

5. HEALTHY LIFESTYLES

5.7 Substance Misuse in Adults - Alcohol

Substance misuse is defined as the continued misuse of any mind-altering substance that severely affects a person's physical and mental health, social situation and responsibilities^{1,2}. Alcohol dependence is the most common form of substance misuse. The current (January 2016) proposed recommendations in this country for lower-risk alcohol consumption are shown in Box 1. These include the recommendation that the lower-risk limit for men is reduced to 14 units a week from the previous limit of 21 units a week³.

Box 1 Recommended lower-risk limits for alcohol consumption in England

- Men and women should not drink more than 14 units of alcohol a week
- Drinking to this level should be spread over at least 3 days per week
- Limit the amount drunk during any single drinking session
- Have several alcohol-free days each week
- Women should not drink at all if planning, or during pregnancy

1 unit of alcohol = 10ml or 8g of pure alcohol.

= one 25ml single measure of whisky (ABV 40%)

= a third of a pint of beer (ABV 5-6%)

= half a standard (175ml) glass of red wine (ABV 12%).

Source: DH: CMO alcohol guidelines review, summary of the proposed new guidelines

5.7.1. The impact of alcohol misuse in adults

Alcohol consumption above lower risk levels is likely to damage health, and in addition alcohol misuse and dependency can have a detrimental effect on individuals and the families and communities around them. It is a significant factor in antisocial and criminal behaviour and also has an impact on businesses and the economy^{4,5,6,7,8}. The national annual cost to society of alcohol-related harm is approximately £21bn⁹. This includes £11bn in crime related to alcohol, £3.5bn cost to the NHS in England and around £7.3bn in lost productivity due to alcohol.

Alcohol misuse is the third biggest risk factor for illness and death after smoking and obesity. Consumption of alcohol above recommended levels contributes to a wide range of health problems, such as high blood pressure, heart disease, strokes, liver disease, and various cancers, including breast, mouth and throat cancers³. Regular excessive consumption of alcohol can also affect sleep, cause sexual problems, is related to depression and can affect relationships. In the short-term there is also an

increased risk of accidents and injuries, being involved in violence, and risky sexual behaviour.

5.7.2 Information on alcohol misuse among adults in Buckinghamshire

5.7.2.1 Prevalence of alcohol misuse

Alcohol problems are widespread, but there are no local data on levels of consumption among adults in Buckinghamshire. Previous synthetic estimates based on 2009 data suggested the prevalence of different levels of risky drinking were not significantly different in Buckinghamshire from England or the South East. Estimates from national surveys suggest that around one in five adults in Buckinghamshire are consuming alcohol at levels that are a risk to their health, which is estimated to be 96,913 adults aged 16 and over¹⁰, which is made up of:

- 27,421 higher risk drinkers (6.5%)
(>35 units for women or >50 units for men per week)
- 69,492 increasing risk drinkers (16.5%)
(>14 and ≤35 units for women, or >21 and ≤50 units for men per week)

In addition, there are an estimated:

- 264,528 lower risk drinkers (62.9%)
(≤14 units for women or ≤21 units for men per week)
- 59,633 abstainers (14.1%)

It should be noted that these estimates are based on previous drinking thresholds. Using the latest guidance, more male drinkers will be in the increasing risk drinking category and fewer will be in the lower risk category.

Alcohol dependency is assessed using a validated tool, the Severity of Alcohol Dependence Questionnaire (SADQ). A score of 4-19 equates to mild dependency, 20-34 moderate dependency, and 35-60 severe dependency. Nationally, alcohol dependency affects about 5.9% of people¹¹. When extrapolated for Buckinghamshire, this equates to about 24,500 people of whom about:

- 22,500 have mild dependency
- 1,700 moderate dependency
- 400 severe dependency

However, as Buckinghamshire has a lower level of most measures of alcohol-related harm compared to national figures (see below), this may be an overestimate of the level of dependency in Buckinghamshire.

5.7.2.2 Deaths due to alcohol misuse

Table 1 shows mortality rates due to alcohol-specific and alcohol-related conditions and chronic liver disease. Alcohol-specific conditions are those where alcohol is causally implicated in all cases, e.g. alcohol poisoning or alcoholic liver disease.

Alcohol-related conditions include all alcohol-specific conditions, as well as those where alcohol is causally implicated in some, but not all cases, for example strokes, various cancers and falls. There are two slightly different definitions, narrow and broad.

Mortality rates in Buckinghamshire were statistically significantly lower than England for all causes except alcohol-related mortality in females, which was similar to England¹². In 2014 in Buckinghamshire, 104 males and 67 females died due to alcohol-related conditions.

Table 1 Mortality due to alcohol, rates per 100,000 population, Buckinghamshire, South East and England

	Bucks male rate (number*)	Bucks female rate (number*)	Bucks total rate	South East rate	England rate
Alcohol-specific mortality 2012-14	10.0 (74)	4.9 (38)	7.4	9.7	11.6
Chronic liver disease 2012-14	9.6 (67)	5.2 (41)	7.3	9.7	11.5
Alcohol-related mortality 2014	48.0 (104)	24.1 (67)	34.7	40.8	45.5

Key

Statistically similar to England	
Statistically significantly better than England	

*Note: numbers of alcohol-specific and chronic liver disease deaths are for a 3-year period

Source: Public Health England, Local Alcohol Profiles

5.7.2.3 Treatment of alcohol misuse and related conditions

Those requiring treatment for alcohol misuse begin in non-structured treatment, which consists of informal assessment, advice and information, referral, brief interventions and extended brief interventions. Structured treatment addresses multiple or more severe needs that would be expected not to respond, or have not responded to non-structured treatment. A structured treatment programme consists of a comprehensive assessment of need and is delivered according to a recovery care plan.

During 2014/15, 613 alcohol-using adults and 296 alcohol and non-opiate using adults accessed the non-structured alcohol treatment service in Buckinghamshire. In the same year there were 397 treatment episodes for alcohol misuse in the

structured treatment servicesⁱ. In 2014/15, Buckinghamshire had fewer alcohol-only clients in treatment and more clients with multiple substance use than nationally¹³.

Data on hospital admissions for conditions which are linked to alcohol are a measure of the health impact of alcohol on the population. In Buckinghamshire in 2013/14, there were 4,447 people admitted with alcohol-related conditions (broad definition), a rate of 906 per 100,000 population, compared with a national rate of 1,253 per 100,000, and there were 955 people admitted to hospital for alcohol-specific conditions, a rate of 190 per 100,000 population, compared with a national rate of 374 per 100,000¹². Almost two-thirds of the people admitted were male. Buckinghamshire admission rates for both alcohol-related (broad definition) and alcohol-specific conditions were statistically significantly lower than the corresponding England rates.

5.7.2.4 Societal impact of alcohol misuse

The rate of alcohol-related crime in Buckinghamshire was 4.07 per 100,000 of the population compared to 5.74 per 100,000 nationally in 2012/13. Alcohol-related recorded crime, including violent crime and sexual offences, accounted for over 2,000 incidents in 2012/13¹⁴, as shown in table 2.

Table 2 Number of alcohol-related recorded crimes, Buckinghamshire 2012/13

Indicator	Number of crimes
Alcohol-related recorded crime	2,053
Alcohol-related sexual crime	57
Alcohol-related violent crimes	1,336

Source: Local Alcohol Profiles, 2014

Nationally, alcohol is associated with just over half of all violent crime (53%) and over a third (36%) of domestic violence incidents⁵. The number of incidents relating to alcohol misuse may be higher than the recorded levels. Substance misuse is also mentioned in 57% of serious case reviews (undertaken after a child dies or is seriously injured and abuse or neglect is thought to be involved). Misuse of alcohol by parents can contribute to physical, psychological and behavioural problems in children⁸.

