APPENDIX A

Alcohol

1. Defining the issue

There are several dimensions to problem drinking, and different approaches to measuring them, resulting in a rather tangled web of terminology.

Hazardous and harmful drinking

The standard way of assessing whether drinking is hazardous or harmful is to administer the 'AUDIT'[1] tool, developed by the World Health Organisation. The tool consists of ten questions, asking not only about alcohol consumption but about the effect it is having on the person's behaviour and feelings. Each question carries a score of 0-4 points, and a total score of 8 or above is indicative of an alcohol problem:

- **Hazardous** drinking (total score 8-15)– drinking above recognised sensible levels but not yet experiencing harm
- **Harmful** drinking (total score 16+) – drinking at levels that lead to significant harm to physical and mental health

Increasing and higher risk drinking

Another way of classifying the level of problem drinking is simply to base it on the amount consumed, based on the government's daily and weekly guidelines:

Table 1 - Classification of alcohol consumption by units consumed

Units consumed	Daily[2]		Weekly[3]	
	M	F	M	F
Lower Risk	not regularly > 3-4	not regularly> 2-3	< 22	< 15
Increasing Risk	↕	↕	↕	↕
Higher Risk	regularly > 8	regularly > 6	> 50	> 35

These guidelines themselves have been criticised as confusing, as the daily and weekly versions appear to contradict each other, and 'units' are poorly understood by the general public.[4,5] The government has asked the Chief Medical Officer to institute a review of the guidelines, and consider whether they need to be revised.[6]

'**Increasing risk**' *roughly* equates to '**hazardous drinking**', and '**higher risk**' *roughly* equates to '**harmful drinking**'. Older publications often used these terms interchangeably, but more recent ones tend to make an effort to stick to the correct terminology, depending on whether or not the 'Audit' tool has been used.

Binge drinking

Binge drinking is the consumption, on a single occasion, of over 8 units of alcohol if male or 6 units if female. Estimates of the prevalence of binge drinking are generally based on asking whether such a drinking session has taken place in the previous week.[7]

Alcohol dependence

Alcohol dependence (or addiction to alcohol) is described by NICE as: *"characterised by craving, tolerance, a preoccupation with alcohol and continued drinking in spite of its harmful consequences".*[8]

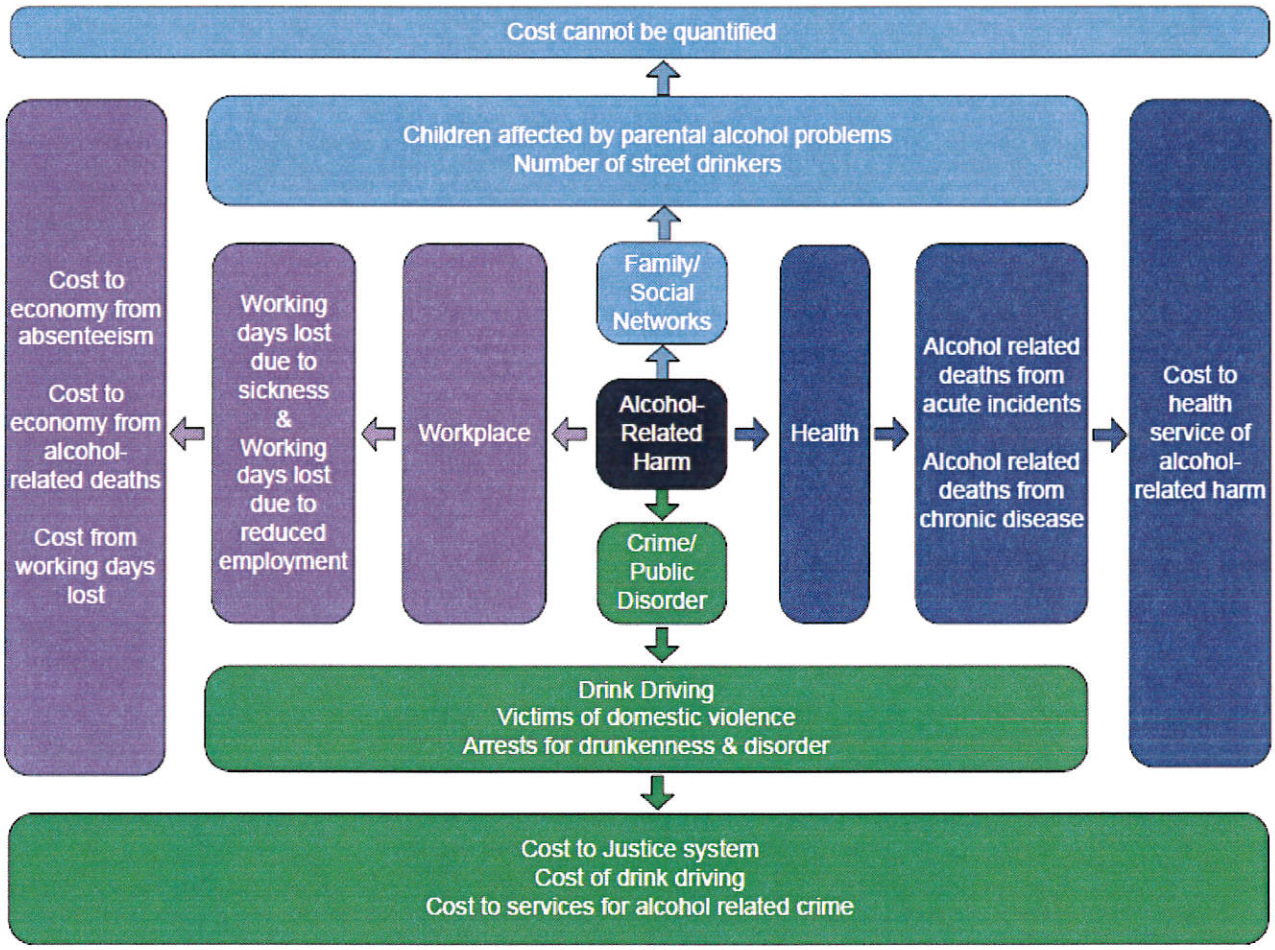
A high score on the AUDIT tool is suggestive of dependence, but this should be confirmed using a special-purpose tool such as the Severity of Alcohol Dependence Questionnaire (SADQ)[9], which asks extra questions about symptoms such as shakes, sweats and fears. The SADQ score indicates whether the patient is dependent, and whether that dependence is mild, moderate, severe or very severe.

2. Why is this issue highlighted?

Range of alcohol harms

The diagram reproduced in Figure 1 conveys a sense of the range, scale and multi-dimensional nature of the harms which can result from alcohol misuse. The repercussions are felt not only by the drinker, but also by those around them, a phenomenon which the former Chief Medical Officer dubbed 'Passive Drinking'.[10]

Figure 1 – Dimensions of alcohol-related harm *Source: NDTMS West Midlands*[11]



The Government's Alcohol Strategy[6]

The government's new Alcohol Strategy was published in March 2012, raising the political profile of alcohol and its associated harms. It contained the following key pledges, although the government has already had second thoughts about the first two:

- The introduction of a minimum unit price for alcohol;
- Greater role for health bodies and health-related objectives in licensing decisions;
- Alcohol screening to be included in NHS Health Check from April 2013;
- A review of the alcohol guidelines for adults.

Minimum pricing

The proposal for minimum pricing was personally championed by the Prime Minister in his Foreword to the Alcohol Strategy[12], and a Home Office consultation was duly launched in November 2012, recommending a minimum price of 45p.[13] Subsequently, however, reports appeared criticising the evidence base for minimum pricing[14,15], and rumours emerged of a cabinet-level split on the issue.[16,17] In its response to the consultation, the Government announced in July 2013 that it would not be proceeding with a minimum price, although the policy would remain under review.[18] It does however intend to introduce a ban on pricing alcohol at below the amount of alcohol duty plus VAT, which should remove some of the very cheapest alcohol from sale.[12,18]

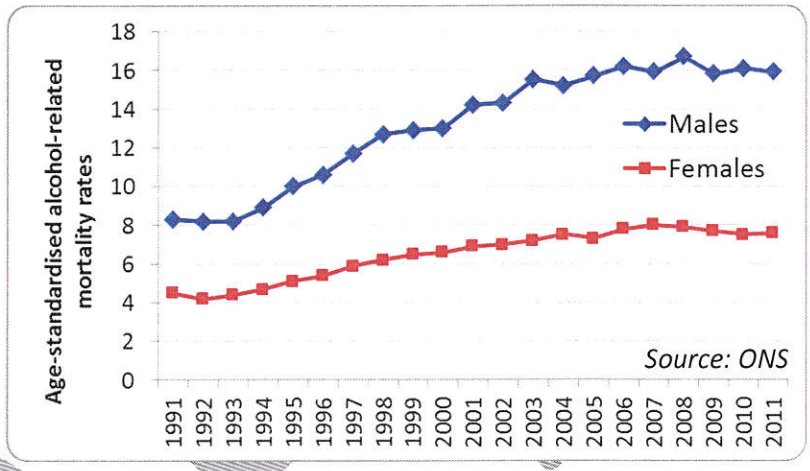
Licensing

In April 2012, Public Health was added to the list of 'responsible authorities' invited to comment upon licensing applications, giving Public Health departments a new role in the licensing process.[19] The Alcohol Strategy proposed to go one step further, by making 'public health' one of the statutory grounds upon which a 'Cumulative Impact Policy' could be declared.[13] This would have allowed the authority to use alcohol-related health as an argument for controlling the density of licensed premises in a specified area. However, the government has now decided not to proceed with this proposal until underlying processes, particularly data collection, have improved.[18]

Alcohol-related deaths

Even using a narrow definition, the rate of 'alcohol-related' deaths has been rising nationally over most of the past two decades (Figure 2).[20,*] These deaths tend to occur at a younger age than, for example, deaths from smoking.[21] The NW had the highest regional alcohol-related mortality rates for both males and females in 2011.[20]

Figure 2 - Alcohol-related deaths (ONS definition[20]), 1991-2011, England



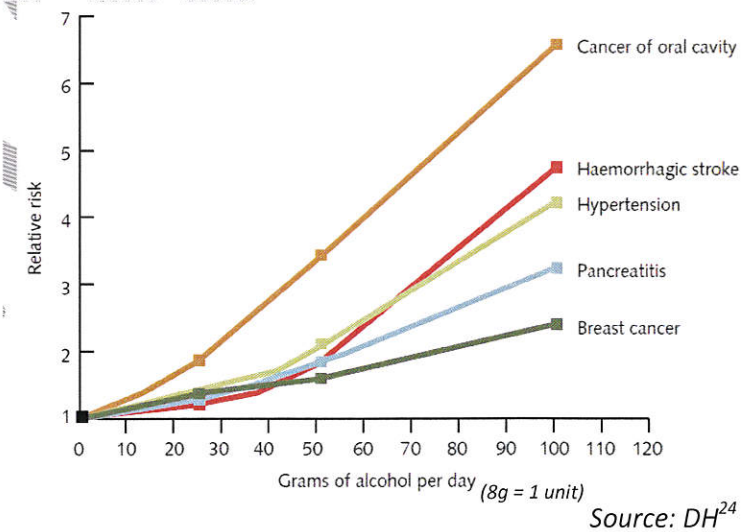
Health consequences

Alcohol also increases the risk of a wide range of illnesses, as shown below. Table 2 shows how many times more likely a 'higher risk' drinker is to develop various illnesses than if they did not drink at all. Figure 3 illustrates how the risk rises steadily with consumption at all levels above zero – there is no 'safe level'.

Table 2- Relative risk of drinking at twice recommended limits v. drinking below them

Illness	Men	Women
Liver cirrhosis	13.0	13.0
Mouth cancer	5.4	5.4
Larynx cancer	4.9	4.9
Oesophagus cancer	4.4	4.4
Liver cancer	3.6	3.6
Haemorrhagic stroke	3.6	3.3
Hypertension	4.1	2.0
Irregular heartbeat	2.2	2.2
Coronary heart disease	1.7	1.3
Colo-rectal cancer	1.5	1.4
Female breast cancer	n/a	1.6

Figure 3 - Relationship between alcohol consumption and severe health harms



Source: DH[24]

Wernicke-Korsakoff syndrome[22,23]

Heavy drinkers are prone to thiamine deficiency, which can trigger an acute reaction known as Wernicke's encephalopathy. If the symptoms (jerky eye movements, loss of balance and disorientation) are recognised in time, Wernicke's may be reversed by administering high-dose thiamine. However, without treatment it can be fatal, or lead to a distinctive type of brain damage known as Korsakoff syndrome. The symptoms of Korsakoff are similar to dementia, although generally affecting a younger age-group (typically males in their fifties). Some cases will respond to thiamine therapy, abstention from alcohol and a healthy diet, but most patients make no more than a partial recovery, or continue to deteriorate and require long-term residential care.

