Liverpool Alcohol Strategy
2015-2020
Draft 4 for stakeholder consultation
June 19th 2015
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(Page numbers will be added when final draft is agreed)

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Foreword (to be written when content of a final draft has been agreed)

To provide the current context in which we work. DPH/CCG or Cabinet Member
Section 1:

In this section the overarching goals of what we seek to achieve over the next five years will be set out.

1.1. Vision

Liverpool is a city that promotes a responsible attitude towards alcohol and minimises the risks, harms and costs of alcohol misuse to allow individuals, families and communities to lead healthier and safer lives.

1.2. Strategic Aims

To realise this vision we will commit to addressing five key strategic aims. These are:

- Encouraging and supporting responsible attitudes and behaviours towards alcohol consumption (Prevention & Early Intervention);
- Delivering evidenced based, recovery focused treatment support to meet individual needs and reduce the effects on health caused by excessive alcohol consumption (Treatment & Recovery);
- Reducing the number of people who experience crime and disorder related to alcohol misuse (Community Safety);
- Protecting children, young people and their families from harm related to alcohol misuse (Protection);
- Ensuring via local licensing decisions and influencing of government policy that accessibility of alcohol is responsibly controlled (Control).

1.3. Key Outcomes

It is our aspiration in meeting the core aims of this strategy to achieve the following outcomes:

- Establish sensible drinking as the norm;
- Ensure people in need of support can access the treatment they require resulting in more people recovering from alcohol misuse and experiencing reduced levels of alcohol related health harm;
- Reduce levels of alcohol related violence and disorder in both the city centre and local neighbourhoods;
- Fewer children, young people and families are affected by alcohol use and misuse;
- Effectively manage the accessibility of alcohol.
Section 2:

In this section the current drinking trends of the population of Liverpool and the subsequent impacts of this alcohol consumption will be discussed.

2.1 Alcohol Consumption in Liverpool

The results of the NHS Merseyside Lifestyle Survey 2012/13 shows consumption of alcohol is highest among Liverpool’s youngest people (62% of those aged 18-24 drink alcohol compared to 47% of those aged 65 and over). Of the other adults in the city aged between 25 and 64, almost three in five (57%) are drinkers. Although older people are less likely to drink alcohol than younger people, those who do drink do so more often. A significantly larger proportion of Liverpool men drink alcohol compared to Liverpool women (63% compared to 49%). Alcohol consumption is also more prevalent among:

- White people compared to BME people (60% compared to 30%);
- Full-time and part-time workers compared to non-workers (67% and 60% respectively compared to 49%);
- Owner occupiers and private renters compared to social renters (61% and 57% respectively compared to 48%);
- People who smoke daily, occasionally, or who used to smoke, compared to those who have never smoked (58%, 70% and 66% respectively compared to 53%);
- People who describe their general health as being good compared to those who consider it bad (60% compared to 38%).

Among those who drink alcohol, seven in ten do so at least once a week (68%); with most saying they do so one to three times a week (54%). Seven per cent drink four to six times a week, and eight per cent drink alcohol every day of the week. Men who drink alcohol do so more regularly than women. Three in four men drink at least once a week compared to three in five women (75% compared to 61%). Men are also significantly more likely than women to drink every day of the week (nine per cent compared to five per cent). The proportion of those who drink every day of the week is significantly higher among those who consider themselves to be in poor health compared to those who consider themselves to be in good health (19% compared to 6%).

Analysis using The Department of Health Alcohol Ready Reckoner breaks down estimates of alcohol consumption by drinking categories, with estimates of Liverpool population numbers illustrated in the table below:
2.2 Impact of Alcohol on the population of Liverpool

Alcohol misuse affects individuals, families and communities across Liverpool and has a wide range of significant effects on its population impacting on health and wellbeing, crime and disorder, children, young people and families, neighbourhoods, work and skills.

2.3 Health Impact of alcohol in Liverpool

The impact of alcohol on global health is well documented. According to the World Health Organisation (WHO) the harmful use of alcohol results in 2.5 million deaths each year globally. Alcohol is associated with more than 60 adverse health consequences and is ranked by WHO as the third leading cause of death and disability in the developed world. A range of metrics are available at a local level that can be used to illustrate the impact of alcohol on the health of the population of Liverpool.

2.3.1 Adult alcohol related hospital admissions

Alcohol related admissions are measured by analysis of all the hospital admissions due to health conditions in which alcohol is determined to be a factor. Each of the conditions is given a fraction weighting pending upon the estimated impact on that condition alcohol is determined to have.

The trends in hospital episodes with alcohol–related conditions (Broad) indicator has replaced the previous alcohol related admissions indicator (NI39) and gives an estimated number of admissions calculated by adding up all of the fractions that have been identified. It is seen as a better measure of the total burden that alcohol has on community and health services. Figures indicate that between 2008/09 and 2013/14 that the rate of hospital episodes with alcohol related conditions (all ages DSR per 100,000 population) rose by 8.7%. This was at a lower rate than the North West and England. At the end of 2013/14 Liverpool was positioned 13th out of 326 Local Authorities.
Admission episodes for alcohol-related conditions (Broad) Persons

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Count</th>
<th>Rate</th>
<th>Rate</th>
<th>Rate</th>
<th>+/- Annual Percent Change</th>
<th>Rank</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Liverpool</td>
<td>North West</td>
<td>England</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2008/09</td>
<td>10,761</td>
<td>2,692.0</td>
<td>2,055.3</td>
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</tr>
<tr>
<td>2009/10</td>
<td>11,655</td>
<td>2,905.7</td>
<td>2,283.0</td>
<td>1,812.8</td>
<td>8%</td>
<td>11%</td>
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<tr>
<td>2010/11</td>
<td>11,929</td>
<td>2,934.9</td>
<td>2,414.5</td>
<td>1,968.9</td>
<td>1%</td>
<td>6%</td>
</tr>
<tr>
<td>2011/12</td>
<td>12,170</td>
<td>2,987.3</td>
<td>2,443.2</td>
<td>2,032.3</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>2012/13</td>
<td>12,011</td>
<td>2,934.9</td>
<td>2,440.5</td>
<td>2,031.8</td>
<td>-2%</td>
<td>0%</td>
</tr>
<tr>
<td>2013/14</td>
<td>12,059</td>
<td>2,950.0</td>
<td>2,570.5</td>
<td>2,111.2</td>
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<tr>
<td>% Change 08/09 - 2013/14</td>
<td>8.7%</td>
<td>20.0%</td>
<td>21.6%</td>
<td></td>
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</tr>
</tbody>
</table>

2.3.2 Young people alcohol-related hospital admissions

Over the period from 2006/07 through to 2013/14 the rate of alcohol specific hospital admissions in under 18’s has fallen from 173.3 per 100,000 population to 48.6 per 100,000 population. Alcohol-specific outcomes include those conditions where alcohol is causally implicated in all cases of the condition; for example, alcohol-induced behavioural disorders and alcohol-related liver cirrhosis. The alcohol-attributable fraction is 1.0 because all cases (100%) are caused by alcohol. Whilst this decrease is at a faster rate than both the North West and England the Liverpool rate is the second highest of the 8 core cities.
2.3.3 Alcohol related mortality

In the period 2006/08 to 2011/13 alcohol specific mortality in males (DSR per 100,000 population) increased by 8%, compared to no change nationally. However alcohol specific mortality in females fell by 12% over the same period whilst there was no change in the national rate. Despite these figures rates of alcohol specific mortality in Liverpool are amongst the highest in England.

