



Opinions on the impact of alcohol on individuals and communities: early summary findings from the North West Big Drink Debate

Penny A. Cook, Karen Tocque, Michela Morleo, Mark A. Bellis

Key findings

In the biggest ever survey of its kind, around 30,000 people gave their opinions on alcohol and its impact on their lives and communities in the North West Big Drink Debate. Key findings highlighted that:

- In line with international evidence, respondents recognised that a number of external factors increase the quantity of alcohol consumed: low prices and discounts (80% thought this increases consumption); large measures (75%); allowing street drinking (68%); advertising (56%) and extended drinking hours (54%).
- Nearly half of participants avoided the town centre at night because of the drunken behaviour of others, and half felt that action was needed to tackle alcohol issues in their area.
- Fewer than half of respondents felt that information on alcohol-related harm (36%) or advice from a GP (48%) would decrease alcohol consumption.
- Nearly three in ten of the respondents drank at hazardous or harmful levels¹, which when extrapolated to the whole population, suggests an estimated 1.33 million adults in the North West drink at such levels. Alcohol intake was high across all population segments, although the type of alcohol consumed showed strong socioeconomic gradients, with wine drinking associated with less

deprived communities and beer or cider intake higher in more deprived locations.

- Very few people felt that the health risks of alcohol were exaggerated. Although only 7% felt that they did not know enough about the health risks, this was higher among harmful drinkers (11%). More than two in five drinkers were concerned about the impact of their drinking on their weight. In particular, those drinking hazardously (58%) and harmfully (60%) were most likely to feel this way. Such health concerns should be used to tailor brief interventions, health messages and campaigns.
- People who drink harmfully were six times more likely to say that alcohol relieves boredom or that it helps them to forget their problems compared with sensible drinkers. Such motivations should be considered when seeking to address alcohol misuse.

Introduction

An estimated 10 million people in England drink at harmful or hazardous levels; 2.9 million drink harmfully (higher risk) and 6.8 drink hazardously (increasing risk) (GHS, 2006). However, alcohol harm is greatest in northern England (Deacon et al., 2007), where, for example, alcohol causes an average 5.8 months life lost for every North West resident compared with 3.6 months in, for instance, the East of England. Further, cities in the North West have the highest rates of alcohol-

¹ Drinking within Government sensible weekly limits is defined as drinking up to and including 14 units for females, and 21 units for males per week. Hazardous consumption is drinking between 15 and 35 units for females, and between 22 and 50 units for males. Harmful consumption is drinking over 35 units for females and over 50 units for males.

specific hospital admissions, alcohol-related crime and violent crime in England (NWPHO, 2007a). In *Safe, Sensible, Social* (the national alcohol strategy), the Government pledge to tackle the range of harms caused by alcohol (Cabinet Office 2007), and key actions include a sharpened criminal justice system for drunken behaviour, the prevention of underage alcohol sales, the provision of public information campaigns and a public consultation on alcohol pricing and promotion.

The Big Drink Debate was launched in May 2008 by Our Life (a region-wide programme that aims to address the North West's poor health) in partnership with the Department of Health and Government Office North West. The project aimed to raise awareness of alcohol issues in the North West and seek public opinion on possible solutions, thus building on the success of the Big Smoke Debate (which found high levels of support for banning smoking in public places: Tocque et al., 2004). This report provides a summary of early findings, which will inform discussions at a summit of public sector leaders who will discuss how best to reduce alcohol-related harm across the North West.

Methods

The Centre for Public Health/North West Public Health Observatory at Liverpool John Moores University was commissioned to design a survey instrument to consult the public and to report on the findings. A short questionnaire was developed to assess levels of alcohol consumption, alcohol-related behaviours, beliefs and opinions on how alcohol affects their lives both positively and negatively (see Appendix). The questionnaire used previously validated questions where available, with new questions validated by an expert panel. The survey was available both online and in paper form from May to August 2008. The paper questionnaire was distributed in a variety of ways across the North West for example through some free local papers, in health settings, and in town and city centres. Awareness was also raised of the online version through the local media. Paper questionnaires had a freepost address for easy return to the Centre for Public Health. An information sheet informed participants that the survey was voluntary and confidential. Approval was gained from Liverpool John Moores University Research Ethics Committee. Results are displayed by demographics and by lifestyle categories (P² People and Places²) to obtain an insight into population sub-groups. P² category was calculated from the participants' postcodes. Extra tables are provided in a supplementary document (see Appendix). Sample sizes vary throughout this report because not all questions were completed by all participants. Therefore, although findings are broken down by demographics, totals represent all those offering an opinion even if they did not supply demographic information.

