Symposium

Evaluating public health approaches to reducing alcohol related harm in an English context
‘The Alcohol Toolkit Study’: a national study of alcohol use in England

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University College London

Dr Jamie Brown, Professor Robert West, Professor Alan Brennan, Professor Colin Drummond, Professor Matthew Hickman, Professor John Holmes, Professor Eileen Kaner, Dr Karen Lock, Professor Susan Michie
Disclosures

• I have received unrestricted research and conference funding from Pfizer

• I am funded by the NIHR School for Public Health Research and CRUK
  – The views reported here are not necessarily those of the NHS, the NIHR or the Department of Health

• Research to date has focused on tobacco control
Objectives:

- Alcohol consumption in the UK
  - Prevalence
  - Alcohol strategies

- Currently available surveys
  - Limitations

- Alcohol Toolkit Study
  - Advantages
  - Design
  - Measures
  - Planned dissemination
Alcohol consumption in the UK

- 10 million adults drink above recommend limits
Alcohol consumption in the UK

**Women**
Should not regularly* drink more than:

- **2-3 units a day**
  That’s no more than a standard 175ml glass of wine (ABV 13%)

**Men**

- **3-4 units a day**
  That’s not much more than a pint of strong lager, beer or cider (ABV 5.2%)

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**Glass of red, white or rose wine**
(ABV 13%)

- Small 125ml: 1.6 units
- Standard 175ml: 2.3 units
- Large 250ml: 3.3 units

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*“Regularly” means drinking this amount most days or every day.*
Alcohol consumption in the UK

- **Binge drinking** (ONS survey, 2012; n=13,000)
  - 24% of men and 17% of women aged 16-24
  - 25% of men and 19% of women aged 25 to 44
  - 20% of men and 11% of women aged 45 to 64
  - 7% of men and 2% of women aged >65

- **Everyday drinking** (ONS survey, 2012; n=13,000)
  - 13% aged >45
  - 4% aged <45

- “Our invisible Addicts” (Royal College of Psychiatrists)
Alcohol consumption in the UK

- 10 million adults drink above recommend limits
- Costs £21 billion per annum (HM Government, 2012)
- Direct cause of 3.5% of all deaths (Jones & Bellis, 2013)
  - Liver disease
  - Oesophagus cancer
  - Colorectal cancer
- Indirect cause of 1.1% of all deaths (Jones & Bellis, 2013)
Alcohol strategies

• 2012 UK Government Alcohol Strategy
  – Helping individuals change their drinking behaviour
  – Taking action locally
  – Improving treatment for alcohol dependence
Improving treatment

• Integrate alcohol into the wider Change4Life brand
  – On going social marketing campaign to communicate the health harms of drinking excessively
• NHS Health Checks
• Invest £488 million to help 120,000 troubled families with alcohol-related problems
• Develop an alcohol intervention pathway for prisons
• Increase the flexibility of Alcohol Treatment Requirement imposed by the court as part of community sentence
Alcohol strategies

• 2012 UK Government Alcohol Strategy
  – Helping individuals change their drinking behaviour
  – Taking action locally
  – Improving treatment for alcohol dependence
  – Sharing responsibility with the alcohol industry
  – Minimum unit price
  – Extending restrictions on advertisement
Alcohol strategies

• Many of these policies have been withdrawn
  – For example, minimum unit pricing

• Have introduced
  – Ban on sales of alcohol ‘below cost’
  – Reductions and increases in alcohol duties
  – Screening and brief interventions (part of NHS health checks)
  – Voluntary agreements with the industry
    • Reduce the availability of high strength canned beverages
    • Lower the strength of existing beverages
    • Promote low strength alternatives
    • Increase the number of product labels with alcohol content information
Monitoring alcohol consumption

- Timely and detailed surveillance data are required
  - Help inform and evaluate national and local alcohol policies

- Several large-scale surveys

  - National Diet and Nutrition Survey (DOH and Food Standards Agency, 2011)
  - Opinions and Lifestyle Survey (a combination of the Opinions Survey and General Lifestyle Survey) (ONS, 2014)
  - Health Survey for England (Bridges et al, 2012)
  - Adult Psychiatric Morbidity Survey (National Centre for Social Research, 2007)
  - General Lifestyle Survey (terminated in 2012) (ONS, 2013)
  - International Alcohol Control Policy Evaluation Study (IAC) (Casswell et al, 2012)

