Bolton's HealthMatters

JSNA: Alcohol

Introduction

The World Health Organisation (WHO) now considers alcohol to be the second biggest cause of preventable death in the UK (after smoking). Alcohol misuse is a persistent problem that crosses all sectors of health and social care. Excessive alcohol consumption has consequences for both the health of the individual – such as chronic liver disease, cardiovascular disease (CVD), cancer, accidents, poor mental health and wellbeing – as well as impacting upon wider social determinants of health – such as family breakdown, antisocial behaviour, and crime.

Bolton frequently scores much worse than the national average across a range of alcohol indicators, indicating the importance of alcohol-related health and harm in the borough. There are significant proportions of the Bolton population that drink at a level that increases their risk of harm or at a level that is already placing them at a high risk of harm. Incidence of alcohol-related harm is increasing nationally, regionally, and locally with the number of 25-34 year olds dying due to cirrhosis increasing seven-fold over the past 30 years in England. Furthermore, incidence of harm is particularly apparent in the boroughs of the North West of England, where elevated harms are associated significantly with higher levels of deprivation.

In England, alcohol misuse costs the NHS around £2.7billion a year, causes 1.1million hospital admissions, and contributes to 1.2million incidents of violent crime a year, 40% of domestic violence cases, and 6% of all road causalities. With the pressure to react to a growing number of urgent needs, preventative and specialist services have struggled to keep pace and hospitals have been bearing the brunt of this increasing burden[1]. As such, costs to the NHS of alcohol harm is predominantly born by acute hospital care (78.3%) followed by ambulance services (13.8%) and primary care (4.1%), while specialist alcohol services account for just 2.0% of the total cost.

Implications for commissioning

NICE recommends a combination of population-level and individual-level approaches are needed to reduce alcohol-related harm. Population-level approaches are important because they can help reduce the aggregate level of alcohol consumed and therefore lower the whole population's risk of harm. Population-level approaches have the advantages that they can help people not in regular contact with services, and those who have been advised to

[1] NHS Confederation (2010) *Too much of the hard stuff: what alcohol costs the NHS*, NHS Confederation.

reduce their intake by creating an environment that supports lower risk drinking. Interventions aimed at individuals can help people become more aware of the risks at an early stage. This is vital as behaviour change is most likely if tackled early; in addition early intervention could prevent extensive damage.

Making alcohol less affordable is the most effective way of reducing alcohol-related harm. Making alcohol less available has also been shown effective by NICE.

There is clear potential to achieve cost savings in local alcohol services. Regionally 'The Case for Change' details alcohol related hospital costs and projects sharp increases in demand. The paper identifies how each locality could save £1.6m.

Inequalities exist in the successful treatment outcomes of clients through the alcohol treatment services. Those population groups who are less likely to have a successful outcome include: men, younger age groups, the most deprived, single/divorced people, and those not in employment. Treatment services therefore need to be increasingly flexible and innovative in order to address the differing needs of these population groups. However, it's also important to recognize that 'treatment services' are not appropriate to all population groups and alternatives need to be suitably funded.

Future work should be tailored to meet the different needs of various and varied population groups including the elderly, younger women, 'home drinkers', and other hidden groups. This will require a varied approach as these are not the 'traditional' drinkers that typically engage with services.

Ensure identification of people who are drinking at increased levels; in addition a combined approach is required to also identify people who are drinking at pre-dependent levels but who without appropriate support will result in them developing dependency and therefore requiring an increased level of service and/or will present to services in crisis.

Who's at risk and why?

The context of alcohol misuse as a Public Health problem is a complex mixture of individual and societal factors and influences. Research has clearly demonstrated that the extent of population-level morbidity and mortality as a result of alcohol misuse is directly linked to the amount of alcohol consumed by that population. Similarly, the risk of alcohol-related harm is correlated with the amount of alcohol an individual consumes. For this reason, prevention must be aimed at reducing the level of alcohol consumed in Bolton, as well as identifying at-risk individuals within our population. However, this task is complicated by the diversity of the risks involved. A description of the complex risks involved in terms of alcohol misuse is

detailed below[2]. The diagram illustrates how the issue crosses many fields other than Public Health:

Men who regularly drink over 50 units per week (or eight units per day) and women who regularly drink over 35 units per week (or six units per day) are most at risk of developing alcohol-related illness or injuries or being admitted to hospital.

