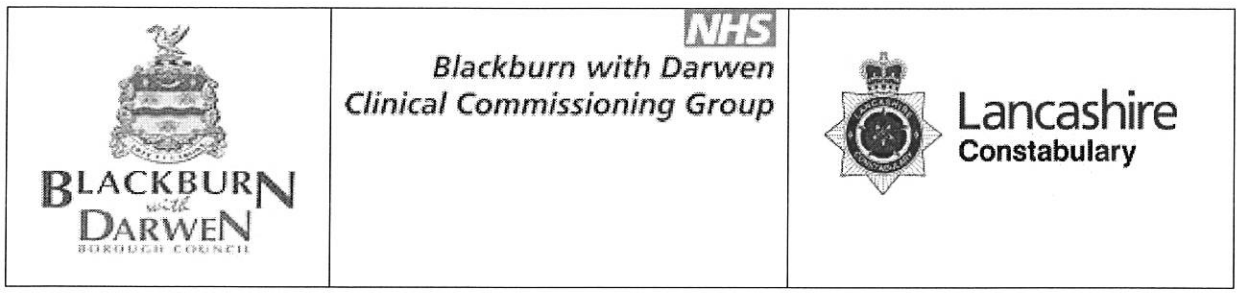


Preventing Harm Improving Outcomes

Blackburn with Darwen's Alcohol Strategy 2014-17

VERSION 0.3 3rd March 2014

Acknowledgements

Sponsors

Cllr Mohammed Khan
Lead Member for Health

Chris Bitthell
Chief Superintendent

Dominic Harrison
Director of Public Health

Chris Clayton
Chief Clinical Operating Officer

Blackburn with Darwen Alcohol Prevention Action Group

Foreword

Blackburn with Darwen's Alcohol Strategy, **Preventing Harm, Improving Outcomes,** comes at an economically challenging time for all stakeholders and this strategy places its focus on the added value we can bring by working together to deliver on key priority areas.

National policy implementation is needed to address several determinants of alcohol related harm, such as pricing, availability, marketing and retail. However, there is much that can be done locally to improve the health, safety and wellbeing of our population, as well as continuing our actions intended to influence national policy and empower our local population.

We need a range of measures, which together provide a template for an integrated and comprehensive approach to tackling the harm associated with alcohol, addressing short term and long term outcomes.

The most important aspect of this Borough wide Strategy is to have dynamic and responsive action plans to support the overarching outcomes, which reflect our local need and assets. By such an approach, which is built upon existing partnerships and local engagement, will enable local plans to evolve as new data, research and intelligence emerge.

We would like to acknowledge all those whose efforts have been successful in introducing effective programmes of work and policy implementation to reduce the harms associated with alcohol. We intend that this strategy will go above and beyond the excellent work that we have already progressed across the Borough. Our vision is to reinforce the strong partnerships and collaborative working that we have here in Blackburn with Darwen empowering our local population to make decisions and to take control of their own lives, therefore, impacting on long term prevention.

Dominic Harrison
Director of Public Health

Cllr Mohammed Khan
Lead Member for Health

Chris Bithell
Chief Superintendent

Dr Chris Clayton
Clinical Chief Operating Officer

Alcohol is taken for granted in the UK today.

It is easy to get hold of, increasingly affordable, advertised everywhere and accepted by many as an integral part of daily life

Health First: an evidence-based alcohol strategy for the UK. Mar 2013.

Executive Summary

Preventing Harm, Improving Outcomes:
Blackburn with Darwen Alcohol Strategy (2014-17)

Nationally, alcohol is consumed by more and more people and in greater volume than at any time in recent history. While the majority of people who drink alcohol do so without causing harm to themselves or others, unfortunately this is not the case for all. ***Alcohol-related harm is acknowledged as a major public health issue.***

Figures both nationally and locally expose the escalating level of harm that has, and continues to be, caused by this increase in alcohol consumption over the past 50 years. The impact from ***the misuse of alcohol affects us all***; as individuals, families and communities, in a wide range of ways, impacting upon those who are living in the disadvantaged areas the most, further exaggerating health inequalities across the borough.

Drinking alcohol is not universal; many people choose to abstain. Indeed, Public Health England identifies Blackburn with Darwen as having ***the highest proportion of non-drinkers in the North West at 22%***, compared with regional average of 15%[1]. This is a positive position which we can build upon and work with key persons about the positive health and social aspects of abstaining from alcohol.

Of particular concern in Blackburn with Darwen is that despite having the highest percentage of non-drinkers in the North West and below national average alcohol consumption rates, the harm caused by alcohol is significantly high. Blackburn with Darwen is ranked 30th worst out of 211 Clinical Commissioning Groups (CCGs) for all liver disease mortality in under 75s with 22 per 100,000 compared to 15 per 100,000 nationally[2]. ***Hospital admissions due to alcohol related disease have risen by 200% over a 10-year period (2002-2012) in Blackburn with Darwen***[1] which is over twice the rate of increase seen in the North West as a whole. We need to understand more about why hospital admissions have increased so dramatically and the demographic make-up of these people.

There is ***good evidence that many interventions which work and are cost-effective*** are being employed successfully across the Borough reducing the harm associated with alcohol consumption, in line with the 'Signs for Improvement' commissioning guidance[3]. These include, the ***Hospital Alcohol Liaison Service (HALs), Recovery Assets Programme, and the Children and Young People Alcohol Pledge, Café Hub*** to name but a few. And there are exciting opportunities to engage with our local communities further. There is much more that can be done and we require successful delivery of this strategy by implementing the responsive

and dynamic action plans that will be reviewed periodically with local communities, even in the midst of austerity. Our work highlights the need to focus thinking and practice, encourages greater collaboration, as well as more effective engagement with the people of Blackburn with Darwen, including those who do not drink alcohol, those who consume alcohol in moderation, those currently accessing support services and those who could be accessing support services but chose not to. Given the ***significant adverse impact alcohol has on crime, health and social services*** within Blackburn with Darwen, and the potential reach for all agencies, across various population groups, we recommend this multi-agency Alcohol Strategy be given a high priority and most importantly help shape the future of the health outcomes of our local population.

The Strategy itself takes a whole system, life course approach considering primary, secondary and tertiary ***prevention*** for individuals, families and communities. It is outcome focused, with ***communication*** and ***engagement*** at the heart of its development and implementation. It considers policy change, which is likely to be a more effective at a population level, and better value for money, way of ***reducing alcohol-related harm*** among the population than actions undertaken by local health professionals[4].

Key strategic priorities and aims:

The strategic aims of the Blackburn with Darwen Alcohol Strategy have been based on the National Alcohol Strategy (which has had full impact assessments completed and, a wide ranging national consultation process) whilst also ensuring they reflect our local priorities based on our Alcohol Joint Strategic Needs Assessment (Appendix A) and our local community voices through a multi-agency action group (Appendix B).

Overall, the Strategy aims to ***prevent*** and ***reduce alcohol-related problems*** through greater partnership working, by utilising the best available evidence of the problems in our community and what is known to work.

PRIORITY 1:
LICENSING AND TRADE RESPONSIBILITY

Aim: To ensure all sections of the alcohol trade promote responsible retailing that supports a reduction in alcohol-related harm.

PRIORITY 2:
HEALTH AND WELLBEING SERVICES

Aim: To ensure an evidence based 'health and wellbeing' focussed prevention, treatment and recovery approach is employed to address the needs of people and their families experiencing alcohol related issues.

PRIORITY 3:
PREVENTION ACROSS THE LIFE COURSE

Aim: To ensure that a coordinated 'whole family' approach is taken for initiatives that work with children, young people, working age, older people, individuals, families and communities, protecting those most affected by alcohol.

PRIORITY 4:
PROTECTION FOR THE COMMUNITY

Aim: To mitigate the role of alcohol in fuelling Crime, Anti-Social Behaviour, Violence and Domestic Abuse.

Governance

The accountability of the Alcohol Strategy is the responsibility of Blackburn with Darwen's Alcohol Strategy Group, which is chaired by a representative from Public Health in the Borough Council and co-chaired by a member of the Families Health and Wellbeing Consortium. The membership comprises key partners and stakeholders, as outlined in Appendix B, and it is each members' responsibility to ensure that as the Strategy develops, they engage and liaise with their organisation, community and peers to ensure wide cascade and ownership of the Strategy.

This strategy will achieved through the development of detailed yet dynamic action plans, each with identified leads, but developed based upon evidence and local consultation. The identified leads will oversee the implementation of the Strategy as a whole, the monitoring and review of associated outcomes and the evaluation of the Strategy's overall effectiveness.

Action plans for each priority area have been drafted and will be updated periodically to reflect emerging evidence and local intelligence. These action plans will complement other strategic plans where alcohol is a key issue:

- Health and Wellbeing Strategy
- Community Safety Partnership's Strategy
- Suicide Action Plans

- Cancer Action Plans
- Emotional Health and Wellbeing Strategy
- Local Policing Plan
- Transforming Lives (Early Action)
- Children's Partnership Plans
- Local Strategic Partnership 2030 Vision
- Local Authorities Corporate Aims and Objectives
- Workforce Wellbeing Plan (currently being developed)
- Accident Prevention Strategy (currently being developed)

Alongside the development of this Alcohol Strategy, an equality impact assessment has been completed and also, a health impact assessment screening tool has been completed. This is part of the formal process for strategy development. Within this process, the groups protected under the 2010 Equality Act, have been all been considered. The protected groups include:

1. Age.
2. Disability.
3. Gender reassignment.
4. Marriage and civil partnership.
5. Pregnancy and maternity.
6. Race.
7. Religion and belief.
8. Sex.
9. Sexual orientation.

