2014/15

Joint Strategic Alcohol Needs Assessment

Tameside Health & Wellbeing Board

Produced on behalf of Tameside Health & Wellbeing Board
By
Public Health Intelligence

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making it happen together in Tameside

Acknowledgements

This Alcohol Needs Assessment was produced by the Public Health Intelligence Team within the Public Health directorate of the council. However, it would not have been possible to produce without the help and information from the following people and partners:

Kate Benson, Public Health TMBC

Diane Barkley, TMBC

Strategic Alcohol Group

Rachel Conner and Louise Bonner, Branching Out

Adele Bowden, Greater Manchester Police

Ceri Schofield, Greater Manchester Probation Service

Joyce Southern, Hospital Alcohol Liaison (HALS) team, Tameside Foundation Trust

Policy and Performance TMBC

Contents

1 - Summary

This Joint Strategic Alcohol Needs Assessment was undertaken to identify the needs of the population living in Tameside in relation to the harm caused by alcohol. This assessment describes the need, service provision, review of the evidence and policy context and makes recommendation based on the findings.

This needs assessment is intended to provide the underpinning analysis and intelligence to support decision makers in developing strategies and to inform commissioning decisions in the broad partnership that aims to reduce alcohol related harm. This includes partners from many sectors: the criminal justice system, health, local government, and the third sector. The challenging financial climate will limit what can be done to address gaps and means that partners will need to align budgets to achieve shared priorities.

Rising alcohol consumption is a cause for concern for many local authorities across England. The UK Government's 'Alcohol Harm Reduction Strategy' has highlighted the need to promote responsible drinking.

Binge drinking is a matter of current social, media and political concern and rarely out of the headlines. However, binge drinking is nothing new in British society and has not always attracted disapproval. Its change in history from a ' manly ' activity to one associated with out of control women represents wider social change and policy interests as well as the reality of a problem.

The impact of alcohol misuse is widespread encompassing alcohol related illness and injuries as well as significant social impacts including crime and violence, teenage pregnancy, loss of workplace productivity and homelessness. As alcohol has become increasingly affordable, consumption has increased and alcohol misuse is now estimated to cost the NHS £2.7 billion a year, almost twice the equivalent figure in 2001. But the cost of alcohol to society as a whole is even greater, estimated to stand at £17-22 billion.

The extent of alcohol use in Tameside is significant across all age groups and in particular in our young people. The North West trading standards survey 2013 revealed that our 14 to 17 year olds are using alcohol on a regular basis and in some cases at harmful levels. What is stark is that 60% of the young people surveyed said that their alcohol was purchased for them by a parent or guardian. The attitudes of our young people are also concerning with a high proportion of them thinking that being drunk is a normal behaviour and the statistics on alcohol admissions to hospital back this up, with a high proportion of our alcohol admissions in under 18s being for alcohol intoxication. Alcohol use in childhood can be detrimental to a child's development, with adverse effects on growth as well as brain, liver, bone and endocrine development. Whereas alcohol related disease is generally thought of as affecting older people, cases of alcohol attributable diseases such as alcoholic liver disease are now being diagnosed in people within their twenties. Young people that drink are also more likely to be involved in accidents, to be victims or perpetrators of crime and violence, and to engage in risky sexual activity.

The statistics for the drinking habits of adults in Tameside are no better, with around 26% of adults drinking at increasing or higher risk levels. Alcohol places a huge burden on the local NHS system, with 70% of attendances at A&E in the early hours and 40% of weekend attendances caused by alcohol. Hospital admissions for alcohol related conditions are worrying for Tameside residents, with admission rates trebling over the last 10 years. Heavy drinking in women has increased by almost a third in the last decade with alcohol hospital admissions and death rates reflecting this. The number of deaths from alcohol related conditions is bleak for both males and females in Tameside, with statistics showing a year on year increase since 2006. Peak age of death from alcohol conditions in Tameside is 50-54 years for males and 60-64 years for females.

Research suggests that alcohol consumption generally declines with age and the proportion of non-drinkers increases. The reasons for this decline in consumption are presumably connected to changes in life circumstances and attitudes and, in the later middle aged and older, growing ill health. However, there is evidence that today's population of older people may be relatively heavier drinkers than previous generations. This could be the result of an effect whereby a generation which has had its formative years at a time of increasing affordability, availability and social acceptability of alcohol may be more likely to retain the habit of drinking. This is true for the older residents of Tameside with people currently aged 46-65 years consuming more alcohol now than any previous generation. Levels of admissions for acute intoxication are high in Tameside with the 60-69 year age group making up the highest proportion of older people admitted to hospital with an alcohol related condition. Alcohol depresses brain function more in older people, impairing co-ordination, which in turn can lead to accidents or falls. Between 2011/12 and 2012/13, 6.2% of alcohol related admissions for falls in Tameside were alcohol related. Of the admissions to hospital for Tameside residents aged 60 plus, with both a fall and alcohol diagnosis; 34.6% had a primary diagnosis of head injury and 10.8% had a primary diagnosis of hip fracture.

Work on reducing harm caused by alcohol is taking place across Tameside through many different forums and services. With recent changes to alcohol commissioning moving to public health in local authorities, now is the ideal opportunity to re think how alcohol harm reduction interventions and services are commissioned, taking into consideration prevention, early intervention, brief intervention and dependency across the life course.

2 - Introduction

Although alcohol drinking is an integral part of many people's family and social life, it is in reality a poison and an addictive substance. It can cause both physiological and psychological harm in users and has wider adverse social consequences. It has been estimated that 1 in 25 deaths worldwide are due to alcohol consumption[1].

Many of the health consequences are well known such as alcohol poisoning and cirrhosis of the liver. Some of the other medical consequences are not so well known, for instance, it is not widely known that alcohol contributes to stroke and other cardiovascular diseases, cancer and congenital deformity. There are also the more acute problems which may be due to alcohol consumption such as assault, including domestic violence and sexual assault, and accidental injury.

Not only does alcohol misuse affect health, but alcohol affects many of the social determinants of health. The social consequences of excess alcohol consumption include crime and disorder; abuse and neglect of loved ones, including children; family breakdown; homelessness; unemployment and poverty; and poor educational achievement.

The widespread nature of alcohol harm and its effects within society requires continued support of a multi-disciplinary approach to challenging alcohol harm both from within the local authority, CCG and through links with external partners and service providers.

The purpose of this alcohol needs assessment is to better understand the health and wellbeing issues of the population of concern, so that needs can be met and health and wellbeing can be improved. This could be through strategy and policy development, reshaping services or the commissioning of interventions to meet the identified needs.

The following needs assessment aims to describe the current context regarding alcohol harm across Tameside and its related issues, through identifying key geographical areas and vulnerable groups affected directly or indirectly by alcohol issues and harm. This needs assessment will draw on a wide range of data and intelligence from various sources and partners. Where possible local data has been used to provide an accurate assessment of harm in Tameside across the life course.

[1] **Public Health England.** [Online] www.lape.org.uk.

3 - Background

Alcohol harm and its effects are a key public health priority, with alcohol being the third biggest lifestyle cause of disease and death after smoking and obesity in England. In 2010/11 there were 1.2 million alcohol-related hospital admissions and 15,000 deaths caused by alcohol in England[1]. In addition to the health implications, alcohol harm has a range of effects upon society including crime and anti-social behaviour, child welfare issues, housing issues and homelessness. The total cost of alcohol harm to the UK economy is estimated to be £21 billion per annum[2]. The cost to the NHS was estimated by NICE in 2008/09 to be £2.9 billion, with £700 million being as a result of A&E attendances[3].

Alcohol harm is a contributing factor in the development of numerous acute and chronic diseases, as well as a predisposing factor in various causes of injury and trauma [4]. There are a number of conditions that have been shown to be wholly attributable to alcohol harm and a number that are partially attributable to alcohol misuse; these are listed in the table in Appendix 1[5].

Most of the list of wholly attributable conditions are either chronic conditions suffered by those with high alcohol consumption, such as alcoholic liver disease, or conditions associated with the acute use of alcohol, for example ethanol poisoning.

Cardiovascular Disease

Heavy alcohol intake over a prolonged period of time can have direct toxic effects upon heart muscle tissue leading to Alcoholic Cardiomyopathy (ACM). Studies suggest that people drinking more than 90 grams of alcohol a day (approximately 12 units) over 5 years are at risk of the development of ACM. In persons developing ACM abstinence is thought to be essential to halt deterioration in heart muscle function[6].

In contrast, moderate drinking is not associated with cardio-toxicity, but is thought to have a protective effect against the development of cardiovascular disease and CHD [4].

In addition to the direct effect of alcohol upon heart muscle, heavy alcohol misuse is associated with increased risk of hypertension, which in turn is a major risk factor for Coronary Heart Disease and Stroke. Studies have shown a significant correlation exists between average alcohol consumption and blood pressure level. In most heavy drinkers with hypertension, blood pressure returns to normal upon abstinence [4].

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[2] **UK Home Office.** *The Govenment's Alcohol Strategy.* 2012.
[3] **NICE.** *Alcohol-use disorders: preventing harmful drinking; Costing Report.* 2010.
[4] *Health Risks and Benefits of Alcohol Consumption.* Alcohol Research & Health, 2000, Vol. 24.
[5] **Jones, Lisa, et al.** *Alcohol Attributable Fractions for England; Alcohol Attributable Mortality and Hospital Admissions.*
[6] **Laonigro, Irma, et al.** *Alcohol abuse and heart failure***.** European Journal of Heart Failure, 2009, Vol. 11.

Cancer

Alcohol is categorised as a grade 1 carcinogen and alcohol misuse is therefore a significant risk factor for the development of various forms of cancer including mouth, pharynx, larynx, oesophagus, stomach, colon, rectum and breast cancer. For cancer risk there is a dose response to alcohol consumption, meaning that the higher a person's alcohol consumption the higher their risk of developing certain forms of cancer [4].

Mental Health

There is an established link between alcohol misuse and the development of certain mental health disorders, including anxiety, affective disorders and psychosis. In addition, alcohol use has been linked to self-harm and suicide.

The co-existence of mental health problems and alcohol misuse is referred to as 'dual-diagnosis'. Some people use alcohol to reduce the symptoms of mental illness, such as anxiety. People with severe mental illness are almost twice as likely to be alcohol dependent compared to the general population, and people with severe enduring mental illness such as schizophrenia are at least three times as likely to be alcohol dependent[7].

Wernicke-Korsakoff Syndrome

A form of dementia called Wernicke-Korsakoff Syndrome is caused by thiamine (vitamin b1) deficiency usually due to alcohol abuse. Symptoms include loss of memory, drowsiness, poor balance, confusion about time and place, loss of spontaneity and poor balance. Post-mortem studies have shown that Wernicke-Korsakoff occurs in 2.5% of the general population and 12.5% of dependent drinkers. Treatment of Wernicke-Korsakoff requires intravenous or intramuscular injection of high-dose thiamine, which can also be used as a preventative measure for those at risk of developing the condition[8.]

Liver Disease

There are three main stages in the development of alcoholic liver disease. The first is referred to as 'alcoholic fatty liver disease' and is caused by heavy alcohol use that can lead to a build-up of fatty acids within the liver. Alcoholic fatty liver disease is reversible, with the liver returning to normal after two weeks of abstinence from alcohol[9].

The next stage of alcoholic liver disease is referred to as Alcoholic Hepatitis and is caused by prolonged heavy alcohol use over many years, which leads the liver tissue to become inflamed. However, Alcoholic Hepatitis can sometimes be caused by binge drinking. Alcoholic Hepatitis is usually reversible, but requires abstinence from alcohol for several months or years [9].

The final stage of alcoholic liver disease is Cirrhosis of the Liver, which is caused by progressive scarring of the liver leading to loss of liver function. In mild cases abstinence from alcohol may allow liver function to return, but the damage is irreversible. Treatment for liver cirrhosis is usually transplantation [9].

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[7] *Cheers? Understanding the Relationship between Alcohol and Mental Health.* **The Mental Health Foundation.** 2006.
[8] *Wernicke-Korsakoff's syndrome factsheet 6 Summary.* **Alcohol Concern.**
[9] NHS Choices. [Online]
http://www.nhs.uk/Conditions/Liver_disease_(alcoholic)/Pages/Introduction.aspx

Pancreatitis

The pancreas is an organ within the body that produces digestive enzymes and hormones, including insulin. Pancreatitis is a condition where the pancreas becomes inflamed.

Acute pancreatitis is where the pancreas becomes inflamed for a short period of time, usually a few days. Symptoms include abdominal pain, nausea, vomiting and fever. Approximately one quarter of cases of acute pancreatitis are caused by heavy drinking. Complete alcohol abstinence for at least six months is advised for those having an episode of acute pancreatitis, to allow the pancreas to recover [10].

Chronic pancreatitis is where the pancreas becomes permanently inflamed and is caused by repeated episodes of acute pancreatitis. Symptoms include severe abdominal pain, back pain, weight loss, diarrhoea, steatorrhoea (fatty stools) and jaundice. Long term heavy alcohol consumption is responsible for approximately 70% of cases of chronic pancreatitis. Although chronic pancreatitis is irreversible, abstinence from alcohol is known to reduce the severity of pain resulting from the condition[11].

Foetal and Child Development

Maternal alcohol use during pregnancy contributes to a range of effects in exposed children, including hyperactivity and attention problems, learning and memory deficits, and problems with social and emotional development.[12] Prenatal alcohol exposure is associated with increased levels of irritability, a temperamental variable known to contribute to poorer maternal attachment and behavioural problems in childhood.[13] The most serious consequence of maternal drinking during pregnancy is Foetal Alcohol Syndrome (FAS).

[10] **NHS Choices**
http://www.nhs.uk/conditions/pancreatitis/Pages/Introduction.aspx
[11] **NHS Choices**
http://www.nhs.uk/conditions/pancreatitis-chronic/Pages/Introduction.aspx
[12] **KELLY, S.J.; DAY, N.; and STREISSGUTH, A.P.** Effects of prenatal alcohol exposure on social behaviour in humans and other species. Neurotoxicology and Teratology 22:143–149, 2000
[13] **COLES, C.D.; PLATZMAN, K.A.; RASKIND–HOOD, C.L.;** et al. A comparison of children affected by prenatal alcohol exposure and attention deficit hyperactivity disorder. Alcoholism: Clinical and Experimental Research 20:150–161, 1997.

4 - Alcohol Consumption

Alcohol Consumption Levels

The impact of alcohol misuse is widespread encompassing alcohol related illness and injuries as well as significant social impacts including crime and violence, teenage pregnancy, loss of workplace productivity and homelessness. As alcohol has become increasingly affordable, consumption has increased – by 121% between 1950 and 2000. One in four adults now drinks above the recommended limits and there has been a corresponding rise in alcohol related disease and mortality

An alcohol unit is defined as 10 millilitres or 8 grams of pure alcohol. One unit roughly equates to a half-pint of standard strength lager, a small glass of wine, or a single (25ml) measure of spirits[14].

UK Government Recommended Guidelines:

Men should not regularly drink more than 3-4 units/day

Women should not regularly drink more than 2-3 units/day

Alcohol Consumption Risk Categories:

Lower risk: 21 or fewer units per week for men; 14 or fewer units per week for women

Increasing risk: 22-50 (men) or 15-35 (women) units per week

Higher risk: Over 50 (men) or over 35 (women) units per week

Binge drinking: consuming double or more than double the daily recommended limit in one day (i.e. 8 units or more for men; 6 units or more for women)

Alcohol Consumption Levels - National Context

Alcohol consumption has been rising in the UK since the late 1970s with a particular rise in the consumption of wine and spirits. In recent years there has been alarm at the increase in 'binge drinking' i.e. the consumption of large quantities of alcohol at a single session and the increased consumption of 'alcopops'.

Alcohol consumption levels are typically measured through surveys such as the Integrated Household Survey and Health Survey for England. However, surveys typically underrepresent alcohol sales data as many people underestimate the amount that they drink. In addition, surveys normally assess alcohol use within the preceding week to the survey and may not be fully representational of a person's usual alcohol use.

[14] **Department of Health.** *Alcohol Needs Assessment Rearch Report (ANARP).* 2004.

Spend on Alcohol

Since 2000, off-trade sales (e.g. supermarkets, off-licences) of alcohol have come to be dominant over on-trade sales (e.g. pubs, clubs). By 2009, the off-trade share had advanced to 65%. [15]

The off-trade's dominance of alcohol sales is the culmination of a long term trend to relax alcohol retailing. For example, in 1978 only one third of supermarkets had a licence to sell alcohol.

The price of off-trade alcohol has fallen in real terms and this is probably a major factor in the off-trade's increasing market share. Off-trade prices of wine and beer were broadly stable in cash terms and so well below Retail Price Inflation (RPI) from 1998 to 2006. On-trade prices have risen faster than RPI alcohol.[16] Until the Licensing Act 2003 came into force (in late 2005), there were effective quantity limits on individual purchases from the off-trade – no more than 12 bottles of wine, for example.

Purchases of alcoholic drinks bought for consumption within the home in the UK, as reported by the Living Costs and Food Survey (LCFS), have increased overall since 1992 from 527 millilitres (ml) per person per week, peaking in 2003/04 at 792 ml per person per week with figures fluctuating since. In 2011 this figure was 728 ml per person per week, a 38% increase since 1992.

Purchases of cider, perry and wine showed the largest increase between 1992 and 2011 compared to other types of drink. Consumption of cider and perry has increased by 85% from 47 ml per person per week to 87 ml and wine consumption has increased by 68% from 152 ml to 255 ml. [17]

The overall volume of alcoholic drinks purchased for consumption outside the home has decreased by 46% from 733 ml per person per week in 2001/02 to 394 ml per person per week in 2011. This reduction is mainly due to a 54% decrease in the volume of beer purchases from 623 ml to 286 ml per person per week over the same period.[18]

Taxation and Pricing

In 2008 alcohol tax was increased. It was estimated that a 10% rise in the price of alcohol would reduce adult alcohol-related mortality by up to 37%. A national review of the evidence on the relationship between alcohol price, promotion and harm was published in 2008 by Sheffield School of Health and Related Research (ScHARR).[20] This reported that the health harms due to alcohol (particularly chronic disease related to alcohol), alcohol-related crime and alcohol-related unemployment and absenteeism all reduced as the cost of alcohol increases. Preventable deaths occurred disproportionately in harmful drinkers and NICE concurs that increasing the real cost of alcohol appears to be the most effective way to reduce alcohol related harm. A minimum price per unit would prevent people, especially young people, from drinking greater quantities of cheaper drinks, and would prevent retailers from selling alcohol below cost price.

[15] BBPA Statistical Handbook, 2010
[16] Central Policy Review Staff report on alcohol, 1979
[17] http://www.hscic.gov.uk/catalogue/PUB10932/alc-eng-2013-rep.pdf
[18] http://www.hscic.gov.uk/catalogue/PUB10932/alc-eng-2013-rep.pdf

Licensing

There is evidence that increased licensing hours are associated with increased alcohol consumption and alcohol-related problems and that reducing the opening hours reduces the chances of harm. The changes to licensing laws in England in 2003 increased the availability of alcohol by allowing 24-hour opening in England and Wales and this has undoubtedly led to an increase in consumption.[19] It is interesting that public health was not considered when the Government changed the licensing laws. [20]

The delivery agreement for PSA25 states that laws and licensing powers introduced to tackle alcohol-fuelled crime and disorder, and protect young people need to be used widely and effectively.[21]

The Night-Time Economy

Since the early 1990s, the Night-time economy (NTE) has emerged as a key focus for urban public policy, reflecting the changing character of towns and cities, particularly the economic importance of leisure, tourism and service economies.

Consuming/drinking alcohol in the Night-time Economy (NTE) can have many benefits. For example, it generates economic activity and employment; it can bring people together to socialise; and it is an enjoyable pastime that many people value. However, it can also come with costs. Some of these costs, e.g., noise pollution, occur because the trading times in the NTE conflict with many people's daily routine/sleep. Other costs, e.g., crime and injury, are facilitated by alcohol which is often highly traded in the NTE.

Daily Alcohol Limits

Current government guidance suggests that adult men should regularly drink no more than 3 to 4 units of alcohol per day and that adult women should regularly drink no more than 2 to 3 units of alcohol per day[22].

The percentage of respondents from the Health Survey for England (2012) aged 16 and over drinking above recommended levels on at least one day in the preceding week is shown in figure 1 by age and gender.

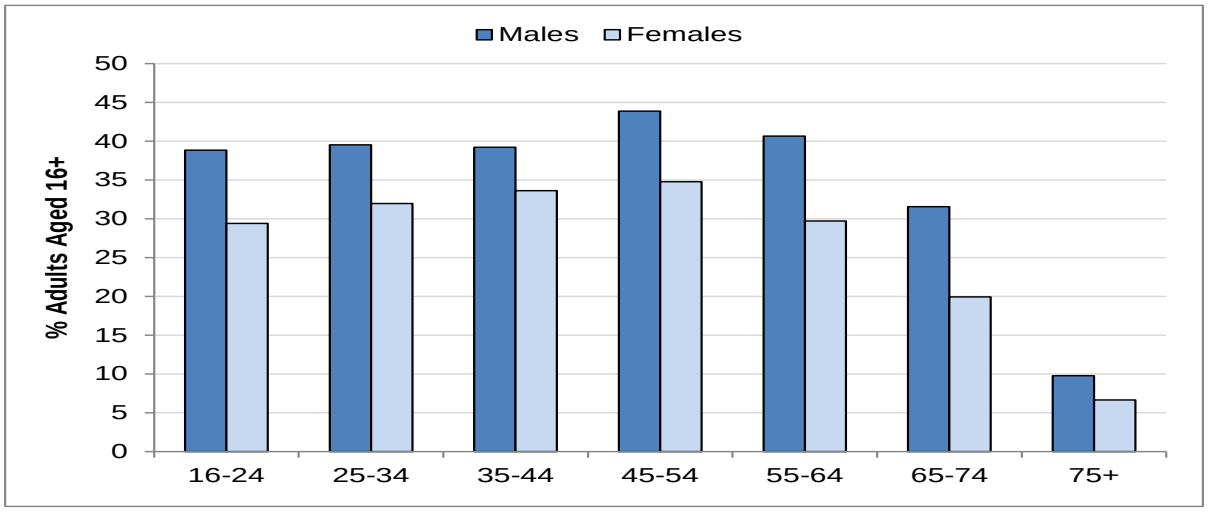
[19] Lesley Smith, David Foxcroft. Drinking in the UK: An exploration of trends. York : Rowntree Foundation, 2009

[20] British Medical Association. Alcohol misuse: Tackling the UK epidemic. London : BMA Board of Science, 2008

[21] HM Treasury. PSA Delivery Agreement 25: Reduce the harm caused by alcohol and drugs

[22] **Health and Social Care Information Centre.** *Statistics on Alcohol: England, 2012.* 2012.

Figure 1: **Percentage of persons aged 16+ reporting drinking above recommended levels on at least one day in the preceding week (2012)**

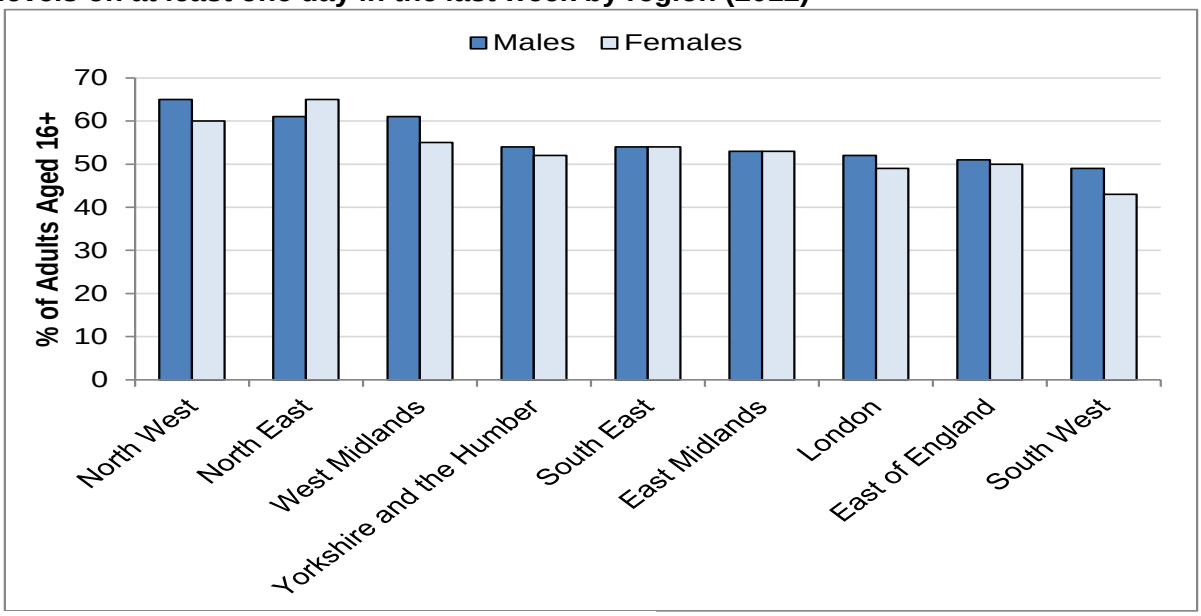


Source: *Health Survey for England (2012)*

The preceding chart illustrates that people drinking more than recommended levels can be seen to decline in both males and females with advancing age. Within all age groups a higher proportion of males exceeded daily alcohol consumption limits.

The percentage of people drinking above recommended levels on at least one day last week by region is shown in figure 2. The percentage of males drinking above recommended levels is highest in the North West compared to other regions, whereas the percentage of females drinking above recommended levels in the North West is second highest out of all regions nationally.

Figure 2: Percentage of persons aged 16 and above drinking above recommended levels on at least one day in the last week by region (2012)



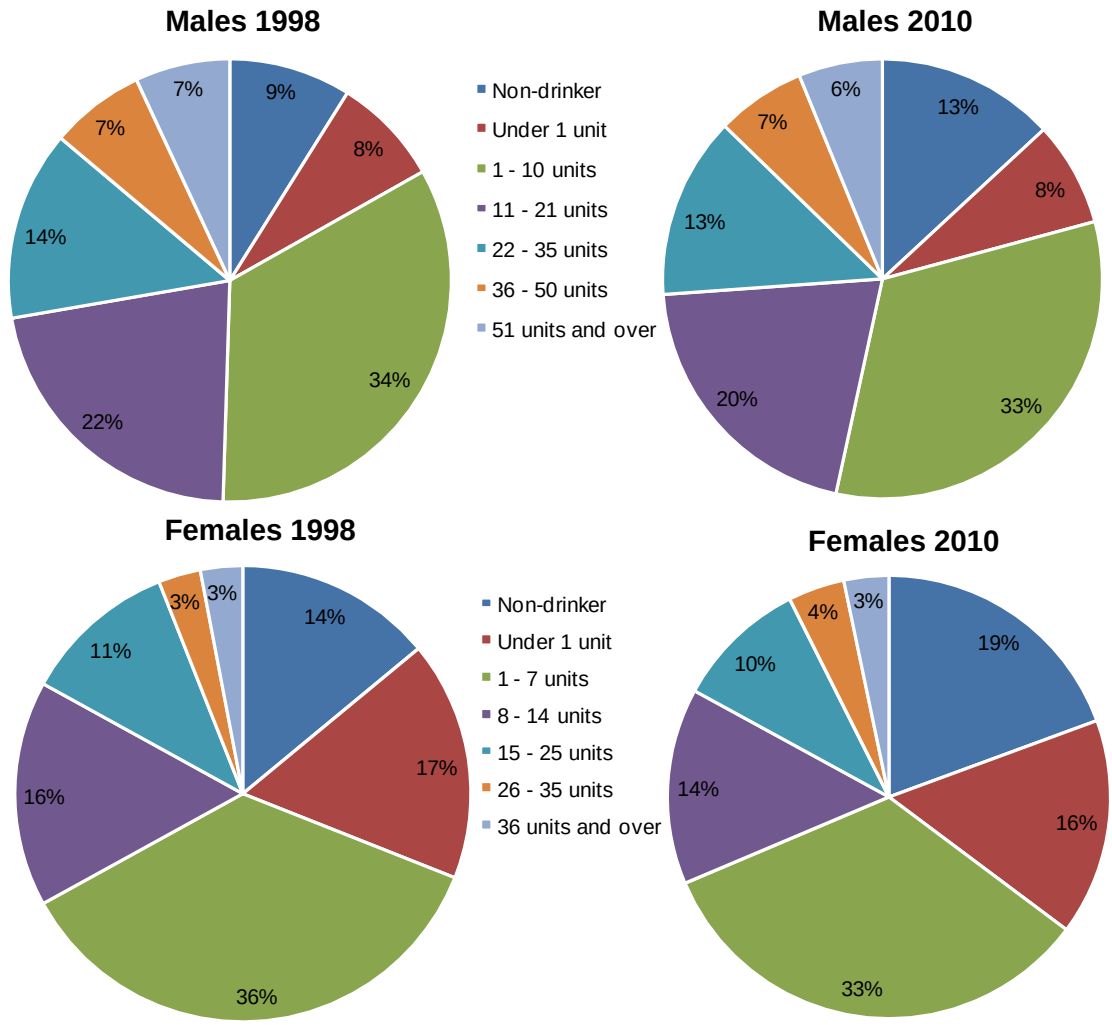
Source: *Health Survey for England, 2013*

Recommended Weekly Alcohol Consumption Limits

The Royal College of Physicians recommends that men drink no more than 21 units of alcohol per week and women no more than 14 units of alcohol per week. Drinking above these levels is considered increasing risk to health and drinking more than 36 units in females and 51 units in males is deemed to higher risk..

