An Alcohol Health Needs Assessment for Liverpool

Title: An Alcohol Health Needs Assessment for Liverpool

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Circulated to: Liverpool Alcohol Strategy Group

Version: 1.9

Status: Final Draft

Date of release: May 2014

Review date: 2017

Purpose: For information

Description: A comprehensive alcohol health needs assessment for Liverpool to inform the redevelopment of the Liverpool Alcohol Strategy.

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Executive Summary

The objectives of this alcohol Health Needs Assessment (HNA) are to:

- Analyse data from available sources relevant to alcohol misuse in Liverpool.
- Describe the scale and consequences of alcohol misuse in Liverpool
- Describe current provision and analyse its cost-effectiveness
- Identify gaps in provision and knowledge using intelligence and stakeholder views
- Make recommendations to inform future cost-effective policy and commissioning decisions

Alcohol causes major health problems—more people are dying from alcohol related causes than deaths from breast cancer, cervical cancer, and infection with methicillin resistant Staphylococcus-aureus combined. A report from the World Cancer Research Fund\(^1\) confirmed that even drinking alcohol within so called “safe limits” increases the risk of cancer of the breast and upper gastrointestinal tract.

Whilst consumption of alcohol is widespread, national and local research\(^2\) \(^3\) suggests that knowledge of recommended guidelines re safe levels of consumption is low. Current guidelines categorise those drinking above recommended guidelines as at:

- Increasing risk (previously hazardous) drinkers:
  - Men who regularly drink more than 3 to 4 units a day but less than the higher risk levels
  - Women who regularly drink more than 2 to 3 units a day but less than the higher risk levels

- Higher risk (or harmful) drinkers (who have a high risk of alcohol-related illness) are defined as:

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\(^2\) House of Commons Science and Technology Committee (2012) Alcohol Guidelines
\(^3\) Liverpool PCT (2012) Fewer Units Campaign
Men who regularly drink more than 8 units a day or more than 50 units of alcohol per week

Women who regularly drink more than 6 units a day or more than 35 units of alcohol per week

Alcohol dependence is defined by:

- Craving, tolerance, and a preoccupation with alcohol and continued drinking in spite of harmful consequences.\(^4\)

Alcohol is now 45% more affordable than it was in 1980\(^5\) and it is estimated that its misuse costs England approximately £21bn per year in healthcare, crime and lost productivity\(^6\). It is estimated that 2.6 million children in the UK are living with parents who are drinking at increasing or higher risk and 705,000 are living with dependent drinkers\(^7\).

The most effective strategies to reduce alcohol-related harm from a public health perspective are those that operate at a macro-level and include minimum unit pricing; restrictions on the physical availability and promotion of alcohol. Other less effective interventions include drink-driving counter measures, brief interventions with at-risk drinkers, and the treatment of drinkers with alcohol dependence\(^8\).

National alcohol policy has changed over recent years, which may be partly due to a transfer of responsibility from the Department of Health to the Home Office. The most recent Government Alcohol Strategy\(^9\) has much more of an emphasis on curbing alcohol related anti-social behaviour in town centres, than on the detriments to health.

The last ten years have seen substantial progress in recognising and supporting children affected by parental substance misuse generally. However, there are some limitations to the

\(^4\) NICE (2011) Alcohol Use Disorders: Diagnosis, Assessment and Management of harmful drinking and dependence
\(^5\) Statistics on Alcohol: England 2012, NHS Information Centre
progress which has been made: There has been a greater focus placed on children who are at risk, particularly those known to child 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 £448million over three years): Attention has also been placed on learning from serious case reviews, including those 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 are often not known to, or engaged with, services.

A report produced by Public Health England\(^\text{10}\) suggests that in 2011/12 alcohol misuse in England is 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 and families affected by alcohol misuse. These costs were further broken down to each local authority: The report estimates that alcohol misuse costs Liverpool a total of nearly £204 million per year, this equates to £203.97 per head of population. Liverpool ranked 20\(^{\text{th}}\) highest out of 326 Local Authorities nationally. The chart below gives a breakdown of these costs by organisation:

- NHS: £45.35m
- CRIME AND LICENSING: £73.00m
- WORKPLACE: £71.34m
- SOCIAL SERVICES: £16.80m
- TOTAL COST+: £203.97m

\(^+\text{Total cost excludes crime related healthcare costs to avoid double counting}\)

Analysis carried out by Liverpool John Moores University\(^\text{11}\) found that the discrepancy between alcohol surveys calculating consumption and actual alcohol sales equals an additional 430 million units of alcohol a week. This is the equivalent of a bottle of wine per

\(^{10}\) PHE (2013) The Cost of Alcohol in Liverpool Local Authority  2011/12
\(^{11}\) LJMU (2009) Off Measure: How we underestimate the amount we drink
adult drinker per week going unaccounted for in the UK. Consumption estimates based on retail sales data in Great Britain indicate that the volume of pure alcohol sold per adult increased by 16% between 1994 and 2005, a result of off-trade sales (i.e. alcohol sold for consumption off the premises, including supermarkets and other off-licenses) increasing at a faster rate than declining on-trade sales (i.e. alcohol sold for consumption on the premises including pubs, clubs and restaurants)\textsuperscript{12}

Analysis using The Department of Health Alcohol Ready Reckoner\textsuperscript{13} breaks down estimates of alcohol consumption in Liverpool by drinking categories, with estimates of expected population numbers illustrated in Table 1 below:

<table>
<thead>
<tr>
<th>Drinking Category</th>
<th>Population Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increasing Risk Drinkers</td>
<td>82,433</td>
</tr>
<tr>
<td>Higher Risk Drinkers</td>
<td>29,502</td>
</tr>
<tr>
<td>Dependent Drinkers</td>
<td>20,292</td>
</tr>
<tr>
<td>Binge Drinkers</td>
<td>97,934</td>
</tr>
</tbody>
</table>

\textit{Table 1: Numbers of Drinkers by Consumption Levels.}

\textit{Source: DoH (2011) Alcohol Ready Reckoner}

Local insight work was conducted in 2012, by interviewing those who drank harmful amounts (those in higher risk category). The research explored attitudes, behaviours, motivations, barriers and beliefs around harmful drinking, and engagement with local health services. The insight consisted of hour long in-depth interviews and found that heavy drinkers in the city could be categorised/segmented into four types:

- Chardonnay social-lites
- Balanced bingers


\textsuperscript{13} http://www.alcohollearningcentre.org.uk/Topics/Browse/Data/Datatools/?parent=5113&child=5109
• Ritual relaxers
• Drinker in denials

Alcohol is a significant contributor to poor health within Liverpool, illustrated using data depicting months of life lost due to alcohol misuse. The data reflects the level of chronic heavy drinking in the population and is most likely to be found in higher-risk drinkers and dependent drinkers.

Harmful drinking is a major risk factor for chronic liver disease. Rates of mortality due to chronic liver disease in the city have fallen in recent years and are currently at their lowest since 2007. However Liverpool continues to have significantly higher death rates than nationally and regionally. The city is currently ranked 7th highest nationally for its male chronic liver disease mortality and 10th highest in the country for its female chronic liver disease mortality. The city has the 2nd highest rates for chronic liver disease mortality in males and females among the core cities and the 2nd highest among local authorities on Merseyside.

When alcohol related admissions are analysed by electoral ward the picture is similar to those for alcohol specific conditions, with the same wards experiencing the highest rates. This indicates the high level of disease burden alcohol places upon communities.

Examining trends in the number of admissions by CCG locality between 2011/12 and 2012/13, there was a reduction of 6% in North locality, a 2% reduction in Liverpool Central and a 1% increase in Matchworks. Comparing 2013/14 Quarter 2 to the same 12 month rolling period in 2012/13, there has been a reduction in the number of alcohol related admissions across all localities and by 6% for Liverpool overall.

Alcohol misuse can affect children directly and indirectly, the scale of which can be difficult to estimate, as often these harms remain hidden and unreported. A national report commissioned by The Children’s Commissioner\textsuperscript{14} in 2012 estimated the indirect impact of parental alcohol misuse (PAM) upon children and young people using a variety of data sources.

\textsuperscript{14} Community Research Company (2012) Silent Voices — Supporting children and young people affected by parental alcohol misuse.
Based upon the report’s estimations, and crudely applying these figures to the Liverpool population, it is estimated that in Liverpool:

- Approximately 23,400 children are living with adults who are binge drinkers
- Approximately 17,160 children are living with adults who drink at increased risk
- Approximately 1,950 children 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%) receiving alcohol treatment in Liverpool lived with children.

Based upon pooled data for years 2008/09-2010/11 there was a fall of -8.3% in the Liverpool hospital admission rate for those aged under eighteen years compared to the previous year. In the five year period between 2004/05-2006/07 and 2008/09-2010/11 there was a fall of -1.8% in the Liverpool rate. In 2008/09-2010/11 Liverpool was ranked 4 highest out of 326 LAs nationally.

Whilst hospital admission rates for those aged under 18 years have declined year on year, in 2012/13 there were 541 young people (aged below 18 years) in specialist treatment services in Liverpool\(^\text{15}\). Of those, 60 (11%) reported having an ‘alcohol only’ problem, whilst 86 (16%) reported using both alcohol and cannabis. The Liverpool rates were lower than national, with those reporting cannabis and alcohol use less than half of the national rate of 34%.

The majority of young people in Liverpool were referred via the Youth Justice system – 62%, compared to 34% nationally, suggesting that alcohol is a significant driver of crime for young people in Liverpool. About 10% of young people in Liverpool re-presented to services within 6 months, compared to 7% nationally.

\(^{15}\) PHE (2013) Alcohol and Drugs: JSNA support pack. Key data to support planning for effective young people’s specialist substance misuse interventions.
There are a number of particular sub-groups of the population who experience disproportionate levels of alcohol related harm. These include:

- Offenders
- Mental health issues
- Lesbian, Gay, Bi-Sexual, Transgender (LGBT)
- Students
- Living in Poverty
- Homelessness
- Street Drinkers

It has been estimated that in a community of 100,000 people each year, 1,000 people will be a victim of alcohol-related violent crime\(^{16}\). Alcohol-related crime and social disorder is estimated to cost UK taxpayers £11bn per year, at 2010/11 estimations.

Estimates produced for Liverpool show that in 2011/12 there were 3,726 crimes and 78 sexual crimes which were attributable to alcohol. The city’s alcohol related crime rates have fallen by 33% between 2007/08 and 2011/12 but remain significantly higher than the North West and England. A similar pattern can be seen for alcohol related violent crimes which have fallen by 35% over the same period. By comparison sexual crime rates attributable to alcohol in the city have increased by 35% during this period although rates are not significantly different to regionally or nationally\(^{17}\).

Alcohol misuse is linked to around half of all violent crimes and around a third of domestic violence incidents\(^{18}\). During 2011/12 there were 1,083 victims of domestic violence in the city supported by services provided by the Citysafe partnership; including multi-agency case risk assessment conferences (MARACs) to reduce levels of repeat victimisation\(^{19}\).

Data from Merseyside Police for 2011 indicated that 62% of offenders arrested for violence tested positive for cocaine (compared to 23% for burglary, 24% for robbery). Alcohol was present in all but one of the offenders who tested positive for cocaine.


\(^{17}\) LAPE: 2012/13

\(^{18}\) NICE (2010)

\(^{19}\) CitySafe Partnership:
In 2011/12 there was a fall of -8.4% in the Liverpool alcohol related crime rate compared to the previous year. In the five year period between 2007/08 and 2011/12 there was a fall of -32.6% in the Liverpool rate. This compares to a fall of -27.1% and -23.2% at regional and national level respectively. In 2011/12 Liverpool was ranked 59 highest out of 326 LAs nationally.

Alcohol Treatment Requirement (ATR) is one of a range of community sentences available to the courts. It provides access to treatment and support programmes for offenders targeting high risk offences such as Domestic Abuse, Violence related offending and more recently Burglary domestic and commercial where alcohol use is identified as a significant factor in offending. Within Liverpool, there were 117 people on an ATR/VATP as at December 2013. Subsequent data suggests that from 1/2/2013 until 1/2/2014:

- Clients who were assessed and received an ATR - 144
- Clients who were assessed and given a VATP – 112

According to the licensing policy at the time of its publication Liverpool had 1,738 licensed premises as well as 51 club premises certificates, with the main concentration of premises providing late night sales concentrated in the city centre. The policy references the invaluable contribution these premises make to the Night Time Economy (NTE) and it could be argued that it is this conundrum which the Local Authority must wrestle with when devising policy in relation to alcohol – the juxtaposition of economic advantages and population health and wellbeing.

Within North West England momentum is growing towards the establishment of a bye-law that would essentially introduce a regional Minimum Unit Price (MUP) for alcohol. At a meeting in early February North West LA CEO’s agreed in principle to establishing a “fighting fund” to support a legal review of the bye-law and develop robust responses that could be used to combat any challenges by the industry. Each Upper Tier LA is currently being asked to contribute £10K to the “fighting fund”.

In addition to seeking to identify monies for a “fighting fund” a request has also been made for names of local Councillors who would be interested in acting as spokespeople and advocates for the introduction of a MUP.
Liverpool supports steps for the introduction of the bye-law. The Mayor has already taken proactive steps to reduce the availability of low cost, high strength alcohol in Liverpool by requesting all supermarkets operating across the city meet with him to discuss the removal of 6.5% strength cheap ciders and lagers from sale.

Public engagement on the issue of MUP will be required to create a favourable political environment to support the introduction of MUP. A recent “expert think-tank” meeting identified the need to have a consistent shared GP message relating to the benefits of introducing a MUP as a key requirement moving forward in convincing communities of the need for the removal of cheap, high strength alcohol.

International evidence suggests that making it more difficult 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 another effective way of reducing alcohol-related harm. In Scotland, protection of the public’s health is part of the licensing objectives.