Throughout the Strategy, we consider the protected groups although it is acknowledged that in some areas, the level of research and evidence is relatively poor and more needs to be done to address this at a local and national level. However, it is by engaging with our local communities and keeping abreast of emerging evidence and intelligence, that our local action plans will be developed enabling us to bring this document alive and thoroughly understand the local picture in relation to the extent of alcohol related harm has on our population. We have gone some way to understanding this need through our Joint Strategic Needs Assessment.

1 Introduction

The consumption of alcohol is an established part of life in the UK today. For the majority of adults in the UK, alcohol is accepted and enjoyed both in the routines of daily life and in the events that mark out the broader pattern of life: birthdays, weddings and celebrations of all kinds[5].

Perhaps contrary to common belief, nationally alcohol sales per head have actually declined since 2004[6], however, it still leaves them at roughly twice the level of the 1950s; the UK now having one of the highest levels of alcohol consumption in Europe[5]. It has been suggested that even if everybody stopped drinking above recommended levels tomorrow, demands on hospitals would remain relatively high for a further decade[7].

Alcohol misuse can, and does, cause harm to individuals, families and to society as a whole, especially in relation to violence, crime, ill health, social functioning and anti-social behaviour and often at lower levels of alcohol consumption than many people realise.

The evidence base is growing:

- **For individuals**, regular drinking increases the risks of a future burdened by illnesses including cancer, liver cirrhosis and heart disease, and a taste for alcohol can turn all too easily into dependence.
- **For families**, alcohol misuse and dependence can lead to relationship breakdown, domestic violence and impoverishment.
- **For communities**, alcohol misuse can fuel crime and disorder and transform town centres into no-go areas.
- **For society** as a whole, the costs of alcohol consumption include both the direct costs to public services and the substantial impact of alcohol-related absenteeism on productivity and earnings. Indeed, it can be a barrier to achieving the outcomes we wish for our local community.

Alcohol is legal, but it ***is*** a drug and needs to be treated with respect. The negative impact of alcohol is a significant public health issue:

The Chief Medical Officer's report (2012)[8] states that alcohol is the **second biggest lifestyle health risk factor** (second only to tobacco).

> Alcohol is the number one risk factor for **ill health and premature death** among males aged 15-59 years and leads to **health inequalities**.
>
> Alcohol is the second biggest cause of **cancer** for people aged over 35 after smoking.
>
> Regularly drinking more than the recommended government limits increases the risk of a range of chronic diseases, being linked to **more than 60 health conditions** including liver disease[2], diabetes, cardiovascular disease, and cancers of the breast and gastrointestinal tract.
>
> High risk drinking also increases the risk of **psychological ill-health**.

However, the impact from alcohol is not restricted to health alone.

All forms of violence are strongly associated with alcohol and research shows that violence increases when alcohol is consumed. Drinking alcohol affects a person's ability to make safe decisions. There are strong links between the harmful use of alcohol and both being a victim of, and perpetrating, violence, including, though not exclusively youth violence.

> Alcohol use directly affects our thinking and physical function.
>
> Harmful alcohol use can reduce self-control and the ability to process information and assess risks.
>
> Harmful alcohol use can heighten emotions and increase impulsive behaviours and make some young people more likely to resort to violence in confrontation.
>
> As alcohol use can lead to reduced physical control and ability to recognise early warning signs it can make some young people easy targets.

[2] South Asian men, particularly Sikh men, have a higher prevalence of alcohol-related liver damage and liver cirrhosis than other ethnic groups. More research is required into the causes of the high rates of liver damage evident among South Asians.

Individual and social beliefs about the effects of alcohol, i.e. increased confidence, increased aggression means that alcohol may be consumed as preparation for involvement in violence and other risk taking behaviour.

Alcohol is a depressant and is often accepted as an aid to coping.

White respondents have higher rates of trouble with the police and antisocial behaviour when drink than Black or Sikh respondents.

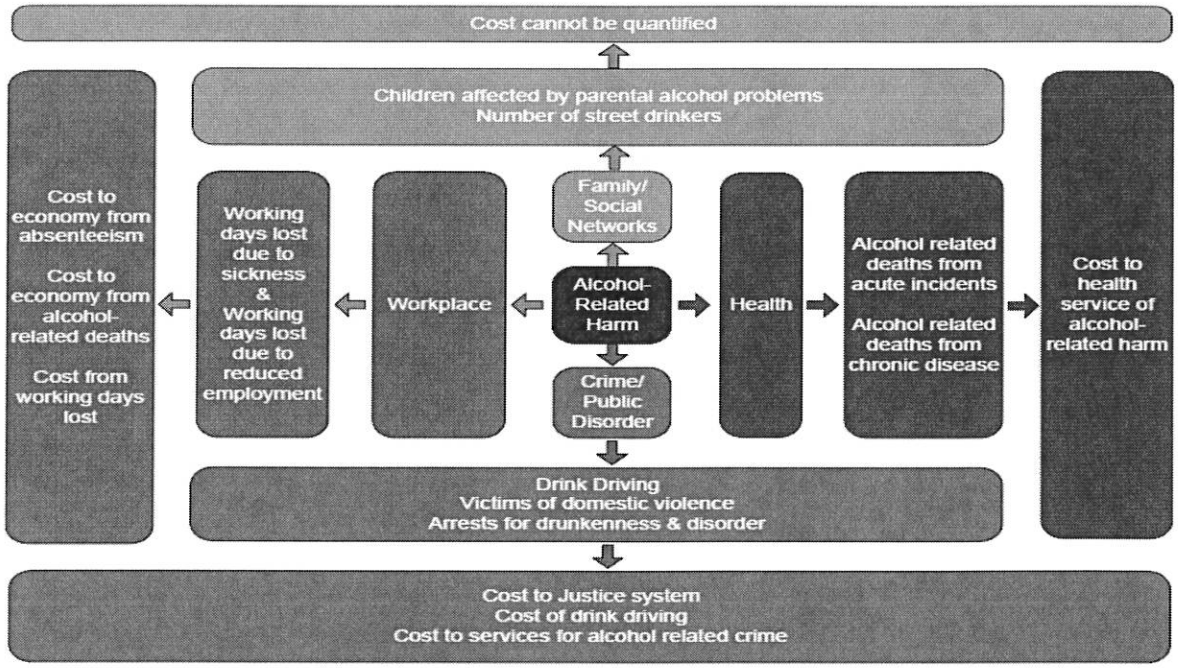
Among drinkers, Pakistani men show signs that their drinking may be a cause for concern compared to other minority ethnic groups.

Alcohol is more affordable and more available than at any time in recent history[5]. While the majority of people who do drink, do so without causing harm to themselves or others, there are some who cause significant harm and concern.

The Government's National Alcohol Strategy[9] and Drink Wise North West[10] both estimate that the total cost to society is about £21bn per year, which does not take into account the impact of alcohol misuse on families and communities. On a similar basis, the personal, social and economic cost in Blackburn with Darwen has been estimated as £68 million per year. However, others have put the national cost at anything up to a staggering £55 billion. Some aspects of alcohol misuse are unquantifiable. Figure 1 (below) demonstrates the range, scale and multi-dimensional nature of the harms that can result from alcohol misuse. The impact on people other than the drinker, such as children has been referred to as 'Passive Drinking'.

Implementing actions in line with the priority areas, which are mainly based on the National Institute of Clinical Excellence (NICE) guidance, has the potential to result in significant improved outcomes and savings through a reduction in hospital admissions, crime and alcohol-related absenteeism[4].

Figure 1. Passive Drinking – the harms arising from alcohol misuse



At a Glance, Cost of Alcohol-related harm to …

Nationally

… Health

- **£4.1 billion a year in NHS costs (2010/11)[1]**
- Over 10m adults currently drink more than recommended guidelines; 2.6 million drink more than twice that[11].
- 2 people are admitted to hospital for alcohol-related harm every minute[9].
- 70% of night-time attendances and 40% of daytime attendances to emergency departments are alcohol related[9].
- Preventable alcohol related illness or injury accounts for 1.1m hospital admissions each year.

…Crime and Disorder

- **£6.9 billion a year (2010/11)[1]**
- About half of all violent crime is alcohol related[9].
- About 40% of domestic violence cases are alcohol related.

… to Society

- **Lost productivity is £7.3 billion (2010/11)**
- Up to 17 working days are lost per person every year through alcohol related absences.
- About 2.6m children living with parents who are drinking hazardously; over 700,000 are living with dependent drinkers[9].
- Alcohol misuse costs for every man, woman and child £416 per year[10].

Blackburn with Darwen

… Health

- **£13.7 million a year in NHS costs (2010/2011)[1]**
- 4,475 alcohol related hospital admissions (2010/11)[1].
- Alcohol related admissions due to alcohol in Blackburn with Darwen have risen by 200% between 2002 and 2012[1].
- 35.3% of Road Traffic Accident deaths were due to high levels of alcohol consumption[1].

…Crime and Disorder

- **£24.31 million a year (2010/11)[1]**
- Approximately 1,110 alcohol related crimes per year[1].
- Higher than average rates for violent crime [1].
- Higher than average rates of recorded crime[1].

… to Society

- **£25.6 million in lost productivity** each year due to absenteeism, reduced employment and premature death[10].
- 5th highest rate - claiming Incapacity Benefit by reason of alcohol[11].
- Taking everything into account alcohol misuse costs every man, woman and child £486 per year, higher than the national average[10].
- More than half of hostels (55%) reported that a majority of their clients have problems with alcohol[12].