Results

Sample size and characteristics

A total of 30,857 adult residents of the North West responded to the Big Drink Debate. Of these, over 28,000 gave responses to opinion questions (with the exact number varying for each question), and 27,715 gave sufficient information to enable calculation of their drinking characteristics. More women (17,767) participated than men (10,000), but 10% did not specify their gender (3,090). Of the respondents who answered questions on drinking behaviour (90%), 23% had not drunk alcohol that week, including 9% who said they never drank. In total, 63% of those who drink at least occasionally were classified as drinking within Government sensible weekly limits (this figure includes those had not drunk in the week before the survey), 22% had drunk at hazardous levels in the previous week and 6.6% had drunk at harmful levels. This would equate to 1.33 million harmful and hazardous drinkers in the North West (763,000 men and 567,000 women; standardised for age and sex using 2007 population estimates). These estimates concur with those from other surveys of the North West population (NWPHO, 2007b). The respondents comprised 93% white British; 1.4% white Irish; 1.3% white European; 0.7% black/black British; 1.3% Asian/Asian British; 0.3% Chinese/Chinese British; 1.0% mixed race; and 1.1% other. Asian/Asian British people were the least likely to drink alcohol, although even in this group 43% drank at least occasionally and 2.7% had drunk at harmful levels in the previous week.

Locations used to buy alcohol, reasons for drinking and type of alcohol

The survey asked respondents where they generally obtained most of the alcohol that they consumed. The supermarket was the most common location for all categories of drinkers, from 71% of hazardous drinkers and 68% of harmful drinkers to 64% of sensible drinkers (65% overall: table 1). An in depth analysis (not shown here) revealed that while 73% of those buying supermarket alcohol said that a good thing about alcohol was that it helped them to relax and unwind, those getting alcohol elsewhere were less likely to say that this was a good thing about alcohol (54%). The proportion of people using supermarkets to buy alcohol rose with increasing income, from 49% of those with a per-person income of less than £4,000, to 74% of those with an income of greater than £37,000. Black/black British, Asian/Asian British and Chinese/Chinese British people were less likely to buy from supermarkets (data not shown).

Of drinkers, 45% bought alcohol from pubs, rising to 53% of hazardous drinkers and 56% of harmful drinkers. Those using pubs were more likely to agree that alcohol made socialising more fun (69%), compared with only 30% of those who

² © Beacon Dodsworth 2008. www.beacon-dodsworth.co.uk/products/people-classification

Table 1. Sources of alcohol and reasons for drinking, by gender, age and drinking category (drinkers only)

