Alcohol Integrated Needs Assessment

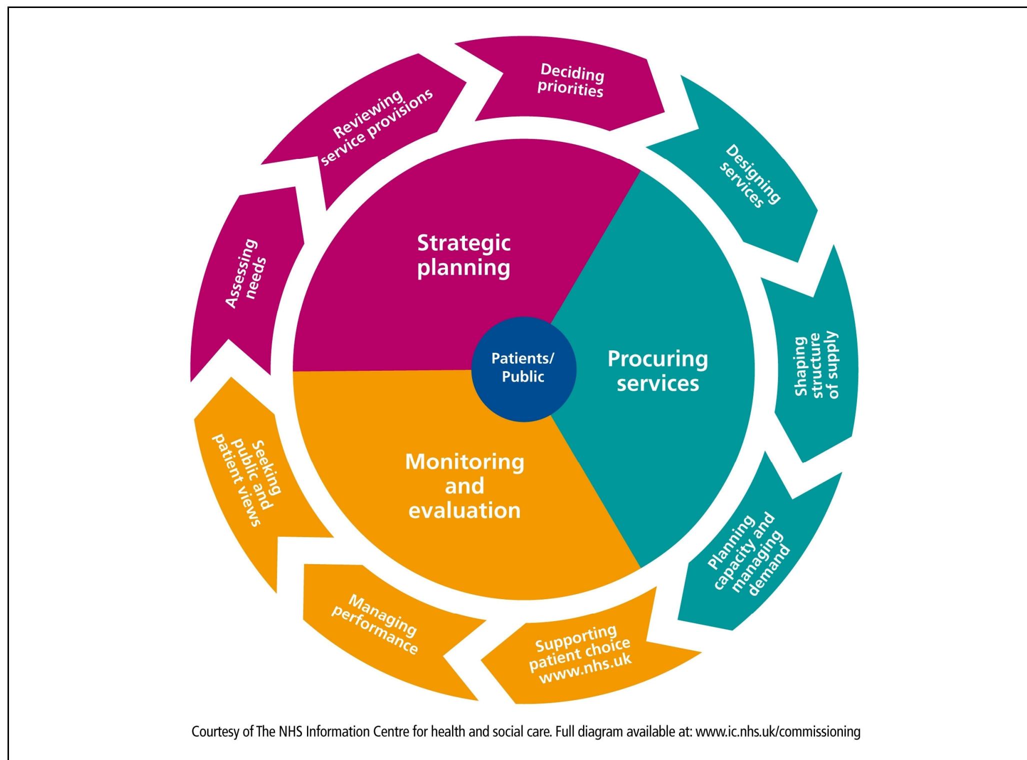
Executive Summary Report for the Herefordshire Health and Wellbeing Board October 2011

1. Introduction

This report provides an executive summary of the Alcohol Integrated Needs Assessment (INA) which has been undertaken by Public Health on behalf of the Health and Wellbeing Board. The full alcohol INA is available separately.

The intention of the alcohol INA is that it will form the alcohol section of the Joint Strategic Needs Assessment which will, in turn, inform the development of strategic plans for alcohol harm reduction as part of the overall Health and Wellbeing Strategy. In effect, the alcohol INA provides the first step of a new commissioning cycle for alcohol harm reduction in Herefordshire (figure 1).

Figure 1 The commissioning cycle



2. Background

The Health and Wellbeing Board has agreed to look at alcohol-related harm to health and alcohol harm reduction services as a practical "working example" in order to a) start the process of addressing alcohol-related harm to health and b) develop a methodology and ways of working which would be applicable to other population health and wellbeing issues.

Alcohol misuse is responsible for a range of acute and chronic health problems in addition to social problems such as crime and disorder, domestic violence and anti-social behaviour. Alcohol is thought to be associated with 25-33% of known cases child abuse.

Guidelines for sensible drinking and definitions of hazardous, harmful and binge drinking are shown in table 1. Alcohol-misuse can also be categorised according to the level of dependence: mild, moderate, severe dependence.

Table 1 Definitions of hazardous, harmful and binge drinking

	Men	**Women**
Sensible Drinking Limits (Dept of Health guidelines)	Men should not regularly drink more than 3-4 units of alcohol per day	Women should not regularly drink more than 2-3 units of alcohol per day Pregnant women or those trying to conceive should avoid alcohol
Hazardous Drinking	Between 22 and 50 units of alcohol per week	Between 15 to 35 units of alcohol per week
Harmful Drinking	More than 50 units of alcohol per week	More than 35 units of alcohol per week
Binge Drinking Is the consumption of at least twice the daily recommended amount of alcohol in a single drinking session	8 or more units in a single session	6 or more units in a single session

3. Health needs assessment and integrated needs assessment

Health needs assessment is a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve population health and reduce inequalities. Typically, the health needs assessment process focuses on healthcare issues, however, the methodology that has been developed for this *integrated* needs assessment widens the scope to ensure that the wider influences on health are also considered – for example by allowing for the inclusion of data and input from partner organisations and

stakeholders such as police, and community and voluntary sector organisations. In relation to this alcohol INA, stakeholder views have been sought using a variety of methods including a questionnaire, semi-structured interviews and an interactive stakeholder event.

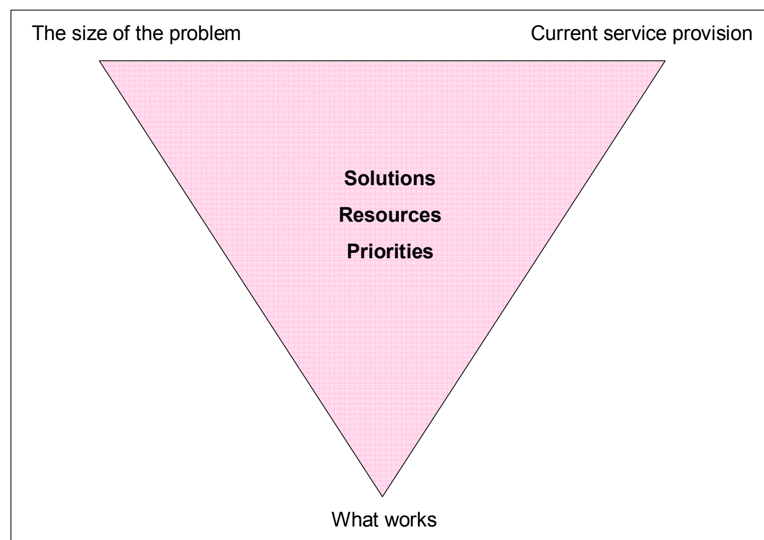
4. INA - the standard methodology

The INA methodology explicitly recognizes the need to address the wider determinants of health and wellbeing and uses both quantitative[A] and qualitative[B] evidence to look at the following three areas (figure 2):

- The nature and size of the problem (in this case alcohol-related harm to health);
- Current service provision;
- The evidence of what works.

