Brighton and Hove
Drug and Alcohol Action Team

Alcohol *(adults)* Needs Assessment 2014

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Contents

Introduction

Alcohol is a legal substance that is enjoyed by many. The health risks associated with alcohol consumption cover a wide spectrum of harms including one off binge drinking, elevated daily consumption and chronic dependent drinking which is often associated with multiple vulnerability. To deliver real positive change health and social care interventions need to match these different patterns of consumption. Many binge drinkers will respond positively to the provision of Information and Brief Advice. However, for those presenting with patterns of entrenched consumption combined with intermittent drug use, more intensive support will be required to yield positive effect.

Though much of the data presented within the needs assessment is drawn from stand alone information sources, made up of different groups of people it is of value to consider the interlocking nature of alcohol harm. Individuals who are recorded as an alcohol related mortality are likely to have been in contact with local health services in the form of hospital admissions, contact with the Community Alcohol Team and detox support.

While estimates of alcohol consumption for males appear to show a fall in the proportion drinking above recommended units women are continuing to drink at the higher levels seen at the beginning of the century. In parallel to this, alcohol specific mortality is also continuing to rise for females.

The historic link between higher levels of alcohol consumption, health harm including alcohol related admissions and deprivation appears to have broken. Residents living in areas of greater deprivation are more likely to have an alcohol related hospital admission but this may not be directly attributable to their consumption of alcohol and is likely to be associated with other life style factors including potentially obesity.

Locally more households in the middle deprivation quintile are drinking at Increasing and Higher Risk levels. This finding is supported by intelligence from national data sets[1]. Because of the inherent strengths and assets associated with this group of drinkers this population are likely to respond positively to health promotion messages that communicate the health harms associated with alcohol including increased risk of certain forms of cancer. The success of stop smoking campaigns could be used as a model for effective interventions with these populations.

This report also includes analysis of the contributory effect of alcohol within Crime and Disorder. Though the incidence of violence against the person continues to fall since peaking in 2006-07, alcohol is still considered a contributory factor with approximately 40% of both perpetrators and victims being recorded as “under the influence” in the case of injury violence cases.

[1] Ng Fat L, Fuller E “Drinking Patterns” Health Survey for England 2011, Health and Social Care Information Centre, December 2012

The cultural and social representation of alcohol consumption is not included within the scope of this assessment however behaviour may be affected by the portrayal of normalised behaviours by the media.

Also outside of the scope of this assessment is the therapeutic support provided by local fellowships such as Alcoholics Anonymous. Many local residents with alcohol problems may choose to wholly engage with the support provided by these organisations rather than that provided by the statutory sector.

Unless otherwise stated all data is for Brighton and Hove.

Note:
This needs assessment was completed to support the re-commissioning of services from 2015-16. The scope of the needs assessment has been limited to the use of routinely available data and has not included a formal review of evidence.

1 Executive Summary

Synthetic drinking estimates and Health Counts

Data drawn from both the synthetic estimates (based on modelled predications)[2] and local surveying appear to evidence that the rise in the local population drinking at Increasing Risk, Higher Risk or Binge Drinking has started to abate. There has been a decline in the estimated population drinking at Increasing Risk or Binge Drinking and the proportion drinking at Higher Risk has plateaued. Local analysis from the Health Counts Survey indicates that the proportion of adult males (aged over 18 years) drinking at Increasing/Higher risk has fallen to 18% from 27% in 2003. This survey also evidences the proportion of females consuming above the recommended weekly units remaining static at 17%.

Health Counts 2012

Intelligence generated from the City wide Health Counts 2012 survey does not indicate a relationship between deprivation and alcohol consumption.

However populations experiencing higher rates of deprivation will not necessarily be less affected by the consequences of alcohol consumption in the form of hospital admissions. The paradox of higher alcohol mortality/alcohol health burden coupled with lower levels of alcohol consumption has been identified through national analysis[3]. It is possible that other determinants of heath, including diet and obesity are affecting hospital admissions related to liver disease which are then included as Alcohol Attributable/Specific admissions.

Data from both local and national datasets evidences a higher proportion of middle income/deprivation households drinking at levels of Increasing and Higher Risk.

Alcohol Mortality

Patterns of alcohol related mortality differ by gender. The rate per 100,000 population for male deaths consistently exceeds those of women. A small increase in the number of deaths in one year will impact on the directly standardised rate. It is therefore important to look at long term trends.

Although males experience more deaths as a result of their use of alcohol a potentially more improving trajectory of disease incidence may be emerging. However, for females this incidence of alcohol disease mirrors that of alcohol consumption with both showing a deteriorating trajectory.

The incidence of male chronic liver disease and alcohol specific mortality[4] has been consistently significantly worse in Brighton and Hove than that of the England average (2008-2010). Both

[2] For a detailed definition of how these measures are generated please see Topography of Drinking Behaviours in England, synthetic estimates of the numbers of abstainers, lower risk, increasing risk and higher risk drinkers in local authorities in England, North West Pubic Observatory, August 2011.

[3] Lecture Alcohol Research UK 2013, "Understanding The Alcohol Harm Paradox to focus the development of interventions" Professor Mark A. Bellis, Lisa Jones, Michela Morleo Centre for Public Health Liverpool John Moores University m.a.bellis@ljmu.ac.uk

[4] Deaths from alcohol-specific conditions, classified by underlying cause of death (International Classification of Diseases (version 10) codes with an attributable fraction of one, Table 1), registered in the respective calendar years 2008-2010 in males and females of all ages. (Local Alcohol Profiles for England 2012 User Guide Updated August 2012)

alcohol specific and attributable mortality[5] for males has fallen, and deaths for chronic liver disease have plateaued across the measurement period (2004-2010).

For females alcohol specific mortality has increased, as have deaths associated with chronic liver disease. Female alcohol attributable mortality has levelled out.

Brighton and Hove has a history of high rates of drug deaths. The incidence of alcohol related mortality is comparable with these rates. The Alcohol Related Mortality Directly Standardised Rate per 100,000 for Males is significantly higher than that for drug related deaths but has historically not garnered attention in the same way as drug deaths.

Alcohol related A&E activity

Despite some monthly fluctuations year-on-year the volume of alcohol related attendances presenting to the A&E department of the Royal Sussex County has increased. The A&E data set under records patients accessing care in relation to alcohol. Referrals between the A&E general clinical team and the specialist alcohol nursing staff reflects the actual incidence of alcohol related presentations experienced by the department.

Maintaining capacity within the Alcohol Nursing Service based in A&E is necessary to sustain integration of contact between the extended A&E clinical team and Alcohol Services. Many of the clients who present repeatedly to A&E are already known to Alcohol Community Support and this intelligence continues to support the provision of assertive outreach to selected members of this high drinking community.

Alcohol related hospital admissions

Under performance in respect of specific alcohol related mortality was referenced earlier and it is of interest to see that a comparable effect is evident here in respect of hospital admissions. Analysis of alcohol related hospital admissions shows that a small cohort of highly dependent patients contribute to inpatient activity through repeat admissions.

Local residents who die from an alcohol related condition are likely to have had an inpatient stay related to their underlying disease in the years and months prior to their death. The trajectories of hospital admissions linked to alcohol related diagnoses may be a predictor of future mortality.

An admission to hospital for an alcohol related condition could also present an opportunity to intervene to prevent further deterioration in a patient's condition. We also identified earlier that many patients admitted for problems associated with use of alcohol will be known to alcohol treatment services. Evidence presented here therefore identifies the potential for greater integration and synergy between the acute and community sectors. Increased attention placed on preventing acute activity by community based services could help in reducing alcohol related hospital activity.

[5] Deaths from alcohol-attributable conditions, classified by underlying cause of death (International Classification of Diseases (version 10) codes, Table 1), registered in the respective calendar year 2010, in males and females, all ages. Children under 16 years were only included if they had an alcohol-specific diagnosis i.e. where the alcohol-attributable fraction equalled one, meaning that alcohol consumption was the sole cause in all cases. For other conditions, the alcohol-attributable fraction estimates were not available for children. (Local Alcohol Profiles for England 2012 User Guide Updated August 2012)

Alcohol treatment population

The typical male and female primary alcohol user is older than their primary drug using contemporaries. Over a third of primary alcohol clients are female. Black and Minority Ethnic (BME) communities are almost universally under-represented across the alcohol treatment population. Information about a client's sexuality was recorded for 80% of clients and indicated that 13% of those in primary alcohol treatment were LGB. It is estimated that between 15-16%[6] of the City's population is LGBT. As such there is probably under-representation of this community within the alcohol treatment population.

10% of clients had a dual diagnosis[7] and are likely to present with more complex needs. 7% of clients currently in treatment for their use of drugs also had alcohol recorded as a second or third problem substance. Similarly, 8% of clients currently in alcohol treatment had a drug using history. 17% of alcohol clients live with children. Half of alcohol clients (50%) either rent privately or own their own home. Over a quarter of those in treatment for alcohol (28%) are in regular employment. These findings indicate the continued importance of ongoing liaison with local employers to support those within the local workforce who experience alcohol related harm. Employment and stable housing are good indicators of potential resilience, often called recovery capital that exists within the alcohol treatment population.

Treatment activity

The number of clients in alcohol treatment is increasing. The alcohol treatment population is characterised by a much more dynamic flow of referrals and discharges when compared with the drug treatment population. 46% of clients were in treatment for less than 3 months and 71% of those in treatment during the 18 month measurement period (1st April 2012- 30th September 2013) left treatment during this time. 31% of clients leaving treatment dropped out without completing their treatment. During the 18 months of the measurement period 12% of those who left treatment in either a planned or unplanned way represented to treatment during this period. As was seen earlier in respect of housing and employment status locally the treatment population has inherent recovery capital. This is also evidenced in respect of the low frequency of Compounding Factors[8] as measured by Public Health England's (PHE) Alcohol Profiling Tool amongst the local alcohol treatment population.

Street drinkers

The 2012 street count identified 93 individual street drinkers[9] across the City of whom 43 were in treatment at the time of review. Half of the street drinkers identified as "high profile"[10] were hostel residents. Though identified as street drinkers, the majority of those in contact with substance misuses services were being supported for their drug rather than alcohol use. The treatment profile of those known to substance misuse services indicates a long treatment

[6] Brighton and Hove City Council Joint Strategic Needs Assessment 2013

[7] **Psychosis with coexisting substance misuse assessment and management in adults and young people, National Clinical Guideline Number** 120**, National Collaborating Centre for Mental Health** *commissioned by the* National Institute for Health & Clinical Excellence *published by* The British Psychological, 2011

[8] Public Health England Alcohol Complexity Index 2011/12 includes the modelling of whether a client has Opiates or Crack Use as their second or third drug, has another 2nd or 3rd Drug, has experienced more than 3 Alcohol Treatment Journeys, has a Housing Issue, Dual Diagnosis, is Unemployed, was a CJS Referral, or A&E Referral, is Living with Children, is Pregnant or Has also had a Primary Drug Journey.

[9] For the purposes of this review a street drinker was defined as 'a member of the street community who drinks alcohol in public areas in groups or alone'

[10] Defined as being a known street presence familiar to street outreach services.

history and a high number of treatment episodes. As such this cohort present as high intensity users of substance misuse services. It is probable that this population are also contributing to alcohol related hospital activity.

Alcohol support in primary care locally enhanced services

The use of routine screening by primary care has the potential to identify problematic use of alcohol prior to any harm being evidenced[11]. Of the 47 general practices in Brighton and Hove 32 are signed up to provide additional alcohol support to their patients via the Locally Enhanced Service "62" specification.

Of the 27 practices that submitted a data return for July-September 2013 just over half (14) had screened in excess of 70% of their newly registered patients. Some practices were performing less well with four practices screening less than 5% of newly registered patients.

Child protection and safeguarding

The overall number of children with a CPP increased during 2013. Both the proportion and number of children with a CPP as a consequence of their parent's use of alcohol rose in excess of this increase. After Domestic Violence/Abuse, Parental Alcohol Abuse is now the second most common reason for a child to have a Protection Plan (December 2013). The interface with alcohol treatment services is currently not recorded. It isn't therefore possible to see how many of the parents identified as in need of support in respect of their use of alcohol are in contact with treatment services.

Families, friends and carers of those affected by alcohol

The National Institute for Care Excellence acknowledged the need to involve families and carers in the treatment of people who misuse alcohol to help support and maintain positive change[12].
Findings from the UK Drug Policy Commission show that at least 1.5m adults in the UK are affected by a relative's drug use[13]. Though this data relates to drug harm it is probable that a similar picture presents for alcohol use. Local intelligence for Brighton and Hove has not been compiled in respect of either drug or alcohol harm experienced by family or friends locally.
One of the support networks available to the family and friends of those affected by substance misuse is the PATCHED service. Anecdotal evidence from the service indicates that over 40% of those in contact were there as a consequence of a friend/family member's alcohol use. Year-on-year PATCHED has seen an increase in those seeking support because of a relative's use of alcohol.

Domestic Violence

As at 23rd October 2013 9.3% (50) of those in alcohol treatment responded positively to any of the domestic violence questions which would indicate that the client had experienced Domestic Violence related behaviours. 31 of those who responded to these questions were female and 19 male. This is comparable with domestic violence amongst the primary drug using population of 9% 105/1,193 for the same measurement period.

[11] National Institute for Health and Social Care Excellence Alcohol-use disorders: preventing harmful drinking, Issued : June 2010 NICE public health guidance 24 guidance.nice.org.uk/ph24
[12] Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence Issued: February 2011 NICE clinical guideline 115 guidance.nice.org.uk/cg115, February 2011
[13] Quoted in "Supporting families affected by drug and alcohol use: Adfam evidence pack" Adfam 2012.

Military Veterans

Alcohol consumption has historically been seen as an important part of military life[14]. On accessing treatment clients are asked if they or a member of their family have served in the armed forces. As at 23rd April 2013, 7 of those in treatment for primary alcohol use were either themselves ex members of the Armed Forces or the partner of someone who had been in military service.

Crime and disorder

Alcohol plays a contributory role in the occurrence of violent crime, including sexual offences, and also in other offences. In Brighton and Hove both violence against the person and criminal damage offences have fallen since 2006-07. The long term trend in the occurrence of sexual offences is less clear and may be masked by changes in the likelihood that victims report to the Police. Most assaults take place in the street or in a dwelling and peak across the weekend, particularly across the late night/early morning period. Offenders whose criminal behaviour is linked with their use of alcohol are being referred to treatment services where needs around alcohol are identified through an assessment conducted by probation services. The use of Alcohol Treatment Requirements being assigned as a community sentence at court has been increasing but the number successfully completed fell between 2011-12 and 2012-13.

Alcohol related collisions involving the person

The number of Alcohol Related Personal Injury Collisions reduced by 75% during the eight year period 2005-2012 from 119 to 30. Recording may have affected the reduction in these incidents but Road Safety specialists from the City believe that this is a genuine reduction in these incidents. The fall in collisions also reflects reduced consumption since the middle of previous decade evidenced earlier in this report.

Disability Living Allowance, Incapacity Benefit (IB) and Severe Disability Allowance (SDA)

Disability Living Allowance data for Brighton and Hove as at May 2013 showed that 0.9% of DLA claimants were doing so because of drug or alcohol use and for the UK as a whole it was 0.7%.

[14] Military Veterans Health Needs Assessment – Sussex 2012, NHS Sussex, June 2012

2 Synthetic Drinking Estimates and Health Counts

2.1 Understanding drinking patterns in the City is an important first step in comprehending need. National estimates apply data generated from the annual General Household Survey to local populations[15]. Tables 1-3 show how the incidence of populations drinking at Increasing Risk[16], Higher Risk[17] and Binge Drinkers[18]. These are synthetic estimates derived from the Local Alcohol Profiles For England over the three year period from 2009-2012. Given that these data are based on modelled estimates there is some limitation in their validity. This should be borne in mind when viewing this data. But in the absence of other measures this information provides insight into annual change and comparison against other areas.

2.2 The proportion of Brighton and Hove residents drinking at Increasing or Higher Risk is greater than that for England across the three year measurement period. This pattern is also true for Binge Drinkers.

2.3 The proportion of local residents drinking at Increasing Risk fell between 2009 and 2012. The proportion of drinkers consuming at Higher Risk appears to have increased and then stabilised across the measurement period. The proportion of binge drinkers has fallen.

Table 1: Alcohol Consumption Synthetic Estimates 2009-10

	Brighton and Hove City PCT (2009-10)			England		
	% of Population	**Lower 95% CI**	**Upper 95% CI**	**% of Population**	**Lower 95% CI**	**Upper 95% CI**
Increasing Risk Drinkers	24.4	22.2	26.6	20.1	18.4	21.8
Higher Risk Drinkers	5.9	5.2	6.5	5.0	4.5	5.6
Binge Drinkers	27.3	22.5	32.8	20.1	19.4	20.8

Source: North West Public Health Observatory Local Area Profiles 2009-10

[15] LAPE estimates are derived from the application of the Ready Reckoner applied to the mid-year population estimates. 2009-10 data (mid-year 2008), 2010-11 data (mid-year 2008) 2011-12 (mid-year 2009)

[16] Men who regularly drink more than 3 to 4 units a day but less than the higher risk levels. Women who regularly drink more than 2 to 3 units a day but less than the higher risk levels

[17] Men who regularly drink more than 8 units a day or more than 50 units of alcohol per week. Women who regularly drink more than 6 units a day or more than 35 units of alcohol per week

[18] Adults who consume at least twice the daily recommended amount of alcohol in a single drinking session: 8 or more units for men and 6 or more units for women.

