Year 10 pupils drinking alcohol in the last 7 days

Alcohol-related admissions caused by disease
- Digestive, 9%
- Circulatory, 15%
- Cancers, 25%

Alcohol health harm
East Sussex

Average monthly alcohol-related call-outs
Excess deaths in the most deprived areas due to alcohol-specific causes, 2012-2014
- Wealden: Males 5, Females 3
- Rother: Males 6, Females 3
- Lewes: Males 1, Females 3
- Hastings: Males 16, Females 6
- Eastbourne: Males 8, Females 1

Why drink?
- Low mood/depression
- Drinking culture
- Boost confidence
- Available & affordable
- Boredom
- Sociable
- Coping mechanism
- Wind down at the end of the day

East Sussex Public Health
October 2016
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Executive Summary

This report provides an update to the report *Alcohol related health harm in East Sussex, February 2015.*

The key findings from this year’s report are as follows:

**Consumption**
- Young people (15 year olds) in East Sussex have significantly higher alcohol consumption compared to the England average. Year 10 pupils reporting that they had had a drink in the last 7 days was highest in Wealden and Hastings.

- Over a third of adults drink alcohol every week. Notable differences between males and females – more males drink alcohol, more regularly and at higher risk – 1 in 3 males compared to 1 in 10 females who drink are drinking at higher risk.

**Reasons for drinking**
- The reasons local people give on why they find alcohol attractive include: low mood/depression; boredom; coping mechanism; peer pressure; availability and affordability and boosts confidence.

**Levels of understanding of safe drinking**
- There is confusion around safe drinking limits with both adults and young people not understanding how to measure the units they are consuming.

- Although limited, there is some awareness of health risks but this is not a deterrent, with young people in particular feeling confident that health problems won’t happen to them.

**Alcohol-related harm**
- Alcohol-related health harms (admissions and deaths) are significantly worse than England in Hastings. Eastbourne generally has similar levels of alcohol-related health harm to England, with Lewes, Rother and Wealden either similar too or significantly better compared to the national average. Alcohol health harm is higher for males.

**Impact on health services**
- A&E attendances during the night-time economy due to assaults are higher for males and for 15-24 year olds. Attendance rates are significantly higher.
than the county average in Eastbourne and Hastings. There are higher rates for persons from more deprived areas.

- Alcohol-related ambulance call-outs have seen a 17% increase in 2015/16 compared to 2014/15. Half are between 8pm and 4am with a further 1 in 5 between 4pm and 8pm. Numbers are highest in Eastbourne and Hastings town centres and in the month of August.

Inequality in life expectancy
- Deaths from alcohol contribute to the gap in life expectancy between the most and least deprived areas within districts and boroughs. In East Sussex the largest impact is on males living in the most deprived parts of Hastings.
Introduction

The overarching aim of the East Sussex Alcohol Strategy 2014-2019 is to make East Sussex a safer and healthier place; it has 3 priority areas:

1. Develop individual and collective knowledge, skills and awareness towards alcohol
2. Provide early help, intervention and support for people affected by harmful drinking
3. Create better and safer socialising

This report focuses on the health aspects of alcohol and pulls together information on alcohol-related behaviours and health outcomes in East Sussex. It provides an update to *Alcohol related health harm in East Sussex, February 2015*. Updates include: alcohol consumption in East Sussex, A&E attendances due to assaults, alcohol suspected ambulance call-outs, alcohol-related hospital admissions and deaths from alcohol. Where there is no new data, it has been stated within the report and information from the previous report has been presented.

The report draws on local and nationally produced data from lifestyle surveys, the ‘East Sussex Drink Debate’, ambulance call-outs, A&E attendances, hospital inpatient admissions and mortality data. Due to the complexity of the issues and limitations of data (despite using a range of data sources) it cannot capture the full extent of the burden that alcohol places on health in East Sussex, but only that which can be measured. Within each section the relevant key objective or outcome from the alcohol strategy has been highlighted.
Alcohol consumption – young people

Key strategy outcome: reduce number of young people & adults drinking above safe limits (priority 1)

70% of 15-year olds in East Sussex have ever had an alcoholic drink. This is significantly higher than the England average of 62%.

8% of 15-year olds in East Sussex report drinking regularly, significantly higher than the England average of 6%.