Specialist Cumulative Impact Policy 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. Since 2010 LCC have introduced SCIPs in four areas of the city:

1. Allerton Road (L18)
2. Lark Lane (L17)
3. Cavern Quarter and Ropewalks area of city centre
4. Specified streets in Kensington, Central and Fairfield electoral wards

The Liverpool Alcohol and Tobacco Unit (ATU) are commissioned by Public Health to support reductions in the illegal importation and distribution of alcohol and tobacco products by working with key agencies such as HM Revenues and Customers, Merseyside Police, Immigration Department and the Department of Work and Pensions.

Through the ATU’s investigatory powers, Liverpool is able to prosecute any person concerned in the sale or supply of alcohol or tobacco products to any child. During 2010/11
– 2012/13 there were 239 test purchases carried out using under age volunteers, of those 65 (27%) resulted in an underage sale. These premises will have subsequently taken through the necessary legislative pathway in an effort to reduce underage drinking.

Public Health Liverpool (PHL) commission a programme of capacity-building in Alcohol Intervention and Brief Advice. This has resulted in the comprehensive training of a range of organisations, including primary care, social care, probation, acute hospital staff and children’s centres. Over the past 4 years 1658 frontline workers have received Alcohol IBA training. Additionally a focus has been given over the past 12 months to the need for those trained to use their developed skills in a routine way thus providing sustainability within the City. The ‘Sustainability Programme’ has seen 41 individuals attending post-alcohol IBA workshops, 37 individuals trained to become Alcohol Workplace Co-Ordinator Champions, and over 1000 previously trained stakeholders taking receipt of 3 “e” nudges (providing an IBA update and prompt for individual action).

The Preventing Alcohol Harm in Liverpool & Knowsley (PREVAIL) ADD IN REFERENCE Project has sought to estimate the prevalence of early liver disease via screening using conventional alcohol markers and new diagnostic tests that detect fibrosis of the liver. This entailed collection of clinical data (heights, waist circumference, weight, blood pressure) and 20ml blood sample (for Liver Function Tests and fibrosis). The work indicated those who were overweight were more likely to show signs of liver damage indicating it could be beneficial to address these two health concerns simultaneously.

Over 2013/14 a total of 362 young people aged 17 years and under were supported in specialist substance misuses support. The type of support provided further to completion of individual comprehensive assessment ranges from brief intervention and motivational enhanced therapy through to solution focused and cognitive behavioural therapy. Referrals were received from a wide range of services that deal with young people including: schools, youth offending service CAMHS, Targeted Youth Support, Children’s Homes etc.

Despite IBA training in primary care, it would appear that relatively few extended brief intervention are taking place – figures show that a mean of 35% of GP patients have been asked about their alcohol consumption – suggesting that a smaller amount would have then
gone on to receive an extended brief intervention. Options currently being considered are how Pharmacists and Health Trainers can be utilised to deliver EBIs.

Between August 2011 and November 2013 there were 9242 referrals to Liverpool Community Alcohol Services, of which 33.1% were offered an appointment (3058). Direct GP referrals accounted for 21.7% (2004) of total referrals, whilst urgent referrals flagged accounted for 6.1% of total referrals made

The numbers accessing treatment services in Liverpool are broken down by Public Health England as per below:

- 1487 in structured treatment (Tier 3/4) in the 12 months to December 2013, this equates to a crude rate of 4.60 per 1,000, with an average rate for Cheshire and Merseyside of 4.96 per 1,000.
- Of those 1,487 in structured treatment, 57% successfully completed treatment, compared to 55% at Cheshire and Merseyside level.
- The majority of those in structured treatment were male (58%), with 14.5% aged under 25 years, compared to an average of 7.1% at the Cheshire and Merseyside level.
- There were 22% of those in structured treatment with a secondary substance problem. With Cocaine (36%) and Cannabis (46%) representing the majority of secondary substance abuse.
- Whilst 38% of those in structured treatment stated alcohol as a secondary or tertiary problematic substance, the highest rate in Cheshire and Merseyside.
- During 2011/12 there were 2,223 individuals aged 15-64 years receiving non-structured interventions (Tier 2) in Liverpool. This equates to a crude rate of 6.56 per 1,000, compared to a Cheshire and Merseyside rate of 9.09 per 1,000.
- Again this population was predominantly male (64%).

Consultation with providers of alcohol services in Liverpool was carried out in three stages throughout the HNA proves. The common themes identified included:

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20 PHE (2013) NDTMS
Poly users – it was felt there were perceived gaps in the system for those with secondary and tertiary substance misuse problems, which could lead to individuals falling through these gaps in accessing support.

Chaotic users outside of city centre were also felt to be under-served by provision.

Dual diagnosis was regularly cited as being problematic, and frustratingly so, as it was a long-standing concern.

Inflexibility in referral criteria for some provision was felt to result in unmet need.

Criteria for attending ATR programme.

Waiting times for detoxification services.

Lack of recovery and after-care support.

Need for multi-agency training (mental health, alcohol and drugs).

Consultation with stakeholders at Merseyside Police highlighted the additional burden that the misuse of alcohol has upon already stretched Police resources. Feedback from the Chief Inspector for Operations described how the main issues for policing and alcohol involved:

Street drinking – particularly in city centre.

Night Time Economy Violence.

Domestic violence.

Alcohol combined with cocaine use leading to violence.
Introduction

A HNA is a systematic method for reviewing the health issues facing a population. A HNA should lead to agreed priorities and resource allocation that will improve health and reduce inequalities.

The aims of the alcohol HNA are to:

- Systematically examine the harm caused by alcohol in Liverpool within different population groups and settings
- Use best available evidence to develop a three year alcohol strategy for Liverpool based upon population need.

The objectives of the alcohol HNA are to:

- Analyse data from available sources relevant to alcohol misuse in Liverpool.
- Describe the scale and consequences of alcohol misuse in Liverpool
- Describe current provision and analyse its cost-effectiveness
- Identify gaps in provision and what we know about alcohol related harm using intelligence and stakeholder views
- Make recommendations to inform future policy and cost-effective commissioning decisions
Background to Alcohol Misuse

Alcohol causes major health problems—more people are dying from alcohol related causes than from breast cancer, cervical cancer, and infection with methicillin resistant Staphylococcus aureus combined. A report from the World Cancer Research Fund confirmed that even drinking alcohol within so called “safe limits” increases the risk of cancer of the breast and upper gastrointestinal tract.

The cultural and sociological factors that determine our patterns of drinking may date back thousands of years and in analysing what interventions are likely to reverse these factors one may look to a similar debate over tobacco control and the effect of passive smoking, yet damage to third parties from exposure to alcohol misuse is far greater. Drinking alcohol is a factor in more than half of violent crimes and a third of domestic violence.

Whilst consumption of alcohol is widespread, national and local research suggests that knowledge of recommended guidelines re safe levels of consumption is low. Current guidelines categorise those drinking above recommended guidelines as at:

- **Increasing risk (previously hazardous) drinkers**:
  - Men who regularly drink more than 3 to 4 units a day but less than the higher risk levels
  - Women who regularly drink more than 2 to 3 units a day but less than the higher risk levels

- **Higher risk (or harmful) drinkers** (who have a high risk of alcohol-related illness) are defined as:
  - Men who regularly drink more than 8 units a day or more than 50 units of alcohol per week
  - Women who regularly drink more than 6 units a day or more than 35 units of alcohol per week

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23 House of Commons Science and Technology Committee (2012) Alcohol Guidelines
24 Liverpool PCT (2012) Fewer Units Campaign
- Alcohol dependence is defined by:
  - Craving, tolerance, and a preoccupation with alcohol and continued drinking in spite of harmful consequences.\(^{25}\)

Alcohol is now 45% more affordable than it was in 1980\(^{26}\) and it is estimated that its misuse costs England approximately £21bn per year in healthcare, crime and lost productivity\(^{27}\). It is estimated that 2.6 million children in the UK are living with parents who are drinking at increasing or higher risk and 705,000 are living with dependent drinkers\(^{28}\).

Alcohol is a causal factor in more than 60 medical conditions, including: mouth, throat, stomach, liver and breast cancers; high blood pressure, cirrhosis of the liver; and depression\(^{29}\). Alcohol misuse contributes to health inequality; nationally the alcohol-related mortality rate of men in the most disadvantaged socio-economic class is 3.5 times higher than for men in the least disadvantaged class, while for women the figure is 5.7 times\(^{30}\).

The relationship between alcohol consumption and socio-economic status is complex, with the adverse effects of alcohol being more pronounced in those in lower socio-economic groups\(^{31}\). 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 impact. Analysis within Liverpool itself suggests that there is a strong correlation 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.

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\(^{25}\) NICE (2011) Alcohol Use Disorders: Diagnosis, Assessment and Management of harmful drinking and dependence
\(^{26}\) Statistics on Alcohol: England 2012, NHS Information Centre
The most effective strategies to reduce alcohol-related harm from a public health perspective are those that operate at a macro-level and include minimum unit pricing; restrictions on the physical availability and promotion of alcohol. Other less effective interventions include drink-driving counter measures, brief interventions with at-risk drinkers, and the treatment of drinkers with alcohol dependence.\textsuperscript{32}

\textsuperscript{32} Record, C. and Day, C. (2009) Britain’s alcohol market: How minimum alcohol prices could stop moderate drinkers subsidising those drinking at hazardous and harmful levels, Clinical Medicine, 9(5), pp421-425.
National Strategic Context

National alcohol policy has changed over recent years, which may be partly due to a transfer of responsibility from the Department of Health to the Home Office. The most recent Government Alcohol Strategy\(^3^3\) has much more of an emphasis on curbing alcohol related anti-social behaviour in town centres, than on the detriments to health.

Political challenge lies in recent moves by the government to enter into voluntary agreements with the drinks industry, especially through its Alcohol Responsibility Deal. The Responsibility Deal has the support of most major drinks producers’ and supermarkets, but support from the six major public health bodies involved in discussions towards the Deal was withdrawn shortly before it was launched. In July 2010 a House of Lords Committee questioned whether the Responsibility Deal was based on a robust model of behaviour change\(^3^4\).

The current government appears to be placing more of a focus and responsibility upon the individual to make healthy choices, advocating theories such as ‘nudge’ and individual responsibility. Whilst this approach can be successful to a point, it assumes that behaviour is not influenced by environmental conditions which are outside of individual control, such as poverty and unemployment - it also runs the danger of creating a culture of blame, whereby society can relinquish its responsibilities to those who do not conform to health messages.

The previous government attempted to minimise harms caused by poor practice in ‘on trade’ premises such as bars and nightclubs. A mandatory code of practice for alcohol retailers came into force in 2010\(^3^5\), banning irresponsible alcohol promotions and competitions, obliging retailers to provide free drinking water, compelling retailers to offer smaller measures and requiring them to have proof of age policies. This approach appears to have done little to reduce levels of consumption in the population, as it does not apply to the off-licensed trade and so does not affect drinking practices outside of bars and clubs.

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\(^3^5\)
‘Safe, Sensible, Social’\(^{36}\) recommended next steps in the National Alcohol Strategy since the publication of the Alcohol Harm Reduction Strategy for England\(^{37}\) and outlined further national and local action to achieve long-term reductions in alcohol-related ill health and crime.

Other national work included The Alcohol Needs Assessment Research Project\(^{38}\) (2005) which was commissioned by the Department of Health; its main focus was to measure the gap between the demand for, and provision of specialist alcohol treatment services in England. Models of Care for Alcohol Misusers\(^ {39}\) provided best practice guidance for local health organisations and their partners in delivering a planned and integrated local treatment system for adult alcohol misusers. The guidance focuses on the principles of commissioning local treatment systems based on a four-tiered framework of provision as well as local systems for screening and assessment:

- **Tier 1** interventions include provision of: identification of hazardous, harmful and dependent drinkers; information on sensible drinking; simple brief interventions to reduce alcohol-related harm; and referral of those with alcohol dependence or harm for more intensive interventions.

- **Tier 2** interventions include provision of open access facilities and outreach that provide: alcohol-specific advice, information and support; extended brief interventions to help alcohol misusers reduce alcohol-related harm; and assessment and referral of those with more serious alcohol-related problems for care-planned treatment.

- **Tier 3** interventions include provision of community-based specialised alcohol misuse assessment, and alcohol treatment that is care co-ordinated and care-planned.

- **Tier 4** interventions include provision of residential, specialised alcohol treatments which are care-planned and co-ordinated to ensure continuity of care and aftercare.

In relation to children and young people, the last ten years have seen substantial progress in recognising and supporting children affected by parental substance misuse generally.

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\(^{36}\) DoH (20004) Alcohol Needs Assessment Research Project

\(^{37}\) Prime Minister’s Strategy Unit (2004) Alcohol Harm Reduction Strategy

\(^{38}\) Home Office (2010) Mandatory Code of Practice for Alcohol Retailers

\(^{39}\) DoH (2006) Models of Care for Alcohol Misusers
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 child 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 £448million over three years): Attention has also been placed on learning from serious case reviews, including those 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 are often not known to, or engaged with, services.

From a research and a children’s rights perspective, the voice of children experiencing parental alcohol misuse – in research and in policy development – tends to be the voice of those already receiving services, with the vast ‘hidden’ majority of children experiencing parental alcohol misuse still without a voice. Second, despite its greater prevalence, far less attention has been given to parental alcohol misuse, an issue that has often been subsumed within the wider drugs agenda. Despite a recommendation in the Hidden Harm progress report\(^{40}\) (that children affected by parental alcohol misuse needed to be given specific attention, there has as yet been no Hidden Harm equivalent for alcohol. Given the common co-existence of alcohol with other problems such as domestic violence or mental health problems, opportunities have been missed for different areas of policy to work together to consider the best integrated response to children (and families) where there is parental alcohol (or drug) misuse.

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\(^{40}\) Advisory Council on the Misuse of Drugs (2007) Hidden Harm – Three Years On, Realities, Challenges and Opportunities
Liverpool Demographic Profile

Figures for 2012 show there are an estimated 469,700 people living in Liverpool. While this is substantially down from the 517,000 living in the city in 1981, it represents a marked increase from the low point seen in 2001. Since that time the number of people in the city has increased by 6.3%.