Within this complex picture, certain groups in Bolton stand out concerning alcohol:

1. Males: Men in Bolton are more likely to drink than women with men aged 16-44 years being the most likely to drink in excess of the recommended daily amount of alcohol;
2. The most deprived quintile of Bolton: The relationship between socioeconomic deprivation and alcohol misuse is complicated, with those in managerial and

[2] Stevens, A. et al (2004) *Health Care Needs Assessment*, Radcliffe Publishing.

professional occupations being more likely to drink regularly compared to those in routine and manual occupations. However, *Indications of Public Health in the English Regions* demonstrates that despite this those in the most deprived quintile experience 2-3 times greater loss of life attributable to alcohol. This pattern is also true for death from alcohol specific causes and alcohol related admissions in Bolton;

3. BME (black and minority ethnic) community: People from BME populations in Bolton are less likely to drink alcohol to excess due to certain cultural and religious beliefs.

Nationally there is growing concern about alcohol related harm in older people. Research conducted by Alcohol Research UK[3] found that older drinkers often have different stressors, precipitating factors and risk factors for relapse than younger drinkers. They may also face a number of age-related barriers to treatment and are more likely to remain 'hidden' from services. The authors go on to argue that frontline health and social care staff may need to increase their competency in recognising and intervening with older people suspected of having an alcohol problem. A report from the Royal College of Psychiatrists[4] advises people over 65 should not drink more than 1.5 units of alcohol a day - at least half the standard adult daily guidelines. The report states:

> *"Current recommended 'safe limits' for alcohol consumption are based on work in younger adults. Because of physiological and metabolic changes associated with ageing, these 'safe limits' are too high for older people; recent evidence suggests that the upper 'safe limit' for older people is 1.5 units per day or 11 units per week"*

This is not currently Department of Health advice.

The level of need in the population

Impact on life expectancy

Digestive diseases, which include cirrhosis of the liver, are amongst the top five causes of the life expectancy gap for both sexes in Bolton when compared to the England average. The contribution it this disease area makes to the life expectancy gap in Bolton has increased over the past decade.

In addition to the above, excessive alcohol misuse is associated with many other illnesses including CVD, cancers, as well as psychological conditions such as depression and organic illnesses (dementia), all of which influence healthy life expectancy. Furthermore, alcohol misuse is linked to other poor lifestyle behaviours such as smoking, obesity, and lack of physical activity.

[3] Alcohol Research UK (2011) *Working with Older Drinkers*, Alcohol Research UK.

[4] Working Group of the Royal College of Psychiatrists (2011) *Our invisible addicts: First Report of the Older Persons' Substance Misuse*, College Report CR165. June 2011.

Mortality

Male alcohol-attributable mortality in Bolton is significantly higher than both the national and regional average and accounts for over one year of life lost in Bolton men who die prematurely (<75 years of age). This mortality rate is static locally, regionally, and nationally. In Bolton, mortality is far higher in men from the most deprived group and the inequality gap between this group and the general population of Bolton shows no reduction over time. Female alcohol-attributable mortality in Bolton is significantly higher than both the national and regional averages and accounts for six months of life lost in Bolton women who die prematurely. Like the male rate, this mortality rate is also static locally, regionally, and nationally. As with Bolton men, mortality is far higher in women from the most deprived quintile, but unlike the picture we see in Bolton women this inequality gap is showing some reduction over time. Bolton is above average for its peer group and within the Greater Manchester conurbation for both sexes.

Mortality from chronic liver disease is increasing in Bolton – a trend that is in line with both the regional and national pattern. There is a marked gradient across quintiles and a significant widening of the inequality gap between the most deprived quintile and Bolton in recent times. Mortality is greatest in the South East of the borough, where it can be over three and a half times the average for England. Again, Bolton has a higher mortality rate than the average for its peer group.