1 in 5 15-year olds in East Sussex have been drunk in the last 4 weeks, significantly higher than 1 in 7 for England.

Year 10 pupils reporting they had had an alcoholic drink in the last 7 days ranges from 28% in Eastbourne to 39% in Hastings and Wealden (Figure 1).

Figure 1
Alcohol consumption - adults

Key strategy outcome: reduce number of young people & adults drinking above safe limits (priority 1)

Based on the Local Alcohol Consumption Survey, for East Sussex adults:

- **20% never** drink alcohol
- **35%** drink alcohol **every week**

There are clear differences in the frequency of drinking between males and females with a higher proportion of males drinking alcohol and drinking it more regularly.

**Figure 2**

Almost 1 in 4 (23%) males are drinking 4 or more times a week compared to fewer than 1 in 10 (8%) females. These are higher proportions compared to the survey averages (17% and 7% respectively).

The Local Alcohol Consumption Survey sampled adults in 25 local authorities. East Sussex data is based on 346 postal survey responses and 305 face-to-face interviews during 29th Feb – 25th April 2016. Analyses are based on data weighted by gender, age and ethnicity.
Of those who report consuming alcohol, **1 in 5** are doing so at **higher risk**.

Data source: AUDIT (Alcohol Use Disorders Identification Test) score from Local Alcohol Consumption Survey, 2016

Figure 3

Of adults who drink alcohol:

more than half the time people are doing so at home

12% only ever drink alcohol at home

12% never drink alcohol at home

Low risk = Zone 1 from AUDIT (lower risk)
Higher risk = Zone 2, 3 & 4 from AUDIT (increasing risk, higher risk and possible dependent)

For East Sussex **males** who drink, **32%** are doing so at higher risk compared to **10%** for **females**

East Sussex Public Health, 2016
Why do people find alcohol attractive?

Key strategy outcome: reduce number of young people & adults drinking above safe levels (priority 1)

The main reasons participants gave for drinking alcohol

Data source: East Sussex Drink Debate Report 2013: Report on qualitative research, Abacus Insight

East Sussex Safer Communities Partnership conducted the East Sussex Drink Debate for 6 weeks from April 2013. The Debate asked people how alcohol features in the lives of individuals, families and communities. Responses were elicited online or in printed forms. Residents and stakeholders were engaged in an open discussion on a range of alcohol-related issues through qualitative research with 136 participants in focus groups and telephone interviews.
Understanding units and safe drinking limits

Key strategy objective: increase knowledge, understanding and awareness of healthy drinking limits (priority 1)

Data source: East Sussex Drink Debate Report 2013: Report on qualitative research, Abacus Insight

Local research shows that although a few adults were able to cite recommended safe limits, there is a widespread lack of understanding for both adults and young people about how people measure the units they are consuming.

“You get different quantities and strengths of drink when home and out. It’s impossible to keep count of units”
(Adult)

“I don’t even think about them”
(Young person)

“People don’t know what a unit is. We’re working with clients to explain the recommended guidelines and we are working with the police who pick up people who are drunk and disorderly. We try to educate.”
(Frontline worker)

Although limited, there was some awareness of health risks and young people in particular were confident that health problems wouldn’t happen to them so knowledge of some of the health consequences doesn’t deter them.
A&E attendances between 8pm and 4am due to assault
Key strategy outcome: reduce demand on emergency services (priority 3)

7 in 10 (71%) A&E attendances between 8pm and 4am due to an assault are for males.

1 in 5 attendances are for each of the age groups 15-19 year-olds (19%) and 20-24 year olds (20%). Three-quarters (73%) of the total attendances during the 3-year period were for persons aged 15-39 years with only small numbers for under 15s and over 60s.

Figure 4

A&E attendances between 8pm and 4am due to assaults, East Sussex residents, 2013/14 to 2015/16, by age group

Due to the limitations of national coding that is used for A&E data, it is not possible to capture alcohol-related A&E attendances. Attendances at A&E during the night time economy (8pm to 4am) as a result of an assault is a proxy measure for a very specific aspect of alcohol-related harm. A&E attendance data does not include data for Minor Injury Units (open 8am-8pm only).
The rate of A&E attendances during the night-time economy (8pm-4am):

- For 15-59 year olds, rates for residents in Eastbourne and Hastings boroughs are significantly higher than the East Sussex average. Rother and Wealden have significantly lower rates than East Sussex.
- For 15-24 year-olds, Hastings has the highest rate and a significantly higher rate than East Sussex; Rother and Wealden have the lowest rates which are significantly lower than East Sussex.