2.3.4 Alcohol related liver disease

Harmful drinking is a major risk factor for chronic liver disease. Rates of mortality due to chronic liver disease in the city fell between 2006/08 and 2009/11 but in recent years have started to rise again. Liverpool continues to have significantly higher death rates than nationally and regionally. The city is currently ranked 4th highest nationally for its male chronic liver disease mortality and 6th highest in the country for its female chronic liver disease mortality.
2.4. Economic Impact of Alcohol to Liverpool

A report produced by Public Health England suggests that in 2011/12 alcohol misuse in England was estimated to cost society around £21.3 billion annually; with a cost of £4.1 billion to the NHS, £6.9 billion caused by crime and licensing, £8.9 billion in costs to the workplace/wider economy and £1.7 billion on social services for children, young people and families affected by alcohol misuse. These costs were further broken down to each local authority. The report estimated that alcohol misuse costs Liverpool a total of nearly £204 million per year, this equates to £203.97 per head of population. Liverpool is ranked 20th highest out of 326 Local Authorities nationally. The following breakdown gives these Liverpool costs in a range of sectors:

- NHS: £45.35m
- CRIME AND LICENSING: £73.00m
- WORKPLACE: £71.34m
- SOCIAL SERVICES: £16.80m

\[\text{TOTAL COST} = £203.97m\]

*Total cost excludes crime related healthcare costs to avoid double counting*

2.5. Impact on families

Alcohol misuse can have a significant impact on families, the scale of which can be difficult to estimate, as often these harms remain hidden and unreported. A national report commissioned by the national Children’s Commissioner in 2012 estimated the indirect impact of parental alcohol misuse upon children and young people using a variety of data sources. Some of the headline figures include:

- An estimated 30% of children live with an adult binge drinker, 22% with an increasing risk drinker and 2.5% with a higher risk drinker.
• An estimated 79,291 babies under 1 year old in England live with a parent who is a problem drinker.

• An estimated 2% of children and young people (UK, under 16 years of age) lived with an adult binge drinker who also had ‘concomitant psychological behaviour’.

• Over three quarters (78%) of young offenders who also misused alcohol had a history of parental substance misuse (or domestic abuse) in their family.

• Evidence of parental alcohol misuse in 22% of serious case reviews.

Based upon the report’s estimations and applying these to the Liverpool population, it is further estimated that in Liverpool:

• Approximately 23,400 children and young people are living with adults who are binge drinkers.

• Approximately 17,160 children and young people are living with adults who drink at increased risk.

• Approximately 1,950 children and young people are living with adults who are higher risk drinkers.

Given the high levels of alcohol related harm in Liverpool these figures are likely to underestimate the true impact of alcohol misuse upon children and young people. Figures for 2011-12 show that more than 1 in 4 people (27%) in receipt of alcohol treatment in Liverpool lived with children.

2.6 Pregnancy

Alcohol consumption by an expectant mother may cause foetal alcohol syndrome and pre-term birth complications which are detrimental to the health and development of neonates (WHO 2011). Foetal Alcohol Spectrum Disorders (FASD) is an umbrella term for several diagnoses related to prenatal exposure to alcohol (i.e. while the baby is still in the womb). Research conducted in Liverpool indicated that women were unaware of the risks of alcohol consumption during pregnancy and how this could lead to foetal alcohol syndrome and sought clearer guidance relating to this. Locally research suggests a further factor compounding the risk faced by pregnant women is the current guidance that it is safe to drink small amounts (one or two units of week). This is confusing given the lack of a widespread understanding as to what a unit of alcohol consists of.

2.7 Students

Nationally there has been a fall in average weekly alcohol consumption among young adults. Yet despite an overall decline in recent years, (which can conversely lead to an increase in the use of sugar sweetened beverages and other health
concerns) over one in five young men (22%) and nearly one in five young women (17%) are still binge drinking (ONS, 2012). The impacts of this trend are experienced in Liverpool. The city has four universities and a large student population of around 70,000 people (which significantly increases the 18-24 old population in the city). The 2014 Local Alcohol Profiles for England (LAPE) indicate that binge drinking in Liverpool is significantly higher than the national average.

### 2.8 Deprivation

The relationship between alcohol consumption and socio-economic status is complex, with the adverse effects of alcohol being more pronounced in those from lower socio-economic groups. This is not solely a result of higher levels of consumption within these groups, but as a result of other confounding factors, such as poverty and unemployment, leading to an inability to ‘protect’ against the negative health impacts. Analysis within Liverpool itself suggests that there is a clear relationship between alcohol-related harm and socio-economic status, as both mortality and morbidity are significantly higher in those living in the most deprived electoral wards. When local data is further disaggregated, mortality and morbidity is highest amongst men aged 35-55 years living in areas of highest deprivation.
2.9 Older People

The sudden disruption in lifestyle caused by retirement and bereavement – which can lead to decreased social activity – is thought to be a major contributory factor among older people who develop a drinking problem. Some justify the regular consumption of particular beverages (i.e. brandy, rum) on the grounds that it acts as an anaesthetic with medicinal properties which help remedy illnesses and pains, but this may instead help to foster a dependence on alcohol. Results from the Liverpool Lifestyles Survey indicated that although older people in Liverpool are less likely to drink alcohol than younger people, those who do drink do so more often. The proportion that are drinking alcohol at least once a week grows with age, ranging from 62% of 18-24 year olds to 76% among those aged 55 and over.

2.10. Street drinkers

A street drinker is defined as a person who drinks heavily in public places and, at least in the short term, is unable or unwilling to control or stop their drinking, has a history of alcohol misuse and often drinks in groups for companionship. Nationally, street drinkers have difficulty in gaining access to healthcare services, especially psychiatric services, and typically suffer from a wide range of illnesses which are exacerbated by drinking, poor diet and sleeping rough for periods of time. Local work using the Mainstay database suggests that there were in the region of 65 habitual street drinkers in Liverpool at April 2014.

2.11 Mental health

The association between problems of mental health and substance misuse are widely recognised. The Co-morbidity of substance misuse and mental illness collaborative study reported that:

- 85% of users of alcohol services were experiencing mental health problems.
- 50% of those in treatment for alcohol problems had ‘multiple-morbidity’.
- 44% of mental health service users were assessed to be drinking alcohol at increasing or higher risk.

Dual diagnosis is the term usually used to describe patients with both severe mental illness (mainly psychotic disorders) and problematic drug and/or alcohol use. Personality disorder may also co-exist with psychiatric illness and/or substance misuse. People with dual diagnosis of drug and alcohol misuse and/or mental health problems are frequently the most in need of treatment services. According to local data there were 72 new presentations in the city to alcohol treatment services with a dual diagnosis in 2011/12 (NTA, 2013).

2.12 Alcohol related brain injury

Alcohol related brain injury (ARBI) is an umbrella term that covers a wide variety of neuropsychological conditions that affect the brain and nervous system being
associated with long term alcohol misuse and related vitamin deficiencies. Patients will usually present with acute confusion, marked lack of insight and convincing confabulation often as a consequence of withdrawal. The confusion experienced may be more permanent when associated with severe physical illness and malnutrition as a consequence of vitamin B1 deficiency.

ARBI tends to affect people in their 40s and 50s with females presenting a decade younger than males. At one extreme is presentation of Wernicke/Korsakoff syndrome and at the milder and less obvious extreme are the more frequent but subtle frontal lobe dysfunctions. Recognition and focus on this relatively small but extremely high impact group will lead to the development of appropriate services to anchor this hard to reach group in health and well-being.