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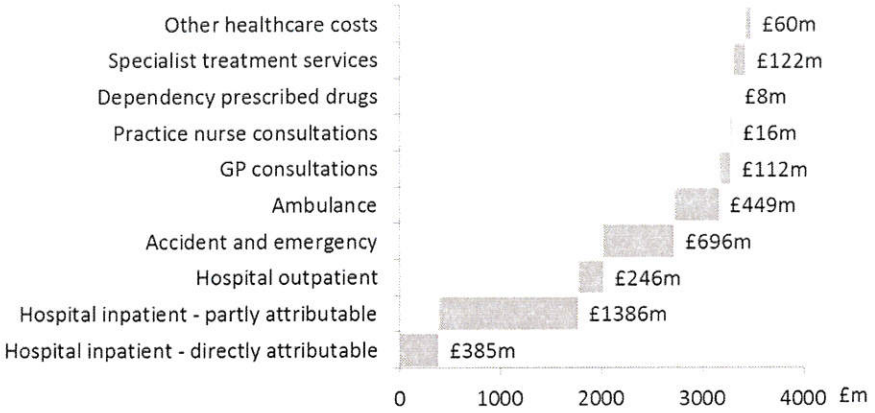
* *The ONS uses a narrow definition of 'alcohol related', restricted to 12 causes most directly due to alcohol consumption.*

Costs

Cost to the NHS

The cost of alcohol harm to the NHS in England is difficult to quantify. DH's own estimate comes to £3.5bn at 2009/10 prices (see Figure 4).[61] Drink Wise North West puts the figure slightly higher, at £4bn for England in 2010/11.[25]

Figure 4 - Cost of alcohol harm to the NHS – 2009/10 prices (England)

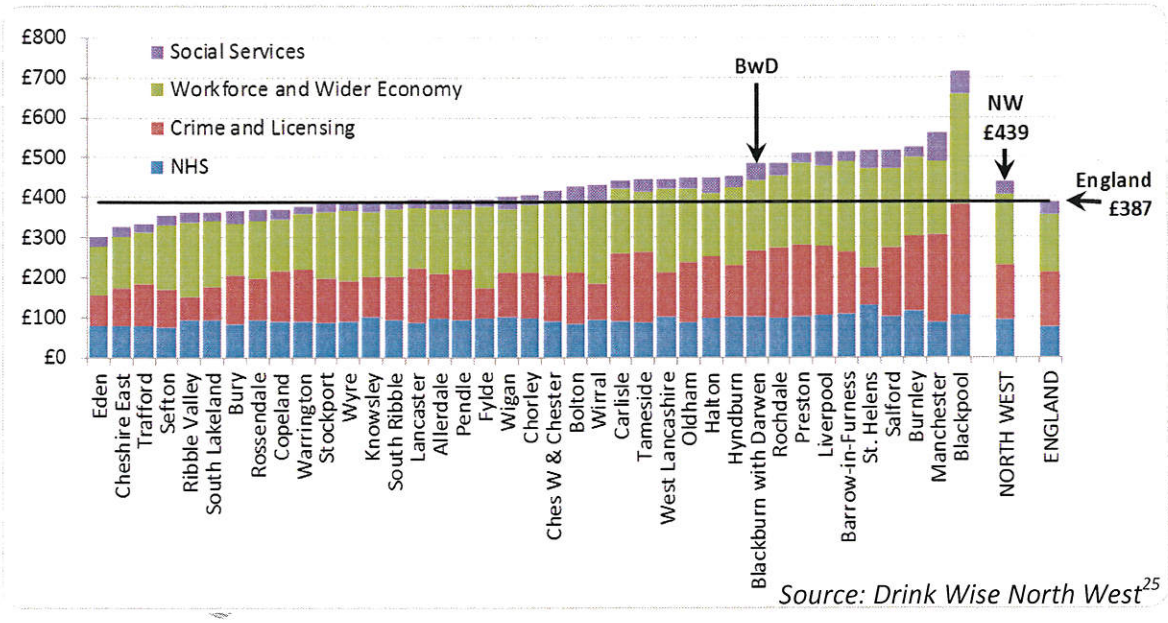


Cost to society as a whole

It is even harder to assess the overall cost of alcohol to the economy as a whole, including aspects such as the cost of crime, social services, and lost productivity. The government's Alcohol Strategy[6] and Drink Wise North West[25] both arrive at estimates of around £21bn pa nationally. However, Drink Wise North West acknowledges that this is only the tip of the iceberg, as alcohol has implications for everything from street cleaning to lives lost, all with a cost attached. The National Social Marketing Centre estimates the true figure to be as high as £55.1bn,[26] including £21.9bn for Disability Adjusted Life Years, and £21bn for informal care and loss of income.

Drink Wise North West estimates that alcohol is costing the Blackburn with Darwen economy at least £486 pa for every man, woman and child in the borough, which is higher than average for the NW and England:

Figure 5 - Estimated cost of alcohol to the economy (2010/11)

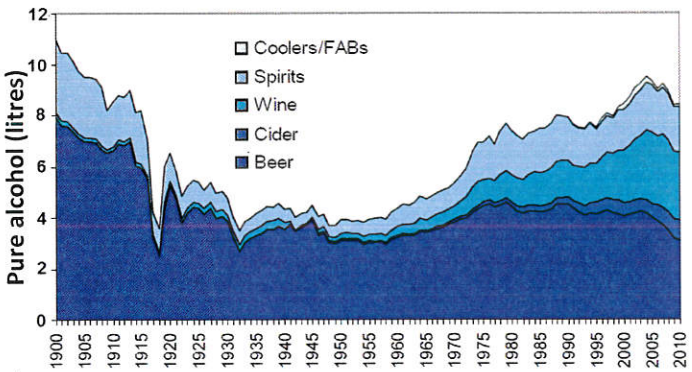


Source: Drink Wise North West[25]

Sales of alcohol

Perhaps contrary to common belief, alcohol sales per head have actually declined since 2004 (Figure 6[27]). They fell again by 2.2% in 2011 and 3.3% in 2012[28], but that still leaves them at roughly twice the level of the 1950s. It has been suggested that even if everybody stopped drinking above recommended levels tomorrow, demand on hospitals would remain relatively high for a further decade.[29]

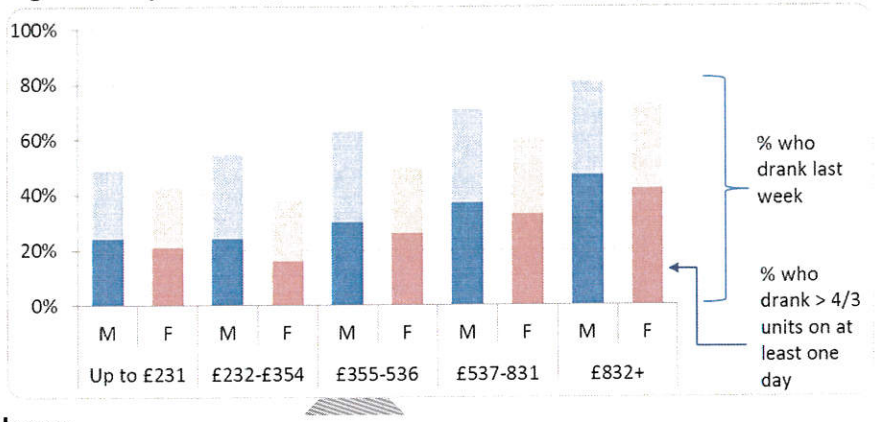
Figure 6 – Annual alcohol consumption per UK resident 1900-2010



3. Who is at risk and why?

Deprivation

Figure 7 – Drinking habits by sex and gross weekly household income quintile (GB 2011)



Socio-economic status & alcohol consumption

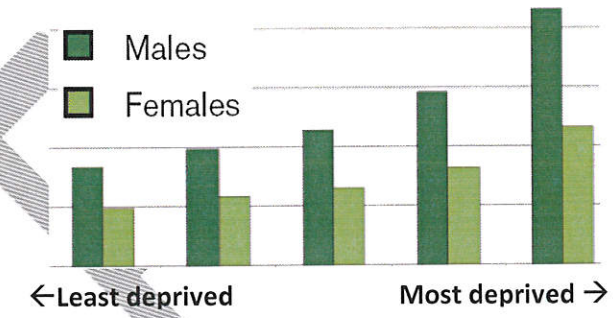
In contrast to what might be expected, national surveys consistently show alcohol consumption levels tending to *rise* with increasing income or social class (Figure 7).

Source: General Lifestyle Survey 2011[30]

Socio-economic status and alcohol harm

The opposite picture emerges when we look at the *harm* arising from alcohol use. Figure 8, adapted from the Marmot Review[31], shows how hospital admission rates due to alcohol increase with deprivation:

Figure 8 - Alcohol-attributable hospital admissions (age standardised rate, 2006-07) by small area deprivation quintile in England



Alcohol-related mortality rates* have also been found to be more than twice as high in the most deprived quintile of wards than in the least deprived[32], and in the Routine & Manual occupational group as compared with Higher & Managerial.[33] These inequalities are particularly sharp in the North West. Alcohol has been identified as one of the main reasons for the failure of the previous government's targets for reducing the life expectancy gap between the 'Spearhead' group of authorities (the most deprived) and England as a whole.[34]

Consumption/harm paradox

The complicated relationship between alcohol and deprivation is summed up by Marmot as follows:

"there is a social gradient in the harms from alcohol consumption but not in alcohol consumption itself" [31]

In other words, even though people with lower socio-economic status are less likely to drink at all, or to exceed recommended limits, they are more likely to suffer harmful consequences if they do. A Commons Health Committee hearing in April 2012 was told that the reasons for this pattern were unclear, but probably had something to do with confounding factors such as diet, other health behaviours, and access to medical services.[35]

Ethnicity

A review of the UK literature on the relationship between alcohol and ethnicity/religion found that Pakistani and other Muslim groups generally consume less alcohol than average, and are much more likely to abstain.[36] However, there is some evidence of polarisation within these communities, with those of a Pakistani or Muslim background who *do* drink having a *higher* average consumption than drinkers in other religious or ethnic groups. One study found that this was particularly true of second-generation Muslim men. There are also indications that South Asian men (mainly from non-Muslim communities) are more likely to develop cirrhosis, and to develop it younger. Further research is needed to establish whether this can be explained by drinking patterns, differing ability to metabolise alcohol, or other factors (e.g. viral hepatitis).

** These findings use a narrow definition of 'alcohol related', restricted to 12 causes regarded as being most directly due to alcohol consumption.*

Age

Young people

In the first official guidance on alcohol consumption in young people, the Chief Medical Officer comments that:

> ***"The drinking behaviours of our children are some of the worst in Europe, the health consequences are alarming and this is a situation that must change."*** [37]

The guidance recommends that no alcohol at all should be consumed before the age of 15. It cites evidence that those who start drinking at an early age are likely to drink more frequently and in greater quantities, to suffer a range of consequences such as injury and violence, teenage pregnancy, and suicidal thoughts and attempts, and to develop alcohol problems which last into adulthood. Drinking at age 15-17 should be confined to no more than one day a week, and strictly supervised, as binge drinking at this age may lead to violent behaviour, risky sexual activity, low educational attainment, and a drift into crime and drugs.

Young people under 17 are more likely to drink at all, to drink frequently, or to drink excessively if they: [38]

- receive less supervision from a parent or other close adult;
- spend more than two evenings a week with friends or have friends who drink;
- are exposed to a close family member, especially a parent, drinking or getting drunk;
- have positive attitudes towards and expectations of alcohol; and
- have very easy access to alcohol.

Effects of parental alcohol misuse

Children and young people are susceptible not only to the consequences of their own drinking, but to the harmful effects of alcohol misuse by the adults around them. Across the UK, it is estimated that 2.6 million children are living with parents who drink hazardously, and 705,000 with dependent drinkers.[39] These children may suffer a lack of supportive and consistent parenting, and even be thrust into the role of carer themselves. Growing up amid the conflict and disharmony associated with alcohol misuse can result in[40]:

- Anti-social behaviour – e.g. aggression, hyperactivity
- Emotional problems – e.g. bed-wetting, depression, and/or
- Problems at school – e.g. learning difficulties, truancy

There is a lack of hard data as to the impact of parental alcohol misuse upon the social care workload, but a frequently-quoted study in four London boroughs in 2000-01 found that alcohol abuse was a factor in 23% of families referred for long-term social work. Largely on the strength of this study, a report by York University for the Scottish Government has recently estimated that anything from 15% to 45% of the volume (and cost) of children and families social work in Scotland could be alcohol-related.[41]

Older people

A recent report from the Royal College of Psychiatrists (RCP) draws attention to the extent of alcohol problems among older people, often in response to psychosocial factors such as bereavement, boredom and loneliness.[42] One in five older men and one in ten older women are estimated to be drinking enough to harm themselves, which represents a rise of 40% in men and 100% in women over the past 20 years. [43]

The College also warns that as balance gets worse with age, even a small amount of alcohol can precipitate falls and accidents. Because of the physiological and metabolic changes associated with ageing, it recommends that the 'safe' limit for older people should be drastically redefined as 1.5 units a day or 11 units a week, and that anything above 4.5 units (male) or 3 units (female) should be regarded as 'binge drinking'.[42]

Researchers at University College London have estimated that using the RCP's guidelines, there are over 3m people aged 65+ drinking above safe limits, which is well above the equivalent number in the 16-24 age-group.[44]

A third of older people with drinking problems develop them for the first time in later life.[43] The Big Lottery Fund has launched a £25m programme called Rethink Good Health specifically to tackle the issue of late onset alcohol misuse among older people.[45]

Gender

In 2011, the General Lifestyle Survey switched its attention from the weekly drinking guidelines to the amount drunk in any one day. It found that nationally, the daily 'lower risk' limit was being exceeded at some point in the week by 34% of men compared with 28% of women. The 'increasing risk' limit was being exceeded by 18% of men and 12% of women.[46] Men also have higher rates of alcohol-related hospital admissions (Figure 8), and there is a large and growing gender gap in alcohol-related mortality rates* (Figure 2).