Table 1

<table>
<thead>
<tr>
<th></th>
<th>Number of attendances (15-24 years)</th>
<th>Rate per 1,000 population (15-24 years)</th>
<th>Number of attendances (15-59 years)</th>
<th>Rate per 1,000 population (15-59 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastbourne</td>
<td>145</td>
<td>4.0</td>
<td>394</td>
<td>2.4</td>
</tr>
<tr>
<td>Hastings</td>
<td>142</td>
<td>4.3</td>
<td>349</td>
<td>2.2</td>
</tr>
<tr>
<td>Lewes</td>
<td>93</td>
<td>3.0</td>
<td>214</td>
<td>1.3</td>
</tr>
<tr>
<td>Rother</td>
<td>61</td>
<td>2.3</td>
<td>150</td>
<td>1.1</td>
</tr>
<tr>
<td>Wealden</td>
<td>114</td>
<td>2.4</td>
<td>226</td>
<td>0.9</td>
</tr>
<tr>
<td>East Sussex</td>
<td>555</td>
<td>3.2</td>
<td>1333</td>
<td>1.6</td>
</tr>
</tbody>
</table>

- Significantly higher than East Sussex
- No significant difference to East Sussex
- Significantly lower than East Sussex

There are 9 wards that have significantly higher rates of A&E attendances for 15-59 year-olds compared to East Sussex: Devonshire, Hampden Park, Langney and Meads in Eastbourne; Baird, Castle, Central St Leonards and Maze Hill in Hastings and Newhaven Valley in Lewes.

Figure 5
There is an association between A&E attendances for assault during the night-time economy (NTE) and the deprivation profile of the area where patients live. Figure 6 shows that the least deprived wards have the lower rates and the most deprived ward (Central St Leonards) has the highest rate in all of East Sussex.

Figure 6

The number of assault attendances during the NTE slightly decreased in 2014/15 from 2013/14 but increased in 2015/16 to the highest number during the 3-year period with the highest increase in the 25-39 years age band.

Figure 7

Numbers of A&E attendances between 8pm and 4am due to assaults by age groups and year
Alcohol-related ambulance call-outs

Key strategy outcome: reduce demand on emergency services (priority 3)

During 2014/15 there were 3,834 alcohol-related ambulance call-outs and in 2015/16 this increased to 4,485 (a 17% increase) (Figure 8). In both years numbers were highest in August.

Figure 8

Half of the alcohol-related call-outs are during the night-time economy (20:00 – 04:00); a further 21% are between 16:00 and 20:00. There are more alcohol-related call-outs during some hours not in the night-time economy (17:00, 18:00 and 19:00) than in some that are (02:00 and 03:00). Of the night-time economy alcohol-related call-outs around a quarter (26%) are on a Saturday night and a further fifth (21%) on a Friday night. (Figure 9 and 10)

Amulance patient clinical records (PCR) contain an indicator for whether the crew on the scene suspect that alcohol has been involved with the incident, and since March 2013 there is a crew condition code for an alcohol-related call-out. There is an element of the crew on the scene making a judgement call as to the involvement of alcohol and as the PCR relates to the patient, not the perpetrator in the case of an assault for example, it is very likely to underestimate call outs that are attributable to alcohol.
Table 2 shows the main reasons/problems for an alcohol-related call-out during the two-year period 2014/15 and 2015/16. Around 1 in 10 call-outs were for each of: mental health problems, trauma, unconscious/faint and falls<12ft.
Table 2

<table>
<thead>
<tr>
<th>Reason/problem</th>
<th>% call-outs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Issues</td>
<td>11%</td>
</tr>
<tr>
<td>Trauma</td>
<td>11%</td>
</tr>
<tr>
<td>Unconscious/Faint</td>
<td>10%</td>
</tr>
<tr>
<td>Falls &lt;12ft</td>
<td>9%</td>
</tr>
<tr>
<td>NHS 111</td>
<td>7%</td>
</tr>
<tr>
<td>Generally Unwell</td>
<td>6%</td>
</tr>
<tr>
<td>Alcohol Intoxication/Related</td>
<td>6%</td>
</tr>
<tr>
<td>Chest Pain/Cardiac Prob</td>
<td>6%</td>
</tr>
<tr>
<td>Limb/Pain Injury</td>
<td>4%</td>
</tr>
</tbody>
</table>

