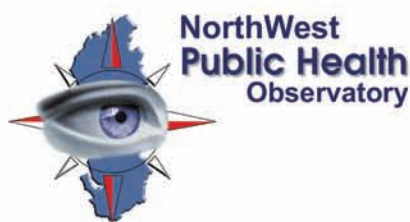


Alcohol pen portraits: segmentation series report 4

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Executive summary

Approximately a fifth of the population in England are thought to drink at hazardous levels of consumption, and a further 5% at harmful levels. Such levels of consumption are associated with a wide range of health, crime and economic harms. However, neither consumption nor harms are universally experienced, and in order to effectively target interventions, it is vital to understand which populations are most at risk. Segmentation tools are one way of doing this, allowing the grouping of populations by age, gender, lifestyle, attitude and motivation. To further understand population segmentation in alcohol misuse, the North West Public Health Observatory has published a series of four reports utilising segmentation tools to discuss alcohol consumption, attitudes and related admission. The first three reports in the series discuss attitudes to alcohol consumption, consumption and related hospital admissions respectively. This report, the fourth in the series, summarises the findings and presents them by classification in order to present an overview of the attitudes, consumption and harms experienced by each segmentation type.

When reading this series of reports, it is important to bear in mind that the findings presented represent only the starting point in understanding alcohol through segmentation techniques and that further research is required to fully comprehend the nuances that exist both between and within the segments.

This report builds on the data analysed and presented in the earlier three reports surrounding attitudes, alcohol consumption and alcohol-related hospital admission. Thus a range of data sources were used in the analysis including: survey data from the North West Big Drink Debate, and North West Regional Health and Lifestyles Survey, and Target Group Index for Great Britain; and an extract from the Hospital Episode Statistics (England for 2006/07).

Key findings from this report show:

- Affluent groups drink higher quantities of wine, and some groups have high levels of hazardous

consumption. They enjoy drinking with food and entertaining. They typically have lower levels of alcohol-related hospital admission. However, admission amongst more affluent groups is increasing. Affluent groups were more inclined to believe that red wine can prevent heart attacks and were aware of the link between consumption and weight gain. However, whilst education is vital in this group, messages must be appropriately directed as they were more likely to believe that they knew enough about the health messages.

- For deprived groups, levels of alcohol consumption contrasted starkly with their experiences of hospital admission. This is because whilst there was very limited evidence of a link between heavier consumption and deprivation, rate of admission was much higher in more deprived groups. Further work is required to establish whether this is due to other socio-economic mediating factors or because of inadequate data collection methods in these groups. Whilst the main motivations for consumption for deprived groups were also around consumption with food and for socialising, deprived groups were more likely than affluent groups to report drinking in order to forget problems and to drink in order to relieve boredom (particularly in males). These represent possible avenues for exploration in developing appropriate interventions.
- Older groups had similar levels of hazardous and harmful consumption to the regional average. However, older people may be more vulnerable to the physical effects of alcohol on the body, and thus experience greater risk at these lower levels. In fact, levels of alcohol-related hospital admission were particularly high in the some of the older groups, especially in the deprived older groups. Older people were more likely to report having concerns relating to alcohol abuse

in the community (e.g. children drinking in the park) and were more likely to report low levels of self-efficacy.

- Younger groups showed the highest levels of consumption and, in some cases had higher levels of alcohol-related hospital admission for mental and behaviour disorders specific to alcohol as well as acute conditions related to alcohol. Motivations for consumption tended to be around consuming alcohol with food, socialising and confidence boosting. Potential interventions for this group would include a minimum price for alcohol because research has shown that this is particularly effective amongst hazardous and harmful consumers.
- The main motivations for consumption for family groups were around consuming alcohol with food and for socialising. Levels of consumption were, in general, similar to the North West overall (a region with significantly higher levels of alcohol misuse than nationally). Experiences of alcohol-related hospital admission varied according to level of deprivation with more deprived family groups being more likely to experience higher levels of admission. Tackling parental misuse of alcohol presents opportunities to

engage with both parents and their children, and research elsewhere has shown promising effects of family interventions on children's consumption.

- Suburban Stability was a group present in P² that did not easily fit into the above categories and so is discussed separately. As for the general population, the main motivations for consumption were around consuming alcohol with food and for socialising. Levels of consumption were, in general, similar to the North West overall (a region with significantly higher levels of alcohol misuse than regionally). This group experienced significantly higher levels of chronic alcohol-related harm than nationally. Further work is needed to understand this group.

Findings such as these are vital in understanding consumption in different populations, and should be used (in conjunction with the other reports in this series and further research) to develop targeted interventions and campaigns. It is only through understanding the populations at risk that effective support, alternative activities and appropriate information can be supplied.

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1 Introduction

1.1 Alcohol misuse

In England, it is estimated that a fifth of the population drink at hazardous levels and a further 5% drink at harmful levels.^[3] Such levels of alcohol misuse have been associated with a wide range of health, crime and economic harms.^[3-5] However, alcohol consumption and related harms are not universally experienced across the country, with areas having different experiences depending on factors such as deprivation.^[3] In order to target interventions, it is vital to understand which populations are most at risk, together with their experiences and use of alcohol.

1.2 Social marketing techniques and segmentation

Social marketing was endorsed through the Government White Paper *Choosing Health* as a health promotion framework to tackle lifestyle harms.^[6] It encourages the development of interventions that are built on deep consumer insight and strategies of effective and sustained engagement.^[7] It can use a wide range of intervention formats such as education, new media and legislation, although the most appropriate mix will depend on the individual group targeted.^[7]

Geodemographic segmentation can be used to maximise the evidence for social marketing interventions (Box 1).^[7-9] This is because it can provide an understanding of people who may have common motivations and lifestyle patterns, and because the technique goes beyond traditional methods of grouping people by age and gender to grouping populations by lifestage, lifestyle, attitude and motivations.^[8] This method is particularly useful when local data are limited or do not exist.^[7]

There are a number of segmentation tools available, and the most appropriate tool to use depends on individual requirements. To date, the North West Public Health Observatory (NWPHO) has recommended the use of People and Places (P²)^[10] because it provides a greater level of discrimination by deprivation than the other systems available.^[9] Others such as Mosaic are also widely used.^[11] However, information is limited as to what extent analyses performed through the different segmentation tools reflect each other, and whether they show the same pattern. This report uses Mosaic and P² categories to provide a summary of the report series.

Box 1: Segmentation techniques

Geodemographic segmentation aims to divide the population into groups, and make members of each group as similar as possible, whilst simultaneously differentiating between the groups as far as possible.^[7] The systems are derived from large numbers of variables (up to 400) that have been collected from an array of different sources, such as the national census and Health Survey for England.^[11] These provide information on factors such as demographics, socio-economic status, housing type and lifestyle. A cluster analysis is then performed to identify typologies. The systems may use different variables and/or algorithms in their development.^[7]

1.3 This series of alcohol reports

This report, published by the NWPHO, is part of a series of four reports utilising segmentation tools to discuss:

- Alcohol-related attitudes and motivations;^[12]
- Alcohol consumption;^[13]
- Alcohol-attributable hospital admission;^[14] and

- Pen portraits (this report). (See Box 2 for a definition of the term.)

Together, the reports aim to synthesise the different data sources that identify at-risk groups as well as to provide an insight into related motivations and attitudes. This report, the final in the series, is a summary document, bringing together the intelligence gathered to provide an in-depth understanding of the groups. The report

provides suggestions for the next steps in developing a truly insightful understanding of the groups through qualitative research. It

suggests areas for further exploration within these contexts and within subsequent social marketing campaigns.