Prevalence

Bolton, along with several other parts of the North West, is well above the national average for the prevalence of problem drinking. The North West Public Health Observatory's Local Alcohol Profile (LAPE) suggests that Bolton is in the top quarter nationally for all measures of alcohol-related harm. In Bolton, approximately 74.2% of the drinking population partake in lower risk drinking, 19.5% are classified as drinking at increasing risk, and 6.3% are higher risk drinkers.

In Bolton, the least deprived group have the highest proportion of people who drink over the weekly limit, but there is little difference across gradients for those drinking severely over the limit. In Bolton, the White British group are far more likely than other ethnic groups to drink over the limit. Bolton is around average for its statistical peers for lower risk and higher risk drinking, but is higher than most for increasing risk.

Excessive alcohol consumption in Bolton adults is increasing at a significant rate with a quarter of the adult population drinking above the recommended level. (This self-reported drinking level also probably underestimates the true level of drinking in Bolton). The increase we see locally in the *Bolton Health & Wellbeing Survey* is mainly due to a rise in

excessive drinking in Bolton women. However, men are still more likely to drink excessively, with Bolton's younger men being more likely to binge drink.

Problematic patterns of drinking are much more common among lesbian, gay, and bisexual (LGB) people than the general population. Binge drinking is high across all genders, sexual orientations, and age groups, with 34% of males and 29% of females reporting binge drinking at least once or twice a week. Available comparable data suggests that binge drinking is more than twice as common in LGB males, and almost twice as common in LGB females, when compared to males and females in the wider population.

Bolton's rate of alcohol-related hospital admissions is lower than is average for the North West, but remains higher than England. Over time the rate of admissions has been increasing nationally, regionally, and locally. Bolton has a lower admissions rate for alcohol-related conditions than is average for its statistical peer group, however, the more deprived areas around the Town Centre and towards the East of the borough have significantly higher admissions rates.

Bolton has a lower rate of child alcohol specific hospital admissions than the North West, but both the local and regional rate are much higher than is average for England. The Bolton trend shows a recent reduction in child alcohol admissions. Children from the most deprived fifth of Bolton's population are the most likely to attend Accident and Emergency for a possible alcohol-related issue. A greater than average proportion of Bolton's children regularly use alcohol, and from national level data this age group tend to consume most over Friday and Saturday and typically drink beer/lager/cider, alcopops, and spirits.

While the highest levels of alcohol consumption are in the least deprived parts of the borough, because of the associated risk factors and comorbidities both hospitalised prevalence and alcohol-attributable mortality are concentrated firmly in the central deprived areas of the borough.

Bolton has a higher rate of claimants of incapacity benefits (working age) where the main diagnosis is alcoholism (168.4 per 100,000) than we see regionally (152.8). Bolton also has a higher rate of alcohol-related recorded crimes (7.9 per 1,000) than the North West (6.7). In addition Bolton has a rate of 5.8 (per 1,000) for alcohol-related violent crimes (higher than the North West) and 0.1 (per 1,000) for alcohol-related sexual offences (equal to the North West). Finally, Bolton has a similar proportion of its population who are employed in bars (1.8%) as the North West (1.9%).

In Bolton there are around 780 reported cases of Domestic Violence (DV) each year. Research suggests the true figure is likely to be in the region of 4,800. Of these some 32% (248 reported or an estimated 1500 including unreported cases) are linked to alcohol.

Key JSNA Indicator Sheets

MORTALITY: Alcohol-Attributable Mortality – Male

MORTALITY: Alcohol-Attributable Mortality – Female

MORTALITY: Chronic Liver Disease

BEHAVIOUR AND ACCESS TO SERVICES: Alcohol Related Admissions

BEHAVIOUR AND ACCESS TO SERVICES: Binge Drinking

BEHAVIOUR AND ACCESS TO SERVICES: Drinking Behaviour

CHILD AND MATERNAL HEALTH: Alcohol

Current services in relation to need

Alcohol treatment services

This section refers to the latest Bolton Drug and Alcohol Needs Assessment[5]. For a more detailed see the full document on Bolton Health Matters by clicking here.