Figure 11 is a map showing the areas with the highest numbers of alcohol-related ambulance call-outs during 2014/15 to 2015/16. Numbers are based on lower super output area\(^1\) (LSOA) with the darker the area the higher the number. Numbers are generally highest in Eastbourne and Hastings town centres (see figures 12 and 13).

Figure 11

\(^1\) Lower Super Output Areas (LSOAs) are statistical geographies with an average resident population of 1,500
Alcohol-related hospital admissions

Key strategy outcome: reduced alcohol related hospital admissions (priority 2)

At an East Sussex level the alcohol-related hospital admission rate largely follows the national trend. At a district and borough level, Lewes, Rother and Wealden districts have always had lower rates than the national average and Lewes and Wealden have also always had lower rates than East Sussex. Hastings has always had the highest rate and consistently higher than the national average and East Sussex. (Figure 14)

Figure 14

Admission episodes for alcohol-related conditions, narrow measure
(directly age-standardised rate per 100,000 population)
2008/09 to 2014/15

There are different ways to capture alcohol related hospital admissions from looking at alcohol specific reasons only (such as alcoholic liver disease), to diseases and injuries where alcohol can play a part (such as breast cancer or falls). In this report the definition for alcohol related hospitals admission is as per the Public Health Outcomes Framework indicator, a ‘narrow measure’, and includes admissions where the primary reason for admission is an alcohol specific or alcohol-attributable condition. See Appendix for further details.
60% of alcohol-related hospital admissions (narrow measure) are for males.

At a district/borough level, Hastings (44%) has the largest proportion of admissions for females and Lewes (34%) the smallest.

The most recent data (2014/15) shows that for both males and females the alcohol-related hospital admission rates in Hastings are significantly higher than England and in Wealden they are significantly lower. In Lewes, admission rates for females are significantly lower than England. (Figure 15)

Across the county the age profile of these admissions varies with Hastings admissions comprising a younger age profile compared to the rest of East Sussex. In Wealden almost half of admissions for males are for those aged 65 years and over. Admissions for females have a slightly younger age profile compared to males. (Figure 16 and 17)

Figure 15

Admission episodes for alcohol-related conditions, narrow measure (directly age-standardised rate per 100,000 population), 2014/15
Public Health England produces *Local Alcohol Profiles for England (LAPE)* which contain a range of indicators around the harm and impact of alcohol. Table 3 is a summary of hospital admission indicators from the profiles for East Sussex and its districts and boroughs.
Eastbourne has similar rates to England for all indicators; Hastings is significantly worse than England for most indicators and Wealden significantly better. Lewes and Rother districts are either similar to or significantly better than England.

Admissions for under 18s are significantly higher than England in both Hastings and Lewes although numbers are small (relates to around 11 young people per year being admitted in each authority).

Figures 18 and 19 show the proportion of alcohol-related admissions that were due to accidents and injuries, mental and behavioural disorders and alcohol poisoning for both males and females in each district/borough. In all districts and boroughs the highest percentages of alcohol-related admissions in both males and females are for accidents and injuries, except for females in Hastings where alcohol poisoning made up the highest percentage.

Alcohol-related accidents and injuries make up a larger proportion of admissions in males and alcohol poisoning a larger proportion of admissions in females.

The percentages of alcohol-related admissions due to accidents and injuries are highest in Wealden and the percentages due to mental and behavioural disorders highest in Hastings and Eastbourne. Alcohol poisoning is highest amongst males in Hastings comprising over 1 in 10 admissions, and amongst females in Lewes, comprising 1 in 6 admissions.
Compared to England, the alcohol-related admission rate for mental and behavioural disorders is significantly lower for males in Lewes, Wealden and in Rother; the rate is significantly higher for females in Hastings. Admissions for alcohol poisoning are significantly higher for both males and females in Hastings but significantly lower for males in Wealden. (Table 4)
Alcohol-related admissions also include diseases where alcohol can play a part. Previous analysis of 2013/14 admissions data showed that half of alcohol-related admissions in East Sussex were due to alcohol-attributable cancers, circulatory diseases and digestive diseases.