The findings are then used to develop recommendations for future action which might include the introduction of evidence-based services or changes to or the withdrawal of ineffective ones.

Figure 2 The "three-legged stool" integrated needs assessment model



[A] Quantitative data – describes numerical data that can be quantified
[B] Qualitative data – tends to be more descriptive, subjective information which does not lend itself to being quantified but is still valid. A combination of both quantitative and qualitative information together is often valuable in understanding the nature and size of an issue.

The size of the problem

Ascertaining the size of the problem involves using a range of quantitative and qualitative data to systematically look at "who", "what", "where" and "when" for example:

- **who** is affected in terms of age, sex, ethnicity, disease or other condition?
- **where** are affected people to be found in the county?
- **what** are the current, past and future trends?

This step also involves comparison with other areas using benchmarking.

Importantly, it also involves stakeholders and partner organizations from beyond the healthcare arena in order that the full range of relevant data sources and wider determinants affecting health and wellbeing are taken into consideration.

Quantitative data sources include a wide range of data sets covering demographics, social, behavioural, economic and environmental determinants of health, data on service access and utilization, and evidence of effectiveness – with analysis and interpretation used to turn this into intelligence.

Qualitative data comes primarily from seeking stakeholder views. This involves wide consultation with service users and their advocates, third sector organizations and providers, public and private sector partners and national players. Wide stakeholder involvement is important not only for gathering data, but also as it encourages wide ownership and supports the ability to implement recommendations.

Stakeholder involvement in alcohol INA:

- Questionnaire survey of 34 key stakeholders (38% response rate)
- Semi-structured 1 hour interviews with key stakeholders
- Participatory stakeholder workshop "Alcohol misuse: we need to CHAT" hosted by Churches in Herefordshire Action Team (CHAT) on 9th September 2011. This was attended by a wide range of representatives from the public sector, private sector and voluntary sector including a local MP, police, nightclub/licensed trade, faith/church, housing, PCT and council.

Current service provision

This step reviews current service provision and looks at service provision in terms of the following six domains of quality: effectiveness, efficiency, access, responsiveness, social acceptability and equity.

Consideration is also given to whether there are any gaps in service provision and, if so, what and where they are. Interagency dimensions to service provision are also examined including whether there are any gaps or barriers between agencies in relation to service provision.

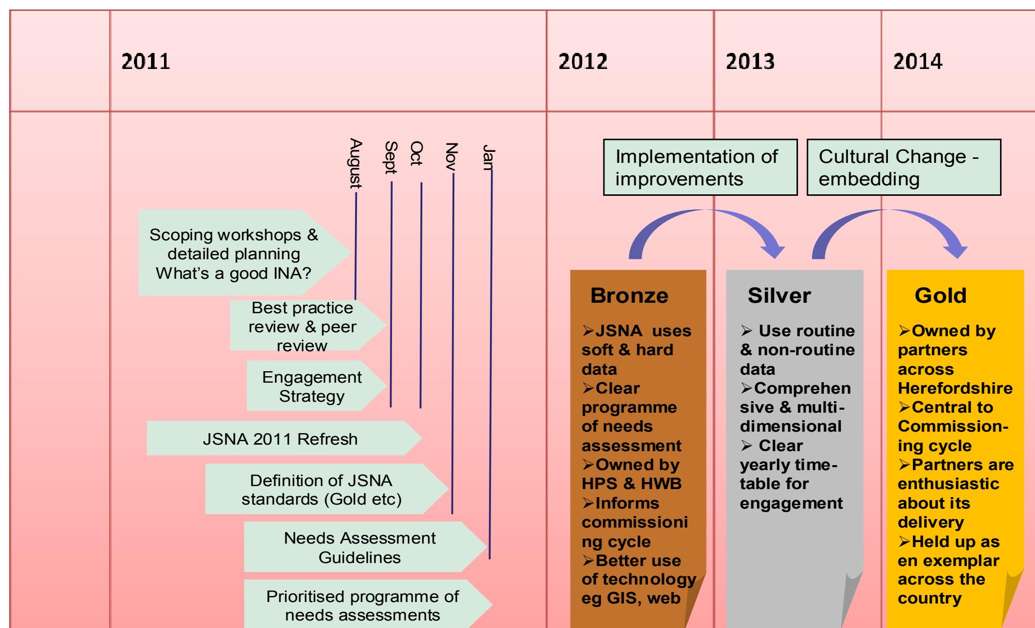
What works

This step in the process involves reviewing the evidence base for interventions/models of care to determine what works, what the evidence for this is

and how strong and reliable this evidence is. This involves a systematic approach to finding evidence and assessing its quality through critical appraisal of published literature and evaluation of national and/or local best practice.

The methodology developed for the alcohol INA provides a basis for a standard methodology from which future INAs can be developed in other topic areas. In addition to supporting the commissioning of services and driving the commissioning cycle, this will contribute to the overall development by 2014 of a comprehensive "gold standard" JSNA which will be central to the commissioning cycle and owned by partners across Herefordshire (figure 3).

Figure 3 Route-map to a "gold standard" JSNA



Recommendations – the final step of the INA

Having considered the issues, current services and the evidence of what works, the final step in the INA process is to make recommendations (such as interventions or suggested models of service provision) and where possible, to identify the resources required for implementation and to recommend priority areas for action, which is particularly important when resources are scarce. The methodology used for the alcohol INA is applicable across both medical and non-medical models of care.

The alcohol INA has built upon standard, accepted healthcare needs assessment methodology by going beyond healthcare data to include other relevant data – for example in relation to crime and disorder, licensing and trading standards.