2.13 Alcohol related crime

Liverpool Citysafe data indicates that in the period 2011-2015 there have been 13,724 recorded alcohol related crimes accounting for 8% of all crimes committed over that period. Over same period there were a total of 3,219 recorded offences of alcohol violence with injury which accounted for 26% of all violence with injury offences.

In the period 2011-2015 there were 1793 sexual offences of which 302 (17%) were alcohol related. Over the same timeframe there were 8,144 recorded Domestic Violence offences of which 2707 (33%) were alcohol related. It is recognised however that the numbers of victims of domestic abuse and sexual offences is likely to be much higher given that a lot of incidents go unreported.
Anti-social behaviour has a huge impact on quality of life, blights communities and neighbourhoods and it is often targeted at those members of society who are least able to protect themselves. During 2011/12, Liverpool's Anti-Social Behaviour Unit (LASBU) obtained 49 Anti-Social Behaviour Orders and 96 Acceptable Behaviour Contracts (Citysafe Annual Plan, 2012/13)

2.14 Lesbian, Gay, Bisexual, Transgender (LGBT) Communities

A North West Gay and Bisexual Men’s Health Survey (Stonewall 2012) indicated that 81.4% of Liverpool men reported having an alcoholic drink within the last 7 days. A total of 68.3% drank alcohol on three days or greater in the last 7 days. A separate report *Prescription for Change Lesbian and bisexual women health check* (2008) indicated that 78.3% of Liverpool women drank alcohol in the last 7 days. Of these women 45.5% drank on 3 days or more. The LGBT rates of alcohol consumption highlighted above are higher than reported heterosexual alcohol consumption.

2.15 Black, Minority and Ethnic groups (BME’s)

Figures from the 2011 Census indicate that 15.2% of the Liverpool population are from a minority ethnic group, i.e. non-white British, equating to almost 71,000 residents. This is slightly higher than the regional average (12.9%), but lower than England (20.2%). The largest BME group in Liverpool are classified as ‘White Other’, equating to 17% of the total Liverpool BME population. The ‘White Other’ classification in the UK Census is used to describe people who self-identify as white, but are neither British nor Irish. The category does not comprise a single ethnic group but is instead a method of identification for white people who are not represented by other white census categories. This means that the ‘White Other’ group contains a diverse collection of people with different countries of birth, religions and languages.

The Liverpool Lifestyles Survey asked the question – ‘do you ever drink alcohol?’ Results demonstrated that only 30% of those in BME groups reported drinking alcohol, compared to 60% of those whose ethnic origin was classified as White Other. These figures must be treated with caution as those classified as White may include the ‘White Other’ group mentioned above.
Section 3:

In this section the processes and principles that will be adopted in delivering the strategy will be discussed.

3 Context for strategy delivery

The delivery and on-going review of the alcohol strategy will be the responsibility of the Liverpool Alcohol Strategy Group. This Group is jointly chaired by the Liverpool City Council Director of Public Health and the Liverpool Clinical Commissioning Group Executive Sponsor for Alcohol. The membership of stake holding agencies is provided in Appendix 1.

A full Action Plan highlighting proposed work to address each of the core aims of this strategy will be produced. A full range of local stakeholders will be encouraged to participate in the development of the Action Plan. The Alcohol Strategy Group will oversee the implementation of this Action Plan by monitoring and evaluating interventions on an annual basis to ensure the overall effectiveness of the strategy. The core aims of the strategy dovetail with the remit of four key strategic groups. These are:

- Liverpool Health & Well Being Board
- Liverpool Community Safety Partnership
- Liverpool Children’s Trust Board
- Healthy Liverpool Programme Board

Decisions around investment, commissioning intentions and proposed actions across five themed areas (Section 4) will be taken in collaboration with these partnership groups. The work will be informed by the Liverpool Comprehensive Alcohol Needs Assessment (2014) and will be driven by a range of national policy drivers and a robust evidence base. A full list of these key reference documents is provided in Appendix 2.

3.1. Cross Cutting Themes.

In addition to the address of the thematic aims and objectives identified within this strategy a range of fundamental cross cutting principles and actions must also be embedded if we are to achieve the core aims and outcomes set out.

3.1.1. Partnership working

Partnership working was highlighted within the DH document Signs for Improvement (2009) as a key activity to have in place in order to achieve the greatest impact on health commissioned outcomes for tackling alcohol related harms. The structural change undergone within public services over the past three years and continued financial pressures on public service accentuate the need for a strong and cohesive partnership focused approach to the address of alcohol misuse.
The cross-cutting nature of alcohol and its impacts across a wide range of policy and service priorities (ie physical activity, obesity, mental health, accidents, sexual health, safeguarding) highlights the essential need for joint-working, as many of the targets held at an organisation level can rise or fall depending on the outcomes from effective partnership activities. We will thus continue to build upon our established foundation of partnership working and ensure there is a co-ordinated approach to delivery of the strategy that maximises resources and avoids unnecessary duplication of effort. In doing this we will ensure that the goals set out within this strategy are linked into other thematic areas and strategies to facilitate delivery of significant outcomes.

It is expected for example that implementation of the strategy will complement the work of a range of other city wide strategic plans where alcohol is also an issue. These include:

- Liverpool Health & Well Being Strategy
- Liverpool CCG Healthy Liverpool Programme
- Children and Young People’s Plan
- Citysafe Annual Plan
- Mental Health Strategy
- Homelessness Strategy
- Commissioning Strategy for Dementia
- Integrated Early Help Strategy
- Violence Against Women and Girls Strategy
- Safeguarding Adults Procedure
- Safeguarding Children Procedure

The partnerships we adopt however will also reach beyond collaboration within the city and extend to sub-regional and regional alliances where collective approaches to address complex issues or achieve policy change are required.

3.1.2. Data collection, recording and analysis

We are committed to improving our understanding of how alcohol misuse impacts on the city. It is essential that data is consistently and accurately recorded alongside evidence of work done and outcomes achieved. We will collect and utilise data to inform our actions and use new evidence and guidance to help inform our work in Liverpool. We will use the data we collect to establish a robust baseline and to develop consolidated performance monitoring procedures to accurately measure the
impact of the strategy and all commissioned interventions. This way of working will support our understanding of what constitutes good practice, effectiveness and value for money.

3.1.3. Communication

Effective communication will be integral to the development, implementation and on-going delivery of the strategy. We will seek views of local stakeholders on how alcohol impacts on them, how we can improve our responses as we progress and how they can support action to address these issues. We will communicate with a wide range of partners and stakeholders including local councillors, local businesses and service providers in the public and third sector as well as individuals and communities across the city to ensure the successful delivery of the strategy. This communication will ensure service user views are built into planning and delivery of services and that the work of partners and service providers is needs led and appropriately co-ordinated. Stakeholders who we will communicate with over the lifespan of this strategy are included in Appendix 3.

3.1.4. Adopting an evidenced based and policy guided approach

Liverpool is proud of its track record of innovative practice in its address of alcohol misuse. Whilst innovation will continue to be a feature of this strategy every effort will be taken to ensure that the most effective interventions and services are delivered. To achieve this goal we will be guided by the established and evolving evidence base and by existing and new government policy as it emerges. Research will be one of the central tenets of the strategy. Where there are gaps in the existing evidence base appropriate research and/or needs assessment exercises will be conducted. Measuring process, impact, outputs and outcomes of interventions will ensure comprehensive evaluation of work programmes and ensure resources available are used to maximum effect.