**Figure 20**

**Table 4**

<table>
<thead>
<tr>
<th>Alcohol hospital admissions indicators</th>
<th>England</th>
<th>East Sussex</th>
<th>Eastbourne</th>
<th>Hastings</th>
<th>Lewes</th>
<th>Rother</th>
<th>Wealden</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions for alcohol-related unintentional injuries</td>
<td>140</td>
<td>131</td>
<td>130</td>
<td>34</td>
<td>34</td>
<td>34</td>
<td>135</td>
</tr>
<tr>
<td>Admissions for alcohol-related unintentional injuries - Males</td>
<td>212</td>
<td>200</td>
<td>194</td>
<td>226</td>
<td>195</td>
<td>216</td>
<td>184</td>
</tr>
<tr>
<td>Admissions for alcohol-related unintentional injuries - Females</td>
<td>74</td>
<td>72</td>
<td>74</td>
<td>70</td>
<td>74</td>
<td>71</td>
<td>74</td>
</tr>
<tr>
<td>Admissions for mental &amp; behavioural disorders due to use of alcohol</td>
<td>84</td>
<td>58</td>
<td>79</td>
<td>99</td>
<td>50</td>
<td>46</td>
<td>29</td>
</tr>
<tr>
<td>Admissions for mental &amp; behavioural disorders due to use of alcohol - Males</td>
<td>120</td>
<td>74</td>
<td>105</td>
<td>112</td>
<td>79</td>
<td>60</td>
<td>40</td>
</tr>
<tr>
<td>Admissions for mental &amp; behavioural disorders due to use of alcohol - Females</td>
<td>50</td>
<td>40</td>
<td>57</td>
<td>84</td>
<td>24</td>
<td>33</td>
<td>18</td>
</tr>
<tr>
<td>Admissions for intentional self-poisoning by &amp; exposure to alcohol</td>
<td>52</td>
<td>38</td>
<td>52</td>
<td>98</td>
<td>48</td>
<td>43</td>
<td>35</td>
</tr>
<tr>
<td>Admissions for intentional self-poisoning by &amp; exposure to alcohol - Males</td>
<td>45</td>
<td>48</td>
<td>49</td>
<td>99</td>
<td>33</td>
<td>40</td>
<td>25</td>
</tr>
<tr>
<td>Admissions for intentional self-poisoning by &amp; exposure to alcohol - Females</td>
<td>59</td>
<td>61</td>
<td>55</td>
<td>96</td>
<td>65</td>
<td>46</td>
<td>45</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Significantly worse compared to England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significantly better compared to England</td>
</tr>
</tbody>
</table>

All indicators are directly age-standardised per 100,000 and for 2014/15

All alcohol-related admissions are as per the narrow measure

Source: Local Alcohol Profiles for England, PHE
Dependent drinkers

Key strategy outcome: local people who need help from alcohol misuse can quickly access treatment (priority 2)

It is estimated that around 5% of dependent drinkers are in treatment. There is variation across the districts and boroughs.

Figure 21

Estimated percentage of dependent drinkers in treatment, by local authority

- Eastbourne: 6%
- Hastings: 9%
- Lewes: 4%
- Rother: 4%
- Wealden: 4%

The previous alcohol health harm report suggested an estimate of 6,600 dependent drinkers in East Sussex. This estimate was based on the JSNA support pack for strategic partners – data for alcohol - East Sussex, 2013. NICE (The National Institute for Health and Care Excellence) suggest that 3.8% of the adult population are dependent drinkers (17,100) with 84% of these mildly dependent (14,400), 14% moderately dependent (2,400) and 2% severely dependent (300) (based on data from the Adult Psychiatric Morbidity Survey 2007). These prevalence estimates have been used for the updated figures presented in this report.
The majority of the adult in-treatment population are males (60%). In terms of age, 1 in 10 (10%) of the adult in-treatment population are aged under 30 years, a third (32%) aged 40-49 years and 1 in 7 (15%) aged 60 years or over.

