Wirral JSNA: Alcohol (adults)

Chapter 10: Summary & key issues

- **Costs:** Alcohol was estimated to cost Wirral £127m in 2013 (health, social cost, criminal justice, and lost productivity). Spend on alcohol interventions and services in 2011/12 was £3.3m.
- **Cost–effectiveness:** Economic analysis of current alcohol treatment services in Wirral conducted in 2013, found that they were generally cost-effective, but recommended some additional actions to further increase their cost-effectiveness (such as targeting more men and this has already started to happen in practice).
- **At risk groups:** Evidence suggests there are specific groups of the population at increased risk of alcohol related harm. Examples include; veterans, people with mental health problems, care leavers, those who started drinking before the age of 15, pregnant women, people taking certain medications, certain ethnicities etc…
- **Disability:** In 2011, Wirral had the highest rate of disability benefit claimants for alcoholism in Merseyside (higher than England and North-West average also)
- **Availability:** availability of alcohol in Wirral is highest in the areas of deprivation (where admissions related to alcohol are also highest)
- **Crime:** Alcohol related crime disproportionately affects the most deprived areas of Wirral, with 39% of all alcohol related crime taking place in these areas.
- Crime/Hospital attendances: In 2010/12, half of all attendances for assault at Arrowe Park A&E were alcohol related
- **Hospital admissions:** The rate of alcohol related hospital admissions in Wirral in 2011/12 was lower than the North-West, but 19% higher than England (and higher than Wirral's statistical comparator Sefton). In terms of numbers, there were around 9,200 admissions.
- **Deaths (deprivation):** Deaths (mortality) related to alcohol (both specific and attributable) was higher in Wirral than England, the North-West and Wirral's statistical comparator Sefton (for men and women). Within Wirral, the wards with the highest rates of deaths were the four most deprived wards (Rock Ferry, Birkenhead & Tranmere, Seacombe and Bidston & St. James).
- **Deaths (men):** The death rate from alcohol (alcohol-attributable mortality rate) amongst men in Wirral is still double England average, despite recent reductions (nationally and regionally, death rates from alcohol are falling)
- **Deaths (women):** The death rate from alcohol (alcohol-attributable mortality rate) amongst women in Wirral has risen for each of the last three consecutive years, unlike nationally and regionally where they have fallen. This means that although death rates from alcohol are still higher in men, the gap between men and women is narrowing.
- **Treatment:** Although there have been year on year reductions in the numbers of people in structured treatment in Wirral since 2009/10, the rate of people in structured treatment in Wirral is more than double the England average (5.3 per 1,000 compared to 2.5 per 1,000). Wirral also had higher rates than the other Merseyside authorities in 2012/13
- **Screening:** The proportion of males categorised as dependent drinkers increased substantially from 11.4% to 28.3% (increase of 251%) in 2012/13. The number of females categorised as dependent drinkers also increased (from 4.8% to 14.7%, an increase of 306%). This is likely to be due to better targeting of clients for screening by services, rather than a true increase.
- **Further key messages** follow each section of the report.

What do we know?

Overview

This chapter relates to alcohol use and misuse amongst adults. A separate document will be available shortly (early 2014) which details the issues for Wirral around young people and substance misuse.

Alcohol plays an important role in the economic and social life of the UK, but excessive consumption also creates negative societal costs. There are around 10,000 (mainly male) deaths caused directly by alcohol per year in the UK for example, and in contrast to other significant causes of premature death, mortality from chronic liver disease and cirrhosis has risen in the UK over the last 50 years (University College London [UCL], 2013).

Local modelling work carried out using World Health Organisation (WHO) Burden of Disease methodology estimated alcohol to be the fifth largest cause of death in Wirral (causing 121 deaths per year, of which 63 were alcohol-specific). The same work also found that of all the lifestyle related causes, it was the second largest cause of Years of Life Lost in Wirral (the first being smoking). Alcohol related hospital admissions have been set as a priority area for the Wirral Health & Wellbeing Board and are included in Wirral Councils Corporate Plan 2013/14.

Facts and figures

10.1: Alcohol Attributable Health Costs

The economic cost to Wirral of alcohol in terms of health, social cost, criminal justice, and lost productivity was estimated at £127million per year in 2013. Of this, £25million was healthcare costs. A breakdown of the healthcare costs for Wirral were calculated in 2009/10 (excluding treatment services) and found that the majority (91%) was spent on NHS hospital services, particularly hospital admissions (see full Liverpool John Moores University Alcohol Needs Assessment for Wirral for a full breakdown of the costs).

Spend on alcohol services

Estimated total spend on alcohol interventions for Wirral in 2011/12 was £3.3million. This does not include management or evaluation costs, spend by local authority trading standards teams on policing illegal alcohol sales, local authority licensing team spend, police crime and disorder spend, or CCG spend on preventing admissions. It is important to note that due to the integration of alcohol and drug services in Wirral and the fact that many clients have concomitant drug, alcohol and mental health problems, it can be difficult to disaggregate spend by client group. Hence, the above figure can only be an estimate.

10.2 Consumption, behaviour, key at-risk groups and availability

Measuring alcohol consumption is difficult because people consciously or unconsciously underestimate the amount of alcohol they consume. Many people do not understand alcohol units and do not know how much they are drinking at home where drinks are not in defined measures (Collins, 2013). In addition, the average alcohol content of wine and beer has increased since the 1970s.

Problem consumption of alcohol is often defined in terms of behaviours and consequences such as domestic and public violence, accidents and loss of employment. However, there are comparatively large numbers of individuals who consume hazardous amounts of alcohol, but continue to function at work and home. The information below attempts to quantify the different kinds of drinkers in Wirral, but as there are no definitive sources of information on consumption and behaviour relating to alcohol, a combination of synthetic (or modelled) estimates and social marketing tool produced estimates are generally used.

Local Alcohol Profiles for England (LAPE) and Public Health Observatory (PHO) estimates

Synthetic estimates of alcohol consumption in Wirral come from the annual Local Alcohol Profiles for England (LAPE, 2012). The next available update for Wirral will be available in January 2014 (showing 2013 data). The LAPE profile currently provides estimates of the proportions of:

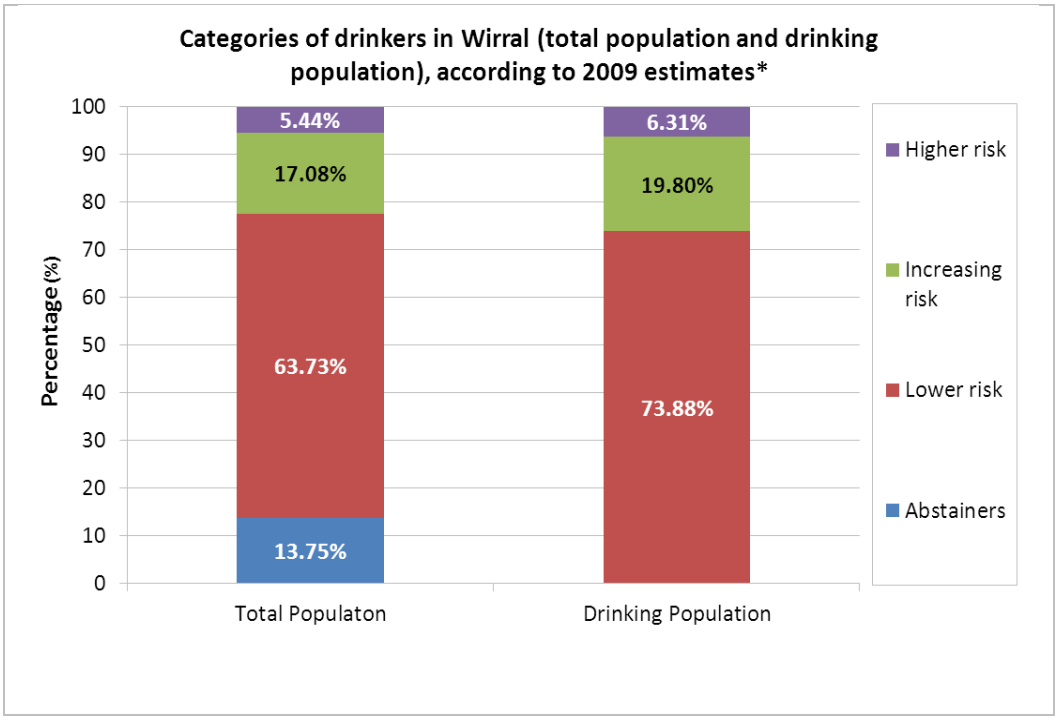
- Non-drinkers (abstainers);
- Lower risk drinkers (previously hazardous drinkers) (women who consume up to 14 units per week; men who consume up to 21 units per week);
- Binge drinkers (women who drink six or more units in one drinking session; men who drink eight or more units in one drinking session; available via the synthetic estimates only);
- Increasing risk drinkers (previously harmful drinkers) (women who drink between 15 and 35 units per week; men who consume between 22 and 50 units per week); and
- Higher risk drinkers (previously dependent drinkers) (women who drink over 35 units per week; men who consume over 50 units per week).

The estimates are developed using statistical models combining national survey and local area level data. The abstention, lower risk, increasing risk and higher risk drinking estimates were developed by North West Public Health Observatory using data from multiple sources including:

- General Lifestyle Survey 2008 and 2009
- Alcohol-specific hospital admissions (HES) 2007/08 to 2009/10, North West Public Health Observatory
- Index of Multiple Deprivation 2010, Department for Communities and Local Government
- Beacon and Dodsworth P2 People and Places classification (People and Places Trees)

Figure 10.2a below shows these estimates both for the total population of Wirral, and also with abstainers removed (i.e. only the drinking population).

Figure 10.2a: Categories of drinkers in Wirral, according to 2009 synthetic estimates

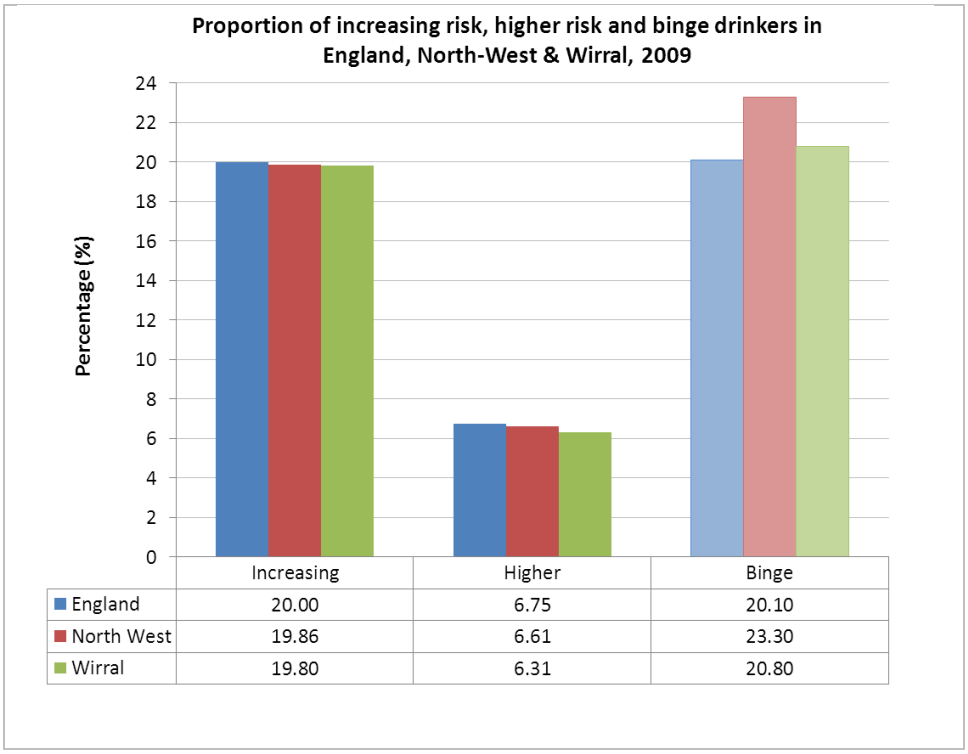


As Figure 10.2a shows, a large majority of the Wirral population (aged 16+) are estimated to be either lower risk drinkers or abstainers (77%). Increasing and higher risk drinkers make up around 23% of the population. Binge drinking estimates are also available, but they are made up of both increasing and higher risk drinkers and so are shown in a different chart below.

Source: Local Alcohol Profiles for England (LAPE), 2012
*most recent year for which estimates are available

Binge drinking estimates were developed by the National Centre for Social Research and East Midlands Public Health Observatory. How Wirral compares to England and the North-West for at risk drinkers (including binge drinkers) is shown in the chart below.

Figure 10.2b: Synthetic estimates of alcohol consumption (amongst those aged 16+) in mid-2009



	Increasing	Higher	Binge
England	20.00	6.75	20.10
North West	19.86	6.61	23.30
Wirral	19.80	6.31	20.80

Figure 10.2b shows that just over one in five Wirral residents (aged 16+) were estimated to be binge drinkers. This was lower than the North West, but slightly higher than England. The number of Wirral residents estimated to be increasing risk drinkers was also almost one in five of the local population. Just over 6% were estimated to be higher risk drinkers. According to these estimates, Wirral appears to have slightly lower proportions of the population in these two categories compared to both the North West and England averages.