Table 2: Alcohol Consumption Synthetic Estimates 2010-11

	Brighton and Hove City PCT (2010-11)			England		
	% of Population	**Lower 95% CI**	**Upper 95% CI**	**% of Population**	**Lower 95% CI**	**Upper 95% CI**
Increasing Risk Drinkers	22.7	7.9	50.7	20.8	6.9	50.0
Higher Risk Drinkers	7.6	2.7	21.4	7.1	2.4	21.5
Binge Drinkers	27.3	22.5	32.8	20.1	19.4	20.8

Source: North West Public Health Observatory Local Area Profiles 2009-10

Table 3: Alcohol Consumption Synthetic Estimates 2011-12

	Brighton and Hove City PCT 2011-12			England		
	% of Population	**Lower 95% CI**	**Upper 95% CI**	**% of Population**	**Lower 95% CI**	**Upper 95% CI**
Increasing Risk Drinkers	21.0	11.7	40.3	20.0	10.8	38.5
Higher Risk Drinkers	7.6	2.7	23.5	6.7	2.4	21.8
Binge Drinkers	25.3	22.9	27.8	20.1	19.4	20.8

Source: North West Public Health Observatory Local Area Profiles 2009-10

2.4 Drinking activity reported from a different source: the 2012 Department of Health Profiles provides an estimate of 24 per cent of adults in the city drinking at increasing risk or higher risk levels. This is not significantly different to the 22 per cent reported in the same survey for England (modelled data based upon 2008/09 data from the General Lifestyle Survey).[19]

2.5 Locally produced data derived from the findings from the Health Counts 2012 survey indicate that 14% of respondents were drinking at increasing risk and 4% at higher risk[20]. This data attributed harmful drinking to a much smaller population with only 18% of the population drinking in this way. Though this is based on self-reported consumption.

2.6 Comparing findings from the 2012 Health Counts survey with that of previous years shows that a smaller proportion of women drink above the recommended levels compared with men. Since the second Health Counts Survey in 2003 fewer men are drinking above recommended levels, while female consumption has remained unchanged.

[19] Association of Public Health Observatories. Health Profile 2012, Brighton and Hove. Available at: http://www.apho.org.uk/resource/view.aspx?RID=50215&REGION=50158&LA=50148&SPEAR=

[20] NHS Brighton and Hove and Brighton and Hove City Council Health Counts Report 1992- 2012, 2013 Available at www.bhlis.org/surveys

Table 4: Health Counts Survey 1992, 2003 and 2012

Drinking above recommended levels (>14 units females and >21 units males)			
	1992	**2003**	**2012**
Males	16%	27%	18%
Females	8%	17%	17%

Source: Health Counts Survey 1992, 2003, 2012

2.7 Alcohol consumption reported in this survey appears to have peaked at the beginning of the 2000's. Male consumption fell by 9% when compared with the previous survey but this is still higher than that reported in 1992 (16%). The proportion of women drinking above the recommended level doubled between 1992 and 2003 and remained at this level in 2012.

2.8 Although the estimates illustrated above are drawn from different data sources a common theme emerges with what appears to be a reduction in the proportion of the population drinking at harmful levels over recent years. This change is stronger for males than females.

2.9 **Summary**

Data drawn from both the synthetic estimates and local surveying appears to evidence that the rise in the local population drinking at Increasing Risk, Higher Risk or Binge Drinking has started to abate. There has been a decline in the estimated population drinking at Increasing Risk or Binge Drinking and the proportion drinking at Higher Risk has plateaued. Self reported drinking from the Health Counts Survey indicates that the proportion of males drinking at Increasing/Higher risk has fallen to 18%. This survey also evidences the proportion of females consuming above the recommended weekly units remaining static at 17%.

3 Health Counts 2012 and Deprivation

3.1 Information from the Health Counts 2012 survey includes analysis of alcohol consumption by Deprivation Quintile. Analysis generated in previous Alcohol Needs Assessments[21] identified that those living in less affluent areas of the City were more likely to die of alcohol related conditions or have a hospital admission related to alcohol. However, the Health Counts Survey identified that there was no significant relationship between Increasing or Higher risk drinking and deprivation. The paradox of higher mortality and health care use related to alcohol coupled with lower levels of consumption has been identified through national analysis[22].

3.2 The 2012 Health Counts Data showed that Increasing Risk and Higher Risk consumption has fallen since 2003 across all deprivation quintiles, with the exception of those living in the middle quintile where Increasing or Higher Risk drinking actually increased. These findings are comparable with those found in the national analysis which indicated that both men and women from higher income households were more likely than those from lower income households to drink on five or more days in the last week. 24% of men and 17% of women in the highest income quintile drank on five or more days in the last week, while for

[21] Alcohol Needs Assessment for Brighton and Hove PCT, Barbara Hardcastle, Public Health Specialist, May 2009

[22] Lecture Alcohol Research UK 2013, "Understanding The Alcohol Harm Paradox to focus the development of interventions" Professor Mark A. Bellis, Lisa Jones, Michela Morleo Centre for Public Health Liverpool John Moores University m.a.bellis@ljmu.ac.uk

those in the lowest income quintile the proportions were 12% and 6% respectively[23]. Higher Risk drinking in 2012 no longer shows any association with deprivation in Brighton & Hove. It is possible that other factors such as obesity are affecting admissions related to liver disease.

3.3 Local need in relation to middle income households was also tangentially referenced in the findings from the re-commissioning consultation which identified the need to provide services to those "functioning addicts including those who work" (n=16). It is possible that these two findings reflect the evolving presentation of alcohol harm amongst more affluent populations locally.

3.4 The Health Counts 2012 data enables analysis of drinking patterns by population group. There was no correlation across most of the population indicators that were measured. However, increasing or Higher Risk drinking is significantly more likely in respondents who define themselves as having no religion (24%) than all respondents, whereas respondents who are Christian (12%), or who have another religion (8%), are significantly less likely to drink at increasing/higher risk levels than all respondents. This may be related to participant's age.

3.5 Individuals who rent their houses from a housing association or a local authority have significantly lower rates of drinking at Higher or Increasing Risk levels (10%) than all respondents. Respondents with no qualifications are significantly less likely (10%) than all respondents to drink at Increasing or Higher risk levels.

3.6 **Summary**

The relationship between alcohol consumption and consequent harms is complex. Intelligence generated from the City wide Health Counts 2012 survey does not indicate a relationship between deprivation and alcohol consumption. However, this does not necessarily indicate that populations experiencing higher rates of deprivation will be less affected by the consequences of alcohol consumption. The paradox of higher alcohol mortality/alcohol health burden coupled with lower levels of alcohol consumption has been identified through national analysis[24]. In contrast alcohol consumption by more affluent/middle quintile deprivation households is increasing but there may be protective lifestyle factors that inhibit this population from experiencing the health harms associated with alcohol. It would be of value to correlate alcohol admission activity against deprivation quintile in the City.

4 Alcohol mortality

4.1 The following section looks at changes in the incidence of alcohol related death. Two categories of deaths are recorded in relation to alcohol: those that are specifically related to alcohol consumption and those that are attributed.

4.2 Alcohol-specific conditions include those conditions where alcohol is causally implicated in *all* cases of the condition; for example, alcohol-induced behavioural disorders and alcoholic liver cirrhosis. By definition, the alcohol-attributable fraction (see below) equals one because no cases would be expected to arise in the absence of alcohol.

4.3 Alcohol-attributable conditions include all alcohol-specific conditions plus those conditions where alcohol is causally implicated in some but not all cases of the

[23] Household Survey 2011, HSE 2011

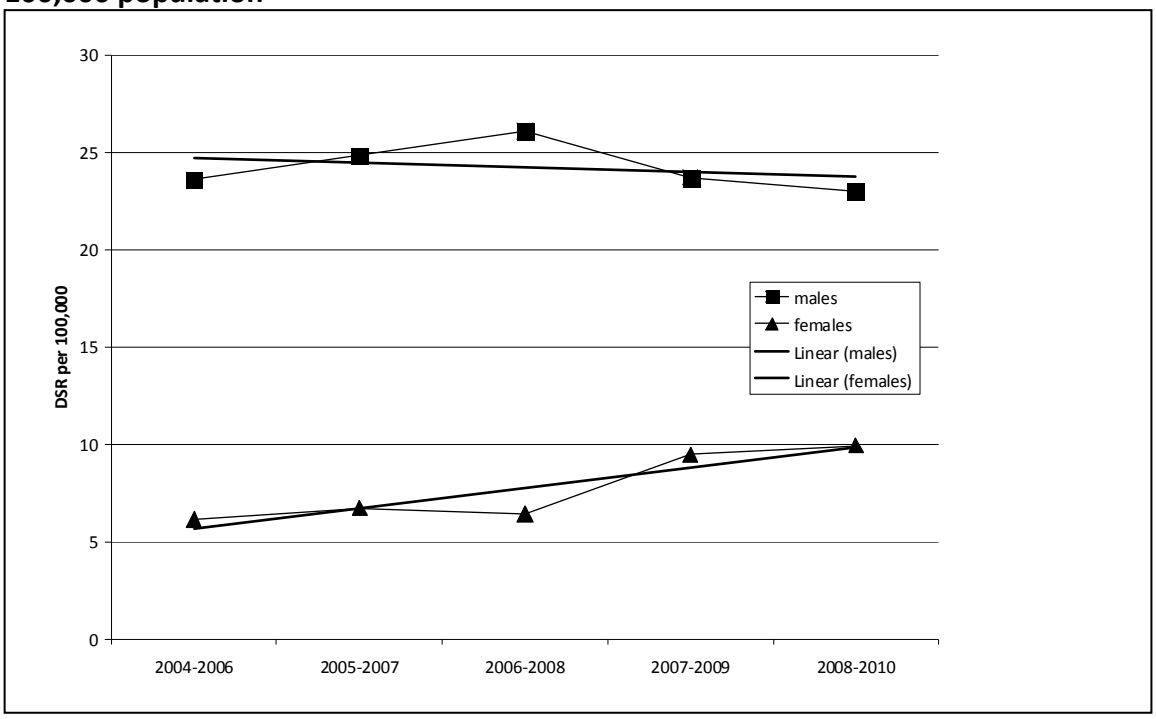
[24] Lecture Alcohol Research UK 2013, "Understanding The Alcohol Harm Paradox to focus the development of interventions" Professor Mark A. Bellis, Lisa Jones, Michela Morleo Centre for Public Health Liverpool John Moores University m.a.bellis@ljmu.ac.uk

condition, for example, for hypertensive diseases, various cancers and falls. The attributable fraction for alcohol-attributable conditions ranges between greater than zero and less than one. For example, the alcohol-attributable fraction for drowning is 0.34 and the alcohol-attributable fraction for assault is 0.27. This means that for 34% of drownings alcohol is implicated. A small change in the number of deaths can impact on the annual rate.

4.4 This section also includes the incidence of deaths from Chronic Liver Disease.

4.5 The chart below shows Directly Standardised Rates (DSR)[25] for Alcohol Specific Mortality[26] between 2004 and 2010. During this period male and female mortality have converged with male deaths falling while those for females showed a slight increase. Despite this positive trend for males, they continue to have higher rates of death than females.

Chart 1: Brighton and Hove Alcohol Specific Morality Females and Males, all ages, DSR per 100,000 population



Source: North West Public Health Observatory Local Area Profiles 2004-2010

[25] Standardised rates are used to allow comparisons across geographical areas by controlling for differences in the age structure of local populations. Age standardised rates can be compared across areas and time periods. They give the number of events that would occur in a standard population (per 100,000) if that population had the age-specific rates of a given area. The rates are standardised to the European Standard Population [ESP]. The age groups used for deriving the standardised rates are as defined in the ESP. Institute of Alcohol Studies accessed online 23rd January 2014

[26] Alcohol-specific mortality - males/females - Deaths from alcohol-specific conditions (all ages, male/female), directly standardised rate per 100,000 population (standardised to the European Standard Population). (NWPHO from Office for National Statistics Public Health Mortality File for 2008-2010 and mid-year population estimates for 2008-2010).

Table 5: Brighton and Hove Alcohol-Specific Mortality: Females and Males, all ages, DSR per 100,000 population[27]

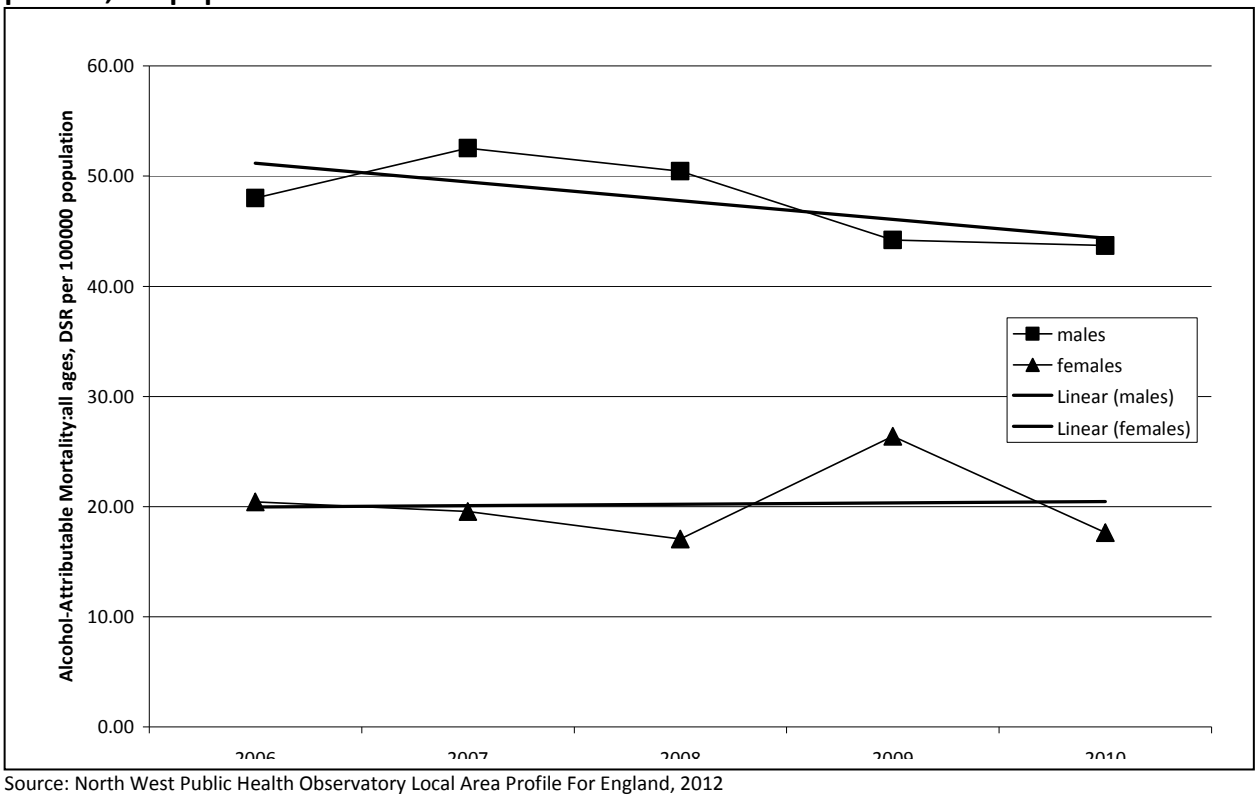
Alcohol Specific Mortality	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010
males	23.60	24.83	26.09	23.71	22.99
females	6.17	6.73	6.44	9.50	9.96

Source: North West Public Health Observatory Local Area Profile For England, 2012

4.6 Chart 2 shows Alcohol Attributable Mortality, Directly Standardised Rates between 2004-2010. This data sets encompasses a wider breadth of diagnoses and hence the DSR is higher.

4.7 As was seen in respect of the Alcohol Specific data set male mortality is higher than that for females. The trend line for male Alcohol Attributable Mortality is negative. A comparable trend was evident for females prior to 2009 when deaths spiked. Data for 2010 continues the downward trajectory for females.

Chart 2: Brighton and Hove Alcohol Attributable Mortality Females and Males, all ages, DSR per 100,000 population scale



Source: North West Public Health Observatory Local Area Profile For England, 2012

[27] North West Public Health Observatory Local Area Profile For England, 2012

4.8 Drug Related Death data from the National Programme for Substance Misuse Deaths has been included in table 6 as a point of comparison. Drug Related Death data is for both genders. Alcohol attributed mortality for women is comparable with that attributed to substance misuse. For males the rate of alcohol attributable mortality across this period was twice that attributed to drugs.

Table: 6 Brighton and Hove Alcohol-Attributable Mortality: all ages, DSR per 100000 population and National Programme for Substance Abuse Deaths (np-SAD) Annual Death Rate per 100,000 population

Alcohol-Attributable Mortality	2006	2007	2008	2009	2010
males	47.99	52.52	50.45	44.19	43.68
females	20.43	19.56	17.05	26.38	17.65
National Programme for Substance Abuse Deaths	17.81	20.73	21.20	23.55	15.69

Source: North West Public Health Observatory Local Area Profiles 2004-2010 and National Programme for Substance Abuse Deaths

4.9 Table 7 - 8 show deaths from Chronic Liver Disease[28] over the three year period 2006-2010. Table 7 shows the total mortality directly standardised rates from 2008 – 2010 compared with the national data set. Table 8 shows the year-on-year change for the City by gender.

Table 7: Brighton and Hove Mortality from Chronic Liver Disease: Male and Female, all ages, DSR per 100,000 population

	All ages, DSR per 100000 population (2008-2010)	Lower 95% CI	Upper 95% CI	Number deaths, all ages, (2008-2010)	Regional Rank	National Rank (England)
Males	22.53	17.51	27.55	80	2/67	20/336
Females	9.70	6.46	12.94	37	4/67	43/336

Source: North West Public Health Observatory Local Area Profiles 2004-2010

[28] Mortality from chronic liver disease- males/females - Deaths from chronic liver disease including cirrhosis (ICD-10: K70, K73-K74) (all ages, male/female), directly standardised rate per 100,000 population (standardised to the European Standard Population). (Compendium of Clinical and Health Indicators, National Centre for Health Outcomes Development 2008-2010 pooled).

Table 8: Brighton and Hove Mortality from Chronic Liver Disease: Male and Female, all ages, DSR per 100000 population 2006 -2010

	Males	Females
2006-2008	22.5	8.8
2007-2009	21.8	10.4
2008-2010	22.5	9.7

Source: North West Public Health Observatory Local Area Profiles 2004-2010

Table 9: Alcohol Mortality Brighton and Hove Compared with England Average 2006-2010

	Males			**Females**		
	2006-2008	**2007-2009**	**2008-2010**	**2006-2008**	**2007-2009**	**2008-2010**
Alcohol Specific Mortality	Sig. Worse	Sig. Worse	Sig. Worse	Not Sig.	Sig. Worse	Sig. Worse
Alcohol Attributable Mortality	Sig. Worse	Not Sig.	Not Sig.	Not Sig.	Sig. Worse	Not Sig.
Mortality from Chronic Liver Disease	Sig. Worse	Sig. Worse	Sig. Worse	Not Sig.	Sig. Worse	Not Sig.