Trends

In a national survey, the number of adults who said they do not drink at all increased slightly from 19% in 2005 to 21% in 2013. The proportion of adults who participated in binge drinking decreased from 18% in 2005 to 15% in 2013¹⁵. There has been a

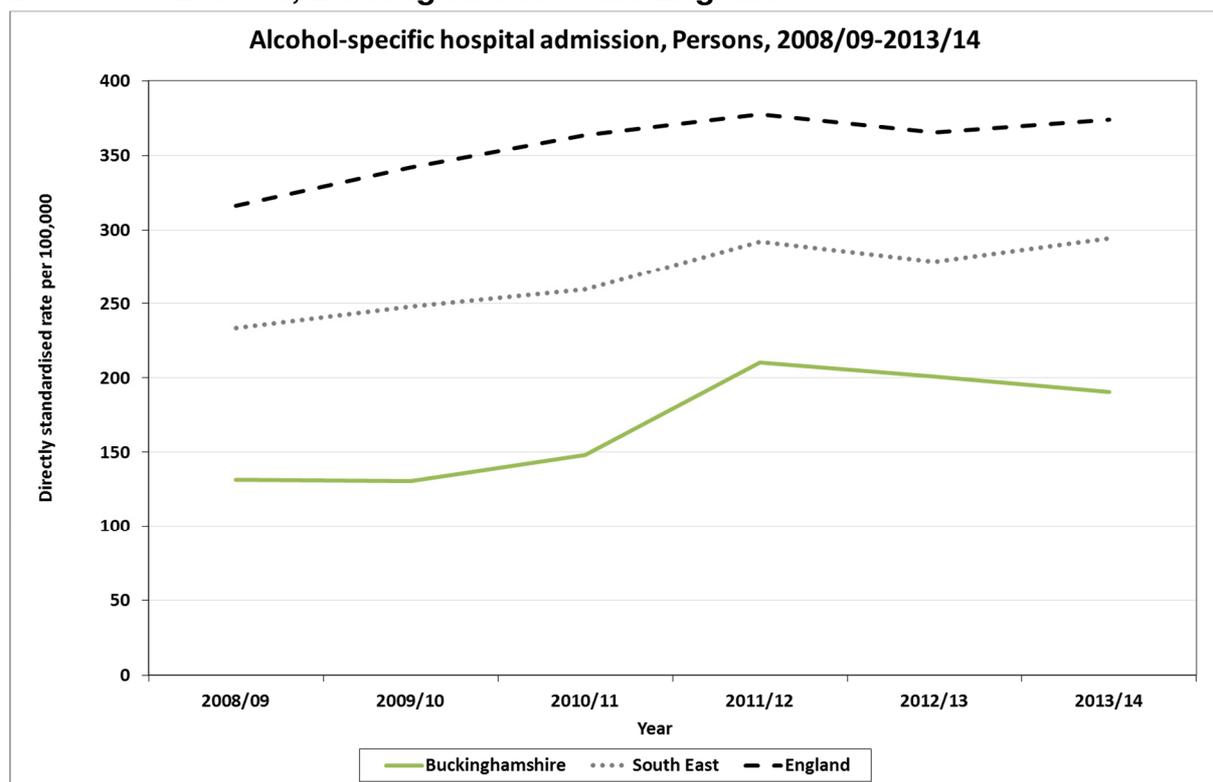
ⁱ NOTE: numbers represent treatment episodes rather than clients as clients may be counted more than once across the year and may also be counted in both treatment services

long-term downward trend in the proportion of adults who report drinking alcohol in the previous week. In 1998, 75% of men and 59% of women drank in the week prior to interview compared to 68% and 54% respectively in 2010¹⁶. However, the Office of National Statistics cautions that people can underestimate the amount of alcohol they consume. Drinking at home is particularly likely to be underestimated as quantities are not measured.

Figures 1 and 2 show trends in people admitted to hospital for alcohol-specific and alcohol-related (broad definition) conditions (i.e. not including repeat admissions) for the period 2008 to 2014. Although lower than national levels, Buckinghamshire levels are mirroring the national upward trend¹².

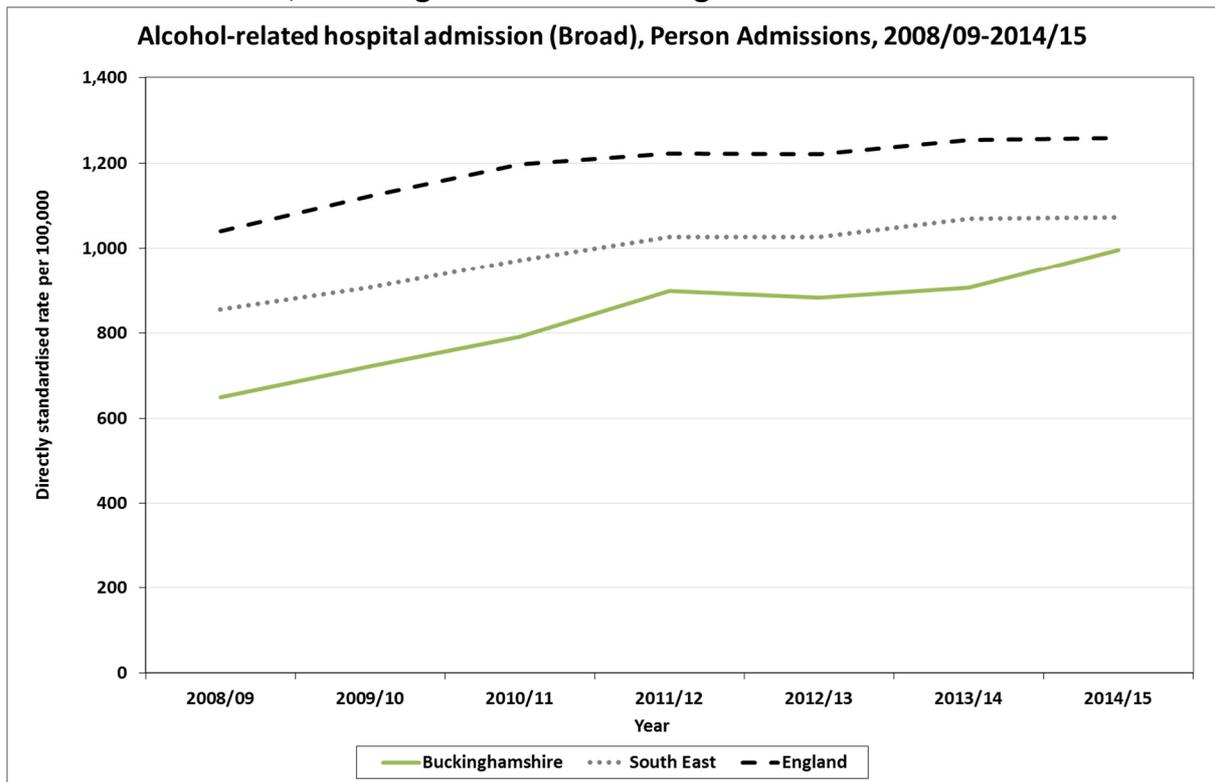
When all admissions are included, rather than the number of people admitted, the alcohol-related hospital admissions rate (broad definition) increases for Buckinghamshire, the South East and England, indicating some people are admitted multiple times (Figure 3).