Mental health

There is a two-way relationship between mental health problems and substance misuse, which often coincide to produce a so-called 'dual diagnosis'. Psychiatric conditions which have been linked with alcohol dependence include major depression, panic disorder, phobias, personality disorders, schizophrenia and suicide.[47]

People with psychiatric disorders who also misuse drugs or alcohol encounter significantly poorer outcomes on a range of issues ranging from mental and physical health to homelessness. Approximately 40% of patients with psychosis are estimated to misuse substances, resulting in worse levels of relapse and hospitalisation, which has prompted the publication of a set of NICE guidelines specifically tailored to their needs.[48]

Not all dual diagnosis patients, however, are at this severe end of the mental health spectrum. The majority have less acute mental health needs, and with mental health and substance misuse services now separately commissioned, there is a growing realisation of the need to ensure that they do not 'slip through the net'.[49,50]

Homelessness

There is a complex cause and effect relationship between homelessness and alcohol misuse, but it is estimated that around half of all homeless people are alcohol dependent.[47] Lack of appropriate housing acts as a barrier to clients making progress in treatment and has a detrimental impact on recovery outcomes.

Adverse childhood experiences

A major research project involving 1500 people in Blackburn with Darwen has shown that compared with those who were exposed to no adverse childhood experiences (ACEs) before the age of 18, those exposed to four or more ACEs have at least twice the risk of becoming heavy drinkers in adulthood. Adverse childhood experiences include factors such as growing up with someone who was mentally ill, had a drink problem or served time in prison, experiencing parental separation or divorce, being sexually abused, or witnessing or being the victim of domestic violence.[51]

Sexual orientation

The limited evidence on drinking patterns among LGBT people comes from international and small-scale UK studies. On balance, it suggests that lesbians and gay men may be more likely to use and misuse alcohol than heterosexual men and women.[47]

Occupation

The proportion of deaths among publicans and bar staff that are alcohol-related* is roughly twice what would be expected for working-age people in England and Wales generally.[52] Other occupations in the drinks, catering and entertainment industry also show above-average proportions of alcohol-related deaths. Excess mortality from alcoholism among innkeepers and their staff is nothing new, having been noted by the Registrar General as long ago as 1895.

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* *These findings use a narrow definition of 'alcohol related', restricted to 12 causes regarded as being most directly due to alcohol consumption.*

4. Level of need in the population

Alcohol consumption

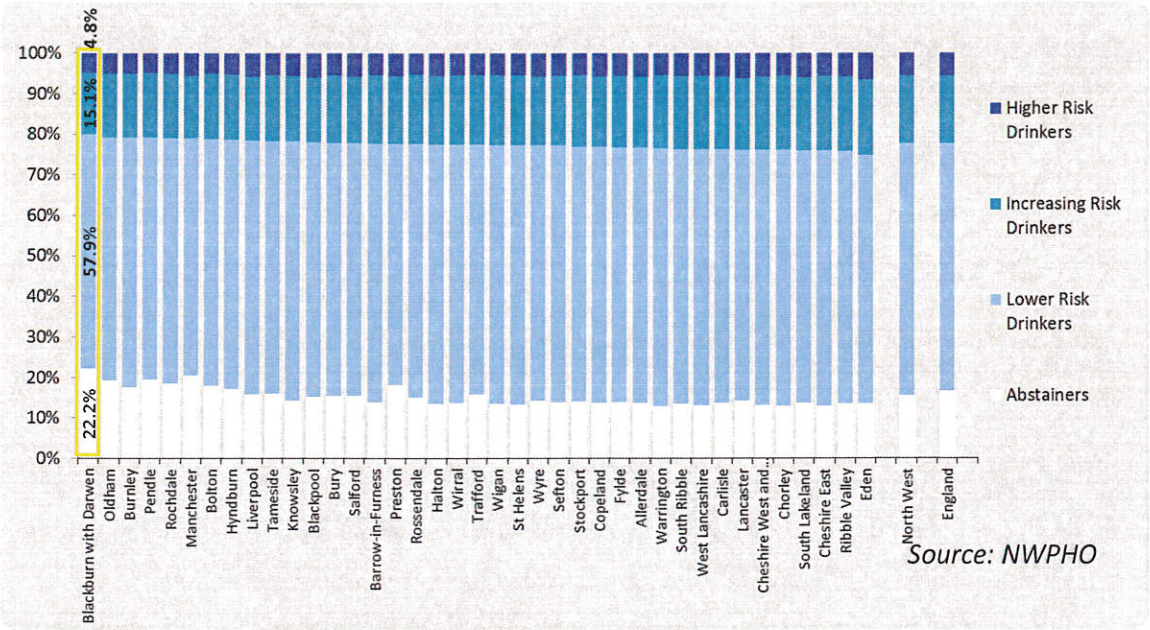
Synthetic estimates*

The Local Alcohol Profiles for England (LAPE) provide synthetic estimates* of the proportion of abstainers and lower-risk, increasing-risk and higher-risk drinkers. The 2012 profile uses a new 'enhanced' model (Figure 9).

Blackburn with Darwen is estimated to have the highest estimated abstinence rate in the North West, as in the previous model. However, it is now also shown as coming highest in the region for abstainers plus lower-risk drinkers put together (or equivalently, lowest for increasing and higher risk drinkers combined):

Figure 9 - Alcohol consumption among residents aged 16+ (synthetic estimates*) – NW local authorities, mid-2009

Source: adapted from LAPE 2012



It must be stressed that this move from mid-table to the most favoured position in the NW is the result of a new (and supposedly better) model. Synthetic estimates are not capable of detecting real change on the ground.

The most striking thing about the new graph is just how little variation it shows across the region, and indeed across the country. In fact, there is not a local authority in the land where the 'increasing and higher risk drinking' estimate differs significantly from the England average.[53]

Anecdotal evidence

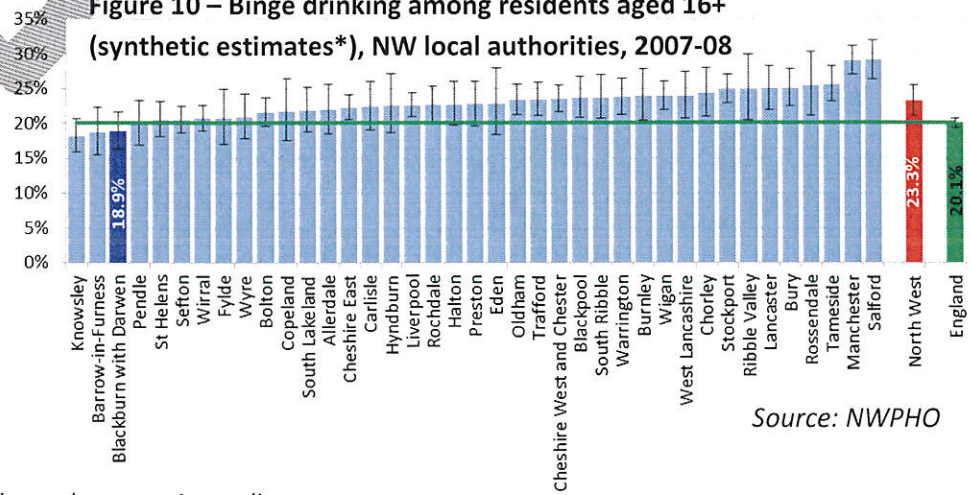
The modelled estimates only go down to district level, but local sources suggest a concentration of alcohol misuse clients in Hostel and HMO (Houses in Multiple Occupation) accommodation within Blackburn with Darwen.

Binge drinking

Synthetic estimates*

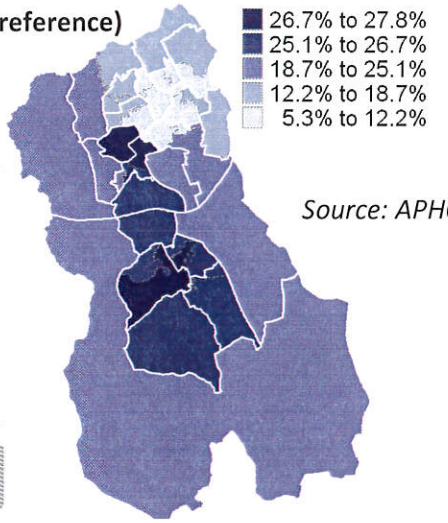
The LAPE estimates of binge drinking have also been re-modelled, but still relate to 2007-08. Blackburn with Darwen's new estimate of 18.9% is now the third lowest in the NW (average 23.3%), but is not significantly different from the England average of 20.1%.

Figure 10 – Binge drinking among residents aged 16+ (synthetic estimates*), NW local authorities, 2007-08



* *For an explanation of this terminology, please see Appendix*

Figure 11 - Binge drinking among residents aged 16+ (synthetic estimates*), Middle Super Output Areas, 2007-08 (showing ward boundaries for reference)



Source: APHO

Synthetic estimates* of binge drinking are also available at Middle Super Output Area (MSOA) level. However, these are now quite old, and only show how binge drinking might be *expected* to vary across Blackburn with Darwen, based on local socio-economic characteristics[54]:

Alcohol dependency

NWPHO has not yet produced local synthetic estimates* of alcohol dependency, but is investigating the possibility of doing so.[55] Based on a national survey in 2007[56], the National Treatment Agency (NTA) has estimated that there may be around 2150 dependent drinkers aged 18-75 in Backburn with Darwen.[57]

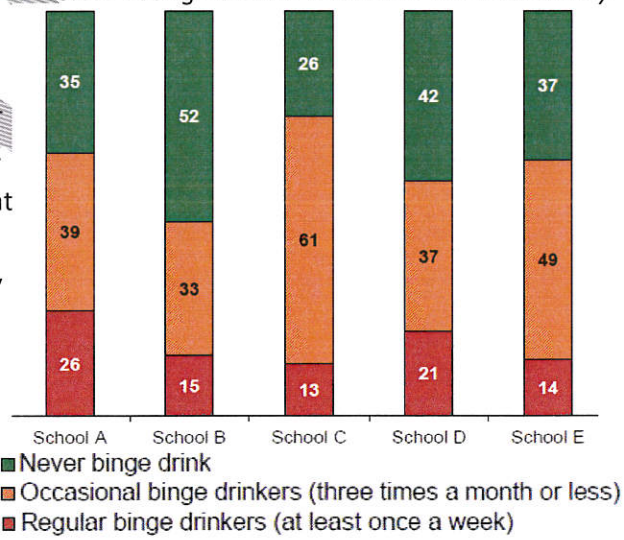
Young people and alcohol

Consumption and binge drinking among 14-17 year-olds

Every two years, Trading Standards North West carries out a major Young Persons' Alcohol and Tobacco Survey among 14-17 year-old pupils (mainly aged 15-16) across the region. The 2013 survey included 516 responses from pupils at five schools in Blackburn with Darwen. The proportion of Indian and Pakistani pupils in these schools is less than half the borough average, and the sampling methods used mean that the survey results cannot be taken as representative of Blackburn with Darwen pupils as a whole.

Figure 12 – Binge drinking in five Blackburn with Darwen schools (2013)

Source: TSNW Young Persons' Alcohol & Tobacco Survey



For example, according to the 2013 survey, the proportion of pupils in the Blackburn with Darwen sample abstaining from alcohol has fallen since 2011, and is now *below* the NW average (having been above average in 2011). However, these findings may reflect the under-representation of Indian and Pakistani pupils in the 2013 sample.

The survey is probably more useful where it deals with issues that are plainly undesirable and/or illegal, as these can at least then be tackled in the schools concerned. For instance, there is clearly scope for interventions aimed at reducing the levels of binge drinking in these five schools (see Figure 12), whatever the pattern may be in the rest of the borough.

Young substance users – the *Too Much Too Young* study[58]

The *Too Much Too Young* study in 2011 recruited 100 young substance users aged 18-25 in Blackburn with Darwen through 'snowball sampling' – i.e. users known to services were asked to approach others in their peer group who may not be. It is important to stress that this sample does *not* enable us to gauge the total number of young substance users in the borough, and does not set out to be representative of young people generally.

The majority of respondents were male, with 91% of white British ethnicity. Alcohol was the most common substance used, cited by 97% of the sample, and 63% had been regular drinkers by age 14. It was the primary substance for 43% of the sample, but was often consumed along with other drugs, particularly cannabis.

Average weekly intake, spread over an average of 3.7 days, was 122 units per week – vastly in excess of the recommended limits. However, only 27% saw their alcohol use as a problem. The main issues arising from it were violence and aggression, as well as the financial consequences, and an inability to engage with work and keep appointments. Over half felt they had been unable to do something because of alcohol in the last year.

* *For an explanation of this terminology, please see Appendix.*

Hospital admissions connected to alcohol

Summary indicators

The LAPE profile contains several summary indicators of hospital admissions connected to alcohol, which are presented as a spine chart in Figure 29. Blackburn with Darwen ranks in the worst quintile nationally for nearly all these measures, the best known of which is the one formerly known as **NI 39**.

NI 39 admission rate

Some conditions are *invariably* caused by alcohol, but the NI 39 indicator uses so-called 'Alcohol Attributable Fractions' * to apply appropriate weights to the many other conditions which *sometimes* are. In 2011/12, and provisionally in 2012/13, Blackburn with Darwen's rate of hospital admissions attributable to alcohol (Figure 13) was the 5th highest of any upper tier local authority in England. The dip between 2010/11 and 2011/12 should be treated with caution (see explanation below), but the continued dip from 3076 in 2011/12 to 2950 in 2012/13 is more encouraging.