- Infrequent
  - Annually or less

- Delay in publication

- Not directly comparable with surveys from other countries
  - Don’t use standardised measures

- Limited in scope
  - Don’t just focus on alcohol consumption
  - Multiple measures of other health behaviours
Alcohol Toolkit Study

• Gather and publish monthly data on representative samples of adults
  – Timely tracking of national patterns of alcohol consumption

• Includes a widely-validated screening tool for risky alcohol use (the AUDIT questionnaire)
  – Permit international comparisons

• Six month follow-up
  – Individual trends and consistency in alcohol-related measures

• Modelled on and involves the same respondents at the Smoking Toolkit Study (Fidler et al, 2011; www.smokinginegland.info)
  – Compare trends in smoking and alcohol use
Methods

• Design
  – Funded by the NIHR SPHR
    • Lead: Susan Michie (UCL)
      – Collaborations with
        » Department of Health
        » Kings College London
        » Public Health England
        » Newcastle University
        » University of Bristol
        » University of Sheffield
        » London School of Hygiene and Tropical Medicine
Methods

• Design
  – Cross-sectional household computer-assisted interviews
  – Conducted by Ipsos Mori
  – 1,800 adults aged 16+ in England
  – Those who agree to be re-contacted are followed-up at 6 months by telephone
  – Baseline data were first collected in March 2014
  – Anticipated that data on around 20,400 individuals will be collected each year over the initial period
Methods

– The key domains addressed at baseline:
  • Prevalence and frequency of harmful alcohol consumption (AUDIT)
AUDIT

- The Alcohol Use Disorders Identification Test

- Developed by WHO (First published in 1989)
  - Screen for excessive drinking
  - Assist in brief assessment
  - Developed and validated over 2 decades

- Hazardous drinking
  - “A pattern of alcohol consumption that increases the risk of harmful consequences for the user or others” (WHO, 2001)

- Harmful drinking
  - “Alcohol consumption that results in consequences to physical and mental health” (WHO, 2001)

- Alcohol Dependence
  - “Cluster of behavioural, cognitive, and physiological phenomena that may develop after repeated use . . . Strong desire to consume alcohol, impaired control over its use . . .” (WHO, 2001)
AUDIT

- >8 indicator of hazardous and harmful alcohol use and possible dependence

- Higher scores indicate greater likelihood of hazardous/harmful drinking

**AUDIT-C**

<table>
<thead>
<tr>
<th>Domains</th>
<th>Question Number</th>
<th>Item Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hazardous Alcohol Use</td>
<td>1</td>
<td>Frequency of drinking</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Typical quantity</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Frequency of heavy drinking</td>
</tr>
<tr>
<td>Dependence Symptoms</td>
<td>4</td>
<td>Impaired control over drinking</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>Increased salience of drinking</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Morning drinking</td>
</tr>
<tr>
<td>Harmful Alcohol Use</td>
<td>7</td>
<td>Guilt after drinking</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>Blackouts</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>Alcohol-related injuries</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>Others concerned about drinking</td>
</tr>
</tbody>
</table>
Methods

- The key domains addressed at baseline are:
  - Prevalence and frequency of harmful alcohol consumption (AUDIT)
  - Current attempts and motivation to reduce alcohol consumption below harmful levels
  - Health-care professional advice about alcohol consumption
  - Types of drink consumed and amount spent
Types of drinks consumed

• 2009 Omnibus Survey: ’Drinking: Adults’ behaviour and knowledge’
  – Women less likely to drink beer and more likely to drink wine, fortified wine, spirits and alcopops than men.
  – Spirits were most popular among women aged 16 to 24
  – Wine most popular among women aged 45-56 years of age.