5. Alcohol INA – summary of findings

5.1 The size of the problem

This section looks at what we know about patterns of drinking in Herefordshire.

5.1.1 Prevalence of hazardous, harmful and binge drinking

Hazardous and harmful drinking

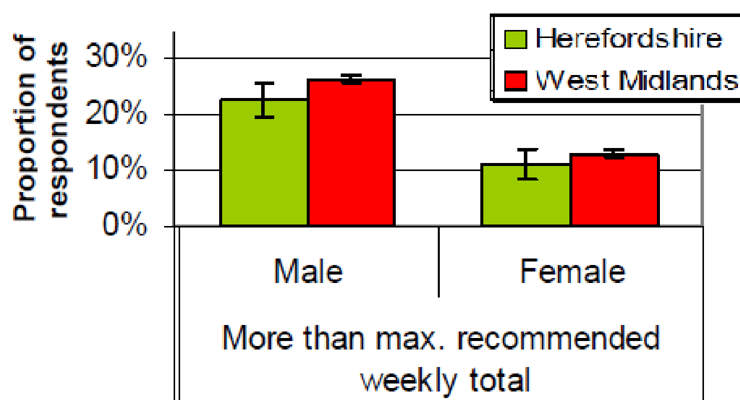
In Herefordshire:

- 18.8% of over 16 year olds drink at a hazardous level; 4.1% drink harmfully and 17.8% binge drink. This is similar to regional and national levels.
- 23% of men and 11% of women drink over the recommended limit (figure 5).

Nationally, the highest levels of hazardous drinking are found in:

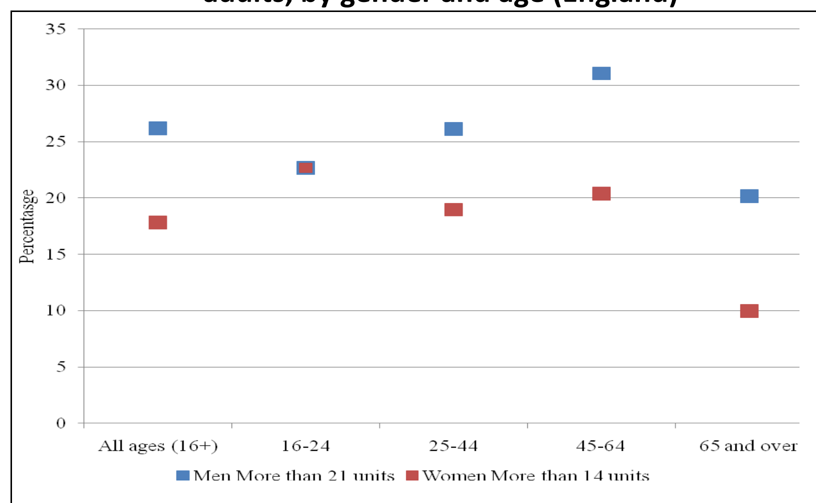
- men aged 45-64
- women aged 16-24 (figure 6).

Figure 5 The proportion of respondents drinking over recommended levels in Herefordshire and West Midlands by sex



Source: Herefordshire Regional Lifestyle Survey (2005)

Figure 6 Hazardous drinking: alcohol consumption (units per week) among adults, by gender and age (England)

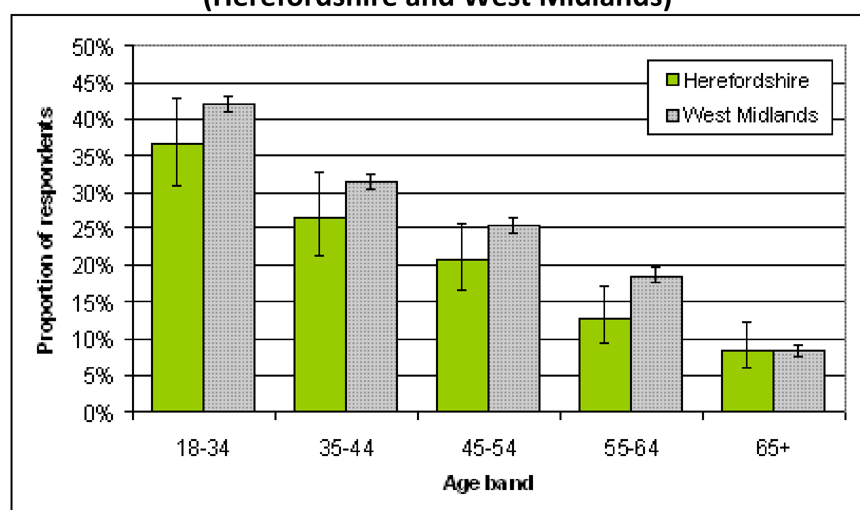


Source: Information centre 2011 statistics on alcohol in England, General Lifestyle Survey 2009. The Office for National Statistics (ONS)

Binge drinking

- Levels of binge drinking are highest in the 18-34 and 35-44 age groups (figure 7). Around twice as many men binge drink compared to women (table 5).
- The highest estimated prevalence of binge drinking is found in Hereford city.
- By the age of 17 only 2% of teenagers are non-drinkers.

Figure 7 Proportion of respondents who binge drink by age group (Herefordshire and West Midlands)



Source: Regional Lifestyle Survey (2005)

Table 5 Binge Drinking in Herefordshire

	Males	Females	Total
Herefordshire	33%	15%	23%
West Midlands Region	36%	19%	28%

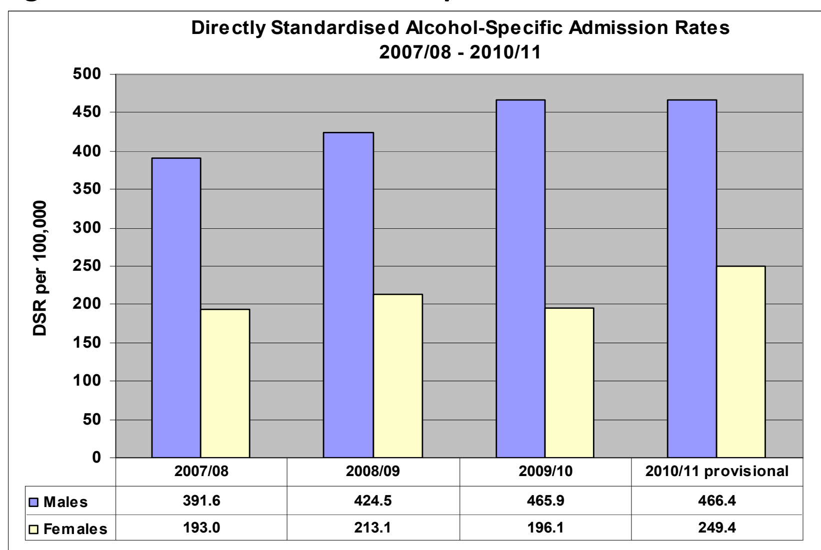
Source: Regional Lifestyle Survey 2005, WMRO & WMPHO