Source: North West Public Health Observatory Local Area Profiles 2004-2010

4.10 Males are experiencing significantly worse alcohol specific and chronic liver disease mortality. Female alcohol specific mortality has deteriorated during this period with deaths significantly worse than the England Average.

4.11 **Summary**

The rate of male deaths consistently exceeds those of women. A small increase in the number of deaths in one year will impact on the directly standardised rate for that year. It is therefore important to look at long term trends.

Looking across the data sets both alcohol specific and attributable mortality for males has fallen and those for chronic liver disease have plateaued across the measurement period. The incidence of male chronic liver disease and alcohol specific mortality was consistently significantly worse than that of the England average during this period.
For females alcohol specific mortality has increased as have deaths associated with chronic liver disease. Female alcohol attributable mortality has levelled off.

Though males experience more deaths as a result of their use of alcohol a potentially more positive trend may be emerging. However, for females this incidence of disease bears comparison with the latest data in relation to patterns of alcohol consumption both of which show a positive trajectory.

Brighton and Hove has a history of high rates of drug deaths. Alcohol related female mortality is comparable with these rates. Male Alcohol Related Mortality is significantly higher than that for drug related deaths. Though mortality related to drugs is for both genders the inclusion of this comparator data helps to illuminate the

significance of alcohol related death within our local population.

5 Alcohol related A&E Activity

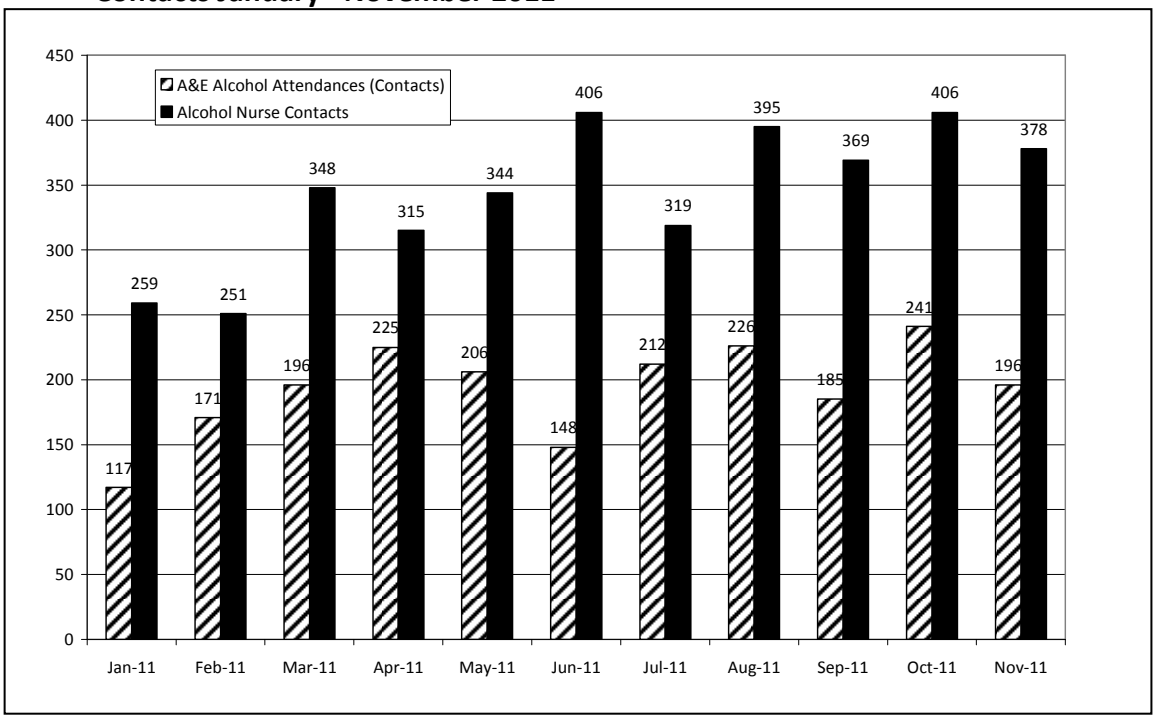
5.1 The data in Chart 3 comes from an extract from the A&E activity file which is sent directly to the Safe in the City Partnership. Alcohol activity[29] is for all attendees irrespective of the place of residence, and as such will include patients who are not residents of Brighton and Hove.

5.2 Most A&E attendances do not convert into a hospital admission. The characteristics of this alcohol using population differ from that of the dependent drinking cohort.

5.3 Alcohol related attendances are likely to be under-reported. Patients attending the department because of injuries sustained as a result of alcohol consumption are likely to have a presenting condition and diagnosis associated with injury rather than alcohol with the effect that alcohol related attendances are consistently under reported if this data set is used alone. Under reporting is clearly evidenced when the A&E alcohol related activity is compared with the referrals to the Alcohol Nurses who are based in A&E. The discrepancy illustrates the strong referral systems that operate between the wider A&E clinical team and the Alcohol Nurses.

[29] An alcohol related A&E attendance is defined as a reference to alcohol presenting as a Reason for Attendance , Diagnosis or Complaint

Chart 3: Monthly Comparison Between A&E Alcohol Attendances and Alcohol Nurse Contacts January– November 2011



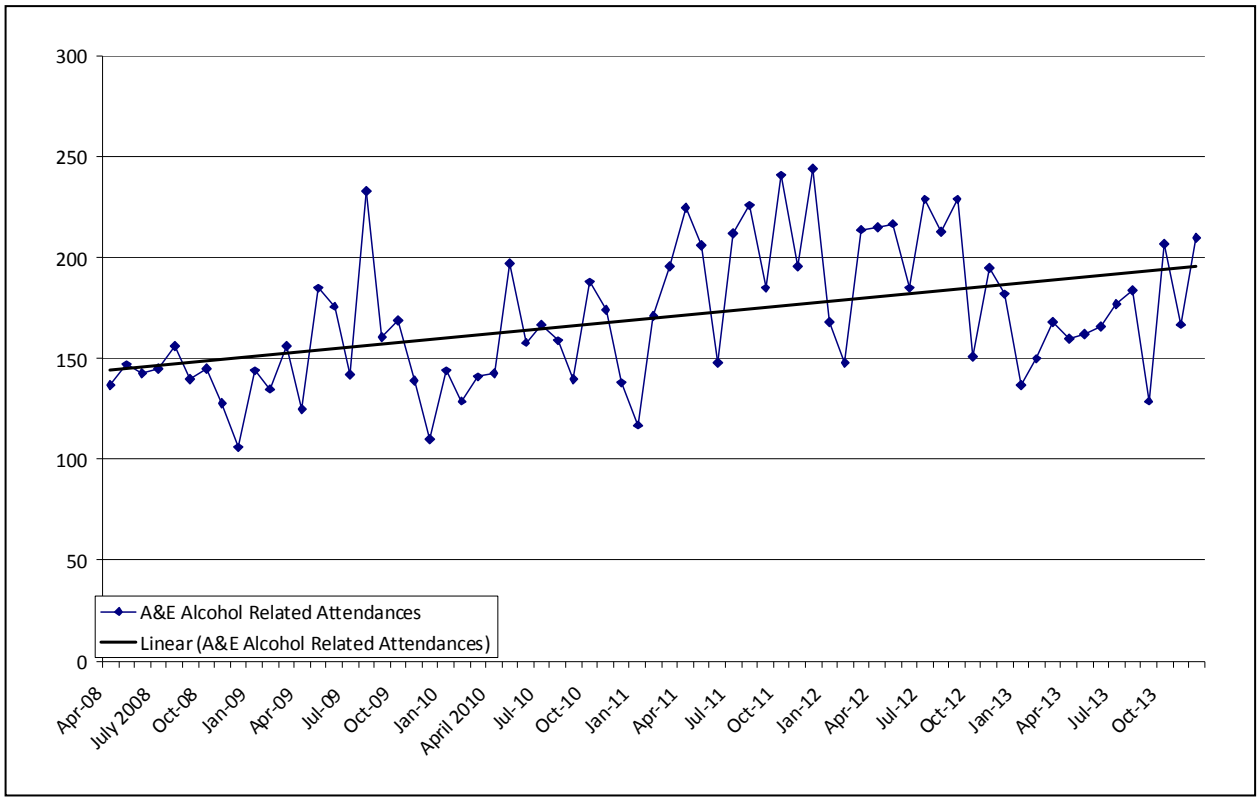
Source: A&E Symphony Management Information System and DAAT Nebula Case Management System

5.4 As illustrated above the discrepancy can be as much as 100% between the two data sets.

5.5 Chart 4 shows that despite some fluctuations alcohol related A&E attendances continue on an upward trajectory. Between 2008-09 and 2012-13 the monthly average attendance increased by 35% from 140 per month in 2008-09 to 189 per month in 2012-13. However, there is intimation of improvement with an average of 173 alcohol related attendances during the first 10 months of 2013-14.

5.5.1 It is possible that some of this increase could be attributed to improved recording, but as illustrated above recorded activity is likely to under represent the volume of alcohol related activity experienced by the department.

Chart 4: Alcohol Related A&E Royal Sussex County Hospital Attendances April 2008 – December 2013



Source: A&E Symphony Management Information System

5.6 Analysis of the A&E data set for January – June 2012 showed that the 18-24 year age group made up over a quarter (27%) of alcohol related attendances. This is despite comprising only 13% of the Brighton and Hove population. As detailed earlier it is not all patients are Brighton and Hove residents. Irrespective of the place of residence of these patients these attendances represent a preventable health burden.

5.7 **Alcohol Nurses In A&E**

5.7.1 The role of specialist alcohol nurses within the emergency department is accepted as good practice[30] and local evaluation has demonstrated their effectiveness in reducing repeat admissions[31]. The A&E nurses form a compliment of three staff. Their roles are to provide Information and Brief Advice to patients attending with an alcohol related condition within the department and to contact those discharged and provide information about local alcohol support in writing or by phone. The team also provides specialist support to ward based staff in managing inpatients with alcohol conditions. Activity for the team for January – November 2011 is shown in Chart 5. We saw earlier in Chart 3 that when at full capacity the Alcohol Nursing team are able to support a higher volume of alcohol related activity than was recorded by the A&E management system. However, Chart 3 shows that when the teams capacity is reduced their activity has dipped below that recorded by the A&E management system with the effect that patients attending A&E for alcohol related problems may not have received additional

[30] Alcohol – can the NHS afford it? Recommendations for a coherent alcohol strategy for hospitals, A report of a Working Party of the Royal College of Physicians February 2001

[31] Alcohol Nurses Based in A&E: Activity Review Including updated review to end of April 2012 10th April 2012

support.

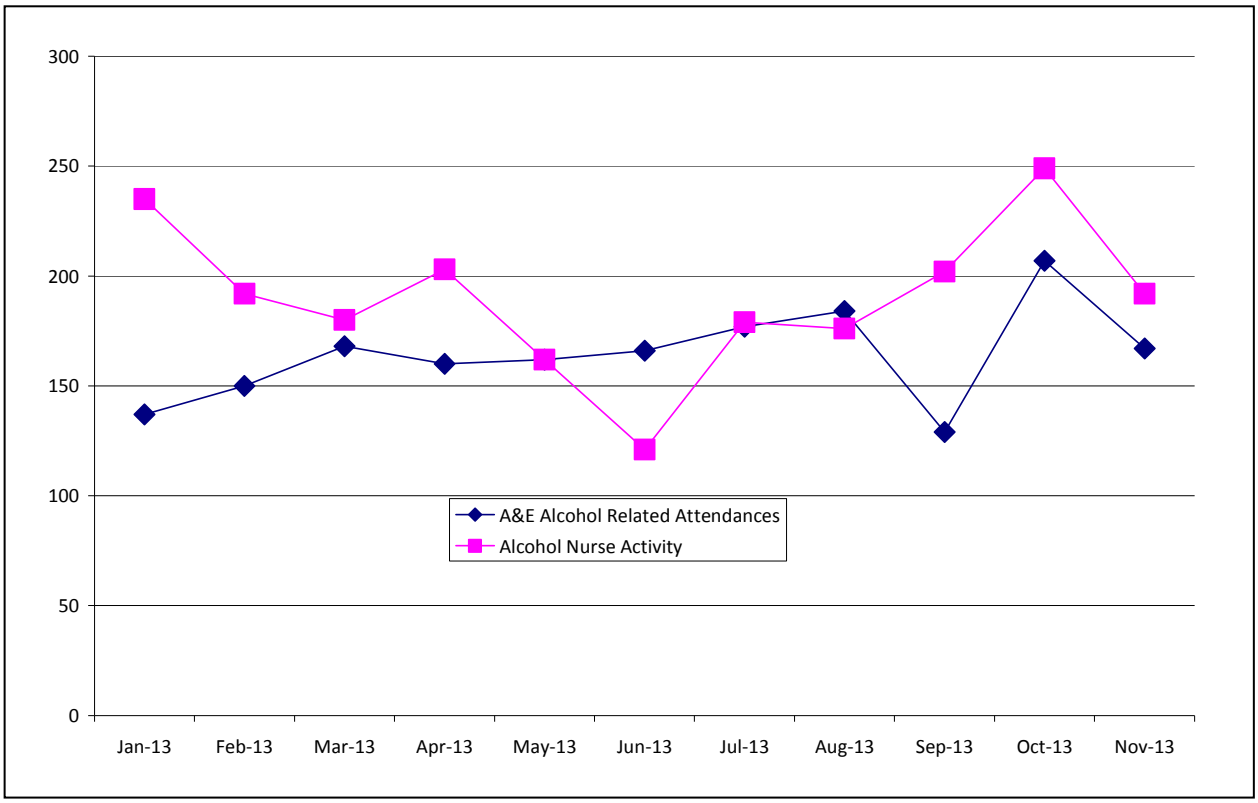
5.7.2 A review of activity (4th January 2011 and 6th December 2011) identified 23% of patients in contact with the Alcohol Nursing team had had more than one attendance related to alcohol. Fourteen patients had more than ten attendances during this period. Based on this level of attendance it is probable that this group of patients would benefit from support from a Tier 3 service.

5.7.3 In order to look at the treatment pathway between this group of patients and the Community Alcohol Team (CAT), activity from the A&E data set was compared with that for the CAT recorded using the Drug and Alcohol Management Information System.

5.7.4 This analysis indicated a high degree of engagement between this group of frequently presenting A&E patients and the Community Alcohol Team[32].

5.7.5 Patients who present on successive occasions to A&E are likely to be known to Alcohol Services. Reducing the wider health burden caused by excessive use of alcohol including that placed upon acute emergency services should be a focus for all alcohol related interventions.

Chart 5: Alcohol Related A&E Activity (Patients) and A&E Alcohol Nurses Contacts Jan -Nov 2013



Source: A&E Symphony Management Information System and DAAT Nebula Case Management System

[32] Alcohol Nurses Based in A&E: Activity Review Including updated review to end of April 2012 10th April 2012

5.8 **Summary**

Despite some monthly fluctuations year-on-year the volume of alcohol related activity has increased. Referrals between the A&E clinical team and the specialist nursing staff appear to better reflect the actual incidence of alcohol related conditions experienced by the department more accurately than the alcohol activity recorded by the A&E data system.

Maintaining capacity within the Alcohol Nursing Service is necessary to sustain integration of contact between A&E and Alcohol Services.

Many of the clients who presented repeatedly to A&E are already known to Alcohol Community Support but had not effectively engaged with the service.

6 Alcohol Related Hospital Admissions

6.1 Table 10 shows alcohol related hospital activity for Brighton and Hove and for England as a whole. Compared with the national data set Brighton and Hove is performing less well in respect of admissions episodes[33] and alcohol specific hospital admissions[34]. Brighton and Hove's activity for attributable hospital admissions bares comparison with that of the national data set.

6.2 Data is also shown for Brighton and Hove's benchmarking group. The benchmarking group is made up of 15 other areas with similar characteristics[35]. Compared with its benchmarking partners the City appears to be performing well, with indicators across three measures indicating "lower harm levels". In relation to alcohol specific admissions higher harm levels are evident.

6.3 In comparison with the national data set (which includes all areas not just the benchmark partners) Brighton and Hove is performing less well for Alcohol Related Admissions and Alcohol Specific Admissions.

[33] Admission episodes for alcohol-attributable conditions (previously NI39): directly age and sex standardised rate per 100,000 population. (Department of Health using Hospital Episode Statistics 2010/11 and Office for National Statistics 2010 mid-year population estimates). Trend data is taken from the years 2008/09, 2009/10 and 2010/11, JSNA support pack for strategic partners Technical definitions for the alcohol data, Public Health England, 2013

[34] Alcohol Attributable Hospital Admissions Persons admitted to hospital due to alcohol-attributable conditions (all ages, all genders), crude rate per 1000 population. (NWPHO from Hospital Episodes Statistics 2010/11 and Office for National Statistics mid-year population estimates 2010). Does not include attendance at A&E., JSNA support pack for strategic partners Technical definitions for the alcohol data, Public Health England, 2013

[35] Brighton and Hove is in the same benchmarking group as: Southampton, Portsmouth, Southend-on-Sea, Bournemouth, Bristol, Plymouth, Blackpool, Reading, North Tyneside, York, Bedford, Torbay, Sefton, Trafford, Bath and Somerset.

Table 10: Alcohol Related Hospital Admissions – 2010/11

	Brighton & Hove		National
	Measure	Harm Level (when compared with bench mark partners)	Measure
Admission episodes[36] *(all genders directly standardised rate per 100,000)*	1986.54	Lower Harm Levels	1814.58
Alcohol attributable hospital admissions[37] *(all genders crude rate per 1000 population)*	13.24	Lower Harm Levels	13.34
Alcohol Specific hospital Admissions[38] *(all genders, crude rate per 1000 population)*	4.95	Higher Harm Levels	3.15

Source: North West Public Health Observatory Local Area Profiles 2004-2010

6.4 Poorer performance in respect of specific alcohol related mortality was referenced earlier and it is of interest to see that a comparable effect is evident here in respect of hospital admissions.

6.5 Alcohol-related admissions to hospital form part of Public Health England's Outcomes Framework[39]. The rate of alcohol admissions fluctuates quarter-by-quarter and year-on-year. The overarching five year trajectory shows increasing rates, though a lower rate appears for the provisional figures for 2012/13.