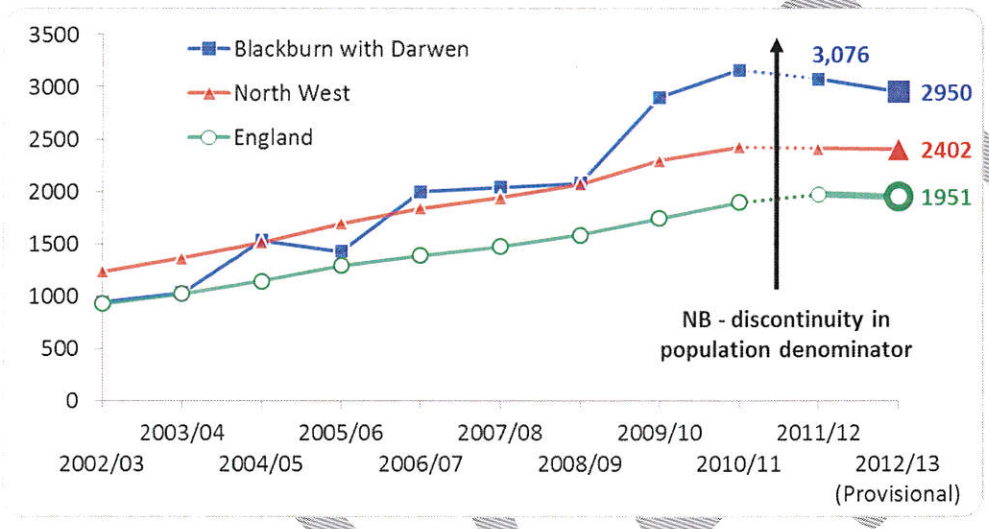


Figure 13 - Rate of alcohol-related admissions per 100,000 population (former NI 39) *[NB : pre-2011/12 rates are subject to revision – please see text]*

Source: www.lape.org.uk

The historical trend prior to 2011/12 needs to be interpreted with caution, for two reasons:

- **Population denominators:** In Figure 13, the 2011/12 and 2012/13 rates are worked out using the latest population estimates based on the 2011 Census. However, the older rates are based on population estimates which are now known to be incorrect. In Blackburn with Darwen's case, the old population estimates are too low, so the historical rates shown in Figure 13 are too high. When they are recalculated using revised population estimates, the apparent drop between 2010/11 and 2011/12 may well disappear.
- **Coding issues:** Over the years, there has been an increasing tendency to list several diagnoses against each admission. This could be inflating the NI39 rate as time goes on, because it is calculated using the highest Alcohol Attributable Fraction * of any of the listed diagnoses. Public Health England has recently consulted on what to do about this, and the decision has been made to introduce a new additional indicator alongside NI39.[59] The new measure will be included in the Public Health Outcomes Framework, and first results are expected to be published in February 2014.

The 2011/12 alcohol-related admission rates are also included in the Health and Social Care Information Centre's latest ***'Statistics on Alcohol'*** report.[60] The HSCIC quotes a higher result for Blackburn with Darwen (3521 per 100,000), but this is purely because they have used a different method of turning the number of admissions into a rate. They also present a version based on primary diagnosis alone, on which Blackburn with Darwen comes only 24th highest. This demonstrates that coding practices can indeed have a major effect on the findings.

* *For an explanation of this terminology, please see Appendix*

Admissions for specific types of liver disease

Admissions for cirrhosis

The Atlas of Variation for Liver Disease[61] presents the 2006/07-2010/11 rate of people admitted to hospital for cirrhosis, which is often (though not always) caused by excess alcohol intake. Blackburn with Darwen's rate puts it in the second highest quintile of PCTs nationally, and in thirteenth highest place within the North West.

Emergency admissions for alcohol-related liver disease

This new indicator forms part of the CCG Outcomes Indicator Set, which will be used to hold Clinical Commissioning Groups (CCGs) to account. The definition of 'alcohol-related' is actually a very narrow one, as only formal diagnoses of 'alcoholic liver disease' are included.

There were only 33 emergency admissions of this kind among patients on the list of a Blackburn with Darwen GP in 2011/12, or 25.8 per 100,000, placing Blackburn with Darwen 84th highest out of 211 CCGs. This puts it well down the list of North West CCGs, 12 of which are among the worst twenty in England.

Impact of alcohol upon mortality

LAPE indicators

The LAPE Profiles contain nine mortality indicators related to alcohol, which are shown as a spine chart in Figure 30 at the rear. Blackburn with Darwen compares badly on most of them, particularly for males. The sole exception is alcohol-attributable* mortality from road accidents, but this is based on a blanket assumption that 35.3% of all such deaths are caused by alcohol, so it is indicative of a low rate of road traffic mortalities in general.

Liver disease mortality

There is now a proliferation of mortality indicators for liver disease, all measuring subtly different things:

Table 3 - Liver disease mortality indicators and their sources *(see below for abbreviations*)*

Indicator	Source	Year	Blackburn with Darwen
Chronic liver disease, all ages, M (rate)	LAPE*	2008-10	**18th highest** out of 151 PCTs
Chronic liver disease, all ages, F (rate)	LAPE*	2008-10	**26th highest** out of 151 PCTs
Chronic liver disease <75, M+F (rate)	Atlas*	2008-10	**17th highest** out of 151 PCTs
Chronic liver disease <75, M+F (YLL*)	Atlas*	2008-10	**18th highest** out of 151 PCTs
All liver disease < 75, M/F/M+F (rate)	NHSOF*	2011	**4th highest** out of 151 PCTs (M+F)
All liver disease < 75, M+F (rate)	CCG OIS*	2012	**30th highest** out of 211 CCGs
All liver disease < 75, M+F (rate)	PHOF*	2009-11	**5th highest** out of 149 upper-tier LAs
All preventable liver disease < 75, M+F (rate)	PHOF*	2009-11	**29th highest** out of 149 upper-tier LAs

Blackburn with Darwen is in the worst quintile for all the indicators, but was particularly bad in 2009/11 on measures of 'All liver disease'. In fact, the component of liver disease mortality *not* considered preventable is bigger in Blackburn with Darwen than anywhere else (Figure 14). This suggests that although they are important, lifestyle factors such as alcohol consumption and obesity do not tell the whole story.

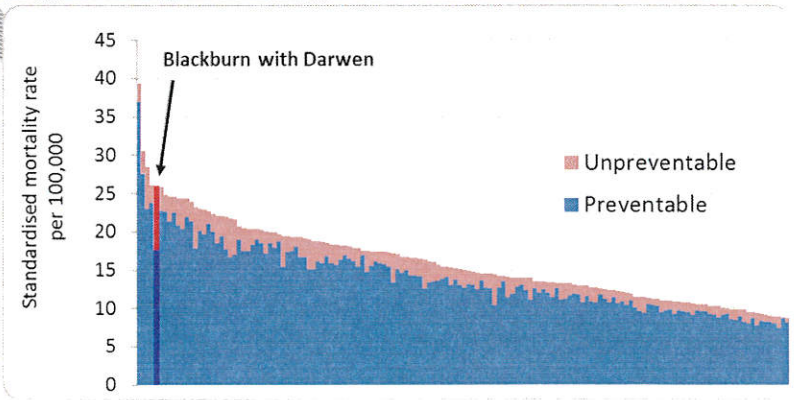


Figure 14 – Mortality from all liver disease (M+F, age under 75, 2009-11), upper tier local authorities, showing preventable/unpreventable split

Life expectancy

New in-house calculations for 2010-12 suggest that if Blackburn with Darwen had the same liver disease mortality rate as England & Wales generally, male life expectancy in the borough would be extended by nearly four months.

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* *LAPE = Local Alcohol Profiles for England, 'Atlas' = NHS Atlas of Variation (Liver Disease), NHSOF = NHS Outcomes Framework, CCG OIS = CCG Outcomes Indicator Set, PHOF = Public Health Outcomes Framework, YLL = Years of Life Lost*

Impact of alcohol upon crime

Synthetic estimates*

Crime	Alcohol Attributable Fraction (AAF)
Violence against the person	0.37
Sexual offences	0.13
Robbery	0.12
Burglary	0.17
Theft of motor vehicle	0.13
Theft from motor vehicle	0.13

Source: NWPHO[62]

There is no national system of logging whether crimes involve alcohol, so the LAPE profiles contain synthetic estimates* of alcohol-attributable crime obtained by applying alcohol-attributable fractions* (Table 4):

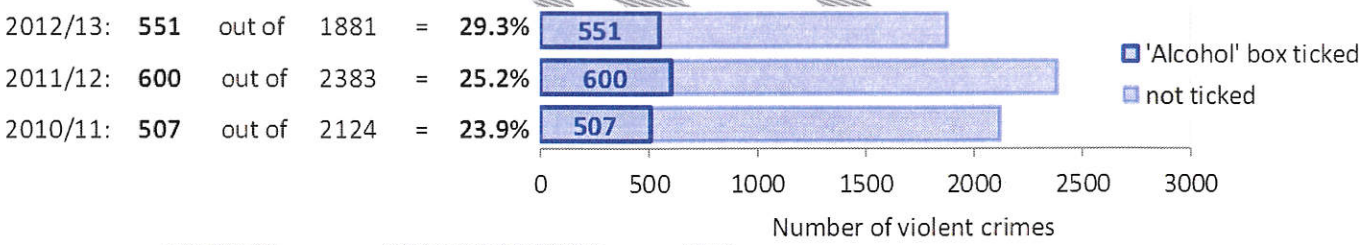
Table 4- Alcohol Attributable Fractions* for crime

Assuming these fractions to be correct, Blackburn with Darwen in 2011/12 was slightly above average in its rates of alcohol-related violent crime, alcohol-related sexual offences, and alcohol-related crime generally (see Figure 31 at rear).

Local estimates

Lancashire Constabulary, however, does operate a system of ticking a box if the officer inputting a crime considers that alcohol was a contributing factor. Figure 15 shows how many violent crimes did or did not have the 'Alcohol' box ticked in each of the last three years. There was a fall in the overall *number* of violent crimes in 2012/13, but the *proportion* flagged as involving alcohol has been steadily rising. Even so, it is well below the government's estimate of 44% of violent crimes being alcohol-related nationally[6], so it may be suspected that the box is not always ticked when it should be:

Figure 15 – Violent crimes with and without 'Alcohol' box ticked, Blackburn with Darwen, 2010/11 to 2012/13



Alcohol & incapacity benefits

The number of incapacity benefit claims by reason of alcoholism has been made available on the web as the result of an FOI enquiry.[63] When this is expressed as a rate, Blackburn with Darwen comes fifth after Blackpool, Manchester, Burnley and Bournemouth, with Salford just behind (Figure 16).

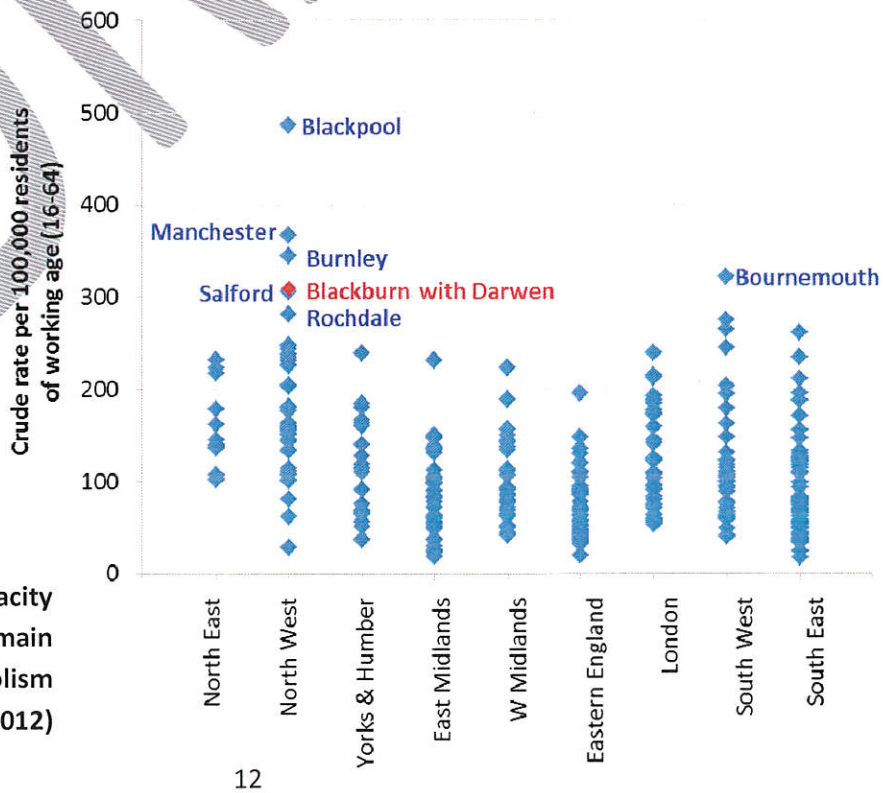


Figure 16 - Claimants of incapacity benefits (IB, SDA and ESA) where main disabling condition is alcoholism (August 2012)

5. Good practice

NICE public health guidance

The latest NICE guidance[64] on preventing harmful drinking spans both policy and practice, arguing that they need to work in tandem to reinforce each other. It contains policy recommendations directed at central government, as well as advice on practical interventions aimed at local agencies:

Figure 17 - Preventing harmful drinking: NICE Public Health Guidance[64]

DH 'High Impact' changes

The *'Signs for Improvement'* commissioning guidance[2], issued in 2009, contains seven influential 'High Impact Changes' to reduce alcohol-related harm. These have been endorsed by the Under Secretary of State for Public Health as recently as November 2011[5]:

1. **Work in partnership**
2. **Develop activities to control the impact of alcohol misuse in the community**
3. **Influence change through advocacy**
4. **Improve the effectiveness and capacity of specialist treatment**
5. **Appoint an Alcohol Health Worker**
6. **Identification & Brief Advice – provide more help to encourage people to drink less**
7. **Amplify national social marketing priorities**

'Health First' strategy

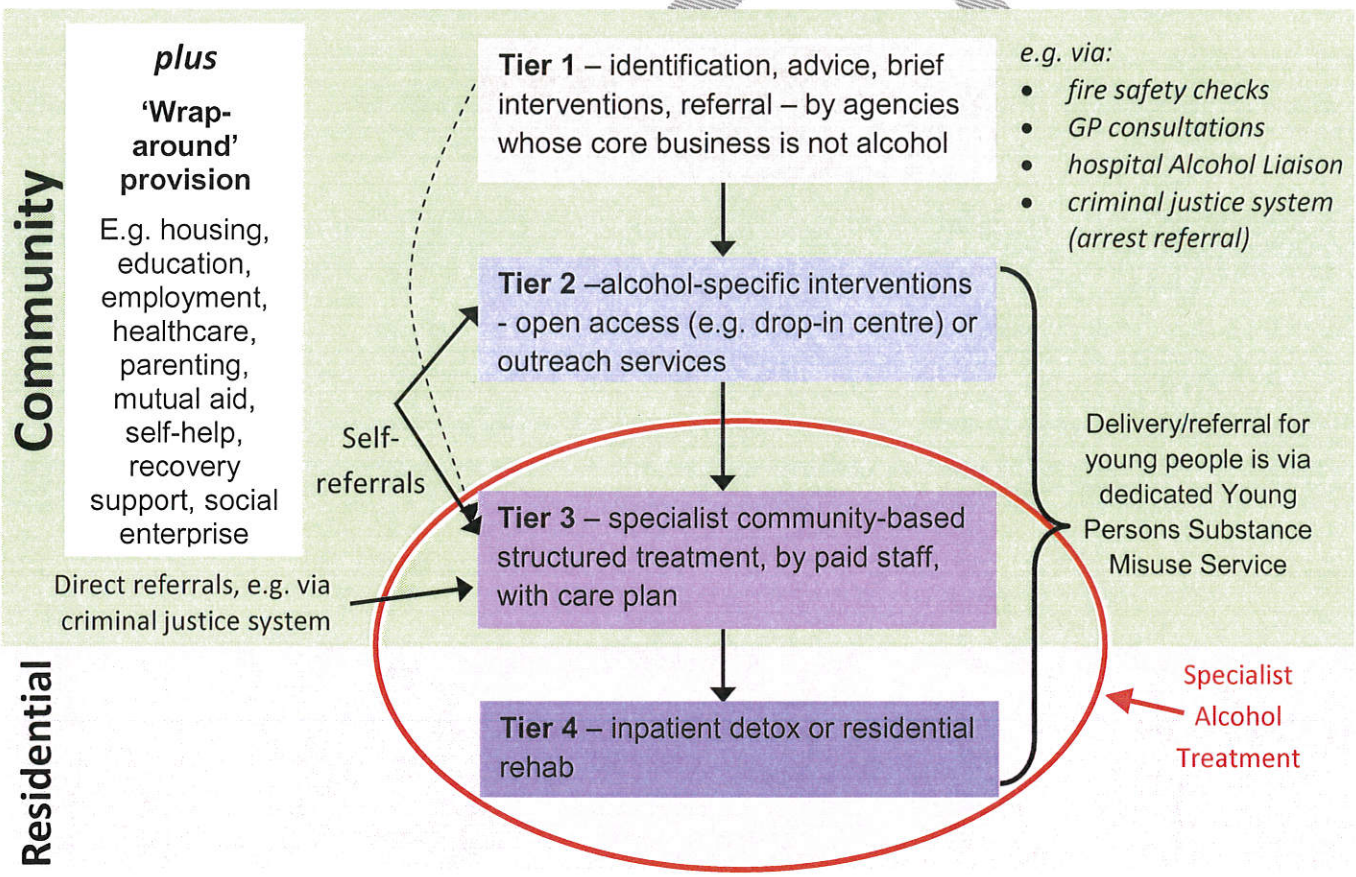
A year after the Government brought out its Alcohol Strategy, an independent group of experts has launched its own 'evidence-based alcohol strategy for the UK', published by the University of Stirling.[65] With its stated vision for *'a safer healthier and happier world where the harm caused by alcohol is minimised'*, the 'Health First' strategy is supported by a wide range of leading charitable, academic and professional organisations in the field.

A key message is the fact that alcohol-related harm is not confined to the minority of very heavy drinkers who suffer acute problems. The greatest overall harm comes in the form of the long-term health consequences experienced by long-term regular drinkers. Many of the report's recommendations aim to reduce the appeal, affordability and availability of alcohol at a population level.

Alcohol treatment – evolving models of care

For several years, care and treatment services for substance misusers have been organised according to the best practice guides known as *Models of care for drug misusers (MoCDM)* and *Models of care for alcohol misusers (MoCAM[66]),* which recommended a standardised four-tier system of 'stepped care'. Figure 18 depicts the way the four-tier system of alcohol misuse services operates in Blackburn with Darwen:

Figure 18 - Format of alcohol misuse services in Blackburn with Darwen



In 2010, however, the Government's Drug Strategy[67] suggested that drug and alcohol treatment should be integrated under a single, more holistic, recovery-focused model of care. The National Treatment Agency for Substance Misuse (NTA) responded by launching a consultation under the banner ***Building recovery in communities***, to explore what such a system should look like. Even though the four tiers were never intended to be rigid[66], the NTA feels that they may have created barriers to treatment. It proposes moving away from them towards an approach more focused upon the service user and their recovery.[68]

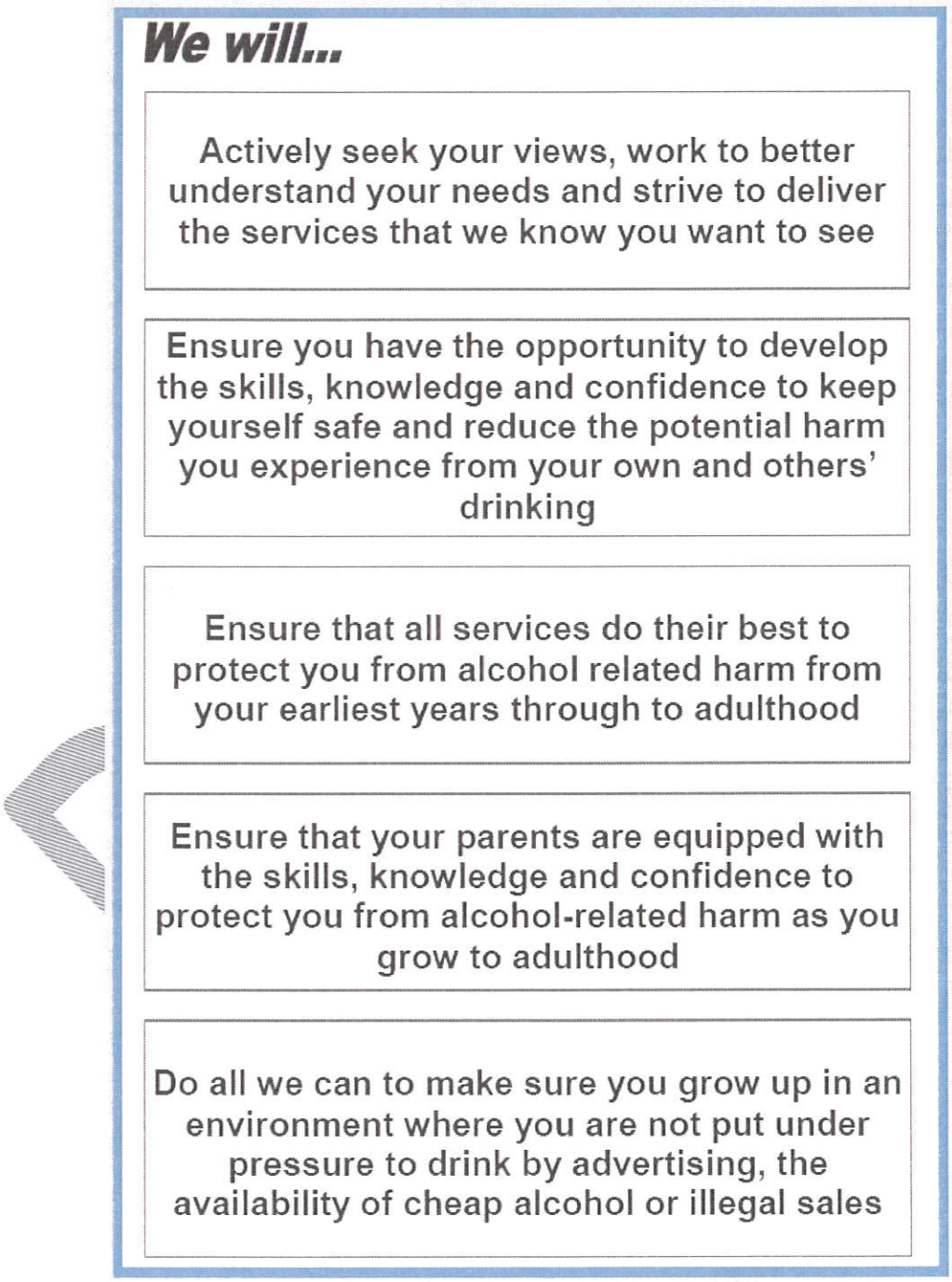
Respondents to the consultation were generally in favour of bringing drug and alcohol treatment together, and moving away from the four-tier system.[69] The concept of 'good practice' therefore seems set to change, and we may expect the shape of service provision to look quite different a few years from now.

North West Young People and Alcohol Programme

Pledges to young people

In 2010, the North West Young People and Alcohol Programme (http://tinyurl.com/ojf7alx) commissioned both a peer research project with young people called 'Alcohol Life Stories'[70] and a review of the evidence base for effective interventions with young people affected by alcohol.[71] Armed with the findings from these pieces of research, they developed a set of **'Pledges to young people'**:[72]

Table 5- the Pledges to Young People (NW Young People and Alcohol Programme)



In Blackburn with Darwen, the Pledges were signed by the Directors of Public Health and Children's Services at a public launch during Alcohol Awareness Week in 2011, with an undertaking to deliver them locally by September 2013. The Pledges have already been incorporated into the borough's Alcohol Strategy and its Children and Young People's Plan.[73]

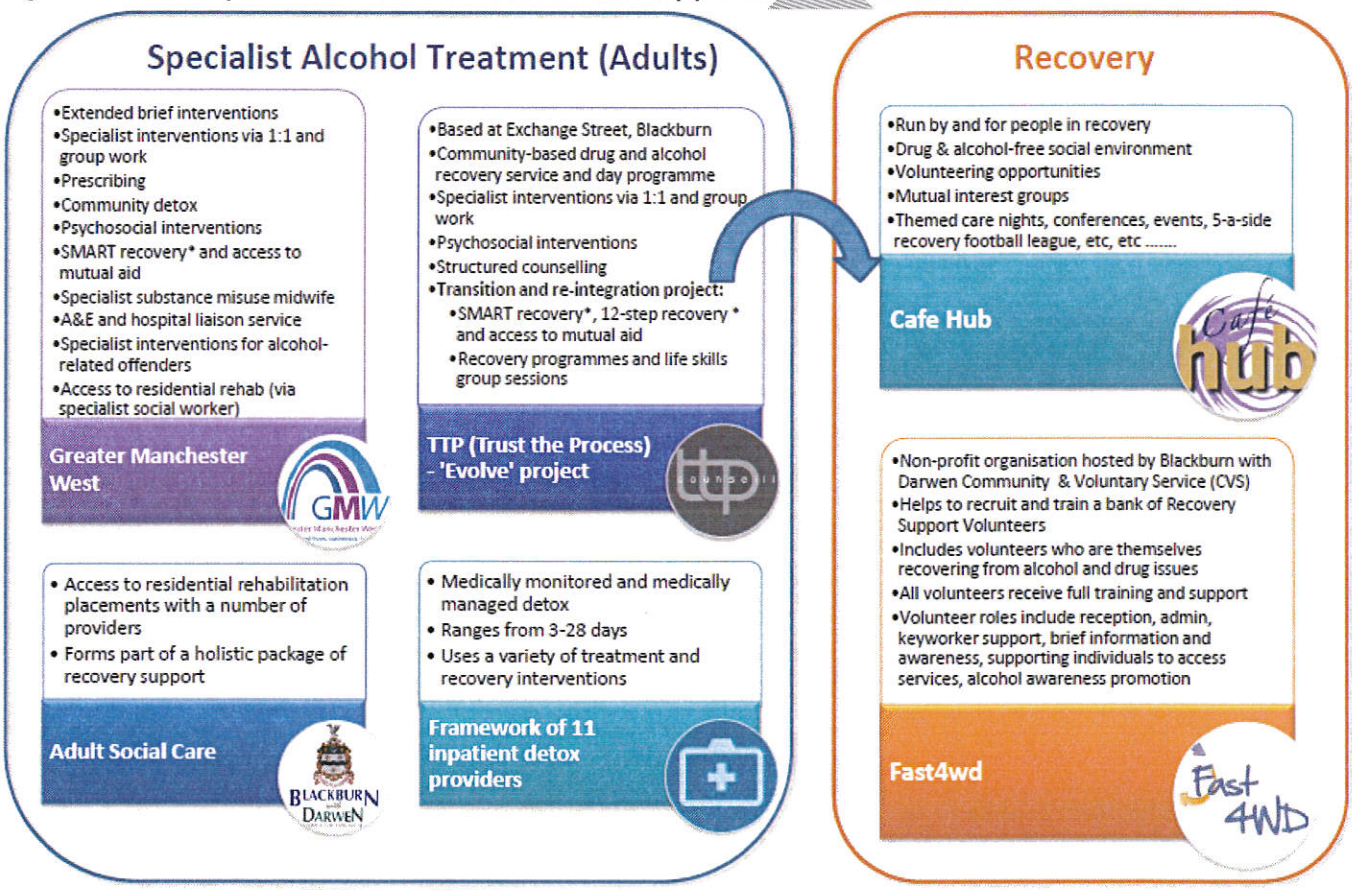
6. Current services / initiatives

Those requiring help with alcohol problems in Blackburn with Darwen, or wishing to volunteer their services, can find relevant information on the 'Your Support Your Choice' site (http://www.yoursupportyourchoice.org.uk/i-need-help-with/health,-recovery-and-wellbeing/drugs-and-alcohol/drug-and-alcohol-services.aspx).