Amount of alcohol consumed

Current methods for estimating levels of alcohol consumption rely on self-reported surveys, and recent research [11]suggests these underestimate the amount we drink, and therefore underestimates the size of the population at risk of alcohol-related harms[9], which often cannot be further segmented by different population groups, such as ethnicity. We know that nationally:

- 83% of those who regularly drink above the guidelines do not think their drinking is putting their long term health at risk.
- Only 18% of people who drink above the lower-risk guidelines say they actually wish to change their behaviour.
- External and environmental factors can hugely influence both positively and Negatively, the amounts that individuals or groups of the population drink and the ways they drink.

Nationally, of those people who consume alcohol, the amount they consume determines their level of drinking behaviours, into lower, increasing and higher risk drinking. Figure 2 below outlines how much alcohol is to be consumed for each level of drinking behaviour for both men and women.

Figure 2. Classification of alcohol consumption by units consumed.

	Men	Women
Lower risk drinking	Men should not regularly drink more than 3–4 units of alcohol per day	Women should not regularly drink more than 2–3 units of alcohol per day
Increasing risk drinking	Men who regularly drink over 3–4 units per day	Women who regularly drink over 2–3 units per day
Higher risk drinking	Men who regularly drink over 8 units per day (over 50 units per week)	Women who regularly drink over 6 units per day (over 35 units per week)

- Regularly means every day or most days of the week (ie. not drinking at these levels once a week)
- If men or women do drink heavily (more than double the lower risk limits on a single occasion), they are advised to avoid alcohol for at least 48 hours
- In pregnancy or when trying to conceive, women should avoid drinking alcohol (no alcohol = no risk of harm to the unborn baby). If choosing to drink, to minimise risk, women should not drink more than 1–2 units once or twice a week.

Understanding the levels of alcohol consumption and the harm associated is complex. This is because of a number of reasons, including much of the local data being estimated based on national levels, people do not always understand how many units of alcohol they are consuming and, emerging evidence suggests that our drinking patterns have changed over time, and the impact can be longer term, (i.e. diseases diagnosed many years after alcohol consumption). Public Health England

figures[1] suggest that for adults living within Blackburn with Darwen, we have the highest proportion of non-drinkers in the North West at 22%, whilst 20% are regularly drinking beyond the recommended levels. This high proportion of abstainers, i.e. those people who do not drink alcohol at all includes people who have never consumed alcohol for a variety of reasons, which may include religion, cultural, personal choice, taste and those people who used to consume alcohol and who may now be in recovery or who have chosen to become abstinent.

Synthetic estimates[1] state that 80% of Blackburn with Darwen's adult population who do drink, do so within lower risk levels as established by the Department of Health, as outlined in Figure 2. This strategy, by taking a population level approach, aims to support such residents to maintain their consumption levels, and possibly even reduce it further, and to support those people who are increasing the through various education, engagement and public protection initiatives such as Dry January, citizen jury events and community asset development. These low level interventions are to empower the low risk drinkers to consider their drinking habits and routine to help avoid escalation into higher risk drinking habits. However, resources must also be targeted towards the 20% whose consumption of alcohol (over the recommended levels) causes problems for themselves, their families and the wider community. This is may be through large scale policy change, programme development or community empowerment to enable a culture change of what is considered normal within our culture.

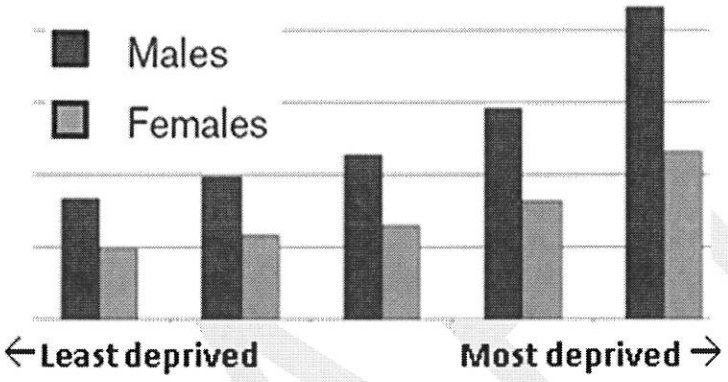
Anecdotal evidence suggests there is a thriving recovery community in Blackburn with Darwen which has been evolving and increasing for many years. The Borough demonstrates successful exits from structured treatment within a system that has been continually developed and this complements the strong foundation of mutual aid which is also available. This supports the promotion of recovery, abstinence from alcohol and in turn has the potential to raise awareness in communities by strengthening peer support. However, there is still more that needs to be done.

Levels of alcohol-related health problems are increasing year on year, with the increased alcohol consumption levels, and the harms associated from alcohol misuse are excessively high. Excessive alcohol consumption is having a detrimental effect on the lives of many people across Blackburn with Darwen, not just those individuals who misuse alcohol, but their relatives, friends and others, of whom all suffer as a result. The harm to children and young people, who often are the silent carers of parents who drink, is often unreported and not easily recognised.

Populations at risk from alcohol consumption

The harms from alcohol affect different population groups to varying levels. Figure 3 shows the picture that emerges when we look at the *harm* arising from alcohol use (adapted from Marmot Review, 2010[12]), which clearly demonstrates that admission rates increase as deprivation increases, for both males and females. Males have, for each deprivation quintile, higher admissions rates when compared with females.

Figure 3. Alcohol-attributable hospital admissions (age standardised rate, 2006-07) by small area deprivation quintile in England. Source: Marmot Review, 2012.



Whilst alcohol consumption is often at overall lower levels in more disadvantaged areas, alcohol-related mortality rates have been found to be more than twice as high in the most deprived quintile of wards than in the least deprived, and twice as high in the Routine & Manual occupational group as compared with Higher & Managerial[13].

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

"There is a social gradient in the harms from alcohol consumption but not in alcohol consumption itself"

Although it is those people with higher income levels who drink higher levels of alcohol, including people from Indian, Chinese, Irish and Pakistani backgrounds, the harm caused by alcohol affects those the most in lower socio-economic groups. This pattern, for those in the more disadvantaged areas, can clearly be seen in the figures for Blackburn with Darwen, outlined in the Joint Strategic Needs Assessment (JSNA; Appendix A). The reason for this relationship is still unclear, but is likely to be due to confounding factors, such as poor diet, other health behaviours, housing conditions and, lack of access to appropriate diagnosis and treatment and recovery orientated services[14]. This reinforces the need for this strategy to be linked with other strategies and priorities via the Health and Wellbeing Strategy and underpinned by strong partnership working.

Alcohol and its impact on Children and Young People

"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."[15]

Nationally, it is estimated that:

- Less than half of pupils (43%) have ever drunk alcohol. Boys and girls were equally likely to have done so. The proportion of pupuls who have had an alcoholic drink increased from 12% of 11 year olds to 74% of 15 year olds.
- 40% of 13 year olds and 58% of 15 year olds who have drunk alcohol have had a negative experience, including taking drugs / having unprotected sex.
- 40% of child protection cases and 74% of child mistreatment cases are alcohol related.
- 8,799 under 18s accessed specialist treatment for tackling alcohol problems (2009).
- 18-24 year olds who binge drink are more likely to admit to criminal or disorderly behaviour during or after drinking compared with other regular drinkers of same age.
- The UK has one of the highest percentage of 15-16 year olds who have engaged in unprotected sex as a result of alcohol use.
- Alcohol damages young people's brain development.
- Drinking alcohol is linked to lower GCSE scores; not being in education, employment or training.
- The drinking patterns of some minority ethnic young people are changing, and that young Asians are now drinking more than previous generations.

Positively, there is gathering evidence to suggest that alcohol consumption has been decreasing in young people in recent years. Within Blackburn and Darwen there has been a halving in the proportion of 14-17 year olds that drink 5 or less units of alcohol from 31% in 2007 to 16% in 2011. However, there are increases in the proportion claiming to drink over 20 units of alcohol per week from 20% in 2007 to 36% 2011. This is significantly higher than the regional average of 21% in 2011[16].

The proportion of the borough's 0-19 population is higher than the national average, 29% of residents compared with 24% nationally. It is imperative that we continue to support children and young people to reduce their levels of alcohol consumption, delay the age at which they may choose to start drinking alcohol and support venues to be alcohol free for those young people who choose not to consume alcohol and, provide a family approach to understanding the risks from alcohol consumption.

National guidance recommends that no alcohol at all should be consumed before the age of 15[15]. 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.

The issue of parental responsibility also needs to be addressed, with evidence suggesting that most young people do not buy alcohol illegally; they get it from their parents and /or older siblings[16], often within the home and sometimes without their parents realising. Pupils' perceptions of their parents' attitudes to their drinking is strongly related to whether or not they have drunk alcohol; if their parents would disapprove, pupils were less likely to consume alcohol.

In Blackburn with Darwen the **Too Much Too Young** study undertaken in 2011[17] recruited 100 young substance misusers aged 18-25 years and found alcohol to be the most common substance, cited by 97% of the sample, 63%, had been regular drinkers by age 14. Average weekly intake, spread over an average of 3.7 days was 122 units per week; vastly in excess of *adult* recommended weekly limits. Of greatest concern, only 27% saw their alcohol use as a problem. The main issues arising from alcohol misuse were violence and aggression, as well as financial consequences, and an inability to engage with work and keep appointments.

Blackburn with Darwen has made a commitment to endorse the aims of the Pledges for Children and Young People[18]. These pledges call for the following commitment within the local areas:

1. To ensure that the focus of policy and practice recognises that children and young people need to be safeguarded from the harms caused by alcohol.

2. To encourage all services that come into contact with children and young people to recognise their role in safeguarding them from the harm caused by alcohol.