[36] Admission episodes for alcohol-attributable conditions (previously NI39): directly age and sex standardised rate per 100,000 population. (Department of Health using Hospital Episode Statistics 2010/11 and Office for National Statistics 2010 mid-year population estimates). Trend data is taken

[37] Persons admitted to hospital due to alcohol-attributable conditions (all ages, all genders), crude rate per 1000 population. (NWPHO from Hospital Episodes Statistics 2010/11 and Office for National Statistics mid-year population estimates 2010). Does not include attendance at A&E.
Trend data is taken from the years 2008/09, 2009/10 and 2010/11.

[38] Persons admitted to hospital due to alcohol-specific conditions (all ages, all genders), crude rate per 1000 population. (NWPHO from Hospital Episodes Statistics 2010/11 and Office for National Statistics mid-year population estimates 2010). Does not include attendance at A&E.
Trend data is taken from the years 2008/09, 2009/10 and 2010/11.

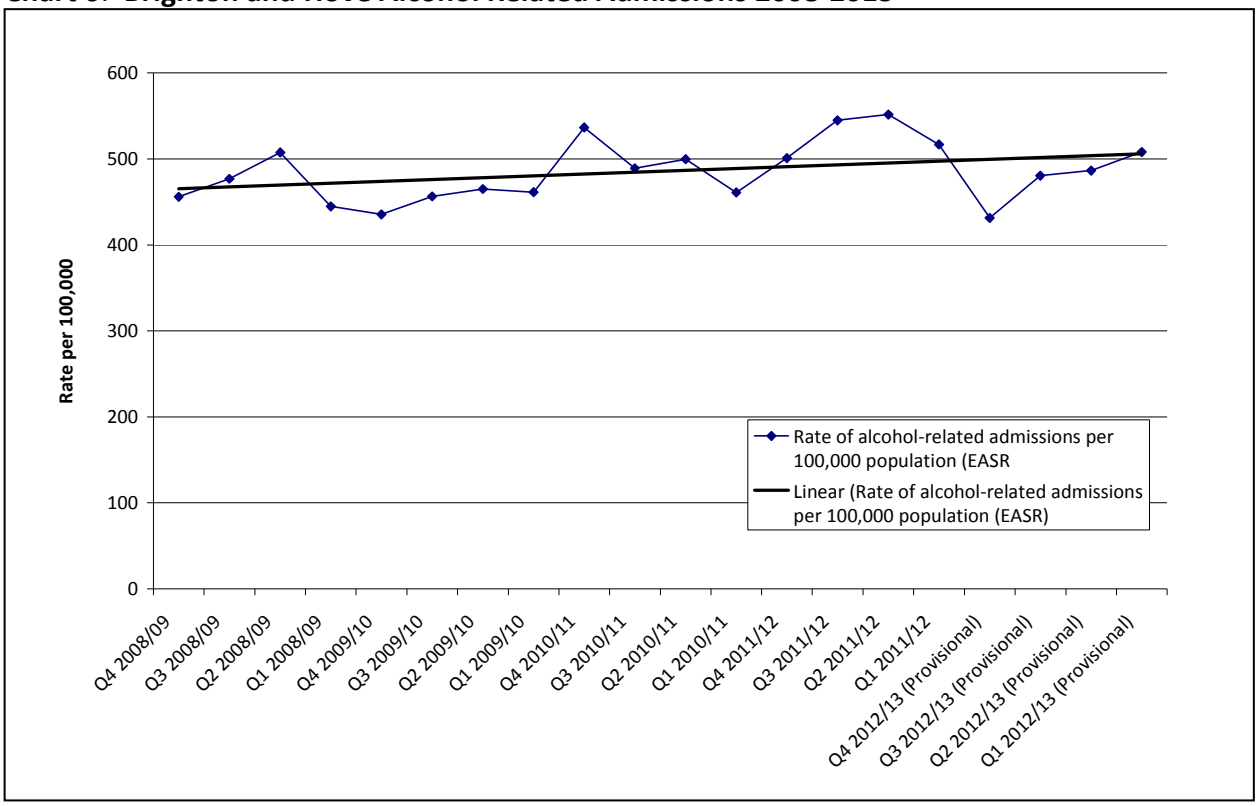
[39] Improving outcomes and supporting transparency, Part 1A: A public health outcomes framework for England, 2013-2016, Department of Health

Table 11: Brighton and Hove Alcohol Related Admissions 2008-2013

Brighton and Hove	Rate of alcohol-related admissions per 100,000 population (European Age Standardised Rate [EASR])
Q1 2012/13 (Provisional)	508
Q2 2012/13 (Provisional)	486
Q3 2012/13 (Provisional)	480
Q4 2012/13 (Provisional)	431
Q1 2011/12	517
Q2 2011/12	552
Q3 2011/12	545
Q4 2011/12	501
Q1 2010/11	461
Q2 2010/11	500
Q3 2010/11	489
Q4 2010/11	537
Q1 2009/10	461
Q2 2009/10	465
Q3 2009/10	456
Q4 2009/10	435
Q1 2008/09	445
Q2 2008/09	508
Q3 2008/09	477
Q4 2008/09	456

Source: North West Public Health Observatory Local Area Profiles 2004-2010

Chart 6: **Brighton and Hove Alcohol Related Admissions 2008-2013**



Source: North West Public Health Observatory Local Area Profiles 2004-2010

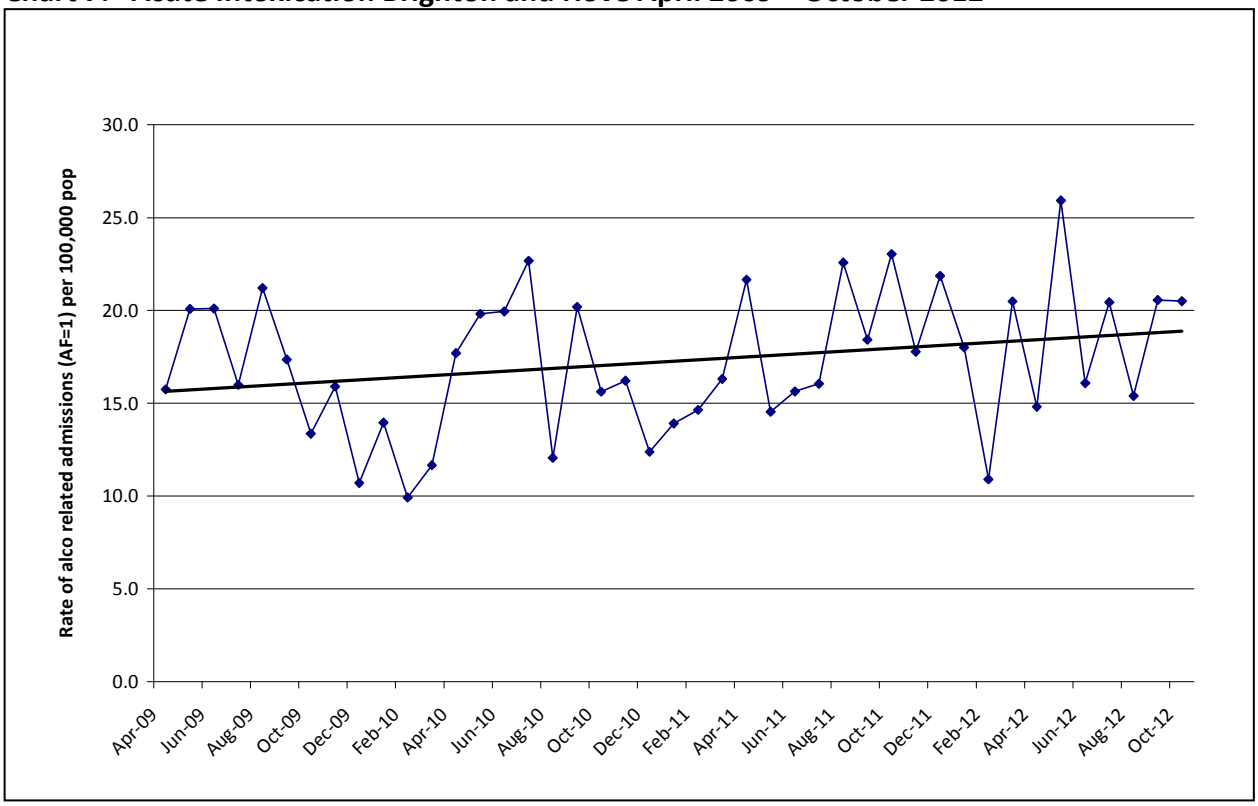
6.6 The charts on the following pages show emergency admissions wholly attributable to alcohol: by diagnosis (April 2009 – October 2012). This data is based on an extract from the Brighton and Hove Secondary User Service data set applying a comparable methodology to that used to generate the national data set.

6.7 The highest number of diagnoses relate to acute intoxication and dependence syndrome. Admissions related to dependence syndrome increased at the greatest rate. Other admissions which contribute to overall alcohol related activity are included in *appendix 1.*

6.8 The trajectory for all diagnoses (bar cirrhosis of the liver) was positive (increasing) during this period.

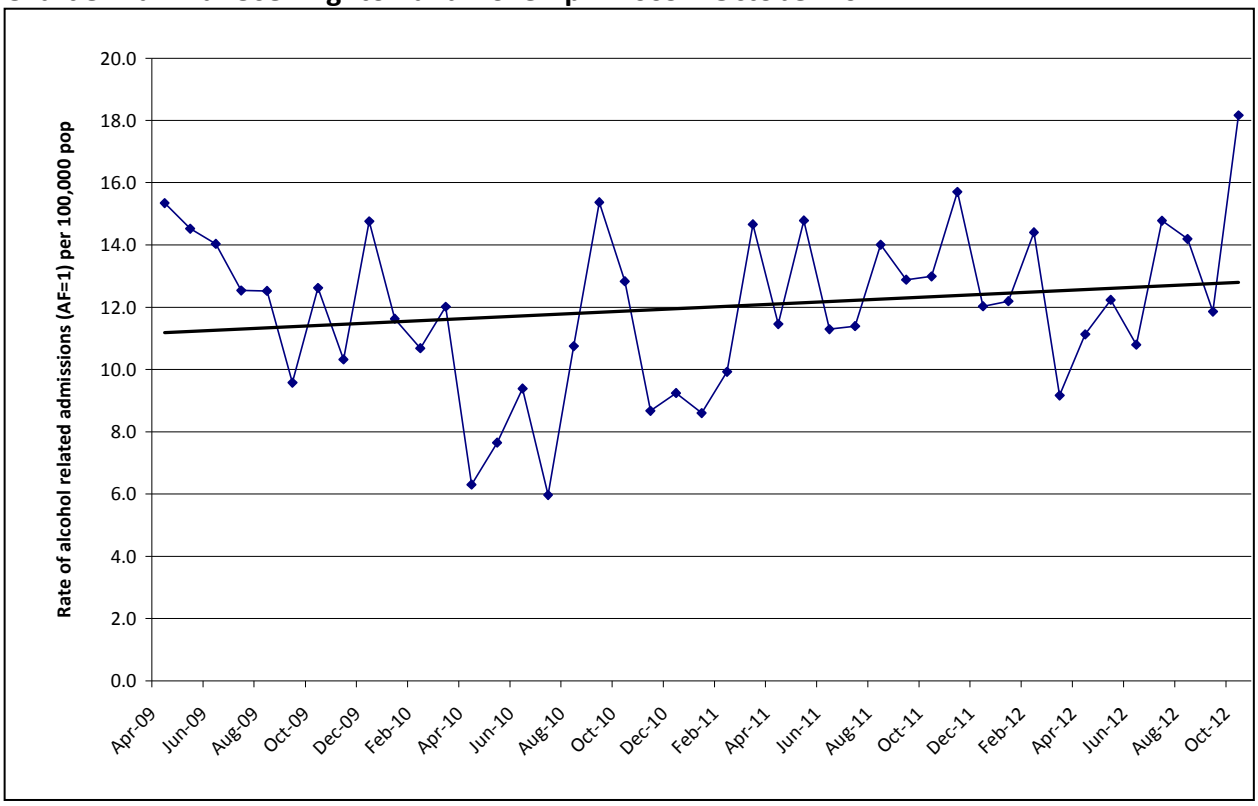
6.9 Please note that the rates (and therefore the individual chart scales) vary between each chart.

Chart 7: Acute Intoxication Brighton and Hove April 2009 – October 2012



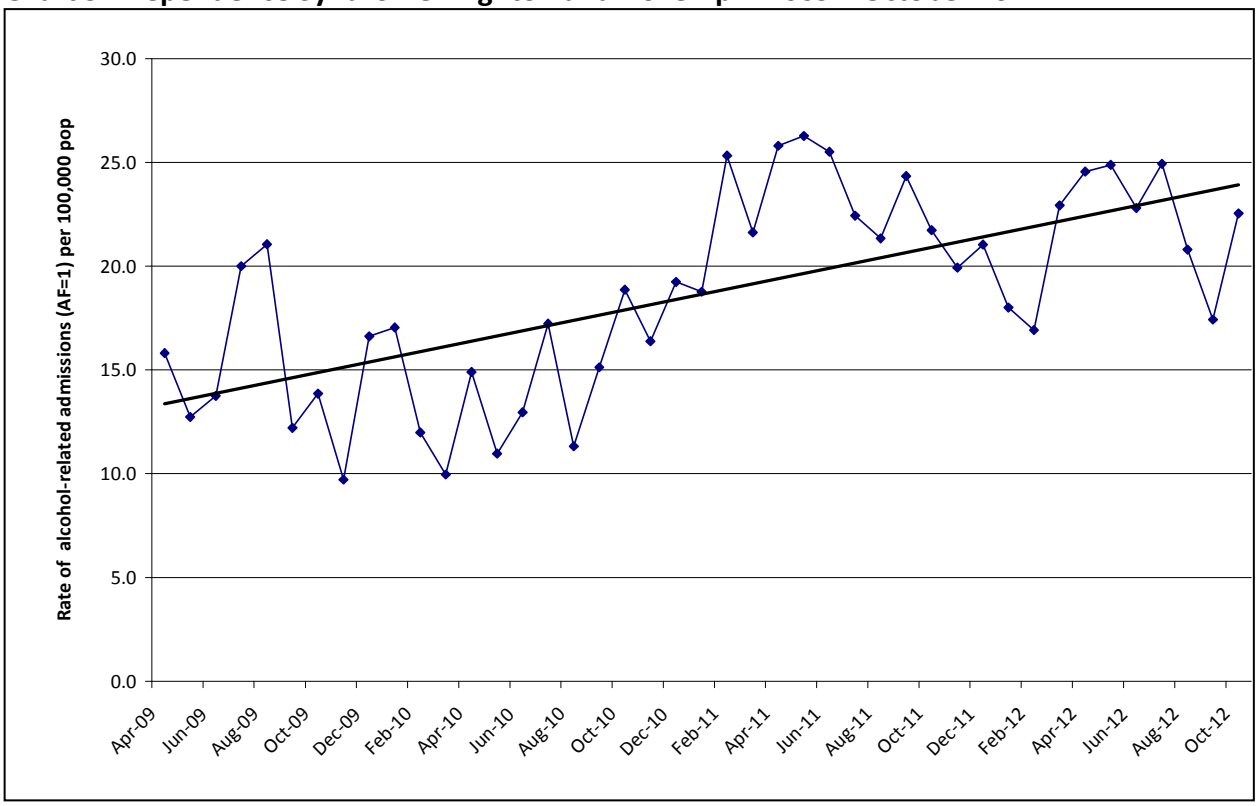
Source: Surrey and Sussex Commissioning Support Unit

Chart 8: Harmful Use Brighton and Hove April 2009 – October 2012



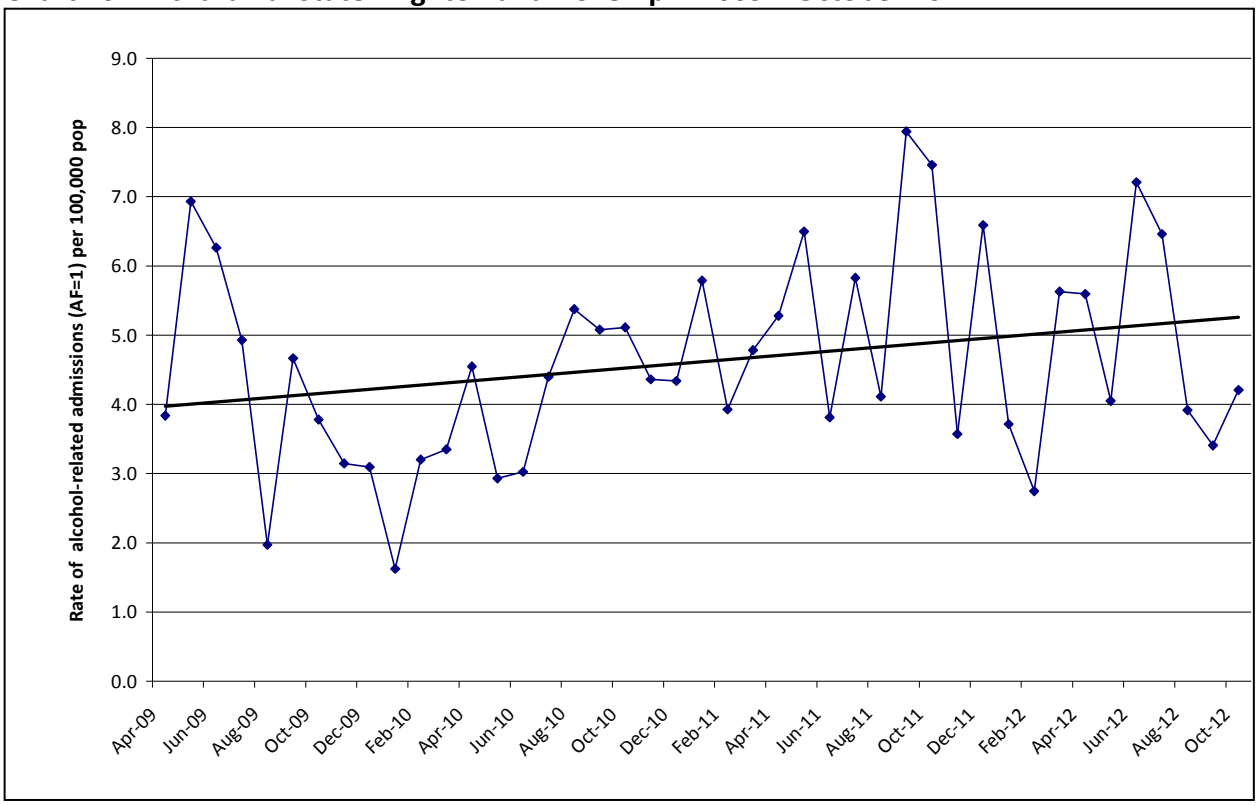
Source: Surrey and Sussex Commissioning Support Unit