Specialist alcohol treatment for adults – service provision

Specialist alcohol treatment comprises Tier 3 and 4 services combined (see Figure 18), and is mainly targeted at dependent drinkers. Figure 19 illustrates the main providers of specialist alcohol treatment for adults in Blackburn with Darwen, and how they link to the recovery services which then step in to provide long-term support and onward development.

Figure 19 - Adult Specialist Alcohol Service and Recovery provision in Blackburn with Darwen



Specialist alcohol treatment for adults - performance

Specialist alcohol treatment services are accessed by approximately 400-450 adults per year in Blackburn with Darwen with a primary alcohol problem, over two-thirds of whom are male.

The figures quoted in this section do not include those undergoing specialist drug treatment who declared (and were treated for) a secondary alcohol problem. In Blackburn with Darwen, 31% of those treated for a primary drug problem in 2011/12 cited alcohol as a secondary issue, compared with 22% nationally.[57,†]

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* **"SMART recovery"** = an abstinence-based, peer-support recovery programme for any addictive behaviour, based on secular, science-based principles (www.smartrecovery.org.uk). **"12-step recovery model"** = holistic, peer-led approach established by Alcoholics Anonymous (www.alcoholics-anonymous.org.uk/?PageID=56), incorporating spiritual principles.

† NB - Blackburn with Darwen provides both alcohol and drug treatment via integrated substance misuse services. This may mean that clients feel less reluctant to disclose a secondary problem than in areas where the services are separate.

Service availability

If the NTA is correct in its estimates, then 23% of dependent drinkers in the borough received treatment in 2011/12, which is well above the national average (13%). Waiting times to access treatment are also better than average, with just 7% of service users in the borough waiting over three weeks, compared to 15% nationally.[57]

Service user profile

Users of specialist alcohol treatment services in Blackburn with Darwen differ in some important respects from the national picture:

Table 6 - Characteristics of primary users of specialist alcohol services, 2012-13

	Blackburn with Darwen	England
Lives with children	47%	29%
Unemployed at start of treatment	80%	59%
Using another drug as well as alcohol (not opiates/crack)*	28%	14%

Source: NTA[74]

These are the top three 'compounding issues', but others include using opiates and/or crack, being pregnant, having a housing issue, or having been referred from the criminal justice system.

Service outcomes

Clients left alcohol treatment in Blackburn with Darwen in 2011/12 with a success outcome in 60% of cases (national average 57%), which represents an improvement of fifteen percentage points in two years.[75]

The average course of treatment lasted 260 days, well above the national average of 175 days, with 18% lasting over a year (England average 15%). While it is important that clients do not drop out prematurely, being in treatment for over a year may indicate that they are not moving effectively through and out of the system.[57]

On the whole, female clients are more likely to self-refer, much less likely to enter Tier 4, and generally have shorter and more successful treatment journeys.[76,77]

Additional alcohol services – adults

As well as specialist treatment, a range of additional services are commissioned to support particular groups affected by alcohol problems, and promote awareness, training and intelligence:

Figure 20 - Additional alcohol services for adults in Blackburn with Darwen

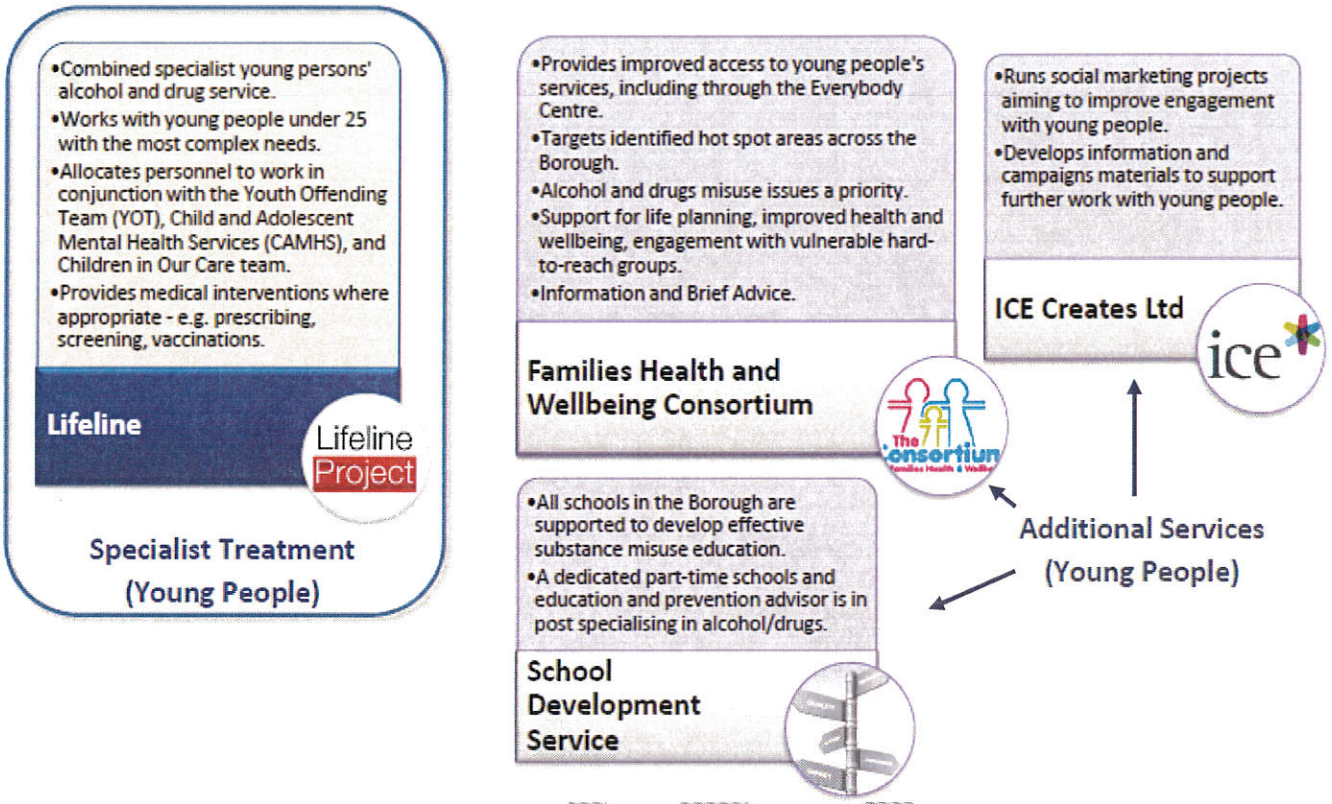
Due to the complex and cross-cutting nature of alcohol issues, they are also addressed through partnership initiatives, such as Community Safety, Women's Aid, Primary Care and Pharmacy provision.

* NB - Blackburn with Darwen provides both alcohol and drug treatment via integrated substance misuse services. This may mean that clients feel less reluctant to disclose a secondary problem than in areas where the services are separate.

† **"Floating housing support"** = housing-related support for vulnerable adults. For a simple description, see http://www.exeter.gov.uk/index.aspx?articleid=7778

Service provision for young people

Figure 21 - Specialist and other alcohol services for young people in Blackburn with Darwen



Delivery points include the flagship '**Everybody Centre**', a dedicated 'one-stop-shop' for young people aged 14-24 providing access to confidential sexual health, drug and alcohol services alongside counselling, mental health services, and general help and advice. The 'one-stop' approach is designed to minimise the risk of young people being stigmatised for accessing a particular service in a particular building.[78,79,80]. Alcohol services available here include drop-in and brief advice and information sessions at Tier 2 level, as well as Tier 3 interventions.

Specialist treatment for young people

User profile

Young people under 18 receive specialist drug and alcohol treatment from integrated substance misuse services, and only one set of statistics is published covering both. The main primary substances resulting in a need for treatment are cannabis and alcohol[81], with 46% of the under-18 treatment population in Blackburn with Darwen using both of these together.[75] At this age, it is deemed to be particularly risky to be drinking almost daily, or exceeding 8 units daily (male) or 6 units daily (female) on 13+days per month. 18% of young people in treatment for drugs and/or alcohol in the borough reported drinking at these levels, compared with 7% nationally.[75]

Compared with young service users nationally, those in Blackburn with Darwen are more likely to be (or have been) looked after, or to be in contact with the criminal justice system, and less likely to be in education, training or employment. This does not necessarily imply that these problems are more prevalent than elsewhere, but may be an indication of the service's success in engaging those young people with the most complex needs.[75]

Outcomes

Treatment outcome data is not broken down by substance, but young people achieve high levels of successful treatment completion locally. 88% leave with a planned exit, and only 6% return to treatment within six months.[75]

Public Protection Service

Blackburn with Darwen's Public Protection Service (incorporating the Trading Standards team) is heavily committed to working to prevent the harm caused by alcohol, both to young people and to adults. Its programme of test purchasing, to detect whether retailers are selling alcohol to persons under the age of 18, is per head of population the most active in the North West.[82] The service also carries out personal visits to all new Designated Premises Supervisors (licence-holders), sometimes on a multi-agency basis, to explain the responsibilities and conditions which are attached to the licence to sell alcohol. It is hoped that these visits help the new DPS to operate their business in a way which meets the statutory obligations to protect public safety avoid public nuisance, protect children from harm and prevent crime and disorder.

Think Family approach

It is well recognised in Blackburn with Darwen that issues such as alcohol misuse affect the whole family, and are likely to be accompanied by multiple other problems. The borough has pioneered the 'Think Family' approach, which aims to help families with complex needs to turn their lives around by devising their own family-focussed plan, supported by an advocate who provides a single point of contact with services for as long as required.

The Blackburn with Darwen pilot scheme involved thirty families, all of whom had problems with alcohol. A report published on the LGA website describes how they were helped by the Think Family pilot, focusing on three case studies which were particularly successful in addressing alcohol misuse issues.[83]

7. Gaps

Information gaps

Treatment capacity

Although the proportion of dependent drinkers in treatment appears to be higher in Blackburn with Darwen than nationally, this is based on very flimsy evidence as to just how many dependent drinkers there are in each locality. There is also little notion of what proportion may reasonably be expected to engage in treatment each year.

The Department of Health has recently issued a tender for a new evidence-based model to help assess the required specialist alcohol treatment capacity in each area.[21] The new model, which should be available in 2014, will estimate the local population of dependent drinkers, the percentage likely to benefit from treatment in any one year, and the scale and type of provision needed to meet this demand.

Consumption trajectories

The lack of evidence on consumption levels (other than crude synthetic estimates) makes it difficult to analyse drinking trajectories and identify opportunities to intervene. 31% of adults entering treatment in Blackburn with Darwen in 2011/12 had drunk at least 800 units in the preceding month, and with better intelligence it might have been possible to offer help before such extreme levels were reached.

Alcohol-related assault data

Under an initiative coordinated by TIIG (Trauma Injury and Intelligence Group), many A&E departments across the North West record whether alcohol had been consumed prior to each assault incident they handle. However, this imposes an extra administrative burden, and has yet to be successfully implemented at Blackburn Royal Hospital.

Evaluation gap

Information and Brief Advice / Opportunistic Brief Interventions

There is strong evidence that opportunistic early identification and brief advice is effective in reducing alcohol consumption and averting related problems.[65] This approach is encouraged in Blackburn with Darwen, but there is a need for a more co-ordinated overview so that it can be properly evaluated.

8. Value for money

Cost-effectiveness of treatment

The most comprehensive recent review of the effectiveness of alcohol treatment services was a study carried out for the National Treatment Agency in 2006.[84] Quoting research carried out in the UK in 2005[85], it concludes that:

for every £1 spent on treatment, the public sector saves £5

This rule of thumb is still widely accepted, and continues to inform decision-making in the field. However, it only takes account of the expenditure saved on health, social and criminal justice services, and does not reflect the long-term effects of reduced drinking on health, so it is almost certainly an underestimate.