	Where alcohol is bought (%)						What is good about alcohol (%)						Total
	Pubs/bars	Supermarkets	Off Licences	Restaurants	Other people	Other	Relax	Socialising more fun	Confidence	Goes with food	Boredom	Forget problems	
Gender*													
Male	53.7	60.9	20.6	15.2	6.4	5.0	68.5	52.9	12.2	43.3	10.5	9.5	9058
Female	39.9	68.8	15.8	23.4	10.8	4.1	66.0	43.9	13.2	51.0	5.9	6.5	16013
Age*													
18-24	78.5	47.5	29.8	17.7	12.1	1.2	60.4	71.9	31.1	27.7	16.4	11.5	2848
25-34	59.5	64.5	23.9	24.6	9.6	2.3	72.5	58.9	19.8	44.9	9.0	9.0	5559
35-44	37.6	71.2	18.1	18.3	8.4	4.2	73.3	45.0	10.9	48.0	6.7	8.1	6116
45-54	33.3	71.4	12.2	19.1	7.5	5.5	68.7	37.9	7.0	53.1	5.1	6.5	5578
55-64	32.4	68.6	8.6	22.1	9.0	6.9	59.6	34.3	3.8	59.0	4.1	4.4	3310
65-74	32.1	59.2	8.4	21.0	10.4	9.5	46.2	31.6	2.1	56.2	4.7	3.6	1179
75+	25.0	60.7	10.3	19.1	14.9	8.7	43.9	25.9	2.9	57.5	7.5	5.3	510
Drinking category*													
Sensible	40.9	64.2	13.4	21.3	9.6	4.1	60.4	41.9	10.0	48.2	4.1	4.3	17273
Hazardous	53.2	70.6	23.6	19.3	8.0	5.4	81.2	58.5	17.2	50.0	11.4	11.2	5969
Harmful	56.0	68.0	36.9	16.7	9.3	4.2	82.1	59.5	25.3	42.1	27.6	26.7	1829
Income													
Under £4,000	58.6	48.6	29.5	13.2	14.3	1.9	58.1	54.1	23.4	29.2	17.6	14.4	1182
£4,000 to £7,999	47.9	58.5	22.1	16.0	12.6	2.7	60.9	45.5	17.4	36.9	13.0	12.0	1386
£8,000 to £16,999	50.1	60.9	19.1	16.5	9.1	3.2	65.3	49.9	16.0	40.0	9.0	8.4	4705
£17,000 to £36,999	46.8	68.7	17.3	21.7	8.7	4.1	70.1	49.5	12.9	50.9	6.9	7.1	10514
£37,000 or above	35.7	73.7	14.6	24.2	8.1	7.0	71.6	42.9	8.3	57.7	4.6	5.3	4994
Unknown	37.9	58.7	14.7	19.3	9.3	4.1	55.4	36.9	9.0	44.0	5.9	6.5	3694
Total	44.6	65.4	17.6	20.2	9.2	4.3	66.5	46.6	12.7	47.6	7.5	7.5	26475

* Total at bottom right of table indicates number of people answering attitude questions. Totals by age, gender and drinking category do not add to the grand total because of missing demographic information.

acquired alcohol from other sources. The use of pubs decreased with increasing income, from 59% of those in the lowest income category to 36% of those with the most income.

Of the locations generally used to obtain alcohol, off licences were most associated with elevated alcohol consumption. In total, 18% of drinkers used off licences (table 1), although this rose to 24% of hazardous drinkers and 37% of harmful drinkers. However, the actual number of hazardous and harmful drinkers buying from off licences is lower than the number obtaining alcohol from supermarkets.

Respondents' views on what is good about alcohol revealed some concerns: people who drink harmfully are six times more likely to say alcohol relieves boredom or that it helps to forget problems than sensible drinkers. Harmful drinkers are also 2.5 times more likely to say that alcohol gives them confidence than sensible drinkers (table 1). In addition, of those who generally purchased from off licences, 23% use alcohol for confidence, 19% to counteract boredom, and 17% for forgetting problems, compared with only 11%, 6% and 6% of those who acquired alcohol from elsewhere. The use of off licences was greatest amongst the poorest (30%

Figure 1. Male consumption of different alcoholic drinks, by People and Places category (mean and 95% confidence interval, n=7,145)