3. To provide a mandate and expectation that all staff who are in contact with children, young people and parents will do all that they can to address alcohol related harm.

4. To provide consistency, structure and a basis to monitor local performance.

Alcohol and Families

Children and young people are susceptible not only to the consequences of their own drinking, as described above, but also to the harmful effects of alcohol misuse by the adults around them. Nationally, it is estimated that 2.6 million children are living with parents who drink hazardously, and 705,000 live with dependent drinkers[19]. This presents a number of potential and often 'hidden' harms.

Drinking during pregnancy can cause premature birth, low birth weight, damage to the central nervous system, physical abnormalities and the difficult to diagnose condition Foetal Alcohol Spectrum Disorder (FASD)[9]. In turn, this condition may not be identified in future diagnosis including Attention Deficit Hyperactivity Disorder (ADHD) and dyspraxia.

Nationally, it is estimated that only 7% of babies with FASD are diagnosed at birth, the average age of diagnosis being 3.3 years. Earlier diagnosis would help prevent this condition in future siblings. Each child with FASD is susceptible to the development of a number of diseases in adult life.

Children of parents who drink excessive amounts, i.e. above the recommended limit, may suffer a lack of supportive and consistent parenting, and even be thrust into the role of carer themselves, often without anyone knowing, the so-called 'silent carers'.

Growing up amid the conflict and disharmony associated with alcohol misuse can result in children and young people having increased[20]:

- Anti-social behaviour such as aggression, hyperactivity.
- Emotional problems such as bed-wetting, depression.
- Problems at school such as learning difficulties, truancy.

Many people who drink became addicted as children or young people. Children and young people are particularly negatively impacted by alcohol if their parents are drinkers as they are likely to become carers for their parents, and more often, carers for their younger siblings. The Silent Voices report 2012[21] states that *"there is a need to continue research to enhance our understanding of protective factors and processes and their evidence of resilience for children living with or affected by parental alcohol misuse."*

Hospital admissions due to alcohol consumption amongst children are increasing for Blackburn with Darwen, which is of major concern and warrants further investigations and scrutiny.

The Blackburn with Darwen Adverse Childhood Experience (ACE) study[22] found that people who had experienced childhood adversity were more likely to display risk taking behaviours when adults, to have poor health, and to continue the cycle into the next generation compared with those people who had no childhood adversity. Living with a parent / carer who is an alcoholic is one of the adverse childhood experiences.

The study found that, compared to a person with no ACEs, if a person had four or more ACEs, their risk of becoming a heavy drinker increased by 3.7 times and the risk of developing liver disease increased by 2.3 times.

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 life-course approach must be adopted to stop the negative impact of alcohol on children and link with other strategies and developments in addition to alcohol alone.

Due to the complexity of this issue it is important that interventions take a multi-agency and whole-family approach. The relationships between universal and specialist services, adult/child and family services, and drug/alcohol treatment services is crucial as well as the relationship with other activity areas, including health and wellbeing, crime and disorder, and planning and licensing.

Alcohol and Older People

"Between 2001 and 2031, there is projected to be a 50% increase in the number of older people in the UK. The percentage of men and women drinking more than the weekly recommended limits has also risen, by 60% in men and 100% in women between 1990 and 2006 (NHS Information Centre, 2009*a*). Given the likely impact of these two factors on health and social care services, there is now a pressing need to address substance misuse in older people"[23] and to understand the picture locally.

As we get older, the negative impact of alcohol on our physical and mental health increases. Ageing slows down the body's ability to break down alcohol and so alcohol remains in the system for longer. This in turn results in the older person reacting more slowly and they tend to lose balance more easily and lead to an increased risk of falls and other accidents. This in turn can lead to long term injury and be a cause for residential care. It may also cause serious complications with any medication(s) the individuals may be taking. Data on numbers of falls and their association with alcohol is limited and further research is needed regarding this.

About a third of older people with alcohol problems develop them for the first time in later life. Bereavement, physical ill-health, becoming a carer, loneliness, difficulty in

getting around, unhappiness and depression can all lead to increased alcohol consumption[24].

Social isolation can result from a loss of contact with family members, loss of partners, loss of mobility, less contact with friends and less involvement with, and action in, the community.

- The number of alcohol related hospital admissions nationally in people aged 65 and above has more than doubled in the recent years (197,000 to 461,000 between 2002-2010; NHS Information Centre, 2011).

- 1 in 5 older men and 1 in 10 older women are drinking enough to harm themselves. This is a 40% and 100% increase respectively over 20 years[25].

- The majority of older people consume alcohol in their home (Omnibus Survey, 2008).

The Community Mental Health Survey (2011) found that older adults are one group that is least likely to be asked about their alcohol use, especially older women. Increased alcohol intake is often hidden in the older population and not always identified because:

- Older people do not talk about it, possibly because of the perception of shame, stigma or embarrassment

- Alcohol problem can be mistaken for physical or mental health problem

- Assumed not to be a problem for this population group

- Older people have a poor awareness of lower risk drinking limits

Action needs to be taken to address this increasingly significant issue, such as developing the skills of frontline workers to be aware of the needs of the ageing population and to 'Make Every Contact Count'[26] with this and every group. It must also be ensured that services are accessible for older people especially those with disabilities.

At the service delivery level, access to prevention and treatment should be enhanced by removing barriers, training of healthcare staff, use of valid screening instruments and developing closer working models – including innovative paradigms – between services at all levels.

Alcohol across the life course

Research shows that White respondents, particularly those from Irish backgrounds, are more likely to report current alcohol use and have higher rates of frequent use than those of other ethnic groups. South Asians are least likely to report frequent alcohol use.

In general, females drink less frequently than males across ethnic groups, though gender difference in White British and Irish, and Black Caribbean and African groups seem to be converging. According to the Joseph Rowntree Trust (2010), the majority of research shows that White British and Irish respondents are likely to drink more units on average than other ethnicities, with South Asian respondents drinking least, and Black Caribbean and Black African respondents falling somewhere in between. Rates are also low for Chinese people. However, of those South Asian respondents who do drink, research finds high rates of alcohol use.

Alcohol can have an impact upon an individual at certain points, particular stages or, across the whole of their life, and be influenced by their age, gender, ethnicity and, their income levels. This strategy is committed to developing the provision of information, advice, screening and support for people at all life stages, which are based on NICE, Department of Health guidance and, local intelligence, which include, but are not exhastive:

Identification and Brief Advice

There are real opportunities, often under-exploited, for health services to identify those at risk and provide advice and support to those that need it, whether via regular contact with NHS staff, or in particular settings such as A&E, through well evidenced brief interventions. Identification and Brief Advice (IBA) is a simple, evidence based intervention aimed at individuals who are at risk through drinking above the guidelines, but not typically seeking help for an alcohol problem. IBA has been proven to reduce drinking, leading to improved health and reduced calls on hospital services. At least one in eight 'at risk drinkers' reduce their drinking as a result of IBA. The National Institute for Health and Clinical Excellence (NICE) recommends that NHS health professionals routinely carry out alcohol screening as an integral part of their practice, focusing on groups at increased risk[9].

Wellbeing Service

This new service in Blackburn with Darwen brings together a wide range of services into one single access point to make getting help easier. The service seeks to address some of the wider determinants of health which impact upon lifestyle and health and support people to make changes to improve health and access appropriate services. This service will communicate the health harms of drinking above the lower-risk guidelines and provide a range of tips and tools to encourage people to drink responsibly.

NHS Health Checks

Since April 2013, the Department of Health has included alcohol identification and any subsequent brief advice needed within the NHS Health Checks, which are commissioned in Blackburn with Darwen for any adults aged 35-75 years.

A&E departments

A&E departments can be a particular flashpoint for those who have drunk to excess, causing fear and distress to others awaiting and administering treatment. The NHS does not tolerate any violence or disorder in hospitals to its staff and to those waiting for medical attention, which is often fuelled by alcohol consumption. A range of measures have been suggested nationally to tackle this unacceptable behaviour. Locally, the Police, Local Authorities and Clinical Commissioning Groups (CCG) are working collaboratively to commission an A&E Police Liaison Officer to reduce the levels of violence within the A&E setting.

Alcohol-related assault data

Through a North West initiative, Trauma Injury and Intelligence Group (TIIG), many A&E departments across the North West record whether alcohol had been consumed prior to each assault incident they handle. This is an excellent opportunity to understand the local picture more, and to identify hotspots for violence and excessive alcohol consumption, whether it is a personal home address or, a licensed premise. Work is underway to improve the collection and sharing of this data.

Recovery Orientated Integrated System

The continued development and promotion of a Recovery Orientated Integrated System (ROIS) is a positive approach within the Borough. This puts the person who requests help at the centre, surrounding them with options and choices so that they can design their own support and recovery journey, as opposed to filtering everyone through a treatment service. Indeed, many may not even enter into services but successfully be supported by the recovery community. People who have experienced alcohol problems and service users themselves have made it clear that recovery is best supported by peers and allies who are trained, competent, and supervised: mutual support and mutual aid groups including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery. Those in recovery are 'assets' which contribute to community developments.

Protected characteristics

As identified within the Governance Section, the protected characteristic group has been considered and where intelligence and evidence is available has been incorporated into the Strategy. For example, older age group has been identified as increasing alcohol consumption whereas young people overall appear to be reducing in their levels of alcohol consumption; although young Asians are now drinking more than previous generations.

It is well recognised that there is often a lack of information available concerning specific groups; unfortunately this sometimes most pronounced in the protected groups, although not exclusive. Through the development and refinement of the local action plans, we aim to gain intelligence around such barriers and challenges, identifying gaps and opportunities. We must build upon local intelligence and contribute to the refresh of the JSNA when relevant.