Similarly, it has been shown that hospital alcohol liaison and outreach can lead to significant cost savings[86], as can non-specialist interventions (Opportunistic Brief Interventions, Information and Brief Advice) offered through mainstream provision.[87] The NTA and Department of Health are developing a Value For Money tool for alcohol investment which should be available in the near future to inform local decision-making.[75]

9. Involvement

Alcohol Awareness Week

Alcohol Awareness Week

Local agencies in Blackburn with Darwen regularly use Alcohol Awareness Week to engage local residents, including young people and existing services users, and raise their awareness of alcohol issues and risks. Alcohol and drug services, domestic violence services, youth agencies, housing organisations, criminal justice agencies and local pharmacies have all used a range of approaches to get their message across, from posters, leaflets and targeted information sessions, to 'alcohol goggles' (which enable the wearer to experience the effect of intoxication without actually getting drunk).

Involving young people

'Respect You' project

Blackburn with Darwen recently commissioned behaviour change specialists ICE Creates to conduct a social marketing campaign with young people, aiming to identify and design interventions that would lead to a change in attitude and risk-taking behaviours involving unsafe sex, drugs and alcohol. Working along with local community groups and organisations such as Café Hub and Fast4WD, the ***'Respect You'*** project was targeted at teenagers aged 13-19, especially those groups which exhibit high levels of alcohol and tobacco use.

Figure 22 - Organisations involved in the 'Respect You' campaign

The campaign used a variety of means to get its message across, including social media, community events and the use of peer mentors. A key element was a competition which invited young people to create a short video expressing their views on risk-taking behaviour. The competition attracted a strong field, and was won by an 18-year old rap-artist with an entry based on her own real life experiences.[88]

Figure 23 - Competition logo

Building social capital – the 'assets approach'

An ever-growing array of initiatives in Blackburn with Darwen aim to harness the knowledge and experience of people who have personally battled with alcohol dependency or witnessed its effect on close family and friends, and who now wish to volunteer some of their time and expertise to help others facing the same situation.

The bank of knowledge about alcohol problems represented by people who have 'been there' themselves is a prime example of what policy-makers call ***social capital*** or a ***community asset***. The recognition of the key role which volunteers with life experience can play in helping others to recover is characteristic of the ***'assets approach'***, which is the driving force behind Blackburn with Darwen's successful 'Your Call' campaign:

Figure 24 - the 'Your Call' banner

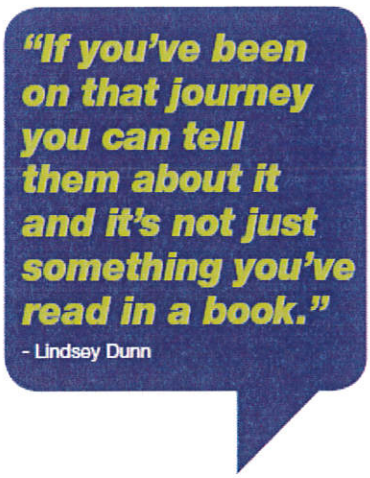
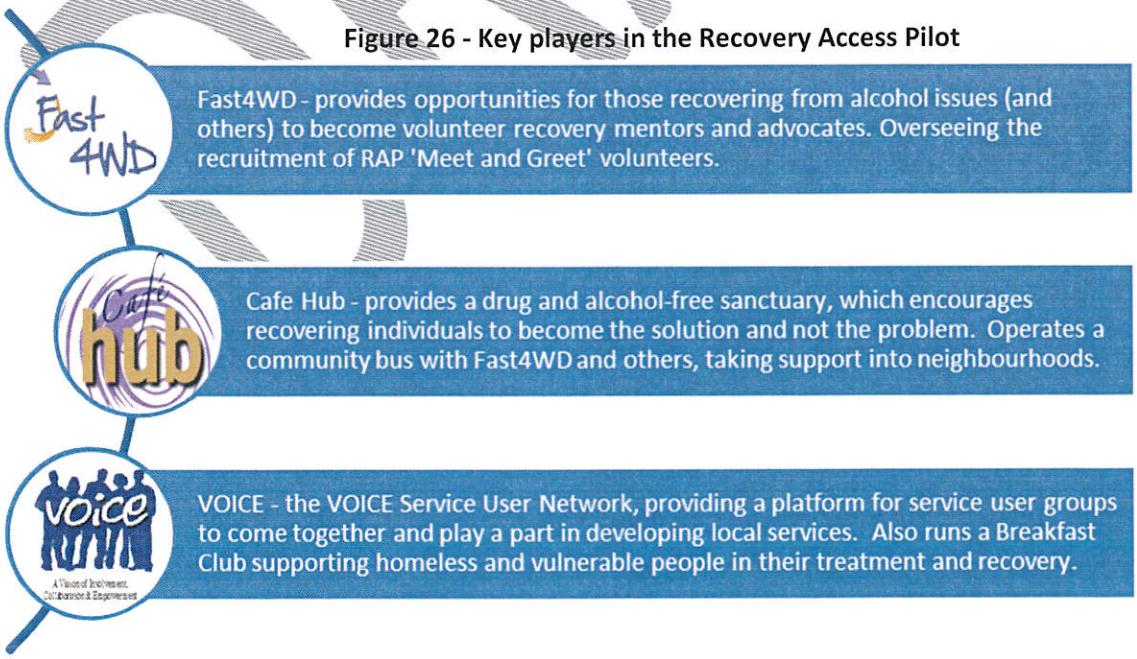


Figure 25 - Fast4wd volunteer Lindsey Dunn, quoted in *The Shuttle*[89]

Recovery Access Pilot

The ***Recovery Access Pilot (RAP)*** is a new initiative to coordinate the assets-based approach to alcohol and drugs recovery within Blackburn with Darwen. The outlets of various support groups and agencies across the borough are being rebranded as ***'Recovery Access Points'***, offering ***'Meet and Greet'*** sessions for people taking their first steps towards addressing their alcohol problem. Many of the volunteers running these sessions have been through alcohol dependency themselves, and are thus uniquely qualified to help others in that position to confront their issues and take responsibility for their own recovery. The volunteers themselves benefit by acquiring new skills and training, which may improve their employability, and they also experience the satisfaction of making a long-term difference to someone else's life.[89,90]

Figure 26 - Key players in the Recovery Access Pilot



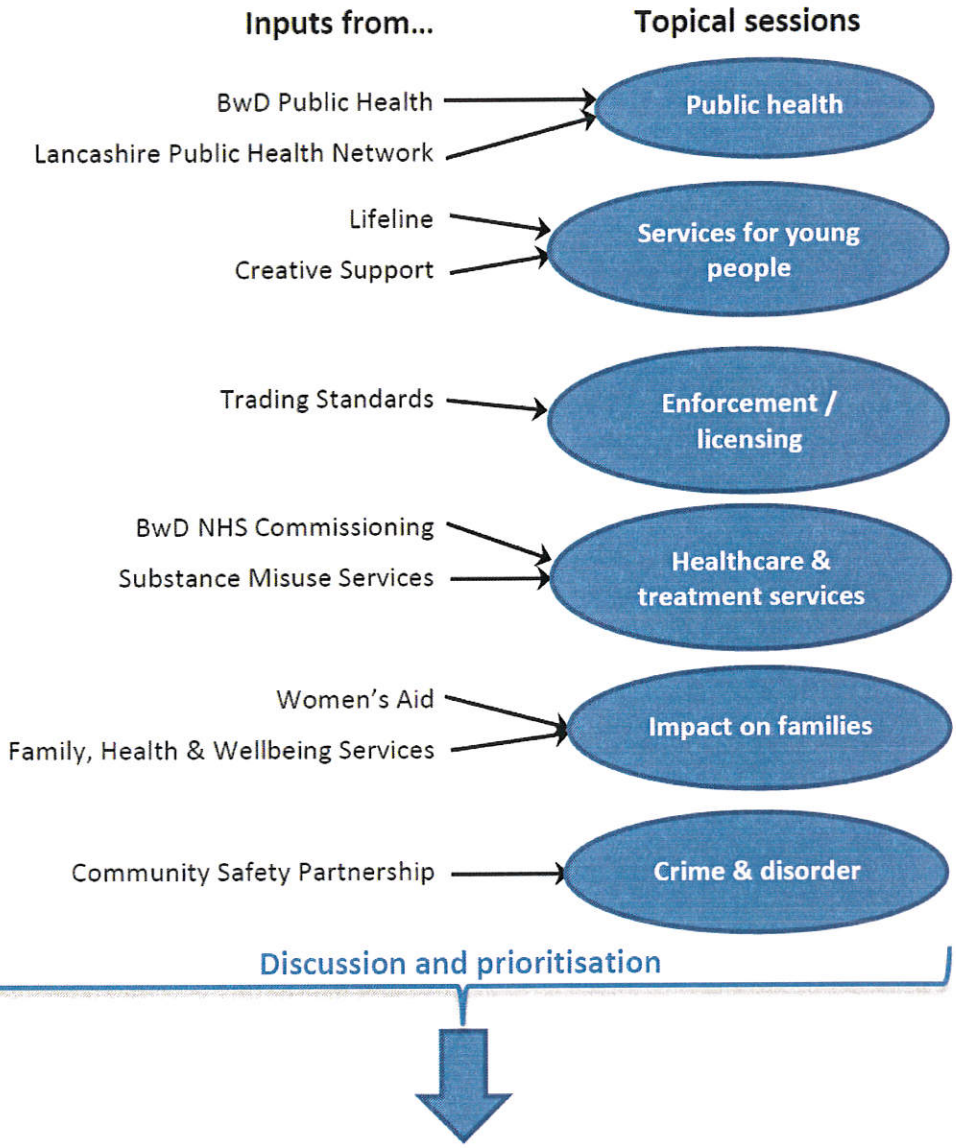
Citizens' Jury

A 'Citizens Jury' involves a group of residents meeting repeatedly to hear and discuss the evidence on an issue of public significance, and then producing a set of recommendations.

In 2011, a Citizens' Jury of Shadsworth residents met over ten weeks to consider ways of reducing the harmful effects of alcohol in the community.[91] Six of these were topical sessions (Figure 27), when representatives of local agencies gave a presentation and then engaged in discussion with the group. After detailed consideration of all the evidence, the group drew up 39 recommendations, some of which are listed below right.

Strong themes to emerge were the importance of community involvement and consultation *before* alcohol services were designed, and a preference for localised, decentralised services. Independent observers from Bolton University found that the Citizens' Jury had been *'effective in enhancing community awareness of alcohol abuse services in Shadsworth'* and had generated *'a high degree of belief in self-help'*.

Figure 27 – Alcohol Citizens' Jury, Shadsworth, 2011



Key recommendations (out of 39)

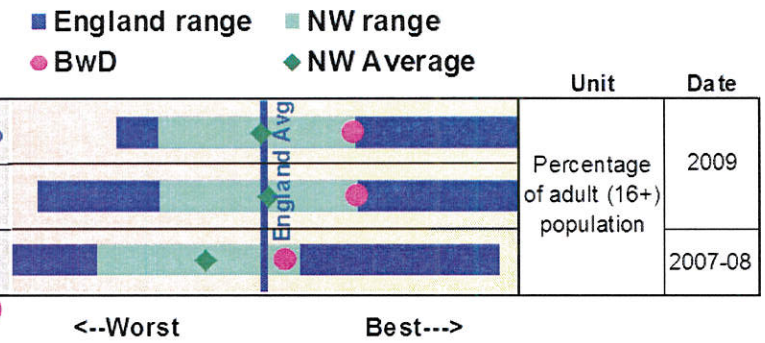
Crime, disorder and communities	• Deliver domestic violence services from a local venue • Community input to Crime & Safety Strategy
Identification, treatment and support	• Engage with community in development of services (*before* designing them) • Promote and deliver alcohol treatment and support from local venues
Children, young people and families	• Adopt a family approach to alcohol awareness • Community groups to work in partnership with 'Think Family'
Campaigns, communications and advocacy	• Community involvement in licensing/planning decisions • More localised campaigns using 'shock tactics'

10. Recommendations

1. Information and awareness campaigns should be coordinated among partners to ensure a strategic approach and maximum impact.
2. The Recovery Community should be supported to build on existing mutual aid and self-help initiatives to sustain recovery and promote social integration.
3. An action plan should be developed to aid the implementation of the Young People's Pledges (see page 15).
4. Efforts should be made to cultivate a better understanding of alcohol-related harm in later life, develop appropriate interventions, and ensure that services are aware of and respond to the alcohol-related needs of older people.
5. In order for Public Health to carry out its role as a 'responsible authority' for licensing applications, including assessing harm and cumulative impact, a robust system of local data gathering and analysis will be required.
6. Work should continue to be coordinated with the Community Safety Partnership, for whom substance misuse remains a strategic priority.