![Liverpool resident population trends 1981 onwards](image)

**Figures 1 and 2: Liverpool Population Trends & Structure, 2012**

*Source: ONS Mid-Year Resident Population Estimates*

Figure 2 shows the current population structure in the city for both males and females. It clearly demonstrates the large student population within the city, with over 11% of people in Liverpool aged between 20 and 24 years old. The relatively large population of children and young adults in the city is reflected in the average age of its residents. At the time of the 2011 Census, the median (average) age in Liverpool was 35 years, compared to 39 years for England.

While the city has a relatively young population, the Office for National Statistics (ONS) project a substantial increase in the number of children and older people in Liverpool over the coming decade.
Figure 3 clearly illustrates the fall in those of working age and a rise in the older population. This will have an impact of what is described as the ‘old age dependency ratio’. This measures the number of people of State Pension Age and over for every 1,000 people of working age. This has implications in terms of increasing prevalence of dementia, but also the ability to meet the needs of those living with dementia, compounded by the decline in the working age population that would ordinarily provide care and economically support the ageing population.

By 2021, it is estimated that the number of people aged over 65 in Liverpool will increase by just over 9%, about 73,500 people. There will be particularly large increases in the number of people aged between 70 and 75, with that population group increasing by more than a fifth.

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 top 5 ethnic minority groups in Liverpool are:
Between the 2001 and 2011 Census, the largest increase has been seen among the White Other group, followed by Black African and Indian. The change in numbers and age profile of these groups will impact on the need to provide culturally sensitive care for particular ethnic groups, with dementia likely to become a more significant problem as these populations age.

**Life Expectancy**

Life expectancy at birth is used as an overarching measure of the health of the population. Figures 6-9 below show how there has been a steady increase in life expectancy in Liverpool, with males expected to live 3.6 years longer than they were in 1995-97 and females 2.3 years longer. Data for 2008-10 show that Liverpool has the second lowest life expectancy of the eight core cities in England, slightly above Manchester.

**Figures 4 to 7: Life Expectancy at Birth in Liverpool, 2010-12**

The gap in life expectancy between Liverpool and England for men has narrowed by 8.8% since 1995-97, while remaining stable for females. Encouragingly, the gap between males
and females within the city has narrowed substantially over the period, from 5.7 years in 1995-97 to 4.1 years in 2010-12 – a reduction of 28%.

**Healthy Life Expectancy**

Healthy life expectancy is often described as a measure of not just whether years are being added to life, but whether life is being added to years i.e. are people living healthier as well as longer lives. Work carried out by the Office for National Statistics suggest that while females in Liverpool live longer than their male counterparts, this does not translate into years of good health, with healthy life expectancy for both standing at around 58 years.

While there is a significant gap in overall life expectancy between Liverpool and England for both males and females, the gap increases further when looking at the number of years lived in good health. Nationally, males live an additional 5 years in good health when compared to Liverpool, with females living an additional 5.9 years. This burden of ill health within the city has significant implications in terms of demand for health and social care services.

*Figures 8 & 9: Healthy Life Expectancy by Core City, 2009-11*

**Main Causes of Death**

Figure 10 illustrates the main causes of death in Liverpool in 2011. Figures show that around 3 in every 4 deaths were due to Cancer, Circulatory Diseases or Respiratory Diseases – consistent with national patterns. Dementia deaths represented 292 (6.9%) of the total 4,232 deaths in Liverpool.
Figure 10: Main Causes of Death in Liverpool, 2011.
Deprivation

The English Indices of Deprivation 2010 (IMD 2010) combine a range of economic, social and housing indicators to provide the most up to date and comprehensive picture of deprivation in England. They provide a measure of relative deprivation, i.e. they measure the position of areas against each other. Results show that Liverpool remains the most deprived local authority in the country, with its position unchanged from the 2004 and 2007 indices (Figure 11).

<table>
<thead>
<tr>
<th>City</th>
<th>Rank of Average Score</th>
<th>Average Rank</th>
<th>Extent</th>
<th>Local Concentration</th>
<th>Income</th>
<th>Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIVERPOOL</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Manchester</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>8</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Birmingham</td>
<td>9</td>
<td>13</td>
<td>10</td>
<td>20</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Nottingham</td>
<td>20</td>
<td>17</td>
<td>17</td>
<td>35</td>
<td>17</td>
<td>13</td>
</tr>
<tr>
<td>Newcastle</td>
<td>40</td>
<td>66</td>
<td>35</td>
<td>15</td>
<td>29</td>
<td>20</td>
</tr>
<tr>
<td>Sheffield</td>
<td>56</td>
<td>84</td>
<td>48</td>
<td>33</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Leeds</td>
<td>68</td>
<td>97</td>
<td>59</td>
<td>44</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Bristol</td>
<td>79</td>
<td>93</td>
<td>73</td>
<td>57</td>
<td>14</td>
<td>9</td>
</tr>
</tbody>
</table>

Note: 1 = most deprived, 326 = least deprived

Figure 11: Indices of Deprivation, 2010

Levels of deprivation within Liverpool are particularly high in the north of the city, where virtually all of the neighbourhoods are ranked in the most deprived one or ten per cent nationally. The map below shows that large areas of Everton, Anfield and Kirkdale are particularly deprived. This concentration of high deprivation also encircles the City Centre; this “inner core” area goes from Everton in the north through Kensington and on to Princes Park and Riverside to the south of the City Centre. Outside of the inner core, Speke Garston, Croxteth and Norris Green also have some of the highest levels of deprivation in the country. (Map 1)
<table>
<thead>
<tr>
<th>Key</th>
<th>Most Deprived Nationally</th>
<th>Count</th>
<th>Percentage</th>
<th>Cumulative Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-1%</td>
<td></td>
<td>42</td>
<td>14.4%</td>
<td>14.4%</td>
</tr>
<tr>
<td>1-5%</td>
<td></td>
<td>73</td>
<td>25.1%</td>
<td>39.9%</td>
</tr>
<tr>
<td>5-10%</td>
<td></td>
<td>33</td>
<td>11.3%</td>
<td>50.9%</td>
</tr>
<tr>
<td>10-20%</td>
<td></td>
<td>43</td>
<td>14.8%</td>
<td>65.6%</td>
</tr>
<tr>
<td>20-50%</td>
<td></td>
<td>60</td>
<td>20.6%</td>
<td>86.3%</td>
</tr>
<tr>
<td>50%+</td>
<td></td>
<td>40</td>
<td>13.7%</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Income & Poverty**

Low income and poverty are significant public health issues, impacting on both physical and mental health. Household income in Liverpool during 2012 was the second lowest of the eight core cities in England. Furthermore, household income in Liverpool fell by over £700 between 2011 and 2012, whereas many of the other core cities saw an increase.

![Figure 12: Median Household Income by Core City, 2012](image)

Research by the Institute of Fiscal Studies has shown the median household incomes in the UK fell in 2010-11 by over 3%, the largest one year fall since 1981. The reduction set average living standards back to below levels since in 2004-5. People are thought to live in relative poverty when their household income is less than 60% of contemporary median household income i.e. £17,279. Data from Consumer classification firm - CACI suggests that almost 40% of Liverpool households can be considered to be living at or close to the poverty line, with an income of less than £17,279. This measure does not take into account the number of people living in that household being supported by that income, therefore the higher the number of people in that household then the lower the standard of living. (Figure 13).
Figure 13: Household Income Distribution in Liverpool, 2012
The economic cost of alcohol consumption is generally measured by harm to the individual and harm to wider society. This may involve calculating factors such as the treatment and prevention of disease, injury and premature death in the healthcare sector, the loss of productivity and earnings through illness, the demand for welfare support and the policing of criminal and antisocial behaviour, all caused by alcohol misuse.

The lack of a definitive set of 'costs' criteria means that there is no single figure representing the cost of alcohol consumption to the UK. The now defunct Government Cabinet Office Strategy Unit attempted to capture a comprehensive list of these harms (and benefits) in a cost-benefit diagram (Figure 14). The diagram key shows those costs which were considered (and those which were not) in the final calculations. The Government decided not to include private costs in the final estimates of the costs of alcohol-related harm, as they 'do not generally justify government action because individuals are assumed to take into account both the private benefits and costs of an activity when making decisions to undertake this activity'.

---

Figure 14

Source: Cabinet Office
A report produced by Public Health England\textsuperscript{42} suggests that in 2011/12 alcohol misuse in England is 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 and families affected by alcohol misuse. These costs were further broken down to each local authority: The report estimates that alcohol misuse costs Liverpool a total of nearly £204 million per year, this equates to £203.97 per head of population. Liverpool ranked 20\textsuperscript{th} highest out of 326 Local Authorities nationally. Figure 15 below gives a breakdown of these costs by organisation:

- NHS: £45.35m
- CRIME AND LICENSING: £73.00m
- WORKPLACE: £71.34m
- SOCIAL SERVICES: £16.80m
- TOTAL COST+: £203.97m

\textit{Total cost excludes crime related healthcare costs to avoid double counting}

![Pie chart showing breakdown of costs by organisation]

\textit{Figure 15}

\textit{Source: PHE (2013) The Cost of Alcohol to Liverpool Local Authority in 2011/12}

\textsuperscript{42} PHE (2013) The Cost of Alcohol in Liverpool Local Authority 2011/12
Alcohol & Behaviours

Analysis carried out by Liverpool John Moores University\textsuperscript{43} found that the discrepancy between alcohol surveys calculating consumption and actual alcohol sales equals 430 million units a week. This is the equivalent of a bottle of wine per adult drinker per week going unaccounted for in the UK. Consumption estimates based on retail sales data in Great Britain indicate that the volume of pure alcohol sold per adult increased by 16% between 1994 and 2005, a result of off-trade sales (i.e. alcohol sold for consumption off the premises, including supermarkets and other off-licenses) increasing at a faster rate than declining on-trade sales (i.e. alcohol sold for consumption on the premises including pubs, clubs and restaurants)\textsuperscript{44}

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. The proportion that drink at least once a week grows with age, ranging from a low of 60% of 18-24 year olds to a high of 76% among those aged 55 and over.

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%)

\textsuperscript{43} LJMU (2009) Off Measure: How we underestimate the amount we drink
- 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\(^45\) breaks down estimates of alcohol consumption by drinking categories, with estimates of Liverpool population numbers illustrated in Table 2 below:

<table>
<thead>
<tr>
<th>Drinking Category</th>
<th>Population Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increasing Risk Drinkers</td>
<td>82,433</td>
</tr>
<tr>
<td>Higher Risk Drinkers</td>
<td>29,502</td>
</tr>
<tr>
<td>Dependent Drinkers</td>
<td>20,292</td>
</tr>
<tr>
<td>Binge Drinkers</td>
<td>97,934</td>
</tr>
</tbody>
</table>

*Table 2: Numbers of Drinkers by Consumption Levels.*

*Source: DoH (2011) Alcohol Ready Reckoner*

**Social Marketing**

Local insight work was conducted in 2012 speaking to people who drank harmful amounts exploring attitudes, behaviours, motivations, barriers and beliefs around harmful drinking,

and engagement with local health services. The insight consisted of hour long in-depth interviews and found that heavy drinkers in the city could be categorised into four segments:

<table>
<thead>
<tr>
<th>Population Group</th>
<th>Characteristics</th>
</tr>
</thead>
</table>
| **Chardonnay social-lites** | 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** | 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.* |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ritual relaxers</strong></td>
<td>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</td>
</tr>
</tbody>
</table>


- at the end of the day. They drink throughout the week as a way to unwind and relax. Like chardonnay social-lites, 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’.*

| Drinker in denials          | 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.*

Using this insight Liverpool has developed and delivered social marketing programmes to influence responsible drinking behaviours. A brand ‘*Fewer Units = More Happy Hours*’ has been established to promote sensible drinking, used most recently within the Alcohol Concern ‘*Drier January*’ 2014 programme.

A dedicated website[^46] providing access to a range of free alcohol resources (i.e. Sensible Drinking, Alcohol & Calories, Unit Calculators, and Drinking Diaries etc.) was established alongside the development of an extensive multi-media campaign and provision of alcohol themed workshops. The programme aimed to encourage an incremental reduction in

[^46]: [www.fewerunits.co.uk](http://www.fewerunits.co.uk)
alcohol consumption levels throughout the month with a clear message that small reductions in levels of alcohol consumed, can have a positive impact on an individual’s health and well-being.

**Alcohol and Health**

**Months of Life Lost**

Alcohol is a significant contributor to poor health within Liverpool. This is clearly illustrated using data depicting months of life lost due to alcohol misuse. The data reflects the level of chronic heavy drinking in the population and is most likely to be found in higher-risk drinkers and dependent drinkers. Figure 16 and 17 below benchmark months of life lost due to alcohol related harm in Liverpool for males and females aged less than 75 years against other Core Cities and neighbouring Local Authorities. Between 2008 and 2010 Liverpool males lost 13.5 months of life due to alcohol harm, this compares to 11.5 months at North West level and 9.1 months in England. Liverpool was ranked 16th out of 326 Local Authorities (LAs) in England where one is the highest number of months of life lost and 326 the lowest. During the same time period Liverpool females lost 6.9 months of life as a result of alcohol related harm, this compares to 5.8 months in the North West and 4.2 months in England.

*Table 16 and 17: Months of Life Lost by Those Aged Less Than 75 Years (Males and Females) 2008-2010*

*Source: Local Alcohol Profiles for England: NWPHO*
Figures 18 and 19 below illustrate the trends in months of life lost due to alcohol for males and females, and whilst the trend for Liverpool males and females are declining, the rate of decline remains above North West (NW) and England trends.

![Figure 18 and 19: Trends in Months of Life Lost (Females and Males) 2008-2010](image)

*Source: Local Alcohol Profiles for England*

**Alcohol Mortality**

Deaths related to alcohol are divided into two categories; alcohol specific and alcohol related mortality. Broadly speaking alcohol attributable deaths make up around 3% of all deaths. Of these, about a third are alcohol specific deaths – e.g. from alcohol poisoning, alcoholic liver disease, alcoholic pancreatitis. The remaining alcohol-attributable deaths are from conditions partially attributed to alcohol, roughly two thirds of which are from chronic conditions such as haemorrhagic stroke, cardiac arrhythmias, malignant neoplasm of oesophagus, with the remainder caused by acute consequences such as road traffic accidents or intentional self-harm.