Chart 9: Dependence Syndrome Brighton and Hove April 2009 – October 2012



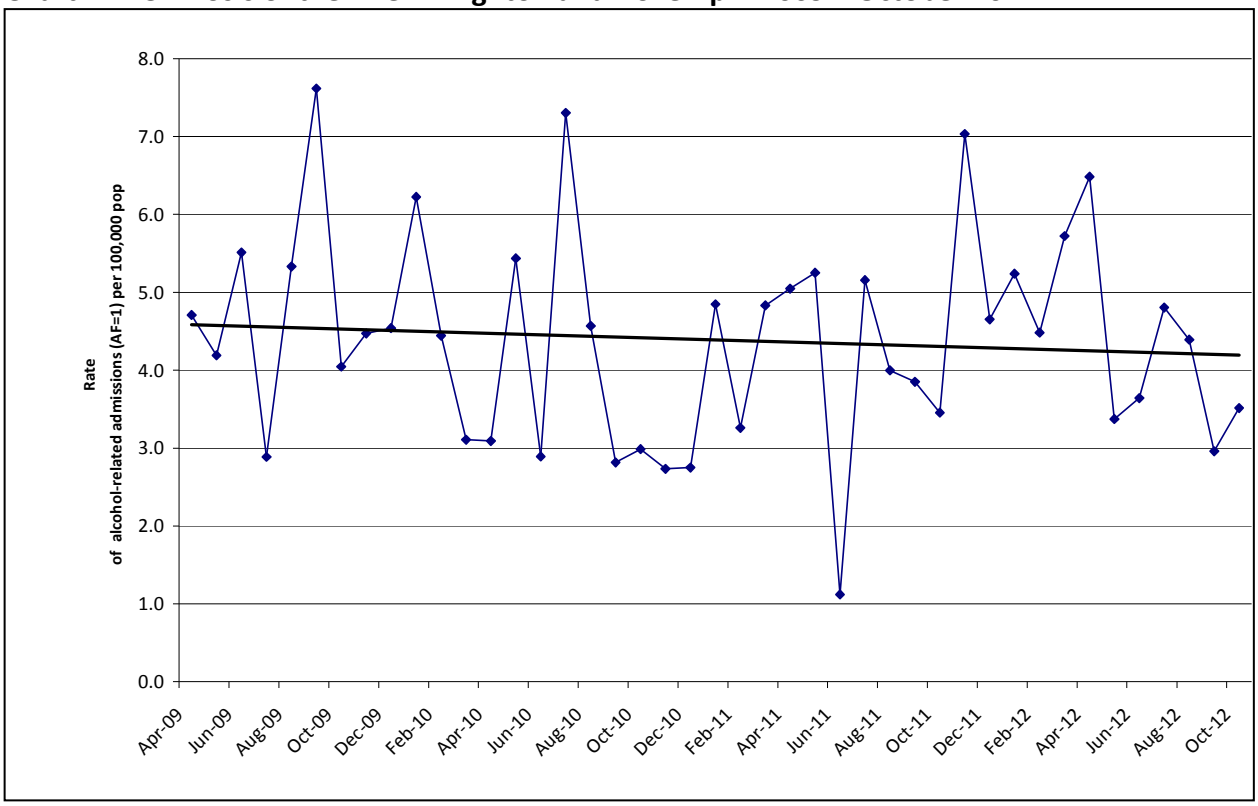
Source: Surrey and Sussex Commissioning Support Unit

Chart 10: Withdrawal State Brighton and Hove April 2009 – October 2012



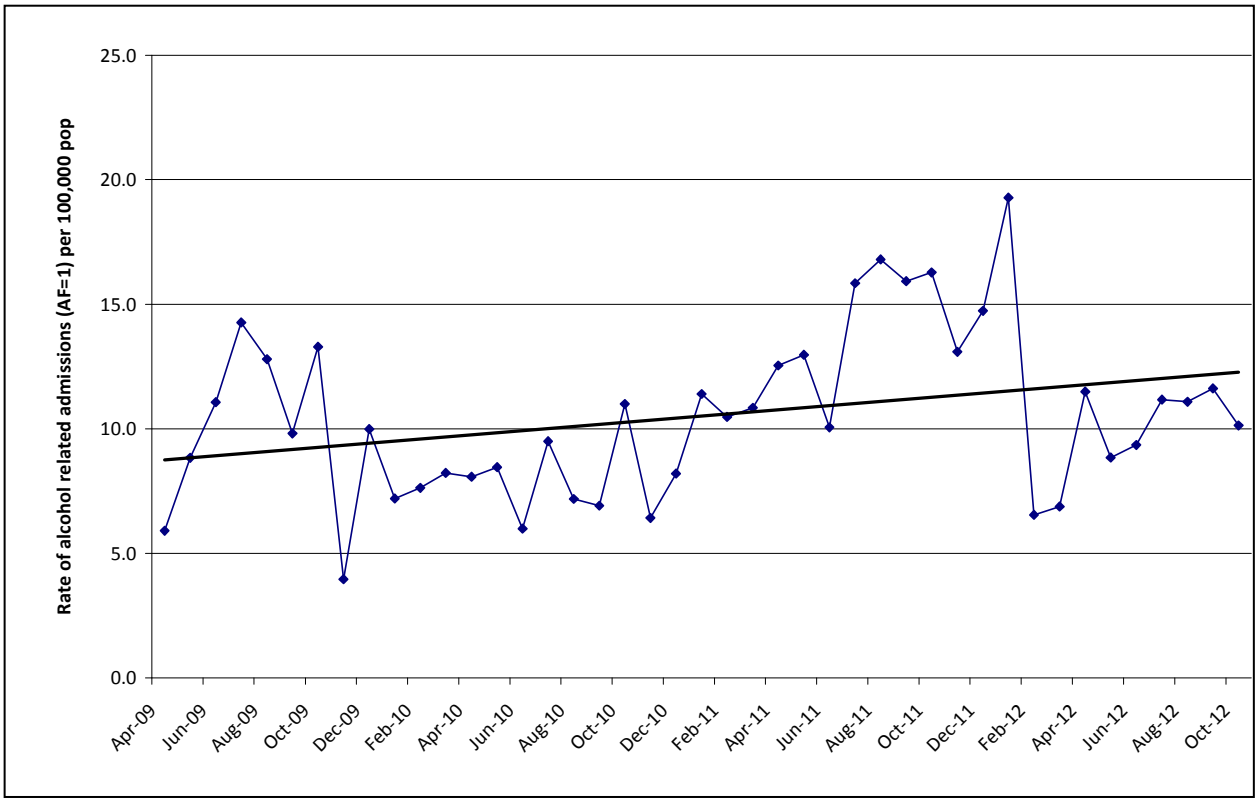
Source: Surrey and Sussex Commissioning Support Unit

Chart 11: Cirrhosis of the Liver Brighton and Hove April 2009 – October 2012



Source: Surrey and Sussex Commissioning Support Unit

Chart 12: Effects of Ethanol



Source: Surrey and Sussex Commissioning Support Unit

6.10 **The Contribution of Repeat Attenders/Admissions to Alcohol Hospital Activity**

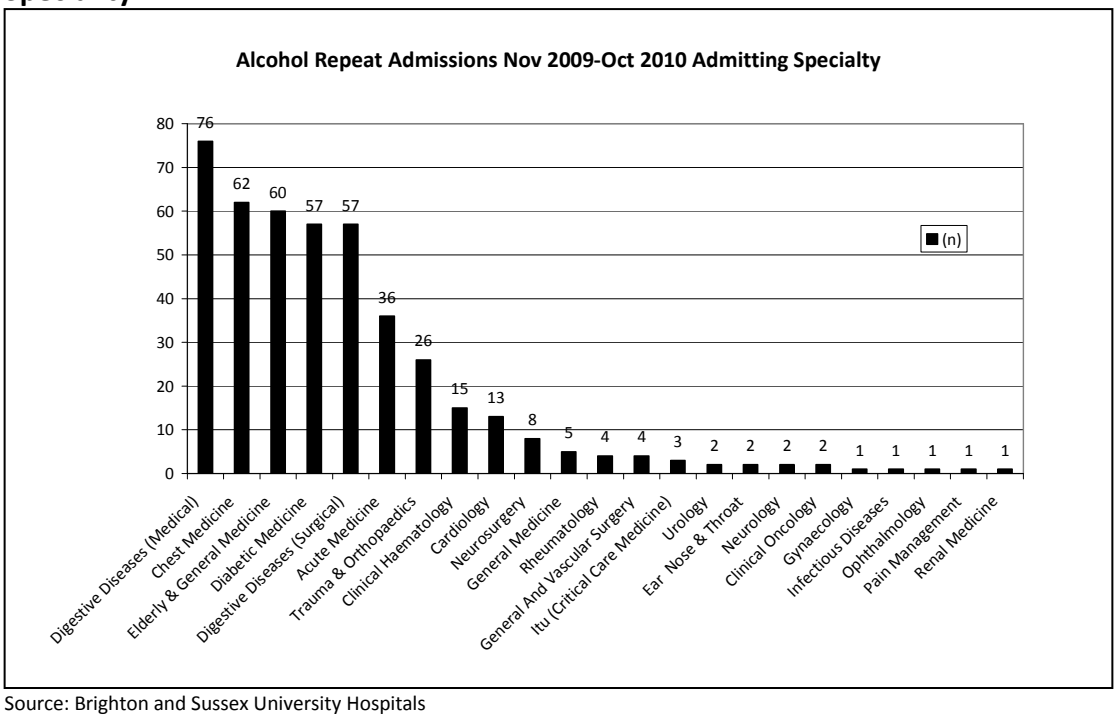
6.10.1 Analysis of alcohol related hospital admissions to the Royal Sussex County Hospital during 2009 identified that 19% of patients admitted with an alcohol related condition were responsible for 41% of all alcohol related admissions. These findings mirrored research from other local authorities[40] who had identified a similar effect whereby a small proportion of patients were disproportionately responsible for a high number of admissions.

6.10.2 Further analysis of this population identified a cohort of admissions attributed to Alcohol Dependency Syndrome. The characteristics of this population differed from those with an alcohol admission related to Acute Intoxication who might have responded to a Brief Intervention. This population was characterised by chronic ill health associated with alcohol use and as such requires more intensive support. The most common admitting speciality for those experiencing repeat admissions was one of the Gastroenterology wards see Chart 12.

6.10.3 A sub-population was identified of twenty-four patients with a diagnosis of dependency syndrome who had had six or more admissions during the sample period, equating to 186 admissions. If the admissions associated with this cohort of patients could be redirected to other services this would generate a reduction of 8% in the overall level of alcohol related admissions. On the basis of this evidence an Assertive Outreach Worker was appointed to intensively support clients presenting with the early signs of dependency.

6.10.4 The routine analysis of this data set against the CAT caseload particularly when compared on a patient-by-patient basis could yield significant intelligence to promote greater community support to this population of dependent drinkers.

Chart 13: Alcohol Repeat Admissions November 2009- October 2010 Showing Admitting Speciality



Source: Brighton and Sussex University Hospitals

[40] Middleborough PCT, F10 Multiple Admissions, 2010

6.11 Summary

6.11.1 Under performance in respect of specific alcohol related mortality was referenced earlier and it is of interest to see that a comparable effect is evident here in respect of hospital admissions

6.11.2 Analysis of alcohol related hospital admissions shows that a small cohort of highly dependent patients over contributing to inpatient activity.

6.11.3 Information about alcohol mortality and hospital related admissions are linked. Residents who die from an alcohol related condition are likely to have had an inpatient stay related to their underlying disease in the years and months prior to their death. The trajectories of hospital activity related to these alcohol related diagnoses may be a predictor of future mortality.

6.11.4 An admission to hospital for an alcohol related condition could also present as an opportunity to intervene to prevent further deterioration in a patient's condition. We also identified earlier that many patients admitted for problems associated with use of alcohol will be known to alcohol treatment services. Evidence presented here therefore identifies the potential for greater integration and synergy between the acute and community sectors which could be facilitated through case record integration on a named patient by patient basis.

7 Alcohol Treatment Population

7.1 Age Gender and Ethnicity

7.1.1 This data in the following section is generated from an extract of those in primary treatment for alcohol during the 18 month period between 1st April 2012 and 30th September 2013 from the Drug and Alcohol Action Team (DAAT) case management system Nebula. Unless otherwise stated all data is drawn from this source. During this time a total of 1,248 clients accessed treatment, totalling 1,353 treatment episodes (105 clients had 2 episodes during this period). Compared with primary drug clients primary alcohol clients are older. The average age of male primary alcohol clients in treatment was 43.18 years compared with 38.8 years for male primary drug clients[41]. The average age of female primary alcohol clients was 42.48 years compared with 36.8 years for primary drug clients.

7.1.2 35% of those being treated for primary alcohol use were female. This compares with the primary drug using treatment population of whom 29% were female during 2012.

7.1.3 Information relating to a client's sexuality was not recorded for nearly 20% of those in treatment during this period. Of those where sexuality was recorded (1,003 records) 13% of clients indicated that they were "homosexual", bisexual or other. Homosexual is used to denote either lesbian or gay clients. It is estimated that between 15-16% of Brighton and Hove's population is LGBT. Transgender is recorded as part of a separate data set and does not relate to sexual orientation and is therefore not included in this analysis. The proportion

[41] Substance Misuse (drugs) Needs Assessment 2013-14 clients in treatment during the calendar year 2012.

of alcohol clients who are LGB is outside the expected ranges for this population. However, given that data was only collected for 80% of those in treatment this finding should be viewed with caution.

Table 12: Sexuality of those in Alcohol Treatment 1st April 2012 - 30th Sept 2013

Sexuality	**(n)**	***%***	
Heterosexual	872	*86.9%*	
Homosexual	111	*11.0%*	*12.9%*
Bisexual	12	*1.09%*	
Other	8	*0.79%*	
	1003		
Not recorded	*245*	*19.6%*	
	1248		

Source: Nebula Case Management System

7.1.4 The table below compares the ethnicity of clients in alcohol treatment locally with that of the national alcohol treatment population. Though the discrepancy between individual ethnic groups locally and national populations is small the overall effect is to generate under-representation equating to 62.2 individuals (5%) of those in treatment during the 18 month measurement period (equating to 41 individuals per annum).

7.1.5 Under-representation within the alcohol treatment population exists amongst populations drawn from the White Irish, White and Black Caribbean, White and Asian, Indian, Pakistani, Bangladeshi, Other Asian, Caribbean, Other Black and Chinese communities.

Table 13: Ethnicity of those in Alcohol Treatment April 2011-September 2013 Compared with the Ethnicity of the National Alcohol Treatment data set 2012-13

	(n)	**%**	% from NDTMS (Alcohol) 2012-13	Difference
White British	1110	88.90%	87.5%	1.44%
White Irish	17	1.40%	1.7%	-0.32%
Other White	46	3.70%	2.7%	1.02%
White and Black Caribbean	4	0.30%	0.6%	-0.33%
White and Black African	15	1.20%	0.2%	1.02%
White and Asian	0		0.2%	-0.24%
Other Mixed	10	0.80%	0.4%	0.42%
Indian	1	0.10%	1.1%	-1.02%
Pakistani	1	0.10%	0.3%	-0.24%
Bangladeshi	0		0.1%	-0.12%
Other Asian	4	0.30%	0.6%	-0.29%
Caribbean	2	0.20%	0.6%	-0.44%
African	10	0.80%	0.6%	0.20%
Other Black	4	0.30%	0.6%	-0.26%
Chinese	0		0.0%	-0.02%
Other	7	0.60%	0.6%	0.04%
Not Stated	*17*	1.40%	2.1%	-0.70%
Inconsistent/Missing	0	0%	1.0%	-1.00%

Source: Nebula Case Management System

7.1.6 Looking at a similar analysis for the alcohol treatment population compared with the ethnicity of the adult (aged over 18 years) population for the City there would appear to be an overall discrepancy equating to 87 BME clients per annum missing from treatment.

Table 13a: Ethnicity of those in Alcohol Treatment April 2011-September 2013 Compared with the Ethnicity of Brighton and Hove from the 2011 Census (adults aged over 18 years)

	1st April 2012-30th September 2013				
Ethnicity	**(n)**	**%**	**Census 2011 Aged Over 18 years**	**Difference**	**Alcohol Treatment Population with Census Estimates Applied**
White British	1110	88.9%	80.8%	8.12%	1008
Other White	46	3.7%	7.8%	-4.12%	98
White Irish	17	1.4%	1.60%	-0.20%	20
White and Black African	15	1.2%	0.4%	0.78%	5
Other Mixed	10	0.8%	0.8%	0.02%	10
African	10	0.8%	1.0%	-0.25%	13
Other	7	0.6%	1.4%	-0.83%	18
White and Black Caribbean	4	0.3%	0.5%	-0.21%	6
Other Black	4	0.3%	0.2%	0.15%	2
Other Asian	4	0.3%	1.2%	-0.93%	15
Caribbean	2	0.2%	0.4%	-0.16%	5
Pakistani	1	0.1%	0.2%	-0.13%	3
Indian	1	0.1%	1.2%	-1.09%	15
White and Asian	0		0.8%	-0.84%	11
Chinese	0		1.1%	-1.15%	14
Bangladeshi	0		0.4%	-0.37%	5
Not Stated	*17*	*1.4%*		*1.40%*	*0*
Inconsistent/Missing	*0*	*0.0%*		*0.00%*	*0*
Total	**1248**				

Source: Nebula Case Management System ONS Census 20111

*No alcohol clients were recorded as White and Asian, Chinese, or Bangladeshi .

7.2 Parental Status, Housing, Employment

Table 14: Recorded Parental Status of Clients in Primary Alcohol Treatment 1st April 2012 – 30th September 2013

	(n)	%
Not a parent	652	*50.6%*
None of the children live with client	407	*31.6%*
All the children live with client	174	*13.5%*
Some of the children live with client	50	*3.9%*
Client declined to answer	3	*0.2%*
Other	1	*0.1%*
Not recorded	*1*	*0.1%*
	1288*	

Source: Nebula Case Management System

*40 clients had more than one treatment episode during this period during which time their parental status changed.