5.1.2 Alcohol-related harm to health

- ***Alcohol-attributable mortality*** is lower in Herefordshire than in the West Midlands but increased by 53% in women and 15% in men between 2004-08.
- ***Alcohol-attributable hospital admissions*** are a major cause of hospital admission in Herefordshire (over 3,500 admissions in 2010/11) and have increased by over 30% since 2007/08.
- ***The alcohol-specific hospital admission*** rate for under 18 year olds is significantly higher than the England average (80.7/100,000 population compared to 64.6/100,000 population).
- ***Alcohol-specific hospital admissions*** in Herefordshire show an upwards trend (figure 8): male admissions have increased by 19% between 2007/08 to 2010/11; female admissions have increased by 29% in the same period. The majority (86%) of alcohol-specific admissions are emergency admissions.

- ***There is a strong social gradient in alcohol-attributable hospital admissions*** within Herefordshire:
  - People living in the most deprived neighbourhoods are twice as likely to be admitted with an alcohol-attributable condition as those who live in the least deprived neighbourhoods (figure 9);
  - **Young people from the most deprived neighbourhoods are twelve times** more likely to be admitted to hospital with an alcohol-attributable condition than those from the least deprived neighbourhoods (figure 10).
  - Alcohol-specific hospital admission rates for young people are higher in Herefordshire than in other areas with similar population characteristics.

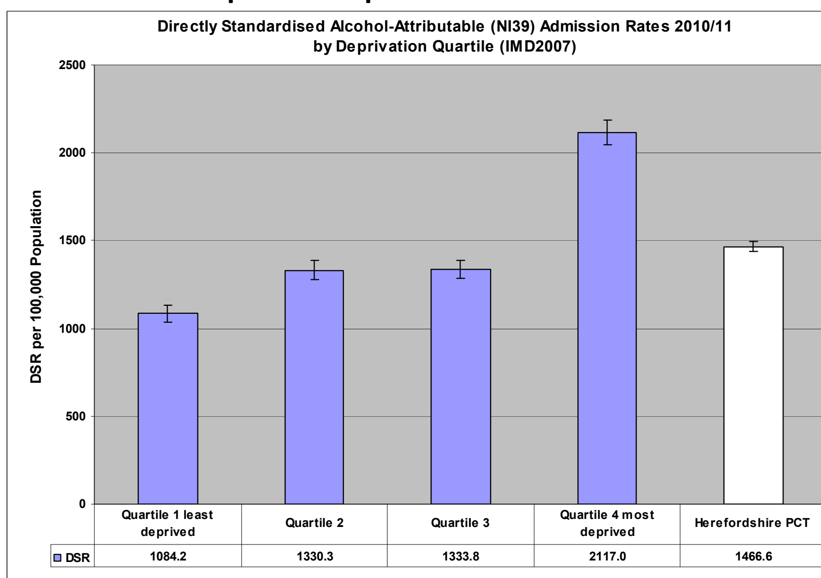
Figure 8 Trends in alcohol-specific admissions of Herefordshire residents



	2007/08	2008/09	2009/10	2010/11 provisional
Males	391.6	424.5	465.9	466.4
Females	193.0	213.1	196.1	249.4

Data Source: Hospital Episode Statistics (HES), Analysis: Public Health Dept, NHSH

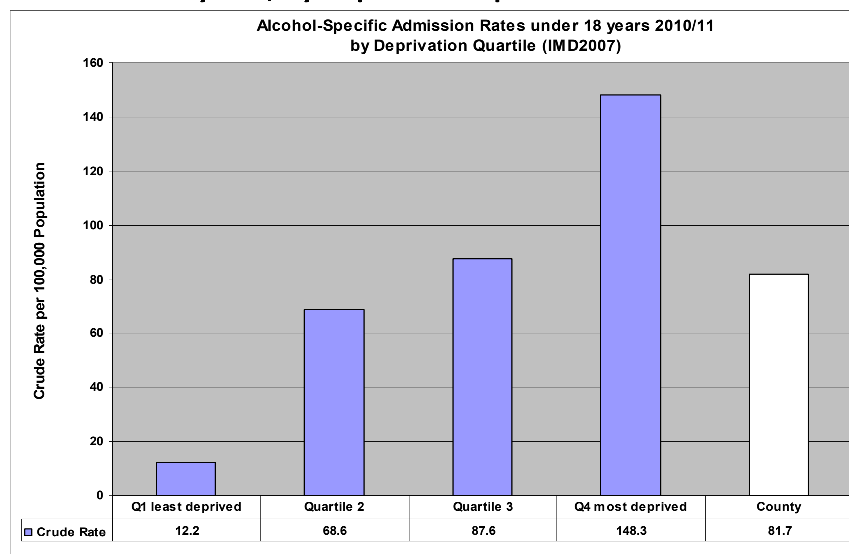
Figure 9 Alcohol-attributable admissions of Herefordshire residents, by deprivation quartile



	Quartile 1 least deprived	Quartile 2	Quartile 3	Quartile 4 most deprived	Herefordshire PCT
DSR	1084.2	1330.3	1333.8	2117.0	1466.6

Data Source: Hospital Episode Statistics (HES), Analysis: Public Health Dept, NHSH

Figure 10 Alcohol-specific admissions of Herefordshire residents under 18 years, by deprivation quartile