• Which of these do you drink most often?
  – Wine
  – Beer or lager
  – Spirits on their own (for example whisky, vodka)
  – Cider
  – Alcopops (for example WKD, Smirnoff Ice)
  – Mixed drinks (for example, gin and tonic, whisky and coke)
  – Other
Methods

– The key domains addressed at baseline are:
  • Prevalence and frequency of harmful alcohol consumption (AUDIT)
  • Current attempts and motivation to reduce alcohol consumption below harmful levels
  • Health-care professional advice about alcohol consumption
  • Types of drink consumed and amount spent
  • Urges to drink
  • Current serious attempts to cut down and stop
  • Serious attempts to quit
  • Help sought
  • Factors contributing to recent attempts to reduce intake
Factors contributing to recent attempts to reduce intake

• Which of the following, if any, do you think contributed to you making the most recent attempt to cut down (or stop altogether)?
  – Advice from a doctor/health worker
  – Government TV/radio/press advert
  – A decision that drinking was too expensive
  – I knew someone else who was cutting down
  – Health problems I had at the time
  – A concern about future health problems
  – Something said by family/friends/children
  – A significant birthday or event
  – Improve my fitness
  – Help with weight loss
  – Detox (e.g., dry January)
  – Other (please specify)
Dissemination

- www.alcoholinengland.info
  - Under construction
  - Timely publication of:
    - Prevalence of hazardous drinking (Alcohol Use Disorders Identification Test (AUDIT) score of >8)
    - Percentage of hazardous drinkers who reporting attempting to reduce their alcohol consumption
    - Prevalence of different methods used by hazardous drinkers attempting to reduce their consumption
    - Prevalence among hazardous drinkers of receipt of advice to reduce alcohol consumption from a health professional in the past year
Dissemination


- Beard, E., Brown, J., West, R., & Michie, S. (other co-authors TBC) (under preparation). *Socio-economic predictors of smoking and harmful/hazardous drinking.* TBC

For further details:
www.alcoholinengland.info
www.smokinginengland.info

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Brief interventions in primary care on smoking and excessive alcohol consumption in England: Findings from a population survey

Dr Jamie Brown, UCL

Professor Robert West, Dr Emma Beard, Professor Alan Brennan, Professor Colin Drummond, Professor Matthew Hickman, Professor John Holmes, Professor Eileen Kaner, Professor Susan Michie
Brief intervention: smoking

• Is effective and cost-effective public health intervention
  – NICE 2006; Stead, Bergson et al. 2008; Aveyard, Begh et al. 2012

• Provided opportunistically by clinicians to unselected smokers can lead to a 1 – 3% increase in stopping
  – Stead, Bergson et al. 2008

• Traditional model involves asking patients about their smoking, advising them to stop, and offering assistance
  – UK Department of Health 2009
Brief intervention: alcohol misuse

- Effective in reducing excessive alcohol consumption
  - reduced intake by 4-5 UK units a week (Kaner et al. 2007)
  - cost-effective under all but most pessimistic modelling assumptions (Purshouse et al. 2013)

- Requires screening and providing high-risk drinkers with structured brief advice or extended brief intervention
  - brief advice is usually 5-min conversation with feedback on screening result and a self-help leaflet, together with practical advice on how to reduce (Purshouse et al. 2013)
  - extended brief intervention is longer (~ 25 min) & based on principles of motivational interviewing (McCambridge et al. 2014)
  - recent pragmatic trial indicated that neither 5 min brief advice nor 20 min session focussed on motivational interviewing conferred additional benefit over screening followed by simple feedback and written information (Kaner et al. 2013)
How does the delivery compare?

- NICE guidelines support the routine delivery of both interventions
- Analyses of GP recording databases indicate:
  - ~50% of all smokers received cessation advice in 2009 (Szatkowski et al. 2011, Taggar et al. 2012)
  - ~10% of excessive drinkers may have received an intervention between 2007-09 (Khadjhesari et al. 2013)
Reasons for the discrepancy?

- More substantial financial incentives to intervene on smoking than alcohol

<table>
<thead>
<tr>
<th>Smoking</th>
<th>Alcohol</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality and outcomes framework</td>
<td>Directed and local enhanced services</td>
</tr>
<tr>
<td>Part of GMS contract for performance management</td>
<td>Optional service</td>
</tr>
<tr>
<td>~£4500 per practice</td>
<td>£2.38 per newly registered patient screened</td>
</tr>
<tr>
<td>Robust monitoring</td>
<td>Less established monitoring</td>
</tr>
</tbody>
</table>

- Concern that lack of QOF indicator represents important missed opportunity to reduce alcohol-related health harms (Alcohol Health Alliance UK 2012)
The need for the current study