Of adults entering treatment during 2015/16 (new presentations):

**21% live with children (own or other)**, this compares to 24% nationally.

**21% are parents not living with children**, this compares to 27% nationally.

During 2015/16 there were **215** children living with adults who were receiving alcohol treatment.
Alcohol-related deaths

There are on average around 68 alcohol-related deaths per year in East Sussex ranging from an average of 11 per year in Lewes to 17 per year in Hastings. During 2011-2015, 63% of deaths were due to alcoholic liver disease, 22% from fibrosis and cirrhosis of the liver, 7% from mental and behavioural disorders due to alcohol use and 4% from accidental alcohol poisoning.

Table 5

<table>
<thead>
<tr>
<th>Age group</th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 45s</td>
<td>24</td>
<td>14</td>
<td>38</td>
<td>11%</td>
</tr>
<tr>
<td>45-54</td>
<td>57</td>
<td>27</td>
<td>84</td>
<td>25%</td>
</tr>
<tr>
<td>55-64</td>
<td>62</td>
<td>32</td>
<td>94</td>
<td>28%</td>
</tr>
<tr>
<td>65-74</td>
<td>53</td>
<td>19</td>
<td>72</td>
<td>21%</td>
</tr>
<tr>
<td>75+</td>
<td>32</td>
<td>20</td>
<td>52</td>
<td>15%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>228</td>
<td>112</td>
<td>340</td>
<td>100%</td>
</tr>
</tbody>
</table>

Data source: ONS Public Health Mortality Files. ONS national statistics definition used – includes causes regarded as being most directly due to alcohol consumption, differs from definition used in local alcohol profiles. (See appendix)

Two-thirds (67%) of alcohol-related deaths are for males. Around 1 in 10 (11%) are for persons aged under 45 years with the majority being for persons aged 45-74 years.

Table 6

The Local Alcohol Profiles for England (LAPE, Source: Public Health England) show that across East Sussex mortality rates from alcohol-specific causes, alcohol-related causes and from chronic liver disease are generally similar to the England rates except in Hastings which has significantly higher rates of alcohol-specific mortality and chronic liver disease, particularly in males.
Alcohol and inequality in life expectancy

Inequalities exist within districts and boroughs with the most deprived areas experiencing lower life expectancies compared to the least deprived areas. Public Health England have developed a tool that breaks down the life expectancy gap by cause of death and have identified the contribution of alcohol-specific deaths to gaps in life expectancy at a local authority level.

Figures 23 and 24 show the life expectancy at birth for males and females in the most and least deprived quintiles (20%) for each local authority area, as well as the contribution to the gap from alcohol-specific mortality.

Figure 22 explains how the data has been presented.

For example, for males in Rother, the life expectancy in the least deprived quintile is 83 years and in the most deprived quintile it is 76.5 years, so there is a gap of 6.5 years, identified by the length of the whole arrow bar (both light and dark purple). The dark purple block at the end of the arrow is the potential gain in life expectancy in the most deprived area if it experienced the same alcohol-specific mortality as the least deprived area which for males in Rother this is 0.3 years. The light purple bar is the gap in life expectancy if the males in the most deprived areas had the same alcohol-specific mortality rate as the males in the least deprived areas (6.2 years).
For both males and females the contribution of alcohol to the gap in life expectancy is greatest for those living in the most deprived areas of Hastings, with a potential gain in life expectancy of one year for males and half a year for females if they experienced the same alcohol-specific mortality rates as males and females living in the least deprived areas. For males in Lewes there is no potential gain (i.e. alcohol-specific deaths do not contribute to the gap and it is due to other causes of death).
Whilst Eastbourne has the second largest potential gain in life expectancy for males, it has the least for females.

Comparing the alcohol-specific death rates in the least deprived areas with the most deprived areas allows the number of ‘excess deaths’ to be calculated. For example, in 2012-14 in Eastbourne there were an ‘extra’ nine deaths due to alcohol-specific causes in the most deprived areas compared to the least deprived areas, eight for males and one for females. If these areas experienced exactly the same rates of alcohol-specific mortality the excess deaths would be zero.