As of January 2013 there is a new recovery focused treatment system in Bolton. Reflecting the current patterns of alcohol and drug use it is a combined substance misuse service. There is a Single Point of Access and Assessment (SPAA) delivered by Arch Initiatives; following assessments, service users will either be offered Brief Advice and Information or guided through other components of the treatment and recovery system. Arch Initiatives act as the case manager throughout the customer's journey as well as delivering services to assist customers in recovery post treatment. Where required, St Martin's Healthcare deliver all pharmacological interventions; there will no longer be a shared care service. Lifeline deliver psychosocial interventions, harm reduction work and recovery groups.

The National Drug Treatment Monitoring System (NDTMS) has for the first time produced details of the consumption and complexity of those presenting for treatment. In Bolton, both the volume of alcohol consumed and the complexity of problems experienced are well above the national average.

Recent achievements of the Bolton Alcohol Treatment System:

1. Bolton reports lower than the North West average across a range of indicators; including alcohol attributable and alcohol specific hospital admissions;

[5] Bolton Council Drug and Alcohol Strategy and Commissioning Team (2013) *Drug and Alcohol Treatment Needs Assessment 2012/13*, Bolton Council.

2. The Single Point of contact (SPOC) created faster access to triage, Brief Interventions (BI) and intermediary interventions. There continued to be a four to six week wait for the Community Alcohol Team (CAT), though this is much shorter than in previous years;
3. The number of people receiving specialist alcohol treatment in the latest year was 516;
4. Almost half (48%) of all alcohol exits were planned and alcohol free or occasional users.

Known challenges for the Bolton Alcohol Treatment System:

1. The profile of drinkers presenting to treatment remain weighted towards the severe end of the spectrum, meaning that the majority of triages resulted in a referral to specialist services. Allied to this the number of presentations for triage is not dropping;
2. Both the volume of alcohol consumed and the complexity of additional problems of those presenting to treatment is much greater than the national average;
3. The impact of drinking upon health is far more acute in deprived communities, even though consumption is far lower in these neighbourhoods; the PCT aims to decrease the health inequality gap.

The average length of latest treatment for all adults in alcohol treatment in Bolton is 0.44 years, which is lower than the national figure (0.70). The proportion of all initial waits where patients wait over three weeks to start their first alcohol intervention is much higher in Bolton (67%) than England (18%). A slightly smaller proportion of the treatment population typically access residential rehab in Bolton (2%) than nationally (4%). Successful completions as a proportion of total number in treatment in Bolton stands at around 36% in Bolton (220 individuals) which is also just higher than the national average (32%).

Primary Care

To support the increasing burden of alcohol in Bolton, Primary Care have developed a scheme to target all patients aged 16 years and over to undertake an AUDIT C questionnaire. This is a two year scheme (between 2011 and 2013) and to date 90,000 questionnaires have been completed. Early findings suggest that in the more affluent areas of the town there are more people drinking at higher risk levels. However, this is not consistent with the prevalence of alcohol related harm, which is more concentrated in the deprived parts of the borough.

By March 2013 we hope to have achieved at least 50% coverage of the target population – this means 114,000 AUDIT Cs completed. Analysis of this data will allow us to produce profiles of drinking habits at individual GP practice level, as well as being able to establish patterns of alcohol use/misuse at a wider Bolton population level.

We also expect, as a result of getting Health Trainers to undertake the full alcohol audit with patients who are AUDIT C positive, to be able to risk stratify our population into the following categories:

1. Low risk drinkers;
2. Hazardous drinkers;
3. Harmful drinkers;
4. Dependent drinkers.

Secondary Care

The nurses on the Gastroenterology ward at Royal Bolton Hospital have been increased recently. Their remit is focused on reducing the length of stay and preventing further presentation and readmission, as well as to support engagement with local community services.

Cost-effectiveness

Most of the cost of treating alcohol-related acute and chronic conditions is spent in hospitals and this is a very cost-intensive way of coping with the problem. In a climate of financial constraints it is important to note that studies describe how investing in alcohol treatment services is cost effective, producing savings for the NHS in averting alcohol related morbidity as well as the costs of treatment.