Figure 1 Trends in people admitted to hospital for alcohol-specific conditions, 2008/09 to 2013/14, Buckinghamshire and England



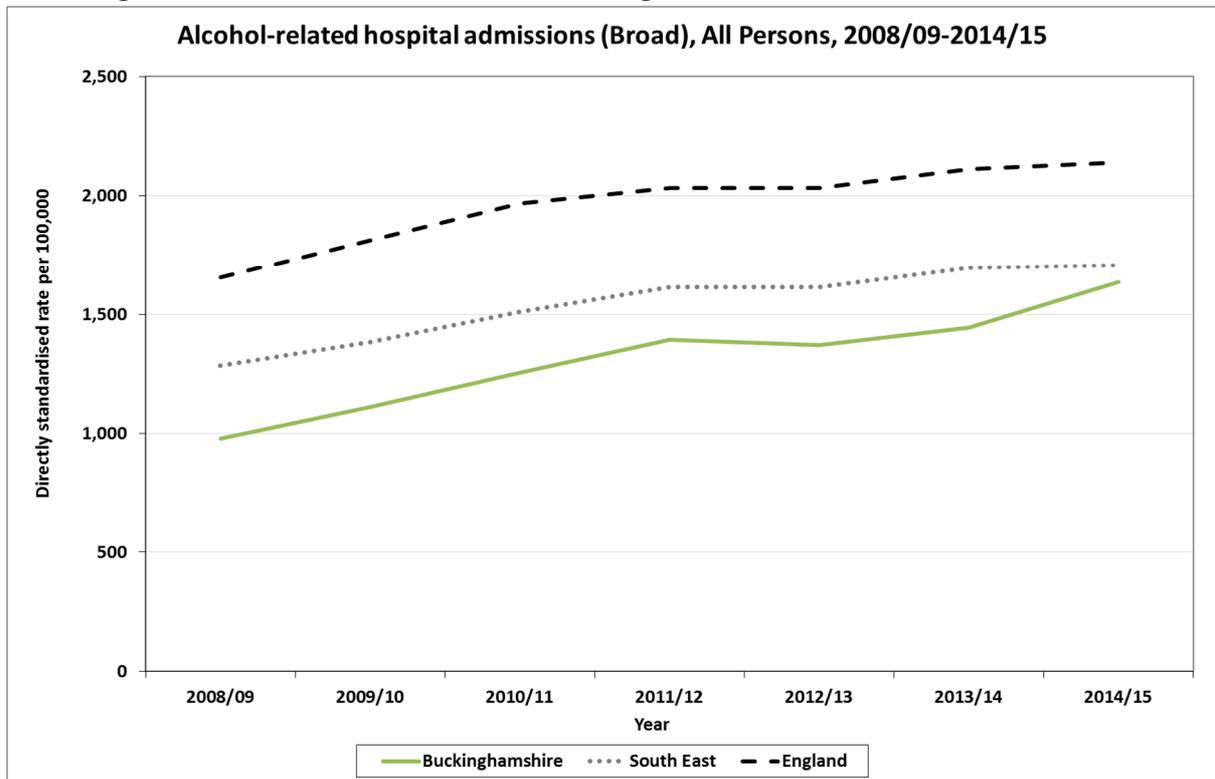
Source: Public Health England

Figure 2 Trends in people admitted to hospital for alcohol-related conditions, 2008/09 to 2014/15, Buckinghamshire and England



Source: Public Health England

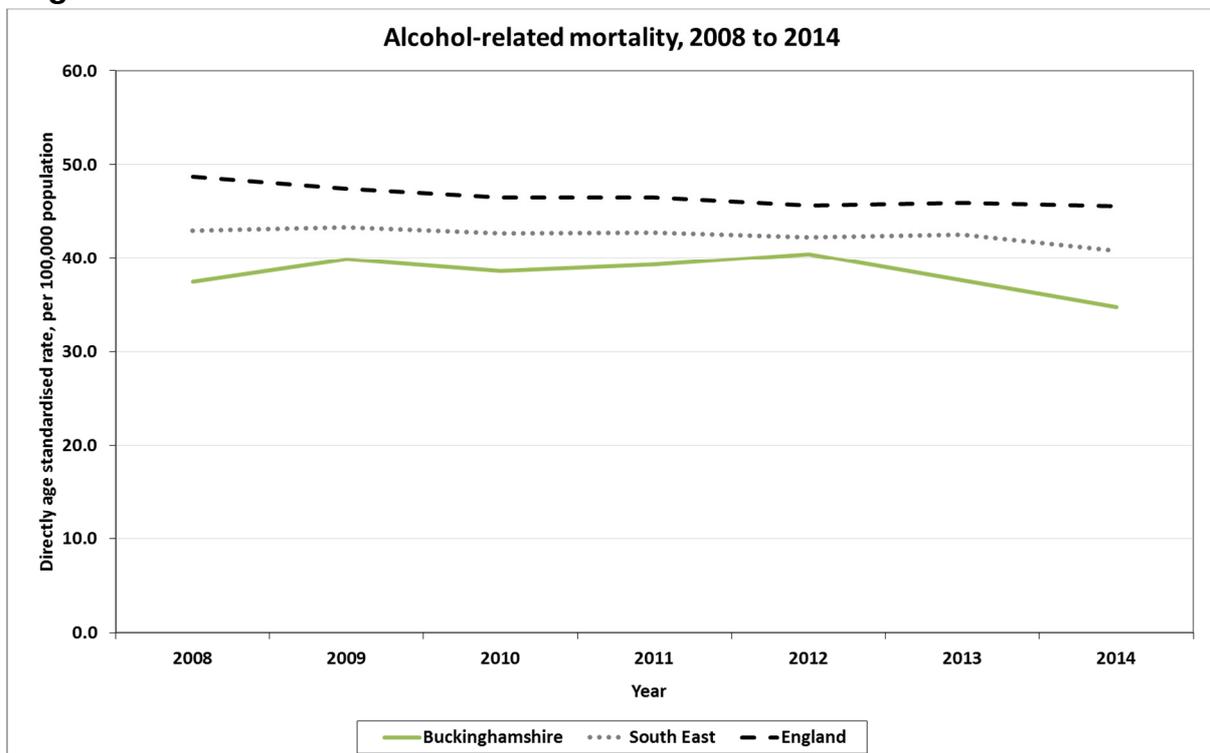
Figure 3 Trends in alcohol-related hospital admissions, 2008/09 to 2014/15, Buckinghamshire, the South East and England



Source: PHE Fingertips, Local Alcohol Profiles for England

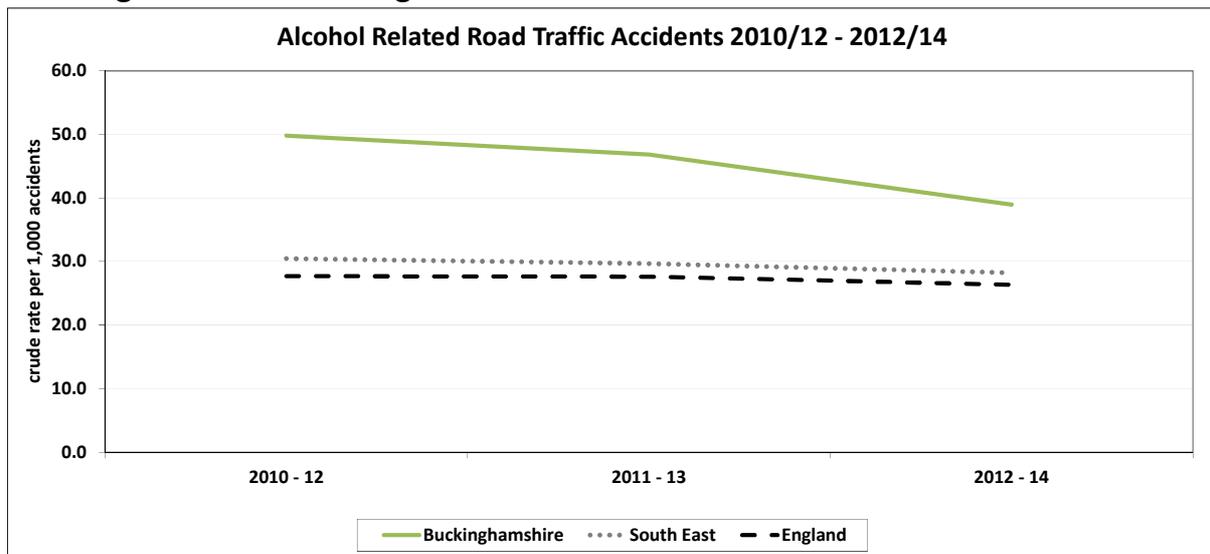
In England in 2013, there were 6,592 alcohol-related deaths, a 1% increase from 2012 (6,495) and a 10% increase from 2003 (5,984)¹⁵. However, the national mortality rate has been gradually declining as shown in figure 4. The mortality rate in Buckinghamshire is lower than England and the South East, and having remained stable between 2009 and 2012, the Buckinghamshire mortality rate declined between 2012 and 2014¹². Figure 5 shows the trend in alcohol-related road traffic collisions. The rate in Buckinghamshire is statistically significantly higher than England, although there has been a slight decline¹².