Figures from the General Lifestyle Survey 2010 show that 26% of men and 17% of women exceeded recommended weekly alcohol consumption levels with a further 7% of men and 3% of women drinking 51 units or more and 36 units or more respectively. There are slight differences between consumption in 2010 compared to 1999 with a higher number of abstainers in 2010 for both males and females. However, there is little difference in the proportion of persons exceeding recommended levels in 1998 and 2010. This suggests that despite national strategies to reduce problematic drinking there has been little change in higher levels of alcohol consumption across the last decade.

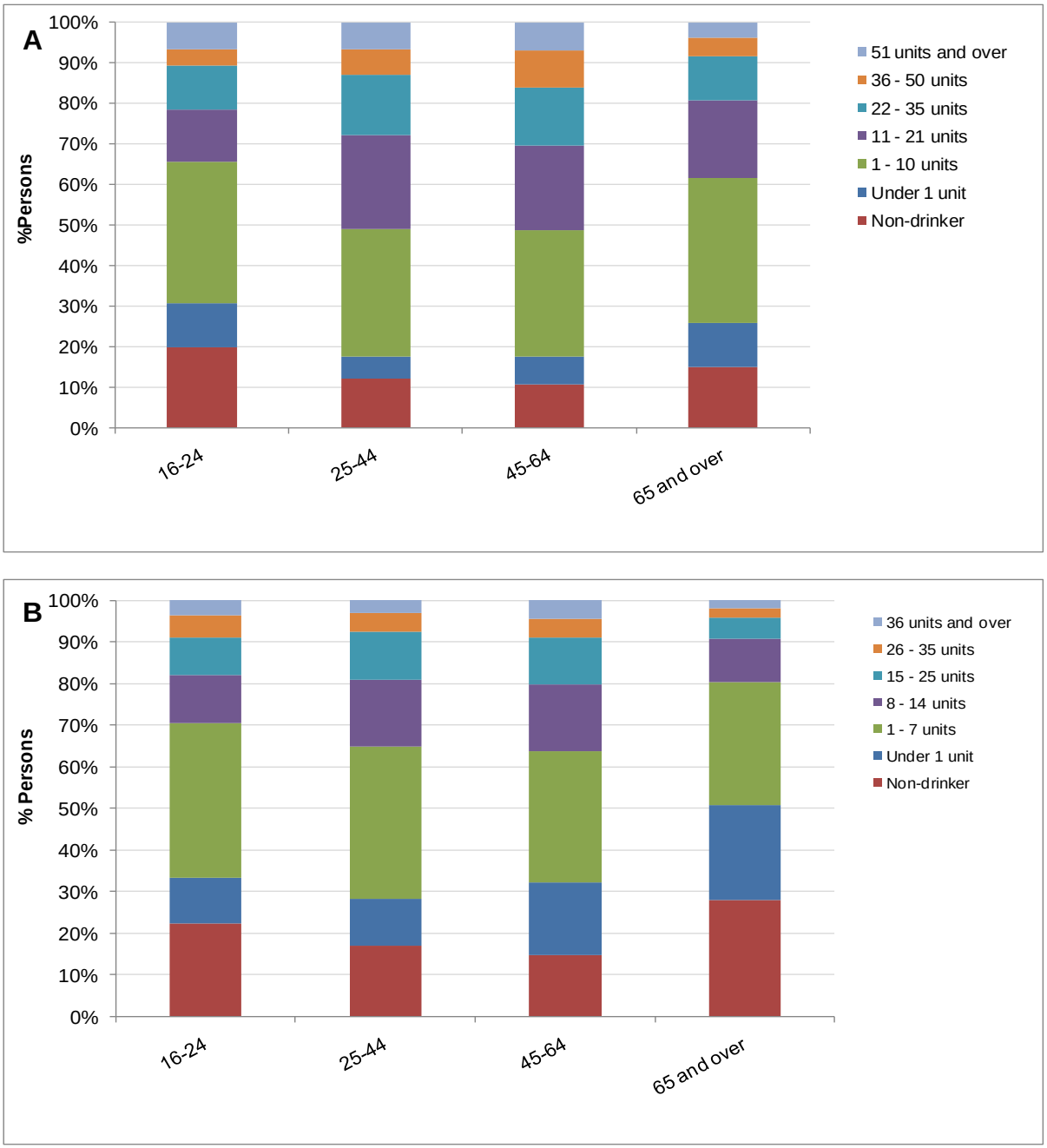
Figure 3: Comparison of Weekly Alcohol Consumption in England in 1998 and 2010



Source: *ONS - General Lifestyle Survey, 2010*

Weekly alcohol consumption by age band is shown in figure 4. The proportion of men drinking at increasing risk and higher risk levels is highest in 45-64 age bands and lowest in the 65 and over age band. In females there is little difference in the level of increasing risk and higher risk drinking between age groups under 65, but there is a lower level of increasing risk and higher risk drinking in those 65 and over.

Figure 4: Weekly Alcohol Consumption in England by Age Band (2010) A) Males B) Females

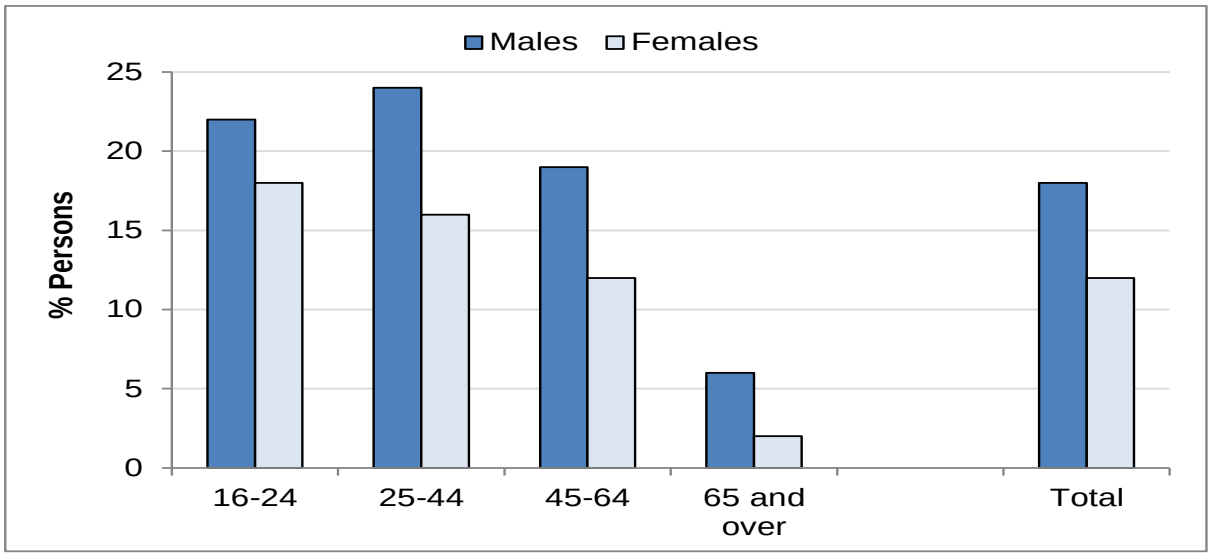


Source: *ONS - General Lifestyle Survey, 2010*

Binge Drinking

Binge drinking is defined by the national alcohol-harm strategy as males consuming 8 or more units in a single session and women drinking more than 6 or more units in a single session. The proportion of the population binge drinking peaks within the 25-34 age groups in males and within the 16-24 age groups in females (figure 5)

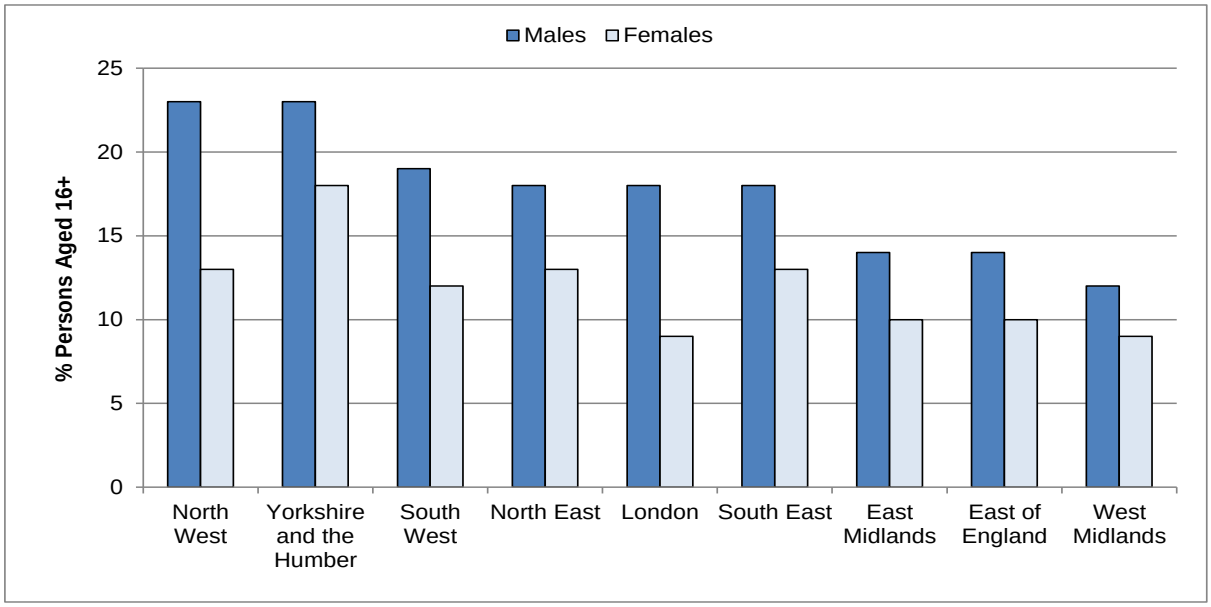
Figure 5: Persons binge drinking on at least one day in the preceding week by Age Group (2011)



Source: *ONS - General Lifestyle Survey, 2012*

There is considerable variation in regional rates of binge drinking. The North West and Yorkshire and the Humber have the highest rate of binge drinking males of all the English regions. Binge drinking is less of a problem in females compared to males; however the North-West has the second highest rate of binge drinking rates in females out of all the English regions at 13% (Figure 6).

Figure 6: Persons Binge Drinking on at least one day in the preceding week by English Region (2011)



Source: *ONS - General Lifestyle Survey, 2012*

Vulnerable Groups

People with Long Term Conditions

Alcohol has a detrimental effect on progression of various long term conditions including hypertension, heart disease, diabetes and mental health conditions[23]. With this in mind, it is important that people suffering with long term conditions are given the advice and support needed to reduce harm from alcohol use. This highlights the importance of making the most of patient reviews to ensure that IBA is offered when appropriate.

Mental Health

Mental health problems can be both caused by and a cause of alcohol misuse. Many people with mental health problems use alcohol to self-medicate. Research suggests that the prevalence of alcohol dependence is almost twice as high in those with psychiatric disorders compared to the general population[24]. Studies have suggested that certain mental health conditions may be associated with a greater risk of alcohol dependence, for example schizophrenia patients have 3 times the average population risk, anxiety patients 1.5 the average population risk and those with depression and affective disorders have 1.9 the average population risk[51]. In Tameside in 2013/14, 25% of those referred to alcohol treatment services had a dual-diagnosis of a mental health condition[25].

It is known that alcohol misuse can be a contributing factor in the development of certain mental health conditions including depression and anxiety. It is therefore important that front line mental health staff are trained in administering AUDIT and IBA, and that referrals from mental health services are made to alcohol treatment services where appropriate and vice versa.

BME Populations

The level of alcohol misuse in many BME communities is less than that of the general population. Some groups such as Indian men have higher rates of alcohol related deaths compared to the general population. However, BME populations are under-represented in alcohol treatment services both nationally and locally[26]. In Tameside in 2013/14, 97% of people referred to alcohol treatment services were white British or white Irish.[27]

LGBT Community

Research suggests that levels of alcohol misuse and dependence are higher within the LGBT community than in the population as a whole. Binge drinking has been suggested to be approximately twice as common in gay and bisexual males and almost twice as common

[23] *Health Risks and Benefits of Alcohol Consumption.* Alcohol Research & Health, 2000, Vol. 24.
[24] *Cheers? Understanding the Relationship between Alcohol and Mental Health.* **The Mental Health Foundation.** 2006.
[25] NDTMS (National Drug Treatment Monitoring System)
[26] Hurcombe, Rachel , Bayley, Mariana and Goodman, Anthony. *Ethnicity and Alcohol: A Review of the UK Literature.* 2010.
[27] NDTMS (National Drug Treatment Monitoring System)

in lesbian, gay and bisexual females, when compared to males and females in the wider population[28].

The LGBT community has traditionally been centred on bars and clubs, which in itself may promote higher levels of drinking. It has been suggested by some that higher levels of drinking within the LGBT community may stem from individuals misusing alcohol as a method of escape from a society where they feel stigmatised and marginalised [55].

Women

Women appear to be more vulnerable than men to many adverse consequences of alcohol use. Women achieve higher concentrations of alcohol in the blood and become more impaired than men after drinking equivalent amounts of alcohol. Research also suggests that women are more susceptible than men to alcohol-related organ damage, cancer, brain damage and to trauma resulting from traffic crashes and interpersonal violence.[29]

Factors that may increase women's risk for alcohol abuse or dependence include genetic influences, early initiation of drinking, and victimisation.

Young People in Transition

Models of Care (2002) focuses on commissioning and provision of drug and alcohol treatment for adults, aged 18 years and older and clearly recognises the important differences between young people's substance misuse services and adult substance misuse services.

Becoming an adult involves many changes in a young person's life. Most young people who have received treatment for drugs and/or alcohol problems have already experienced other significant problems in their life. Young people need to be protected from feeling "dumped, cut off and abandoned" as they reach the transition period[30]

Children and Young People Leaving Care

Young people leaving care are one of the most vulnerable groups in our society. In 'Young People Leaving Care: A study of costs and outcomes', [31] (2002) states that young people in care started using drugs and alcohol earlier than their peers and that some young people had turned to drugs as a means of compensating for negative experiences such as loss and rejection. Some young people who have substance misusing parents – and this may be one of the reasons they have come to be in care – may view substance and alcohol misuse as 'normal'.[32]

[28] Buffin, J. , Roy, A., Williams, H., and Winter, A. (Part of the Picture: Lesbian, gay and bisexual people's alcohol and drug use in England (2009-2011)
[29] http://pubs.niaaa.nih.gov/publications/aa46.htm
[30] Shaw, Southwood, McDonagh, 2004

[31] Dixon, Wade, Byford, Weatherly & Lee (2006) Young People Leaving Care: A Study of Costs and Outcomes. University of York, York: www.york.ac.uk
[32] Ward, J, Henderson, Z and Pearson, G (2003) *One Problem Among Many: Drug use among care leavers in transition to independent living*. London: Home Office.

Young people leaving care are expected to live independently much earlier than their peers and have less support and help to do this. Care leavers identify personal relationships and feelings, skills for independence and safe housing as key issues for their health and well-being.

50+ Age Group

A substantial number of older adults are drinking at higher than recommended levels and it is a growing problem that is often ignored or missed by many healthcare providers.[33]

Older people may not be aware that recommended alcohol limits are lower for them than for younger people. Older adults are more sensitive to alcohol and less able to metabolize it both of which contribute to adverse effects at any level of drinking.

Drinking at an older age can have additional negative effects:

- Exacerbate some medical conditions
- Reduce the ability to function
- Increase the risk of falling
- Negatively interact with medication

[33] http://www.niaaa.nih.gov/alcohol-health/special-populations-co-occurring-disorders/older-adults

Starting and Developing Well

Pregnant Women

The 2010 NICE guidance 'antenatal care' sets out the recommendations for pregnant women with respect to alcohol consumption. Specifically, it recommends that pregnant women and women trying to conceive should avoid drinking alcohol and that if they do choose to drink, to minimise the risk to their unborn child, not to drink more than one or two units of alcohol once or twice a week and should not get drunk [34]. NICE additionally advised that the risks of miscarriage in the first three months of pregnancy mean that it is particularly important for a woman not to drink alcohol at all during that period and preferably pre-conception [23].

Effects upon Foetal Development

Foetal Alcohol Spectrum Disorders (FASD) are a range of conditions that can occur in persons whose mother drank alcohol during pregnancy. Although there are no accurate measurements of FASD in the UK, it is estimated that as many as 1 in 100 children have some form of FASD and it is the most common cause of non-genetic learning disability.[35] Prenatal exposure to alcohol can have a range of deleterious effects upon a child including facial deformities, brain damage, major organ damage and hearing and vision impairments; Damage to the brain results in developmental disabilities, including learning and social difficulties, as well as impairment of language, motor skills, memory and attention. [24]

Alcohol Harm in Children and Young People

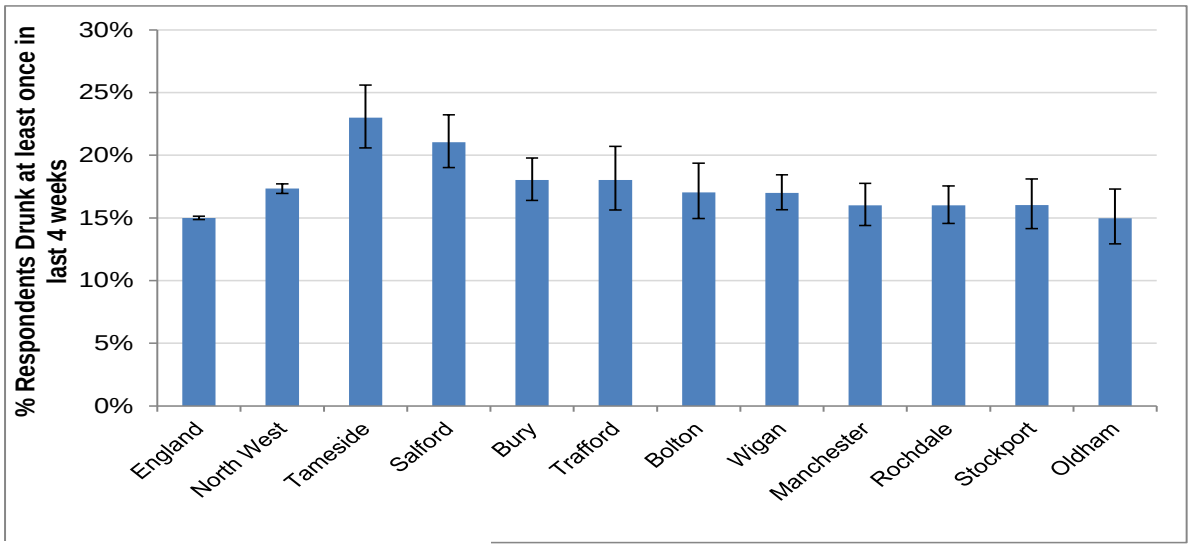
There are significant health and social implications for children consuming excessive quantities of alcohol and the chief medical officer recommends that children under the age of 15 should not drink alcohol at all [36]. Alcohol use in childhood can be detrimental to a child's development, with adverse effects on growth as well as brain, liver, bone and endocrine development. Whereas alcohol related disease is generally thought of as affecting older people, cases of alcohol attributable diseases such as alcoholic liver disease are now being diagnosed in people within their twenties. Young people that drink are also more likely to be involved in accidents, to be victims or perpetrators of crime and violence, and to engage in risky sexual activity.

The extent of alcohol misuse in children is a significant issue in Tameside. The Tellus 4 survey of children in school years 6, 8 and 10 reported that 23% of children within those age groups in Tameside had been drunk at least once within the previous 4 weeks, as shown in

[34] **NICE.** *Antenatal care.* 2010.
[35] **Blackburn, Carolyn; Carpenter, Barry; and Egerton, Jo.** *Facing the challenge and shaping the future for primary and secondary aged students with Foetal Alcohol Spectrum Disorders (FAS-eD Project).* s.l. : National Organisation on Fetal Alcohol Syndrome UK, 2009.
[36] **NICE and SCIE.** *Looked-after children and young people.* 2013

Figure **7**. Tameside has the highest figure out of all greater Manchester local authorities for this indicator, at 53% and 33% higher that England and the North West respectively.

Figure 7: Percentage of children in years 6, 8 and 10 who said they had, been drunk at least once in the previous 4 weeks: England, North West and Greater Manchester local authorities.



Source: Tellus 4 survey (2009)

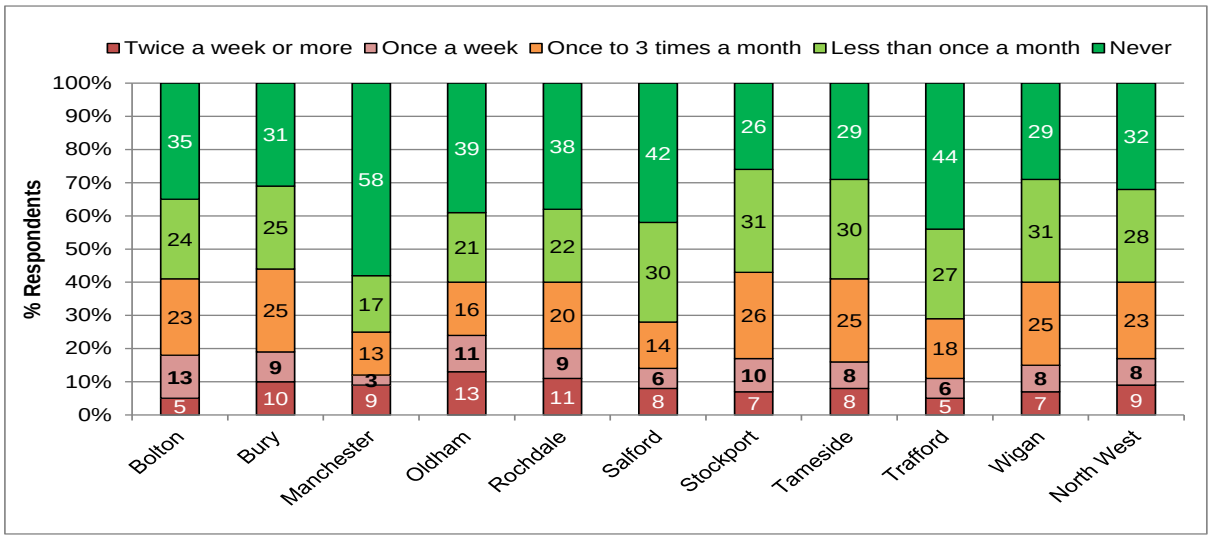
North-West Young Persons' Alcohol & Tobacco Survey 2013

Every two years Trading Standards North West undertakes a survey of young people's behaviours and attitudes with respect to alcohol and tobacco. These results provide a picture of the current situation with regard to underage drinking in Tameside compared to other local authorities.

The Frequency of Alcohol Misuse in Young People

Tameside has the second lowest proportion out of Greater Manchester local authorities of young people aged 14-17 who reported never drinking alcohol (figure 8), with 29% of 14-17 year olds in Tameside reporting never drinking alcohol. The proportion of Tameside respondents reporting that they never drink alcohol increased from 14% in 2007 (n=514) to 29% in 2013 (n=689).

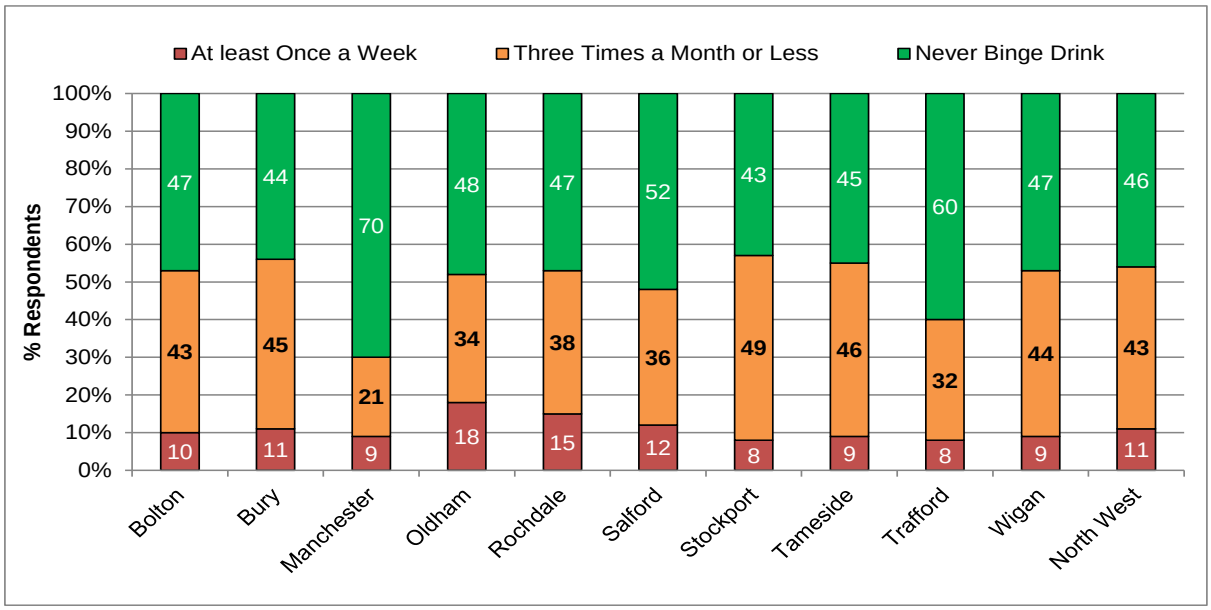
Figure 8: Frequency of Alcohol Consumption by Young People aged 14-17 by Greater Manchester Local Authority



Source: *Trading Standards North West, 2013*

Tameside has the second highest proportion of young people aged 14-17 who reported binge drinking out of Greater Manchester local authorities, but has the second lowest proportion of 14-17 year olds who report binge drinking at least once per week (figure 9). The percentage of respondents aged 14-17 years old who reported regularly drinking 5 or more drinks on one occasion, has fallen from 40% in 2007 (n=514) to 9% in 2013 (n=689).

Figure 9: Frequency of Binge Drinking in 14-17 year olds by Greater Manchester Local Authorities

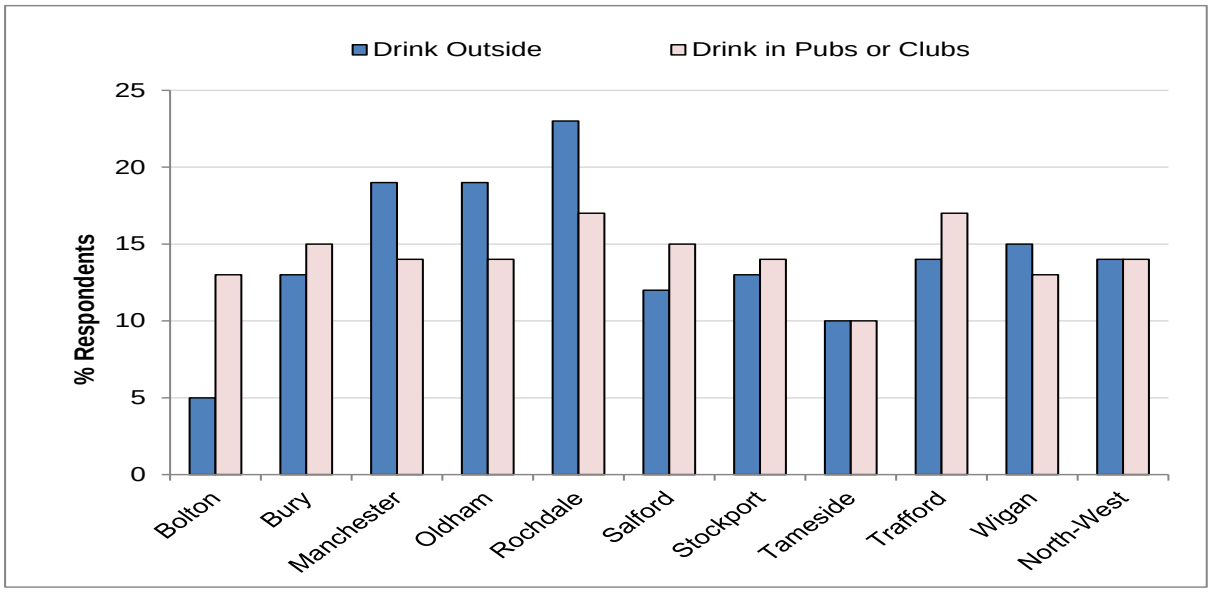


Source: *Trading Standards North West, 2013*

The percentage young people aged 14-17 reporting drinking alcohol outside or in pubs or clubs, is shown in Figure 10 for Greater Manchester local authorities. Out of Greater Manchester local authorities, Tameside has the second lowest proportion of young people

reporting that they drank alcohol outdoors (10%) and the lowest proportion of young people reporting that they drank alcohol in pubs or clubs (10%).