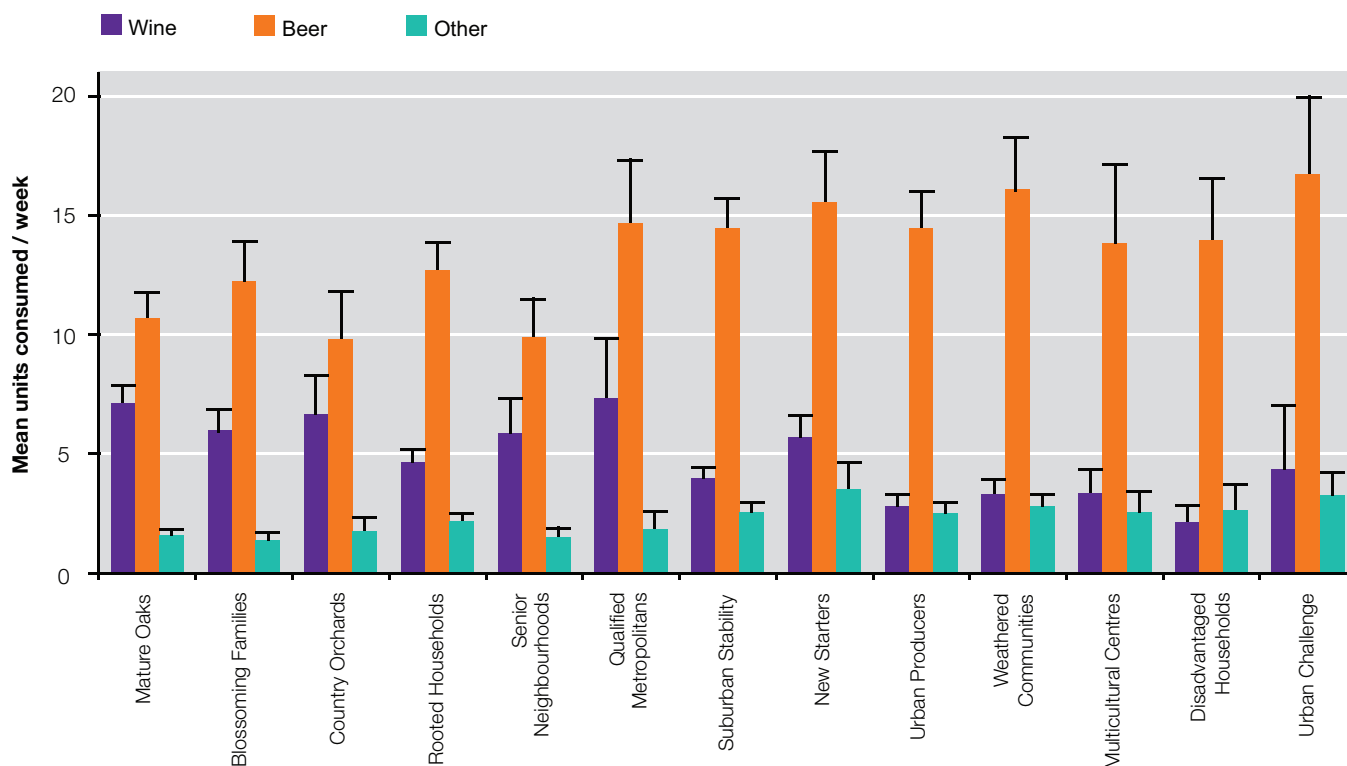
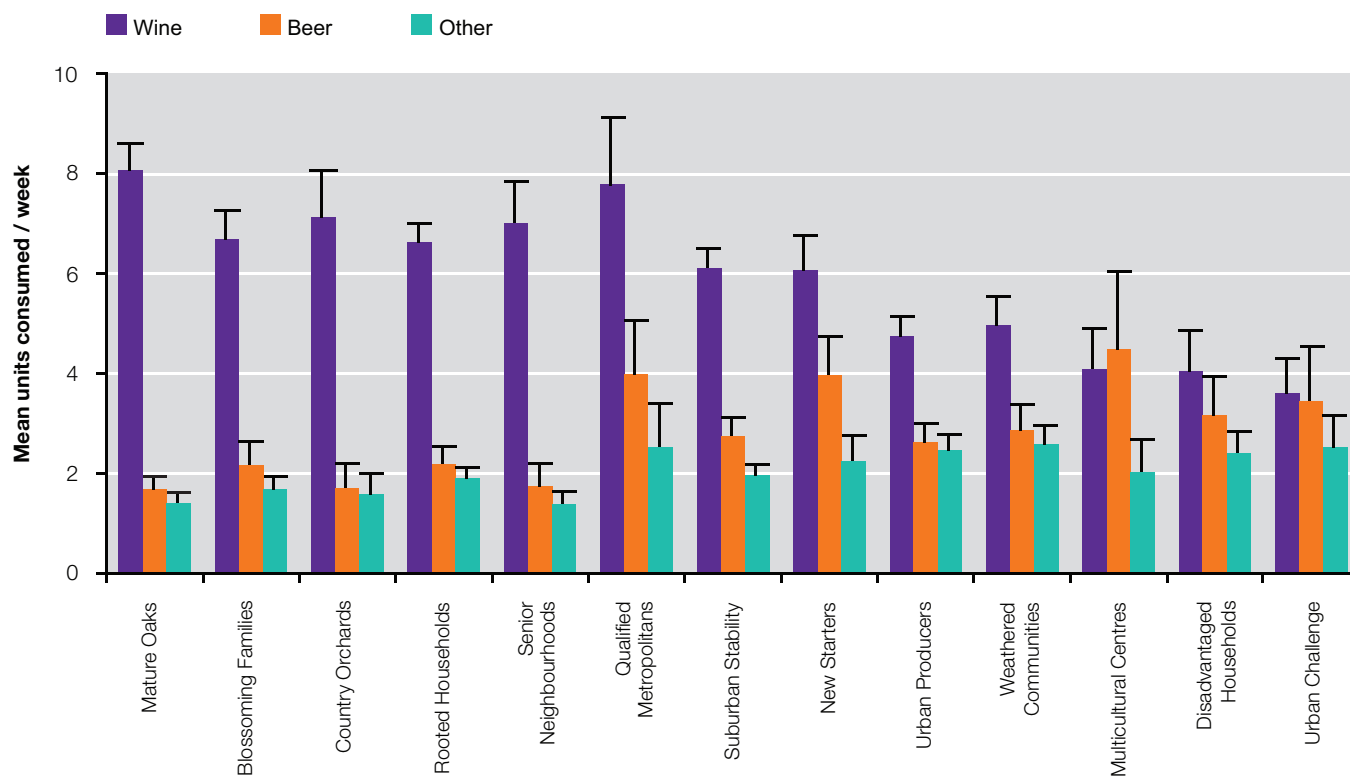