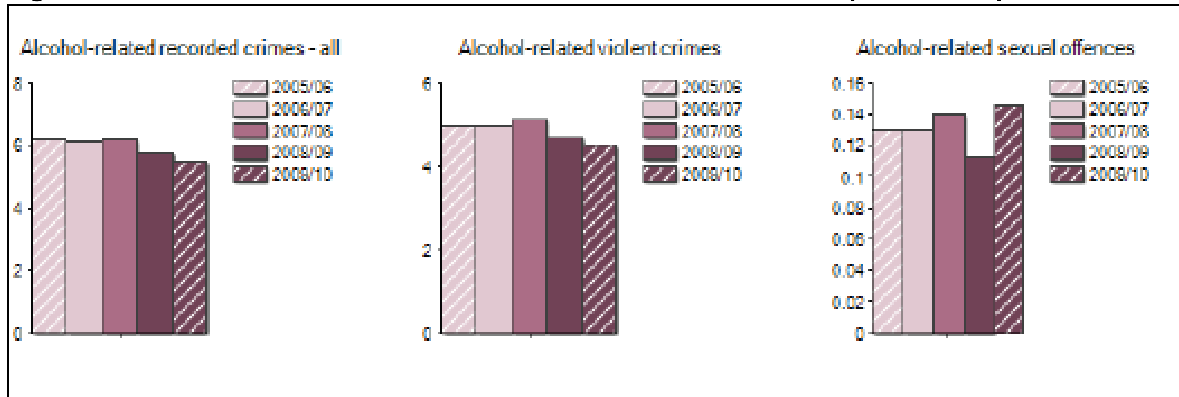
5.1.3 The wider picture

- Data from A&E shows that between October 2010–March 2011 (the 1st 6 months' data from the new A&E database) out of 211 alcohol-related attendances: 74% of had an alcohol-related assault; 17% had an alcohol-related injury; 66% were male; 47% were 16-24 years old.
- Herefordshire's alcohol-related recorded crime rate is lower than in the West Midlands (5.5/1,000 population compared to 8.1/1,000). There has been a gradual overall fall in alcohol-related crime over recent years – although not in alcohol-related sexual offences (figure 11).
- There are approximately 1,000 licensed premises in Herefordshire. Alcohol-related assaults generally occur near to licensed premises (figure 12).
- In relation to under-age drinking and binge drinking in young people:
  - Under-age drinkers in the 12-14 year old age group typically obtain alcohol at home; 15-17 year olds are more likely to be bought alcohol by an older friend (proxy sales).
  - "Pre-loading" – drinking before a night out - is common.

Compared to the rest of the West Midlands and England (figure 13) Herefordshire has:

- significantly higher levels of alcohol-specific hospital admissions in under 18 year olds
- significantly higher levels of mortality from alcohol-related land transport accidents than the regional and national average (Herefordshire: 4/100,000 population; England: 1.7/100,000 population).
- a relatively high proportion of employees who work in bars (3.1% of all employees) compared to England (2.4%).

Figure 11 Alcohol-related recorded crime in Herefordshire (2005-2010)



Source: North West Public Health Observatory - LAPE Report 2010

Figure 12 Prevalence of incidence of alcohol related assault or accident against location of licensed premises

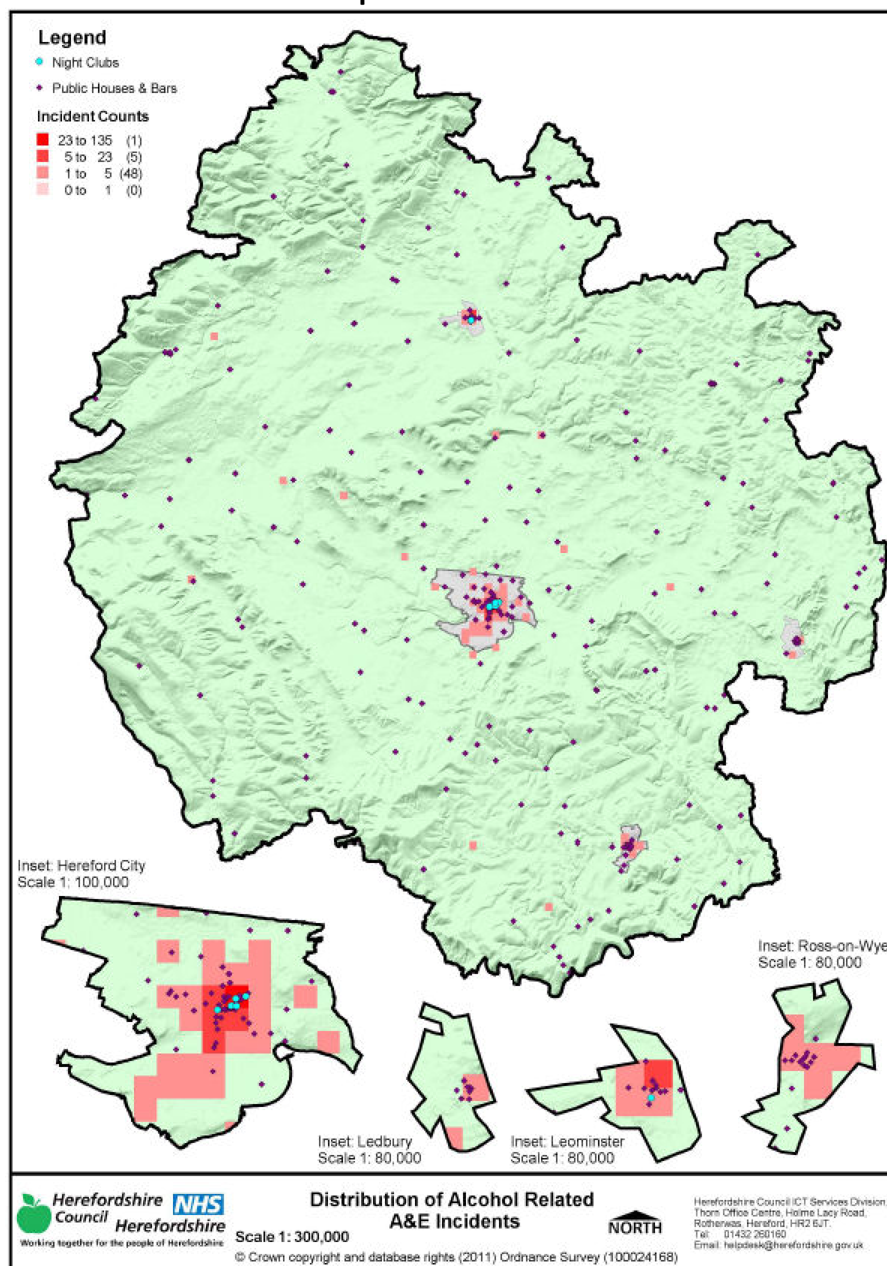


**Figure 13	Profile of alcohol-related harm – Herefordshire 2010**

Source: North West Public Health Observatory - LAPE Report 2010

5.2 Current service provision

Alcohol harm reduction services can be categorised into four tiers which range from tier 1 (the least intrusive) to tier 4 (the most intrusive). These can be summarised as:

- Tier 1 identification of those at risk and the provision of simple brief advice
- Tier 2 extended brief interventions
- Tier 3 less intensive specialist treatment
- Tier 4 intensive specialist treatment

These are aligned to levels of risk/harm from alcohol misuse as discussed in more depth in section 5.3 and provide for the development of an integrated, care-pathway approach.

Currently, the main dedicated alcohol-harm reduction services in Herefordshire consist of the Community Alcohol Service and the Alcohol Liaison Nurse Service.

The Community Alcohol Service

The Community Alcohol Service (CAS) is the main alcohol harm reduction service in Herefordshire:

- CAS has 3.5 WTE staff covering Hereford, Bromyard, Ledbury, Ross-on-Wye and Leominster;
- 2 sessions/week psychiatrist support for community withdrawal (Hereford only);
- 584 referrals to CAS in 2010/11 - the majority of CAS referrals are from GPs;
- The majority of CAS activity consists of Identification and Brief Advice (IBA) (ie tier 1 and 2)
- CAS only provides limited tier 3 and 4 services because of its focus on IBA (although it is intended as a specialist tier 3 and 4 service);
- Specialist capacity and activity (tier 3 and 4) is low:
  - clients requiring specialist support are placed on a waiting list;
  - a high proportion (estimated at 75%) are lost to follow up;
  - a high proportion (estimated at 50%) are referred for residential withdrawal due to lack of community provision;
  - 1 community supervised withdrawal/month on average;
  - 3 residential supervised withdrawals/year on average.

Although CAS is designed to provide a tier 3 and 4 service with community based care, planned treatments, counselling individual and family, community supervised withdrawal and assessment for residential rehabilitation, it is evident that this service primarily provides a tier 1 and 2 service due to the lack of provision at this level elsewhere in the county.

Alcohol Liaison Nurse Service

An Alcohol Liaison Nurse (ALN) based in Hereford County Hospital provides screening and brief advice to patients in A&E, admissions and on the wards.

- The majority of patients receive tier 1, simple brief advice;
- Activity is relatively low and a relatively high proportion of those referred to the ALN, do not attend for further support;
  - 102 patients were referred and 66 screened in 2008/09
  - 78 patients were referred and 57 screened in 2009/10
  - 164 patients were referred and 66 screened in 2010/11
- There is lack of provision for those requiring onward referral for specialist treatment with a high proportion of onward referrals being lost to follow up.

Identification and brief advice

Over recent months considerable progress has been made in relation to the introduction of structured brief intervention for alcohol in primary and secondary care and in locality settings:

- Identification and Brief Advice (IBA - brief intervention for alcohol) is in the 2011/12 CQUIN;
- Roll-out of a training programme for IBA which supports CQUIN delivery and is providing training for primary and secondary care staff;
- An alcohol-related assault and injury database installed in A&E is informing joint work eg between Public Health, Wye Valley NHS Trust, Licensing/Trading Standards, Police, Ambulance. This is supporting work to reduce alcohol-related A&E attendances (see below);
- A Directly Enhanced Service (DES) is in place for GPs to provide IBA, although this is limited to new patients;
- IBA is currently also provided by CAS.

Summary of stakeholder views

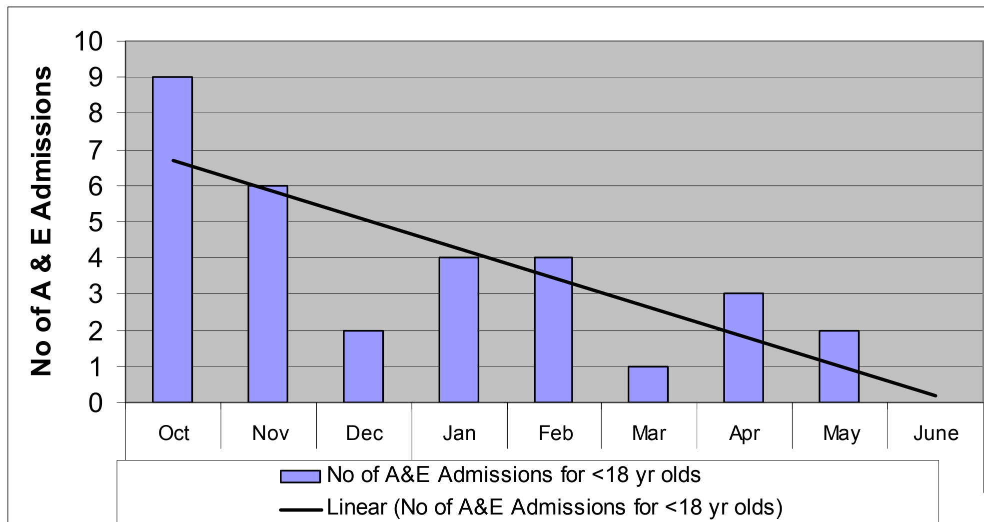
Key findings from stakeholder engagement include:

- Increased identification and support for hazardous and harmful drinkers is needed to include:
  - Expansion of IBA in primary and secondary care
  - Extension of IBA to generic/non-health settings
- The Community Alcohol Service should focus on providing specialist treatment and not IBA
- Binge drinking amongst teenagers and the relationship of this with crime is a significant issue in Herefordshire.

Licensing and enforcement

Since November 2010, Herefordshire Trading Standards' Licensing team working with the police, public health and other partners has undertaken a covert operation to "crackdown" on under-age sales, informed by the identification of "hotspot" using the A&E database. Figure 14 shows that there has been a dramatic fall in alcohol-related A&E admissions in under 18s since this operation began.