Box 2: Pen Portraits

The development of pen portraits is a technique used in social marketing to aide practitioners in defining their target audience. The pen portrait is a fictitious character to which a message or an intervention is targeted. Practitioners define who the pen portrait represents, their motivations, their likes and dislikes, their peer group, and even their name. The message or intervention developed must serve this character. The magazine 'Marie Claire' has created one such pen portrait as an example of their reader, who they see as having an average age of 33 years, and who enjoys spending money on clothes and toiletries.^[15]

2 Methodology

This report builds on the data analysed and presented in the earlier three reports surrounding: attitudes,^[12] alcohol consumption,^[13] and alcohol-attributable hospital admission.^[14] (For the individual methodologies used in these analyses, see the relevant report.)

Table 1: Classification systems.

Classification system	Number of segments	Segmented according to...
Mosaic	11*	Age, deprivation, urban vs rural, and lifestyle factors such as career, family and housing status
People and Places (P ²)	13*	Age, deprivation, ethnicity, urban vs rural and lifestyle factors such as career and family status

*Two segments were not included in this analysis: Unclassified from each of P² and Mosaic classification systems.

2.2 Variables investigated

Using the Mosaic and P² classification systems, this report presents data on:

- The estimated proportion of the sampled populations who were hazardous drinkers (consuming 15 to 35 units per week for females and 22 to 50 units for males – one unit was defined as being 10ml or 8g of pure alcohol).
- The estimated proportion of harmful or 'higher risk' drinkers under new terminology (consuming more than 35 units per week for females and more than 50 for males).^[16]
- Details of typical consumption preferences, motivations and alcohol-related concerns.
- Rates of acute and chronic alcohol-attributable hospital admission (report number 3 has further details on the types of admission were included for the analysis).^[14]

2.3 Presenting the data

Tables display key findings for the groups in relation to the proportion of hazardous drinkers; the proportion of harmful drinkers; the rate of alcohol-attributable acute hospital admission; and the rate of alcohol-attributable chronic admission. Other relevant findings from the series are also discussed where appropriate. When this

2.1 Geodemographic analysis

People and Places (P²) and Mosaic (Table 1) are used in this report to display likely characteristics of population groups in terms of consumption patterns, preferences and hospital admission related to alcohol.

occurs, references are provided to the relevant report.

Segments from Mosaic and P² have been grouped by deprivation and lifestage for comparison purposes.^[8] Thus, classifications have been grouped under the following headings: affluent groups, deprived groups, older groups, younger groups, family groups and the P² group Suburban Stability is discussed separately (as it does not obviously fall under the other headings). Where segments fitted into more than one category, they have been listed under each of the appropriate headings (this was only applicable for a small number of groups). Each section provides a brief description of the classifications discussed.

Within their groups, the classifications are ranked according to average income levels or average income deprivation (that is the proportion of the population living in households with an income of <60% of median). Percentages are discussed as being significantly different from the average where the 95% confidence intervals (95% CIs) do not overlap. Although figures have been rounded to one decimal place, significance is taken from the unrounded figure. Cells shaded in dark green are significantly higher than the average, and cells shaded in light green are significantly lower than the average (see key below). Data were analysed using SPSS version 17.

Key for tables:

Dark green cell	Significantly <i>higher</i> than average
Light green cell	Significantly <i>lower</i> than average
95% CI	95% confidence interval
DSR	Directly standardised rate

2.4 Data limitations

The limitations of the individual data analyses are presented in the respective reports.^[12-14] However, there are a number of issues that should be raised here:

- Data on consumption and some of the intelligence surrounding attitudes are for the North West,^[12, 13] a region with higher levels of alcohol consumption and related harm compared with elsewhere in England.^[3, 17] Target Group Index (TGI) data are for Great Britain,^[12] and hospital data are for England.^[14] This may affect comparability between the data.
- Because report 1 (on consumption motivations, attitudes and concerns) was only able to examine Mosaic and P² classifications, these are the only

classifications discussed in this final summary report.

- All area-based classifications are subject to ecological fallacy.^[7] Thus, not every individual, nor any individual in particular, will necessarily demonstrate all of the characteristics of the area in which they live.
- Individuals may move between the segments over time and in different situations.^[18]

Thus, the classifications can only provide a statistically-based stereotype and should always be used in conjunction with other local knowledge. This analysis provides a starting point with which to compare likely differences between geographical areas, so that further insight can be gathered.

3 Findings

3.1 Affluent groups

The groups considered under this heading and their characteristics are highlighted in Box 3. Whilst there are evident similarities in the groups collated for this section, they do contain people at three very different lifestages which may affect motivations to drink: those with young dependent children, those with older children and those whose children have left home, as well as those who are retired. It is important to consider individual lifestage in undertaking further research.

3.1.1 Consumption preferences and motivations

In general, the analysis from the first report in the series showed that a relatively high proportion of the people in affluent groups reported that they enjoyed consuming alcohol with food and that they enjoy entertaining at home.^[12] This was especially the case for females. In fact, these groups were more likely to report that most of their alcohol consumption was done in the home. This may be to relax, as associations were identified between lower levels of deprivation and drinking without friends/family, especially for wine consumption. There were high levels of wine consumption in these more affluent groups in a variety of settings (at home and outside the home, with food and without, and with friends/family).^[12] Females were most likely to consume wine. For males, high proportions reported drinking beer/lager/cider/ale (hereafter referred to as beer) outside the home (with and without food). Men also consumed dark spirits in the home when relaxing.

3.1.2 Consumption

Overall, rates of harmful drinking were similar to or lower than the regional average (Table 2). However, hazardous drinking rates were significantly higher in two segments for both genders (Mosaic Career Professionals and P² Mature Oaks) and for females of P² Blossoming Families.

The second report in the series showed that males and females in all but one of the affluent groups (Mosaic Country Orchards females) drank significantly higher quantities of wine than average.^[13] However, for males, the largest quantities of alcohol were consumed via beer.

3.1.3 Alcohol-related concerns

As shown by the first report in the series, affluent groups were more likely to believe that red wine could prevent heart attacks.^[12] This belief was evident across both males and females. However, one way to engage with affluent females could be through their diet as they were more likely to report that they were trying to lose weight 'most of the time', and that drinking made them put on weight.^[12] While such beliefs could represent important intervention opportunities, it is vital that any such initiatives are targeted correctly. This is because affluent groups were more likely to believe that they know enough about the risks of alcohol already.

3.1.4 Hospital admission

Rates of alcohol-attributable chronic and acute hospital admission were significantly lower than the overall average for all of the affluent segments for both males and females in England in 2006/07 (Table 2), even for those categories with significantly higher rates of hazardous drinking (see Section 3.1.2). This pattern continued for admission relating to alcohol specific mental and behavioural disorders, which is discussed in the second report of the series.^[14] For conditions with a low alcohol-attributable fraction, affluent groups were similar to the average, except for P² Mature Oak males and Mosaic Career Professional females where rates were lower.^[14] (For details of the conditions involved in these analyses, see segmentation report 3.)^[14]

Box 3: Affluent groups.

Mosaic categories used:

- *Rural Area Residents*: The most affluent group in Mosaic (with 11 segments in total). Most people own their own home, the average age of people living in the area is increasing and there can be a lack of facilities. Children usually have a good education.
- *Career Professionals*: The second most affluent group in Mosaic. They live in sought after locations and can afford luxury products.
- *Suburban Older Families*: The third most affluent group in Mosaic. Families are based in comfortable, mature homes. Children are becoming more independent.

People and Places (P²) categories used:^[1, 2]

- *Mature Oaks*: The most affluent group in P² (with 13 segments in total), they are generally middle aged and older people (many are 45-64 and some are past retirement). The majority are married couples with teenage children living with them or adult children who have left home.
- *Blossoming Families*: The second most affluent group in P², it mainly consists of families (often aged 25-54 years), who are either married or cohabiting. There are many infants and young children, with some teenagers.
- *Country Orchards*: The third most affluent group in P², it generally includes people aged 55-65 years with many past retirement age. They tend to be married couples whose children have left home, although there are still children in some of the younger households.

Table 2: Hospital admissions and drinking patterns for affluent groups by gender and classification.