7.2.1 Children are defined as being aged under 18 years. 49% of those in treatment were a parent but only 17% of clients lived with all or some of their children.

7.3 Housing Status

Table 15: Housing Status Clients in Primary Alcohol Treatment 1st April 2012 – 30th Sept 2013

	(n)	%
Private rented	405	*31.1%*
Owned property	253	*19.4%*
Local Authority (LA) Registered	214	*16.4%*
Settled with friends/family	117	*9.0%*
Supported housing/hostel	89	*6.8%*
Direct access short stay hostel	71	*5.4%*
Social Landlord (RSL) rented	67	*5.1%*
Staying with friends/family as a short term guest	26	*2.0%*
Live on the streets	25	*1.9%*
Short term B&B or other	18	*1.4%*
Sleep on different friends floor each night	13	*1.0%*
Approved premises	2	*0.2%*
Traveller	1	*0.1%*
Squatting	1	*0.1%*
Not recorded	*1*	*0.1%*
	1303	

Source: Nebula Case Management System

*the housing status of 55 clients changed during this period

When compared with the housing status of clients in drug treatment primary alcohol
7.3.1 clients are more likely to rent privately (31%) compared with 22% of drug treatment clients. 19% of primary alcohol clients own their own property compared with 4% of drug clients. Alcohol clients are less likely to live in Local Authority Registered accommodation (16%) compared with 30% of drug clients.

7.3.2 Analysis from housing services shows that 138 tenants living in bands 2 and 3 housing[42] had alcohol problems. This was an increase of 22% from 138 to 169 between 2010/11 and 2011/12.

7.3.3 Preliminary findings from an audit of members of the homeless community[43] indicated that a third (33%) were in recovery from or had current problems with their use of alcohol.

7.4 Employment

7.4.1 A higher proportion of primary alcohol clients are in regular employment (28%) compared with those being supported for primary drug use (13%). The proportion of clients unemployed and seeking work is broadly comparable between the two treatment populations (primary drug clients 32%, alcohol clients 36%).

Table 16: Employment Status of Clients in Primary Alcohol Treatment 1st April 2012 – 30th September 2013

	(n)	%
Unemployed and seeking work	462	*36.3%*
Regular Employment	363	*28.5%*
Long term sick or disabled	236	*18.5%*
Retired from paid work	60	*4.7%*
Other	38	*3.0%*
Homemaker	34	*2.7%*
Not receiving benefits	25	*2.0%*
Pupil/Student	20	*1.6%*
Not known	20	*1.6%*
Unpaid voluntary work	8	*0.6%*
Unemployed	4	*0.3%*
Not stated/missing	4	*0.3%*
	1274*	***100.0%***

Source: Nebula Case Management System

* the status of 48 clients changed over this period

7.5 Dual Diagnosis

7.5.1 In 2011 National Institute for Health & Clinical Excellence published guidance[44] that

[42] Band 2 is high support accommodation with 24 hour staffing and intensive support Band 3 is step down accommodation, independent flats and shared houses with several support hours a week.

[43] Homeless Health Needs Audit, Brighton and Hove City Public Health Department, 2013

[44] Psychosis with coexisting substance misuse assessment and management in adults and young people, National Clinical Guideline Number 120, National Collaborating Centre for Mental Health commissioned by the National Institute for Health & Clinical Excellence published by The British Psychological, 2011

included the assessment and management of adults and young people with a dual diagnosis, including those co-presenting with mental health and problematic alcohol use. During the 18 months 1st April – 30th September 2013 128 clients, 10% of those in treatment for primary alcohol use had a dual diagnosis. This is a lower proportion than within the primary drug using population (13%). Of those with this condition 73 were female and 55 male. Women are over-represented amongst those clients with a dual diagnosis.

7.6 Primary Drug Clients use of Alcohol

7.6.1 Data from the 2012-13 Substance Misuse (Drugs) Needs Assessment showed that 7% of primary drug clients were using alcohol as a second or third substance in addition to their main drug.

7.6.2 Similarly, one hundred clients (8% of those in alcohol treatment) being supported for primary alcohol use (1st April 2012 – 30th September 2013) had previously been drug injectors (90) or were currently injecting (10). This finding indicates the need identified through the audit of overdoses[45] that some primary alcohol clients could benefit from access to a Naloxone mini-jet and also the over-lapping nature of substance misuse as experienced by our local population.

7.7 Summary

7.7.1 The typical male and female primary alcohol user is older than their primary drug using contemporaries. Over a third of primary alcohol clients are female. BME communities are almost universally under-represented amongst the alcohol treatment population.

7.7.2 Information about a client's sexuality was recoded for 80% of clients and indicated that 13% of those in primary alcohol treatment were LGB. It is estimated that between 15-16% of the City's population is LGBT. As such there is probably under-representation of this community within the alcohol treatment population.

7.7.3 10% of clients had a dual diagnosis and as such are likely to present with more complex needs.

7.7.4 7% of clients currently in treatment for their primary use of drugs had alcohol recorded as a second or third problem substance. Similarly, 8% of clients currently in alcohol treatment had a history of drug use.

7.7.5 17% of alcohol clients live with children. Half of alcohol clients (50%) either rent privately or own their own home. Over a quarter of those in treatment for alcohol (28%) are in regular employment.

7.7.6 Some of the problems of under-representation evident within the drug treatment population exist for those being supported for their use of alcohol. However, a higher proportion of alcohol clients in treatment are in stable housing, which provides evidence of inherent recovery capital.

8 Treatment Activity

8.1 The table below shows activity across a two year period for new presentations and the total number of primary alcohol clients. Between the two measurement periods

[45] Opiate Overdoses January - October 2012, Brighton and Hove Drug and Alcohol Action Team, 2012

the number of clients in contact with treatment services increased by 11% (90 clients).

Table 17: 2011-2013 Alcohol Treatment Activity

Year	Number of alcohol clients in contact with treatment services in the last 12 months rolling 12 month figure
2012-13	932
2011-12	842

Source: Alcohol Treatment Data Executive Summary

8.2 **Time in Treatment**

8.2.1 During the 18 months 1st April 2012 – 30th September 2013 there were a total of 1,248 individual clients in contact with treatment services of whom 65% were referred into treatment during the measurement period.

Table 18: Treatment Map 1st April 2012- 30th September 2013

1,248 clients (1,353 episodes)		
326 in treatment as at 1st April 2012	817 new referrals	105 re-presentations (during this period)
26%	*65%*	*8%*

Source: PHE Alcohol Needs Assessment 2012-13

8.2.2 The information on the following sections is taken from a data extract of activity from the Nebula Case Management System. The table overleaf shows a "snapshot" profile of clients in contact with alcohol treatment services during the 18 months 1st April 2012 – 30th September 2013.

8.2.3 46% of those in treatment had been in contact with the service for three months or less.

Table 19: Time In Treatment for Clients in Treatment 1st April 2012 – 30th September 2013

	(n)	*%*
2 years +	38	*2.8%*
2 years	35	*2.6%*
Up to 18 months	76	*5.6%*
Up to 1 year	25	*1.8%*
Up to 11 months	30	*2.2%*
Up to 10 months	32	*2.4%*
Up to 9 months	39	*2.9%*
Up to 8 months	70	*5.2%*
Up to 7 months	79	*5.8%*
Up to 6 months	83	*6.1%*
Up to 5 months	129	*9.5%*
Up to 4 months	101	*7.5%*
Up to 3 months	143	*10.6%*
Up to 2 months	165	*12.2%*
Up to 1 month	162	*12.0%*
less than a month	146	*10.8%*
	1353	

Source: Nebula Case Management System

8.3 **Discharges**

8.3.1 71% of the treatment population (n=889) left treatment during the 18 month measurement period. Nearly 60% of those leaving treatment did so in a planned way.

Table 20: Summary of Discharges for those in Treatment 1st April 2012- September 2013

	(n)	%
Planned	530	59.6%
Unplanned	359	40.4%
	889	**100.0%**

Source: Nebula Case Management System

Table 21: Details of Discharges for those in Treatment 1st April 2012- September 2013

	(n)	%
Treatment completed - alcohol free	417	46.9%
Incomplete - dropped out*	278	31.3%
Treatment completed - occasional user	104	11.7%
Incomplete - *treatment commencement declined by client**	47	5.3%
Incomplete - treatment withdrawn by provider*	12	1.3%
Incomplete - client died*	10	1.1%
Treatment completed - drug free	9	1.0%
Transferred - not in custody*	5	0.6%
Transferred - in custody*	4	0.4%
Incomplete - retained in custody*	3	0.3%
	889	

Source: Nebula Case Management System

* Unplanned discharges

8.3.2 The table above shows that 31% of those leaving treatment "dropped out". Data from Public Health England[46] for Brighton and Hove during 2012-13 indicated 59% of all exits from treatment were successful compared with 63% for the national data set.

8.3.3 Of the 530 clients who were discharged from treatment in a planned way during this 18 month period (1st April 2012-30th September 2013) 59 clients (11%) had re-presented to treatment within this time scale. 14 of the 59 had been discharged as "occasional users" with the remainder discharged alcohol free.

[46] Alcohol and drugs: JSNA Support Pack, key data to support planning for effective alcohol prevention, treatment and recovery: Brighton and Hove, 2012-13.

Table 22: Alcohol Re-presentations Across the 18 month period 1st April 2012 – 31st Sept 2013

Clients with a planned discharge re-presenting to treatment	(n)
Less than a month	4
Less than 2 months	4
Less than 3 months	6
Less than 4 months	4
Less than 5 months	7
Less than 6 months	7
Less than 7 months	3
Less than 8 months	9
Less than 9 months	4
Less than 10 months	2
Less than 11 months	1
Less than 12 months	2
Over a year	6
Total	**59**

Source: Nebula Case Management System

8.3.4 Additionally, of the 359 clients who had an unplanned discharge 45 (12%) of these clients had re-presented to treatment within the 18 month measurement period. In total of all those leaving treatment during this 18 month period 12% (104/889) had re-presented to treatment during this 18 month period. This is comparable to the 10% representation rate for alcohol clients who successfully completing treatment and re-presenting to treatment during Quarter 2 2013-14.

8.4 **Findings from the Alcohol Profiling Tool**

8.4.1 The Alcohol Profiling Tool analyses new treatment journeys for clients commencing treatment during 2012/13. The tool enables comparison between local and national populations in respect of volume of consumption in the 28 days prior to commencing treatment and compounding (aggravating) factors such as use of drugs, more than three treatment journeys etc.

Table 23: Number of Units Consumed per Month ('month' = the 28 days prior to initial assessment) Brighton and Hove and England

	Brighton and Hove		National		Difference
	No.	%	No.	%	
Missing	0	0	1692	2%	-2%
0	37	6%	5400	7%	-1%
1-199	87	14%	13535	18%	-4%
200-399	128	21%	13914	18%	3%
400-599	143	24%	14508	19%	4%
600-799	74	12%	8967	12%	0%
800-899	56	9%	7045	9%	0%
1000+	81	13%	10545	14%	-1%
Total Clients (new journeys)	**606**	**100%**	**75606**	**100%**	

Source: PHE Alcohol Profiling Tool 2012-13

8.4.2 Brighton and Hove has a higher proportion of clients in the median band consuming between 200-599 units

8.4.3 Some clients recorded as consuming no units will have been engaged with treatment as part of relapse prevention. All of those in treatment during this period were consuming alcohol at Higher Risk levels (regularly drinking more than 6 units a day or over 35 a week for women and 8 units a day or over 50 units a week for men).

Table 24: Compounding Factors Brighton and Hove and National

	Brighton and Hove		National		Difference
	No.	**%***	**No.**	**%**	
OCU 2nd or 3rd Drug	**18**	***3%***	**3184**	***4%***	-1%
Other 2nd or 3rd Drug	**69**	***11%***	**10569**	***14%***	-3%
3+ Alcohol Treatment Journeys	**79**	***13%***	**12875**	***17%***	-4%
Housing Issue	**76**	***13%***	**10244**	***14%***	-1%
Dual Diagnosis	**47**	***8%***	**14980**	***20%***	-12%
Unemployed	**383**	***63%***	**45400**	***60%***	3%
CJS Referral	**9**	***1%***	**4856**	***6%***	-5%
Living with Children	**117**	***19%***	**21521**	***28%***	-9%
Pregnant	**2**	***0%***	**353**	***0%***	0%
Has also had a Primary Drug Journey	**36**	***6%***	**7712**	***10%***	-4%

Source: PHE Alcohol Profiling Tool

** % displayed as the proportion of clients who meet each complexity item, clients may score more than 1 complexity item, therefore % may total more than 100%*

8.4.4 Brighton and Hove alcohol treatment population appears to have fewer compounding factors across eight of the ten indicators. The number of pregnant women in treatment is comparable with the national data set. Unemployment appears to be the only compounding factor where Brighton and Hove is performing less well.

8.4.5 Locally clients in alcohol treatment are more likely to have two or fewer compounding factors compared with the national data set.

Table 25: Number of Compounding Factors Scored by Client

	Brighton and Hove		National		Difference
	No.	**%**	**No.**	**%**	
0	**118**	***19%***	**11082**	***15%***	5%
1	**227**	***37%***	**23737**	***31%***	6%
2	**187**	***31%***	**22363**	***30%***	1%
3	**62**	***10%***	**12221**	***16%***	-6%
4+	**12**	***2%***	**6203**	***8%***	-6%

Source: PHE Alcohol Profiling Tool

8.4.6 This would appear to indicate that clients in alcohol treatment in Brighton and Hove have fewer compounding (aggravating) factors and as such potentially more recovery capital.

8.5 **Summary**

8.5.1 The number of clients in treatment is increasing. The alcohol treatment population is characterised by a much more dynamic flow of referrals and discharges when compared with the drug treatment population. 46% of clients

were in treatment for less than three months and 71% of those in treatment during the 18 month measurement period left treatment during this time.

8.5.2 31% of clients leaving treatment dropped out. Locally 66% of those completing treatment re-presented within six months.

8.5.3 As was seen earlier in respect of housing and employment status locally the treatment population has inherent recovery capital. This is also evidenced in respect of the low frequency of compounding factors presented here.

9 Street Drinkers

9.1 A count of the street drinking population in 2013 by Equinox identified a population of 93 individuals. For the purposes of this count, a street drinker is defines as: 'a member of the street community who drinks alcohol in public areas in groups or alone'. In order to establish the degree of integration between the Street Drinking population and substance misuse treatment services the two data sets were compared[47]. 43 of the 93 clients (46%) recorded on the Count were in treatment at the time of this review which took place six months after the count on 9th January 2013.

9.2 Some members of the street drinking population are more visible/prominent than others. The researchers who conducted the count categorised the population in to three groups: high profile, lower presence and those who were only seen on the day of the count. The table below shows the participants status and whether they were in treatment. A third of those included within the count were not known to Equinox before the count took place and a third were lower profile and a third were considered high profile.

Table 26: Street Drinkers by Profile Category and Treatment Status

Status	(n)	In treatment	% in Treatment
High Profile	33	21	63.60%
Lower Presence	24	13	37.50%
Only seen on count	36	9	25.00%
Total	**93**	**43**	

Source: Equinox Brighton and Hove 2013 and DAAT Nebula Case Management

9.3 Half of the high profile clients included in the count were hostel residents, a third were sleeping rough and the remainder were in B&B accommodation. Interestingly though the inclusion criteria for those taking part in the Count was being a Street Drinker most of those known to treatment were being supported for their primary drug use.

[47] Information was securely shared between services. Names (first and second) were recorded for the Street Drinking population. Dates of birth were not recorded for this population. Errors may have occurred when different clients with the same name were listed on both the Street Drinking list and within the substance misuse case record system.

Table 27: Clients Primary Substance on Last/Current Treatment Journey

Substance	(n)	%
Heroin illicit	30	66.7%
Alcohol unspecified	8	20.5%
Methadone unspecified	3	7.7%
Other Opiates	1	2.6%
Methadone prescription	1	2.6%
	43	

Source: Equinox Brighton and Hove 2013 and DAAT Nebula Case Management

9.4 Those within this population who had accessed substance misuse services had been in treatment for much longer than the wider treatment population[48] with 59% of the Street Drinking primary drug users in treatment for more than 6 years, compared with 20% of the wider treatment population. Similarly, when we compare the number of treatment episodes that the Street Drinking population had experienced with that of the wider treatment population a distinct difference occurred between these two groups. Within the wider treatment population 27.3% of clients had had 3 or more treatment episodes. But for the Street Drinking cohort over half (58%) had had 3 or more episodes of treatment.

9.5 **Summary**

9.5.1 The 2012 street count identified 93 individual street drinkers. Of whom 43 were in treatment at the time of this review. Half of the street drinkers identified as high profile were hostel residents. Analysis of the substance misuse activity associated with this population indicates that though identified as street drinkers the majority of those in contact with substance misuses services were being supported for their drug use. The treatment profile of those known to substance misuse services indicates a long treatment history and a high number of treatment episodes. As such this group present as high intensity users of substance misuse services.

10 Alcohol Support in Primary Care Locally Enhanced Services

10.1 In Brighton and Hove there are a total of 47 surgeries, of which 32 are signed up to deliver the Locally Enhanced Service (LES) for Alcohol (LES62). Alcohol screening of newly registered clients forms part of the LES. Screening in primary care has the potential to acting as a gateway into treatment[49].

10.2 Activity for quarter one 2013-14 shows that of the 32 surgeries in the City signed up to deliver the LES, 26 practices provided screening interventions.

10.3 Screening activity relates to the number of FAST screening questionnaires used with newly registered patients aged over 16 and patients consulting with at risk clinical presentations as well as opportunistic screening (e.g. chronic disease management reviews, maternity bookings, travel clinics, 15 year boosters and contraceptive advice sessions) and those patients who express concern

[48] Drug Treatment Population as at October 2012.

[49] National Institute for Health and Social Care Excellence Alcohol-use disorders: preventing harmful drinking, Issued : June 2010 NICE public health guidance 24 guidance.nice.org.uk/ph24

themselves about their use of alcohol.