**Alcohol Specific Mortality**

Liverpool alcohol specific mortality data for 2008 to 2010 was analysed by gender. Results indicate that the male directly standardised rate (DSR) of 25.5 per 100,000 significantly above the national rate of 13.2 per 100,000 (p<0.05) but encouragingly there was a fall of -8.5% in the Liverpool rate compared to the previous year. With Liverpool now ranked 9th worst of the 326 LAs, compared to 4th worst the previous year (Figure X). The female DSR
was 12.1 per 100,000 for the same time period; this was a fall of -12.9% compared to the previous year. In the five year period between 2004-06 and 2008-10 there was a fall of -21.4% in the Liverpool rate, with Liverpool was ranked 12 highest out of 326 LAs nationally (Figure 20).

![Figure 20: Alcohol Specific Mortality 2008-2010 (Males and Females)](image)

**Source:** Local Alcohol Profiles for England, North West Public Health Observatory/Healthcare Public Health

When alcohol-specific mortality was pooled (2008-2012) and analysed at electoral ward level no wards had mortality rates which were significantly higher than the Liverpool average whilst rates in Church, Childwall, Mossley Hill and Wavertree wards were significantly lower. There were 18 out of 30 (60%) of wards showing an improvement in mortality rates on the previous year (Figure 21). In the five year period 2008-12 there were 414 alcohol-specific deaths, 66% of which were among males and 95% of all alcohol-specific deaths occur among persons aged under 75 years. Analysis shows that 86% of all alcohol-specific deaths have Alcoholic Liver Disease recorded as the underlying cause of death and 10 alcohol-specific deaths occurred in persons under 30 years of age, a further 38 deaths occurred in persons aged 30-39 years and 118 deaths occurred in persons aged 40-49 years.
Figure 21: Directly Age Standardised Mortality Rates per 100,000 population due to Alcohol-specific conditions, all ages, 2008-12 (Pooled) by Liverpool Ward of Residence

Map 2 below illustrates the ‘density’ of alcohol specific mortality at electoral ward level. It clearly depicts higher levels of alcohol specific mortality in the North of Liverpool.
Chronic Liver Disease

Harmful drinking is a major risk factor for chronic liver disease. Rates of mortality due to chronic liver disease in the city have fallen in recent years and are currently at their lowest since 2007. However, Liverpool continues to have significantly higher death rates than nationally and regionally. The city is currently ranked 7th highest nationally for its male chronic liver disease mortality and 10th highest in the country for its female chronic liver disease mortality. The city has the 2nd highest rates for chronic liver disease mortality in males and females among the core cities and the 2nd highest among local authorities on Merseyside (figures 22 and 23).

Figure 22 and 23: Directly Age Standardised Mortality Rates per 100,000 population from Chronic Liver Disease: Males & Females, all ages, 2008-10 (Pooled) Source: LAPE
**Alcohol-Attributable Mortality**

In 2010 males in Liverpool had an alcohol-attributable mortality rate of 58.6 per 100,000. This compares to a NW rate of 43.4 per 100,000 and an England rate of 35.5 per 100,000. The Liverpool rate was a fall of -4.7% compared to the previous year. In the five year period between 2006 and 2010 there was a fall of -6.6% in the Liverpool rate. In 2010 Liverpool was ranked 6 highest out of 326 LAs nationally (Table 3).

During the same time period Liverpool females had an alcohol-attributable mortality rate of 26.2 per 100,000, this compares to a NW rate of 19.0 per 100,000 and an England rate of 14.7 per 100,000. This was a fall of -3.4% in the Liverpool rate compared to the previous year. In the five year period between 2006 and 2010 there was a fall of -16.8% in the Liverpool rate. In 2010 Liverpool was ranked 26 highest out of 326 LAs nationally (Table 4).

<table>
<thead>
<tr>
<th>Year</th>
<th>Directly age standardised male rate per 100,000</th>
<th>+/- Annual Per cent Change</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Liverpool</td>
<td>North West</td>
<td>England</td>
</tr>
<tr>
<td>2006</td>
<td>62.78</td>
<td>45.68</td>
<td>37.43</td>
</tr>
<tr>
<td>2007</td>
<td>68.74</td>
<td>47.32</td>
<td>36.13</td>
</tr>
<tr>
<td>2008</td>
<td>51.02</td>
<td>46.36</td>
<td>37.11</td>
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<tr>
<td>2009</td>
<td>61.48</td>
<td>45.73</td>
<td>35.86</td>
</tr>
<tr>
<td>2010</td>
<td>58.62</td>
<td>43.42</td>
<td>35.48</td>
</tr>
</tbody>
</table>

*Table 3: Alcohol-Attributable Male DSR (2010)*

*Source: Local Alcohol Profiles for England, North West Public Health Observatory/Healthcare Public Health*

<table>
<thead>
<tr>
<th>Year</th>
<th>Directly age standardised rate per 100,000</th>
<th>+/- Annual Per cent Change</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Liverpool</td>
<td>North West</td>
<td>England</td>
</tr>
<tr>
<td>2006</td>
<td>25.44</td>
<td>20.54</td>
<td>15.52</td>
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<tr>
<td>2007</td>
<td>25.00</td>
<td>20.11</td>
<td>15.18</td>
</tr>
<tr>
<td>2008</td>
<td>28.80</td>
<td>20.58</td>
<td>15.28</td>
</tr>
<tr>
<td>2009</td>
<td>21.90</td>
<td>19.57</td>
<td>14.87</td>
</tr>
<tr>
<td>2010</td>
<td>21.16</td>
<td>19.02</td>
<td>14.70</td>
</tr>
</tbody>
</table>

*Table 4: Alcohol-Attributable Female DSR (2010)*

*Source: Local Alcohol Profiles for England, North West Public Health Observatory/Healthcare Public Health*
Alcohol and Hospital Admissions

New Local Alcohol Profiles for England (LAPE 2014) were released on 29th April 2014, following the release of this health needs assessment. Data within the profiles have been calculated using new alcohol-attributable fractions and a new standard population (the European Standard Population 2013). Information contained within this needs assessment is correct at time of publication, but will need to be reviewed in light of these national changes.

1. Alcohol Specific Admissions

In 2010/11 the DSR per 100,000 for male alcohol specific admissions was 1,071.7 per 100,000. This was a fall of -1% in the Liverpool rate compared to the previous year. In the five year period between 2006/07 and 2010/11 there was a fall of 0.5% in the Liverpool rate. In 2010/11 Liverpool was ranked 2 highest out of 326 LAs nationally (Figure 24 and 25).

Figure 24 and 25: Trends in Directly Age Standardised Rates per 100,000 population for admissions to hospital with alcohol specific conditions: Males, all ages, 2006/07-2010/11 Source: LAPE
In 2010/11 the DSR per 100,000 for female alcohol specific admissions was 535.8 per 100,000. This was a fall of 3.6% in the Liverpool rate compared to the previous year. In the five year period between 2006/07 and 2010/11 there was an increase of 18.4% in the Liverpool rate. In 2010/11 Liverpool was ranked 3 highest out of 326 LAs nationally (Figure 26 and 27).

Figure 26 and 27: Trends in Directly Age Standardised Rates per 100,000 population for admissions to hospital with alcohol specific conditions: Females, all ages, 2006/07-2010/11 Source: LAPE

Examining trends by CCG locality there was a reduction in rates of admission between 2011/12 and 2012/13 across all localities with the exception of Matchworks which saw a 7% increase (3% among males and 15% among females). Over the same period, the greatest reduction was seen in North (a fall of 6%). Comparing rates of admission in the latest quarter 2013/14 Quarter 2 to the same 12 month rolling period in 2012/13, there has been a reduction across all localities and by 11% for Liverpool overall.

Trends in alcohol specific admissions by electoral ward are illustrated in Map 3 below. Those wards with the highest rates of admissions include:

- Kirkdale
- Everton
- Central
- Princes Park
- Tuebrook and Stoneycroft
Alcohol specific admission rates per 100,000 European Standard Population 2012/13 by Liverpool ward

Map 3: Alcohol Specific Admission Rates per 100,000 2012/13 by Liverpool Ward
Source: Public Health Liverpool
2. Alcohol-Attributable Admissions

The rate of admission in 2012/13 (provisional) in Liverpool was 2939.7 per 100,000 population, a fall of -2% on 2011/12 and was ranked 7th highest out of 326 local authorities in England. Encouragingly the Liverpool rate has fallen for the second consecutive year. Liverpool has the second highest rate of admission among its benchmarking peers the Core Cities, and the highest rate among local authorities on Merseyside (figures 28 and 29).

![Figure 28 and 29: Trends in Directly Age Standardised Rates per 100,000 population for admissions to hospital with alcohol related conditions: Persons, all ages, 2002/03 – 2012/13](source: LAPE)

**Males**

In 2010/11 there was a fall of 0.4% in the alcohol-attributable admission rate for males compared to the previous year. In the five year period between 2006/07 and 2010/11 there was an increase of 8.4% in the Liverpool rate. In 2010/11 Liverpool was ranked 2 highest out of 326 LAs nationally (Figures 30 and 31).

![Figure 30 and 31](source: LAPE)
Figure 30 and 31: Trends in Directly Age Standardised Rates per 100,000 population for admissions to hospital with alcohol attributable conditions: Males, all ages, 2006/07 – 2010/11
Source: LAPE

Females

In 2010/11 there was a fall of 1.5% in the Liverpool rate compared to the previous year. In the five year period between 2006/07 and 2010/11 there was an increase of 17.5% in the Liverpool rate. In 2010/11 Liverpool was ranked 4 highest out of 326 LAs nationally (Figure 32 and 33).

Figure 32 and 33: Trends in Directly Age Standardised Rates per 100,000 population for admissions to hospital with alcohol attributable conditions: Females, all ages, 2006/07 – 2010/11
Source: LAPE

When alcohol related admissions are analysed by electoral ward the picture is similar to those for alcohol specific conditions, with the same wards experiencing the highest rates. This indicates the high level of disease burden alcohol places upon communities (Map 4).

Examining trends in the number of admissions by CCG locality between 2011/12 and 2012/13, there was a reduction of 6% in North locality, a 2% reduction in Liverpool Central and a 1% increase in Matchworks. Comparing 2013/14 Quarter 2 to the same 12 month rolling period in 2012/13, there has been a reduction in the number of alcohol related admissions across all localities and by 6% for Liverpool overall.
Alcohol related admission rates per 100,000 European Standard Population 2012/13 by Liverpool ward

Date created: 23/01/2014
Liverpool City Council | Millennium House | Victoria Street | Liverpool L1 6DD
Liverpool Public Health Epidemiology Team | Email: sophie.kelly@liverpool.gov.uk
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**Alcohol and Health Inequality**

**Children and Young People**

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

- An estimated 1.5 million people in England and Wales are alcohol dependent
- It is estimated that 30% of children live with an adult binge drinker, 22% with a hazardous drinker and 2.5% with a harmful drinker
- It is estimated that 79,291 babies under 1 year old in England live with a parent who is a problem drinker
- It is estimated that 2% of children (UK, under 16 years) 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
- Child Line (April 2008-March 2009): 4,028 children were concerned about parental alcohol misuse (21% of all callers) – 71% were girls, 60% aged 12-15 years and 20% aged 5-11 years

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

- Approximately 23,400 children are living with adults who are binge drinkers
- Approximately 17,160 children are living with adults who drink at increased risk

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• Approximately 1,950 children 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%) receiving alcohol treatment in Liverpool lived with children.

The report makes recommendations that require changes to policy, practice and research agendas, at both national and local level. These include:

• That Government and local policy makers give as much attention to alcohol misuse as to drug misuse within policy programmes on parental substance misuse, focus alcohol policies on children and families and not just on health and crime issues, and address the problem of parental alcohol misuse directly through family and related policy programmes.

• That Government encourages local service commissioners and providers, including those in health, social care and other related services, to seek to find ways of improving the delivery of services

• That there is greater involvement of children and young people in research, service development and evaluation, this should include:

  o Children’s experience: the specific impact of parental alcohol misuse as distinct from other substance misuse; the impact on groups of children about whom little is known; the impact of different levels and patterns of consumption of alcohol by their families; how children are affected by a combination of parental alcohol misuse and domestic violence.

  o Protective factors and resilience: longitudinal research which looks into how protective factors and processes operate over time.

  o Meeting needs: further evaluative research into how services can benefit children and families; studies into how the response of universal services might be improved.

Whilst it’s certainly true that not all troubled families will experience substance use, and not all families with substance use problems will be ‘troubled’, for many of those defined as 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 Troubled Families Programme. Local commissioning arrangements in this area provide family focused support, with the objective of stopping inter-generational substance misuse.

It was also recognised that the current alcohol strategy, which included an outcome to reduce the impact of alcohol related harm upon children and young people, required additional strengthening. The recognition of this gap in knowledge 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, current understanding of alcohol consumption during pregnancy and the translation of alcohol related evidence into local practice. The findings of this work will assist in developing the future provision of alcohol services for parents and children in the city.

**Hospital Admissions - Children and Young People**

Based upon pooled data for years 2008/09-2010/11 there was a fall of -8.3% in the Liverpool hospital admission rate for those aged under eighteen years compared to the previous year. In the five year period between 2004/05-2006/07 and 2008/09-2010/11 there was a fall of -1.8% in the Liverpool rate. In 2008/09-2010/11 Liverpool was ranked 4 highest out of 326 LAs nationally. Whilst admission rates for those aged under 18 years have declined year on year since 2006/07-2010/11, they remain higher than both North West and England rates (Figure 34).

![Trends in Under 18s admitted to hospital with alcohol specific conditions: Persons, crude rate per 100000 population (2008/09-2010/11)](image)

**LivHIR (2011) Talking About Alcohol.** Accessed at: [www.liv.ac.uk](http://www.liv.ac.uk)
Figure 34: Trends in Directly Age Standardised Rates per 100,000 population for admissions to hospital with alcohol attributable conditions: Females, all ages, 2006/07 – 2010/11 Source: LAPE

When hospital admission rates for Liverpool (2008/09-2010/11) are benchmarked against other Core Cities and geographical neighbours, Liverpool has a statistically significantly higher rate than all Core City comparators, and those of Knowsley and Sefton (p. 0.05) at 135.45 per 100,000 population (Figure 35 and 36). Liverpool’s rate was the 4th highest of all 326 Local Authorities.