Excellent work is already ongoing in this area and there are a number of examples of good practice and more specifically, we are working with partner agencies, including academic institutions, the voluntary, faith and community sector as well as the community to explore several pieces of research such as attitudes and consumption of alcohol within the BME community; alcohol awareness within the older population; alcohol, drug and sexual risk taking behaviours and attitudes of students in higher education. We are also working across Pan Lancashire to engage and work with stakeholders, staff and local residents in relation to the minimum unit price, what it is and what it means for different population groups. It is important to continue to build upon such excellent partnership work streams to really understand our local picture.

Crime and Disorder

Alcohol misuse places a profound burden on the social fabric of the UK. In addition to the extensive healthcare costs, lost productivity and premature deaths, there are a range of crime and disorder problems associated with excessive consumption of alcohol. This includes alcohol-specific crime, such as being drunk and disorderly in public, criminal damage and, drink-driving.

Many other offences can take place under the influence of alcohol, such as alcohol related violence, anti-social behaviour, domestic violence, property damage and arson. It is well evidenced that alcohol consumption is a risk factor for many types of violence, including child abuse, youth violence, intimate partner violence and elder abuse. Individuals who start drinking at an earlier age, who drink frequently and who drink in greater quantities, are at increased risk of involvement in violence as both victims and perpetrators (World Health Organization, 2012).

In its report "Alcohol misuse: tackling the UK epidemic,"[27] the British Medical Association outlined the extent and impact of alcohol-related crimes and behaviours in the UK:

- Among victims of violent crimes in England and Wales 44% perceived the offender as under the influence of alcohol at the time of the crime.
- Alcohol consumption is strongly associated with anti-social behaviour such as nuisance and rowdy behaviour, noise disturbance, littering, and harassment.
- Nearly half of domestic violence offenders were under the influence of alcohol at the time of their offence, and alcohol-fuelled domestic violence is more likely to result in victim injury and the need for medical care.

Domestic abuse is a priority for the Borough; the number of reported incidents of domestic violence has increased to 3,300 per year and accounts for a third of all violent crime in Blackburn with Darwen.

Nationally, domestic abuse was linked to almost 70% of all child protection cases and victims of domestic abuse are 15 times more likely to abuse alcohol.

Licensing

Nationally, in April 2012, Health was added to the list of 'responsible authorities' invited to comment upon licensing applications. Public Health departments have retained this responsibility since transferring to local government control in April 2013. The Alcohol Strategy proposes to go one step further, by making 'public health' one of the statutory grounds upon which a 'Cumulative Impact Policy'[28] can be declared, allowing the authority to control the density of licensed premises in a specified area.

Listed below are recommendations for licensing, devised by Public Health England[4].

- Use local crime and related trauma data (i.e. TIIG) to map the extent of alcohol-related problems before developing or reviewing a licensing policy. If an area is saturated with licensed premises and the evidence suggests that additional premises may affect the licensing objectives, adopt a 'cumulative impact' policy. If necessary, limit the number of new licensed premises in a given area.
- Ensure sufficient resources are available to prevent under-age sales, sales to people who are intoxicated, proxy sales (that is, illegal purchases for someone

who is under-age or intoxicated), non-compliance with any other alcohol license condition and illegal imports of alcohol.

- Work in partnership with the appropriate authorities to identify and take action against premises that regularly sell alcohol to persons who are under-age, intoxicated or making illegal purchases for others.

- Undertake test purchases (using 'mystery' shoppers) to ensure compliance with the law on under-age sales. Test purchases should also be used to identify and take action against premises where sales are made to people who are intoxicated or to those illegally purchasing alcohol for others.

- Ensure sanctions are fully applied to businesses that break the law on under-age sales, sales to those who are intoxicated and proxy purchases. This includes fixed penalty and closure notices (the latter should be applied to establishments that persistently sell alcohol to children and young people).

Blackburn with Darwen has endorsed a number of key strategies to tackle alcohol related problems in direct response to policy, the evidence base and issues raised by residents, businesses, police and other partners. These include proactive test-purchasing, endorsement of the Challenge 21 scheme and supporting the minimum unit price (MUP). The Borough's statement of Licensing Policy (2010) stipulates a number of conditions and tactics to be employed to regulate and influence alcohol related problems.

Reducing alcohol consumption

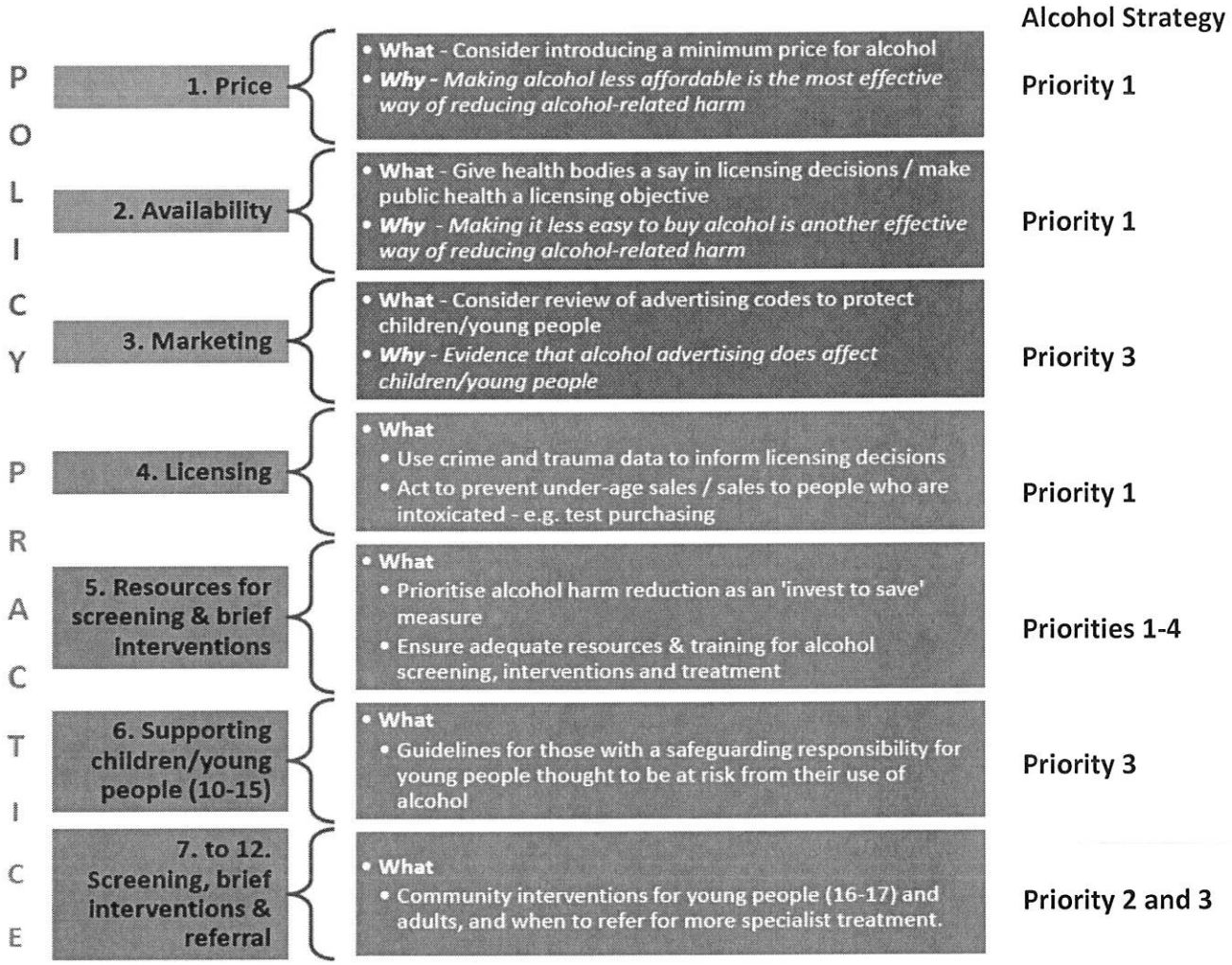
Increased consumption is closely linked to increased affordability – alcohol is now 50% more affordable than it was 20 years ago.

The most effective way to reduce the harm from alcohol is to reduce the affordability, availability and attractiveness of alcohol products.

Health First 2013

Figure 4 summarises NICE guidance on preventing harmful drinking. It spans both policy and practice, arguing that they need to work in tandem to reinforce each other. It contains policy information directed at government as well as advice on practical interventions for local agencies. The figure below also identifies where each of these recommendations is addressed within our local strategy.

Figure 4. Summary of National Institute Health and Clinical Excellence (NICE) guidance[4], aligned to the Alcohol Strategy Priority areas



Minimum Unit Pricing: MUP

There is a clear relationship between affordability and how much people drink[15]. The most effective way to reduce costs of alcohol harm is to control the price and availability of alcohol. Minimum pricing directly links price to alcohol content by setting a floor price below which a single unit of alcohol cannot be sold. The main impact will be on supermarkets and off-licenses; particularly where alcohol is sold in bulk packages, promotional deals or in high strength products. Prices in the on-trade (e.g. pubs and clubs) will be largely unaffected as they typically sell at well above the minimum levels under discussion. Despite little impact on current on-trade prices, evidence suggest on-trade sales will increase as drinkers return to pubs following supermarket price increases[28]. Minimum Unit Pricing (MUP) policies are effective in reducing alcohol consumption, reducing alcohol-related harms (including alcohol-attributable deaths, hospitalisations, crimes and workplace absences) and reducing

the costs associated with these harms. Countries that have introduced MUP have found it to have a real effect on alcohol consumption and to reduce the harm associated with alcohol[29].