Figure 14 **Alcohol-related A&E admissions in under 18 year olds in Herefordshire (Oct 2010–June 2011)**



National recommendations for alcohol services - the stepped care service model

A stepped care service model has been advocated for alcohol harm reduction services.[1] This involves offering interventions which are appropriate to the individual's level of alcohol-related risk/harm with a spectrum of four levels of intervention being available (figure 15). Moving from left to right along this spectrum, clients are offered the least intrusive and least expensive intervention that is likely to be effective irrespective of the level of misuse. The next intensive treatment is only offered if the first line intervention fails and so on from left to right along the triangle shown in figure 15.[1] Existing services in Herefordshire and local gaps within the stepped care model are discussed in summarised in table 6.

Figure 15 **Spectrum of responses to alcohol-related problems[1]**

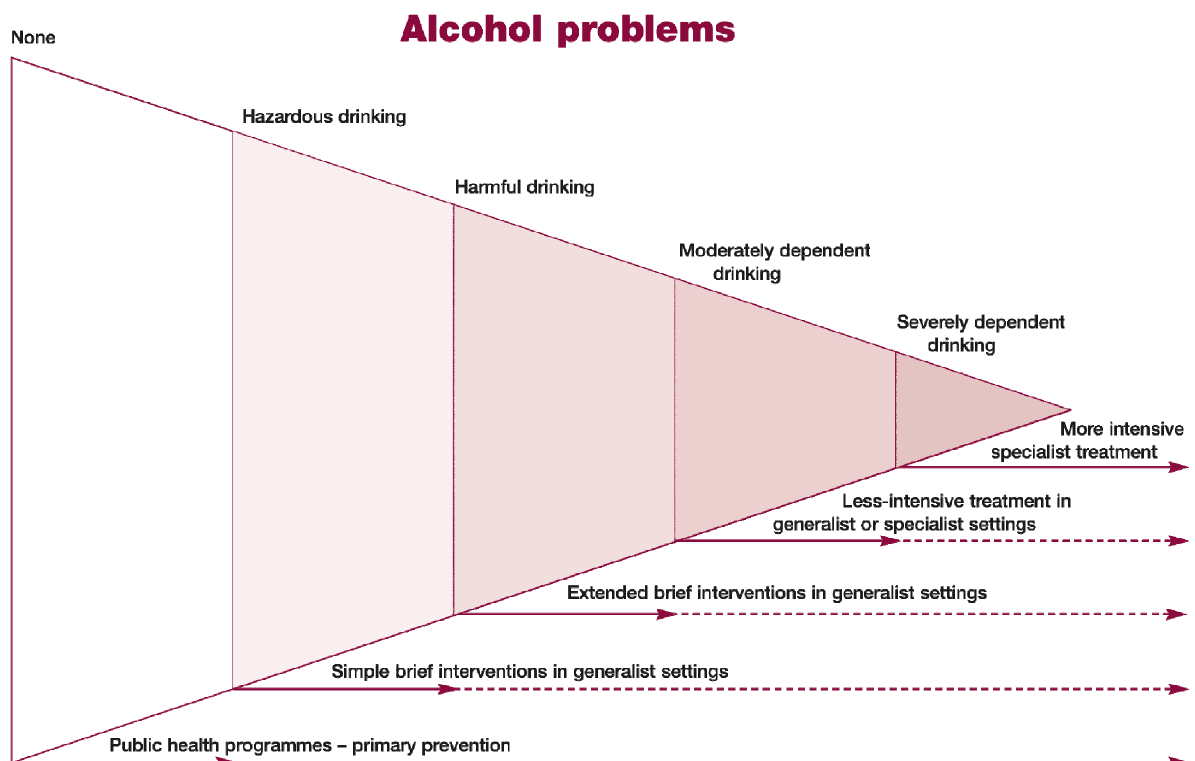


Table 6 Summary of existing alcohol harm reduction services in Herefordshire and gaps in existing provision by tier

	Existing service	**Gaps**
Tier 1	Recent increase in primary and secondary care-based IBA linked to training, and CQUIN	Provision of IBA in generic (non-healthcare) and settings where alcohol is not the main focus
Tier 2	Some provision from CAS & ALN	Scope to develop a wider network of providers
Tier 3	Very limited service from CAS	Gap in community-based support including detoxification Specialist services unable to focus on specialist work due to lack of provision at tier 1 and 2
Tier 4	No specialised service in county	Residential detoxification and rehabilitation within county
Integration between tiers	Specialist services providing non-specialist activity	Lack of integration, between services working at different levels Care pathways not clear

5.3 What works

A range of interventions are available which aim to reduce alcohol-related harm to health and to minimise its impact on health and wider society. Some interventions are more effective if offered in a specific setting targeting a specific group of people. The evidence-base for each requires rigorous evaluation before being put into practice.

A critical literature review has been undertaken to determine the cost and clinical effectiveness of these interventions - the section below gives a brief summary.

1. Educational programmes

- Current evidence suggests that universal multi-component programmes (ie combined school, family or community interventions) designed to impact on range of health and lifestyles behaviours among young people are effective in preventing alcohol misuse in school-aged children up to 18 years of age.[2]

- Universal family-based prevention programmes (eg psychosocial and educational interventions) can be effective in this age group.[3]
- Certain generic psychosocial and developmental prevention programs including “Life Skills Training Program”, the “Unplugged Program” and the “Good Behaviour Game” can also be effective in young people.[4]
- However, there is evidence to suggest that classroom-based programmes taught by adult health educators and uniformed police officers have no medium or long-term effects on alcohol use.[5]

2. Alcohol pricing

- Making alcohol less affordable is the most effective way of reducing alcohol harm. The evidence suggests that the most cost-effective policy intervention is to reduce demand for alcohol through minimum pricing; a 50p minimum price would result in an estimated 12.4% fewer hospital admissions each year.[6]

3. Licensing restrictions

- There is evidence to suggest that licensing restrictions (eg reducing the density of alcohol outlets and reducing licensing hours, reduced access to retail outlets and a comprehensive ban on advertising) would reduce alcohol-related harm.[7]
- Cost-effectiveness analyses show that a cumulative 10 year harm reduction for public sector of between £0.4b and £5.1b could be achieved by a 10% decrease in the number of both off-trade and on-trade outlets; a cumulative 10 year savings for the public sector, ranging from a loss of £0.36b to a gain of £5.2b could be achieved by 10% reduction in trading hours; and a cumulative 10 year savings for the public sector could be as much as £33.5b with a total advertising ban and associated price control.[8]