- Figures derived from GP recording may over-estimate the delivery of smoking brief interventions
  - Prior to QOF incentives there was good correspondence between GP recording and proportion of patients recalling advice in the national ‘Patient Survey’
  - Since introduction in 2004 the rate of recording has exceeded that of patient recall (Szatkowski et al. 2011)
  - While, patient survey is limited as represents a self-selected sample of patients who chose to return the survey
- Estimates of delivery for alcohol may also be inaccurate because based on the rate at which GPs record screening rather than conduct intervention
  - There are read codes for delivery but rarely used (O’Donnell et al. 2013)
The need for the current study

• In the context of differential financial incentives for their delivery within primary care in England, up-to-date and representative data from the perspective of patients are needed on the prevalence and characteristics of people who smoke or drink excessively and who receive a brief intervention.
Study design and sampling

- Cross-sectional household surveys of representative samples of adults in England
- Each month new sample of ~1800 adults (16+) selected by random location sampling
  - Fidler et al. 2011, Beard et al. in preparation
Study population and measures

Between March to August 2014

8,465 adults aged 16 and over surveyed

1,676 smokers

1,083 hazardous drinkers

966 visited GP in last year

589 visited GP in last year

How many recall receiving at least smoking brief intervention?

How many recall receiving at least alcohol brief intervention?

Range of socio-demographic, smoking and drinking characteristics

Range of socio-demographic, smoking and drinking characteristics
Smokers in England who reported visiting their GP appeared more than eight times more likely to receive advice on their smoking than hazardous drinkers were to be advised about their alcohol consumption.
Associations with smoking brief intervention

No univariable associations with sex, region, educational attainment, children in household, ethnicity, disability or hazardous drinking.
## Associations with smoking brief intervention

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Adj. OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>1.02 (1.01-1.03)*</td>
</tr>
<tr>
<td>Women</td>
<td>1.40 (1.06-1.85)*</td>
</tr>
<tr>
<td>Social grade C2DE</td>
<td>0.72 (0.54-0.96)*</td>
</tr>
<tr>
<td>Region</td>
<td></td>
</tr>
<tr>
<td>North (reference)</td>
<td>-</td>
</tr>
<tr>
<td>Central</td>
<td>1.33 (0.95-1.87)</td>
</tr>
<tr>
<td>South</td>
<td>0.83 (0.61-1.13)</td>
</tr>
<tr>
<td>No post 16 qualifications</td>
<td>0.83 (0.63-1.10)</td>
</tr>
<tr>
<td>Children in household</td>
<td>0.99 (0.72-1.37)</td>
</tr>
<tr>
<td>White</td>
<td>1.13 (0.71-1.81)</td>
</tr>
<tr>
<td>Disability</td>
<td>1.16 (0.80-1.68)</td>
</tr>
<tr>
<td>Hazardous drinking (AUDIT ≥ 8)</td>
<td>1.14 (0.82-1.59)</td>
</tr>
<tr>
<td>Past year quit attempts</td>
<td><strong>1.39 (1.20-1.61)</strong>*</td>
</tr>
<tr>
<td>Time with urges to smoke (0-5)</td>
<td>1.15 (1.00-1.33)</td>
</tr>
<tr>
<td>Strength of urges to smoke (0-5)</td>
<td>1.00 (0.85-1.18)</td>
</tr>
</tbody>
</table>
Associations with alcohol brief intervention

No univariable associations with social grade, region, educational attainment, children in household, ethnicity, or smoking status.
## Associations with alcohol brief intervention

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<tr>
<td>Women</td>
<td>0.40 (0.14-1.12)</td>
</tr>
<tr>
<td>Social grade C2DE</td>
<td>1.12 (0.49-2.56)</td>
</tr>
<tr>
<td>Region</td>
<td></td>
</tr>
<tr>
<td>North (reference)</td>
<td>-</td>
</tr>
<tr>
<td>Central</td>
<td>1.14 (0.44-2.94)</td>
</tr>
<tr>
<td>South</td>
<td>0.79 (0.33-1.89)</td>
</tr>
<tr>
<td>No post 16 qualifications</td>
<td>0.70 (0.29-1.69)</td>
</tr>
<tr>
<td>Children in household</td>
<td>1.16 (0.39-3.46)</td>
</tr>
<tr>
<td>White</td>
<td>0.83 (0.10-7.14)</td>
</tr>
<tr>
<td>Disability</td>
<td>2.07 (0.82-5.26)</td>
</tr>
<tr>
<td>% (N) Smoking status</td>
<td></td>
</tr>
<tr>
<td>Never smoker (reference)</td>
<td>-</td>
</tr>
<tr>
<td>Ex-smoker</td>
<td>1.17 (0.47-2.91)</td>
</tr>
<tr>
<td>Current smoker</td>
<td>0.61 (0.22-1.73)</td>
</tr>
<tr>
<td>Mean (SD) AUDIT score</td>
<td><strong>1.19 (1.12-1.28)</strong> *</td>
</tr>
</tbody>
</table>
Discussion