3.1.5. Workforce Development

At a time when resources are significantly stretched we need to ensure that all organisations and services engaged in the implementation of the strategy have opportunity to ensure their staff team has access to the knowledge and skills required to deliver the relevant services. This will require provision of workforce development opportunities through training, skill sharing and information exchange across the stakeholder network.
Section 4:

In this section the key themes of activity required to address alcohol related harm in Liverpool will be identified.

4. Responding to alcohol related harm

To meet the aims and achieve the outcomes set within this strategy a range of objectives will need to be addressed in each of the core themed areas of prevention and early intervention, treatment and recovery, enforcement, protection and control.

(More detailed implementation action plans will be developed for each of the strands of activity, outlining activities and milestones, lead agencies and timescales. These will be regularly reviewed and updated. Progress against the implementation plans will be monitored by the Liverpool Alcohol Strategy Group, and reported to other strategic boards as required).

4.1: Changing attitudes towards alcohol (Prevention & Early Intervention)

Alcohol misuse can have serious long term impacts on an individual’s health. To support people to drink sensibly the Department of Health have produced guidance recommending safe drinking parameters for males and females. The guidance states that males should not regularly drink more than three to four units of alcohol daily and that females should not regularly drink more than two to three units daily. The guidance also states that both males and females should seek to have at least two alcohol free days in a week. Estimating individual alcohol consumption however can be challenging. Different strengths of alcohol and a wide variance in the measures in which alcohol is consumed can make it difficult to track consumption levels.

Understanding drinking behaviours is a complex process. Individual consumption levels can also fluctuate depending on circumstances (i.e. celebrations, stress, holidays, boredom etc). Additionally, patterns of consumption and the drivers for consuming alcohol are also influenced by the social context of an individual’s lifestyle (friendship groups and lack of them, working patterns, childcare responsibilities, levels of disposable income, illnesses/ailments etc). The challenge moving forward therefore is to develop a behaviour-change plan that helps us understand, address and influence behaviours at an individual, social and environmental level.

This will necessarily require utilising social marketing and early intervention techniques such as provision of alcohol identification and brief advice. Social marketing programmes will be insight driven to ensure targeting of messages towards specific segments of the population and will use a mix of methods to drive behaviour change. Early intervention will require delivery of an extensive alcohol identification and brief advice (IBA) programme. Evidence reviews suggest that this will have an effect on the drinking behaviours of 1 in 8 individuals drinking at increasing and higher risk. Social marketing programmes and provision of alcohol...
IBA were highlighted as high impact mechanisms to leverage behaviour change within the Department of Health guidance document *Signs for improvement (2009)*.

In developing a social marketing and early intervention strategy it will also be important in ensuring a consistent message is delivered that professionals are educated about the alcohol behaviour change strategy so they can support it and respond appropriately to patients and the public.

**What has been achieved?**

*Behavioural insight research:* Local insight work has been conducted with people who drink harmful amounts of alcohol exploring attitudes, behaviours, motivations, barriers and beliefs around harmful drinking and engagement with local health services. The insight found that heavy drinkers in the city could be categorised into four segments which in Liverpool are defined as Chardonnay Socialites, Balanced Bingers, Ritual Relaxers and Drinkers in Denial. An illustration of the key characteristics of each of these groups can be found in Appendix 4.

*Social marketing programmes:* Using this insight Liverpool has developed and delivered social marketing programmes to encourage responsible drinking behaviours. A Liverpool branded strap-line ‘*Fewer Units = More Happy Hours*’ has been established to underpin all sensible drinking messages. This provides a consistent affirmation that achieving an incremental decrease in alcohol consumption can have positive impact on an individual’s health and well-being. This message has been built into themed interventions such as *Drop a Drink Size* which via a focus on the calorie levels within alcohol seeks to motivate individuals to review where they may reduce their alcohol consumption levels.

*Website development:* A dedicated website www.fewerunits.co.uk providing access to a range of free alcohol resources (i.e. Sensible drinking guidance, Alcohol & calories, Unit calculators, and Drinkers diaries etc.) is now established. The website also provides details of a range of support options for organisations and voluntary groups who wish to cascade sensible drinking messages within their own setting. Support includes alcohol awareness workshops run by the Liverpool Community Health (LCH) Health Promotion Service and guidance through the Health at Work Team on the introduction of alcohol policy in the workplace.

*Student Fayres and Workshops:* The Liverpool City Council Alcohol & Tobacco Unit have since 2011 provided alcohol awareness and sensible drinking advice to 2,950 university students at organised health fayres and provided 11,430 pupils from 86 Liverpool schools with lessons relating to the signs and dangers of illicit alcohol.

*Identification & Brief Advice:* Since 2011 over 1,500 stakeholders have been provided with the skills to deliver IBA. This has been delivered to a wide range of stakeholders including primary care, hospital A&E wards, community pharmacy, job centres, sexual health clinics and within criminal justice settings. Many of these
stakeholders have also taken advantage of the follow-up refresher and update training that has also been made available to support the longer term sustainability of skills developed. As part of the capacity building support that has been rolled out across the city each GP practice has been provided with its own Alcohol IBA Resource Kit.

**Objectives**

- Continue to develop systems to ensure robust and timely information and intelligence on the use and impact of alcohol in the city is available in order to ensure effective responses to changing patterns of drinking behaviours.
- Implement consistent and evidenced based social marketing programmes using population segmentation and behavioural insight techniques ensuring the work is accessible and appropriately targeted to facilitate sensible drinking choices.
- Provide self-help information for individuals (using a range of resources including social media, leaflets and www.fewerunits.co.uk.) to enable them to understand the influence of alcohol on their lives so they can develop the skills to change behaviours where necessary.
- Groups at risk of alcohol misuse and harm must receive targeted brief information, advice and support as the norm. This can be delivered as part of the broad range of services provided across Liverpool including; primary care, hospitals, pharmacy, sexual health services, mental health services, services within police and other criminal justice settings and employment and training settings.
- Via the *Workplace Wellbeing Charter* promote and support the development and implementation of workplace alcohol policies and interventions to reduce alcohol-related harm in the workplace.
- Ensure that age appropriate, evidence based alcohol education is made available for children, young people and parents in a range of settings (see 4.4).
- Work in partnership with a range of educational establishments (including schools, colleges and universities) to highlight the harmful impacts of binge drinking (extending from its impact on health through to the increased risks to personal safety and becoming a victim of crime) and promote adoption of sensible drinking behaviours.

**4.2: Treatment & Sustainable Recovery**

There are a significant number of people across the city drinking at levels that are harmful to their health. Within the recent Liverpool Alcohol Needs Assessment it was forecast that there are approximately 82,433 people drinking at increasing risk, 29,502 people drinking at higher risk and a further 20,292 who have a physical and psychological alcohol dependency.
Those who experience chronic alcohol related problems often have complex needs that require the support of a wide range of specialist agencies. The alcohol related harm experienced by this group can include poor mental health and wellbeing, poor sexual health, increased vulnerability to accidents and violence, increased cancer risk and exacerbation of long term conditions such as heart disease and hypertension.

The relationship between liver disease and alcohol misuse is also significant. The process of liver disease is silent but when liver disease has developed it presents as an acute illness resulting in significant hospital bed occupancy typically over 8 weeks in duration. A third of patients with alcohol related liver disease are severely alcohol dependent and roughly 20-30% of lifelong drinkers develop cirrhosis. It is estimated that three quarters of deaths from liver disease are the result of excess alcohol consumption.