Figure 2. Female consumption of different alcoholic drinks, by People and Places category (mean and 95% confidence interval, n=12,580)



compared to 15% of the most well off). There was a tendency for Chinese people and those of mixed race to say that alcohol was good for forgetting problems and relieving boredom compared to those identifying themselves as white British ($P<0.01$), but the sample size was small (63 and 243 respectively).

Those who bought alcohol from restaurants were more likely to use alcohol as a complement to food (74%) compared with those who did not (40%). Buying alcohol in restaurants was

linked to income, with 24% of those in the highest income category compared with 13% of those in the lowest income category using restaurants, and was more common in sensible drinkers (21%) than harmful drinkers (17%). Compared to white British people, Asian/Asian British were less likely to cite food as a reason for drinking, while those classifying themselves as white European were more likely to say alcohol went with food ($P<0.01$). Drinking alcohol as a complement to food was least prevalent in the youngest age group (18-24 years).

Table 2. Percentage of respondents agreeing that access and availability of alcohol increases alcohol use, by gender, age and drinking category

	Large measures	Low prices and discounts	Strong drinks	Advertisements	Extended licensing hours	Allowing street drinking	Total (100%)
Gender*							
Male	71.9	78.6	46.9	56.5	46.9	61.8	9920
Female	78.0	82.3	48.8	56.7	57.9	71.4	17661
Age*							
18-24	64.3	79.9	35.8	52.8	56.6	64.5	3002
25-34	74.7	80.8	40.6	49.3	46.4	61.7	5933
35-44	76.9	81.2	48.8	55.9	52.1	66.0	6625
45-54	79.9	82.0	54.7	60.9	54.3	70.6	6148
55-64	79.2	81.6	55.6	62.5	58.8	75.0	3771
65-74	75.4	78.2	53.2	61.0	64.5	74.9	1450
75+	69.4	76.3	49.4	62.2	71.1	78.4	693
Drinking category*							
None	77.0	84.6	58.1	66.5	69.7	76.2	2483
Sensible	76.9	82.3	48.2	58.6	56.2	70.3	17261
Hazardous	74.7	77.7	45.1	50.3	44.8	61.9	5963
Harmful	67.2	74.4	43.4	44.2	41.4	53.9	1824
Total	75.5	80.6	48.0	56.4	53.9	67.8	28215

* Total at bottom right of table indicates number of people answering attitude questions. Totals by age, gender and drinking category do not add to the grand total because of missing demographic information.