• Findings similar to estimates from GP recording databases
  – Current figures are up-to-date and from the perspective of patients in a representative sample

• People who scored more highly on AUDIT were more likely to recall a brief intervention
  – Consistent with analysis indicating GPs worse at identifying hazardous/harmful drinkers compared with those who were dependent (Cheeta, Drummond et al. 2008)
Discussion

- Association of smoking brief intervention with age, sex and past quit attempts reflects the profile of treatment-seeking smokers
  - likely related to GPs focusing on smokers who express interest in stopping (Kotz, Fidler et al. 2009)
  - suggest GPs are not yet following the latest national guidance from the NCSCT recommending GPs go straight to the offer of support rather than assess interest in quitting (National Centre for Smoking Cessation and Training, Aveyard, Begh et al. 2012)

- Smokers from a lower social grade appeared less likely to receive an intervention, which is a concern for health inequalities
Implications

• In view of the more substantial financial incentives to intervene on smoking, this study adds to the evidence suggesting that greater incentives (e.g., QOF indicator) would likely be associated with greater delivery of alcohol brief intervention (Michaud et al. 2007; Lapham et al. 2012, Hamilton et al. 2013, 2014)
  – Clearly other possible reasons but magnitude of difference suggests number of factors could be important and there would remain scope for a significant impact of greater financial incentive
Conclusion

• This study highlights the discrepancy between delivery of smoking and alcohol brief interventions in England
• Hazardous drinkers who visit their GP appear more than eight times less likely to receive advice about their alcohol consumption than smokers are to be advised on their smoking
Funders: The ATS is funded by the NIHR School for Public Health Research; The STS is primarily funded by Cancer Research UK; JB is funded by a fellowship from the Society for Study of Addiction. UCL research team is part of UKCTAS.

Co-authors: Robert West, Emma Beard, Alan Brennan, Colin Drummond, Matthew Hickman, John Holmes, Eileen Kaner, Susan Michie

Other ATS collaborators: Karen Lock, Crispin Acton, Matthew Walmsley

For further details: www.alcoholinengland.info (soon), www.smokinginengland.info

jamie.brown@ucl.ac.uk
Smoking & alcohol misuse

- Smoking and alcohol use are two of the five leading risk factors for the global burden of disease (Lim et al. 2012)
Smoking & alcohol misuse

• Smoking and alcohol use are two of the five leading risk factors for the global burden of disease (Lim et al. 2012)
• Reducing this burden is a public health priority and could be addressed by increasing the rate at which health professionals intervene opportunistically
Objective

• The objective of this study was to assess and compare the extent to which patients recall being advised on their smoking and alcohol consumption in the context of differential financial incentives for their delivery within primary care in England
Study population and measures

Between July 2009 and Feb 2014

- **Characteristics**
  - Mean (SD) age
  - % (N) Women
  - % (N) Social grade C2DE
  - % (N) Region
  - % (N) No post 16 qualifications
  - % (N) Children in household
  - % (N) White
  - % (N) Disability

- **Smokers**
  - % (N) Hazardous drinking (AUDIT ≥ 8)
  - Mean (SD) past year quit attempts
  - Mean (SD) time with urges to smoke (0-5)
  - Mean (SD) strength of urges to smoke (0-5)

- **Hazardous drinkers**
  - % (N) Smoking status
  - Mean (SD) AUDIT score (8-40)

8,465 adults aged 16 and over surveyed

Range of socio-demographic, smoking and drinking characteristics
Financial disclosure

• JB & EB has received an unrestricted research grant from Pfizer; RW undertakes research, consultancy & receives fees for speaking from companies that manufacture smoking cessation medications (Pfizer, J&J, McNeil, GSK, Nabi, Novartis, and Sanofi-Aventis); there are no other financial relationships with any organisations that might have an interest in the work