In recent years guidance from a range of sources including the Department of Health, Public Health England and the National Institute of Clinical Excellence has advocated a whole systems approach to provision of alcohol treatment. This will necessarily require provision of a range of services from opportunistic population screening provided via Alcohol IBA programmes (previously discussed) through to structured treatment programmes for more complex clients.

The most significant and immediate reduction in alcohol attributable hospital admissions can be achieved through increasing the capacity and effectiveness of specialist structured treatment. This treatment must provide a range of options including community and inpatient assisted withdrawal programmes and psychological intervention. Specialist treatment services must link to the broader range of services that are necessary to support recovery including housing, education and employment services, mutual aid and peer support opportunities. Guidance from the DH Alcohol Needs Assessment Research Project (ANARP) suggests that local areas should aspire to the provision and uptake of such specialist treatment for at least 15% of the estimated dependent drinkers in the area.

In addition to structured treatment the Royal College of Physicians advocate the provision of Alcohol Liaison Nursing Services within the A&E Departments of acute hospitals. The designated function of the service is to reduce alcohol related admissions, support earlier discharge and contribute to a reduction in re attendance (and in doing so contribute to cost reductions to the health economy).

**What has been achieved?**

*A new community based treatment system:* A new combined community and Liverpool Royal Broad Green Hospital alcohol service has been established offering individual specialist help to problem drinkers across a range of neighbourhood based clinics. In 2013/14 a total of 1,752 Liverpool residents accessed specialist community alcohol treatment support across the city.
Hospital Alcohol Liaison Service: A nurse led hospital based service is now operated in the city at both Liverpool Royal Broad Green Hospital Trust and Aintree University Hospital NHS Foundation Trust. The introduction of the service has seen an increase in the screening (including screening for end organ damage) and management of alcohol withdrawal on hospital wards and contributed towards reducing the length of patient hospital stay. A multi-disciplinary team approach operates to ensure patients are provided with the most appropriate pathway of care whilst in hospital and at discharge.

Alcohol pathway development: An alcohol pathway defining criteria for referral into specialist treatment support has been established and implemented with key stakeholders.

Establishment of improved screening and assessment: Close liaison between psychiatry and other hospital teams (Alcohol Liaison Service/Hepatology) has resulted in the development of an Alcohol Related Brain Injury Clinic and rapid assessment for patients at Royal Liverpool &Broad Green Hospital Trust

Embedding of robust protocols: Development of clear Pharmacotherapy protocols has resulted in patients now being treated with baclofen to suppress the symptoms and consequences of alcohol dependence.

Innovative recovery approaches: The Brink, Liverpool’s first alcohol free bar has been opened in the city centre. All the profits made at the bar go into a rehabilitation programme tailored to provide help when it is most needed. Support is offered pre-abstinence and when people are going through the change process towards an alcohol free lifestyle.

Objectives

- Regularly carry out an assessment of need for alcohol treatment and care interventions across all tiers of support and review the system to optimise access, capacity, effectiveness and value for money.
- Work to continue to deliver a community alcohol service in Liverpool ensuring it is recovery focused, outcome based and compliant with Models of Care for Alcohol Misuse (MoCAM) and National Institute of Clinical Excellence (NICE) commissioning and clinical guidance.
- Continue to develop Hospital Alcohol Liaison Service provision to alleviate unnecessary hospital admission and fast track clients into appropriate treatment support where necessary.
- Define services for people with dual diagnosis (anxiety disorder, mild to moderate depression, Post Traumatic Stress Disorder, Adult Deficit Hyperactivity Disorder) and ensure an Improving Access to Psychological Therapies (IAPT) service is available to people with alcohol needs.
- Strengthen detection of early liver disease and its treatment by improving the level of expertise and facilities in primary care.
• Ensure integrated treatment pathways are in place throughout the treatment system to ensure treatment and recovery is person centred, via timely access, effective multi-agency working and care co-ordination.
• Ensure effective responses to vulnerable groups/individuals and those with complex needs (e.g. the homeless, street drinkers, sex workers) affected by alcohol misuse.
• Provide high quality treatment for those within the Criminal Justice System from pre-arrest through to ensuring their continuity of support to achieve their seamless transition into community on release from prison.
• Ensure high quality aftercare is available for those clients exiting structured alcohol treatment to include bespoke wrap around recovery package addressing the needs of each individual service user.
• Continue to build an effective recovery community in Liverpool which includes effective mutual support.
• Consider the option of including an Alcohol Recovery Centre within the Night Time Economy to alleviate some of the existing pressure on Accident & Emergency and ambulance call outs over the weekend period.

4.3: Addressing alcohol related crime (Community Safety)

Alcohol consumption has a significant impact upon crime. A large proportion of alcohol related crimes occur at weekend and most significantly within the city centre night time economy. The range of crimes associated with alcohol extend from alcohol specific crimes such as being drunk and disorderly in public through to alcohol related violence and anti-social behaviour as well as crimes that may be indirectly a consequence of an individual’s alcohol consumption such as theft. There is also evidence that being drunk also increases the likelihood of becoming a victim of crime.

Whilst alcohol related violent crime is a particular challenge within the night time economy, alcohol related anti-social behaviour is a feature that can cause alarm, harassment or distress across residential neighbourhoods. The use of alcohol by young people is often the precursor to youth nuisance complaints. This in turn contributes negatively on perceptions of safety in local neighbourhoods.

A complex relationship exists between alcohol use and domestic abuse. There is no specific evidence that alcohol alone causes domestic abuse however data clearly demonstrates that where violence has occurred alcohol is often present. Alcohol can also increase the frequency and severity of domestic abuse. In Liverpool there were 8 domestic homicides between 2012 and 2014. Of these 6 involved definite alcohol use or other substance abuse. The impact of alcohol in incidents of domestic violence is then further compounded where the victims/survivors of domestic abuse
use alcohol to cope with the violence or to escape from the physical or psychological pain of abuse.

To respond to the range of challenges presented by alcohol related crime and anti-social behaviour we will via Citysafe, Liverpool’s Community Safety Partnership continue to deliver a matrix of inter related-initiatives to reduce its potential impacts.

**What has been achieved?**

*Designing out crime:* Implementation of action from the recommendations within the report *Designing Out Crime* within the night time has seen the introduction of annual Light Night events and a review of the location of taxi ranks across the city centre.

*High visibility policing:* Use of high visibility policing techniques via the placement of resources at key locations across the evening has been successfully used to ensure events likely to generate excessive drinking are appropriately controlled.

*Taxi marshalling:* In support of steps to ensure night time economy users can leave the city quickly and safely support has been provided to the provision of a taxi marshalling scheme geared towards reducing potential alcohol fuelled conflicts at the end of the evening.

*Safer pubs and clubs:* Research indicates an increase in violence when people use alcohol and cocaine at the same time. To combat this problem cocaine torches which illuminate traces of cocaine have been successfully used in over 50 venues as a measure towards achieving a safer night time environment.

*Say no to drunks:* Sale of alcohol to a person who is excessively drunk is against the law and also increases the risk of the individual becoming a perpetrator or victim of alcohol related crime. *Say no to drunks* was voluntarily participated in by over 20 bars located in the Ropewalks area of the city. As part of the intervention door staff were issued with breathalysers to test individuals suspected of being excessively drunk whilst bar staff were provided with the skills to identify and refuse sale to excessively drunk individuals.

*Seizure of illicit alcohol:* Over the period 2011 to 2014 over 3,300 litres of illicit alcohol with an estimated value of over £32,000 has been seized. Primarily vodka, whiskey, sambuca and wine, the alcohol was either counterfeit or smuggled/non duty paid.