Figure 10: Percentage of young people aged 14-17 reporting drinking alcohol outside or in Pubs or clubs

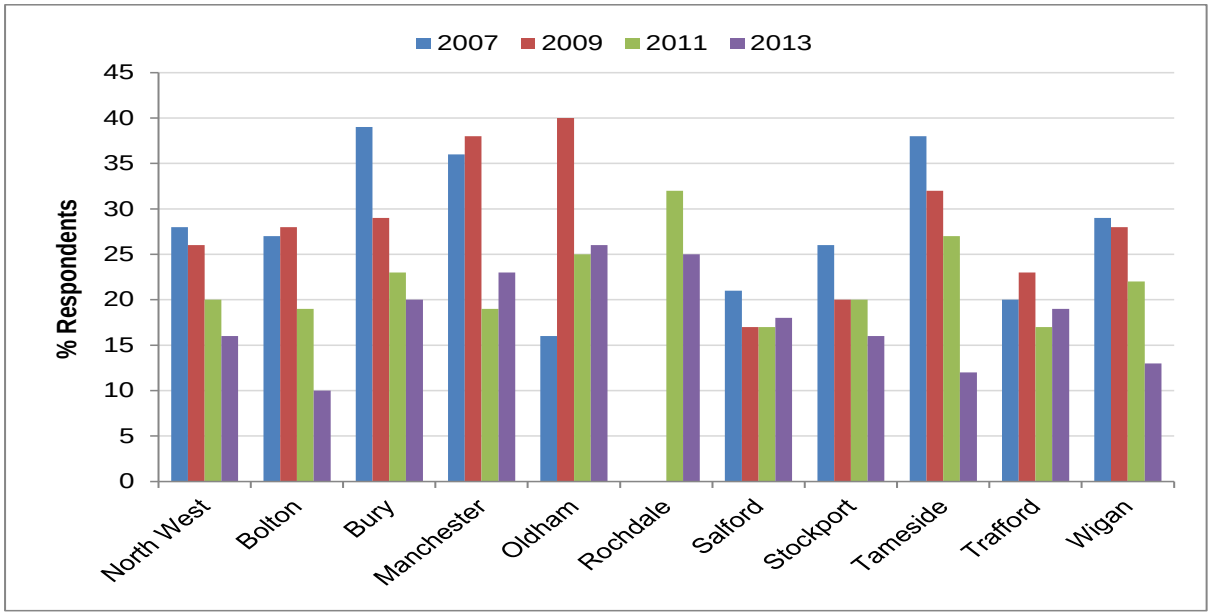


Source: *Trading Standards North West, 2013*

At 12% Tameside has the second lowest proportion of young people aged 14-17 who buy alcohol for themselves out of all Greater Manchester local authorities (Figure 11). The proportion of young people who buy alcohol for themselves in Tameside has fallen from 38% in 2007, reflecting reductions from the North West as a whole. So although alcohol misuse is prevalent within young people in Tameside, it would appear that the availability of alcohol to young people in Tameside is comparatively lower. However, there is anecdotal evidence of a culture of parents buying alcohol for children and young people in Tameside. This is consistent with the findings of the 2013 North West Trading Standards survey, which shows that 60% of Tameside young people report getting alcohol from parents or guardians in 2013 which has increased from 41% in 2007.

The survey also asked young people aged 14-17 a number of questions about their attitudes toward drinking alcohol. Within the Tameside respondents, 70% thought that drinking alcohol was fun with 59% of respondents reporting that they thought that it is normal to get drunk.

Figure 11: **Percentage of young people aged 14-17 who buy alcohol for themselves.**

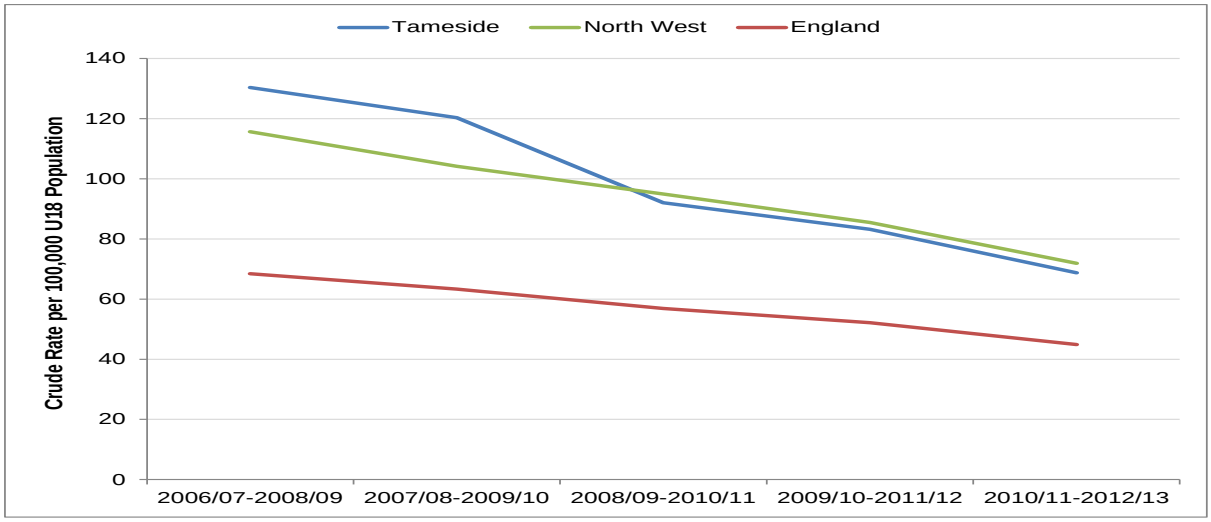


Source: *Trading Standards North West, 2013*

Alcohol Specific Admissions in Under-18s

The rate of alcohol specific hospital admissions in under-18s is shown for Tameside, the North West and England in Figure 12. Between the periods 2005/06 to 2007/08 and 2010/11 to 2012/13 the rate of alcohol specific admissions in under-18s decreased by 47.3% in Tameside compared to 35% and 34.4% in the North West and England respectively. Rates of alcohol specific admissions in under-18s in Tameside were equivalent to that of the North West for the period 2008/09 to 2010/11, but 59.5% higher than England.

Figure 12: Alcohol Specific Admissions in Under-18s. Three year pooled averages...

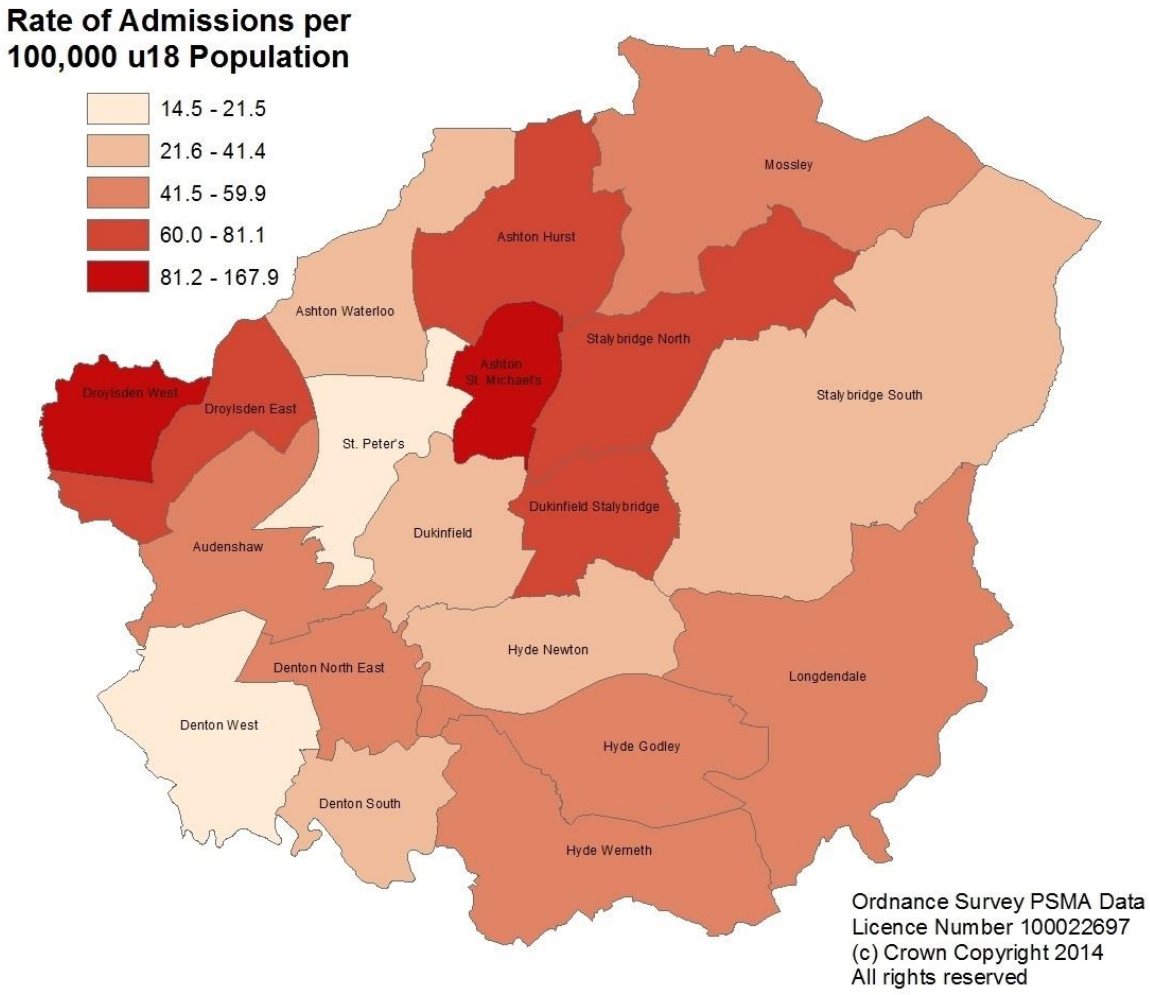


Source: *NWPHO – Local Alcohol Profiles for England, 2014*

Alcohol Specific Admissions for Under-18s by Ward of Patient Residence

Rates of directly age standardised alcohol specific admissions in under 18s by ward of patient residence are shown in Map 1. Wards with the highest rates of admissions for under 18s are Ashton St. Michael's at 168 admissions per 100,000 population aged under 18 and Droylsden West at 137 admissions per 100,000 population aged under 18. Unexpectedly, Ashton St. Peters had the lowest rate of alcohol specific admissions for under 18s, despite having the highest levels of other alcohol misuse indicators within the borough. However, a caveat relating to the analysis of alcohol specific admissions in under 18s at ward level is that the total number of alcohol specific admissions for each ward is small at less than 20 and therefore findings lack statistical significance.

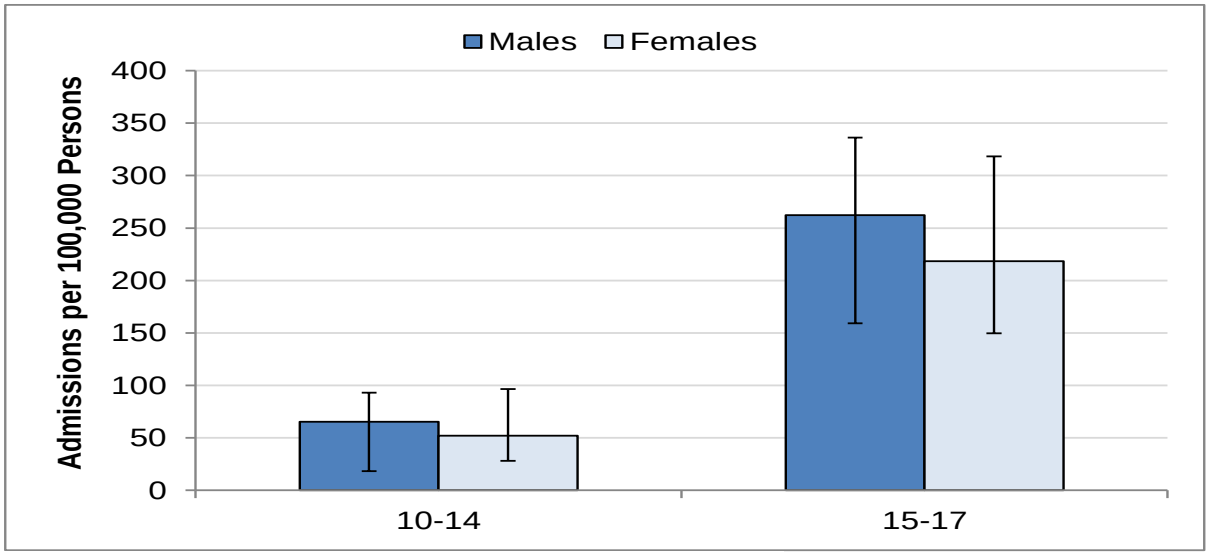
Map 1: Alcohol Specific Admissions by Ward of Residence for under-18s 2010-2012. Directly Age Standardised Rate (DSR)



The rate of alcohol specific and alcohol intoxication hospital admissions are shown in Figures 13 and 14 respectively by the age bands 10-14 and 15-17. Admissions for alcohol specific conditions and intoxication are negligible in younger age bands. Alcohol intoxication

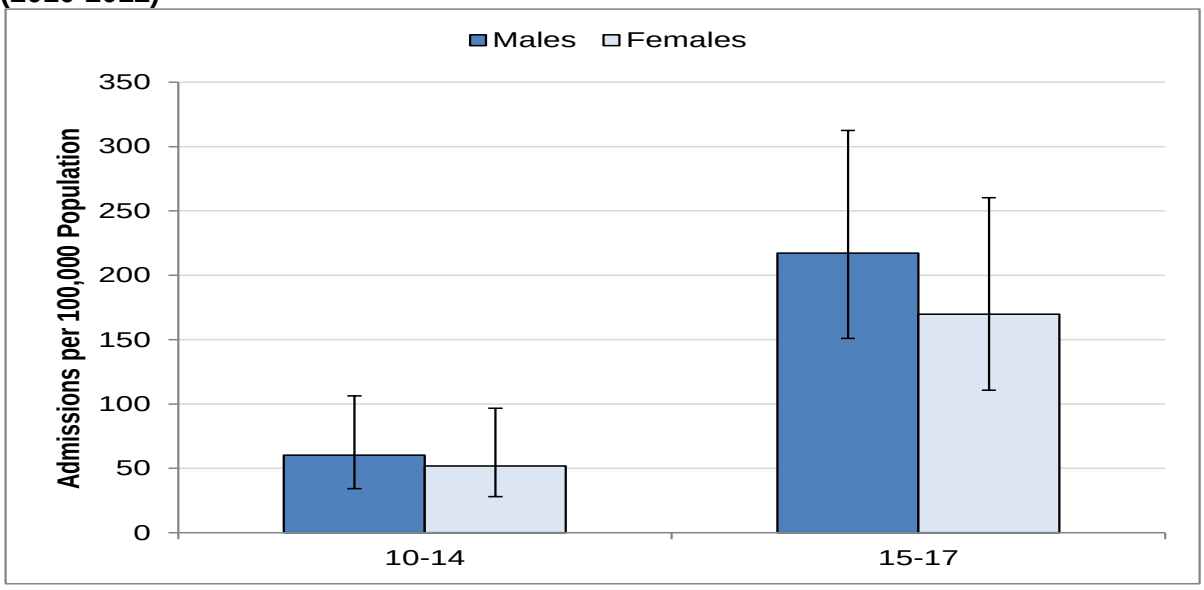
admissions make up the majority of alcohol specific admissions in children and young people.

Figure 13: Alcohol Specific Hospital Admissions in Tameside Children by Age and Sex (2010-2012)



Source: *Secondary User Statistics (SUS) NHS*

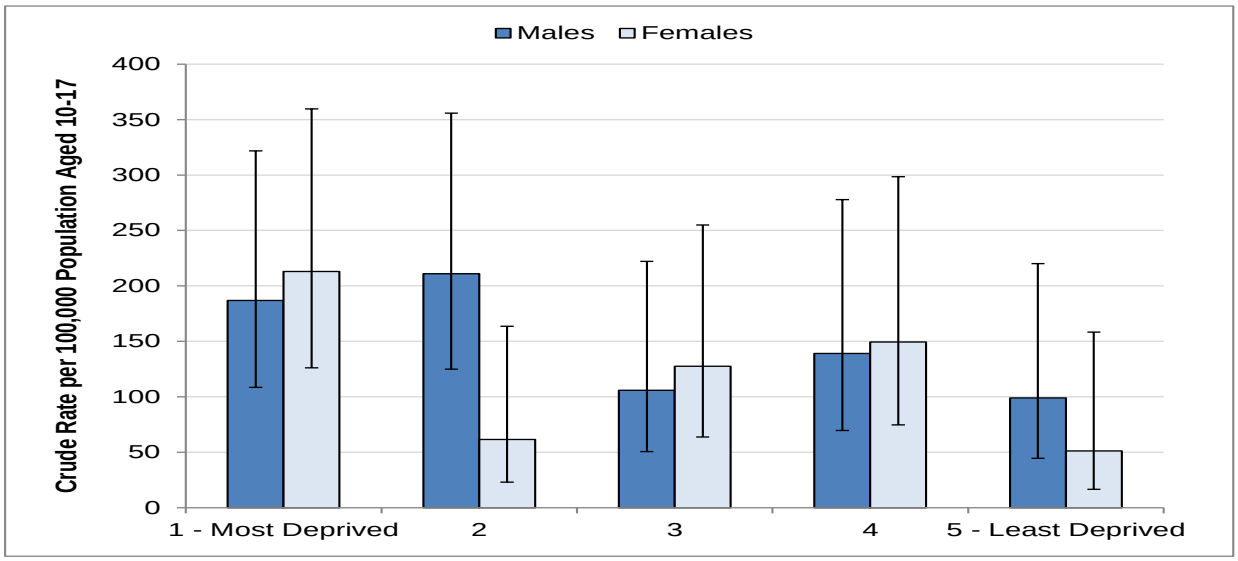
Figure 14: Alcohol Intoxication Admissions in Tameside Children by Age and Sex, (2010-2012)



Source: *Secondary User Statistics (SUS) NHS*

The rates of alcohol specific hospital admissions for Tameside's young people aged 10-17 are shown in figure 15 by local deprivation quintiles (IMD 2010). In males aged 10-17, alcohol specific hospital admissions are highest within the most deprived 40% of the population, whereas the rate of alcohol specific hospital admissions in females is highest within the most 20% deprived quintile of the population. However the number of alcohol admissions for each IMD 2010 quintile by sex is too small for these observations to be statistically significant.

Figure 15: Alcohol Specific Hospital Admissions in Tameside Children aged 10-17 by Tameside IMD2010 deprivation quintiles



Source: *Secondary User Statistics (SUS) NHS*

Use of Alcohol and Drug Treatment Services for Children and Young People in Tameside

Alcohol and drug treatment services for young people under the age of 19 are provided in Tameside by 'Branching Out', a service run by Lifeline. Branching Out currently offers specialist psychosocial or clinical interventions to approximately 150 young people a year, with an average age of 15. The team also delivers targeted group work to over 400 young people and support to approximately 100 parents and carers.

Approximately 40% of young people accessing treatment through Branching Out present with a primary alcohol issue and nearly 90% of service user use alcohol regularly. In 2013/14, approximately 50% of service users accessing branching-out services were being treated for alcohol misuse and misuse of one or more other substances.

Potential barriers to young people accessing alcohol services in Tameside include[37]:-

- There is a particular stigma associated with alcohol misuse and it may be difficult for young people to admit that they have a problem with alcohol.
- Branching Out is located in Ashton-Under-Lyne and may therefore not be geographically convenient for some young people to get to for treatment services.
- Links with and referral to 'Branching Out' from primary care have got the potential to be improved.
- As is the case for adult alcohol treatment services, young people from ethnic minorities are underrepresented within alcohol treatment services in Tameside. Reasons for this could include cultural factors which may increase the stigmatism associated with alcohol misuse problems.

[37] Branching Out, 2014 (personal communication)

- The numbers of people being referred to 'Branching Out' services from the criminal justice system are falling. Explanations for this include police cuts and the increase in the implementation of restorative justice. This suggests that many young people who offend as a result of alcohol problems are not having their alcohol treatment needs met.

Map 2 shows the rate of young people aged 12-19 accessing treatment through 'Branching Out' by ward of residence over the 3 year period 2011/12, 2012/13 and 2013/14. Rate of access to Branching Out services in Tameside is highest in St. Peters at 923 per 100,000 population aged 12-19 years and lowest in Droylsden East at 227 per 100,000 population. Figure 16 illustrates that there is a strong positive relationship between deprivation and the number of young people accessing 'Branching Out' services.

Map 2: Rate of Young People Aged 12-19 in Tameside in Treatment with Branching Out (2011/12, 2012/13 and 2013/14 pooled)

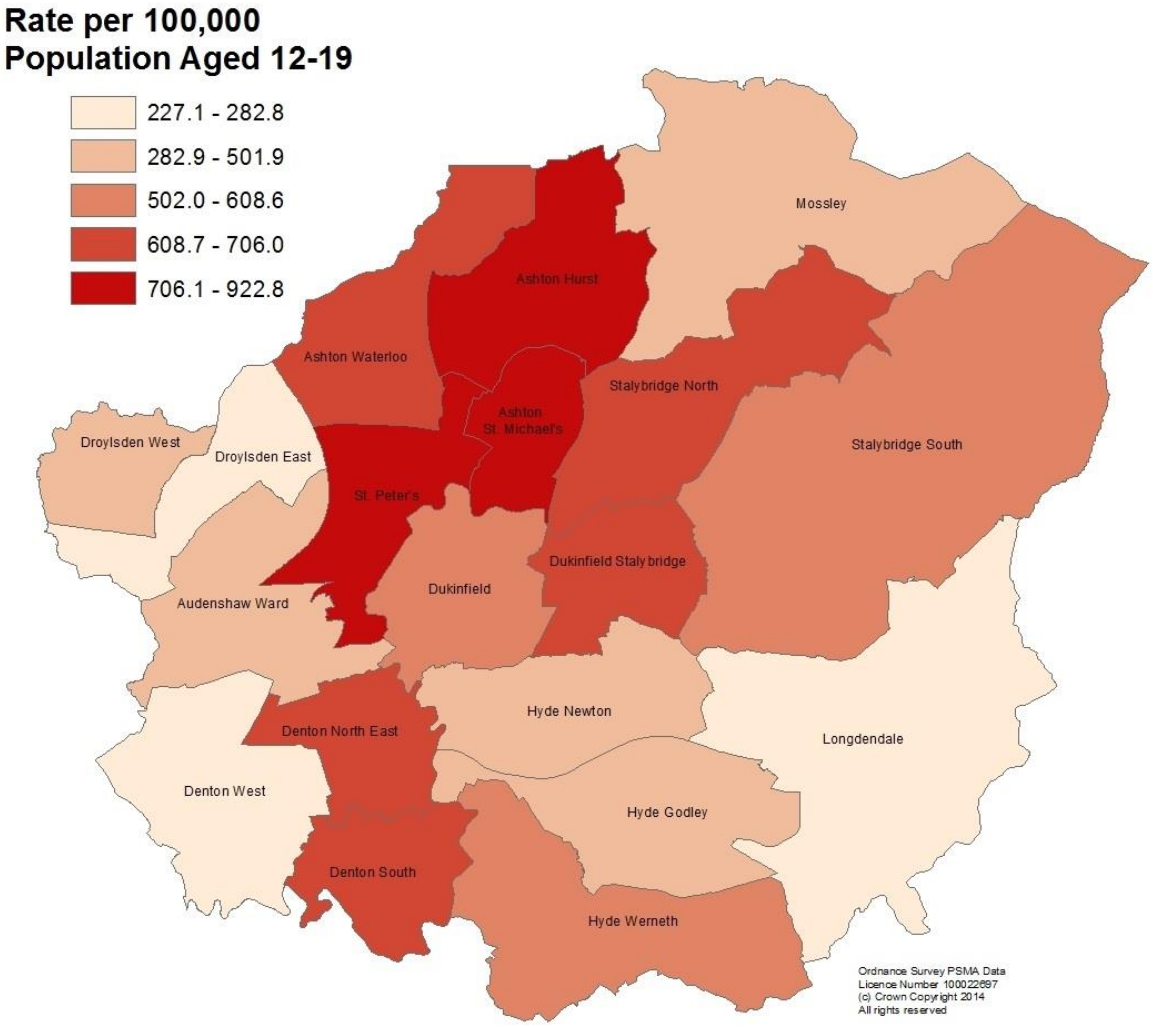
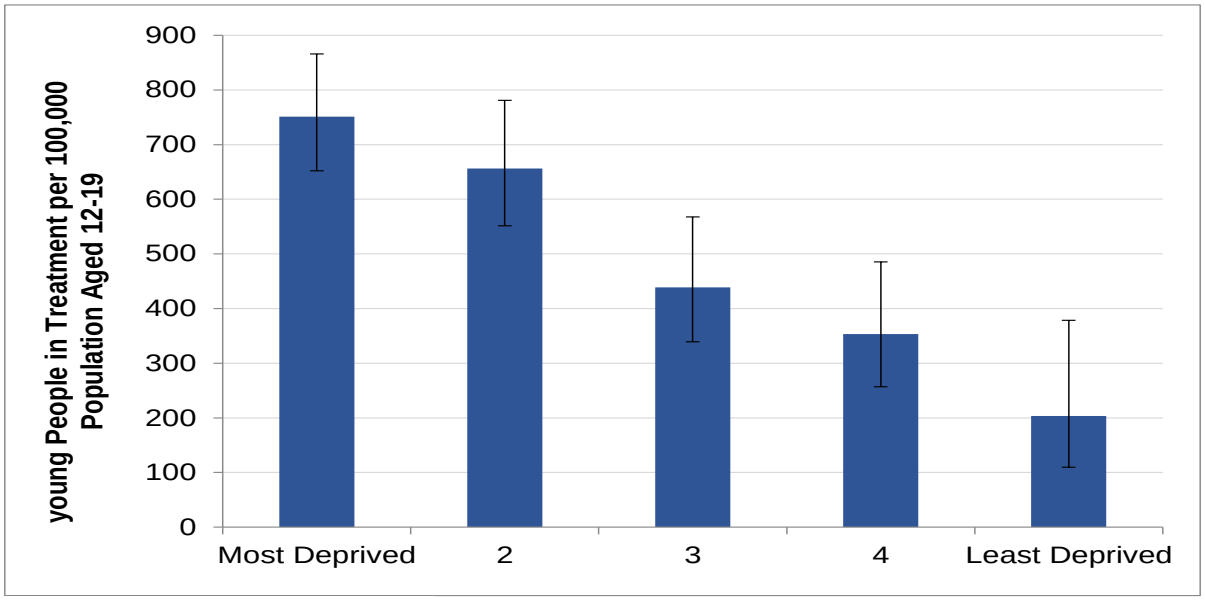


Figure 16: Rate of Tameside Young People Aged 12-19 years in Treatment with 'Branching Out' by National IMD 2010 Quintiles (2011/12, 2012/13 and 2013/14 pooled)



***Source:** 'Branching Out'*

Sexual Health

There is a well-established association between alcohol misuse and poor sexual health outcomes including unplanned pregnancy and sexually transmitted infections. Drinking reduces inhibitions and affects judgement which in turn can lead to unprotected sex. Alcohol use and sexual activity are linked with 82% of 16-30 year olds reporting drinking alcohol before engaging in sexual activity[38].

The association between alcohol use and sexual activity is a particular problem for young people. Within a sample of 2,000 UK 15-16 year olds, 11% had regretted having sex under the influence of alcohol[39]. Young people are limited in their experience of drinking and are more likely to engage in risk taking activity whilst under the influence of alcohol.

In 2013/14, 38% of young people accessing drug and alcohol treatment services in Tameside and Glossop were offered a sexual health intervention.

Child welfare

Alcohol misuse in parents has a range of negative implications for child welfare. It is estimated that 2.6 million children in the UK are living with parents who are drinking hazardously[40]. Children of heavy drinkers are at increased risk of emotional and physical abuse with alcohol or other substance abuse evident in 57% of child protection cases involving serious fatal child abuse in the UK [29].