Figure 4 Trend in alcohol-related mortality, 2008-2014, Buckinghamshire and England



Source: Public Health England

Figure 5 Trend in alcohol-related road traffic collisions, 2010/12-2012/14, Buckinghamshire and England



Source: Public Health England

5.7.3 Alcohol misuse in different population groups

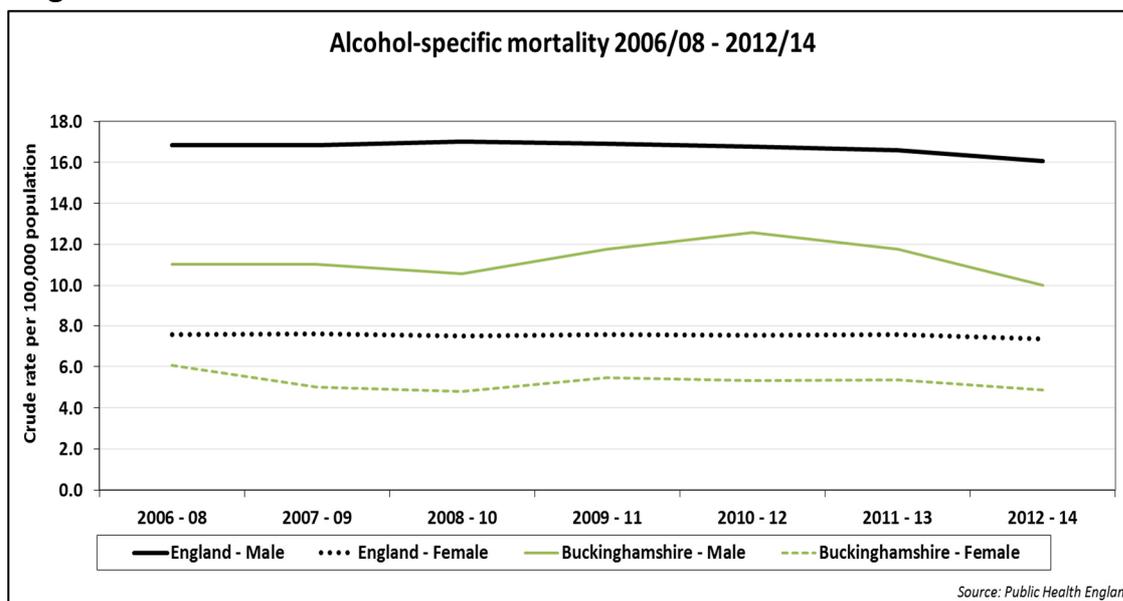
5.7.3.1 Age and gender

National data show that in 2013, those aged 16 to 24 years were least likely to have drunk in the last week. However, for people aged 65 and over, although only one in two drink alcohol, of those that do, a third drink alcohol on nearly every day of the week. Overall, the most likely age group to drink alcohol in a given week are those aged 45 to 64¹⁷.

Men consume more alcohol than women, both in numbers who drink and the average level of consumption; however, data from the Office from National Statistics shows that the gap is closing. Almost two-thirds of men reported drinking alcohol in the last week compared to a little over half of women¹⁷.

As shown in Table 1 above, alcohol-specific and alcohol-related mortality in Buckinghamshire are around twice as high in men as in women. This gender difference is similar nationally although rates are higher; in 2012/14 the England alcohol-specific mortality rate was 7.4 per 100,000 for women and 16.1 per 100,000 for men. Trend data show that nationally and in Buckinghamshire, alcohol-specific mortality rates have declined gradually in both men and women between 2006/08 and 2012/14¹² (figure 6).

Figure 6 Alcohol-specific mortality, by gender in Buckinghamshire and England



5.7.3.2 Ethnicity

Results of a national survey show that the proportion of men who drink more than 21 units a week was higher for White men than men in other ethnic groups; 25% compared with 6% of Black men and 6% of Asian men. The difference was similar for women; 19% of White women, compared with 6% of Black women and 2% of Asian women drank over 14 units a week¹⁸. The Buckinghamshire population is predominately White (86.4%), and a more detailed breakdown of ethnicity in Buckinghamshire can be found in Chapter 3 of the JSNA. It should be noted that this survey was based on previous recommended drinking guidelines.

5.7.3.3 Socio-economic differences

Data from the Health Survey for England show that people who are employed and in a higher income household are more likely to drink alcohol, and more likely to drink at higher levels than those out of work¹⁸. Levels of non-drinking are higher, and levels of lower risk and increasing risk drinking are lower among people from more deprived socio-economic groups (table 3). However, the associations between increasing and higher risk drinking and the different deprivation quintiles were not statistically significant.

Table 3 Proportion of adult population drinking at different risk levels, by deprivation quintile, England 2014

Estimated weekly alcohol consumption	IMD quintile				
	Least deprived	2nd	3rd	4th	Most deprived
Men					
Non-drinker	7	10	13	22	24
≤21 units (lower risk)	69	65	64	60	57
>21, ≤50 units (increasing risk)	20	19	18	13	12
>50 units (higher risk)	4	6	5	6	7
Women					
Non-drinker	14	17	20	24	34
≤14 units (lower risk)	65	66	65	61	55
>14, ≤35 units (increasing risk)	16	14	12	11	8
>35 units (higher risk)	5	3	4	3	3

NOTE: risk levels relate to previous definitions. Numbers of men at increasing risk according to new (January 2016) guidelines are likely to be higher.