The largest proportion of the respondents drank once or twice a week (39%). Both abstinence and daily (or almost daily) consumption increased with age (Appendix: table A.2 provides data on the quantities of different types of alcohol drunk and the frequency of drinking by demographics). The type of alcohol drunk was strongly related to gender and income. Male drinkers consumed an average of 23 units per week (14.9 of which were beer/lager/cider and 5.4 wine) while females drank on average 12 units (the majority of which were wine, 7.0 units). While the total number of units drunk differed little by income category, wine drinking increased with increasing income (3.3 to 9.2 units) while beer/lager/cider decreased (10.1 to 6.8 units). These relationships between

gender and income are confirmed when alcohol intake by different lifestyle groups is considered³. Figures 1 and 2 show type and amount of alcohol consumed by lifestyle groups, which are ordered by deprivation from the least deprived communities such as 'mature oaks' and 'country orchards' to the most deprived populations such as 'urban challenge' and 'weathered communities' (see Appendix for descriptions of groups). For men (figure 1), all lifestyle groups consume more units of alcohol from beer than other types of drink but the more affluent communities have a greater intake of wine than the more deprived communities, for who the vast majority of units of alcohol comes from beer. For females on the other hand (figure 2), the vast majority of units consumed per

³ People and Places (P2) lifestyle groups are described in more detail at www.nwpho.org.uk/bigdrinkdebate

person comes from wine in the more affluent communities whilst the most deprived communities have almost equal weekly units intake from wine, beer and other beverages.

Views on access and availability of alcohol

Table 2 summarises people's views on whether factors related to access and availability of alcohol increase or decrease alcohol use. There was widespread agreement that low prices and discounts increased the amount of alcohol drunk (81%), as did large measures (75%), allowing street drinking (68%) and alcohol advertising (56%). However, when asked whether increasing the price of alcohol would decrease use, only 22% agreed, with agreement less likely amongst females and older people (Appendix table A.3). Those who drink sensibly or not at all, females, people in older age groups and Asian/Asian British people were more likely to agree that low prices and discounts, large measures, extended licensing hours and street drinking increased the quantity of alcohol drunk.

Health effects of alcohol and factors that increase or reduce alcohol intake

Only 11% thought that drugs were responsible for more deaths than alcohol⁴, and 8% that the risks of alcohol were exaggerated (for full results, see Appendix table A.4). Those in the youngest age group (18-24 years), the older age groups (65+ years) and harmful drinkers were the most likely to hold these views. Males and those from ethnic minority groups were also more likely to think that risks were exaggerated. Awareness that the north of England experiences higher levels of harm was relatively low (37%), while awareness of the link between violence and alcohol was high (86%). The questionnaire asked whether participants believed that alcohol was protective against breast cancer, which is not in fact true. Only 2.7% believed this to be true (although this misconception doubled in harmful drinkers, 5.4%). Alcohol is commonly reported in the media to be protective against heart disease (although evidence shows this only applies to very small quantities of alcohol, a unit a day, among older males: Morleo et al. 2008a), and 42% of respondents believed this to be the case. Belief was highest

Table 3. Percentage of respondents with concerns about alcohol use in the community, by gender, age and drinking category