[38] **Royal College of Physicians and BASHH.** *Alcohol and Sex: A Cocktail for Poor Sexual Health.* 2011.
[39] **Bagnall G., Plant MA.** *HIV/AIDS risks, alcohol and illicit drug use among young adults in areas of high and low rates of HIV infection.* s.l. : AIDS Care, 1991.
[40] **Turning Point.** *Bottling it up: the next generation. The effects of parental alcohol misuse on children and families.* 2011.

As of 31st December 2013, 17.2% of Tameside Child Protection Plans cited parental alcohol misuse as an associated factor, with 7.1% of Child Protection Plans citing both parental alcohol misuse and domestic violence as associated factors.

In 2013/14, 19% of people accessing alcohol treatment services in Tameside were parents living with dependent children[41].

Parents that abuse alcohol in the presence of their children may also have a negative influence upon the attitudes of children towards drinking and their subsequent alcohol use. Children who see their parents get drunk are twice as likely to get drunk themselves[42].

Looked After Children

Many young people in local authority care come from families with complex needs including alcohol misuse, drug abuse and domestic violence. Therefore many looked after children consider alcohol misuse to be normal. Looked after children may be more likely to start drinking at an earlier age, consume more and are more likely to become alcohol dependent as adults. In 2013/14, 23% of young people accessing drug and alcohol services through branching out were looked after children. Children leaving care at 18 are also considered to be at risk of alcohol related problems including dependency[43].

[41] **NDTMS** - National Drug Treatment Monitoring System
[42] *Young people, alcohol and influences: A study of young people and their relationship with alcohol.* s.l. : Joseph Rowntree Foundation, 2011.
[43] *Young people, alcohol and influences: A study of young people and their relationship with alcohol.* s.l. : Joseph Rowntree Foundation, 2011.

Starting and Developing Well: Key Findings

- The extent of alcohol misuse in young people is significant for Tameside
- Tameside has the second lowest proportion across GM where people aged 14 to 17 years reported never drinking alcohol
- Tameside has the second largest proportion in GM who reported binge drinking
- The proportion who reported regular drinking has fallen from 40% in 2007 to 9% in 2013
- Young people in Tameside tend not to drink in pubs and clubs compared to the rest of GM (second lowest)
- Tameside have the second lowest proportion (12%) that buy alcohol themselves
- Evidence suggests that in Tameside it is parents that are buying alcohol for 14-17 year olds. 60% of the young people in the survey reported parents buying their alcohol for them which is an increase of 32% from the 2007 survey
- Alcohol admissions for young people under 18 years has been decreasing since 2006 and although now lower than the North West average, Tameside is still significantly higher than the England average
- Alcohol admissions are significantly higher in the more deprived wards of Tameside.

6 - Living and Working Well

Synthetic estimates of Lower Risk, Hazardous and Harmful Drinkers in Tameside

Currently there are no direct measures of the level of alcohol harm at local authority level. However, Public Health England publishes synthetic estimates of the proportion of the population who are lower risk drinkers, increasing risk drinkers and higher risk drinkers[44]. Synthetic estimates are modelled upon drinking level data from the General Lifestyle survey at national level and are the expected levels of alcohol consumption based upon other factors including levels of hospital admissions resulting from alcohol consumption, population demographics (age, sex and ethnicity), levels of deaths relating to alcohol and levels of deprivation [33].

Estimates of the percentage and numbers of people in Tameside drinking at different levels are shown in Table 1. In addition to these figures, 25.6% of the Tameside adult population are estimated to be binge drinkers, amounting to 45,312 persons.

Table 1: **Estimated Percentage and Numbers of Lower Risk, Increasing Risk and Higher Risk Drinkers based upon synthetic estimates and the census 2011 population**

	% Adults	% Drinking Adults	Estimated Number of Adults (16+) In Tameside
Abstainers	16.1	-	28,426
Lower Risk Drinking	62.3	74.2	110,253
Increasing Risk Drinking	16.3	19.4	28,780
Higher Risk Drinking	5.4	6.4	9,540
Total	100	100.0	177,000

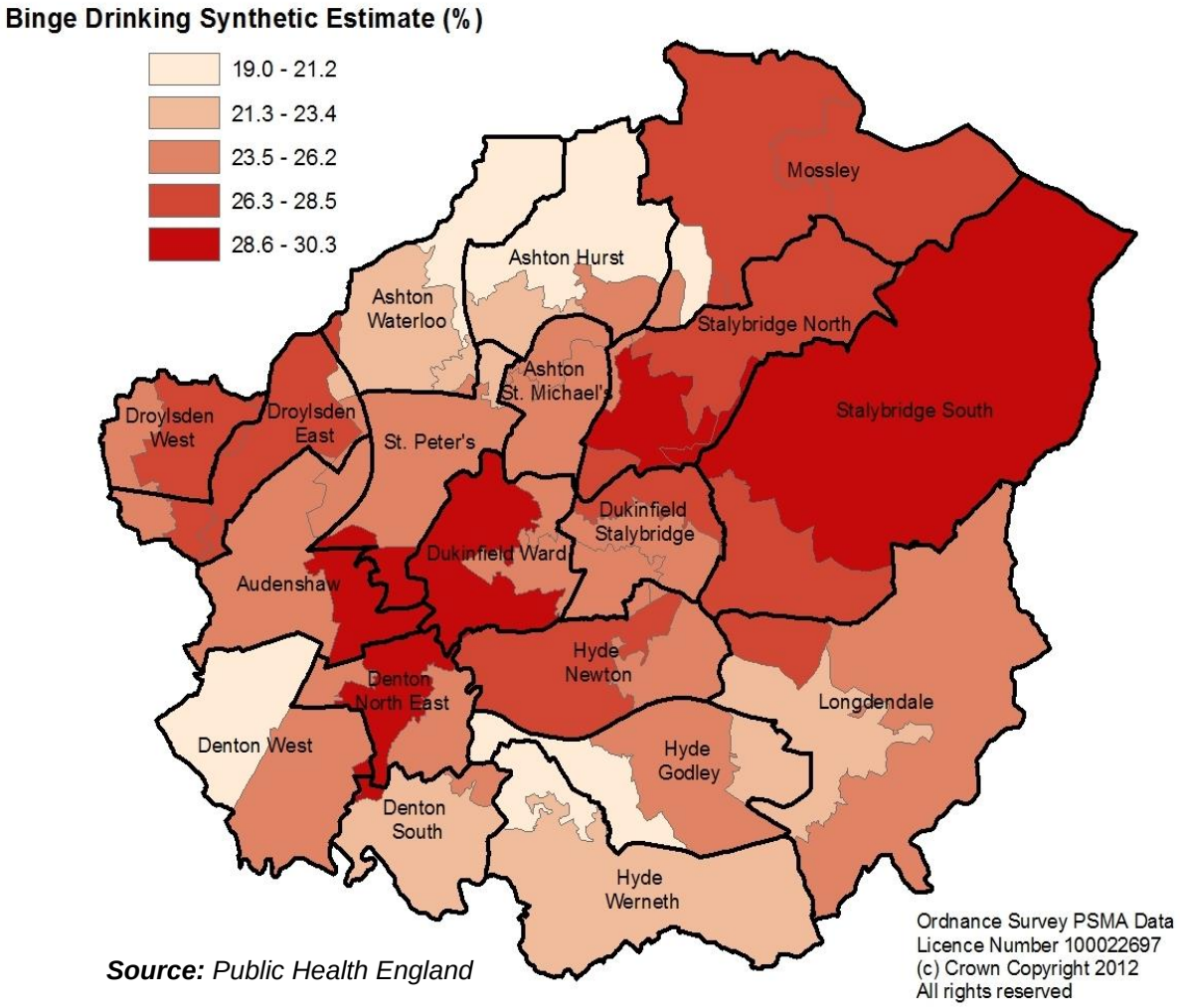
Source: *NWPHO – Local Alcohol Profiles for England 2012*

Synthetic Estimates of Binge Drinking at Medium Super Output Area (MSOA)

Synthetic estimates of binge drinking in Tameside are shown at MSOA level with wards overlaid in Map 3. It can be seen that there are areas including parts of Stalybridge, Audenshaw and Denton, where the expected prevalence of binge drinking is high at approximately 30%. Conversely, there are areas of Ashton, Denton and Hyde where the expected prevalence of binge drinking is low at approximately 20%.

[44] **Public Health England.** [Online] www.lape.org.uk.

Map 3: Synthetic Estimates of Binge Drinking in Tameside at MSOA level with wards overlaid



Source: *Public Health England*

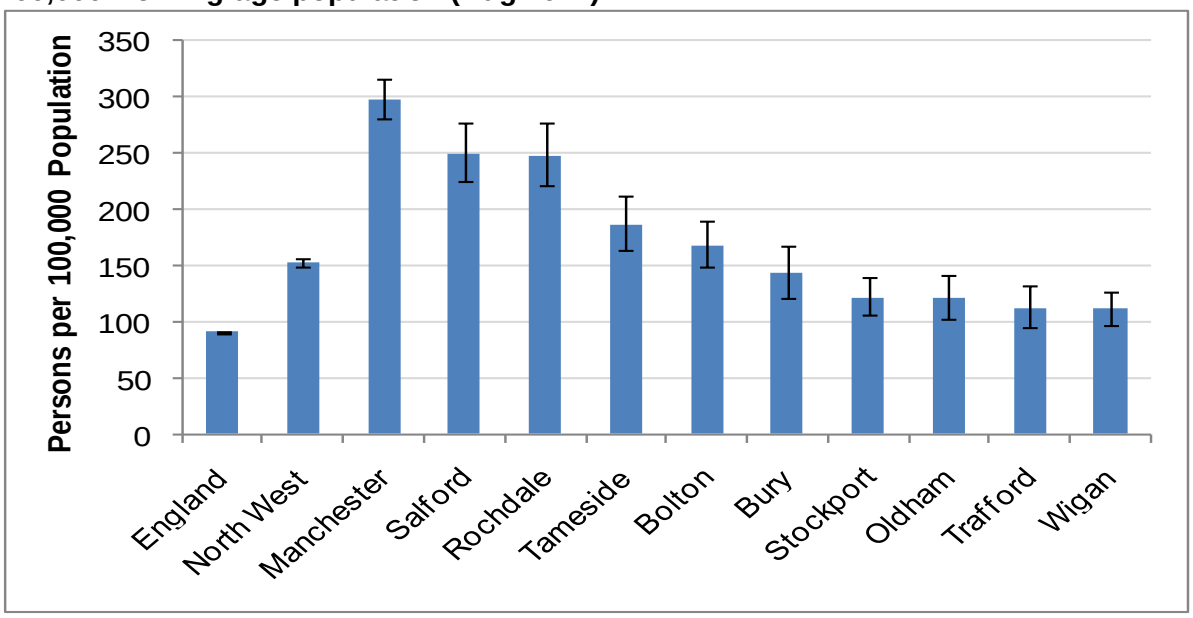
Dependent Drinkers

The proportion of the national adult population in 2007 dependent on alcohol was estimated to be 9.3% in men and 3.6% in women[45]. Applying this to the population of Tameside gives an estimate of 14,200 dependent drinkers across the borough.

The proportion of the population claiming incapacity benefit in 2011 for alcoholism is shown in Figure 17 for Greater Manchester Local Authorities, England and the North West. Tameside had a claimant rate for alcoholism that was significantly higher than the rate for the North West and approximately twice that of England. This suggests that the estimate above based upon the national prevalence of alcohol dependency may greatly underestimate the extent of alcohol dependency in Tameside.

[45] **Department of Health.** *Alcohol Needs Assessment Rearch Report (ANARP).* 2004.

Figure 17: Claimants of IB/SDA whose main medical reason is alcoholism. Rate per 100,000 working-age population (Aug 2011)



Source: *NWPHO*

Commissioned Services

The responsibility for Commissioning Alcohol Services transferred to Tameside Council in April 2013. There is a range of services available in Tameside to meet local needs from early intervention and prevention, specialist services and inpatient detoxification and residential rehabilitation.

Tier 1/Tier 2 Service – Identification and Brief Advice/Brief intervention (IBA/BI) Training Programme

- Information about the effects of alcohol to individuals and society including the local picture of alcohol related harm.
- Information and updates on alcohol units and levels of risk associated with consumption.
- Information and updates on alcohol units and levels of risk associated with consumption.
- The skills to raise the issue of alcohol and how to determine risk using the AUDIT assessment tool.
- Resources, leaflets, prompt cards, posters, unit wheels etc. to facilitate IBA/ BI within their role.
- Motivational approaches and techniques to deliver effective Brief Interventions.

A range of partners and organisations delivers IBA/BI across Tameside including Primary Care, Tameside Hospital, New Charter Housing, TMBC, Community Health Services, GMP and GMFRS.

Tier 2 and 3 Services –

- Early Intervention and Prevention Service commissioned from Lifeline, Branching Out (CYP Specialist Substance Misuse Service), Nationally and Locally Enhanced Services in Primary Care, Pennine Care Specialist Substance Misuse Services, ADS Alcohol

Services, Community based Tier 3 Drugs Service plus the Drug Intervention Programme for Criminal Justice clients deals with alcohol use by clients, Recovery and Reintegration Service commissioned from Acorn, Alcohol Treatment Requirement (Court ordered treatment) commissioned from ADS, Peer Mentoring Programme, Integrated Offender Management and Multi-agency Reduction Reoffending Group dealing with the impact of alcohol use by offenders and the Bridges Domestic Abuse Service

Tier 4 Services

Preferred Provider list for Inpatient Detoxification and Residential Rehabilitation

Hospital Alcohol Liaison Service (HALS) and CYP Specialist Alcohol Nurse

The HALS service aims to work with patients attending THFT for urgent and planned care that have been identified as harmful or dependent drinkers or who attend because of alcohol related harm, the aim being to reduce the level of alcohol harm suffered by those patients.

The HALS team will provide Brief Intervention to patients identified in A&E, on wards or at preoperative assessments as drinking at harmful levels. Patients admitted for alcohol related harm or who are identified, as dependent drinkers will be supported by the team to move into community based alcohol treatment services; where appropriate discussions will be undertaken to maximise the opportunities for planned Quick Start detoxification with patients who are admitted for more than 3 days and the opportunity for them to progress into the Ambulatory Detox clinic where appropriate.

The CYP Specialist Alcohol nurse will provides the opportunity to bridge the gap between hospital, community and voluntary services.
The key objectives for this service are as follows:

- Reduce A&E attendances and re presentations
- Increase referrals into appropriate services within the hospital and community.
- To increase partnership working between Tameside Foundation Trust, specialist community and voluntary services.
- To critically evaluate at the end of year one making recommendations to inform future provision.
- Establish close working practices with HALS team including management, performance and governance arrangements.

Health Improvement Team's alcohol work

The Health Improvement Team promotes lower risk drinking in its interactions with clients and actively signpost into specialist services where appropriate. For example, Health Trainers routinely ask about alcohol consumption as part of a lifestyle assessment and may support clients to set goals around reducing consumption. The NHS Health Checks for 40-74 year olds being carried out in community and workplace settings include the Alcohol Audit and participants are given both verbal and written information about the effects of alcohol on health. Weight Matters Advisors have been piloting the Audit C as part of the client's individual Personal Health Plan as well as highlighting the calories in alcohol. This is now being extended to include the full Audit. Smoking Advisors highlight the interplay between alcohol and some non-nicotine treatments, as well as the risk of alcohol lowering inhibitions and increasing the risk of a quitter smoking a cigarette.

The Family Health Mentors Programme (SFT) supports young people in school and other settings to reduce alcohol consumption to less risky levels.

Alcohol Specific Hospital Admissions

Alcohol specific hospital admissions are for conditions which are wholly attributable to alcohol use. The range of alcohol specific conditions is shown in Table 2.

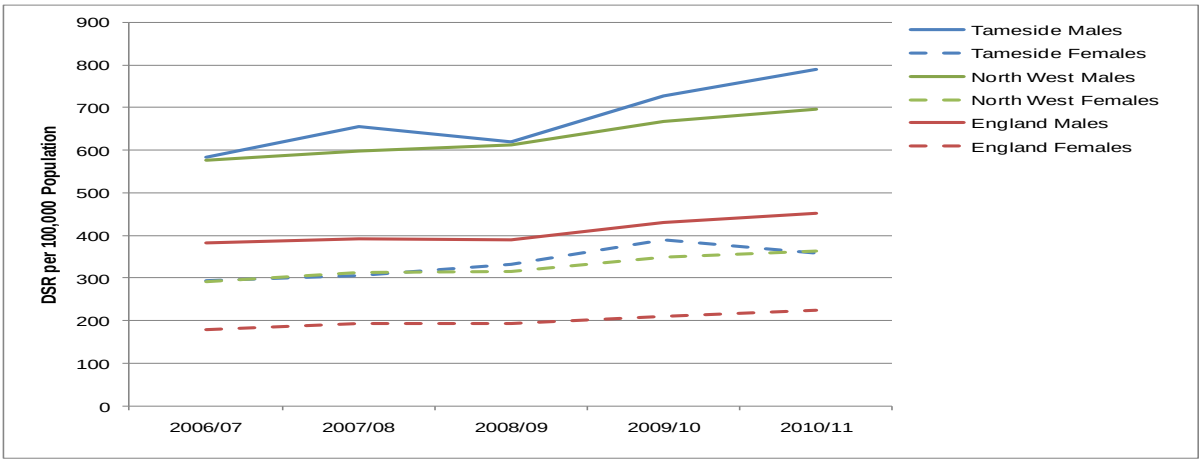
Table 2: **Alcohol specific conditions**

Condition	ICD-10 Code
Alcohol induced pseudo Cushing's syndrome	E244
Mental and behavioural disorders due to use of alcohol	F10
Degeneration of nervous system due to alcohol	G312
Alcoholic polyneuropathy	G621
Alcoholic myopathy	G721
Alcoholic cardiomyopathy	I426
Alcoholic gastritis	K292
Alcoholic liver disease	K70
Alcohol induced chronic pancreatitis	K860
Ethanol poisoning	T510
Methanol poisoning	T511
Toxic effect of alcohol unspecified	T519
Accidental poisoning by and exposure to alcohol	X45

Trend in Alcohol Specific Admissions

The trend in the directly age standardised admission rate of alcohol specific conditions in Tameside, the North West and England is shown in Figure 18. In 2010/11 the number of alcohol specific admissions for males in Tameside was 13.3% higher than for the North West and 74.8% higher than for England. The rate of alcohol specific admissions for Males in Tameside increased by 35% over the four year period 2006/07 to 2010/11, compared to 21% and 18% in the North West and England respectively.

Figure 18: Trend in Alcohol Specific Admissions in Tameside, North West and England by Sex



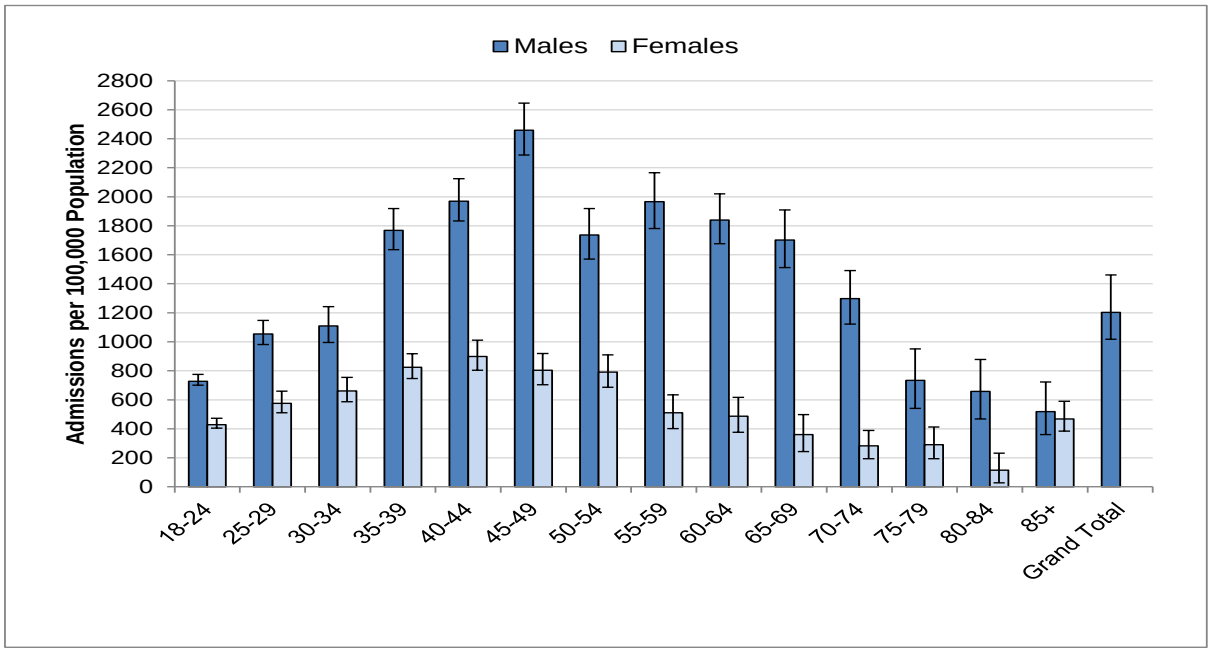
Source: *NWPHO – Local Alcohol Profiles for England*

The rate of alcohol specific admissions in 2010/11 for females in Tameside was 59.9% higher than that for England and equivalent to that of the North West. The rate of alcohol specific admissions in females increased by 22% over the four year period 2006/07 to 2010/11, compared to 25% and 26% in North West and England respectively. The Rate of alcohol specific admissions in 2010/11 for males in Tameside was 2.2 fold the rate for females. The difference in the rate of alcohol specific admissions between males and females reflects the proportional difference in level hazardous and harmful drinkers between the male and female population.

Alcohol Specific Admissions in Tameside by Age-Band

Alcohol specific admission rates by five year age band and sex are shown in Figure 19. In both males and females the rate of alcohol specific admissions peaks within the 45-49 age group, which may reflect an age at which the cumulative effects of hazardous and harmful drinking may impact upon health rather than higher levels of problematic drinking within the age group.

Figure 19: Alcohol Specific Admissions in Tameside Adults by Age Band and Sex (2010-2012)

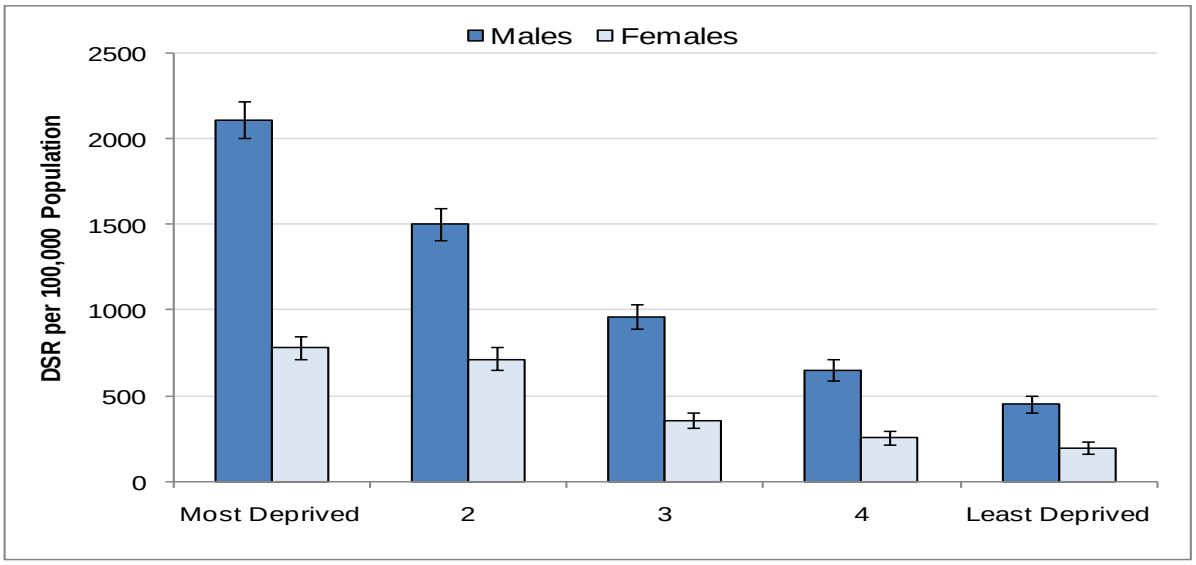


Source: *Secondary User Statistics (SUS) NHS*

Alcohol Specific Admissions in Tameside by Deprivation

Directly age standardised admission rates for alcohol specific conditions by Tameside quintiles of IMD2010 (a measure of deprivation) and sex are shown in Figure 20. There is a large inequality in alcohol specific admissions with respect to deprivation with the most deprived quintile having 4.4 times and 3.4 times the rate in the least deprived quintile in males and females respectively.

Figure 20: Directly Age Standardised Alcohol Specific Admissions by Local Tameside Quintiles of IMD2010 and sex (2010-2012)

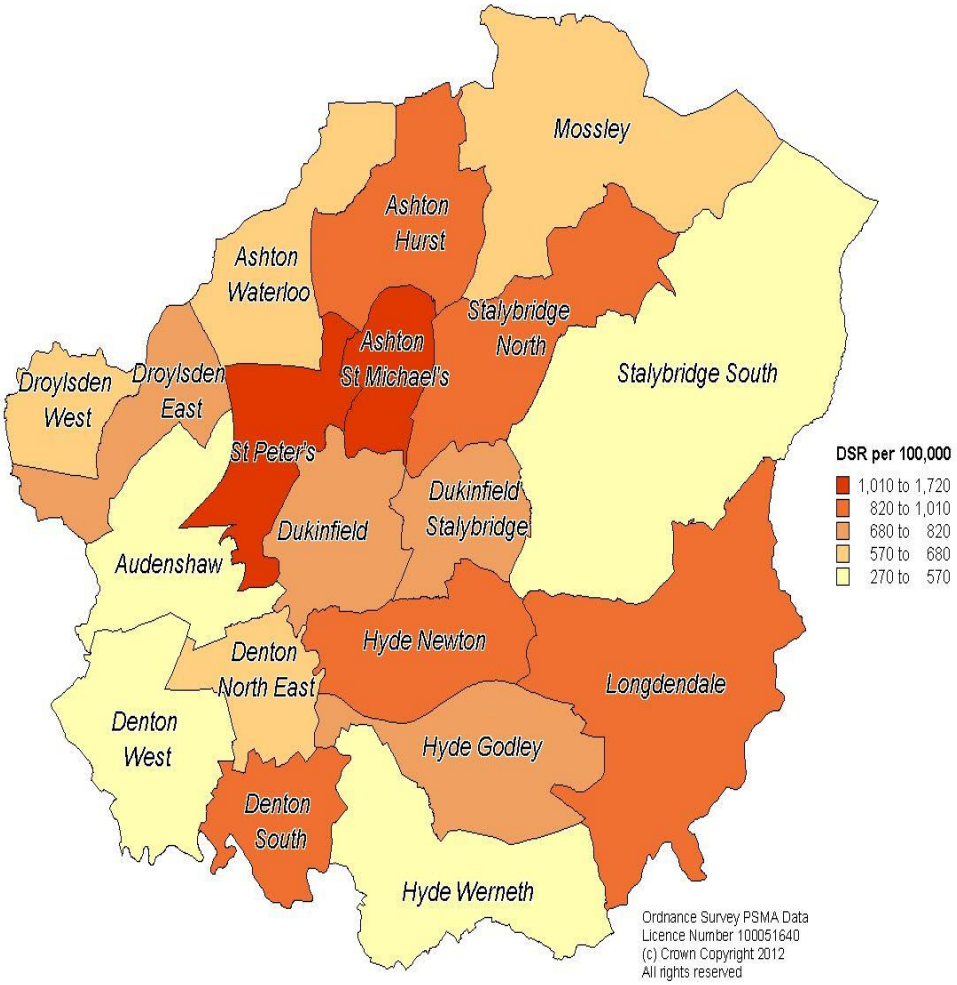


Source: *SUS/NHS*

Alcohol Specific Admissions by Ward of Patient Residence

Rates of directly age standardised alcohol specific admissions by ward of patient residence are shown in Map 4. Wards with the highest rates of admissions are the particularly deprived wards of St. Peter's and Ashton St. Michael's. St. Peter's had the highest rate of alcohol specific admissions at 1,714 per 100,000, 6 times higher than that of Denton West with the lowest rate of alcohol specific admissions at 279.2 per 100,000.