4. Alcohol misuse treatment interventions

The National Treatment Agency proposes a stepped care model as outlined in section 5.2.[1] A critical review of the evidence on the clinical and cost effectiveness of various interventions within the stepped model suggests that:

- **Brief interventions are effective** in reducing alcohol consumption among hazardous and harmful drinkers to low-risk levels.
- **Brief interventions are one of the most cost-effective of all health service interventions** and lead to health gain. In the average PCT (population 350,000), for every £91,611 invested there would be a saving of £393,927 in return on investment (£4.30 for every £1).[9] Brief intervention can be offered in variety of settings such as GP practices, community pharmacies and A&E departments.
- Less intensive treatments including “A basic treatment scheme”, “Brief conjoint marital therapy”, “Condensed cognitive behavioural therapy”,

"Motivational interviewing" and "Motivational enhancement therapy" are also effective in reducing alcohol problems in moderately dependent drinkers and can sometime benefit harmful drinkers without dependence.

- Alcohol-focussed specialist treatment (psychosocial treatments) including "Social behaviour and network therapy", "Behavioural self-control training" and "Coping and social skills training" are effective in achieving moderate drinking in dependant drinkers.
- Both "Social behaviour and network therapy" and "Motivational enhancement therapy" can yield £5 net saving to the public sector for every £1 invested in these interventions.[10]
- A range of pharmacotherapies involving detoxification and relapse prevention are effective in minimising alcohol harm in dependant drinkers.

6. Alcohol INA – summary of recommendations

The recommendations from the alcohol INA are summarised here. They are presented within the framework of the "ladder of interventions" which contains eight categories or "steps" which range from the least intrusive ("do nothing") to the most intrusive ("eliminate choice").

Step one – do nothing or simply monitor the current situation

- Coordinated data collection and monitoring of alcohol-related risk and harm in Herefordshire across the lifecourse and including:
    - existing routinely available data supplemented by non-routinely available data from eg schools, 3rd sector, NHS treatment services
    - continued collection of data on alcohol-related A&E attendances through the A&E database
    - continued long-term funding for A&E database
- Further refinement of the A&E alcohol database
- Carry out further analysis to better understand the link between domestic violence and alcohol in Herefordshire.

Step two – provide information

Run social marketing campaigns as part of an overall multi-component strategic approach:

- for 11-16 year olds and families on wider lifestyle risk factors including alcohol, addressing social norms and supporting the development of social interaction skills
- for 15-24 year olds and families focusing on social norms and binge drinking:
    - building on existing good practice including the Bottletop programme and the willingness of the Further Education Colleges to address alcohol-related harm
    - to encourage sensible drinking at home

- to discourage parental support of "pre-loading"
- to reach out particularly to young people from deprived communities (to address the 12-fold gap in alcohol-specific admissions in u18s).

Step three – enable choice and support people to change their behaviour

- Develop clear commissioning intentions for alcohol services from tier 1 to tier 4 and ensure a choice of services is available from tier 1 to tier 4 as part of an integrated care pathway including:
  - identification and support for people who are at risk of alcohol-related harm to their health because of hazardous or harmful drinking using IBA provided in a wide range of health and non-health settings across the county
  - release of specialist capacity within CAS to concentrate on the provision of specialist services rather than tier 1 or 2 services, thereby increasing capacity and choice of specialist care
- Healthy Lifestyle Trainer Service to undertake targeted work with post-16 providers to support 16-17 year olds at highest risk with healthy lifestyle choices.

Step four - guide choice through changing the default choice

- Free fresh drinking water should be available in pubs and clubs to provide an alternative to alcohol. This is currently a licensing requirement and there is scope to explore the role of the licensing team in enforcing this.
- Explore opportunities to encourage pubs, clubs, restaurants to set small measures as the default serving (eg when serving wine or spirits).

Step five - guide choice through incentives

- Support and evaluate initiatives that incentivise licensed premises to prevent under-age drinking. For example, initiatives which incentivise door and/or bar staff to report fake/fraudulent ID and proxy sales.
- Work with Hereford Against Night-time Disorder (HAND) and Ledbury Against Night-time Disorder (LAND) to encourage the development of incentives for licensed premises – linking with existing inspection work.

Step six - guide choice through disincentives

- Local use of fixed penalty fines in relation to under-age sales.
- Strengthen joint planning of enforcement activity/penalty notices with Police.
- Continue to use Expedited License Reviews for licensed premises in breach of Licensing Objectives (as described in the Licensing Act 2003).

Step seven - restrict choice

- Explore working with local/national retailers to encourage sensible in-store placement of alcohol in order to discourage hazardous, harmful and binge drinking. The Public Health Responsibility Deal provides a possible mechanism for this.

- Intelligence-led local enforcement, including spot checks, for under-age sales at off-licence and on-licence premises – moving towards regular, frequent and comprehensive inspections.
- Undertake surveillance of licensed premises in relation to sales to intoxicated customers and where appropriate request that the Police undertake a licensing review.
- Promote a sensible drinking culture in Herefordshire through the use of Cumulative Impact Zone powers including review of existing requirements regarding density of outlets and proximity of outlets to key settings (eg schools, fast food outlets).

Step eight - eliminate choice

- Increase use of Section 27 Dispersal Orders as part of a regular programme.
- Subject to anticipated changes to the Licensing Act (2003), to explore opportunities to restrict opening times by bringing the "terminal hour" (closing time) forwards to 2am (this is currently 3.30am in 2 clubs and 2.30-3am in others). This would reduce the time available for people to drink at licensed premises and would increase the time for people to sober up before the following morning (thereby reducing the risk of them being involved in accidents on the road or at work the following morning).

REFERENCES:

[1] National Treatment Agency for Substance Misuse (2006) Review of effectiveness of the treatment for alcohol problems, National Treatment Agency for Substance Misuse

2 Universal multi-component prevention programmes for alcohol misuse in young people; *The Cochrane Library*2011, Issue 9

[3] Universal family-based prevention programmes for alcohol misuse in young people; *The Cochrane Library*2011, Issue 9

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