Classification		Alcohol consumption (North West, 2007-08)		Alcohol-attributable hospital admission (England, 2006/07)	
		Hazardous	Harmful	Acute	Chronic
		Percentage (95% CI)		DSR per 100,000 (95% CI)	
MALES					
Mosaic	Rural Area Residents	17.5 (15.3-19.9)	3.6 (2.6-4.9)	86.1 (82.3-89.8)	584.9 (573.2-596.6)
	Career Professionals	20.3 (18.7-21.8)	5.1 (4.3-6.0)	123.9 (119.6-128.2)	539.9 (532.1-547.6)
	Suburban Older Families	17.9 (16.9-18.9)	4.8 (4.3-5.4)	113.5 (110.1-116.9)	705.0 (697.8-712.1)
People and Places (P ²)	Mature Oaks	20.2 (18.8-21.6)	5.4 (4.7-6.3)	99.5 (95.7-103.4)	555.9 (548.8-563.0)
	Blossoming Families	19.5 (17.4-21.8)	4.9 (3.8-6.2)	103.5 (98.6-108.3)	611.6 (599.6-623.6)
	Country Orchards	16.2 (14.3-18.3)	3.9 (2.9-5.0)	115.0 (108.9-121.2)	579.3 (568.9-589.7)
Overall		18.1 (17.7-18.6)	5.8 (5.5-6.0)	153.2 (151.7-154.7)	739.8 (736.6-743.0)
FEMALES					
Mosaic	Rural Area Residents	12.2 (10.4-14.2)	2.6 (1.7-3.6)	82.5 (78.8-86.1)	298.8 (290.5-307.0)
	Career Professionals	16.4 (15.0-17.8)	3.2 (2.5-3.9)	127.3 (123.0-131.6)	261.5 (256.4-266.7)
	Suburban Older Families	12.3 (11.5-13.1)	2.7 (2.3-3.1)	103.6 (100.3-106.9)	358.1 (353.3-362.9)
People and Places (P ²)	Mature Oaks	16.0 (14.8-17.3)	3.3 (2.8-4.0)	95.2 (91.4-99.1)	283.5 (278.4-288.6)
	Blossoming Families	16.9 (15.0-19.0)	2.9 (2.1-3.9)	104.6 (99.7-109.4)	325.1 (316.8-333.4)
	Country Orchards	11.6 (10.0-13.4)	2.2 (1.5-3.1)	104.8 (98.7-110.8)	302.1 (294.4-309.9)
Overall		12.8 (12.5-13.2)	3.0 (2.8-3.1)	143.2 (141.7-144.7)	397.7 (395.4-399.9)

Key:

Dark green cell

Significantly *higher* than average

Light green cell

Significantly *lower* than average

95% CI

95% confidence interval

DSR

Directly standardised rate

3.2 Deprived groups

The groups considered under this heading and their characteristics are highlighted in Box 4. Whilst there are evident similarities between those listed in this section, this group does include people at all lifestages. Thus, it may be important to examine these groups separately as the motivations to drink and consequently the approaches that can be used to encourage sensible drinking will vary significantly between them.

3.2.1 Consumption preferences and motivations

As the first report in the series showed, whilst the most popular answers for motivations for consumption continued to be around socialising and consuming alcohol with food, deprived groups were less likely to report these motivations than affluent groups.^[12] These groups were also less likely to report that they enjoyed entertaining and more likely to report that they rarely sat down to eat together. Instead, deprived groups were more likely to report motivations surrounding using alcohol as aide to overcome negative situations than more affluent groups. Thus deprived groups were more likely to report that they used alcohol to forget problems and/or to relieve boredom. This was especially the case for males. Finally, deprived groups were more likely to report that they enjoyed trying new drinks than affluent groups.^[12]

3.2.2 Consumption

All of the segments in the deprived groups had either average or significantly lower proportions of hazardous drinkers than the regional average (Table 3). In fact as shown by the second report in the series, all of these segments (across both genders) had significantly higher proportions of non-drinkers.^[13] Levels of harmful consumption were also similar to the region overall. However, one segment (male Mosaic Social Housing) had a significantly higher proportion of harmful drinkers.

The second report in the series showed that in general, quantities of wine, beer and other drinks consumed were similar to or

lower than the regional average.^[13] As with other groups, males typically consumed their largest quantities of alcohol through beer. Women consumed similar quantities of wine and beer. However women in Mosaic Social Housing and P² Multicultural Centres consumed significantly higher quantities of beer than average.

3.2.3 Alcohol-related concerns

As shown by the first report in the series, deprived groups typically identified a number of alcohol-related concerns.^[12] Males may avoid town centres at night due to drunken behaviour of others.^[12] Overall, there may be higher levels of concern in relation to crime in their area. In relation to health, deprived groups may be more likely to disagree that the health risks are exaggerated but more likely to think that they do not know enough about the health risks (especially males). Diet may be one route to explore with this group as they are less likely to think that there are 'more calories in a bottle of red wine than in a mars bar', especially males. However, it may be difficult to engage this group unless their identified low levels of self-efficacy are tackled simultaneously.

3.2.4 Hospital admission

Typically, the more deprived segments experienced significantly higher levels of alcohol-attributable hospital admission in relation to alcohol specific mental and behavioural disorders,^[14] and chronic conditions in England in 2006/07 (Table 3). This was true for both males and females. For acute conditions, experiences appear more mixed. However, analysis of all six segmentation tools in the third report of the series shows that overall, there was a strong negative relationship between deprivation and admission.^[14] In addition, males in the Mosaic Social Housing segment experienced significantly higher levels of admission relating to conditions with low alcohol-attributable fractions, as discussed in the third report in the series.^[14]

Box 4: More deprived groups.

Mosaic categories used:

- *Inner City and Manufacturing Communities*: The fifth most deprived Mosaic group (of 11). People living in close-knit communities. Most hold responsible jobs but educational attainment is often low.
- *Older People in Social Housing*: The third most deprived group in Mosaic. They are mainly reliant on state benefits and may live in local authority housing.
- *Low Income Families*: The second most deprived group in Mosaic. They may live on large municipal estates in outer city suburbs. Educational achievement is low.
- *Social Housing*: The most deprived group in Mosaic. People who are struggling and may be reliant on the council for housing/benefits. Educational achievement is low.

People and Places (P²) categories used:^[1, 2]

- *Multicultural Centres*: The third most deprived P² group (of 13), it consists of large families where parents originate from India, Pakistan, Bangladesh, Africa, the Caribbean or China. There is a combination of young parents with teenagers.
- *Disadvantaged Households*: The second most deprived P² group, consists of young parent families (16-34 years). Many cohabit or are lone-parents.
- *Urban Challenge*: The most deprived P² group, the majority are elderly. A high proportion live alone.

Table 3: Hospital admissions and drinking patterns for more deprived groups by gender and classification.