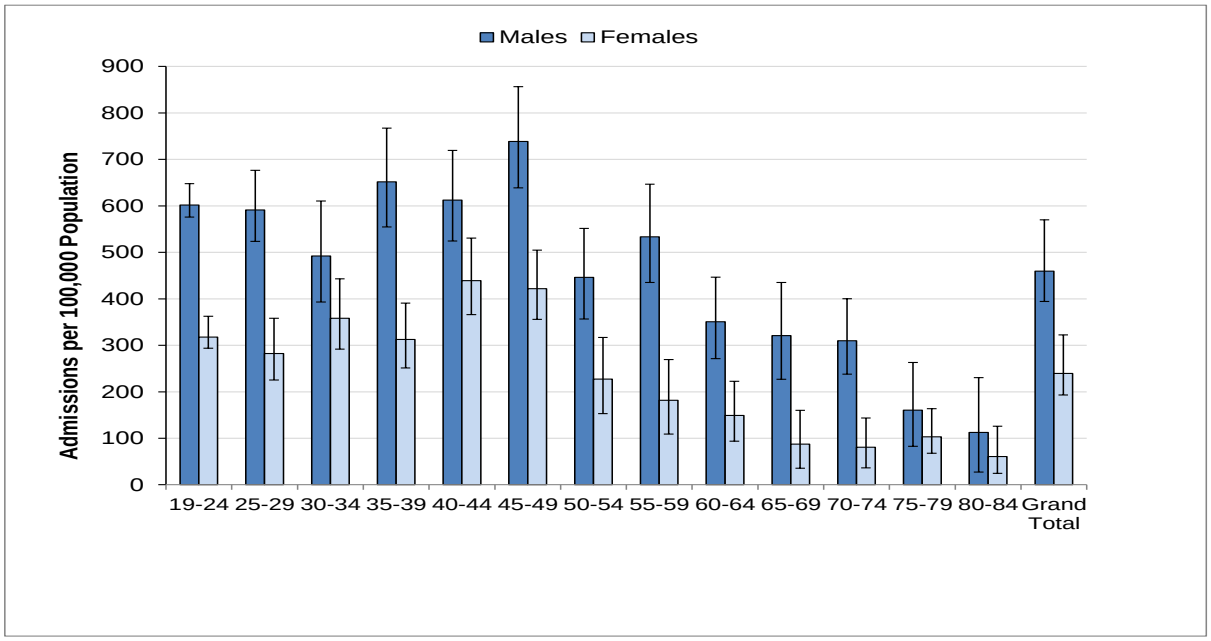
Map 4: Alcohol Specific Admissions by Ward of Residence 2010-2012. Directly Age Standardised Rate (DSR)



Acute Alcohol Intoxication Admissions

The rate of hospital admission in Tameside for alcohol intoxication by age and sex for the period 2010 to 2012 is shown in Figure 21 and can be seen to peak in males in the 45-49 age-bands and in females in the 40-44 age-bands.

Figure 21: Alcohol Intoxication Admissions in Tameside Adults by Age and Sex (2010-2012)

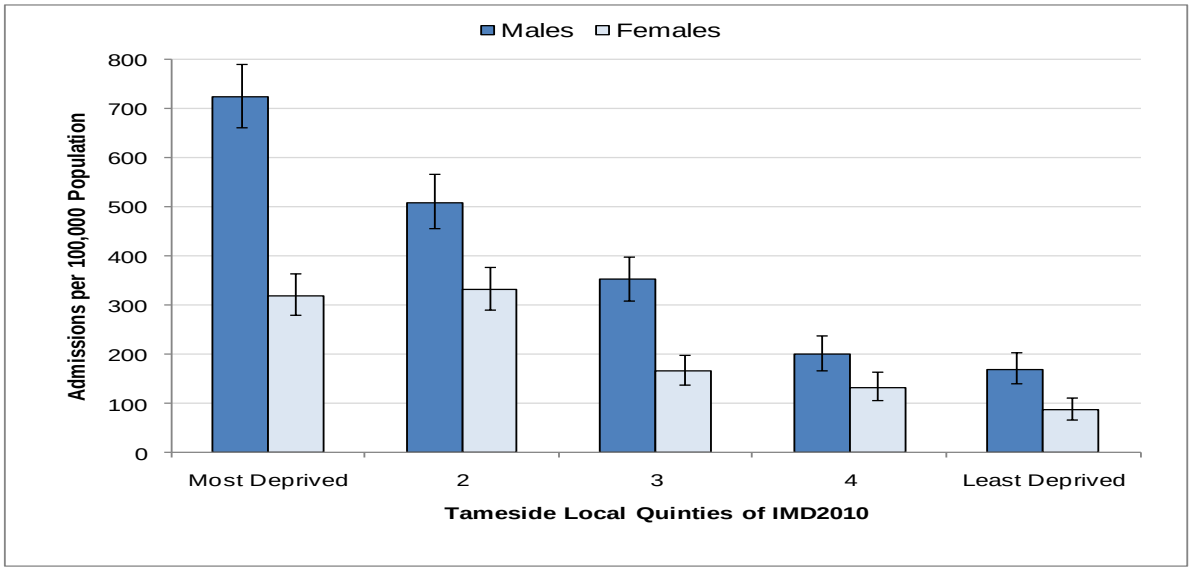


Source: *SUS/NHS*

Alcohol Intoxication Admissions by Deprivation

Directly age standardised admission rates for alcohol intoxication by Tameside quintiles of IMD2010 and sex for the period 2010 to 2012 are shown in Figure 22. There is a large inequality in alcohol specific admissions with respect to deprivation with the most deprived quintile having 4.3 times and 3.7 times the rate in the least deprived quintile in males and females respectively.

Figure 22: Directly Age Standardised Alcohol Intoxication Admissions by Local Tameside Quintiles of IMD2010 and sex (2010 to 2012)

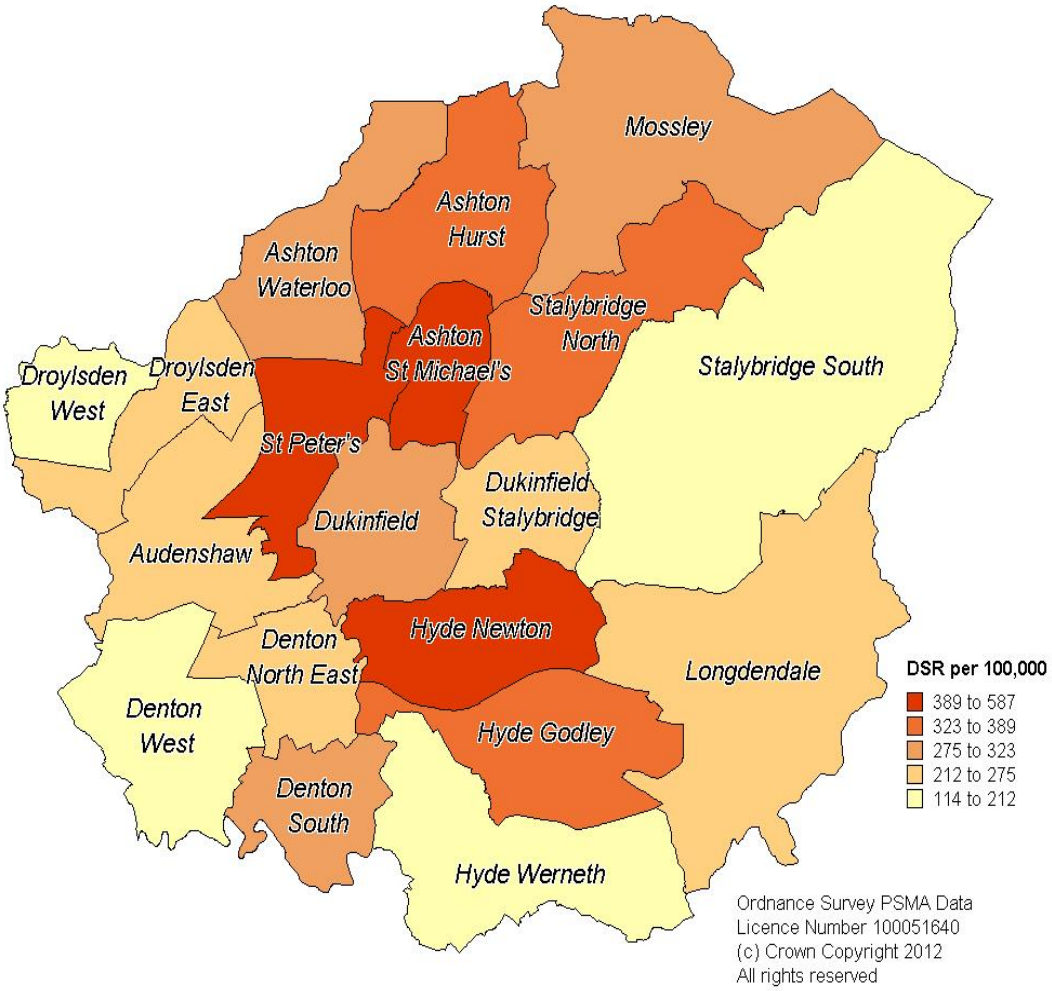


Source: *SUS.NHS*

Alcohol Intoxication Admissions by Ward of Residence

Rates of directly age standardised alcohol intoxication admissions by ward of patient residence for 2010 to 2012 are shown in Map 5. As with alcohol specific admissions, wards with the highest rates of admissions are the particularly deprived wards of St. Peter's and Ashton St. Michael's. St. Peter's had the highest rate of alcohol intoxication admissions at 587 per 100,000, 5.1 times higher than that of Denton West with the lowest rate of alcohol intoxication admissions at 115 per 100,000.

Map 5: Directly age standardised admission rate for alcohol intoxication by Tameside ward of residence 2010-2012

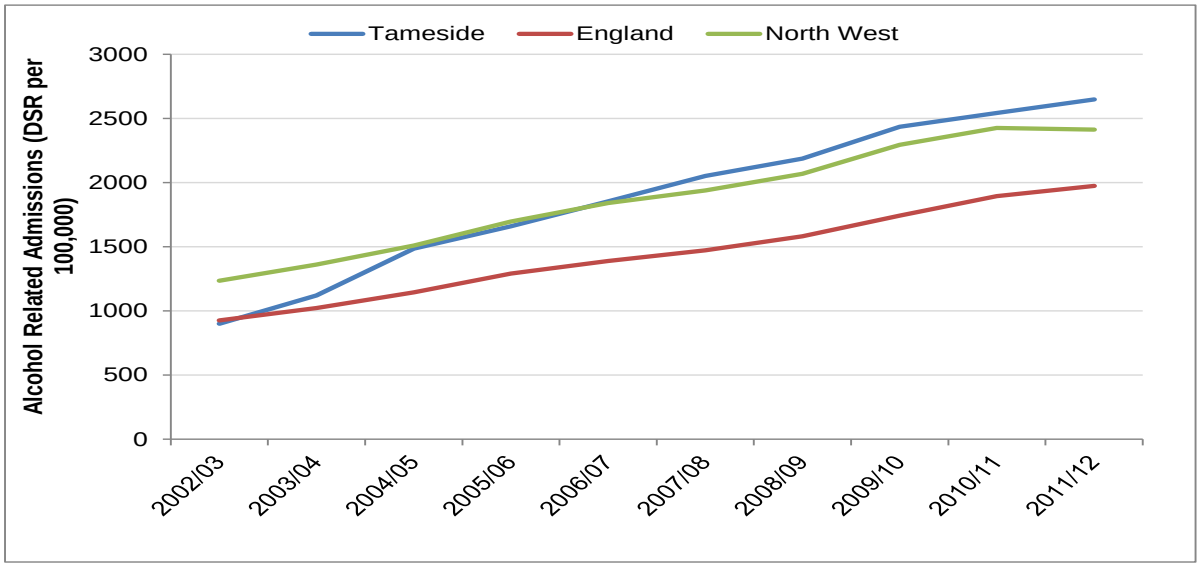


Alcohol Related Hospital Admissions

In addition to the alcohol specific admissions that are wholly attributable to alcohol use, there are a number of conditions that are partly attributable to alcohol use. These include, but are not limited to, conditions such as hypertension, certain cancers, diabetes and certain acute injuries resulting from causes such as fire or falls. The extent to which a condition is attributable to alcohol use is defined by alcohol attributable fractions, where 1 is wholly attributable and fractions between 0 and 1 are partly attributable. The AAF for a condition may be different depending on the age-range and sex of the patient. Alcohol related hospital admissions are produced by applying alcohol attributable fractions to the number of hospital admissions over a given period. [46]

The trend in the rate of alcohol related admissions between 2002/03 and 2011/12 is shown in Figure 23 for England, the North West and Tameside. Across the 10 year period alcohol related admissions in Tameside have approximately trebled, whereas the rate in the North West and England has increased by 2.1 fold and 2.0 fold respectively. In 2011/12 the rate of alcohol related admissions was 34% higher in Tameside compared to England and 10% higher in Tameside compared to the North West. [47]

Figure 23: Directly Age Standardised Rate of Alcohol Related Admissions per 100,000 population 2002/03 to 2011/12



Source: NWPHO

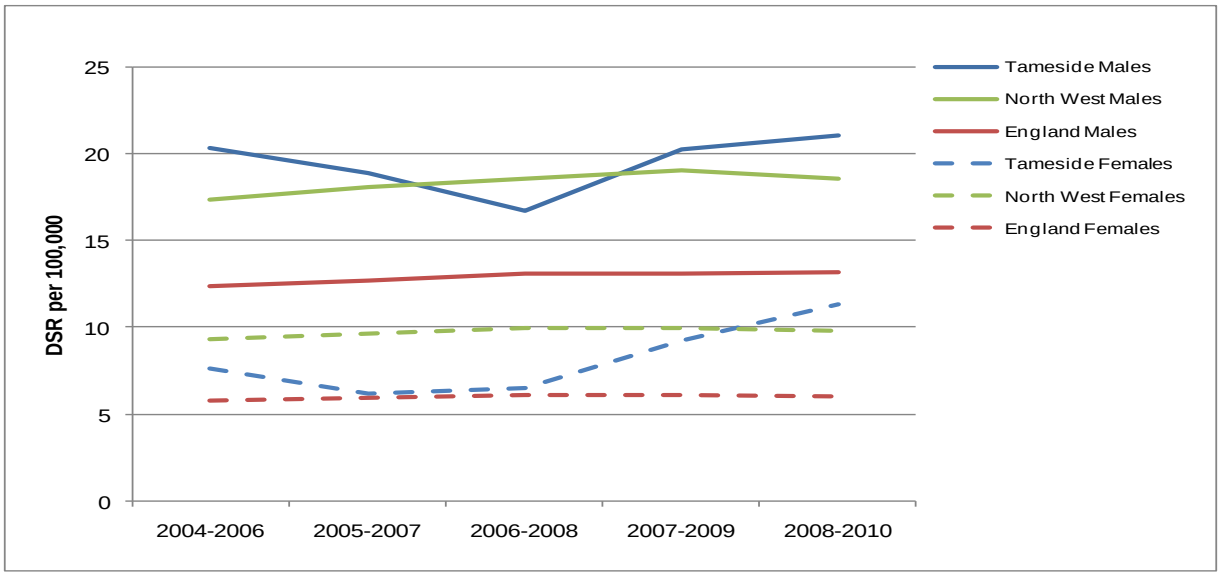
Alcohol attributable fractions methodology and ICD10 codes**:**
http://www.lape.org.uk/downloads/LAPE%20User%20Guide_Final.pdf

[46] **Jones, Lisa, et al.** *Alcohol Attributable Fractions for England; Alcohol Attributable Mortality and Hospital Admissions.*
[47] **Public Health England.** [Online] www.lape.org.uk.

Alcohol Specific Mortality

Alcohol specific mortality is defined by the same conditions listed in Table 2. For the period 2008-2010 alcohol specific mortality in Tameside exceeded that of the North West and England for both males and females (Figure 24). The rate for females in Tameside has seen a major increase between the periods 2006-2008 to 2008-2010 increasing by 74%.

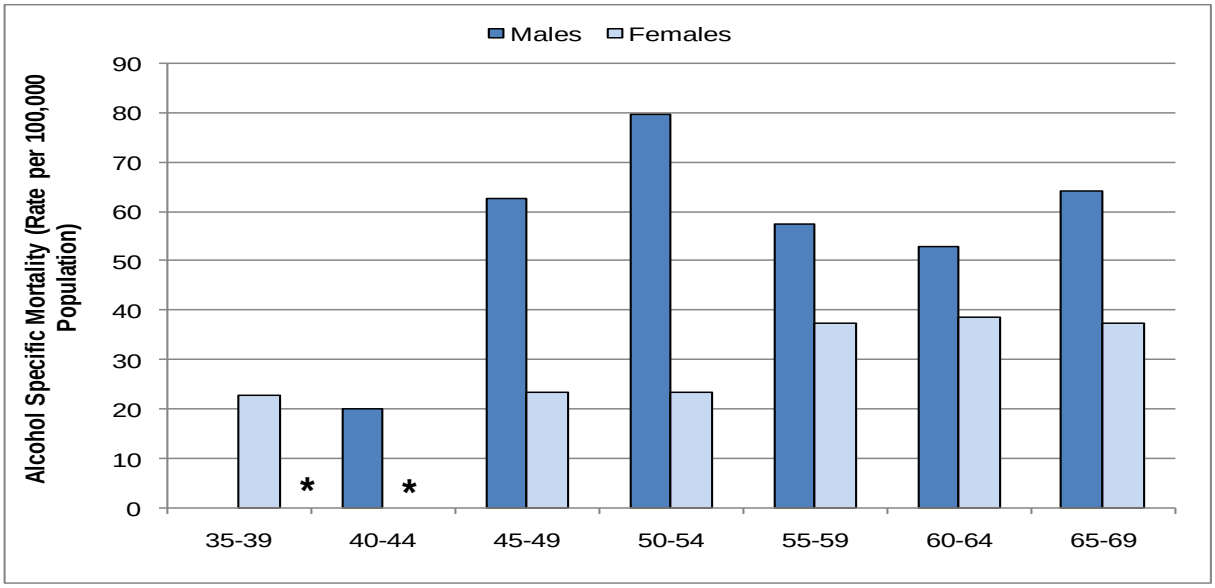
Figure 24: Trend in Alcohol Specific Mortality in Tameside, North West and England by Sex



Source: ***NWPHO***

Alcohol specific mortality by 5 year age bands and sex for the period 2009 to 2011 is shown in Figure 25. Alcohol specific mortality peaks in the 50-54 age bands in males, but in females the rate is at its highest between the ages 55 and 69. Although not shown due to small numbers of deaths, the rate of alcohol specific mortality reduces considerably in both males and females over 70 years.

Figure 25: Alcohol Specific Mortality Rates by 5 year age band and sex

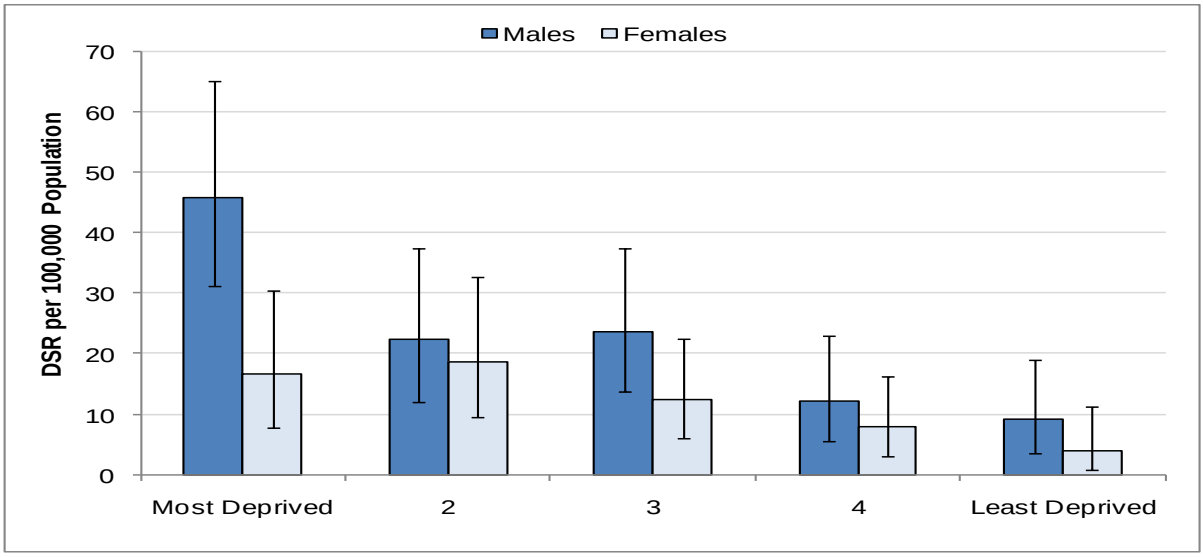


**Suppressed Due to Low Numbers of Deaths*

Source*: PHMF*

Deprivation is a clear factor in mortality from alcohol specific conditions with a gradient being seen across the IMD2010 quintiles (Figure 26). The rate for males in the most deprived quintile is by far the highest amounting to a rate 5 times higher than the rate in the least deprived quintile and 2.1 times higher than the rate in the second most deprived quintile. In Females the rate of mortality in the most deprived quintile is 4.3 times that of the least deprived quintile.

Figure 26: Age standardised alcohol specific mortality rates by local Tameside quintiles of IMD2010 and sex



Source: PHMF

Homelessness

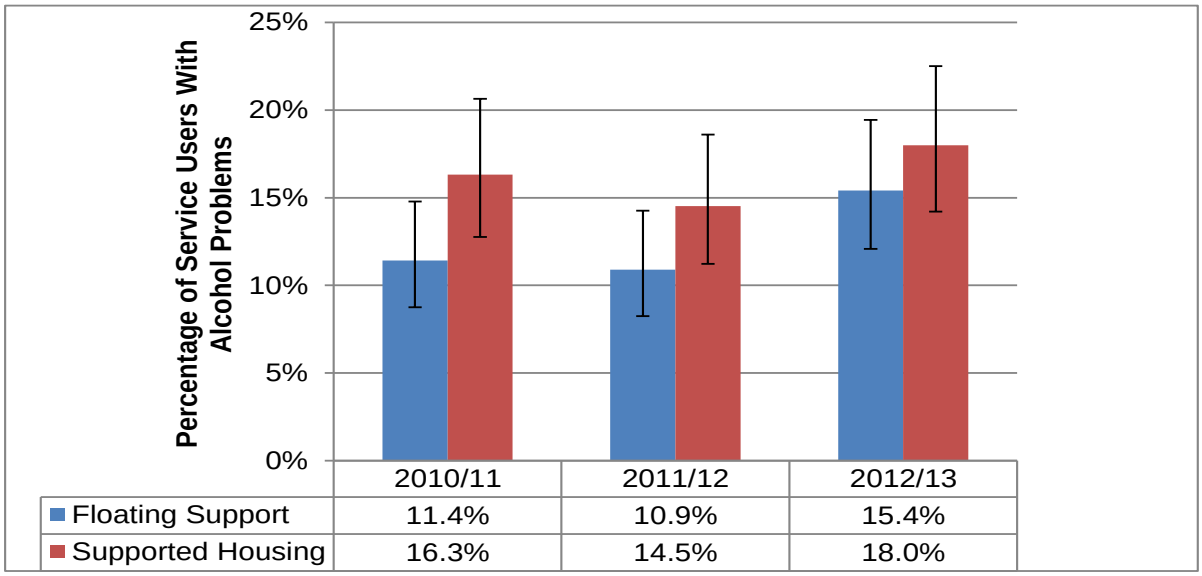
There are high levels of alcohol harm in homeless populations. Alcohol misuse can either be a cause of homelessness or a result of homelessness; for many homeless people alcohol misuse forms part of a complex set of issues. A survey of 300 homeless people reported that 25% of those surveyed were dependent on alcohol, 63% said drug or alcohol use was one of the reasons why they became homeless, with the longer the length of dependency, the longer the periods of homelessness.[48] Drug and alcohol misuse are a major cause of premature mortality among homeless people, accounting for just over a third of all deaths in the homeless population.[37]

The percentage of people in Tameside accessing floating housing support and supported housing who are deemed to have alcohol misuse problems is shown in Figure 27. Floating housing support is provided to people who are in danger of losing their own home. In 2012/13, 15.4% of those accessing floating housing services and 18% those accessing supported housing services were deemed to have alcohol misuse problems.

In Tameside in 2013/14, 13% of those accessing alcohol treatment services were recorded as having housing problems.[49]

[48] **Crisis.** *Homelessness: A silent killer.* 2011.
[49] NDTMS - National Drug Treatment Monitoring System

Figure 27: Percentage of People in Tameside accessing floating housing support and supported housing that are reported to have an alcohol use disorder



	2010/11	2011/12	2012/13
Floating Support	11.4%	10.9%	15.4%
Supported Housing	16.3%	14.5%	18.0%

Source: *St Andrews client record data*

Alcohol and Crime

There is a well-established link between alcohol misuse and crime, with the Home Office estimating that alcohol-related crime costs the UK £8 billion to £13 billion a year[50].

In England and Wales alcohol is thought to contribute to approximately half of all violent crimes amounting to 1.2 million per annum, with a fifth of all violent incidents occurring in or around licensed premises.[51] Alcohol fuelled violence puts a large strain upon public services including the Police, Ambulance service and A&E departments. Both hospital admissions and A&E attendances for alcohol related violence are highest for males from deprived communities.[52] Alcohol use also predisposes an individual to be a victim of violent crime. Persons at risk of being perpetrators and victims of alcohol fuelled violence share common risk factors which include being male, aged 16-29, unemployed and regular binge drinkers.[41] The extent of alcohol related violent assaults may be grossly underestimated by crime figures, as it has been shown that less than a quarter of assaulted persons visiting A&E report the offence to police.[53]

A study into domestic violence found that alcohol had been consumed prior to the offence in nearly three quarters of domestic violence cases and was a contributing factor in almost two thirds.[54]

Alcohol is also a major factor in sexual crimes, with an estimated 19,000 alcohol-related sexual assaults occurring each year in England and Wales. Over a third of offenders and a

[50] **NICE.** *Alcohol-use disorders: preventing harmful drinking; Costing Report.* 2010.
[51] **Department of Health.** *Protecting People Promoting Health; A public health approach to violence prevention for England.* 2012.
[52] **Faculty of Public Health.** *Alcohol and Violence Briefing Statement.* 2005.
[53] **Home Office.** *Violence in the night-time economy: key findings from the research.* 2004.
[54] **Home Office.** *Domestic violence offenders: characteristics and offending related needs.*

quarter of victims are thought to have consumed alcohol before the occurrence of a serious sexual assault.[12]

The proportion of crime that is related to alcohol use in the offender is shown in Table 3. Over the four years of data available the number of crimes committed with an alcohol marker has declined by 15% whereas the total number of crimes committed in Tameside has declined by 25%. As a result the proportion of crimes that are alcohol related has increased from 9.2% to 10.5%.