	Avoid town at night	Action needed in area	Drunken behaviour of others	Crime in area	Litter in area	Children drinking	Home fire risk	Total (100%)
Gender*								
Male	43.6	46.8	70.0	55.1	47.2	70.8	15.3	9944
Female	45.6	52.4	73.4	56.3	44.6	78.2	19.9	17696
Age*								
18-24	25.4	40.2	59.5	46.8	26.8	59.7	17.4	3019
25-34	35.8	48.6	67.5	54.0	38.1	71.9	14.1	5953
35-44	45.7	51.9	72.7	56.6	45.1	79.2	16.0	6633
45-54	50.1	54.2	76.8	59.1	50.5	79.1	20.3	6156
55-64	56.2	54.4	80.2	61.0	58.6	81.5	22.8	3771
65-74	60.7	49.4	75.5	55.3	59.0	78.3	24.2	1452
75+	59.0	42.2	69.4	48.8	51.3	69.7	23.3	695
Drinking classification*								
None	63.0	60.3	77.7	64.2	56.7	76.3	25.6	2487
Sensible	46.9	52.5	75.2	58.4	47.8	77.6	18.0	17313
Hazardous	34.1	43.8	65.8	49.2	37.8	72.7	16.0	5962
Harmful	35.3	37.5	56.6	42.9	33.4	64.1	18.1	1827
Total	44.8	50.1	71.4	55.3	45.0	74.8	18.1	28289

* Total at bottom right of table indicates number of people answering attitude questions. Totals by age, gender and drinking category do not add to the grand total because of missing demographic information.



⁴ In fact, alcohol is related to far more deaths than illegal drugs. In 2005, there were 23,081 alcohol-related deaths in England (NWPHO 2007b). In the UK in 2005, there were 3,301 drug-related deaths (Corkery et al. 2008).

among those aged 55-64 years (52%) but a notable proportion of younger age groups believed this as well (for example, a third of 18-24 year olds).

Those who were aware of the fact that there are more calories in a bottle of red wine than a chocolate bar (43%) were also more likely to be concerned about their weight. Concern about weight decreased with age (from 48% in the youngest age group to 14% of the oldest age group), and increased with level of drinking (from 22% of non-drinkers to 59% of harmful drinkers). Overall, 7% admitted to not knowing enough about the health risks of alcohol, rising to 12% of harmful drinkers and 13% of those in the youngest age category.

There was overall agreement that stress and depression (86%) and work-related stress (87%) increased people's alcohol use (Appendix: table A.6). Only 36% of respondents felt that providing more information on the health risks of alcohol would decrease alcohol use. Advice from a GP was rated as effective in reducing alcohol consumption by 48% of respondents. Having children was seen by most as a moderating factor for alcohol intake (71%), as was strong religion/faith (67%). Personal experience of alcohol harm was rated as being likely to reduce alcohol intake (72%), but negative experiences while drunk were seen as less likely to reduce intake (48%).

Perceptions of alcohol in the community

Table 3 shows people's concerns about alcohol use in their local community. Concerns tended to peak in those aged 55-64 years, and were higher in those who did not drink or who drank within the sensible guidelines. Children drinking in public created the highest level of concern (75%; although only 64% of harmful drinkers expressed this as a concern). The drunken behaviour of other people was a concern for 72% of all respondents (but only for 56% of harmful drinkers). A high proportion of people claimed to avoid town centres at night because of drunkenness (45%) and half felt that action was needed to tackle the effects of alcohol-related harm in their area. Fewer people were concerned about fire risk in the home (18%).

Discussion

The Big Drink Debate aimed to find out how people in the North West viewed the effects of alcohol in society, and which factors impact on alcohol use. The drunken behaviour of other people was perceived as a concern for over two thirds of respondents, and nearly half claimed to avoid town centres at night because of this. Three quarters of the respondents of this survey were concerned about children drinking in public in their area. Previous studies have also linked perceived dominance of 'youth culture' in town centres with fears of safety (Thomas and Bromley, 2000) and in qualitative studies people have cited discomfort with nightlife culture as a reason

to avoid town centres (Eldridge and Roberts, 2008). Stimulating public discussion on alcohol policy and the role of citizens are key factors in developing effective action (Giesbrecht, 2007). The findings from the Big Drink Debate will help the North West as a region and local communities mobilise action to tackle alcohol as a cause of harm in the population. There is a need to change the relationship that the region has with alcohol and to convince drinkers that consuming less and paying more is likely to improve their health and the prospects of the North West as a whole.