Figure 28 - Consumption estimates from LAPE profile*

	Indicator	Sex	Blackburn with Darwen Score	Blackburn with Darwen Rank*	NW Region worst	NW Region avg	NW Region best	ENGLAND worst	ENGLAND avg	ENGLAND best	Unit	Date
Synthetic	Abstainers + Lower Risk Drinkers combined	M/F	80.0%	308th	74.9%	77.6%	80.0%	73.8%	77.7%	84.3%	Percentage of adult (16+) population	2009
Synthetic	Higher Risk Drinkers	M/F	4.8%	316th	6.6%	5.6%	4.8%	7.6%	5.6%	3.4%	Percentage of adult (16+) population	2009
Synthetic	Binge Drinkers	M/F	18.9%	186th	29.1%	23.3%	18.2%	33.7%	20.1%	7.5%	Percentage of adult (16+) population	2007-08

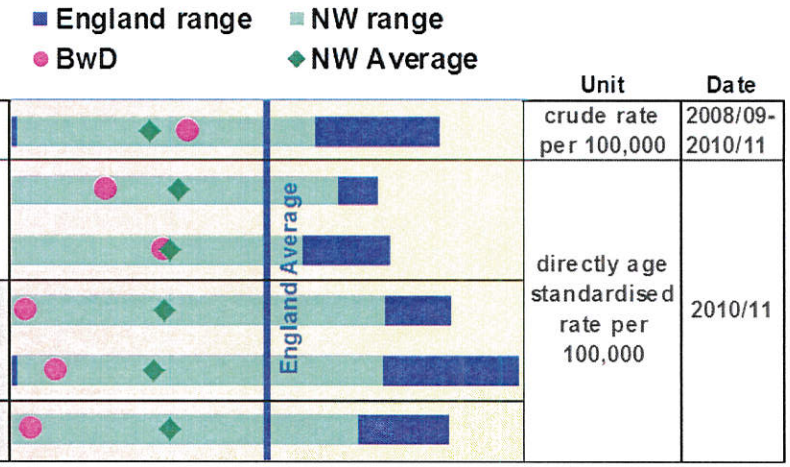


** Out of 326 local authorities. (1st = worst)*

In Figure 28, abstinence and lower-risk drinking have been combined, as one is not officially seen as any more desirable than the other. Increasing risk drinking is difficult to interpret in isolation, so it has been omitted. Proportions differ from the LAPE profile due to the use of the whole-population denominator throughout.

Figure 29 - Admissions indicators from LAPE profile*

	Indicator	Sex	Blackburn with Darwen Score	Blackburn with Darwen Rank*	NW Region worst	NW Region avg	NW Region best	ENGLAND worst	ENGLAND avg	ENGLAND best	Unit	Date
Specific	Alcohol-Specific Admissions < 18	M/F	81	59th	136	94	40	138	56	0	crude rate per 100,000	2008/09-2010/11
Specific	Alcohol-Specific Admissions (all ages)	M	897	8th	1164	696	249	1164	451	139	directly age standardised rate per 100,000	2010/11
Specific	Alcohol-Specific Admissions (all ages)	F	369	22nd	586	363	174	586	225	51	directly age standardised rate per 100,000	2010/11
Attributable	Alcohol-Attributable Admissions (all ages)	M	2417	5th	2479	1888	1023	2479	1485	769	directly age standardised rate per 100,000	2010/11
Attributable	Alcohol-Attributable Admissions (all ages)	F	1313	8th	1401	1095	587	1412	846	289	directly age standardised rate per 100,000	2010/11
Attributable	Alcohol-Attributable Admissions (all ages) - NI 39**	M/F	3163	5th	3276	2425	1404	3276	1895	910	directly age standardised rate per 100,000	2010/11



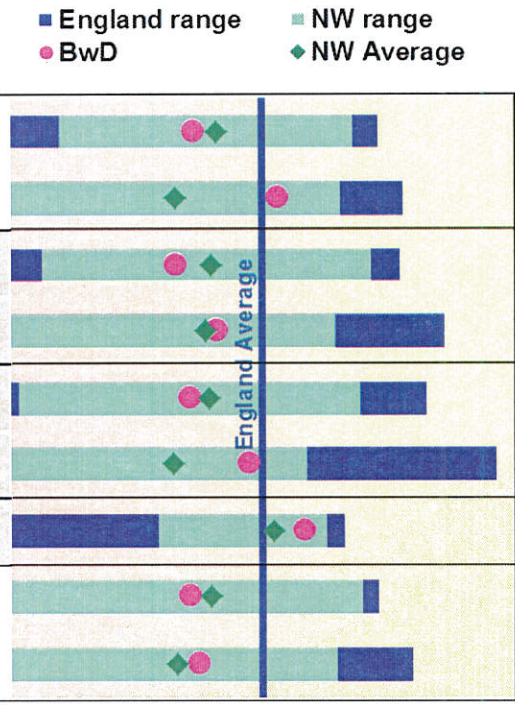
** Out of 326 local authorities. (1st = worst)*

*** Only NI 39 is literally the estimated admissions, expressed as a rate. Other indicators are estimated number of people admitted, expressed as a rate.* *For later data, see p10.*

** N.B.: The spine charts in this section present the key LAPE indicators re-ordered and grouped according to topic. Those which are synthetic estimates, or rely upon Alcohol Attributable Fractions (see Appendix), are shaded grey to indicate uncertainty, as they are based on assumptions which may not hold true in every locality.*

Figure 30 - Mortality indicators from LAPE profile*

	Indicator	Sex	Blackburn with Darwen Score	Blackburn with Darwen Rank*	NW Region worst	NW Region avg	NW Region best	ENGLAND worst	ENGLAND avg	ENGLAND best	Unit	Date
Specific	Alcohol-Specific Mortality (all ages)	M	20.8	31st	36.2	18.5	2.8	41.7	13.2	0.0	Directly age standardised rate per 100,000	2008-10
		F	5.3	157th	16.8	9.8	2.7	16.8	6.0	0.0		
Attributable	Alcohol-Attributable Mortality (all ages)	M	48.8	25th	69.4	43.4	18.9	74.1	35.5	14.5		2010
		F	18.1	56th	33.7	19.0	9.2	33.7	14.7	1.0		
	Months of life lost**	M	12.3	31st	20.1	11.5	4.7	20.4	9.1	1.8	Months	2008-10
		F	4.4	105th	8.7	5.8	3.4	8.7	4.2	0.0		
	Mortality - land transport accidents	M/F	0.6	308th	3.0	1.1	0.3	5.3	1.3	0.0	Directly age standardised rate per 100,000	
	Mortality from chronic liver disease (all ages)	M	22.2	25th	43.6	19.8	2.0	43.6	13.7	0.0		
		F	9.9	37th	18.8	11.1	3.5	18.8	7.0	0.0		



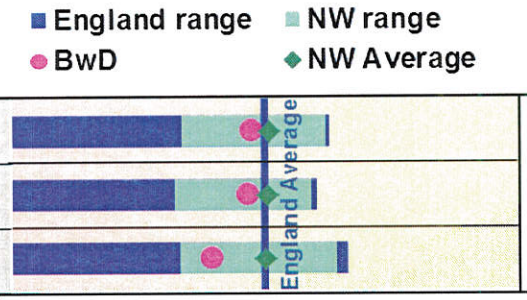
* Out of 326 local authorities. (1st = worst)

** Gain in life expectancy if all alcohol-related deaths under 75 were prevented

* N.B.: The spine charts in this section present the key LAPE indicators re-ordered and grouped according to topic. Those which are synthetic estimates, or rely upon Alcohol Attributable Fractions (see Appendix), are shaded grey to indicate uncertainty, as they are based on assumptions which may not hold true in every locality.

Figure 31 - Crime indicators from LAPE profile*

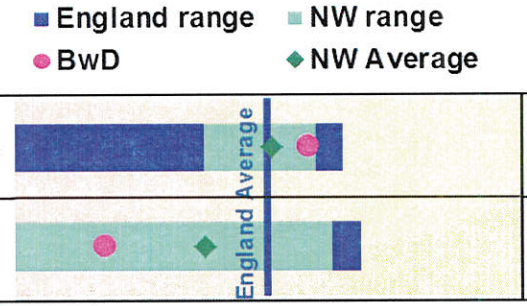
	Indicator	Sex	Blackburn with Darwen Score	Blackburn with Darwen Rank*	NW Region worst	NW Region avg	NW Region best	ENGLAND worst	ENGLAND avg	ENGLAND best	Unit	Date
Attributable	All alcohol-related crimes	M/F	7.9	74th	13.1	6.7	2.6	25.5	7.0	2.4	Crude rate per 1000 population	2011/12
Attributable	Alcohol-related violent crime	M/F	6.1	71st	11.1	4.9	2.0	22.0	5.0	1.5		
Attributable	Alcohol-related sexual offences	M/F	0.18	44th	0.21	0.12	0.05	0.39	0.13	0.04		



* Out of 326 local authorities. (1st = worst)

Figure 32 - Miscellaneous indicators from LAPE profile*

Indicator	Sex	Blackburn with Darwen Score	Blackburn with Darwen Rank*	NW Region worst	NW Region avg	NW Region best	ENGLAND worst	ENGLAND avg	ENGLAND best	Unit	Date
% of employees working in bars	M/F	1.1%	306th	3.3%	1.9%	0.9%	7.3%	2.0%	0.4%	Percent	2010
Incapacity Benefit/Severe Disablement Allowance claimants with alcoholism as main condition	M/F	248.8	6th	338.7	152.8	29.59	338.7	91.52	0	Crude rate per 100,000 working age	2011



* Out of 326 local authorities. (1st = worst)

* *N.B.: The spine charts in this section present the key LAPE indicators re-ordered and grouped according to topic. Those which are synthetic estimates, or rely upon Alcohol Attributable Fractions (see Appendix), are shaded grey to indicate uncertainty, as they are based on assumptions which may not hold true in every locality.*

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Appendix

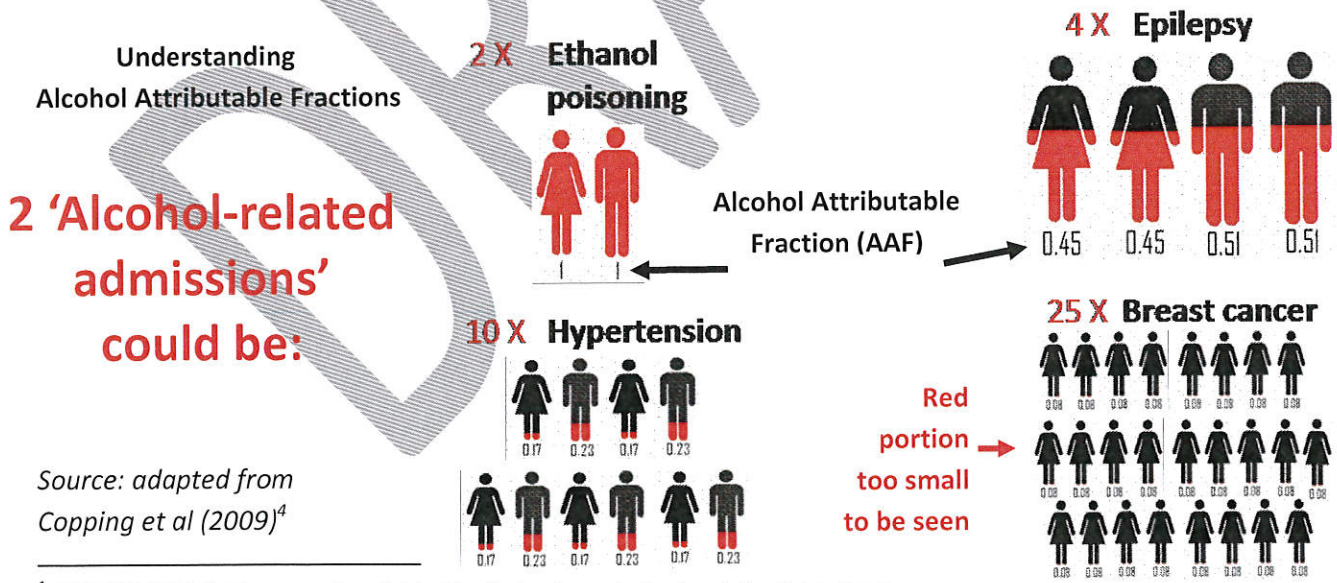
Understanding the LAPE profiles

Much of the local data in this document comes from the Local Alcohol Profiles for England, or LAPE (www.lape.org.uk). It is important to appreciate the methodology and terminology behind these profiles.

- **Synthetic Estimates**
  Local data on drinking habits is scarce, but we do have local data on factors such as age distribution, ethnicity and deprivation. National surveys allow us to analyse how drinking habits relate to these socio-economic characteristics, and LAPE then uses this relationship to construct '**modelled**' or '**synthetic**' estimates of local consumption.[1] It is important to realise that these estimates only tell us what drinking levels we can *expect* to have locally, and will not pick up real change on the ground.

- **'Alcohol-specific'**
  By definition, alcohol is the only possible reason for certain illnesses or conditions – for example, ethanol poisoning, or alcoholic liver disease. These are known as 'alcohol-specific' conditions. Alcohol-specific mortality or admission rates can be worked out directly from local data, based on the known cause of each death or hospital admission, without any need for modelling.

- **'Alcohol-related' (or 'alcohol-attributable'), and 'Alcohol Attributable Fractions' (AAFs)**
  Alcohol is responsible for 100% of alcohol-specific admissions and deaths, but it also accounts for a *proportion* of admissions and deaths from many other causes, ranging from epilepsy to breast cancer[2]. It is similarly implicated in a *proportion* of crimes - e.g. 17% of burglaries - and just over a third of fatal transport accidents.[3] These typical proportions are published as **Alcohol Attributable Fractions (AAFs)**. By applying them to local counts, we can model the *likely* number of deaths, admissions or other events which are '**alcohol-attributable**' or '**alcohol-related**'. However it is always possible that the assumptions embodied in the Alcohol Attributable Fractions do not hold true locally.



Source: adapted from Copping et al (2009)[4]

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