Source: Local Alcohol Profiles for England (LAPE), 2012

Applying these percentages to the *total* Wirral population* aged 16+, would give figures of:

- 53,175 increasing risk drinkers
- 16,950 higher risk drinkers

*Census 2011 figures (total population 268,560)

This makes a total of **70,125** increasing risk and higher risk drinkers (aged 16+) in Wirral overall

It should be noted that binge drinkers are defined as coming from within both the Increasing and Higher risk drinking population. **They are not a separate group of drinkers and their numbers should not be added to the Increasing and Higher risk drinking population**. Estimates suggest there are:

- 55,860 binge drinkers in Wirral

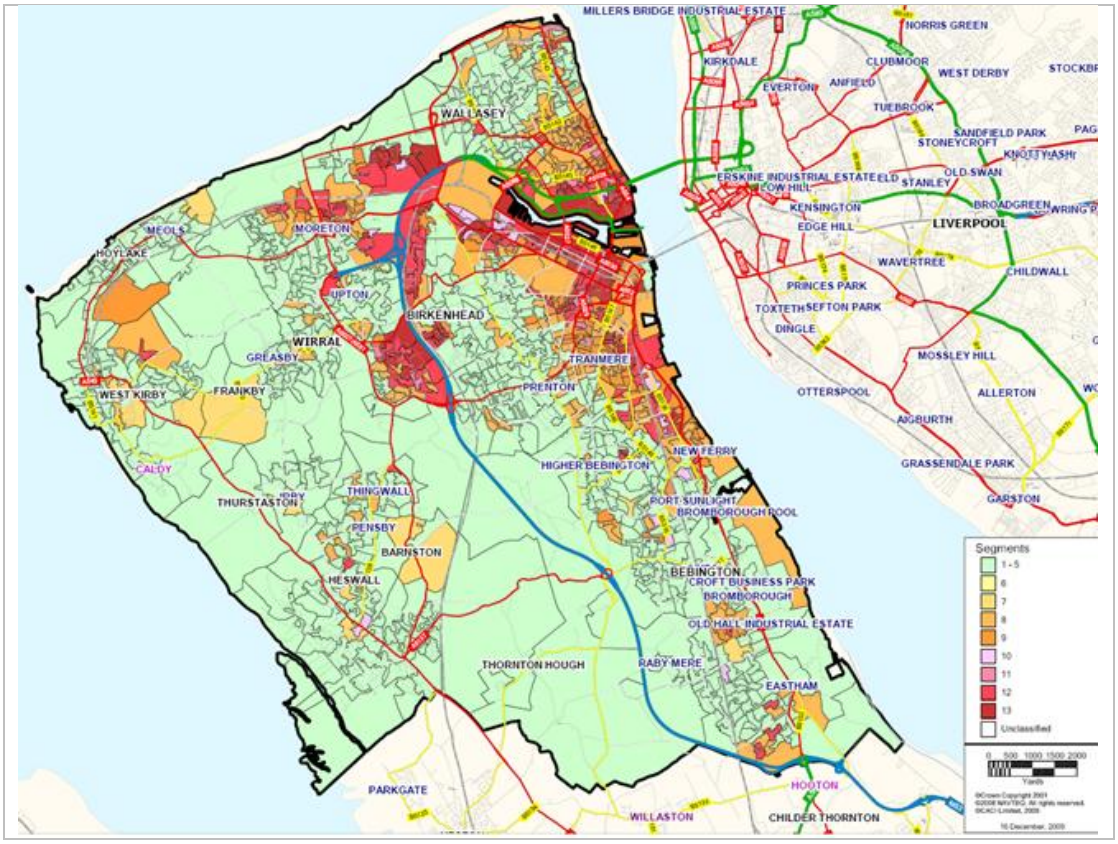
Public Health England (PHE) Alcohol tool estimates

The information below comes from the Public Health England Alcohol social marketing tool. This PHE tool splits the population into thirteen segments in terms of their drinking behaviour. Public Health England PHE) recommends the primary segments to focus on are 10, 12 and 13 (secondary target segments are 8 and 9; all of the others are not targets for intervention).

- The tool estimates that there are **44,237** people in Wirral in primary target segments 10, 12 and 13.
- The tool estimates that there are **79,688** people in Wirral in secondary segments 8 and 9.
- This makes a total of **123,925** at risk drinkers in Wirral

The tool gives brief descriptions of each of the segments, and where (geographically) they are likely to live in concentrated numbers in Wirral. See the Map 10.2 below.

Map 10.2: Location of at-risk drinkers in Wirral according to the PHE alcohol social marketing tool



As the map shows, the primary target segments in Wirral appear to (broadly) correspond with the areas of deprivation. Brief descriptions for the three primary targets for intervention are shown below.

Segment 10 includes high numbers of pensioners, who are generally in poor health with conditions that include asthma, angina and heart problems. They have high acute hospital admissions. They often live alone and in local authority flats. As well as drinking beer and spirits, they are likely to smoke.	**Segment 12** includes people with a broad range of ages, who are likely to live in terraces, often in former industrial areas. They generally have the worst levels of overall health, with asthma, cholesterol and heart conditions as well as high acute hospital admissions. They are likely to smoke and drink beer and lager, at home and in pubs.	**Segment 13** includes young people in their 20s who have a very high rate of acute admissions. They are likely to live alone in local authority flats or hostels, be unemployed and some are single parents. They are likely to drink large amounts of both beer and spirits and to smoke.

PHE maintain that the segmentation tool is designed for alcohol related social marketing and can assist in; defining priority audiences; targeting communications campaigns to postcode level and using the most appropriate and cost effective media channels and messages. They state that it has **not** been designed to guide policy planning or commissioning of services because it has been configured according to the priorities set out in the social marketing programme (e.g responsiveness to direct marketing communications, media etc.) and therefore it should only be used in conjunction with commissioning activity focussed on social marketing. The segments were produced using data from Health ACORN, 2006/07 alcohol attributable hospital admissions data from North West Public Health Observatory (NWPHO) and 2009 TGI (Target Group Index) data.

Key at-risk groups (according to wider literature)

In their guidance on the prevention of harmful drinking, National Institute for Health & Clinical Excellence (NICE) state that both population-wide and individual interventions are needed to reduce alcohol-related harm, benefit society and help reduce health inequalities (alcohol-related problems have a disproportionate effect on disadvantaged groups).

Population-level approaches are important as they can help reduce the aggregate level of alcohol consumed - therefore lowering the whole population's risk of alcohol-related harm - plus reach those

not in regular contact with relevant services. They can also help reduce the number of people who start drinking harmful or hazardous amounts in the first place.

In addition, they may help those who have been specifically advised to reduce their alcohol intake by creating an environment that supports lower risk drinking. NICE acknowledge that some people drink alcohol as a result of underlying problems and that these need to be addressed along with any alcohol-related issues. They recommend therefore that at the individual level, prevention and screening activity should focus on key groups who may be at an increased risk of alcohol-related harm as described below.

Key groups at risk of misusing alcohol or those for whom alcohol misuse could result in increased levels of harm

Specific groups of young people who:

- Are looked after (or have left care), involved with child safeguarding agencies [NICE, 2010]
- Who truant on a regular basis [NICE, 2010]
- Are involved in crime and anti-social behaviour [NICE, 2010]
- People who started drinking before age 15 (significantly more likely to go on to misuse alcohol) [NICE, 2010]
- Have a history of family violence, depression, stressful life events or family history of alcohol issues [NICE, 2010]

Regular attenders at health services

A history of presenting at health services for accidents or minor injuries, or for sexual health issues (e.g at genito-urinary medicine (GUM) for emergency contraception) is often indicative of alcohol misuse [NICE, 2010].

People living in deprivation

Those living in the most deprived 20% of areas in England (which equates to 32% of the Wirral population), are up to three times more likely to die of causes influenced, in part, by alcohol. They are also up to five times more likely to die of an alcohol-*specific* cause and up to five times more likely to be admitted to hospital because of an alcohol-use disorder [NICE, 2010].

Veterans

People who served in the forces are more than twice as likely to go on and develop an alcohol problem. Nationally, ONS report that 13% of veterans are likely to be higher risk drinkers, compared to 6% of the general population.

Certain ethnicities

People of Irish, Polish and certain other Eastern European backgrounds have been identified as being at higher risk than the general population of developing alcohol problems [Joseph Rowntree Foundation, 2010].

People with mental health problems or behavioural disorders

Depressed or anxious people are at high risk for alcohol misuse and likewise, a large proportion of alcohol-dependent people suffer from an accompanying mental health problem (depression being the most common) [Royal College of Psychiatrists, 2010]. Alcohol also interferes with sedative medications (see People taking certain medications below). Studies indicate that alcohol misuse is related to impulsive, excitable, and novelty-seeking behaviour. Specifically, children with attention deficit hyperactivity disorder (ADHD) have a higher risk for alcohol misuse in adulthood. In adolescence, conduct disorders are associated with a four-fold greater risk of drinking alcohol at least twice a week [Royal College of Psychiatrists, 2010].

Pregnant women

Drinking more than two units of alcohol on more than two occasions a week (that is, above the recommended amount), results in an increased risk of: miscarriage, stillbirth, poor growth and development in the womb, prematurity (the baby being born too early), the baby being born too small, the baby being affected with a physical disability after birth, the baby having learning difficulties and the baby being susceptible to illness later in adult life (Royal College of Obstetricians & Gynaecologists

Factsheet, 2011). For more information on Foetal Alcohol Spectrum Disorder (FASD), see page 16 of this report.

People with specific physical conditions
Relevant physical conditions include hypertension and gastro-intestinal or liver disorders [NICE, 2010]. See point below about medications/ long term conditions also.

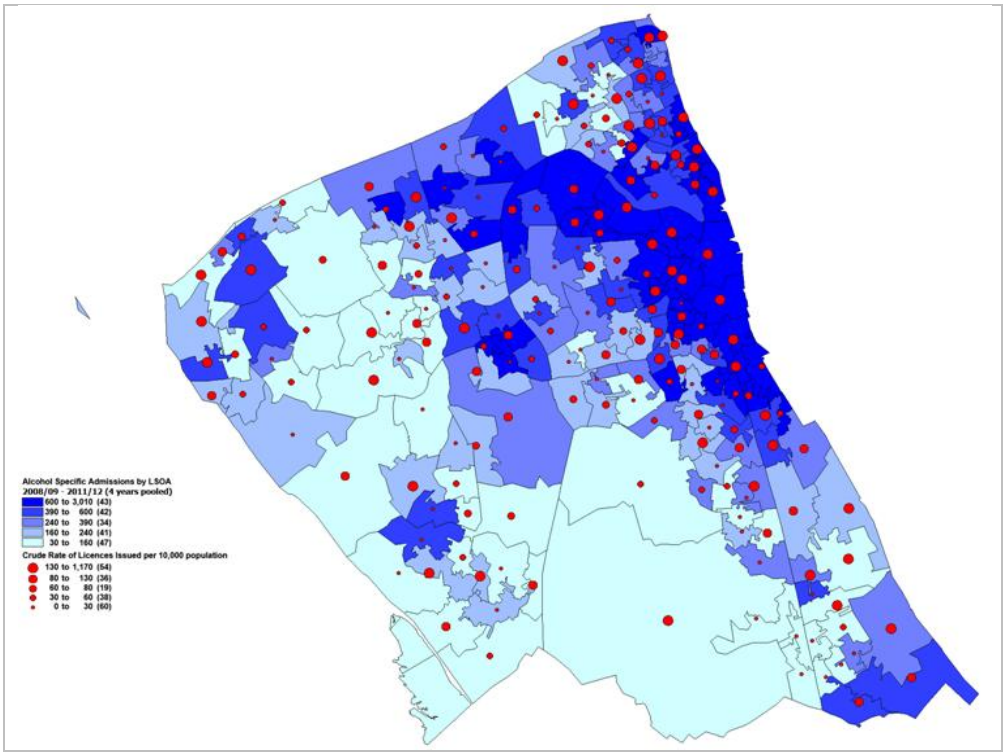
People taking certain medications
Alcohol can reduce the effect of medications and increase harmful side-effects. For example, people taking sedative drugs (like diazepam/Valium) or antidepressants (like fluoxetine/Prozac) should avoid alcohol altogether. People taking other long-term medications should also be aware that alcohol can make some drugs less effective, meaning long term conditions get worse. Examples include drugs for epilepsy or diabetes, or drugs like warfarin which thin the blood (Drinkaware, 2013)

10.3 Availability and pricing

Availability

There is a growing body of evidence to suggest that when the availability of alcohol is increased, significant negative alcohol-related outcomes result (Gruenewald, 2007; Livingston et al., 2007; Livingston, 2011a). In 2011/12, Wirral had 858 active alcohol licenses. This translates as a rate of 27.8 licenses per 10,000 population, an increase of 4.5% over the four years since 2008/09. Off-licenses accounted for 30.7% of overall licenses, on-licenses accounted for 56.5% and other licenses 12.8%. Wirral has also seen a shift in the *type* of alcohol licensed premises, with the biggest increase in supermarkets selling alcohol (up 13.6% since 2008/09).