Table 28: LES 62 Alcohol Screening and Brief Interventions in Primary Care

	Interventions (n)
Screenings	4081
Brief interventions	272
Extended brief interventions	23
6 month follow up	0
Annual retainer (one per year)	9

Source: Brighton and Hove Public Health

10.4 Of the 295 interventions delivered 8% of this population (23) received in an extended brief intervention based on scoring 3 or more on the FAST. This comprised a course of six sessions of 1-1 support. Also during this period a member of staff from 9 practices attended the Health Promotion run "Supporting Behaviour Change" course (and provided evidence of cascading this learning) in addition to attended the "Alcohol Update" course.

10.5 Applying the number of screenings to the number of newly registered patients per practice enables greater understanding of the proportion of eligible patients who have been screened. Looking at performance for all the practices who submitted activity in total 4,081 initial screenings were completed over this three month period equating to 76% of all the newly registered patient population[50].

10.6 Looking at individual practice activity 14 were successful in screening in excess of 70% of their newly registered patients during this quarter, while four practices screened less than 5% of newly registered patients.

10.7 **Summary**

10.7.1 Of the 47 general practices in Brighton and Hove 32 are signed up to provide additional alcohol support to their patients via the Locally Enhanced Service 62 specification.

10.7.2 Of the 32 LES practices 27 submitted a data return for the July-September 2013 period and just over half (14) had screened in excess of 70% of their newly registered patients. Some practices were performing less well with 4 practices screening less than 5% of newly registered clients. This effectively equates to 1,298 newly registered patients with LES practices who could have received an alcohol screen. Additionally patients accessing care from non LES surgeries may not have had the opportunity to complete a screen.

11 Child Protection and Safeguarding

11.1 Children may have a Child Protection Plan (CPP) for more than one reason. Hence the proportions below total more than 100%. The proportion of children with a (CPP) as a consequence of their parental alcohol misuse increased over

[50] Some practice provided screenings in excess of the number of newly registered patient population indicating that they were screening those considered at risk too.

the four monitoring periods January 2011 to December 2013.

11.2 Up to February 2013 the absolute number of children affected by parental alcohol misuse remained approximately the same: between 62-65. However, by the end of the year this figure had increased to a total of 88 children. The overall number of Children with a CPP increased by 25% between February and December 2013. The proportion of children who had a CPP related to Parental Alcohol Misuse increased by 40% across the same period.

Table 29: Children with a Child Protection Plan 2011, 2012 and 2013

Underlying Cause	**Jan-11**		**Feb-12**		**Feb-13**		**Dec-13**	
	Count	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**
Physical Care /Neglect Issues	162	40.3%	124	36.7%	73	29.0%	86	27.3%
Domestic Violence/Abuse	137	34.1%	169	50.0%	141	56.0%	172	54.6%
Parental MH Problems	80	19.9%	79	23.4%	56	22.2%	78	24.8%
Parental Alcohol Misuse	**65**	**16.2%**	**62**	**18.3%**	**63**	**25.0%**	**88**	**27.9%**
Emotionally unavailable/inappropriate expectations of child	50	12.4%	68	20.1%	60	23.8%	75	23.8%
Adult Convicted/Cautioned/Alleged - Physical Abuse	47	11.7%	43	12.7%	52	20.6%	68	21.6%
Parental Drug Misuse	**42**	**10.4%**	**58**	**17.2%**	**43**	**17.1%**	**57**	**18.1%**
Non Compliance with Health Care Advice/Treatment	36	9.0%	22	6.5%	5	2.0%	23	7.3%
Parental Learning Difficulties	20	5.0%	20	5.9%	7	2.8%	5	1.6%
Adult Convicted/Cautioned/Alleged - Sexual Abuse	12	3.0%	21	6.2%	34	13.5%	42	13.3%
YP Convicted/Cautioned/Alleged - Sexual Abuse	4	1.0%	3	0.9%	1	0.4%	9	2.9%
Unknown	*11*	*2.7%*	*3*	*0.9%*	*0*	*0.0%*	*0*	*0.0%*
Total	**666**		**672**		**535**		**703**	
Number of Children Subject of a CP Plan	**402**		**338**		**252**		**315**	1

Source: Brighton and Hove Care First

11.3 After Domestic Violence/Abuse, Parental Alcohol Abuse is now the second most common reason for a child to have a Protection Plan (December 2013).

11.4 Safeguarding information does not show whether a parent is in receipt of support for their substance misuse.

11.5 Recent analysis conducted by the Public Health Team identified that whilst the correlation is not strong it can be seen that authorities with higher deprivation/population risk factors (including drug and alcohol use and mental health) tend to have a higher rate of child protection plans/children in care.

11.6 **Summary**

11.6.1 The overall number of children with a CPP increased during 2013. Both the proportion and number of children with a CPP as a consequence of their parent's use of alcohol rose during this period. After Domestic Violence/Abuse, Parental Alcohol Abuse is now the second most common reason for a child to have a Protection Plan (December 2013). The interface with alcohol treatment services is currently not recorded. It isn't therefore possible to see how many of the parents identified as in need of support in respect of their use of alcohol are in contact with treatment services.

12 Families, Friends and Carers of Those Affected by Alcohol

12.1 The National Institute for Care Excellence acknowledged the need to involve families and carers in the treatment of people who misuse alcohol to help support and maintain positive change[51].

12.2 Findings from the UK Drug Policy Commission show that at least 1.5m adults in the UK are affected by a relative's drug use. These families experience harms amounting to £1.8 billion per year, and provide support for drug users which would cost the state £750m to provide[52]. Though this data relates to drug harm it is probable that a similar picture presents for alcohol use. Local intelligence for Brighton and Hove has not been compiled in respect of either drug or alcohol harm experienced by family or friends locally.

12.3 One of the support networks available to the family and friends of those affected by substance misuse is the PATCHED service. Anecdotal evidence from the service indicates that over 40% of those in contact were there as a consequence of a friend/family member's alcohol use. Year-on-year PATCHED has seen an increase in those seeking support because of a relative's use of alcohol.

13 Domestic Violence

13.1 As part of the Comprehensive Assessment clients in alcohol treatment are asked a range of questions used to identify Domestic Violence. 31 of those who responded to these questions were female and 19 male. Activity data as at 23rd October 2013 indicated that of the 537 primary alcohol clients in treatment on that date a total of 50 (9%) responded positively to any of the domestic violence questions which are used to identify domestic violence related behaviour. This is comparable with domestic violence amongst the primary drug using population of 9% 105/1,193 for the same measurement period.

14 Military Veterans

14.1 Alcohol consumption has historically been seen as an important part of military life[53]. On accessing treatment clients are asked if they or a member of their family have served in the armed forces. As at 23rd April 2013 7 of those in treatment for primary alcohol use were either themselves ex members of the Armed Forces or the partner of someone who had been in military service.

15 Crime and Disorder

15.1 Within the police crime recording system used by Sussex Police it is possible to record

[51] Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence Issued: February 2011 NICE clinical guideline 115 guidance.nice.org.uk/cg115, February 2011

[52] Quoted in "Supporting families affected by drug and alcohol use: Adfam evidence pack" Adfam 2012.

[53] Military Veterans Health Needs Assessment – Sussex 2012, NHS Sussex, June 2012

information on the implication of alcohol in an incident by indicating whether those involved were or were not "perceived to be under the influence (PUI)", or whether this information is not known. Unfortunately, this data field is only completed in a minority of all police records, but in 2012/13, of those crimes where the 'PUI' field was used, 24% of total crime had a *victim* who was under the influence of either alcohol or both alcohol and drugs at the time of the offence. Similarly, 36% of total crime (where information was recorded) had a *suspect* who was under the influence of either alcohol or both alcohol and drugs.

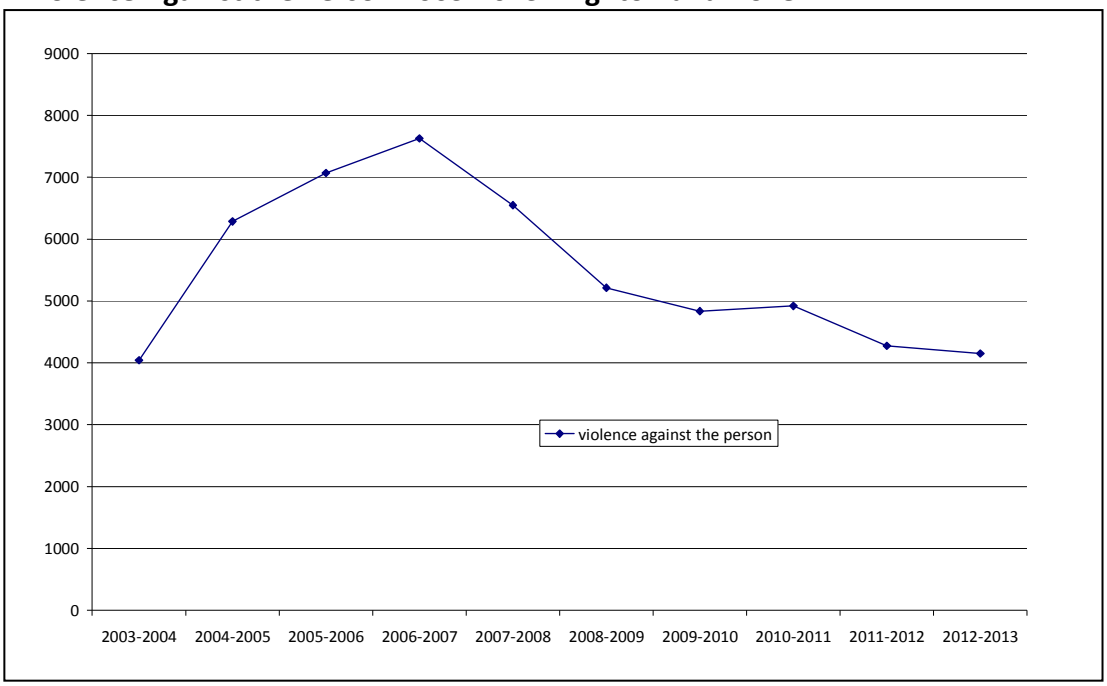
15.2 Looking at particular types of offence the proportion of those "under the influence" is even higher. In the case of injury violence offences 42% of victims and 39% of suspects were under the influence; in domestic violence offences 31% of victims and 43% of suspects under the influence.

15.3 In the absence of complete police records on alcohol-related crimes and incidents, the data reported below is for crimes (violence against the person, sexual offences and criminal damage) where research indicates that alcohol has a contributory role.

15.4 **Violent Incidents**

15.4.1 Findings from the 2011/12 Crime Survey for England and Wales (CSEW) identified that victims believed the offender(s) to be under the influence of alcohol in around half (47%) of all violent incidents. The chart below shows the absolute number of Violence Against the Person offences over the ten year period 2003-2013. The incidence of these crimes peaked in 2006-07 and then trend line subsequent to that period has shown a negative trajectory.

Chart 14: Violence Against the Person 2003-2013 Brighton and Hove



Source: Brighton and Hove Community Safety Team

15.5 Sexual Offences

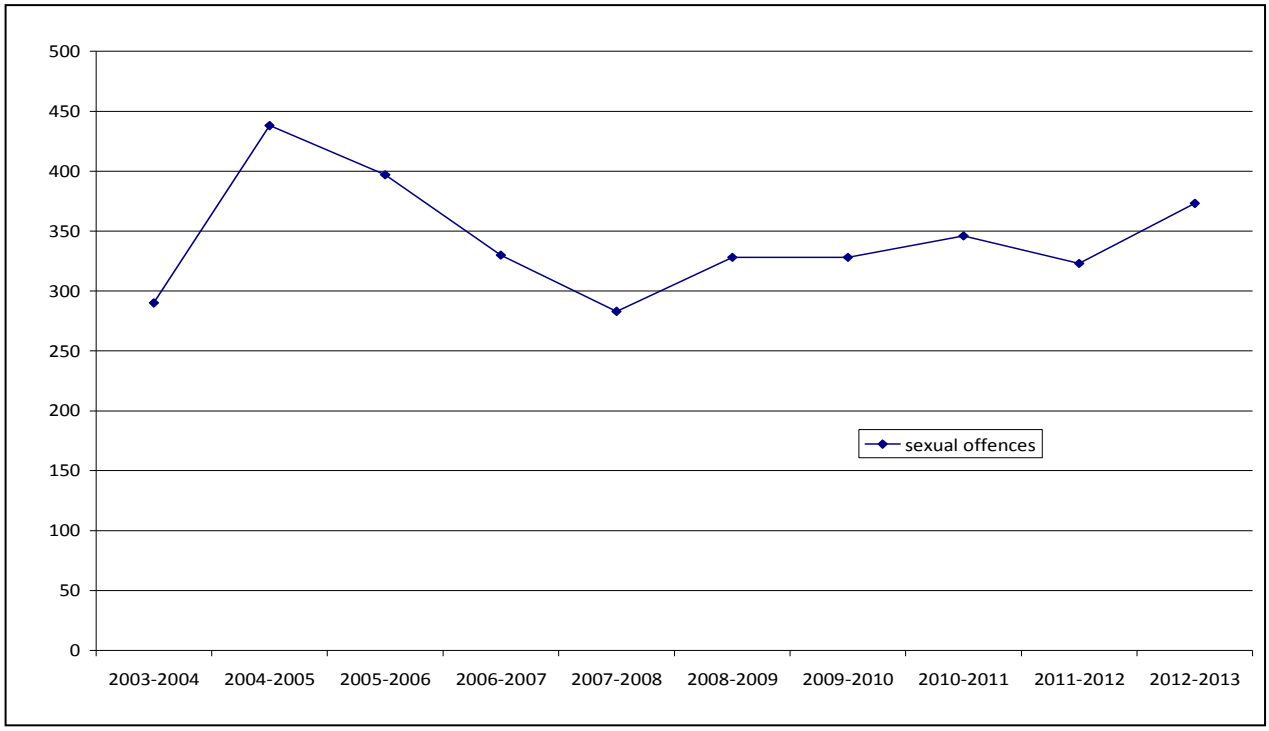
15.5.1 National research indicated that 40% of those who had experienced serious sexual assault since the age of 16 thought the offender was under the influence of alcohol and 13% thought the offender was under the influence of drugs at the time of the incident[54]. Around a third of victims (32%) said they themselves were under the influence of alcohol and 3% were under the influence of drugs at the time of the incident.

15.5.2 Locally, in 2012/13 34% of sexual offences (where information was recorded) had a *suspect* who was perceived under the influence of either alcohol or both alcohol and drugs at the time of the offence. 47% of sexual offences (where information was recorded) had a *victim* who was under the influence of either alcohol, or both alcohol and drugs[55].

15.5.3 The chart below shows the number of police recorded sexual offences since 2003-2013. Sexual offences are a widely underreported offence type, but more recently there has been a rise in reporting, including the reporting of historical offences.

[54] 2011/12 Crime Survey for England and Wales
[55] Crime data: Sussex Police Brighton and Hove 'CADDIE' crime dataset April 2012 – March 2013

Chart 15: Sexual Offences 2003-2013 Brighton and Hove



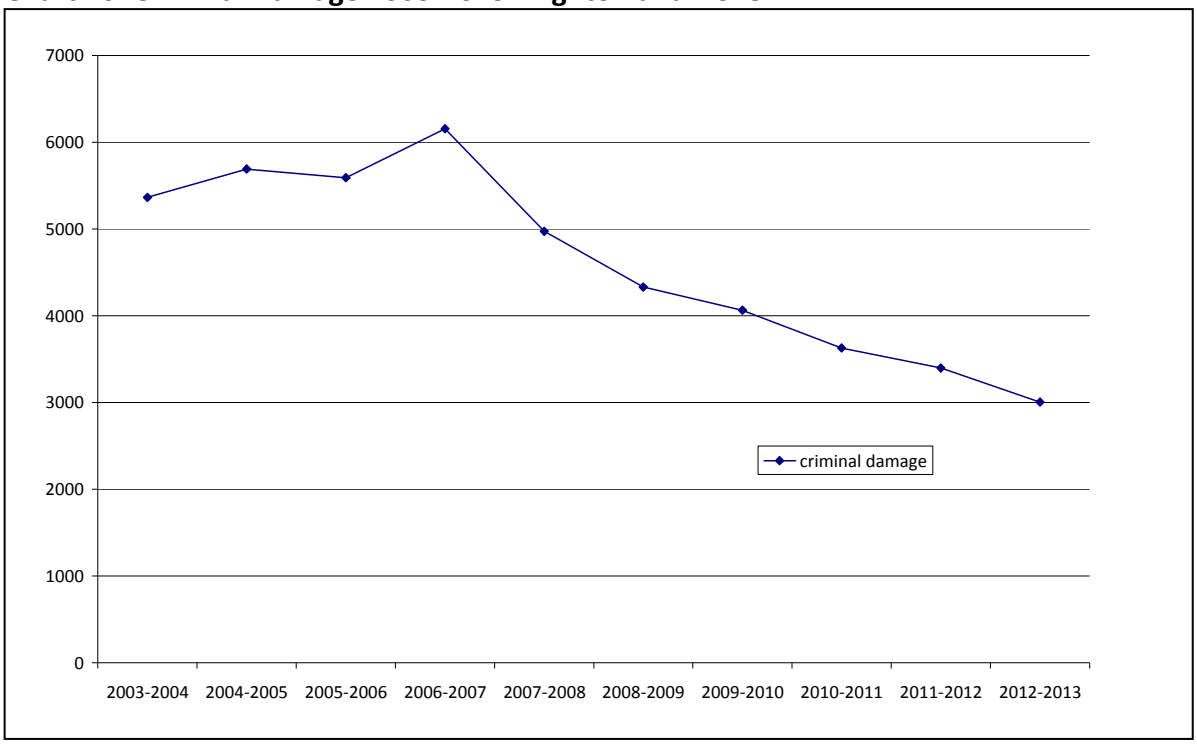
Source: Brighton and Hove Community Safety Team

15.5.4 The number of sexual offences peaked in 2004-2005 and fell to its lowest level in 2007-2008, since which time there has been gradual year-on-year increase.

15.6 **Criminal damage**

15.6.1 Alcohol consumption is also associated with criminal damage offences. We saw earlier that incidents of Violence Against the Person peaked in 2006-07. Incidents of Criminal Damage present in a similar pattern. With a year-on-year fall since 2006-7.

Chart 16: Criminal Damage 2003-2013 Brighton and Hove



Source: Brighton and Hove Community Safety Team

15.6.2 The 2010 Alcohol Needs Assessment[56] reported that in 2010/11 47% of assaults took place in the street and 29% in a dwelling. Analysis showed an assault hotspot covering an area south of Church Street, as far as the seafront, and between Churchill Square to the west and the Old Steine to the east. This demonstrates a clear overlap between assaults and the density of licensed premises.