Over the three-year period Lewes (4) had the fewest excess deaths due to alcohol-specific causes in its most deprived areas and Hastings (22) had the most. Eastbourne and Rother both had nine excess deaths but there were more for males in Eastbourne.
Alcohol-related road traffic accidents

Compared to England, alcohol-related road traffic accidents are significantly higher in Wealden and Rother districts. (Source: Local Alcohol Profiles for England, PHE 2016)

Figure 26

Alcohol-related road traffic accidents (at least one driver failed a breath test), rate per 1,000 accidents, 2012-2014

- England
- Wealden
- Rother
- Lewes
- Hastings
- Eastbourne

Rate per 1,000 accidents

= significantly higher rate compared to England
Claimants of benefits due to alcoholism

Eastbourne and Hastings have significantly higher rates of claimants of benefits where alcohol misuse is the main disabling condition and Lewes, Rother and Wealden have significantly lower rates, when compared to the national average. (Source: Local Alcohol Profiles for England, PHE 2016)
Key findings

Consumption

- Young people (15 year olds) in East Sussex have significantly higher alcohol consumption compared to the England average. Year 10 pupils reporting that they had had a drink in the last 7 days was highest in Wealden and Hastings.

- Over a third of adults drink alcohol every week. Notable differences between males and females – more males drink alcohol, more regularly and at higher risk – 1 in 3 males compared to 1 in 10 females who drink are drinking at higher risk.

Reasons for drinking

- The reasons local people give on why they find alcohol attractive include: low mood/depression; boredom; coping mechanism; peer pressure; availability and affordability and boosts confidence. NO UPDATE

Levels of understanding of safe drinking

- There is confusion around safe drinking limits with both adults and young people not understanding how to measure the units they are consuming. NO UPDATE

- Although limited, there is some awareness of health risks but this is not a deterrent, with young people in particular feeling confident that health problems won’t happen to them. NO UPDATE

Alcohol-related harm

- Alcohol-related health harms (admissions and deaths) are significantly worse than England in Hastings across a range of indicators. Eastbourne generally has similar levels of alcohol-related health harm to England, with Lewes, Rother and Wealden either similar too or significantly better than the national average. Alcohol health harm is higher for males than females.
Impact on health services

- A&E attendances during the night-time economy due to assaults are higher for males and for 15-24 year olds. Attendance rates are significantly higher than the county average in Eastbourne and Hastings. There are higher rates for persons from more deprived areas.

- Alcohol-related ambulance call-outs have seen a 17% increase in 2015/16 compared to 2014/15. Half are between 8pm and 4am with a further 1 in 5 between 4pm and 8pm. Numbers are highest in Eastbourne and Hastings town centres and in the month of August.

Inequality in life expectancy

- Deaths from alcohol contribute to the gap in life expectancy between the most and least deprived areas within districts and boroughs. In East Sussex the largest impact is on males living in the most deprived parts of Hastings.
What does this mean for local action?

The findings of this report indicate that local action needs to focus on the following:

- Delaying onset of drinking and reducing alcohol consumption in young people.

- Helping people to understand safe drinking limits in line with Chief Medical Officer guidelines.

- Reducing alcohol-related harm where need is greatest, that is, in Hastings Borough where interventions need to be targeted in the more deprived areas and with a particular focus on men.

- Working to address the underlying reasons why people use alcohol as a coping mechanism and enabling those who are drinking at unsafe levels due to mental health issues to access other means of support and intervention.

- Addressing alcohol-related A&E attendances and ambulance call-outs in Hastings and Eastbourne town centres both during the night-time economy and early evening, particularly on Friday and Saturday nights with the month of August requiring particular attention. Particular attention to be given to reducing levels of accidents and injuries.

- Encouraging dependent drinkers to access treatment and health professionals to raise the issue of alcohol intake with their patients, making every contact count.

- Targeting drink-driving in the rural areas of Rother and Wealden.

All interventions to tackle alcohol-related harm should be based on the best available evidence. The international evidence on the prevention of drug and alcohol use (PHE, 2015) can be used as a guide. This classifies interventions as:

- ‘Universal’, where they address an entire population (e.g. TV audience, local community, school pupils);
- ‘Selective’, where they serve specific sub-populations (e.g. individuals, groups, families and communities, whose risk of substance misuse is known to be higher than average, either imminently or over a lifetime) and
- Indicated, where prevention is aimed at people who are already using substances, are not yet experiencing dependence, but who may be showing
signs of problematic use (e.g. falling grades at school, absenteeism from work, antisocial behaviour, mental health problems).