Classification		Alcohol consumption (North West, 2007-08)		Alcohol-attributable hospital admission (England, 2006/07)	
		Hazardous	Harmful	Acute	Chronic
		Percentage (95% CI)		DSR per 100,000 (95% CI)	
MALES					
Mosaic	Inner City and Manufacturing Communities	17.7 (16.9-18.6)	6.2 (5.7-6.8)	319.5 (310.1-328.9)	834.3 (825.7-842.9)
	Older People in Social Housing	17.4 14.6-20.4	4.6 (3.1-6.4)	190.8 (179.2-202.4)	1141.3 (1117.7-1165.0)
	Low Income Families	15.0 (13.7-16.4)	6.0 (5.1-7.0)	134.6 (128.4-140.8)	1207.6 (1189.1-1226.0)
	Social Housing	17.3 (15.2-19.6)	7.5 (6.1-9.2)	116.9 (109.9-124.0)	1101.1 (1081.0-1121.2)
People and Places (P ²)	Multi-Cultural Centres	14.5 (12.1-17.2)	6.0 (4.5-7.9)	162.2 (155.9-168.5)	1027.6 (1009.3-1046.0)
	Disadvantaged Households	15.2 (13.6-17.1)	5.9 (4.9-7.2)	304.2 (292.3-316.1)	1087.8 (1063.9-1111.6)
	Urban Challenge	17.0 (15.0-19.1)	7.0 (5.6-8.5)	358.6 (339.2-378.1)	1258.2 (1221.5-1294.7)
Overall		18.1 (17.7-18.6)	5.8 (5.5-6.0)	153.2 (151.7-154.7)	739.8 (736.6-743.0)
FEMALES					
Mosaic	Inner City and Manufacturing Communities	13.1 (12.3-13.8)	3.2 (2.8-3.6)	291.6 (283.1-300.1)	453.9 (448.0-459.7)
	Older People in Social Housing	8.2 (6.4-10.2)	1.5 (0.8-2.5)	163.7 (152.8-174.6)	634.7 (618.4-651.0)
	Low Income Families	9.1 (8.2-10.1)	2.0 (1.6-2.6)	125.3 (119.2-131.3)	699.7 (687.4-712.0)
	Social Housing	10.7 (8.9-12.6)	4.1 (3.0-5.4)	105.7 (98.8-112.5)	600.9 (586.7-615.2)
People and Places (P ²)	Multi-Cultural Centres	10.3 (8.1-12.7)	3.5 (2.3-5.1)	148.0 (142.2-153.8)	542.8 (530.1-555.5)
	Disadvantaged Households	10.9 (9.6-12.4)	2.4 (1.7-3.1)	261.9 (251.5-272.3)	628.4 (611.4-645.3)
	Urban Challenge	8.7 (7.2-10.4)	3.2 (2.3-4.3)	308.0 (289.0-326.9)	723.7 (695.4-752.1)
Overall		12.8 (12.5-13.2)	3.0 (2.8-3.1)	143.2 (141.7-144.7)	397.7 (395.4-399.9)

Key:

Dark green cell

Significantly *higher* than average

95% CI

95% confidence interval

Light green cell

Significantly *lower* than average

DSR

Directly standardised rate

3.3 Older groups

The groups considered under this heading and their characteristics are highlighted in Box 5. Although this group contains people who largely fall into two life stages (retired couples or those living alone who have lost their life partner), there are considerable variations in levels of income, and motivations to stay healthy may differ.

3.3.1 Consumption preferences and motivations

The data analysed in the first report of the series did not show older people as having any particular issues that can be targeted in terms of their consumption preferences and motivations.^[12] Main motivations for consumption were similar to the North West overall and relate to consumption with food and socialising. However, deprived groups (including deprived older groups) were more likely to report drinking to forget and to relieve problems than affluent groups and tended to be less likely to state that they enjoyed alcohol with food (see Section 3.2). However, in isolation, very few of the older, more deprived segments showed significantly higher levels of these motivations than average for any one marker. One area where a more generic conclusion could be drawn across the older groups was that they are less likely to report that they enjoy trying new drinks.

3.3.2 Consumption

The older segments showed average or below average proportions of hazardous and harmful drinkers compared with the overall North West population (Table 4). Many of these groups had significantly larger proportions of moderate^a consumers (for example, P² Rooted Households and Mosaic Suburban Older Families for both males and females, male P² Senior Neighbourhoods).^[13]

The second report in the series showed that in the more affluent older groups (Mosaic Suburban Older Families, P² Rooted Households and Senior Neighbourhoods), significantly more wine was consumed than

the overall regional average.^[13] However, for males across all groups, the largest quantities of alcohol were consumed through beer. For males in P² Weathered Communities, significantly more beer was consumed than the regional average.

3.3.3 Alcohol-related concerns

As shown by the first report in the series, older groups were more likely to hold a number of concerns in relation to alcohol.^[12] They were more likely to report being concerned about children drinking in the parks/streets and about the drunken behaviour of others. In fact, higher proportions reported that they may avoid town centres at night due to drunken behaviour of others. These concerns and avoidance tactics were especially prevalent in females. In addition to these concerns, older people were less likely to think that the health risks associated with alcohol were exaggerated.

Older people might be less able to change their situation or concerns as they displayed low levels of self-efficacy. Affluence was a factor here as deprived groups in general reported lower levels of self-efficacy than affluent groups (see Section 3.2).

3.3.4 Hospital admission

Hospital admission data present two very different experiences (Table 4). Across both genders, affluent groups (that is, Mosaic Suburban Older Families and Independent Older People, and P² Rooted Households and Senior Neighbourhoods) had significantly lower rates of admission (for both acute and chronic alcohol-attributable conditions) than nationally in 2006/07. However, deprived older groups (Mosaic Older People in Social Housing and P² Weathered Communities) suffered significantly higher levels of admission. This pattern continues for admission for alcohol specific mental and behavioural disorders, which is discussed in the third report in the series.^[14] However, for admission relating to conditions with a low alcohol-attributable fraction, the only significant difference is for the deprived male groups (Mosaic Older People in Social Housing and P² Weathered Communities) who experienced significantly higher levels.^[14]

^a Moderate drinkers are those who drink less than 15 units per week for females and less than 22 for males.^[16]

Box 5: Older groups.

Mosaic groups used:

- *Suburban Older Families*: The third most affluent group in Mosaic (of 11). They are based in comfortable, mature homes. Children are becoming more independent.
- *Independent Older People*: The fourth most affluent group in Mosaic. These pensioners are relatively active and have a source of income outside the state pension.
- *Older People in Social Housing*: This is the third most deprived group in Mosaic. They are mainly reliant on state benefits and may live in local authority housing.

People and Places (P²) categories used:^[1, 2]

- *Rooted Households*: The fourth most affluent group in P² (of 13), it is generally an older group although there are a wide range of age groups from young adults to those of a pension age. Most are married couples and few have children living at home.
- *Senior Neighbourhoods*: The fifth most affluent group in P², it mostly consists of retired individuals aged 55-75 years with a significant number being over 74 (although some may be late middle aged). There are very few children and the majority live on their own.
- *Weathered Communities*: This is the fourth most deprived group in P². It mostly includes people past retirement age, with many being older than 75 and living alone.

Table 4: Hospital admissions and drinking patterns for older groups by gender and classification.

Classification		Alcohol consumption (North West, 2007-08)		Alcohol-attributable hospital admission (England, 2006/07)	
		Hazardous	Harmful	Acute	Chronic
		Percentage (95% CI)		DSR per 100,000 (95% CI)	
MALES					
Mosaic	Suburban Older Families	17.9 (16.9-18.9)	4.8 (4.3-5.4)	113.5 (110.1-116.9)	705.0 (697.8-712.1)
	Independent Older People	17.9 (16.4-19.5)	5.1 (4.2-6.0)	179.4 (175.4-183.3)	706.2 (695.4-716.9)
	Older People in Social Housing	17.4 (14.6-20.4)	4.6 (3.1-6.4)	190.8 (179.2-202.4)	1141.3 (1117.7-1165.0)
People and Places (P ²)	Rooted Households	18.0 (17.0-19.1)	5.2 (4.6-5.8)	125.2 (121.6-128.9)	672.2 (664.8-679.5)
	Senior Neighbourhoods	17.3 (15.7-19.0)	4.2 (3.4-5.1)	138.2 (131.1-145.2)	651.1 (638.9-663.3)
	Weathered Communities	17.1 (15.8-18.4)	6.5 (5.7-7.5)	237.4 (229.7-245.0)	985.5 (970.8-1000.3)
Overall		18.1 (17.7-18.6)	5.8 (5.5-6.0)	153.2 (151.7-154.7)	739.8 (736.6-743.0)
FEMALES					
Mosaic	Suburban Older Families	12.3 (11.5-13.1)	2.7 (2.3-3.1)	103.6 (100.3-106.9)	358.1 (353.3-362.9)
	Independent Older People	11.5 (10.3-12.8)	2.1 (1.6-2.7)	169.5 (165.7-173.4)	377.5 (370.1-384.9)
	Older People in Social Housing	8.2 (6.4-10.2)	1.5 (0.8-2.5)	163.7 (152.8-174.6)	634.7 (618.4-651.0)
People and Places (P ²)	Rooted Households	13.3 (12.4-14.2)	2.7 (2.3-3.2)	116.8 (113.3-120.4)	358.9 (353.7-364.1)
	Senior Neighbourhoods	10.8 (9.5-12.2)	2.4 (1.8-3.1)	131.2 (124.2-138.1)	338.6 (329.9-347.2)
	Weathered Communities	10.2 (9.3-11.3)	2.9 (2.4-3.5)	212.8 (205.6-220.0)	552.3 (541.6-562.9)
Overall		12.8 (12.5-13.2)	3.0 (2.8-3.1)	143.2 (141.7-144.7)	397.7 (395.4-399.9)