By setting a MUP of 50p per unit of alcohol, the Sheffield study[30] also estimated the policy would lead to 42,500 fewer crimes in the first year and over 10 years lead to 14,960 fewer deaths and 481,373 fewer hospital admissions.

MUP is a highly targeted intervention focussing on those who suffer the greatest harms from alcohol as it makes it very difficult for heavy drinkers to maintain their drinking levels without increasing the costs. The effect would be greatest among the 5% of the population classified as harmful drinkers[31] and there are also considerable gains in the well-being of people exposed to the heavy drinking of others. This in turn would also have a positive impact on reducing health inequalities.

However, all people who drink alcohol will see health benefits from MUP, including moderate drinkers, although the biggest health benefits would be for young people, and for those people who are ill, particular if they have cardiovascular disease, including heart attack, angina and stroke. A 50p MUP is likely to reduce rates of high blood pressure, diabetes and heart disease as well as liver damage and a range of cancers. It could also significantly reduce 1,000s of trips to A&E by dangerously drunk people.

5

Units of Alcohol in your drink: how to work it out

Start with how much of each type of drink is consumed in litres e.g. 75 cl bottle of wine = 0.75 litres, 500 ml = 0.5 litres, 1 pint = 0.57 litres, and multiply this by the abv % (alcohol by volume) number shown on the drink container or dispenser.

For example: half of a 75 cl bottle of Wine at 13% abv = 0.75 litres divide by 2 = 0.375 litres, multiplied by 13 = 4.88 units, then add one pint of lager at abv 4% = 0.57 litres multiply by 4 = 2.28 units. A total of over 7 units.

Drink:	Units calculation:	Units:	Cost at MUP of 50p per unit	MUP will increase price?	How much will take you to the Drink Drive limit of 4 units
75cl bottle of red wine	0.75 litre x 12% abv	9	£4.50	no	Under half (0.45) of a bottle
1 litre bottle of Vodka	1 litre x 37.5% abv	37.5	£18.75	no	Just over one tenth of a bottle
70 cl bottle of spirits	0.70 litre x 37.5% abv	26.25	£13.13	no	Just over one sixth of a bottle
1 pint Premium Lager	0.57 litre x 5.2% abv	2.97	£1.49	no	One and a half pints is over the limit
Half pint draught bitter	0.285 litre x 3.75% abv	1.07	£0.53	no	4 halves is over the limit
Single 25 ml pub measure spirits	0.025 litre x 37.5% abv	0.94	£0.47	no	4 singles is just under 4 units
500ml can super strength lager	0.5 litre x 9%	4.5	£2.25	yes	1 can is over the limit
3 litre bottle White Cider	3 litre x 7.5 abv	22.5	£11.25	yes	A fifth of a bottle is over the limit
Single 50ml pub measure sherry or port	0.05 litre x 18% abv	0.9	£0.45	no	4 singles is just under 4 units
Small pub glass 125ml white wine	0.125 x 11% abv	1.38	£0.69	no	Less than 3 glasses is over 4 units
Medium pub glass 175ml red wine	0.175 x 13% abv	2.28	£1.14	no	2 glasses is over the limit
Large pub glass 250ml white wine	0.250 x 12% abv	3	£1.50	no	1 and a half glasses is over the limit
1 pint draught lager	0.57 litre x 4% abv	2.28	£1.14	no	One and 3/4 pints is on the limit
Medium pub glass 175ml sparkling wine	0.175 litre x 10% abv	1.75	£0.88	no	2 and a half glasses is over the limit
70 cl bottle pre-mixed drink (breezer etc)	0.7 litre x 4% abv	2.8	£1.40	no	1 and a half bottles is over the limit
Premium shot spirit 25ml single	0.025 litre x 40% abv	1	£0.50	no	4 shots is on the 4 unit limit
1 pint draught cider	0.57 litre x 5% abv	2.85	£1.43	no	A pint and half is near the limit
440ml can cider/lager/beer	0.44 litre x 4% abv	1.76	£0.88	yes	2 and a half cans is over the limit
1 pint dark stout	0.57 litre x 4.3% abv	2.45	£1.23	no	One and 2/3rds pints is over the limit
70c cl bottle cream liqueur	0.7 litre x 17% abv	11.9	£5.95	no	A third of a bottle is almost 4 units

- Minimum Unit Price comparison shows the drinks that will cost more under a MUP of 50p per unit, where they show no increase this means they are already generally* more expensive than 50p per unit. *There are budget brands of all alcohol drinks that may cost less than 50p per unit, for the purposes of our chart we are using the mid-range quality/cost drinks as a gauge. Also note heavily discounted leading brands may be less than 50p per unit.
- The abv strengths shown are averages for the type of drink described, please note the abv % figure is by law displayed on all alcohol drinks or the dispenser (pump).
- The Drink Drive limit of 4 units is a guide only, in the UK the law states the alcohol limit for drivers is 80 milligrammes of alcohol per 100 millilitres of blood, 35 microgrammes per 100 millilitres of breath or 107 milligrammes per 100 millilitres of urine.
- It should also be noted that the BAC (blood alcohol content) as determined above can be influenced by many factors, metabolism, age, gender and other attributors.

How we will deliver: local response

The Blackburn with Darwen Alcohol Prevention Group will oversee the development and implementation of this strategy, with its overarching purpose being:

- To provide a strategic oversight, ensure a collaborative approach and to reduce levels of alcohol related harm
- To develop and implement an evidence-based strategy and action plan to reduce alcohol consumption, founded on a detailed and intelligent analysis of local need, to reduce inequalities between the most advantaged and least advantaged in Blackburn with Darwen

Partners involved

Running throughout this strategy is the commitment to ensure that all partners are able to identify those people most in need of support and provide a whole family and whole system response. This is necessary because alcohol misuse and its impact on individuals, families and communities is complex and multifactorial. The workforce, including those in the voluntary, faith and community sector, carers, those in therapy and the wider community are important assets in engaging with and communicating consistent health messages, and we will ensure that they are equipped with the skills and knowledge to do so.

We will improve access to and availability of appropriate treatment and support for vulnerable people, their family or carers, including older people and BME communities. The needs assessment process will continually be developed to identify those who find it difficult to access services. Several research projects are proposed to support this, including exploration regarding the associations with alcohol and Black and Minority Ethnic Communities, older people, risk taking behaviours in young people.

We will ensure that on-going recovery network developments consider causal factors of problematic alcohol misuse and behaviours to encourage a system of provision which aspires to improve outcomes for all including children, families and carers.

Intrinsic to the success of this strategy is the associated communications and engagement work. Communication campaigns have been aligned to each of the priority areas which will utilise various forms of media, targeting different population groups and the various aspects of alcohol related use and abuse, as the local action plans develop. These campaigns will also seek to reflect and amplify national campaign messages where appropriate.

These are outlined below:

Priority 1 **Licensing**	Minimum Unit Pricing Challenge 25
Priority 2 **Recovery focussed treatment services**	Pre-loading Promotion of support and services (Your support, your choice)
Priority 3 **Prevention across life course**	Dry January, Alcohol Awareness Week (themed to reflect priorities in the Borough) Change 4 life
Priority 4 **Community Safety**	Your Community, Your Call Endorsement of national campaigns (e.g. pre-Christmas, World Cup, Domestic Violence awareness)

Strategy development

The cross-cutting nature of this strategy means that responsibility for its development and delivery cannot sit with one single organisation. Hence, an effective partnership with strategic representation from partner organisations has been established, through the Alcohol Prevention Strategy Group, which leads the development and implementation of this Strategy and will be consulted with the alcohol prevention reference group going further.

This Alcohol Strategy is informed by the National Alcohol Strategy (2012)[9], the Health First Report (2013)[5] and NICE guidance, but also builds on the foundations of the previous borough-wide strategy (2008-2011).

This strategy has undergone a wide and thorough engagement process to ensure the views of partner agencies, service users and the residents of Blackburn with Darwen are incorporated and that it is embedded within the practice of all partners. There have been workshop events with the alcohol prevention action group, specific events focussing on the Children and Young People and the Alcohol Pledges, development of the recovery model for those who are in treatment, discussions with key multi agency / single agency committees, i.e. Clinical Commissioning Group Governing Body, Health and Wellbeing Board, Licensing Committee and much media interest with a two radio interviews and a press release.

However the development of the local plans will require refining further and annual refresh to ensure that any emerging evidence or intelligence can inform the process and respond in a timely and effective manner.

The priorities and resulting action plans have been agreed by the Alcohol Prevention Action Group, underpinned by the evidence-base, intelligence and needs outlined in the Borough's Story of Place, and our Alcohol Joint Strategic Needs assessment as well as the Director of Public Health's Annual Report (2013/14).

Strategy delivery, monitoring and review

Delivery of this Strategy will be overseen by the Alcohol Prevention Action Group and, the newly forming Alcohol Prevention Reference Group.

The draft Alcohol Strategy has been presented and cascaded to various partner organisations, including all members and associate members of the Health and Wellbeing Consortium, community groups and service users and has been available online for comment. There has also been much media interest, with Public Health colleagues providing radio interviews and press releases about the strategy, encouraging people to comment on the Strategy. There will a piece in our Shuttle promoting the Strategy, and will encourage residents to comment and influence the development of the detail behind the strategy.