<table>
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<th>Local Authority</th>
<th>Number</th>
<th>Crude rate per 100,000 population</th>
<th>Lower 95% CI</th>
<th>Upper 95% CI</th>
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Figure 36: Source: Local Alcohol Profiles for England, North West Public Health Liverpool Observatory/Public Health Liverpool
Figure 36: Directly Age Standardised Rates per 100,000 population for admissions to hospital with alcohol attributable conditions: Females, all ages, 2010/11 Source: LAPE
Young People in Specialist Treatment Services

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 Liverpool rates were lower than national, with those reporting cannabis and alcohol use less than half of the national rate of 34%.

The majority of young people in Liverpool were referred via the Youth Justice system – 62%, compared to 34% nationally, suggesting that alcohol is a significant driver of crime for young people in Liverpool. About 10% of young people in Liverpool re-presented to services within 6 months, compared to 7% nationally.

Young Offenders

A recent report identified drug and alcohol issues as a major health need for young offenders. This was raised by both supporting personnel and the young people themselves. Alcohol was thought to play a part directly – in relation to associated offending behaviour, but also where parents had problems with alcohol misuse. Issues in relation reducing alcohol related harm could also be hampered by young people being placed in accommodation with other young people with drug and alcohol issues. This made it more difficult for young people to not to use alcohol themselves.

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’

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49 PHE (2013) Alcohol and Drugs: JSNA support pack. Key data to support planning for effective young people’s specialist substance misuse interventions.
50 Liverpool Public Health Observatory (2013) Health needs assessment of young offenders in the youth justice system on Merseyside
• 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 coexist 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. The term originated from the USA in the 1980s and more recently has been adopted in the UK. The nature of the relationship between these two conditions is complex and sometimes controversial:

• A primary psychiatric illness may precipitate or lead to substance misuse. Patients may feel anxious, lonely, bored, have difficulty sleeping or may want to 'block out' symptoms or medication side-effects.
• Substance misuse may worsen or alter the path of a psychiatric illness.
• Intoxication and/or substance dependence may lead to psychological symptoms
• Substantive misuse and/or withdrawal may lead to psychiatric symptoms or illness. It may act as a trigger in those who are predisposed.

The co-morbidity study found that community mental health patients reporting harmful alcohol misuse, and patients in substance misuse services who had psychiatric disorders were largely unrecognised as having co-morbidities by their respective services.

A report for the Mental Health Foundation underlines the large overlap between substance misuse and mental health problems, though it points out that mental illness and substance misuse occurring simultaneously affects a smaller proportion of people. The report found that:

• Between a third and half of people with severe mental health problems consume alcohol or other substances to levels that meet criteria for ‘problematic use’
• 51% of alcohol-dependent adults say they have a mental health problem.

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• 44% of people using services of Community Mental Health Teams in four urban centres reported problematic drug or alcohol use in the preceding year.

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). Members of the Mental Health ‘Making it Happen’ Group with lived experience of mental illness confirmed that people with dual diagnosis are treated for mental health issues by one service and alcohol issues by another: they are not treated holistically. They also felt as if they face a double stigma.

The group felt that a single service for people with mental health issues and addiction would be more effective at dealing with the needs of service users, rather than having to be assessed for eligibility for both services separately.

Mersey Care NHS Trust host a thriving dual diagnosis network which meets two to three times a year as a forum to discuss best practice and share case examples. However, it was recognised that the Dual Diagnosis Strategy is out of date and is in the process of being re-developed.

Alcohol-related dementia is often called Korsakoff’s syndrome. It can occur in people who have regularly consumed a large amount of alcohol. Korsakoff’s syndrome is caused by a lack of thiamine (vitamin B1) in the body, which affects the brain and other parts of the nervous system (The Alzheimer’s Society, 2013).

In a comprehensive review of the literature (Smith & Atkinson, 1995) estimated that alcohol was a contributing factor in between 21% and 24% of all people of working age, presenting with dementia. Applying these estimates to people with dementia aged under 65 years it is estimated around 36 people in the city have dementia which is alcohol related and numbers are predicted to increase to 39 people in 2021. As these estimates are based on numbers of patients on the dementia register, true prevalence is likely to be higher due to undiagnosed cases.
Offenders

A report by The Prison Reform Trust\textsuperscript{53} suggested that 75% of all prisoners had a dual diagnosis of mental health and substance misuse, whilst smoking, drinking and drug taking often co-exist. There is high prevalence of alcohol and poly misuse among the prison population; between 12% and 21% have at least four mental disorders simultaneously (including drug and alcohol dependence, personality disorder, neurotic disorder and psychosis); between 35% and 52% are dependent on opiates, stimulants or both; and 20%–30% are severely dependent on alcohol.

Lesbian, Gay, Bi-Sexual, Transgender (LGBT)

A cross-sectional survey in England & Wales\textsuperscript{54} included questions on alcohol intake. This survey reported that lesbian women consumed more alcohol than heterosexual women. The Prescription for Change Scotland report\textsuperscript{55} reported that lesbian and bisexual women in Scotland reported a higher frequency of drinking alcohol: 13% reported drinking on 5 or more days a week, compared with 7% of the general female population.

The Stonewall report on Lesbian, Gay & Bisexual People in Later Life also found that older LGBT people drink alcohol more often than the heterosexual population with 45% drinking on at least 3 or 4 days a week compared to 31% of heterosexual people.

Black, Minority, Ethnic Groups (BME)

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.

Euromonitor International provides research on the alcoholic drinks industry. Data\textsuperscript{56} suggests that Estonians and Lithuanians have rapidly become the world’s dominant drinking populations over the last few years – as measured by overall litres of alcohol consumed per person. Latvia, Finland and Russia are close behind, but consumption rates have plateaued recently. Other ‘heavy-drinking’ countries like Germany and the Czech Republic have stayed steady during the last decade.

**Students**

Liverpool has a large student population having four universities with around 70,000 students. Nationally there has been a fall in average weekly alcohol consumption among young adults. Yet despite an overall decline in recent years, over one in five young men (22%) and one in five young women (17%) are still binge drinking (ONS, 2012). The results of the NHS Merseyside Lifestyle Survey 2012/13 shows a significantly larger proportion of Liverpool men drink above the recommended guidelines compared to Liverpool women (14% compared to 10%).

**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

\textsuperscript{56} http://www.euromonitor.com/alcoholic-drinks
a result of other confounding factors, such as poverty and unemployment, leading to an inability to ‘protect’ against the negative health impact. 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.

**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 that are all related to prenatal exposure to alcohol (i.e. while the baby is still in the womb). As well as the immediate risks to the unborn child such as spontaneous abortion, research shows that parental alcohol misuse can have a considerable negative effect on children, young people and the family.

**Homelessness**

Alcohol dependency is more prevalent among the homeless population especially rough sleepers. Drug and alcohol abuse especially when combined with a mental illness are linked to homelessness as causal risk factors but also as the consequences of being homeless.

During the first 9 months of 2012-13 there were 1,240 people accessing homelessness services in Liverpool, with around 140 people receive support each month. Around a third of those in touch with services were female (36%), with around two thirds male (64%), and figures for the period indicate that almost half of people were under the age of 30, with around 1 in 6 people accessing services were under 20 (Figure 37).
While the majority of people accessing homeless services are White British (78%), the level is lower than the general population (85%). The largest ethnic minority groups over the 9 months were: Black African (3.3%), White Other (2.8%) and Asian Other (2.5%).

The number of known rough sleepers in the city is relatively low. Over the period between January and March 2013, 25 individuals were found to be sleeping out in the city, with the number in any one night much lower. Information from the Whitechapel Centre suggests that the numbers seen out in recent months have remained steady. Those seen out in general tend to be entrenched/long term rough sleepers or individuals who are seen only sporadically and don’t engage. Those who are new to rough sleeping are being picked up via the Hub.

**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

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typically suffer from a wide range of illnesses which are exacerbated by drinking, poor diet and sleeping rough for periods of time\textsuperscript{58}.

There are limited national statistics regarding the number of persistent street drinkers in England and Wales, and information on street drinking is not collected systematically. Estimates suggest that there were between 5,000 and 20,000 persistent street drinkers in England and Wales\textsuperscript{59}. Local work using the Mainstay database suggests that there are in the region of 65 habitual street drinkers in Liverpool at the time of writing.

In 2012 Liverpool City Council, Merseyside Police and NHS Merseyside commissioned a pilot scheme that would test the effectiveness of a ‘wet facility’ in addressing the impact of street drinking in the city centre area. The pilot ran between the 30th August and 28th September 2012, from 10am to 8pm, seven days per week. The facility was situated on a plot of land located at 99 Renshaw Street.

The aim of the wet facility was to provide a designated area where street drinkers could continue to use alcohol, in a controlled and non-criminalising environment. Whilst at the facility, individuals could also be supported to access and engage with both social and health related services. The site was operated by staff and volunteers from ‘The Basement’ and ‘Whitechapel Centre’ – third sector organisations, already involved in supporting the needs of this population.

A total of 191 unique individuals attended the Wet Facility at least once over the duration of the pilot. The mean daily attendance was 27. The majority of users heard about the Wet Facility through word of mouth or through Whitechapel/Basement staff. This highlights the difficulty of communicating appropriate messages to this population through ‘traditional’ vehicles of communication – including the police, print/broadcast media, healthcare sector, alcohol services etc. – these do not appear to be effective in reaching them. It also highlights the ability of certain key local partnerships, such as Whitechapel and Basement, in being able to reach this target demographic.


\textsuperscript{59} Mental Health Foundation, (1996) Too Many for the Road: Report of the MHF Expert Working Group on Persistent Street Drinkers. MHF.
Participant’s accommodation status suggested that 24.1% (46) were of No Fixed Abode, 14.1% (27) were rough sleepers, 16.2 (31) were in rented or tenancy accommodation, 11% (21) were in a hostel, 1 participant was in ‘sit up’ accommodation and 34% (65) were ‘not known’.

The age range of street drinkers varied with 85.3% (163) of participants were over the age of 30, 51.3% (98) of participants were over the age of 40, and 11.5% (22) were above the age of 50. Of the 191 participants, 81.2% (155) were male and 18.8% (36) were female. The majority at 66% (126) were White British; 9.4% (18) were non-British or non-White; and 24.6% (47) did not have captured ethnicity data.

13.6% (26) described themselves as having a disability. 48.7% (93) described themselves as disability-free and 37.7% (72) chose not to say or did not have data captured.

Currently partners are considering the development of a temporary evaluated wet facility in the city centre for summer 2014, with a view to establishing more sustainable options for the long term.

**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, as are isolation and loneliness. 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.

Researchers have identified 3 types of elderly drinkers:

1. Early-onset drinkers (Survivors): those who have a continuing problem with alcohol which developed in earlier life. Because of the health risks connected to

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heavy drinking and dependence on alcohol, the lifespan of a problem drinker may be
shortened by on average 10 to 15 years.

2. Late-onset drinkers (Reactors): they begin problematic drinking later in life, often
in response to traumatic life events such as the death of a loved one, loneliness,
pain, insomnia, retirement, etc.

3. Intermittent (Binge drinkers): they use alcohol occasionally and sometimes drink
to excess which may cause them problems.

It is thought that both the late-onset drinkers and the intermittent or binge drinkers have a
high chance of managing their alcohol problem if they have access to appropriate treatment
such as counselling and general support.

Historically, older people have tended to drink less than any other age group. Trend data
shows a decrease in the proportion of those aged 65 and over consuming alcohol, from 8.7
units per week in 2005 to 8.1 units in 2010. Drinkers aged of 65 and over consumed
between 3.4 and 5.6 fewer units per week than the total weekly average\textsuperscript{61}.

Figures released by The Office for National Statistics\textsuperscript{62} suggested that the proportion of
people aged 65 years and over claiming to have consumed alcohol in the last week has been
below the overall average for adults of both sexes in recent years. From 2005 to 2011, fewer
women aged 65 years and over drank in the last week than all other age groups [between
42\% and 45\%]; on average, over half of all females across all age groups reported drinking at
least once in the last week. Two-thirds of older males [between 63\% and 66\%] reported
drinking at least once in the last week, consistently lower than the average for all age groups
[between 66\% and 72\%].

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 60\% of 18-24 year olds to 76\% among those aged 55 and over.

\textsuperscript{61} Source: Office for National Statistics [ONS] (March 2012), Drinking Tables, in 'General Lifestyle Survey, 2010'

\textsuperscript{62} ONS (March 2013), Drinking [Chapter 2], in 'General Lifestyle Survey, 2011'
**Alcohol and Crime**

Alcohol-related crime is a ‘popular’ rather than a legal term. It is used to refer to two types of criminal offence:

- Alcohol-defined offences such as drunkenness offences or driving with excess alcohol
- Offences in which the consumption of alcohol is thought to have played a role of some kind in the committing of the offence, usually in the sense that the offender was under the influence of alcohol at the time. Examples of offences often committed by people under the influence are assault, breach of the peace, criminal damage and other public order offences

It has been estimated that in a community of 100,000 people each year, 1,000 people will be a victim of alcohol-related violent crime. Alcohol-related crime and social disorder is estimated to cost UK taxpayers £11bn per year, at 2010/11 prices.

Several studies of crime and social disorder in city centres have observed a direct relationship between the density of night time outlets licensed to sell alcohol – otherwise known as “high-risk premises” – and the prevalence of criminal activity, especially violent crimes committed. Successive Governments have been committed to tackling the problem by a variety of legislative means. Policies to combat alcohol-related crime and social disorder include the tightening licensing regulations for night time outlets permitted to sell alcohol, and the imposition of tough custodial penalties for criminal behaviour linked to alcohol.