Key:

Dark green cell	Significantly <i>higher</i> than average
Light green cell	Significantly <i>lower</i> than average

95% CI
DSR

95% confidence interval
Directly standardised rate

3.4 Younger groups

The groups considered under this heading and their characteristics are highlighted in Box 6. These groups fall into two main lifestages: young singles and young couples, with a third group who may have children. There may be differences between the individuals within the groups because of the varying levels of education, which may impact on individual levels of self efficacy, ability to access information and also aspiration.

3.4.1 Consumption preferences and motivations

As shown in the first report in the series, younger groups reported a number of motivations for alcohol consumption.^[12] They reported that they enjoyed consuming alcohol with food and, although proportions were smaller, were more likely to report that they drank alcohol in order to boost confidence compared with other segments. Females in particular were more likely to report these motivations. In addition, younger groups were also more likely to report that alcohol was part of socialising and that they enjoyed going to the pub (especially for males). Both genders reported that they liked to try new things.

Beer was consumed in a variety of different settings (at home and outside the home, with food and without, and with friends/family and without), particularly by males.^[12] Wine consumption was also highly prevalent but consumption was mostly associated with drinking in the home. White spirits were consumed both in and outside the home, and males may consume dark spirits outside the home without food. Younger groups were more likely to agree that they would pay for good quality beer (especially males) and wine.

3.4.2 Consumption

Across both genders, younger groups showed significantly higher levels of hazardous consumption than the overall regional average (Table 5). Harmful consumption was also significantly higher in these groups (except for P² Qualified

Metropolitans, where levels were closer to the regional average).

Report 2 in the series shows that all of the segments consumed significantly higher quantities of both wine and beer compared with overall.^[13] In addition, both males and females in the P² New Starters and Mosaic Educated Young Single People consumed significantly higher quantities of other drinks (for example, spirits, alcopops, fortified wines). The largest quantities of alcohol were consumed via beer for males and wine for females.

3.4.3 Alcohol-related concerns

As report 1 in the series shows, in comparison with the other groups, females in the younger groups were less likely to be trying to lose weight 'most of the time' and were less likely to report often being on a diet.^[12] However, they were more likely to report that drinking made them put on weight. Males also reported this. Perhaps linked with this, younger groups were more likely to correctly perceive that there are more calories in a bottle of red wine than a Mars, especially females. Both males and females in the younger groups showed a high level of self-efficacy overall.

3.4.4 Hospital admission

The hospital admission data presented a mixed picture of the experiences of young people (Table 5). Rates of chronic alcohol-attributable admission were significantly lower for both genders in Mosaic Educated Young Single People and P² Qualified Metropolitans than England overall in 2006/07. However, P² New Starters of both genders experienced significantly higher levels of these types of admission, as well as admission for alcohol specific mental and behavioural disorders, as shown in report 3 of the series.^[14] Rates of acute admission were also higher in some groups than average. In addition, Mosaic Educated Young Single People (of both genders) experienced significantly higher levels of admission for alcohol specific mental and behavioural disorders.^[14]

Box 6: Younger groups.

Mosaic categories used:

- *Educated Young Single People*: A group of average deprivation levels, being the sixth most deprived group in Mosaic (of 11). They are mostly well educated, and are liberal in their attitudes. Few have children and the neighbourhoods can be transient (some are university neighbourhoods).

People and Places (P²) categories used:^[1, 2]

- *Qualified Metropolitans*: This group mainly consists of young adults (16-35 years) who are cohabiting and do not have children. A large number are students and there are some single-person households. There is a multi-cultural population and is a group of average deprivation, being the sixth least deprived group in P² (of 13).
- *New Starters*: This group mainly consists of young people aged 16-34 years with no children. A number of people live alone. Also, some older households, aged 35-54, do have children and are cohabiting. There is a mix of people from multicultural backgrounds. This is group has average levels of deprivation, being the sixth most deprived group in P².

Table 5: Hospital admissions and drinking patterns for younger groups by gender and classification.

Classification		Alcohol consumption (North West, 2007-08)		Alcohol-attributable hospital admission (England, 2006/07)	
		Hazardous	Harmful	Acute	Chronic
		Percentage (95% CI)		DSR per 100,000 (95% CI)	
MALES					
Mosaic	Educated Young Single People	27.0 (24.3-29.7)	9.0 (7.3-10.8)	279.8 (270.5-289.2)	683.5 (669.2-697.8)
People and Places (P ²)	Qualified Metropolitans	33.5 (26.8-40.8)	7.6 (4.2-12.4)	104.2 (98.9-109.4)	644.0 (629.7-658.3)
	New Starters	26.3 (23.9-28.7)	8.9 (7.4-10.5)	178.4 (170.6-186.2)	848.9 (829.8-868.0)
Overall		18.1 (17.7-18.6)	5.8 (5.5-6.0)	153.2 (151.7-154.7)	739.8 (736.6-743.0)
FEMALES					
Mosaic	Educated Young Single People	22.7 (20.1-25.4)	5.5 (4.2-7.1)	246.6 (237.7-255.4)	336.1 (326.8-345.4)
People and Places (P ²)	Qualified Metropolitans	30.0 (23.4-37.3)	4.4 (1.9-8.6)	97.1 (92.1-102.1)	307.9 (298.7-317.0)
	New Starters	18.4 (16.2-20.7)	4.6 (3.5-6.0)	159.9 (152.4-167.3)	439.5 (426.1-452.8)
Overall		12.8 (12.5-13.2)	3.0 (2.8-3.1)	143.2 (141.7-144.7)	397.7 (395.4-399.9)

Key:

Dark green cell

Significantly *higher* than average

95% CI

95% confidence interval

Light green cell

Significantly *lower* than average

DSR

Directly standardised rate

3.5 Family groups

The groups considered under this heading and their characteristics are highlighted in Box 7. These groups fall mainly into two lifestyles: families with young dependent children, or families with older teenagers. There is considerable variation by income, which may impact on lifestyle differences and alcohol consumption.

3.5.1 Consumption preferences and motivations

The preference and motivation data from the first report in the series did not highlight any particular issues that can be targeted to family groups as a whole.^[12] As with the North West generally, their main reason for consumption is in relation to consumption with food and socialising. Family segments in deprived areas were typically more likely to report drinking in order to forget and/or to relieve boredom and tended to be less likely to report enjoying alcohol with food (see Section 3.2). Thus, groups such as Mosaic Low Income Families (both males and females) were significantly more likely to report drinking to forget problems and/or to relieve boredom compared with average. Male P² Urban Producers were also more likely to report this compared with average. Mosaic Suburban Older Families and P² Blossoming Families (both males and females), in comparison, were significantly more likely to report drinking alcohol with food than average. One area where a more generic conclusion could be drawn across the family groups was that they reported consuming beer in the home in a variety of circumstances (with and without food, with and without friends/family).^[12] This was especially the case for males.

3.5.2 Consumption

Proportions of hazardous and harmful consumers in family groups were average or below average, except for females in Mosaic Young Families and P² Blossoming Families, where the proportion of hazardous drinkers was significantly higher than regionally (Table 6). Moderate drinking was significantly higher in Mosaic Younger Families and Suburban Older Families and P² Blossoming Families.^[13] Further, Mosaic Low Income Families had significantly

higher proportions of non-drinkers for both genders.