The survey revealed that 22% of all respondents had drunk at hazardous levels in the previous week and 6.6% had drunk at harmful levels. In total, it is estimated that there are 1.33 million harmful and hazardous drinkers in the North West (763,000 men and 567,000 women⁵). These figures concur with other surveys of the North West population (NWPHO, 2007a). Overall alcohol consumption varied little across population groups. Wine was more associated with affluent populations and beer or cider with more deprived communities. Locations used to purchase alcohol also varied by income level, with the better off being more likely to buy from supermarkets and less likely to buy alcohol in pubs or from off licences. In fact, those living in more affluent areas were more likely to be drinking at hazardous levels compared with other areas, a trend which may lead to further increases in alcohol-related ill-health and mortality in the future (NWPHO, 2007b). This is because, for example, consumption of 21 units per week (3 units per day) more than doubles the risk of developing liver cirrhosis compared with non-drinkers (Corrao et al., 2004). Thus, it is important to understand the health behaviours of such groups in order to try to reduce the potential for harm. People of lower socioeconomic status were more likely to agree that alcohol gave them confidence, helped them to forget problems and relieved boredom, and less likely to say that alcohol helped them to relax or was a complement to food. These different motivations for drinking need to be understood when seeking to address alcohol misuse.

Respondents also gave their views on external factors that increased alcohol use. Here, low prices and discounts, serving drinks in large glasses, alcohol advertising and extended drinking hours were considered by the majority to increase the amount of alcohol drunk. Factors such as price, increased strength of drinks and longer hours have strong links with overall quantities of alcohol consumed (Morleo et al., 2008b, 2008c; Phillips-Howard et al., 2008). However, any action on alcohol pricing would need to be consistent across all alcohol products and outlets in order to avoid consumers switching to cheaper alternatives as happened in Sweden (Ponicki et al., 1997). This is particularly important as hazardous and harmful drinkers acquired alcohol from all types of establishment. Further, when respondents were asked whether increasing alcohol prices would decrease

⁵ Estimates are standardised for age and sex related prevalence using 2007 population estimates

consumption, fewer than a quarter agreed. This may be because, while providing cheap alcohol increases consumption, subsequently increasing prices may not change consumption levels if individuals have already developed an expectation of being able to drink at a certain level.

Relatively few people thought that the risks of alcohol use were exaggerated. Some felt they did not know enough about the health risks, and, encouragingly, this was more prevalent amongst harmful drinkers. Moreover, harmful drinkers were more likely to be aware of the calorific content of alcohol and to be concerned about weight gain due to alcohol, providing a possible focus for future health promotion initiatives. Nearly half of people thought that advice from a GP would decrease alcohol consumption, and this concurs with findings that brief interventions delivered by GPs are effective at reducing alcohol intake (Moyer et al., 2002).

The Big Drink Debate has revealed that residents of the North West are concerned about the negative effects of alcohol on society, and are aware that external factors, such as price and availability, affect alcohol use. Action is now needed in the North West to take these findings forward and create policies that will shift alcohol culture and reverse the harm caused by alcohol to the region's health and economy.

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Appendix

Additional supporting materials and analyses are available at www.nwpho.org.uk/bigdrinkdebate

Table A1. – Sources of alcohol and reasons for drinking, by gender, age and drinking category (drinkers only)

Table A2. – Number of units drunk per week (average in drinkers) and frequency of drinking (percentage), by gender, age and drinking category

Table A3. – Percentage of respondents agreeing that access and availability of alcohol influences alcohol use, by gender, age and drinking category

Table A4. – Percentage of respondents agreeing with alcohol harms, by gender, age and drinking category

Table A5. – Percentage of respondents with concerns about alcohol use in the community, by gender, age and drinking category

Table A6. – Percentage of respondents agreeing that personal factors influence alcohol use, by gender, age and drinking category

Table A7. – Descriptions of the P² People & Places lifestyle groups
Copy of Big Drink Debate Questionnaire

Contact for more information on Big Drink Debate findings:

Penny A. Cook
Centre for Public Health
Faculty of Health and Applied Social Sciences
Liverpool John Moores University
Castle House
North Street
L3 2AY
p.a.cook@ljmu.ac.uk
0151 231 4510

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