Statistics on alcohol related crime are derived using Home Office counting rules and National Crime Recording Standards. Police recorded crime statistics cover all notifiable offences recorded by the police for Home Office records. This recording does not include minor summary offences including anti-social behaviour, crimes not reported to the police and those that the police do not record. Due to the very nature of alcohol related crime this

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has the potential to result in significant levels of under-reporting and hides the true contribution to crime within the community.

Estimates produced for Liverpool show that in 2011/12 there were 3,726 crimes and 78 sexual crimes which were attributable to alcohol. The city’s alcohol related crime rates have fallen by 33% between 2007/08 and 2011/12 but remain significantly higher than the North West and England. A similar pattern can be seen for alcohol related violent crimes which have fallen by 35% over the same period. By comparison sexual crime rates attributable to alcohol in the city have increased by 35% during this period although rates are not significantly different to regionally or nationally (Source: LAPE, 2012/13).

Anti-social behaviour has a huge impact on the quality of life, blights communities and neighbourhoods, and it is often targeted at those members of society who are least able to protect themselves. Anti-social behaviour orders (ASBOs) are designed to protect the public from behaviour that causes or is likely to cause harassment, alarm or distress, and aims to reduce the risk of further anti-social behaviour by prohibiting the offender from doing certain things, such as going to a specified location, or drinking alcohol in a public place (CPS, 2012). 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).

Alcohol misuse is linked to around half of all violent crimes and around a third of domestic violence incidents. During 2011/12 there were 1,083 victims of domestic violence in the city supported by services provided by the Citysafe partnership; including multi-agency case risk assessment conferences (MARACs) to reduce levels of repeat victimisation.

Data from Merseyside Police for 2011 indicated that 62% of offenders arrested for violence tested positive for cocaine (compared to 23% for burglary, 24% for robbery). Alcohol was present in all but one of the offenders who tested positive for cocaine.

Crime data for Liverpool is taken from Local Alcohol Profiles for England and is calculated by using Office for National Statistics (2010) mid-year population estimates, the application

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64 NICE (2010)
65 CitySafe Partnership:
66 Accessed at: www.lape.org.uk
of alcohol attributable fractions for each crime category and survey data on arrestees who tested positive for alcohol by the former UK Prime Minister’s Strategy Unit. Certain caveats must be considered when using these figures such as; data based upon incident rather than offender’ city centre data will be affected by smaller resident (denominator) populations; fluctuations in population size.

In 2011/12 there was a fall of -8.4% in the Liverpool alcohol crime rate compared to the previous year. In the five year period between 2007/08 and 2011/12 there was a fall of -32.6% in the Liverpool rate – this compares to a fall of -27.1% and -23.2% at regional and national level respectively (Figure 38 and 39). In 2011/12 Liverpool was ranked 59 highest out of 326 LAs nationally.

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<td>2010/11</td>
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<tr>
<td>2011/12</td>
<td>8.4</td>
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<tr>
<td>+/- 5 Year Percent Change</td>
<td>-32.6%</td>
<td>-27.1%</td>
<td>-23.2%</td>
</tr>
</tbody>
</table>

**Figure 37**
*Source: Local Alcohol Profiles for England, North West Public Health Liverpool Observatory/Public Health Liverpool*

<table>
<thead>
<tr>
<th>Year</th>
<th>Crude rate per 1,000 population</th>
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<tr>
<td>2007/08</td>
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<tr>
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<td>2011/12</td>
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**Figure 39**
*Source: Local Alcohol Profiles for England, North West Public Health Liverpool Observatory/Public Health Liverpool*
## Alcohol Related Crime by Ward

<table>
<thead>
<tr>
<th>WARD</th>
<th>Total Alcohol Related Crime Rate per 1000</th>
<th>Alcohol Related Violence Rate per 1000</th>
<th>Alcohol Related ASB Rate per 1000</th>
<th>Alcohol Related Theft Rate per 1000</th>
<th>Alcohol Related Drunk and Disorderly Rate per 1000</th>
<th>Alcohol Related Domestic Abuse Rate per 1000</th>
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<tr>
<td>RIVERSIDE</td>
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<td>COUNTY</td>
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<td>7.9</td>
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<td>5.7</td>
<td>5.6</td>
</tr>
</tbody>
</table>

**KEY:**
- Significantly worse than the Liverpool average (95% level of confidence)
- Significantly better than the Liverpool average (95% level of confidence)


Notes: Alcohol related crime relates to any crime that has been flagged as being 'alcohol related' or 'involves licensed premise'. It is not an automatic filled field and relies on the inputter to flag the offence, therefore the figure is not guaranteed to be 100% accurate.

Alcohol related ASB has been extracted from the total amount of ASB incidents recorded using a search for works such as "drunk", "alcohol", "intoxicated" etc. and therefore is an estimate of the amount of ASB that is recorded. ASB refers to the number of calls received by Merseyside Police that are categorised as ASB. Each calls received does not necessarily equal one incident as more than one person could call about the same incident.

## Alcohol Treatment Requirement

Alcohol Treatment Requirement (ATR) is one of a range of community sentences available to the courts. It provides access to treatment and support programmes for offenders targeting high risk offences such as Domestic Abuse, Violence related offending and more recently Burglary domestic and commercial where alcohol use is identified as a significant
factor in offending. ATR’s are also suitable for hazardous and harmful drinkers in certain circumstances; where alcohol is the dominant feature in the offending and the offender would benefit from treatment. Once the order is imposed by the courts, the individual must agree to a treatment plan with probation and the treatment provider. This plan then sets out the level of treatment required throughout the order.

The Legal Aid, Sentencing and Punishment of Offenders Act (2012)\(^67\) (LASPO) removes the specification for an ATR to have a minimum length of 6 months. These provisions aim to provide local Trusts with the flexibility to tailor treatment requirements to individual treatment need, changing patterns of substance misuse, and the move towards a recovery focused approach to treatment through:

- Promoting personal and behavioural change
- Helping offenders produce a personal action plan so they can identify what they must do to reduce offending and address their alcohol use
- Access treatment and/or support
- Explain the links between alcohol use and offending and how alcohol affects health

Voluntary Alcohol Treatment Programme (VATP) is a voluntary arrangement and targets offenders who do not meet the ATR criteria but whose offence is alcohol related, for example shop lifting, persistent drunk and disorderly and some driving offences. VATP treatment programmes are the same as ATR but not enforceable.

An independent study by the Institute for Criminal Policy Research\(^{68}\) found that probationers on ATRs reduced the overall rate of their known offending by 60%. However the rate of reduction was identical to that for a matched comparison group of alcohol misusers supervised prior to the introduction of ATRs - though it found the ATR group had different and often more complex needs.

The research also indicated that over the life of the ATR there had been a 37% overall reduction in the self-reported number of drinking days (as measured by the Treatment

\(^{67}\) Accessed at: http://www.legislation.gov.uk/ukpga/2012/10/contents/enacted

Outcomes Profile), with nearly half (46%) moving from dependency during the course of the requirement, however high levels of on-going alcohol-related need were still identified even for those completing the ATR. The authors concluded that the main implications of their research relate to developing effective strategies to ensure that:

1. ATRs and overall court orders reach completion;
2. Offending outcomes for a large minority of the ATR group are improved;
3. Adequate provisions for on-going through care and aftercare in non-CJS settings, post-ATR completion, are in place.

Within Liverpool, there were 117 people on an ATR/VATP in December 2013.

Data from 1/2/2013 until 1/2/2014:

- Clients who were assessed and received an ATR - 144
- Clients who were assessed and given a VATP – 112

**Licensing**

The Licensing Act\(^69\) was introduced by the previous Labour government with the view that the previous Act was anachronistic, and that a move away from the fixed opening and closing times of licensed premises would lead to a more ‘Mediterranean’ style of drinking culture and reduce social disorder in towns and cities.

The current Act has four primary licensing objectives which include:

1. The prevention of crime and disorder
2. Public safety
3. Prevention of public nuisance
4. Prevention of children from harm

It is the duty of each Local Authority to act as a Licensing Authority in assessing and reviewing license applications, as well as any variations to licensing conditions. The Act requires Liverpool City Council (LCC) to publish and review its licensing policy every five years. The current licensing policy for Liverpool\(^{70}\) issued in 2011 has recently been revised to accommodate changes to its specialist cumulative impact policy arrangements.

According to the licensing policy at the time of its publication Liverpool had 1,738 licensed premises as well as 51 club premises certificates, with the main concentration of premises providing late night sales concentrated in the city centre. The policy references the invaluable contribution these premises make to the Night Time Economy (NTE) and it could be argued that it is this conundrum which the Local Authority must wrestle with when devising policy in relation to alcohol—the juxtaposition of economic advantages and population health and wellbeing.

The Police Social Responsibility Act (2012)\(^{71}\) made Public Health a responsible authority in reviewing license applications. However the failure to make Public Health an additional licensing objective following consultation as part of the current Government’s alcohol strategy has meant that it can be difficult to apply population health intelligence to the granting of a singular premises license.

Despite the difficulties in being able to systematically apply Public Health data to the licensing objectives, Liverpool’s Public Health team in collaboration with other responsible authority partners have been able to apply the appropriate public health data to advocate against the granting of individual license applications, where data is pertinent to the current licensing objectives.

The methodology for applying the data involves the premises for which the alcohol licence is being reviewed is plotted onto a raster map alongside GP practices in the area. A 1 km perimeter boundary is added to the map to identify those practices within walking distance of the premises. A league table of alcohol specific hospital admissions rates by GP practice


is provided with the map, which highlights the admission rates for practices within the 1 km vicinity and their rank out of 94 practices in the city. By presenting this information in a map and league table the Public Health alcohol lead is able to see at a glance whether admission rates are high in the area and to provide representative evidence at the licencing review (Map 5).

In addition Public Health has provided evidence on the wider determinants of health to inform the SCIP introduced for certain streets in Kensington, Fairfield and Central wards. This included information on child poverty, pupil attainment and absence, 1st time entrants into Youth Offending Service, levels of crime (statistically 50% of all violent crime is alcohol related), worklessness and welfare benefit levels and car ownership.
Map 5: Map of licenced premises and deprivation
Intervening to Reduce Harm

With the passing of The Health and Social Care Act (2012), responsibility for the commissioning of drug and alcohol services moved to Public Health in Local Authorities. Locally the change brought about the integration of the previously titled Drug and Alcohol Action Team who held responsibility for the commissioning of treatment type services in the city with Public Health population/preventive services.

Alongside the legislative changes, The Liverpool Alcohol Strategy Group has now been reconvened to oversee delivery of work to address alcohol misuse across the city. The Group reports to the Better Lifestyles Group and the Health & Well Being Board. A key focus for the Alcohol Strategy Group in 2014 will be to update the current Liverpool Alcohol Strategy to ensure it is fit for purpose.

Prevention and Early Identification

NICE\textsuperscript{72} suggest it is necessary to apply a combination of interventions to reduce alcohol-related harm – to the benefit of society as a whole. 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 alcohol-related harm. They can help:

- Those who are not in regular contact with the relevant services
- Those who have been specifically advised to reduce their alcohol intake, by creating an environment that supports lower-risk drinking
- They can also help prevent people from drinking harmful or hazardous amounts in the first place.

Interventions aimed at individuals can help make people aware of the potential risks they are taking (or harm they may be doing) at an early stage. This is important, as they are most likely to change their behaviour if it is tackled early. In addition, an early intervention could prevent extensive damage.

\textsuperscript{72} NICE (2010) Alcohol Use Disorders – Preventing Harmful Drinking. PH24.
NICE make a series of 12 recommendations, but make clear that it is those recommendations (1-3) to be made at policy level which will have the biggest impact and be most cost-effective than actions undertaken by local health professionals. The recommendations and interventions are summarised below:

1. **Price**

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.

Within North West England momentum is growing towards the establishment of a bye-law that would essentially introduce a regional Minimum Unit Price (MUP) for alcohol. At a meeting in early February North West LA CEO’s agreed in principle to establishing a “fighting fund” to support a legal review of the bye-law and develop robust responses that could be used to combat any challenges by the industry. Each Upper Tier LA is currently being asked to contribute £10K to the “fighting fund”.

In addition to seeking to identify monies for a “fighting fund” a request has also been made for names of local Councillors who would be interested in acting as spokespeople and advocates for the introduction of a MUP.

Liverpool supports steps for the introduction of the bye-law. The Mayor has already taken proactive steps to reduce the availability of low cost, high strength alcohol in Liverpool by requesting all supermarkets operating across the city meet with him to discuss the removal of 6.5% strength cheap ciders and lagers from sale.
Public engagement on the issue of MUP will be required to create a favourable political environment to support the introduction of MUP. A recent “expert think-tank” meeting identified the need to have a consistent shared GP message relating to the benefits of introducing a MUP as a key requirement moving forward in convincing communities of the need for the removal of cheap, high strength alcohol.

2. **Availability**

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 another effective way of reducing alcohol-related harm. In Scotland, protection of the public’s health is part of the licensing objectives.

Specialist Cumulative Impact Policy 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. Since 2010 LCC have introduced SCIPs in four areas of the city:

1. Allerton Road (L18)
2. Lark Lane (L17)
3. Cavern Quarter and Ropewalks area of city centre
4. Specified streets in Kensington, Central and Fairfield electoral wards

Each of the 4 SCIPs are reflective of the particular issues in each of those areas. The SCIP in the city centre excludes certain types of premises, such as those with a license to consume alcohol off the premises, as they were not viewed as contributing to the reported increases in crime and disorder and public nuisance in the area. Whereas the SCIP in Kensington, Central and Fairfield wards has a specific focus on the off-licensed trade.

3. **Marketing**

There is evidence that alcohol advertising does affect children and young people. It shows that exposure to alcohol advertising is associated with the onset of drinking among young people and increased consumption among those who already drink. All of the evidence
suggests that children and young people should be protected as much as is possible by strengthening the current regulations.