The second report in the series showed that for a number of the affluent family groups (Mosaic Suburban Older Families and P² Blossoming Families), significantly more wine was consumed by these groups than the overall regional average.^[13] However, for males across all family groups, the largest quantities of alcohol were consumed via beer. Male P² Urban Producers, consumed significantly more beer than regionally.

3.5.3 Alcohol-related concerns

The first report in the series showed that there were a number of concerns that appeared to be typical to family groups.^[12] Firstly, females in the family groups were more likely to be trying to lose weight 'most of the time'. Secondly, these groups were more likely to report having concern about children drinking in the streets and/or parks.

3.5.4 Hospital admission

The hospital admission data presented varying experiences for family groups (Table 6). For both genders, affluent family groups (Mosaic Suburban Older Families and Younger Families, and P² Blossoming Families) experienced significantly lower levels of admission than England overall for alcohol specific mental and behavioural disorders (as shown by the second report in the series),^[14] as well as alcohol-attributable acute and chronic conditions in 2006/07. There was no significant difference for admission relating to conditions with low alcohol-attributable fractions, except for Mosaic Younger Families where rates were again significantly lower.^[14]

However, across both genders, the deprived groups (Mosaic Upwardly Mobile Families and Low Income Families, and P² Urban Producers) experienced significantly higher levels of hospital admission for alcohol-attributable chronic conditions (Table 6), as well as alcohol-specific mental and behavioural disorders.^[14] In addition, for males in these groups, significantly higher levels of admission relating to conditions with low alcohol-attributable fractions were experienced. For acute admission, experiences were more mixed.

Box 7: Family groups.

Mosaic categories used:

- *Suburban Older Families*: The third most affluent group in Mosaic (of 11). Families are based in comfortable, mature homes. Children are becoming more independent.
- *Younger Families*: A group of average deprivation being the fifth most affluent group in Mosaic. They are focused on their career and home. Most are young and married.
- *Upwardly Mobile Families*: The fourth most deprived group in Mosaic. They may live in ex-council housing, often in towns rather than larger cities. Children tend to achieve moderate educational success.
- *Low Income Families*: The second most deprived group in Mosaic. They may live on large municipal estates in outer city suburbs. Educational achievement is low.

People and Places (P²) categories used:^[1, 2]

- *Blossoming Families*: The second most affluent group in P² (of 13). The group mainly consists of families (often aged 25-54 years), who are either married or cohabiting. There are many infants and young children, and some teenagers living within these families.
- *Urban Producers*: The fifth most deprived group in P². Many households are couples aged 25 to 34 years who are unmarried and have children. There are also some people aged 16 to 24 with children.

Table 6: Hospital admissions and drinking patterns for family groups by gender and classification.

Classification		Alcohol consumption (North West, 2007-08)		Alcohol-attributable hospital admission (England, 2006/07)	
		Hazardous	Harmful	Acute	Chronic
		Percentage (95% CI)		DSR per 100,000 (95% CI)	
MALES					
Mosaic	Suburban Older Families	17.9 (16.9-18.9)	4.8 (4.3-5.4)	113.5 (110.1-116.9)	705.0 (697.8-712.1)
	Younger Families	18.1 (16.7-19.6)	6.2 (5.3-7.2)	121.8 (116.7-126.9)	591.9 (581.7-602.1)
	Upwardly Mobile Families	17.6 (16.2-19.1)	5.1 (4.3-6.0)	210.3 (204.4-216.2)	956.6 (944.5-968.7)
	Low Income Families	15.0 (13.7-16.4)	6.0 (5.1-7.0)	134.6 (128.4-140.8)	1207.6 (1189.1-1226.0)
People and Places	Blossoming Families	19.5 (17.4-21.8)	4.9 (3.8-6.2)	103.5 (98.6-108.3)	611.6 (599.6-623.6)
	Urban Producers	17.2 (16.1-18.3)	6.0 (5.4-6.8)	218.7 (213.0-224.4)	927.9 (916.3-939.4)
Overall		18.1 (17.7-18.6)	5.8 (5.5-6.0)	153.2 (151.7-154.7)	739.8 (736.6-743.0)
FEMALES					
Mosaic	Suburban Older Families	12.3 (11.5-13.1)	2.7 (2.3-3.1)	103.6 (100.3-106.9)	358.1 (353.3-362.9)
	Younger Families	16.5 (15.2-17.9)	3.3 (2.7-4.1)	115.1 (110.3-119.9)	322.4 (315.6-329.2)
	Upwardly Mobile Families	10.0 (9.0-11.1)	3.0 (2.4-3.7)	191.6 (186.1-197.1)	534.0 (525.8-542.1)
	Low income families	9.1 (8.2-10.1)	2.0 (1.6-2.6)	125.3 (119.2-131.3)	699.7 (687.4-712.0)
People and Places	Blossoming Families	16.9 (15.0-19.0)	2.9 (2.1-3.9)	104.6 (99.7-109.4)	325.1 (316.8-333.4)
	Urban Producers	11.7 (10.8-12.6)	2.8 (2.3-3.2)	200.7 (195.4-206.1)	526.9 (518.6-535.2)
Overall		12.8 (12.5-13.2)	3.0 (2.8-3.1)	143.2 (141.7-144.7)	397.7 (395.4-399.9)

Key:

Dark green cell

Significantly *higher* than average

95% CI

95% confidence interval

Light green cell

Significantly *lower* than average

DSR

Directly standardised rate

3.6 Suburban Stability

The group considered under this heading is P² Suburban Stability and their characteristics are highlighted in Box 8.

3.6.1 Consumption preferences and motivations

The data analysed in the first report of the series preference and motivation data did not highlight any particular issues that can be targeted to the P² Suburban Stability segment.^[12] Thus, their main motivations for consumption were similar to residents of the North West overall and related to consuming alcohol with food and socialising,

3.6.2 Consumption

Proportions of hazardous and harmful consumers in P² Suburban Stability did not differ from the regional average (Table 7). The second report in the series showed that males consumed their largest quantities of alcohol via beer while for women, this was achieved through wine.^[13]

3.6.3 Alcohol-related concerns

The data from the first report in the series in relation to alcohol-related concerns held did not highlight any particular issues that can be targeted to the P² Suburban Stability segment in comparison with the other groups.^[12] However, their main concern (as with the other groups), was children drinking in parks/streets.

3.6.4 Hospital admission

Across both genders, this segment experienced significantly higher levels of hospital admission due to alcohol-attributable chronic conditions in England in 2006/07. However, males had significantly lower rates of admission due to alcohol specific mental and behavioural disorders, as shown by the third report in the series.^[14] Rates of admission due to conditions with low alcohol-attributable fractions were similar to the average for both genders.

Box 8: Suburban Stability.

The People and Places (P²) category used in this section is *Suburban Stability*.^[1, 2] This group includes an extremely wide range of age groups from young adults to those who are over 75 years old. Many of the parents are unmarried. This is the seventh most deprived group in P² (out of 13 groups analysed), and so is a group of average affluence.

Table 7: Hospital admissions and drinking patterns for other groups by gender and classification.