• All funders had no final role in the study design; in the collection, analysis and interpretation of data; in the writing of the report; or in the decision to submit the paper for publication
Investigating local policy drivers for alcohol harm prevention

- A comparative case study of two local authorities in England

John Mooney, Sheffield Alcohol Research Group
ScHARR, University of Sheffield

Co-authors: John Holmes, Alan Brennan, Petra Meier, Matt Hickman, Karen Lock.
Overview

• Background to SPHR WP6 & origins of locally adapted policy model
• New local alcohol policy landscape
• Case study method & LA site selection
• Preliminary results from case study sites
• Use of story-board technique
• Conclusions & Next Steps
SPHR Alcohol Programme

**Overall Aim:**
To identify and evaluate approaches to reducing alcohol-related harm that are relevant in an English public health policy context.

**Overall Structure:**
Involves a cluster of interlinked work-packages that have been developed from a “conceptual framework”/...
SPHR Alcohol Programme: All Six Work-Packages

1. NEW TECHNOLOGIES FOR REDUCING EXCESSIVE ALCOHOL USE
2. DEVELOPING SCREENING AND BRIEF INTERVENTIONS IN POLICE CUSTODY SETTINGS
3. RISKY SEXUAL BEHAVIOUR AND ALCOHOL MISUSE IN YOUNG PEOPLE
4. CHANGING ENVIRONMENTAL CUES TO ALCOHOL CONSUMPTION
5. TRACKING KEY PERFORMANCE INDICATORS OF ALCOHOL CONSUMPTION IN ENGLAND
6. PREVENTING ALCOHOL-RELATED HARM: TESTING AND GENERATING EVIDENCE AND EVALUATIONS FOR LOCAL PRACTITIONERS AND POLICYMAKERS
SPHR Alcohol: Work-Package 6: Guiding Principles / Overall Aims

“to improve the (local) evidence base for cost-effective and generalizable public health interventions (i.e. context specific evidence for alcohol harm reduction)

“to enable local practitioners and policy makers to engage with research and actively seek out high quality evidence to inform their decisions....
Origin & Rationale for the development of A Local Alcohol Policy Model…

• Ultimate response of UK Government to the best evidenced policy intervention at the national level (namely MUP for alcohol)…

• New emphasis on localism for health (and disease prevention…)

• Transfer of specialist Public Health workforce (back…) to local government

• Allocation to DPH within LAs of responsible authority status w.r.t. alcohol licensing
2003 Licensing Act & Revision in 2012

Responsible Authorities:
- Police
- Fire Service
- Health & Safety
- Child Protection
- Trading Standards
- Planning
- Licensing authority
- Director of Public Health

The Licensing Objectives:
1. The prevention of crime and disorder
2. Public safety
3. The prevention of public nuisance
4. The protection of children from harm.
(5. Public health) [Scotland].
Characteristics of local government policy environment

- Influenced by a wide range of factors:
  - Social demographic profile
  - Perceived importance of issue in question
  - Political climate
  - Stakeholder acceptability

So: Strong need to locally tailor policy response → Choice of case study method
Case Study Methodology

- Provides a form of enquiry that elevates a view of life in all its complexity:

“Case study is an in-depth exploration from multiple perspectives of the complexity and uniqueness of a particular project, policy, institution… in a ‘real-life context’”
Case Study ‘Methodology’

- Routinely makes use of multiple methods
- For current work with local authorities in England used:
  - semi-structured interviews
  - documentary analysis
  - non-participant observation
Rationale for Case Study Selection

**Bradford:**
- High alcohol attributable admissions
- Stated Commitment to interventionist approaches (e.g. Signed up to Stirling Recmnds)
- High quality health intelligence around alcohol