The Alcohol Health Alliance and Alcohol Concern advocate a move towards the “Loi Evin” approach adopted in France which essentially bans any advertising that might reach young people in significant numbers. The Liverpool Alcohol Strategy Group will work alongside the local lobbying group, Drink Wise North West to advocate that our position be aligned with the recommendations set out by Alcohol Concern:

- Only advertise product characteristics (avoiding lifestyle images)
- Statutory and independent regulation (rather than self-regulation by the industry itself)
- Meaningful Sanctions (such as fines linked to budget size and level of exposure to children)
- Prohibit Sponsorship (of sporting cultural and musical events)
- Restrict cinema advertising (for all films without an 18 classification)

4. Licensing

NICE suggest using local crime and related trauma data to map the extent of alcohol-related problems before developing or reviewing a licensing policy. If an area is 'saturated' with licensed premises and the evidence suggests that additional premises may affect the licensing objectives, adopt a 'cumulative impact' policy. If necessary, limit the number of new licensed premises in a given area.

Ensure sufficient resources are available to prevent under-age sales, sales to people who are intoxicated, proxy sales (that is, illegal purchases for someone who is under-age or intoxicated), non-compliance with any other alcohol licence condition and illegal imports of alcohol.

Work in partnership with the appropriate authorities to identify and take action against premises that regularly sell alcohol to people who are under-age, intoxicated or making illegal purchases for others.
Undertake test purchases to ensure compliance with the law on under-age sales. Test purchases should also be used to identify and take action against premises where sales are made to people who are intoxicated or to those illegally purchasing alcohol for others.

Ensure sanctions are fully applied to businesses that break the law on under-age sales, sales to those who are intoxicated and proxy purchases. This includes fixed penalty and closure notices (the latter should be applied to establishments that persistently sell alcohol to children and young people).

The Liverpool Alcohol and Tobacco Unit (ATU) are commissioned by Public Health to support reductions in the illegal importation and distribution of alcohol and tobacco products by working with key agencies such as HM Revenues and Customers, Merseyside Police, Immigration Department and the Department of Work and Pensions.

The unit comprises of Liverpool Trading Standards Enforcement Officers and Merseyside Police Officers, and much of its work is intelligence led, through the identification, investigating and arresting offenders who deal in illegal and non-duty paid alcohol and tobacco products. The ATU is able to conduct financial investigations in conjunction with ATU financial investigators in order to seize and deny further access to assets and funds utilised by criminal enterprises and organisations. They also have a strong role in awareness raising of the harmful effects of counterfeit alcohol to the community.

The prevalence of underage drinking among children in England is widespread; 43% of all 11 to 15 year-olds surveyed said that they had drunk alcohol at least once in 2012. The number and proportion of those who had drunk alcohol at least once increases with age, rising from 12% of 11 year-old schoolchildren to almost 4 in every 5 (74%) by the age of 15 in 2012.

Through the ATU’s investigatory powers, Liverpool is able to prosecute any person concerned in the sale or supply of alcohol or tobacco products to any child. During 2010/11 – 2012/13 there were 239 test purchases carried out using under age volunteers, of those 65 (27%) resulted in an underage sale. These premises will have subsequently taken through the necessary legislative pathway in an effort to reduce underage drinking.
5. **Resources for Screening and Brief Intervention**

Prioritise alcohol-use disorder prevention as an 'invest to save' measure. Ensure there are locally defined integrated care pathways are reviewed. Ensure plans include screening and brief interventions for people at risk of an alcohol-related problem (hazardous drinkers) and those whose health is being damaged by alcohol (harmful drinkers). This includes people from disadvantaged groups. Make provision for the likely increase in the number of referrals to services providing tier two, three and four structured alcohol treatments as a result of screening.

Ensure at least one in seven dependent drinkers can get treatment locally.

Include formal evaluation within the commissioning framework so that alcohol interventions and treatment are routinely evaluated and followed up. The aim is to ensure adherence to evidence-based practice and to ensure interventions are cost effective.

Ensure an appropriately trained nurse or medical consultant, with dedicated time, is available to provide strategic direction, governance structures and clinical supervision to alcohol specialist nurses and care givers.

Ensure community and voluntary sector providers have an appropriately trained professional who can provide strategic direction, governance structures and supervision to those providing screening and brief interventions.

Ensure staff are allowed time and resources to carry out screening and brief intervention work effectively. Staff should have access to recognised, evidence-based packs. These should include: a short guide on how to deliver a brief intervention, a validated screening questionnaire, a visual presentation (to compare the person's drinking levels with the average), and practical advice on how to reduce alcohol consumption, a self-help leaflet and possibly a poster for display in waiting rooms.

Ensure staff are trained to provide alcohol screening and structured brief advice. If there is local demand, staff should also be trained to deliver extended brief interventions.

Public Health Liverpool (PHL) commission a programme of capacity-building in Alcohol Intervention and Brief Advice. This has resulted in the comprehensive training of a range of...
organisations, including primary care, social care, probation, acute hospital staff and children’s centres. Over the past 4 years 1658 frontline workers have received Alcohol IBA training. Additionally a focus has been given over the past 12 months to the need for those trained to use their developed skills in a routine way thus providing sustainability within the City. The ‘Sustainability Programme’ has seen 41 individuals attending post-alcohol IBA workshops, 37 individuals trained to become Alcohol Workplace Co-Ordinator Champions, and over 1000 previously trained stakeholders taking receipt of 3 “e” nudges (providing an IBA update and prompt for individual action).

Over the past 4 years 1658 frontline workers have received Alcohol IBA training. Additionally a focus has been given over the past 12 months to the need for those trained to use their developed skills in a routine way thus providing sustainability within the City of a resource to provide IBA. The Sustainability Programme has seen 41 individuals attending Post Alcohol IBA workshops, 37 individuals trained to become Alcohol Workplace Co-Ordinator Champions and over 1000 previously trained stakeholders taking receipt of 3 “e” nudges (providing an IBA update and prompt for individual action).

PHL also commission an Alcohol Champion Assertive Outreach Programme within three of the city wards most significantly affected by alcohol by enabling local residents to raise discussions about alcohol consumption and sensible drinking with their own peer groups.

6. Supporting Children and Young People

Routinely assess the ability of these children and young people to consent to alcohol-related interventions and treatment. Some will require parental or carer involvement. Obtain a detailed history of their alcohol use (for example, using the Common Assessment Framework as a guide). Include background factors such as family problems and instances of child abuse or under-achievement at school. Use professional judgement to decide on the appropriate course of action. In some cases, it may be sufficient to empathise and give an opinion about the significance of their drinking and other related issues that may arise. In other cases, more intensive counselling and support may be needed. If there is a reason to believe that there is a significant risk of alcohol-related harm, consider referral to child and adolescent mental health services, social care or to young people's alcohol services for treatment, as appropriate and available. Ensure discussions are sensitive to the child or
young person’s age and their ability to understand what is involved, their emotional maturity, culture, faith and beliefs. The discussions (and tools used) should also take into account their particular needs (health and social) and be appropriate to the setting.

7. Screening Young People (aged 16-17 years)

Complete a validated alcohol screening questionnaire with these young people. Alternatively, if they are judged to be competent enough, ask them to fill one in themselves. In most cases, AUDIT (alcohol use disorders identification test) should be used. If time is limited, use an abbreviated version (such as AUDIT-C, AUDIT-PC, CRAFFT, SASQ or FAST). Screening tools should be appropriate to the setting. For instance, in an emergency department, FAST or the Paddington Alcohol Test (PAT) would be most appropriate. Focus on key groups that may be at an increased risk of alcohol-related harm. When broaching the subject of alcohol and screening, ensure discussions are sensitive to the young person’s age and their ability to understand what is involved, their emotional maturity, culture, faith and beliefs. The discussions should also take into account their particular needs (health and social) and be appropriate to the setting. Routinely assess the young person’s ability to consent to alcohol-related interventions and treatment. If there is doubt, encourage them to consider involving their parents in any alcohol counselling they receive.

8. Extended Brief Interventions (aged 16-17 years)

Ask the young person's permission to arrange an extended brief intervention for them. Appropriately trained staff should offer the young person an extended brief intervention. Provide information on local specialist addiction services to those who do not respond well to discussion but who want further help. Refer them to these services if this is what they want. Referral must be made to services that deal with young people. Give those who are actively seeking treatment for an alcohol problem a physical and mental assessment and offer, or refer them for, appropriate treatment and care.

9. Screening Adults

NHS professionals should routinely carry out alcohol screening as an integral part of practice. For instance, discussions should take place during new patient registrations, when
screening for other conditions and when managing chronic disease or carrying out a medicine review. These discussions should also take place when promoting sexual health, when seeing someone for an antenatal appointment and when treating minor injuries. Where screening everyone is not feasible or practicable, NHS professionals should focus on groups that may be at an increased risk of harm from alcohol and those with an alcohol-related condition. This includes people:

- with relevant physical conditions (such as hypertension and gastrointestinal or liver disorders)
- with relevant mental health problems (such as anxiety, depression or other mood disorders)
- who have been assaulted
- at risk of self-harm
- who regularly experience accidents or minor traumas
- who regularly attend GUM clinics or repeatedly seek emergency contraception

Non-NHS professionals should focus on groups that may be at an increased risk of harm from alcohol and people who have alcohol-related problems. For example, this could include those:

- at risk of self-harm
- involved in crime or other antisocial behaviour
- who have been assaulted
- at risk of domestic abuse
- whose children are involved with child safeguarding agencies
- with drug problems.

When broaching the subject of alcohol and screening, ensure the discussions are sensitive to people’s culture and faith and tailored to their needs. Complete a validated alcohol questionnaire with the adults being screened. Alternatively, if they are competent enough, ask them to fill one in themselves. Use AUDIT to decide whether to offer them a brief intervention (and, if so, what type) or whether to make a referral. If time is limited, use an abbreviated version (such as AUDIT-C, AUDIT-PC, SASQ or FAST). Screening tools should be
appropriate to the setting. For instance, in an emergency department FAST or PAT would be most appropriate. Do not offer simple brief advice to anyone who may be dependent on alcohol. Instead, refer them for specialist treatment (see recommendation 12). If someone is reluctant to accept a referral, offer an extended brief intervention (see recommendation 11). Use professional judgement as to whether to revise the AUDIT scores downwards when screening:

- women, including those who are, or are planning to become, pregnant
- younger people (under the age of 18)
- people aged 65 and over
- those from BME groups.

Use culturally sensitive materials for screening

Biochemical measures should not be used as a matter of routine to screen someone to see if they are drinking hazardously or harmfully. (This includes measures of blood alcohol concentration [BAC].) Biochemical measures may be used to assess the severity and progress of an established alcohol-related problem, or as part of a hospital assessment (including assessments carried out in emergency departments).

The Preventing Alcohol Harm in Liverpool & Knowsley (PREVAIL) Project has sought to estimate the prevalence of early liver disease via screening using conventional alcohol markers and new diagnostic tests that detect fibrosis of the liver. This entailed collection of clinical data (heights, waist circumference, weight, blood pressure) and 20ml blood sample (for Liver Function Tests and fibrosis). The work indicated those who were overweight were more likely to show signs of liver damage indicating it could be beneficial to address these two health concerns simultaneously.

Over 2013/14 a total of 362 young people aged 17 years and under were supported in specialist substance misuses support. The type of support provided further to completion of individual comprehensive assessment ranges from brief intervention and motivational enhanced therapy through to solution focused and cognitive behavioural therapy. Referrals were received from a wide range of services that deal with young people including: schools, youth offending service CAMHS, Targeted Youth Support, Children’s Homes etc.
10. **Brief Advice for Adults**

Offer a session of structured brief advice on alcohol. If this cannot be offered immediately, offer an appointment as soon as possible thereafter. Use a recognised, evidence-based resource that is based on FRAMES principles (feedback, responsibility, advice, menu, empathy, and self-efficacy). It should take 5–15 minutes and should:

- cover the potential harm caused by their level of drinking and reasons for changing the behaviour, including the health and wellbeing benefits
- cover the barriers to change
- outline practical strategies to help reduce alcohol consumption (to address the 'menu' component of FRAMES)
- lead to a set of goals

Where there is an on-going relationship with the patient or client, routinely monitor their progress in reducing their alcohol consumption to a low-risk level. Where required, offer an additional session of structured brief advice or, if there has been no response, offer an extended brief intervention.

11. **Extended Brief Intervention for Adults**

Offer an extended brief intervention to help people address their alcohol use. This could take the form of motivational interviewing or motivational-enhancement therapy. Sessions should last from 20 to 30 minutes. They should aim to help people to reduce the amount they drink to low risk levels, reduce risk-taking behaviour as a result of drinking alcohol or to consider abstinence.

Follow up and assess people who have received an extended brief intervention. Where necessary, offer up to four additional sessions or referral to a specialist alcohol treatment service (see recommendation 12).

When LCAS was launched in Liverpool in 2011 the service was established to provide Tier 2 support (including EBI) as well as Tier 3 work. Whilst it still provides this option LCAS has in recent times seen a shift in its client focus and now deals primarily with clients who have complex needs.
In Liverpool whist primary care teams have been trained to provide brief interventions, it would appear from looking at the most recent CCG figures that relatively few extended brief intervention are taking place – figures show that a mean of 35% of GP patients have been asked about their alcohol consumption – suggesting that a smaller amount would have then gone on to receive an extended brief intervention. Options currently being considered are how Pharmacists and Health Trainers can be utilised to deliver EBIs.

12. Referral

Consider making referral for specialist treatment if one or more of the following has occurred. They: show signs of moderate or severe alcohol dependence: have failed to benefit from structured brief advice and an extended brief intervention and wish to receive further help for an alcohol problem: show signs of severe alcohol-related impairment or have a related co-morbid condition (for example, liver disease or alcohol-related mental health problems).

Liverpool Community Alcohol Service (LCAS) was launched in 2011 to provide comprehensive assessment, treatment and onward referral to clients requiring specialist alcohol support from 75 community locations across the city. The provision ranges from brief Intervention to community detoxification and includes provision of a specialist alcohol nurse at Brownlow Group Practice. The service is a joint venture between mental health and acute services to provide holistic specialist support to individuals. Since its launch the service has seen year on year increases in referrals (Figures 41 and 42).
Between August 2011 and November 2013 there were 9242 referrals to Liverpool Community Alcohol Services, of which 33.1% were offered an appointment (3058). Direct GP referrals accounted for 21.7% (2004) of total referrals, whilst urgent referrals flagged accounted for 6.1% of total referrals made (Figure XX).