*Alcohol Treatment Requirement:* Where alcohol has been assessed to be a significant contributor to offending behaviour the perpetrator can be required as part of their sentencing condition to fulfil an Alcohol Treatment Requirement. This requires that the perpetrator attends a programme of structured sessions with a specialist alcohol treatment worker to work through the impact of alcohol on their offending behaviour and subsequently address their alcohol consumption.
**Street drinking:** Begging, street nuisance and disorder are all issues presented by street drinking. Street drinkers often have complex health problems and can often be detached from formal healthcare systems. Liverpool has adopted innovative approaches to provide support to street drinkers and address the challenges this presents to surrounding businesses. Actions that have been piloted have included the testing of a temporary Wet Facility safe haven in a city centre location and a programme of extended outreach support geared towards providing access to healthcare and safe accommodation.

**There’s No Excuse’ campaign:** was developed to raise awareness of the issue of low level sexual assault in nightlife among male patrons and reinforce the criminality of this behaviour. Launched in September 2014 it had three core aims: (1) to raise awareness of the issue of unwanted sexual touching in the city’s night time economy; (2) to clarify that under current UK law any such activity constitutes a sexual offence; and (3) to promote public confidence and reassurance that this is an issue that the city council and the police take very seriously. The campaign was targeted at male nightlife users aged 18 to 24 years in licensed venues across the city. The campaign evaluation indicated it was received very positively, particularly among female nightlife users who recognised a clear need for efforts to address this problem, and represents an important first step towards addressing unwanted sexual touching in the night time economy.

**Domestic Homicide Reviews:** The Liverpool Community Safety Partnership has conducted 6 Domestic Homicide Reviews and 2 single agency reviews to review lessons from domestic homicides and within developed its understanding of the impact of alcohol as an aggravating factor.

**Objectives**

- Continue to proactively manage the night time economy of the city centre utilising high visibility and early intervention policing at key times and identified hotspots through joint collaboration of partners to maximise resources.
- Explore options to reduce the number of vertical drinking establishments in the city centre including within conducting a systematic review of the Designing Out Crime Report to ensure those that are affordable will provide sustainable benefit towards the reduction of alcohol related injuries.
- Address the impacts of preloading in the night time economy by continuing to work with the licensed trade and supporting them to educate customers and prevent those who are already vulnerable from excess alcohol consumption from continuing their behaviour.
- Continue to work with the Business Improvement District and with successful schemes such as Purple Flag.
- Examine options for developing further night time venues /events which are non-alcohol based (ie as already achieved at The Brink).
- Ensure that interventions are available across all areas of the Criminal Justice System to support offenders to address their drinking behaviour and its link to their offending.
- Continue to fund prevention services for young people that tackle the factors and links that exist between substance misuse and offending.
- Enhance data collection and sharing to facilitate targeted action in the areas of the city disproportionately affected by alcohol related crime in the city.
- Consolidate partnerships with communities and existing neighbourhood infrastructure to establish the precise nature and prevalence of alcohol related crime and anti-social behaviour to effectively target resources.
- Ensure there is a robust communication plan in position that informs communities about the delivery of appropriate responses to alcohol related crime and anti-social behaviour and clearly articulates outcomes.
- Achieve a reduction in the number of families who experience domestic violence related to the misuse of alcohol.
- Increase referral of alcohol misusers who are also victims of domestic violence into MARAC and other domestic violence pathways.

4.4: Supporting Children, Young People & Families (Protection)

The impact of alcohol use during childhood leads to learned behaviour in children and young people normalising its use as a life choice. Safeguarding and promoting the well-being of children, young people and vulnerable adults is a key responsibility across all partnership working. Misuse of drugs and alcohol can have far reaching effects for children and young people as well as adult parents/carers.

There are a wide range of potential serious consequences that can result from the misuse of alcohol. Amongst a range of risk factors associated with the misuse of alcohol by young people are; drug misuse, teenage pregnancy, youth offending, truancy and school exclusion. In 2012/13 there were 541 young people (aged below 18 years) in specialist treatment services in Liverpool. Of those, 60 (11%) reported having an ‘alcohol only’ problem, whilst 86 (16%) reported using both alcohol and cannabis.

The evidence base relating to best practice in delaying the onset and thus minimising the potential harm of alcohol consumption amongst young people is constantly evolving. Guidance clearly indicates that; developing communication skills, building confidence and positive self-esteem, setting healthy goals, resilience and problem solving, addressing social norms, resisting peer pressure and anger management should be built into programmes to support young people. Engaging parents in the process is seen as a key element in achieving successful longer term outcomes.
The impacts of alcohol on a young person can often be indirect and caused by parental alcohol misuse. This can impact on a child’s life even before they are born. For example parental alcohol misuse during pregnancy is linked to a number of mental and physical disabilities that can affect foetal brain development throughout pregnancy leading to significant problems from birth through to adulthood.

Parental alcohol misuse can have a significant impact throughout childhood and can impact on future life chances. The effects of these impacts range from a young child taking on the responsibility as a carer for their parents and/or siblings through to the psychological trauma of hearing and/or witnessing domestic abuse. These childhood experiences can and do have effects on educational attainment and emotional well-being. The consequences of parental alcohol misuse are further compounded in that the stigma and shame experienced by some parents prevents them from identifying themselves as problematic drinkers. At the same time children may also suffer shame because of home circumstances but because of love and loyalty to their parents they often do not recognise that they are a young carer or that there is support available for them.

The last ten years have seen substantial progress locally and nationally in recognising and supporting children affected by parental substance misuse generally. However, there are some limitations to the progress which has been made: There has been a greater focus placed on children who are at risk, particularly those known to social care services or who are the target of the Government’s family agenda (the 120,000 so-called ‘troubled families’ targeted by a new ‘payment-by-results’ fund of £448 million over three years). In Liverpool there were 2,108 families in the initial cohort and a further 7,000 families are now included in the new Families Programme. Attention has been placed on learning from serious case reviews some of which have received significant media attention. This has meant that there has been less progress made in identifying and supporting the larger numbers of children defined as ‘in need’ and who maybe not known to, or engaged with, services. The Office of the Children’s Commissioner 2014 thus advises of the critical importance of a cross agency and cross professional local strategy relevant to parental alcohol misuse as an essential component for effective collation of information in order to identify children, young people and families in need of support at an early stage. In Liverpool this has seen a move away from use of the Common Assessment Framework (CAF) and a move towards use of the Early Health Assessment Tool (EHAT) promoting an earlier proactive response to potential problems

**What has been achieved?**

**Families Agenda focus:** Whilst it’s certainly true that not all families in this cohort will experience substance misuse, and not all families with substance use problems will be ‘troubled’, for many of those who fit the definition of a ‘Troubled Family’, alcohol is likely to be a contributory factor. Improvements in physical and mental health, including substance misuse, are included as a local measure within the Liverpool
Families Programme. Local commissioning arrangements in this area provide family focused support, with the objective of breaking the cycle of behaviours damaging to health and well-being including inter-generational substance misuse.

Young person focused alcohol treatment support: Specialist substance misuse support services have over the past 3 years provided one to one support for young people in need of specialist support alongside a programme of targeted and universal support provided in a wide range of community settings. This work alongside that of other partners including the Youth Offending Service, Healthy Schools and the Alcohol and Tobacco Unit has contributed to a decline in the number of young people under18 years of age admitted to hospital with an alcohol specific diagnosis. Between the periods 2008/11 and 2010/13 alcohol specific admissions dropped from 358 to 231. This decline resulted in Liverpool dropping from 4th to 14th in the under 18s alcohol specific admissions league table.