There is clear potential to achieve cost savings in respect of presentations from 'Frequent Flyers'. The most common and the most expensive representations are relating to alcohol and mental health, a finding that underlines the importance of the current dual diagnosis work and indicates opportunities for closers working between addiction and mainstream mental health services.

The picture of increasing demands threatens to destabilise NHS services which are already facing significant budgetary constraints. This information is not new, but it still appears to be difficult to engage decision makers in a meaningful discussion. The North West 'Case For Change' identified that 55% of beds are utilised for alcohol related activity. Further, that between 2002 and 2009 there was a 69% increase in the rate of alcohol related acute admissions in the North West, such that now 70% of the total cost of alcohol related harm is born by the NHS and of this 45% is attributed to alcohol related inpatient admissions. The trend as with other lifestyle related conditions, is that without proactive measures demand will continue to increase. Therefore managing alcohol related disorders is critical to future NHS acute sector demand management. The Case for Change identifies £1.6m of cost savings that could be achieved in each locality.

The North East Ambulance Service report that more than one in ten call-outs are alcohol related. There is no comparable data for the North West, but figures are likely to be similar.

It is relatively easy, using published outcome and cost data, to demonstrate that targeted investment can achieve savings, for example Department of Health produces a very simple spreadsheet that projects savings which should be achieved by implementing any of the 'High Impact Changes'. Regrettably things are not as simple as they first appear; one needs to distinguish between a 'saving' and a 'cashable benefit'. An averted Emergency Department (ED) presentation is a 'saving', however the main cost of ED provision is staff and staff are not stood down because of one less presentation. At present demand continues to increase, but if in a year the rate of projected increase is curtailed and there were 100 less presentations per week than currently predicted, and this pattern was consistent, then over time the savings would describe a cashable benefit. Here we are describing potential savings; operational managers are best qualified to comment on the extent to which these can be realised as 'cashable benefits'.

Projected service use and outcomes

Forecasts from PANSI show that the number of adults having a moderate or severe alcohol dependency in Bolton will remain relatively stable until 2030. However, this is contradicted to a certain extent by the increasing prevalence of alcohol misuse determined through local surveys, as well as the increasing prevalence of alcohol related chronic diseases, in particular the local rises in chronic liver disease.

In the short to medium term, if adults in Bolton drinking at increasing risk, high risk, and dependent levels continue to drink into older age, there is likely to be an increased demand for specialist alcohol treatment services for older people, as well as other more generic services such as orthopaedics, mental health, primary care, and unscheduled care.

Previous HNAs in Bolton have found that across the board alcohol consumption in the town appears to increase with additional disposable income. Thus the heaviest drinking areas are the more affluent ones. However, the impact of alcohol on health is more acute in the areas of deprivation, raising issues about resilience. There has been speculation that one should expect to see an increase in consumption as a response to stress and anxiety in the current recession. Research based on drinking patterns observed in other economic downturns worldwide indicates that alcohol consumption will fall. However, this research does not comment on the impact alcohol consumption will have on health. Studies suggest that more

affluent groups will use increased leisure time to pursue healthy activities, so that in some circumstances health actually improves[6].

The total funding allocation for Bolton's alcohol treatment services for 2013/14 is likely to be subject to a significant reduction in comparison to 2012/13. Such reductions will have an effect on service delivery in the future, with an increasing necessity to produce 'more for less' in terms of outcomes.

In Bolton alcohol is an important aspect of the legitimate (as opposed to illegal) local economy. There are around 780 licensed premises in Bolton covering restaurants, bars, pubs, clubs, casinos and hotels as well as off-licensed venues. The expansion of Bolton University is expected to increase the size of this sector in the future.

Evidence of what works

Bolton's Health Matters has created a collection of evidence and intelligence to ensure best practice in decision within this area. To view this collection, please click here

Community views and priorities

A survey[7] conducted by Our Life captured some opinions from Bolton residents relating to the impact of alcohol on the local community. The headline figure was that 77% of people in Bolton said that they were concerned about the drunken behaviour others. The survey also found:

- 51.6% believe action is needed to tackle alcohol-related behaviour;
- 59.6% see alcohol-related crime as a concern locally;
- 79.3% think low prices and discounts increase people's alcohol consumption.