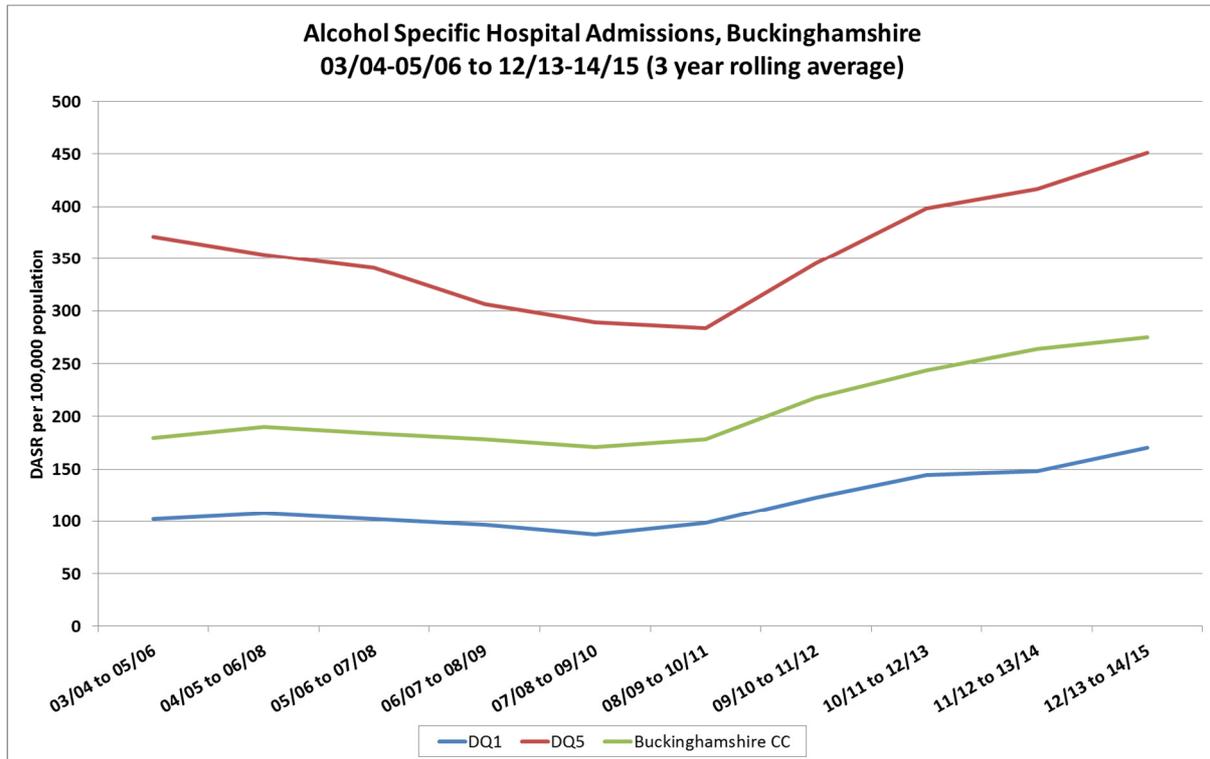
Source: Health Survey for England

There is strong evidence that alcohol is a factor underlying higher mortality risks in more disadvantaged populations. Despite consuming less alcohol than higher socioeconomic groups, research suggests that lower socioeconomic groups experience greater alcohol-related harm; known as the ‘alcohol harm paradox’¹⁹. A range of possible explanations have been put forward for this, such as differing patterns of consumption, inaccurate consumption reporting and the interaction of alcohol with other unhealthy behaviours and/or socioeconomic determinants of health¹⁹.

Alcohol-specific hospital admissions are consistently higher in the most deprived population quintile in Buckinghamshire than in the least deprived population quintile (Figure 7). Figure 8 shows alcohol-specific hospital admissions by deprivation quintile in Buckinghamshire for 2012/13 to 2014/15. Those in the most deprived two-fifths of the population (DQ4 & DQ5) had statistically significantly higher rates of admission than the average for the county; while those in the least deprived two-fifths (DQ1 & DQ2) had significantly lower rates of hospital admissions²⁰.

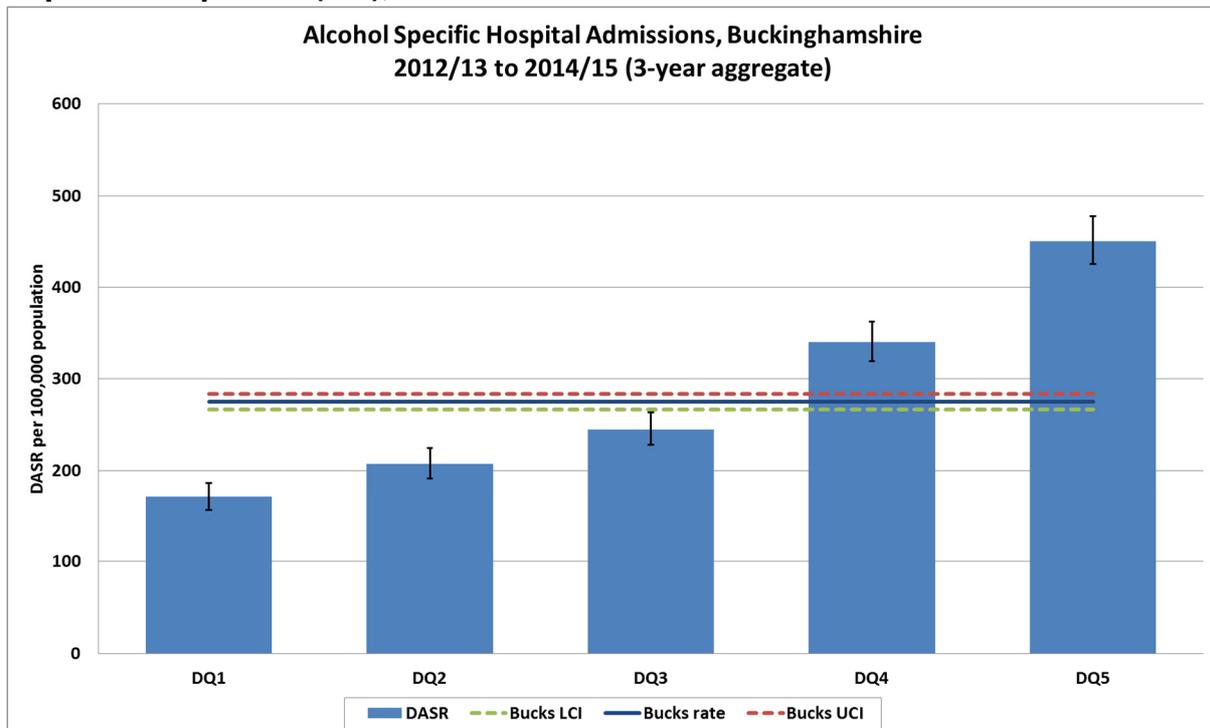
A similar trend can be seen for alcohol-related hospital admissions broad definition (Figures 9 and 10) and narrow definition (Figures 11 and 12).

Figure 7 Trend in alcohol-specific hospital admissions, Buckinghamshire's most and least deprived population quintile, 2003/04-2005/06 to 2012/13-2014/15