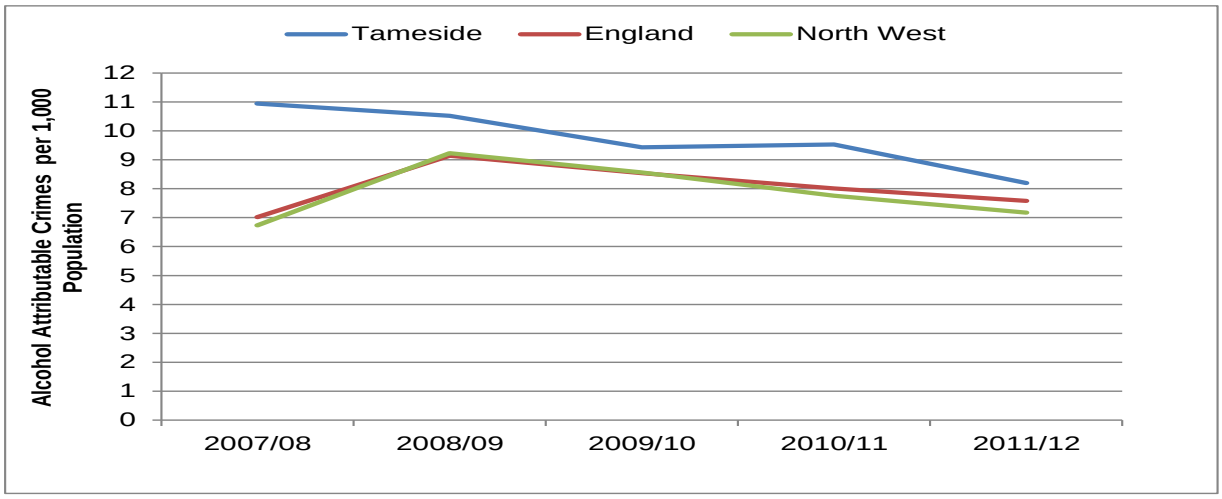
Table 3: Alcohol Related Crime in Tameside

Year	All Tameside Crime	Alcohol Marker	%
01/09/2012 - 31/08/2013	13,503	1,414	10.50%
01/09/2011 - 31/08/2012	15,114	1,678	11.10%
01/09/2010 - 31/08/2011	17,700	1,769	9.90%
01/09/2009 - 31/08/2010	18,007	1,661	9.20%
Total	**64,324**	**6,522**	**10.10%**

Source: GMP

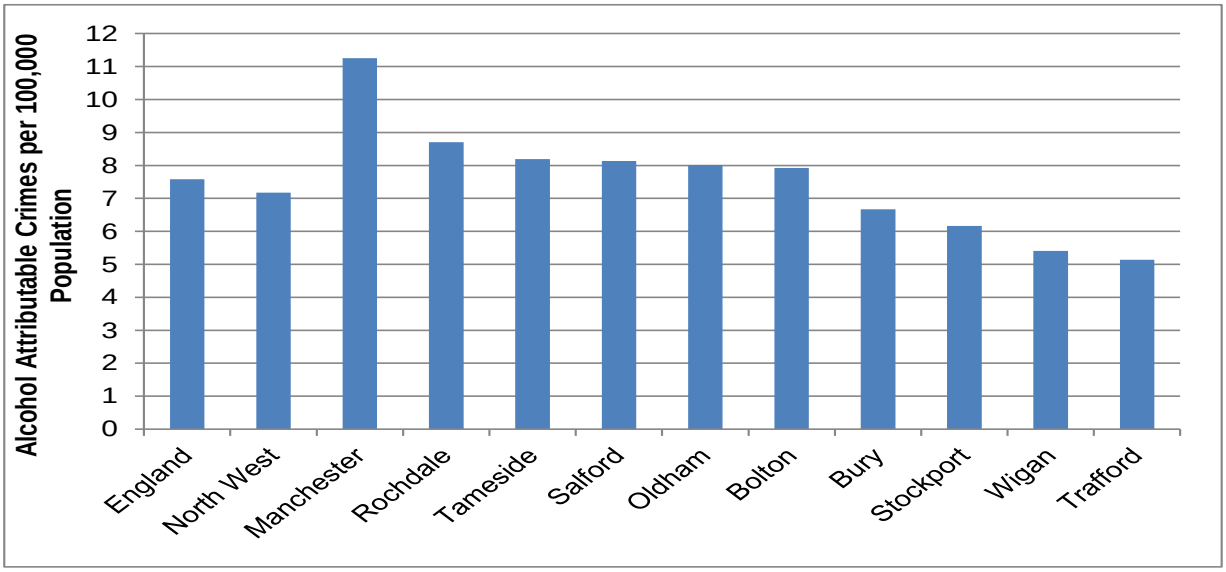
The rate of alcohol-attributable crime per 1,000 population is shown for Tameside, England and the North-West in Figure 28. Although levels of alcohol-attributable crime are higher in Tameside compared to both England and the North-West, levels have fallen by 25% over the five year period 2007/08 to 2011/12. Levels of alcohol-attributable crime are the third highest out of Greater Manchester local authorities, as shown in figure 29.

Figure 28: Alcohol Attributable Crimes per 1,000 population (2007/08 to 2011/12)



Source: *LAPE*

Figure 29: Alcohol Attributable Crimes per 1,000 population (2007/08 to 2011/12)

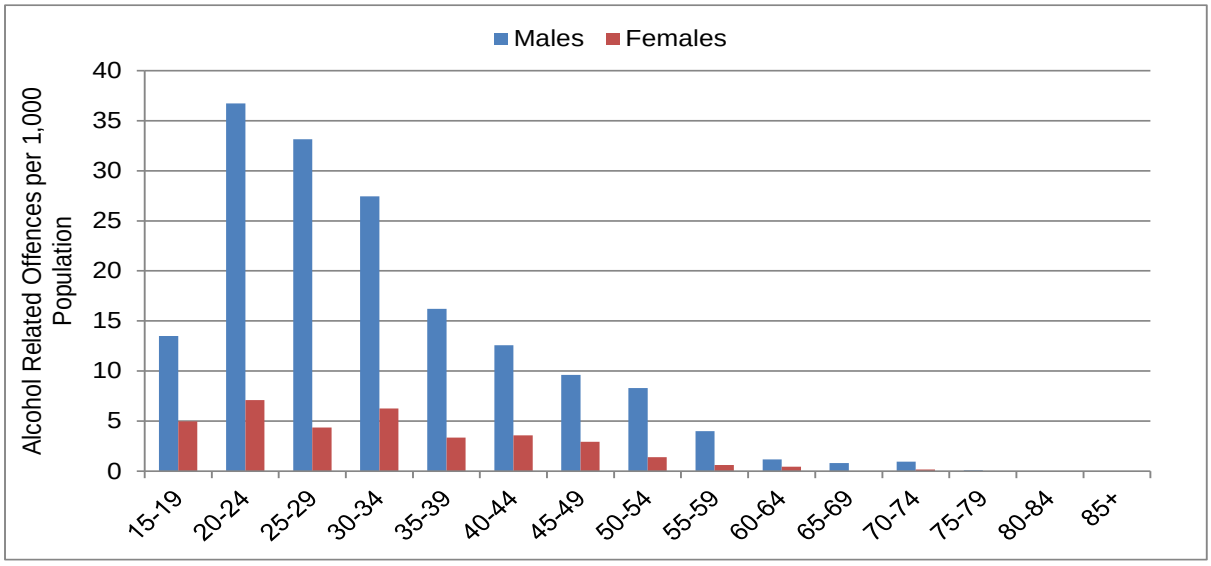


Source: *LAPE*

Alcohol Related Crime by Age of Offender

The rate of alcohol related crime by the age of the offender is shown in Figure 30. The rate of alcohol related offences is highest for the 20-24 age band and declines within younger and older age bands. The difference in males and female alcohol related offending rates is at its greatest at 7.6 times higher within the 25-29 age band.

Figure 30: Alcohol Related Offences per 1,000 population by 5 year age-band of offender (2012/13)



Source: *LAPE*

Alcohol Related Crime by Age and Sex of Victim

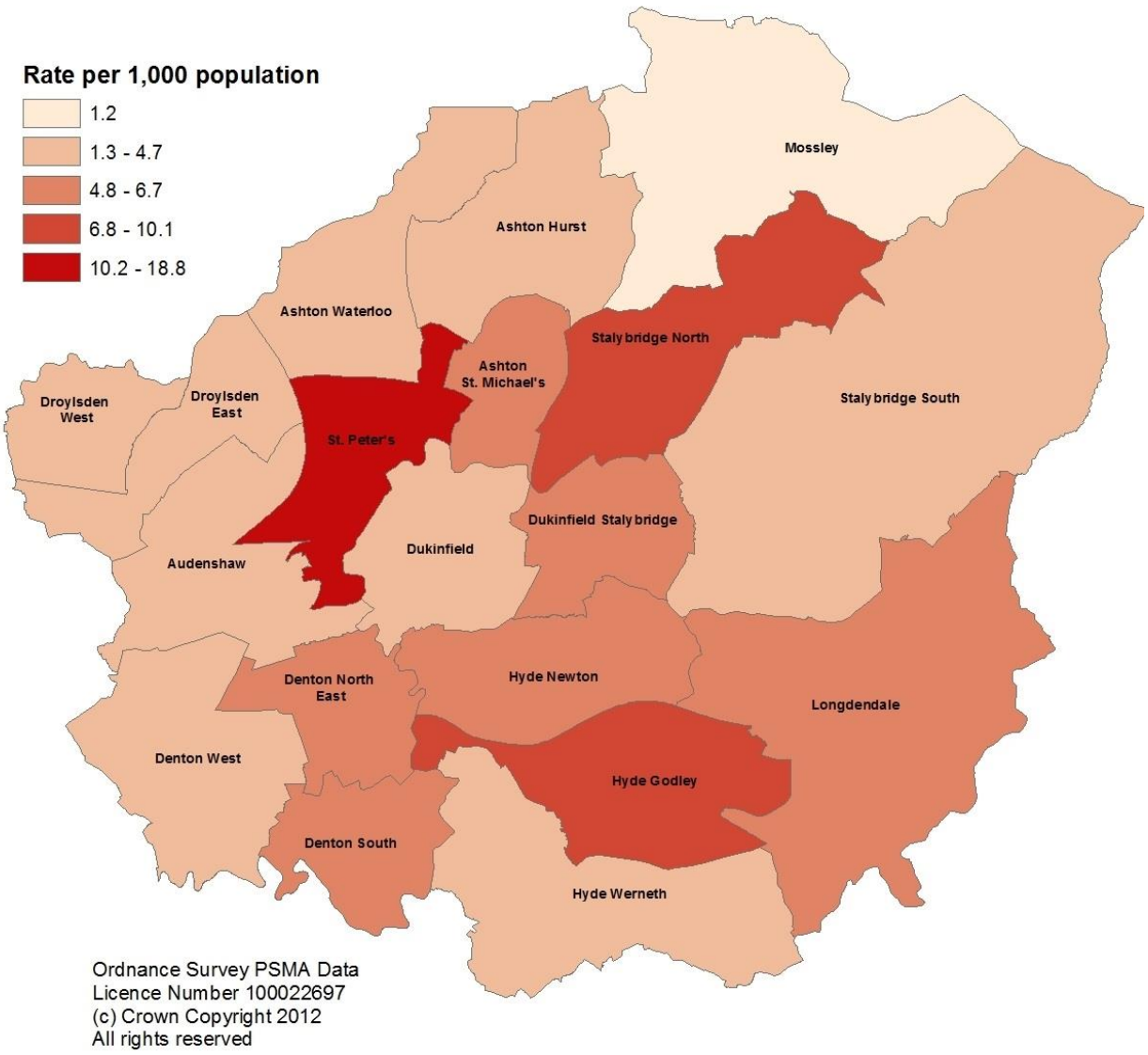
The rate of alcohol related crime committed against males peaks with the age of the victim within the 30-34 age band whereas the rate of alcohol related crime committed against

women peaks within the 20-24 age band. The rate of alcohol related crime committed against females is higher than that committed against males between the age bands 15-19 and 45-49. Within the victim age ranges of 50 to 64, males are more likely to be a victim of alcohol related crime. Within the 20-24 age band the rate of alcohol related crime against females is nearly three times that against males. Whereas males are more likely to be the perpetrators, females are more likely to be the victims of alcohol related crime in Tameside.

Alcohol Related Crime by Ward

The rate of alcohol related crime by Tameside wards for 2012/13 is illustrated in Map 6. St. Peter's has by far the highest rate of alcohol related crime at 18.8 crimes per 1,000 population, followed by Stalybridge North and Hyde Godley with rates of 10.1 and 6.7 per 1000 population respectively.

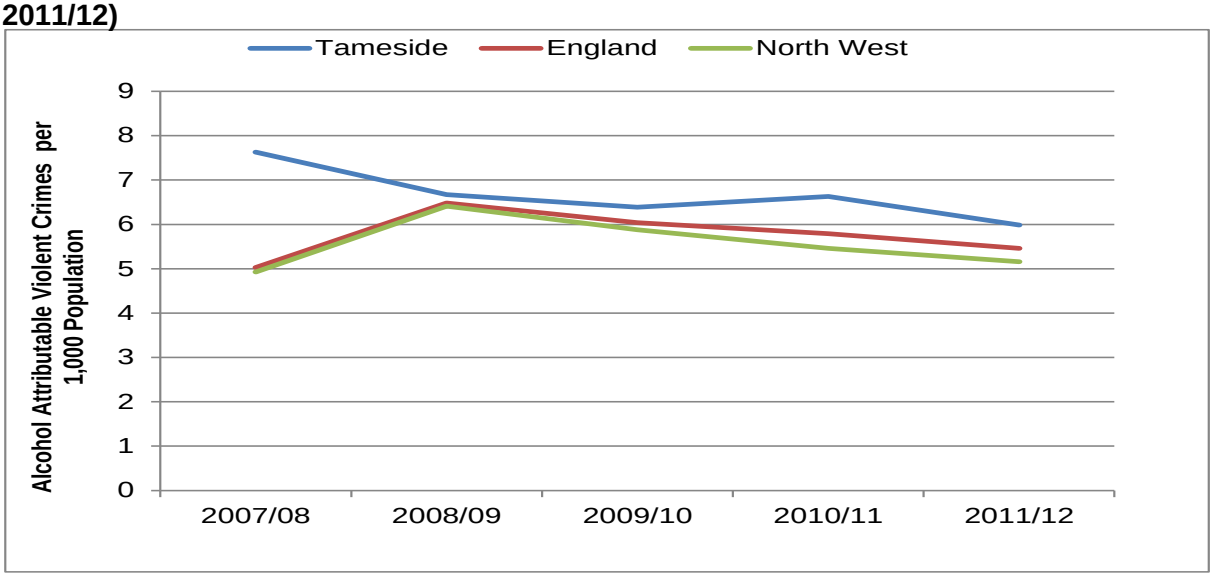
Map 6: Alcohol Related Crime Rate by Tameside Wards (2012/13)



Alcohol Attributable Violent Crime

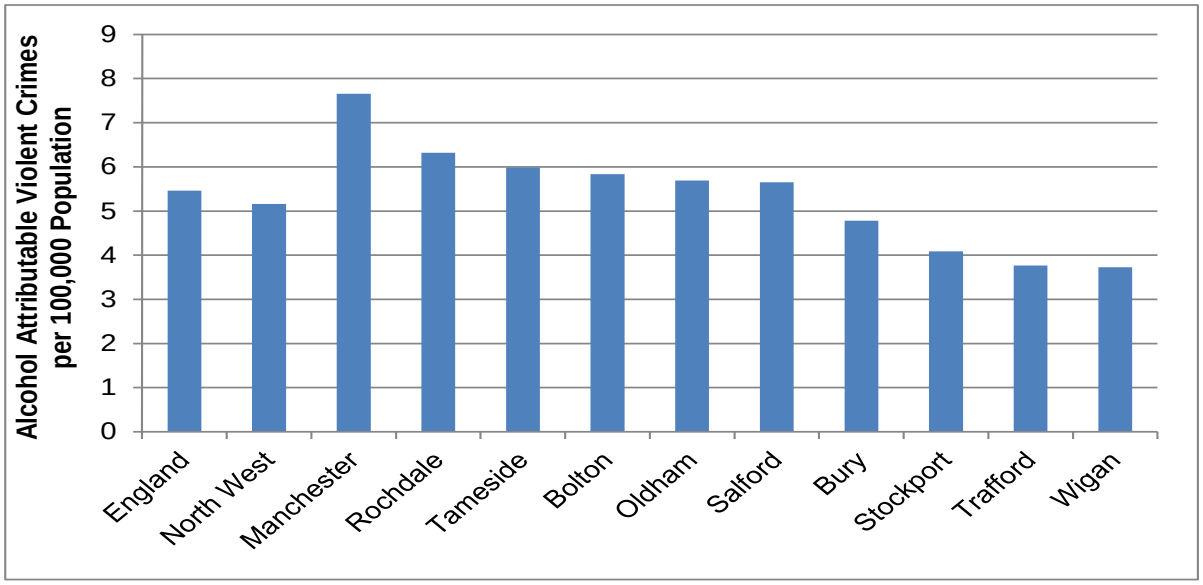
The rate of alcohol attributable violent crime is shown in Figure 32 for Tameside, the North-West and England. The level of alcohol attributable violent crime has fallen by 21% from 2007/08 to 2011/12 but remains 10% higher than that of England. Tameside has the third highest rate of alcohol attributable violent crime in Greater Manchester after Manchester and Rochdale as shown in Figure 33.

Figure 32: **Alcohol Attributable Violent Crimes per 1,000 population (2007/08 to 2011/12)**



Source: *LAPE*

Figure 33: Alcohol Attributable Violent Crimes per 1,000 population (2007/08 to 2011/12)

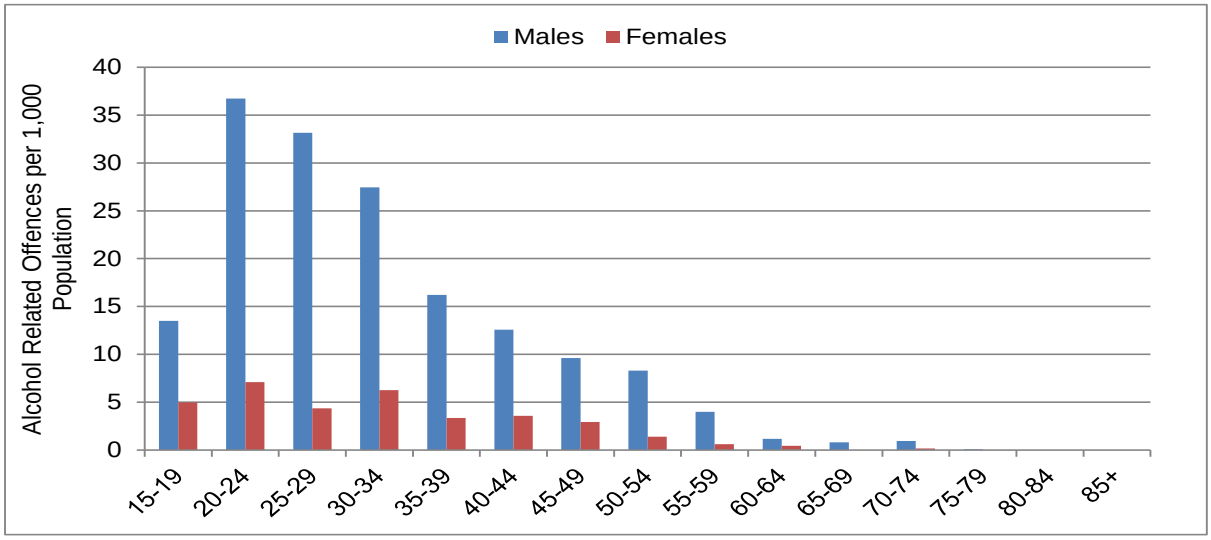


Source: *LAPE*

Alcohol Related Violent Crime by Age and Sex

The rate of alcohol related violent crime by the age and sex of the offender is shown in Figure 34. The rate of alcohol related violent offences is highest for the 25 to 29 age band in males and for the 20-24 age band in females and declines within younger and older age bands. The difference in males and female alcohol related offending rates is at its greatest at 7.5 times within the 25-29 age bands.

Figure 34: Alcohol Related Violent Offences per 1,000 population by 5 year age-band and sex of offender (2009-2012)



Source: *LAPE*

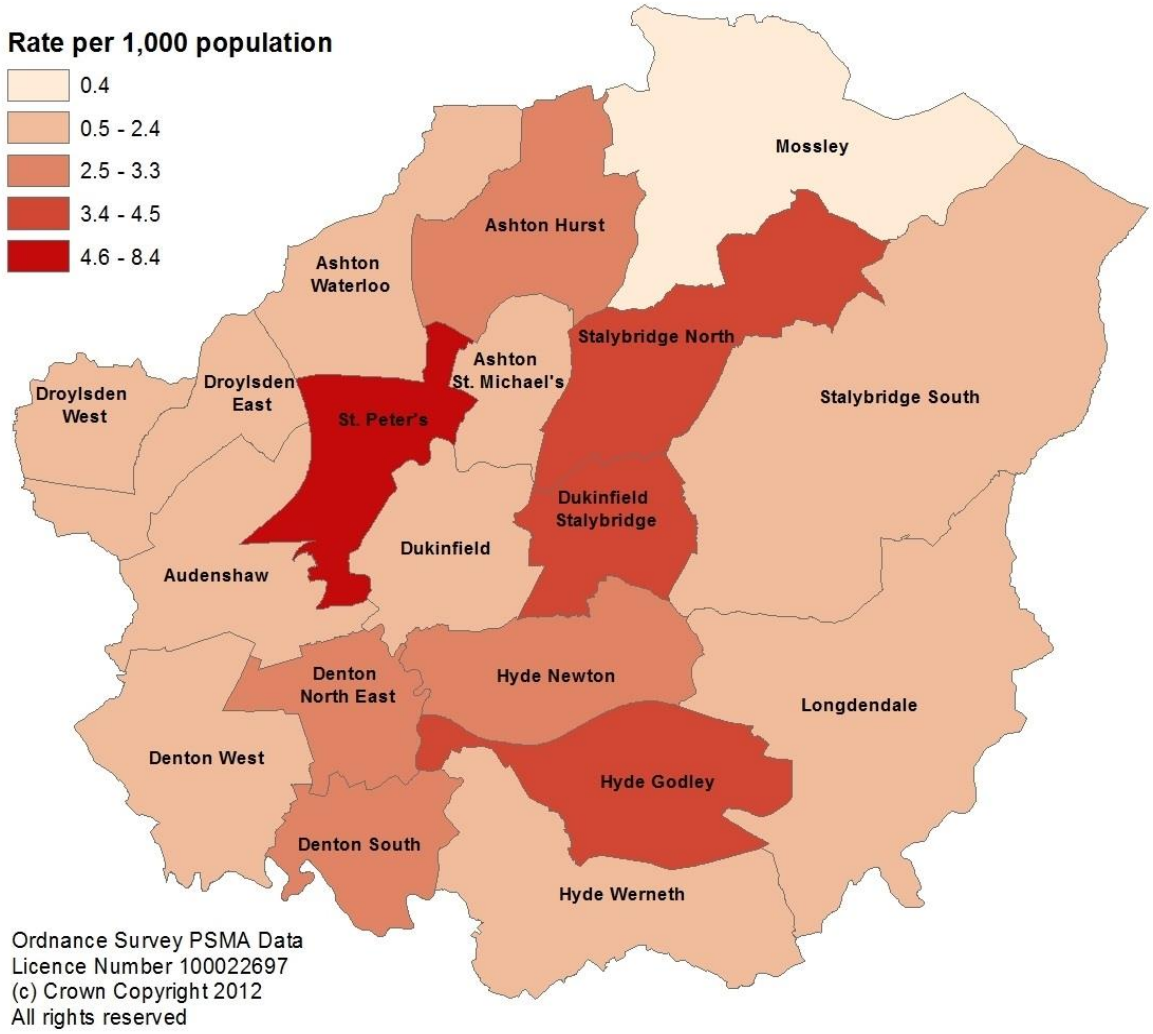
Alcohol Related Violent Crime by 5 year age band and Sex of Victim

The rate of alcohol related violent crime committed against males peaks with the age of the victim within the 30-34 age band whereas the rate of alcohol related violent crime committed against women peaks within the 20-24 age band. In all age bands except for 50-54 the rate of alcohol related violent crime committed against women is higher than that committed against men. The disparity between the rate of alcohol related violent crime committed against males and females is greatest within the 20-24 age band, where the rate of alcohol related violent crime committed against females is 2.9 fold than that committed against males.

Alcohol Related Violent Crime by Ward

The rate of alcohol related violent crime by ward of occurrence is shown in Map 7. The rate of alcohol related crime per 1,000 population ranges from 0.4 in Mossley through to 8.4 in St. Peter's.

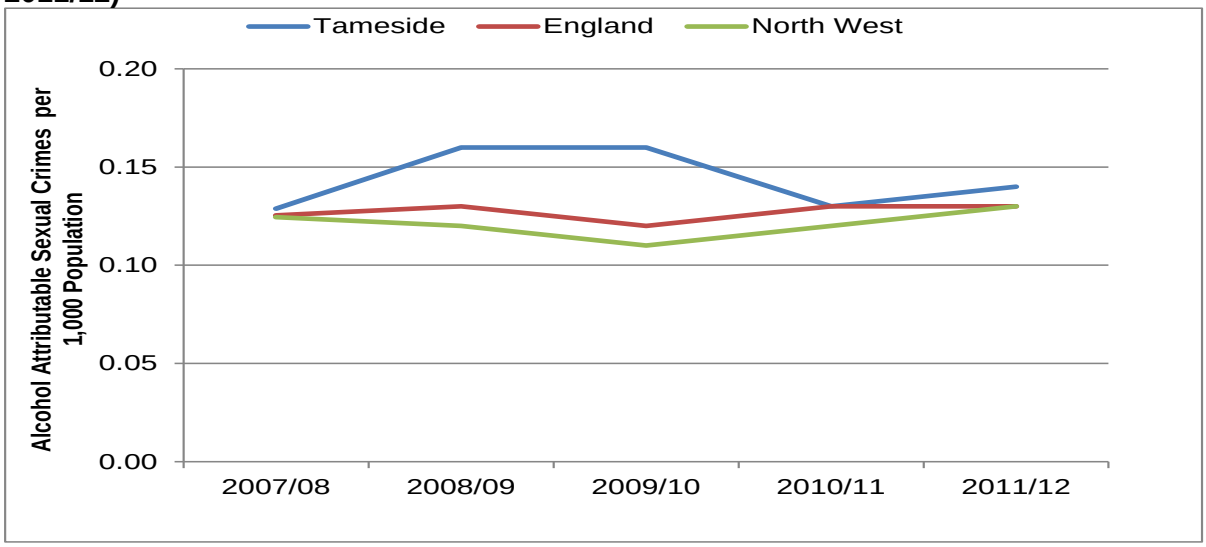
Map 7: Alcohol Related Violent Crime Rate by Tameside Wards (2012/13)



Alcohol Attributable Sexual Crime

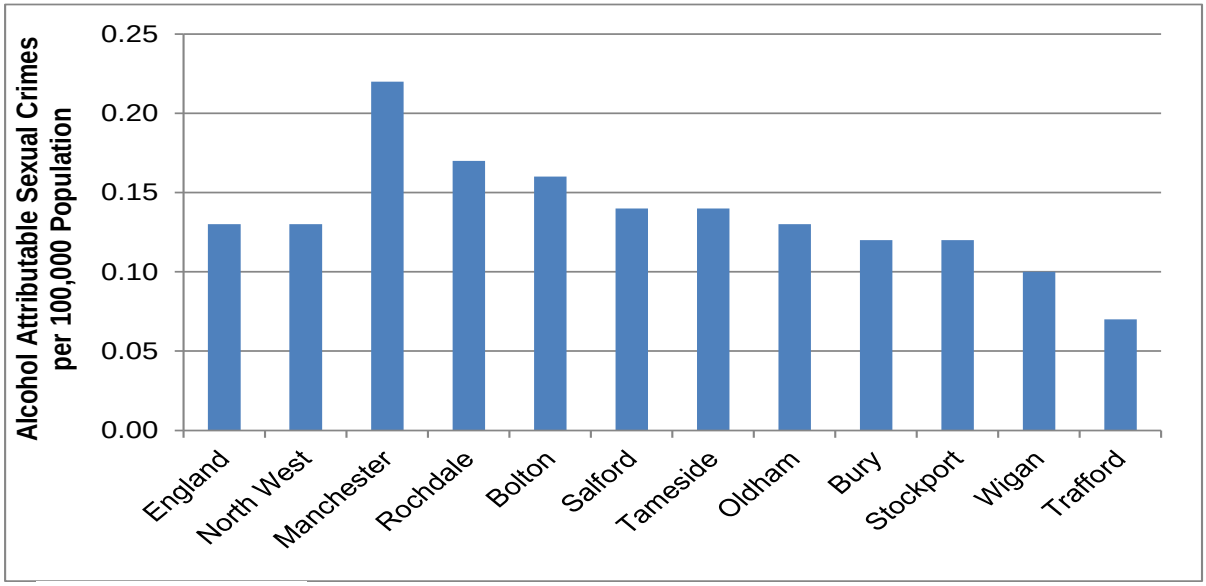
The rate of alcohol attributable sexual crime is shown in Figure 36 for Tameside, the North-West and England. The level of alcohol attributable sexual crime has remained fairly consistent in Tameside from 2007/08 to 2011/12. Tameside has the fifth highest rate of alcohol attributable sexual crime in Greater Manchester as shown in Figure 37. The number of alcohol attributable sexual crimes is too low to reliably analyse this category by population groups as presented for all alcohol related crimes and alcohol related violent crime.