Improved local evidence base: It was recognised within the previous Liverpool Alcohol Strategy (Reducing Harm, Improving Care), which included an outcome to reduce the impact of alcohol related harm upon children and young people, that there were gaps in local knowledge which led to local work being commissioned. This included research to develop a greater understanding of the role of parental alcohol consumption on subsequent consumption in young people, on current understanding of alcohol consumption during pregnancy and on the translation of alcohol related evidence into local practice. The findings of this research work will assist in developing the future provision of alcohol services for parents, children and young people in the city.

Addressing of underage sales of alcohol: Through the Alcohol and Tobacco Unit “Knock Back” training has been provided to licensees in the on and off trade. The training advises of the consequences for the designated premises supervisor, the seller and the premise of selling to somebody who is underage and it advises as to the type of ID that is acceptable where the potential purchaser is suspected of being under 18 years of age. In the period 2011 -14 a total of 1,649 accessed the training. Additionally 645 test purchases of alcohol have also been conducted of which 95 resulted in an underage sale. Where an underage sale occurs a meeting with the Designated Premises Supervisor (DPS) is arranged to bring the incident to their attention and put in place additional conditions on the premise licence to prevent the same incident occurring again. Where these additional conditions are not observed a licence review is called at which if necessary the premise licence can be revoked.

Objectives

- Increase awareness and improve guidance relating to the harm of alcohol to the unborn child by ensuring pregnant women are proactively identified as having an alcohol misuse problem and providing easy access to effective alcohol treatment services and recovery support.
• Continue to provide alcohol and substance misuse education in settings such as schools and colleges to children and young people at all stages of development.
• Develop insight driven social marketing interventions to encourage safe responsible drinking and signpost to appropriate treatment services for children and young people.
• Develop parents understanding of the impact of their own alcohol use on their own children and the current guidance relating to young people and alcohol consumption.
• Ensure that universal and targeted services working with children, young people and vulnerable adults are able to identify alcohol misuse and respond appropriately.
• Provide access to high quality specialist treatment for young people who misuse alcohol.
• Tackle the link between alcohol and sexual risk taking behaviour by providing brief alcohol advice as part of sexual health service delivery and ensuring there are clear referral pathways into specialist treatment when necessary.
• Ensure robust links between young people, adult, community and criminal justice alcohol treatment pathways.
• Develop increased understanding and identification of parental alcohol misuse amongst staff working directly with children, young people and parents.
• Ensure that alcohol misuse is identified and the issues that arise are responded to appropriately as part of a co-ordinated response to support children, young people and family members who are affected and harmed by the alcohol misuse of others.
• Ensure young people and adult alcohol treatment services identify and respond to safeguarding issues for children as part of an integrated response to children affected by parental alcohol misuse.
• Work with retailers to implement the Challenge 25 intervention and as appropriate operate test purchasing exercises to tackle underage sales to minors.
• Develop a targeted proxy purchasing approach via a mechanism through which members of the public are able to report where they have been approached by young people to purchase alcohol.
• Develop a restorative justice approach to deal with under18s who attempt to buy alcohol.

4.5: Influencing the accessibility of alcohol (Control)

Accessibility of alcohol in the context of its affordability, availability and advertising has been a significant factor that has influenced the increased levels of its consumption and subsequent misuse over the past 40 years. It is thus critical that
steps are taken to responsibly control the factors that enhance its easy access to residents of the city.

**Affordability:** Making alcohol less affordable is the most effective way of reducing alcohol-related harm. The current excise duty varies for different alcoholic products (for historical reasons and under EU legislation). This means that the duty does not always relate directly to the amount of alcohol in the product. In addition, an increase in the duty levied does not necessarily translate into a price increase as retailers or producers may absorb the cost.

There is extensive international and national evidence (within the published literature and from economic analyses) to justify reviewing policies on pricing to reduce the affordability of alcohol. Liverpool will continue to support calls for a *Minimum Unit Price (MUP)* for alcohol believing the minimum price should be index linked to the rate of inflation to ensure the impacts of its introduction are maintained year on year.

**Availability:** There are currently 2,148 premises licensed to serve alcohol in Liverpool. This equates to one licensed premise for every 175 adults. Sales of alcohol and related harm increase in line with both the number of shops and bars selling alcohol and the number of hours permitted to sell alcohol. The *Alcohol Health Alliance* states that any local authority committed to improving the health of the public should seek to reduce alcohol consumption by restricting the overall availability of alcohol across all places of sale. International evidence suggests that making it less easy to buy alcohol, by reducing the number of outlets selling it in a given area and the days and hours when it can be sold, is an effective way of reducing alcohol-related harm.

*The Licensing Act 2003* and its regulations sets out the law on alcohol licensing decisions that can be used to control availability of alcohol. It does this by providing a framework through which Licensing Authorities can process and determine applications and exercise other licensing functions. Licensing Authorities must promote the statutory licensing objectives of:

- Preventing crime and disorder
- Preventing Public nuisance
- Ensuring public safety
- Protecting children from harm

Amended guidance issued under the Section 182 of the Licensing Act 2003 now provides powers for the police and licensing authorities to close down problem premises and deal with alcohol-fuelled crime and disorder whilst enabling tougher action on irresponsible pubs and clubs. In addition the *Police Reform and Social Responsibility Act 2011* provides new powers to reduce alcohol related crime and disorder and reduce underage sales. Local Authorities are now given direction to adopt a range of additional policies including *Early Morning Restriction Orders (EMRO’s)*, *Late Night Levy’s (LNL’s)* and *Cumulative Impact Policies (CIPs)*.
Liverpool will adopt a partnership approach to determine where and when it will utilise the powers at its disposal to responsibly control the availability of alcohol.

Advertising: The alcohol industry has over the past decade switched the focus of its estimated £800 million marketing budget to focus predominantly on digital marketing. As a form of communication heavily used by young people this is a cause for concern. It is estimated 67% of 12-15 year olds have a social media profile and the voluntary safeguards the media have put in place for television, radio and print advertising are virtually non-existent in the virtual world. Liverpool is thus committed to lobbying for more transparent restriction on the advertising of alcohol products.

What has been achieved?

Lobbying for changes to the pricing of alcohol products: In 2012 Liverpool provided a comprehensive response in favour of a "Minimum Unit Price" to the Government’s consultation on the introduction of a MUP of 45p. As a consequence of the subsequent decision not to introduce a MUP in England Liverpool has continued to work as part of a consortium of North West Local Authorities to review what alternative legal strategies might be used to control the affordability of alcohol locally.

Raising awareness of the impacts of alcohol advertising: A public awareness programme highlighting the impacts of alcohol advertising on young people aged 12-15 has been implemented to highlight the knowledge young people have of alcohol products and illustrate the impacts of alcohol advertising on minors. This work was then presented as evidence to further lobby for a MUP to protect young people from the harm of alcohol.

Use of Cumulative Impact Policy (CIP): A CIP is a tool that can be used by Licensing Authorities to limit the concentration of licensed premises in designated areas so as to uphold the requirements of the licensing objectives. Liverpool currently has CIPs implemented in five areas of the city.

Responsible Authority liaison meetings: A fortnightly schedule of “Responsible Authority” meetings are run to allow collective and joined-up consideration of grant applications, variations and reviews made to the Licensing Authority. This has resulted in the successful challenge to the extension of opening hours on a number of off licences including one licence where conditions were imposed not to sell any high strength drinks including artisan beers.