Action plans have been, and will continue to be, developed with a range of tasks required to implement this strategy. Through such action plans, it will be possible to determine progress against the Strategy's aims and objectives. These plans will be regularly reviewed to ensure that the work is undertaken, that it continues to be informed by the needs assessments undertaken in the Borough and that interventions are evidence based. It will also be updated to reflect changes in local delivery structures, national legislation and national and local policy.

We will ensure that information is shared with local communities about what partners are doing to address the alcohol-related harm in the borough, via continued consultation and community engagement work.

Links to strategic priorities

There are a number of strategic priorities that are driving forward this Strategy[9], including:

- Reduce the overall alcohol consumption in the population
- Reduce the incidence of alcohol related illness, injuries and deaths
- Reduce the incidence of alcohol-related disorder, anti-social behaviour, violence and crime

The nationally produced Public Health Outcomes Framework[32] provides a model from which our outcomes are developed:

Domain 2: Health improvement

i. Reduction in alcohol-related admissions to hospital.
ii. Reduction in the people entering prison with substance dependence issues who are previously not known to community treatment.
iii. Increased take up of the NHS Health Check programme for those eligible, which now incorporates alcohol consumption levels

Domain 4: Healthcare public health and preventing premature mortality

I. Reduction in mortality from liver disease.

Priority Number 1: Licensing and trade responsibility

Aim

To ensure all sections of the alcohol trade promote responsible retailing that supports a reduction in alcohol-related harm

Challenges for Blackburn with Darwen

One of the biggest challenges that we face is the availability of the 'off trade' sales, i.e. the low cost sales within local supermarkets/local shops, which can be open 24 hours a day, as opposed to more controlled purchases through 'on-trade[3]' sales, i.e. pubs/clubs. Because alcohol is so cheaply available off-trade, and the strength of alcoholic drink products has increased over time, people are frequently drinking more units of alcohol at home, often without realising it. The numbers of people drinking at home are increasing, which includes those who are pre-loading (where a person drinks large amounts of alcohol before going out for the evening).

In Blackburn with Darwen there are currently 326 premises that are licensed to sell alcohol, of which 13.5% (n=44) sold alcohol to people under 18 years of age in 2012/13 as identified through the local testing programme.

The Trading Standards North West Survey: *Young Peoples' Attitudes and Behaviours to Alcohol and Tobacco* (2013)[33] revealed that of those aged 14-17 in Blackburn with Darwen who took part in the survey:

- About a quarter (26%) said they drink alcohol at least once a week, of which 18% was in pubs/clubs and 19% in parks and streets.
- Nearly two-thirds (62%) said that they got alcohol from family or friends over the age of 18.
- 16% said that they bought it themselves; higher than the 13.5% identified in the local programme described above.

Whilst many young people, under the age of 18, obtain alcohol from their home / friend's homes, a significant proportion of young people are able to purchase alcohol from licensed premises.

[3] On Sales refers to alcohol purchased in pubs or clubs

What is known to be effective

Controls on price and availability have been identified by the World Health Organization (World Health Organization Europe, 2011) as the most effective measures that governments can implement to reduce the harm caused by alcohol. Minimum unit price for Alcohol (MUPA) is considered the most effective approach to reduce the levels of consumption of very low cost alcohol.

Other initiatives have been found to have a positive impact on reducing the harm caused by low cost, high alcohol content drinks, i.e. retailers not selling such drinks. There is evidence that initiatives which: prevent under-age sales; sales to people who are intoxicated; proxy sales (i.e. illegal purchases for some-one who is under-age or intoxicated); non-compliance with any other alcohol license condition and preventing illegal imports of alcohol, are effective (NICE PH 24, 2010). Through the Borough Council's Licensing Department, these initiatives are being implemented.

Public Health has sought to include in the Borough's Statement of Licensing Policy controls on licensed premises where sales of low cost and/or super strength beers, lagers and ciders (for the purposes of this strategy super strength is 6% by volume alcohol or above) have led to concerns that the Licensing Objectives are not being promoted.

These controls may include restricting sales of super strength beer, lager and ciders at licensed premises, and the requirement to charge a minimum unit price or a minimum cost per drink as part of a package of measures to deal with concerns and problems.

Any such controls considered would be agreed with the license holder and would constitute a mutually approved condition attached to their license to retail alcohol.

There are initiatives that can be implemented which reduce the opportunity for under age sales, such as 'Challenge 25' (previously 'Challenge 21').

We know that local crime and related trauma data can be mapped to demonstrate the impact of alcohol, including the link with licensed premises. Through this intelligence and if an area is saturated with licensed premises and the evidence suggests that additional premises may affect the licensing objectives, a 'cumulative impact' policy could be adopted, which may result in limiting the number of new licensed premises in a given area. It is imperative that we ensure that we have, as a minimum, local TIIG data captured.

What we will do

1. We will ensure that there is commitment to address the problems associated with very cheap and high alcohol content drink; encouraging availability to be restricted in areas of most need by:

   a) Supporting and lobbying for a minimum unit price for alcohol (MUPA).

b) Exploring the opportunities to reduce the availability of super-strength alcohol that is on sale in the Borough, focusing on the off-trade licensees, and learning from other areas.

c) Reinforcing 'Challenge 25' at a whole system wide approach and, proxy sales messages.

2. We will ensure that we continue to develop and implement robust systems and have procedures in place to support a positive and responsible alcohol trade by:

   a) Supporting the use of 'Challenge 25' policies.

   b) Supporting all alcohol retailers to engage in the community alcohol network (CAN).

   c) Ensuring robust licensing procedures are in place, in particular focussing on health data to reduce the impact of health related harm for the public.

Priority Number 2: Health and Wellbeing Services

Aim

To ensure an evidence based 'health and wellbeing' focussed treatment and recovery approach is employed to address the needs of people and their families experiencing alcohol related misuse

Challenges for Blackburn with Darwen

To successfully address the challenges associated with alcohol misuse a coordinated and whole system approach is required. It is acknowledged that people with alcohol misuse related problems bring a number of significant pressures to bear on their own family life, their ability to function positively within society, and our public service provision.

The complex and problematic behaviour associated with alcohol misuse impacts negatively on the lives of others. They also affect a range of provisions and increase demands faced by our accident and emergency departments, hospitals and other emergency services, families and wider communities. Local Authorities, Clinical Commissioning Groups, the wider NHS, the Police and other statutory bodies and the voluntary, faith and community sector must work together to address local needs that are both identified within the Alcohol Joint Strategic Needs Assessment (Appendix A) and emerge as new intelligence emerges.

Treatment services which take a recovery orientated integrated system (ROIS) approach are already being commissioned in Blackburn with Darwen and excellent services are provided. Furthermore, interventions aimed at individuals can help make people aware of the potential risks they are taking (or harm they may be doing) at an early stage. This is important, as they are most likely to change their behaviour if tackled early. In addition, an early intervention could prevent extensive damage[4].

What is known to be effective

Promoting and enabling the delivery of effective specialised treatment and recovery services is important to improve public health and social outcomes. Involvement in service planning and delivery by people who are able to contribute to the growth of innovative recovery focussed projects that are developed and underpinned by volunteer advocates is crucial. This ensures positive influence and role model opportunities to contribute to the on-going support needs of others, many of whom place high demands on their families, communities, hospitals, the criminal justice system and other universal services.

Recovery orientated community support which goes beyond addressing the medical or mental health complexities associated with alcohol related behaviours needs to be promoted. By

reinforcing responsibility and resilience among recovery focussed networks we should promote awareness, information and advice within communities to ensure improved outcomes for all.

Evidence states that both screening and brief interventions for people at risk of an alcohol-related problem (hazardous drinkers) and those whose health is being damaged by alcohol (harmful drinkers) should be carried out. This includes people from all population groups including, young people, members of the Black and Minority Ethnic community and offenders [4].

Alcohol screening involves identifying people who are not seeking treatment for alcohol problems but who may have an alcohol-use disorder; the scope for delivering these brief (and often low level interventions) is vast, for example, community pharmacists, wellbeing services, community assets.

Brief interventions comprise short sessions of structured brief advice or, longer, more motivationally-based sessions (i.e. an extended brief intervention) and aim to help reduce alcohol consumption (sometimes even to abstain) and can be carried out by non-alcohol specialists.

For young people (16-17 years), screening should be undertaken utilising a validated alcohol screening questionnaire. In most cases, AUDIT (alcohol use disorders identification test) should be used and the focus should be on key groups who may be at an increased risk of alcohol-related harm, which includes, but is not exhaustive, those:

- Who have had an accident or a minor injury.
- Who regularly attend genitourinary medicine (GUM) clinic; repeatedly seek emergency contraception.
- Involved in crime or other antisocial behaviour.
- Who truant on a regular basis.
- At risk of self-harm.
- Who are looked-after children.
- Involved with child safeguarding agencies.

Those seeking treatment should receive physical and mental assessments and offered/referred for treatment and care, delivered by appropriately trained and competent staff.

What we will do

1. Ensure that we have high quality services for individuals and families, developed in partnership, with service user representation and volunteer advocates, which enhance the wider developing recovery system of support that is asset based.

2. Continued monitoring and development of the hospital alcohol liaison service (HALs) including on-going opportunities to enhance outcomes, including working collaboratively with the A&E Police Liaison Service.

3. Improve opportunities to deliver training packages which include identification and brief advice (IBA) services across communities.

4. Support and champion the development of knowledgeable Health and Wellbeing services that promote and deliver prevention, sensible drinking and abstinence programmes as their core business, as appropriate.