**Newcastle:**
- Highest region in England for Alcohol Attributable Mortality & Liver disease
- Commitment to explore innovative structural & fiscal policy solutions
<table>
<thead>
<tr>
<th>Alcohol treatment prevalence per 1,000 population</th>
<th>Months of life lost - males</th>
<th>Alcohol-specific mortality - males</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims of incapacity benefits - working age</td>
<td>Alcohol-attributable hospital admission - males</td>
<td>Alcohol-attributable hospital admission - females</td>
</tr>
<tr>
<td>Alcoholic-related violent crimes</td>
<td>Alcohol-related hospital admission - males</td>
<td>Alcohol-attributable hospital admission - females</td>
</tr>
<tr>
<td>Alcohol-related recorded crimes</td>
<td>Alcohol attributable conditions (previously N12)</td>
<td>Alcohol attributable mortality - males</td>
</tr>
<tr>
<td>Alcohol-specific hospital discharge - males</td>
<td>Mortality from chronic liver disease - males</td>
<td>Alcohol attributable mortality - females</td>
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<tr>
<td>Mortality from liver cirrhosis - females</td>
<td>Mortality from cirrhosis - females</td>
<td>Mortality from cirrhosis - males</td>
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<tr>
<td>Mortality from liver cirrhosis - males</td>
<td>Mortality from liver cirrhosis - females</td>
<td>Mortality from liver cirrhosis - males</td>
</tr>
</tbody>
</table>

### Admission episodes for alcohol-attributable conditions

- Employees in bars - % of all employees
- Drinking binge (synthetic estimate)
- Mortality from land transport accidents
- Alcohol-attributable hospital admission - males
- Alcohol-attributable hospital admission - females
Bradford sample findings

• Stated commitments to tackling wider alcohol harms but in practice approach is very treatment focused (around community ABIs).

• The focus was deliberate, arising out of LAPE profile high admission rates & evidence of ‘hidden’ levels of alcohol misuse in S Asians.
Bradford sample quotes:

“We’ve concentrated first and foremost on getting the treatment system right…”

LA Alcohol Commissioning Lead

“To my mind, most of it is opportunistic, so for someone with HBP, if you don’t ask them about their drinking, your being negligent

LA Public Health Consultant
Newcastle Sample Findings

• Very pro-active programme of interventions to tackle the commercial alcohol high strength cheap drink ban (started May 2014).

• As in some other areas, the Police have taken on leading role in dealings with licensed premises.
Newcastle sample quotes:

“While the current council members are still supportive of business, they are more prepared to acknowledge the downside of alcohol”

LA Public Health Alcohol Lead

“70% (of offenders) identify alcohol as ‘criminogenic’: either because intoxicated at the time or motivated to steal by addiction”

LA Information Specialist

“if we don’t get the night-time economy right – we haven’t got a prayer...”

Police Superintendent
Policy example 1: Cumulative Impact Zones

• Cumulative impact' refers to the detrimental effect on licensing objectives* when a significant number of licensed premises are concentrated in one area.

• A Cumulative Impact Policy creates “a rebuttable presumption that any new application for a premises licence or major variation of one within a specific area, likely to add to the existing cumulative impact, will be refused.”

*Current licensing objectives: (i) the prevention of crime and disorder; (ii) public safety; (iii) prevention of public nuisance, and (iv) the protection of children from harm
Sample Outputs: Use of CIZs in Islington, London
Policy example 2: ‘Reducing the Strength’