Working with the licence trade: Over the period 2011-14 there have been 1,130 visits to the licensed trade. These visits may be either of a routine nature, advisory visits where a trader makes an enquiry, or assist for support and visits following a complaint about a premise.

Voluntary removal of super strength products: High strength low cost alcohol (most usually cider, lager and wine) are products most frequently purchased by those most vulnerable to its impact (young people and street drinkers). In the absence of
minimum unit price legislation for alcohol Liverpool has worked with the licensed trade located in the closest proximity to where street drinking is known to occur to voluntary remove single cans of 6.5% strength cider and lager from sale as a step to control access to cheap alcohol.

**Objectives**

- Review the Liverpool *Statement of Licensing Policy* in line with best practice to ensure it supports alcohol harm reduction in the city.
- Consider the use of available tools such as the possible introduction of Late Night Levy and Early Morning Restriction Orders as options to control availability of alcohol within the Night Time Economy.
- Review current Cumulative Impact Policies (CIP’s) in the city and the impact of licensed premises in areas of the city with high levels of alcohol related harm and consider the feasibility of expanding existing CIPs or introducing new CIPs in targeted areas of the city.
- Continue via the Liverpool Responsible Authorities to proactively manage new license applications of concern and take action in a partnership approach against those premises causing problems.
- Explore how health bodies in partnership with other Responsible Authorities can influence licensing under the Licensing Act.
- Ensure that licensed premises have information about the law, their responsibilities and good practice in the sale of alcohol.
- Identify irresponsible retail practice through surveillance and intelligence received from Responsible Authorities and the community.
- Develop a voluntary code for off licenses and supermarkets to raise standards in responsible retailing across the city.
- Continue to work with off and on licensed premises to prevent the selling of alcohol to drunks taking proactive action when necessary.
- Work with central government to develop clearer rules around knowingly selling alcohol to drunks.
- Work to influence government policy on the introduction of an appropriate Minimum Unit Price for Alcohol, more robust and transparent restrictions on alcohol advertising and the introduction of public health consideration as a 5th Licensing Objective.
References
List of references to be added
Appendix 1: Alcohol Strategy Group: Membership

- Liverpool City Council (Public Health, Safer and Stronger Communities, Adult & Children Social Care, Licensing)
- Liverpool Clinical Commissioning Group
- Merseyside Police
- Merseyside Community Rehabilitation Company and National Probation Service
- Royal Liverpool and Broadgreen University Hospital NHS Trust
- Aintree University Hospitals NHS Foundation Trust
- Liverpool Community Health NHS Trust
- Merseycare NHS Trust
- Alder Hey Children’s NHS Foundation Trust
- Merseyside Fire and Rescue Service
- Liverpool Charity and Voluntary Services
- Liverpool Local Involvement Network
- Liverpool Women’s NHS Trust
- Public Health England
- Addaction
Appendix 2: National Policy Drivers and Legislation

- The Government's Alcohol Strategy 2012 (HM Government 2012)
- Health First: An evidenced based alcohol strategy for the UK (University of Stirling 2013)
- Healthy Lives, Healthy People: Our strategy for public health in England (Department of Health 2010)
- Improving Outcomes and Supporting Transparency; a public health outcomes framework for England 2013 – 2016 (Department of Health 2013)
- No health without mental health – a cross cutting government mental health strategy for people of all ages (Department of Health 2011)
- Police Reform and Social Responsibility Act (HM Government 2011)
- Selling Alcohol Responsibly: The new Mandatory Licensing Conditions (Home Office 2010)
- The Troubled Families Programme (Department for Communities and Local Government 2012)
- Breaking the Cycle: Effective Punishment, Rehabilitation and Sentencing of Offenders (Ministry of Justice 2010)
- Signs for Improvement – commissioning interventions to reduce alcohol related harm (Department of Health 2009)
- Local Routes: Guidance for developing alcohol treatment pathways (Department of Health 2009)
- Silent Voices: Supporting children & young people affected by parental alcohol misuse (The Office of the Children’s Commissioner 2012)
- People who abuse children: (Priory Group 2006)
- I think you need someone to show you what help there is: Parental alcohol misuse – uncovering and responding to children’s needs at a local level (The Office of the Children’s Commissioner 2014)
- Alcohol use disorders: Preventing the development of hazardous and harmful drinking (National Institute of Clinical Excellence PH24)
- Alcohol use disorders: physical complications (National Institute of Clinical Excellence, CG 100)
- Alcohol dependence and harmful alcohol use (National Institute of Clinical Excellence, CG 115)
- Review of the effectiveness of treatment for alcohol problems (National Treatment Agency, 2006)
- Models of Care for alcohol misusers (Department of Health 2006)
- Making the Connection: Developing integrated approaches to domestic violence and substance abuse (London Drug and Alcohol Network 2013)
- Working with change resistant drinkers (Alcohol Concern 2015)
- Liverpool Public Health Annual Report (Liverpool City Council, 2014)
- North West Gay and Bisexual Men’s Health Survey (Stonewall, 2012)
- Prescription of Change: Lesbian and Bisexual Women Health Check (Stonewall, 2008)
Appendix 3: Stakeholders communicated with over lifespan of the strategy

A full list of organisations and agencies consulted will be included here at the end of the consultation process.
Appendix 4: Key population drinking characteristics

**Chardonnay socialites**

These people are typically middle aged men and women with families who drink to socialise. They are more likely to report that they do not get drunk and know their limits. They tend to drink wine throughout the week with an evening meal and drink more heavily at weekends when socialising with friends at home or in a restaurant. This group is often shocked to realise they are heavy drinkers and surprised to see how much they have been drinking in their diary. They have often noted the short term consequences of drinking especially putting on weight and there has been an ‘under current’ of unease about their alcohol consumption.

Key barriers to stopping drinking or cutting down are that drinking is seen a key part of their social life.

**Balanced bingers**

Balanced Bingers are typically younger people with no children (although some family people also fall into this category). They usually drink heavily at weekends in social settings, usually at a pub, bar or club and like to mix different strengths in one evening. They know that they drink a lot on these nights out but feel this is balanced by not drinking on other nights of the week. They often cite other healthy behaviours as balancing out their alcohol consumption such as gym/sport. They tend to believe their drinking will naturally decrease over time as they ‘settle down’.

Key barriers to stopping drinking or cutting down are that they do not feel their drinking is problematic and that they have a healthy lifestyle.

**Ritual relaxers**

Ritual Relaxers tend to be single people of all ages. They are often single parents or may work unsocial hours and typically drink on their own as a way of relaxing at the end of the day. Like Chardonnay Socialites, they are often shocked to see how much they have been drinking, will be aware of short term consequences and will feel uneasy about their alcohol consumption.

Key barriers to stopping drinking or cutting down are that a drink at the end of the day is considered a ‘reward’.

**Drinkers in denial**

Tend to be older males (although some women also fall into this category). They typically drink at the pub when socialising with friends or watching the match. Some also drink at home. This group has a strong preference for pints and spirits and tend
to drink often – many are retired so have lots of spare time and fewer responsibilities. This group are unwilling to change their alcohol consumption. They enjoy drinking and have been doing so for a long time so it is part of their identity. Whilst they recognise the health consequences they would rather continue to drink.

Key barriers to stopping drinking or cutting down are they do not think their drinking is problematic and they would not consider going to the pub and not having a drink.