When designing interventions, it is important to bear in mind that:

- The social, economic and environmental circumstances within which people live and work impact on their vulnerability and exposure to problems or stressful life events, which in turn influence alcohol-related health harm. (See appendix III for further detail)

- Many of the prevention interventions that influence alcohol use may not be alcohol-specific and may already exist as broader interventions (such as parenting programmes, education in schools around personal and social skills, increasing social support to people who are isolated and lonely).

- Evidence and good practice guidance indicates that communities should be involved in the co-production of solutions to address alcohol issues in their own area (an important consideration for work in Hastings).

- In tackling alcohol misuse and associated harm and disorder, partnership work is key as it requires education, awareness-raising, enforcement, industry involvement, community initiatives, and care and treatment provision.

Interventions should be carefully monitored and evaluated to assess they are meeting identified need and achieving intended outcomes.
Appendix I – alcohol-related admissions and alcohol-specific deaths definition

https://publichealthmatters.blog.gov.uk/2014/01/15/understanding-alcohol-related-hospital-admissions/

Alcohol causes, or can contribute to the development of, many health conditions. Academics have been able to use high quality research evidence to estimate what proportion of cases of a health condition are alcohol-related. Conditions such as alcoholic liver disease where alcohol is the sole cause are known as alcohol-specific or wholly alcohol-attributable conditions and their alcohol-attributable fraction is 1.0 (100 per cent). For other conditions, where alcohol has a proven relationship but it is one of a range of causative factors, an estimate of the contribution alcohol makes is calculated. For example, it is estimated that alcohol plays a causative role in 25-33 per cent of cardiac arrhythmias. These are the partially alcohol-attributable conditions and the alcohol-attributable fractions would be 0.25-0.33. Fractions differ slightly for men and women. Some external cause codes also have an alcohol-attributable fraction (for example, 27 per cent of assaults are estimated to be alcohol-related and therefore the alcohol-attributable fraction is 0.27).

The total number of alcohol-related hospital admissions, as described by the indicator, is not a number of actual people or a number of actual admissions but an estimated number of admissions calculated by adding up all of the fractions we have identified.

In this report, alcohol related admissions are the number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause (referred to as a narrow measure, and is used in the Public Health Outcomes Framework). The indicator is a directly age-standardised rate per 100,000 population, standardised to the 2013 European Standard population (2013 ESP).

See the Local Alcohol Profiles for England (LAPE) user guide for further details: http://www.lape.org.uk/downloads/Lape_guidance_and_methods.pdf
Alcohol-attributable fractions used to calculate alcohol-related hospital admissions

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*note for alcohol-specific deaths and inequality in life expectancy definition uses all wholly attributable conditions except T51.0 and T51.1
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Appendix II – alcohol-related deaths definition

The Office for National Statistics (ONS) definition for alcohol-related deaths is where the underlying cause is one of:

- mental & behavioural disorders due to use of alcohol (ICD10 F10)
- degeneration of nervous system due to alcohol (ICD10 G312)
- alcoholic polyneuropathy (ICD10 G621)
- alcoholic cardiomyopathy (ICD10 I426)
- alcoholic gastritis (ICD10 K292)
- alcoholic liver disease (ICD10 K70)
- chronic hepatitis, not elsewhere classified (ICD10 K73)
- fibrosis and cirrhosis of liver (ICD10 K74, excluding K743-K745 – biliary cirrhosis)
- alcohol induced chronic pancreatitis (ICD10 K860)
- accidental poisoning by and exposure to alcohol (ICD10 X45)
- intentional self-poisoning by and exposure to alcohol (ICD10 X65)
- poisoning by and exposure to alcohol, undetermined intent (ICD10 Y15)
Appendix III – alcohol harm and influencing factors


Although the volume of alcohol consumed is a clear indicator of potential harm to health, other factors affect the relationship. The impact of harmful drinking and alcohol dependence is much greater for those in the lowest income bracket and those experiencing the highest levels of deprivation. The reasons for this are not fully understood. People on low income do not tend to consume more alcohol than people from higher socio-economic groups. The increased risk is likely to relate to the effects of other issues affecting people in lower socio-economic groups.

For further detail on the impact of social determinants and alcohol harm please see Alcohol and inequities. Guidance for addressing the inequities in alcohol-related harm. World Health Organization (WHO), 2014.