• Most often based on a voluntary agreement by licensees…
• …Whereby they undertake to remove all high strength beers and ciders (e.g. >6.5%)
• Targeted initially at dependent drinkers & associated street crime etc.
• Early evaluations promising: Ipswich RTS currently being evaluated by LSHTM
<table>
<thead>
<tr>
<th>Intervention Category</th>
<th>Sub-category &amp; key feature(s)</th>
<th>Policy / Measure</th>
<th>Applicability / examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Availability</strong></td>
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<tr>
<td>Licensing</td>
<td>Licensing 4 Objectives (England &amp; Wales): (i) Crime &amp; disorder prevention (ii) Public safety (iii) Prevention of nuisance (iv) Child protection</td>
<td>Licensing policy statements</td>
<td>Need to be consistent with the (4) licensing objectives</td>
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<tr>
<td></td>
<td>Cumulative impact zones (CIZ’s) re: new licence applications can be challenged if cumulative existing impact is troublesome.</td>
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<td>Individual premises: on or off-trade – where existing provision is already a concern</td>
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<td></td>
<td>Early morning restriction orders (EMRO’s) &amp; Late night Levies (LNLs)</td>
<td>Night-time &amp; early morning restrictions. To date these have not been tried in any LA.</td>
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<td>Conditional Licence measures</td>
<td>Premises specific ’effective MUP’ condition such as only being allowed to supply ’higher’ end-value drinks</td>
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<td>Information based approaches involving ’real-time’ data sharing between agencies such as the Police, NHS and LA</td>
<td>Real-time local intelligence to inform licensing decisions / reviews (e.g. Cardiff Model: whereby police and LA receive geographically referenced incident data from local A &amp; E units).</td>
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<tr>
<td>Planning</td>
<td>Provisions for opening hours / selling conditions</td>
<td>Where licensing and planning provisions differ, an organisation needs to comply with both – so most stringent takes precedence</td>
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<td></td>
<td>Spatial planning</td>
<td>Concentration of outlets – as has been used for fast food takeaways</td>
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<td>Changing trends / Market forces not subject to LA control</td>
<td>The migration of ‘on-trade’ business into city centres and away from local areas.</td>
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<tr>
<td>Behavioural</td>
<td>Brief interventions: starting with screening questionnaire (e.g. AUDIT)</td>
<td>Healthcare settings</td>
<td>- GP practice / Specialist Nurse - A &amp; E setting</td>
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<td></td>
<td></td>
<td>Non-health care settings</td>
<td>- Workplaces - Criminal Justice</td>
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<tr>
<td>Voluntary / (Partnership approaches)</td>
<td>Removal of cheap high strength beers and ciders</td>
<td>On and off trade – although principally affects ’off-trade’.</td>
<td>Ipswich Model: 2/3 of all off-licence &amp; retailers signed up</td>
</tr>
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<td></td>
<td>Community Alcohol Partnerships (CAP)</td>
<td>Often focused on teenager / under-age awareness raising</td>
<td>Rotherham CAP: Schools and local on and off-trade premises</td>
</tr>
</tbody>
</table>
How to make sense of pattern of policy provision

One method is to build a story board/…

Case Study 1: City A

Addressing issue offers a means of focusing on higher risk groups

Admissions costly and disruptive

Public Health targets driven

Higher risk longer term of more people
Eventually needing emergency treatment

Regulatory approaches are more politically challenging and perceived to be conflict with local economic growth agenda

Lack of champions for upstream Interventions, such as RTS*

Guiding Question: Why the focus on health service interventions?

*RTS = Reducing the Strength Campaigns
Case Study 2: City B

New licence applications in CIZ areas now need to demonstrate special case status: leads to decline in new applications

Leads to setting up of cumulative impact zones (CIZ)

Hot spots identified using Crime and ambulance data...

Police decide to adopt a preventative approach

High crime & disorder in city centre

Reduced licence approvals: innovative ‘special cases’ such as local MUP

Licence scrutiny can be resource intensive, Potentially diverting attention to less visible (but higher need and harms areas)

Areas without CIZ now seen as ‘welcoming’ for new licences

But CIZ policy is not without its drawbacks...

Q: Why does city B have a strong focus on licensing and availability?
Explanation of map (supl slide)

- Map demonstrates:
  - ‘multi-component strategy’
  - CIZ Covers whole of city centre area…
  - Includes late night levy (since Sept. 2013)
  - Includes two ‘special stress areas’
In Conclusion

- Wide differences apparent in the overall strategic approaches in these two study areas
- Differences appear to have come about through rational decision making re: priorities
- Both areas supported by detailed local intelligence on alcohol harms – so in good position to monitor & review
- Treatment services and prevention not seen as ‘mutually exclusive’ but complementary & better integration sought in both areas…
Current Status of LA Policy Work

- Finalising transcript coding (10-12 agreed secondary level codes)
- Beginning detailed documentary analysis
- Comparing lessons learned with collaborating sites (3 Depts; 6 LA’s)
- Larger audit of LA Alcohol strategies being undertaken in collaboration with PHE
Acknowledgement of funding source

Funded by UK NIHR, School for Public Health Research
Joint project leads: Prof. Alan Brennan (ScHARR) & Dr Karen Lock (LSHTM, University of London)

Collaboration also with Universities of Bristol & Liverpool / Lancaster (LiLAC)

This is an outline of independent research funded by the NIHR SPHR
The views expressed are those of the author(s) and not necessarily those of the NHS, the NIHR or the Department of Health.
Public health and alcohol licensing in England
LGA and Alcohol Research UK briefing