Priority Number 3: Prevention across the life course

Aim

To ensure that a coordinated 'whole family' and population approach is taken for initiatives that work with children, young people, working age and older people, families and communities, to lower the population's risk of alcohol-related harm

Challenges for Blackburn with Darwen

Population-level approaches are important because they can help reduce the aggregate level of alcohol consumed and therefore lower the whole population's risk of alcohol-related harm. They can help:

- Those who are not in regular contact with the relevant services.
- Those who have been specifically advised to reduce their alcohol intake, by creating an environment that supports lower-risk drinking.

NICE Guidance, 2013.

A life course approach, from pre- and early pregnancy through to older age, should be taken to address health and social consequences of alcohol use / misuse.

Alcohol misuse can be a barrier to children having the best start in life, impacting upon parenting capacity and family functioning. Children living with one or more parents living with alcohol misuse are more likely to face social and economic hardship, do less well at school, and have poorer emotional health and mental wellbeing. Approximately 2.6 million children nationally are living with parents who drink hazardously; 705,000 with dependent drinkers[19]. The consequences of growing up with alcohol misuse and other risk taking behaviours reach far into adulthood. Research carried out in Blackburn with Darwen shows that children who are exposed to four or more adverse childhood experiences (ACE[4]) before reaching the age of 18 years are 3.7 times more likely to become heavy drinkers in adulthood.

It is important to identify vulnerable individuals / groups who can be adversely affected by their own, or others, alcohol use. Evidence suggests that ***older people*** are drinking more alcohol than in the past. The Royal College of Psychiatrists highlights the extent of alcohol problems among older people, often in response to psychosocial factors such as bereavement, boredom and loneliness. Alcohol misuse is also a contributing factor to increased risk of falls, accidents and fires in the home. Within Blackburn with Darwen, we have an increasing older population, and falls are one of the leading causes of death in the over 70s.

[4] ACE includes a person growing up in a household with someone who is mentally ill, misusing alcohol, having served time in prison, experiencing parental separation/divorce, sexually abused, or witnessing/ victim of domestic violence.

What is known to be effective

Advertising, the availability of cheap alcohol, peer pressure and parental influences all have a part to play in levels of consumption amongst young people. It is important that evidence-based initiatives that create safer and healthier environments for young people to grow up in are implemented. This includes continuing efforts to limit underage sales to children and young people, lobbying around alcohol pricing and supporting licensing activities, i.e. 'Challenge 25' and also many partnership initiatives, in particular those involving local schools, colleges and communities.

It is important that alcohol education in schools is part of existing curricula. Evidence demonstrates that school interventions on alcohol use should be integrated with community activities as well as personal, social, health and economic curricula[34] (NICE PH7). Accurate and age-appropriate health messages should be given to young people so that they can make safer choices around alcohol use.

Alcohol education needs to be tailored for different age groups and take different learning needs into account (based, for example on individual, social and environmental factors). Education programmes should:

- Increase knowledge of the potential damage alcohol use can cause – physically, mentally and socially.
- Provide the opportunity to explore attitudes and perceptions of alcohol use.
- Help develop decision making, assertiveness, coping and verbal/non-verbal skills to reduce alcohol related harm.
- Help develop self-esteem.
- Increase awareness of how the media, advertisements, role models and the views of parents, peers and society can influence alcohol consumption.

What we will do

1. Endorse the Pledges for Children and Young People and Alcohol, and ensure that they continue to be implemented through the Pledges Action Plan:

    1. *Actively seek your views, work to better understand your needs and strive to deliver the services that we know you want to see.*
    2. *Ensure you have the opportunity to develop the skills, knowledge and confidence to keep yourself safe and reduce the potential harm you experience from you own and others' drinking.*
    3. *Ensure that all services do their best to protect you from alcohol related harm from your earliest years through to adulthood.*

4. *Ensure that your parents are equipped with the skills, knowledge and confidence to protect you from alcohol-related harm as you grow to adulthood.*
5. *Do all we can to make sure you grow up in an environment where you are not put under pressure to drink by advertising, the availability of cheap alcohol or illegal sales.*

2. A population approach will address the needs and issues of all population groups by:
    i. Communication and engagement activities.
    ii. Low level interventions (i.e. awareness campaigns and IBA).
    iii. Routine enquiry (including NHS Health Checks).

3. A targeted approach will address the needs and issues of specific groups/communities by:
    i. Focusing on older people living in isolation.
    ii. Further exploring alcohol consumption with various groups such as BME and lesbian, gay, bisexual and transsexual (LGBT) communities.
    iii. Empowering local people to understand the impact of alcohol misuse on their mental health and wellbeing, in particular those living in more disadvantaged areas.
    iv. Supporting local people to understand the true long term health impact of alcohol.

Priority Number 4: Protection for the Community

Aim:

To mitigate the role of alcohol in fuelling Crime, Anti-Social Behaviour, Violence and Domestic Abuse.

Challenges for Blackburn with Darwen

Alcohol consumption levels tend to be lower in the more disadvantaged areas, however, the negative impact and the harm associated from alcohol is higher in such areas (Marmot, 2010). As a Borough, we have a higher proportion, when compared with regional levels, of abstainers (i.e. do not drink, have never drunk or, were drinkers and no longer drink). However, we do have a high proportion of people who drink to hazardous levels, similar to regional levels across the country. The high levels of alcohol consumption across the Borough results in high attendance at local A&E departments; high levels of alcohol related crime and disorder and high levels of alcohol related health conditions, such as liver disease, cardiovascular disease, stroke and cancer.

Alcohol misuse[15] is a risk factor for many types of violence including child abuse, violence in public settings, youth violence, sexual violence, intimate partner violence and elder abuse. In England and Wales, alcohol is thought to play a part in approximately 1.2 million violent incidents per year - almost half of all violent crimes, with devastating health consequences for victims, their family, friends and the wider community. Whilst health, police and other public services deal with the consequences of alcohol-related violence, the same workers are also victims; for example, 116,000 NHS staff are assaulted each year, primarily by patients and relatives.

Individuals who start drinking at an earlier age, who drink frequently and who drink in greater quantities, are at increased risk of involvement in violence as both victims and perpetrators. At least 1 in 5 crimes in Blackburn with Darwen are alcohol related, which rises to 1 in 3 for violent crime. Within the Borough, we are estimated to have significantly higher alcohol related recorded crimes (ranked 253/326 local authorities); alcohol related violent crimes (ranked 256/326 local authorities) and alcohol related sexual offences (ranked 282/326 local authorities; data not significantly different).

In the autumn of 2015, Blackburn with Darwen is planning to regenerate the town centre, by developing the Blackburn Cathedral Quarter. It is important that this exciting new proposal is supported by an effective Alcohol Strategy, which aims to reduce the harm associated with alcohol, including the local community.

What is known to be effective

The relationship between alcohol use and violence is multifaceted and complex, involving a link between biological processes, broad social and economic forces, and settings in which people obtain/consume alcohol. Although often triggered by an event, i.e. an argument, such behaviour may have its roots in long-term predisposing factors, i.e. adverse childhood experiences.

It is vital that a whole system approach is taken to address the community element of alcohol misuse, addressing the root causes, focusing on those who are most at risk of being a victim or perpetrator of crime, violence and / or anti-social behaviour. As part of this holistic approach to supporting some of the most complex – need individuals in our community we will work with key partner organisations to support the implementation of the A & E Police Liaison role. During the scoping of this work it was identified that individuals who often present at the A&E Department can cause disruption and impact on the delivery of quality care both for themselves, other patients, carers as well as clinical staff within the department, and who often represent repeatedly at A&E. These may be referred to as frequent flyers. This creates issues in relation to the increasing pressure on Police resources which are being diverted away from mainstream Police work in order to respond to incidents within the A&E department of the acute trust.

Measures to limit access to alcohol and reduce alcohol consumption among hazardous and harmful drinkers can play an important part in violence prevention initiatives. This includes reducing the density of alcohol outlets, controlling alcohol sales times and controlling the price of alcohol, such measures are addressed in Priority Programme 1.

Interventions that focus on harmful and hazardous drinkers can have benefits in preventing violence (Department of Health, 2012). This includes screening and brief interventions, which are prioritised within Priority Programme 2.

More intensive programmes have also reported positive results, such as cognitive behavioural therapy with non-dependent drinkers has been found to reduce their risks of perpetrating abuse, while programmes with partners of problem drinkers have shown benefits in reducing intimate partner violence (Department of Health, 2012).

Evidence based initiatives that support individuals and families to address their alcohol consumption, rehabilitation and integration within local communities, e.g. bespoke support for those wishing to engage with treatment through assertive outreach will be taken.

What we will do

By intervening early we can prevent escalation and more serious harm at a later date as over time problems of alcohol misuse become increasingly difficult to resolve successfully.

1. Intervene early with individuals who are at risk of causing harm fuelled by alcohol, including harm within the home and with families seeking support and within our neighbourhoods where alcohol is a particular risk factor for anti-social behaviour and violence.

2. Implement a robust approach, combining assertive outreach with bespoke innovative long term support options and, where necessary, enforcement measures with known hazardous drinkers

3. To support the pilot of an Early Action Police Liaison Role within the A&E Department at Royal Blackburn Hospital for a 12 month period. This is to provide a safe and integrated police support role within A&E to facilitate early referral into targeted services to improve outcomes for individuals and families and potentially reduce demand.

Contact details

If you require further information of Blackburn with Darwen's Alcohol Strategy, please contact Blackburn with Darwen Borough Council on the contact details below.

Public Health Administration Team

Blackburn with Darwen Borough Council

Specialist Public Health Directorate

6th Floor

10 Duke Street

Blackburn

BB2 1DH

Telephone: 01254 585585

Website: www.blackburn.gov.uk

Email: publichealthadmin@blackburn.gov.uk

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