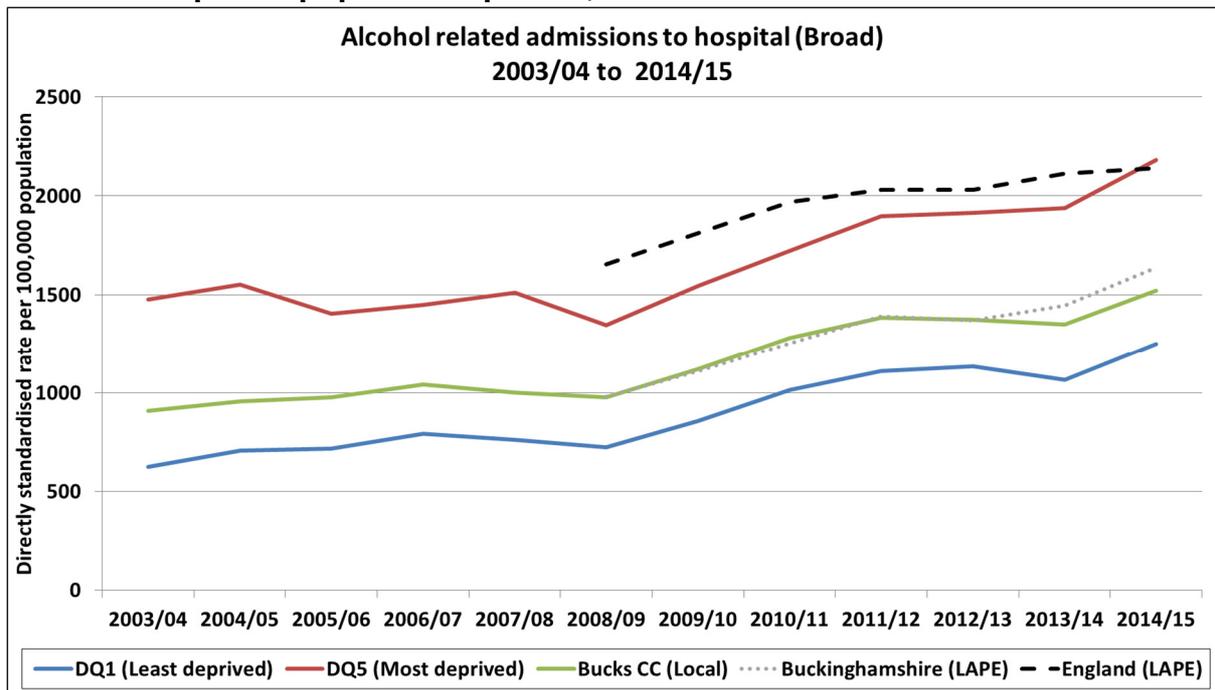
Source: Source: Local admissions data: SUS Admitted Patient Care (APC) Minimum Data Set (MDS)

Figure 8 Alcohol-specific hospital admissions in Buckinghamshire by deprivation quintile (DQ), 2012/13 to 2014/15



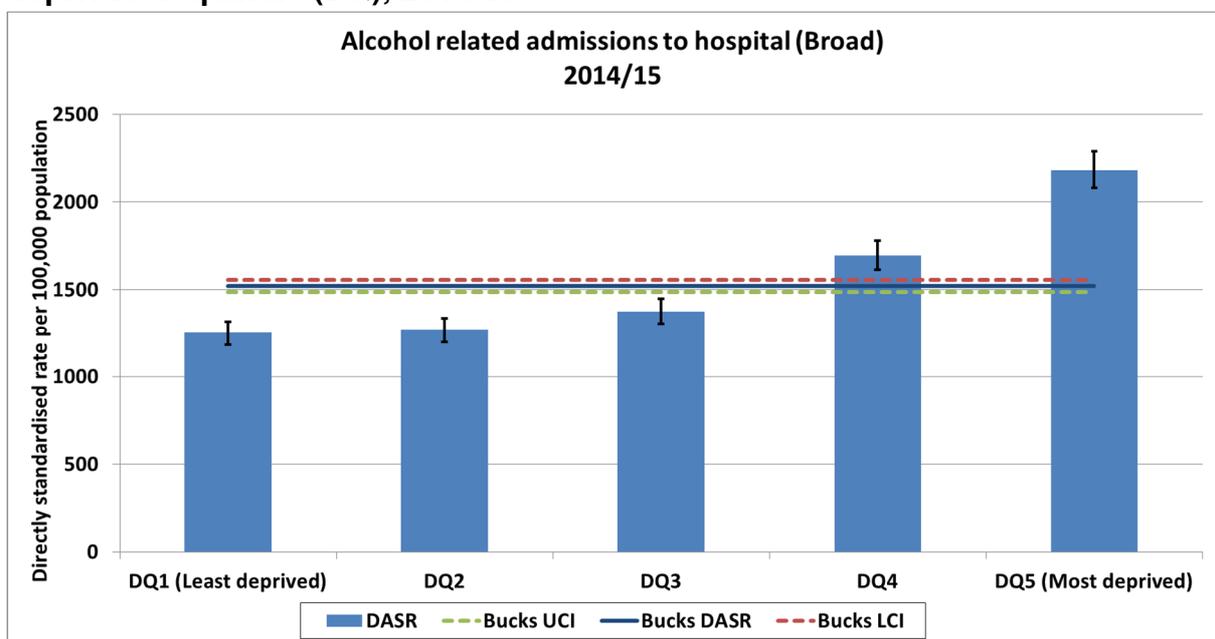
DQ 1 = least deprived DQ 5 = most deprived DASR: Directly age-standardised rate
 Source: Local admissions data: SUS Admitted Patient Care Minimum Data Set

Figure 9 Alcohol-related hospital admissions (broad), Buckinghamshire's most and least deprived population quintile, 2003/04 to 2014/15



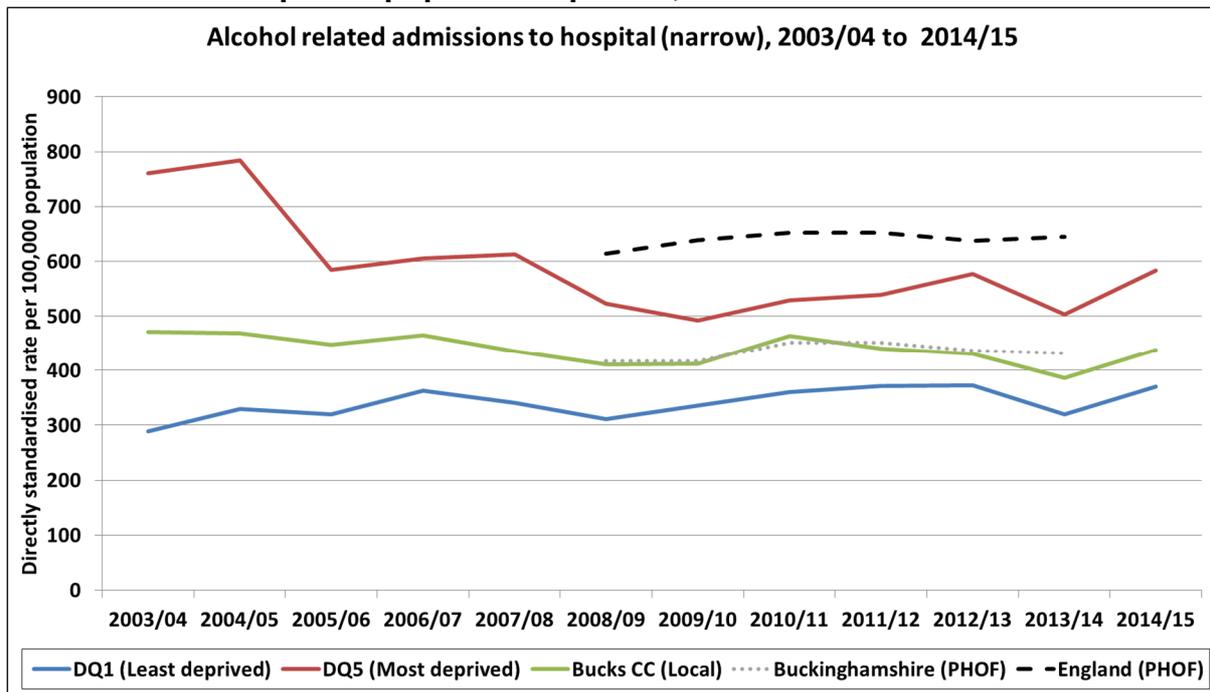
Source: Local admission data: SUS Admitted Patient Care Minimum Data Set

Figure 10 Alcohol-related hospital admissions (broad) in Buckinghamshire by deprivation quintile (DQ), 2014/15