Map 10.3: Alcohol specific hospital admissions by Wirral LSOA (Lower Super Output Area), 2008/09 to 2011/12, (4 years pooled), with rate of licences issued (per 10,000 population) overlaid

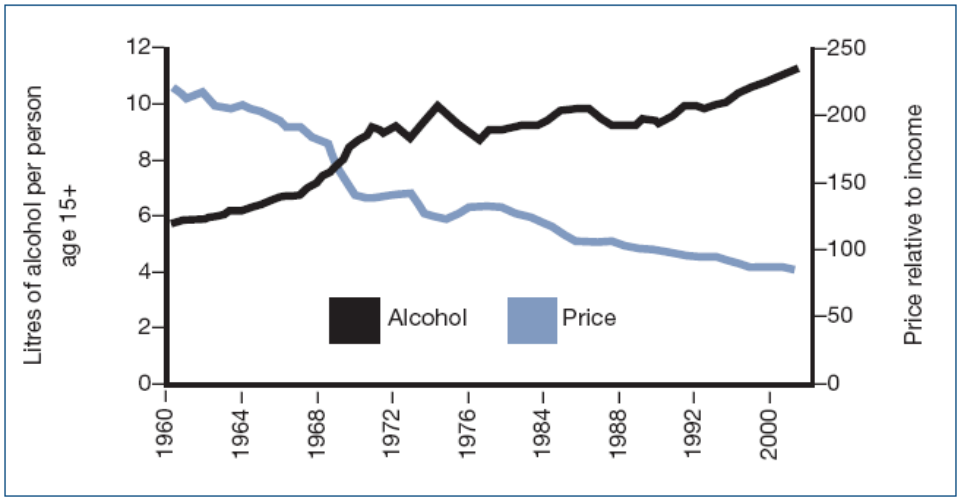


As Map 10.3 shows, not only are alcohol specific hospital admissions higher in the more deprived areas of Wirral, there are also more licences premises per head of the population in these areas. There is one red dot per LSOA and the larger the red dot, the higher the number of licences issued in that LSOA. The areas of Birkenhead, Tranmere, Rock Ferry, Seacombe and Liscard appear to have the greatest concentration of licenced premises.

Source: Murray, B, 2013

Alcohol consumption increased steadily during the last century (the exception being a sharp decline during the First World War when taxation increased dramatically) and good evidence points to recent upward trends being driven not only by availability, but also by affordability (or price). Evidence shows that increases in cost impact most on those who drink most (UCL, 2013).

Figure 10.3a: Relationship between price and alcohol consumption in the UK, 1960-2002



As the chart shows, the relative cost of alcohol has fallen dramatically since 1960, whilst consumption has increased just as dramatically. Both international and historical evidence from the UK supports a link between price and consumption. Evidence also suggests that a minimum unit price of 50p would reduce total alcohol consumption by 6.7% in the UK (UCL, 2013).

Source, University College London School of Pharmacy, 2013

Consumption, behaviour, key at-risk groups and availability key messages

- **One in four Wirral residents is estimated to be either an increasing or higher risk drinkers (around 70,000 people)**
- **Alcohol was estimated to cost Wirral £127m in 2013 (health, social cost, criminal justice, and lost productivity). Spend on alcohol interventions in 2011/12 was £3.3m.**
- **Target populations for intervention (according to social marketing tools) are primarily areas of deprivation in Wirral**
- **Availability of alcohol in Wirral is highest in the areas of deprivation (where admissions related to alcohol are also highest)**
- **Evidence suggests there are specific groups of the population at increased risk of alcohol related harm. Examples include; veterans, people with mental health problems, care leavers, those who started drinking before the age of 15, pregnant women, people taking certain medications, certain ethnicities etc…**

10.4 Wider social impacts (crime, homelessness, employment)

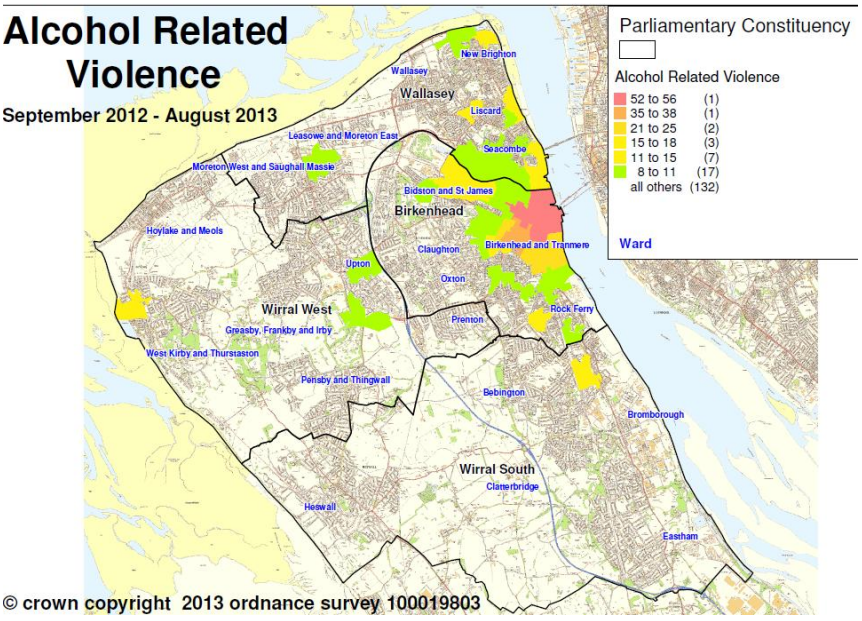
Alcohol related-crime

Data in this section are from the 2012 Local Alcohol Profiles for England (LAPE), local police incident data, and the Probation Service. Where possible, data is provided by area (where the incident took place) and over time to allow trend analysis. However, because some data on alcohol-related crime relate to the offence rather than the offender, details on the residence, gender or age of offenders are not always available. It is also important to note that recorded crime does not represent all crime, only those reported to the authorities (e.g rape is one of the most under-reported crimes). Other factors which may affect crime recording are changes to; policing policy; and reporting and recording mechanisms.

In 2012/13 alcohol was deemed a causal factor in 11% per cent of all crime in Wirral (1,655 out of a total of 14,410 crimes in Wirral). This is a rate of 5.2 alcohol fuelled crimes per 1,000 population. The offence groups which stand out as being particularly linked to alcohol are criminal damage and violence (Wirral Council Community Safety Team, 2013).

Areas of deprivation see a disproportionately high amount of crime, with 39% of alcohol related crime, taking place in the most severely deprived areas of Wirral in 2012/13. This is an area which only comprises 11% of the population, but a contributory factor is the Night Time Economy, which is both centred in Birkenhead & Tranmere ward and attracts visitors from across Wirral. See Map x below.

Map 10.4: Alcohol related violence in Wirral, 2012/13



The map below shows clustering of alcohol related violent crimes recorded in 2012/13. The main hotspot is in the Birkenhead and Tranmere Ward centred in the Birkenhead 'Night Time Economy' area, mirroring last year's figures (for violence with or without injury). There were 35 alcohol related violent crimes, 57 % of offences took place on Argyle Street and 57% were committed by strangers. The most prevalent days and time periods were: Tuesday, Saturday and Sunday between 00:00 and 03:59. Secondary warm spots include Bidston and St James, Seacombe, Liscard, New Brighton, Rock Ferry and West Kirby.

Source: Wirral Council Community Safety Team, 2013

The polarisation of crime in Wirral is shown by the disproportionately high crime rates in the east of the Borough compared to Wirral overall during 2013. The rate of alcohol fuelled crime for the six wards with rates above the Wirral average in 2013 are shown in the table below.

Table 10.4a: Rate of alcohol related crime by Wirral ward, 2013

Ward	Alcohol Related Crime (Rate Per 1,000)
Bromborough	4.91
New Brighton	5.79
Liscard	6.55
Seacombe	8.23
Rock Ferry	8.24
Bidston and St James	11.46
Birkenhead and Tranmere	21.18
Wirral	**4.85**

Source: Wirral Council Community Safety Team, 2013

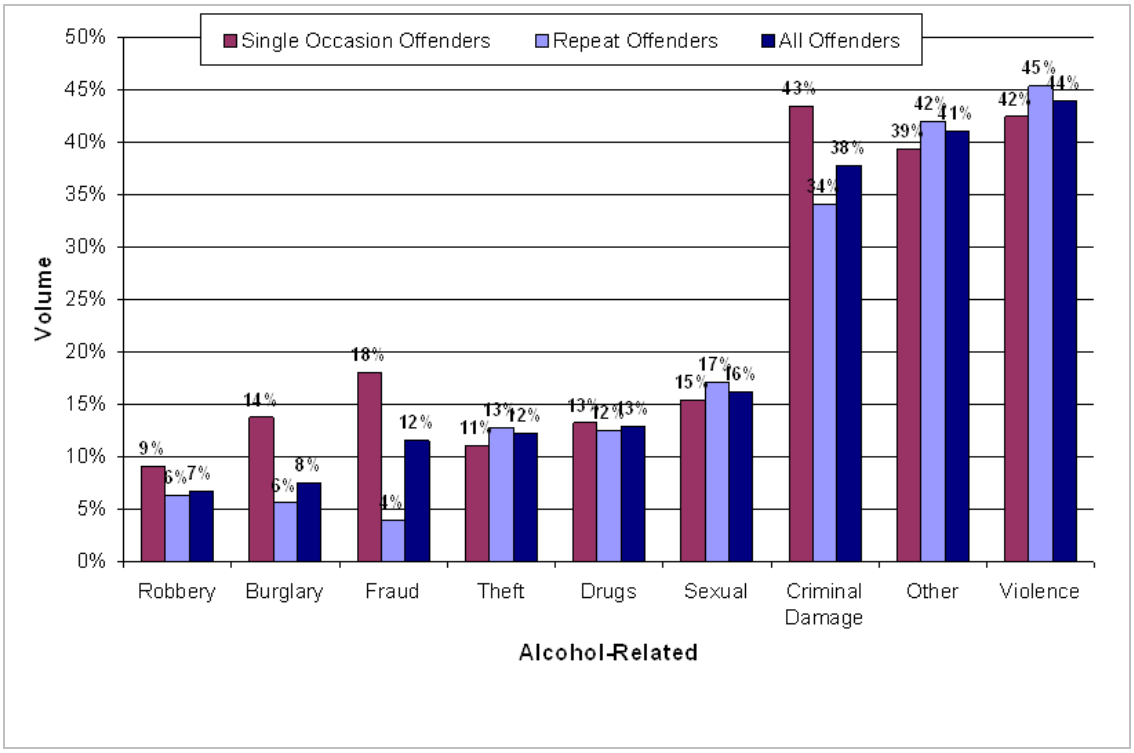
As the table shows, the wards with the highest rates of alcohol-related crime were - broadly speaking - the more deprived wards in Wirral (with the exception of Bromborough and New Brighton).

A recent briefing by the Trauma, Injury Intelligence Group detailing alcohol related assaults who had presented to Arrowe Park A&E in Wirral for the period February 2013 to August 2013 is also available here. A summary of some of the findings are:

- Half (46%) of all assaults were related to alcohol (patient had consumed alcohol in the 3 hours prior to the incident)
- Two out of three (68%) of victims of alcohol-related assault had informed Merseyside Police
- Most common location for the assault was Birkenhead town Centre (35%), peak time was midnight, and peak days were, unsurprisingly, Sunday and Saturday.

Alcohol-Related offences by offence group and type of offender

Figure 10.4b: Percentage of alcohol related offences by age group and gender, Wirral, 2012/13



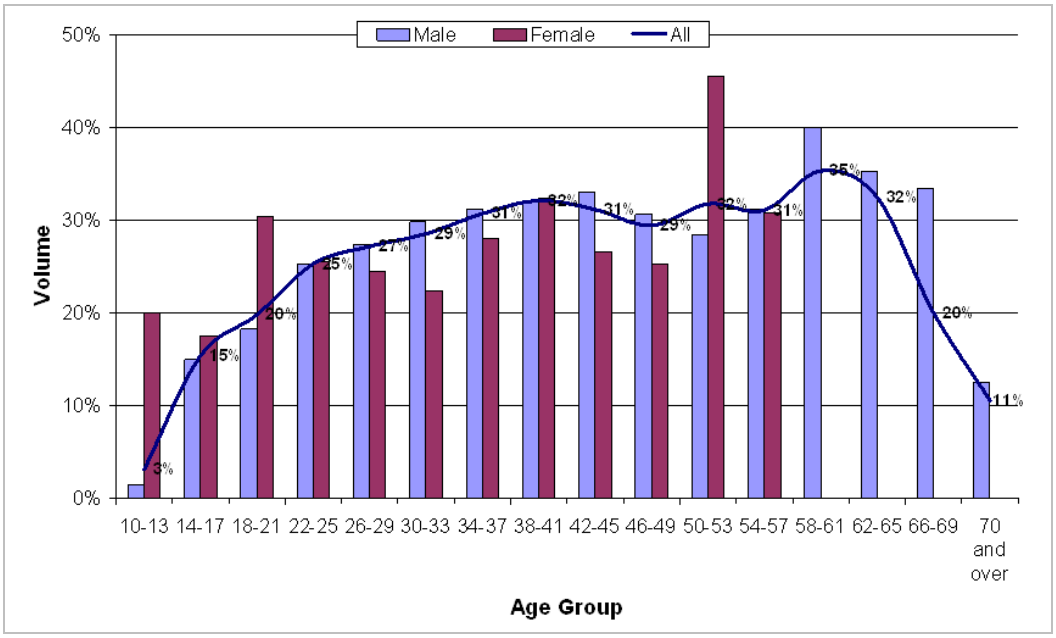
Three offence groups stand out as being particularly linked to alcohol; criminal damage, violence and other offences. Violence appears to be most likely offence to be committed by repeat offenders (45%). Criminal damage appears to be most likely to be committed by single occasion offenders (43%).

Source: Wirral Council Community Safety Team, 2013

Alcohol-Related Offences by Age Group and Gender

The chart below shows what percentage of all crimes committed in Wirral in 2012/13 by males and females in the age bands shown, were alcohol related.

Figure 10.4c: Percentage of alcohol related offences by age group and gender, Wirral, 2012/13



The teens and early 50's appears to be the peak ages for women to commit alcohol related offences. For men, there is less fluctuation, but late 50's appears to be a peak. Note that these are percentages which may disguise low figures. For example, in the case of 20% of offences in 10-13 year old girls, this equates to just 3 offences.

