free, buy-two-get-one-free and buy-three-get-one-free) leads to overall harm reductions similar to a 30p minimum price.
- A total ban on off-trade discounting is estimated to reduce consumption by 2.8%, although this may only prove effective if retailers were also prevented from responding by simply lowering their non-promotional prices.

#### *4. What would be the effect of banning alcohol advertising?*

There is some uncertainty over the mechanisms linking advertising to consumption, and thus it is unclear whether advertising restrictions can be expected to have an immediate effect on consumption. The international evidence suggests that effects of advertising may be cumulative over time, and may work through influencing attitudes and drinking intentions rather than consumption directly. Appropriate UK data are not available and we have been limited to exploratory analyses based on the international literature.

#### *5. What are the savings for each policy the review has looked at relating to health harm?*

The general pattern here is that the more restrictive the policy, the greater the harm reduction. Higher minimum prices lead to greater harm reductions, and this goes up steeply – for example, there is relatively little effect for a 20p minimum price, but 30p, 40p, 50p and 60p have increasing effects. Similarly, a ban on just BOGOFs (buy-one-get-one-free) does not affect health harm very much, but banning discounts larger than 10%, or even a total ban on sales promotions in the off-trade lead to substantial estimated harm reductions. For example:

- A 40p minimum price gives an estimated reduction of around 41,000 hospital admissions per annum.
- The financial value of avoided mortality and morbidity is valued using direct (NHS) costs avoided and also using the quality-adjusted life years (QALY) measure. For both, higher prices lead to increased savings. The annual direct costs savings from a 40p minimum price are estimated at £116m, for a 30p (off-trade) and 80p (on-trade) minimum price pairing £72m, and from a total ban on price promotions £111m, the corresponding quality of life-related savings are estimated at £424m, £254m and £415m.

#### *6. What are the savings for each policy you have looked at relating to crime?*

The review takes into account estimated reductions in the absolute number of violent offences, thefts, robbery, criminal damage and other crime and the corresponding savings in prevention, detecting and prosecuting. The researchers also valued the effect of reducing crime on the quality of life of victims.

- A minimum price of 30p is estimated to reduce total crimes by around 3,800 per annum whereas a 40p minimum price is estimated to reduce crimes by 16,000 per annum and a 30p off-trade paired with a 80p on-trade minimum price by 68,000 per annum. An off-trade discount ban would lead to an estimated prevention of 14,000 crimes per annum, of which 4,000 are violent offences.
- Crime harms are estimated to reduce particularly for 11-18 year-olds as they are disproportionately involved in alcohol-related crime and are affected significantly by targeting price rises at low-priced products.
- Crime costs are also estimated to reduce as prices increase. A 30p, 40p and 30p(off-trade)/80p (on-trade) minimum price is estimated to lead to direct cost savings of around £4m, £17m and £65m per annum respectively, whereas the value of gains in quality of life

associated with decreased crime is estimated at £4m; £21m and £88m per annum respectively. A ban on price promotions in the off-trade decreases direct crime costs by £18m per annum and the cost of quality of life lost by £25m per annum.

- It is important to note that different policies emerge as effective when compared to health harms: discount bans, targeting cheap off-trade alcohol and low minimum pricing options, which influence only the off-trade sector, are all less effective in reducing crime when compared to policies that also affect the on-trade sector. This is because many of the offenders are young males who purchase just over 75% of their alcohol in the on-trade.

#### *7. How would absences from work and unemployment be affected by each of the policies?*

Generally, all policy options that target harmful and hazardous drinkers are effective in reducing alcohol-related harm in the workplace.

- Unemployment due to alcohol problems occurs mainly in the harmful drinker group and is estimated to reduce as prices increase: e.g. 3,800 avoided unemployment cases per annum for a 30p minimum price versus 12,400 for a 40p minimum price.
- Absence reductions occur mainly in the hazardous and harmful drinker groups: e.g. for a 40p minimum price, the 100,000 estimated reduction in days absence per annum includes 35,000 days for hazardous and 55,000 days for harmful drinkers.
- The largest financially valued component of harm avoided due to policy changes is in the estimated unemployment reductions, valued at £303m per annum for a 40p minimum price and £173m at a 30p/80p off-trade/on-trade minimum price.

#### *8. What are the overall financial savings that might be expected as a result of different pricing and promotion policies?*

The majority of the policies appraised have estimated total reductions in harm valued over £500m and some are valued higher than £5billion over a ten-year period.

#### **Reference:**

**INDEPENDENT REVIEW OF THE EFFECTS OF ALCOHOL PRICING AND PROMOTION: Part B Modelling the Potential Impact of Pricing and Promotion Policies for Alcohol in England: Results from the Sheffield Alcohol Policy Model Version 1.0**

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[www.dh.gov.uk/en/Publichealth/Healthimprovement/Alcoholmisuse/DH\\_4001740](http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Alcoholmisuse/DH_4001740)