15.6.3 The 2010 Needs Assessment identified, as might be expected, the incidence of assaults peaks late-night and at weekends. There is a peak on Friday night/ Saturday morning between 23.00hrs and 02.00hrs and another more extended peak on a Saturday night/ Sunday morning between 22.00hrs and 04.00hrs.

15.7 **Public perception of drunk and rowdy behaviour**

15.7.1 Sussex Police conduct an ongoing telephone survey to collect the views of its residents on crime and policing issues. Data for the latest 12 month period (October 2012 – September 2013) show that 5% of those surveyed thought that people being rowdy or drunk was a big or very big problem in their neighbourhood. Perceptions of drunk and rowdy behaviour has on average fallen slightly across the city over the last two years.

[56] Alcohol Intelligent Commissioning Pilot, **Alcohol Needs Analysis, Safe in the City Partnership,2010**

Table 30: Proportion of respondents to the Police Local Neighbourhood Telephone Survey: who thought that people being drunk or rowdy in public places is a "fairly big" or "very big problem"

Measurement Period	12 months to Jun 12	12 months to Mar 13	12 months to Jun 13	12 months to Sep 13
Total Sampled	1550	1610	1519	1374
All Brighton & Hove	***5.9***	***5.5***	***5.1***	***4.9***
East B&H	4.3	3.2	3.2	4.1
Central B&H	10.6	11.2	9.3	8.1
West B&H	2.6	2.2	2.6	2.6

Source: Brighton and Hove Community Safety Team

15.7.2 A higher proportion of residents living in the Central area of the City consistently considered the issue of drunk or rowdy behaviour a problem when compared with those living elsewhere. This finding correlates with the location of incidents of assault detailed earlier.

15.8 **Criminogenic needs of offenders linked to alcohol**

15.8.1 Information from the probation service (for 2011-12 and 2012-13) shows that, where an offender had been given an assessment, about 70% of those who had committed violence against the person or criminal damage offences had identified needs related to their use of alcohol[57].

15.8.2 In Brighton & Hove in the first 6 months of 2013-14, 897 people were screened and 563 assessed via the Criminal Justice Liaison and Diversion Scheme. Of these 139 had identified needs related to alcohol misuse, of whom 41 (29%) were referred to treatment services. Data on presentation and ongoing engagement at services and on outcomes achieved are not currently available[58].

15.9 **Alcohol Treatment Requirements (ATRs)**

15.9.1 Alcohol Treatment Requirements are a community sentence available to the courts. Data from the Brighton probation office, which will predominately support Brighton and Hove residents, shows a steady increase in the use of ATRs. In 2010-11, 21 ATRs were issued, in 2011-12, 55 and in 2012-13, 63. The percentage of Alcohol Treatment Requirements applied to offenders through sentencing which were successfully completed in 2012-13 was 44%, down from 55% in 2011-12[59].

15.10 **Summary**

15.10.1 Alcohol plays a contributory role in the occurrence of violent crime, including sexual offences, and also in other offence types. Both violence against the person and criminal damage offences have fallen since 2006-07. The long term trend in the occurrence of sexual offences is less clear and may be masked by changes in the likelihood that victims report to the police. Most assaults take place in the street or in a dwelling and peak across the weekend, particularly across the late night/early morning period. Offenders whose criminal behaviour is linked with their use of alcohol are being referred to treatment services where needs around alcohol are

[57] Information from OASys assessments sourced locally from Surrey and Sussex Probation Trust
[58] Sussex Health & Criminal Justice Liaison & Diversion Scheme Report, Sep 2013
[59] Locally sourced data from Surrey and Sussex Probation Trust

identified through an assessment. The use of Alcohol Treatment Requirements being assigned as a community sentence at court has been increasing but the number successfully completed fell between 2011-12 and 2012-13.

16 **Alcohol Related Collisions Involving the Person**

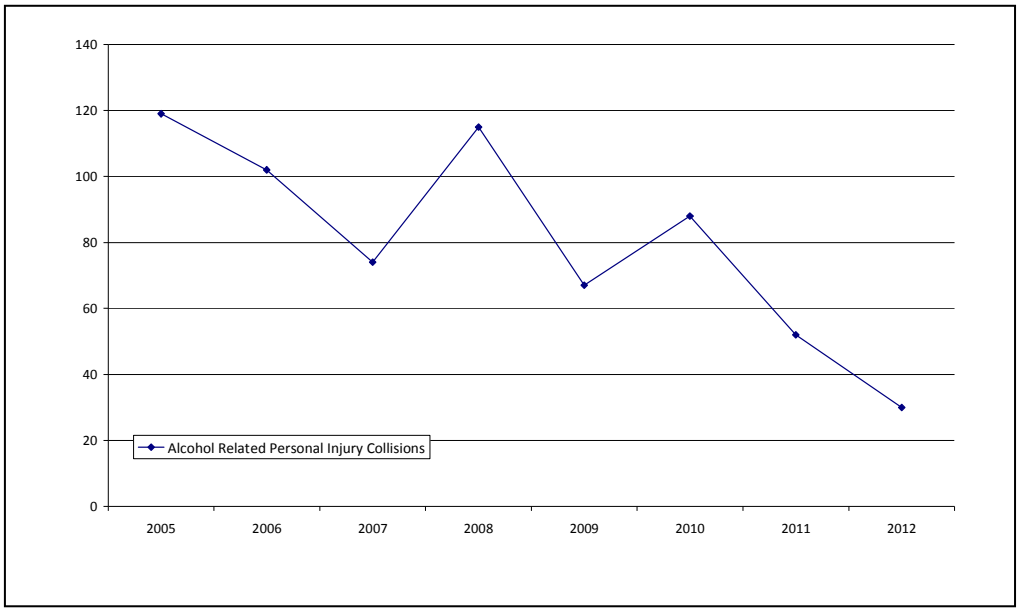
16.1 The activity below details incidents of collisions with vehicles that involved alcohol. The data includes all casualties where either a driver failed a breath test and/or was considered to be impaired by alcohol. It does not include any casualties where the pedestrian was considered impaired. This does not mean that the alcohol-related driver was responsible for the collision, only that they were involved in the incident (though the majority are also the responsible driver). The "Impaired by alcohol" contributory factor can only be used where an officer attended the scene of the collision. It cannot be added if the collision is reported at a later date.

Table 31: Alcohol Related Collisions Involving the Person 2005-2013

	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	**Total**
2005	1	2	3	6	9	10	11	13	15	16	16	17	**119**
2006	1	1	2	4	5	8	8	10	14	15	16	18	**102**
2007	2	3	3	5	5	6	7	7	8	8	9	11	**74**
2008	0	6	6	9	10	10	11	12	12	13	13	13	**115**
2009	0	1	2	2	3	5	7	7	10	10	10	10	**67**
2010	1	1	1	1	2	7	9	9	9	16	16	16	**88**
2011	3	3	4	4	4	4	4	4	5	5	6	6	**52**
2012	0	0	2	2	2	3	3	3	3	3	4	5	**30**

Source: Brighton and Hove City Council

Chart 17: Annual Incidence of Collisions Involving the Person 2005-September 2013



16.2 The number of Alcohol Related Personal Injury Collisions reduced by 75% during the 8 year period 2005-2012 from 119 to 30. Recording may have affected the reduction in these incidents but Road Safety specialists from the City believe that this is a genuine reduction in these incidents. The fall in activity also reflects falls in alcohol consumption since the middle of previous decade evidenced earlier in this report.

17 Fires where alcohol was a contributory factor

17.1 The data below is from East Sussex Fire Brigade. The Fire Service is not able to distinguish between alcohol and drugs as a contributory factor in a fire, so both causal factors are presented together. The data in Table 32 is based on crews identifying in their reports that they suspect alcohol or drugs were a contributory factor and is likely to reflect under-reporting of these incidents.

17.2 Of those incidents were drugs or alcohol were a contributory factor most of these fires were accidental and occurred in a dwelling.

17.3 Activity for this period shows that the total number of fires (irrespective of there being a drug or alcohol contribution) fell by 6% during this period from 543-513. The total number of incidents (32) were drugs or alcohol was considered a contributory factor remained the same between the two measurement periods. Given the overall fall in the number of fires across this period this equates to a slight increase (from 5.9%-6.23%) in the proportion of fires were substance misuse was a contributory factor.

Table 32: Was impairment due to suspected drugs/alcohol a contributory factor in the fire? 2011-12 to 2012-2013

	2011/12	2012/13
Accidental dwelling fires	243	217
Deliberate primary fires	137	155
Other Accidental fires	163	141
Primary fires	**543**	**513**
Total Primary fires D&A contributory factor	**32**	**32**

Source: East Sussex Fire and Rescue

17.4 **Summary**

In total there were 32 fire incidents where drugs or alcohol were considered as a contributory factor in 2012/13. This equates to 6% of all fire incidents. Though the total over all number of fires in the City fell between 2011/12 and 2012/13 the contribution of drugs and alcohol did not fall during this period.

18 Disability Living Allowance Incapacity Benefit (IB) and Severe Disability Allowance (SDA)

18.1 Disability Living Allowance data for May 2013 showed that 0.9% of DLA claimants were doing so because of drug or alcohol use and for the UK as a whole it was 0.7%.

Appendix 1

Table 33: Emergency Alcohol Admissions to Hospital by Diagnosis

Diagnosis		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Tot
Alcoholic cardiomyopathy	09/10	0	0	1	1	1	0	0	2	0	1	1	2	9
	10/11	0	0	1	0	0	0	0	0	0	0	0	0	1
	11/12	1	0	0	0	0	0	0	0	0	1	0	0	2
	12/13	0	1	2	0	0	0	1	0	0	0	0	0	4
Alcoholic cirrhosis of liver	09/10	11	9	12	7	12	18	9	10	10	14	10	7	129
	10/11	7	13	7	17	13	7	7	6	6	11	8	12	114
	11/12	12	13	3	12	9	9	8	15	12	12	11	12	128
	12/13	15	8	9	11	10	8	7	0	0	0	0	0	68
Alcoholic fibrosis and sclerosis of liver	09/10	0	0	0	0	1	0	0	0	0	0	0	0	1
	10/11	0	0	0	0	0	0	1	0	1	3	0	0	5
	11/12	0	0	0	0	0	0	0	0	1	0	0	0	1
	12/13	1	0	1	0	0	0	0	0	0	0	0	0	2
Alcoholic fatty liver	09/10	0	1	0	0	0	0	0	0	0	0	0	1	2
	10/11	0	0	0	0	0	0	0	0	0	0	0	0	0
	11/12	0	0	0	0	0	0	0	0	0	0	0	0	0
	12/13	1	0	1	0	0	0	0	0	0	0	0	0	2
Alcoholic gastritis	09/10	1	1	2	1	1	1	1	1	0	1	0	0	10
	10/11	0	2	2	1	0	0	0	1	0	0	0	1	7
	11/12	0	0	1	2	1	0	0	2	2	0	0	1	9
	12/13	0	1	0	0	2	1	0	0	0	0	0	0	4
Alcoholic hepatic failure	09/10	0	0	0	0	0	0	0	0	1	0	0	0	1
	10/11	0	2	0	0	3	1	0	0	0	0	0	0	6
	11/12	2	1	0	1	0	2	0	0	0	0	0	0	6
	12/13	0	1	0	0	0	0	1	0	0	0	0	0	2
Alcoholic hepatitis	09/10	0	0	6	0	2	0	0	0	0	2	0	2	12
	10/11	1	0	4	6	2	5	2	0	1	1	1	0	23
	11/12	1	4	2	1	4	1	2	0	3	3	0	1	22
	12/13	0	1	0	2	0	1	1	0	0	0	0	0	5
Alcoholic liver disease, unspecified	09/10	2	5	2	3	6	1	12	7	7	7	6	6	64
	10/11	10	9	9	13	16	16	13	7	9	8	6	5	121
	11/12	6	6	4	10	3	6	4	8	10	11	4	7	79
	12/13	8	11	5	9	11	15	8	0	0	0	0	0	67
Alcoholic polyneuropathy	09/10	0	3	0	0	0	0	0	0	0	1	0	0	4
	10/11	0	0	0	0	0	0	0	0	0	0	0	0	0
	11/12	0	0	0	1	0	1	0	0	0	0	0	0	2
	12/13	0	0	1	0	0	0	0	0	0	0	0	0	1
Alcohol-induced chronic pancreatitis	09/10	3	3	5	3	6	4	5	4	4	3	3	1	44
	10/11	4	4	4	8	4	6	2	2	7	1	6	6	54
	11/12	2	3	8	2	5	1	2	5	4	1	3	3	39
	12/13	3	1	4	5	3	1	3	0	0	0	0	0	20
Degeneration of nervous system due to alcohol	09/10	0	0	0	0	0	0	1	0	0	0	0	1	2
	10/11	0	0	0	0	0	0	1	0	1	0	0	0	2
	11/12	0	0	0	0	0	0	2	0	1	1	1	0	5
	12/13	1	0	1	0	1	0	1	0	0	0	0	0	4
Withdrawal state with delirium	09/10	0	0	1	0	0	1	1	0	0	1	0	0	4
	10/11	0	0	1	1	2	0	0	0	1	1	0	1	7
	11/12	0	0	0	0	1	0	0	2	0	0	0	2	5
	12/13	1	0	1	0	1	0	0	0	0	0	0	0	3
Other mental and behavioural disorder	09/10	0	0	0	0	0	0	0	0	0	0	0	0	0
	10/11	0	0	0	0	0	0	1	0	0	0	0	0	1
	11/12	0	0	0	0	0	0	0	1	0	0	0	0	1
	12/13	0	0	0	0	0	0	0	0	0	0	0	0	0
Residual & late-onset psychotic disorder	09/10	0	1	0	0	0	0	2	1	0	0	1	1	6
	10/11	0	0	1	0	0	0	2	0	0	0	0	1	4
	11/12	2	0	0	0	0	1	1	0	0	0	1	0	5
	12/13	0	0	0	0	0	1	0	0	0	0	0	0	1

Unspecified mental behavioural disorder	09/10	1	2	0	0	0	0	0	0	0	0	0	1	4
	10/11	1	0	1	1	0	0	0	0	1	0	0	0	4
	11/12	0	0	0	0	0	1	0	0	0	0	0	0	1
	12/13	0	0	0	0	0	0	0	0	0	0	0	0	0
Acute intoxication	09/10	44	52	53	41	54	47	36	43	29	36	27	32	494
	10/11	47	52	54	60	33	52	42	45	33	35	42	43	538
	11/12	58	40	42	44	61	48	59	48	59	46	30	55	590
	12/13	41	67	43	56	43	53	50	0	0	0	0	0	353
Psychotic disorder	09/10	0	0	0	0	0	1	0	0	0	0	0	0	1
	10/11	1	0	1	2	1	0	1	0	0	0	0	1	7
	11/12	0	1	0	0	0	1	0	1	0	0	0	0	3
	12/13	0	0	0	1	0	0	0	0	0	0	0	0	1
Amnesic syndrome	09/10	0	0	1	1	2	1	0	3	4	0	1	0	13
	10/11	3	1	0	0	4	0	3	3	1	1	2	0	18
	11/12	1	0	1	1	1	1	0	1	0	1	1	0	8
	12/13	1	2	0	1	0	0	0	0	0	0	0	0	4
Dependence syndrome	09/10	41	32	35	52	51	33	36	25	43	44	32	26	450
	10/11	40	28	35	43	28	36	48	41	49	49	66	54	517
	11/12	66	67	67	61	55	61	54	51	52	47	45	59	685
	12/13	63	61	59	64	54	48	57	0	0	0	0	0	406
Harmful use	09/10	40	40	37	34	34	23	33	26	40	31	27	32	397
	10/11	16	21	25	15	27	40	32	22	24	23	27	36	308
	11/12	29	39	31	30	38	33	33	41	32	31	40	25	402
	12/13	27	32	29	40	38	32	48	0	0	0	0	0	246
Withdrawal state	09/10	10	17	16	11	5	11	9	9	7	6	8	8	117
	10/11	12	8	7	11	13	12	12	11	11	14	11	13	135
	11/12	13	15	10	14	10	20	19	10	16	10	7	13	157
	12/13	13	10	19	17	10	9	11	0	0	0	0	0	89
Diagnosis		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Tot
Occurrence at school other instit'n/pub admin area	09/10	0	0	0	0	0	0	0	0	0	0	0	0	0
	10/11	0	0	0	0	0	0	0	0	0	0	0	0	0
	11/12	1	0	0	0	0	0	0	0	0	0	0	0	1
	12/13	0	0	0	0	0	0	0	0	0	0	0	0	0
Occurrence at home	09/10	0	0	0	0	0	0	1	0	0	0	0	0	1
	10/11	0	0	0	0	0	0	0	0	0	0	0	0	0
	11/12	0	0	0	0	0	0	0	0	0	0	0	0	0
	12/13	0	0	0	0	0	0	0	0	0	0	0	0	0
Toxic effect of alcohol, unspecified	09/10	0	0	0	0	0	0	1	0	0	0	0	0	1
	10/11	0	1	0	0	2	1	0	0	0	0	0	1	5
	11/12	0	0	0	0	0	1	1	0	1	2	7	1	13
	12/13	0	2	1	2	0	1	2	0	0	0	0	0	8
Toxic effect of ethanol	09/10	16	24	31	38	35	27	36	11	28	21	21	24	312
	10/11	22	25	18	24	19	16	31	19	24	31	30	29	288
	11/12	36	35	28	45	46	45	45	35	39	53	18	20	445
	12/13	33	24	25	32	30	30	27	0	0	0	0	0	201
Toxic effect of methanol	09/10	0	0	0	0	0	0	0	0	0	0	0	0	0
	10/11	0	0	0	0	0	0	0	0	0	0	0	0	0
	11/12	1	0	0	0	0	0	0	0	0	0	0	0	1
	12/13	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total	09/10	169	190	202	192	210	168	183	142	173	168	137	144	2078
	10/11	164	166	170	202	167	192	198	157	169	178	199	203	2165
	11/12	231	224	197	224	234	232	230	220	232	219	168	199	2610
	12/13	208	222	201	240	203	200	217	0	0	0	0	0	1491