Source: Wirral Council Community Safety Team, 2013

Anti-Social Behaviour (ASB) involving alcohol

In 2012/13, 15% of all ASB incidents in Wirral were alcohol related. A high proportion of these were distributed in and around Birkenhead (the major Night Time Economy area in Wirral). There were also a high number of alcohol related ASB incidents in the Liscard area. Within these hotspots, there are four parks and open spaces; Birkenhead Park, Mersey Park, Victoria Park and Central Park.

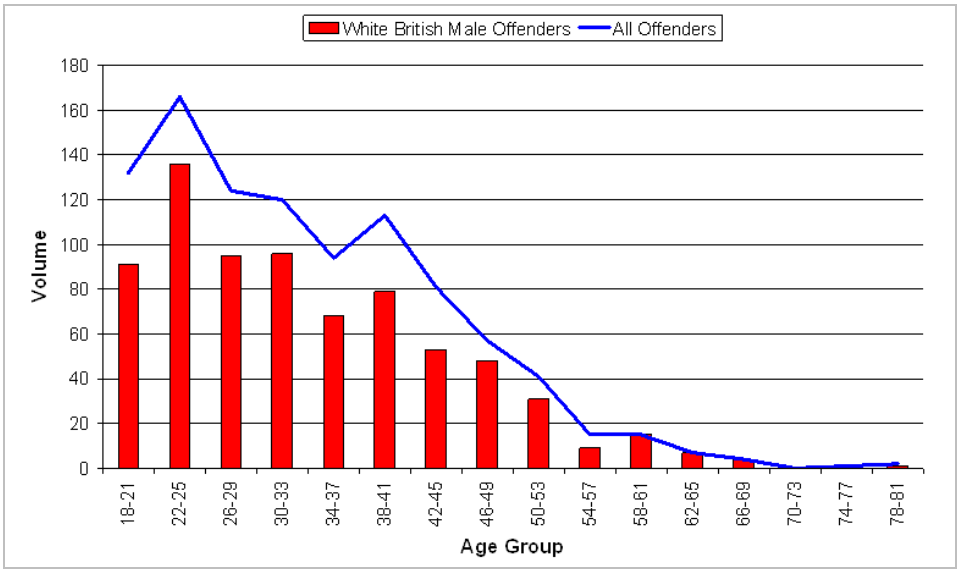
In 2012/13, 39% of *all* reported ASB incidents were reported as involving people aged under 18 year olds, and of these, 6% involved alcohol. This means that in total, 2% of all ASB incidents in Wirral involved both youths *and* alcohol. The hotspots for youth and alcohol related ASB incidents were: Woodhey near New Ferry/Rock Ferry. Other areas included Liscard/Egremont, Birkenhead/ Tranmere, Upton/Woodchurch, Noctorum/Oxton and West Kirby.

Between 2008 and 2010, there were five alcohol-related Section 30 dispersal orders for ASB in Wirral. In three cases, the reasons given for the order were 'youths causing annoyance and under-age drinking'.

Violence offences involving alcohol

The proportion of violent crime where alcohol was a causal factor in 2012/13 was 34%, a small decrease compared to the previous year (36% in 2011/12). Below are some key facts on alcohol related violence perpetrated by adults in Wirral.

Figure 10.4d: Profile of offenders committing alcohol related violence in Wirral, 2012/13



- 75% were White British males
- The peak age was 22-25 (14%)
- 67% knew their victim, (this is 4% less than in the previous year)
- 34% were involved in alcohol related domestic violence
- 12% were using drugs and alcohol when the offence was committed
- 10% of offences took place on licensed premises

Source: Wirral Council Community Safety Team, 2013

Domestic violence involving alcohol

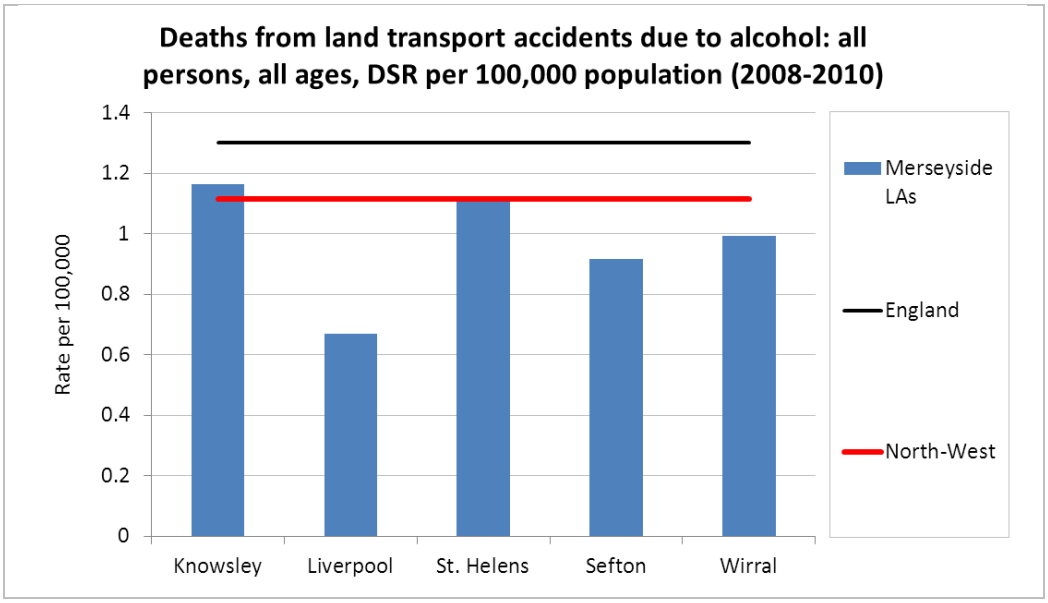
During 2010/11 and 2011/12, of the 2,038 domestic violence cases referred to Wirral Family Safety Unit, one in six were alcohol related (17.3%). The rate of alcohol-related domestic violence crimes in Wirral during 2010/11 was 1.1 per 1,000 population; a rise of 36% on 2008/09, but a reduction of 15% on 2009/10. In 2010/11, alcohol-related domestic violence made up 2.2% of all crime (compared to 2.5% on 2009/10) and 12% of all violent crime in (compared to 13% in 2009/10).

Sexual violence involving alcohol

The number of incidents of sexual violence involving alcohol Wirral in 2012/13 was 36. This equates to a rate which is below that of England, the North-West and Sefton (statistical comparator for Wirral). This indicator has seen a steep rise in Wirral in recent years however, see the 'Trends' section for more information.

Road traffic incidents involving alcohol

Figure 10.4e: Deaths from alcohol-related land transport accidents: rate per 100,000, 2008-10

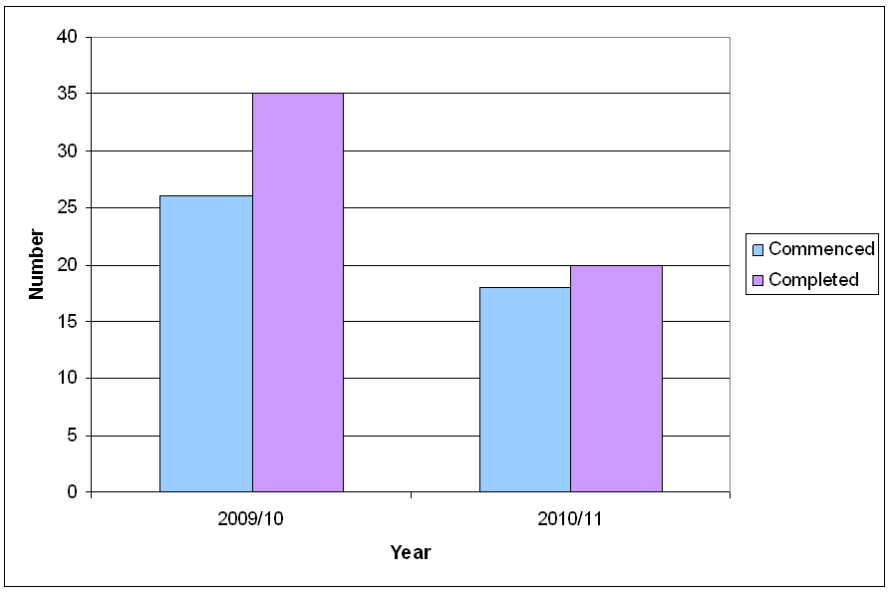


As Figure 10.x shows, Wirral was below both the North-West and England for land transport accidents involving alcohol in 2008/10. Rates were slightly higher than Sefton, our statistical near neighbour, but not significantly. In actual numbers, there were 11 deaths from land transport accidents due to alcohol in Wirral in 2008/10.

Source: Local Alcohol Profiles for England (LAPE), 2012

Drink Driving

Figure 10.4f: Drink Impaired Drivers programme 2009/10 to 2010/11: Commencement and completion



In Wirral during 2010/11, 18 people were sentenced to and commenced the Drink Impaired Drivers (DID) programme; 20 people completed. This was slightly lower than in the previous year. Due to the course being a 14 week rolling programme commencements and completions are not comparable, as courses run over two consecutive financial years someone may commence in one year and complete in another.

Source: Merseyside Police, 2011

Accidents

Of the 815 fires that occurred in Wirral between 2008/09 to 2010/11, the person(s) involved were judged to be under the influence of either drugs or alcohol in 30 (3.7%) cases. The majority of these fires were accidental (n=28), two were recorded as 'deliberate'. Between 2008/09 and 2010/11, there were two fatalities in Wirral for which alcohol was recorded as a contributory factor.

Housing & homelessness

There is some evidence of a link between alcohol and homelessness, although the causal relationship is not clear. For example, dependence can lead to homelessness or exacerbate existing problems, but conversely alcohol misuse may develop as a result of being homeless (Cabinet Office, 2004). Across

the 22 different housing providers in Wirral, 324 clients in supported housing were referred to specialist alcohol services during 2010/11.

In 2010-11, 200 housing advice cases were opened in which alcohol, drugs or a combination of both were indicated as issues. Just over a quarter (n=53) were prevented from becoming homeless (Table 10.g). The number of cases opened saw a one and a half fold increase from 2008-09, but fell by 15%, from 2009-10.

Table 10.4g: Housing advice cases opened and those prevented from homelessness 2008/09 to 2010/11

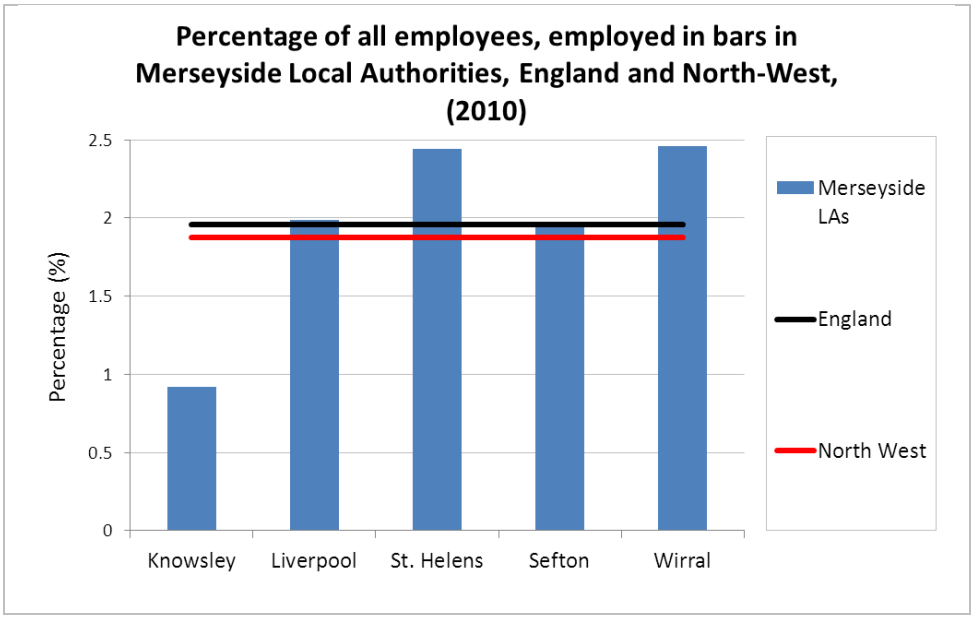
	2008/09		2009/10		2010/11	
	Cases Opened	**Homele'sns Prevented**	**Cases Opened**	**Homele'sns Prevented**	**Cases Opened**	**Homele'sns Prevented**
Alcohol Use	35	7	53	22	46	17
Drug Misuse	23	6	44	20	39	9
Drug & alcohol	9	*	12	8	13	*
Mental Health Drug & Alcohol	5	*	*	*	5	*
Mental Health & Alcohol	13	*	9	*	16	6
Mental Health & Drugs	12	6	13	6	14	*
Offending history	24	7	65	263	46	10
Offending history & alcohol	*	*	13	7	6	*
Offending history & drugs	*	*	16	9	11	*
Offending history, drugs & alcohol	*	*	7	5	*	*
Total	**125**	**31**	**234**	**104**	**200**	**53**

Source: Wirral Housing Options Team, 2011
*numbers less than 5 suppressed for reasons of confidentiality

Employment

Whilst the Night-Time Economy provides jobs and contributes to the local economy, the flip side of this is that alcohol misuse can affect the ability of individuals to work. Workers who misuse alcohol for example are more likely to have a higher rate of sickness absence and national figures show that unemployed people have higher levels of alcohol consumption compared to the general population. Overall, there are a greater proportion of dependent drinkers within this group (Source: Institute of Alcohol Studies, 2009). See charts below for more details.