Figure 36: Alcohol Attributable Sexual Crimes per 1,000 population (2007/08 to 2011/12)



Source: *LAPE*

Figure 37: Alcohol Attributable Sexual crimes per 1,000 population (2007/08 to 2011/12



Source: *LAPE*

Alcohol Related Hate Crime

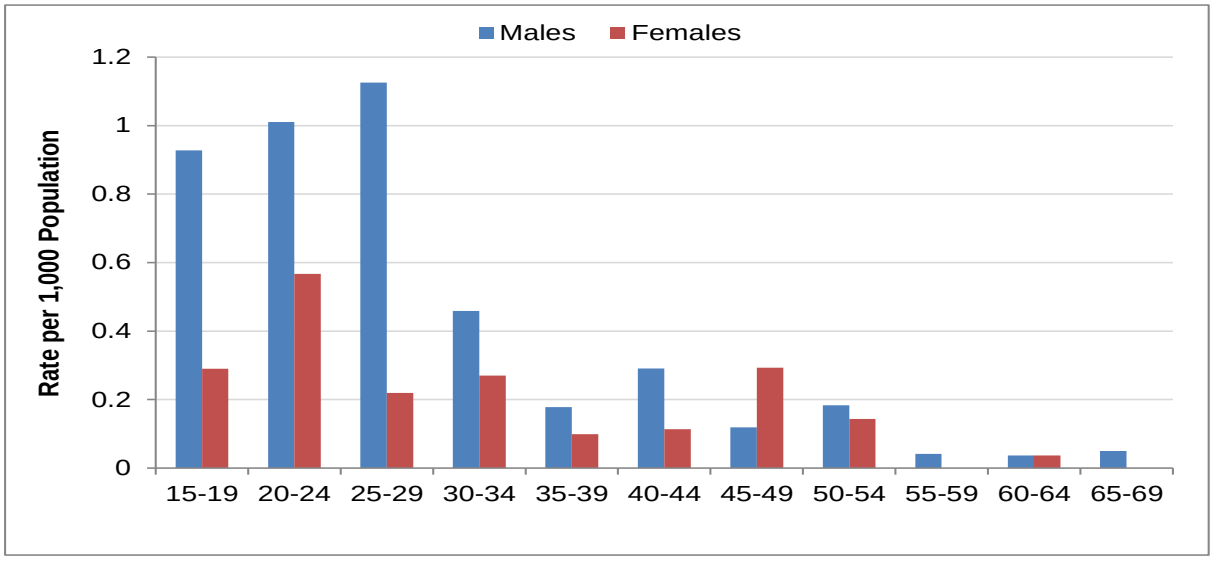
Hate crime is defined as being perceived by the victim to be motivated by hate or prejudice. Greater Manchester Police record hate crimes that have either been motivated by or perceived to be motivated by disability, gender, race or ethnicity, religion/belief, sexual orientation or a combination of these characteristics[55].

[55] GMP. [Online] http://www.gmp.police.uk/content/section.html?readform&s=C4D5E39C4F3817F680257961004019B9

In 2013 21% of hate crimes occurring in Tameside that were reported to Greater Manchester Police were recorded as being associated with alcohol use.[56]

The rate of alcohol related hate crime per 1,000 Tameside residents is shown by the age of offender in Figure 38. Offending rates for alcohol related hate crime between 2009 and 2012 in males are highest with the age bands 15 to 29, peaking at 25-39 at 1.1 reported incidents per 1,000 population and declining within older age groups. The incidence of alcohol related hate crime in females between 2009 and 2012 is considerably lower peaking in the 20-24 age bands at 0.56 reported incidents per 1,000 population. Of all alcohol related hate crimes in Tameside recorded between 2009 and 2012, 79% were recorded as being religiously or racially aggravated.

Figure 38: Alcohol Related Hate Crime by Age and Sex of Offender (2009-2012)



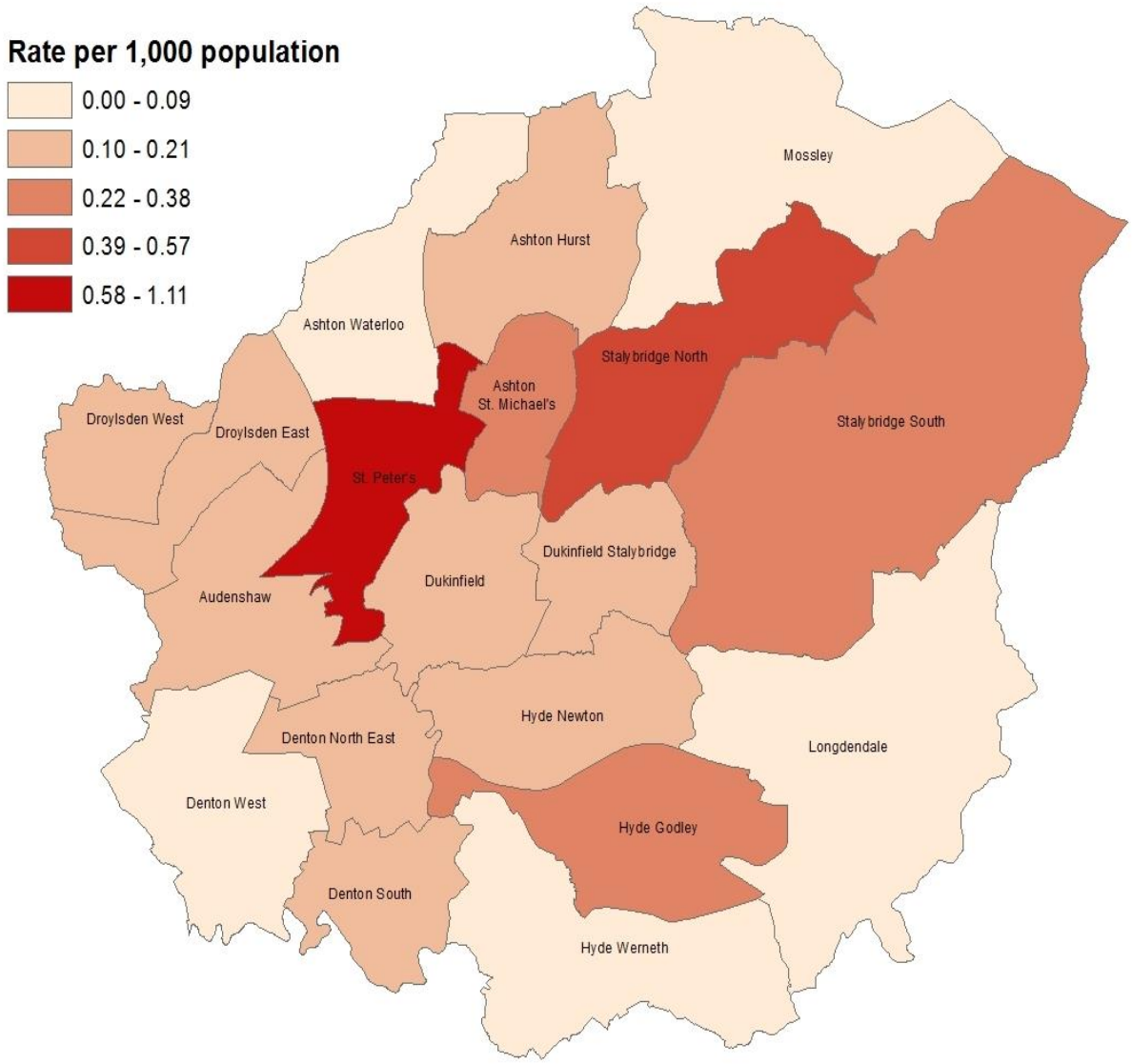
Source: *GMP*

Alcohol Related Hate Crime by Ward

The rate of alcohol related hate crime recorded between 2009 and 2012 by ward of occurrence is shown in Map 8. The rate of alcohol related crime per 1,000 population ranges from zero in Mossley through to 1.1 in St. Peter's.

[56] Greater Manchester Police **(GMP)**

Map 8: Alcohol Related Hate Crime Rate by Tameside Wards (2009 to 2013)



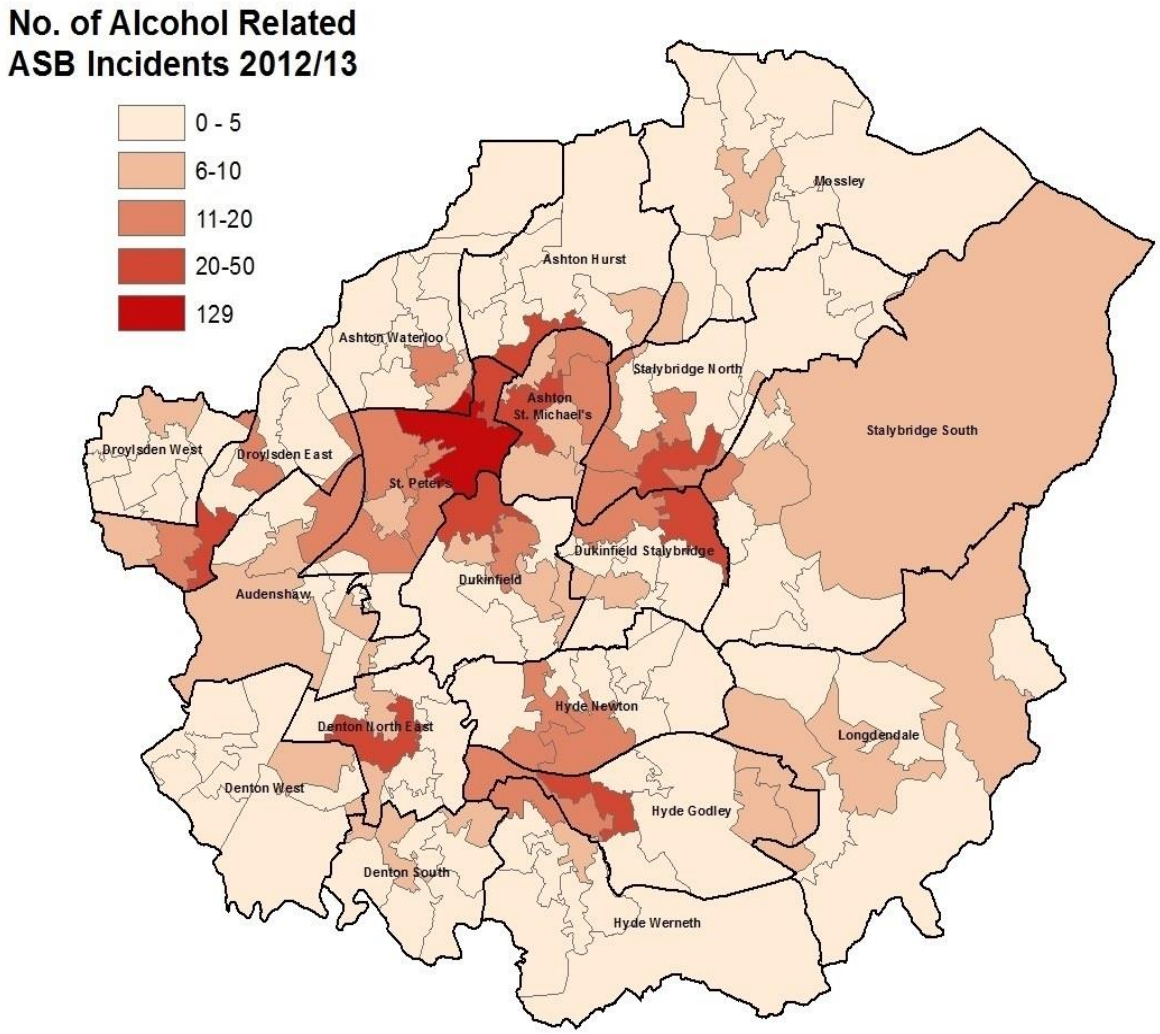
Source: *GMP*

Alcohol Related Anti-Social Behaviour

Greater Manchester Police define anti-social behaviour (ASB) as an aggressive and destructive activity that intimidates, threatens and causes distress. It can include among other issues, rowdy or yobbish behaviour, street drinking and vandalism. Alcohol related anti-social behaviour is a particular problem for town centres and is often associated with binge drinking.

Map 9 shows the distribution of reported incidents of alcohol related anti-social behaviour in Tameside for 2012/13 by lower super-output area (LSOA). The LSOA comprising Ashton town centre had by far the highest number of recorded incidents at 129. Other incidence hotspots for the alcohol related ASB include areas central to Stalybridge, Dukinfield and Hyde.

Map 9: Numbers of Reported Alcohol Related Anti-Social Behaviour Incidents by Tameside LSOAs with ward boundaries overlaid (2012/13)



Source: *GMP*

Domestic Violence

There are strong links between alcohol misuse and the incidence of domestic violence. The 1996 British Crime Survey has indicated that in 32% of intimate partner violence incidents were committed when the perpetrator was under the influence of alcohol.[57] Although the majority of people with alcohol problems are not perpetrators of domestic violence, a link between alcohol problems and domestic violence exists. Among 75 US male alcoholics undergoing alcohol treatment, 62% had committed husband to wife violence, compared to just 12% of a matched group of non-alcoholics. Research also shows that the likelihood of domestic violence increases with the quantity of alcohol consumed and that the likelihood of a victim being injured as a result of an incident of domestic violence is increased significantly if alcohol is a contributing factor.[58]

In 2013, 38.5% of domestic violence incidents occurring in Tameside that were reported to Greater Manchester Police were recorded as being associated with alcohol use.[59]

There is anecdotal evidence to suggest that the awareness of domestic violence incidents by front line alcohol service staff is increasing in Tameside which may indicate that the incidence of domestic violence associated with people with alcohol problems may be rising.

Victims of domestic violence have an increased risk of having alcohol problems. The 1996 British Crime Survey reported that men and women who drink alcohol heavily are more likely to report being victims of domestic abuse than those who do not. Victims of domestic violence may use alcohol as a coping mechanism and alcohol misuse or dependency may be one symptom of post-traumatic stress and psychiatric disorder resulting from victimisation experiences.[45]

Approaches to the problem of domestic violence associated with alcohol misuse, include:-

- Campaigns to raise awareness of the link between alcohol and domestic violence.
- Partnership working between different stakeholders including public health, alcohol service providers, the police and criminal justice system to increase referral of perpetrators of alcohol fuelled domestic violence to alcohol treatment services.

Accidents

Alcohol is a depressant that causes decreased motor functioning in individuals as well as altered judgement. As a result alcohol is implicated as a contributing factor in 20 to 30% of accidents nationally.[60] In 2010 nearly 10,000 road casualties occurred in the UK where the driver was over the legal alcohol limit which represents approximately 5% of all casualties. Approximately 40% of all fire casualties, 30% of all drowning and 35% of all workplace accidents are alcohol related[47].

[57] **Home Office.** *Alcohol and intimate partner violence: Key Findings from the Research*
[58] **Kyriacou, Demetrios N, et al.** *Risk Factors for Injury to Women from Domestic Violence.* 25, s.l. : The New England Journal of Medicine, Vol. 341.
[59] **Greater Manchester Police**
[60] **NWPHO.** *Alcohol: Some Sobering Statistics from the NWPHO.*

Workplace Absenteeism

An estimated 3 to 5% of all workplace absences are related to alcohol misuse, amounting to approximately 8 to 14 million days per annum nationally.[61] A study by YouGov for PruHealth found that each day approximately 200,000 workers turn up to work with a hangover from the night before.[62] A raised blood alcohol level at work decreases a person's judgement and increases the risk of errors and accidents as well as reducing productivity.

[61] **Health and Safety Executive (HSE).** *Don't mix it. A guide for employers on alcohol at work.* 2011.
[62] **Pru Health.** *200,000 HUNGOVER WORKERS ON ANY GIVEN DAY. Effects of 'booze britain' hit the workplace.* 2006.

Living and Working Well: Key Findings

- Approximately 26% of adults in Tameside drink at increasing or higher risk levels
- There are around 14,200 dependant drinkers in Tameside
- Tameside has significantly higher disability claimant rate for alcoholism than both the North West and England averages
- Tameside has significantly higher rates of hospital admissions for alcohol specific conditions; these admissions have increased by 35% for males in Tameside between 2006/07 and 2010/11
- The highest proportion of hospital admissions in Tameside for males was in age group 45-49 years and for females 40-44
- Significantly more males than females were admitted to hospital due to alcohol
- Alcohol admissions are significantly higher in the more deprived wards with Ashton St Peter's and Ashton St Michaels
- Alcohol specific mortality is higher in Tameside for both males and females than both the North West and England averages.
- The highest rate of mortality for males is in age group 50-54 years and for females 60-64 years
- Crime: The proportion of crimes committed with an alcohol marker is just over 10% a slight increase since 2009
- The level of alcohol attributable violent crime has fallen by 21% between 2007/08 and 2011/12 but it is still higher than the England average

6 - Ageing and Dying Well

Evidence suggests that the UK may be on the cusp of an epidemic of alcohol-related harm amongst older people:

- An estimated 1.4 million people aged 65 and over currently exceed recommended drinking limits[63]
- 3% of men and 0.6% of women aged 65-74 are alcohol dependent[64]
- There has been a steady increase in the amount of alcohol consumed by older age groups in recent years[65]
- The sizeable cohort of 'baby-boomers', currently aged 46-65, consume more alcohol than any previous generation[66]

As individuals become older, they often experience multiple losses, for example, loss of family, friends and health, and changes in role such as retirement or becoming a caregiver for an elderly partner or relative. Additional stressors (e.g. chronic pain or insomnia) and multiple crises (e.g. economic and health problems) may result in an overwhelming situation in which alcohol misuse may begin or increase. Approximately one third of older drinkers, known as 'late-onset' drinkers, first develop a drink problem in later life.[67] .The other two thirds of older drinkers, known as 'early-onset' drinkers develop an alcohol problem earlier in life (by definition, before the age of 40).[68]

Older People and Alcohol Misuse

With the number of older people increasing nationally, the problem of alcohol related harm in the elderly is increasing. Evidence suggests that the upper safe limit for older people is 1.5 units per day[69]. Older people are more susceptible to the deleterious effects of alcohol use compared to younger adults, with alcohol consumption leading to higher comparable blood alcohol levels, as the aging body is less effective in processing alcohol. Alcohol depresses brain function more in older people, impairing co-ordination, which in turn can lead to accidents or falls[70]. The prevalence of alcohol misuse disorders within older age groups is considerably lower than in young age groups. However, considering the lower recommended consumption limits and the increased impact of alcohol use within the elderly, existing measures of alcohol misuse such as the AUDIT C tool may not be suitable for the elderly and alcohol misuse disorders in older people may be considerably underdiagnosed.[71]

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[63] NHS Information Centre (2009). Adult Psychiatric Morbidity in England 2007. S. McManus, H. Meltzer, T. Brugha, P. Bebbington and R. Jenkins. London.
[64] NHS Information Centre 2009
[65] Smith and Foxcroft 2009
[66] NHS Health Scotland 2006
[67] **Widner and Zeichner 1991; Dufour and Fuller 1995; Mellor, Garcia et al. 1996**
[68] Widner and Zeichner 1991)).
[69] **Royal College of Psychiatrists (2011)**. Our Invisible Addicts
[70] **Alcohol Concern**. Acquire – Information and Research Bulletin. Autumn 2002
[71] O'Connell, H., Chin, A, , Cunningham, C., Lawlor, B, (2003). Alcohol use disorders in elderly people—redefining an age old problem in old age BMJ 2003;327:664–7

Studies suggest that one in five older men and one in 10 older women drink enough to harm themselves, a rise of 40% in men and 100% in women over the past 20 years.[56]

It is known that people over 60 are not proportionally represented in Alcohol Treatment Services. In Tameside in 2013/14, 4% of male and 2% of female referrals to alcohol treatment services were aged 60+. To put these figures in context the over 60s population equates to approximately 21% of the total Tameside male population and 23% of the total Tameside female population.[72]

Although alcohol misuse in older people may have developed earlier in their life, there are socio-demographic factors affecting some older people that are associated with the development of alcohol misuse disorders within old age and about a third of older people with drink problems develop them for the first time in later life. It is suggested that such socio-demographic factors include being male, socially isolated, single and separated or divorced. Other reasons for alcohol misuse in old age may include bereavement, loneliness, pain, ill health, disability and depression.[58]

Older people that drink heavily are at greater risk of developing physical consequences, for example, heart, liver and mental health conditions.[56] Recent statistics warn of a rise in the number of hospital admissions for over 60's with alcohol related mental health problems. The same report found an increase in the last decade in the number of over 60's being admitted to hospital for Wernicke-Korsakoff syndrome which is a form of dementia associated with alcohol use.[73]

Alcohol depresses brain function more in older people, impairing co-ordination, which in turn can lead to accidents or falls. Within the period 2011/12 to 2012/13, 6.2% of admissions for falls in Tameside residents aged 60 plus also contained an alcohol specific diagnosis suggesting that alcohol was associated with the fall. Of the admissions to hospital of Tameside residents aged 60 plus with both a fall and alcohol specific diagnosis, 34.6% had a primary diagnosis of head injury and 10.8% had a primary diagnosis of hip fracture.

Front line teams in regular contact with elderly people should have IBA training and be in a position to offer brief alcohol advice where appropriate and refer heavier users of alcohol to alcohol treatment services.

Researchers have identified 3 types of elderly drinkers:[74]

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 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.

[72] NDTMS

[73] **Alcohol Concern.** *Trends in alcohol related admissions for older people with mental health problems: 2002 to 2012.* 2013.

[74] http://www.ias.org.uk/Alcohol-knowledge-centre/Alcohol-and-older-people/Factsheets/Older-peoples-drinking-habits-Very-little-very-often.aspx

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

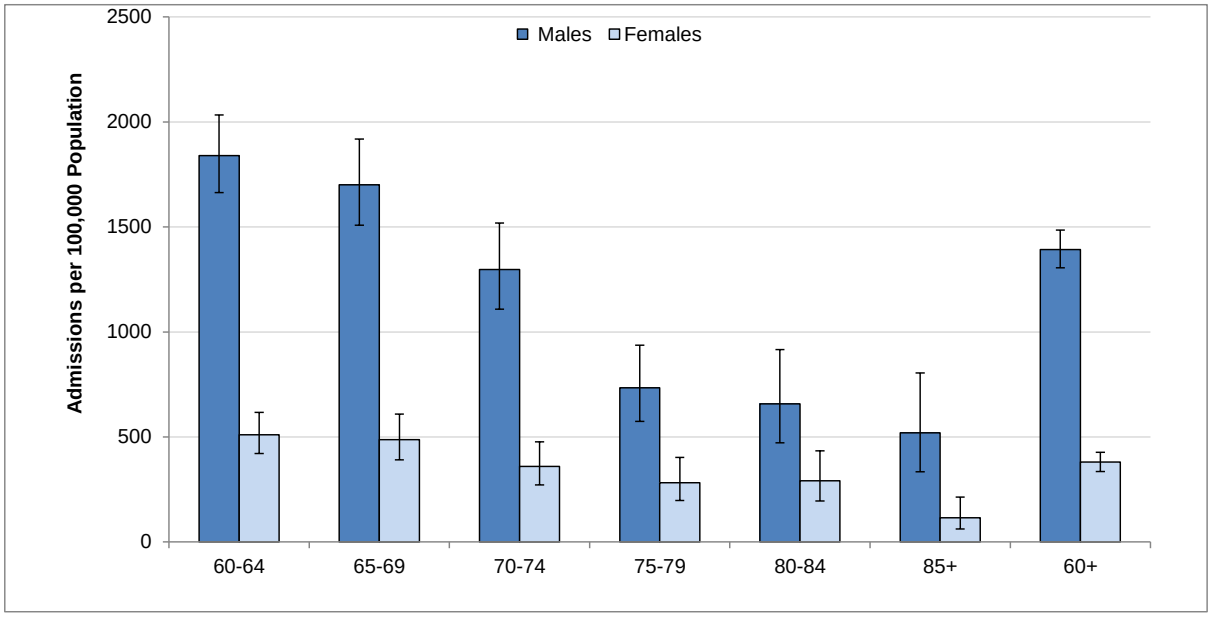
Alcohol and Dementia

Alcohol can contribute to the development of dementia, with 10% of elderly people presenting with dementia having alcohol-related brain damage. It is suggested that there is a J-Shaped relationship between alcohol consumption levels and risk of age associated cognitive impairment with low to moderate alcohol consumption associated with a decreased risk and heavy alcohol use associated with increased risk of cognitive impairment and dementia[75]. Heavy drinking may be to blame for as many as 1 in 4 cases of dementia in the UK, and there is a concern that the increased levels of binge drinking within this population over the last few decades could result in an increase in dementia as the increased population exposed to binge drinking ages.

Alcohol Hospital Admissions in Older Tameside Residents

The rate of alcohol specific hospital admissions in older Tameside residents by 5 year age band and sex are shown in Figure 39. Alcohol Specific hospital admissions in older people are highest in the 60-64 age band and decline with each subsequent increment in age band.

Figure 39: Alcohol Specific Admissions in Tameside Residents Aged 60 plus between 2010 and 2012



Source: Secondary User Statistics (SUS)

The proportion of alcohol specific admissions due to different admission categories differs with increasing age band. Whereas the proportion of alcohol specific hospital admissions that can be accounted for by alcohol intoxication are much lower in older compared to younger Tameside residents, the proportion of admissions that can be accounted for by somatic disease are increased. This reflects the decreasing prevalence of harmful drinking

[75]GUPTA, S. AND WARNER, J. Alcohol-related dementia: a 21st-century silent epidemic? *The British Journal of Psychiatry (2008) 193: 351-353*

with increasing age, but the increasing chronic effects of problem drinking become more apparent with advancing age.

Ageing and Dying Well: Key Findings

- People over the age of 60 are not proportionally represented in alcohol treatment services. In 2012/13 only 4% of males and 2% of females were referred to alcohol services
- Between 2011/12 and 2012/13, 6.2% of alcohol related admissions for falls in Tameside were alcohol related
- Levels of admissions for acute intoxication are high in Tameside with the 60-69 year age group making up the highest proportion (2,300/100,000)
- People currently aged 46-65 years consume more alcohol now than any previous generation
- Research shows that 1 in 5 men over 60 and 1 in 10 women over 60 drink enough to harm themselves, a rise of 40% in men and 100% in women over the last 20 years

7 - Prevention of Alcohol Harm: Policy Context

National Strategy and Policy

The 'Alcohol Harm Reduction Strategy for England' (2004) was the Government's first alcohol harm reduction strategy that described policy aimed at tackling some of the key issues associated with alcohol misuse. It includes:-

- Improved training of staff to identify the signs of alcohol misuse in individuals and to administer advice and signpost or refer individuals to alcohol treatment services where required.
- Carrying out a national audit of alcohol treatment services to identify any gaps in demand and service provision.
- Providing more help to the people most vulnerable to the effects of alcohol misuse including young people, the homeless and the mentally ill.
- Working with the alcohol industry to promote a responsible charter, including not producing drinks that are marketed at underage drinkers or marketing drinks intended for people to drink well over recommended levels.
- The promotion of greater use of measures such as exclusion orders and fixed penalty notices to deal with alcohol related crime and anti-social behaviour.

The Government white paper 'Delivering Choosing Health: Making Healthier Choices Easier' (2007) set out key public health principles for promoting healthier lifestyles, with a specific focusing on reinforcing alcohol harm reduction by:

- Building on commitments within the Government 2004 Alcohol Strategy.
- Providing guidance and training to ensure all health professionals are able to make an early identification of alcohol related problems.
- Piloting approaches to targeted screening and brief intervention in both primary care and hospital settings.
- Launching initiatives within the criminal justice system to reduce offending, by ensuring alcohol treatment needs are met.
- Developing a programme of improved alcohol treatment services.

The Government's current Alcohol Strategy (2012) sets out how the Government aims to tackle alcohol misuse and its effects. This includes:-

The Alcohol Strategy sets out proposals to crackdown on our 'binge drinking' culture, cut the alcohol fuelled violence and disorder that blights too many of our communities, and slash the number of people drinking to damaging levels.

The Strategy includes commitments to:

- consult on a minimum unit price for alcohol
- consult on a ban on the sale of multi-buy alcohol discounting

- introduce stronger powers for local areas to control the density of licensed premises including making the impact on health a consideration for this
- pilot innovative sobriety schemes to challenge alcohol-related offending

'In November 2012, the Home Office launched a ten-week consultation on five key areas (the consultation') with the aim of reducing alcohol fuelled crime and anti-social behaviour:

- a ban on multi-buy promotions;
- a review of the existing mandatory licensing conditions;
- health as a licensing objective for cumulative impacts;
- cutting red tape for responsible businesses; and
- minimum unit pricing.

May 2014: On minimum pricing the government have announced that it would *not* be proceeding with minimum unit pricing after all. According to the Government, there was not enough "concrete evidence" that such a policy would be effective in reducing the harms associated with problem drinking without penalising responsible drinkers.
A proposed ban on multi-buy promotions has also been dropped, but previous plans for a 'below cost ban' have been resurrected, meaning alcohol will not be sold at lower than duty + VAT to 'stop the worst cases of heavy discounting'.

The full Alcohol Harm Reduction Strategy can be found here alcohol-strategy

The Government's response to the consultation can be found here consultation response

8 – Prevention and Early Intervention of Alcohol Harm: Guidance and Quality Standards

The 2010 NICE guidance document 'Alcohol-Use Disorders: Preventing Harmful Drinking' recommends a number of measures to prevent harmful alcohol use in adults and adolescents, as well as early intervention measures to target those already drinking at harmful levels. Specifically the guidance includes:-

- A recommendation to reduce the unit cost of alcohol, which they state to be the most effective measure of reducing alcohol-related harm. However this now contradicts the May 2014 response from the Government which states lack of concrete evidence.
- To take consideration of public health interests in the licensing process, including the reviewing of trauma and injury data to identify trouble hotspots and reducing the availability of alcohol by limiting the density of licensed premises in an area.
- Measures to minimise the exposure of under 18s to alcohol advertising, which has been associated with the onset of drinking in young people and increased consumption in young people who already drink.
- Actions that should be taken to target identification and brief advice (IBA) at young people and adults. Targeting of IBA for children and young adults should focus upon key vulnerable groups including those who have had an accident or a minor injury, those who regularly attend genito-urinary medicine (GUM) clinics or repeatedly seek emergency contraception, those involved in crime or other antisocial behaviour, those who truant on a regular basis, those at risk of self-harm, those who are looked after, those involved with child safeguarding agencies. Screening of adults should pay particular attention to those with existing physical conditions such as hypertension or liver disease, those who have mental health problems, those who have been assaulted, those at risk of self-harm.
- IBA can be delivered by professionals who work in many public facing roles including in primary healthcare, emergency departments and other secondary healthcare, higher education, the criminal justice system, social services.