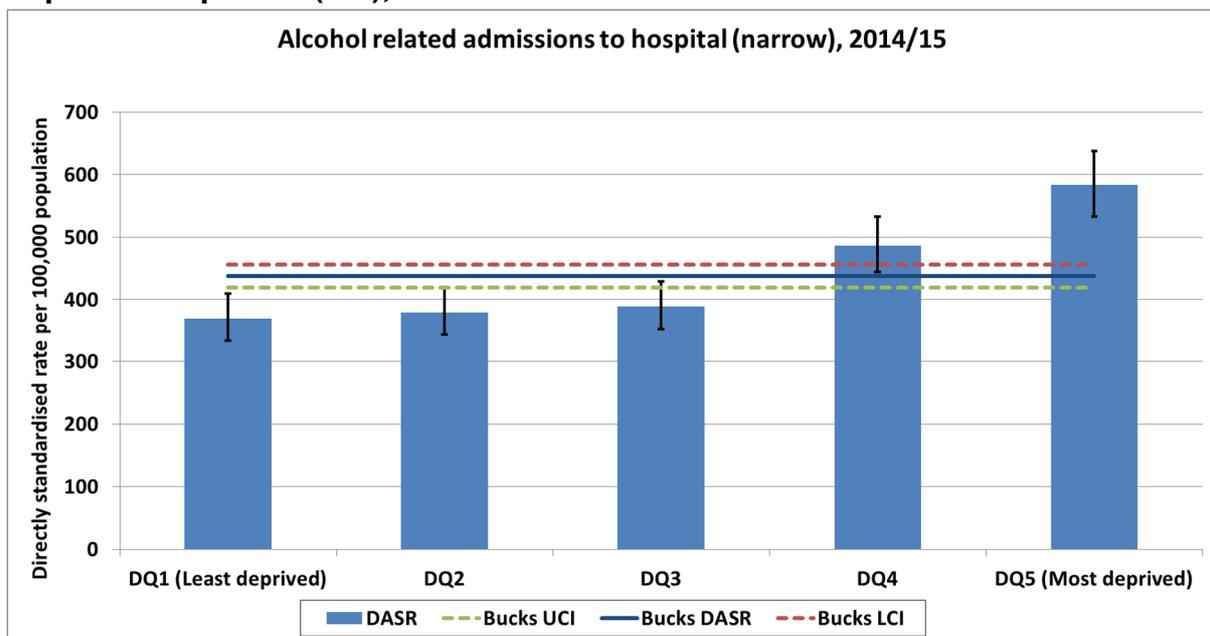
Source: Local admission data: SUS Admitted Patient Care Minimum Data Set

Figure 11 Alcohol-related hospital admissions (narrow), Buckinghamshire's most and least deprived population quintile, 2003/04 to 2014/15



Source: Comparator data: Public Health Outcomes Framework (LAPE Fingertips); Local admission data: SUS Admitted Patient Care Minimum Data Set; Population data: ONS Small Area Population Estimates Mid-2001 to Mid-2014; Deprivation Quintiles: Department for Communities and Local Government, English indices of deprivation 2010

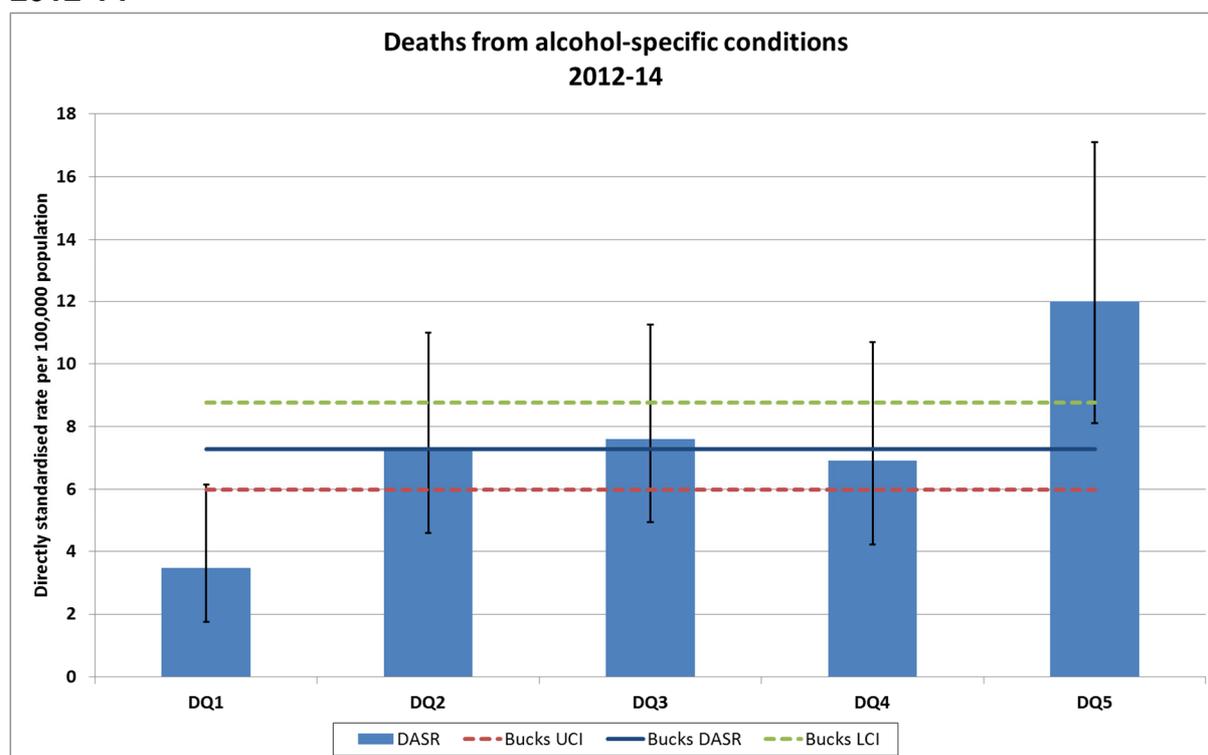
Figure 12 Alcohol-related hospital admissions (narrow) in Buckinghamshire by deprivation quintile (DQ), 2014/15



Source: Local admission data: SUS Admitted Patient Care Minimum Data Set; Population data: ONS Small Area Population Estimates Mid-2001 to Mid-2014; Deprivation Quintiles: Department for Communities and Local Government, English indices of deprivation 2010

There are also strong links between deprivation and deaths related to alcohol. Alcohol-specific mortality is statistically significantly higher in the most deprived quintile of the Buckinghamshire population than the least deprived quintile (figure 13)¹².

Figure 13 Alcohol-specific mortality by deprivation quintile, Buckinghamshire 2012-14