Figure 10.4h: Percentage of all employees employed in bars in Merseyside local authorities, England and North-West, 2010

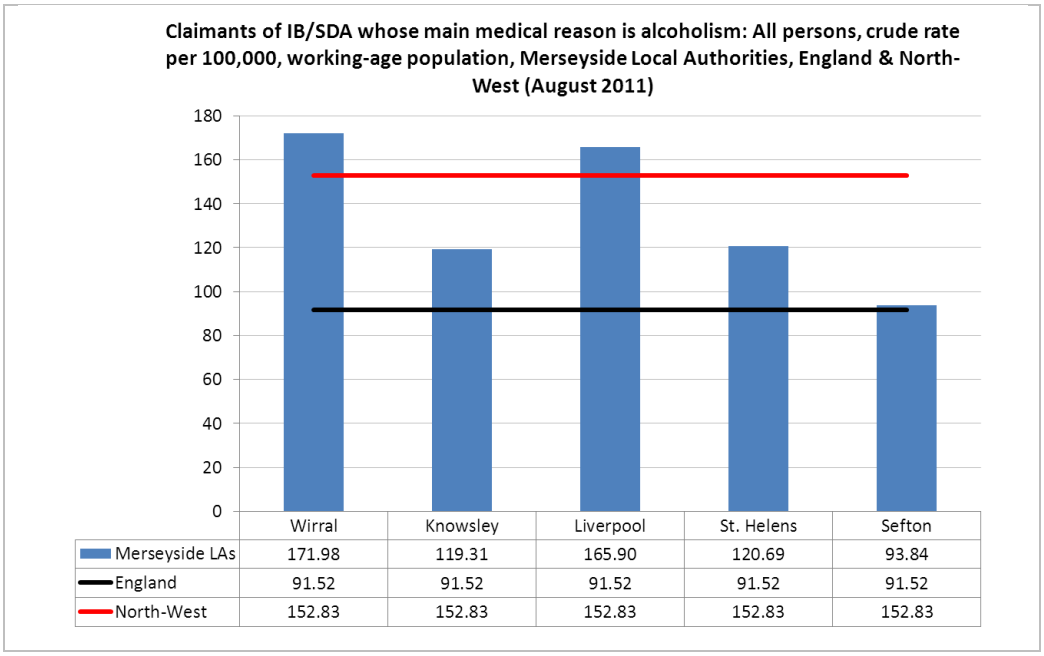


In actual numbers, there were around 2,400 employees working in bars in Wirral in 2010. As a percentage of the working age population, Wirral had a higher proportion of people working in bars than both the North-West, England and our statistical near neighbour, Sefton. Wirral had the highest percentage of people employed in bars of all the Merseyside authorities in 2010 (2.45%). Reasons for this are unclear.

Source: Local Alcohol Profiles for England (LAPE), 2012

Worklessness

Figure 10.4i: Rate of claimants of disability benefits, where main reason was alcoholism, Merseyside local authorities, North-West & England, 2011



	Wirral	Knowsley	Liverpool	St. Helens	Sefton
Merseyside LAs	171.98	119.31	165.90	120.69	93.84
England	91.52	91.52	91.52	91.52	91.52
North-West	152.83	152.83	152.83	152.83	152.83

In 2011, Wirral had the highest rate of disability benefit claimants for alcoholism in Merseyside. All of the authorities in the county were above the England average, but only Wirral and Liverpool were also above the regional average. Wirral had almost twice the rate of statistical near neighbour Sefton,

Source: Local Alcohol Profiles for England (LAPE), 2012

Key Messages: Wider social impacts

- **Alcohol was a causal factor in over 1 in 10 of all crime committed in Wirral in 2012/13 (1,655 out of a total of 14,410 crimes or 11%)**
- **The rate of alcohol related crime was four times higher in Birkenhead & Tranmere in 2012/13 than in Wirral overall**
- **39% of alcohol related crime took place in the deprived areas of Wirral**
- **The offences which stood out as being particularly linked to alcohol in 2012/13 were violence and criminal damage and the most typical offender profile was a young, white male who knew their victim**
- **One in three alcohol-related violence incidents were domestic violence (34%)**
- **One in seven Anti-Social Behaviour (ASB) incidents were alcohol related (15%)**
- **Wirral had a higher percentage of its population employed in bars in 2011 (2.45% or 2,400 people) than Merseyside, the North-West and England**
- **In 2011, Wirral had the highest rate of disability benefit claimants for alcoholism in Merseyside (higher than England and North-West average also)**
- **In 2010/11, 200 housing advice cases were opened for clients with alcohol and/or drug issues. A quarter were prevented from becoming homeless**
- **Estimated spend on alcohol interventions (including treatment services) for Wirral in 2011/12 was £3.3million**
- **The economic cost to Wirral of alcohol (health, social, criminal justice and lost productivity) was estimated to be £127million in 2013. Of this, £25million was healthcare**

10.5 Morbidity

Hospital Admissions

Admissions related to alcohol are a good barometer for alcohol problems in general. Alcohol-related admissions data is based on methodology developed by the North West Public Health Observatory (NWPHO) and estimates the proportion of diseases, injuries and conditions which are attributable to alcohol consumption.

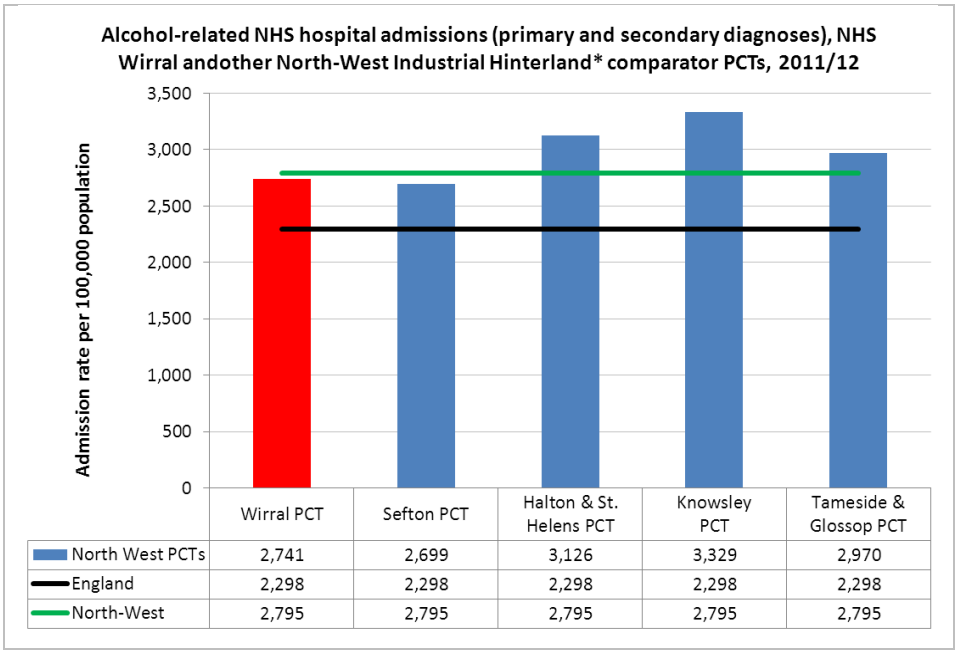
Alcohol related hospital admissions have two components:

1. Admissions classified as being ***wholly*** attributable to alcohol
2. Admissions classified as being ***partially*** attributable to alcohol

See glossary for more detailed definitions of these terms, but in summary; wholly attributable admissions are where the reason for admission is a condition which is caused specifically by alcohol consumption; partially attributable admissions are where the reason for admission is a condition where some, but not all cases result from alcohol consumption.

Data for alcohol related hospital admissions (and its two components) are shown in the charts below. Wirral is shown with the other Office for National Statistics (ONS) Industrial Hinterland* comparators in the North-West region, plus England and the North-West overall.

Figure 10.5a: Alcohol related NHS hospital admission rate in England, the North-West, NHS Wirral and other North West Industrial Hinterlands* comparator PCTs, 2011/12



	Wirral PCT	Sefton PCT	Halton & St. Helens PCT	Knowsley PCT	Tameside & Glossop PCT
North West PCTs	2,741	2,699	3,126	3,329	2,970
England	2,298	2,298	2,298	2,298	2,298
North-West	2,795	2,795	2,795	2,795	2,795

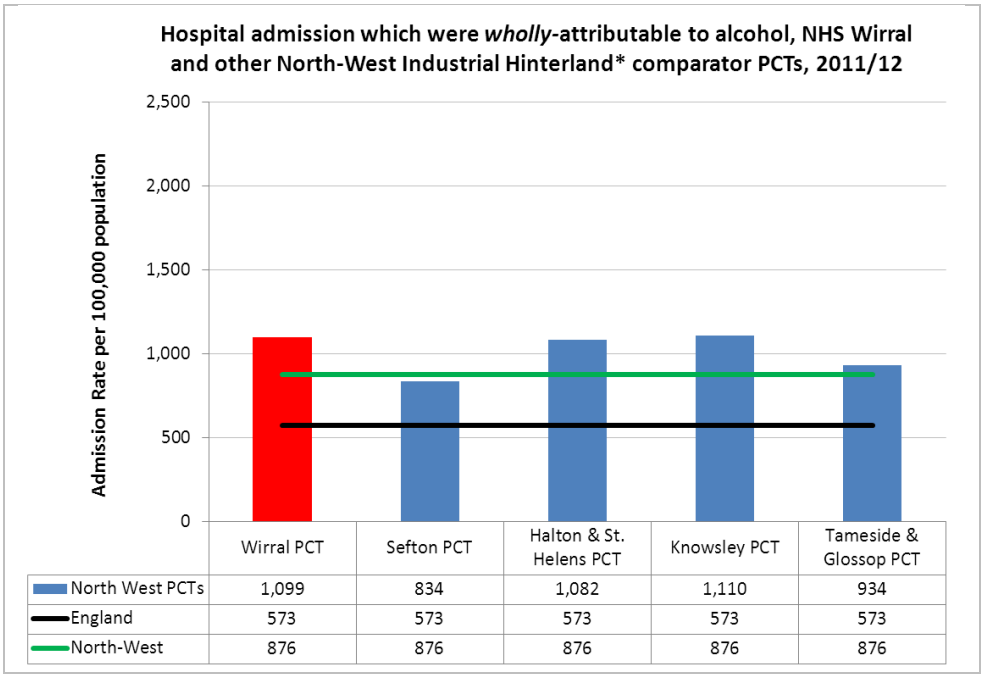
The chart shows that the rate of all alcohol related hospital admissions in Wirral in 2011/12 was slightly lower than the North-West overall, but higher than England (by 19%). Of the four Industrial Hinterland* comparators in the North-West region, only Sefton had lower rates than Wirral. The other 3 PCTs were all higher (and higher than the North-West average also). The actual number of admissions in Wirral (which gives the rate of 2,741 per 100,000 population) was approximately 9,200 (ONS figures rounded to nearest 100).

Source: ONS, 2013

***Note:** the Industrial Hinterlands Group is one of seven groups devised by the Office of National Statistics to classify areas using indicators from the Census such as employment and housing. The groupings enable more relevant comparisons to be made between demographically similar areas. Only those North-West PCTs classified as Industrial Hinterlands have been used here as comparators.

The two charts below shows the two components which make up alcohol related admissions **A) wholly attributable admissions** and **B) Partially attributable admissions**, and describes how Wirral compares to England, the North-West and other Industrial Hinterlands comparators in the North West on both of these components of alcohol related admissions.

Figure 10.5b: Hospital admissions which were *wholly* attributable to alcohol **(A)** in England, the North-West, NHS Wirral and other North West Industrial Hinterlands comparator PCTs, 2011/12



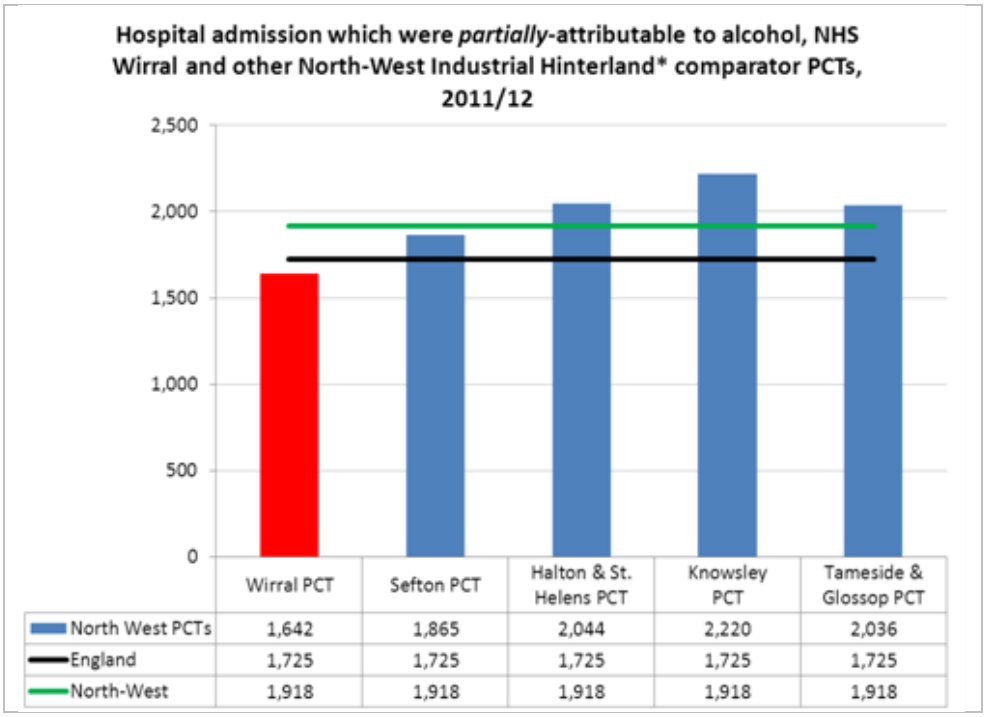
	Wirral PCT	Sefton PCT	Halton & St. Helens PCT	Knowsley PCT	Tameside & Glossop PCT
North West PCTs	1,099	834	1,082	1,110	934
England	573	573	573	573	573
North-West	876	876	876	876	876

As charts 10.5b shows, the rate of hospital admissions which were wholly related to alcohol were higher in Wirral than both England and the North-West overall in 2011/12. They were also considerably higher than all of our other North West Industrial Hinterland comparators, except for Knowsley PCT. In actual numbers, there were 3,500 admissions to Hospital which were wholly attributable to alcohol in Wirral in 2011/12 (figures rounded to nearest 100 by ONS).