Classification		Alcohol consumption (North West, 2007-08)		Alcohol-attributable hospital admission (England, 2006/07)	
		Hazardous	Harmful	Acute	Chronic
		Percentage (95% CI)		DSR per 100,000 (95% CI)	
MALES					
People and Places	Suburban Stability	18.2 (17.1-19.3)	6.0 (5.3-6.7)	158.4 (154.4-162.4)	771.5 (763.3-779.7)
Overall		18.1 (17.7-18.6)	5.8 (5.5-6.0)	153.2 (151.7-154.7)	739.8 (736.6-743.0)
FEMALES					
People and Places	Suburban Stability	13.4 (12.5-14.4)	3.3 (2.8-3.8)	147.4 (143.6-151.3)	417.0 (411.2-422.8)
Overall		12.8 (12.5-13.2)	3.0 (2.8-3.1)	143.2 (141.7-144.7)	397.7 (395.4-399.9)

Key:

Dark green cell	Significantly <i>higher</i> than average	95% CI	95% confidence interval
Light green cell	Significantly <i>lower</i> than average	DSR	Directly standardised rate

4 Discussion

Segmentation is vital to understanding how consumption patterns, behaviours, motivations and harms experienced vary across the population.^[1, 8] It allows individuals to be grouped alongside like-minded others to develop portraits based on commonalities. These can then be used to establish effective levers for behaviour change. Thus, it is clear from this analysis of secondary segmentation data that the motivations to drink and experiences of consumption vary according to population group. Because of this, different approaches are required to reduce consumption and related harms depending on the target group. This is especially important as generic approaches may widen health inequalities further if they do not impact on deprived groups.^[19]

The sections below present an overview of the clustered portraits, highlighting key issues for those groups, and potential levers for behaviour change. The intelligence provided represents a vital starting point for understanding these groups, but qualitative research is essential in understanding these issues further. This will enable the development of a deeper insight in relation to behavioural motivations. Thus, possible recruitment strategies for qualitative research are discussed. For further details of this, see Carlin et al. (2008).^[1]

The other reports in the series present the in-depth analysis and discussion of the findings outlined here, and should be read in conjunction with this report for a comprehensive understanding of the intelligence outlined.^[12-14] These accompanying reports bring together a wider range of literature than is possible here, and provide discussion by topic rather than by pen portrait type.

4.1 Affluent groups

Typically, affluent groups showed high quantities of wine consumption, and some of the categories had higher proportions of hazardous drinkers compared with the North West overall. They enjoyed drinking with food and entertaining. They typically had low levels of acute and chronic hospital admission, but some affluent areas have experienced increases in alcohol-

attributable hospital admission over time.^[3] Because affluent groups were more inclined to believe that red wine protects against cardiovascular diseases and females in particular were concerned about their weight, intervention opportunities could include education initiatives highlighting that red wine's role in cardiovascular disease is not straightforward and of the strong links between alcohol consumption and weight gain.^[20] Another route that warrants further exploration is affluent groups' tendency to strongly value their health and to report high levels of self-efficacy.^[1] However, it is vital that such messages are delivered through an appropriate medium and use a suitable tone as affluent groups often believe that they know enough about the risks of alcohol, and so may be reluctant to learn any more. Initiatives must resonate with their drinking behaviours: that is, home drinking, and use of their purchasing outlets, rather than using images of young people binge drinking in nightlife venues. This is particularly important as affluent groups may not perceive themselves as going out to get drunk,^[1] and so current advertising around the impacts of binge drinking may not be salient to them.

Qualitative work is required to understand why individuals in these groups drink so much in terms of their individual lifestage, their tendency to consume at home, and using alcohol as a relaxant and/or when entertaining. Further research could explore gender differences, as more affluent males may be more likely to visit the pub in the evening than other groups.^[1] Qualitative work could also contribute to identifying relevant alternative propositions that could be offered or suggested in order to reduce the quantities of alcohol consumed both through messaging techniques but also through tangible products that could be offered in competition to alcohol. Such exchange techniques are vital in developing effective social marketing campaigns,^[8] may want to look health and diet for women, towards driving and general risk-taking for males.^[1]

In earlier analyses of TGI data, authors identified promising recruitment sites for qualitative research, including: off licences

(Majestic Wines); and supermarkets (Marks and Spencers, Sainsbury's, Tesco, and Waitrose).^[1] Suburban pubs may also be appropriate, particularly for males. In fact, because of the differing motivations and attitudes between men and women, it may be appropriate to run separate focus groups according to gender.

4.2 Deprived groups

The most popular motivations for consumption among deprived groups were around socialising and consuming alcohol with food. Further, deprived groups were more likely to report using alcohol to forget problems and/or relieve boredom than affluent groups. They may also drink in order to get drunk.^[1] Whilst consumption with food was one of the common motivations for consumption (which can help reduce inebriation),^[20] this group were much less likely to drink alcohol with food than affluent groups, and preferred to drink in the pub than at home. More deprived groups, such as Mosaic Inner City and Manufacturing Communities may also purchase alcohol through off-licence sales at the pub.^[1]

Likelihood of both non-consumption and harmful consumption increased with deprivation. However, individually only one of the deprived groups showed a higher prevalence of harmful consumption than the overall average. Levels of hazardous consumption were similar to or significantly lower than the overall average. In stark contrast, the vast majority of the deprived groups experienced significantly higher levels of alcohol-attributable hospital admissions than overall (including admission for alcohol-attributable chronic conditions, which make up a considerable proportion of alcohol-attributable admissions overall,^[14] and which it is vital to address if rates are to be reduced). In fact, deprived groups are known to be at increased risk to alcohol-related harm.^[3, 17, 21]

The fact that alcohol-related harm can be high, while consumption levels are not could be due to a number of factors. Firstly, there could be higher levels of under-reporting of alcohol consumption in more deprived groups. For example, those more likely to under-report nutritional intake have lower levels of educational achievement and are

more likely to be overweight.^[22-25] Whilst less is known about the characteristics of those prone to under-report alcohol consumption, it may be that these groups who are experiencing higher levels of harm, are under-reporting consumption. Further research is needed to confirm this.

Secondly, the discrepancy could be due to other influences: as well as being more likely to suffer from alcohol-related harms, deprived groups are also more vulnerable to obesity, violence and other health conditions, all of which can combine to lead to an admission that could be allocated as alcohol-attributable.^[21, 26, 27] Inequalities research demonstrates that after controlling for risk behaviours (e.g. alcohol intake), deprivation *per se* is related to a number of adverse health outcomes.^[28]

It is a national Government priority to reduce health inequalities amongst deprived groups.^[8] In order to do this, it is vital that these groups are targeted with appropriate interventions. To do this, Government guidance highlights the importance of tackling health as a whole within the individual rather than through specific issues,^[8] and therefore approaches to reducing consumption in deprived groups need to focus on improving levels of general wellbeing. This reflects the likelihood of health being affected by a wide of different influences. Interventions should also address dealing with life's challenges, raising aspirations/achievement and supporting people. This is particularly important for males, who may not have strong social networks and may be using the pub as a support mechanism rather than for socialising.^[1]

Qualitative research would be useful in a number of ways. Firstly, research with family groups could be used to develop an understanding of how they spend time together. This would be valuable because high quality personal relationships are important in maintaining wellbeing.^[29, 30] Thus, activities which promote high quality personal relationships through existing mainstream routes into families (such as Children's Centres and the extended role of schools)^[31] may present opportunities to encourage healthier consumption of alcohol. Such activities will bolster messaging, offering a 'feel good' element to change.

Secondly, qualitative research could be used to further understand the role of the pubs in these communities, and how this differs by gender.^[1] Within this, it would be useful to explore what alternatives can be offered to the pub and/or to consider how the role of the pub can be expanded. For example, in Knowsley (Merseyside) under the PITSTOP initiative, a programme was established in venues such as pubs to provide a health check-up to males aged 50 to 65 years.^[8]

In earlier analyses of TGI data, authors identified promising recruitment sites for qualitative research, including: off-licences (independent and chain-based off-licences such as Victoria Wine), and supermarkets (Aldi, Asda, Morrisons and Somerfield).^[1] Door to door enquiries may also be used in appropriate postcodes. Men and women may need to be recruited separately because of the different issues involved.