NICE have developed a pathway that covers prevention, diagnosis and management of alcohol-related disorders including hazardous and harmful drinking, alcohol dependence and the physical complications of alcohol use in adults and children and young people aged under 18 years in educational institutions.

The pathways can be found here ⩥pathways.nice.org.uk/

Alcohol Dependence and Harmful Use of Alcohol

Quality Standards QS11

The NICE quality standard defines clinical best practice within this topic area. It provides specific, concise quality statements, measures and audience descriptors to provide the public,

health and social care professionals, commissioners and service providers with definitions of high-quality care.

→ http://www.nice.org.uk/guidance/index.jsp?action=byID&o=13834

Alcohol: Preventing Harmful Alcohol Use in the Community

A NICE quality standard on Alcohol: Preventing Harmful Alcohol Use in the Community is being developed and is due for release in December 2014. This quality standard will cover the prevention of harmful alcohol use in the community. It will not cover screening and brief interventions as this was previously covered by NICE quality standard 11.

9– Evidence Review

Decisions about policy and practice in the public sector are increasingly driven by consideration of the best available evidence. The process of drawing together, analysing and integrating evidence from research is a central principle of evidence-based practice. Typically, the process of reviewing an area of practice or intervention will include the production of a systematic review of effectiveness, in-depth analysis or some other review-level production and interpretation of evidence from research.

Strategies for reducing per capita consumption of alcohol aim to reduce average consumption and, in the case of binge drinking, the model level of consumption; Studies have demonstrated that reduction of harm at the population level is best achieved among moderate drinkers rather than risky or heavy drinkers; this is the 'alcohol preventive paradox' which was put forward by Kreitman (1986).[76]

Strategies to control per capita consumption include the use of taxation to raise the price of alcohol, restrictions on distribution outlets, restrictions on advertising, law enforcement (e.g. on underage purchasing of alcohol), and national and local media campaigns to provide awareness of recommended drinking levels and of the harms associated with alcohol misuse.[77]

Reduction of alcohol-related harm strategies aim to address the harm associated with alcohol use, for example alcohol-associated domestic violence or fights and incidents around drinking venues, homelessness, family disruption, child neglect and sexual abuse, loss of workplace productivity or the risks to health. Harm reduction rather than a reduction in the amount of alcohol consumed is often the objective of such interventions. Examples include the introduction of shatterproof glasses in public houses, training of professionals to identify and respond to alcohol-related health and social problems (e.g. nurses, social workers, and doctors), training of those who serve in public houses or entertainment venues to identify and refuse intoxicated customers, placing a ban on street drinking and enforcing the law on underage purchasing.[78]

It is also important to link interventions at the national level – for instance, the control of price, advertising or legislation to control the distribution and sale of alcohol – with action at local level, for instance through local licensing regulations, local policing and local awareness campaigns.

Targeting the consumption and drinking patterns of 'high risk' or 'vulnerable groups' – approaches are aimed at individuals and groups (e.g. professional women, young people, young black males, 'binge' drinkers) rather than at the population as a whole. This also includes using targeted brief interventions to reduce the amount of alcohol consumed or to

[76] Kreitman, N. (1986). Alcohol consumption and the preventive paradox. British Journal of Addiction 81: 353-63.
[77] (Lemmens, 2001) http://www.diva-portal.org/smash/get/diva2:360384/FULLTEXT01.pdf
[78] (Plant et al., 1997). http:///alcohol/documents/alcohol_europe_en.pdf

tackle harmful drinking patterns and drinking contexts such as intoxication, drinking while working with machinery or drink driving or media campaigns with messages specifically tailored to the target group or target behaviour, introducing school education programmes and workplace policies. [79]

Affordability of Alcohol

Harm from alcohol-use disorders costs a substantial amount of money and increases in prices of alcoholic drinks may be associated with reductions in drinking and in harms, including deaths, associated with drinking.[80] Minimum unit pricing seems to affect the population of drinkers at highest risk across all socio-economic categories. People with the lowest income do not seem to be particularly disadvantaged by minimum unit pricing because this group drinks less than people with higher income. Increases in tax on alcohol seem to be associated with reductions in drinking and reductions in tax seem to be associated with increases in drinking. The level of increased drinking after tax reductions may differ across age groups, gender and socio-economic status. However, tax levels may not directly affect binge drinking in young people. There is potential for tax models to be tailored so that benefits of increased tax spending offset the disadvantages to consumers of higher alcohol prices.[81]

Increases in tax on alcohol seem to be associated with reductions in drinking, and reductions in tax seem to be associated with increases in drinking. The level of increased drinking after tax reductions may differ across age groups, gender and socio-economic status. However, tax levels may not directly affect binge drinking in young people. There is potential for tax models to be tailored so that benefits of increased tax spending offset the disadvantages to consumers of higher alcohol prices.[82]

Availability

A higher density of off-premises alcohol outlets may be associated with increases in mortality, rates of admission to hospital because of assault or alcohol-related disease and domestic violence. Higher density of other types of licensed premises may also be associated with increases in admission to hospital because of assault or alcohol-related disease.[83]

Marketing

Young people in the UK may have high levels of exposure to alcohol advertising on television and online media, and may own a substantial amount of alcohol-branded items.

[79] /nta_review_of_the_effectiveness_of_treatment_for_alcohol_problems
[80] Alcohol use disorders: preventing harmful drinking-evidence up date 2014. https://www.**evidence**.nhs.**uk/evidence**-update-54
[81] Alcohol use disorders: preventing harmful drinking-evidence up date 2014. https://www.evidence.nhs.uk/evidence-update-54
[82] Alcohol use disorders: preventing harmful drinking-evidence up date 2014. https://www.evidence.nhs.uk/evidence-update-54
[83] Alcohol use disorders: preventing harmful drinking-evidence up date 2014. https://www.evidence.nhs.uk/evidence-update-54

Young people who drink or binge drink may have higher exposure to alcohol advertising than those who do not drink or binge drink[84]

Licensing

Environmental factors of licensed premises, such as loud music, may be associated with increases in risky drinking, intoxication, and violence. NICE PH24 recommends that alcohol licence-holders and designated supervisors of licensed premises (such as local authorities, trading standards officers, the police, magistrates, and revenue and customs) should work in partnership with the appropriate authorities to identify and take action against premises that regularly sell alcohol.[85]

Screening and Brief Intervention

Healthcare professionals seem to have a generally negative attitude towards people with alcohol-use disorders, but this perception may be improved with education and training. Extended brief interventions may be effective in reducing drinking and harm from drinking in people aged under 21 years. However, evidence of effectiveness in people younger than 17 years remains limited. Simply asking questions about drinking does not seem to affect drinking behaviour.[86]

Universal alcohol screening may result in more people being asked about alcohol use than consultation-based targeted screening, but neither screening system seems to consistently identify people with risky alcohol-use who should then receive brief intervention. However, universal screening may detect risky drinking at an earlier stage than consultation-based screening.

Brief interventions in people admitted to hospital for reasons other than alcohol use may be effective in reducing alcohol consumption particularly those interventions that involve multiple sessions.[87]Brief advice or lifestyle counselling may not reduce drinking more than personalised feedback after screening plus a patient information leaflet; the effect of lifestyle counselling may have been reduced because many patients did not attend a subsequent counselling session. Costs of implementing schemes to increase screening and brief interventions for alcohol-use disorders may be offset by long-term savings.

Nurse-led brief interventions to reduce alcohol use delivered in a sexual health clinic may be acceptable to patients in this setting but may not be effective in reducing harmful or hazardous drinking. Brief intervention to reduce alcohol use delivered in the emergency

[84],[82,83], Alcohol use disorders: preventing harmful drinking-evidence up date 2014. https://www.evidence.nhs.uk/evidence-update-54
[85] Hughes K, Quigg Z, Eckley L et al. (2011) Environmental factors in drinking venues and alcohol-related harm: the evidence base for European intervention. Addiction 106: 37–46
[86] [86]Alcohol use disorders: preventing harmful drinking-evidence up date 2014. https://www.evidence.nhs.uk/evidence-update-54
[87] Alcohol use disorders: preventing harmful drinking-evidence up date 2014. https://www.evidence.nhs.uk/evidence-update-54

department may not reduce subsequent injuries. Brief or extended multi-contact interventions delivered in primary care may be effective in reducing alcohol consumption.[88]

Other Interventions

Computer-based interventions may be effective for reducing drinking but the evidence base seems to be inconsistent in both results and quality of studies.

Social norms interventions may not be effective in reducing quantity of drinking and effects on binge drinking seem to be inconsistent but interventions involving web-feedback may reduce alcohol-related problems[89]

[88] Alcohol use disorders: preventing harmful drinking-evidence up date 2014. https://www.evidence.nhs.uk/evidence-update-54

[89] Alcohol use disorders: preventing harmful drinking-evidence up date 2014. https://www.evidence.nhs.uk/evidence-update-54

10 – Conclusion and Recommendations

Alcohol and its use is a complex issue for public health. It seems for some the messages around alcohol harm are filtering through but not to all and there are still high levels of admissions and deaths in Tameside from alcohol related conditions that are not improving and in some instances getting worse.

Most people who enjoy drinking find it a sociable and relaxing thing to do and don't over indulge – more than 70% of people drink within the recommended drinking guidelines in the UK. In general, drinking within the guidelines is compatible with a healthy lifestyle.

Light and moderate drinkers - that is 2 to 3 units for women and 3-4 for men a day of any form of alcohol - live longer than those who abstain or drink heavily. This widely accepted relationship is known as the J-shaped curve. The relative risk of mortality is lowest among moderate consumers.

Although drinking should be for pleasure rather than for any health benefit, there is consistent medical evidence to show that light to moderate consumption of alcohol may be beneficial to health, especially for men over 40 and post-menopausal women, where the risk of heart attack is higher. Cardiovascular disease is the most common cause of death in the UK accounting for 4 in every 10 deaths. Almost 2.6 million people are affected by heart and circulatory conditions in the UK with someone having a heart attack every 2 seconds.

The acceptance by many that alcohol forms part of a balanced diet and lifestyle is due, in part, to the growing body of evidence from eminent researchers and physicians that drinking in moderation is not only enjoyable and sociable but may prolong life by protecting against coronary heart disease and stroke as well as late-onset diabetes, Alzheimer's disease and in the words of Plato, the 'crabbedness of old age'!

However, there are members of our community that misuse alcohol at harmful levels. Some of these people are in alcohol treatment services others probably don't even associate themselves as having an alcohol problem. Therefore there is work to be done to identify those in Tameside who are at risk of drinking at harmful levels and those who currently drink more than the recommended guidance on a regular basis.

Recommendations

Supply and Licensing of Alcohol

Effective harm prevention and the promotion of responsible drinking not only requires targeting education, information and support at an individual level among young people, but control of the concentration of alcohol outlets at a community level. Therefore a co-ordinated, multi-agency approach to licensing is recommended so that:

- The presumption of approving license applications is challenged
- An alcohol license saturation policy could be introduced in Tameside to prevent further licenses being issued in areas with an existing high-density of licenses
- The direct and indirect supply of alcohol to children is reduced
- Information on the cumulative health impacts and alcohol-related harm is considered in all licensing decision-making so that the density of licenses in Tameside compared to other areas is better understood.
- Retailers are discouraged from promoting multi-purchase discounted alcohol

Consumption of alcohol

Efforts are needed by all partners to help reduce alcohol consumption in those people who are drinking at increased and higher levels of risk. This can be addressed by:

- Recognising the risk groups identified in this needs assessment and understanding the opportunities to intervene
- Reducing children's consumption of alcohol
- Reducing alcohol consumption in those people drinking above the recommended safe limits for consumption and reduce dependency on alcohol
- Ensuring the consistent use of identification and brief advice across primary care, secondary care, criminal justice, social care, housing support settings to identify individuals at risk of alcohol misuse, provide brief advice and refer individuals appropriately
- Providing extended brief intervention to those at higher risk or alcohol dependent individuals who are not ready for change
- Developing a local programme to help reduce alcohol consumption and harm based on national social marketing work. In addition to educational campaigns, targeted social marketing efforts aimed at higher-risk drinkers to reduce alcohol-related hospital admissions
- Using geodemographic segmentation to help understand which groups in Tameside are most likely to misuse alcohol and to understand which approaches are most likely to help these groups to drink more safely including understanding how young people access alcohol locally

Prevention and Education

A range of prevention and education recommendations to reduce harm from alcohol are made:

- Raising awareness of personal alcohol consumption levels and associated risk
- Helping people to recognise if they are drinking above safe consumption limits and reduce their consumption, if necessary, enabling higher risk drinkers to understand why they should cut down and to provide the necessary support and information to help them to cut down
- Develop stronger links between public health, health services and schools to enable more effective prevention and education for children

- Provide drug and alcohol awareness sessions in schools for children and parents in partnership with the education sector
- Promote the use of the Under the Influence alcohol discussion kit to raise awareness of alcohol-related issues in community groups. http://ourlife.org.uk/undertheinfluencekit

Reducing the Health Impacts of Alcohol

A wide range of activities that together can be used to reduce the health impacts of alcohol include:

- Services dealing with sexual health or substance misuse should be encouraged to provide seamless support for young people who may present with either a sexual health or an alcohol problem, recognising they will often have problems with both
- Continue to raise awareness of the need for women who are pregnant or trying to conceive to avoid alcohol including by increasing the awareness of health professionals
- Appropriate awareness of Foetal Alcohol Spectrum Disorders is crucial for those working in midwifery to identify and provide proper interventions for women drinking during pregnancy
- Ensure that maternity unit clinicians receive identification and brief advice training and can identify people at risk, offer brief intervention and refer appropriately to specialist alcohol treatment services
- Increase the emphasis to parents on the impact that alcohol can have after the baby is born to include a discussion on areas other than breastfeeding
- Raise awareness amongst parents that becoming a new parent is often associated with increasing alcohol consumption and provide parents with information about the impact of alcohol on parenting
- Raise awareness amongst school nurses, health visitors and midwives of the possible role of children acting as carers due to parental alcohol misuse. These children may need support and safeguarding / child protection issues may be relevant

Reducing the Socio-economic Impacts of Alcohol

Raise awareness amongst parents with alcohol dependency or higher risk drinking of:

- Adverse impacts on children resulting from parental drinking and the impacts of drinking at home in the presence of children
- Improve awareness and education amongst adults of the range of adverse effects that can result from children's consumption of alcohol
- Ensure that parental alcohol misuse and alcohol-related domestic abuse are addressed within local commissioning arrangements for both adults and children's services
- Ensure that clinicians and Children's Services work in partnership to help identify and address alcohol-related domestic abuse in families

Reducing the Crime and Disorder Impacts of Alcohol

Effective information sharing is critical to establishing joint understanding of local problems:

- Continue to embed information sharing between partners
- Further develop information sharing between Tameside Foundation Trust Hospital, the Community Safety partnership, Tameside Constabulary and other partners through the use of a CQUIN and use these opportunities to include further understanding of alcohol-related health effects
- Help to target licensing resources by using intelligence gathered from alcohol-related offences and use of health services
- Continue the use of the Alcohol Strategy Group to help address local alcohol misuse issues such as anti-social behaviour and the supply of alcohol to young people

Acute Healthcare Services

A range of recommendations are made for helping to reduce the harm from alcohol in acute settings through the:

- Increase, identification and provision of brief advice and appropriate referral of patients at risk of harm from alcohol misuse in acute healthcare settings
- Liaison and Assertive Outreach service to offer support after discharge from hospital
- Promote awareness and use of identification and brief advice among healthcare professionals
- Engage with A&E staff in training to change attitudes on the importance of screening for alcohol use, raise awareness regarding the effectiveness of treatment and address staff reported problems in difficulties with asking people about alcohol use
- Ensure Midwifery staff understand the potential impact of alcohol use and its links to domestic violence and issues of safeguarding for children
- Use of a CQUIN to help establish change

Specialist Alcohol Treatment Services

The following recommendations are made for specialist services:

- Ensure the provision and uptake of evidence-based specialist treatment for dependent drinkers in the Tameside population is in line with NICE guidance. http://www.nice.org.uk/
- Increase the number of parents who have children aged less than 18 years and receive structured treatment for their alcohol problems
- Increase the number of parents who have children aged less than 18 years and receive structured treatment for their alcohol problems where there are child protection concerns
- Continue the commissioning of a specialist alcohol nurse in TFT linked to A&E/ fracture clinic
- Consider implementing an alcohol case finding programme to identify and offer support to people with alcohol misuse problems using TFT services

- Improve communication between specialist alcohol treatment services and primary care. Primary care clinicians may be unaware of whether patients are accessing specialist treatment for alcohol and treatment outcomes
- Provide a wide range of community-based, accessible, non-stigmatising treatment, support and recovery services
- Work to de-stigmatise specialist alcohol treatment services
- Ensure services do not end abruptly and allow gradual transition into independence and ongoing recovery
- Develop more opportunities for people who have recovered from alcohol misuse to support people with existing alcohol misuse problems

Partnership Working

Strengthening partnership working is essential to tackling the harm from alcohol and forms one of the recommended high impact changes in order to:

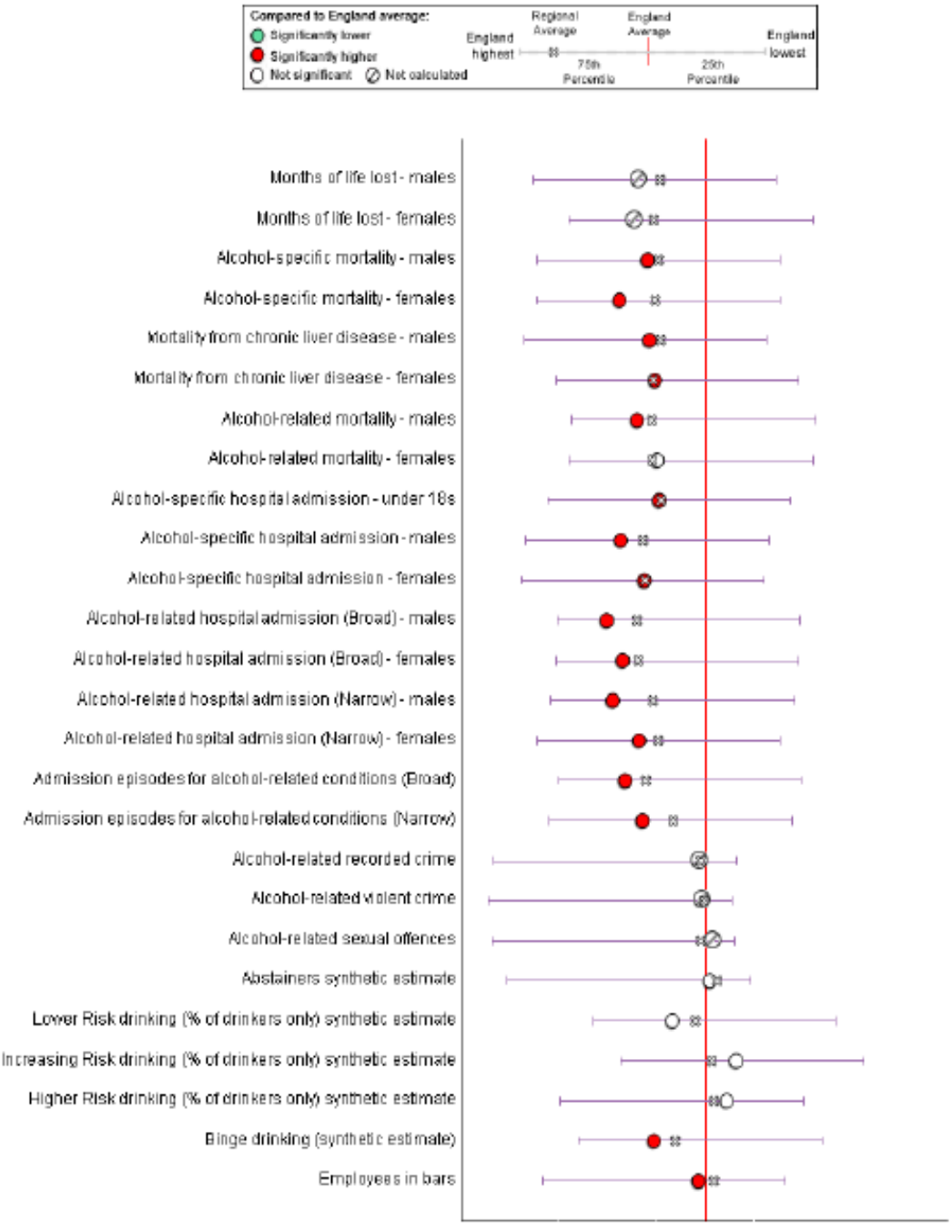
- Contribute to the reduction of health inequalities by reducing the harm from alcohol, which have a disproportionate effect on disadvantaged groups
- Ensure that consistent messages regarding safe consumption of alcohol are given to the general public
- Review what messages are given regarding safe consumption of alcohol in conjunction with geodemographic segmentation approaches
- Review how specific risk groups are targeted for alcohol harm reduction using public health intelligence and geodemographic segmentation

APPENDIX 1

Public Health England

Tameside

LAPE
Local Alcohol Profiles for England

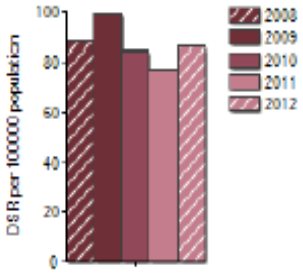


Public Health England

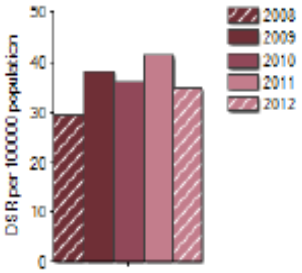
Tameside

LAPE
Local Alcohol Profiles for England

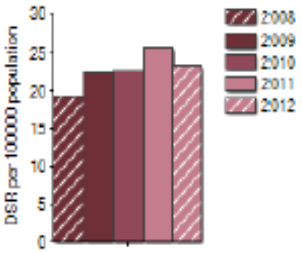
Alcohol-related mortality - males



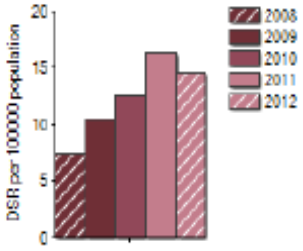
Alcohol-related mortality - females



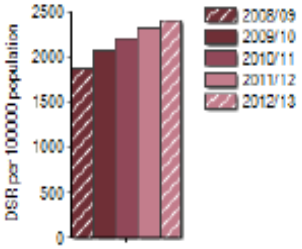
Mortality from chronic liver disease - males



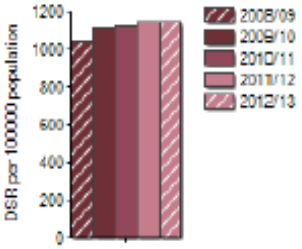
Mortality from chronic liver disease - females



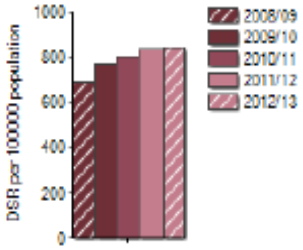
Alcohol-related hospital admission (Broad) - males



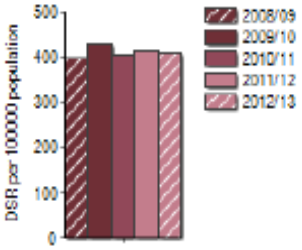
Alcohol-related hospital admission (Broad) - females



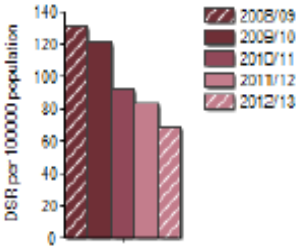
Alcohol-related hospital admission (Narrow) - males



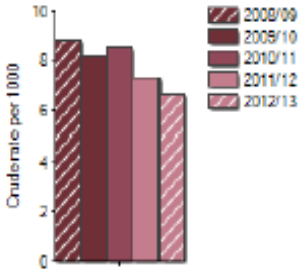
Alcohol-related hospital admission (Narrow) - females



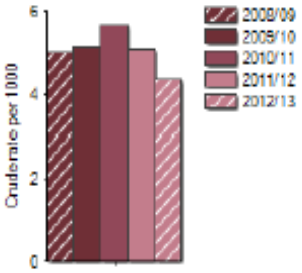
Alcohol-specific hospital admission - under 18s



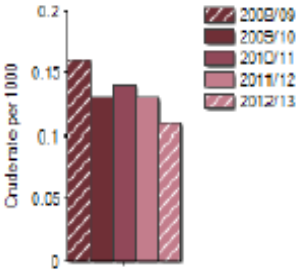
Alcohol-related recorded crimes



Alcohol-related violent crimes



Alcohol-related sexual offences



Public Health England

Tameside

LAPE
Local Alcohol Profiles for England

ID	Indicator	Measure (a)	National Rank (b)	Regional Average
1	Months of life lost - males	17.3	318	15.3
2	Months of life lost - females	8.3	314	7.5
3	Alcohol-specific mortality - males	23.4	305	21.7
4	Alcohol-specific mortality - females	14.5	319	11.3
5	Mortality from chronic liver disease - males	25.6	311	23.7
6	Mortality from chronic liver disease - females	12.8	303	12.9
7	Alcohol-related mortality - males	86.2	314	81.3
8	Alcohol-related mortality - females	34.9	285	35.6
9	Alcohol-specific hospital admission - under 18s	68.7	281	67.7
10	Alcohol-specific hospital admission - males	961.6	321	841.9
11	Alcohol-specific hospital admission - females	380.9	310	379.0
12	Alcohol-related hospital admission (Broad) - males	2,395.9	320	2,174.3
13	Alcohol-related hospital admission (Broad) - females	1,140.7	312	1,081.8
14	Alcohol-related hospital admission (Narrow) - males	838.6	316	730.0
15	Alcohol-related hospital admission (Narrow) - females	406.9	305	377.5
16	Admission episodes for alcohol-related conditions (Broad)	2,826.1	310	2,620.2
17	Admission episodes for alcohol-related conditions (Narrow)	830.6	304	735.4
18	Alcohol-related recorded crime	6.7	259	6.2
19	Alcohol-related violent crime	4.4	234	4.0
20	Alcohol-related sexual offences	0.1	167	0.1
21	Abstainers synthetic estimate	16.1	84	15.4
22	Lower Risk drinking (% of drinkers only) synthetic estimate	74.2	46	73.5
23	Increasing Risk drinking (% of drinkers only) synthetic estimate	19.4	56	19.9
24	Higher Risk drinking (% of drinkers only) synthetic estimate	6.4	70	6.6
25	Binge drinking (synthetic estimate)	25.6	297	23.3
26	Employees in bars	1.9	160	1.6

Footnotes	Definition
Alcohol-specific	Alcohol-specific outcomes include those conditions where alcohol is causally implicated in all cases of the condition; for example, alcohol-induced behavioural disorders and alcohol-related liver cirrhosis. The alcohol-attributable fraction is 1.0 because all cases (100%) are caused by alcohol.
Alcohol-related	Alcohol-related conditions include all alcohol-specific conditions, plus those where alcohol is causally implicated in some but not all cases of the outcome, for example hypertensive diseases, various cancers and falls. The attributable fractions for alcohol-related outcomes used here range from between 0 and less than 1.0. For example, the alcohol-attributable fraction for mortality from pneumonia among men aged 75 and over is 0.10 because the latest epidemiological data suggest that 10% of pneumonia cases among this population are due to alcohol. Outcomes where alcohol has a protective effect (i.e. the fraction is less than 0) are not included when the alcohol-attributable fractions are applied to mortality and hospital episode statistics data.
Indicator value	The actual indicator value for the Local Authority as calculated in the definitions below.
Ranks	The rank of the local indicator value among all 326 Local Authorities in England. A rank of 1 is the lowest value Local Authority in England and a rank of 326 is the highest except for indicators 21 & 22 were the ranking is reversed (1 is the highest value and 326 the lowest).
Suppression	Where values in 'Trend Charts' and 'Data' are blank, data have been suppressed to prevent disclosure unless otherwise stated. For mortality data counts below 3 have been suppressed and for HES data, counts below 6 have been suppressed (HES counts of 0 do not require suppression). Further suppression has been applied to the datasets in LAPE to prevent disclosure through subtraction.