Source: ONS, 2013

***Note:** the Industrial Hinterlands Group is one of seven groups devised by the Office of National Statistics to classify areas using indicators from the Census such as employment and housing. The groupings enable more relevant comparisons to be made between demographically similar areas. Only those North-West PCTs classified as Industrial Hinterlands have been used here as comparators.

Figure 10.5c: Hospital admissions which were *partially* attributable to alcohol **(B)** in England, the North-West, NHS Wirral and other North West Industrial Hinterlands comparator PCTs, 2011/12



The opposite appears to be true for admissions which were partially attributable to alcohol however. The rate in Wirral was lower than both England and the North-West and all of the other Industrial Hinterland comparators. In actual numbers, there were 5,800 admissions to hospital which were partially attributable to alcohol in Wirral in 2011/12 (figures rounded to nearest 100 by ONS).

Source: ONS, 2013

*****Note: the Industrial Hinterlands Group is one of seven groups devised by the Office of National Statistics to classify areas using indicators from the Census such as employment and housing. The groupings enable more relevant comparisons to be made between demographically similar areas. Only those North-West PCTs classified as Industrial Hinterlands have been used here as comparators.

Foetal Alcohol Spectrum Disorders (FASD)

FASD is an umbrella term used to describe the range of disabilities that may affect people whose mothers drank alcohol in pregnancy. The term covers several diagnoses, which include: foetal alcohol syndrome (FAS), partial foetal alcohol syndrome (pFAS), alcohol-related neurodevelopmental disorder (ARND) and alcohol-related birth defects (ARBD). Of all children affected, 10 to 15 per cent are affected by FAS, 30 to 40 per cent by PFAS, and nearly half by ARND (British Medical Association, 2007). Those affected often experience an array of health problems such as:

- Lower-than-average IQ (not always)
- Difficulties with attention and memory
- Difficulty seeing the consequences of actions
- Impulsive behaviour/inability to control impulses
- Difficulty dealing with concepts like time, finance etc.
- Difficulty co-operating with others, aggression
- Problems sucking and feeding in new-borns (and sometimes symptoms of alcohol withdrawal)
- Hyperactivity
- Poor judgement
- Poor problem-solving skills
- Speech and language delay
- Poor hearing and/or vision
- Abnormalities of the valves of the heart
- Bone and joint problems
- Kidney problems

National (and local) data on the prevalence of Foetal Alcohol Spectrum Disorders (FASD) is unavailable, but emerging international research indicates clearly that some populations are more at risk, such as those experiencing high levels of deprivation and poverty. Incidence of FASD in Western countries in general is estimated to be 9 per 1,000 live births. Although not a common condition, FASD is regarded as the leading known cause of non-genetic intellectual disability in the Western world [British Medical Association, 2007].

The estimate for Western countries, if applied to births in Wirral indicates that around 30 children per year would be born with FASD locally (with rates highest in areas of deprivation). This in turn could mean there are around 540 children and young people aged 0-18 in Wirral with FASD.

Accident & Emergency Department Presentations

In 2010/11 and 2011/12, the overall proportion of alcohol related A&E attendances at Arrowe Park Hospital was 6% (11,046 out of 181,986, see table 10.2.x). In both years, almost half of all the presentations for assault at Arrowe Park A&E were as a result of alcohol (47%).

Between 2010/11 and 2011/12, the largest percentage decrease in attendances (by cause) were for ingestions (-75%) and deliberate self-harm (-10.61%). The largest increase was for other (+84%) which includes bites, burns, scalds and inhalations. Road traffic collisions were also up (+51% although numbers are small).

Table 10.5d: Number of alcohol related presentations to Wirral emergency department by year, cause and proportion related to alcohol 2010/11 and 2011/12

Cause	2010/11 All	2010/11 Alcohol only	2011/12 All	2011/12 Alcohol only	% change between 2010/11 and 2011/12 (alcohol only)	% related to alcohol (both years)
Assault	1,616	754	1,590	761	0.93%	47.26%
Deliberate self-harm	718	358	792	320	-10.61%	44.90%
Fall	15,604	1,088	13,457	1,067	-1.93%	7.42%
Ingestion	238	32	135	8	-75.00%	10.72%
Non-Trauma	55,101	2,462	55,824	2,646	7.47%	4.60%
Road traffic collision	2,908	39	2,545	59	51.28%	1.80%
Struck	4,030	183	3,460	187	2.19%	4.94%
Wound/cut	2,348	224	2,234	244	8.93%	10.21%
Other*	7,821	216	11,565	398	84.26%	3.17%
Total	**90,384**	**5,356**	**91,602**	**5,690**	**6.24%**	**6.07%**

Source: Trauma and Injury Intelligence Group, 2012 http://www.tiig.info/
*includes bite, burn/scald (fire & non-fire), drown/immersion, electrical, firearms, glass, inhalation, non-drown asphyxia, sports injuries, stab and other undefined.

Further analysis of presentation data (conducted by Arrowe Park Hospital for a separate piece of work) for 2011/12 showed that those who presented as an emergency (non-elective) for alcohol related causes were most likely to stay for one bed day (n=4,360) or not be admitted at all, n=3,619). Those who presented electively (planned attendances) were also most likely not to be admitted (n=7,242).

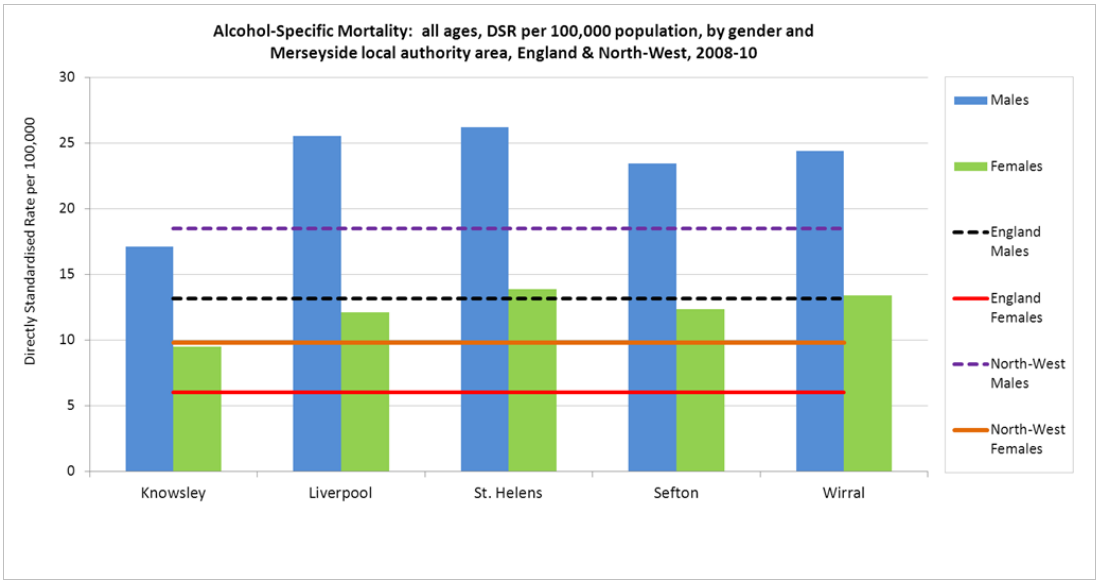
Morbidity key messages

- **The number of alcohol related admissions in Wirral in 2011/12 was around 9,200**
- **The rate of alcohol related hospital admissions in Wirral in 2011/12 was slightly lower than the North-West overall, but 19% higher than England. Wirral was comparable with other Merseyside local authorities (only Sefton was lower)**
- **Alcohol related hospital admission rates (overall) in Wirral were higher than England, but lower than the North-West in 2011/12. Of the two components which make up this overall rate (wholly attributable and partially attributable), Wirral was higher than all of our 'near neighbours' for wholly attributable rates (and lower for partially attributable)**
- **In 2010/12, half of all attendances for assault at Arrowe Park A&E were alcohol related**
- **Applying published incidence rates of Foetal Alcohol Spectrum Disorder to the Wirral population, indicates that there may be around 30 children born per annum locally with the condition (or around 540 children aged 0-18)**

10.6: Mortality

Alcohol-specific mortality

Figure 10.6a: Alcohol-specific mortality, all ages, DSRs per 100,000, by gender and Merseyside local authority, 2008/10



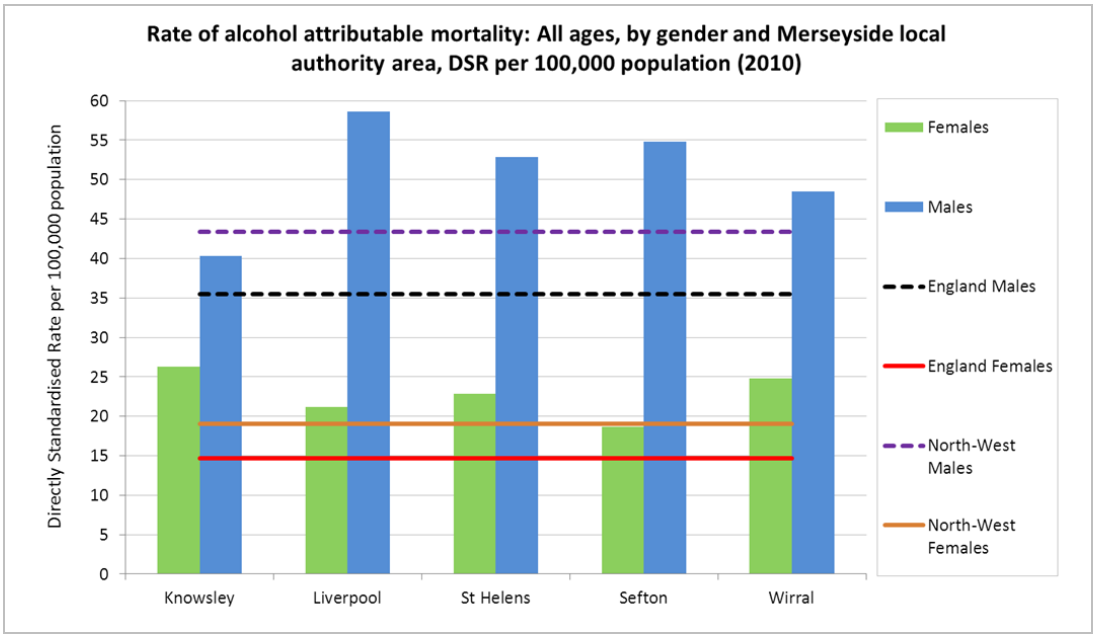
Source: Local Alcohol Profiles for England (LAPE), 2012

Figure 10.6a shows that alcohol-specific mortality in 2008/10 was higher for both men and women in Wirral compared to England and the North-West overall. Rates were also slightly higher than Sefton, which is often used as a comparator for Wirral, due to its demographic similarity. As the chart also shows, mortality amongst men was almost double the rate for women.

The actual number of deaths that these rates represent is 119 (males) and 70 (females), making a total of 189 alcohol specific deaths in Wirral during 2008/10 (3 calendar years of 2008, 2009, 2010 pooled).