4.3 Older groups

Regional data showed that a number of the older segments had significantly lower proportions of hazardous and harmful consumers than the North West overall. However, current recommended limits for alcohol consumption (which are used in this report and elsewhere to categorise drinkers according to risk)^[16, 32, 33] are based on the impacts of alcohol consumption on an 'average' adult and do not account for changes known to occur in an the ageing body.^[33] In fact, relatively low levels of consumption can lead to problems in an older person.^[34, 35] For example, they may be more vulnerable to the effects of alcohol because of changes in body composition that reduce tolerance.^[35] This can be further affected by the use of medication, which is more common amongst older people.^[35] Finally, it has been suggested that survey data from older people may be less reliable because of memory problems, difficulties in answering computational questions and perceived stigma surrounding alcohol consumption.^[34] This may explain why despite relatively low consumption estimates, some older segments (that is, those in the more deprived areas) showed significantly higher levels of alcohol-attributable hospital admission than England overall. However, this discrepancy may also

be due to older people having higher levels of hospital admission overall.^[5]

In addition to the physical effects of alcohol, older people may be vulnerable to alcohol misuse if they have suffered significant loss,^[36] or are living alone. Our data showed that older groups (particularly females) were more likely to hold a number of concerns in relation to alcohol: they were more likely to report being concerned about children drinking in the parks/streets and about the drunken behaviour of others. In fact, higher proportions reported that they may avoid town centres at night due to drunken behaviour of others than other groups (particularly females). The increased prevalence of such concerns amongst older people is consistent with findings from the British Crime Survey.^[37] This is an important avenue for interventions to be established especially considering older segments have lower levels of self-efficacy than other groups, and so may not be able to manage such situations themselves. In fact, isolation and associated lower levels of wellbeing may be a driver to drink, as older individuals are more likely to care for and to lose partners and friends.^[36] Intervention mixes should consider incorporating social networking strategies and initiatives that aim to get people out of the house.

Qualitative research could further investigate the role of alcohol in bereavement and alternative avenues of support.^[1] However, it is recommended that further exploration of the existing literature is conducted alongside consultation with specialist agencies in order to understand the sensitive issues involved.^[1]

4.4 Younger groups

Younger people (aged 18-24 years) are a priority group for national Government in tackling alcohol misuse and related harm.^[32] These groups displayed some of the highest levels of alcohol consumption in the segments and they were significantly more likely to be hazardous and harmful drinkers compared with the North West region overall. Because of such consumption patterns, rates of alcohol-attributable hospital admission were significantly higher than England averages, particularly in relation to acute admission and admission for mental and behavioural disorders but

also for chronic admissions for one group. However, individuals drinking in such large quantities may be experiencing harms outside of hospital admission. Qualitative research with young people across England and Wales highlights that drunken fights are difficult to avoid when in nightlife environments, and many reported committing pranks when drunk (such as climbing buildings or stopping traffic).^[38] Such behaviours put young people at increased risk of harm, but the young people themselves do not necessarily see these incidents in this light, rather as being part of the experience,^[38] and may not necessarily experience hospital admission as a result.

For younger groups, alcohol was a social lubricant being used to gain confidence, when eating and when socialising.^[38] Women, in particular may have reported seeking a confidence boost through alcohol, potentially because of a desire to be attractive to the opposite sex.^[1] Both genders may also drink in order to get drunk.^[1, 38] Research across Europe has highlighted the use of alcohol by young people as a sexual facilitator, and recommends the development of sexual health strategies and interventions in conjunction with substance use programmes.^[39]

Pricing strategies may be particularly effective with young people because harmful and hazardous consumers typically pay less for their alcohol than more moderate consumers.^[40] In fact, it has been suggested that establishing a minimum price of 50p per unit would decrease the proportion of hazardous and harmful consumers by 6% and 10% respectively.^[40] Responsible beverage programmes are also worth further exploration, as they may reduce more extreme consumption patterns.^[38, 41] However, this will only affect consumption in nightlife venues, and not in the home.

Alcohol is an important and valued part of young people's lives. Thus, it is vital to qualitatively explore the types of exchanges that could be offered to replace or reduce alcohol use. Possibilities for further exploration could include peer pressure, levers for gaining confidence and the use of

self-efficacy. Peer group pressures particularly warrant further exploration because of feelings of heightened safety when with friends (which may cloud proper judgement), and because of group encouragement to become involved in excessive drinking and alcohol-fuelled pranks.^[38, 42] The data presented here showed potential levers that could be used to affect behaviour change and these should be explored further. These are particularly around issues such as weight gain, which has strong links with alcohol.^[20] However, any messages developed with which to target young people must use an appropriate tone and technique to avoid appearing to lecture them.^[38]

In earlier analyses of TGI data, authors suggested that members of the younger groups could be recruited through snowballing social networks or educational establishments.^[1] Men and women should be recruited separately as well as those with and without children.^[1]

4.5 Family groups

Motivations for consumption were similar to those of the North West overall for family groups. Thus, the main motivations were around alcohol consumption with food and when socialising. Most family group segments showed average or below average consumption compared with regionally (although the North West region does have significantly higher levels of alcohol misuse than England overall).^[3, 17] Whilst the more affluent family groups showed levels of alcohol-attributable acute and chronic hospital admission that were significantly lower than average, the more deprived family groups had rates of admission that were significantly higher than average.

Family groups such as Mosaic Younger Families may be experiencing or have experienced marital problems, with high numbers of divorced or separated households compared with the UK overall.^[1] Marital stresses will inevitably impact upon alcohol consumption and related behaviours: for example, a study in the United States of America noted that a per capita increase in alcohol consumption by one litre can lead to a 20% increase in divorce rates.^[43]

Tackling alcohol consumption amongst parents and family groups presents opportunities not only to influence parents' drinking habits but also to impact on their children's behaviour. Family interventions such as PARTNERS and the Strengthening Families Programme have shown significant effects on consumption by children.^[44] Further details on the impacts on parents' consumption are required but opportunities for such a strategy could be explored more qualitatively. However, themes for qualitative research will vary according to circumstance and level of deprivation.

Qualitative research in the affluent family groups (such as Mosaic Young Families) could concentrate on areas such as habitual alcohol consumption, the role of alcohol in relationships, and the value of their health (particularly in relation to their children).^[1] The link between alcohol and personal appearance could also be explored. Recruitment could occur through channels such as door to door, or in shops including Asda and Tesco.^[1]

Qualitative research in family groups that have more average levels of affluence (such as Mosaic Upwardly Mobile Families) may want to explore issues such as causes of anxiety for women, and enjoyment of car ownership and pub usage for males, both of which have been identified as important drivers for behaviour elsewhere.^[1] For avenues of exploration with deprived groups, please see Section 4.2.

In earlier analyses of TGI data, authors identified promising recruitment sites for qualitative research, including supermarkets such as Asda, Lidl, and the Co-Op.^[1] Whatever the level of deprivation, qualitative research needs to account for the potential for differing marital statuses and gender, and may need to recruit accordingly.^[1]

4.6 Suburban Stability

P² Suburban Stability covers a wide range of different types of people and so it does not easily sit within the other categories of affluent people, deprived people, older groups and younger groups. Because of this, the group has been dealt with separately.

The reasons for consumption amongst P² Suburban Stability were consistent with the North West region, and so centred mainly around consuming alcohol with food and socialising. Their levels of consumption were similar to the North West region overall. However, the North West overall has significantly higher levels of alcohol misuse and related harm than elsewhere in England.^[3, 17] Despite these average levels of consumption, they experienced significantly higher levels of chronic alcohol-related harm than nationally. It is worth remembering that admission for alcohol-related chronic conditions makes up a significant proportion of alcohol-related hospital admissions overall,^[14] and thus, further action and research is urgently needed in order to develop a comprehensive understanding of this group and their experiences of hospital admission, as without this, it may be difficult to effectively reduce alcohol misuse and related harm.

5 Conclusion

This report has outlined the attitudes surrounding alcohol, consumption patterns of alcohol and related harms that are experienced in different population groups in order to develop understanding in relation to alcohol misuse. The findings should be used (in conjunction with the other reports in this series and further research) to develop targeted interventions and campaigns. After all, it is only through understanding the populations at risk that effective support, alternative activities and appropriate information can be supplied.

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