Equality impact assessments

A Health Impact Assessment (HIA) was carried out upon the proposed model for the new drugs and alcohol treatment system in Bolton[8]. The HIA included an assessment of the impact upon inequalities in the borough; HIA can contribute to health equity by identifying the different groups within the population who will experience health gains and losses under each proposal so that decision makers can see how the proposals affect health inequality and so choose the most equitable.

[6] Bolton Council Drug and Alcohol Strategy and Commissioning Team (2013) *Drug and Alcohol Treatment Needs Assessment 2012/13*, Bolton Council.
[7] Our Life (2009) *Big Drink Debate*, Our Life.
[8] Barker, A. (2011) *Health Impact Assessment of the Proposed Model for a New Integrated Drugs and Alcohol Treatment System*, NHS Bolton.

The HIA concluded that the potential health impacts, positive and negative, of the new system are likely to affect specific sub-groups (socially excluded, vulnerable or otherwise disadvantaged) disproportionately compared with the whole population. This is necessary as the service is designed to target explicitly a specific sub-group of the Bolton population, namely people who are using and/or misusing legal, illegal and/or prescribed substances who are aged 18 years or over.

The HIA concludes that the health and health equity impacts of the new system are significantly positive and should contribute positively to both the physical and mental health and wellbeing of the participants in the treatment programme. Some negative impacts regarding equality were recorded (such as increased use of digital resources for referrals and interventions as this relies on persons being computer literate) but these will be monitored and where possible addressed to reduce their impact.

The overall conclusion for the proposal is that if implemented it will have a strong positive health impact on the target groups and their associated social interaction.

Unmet needs and service gaps

Despite local actions and strategies the greatest preventative gains can be expected to come from central policies focused on the monetary cost and control of alcohol.

Alcohol misuse remains a problem in Bolton and particular attention should be given to the increase in young female excessive drinkers in the borough as this group may become a major health need concern in the future. Men and women have different service needs and so the needs of women may need to be addressed by different treatment approaches.

Despite higher levels of alcohol consumption in the less deprived areas of the district, by far the highest rates of hospital admissions and mortality attributable to alcohol are found in the central deprived areas of Bolton.

Over recent years certain areas within Bolton have shown significant increases in the level of alcohol misuse (in particular, Egerton & Dunscar, Smithills N&E, Johnson Fold & Doffcocker, Middlebrook & Brazley, Lostock & Ladybridge, and Little Lever). The majority of these areas are amongst the least deprived areas of Bolton and therefore differential approaches need to be employed to meet the diverse needs of these communities.

Drinking at home is becoming an increasing problem. At home is the most frequent place where people consume alcohol, this behaviour becomes more common with age, and while sales on licensed premises are decreasing, increases in consumption suggests that greater amounts are now being consumed at home that previously and that this is increasing year on year.

Services should be sensitive to the needs of ethnic minorities in the borough, especially where cultural backgrounds stigmatise the use of alcohol.

It has been commented on that the use of Alcohol Use Disorders Identification Tool (AUDIT) as the assessment tool disadvantages prisoners returning to Bolton seeking support to remain alcohol free. This is because AUDIT scores against current behaviour. Furthermore, while there is in place a referral route from prison to services it is very much under-utilised at present – however, this is one of the areas to be developed by the newly redesigned services.

Dual diagnosis is a historical problem for services and so special consideration must be given to alcohol misusers with psychological problems. Currently, 11% of new alcohol presentations are reported as having a mental health issue, but all evidence indicates that a higher proportion of treatment clients are likely to have concurrent mental health needs. However, this is likely to be under-reported. In addition, it is known that mental health issues also arise once clients have stabalised and/or reduced their drinking which may not have been prevalent at the point of engaging with services.

Recommendations for further needs assessment work

Assessment and regular monitoring/analysis of the Public Health Outcomes Framework indicators linked to alcohol are necessary. These are: 2.18 Alcohol related admissions to hospital; 4.6 Mortality from liver disease (<75).

Key contacts

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