Alcohol-attributable mortality

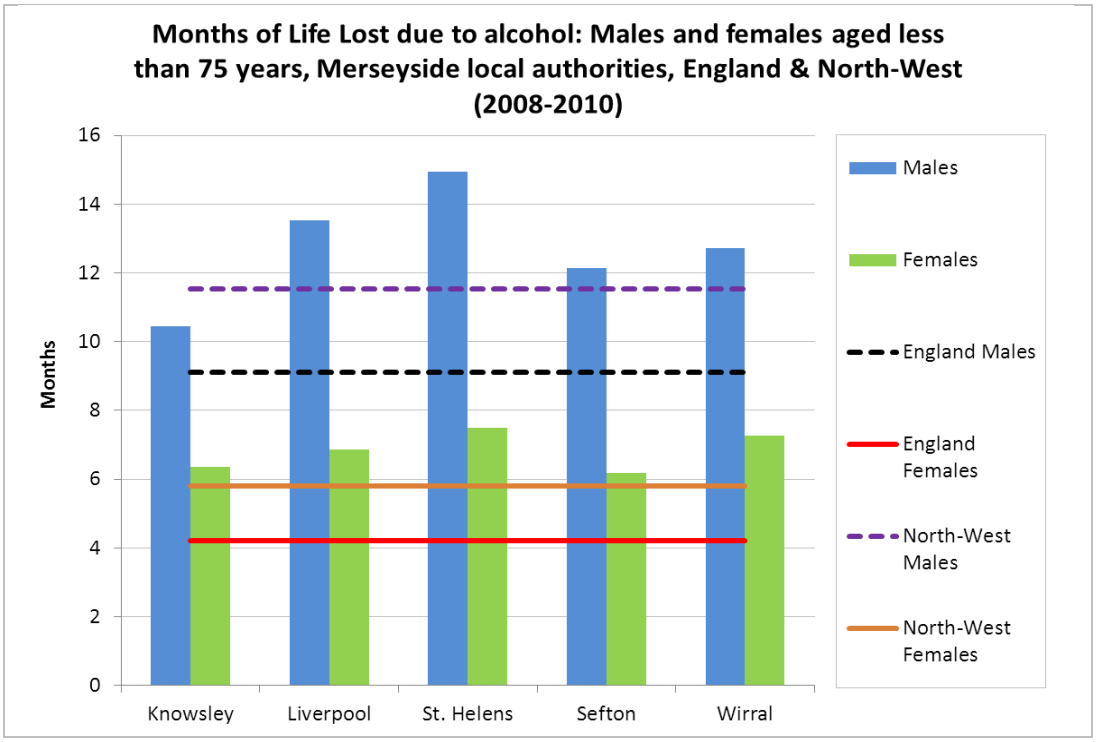
Figure 10.6b: Rate of alcohol-attributable mortality: all ages, by gender and Merseyside local authority area, England & North-West, 2010



Source: Local Alcohol Profiles for England (LAPE), 2012

Figure 10.6b shows the rate of alcohol attributable mortality in Wirral was higher than the national and regional averages for both males and females in 2008/10. It was also higher than our statistical near neighbour Sefton (for females), but interestingly, not for males (Sefton was higher).

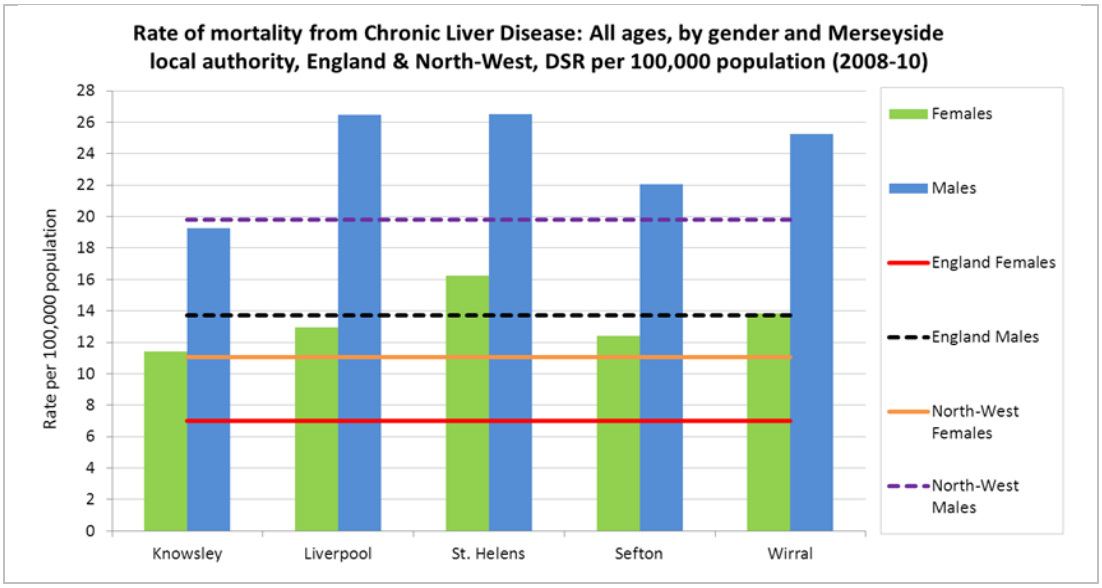
Figure 10.6c: Months of Life Lost due to alcohol in those aged under 75, by gender and Merseyside local authority area, England & North-West, 2008/10



As Figure 10.6c shows, the average number of months of life lost in those aged under 75 in Wirral in 2008/10 was higher (for both males and females) than either England or the North-West. It was over 1 year for men, and over 7 months for women. This was higher than our near neighbour Sefton, but lower than St. Helens or Liverpool.

Source: Local Alcohol Profiles for England (LAPE), 2012

Figure 10.6d: Rate of mortality from chronic liver disease, all ages, by gender and Merseyside local Authority, England & North-West, Directly Standardised Rate per 100,000 (2008 to 2010)



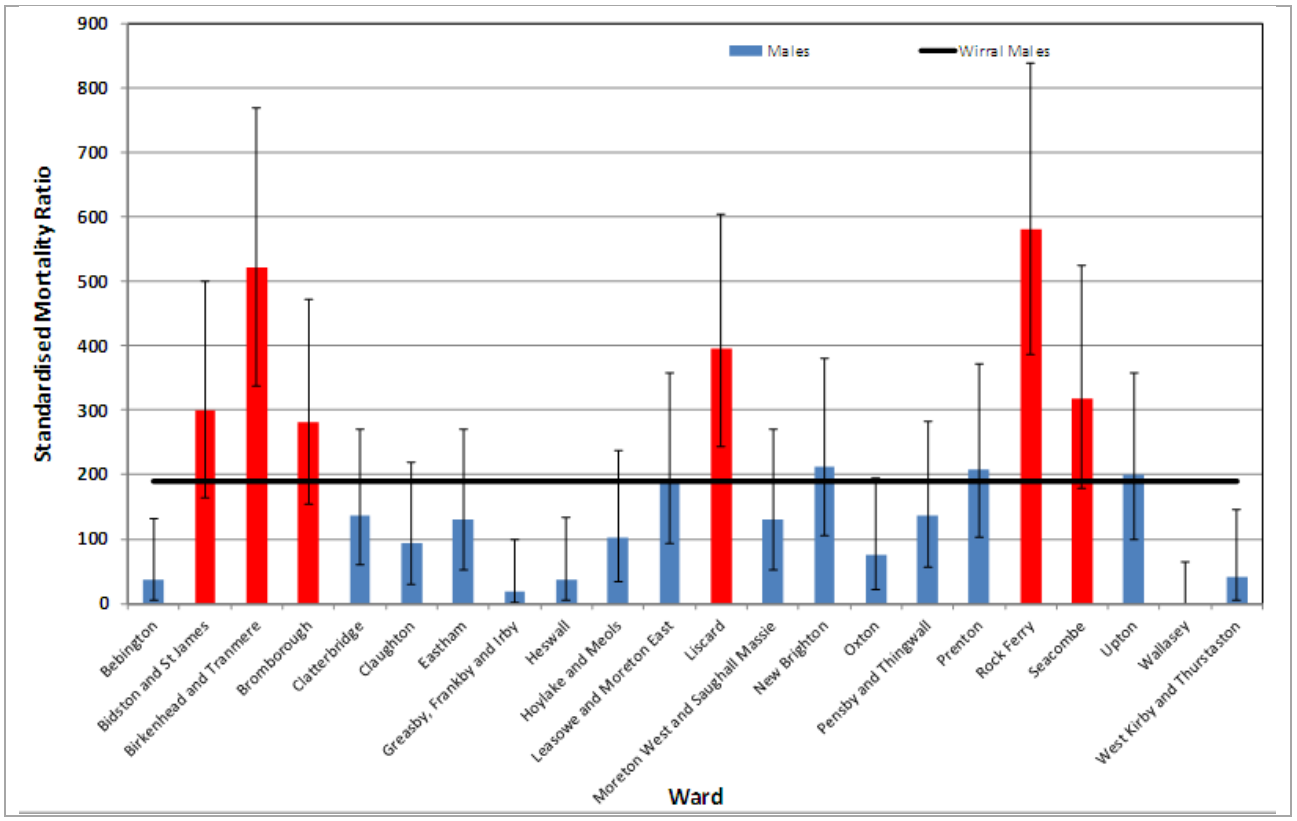
As Figure 10.6d shows, mortality from chronic liver disease in Wirral was higher than the national and regional averages for both males and females in 2008/10. It was also higher than our statistical near neighbour Sefton (for both males and females).

Source: Local Alcohol Profiles for England (LAPE), 2012

Mortality by ward (wholly attributable)

In Wirral during 2007-11 there were 324 deaths 'wholly attributable' to alcohol (meaning causes which are only caused by alcohol). **The national average for England is always 100 with SMRs.** So an SMR for males of 189 in Wirral shows that deaths in men caused just by alcohol were 89% higher than the national average. For females, the SMR was 181, meaning that deaths caused only by alcohol were 81% higher than the national average. When alcohol deaths were examined by ward, mortality varied significantly for both males and females (see charts below which show five years of pooled data due to small annual numbers). Wards that were significantly different from the Wirral average are shown in red. These wards include some of the most deprived areas in Wirral.

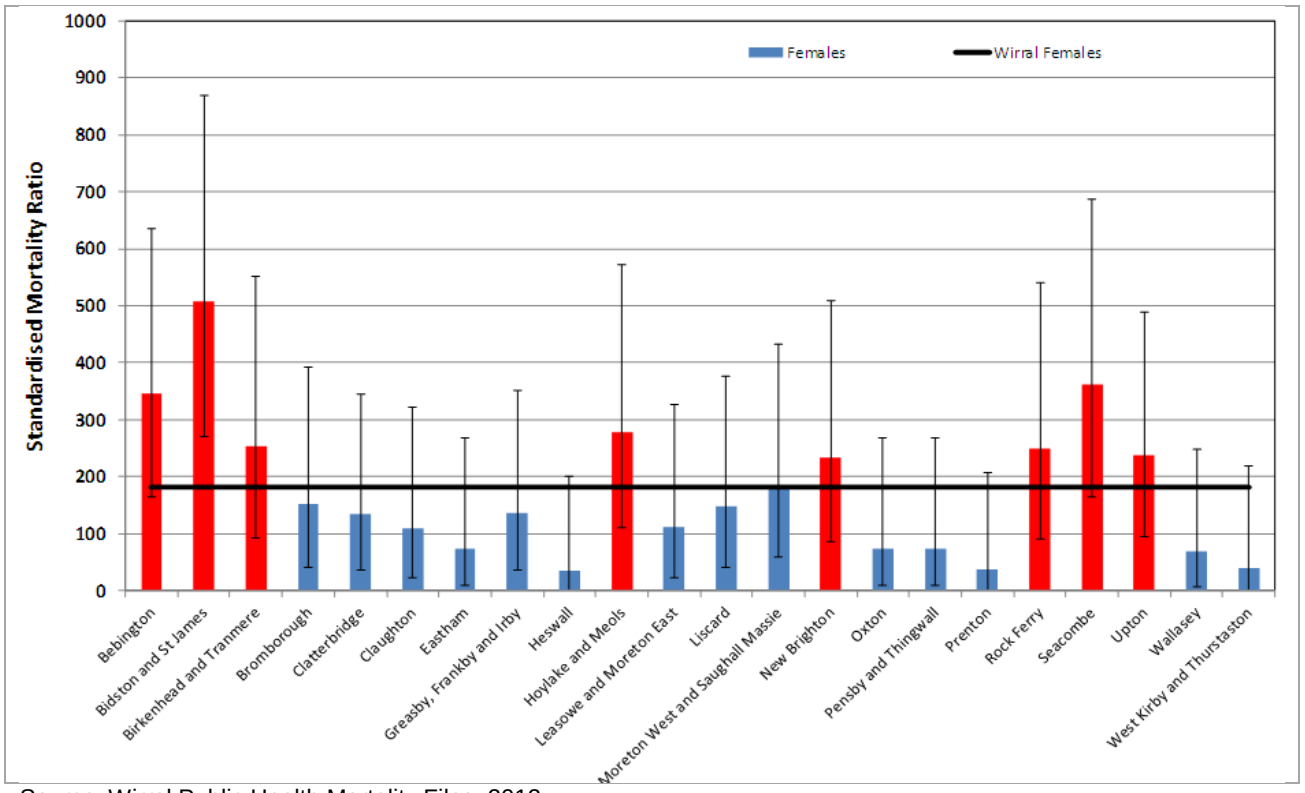
Figure 10.6e: Wholly Attributable Alcohol Related Death rates by Ward, Males, 2007-11



Source: Wirral Public Health Mortality Files, 2012

As Figure 10.6e shows, mortality from alcohol amongst men in Wirral was highest in Rock Ferry ward (almost 5 times the national average with a Standardised Mortality Ratio or SMR of 580), followed by Birkenhead & Tranmere, where the rate was almost four times the national average. Overall, the SMR for all Wirral men was 185, so 85% higher than the national average. The lowest rates were in Greasby, Frankby & Irby and Wallasey.