In conjunction with the on-going development of LCAS, LCCG have recently introduced a Primary Care Pathway to support clinicians in identifying and supporting those with alcohol related health concerns in a systematic way, figure 43 below illustrates the pathway detail.
Figure 43

Source: Liverpool CCG Alcohol Programme Board May 2014
Secondary Prevention/Intervention

Harmful drinking is defined as a pattern of alcohol consumption causing health problems directly related to alcohol. This could include psychological problems such as depression, alcohol-related accidents or physical illness such as acute pancreatitis. In the longer term, harmful drinkers may go on to develop high blood pressure, cirrhosis, heart disease and some types of cancer, such as mouth, liver, bowel or breast cancer\(^73\).

Alcohol dependence is characterised by craving, tolerance, a preoccupation with alcohol and continued drinking in spite of harmful consequences (for example, liver disease or depression caused by drinking). Alcohol dependence is also associated with increased criminal activity and domestic violence, and an increased rate of significant mental and physical disorders. Although alcohol dependence is defined in ICD-10 and DSM-IV in categorical terms for diagnostic and statistical purposes as being either present or absent, in reality dependence exists on a continuum of severity. However, it is helpful from a clinical perspective to subdivide dependence into categories of mild, moderate and severe. People with mild dependence (those scoring 15 or less on the Severity of Alcohol Dependence Questionnaire; SADQ) usually do not need assisted alcohol withdrawal. People with moderate dependence (with a SADQ score of between 15 and 30) usually need assisted alcohol withdrawal, which can typically be managed in a community setting unless there are other risks. People who are severely alcohol dependent (with a SADQ score of more than 30) will need assisted alcohol withdrawal, typically in an inpatient or residential setting. In this guideline these definitions of severity are used to guide selection of appropriate interventions\(^74\).

To support implementation of quality assured treatment services NICE issued a quality statement\(^75\). The flow chart below outlines 13 quality statements, within five over-arching areas (figure 44):

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\(^73\) NICE (2010) Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. CG115

\(^74\) NICE (2010) Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. CG115

\(^75\) NICE (2011) Support for Commissioners Using Quality Standards on Alcohol Dependence and Harmful Alcohol Use
Figure 44

Source: NICE (2011) Support for Commissioners Using Quality Standards on Alcohol Dependence and Harmful Alcohol Use
**Tertiary Intervention**

In Liverpool alcohol services are provided through a network of service providers organised around treatment and recovery themes.

1. **Inpatient Services**

Inpatient detoxification from alcohol is provided within a residential unit, usually over a period of 5-10 days. The service is provided by a multidisciplinary team involving covering nursing, psychiatry, clinical psychology and occupational therapy. During the inpatient stay a group work based relapse prevention programme will prepare service users for discharge and provides them with pathways to access after care services.

2. **Liverpool Community Alcohol Service (LCAS)**

LCAS provides a range of alcohol treatment services at the Royal Liverpool & Broadgreen University Hospital Trust and in a range of community settings across the city, covering advice for people with alcohol problems, health assessment and a range of alcohol treatments, detoxification and onward referral to specialist services if necessary.

3. **Residential Rehabilitation Placements**

These placements provide intensive treatment within a residential unit. This would include 1 to 1 sessions and group therapy.

4. **Day Programmes**

Day programmes offer structured support for 48 days of treatment over 11 full-time weeks of four and a half days. Clients can choose to take the spiritual approach (12 steps) or cognitive approach (ITEP) when starting the main programme, which includes one to one counselling and group work.

5. **Pre-Abstinent Support**

This approach offers one-to-one sessions, group support and onward referral for those who are considering becoming abstinent from alcohol, or would like help to access abstinence-based treatment.
6. **Aftercare Support**

A range of services are offered with a focus on supporting those who have completed treatment to maintain abstinence and to reintegrate into mainstream life. The services cover a range of activities such as creative writing, drama and music, yoga, employment, training and education.

7. **Provision for Children and Young People**

Specialist substance misuse support (including alcohol support) is provided to young people aged 18 and under across the city. These services also provide a transitional support service for clients (aged 19-24) who are not ready to enter adult service provision. In 2013/14 259 individuals used the transitional support service. Family support is also offered to the families (children & their carers i.e. grandparents) of parents who misuse alcohol.

A local provider also offers specialist counselling to young people aged 18 and under who have a substance misuse problem (including alcohol). In 2013/14 150 individuals accessed this support service.

8. **Treatment Data**

Figures from Public Health England\(^7^6\) confirm the number of people in structured treatment (Tier 3/4) in Liverpool in the 12 months to December 2013 stood at 1,487 of those aged 15-64 years. This equates to a crude rate of 4.60 per 1,000, with an average rate for Cheshire and Merseyside of 4.96 per 1,000. Of those 1,487 in structured treatment, 57% successfully completed treatment, compared to 55% at Cheshire and Merseyside level.

The majority of those in structured treatment were male (58%), with 14.5% aged under 25 years, compared to an average of 7.1% at the Cheshire and Merseyside level. There were 22% of those in structured treatment with a secondary substance problem. With Cocaine (36%) and Cannabis (46%) representing the majority of secondary substance abuse. Whilst 38% of those in structured treatment stated alcohol as a secondary or tertiary problematic substance, the highest rate in Cheshire and Merseyside.

\(^7^6\) PHE (2013) NDTMS
During 2011/12 there were **2,223** individuals aged 15-64 years receiving non-structured interventions (Tier 2) in Liverpool. This equates to a crude rate of 6.56 per 1,000, compared to a Cheshire and Merseyside rate of 9.09 per 1,000. Again this population was predominantly male (64%).
Stakeholder Views

Consultation with providers of alcohol services in Liverpool was carried out in three stages: Stakeholders were presented with population level data regarding alcohol misuse in Liverpool and group discussions took place using a pre-designed survey (Appendix A): The survey was then sent out to all providers for completion and return: Following collation of responses, feedback of emerging themes was given at a subsequent group session.

Common stakeholder themes included: Poly users – it was felt there were perceived gaps in the system for those with secondary and tertiary substance misuse problems, which could lead to individuals falling through these gaps in accessing support: Chaotic users outside of city centre were also felt to be under-served by provision, with many providers situated and operating within boundaries that focus mainly upon the city centre. This was further developed by a sense of a lack of community outreach in areas situated at the peripheries of the city – with Speke and Garston being a recurrent location cited.

The issue of those with a dual diagnosis was regularly cited as being problematic, and frustratingly so, as it was a long-standing concern: The inflexibility in referral criteria for some provision was felt to result in unmet need, particularly referral criteria and fixed appointment times for those with chaotic lifestyles: A regularly cited gap involved those who did not meet the criteria for an ATR and were subsequently left without support and therefore at greater risk of re-offending and relapse: Waiting times for detoxification services were another cited issue, further work is needed to benchmark current local waiting times and better understand, of those waiting for residential services, what proportion have alcohol as the primary substance of misuse.

It was also felt that a lack of recovery and after-care support, post detoxification and gaps in recovery programmes meant greater risk of relapse. It was suggested that a mapping exercise is needed to better understand the profile of those requiring after care support, again to delineate those whose primary issue is alcohol misuse. It was recognised that much of the provision has evolved historically based upon previous higher numbers of drug misusers in the city.
There was a clear recognition amongst all stakeholders that there was a need for multi-agency training (mental health, alcohol and drugs), with some standardised accreditation of those involved in providing training programmes to ensure consistency in approach for service users.

Consultation with stakeholders at Merseyside Police highlighted the additional burden that the misuse of alcohol has upon already stretched Police resources. Feedback from the Chief Inspector for Operations described how the main issues for policing and alcohol involved:

- Street drinking – particularly in city centre
- Night Time Economy Violence
- Domestic violence
- Alcohol combined with cocaine use leading to violence

Police feedback related to street drinking identified this as the number one priority for businesses, B.I.D and residents in 2011/12 and 2012/13 - during this time in excess of £100,000 was spent in processing street drinking related ASBO/CRASBO applications and breaches. This was felt to be fuelled by the easy availability of alcohol (78 off licences) within the city centre, alongside the 24hour licensing of some premises. Street drinking thought to lead to an increase in associated crime such as shoplifting and begging.

Feedback reported that an estimated 97% of offenders arrested post 23:00 hours for a violence offence admitted consuming alcohol prior to the offence. Alcohol was a contributory factor in every recorded assault (58) on Police officers in the NTE 2012/2013 (injuries include broken leg/ribs/hand, bites, concussion, as well as a plethora of more minor injuries).
Recommendations and Conclusions

It is apparent from the information presented that alcohol misuse poses a significant public health problem in Liverpool. The main thrust of any alcohol strategy needs to be cognisant of the fact that the most effective strategies to reduce alcohol-related harm are those that operate at a macro-level and include; minimum unit pricing; restrictions on the physical availability and promotion of alcohol. However it is imperative that local policy makers do not let these issues deter them from taking decisive action to curb the trends in alcohol related problems. Much can be done at a local level to influence the macro environment to make alcohol less accessible, available and affordable.

Positively some of the recent data suggests that Liverpool is clearly making some headway in reducing alcohol related harm within its population. The scale of the alcohol burden means that we must go above and beyond other areas in order to close the gap in alcohol related health inequalities.

Overarching Recommendations

- Policy makers should focus on those interventions that will ultimately change environmental conditions in which people live.

- There are specific geographical areas within the city where levels of specific alcohol related harm are comparatively higher. Any investment and commissioning decisions need to be reflective of these differences in need.

- More than half the adult population of Liverpool is drinking above recommended guidelines, making it a population issue. To address this issue will therefore require multiagency working and co-ordination. The Health and Wellbeing Board and The Liverpool Alcohol Strategy Group need to drive this work across all sectors.

Key Outcome 1: Changing knowledge, skills and attitudes toward alcohol

- Continued awareness-raising of alcohol related harm to increase public knowledge and self-awareness of ‘safe’ levels of consumption.
• Research shows that by shifting the population mean through small improvements in levels of consumption, significant reductions can be made in reducing the prevalence of alcohol related harm. This suggests that a focus on the largest cohort drinking above recommended guidelines (those at increasing risk) will bring about the most substantial shift in prevalence of alcohol related harm.

• Use of local population insight into the geo-demographic characteristics of those drinking above recommended guidelines should be used to develop messages and campaigns that will resonate with these groups.

• Attention should be paid to gender differences and the rising prevalence of alcohol related harm in the female population to curb further increases. It may be that drivers of increasing harm differ between genders and interventions/messaging will need to take these differences into account.

• Survey data in relation to alcohol related harm amongst the BME population needs to be improved to better understand unmet need and cultural differences in consumption and behaviour patterns

• Liverpool should continue to invest in screening and brief/extended intervention and/or advice, alongside capacity building within the treatment system for resulting increases in those identified

**Key Outcome 2: Creating safer drinking environments**

• Continued focus is needed on reducing the density of alcohol related premises across the city, through interventions such as SCIP. Public health intelligence regarding the levels of alcohol related harm should be used to support these decisions.

• Due to changing trends in alcohol consumption towards off-trade sales, policy makers should direct increased focus as an area for scrutiny, alongside continued licensing, enforcement and regulation.
• Consideration should be given to support the cost of policing in the city centre through the use Late Night Levies on high density areas where prevalence of alcohol related violence is high

• Development of local multi-agency initiatives should include the issues of street drinking, domestic violence, and night time economy violence (particularly linked to cocaine use).

**Key Outcome 3: Supporting individual needs**

• Certain sub-groups of the population require additional support due to disproportionately higher levels of need. These include; offenders; those with mental health issues; LGBT; students; those living in poverty; homeless; street drinkers.

• Evaluation of the local ATR programme in relation to completion and reoffending rates is required to support policy makers in future commissioning and investment decisions.

• Further investigation is needed to better understand low rates of brief interventions taking place in primary care, alongside referral patterns and DNA rates to LCAS, as these two issues may be related

• Improvements are needed in the pathway of care for those with dual diagnosis. Service users report a lack of a holistic view of their needs and fragmentation in service delivery.

• It is recognised that within the prison population there are high levels of alcohol related harm. Whilst those with dependency issues will undergo detoxification, the pathway for those at higher or increasing risk is less clear. Further work is needed to explore what services are available to reduce harm within these groups.

• There is a need to consider the wider determinants of health when looking at alcohol related harm in older people. Issues of disruption of social activity, isolation and loneliness contribute significantly to increased consumption. Counselling and general support should therefore be factored into any service design.
• Treatment data supports the link between alcohol and secondary, tertiary drug use. Drug intervention programmes need to consider any dual dimensions in coordination of support packages

• The issue of unmet need for those with a dual diagnosis continues to be cited as a gap in provision. Policy makers need to consider ways to address this long-standing concern. One way of addressing this issue may be in the establishment of multi-agency training programmes

• Referral criteria for alcohol related programmes need to be developed in an inclusive way that does not result in unmet need.

• Cited gaps in recovery and after care need to be further explored to better understand need.

**Key Outcome 4: Support for children, young people and parents in need**

• Further work is needed to better understand unmet need in relation to children and young people affected by parental alcohol misuse in Liverpool. This will support tailored provision at the scale and intensity required.

• Alcohol misuse plays a significant role in ‘offending’ behaviour by young people. The recommendations included in the report by Liverpool Public Health Observatory should be considered in the design and delivery for services relating to young offenders in Liverpool, particularly in relation to accommodation requirements

• Further work is needed to understand how Liverpool best identifies young people at risk of alcohol related harm.

**Key Outcome 5: Reducing the availability and affordability of alcohol**

• Lobbying work should continue for a national alcohol MUP. This should run alongside continued efforts to investigate the introduction of local bye-laws, should national action fail to occur. Local Authorities should combine forces to lobby for legislative change that has an impact at population level, including those that involve:
- Price
- Availability
- Marketing
- Licensing

- Consultation and PR activity is needed to improve public understanding of the societal benefits of MUP.

- Partners should continue to lobby the government to include public health as part of its licensing objectives.