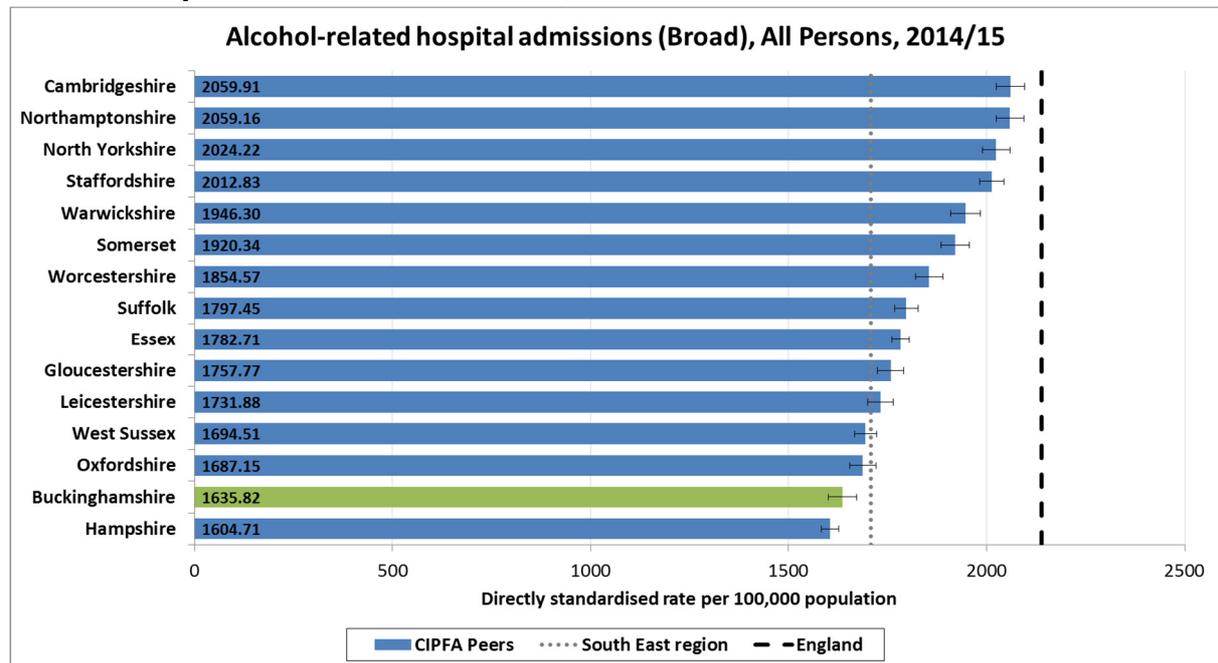
Source: Public Health England

5.7.4 Geographical variations in alcohol misuse

There are no up-to-date data on differences in alcohol consumption between the District areas within Buckinghamshire, although synthetic estimates based on 2009 data suggested rates were not significantly different from England or the South East¹⁰. The 2014 Health Survey for England found no statistically significant differences between England and the South East in levels of risky drinking behaviour, and it is unlikely that Buckinghamshire is significantly different from these

Figure 14 shows the rate of people admitted to hospital for alcohol-related conditions (broad definition) in 2014/15 in Buckinghamshire and its group of 15 CIPFA comparator Local Authorities. Buckinghamshire had the second lowest rate of alcohol-related admissions, which was statistically significantly lower than all but three of the other Local Authority areas¹². The whole group had statistically significantly lower admission rates than the England average, but only two, including Buckinghamshire, had statistically significantly lower rates than the South East.

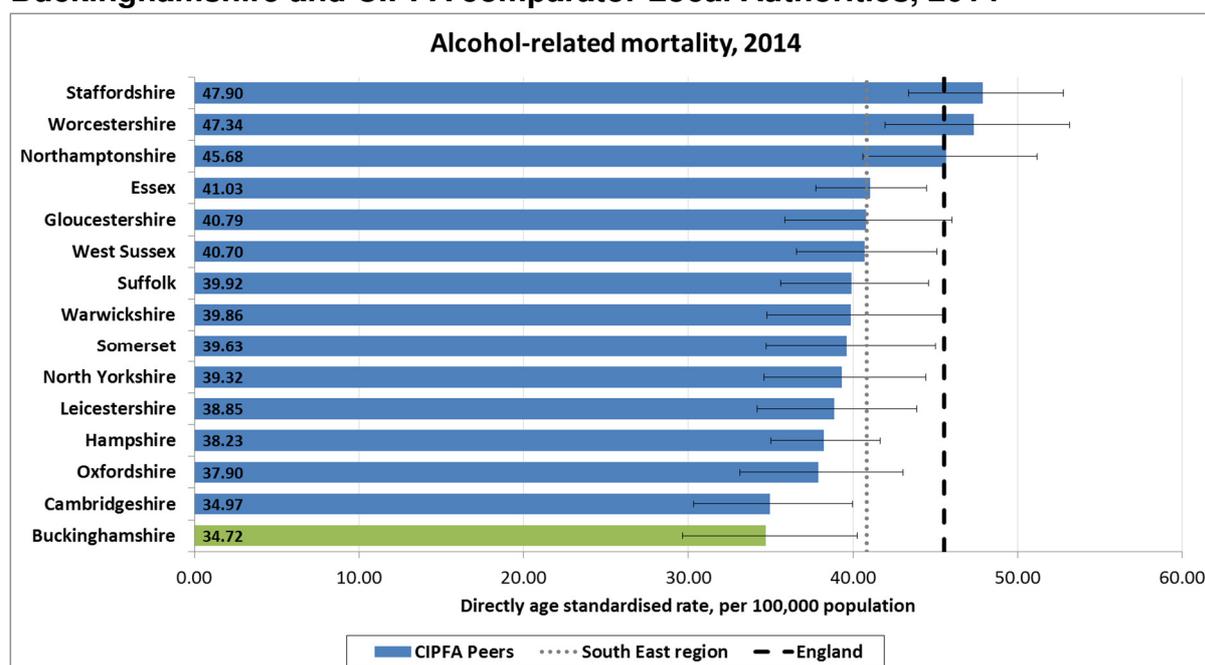
Figure 14 Alcohol-related hospital admissions (broad), Buckinghamshire and CIPFA comparator Local Authorities, 2013-14



Source: Public Health England

As shown in table 1 above, the Buckinghamshire mortality rates for alcohol-specific and alcohol-related deaths and for deaths due to chronic liver disease were all statistically significantly lower than those for England. The Buckinghamshire rates were not significantly different from the South East rates. Buckinghamshire also has the lowest alcohol-related mortality compared to its CIPFA comparator group¹², although it is only statistically significantly lower than the two local authorities with the highest rates (figure 15).

Figure 15: Alcohol-related mortality (rate per 100,000 population), Buckinghamshire and CIPFA comparator Local Authorities, 2014



Source: Public Health England

5.7.5 Horizon scanning

The Chief Medical Officer recently reviewed the guidance for alcohol consumption, lowering the recommended unit allowance for lower risk drinking for men from 21 to 14 units per week. This will put a larger proportion of the population into the increasing risk category. The Chief Medical Officer also included advice on avoiding drinking on consecutive days and having two alcohol free days per week. The new guidance will need to be communicated at a local level to front line professionals and residents.

5.7.6 Conclusions

Alcohol consumption above lower risk levels is likely to damage health and have a detrimental effect on individuals and the families and communities around them, including an association with crime and antisocial behaviour. There are no local data on levels of alcohol consumption among adults in Buckinghamshire, but estimates suggest that levels of risky drinking are not significantly different from those nationally. At least one in five adults in Buckinghamshire (over 100,000 individuals) may be consuming alcohol at levels that are a risk to their health, almost a quarter of whom may have some degree of alcohol dependency. National surveys have shown that the number of binge drinkers is reducing and the number abstaining from alcohol is increasing.

Measures of the impact of alcohol misuse in Buckinghamshire suggest lower levels of most types of alcohol-related harm, including lower rates of deaths and hospital admissions related to alcohol than nationally and in similar Local Authority areas. While rates of hospital admissions related to alcohol misuse appear to be increasing, mortality rates are gradually declining both locally and nationally. Over 900 adults accessed Buckinghamshire treatment services for alcohol misuse in 2014/15.

Levels of alcohol consumption and of health problems associated with alcohol are significantly higher among men than women, and tend to be higher among White ethnic groups. Alcohol consumption also appears to be higher in less deprived groups of the population, although more deprived groups appear to experience greater alcohol-related harm.

While the picture relating to alcohol consumption in Buckinghamshire adults is generally favourable compared with other areas, alcohol misuse is still a major cause of ill-health, death, crime and antisocial behaviour. There is a cohort of the local population who are drinking at increasing or high risk levels, which is likely to be having an impact both for them as individuals and on their families, services and the wider community. Partnership working across the county to prevent and reduce the harms of alcohol misuse will benefit the health and wellbeing of residents in Buckinghamshire.

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