Figure 10.6f: Wholly Attributable Alcohol Related Death rates: by Ward, Females, 2007-11



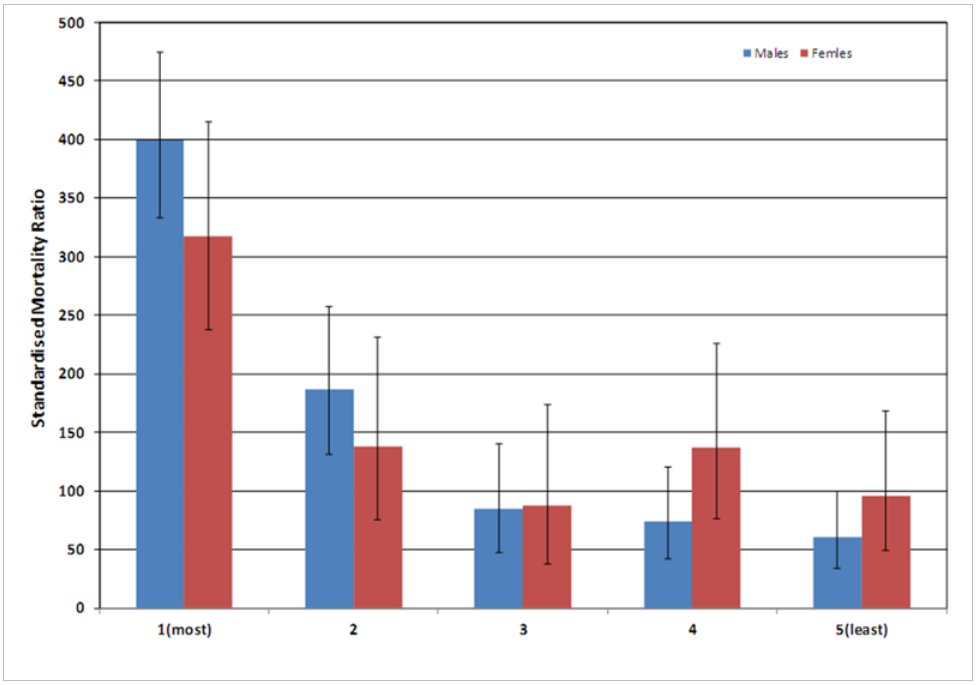
Source: Wirral Public Health Mortality Files, 2012

As stated above, the England average is always 100 for SMRs. Mortality specifically caused by alcohol amongst females in Wirral, as seen in Figure 10.6f, was highest in Bidston & St James, with an SMR of 507 (over 4 times the national average) and lowest in Heswall and Prenton. Most of the above average wards were those with high levels of deprivation (as was the case for men). The exception was Hoylake & Meols, which had an SMR of 278, meaning deaths there were 178% above the national average for 2007-11. The overall SMR from alcohol for women in Wirral was 176 (so 76% higher than England).

Mortality by deprivation

The chart below, Figure 10.6g, shows mortality attributable to alcohol by deprivation. Deprivation was calculated using the IMD 2010 Lower Super Output Area (LSOA) scores (aggregated into 5 quintiles, 1 being the most deprived and 5 being the least deprived).

Figure 10.6g: Wholly Attributable Alcohol Related Death rates by deprivation quintile in Wirral, 2007-11



In Wirral, mortality from alcohol is highest in the most deprived quintile (or 20%) of the population. Males in the most deprived quintile of the population had an SMR of 399, compared to an SMR of only 59 in the least deprived or most affluent quintile. The picture was similar for females, with an SMR of 316 in the most deprived quintile, compared to 91 in the least deprived quintile. The inequality appears to be more marked amongst men. The disparities were not quite as wide for women.

Source: Public Health Mortality Files, 2012

Interestingly, in the two least deprived quintiles, mortality was actually higher for women. This is a reversal of the situation in the two most deprived quintiles, where mortality amongst males is higher.

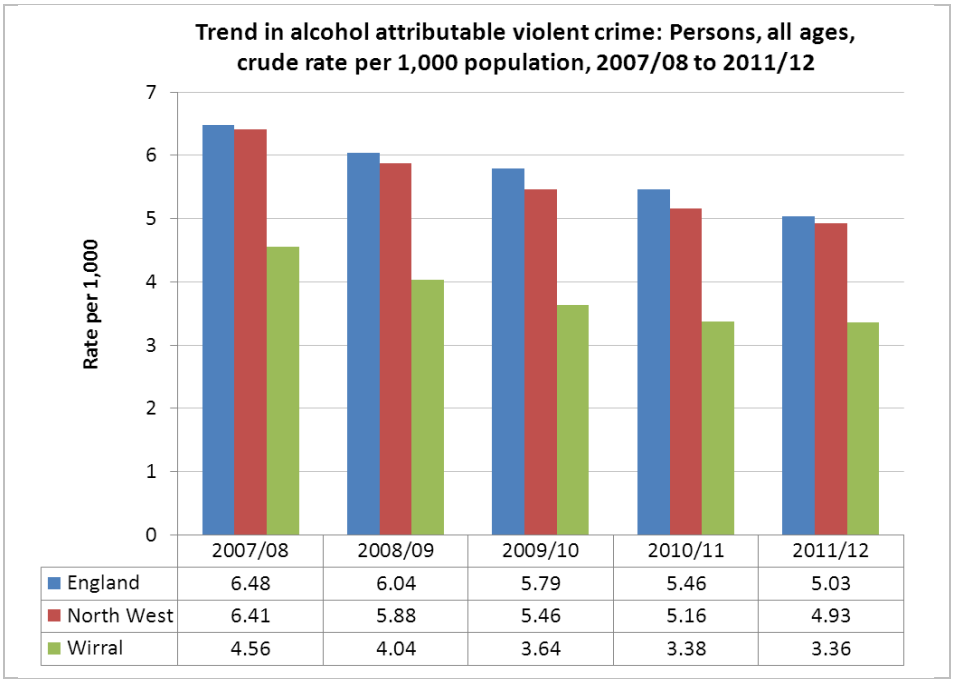
Mortality Key Messages

- **Mortality related to alcohol (both specific and attributable) was higher in Wirral than both England and the North-West for both males and females (and was also higher than statistical comparator Sefton).**
- **The wards with the highest rates of deaths caused wholly by alcohol were Rock Ferry and Birkenhead & Tranmere (for men), and Seacombe and Bidston & St. James (for women). These are the four most deprived wards in Wirral.**
- **Mortality wholly caused by alcohol was almost 7 times higher in the most deprived quintile of the male population in Wirral, compared to the least deprived quintile (SMR of 398 vs. 59). In women it was 3 times higher (SMR of 316 vs. 91).**
- **Months of life lost due to alcohol in Wirral in 2008/10 were 12 (or 1 year) for men and 7 months for women. This was higher than equivalent figures for England, the North-West and Sefton (statistical comparator for Wirral)**

10.7 Trend in wider social impacts

Crime

Figure 10.7a: Trend in rate of alcohol attributable violent crime: Persons, all ages, 2007 to 2012



	2007/08	2008/09	2009/10	2010/11	2011/12
England	6.48	6.04	5.79	5.46	5.03
North West	6.41	5.88	5.46	5.16	4.93
Wirral	4.56	4.04	3.64	3.38	3.36

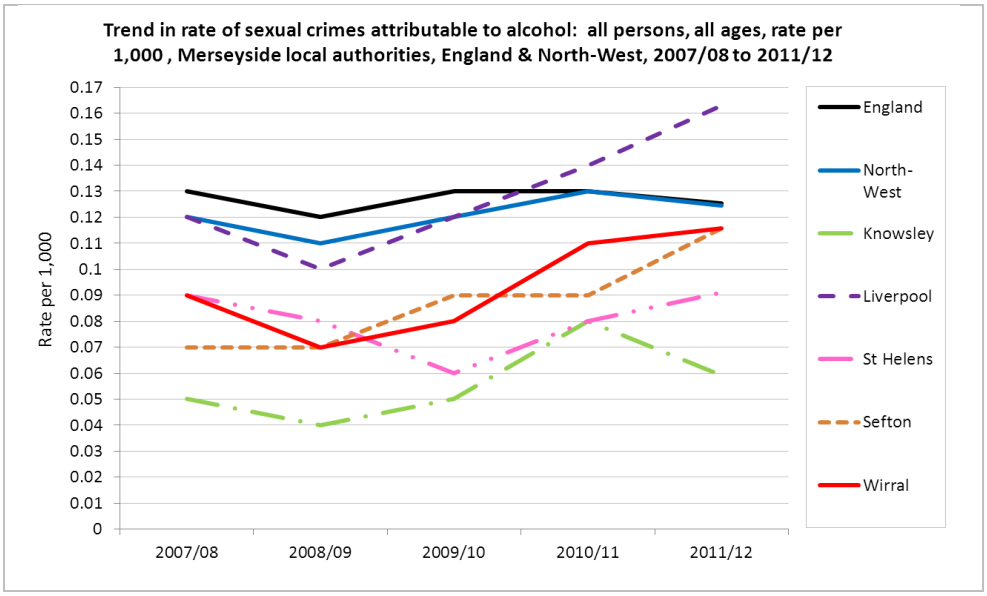
As Figure 10.7a shows, the rate of alcohol attributable violence crime is lower in Wirral than in either England or the North-West overall. It has also reduced in every year since 2007/08 and this is not just the case in Wirral, but is a trend which is apparent in England and the North-West overall.

Source: Local Alcohol Profiles for England (LAPE), 2012

Sexual violence

The data in Figure 10.7b below, shows alcohol related sexual crime by the location of the offence (rather than residence of victim or offender) and may help to explain high rates in Liverpool, which has a significant Night-Time Economy visited by people from around the region.

Figure 10.7b: Trend in rate of sexual violence attributable to alcohol, Merseyside local authorities, England, North-West & Wirral (2007-12)



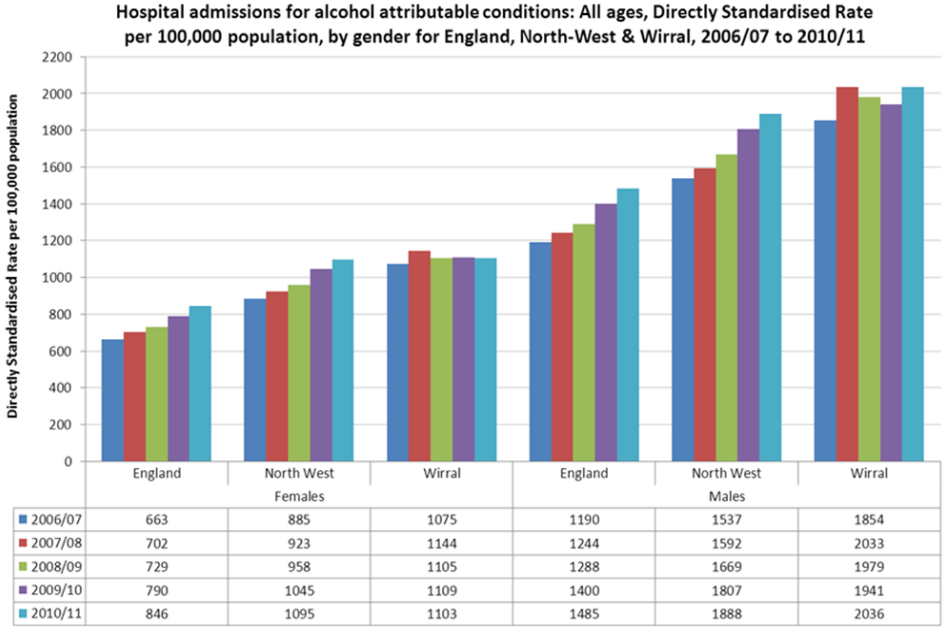
The rate of alcohol related sexual crime in Wirral in 2011/12 was below England and the North-West, but the trend is an upward one. This is against a downward national and regional trend. The recent upward trend (last three years) is also apparently in Sefton and Liverpool. In numbers, the Wirral rate refers to 36 offences in 2011/12.

Source: Local Alcohol Profiles for England (LAPE), 2012

Morbidity trends

Trend in hospital admissions caused (partially or wholly) by alcohol

Figure 10.7c: Trend in hospital admissions for alcohol *attributable* conditions by gender, directly standardised rates per 100,000 population for England, North-West & Wirral



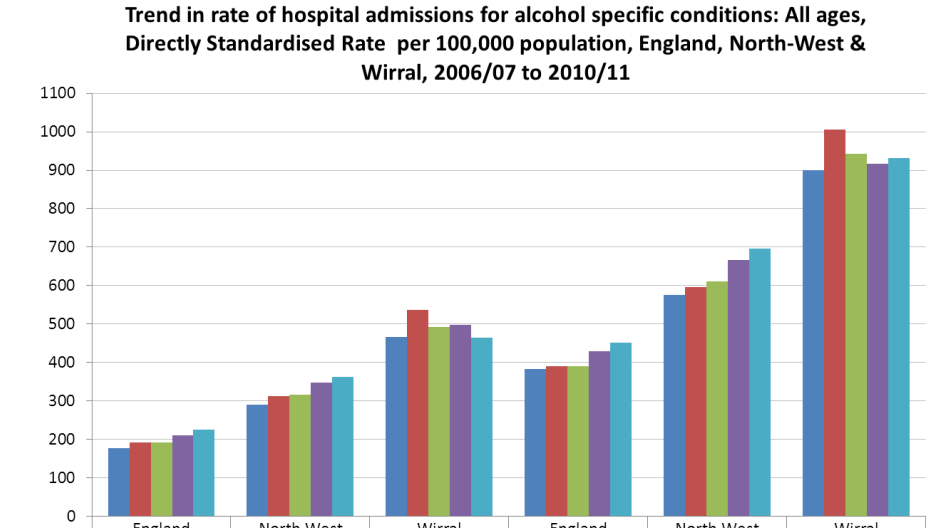
	England	North West	Wirral	England	North West	Wirral
	Females			Males		
2006/07	663	885	1075	1190	1537	1854
2007/08	702	923	1144	1244	1592	2033
2008/09	729	958	1105	1288	1669	1979
2009/10	790	1045	1109	1400	1807	1941
2010/11	846	1095	1103	1485	1888	2036

As the chart shows, Wirral has consistently had a higher rate of alcohol-attributable admissions than both the North-West and England from 2006/07 to 2010/11 for males and females. Admission rates for women appear to have stabilised for the last three years in Wirral, but are still higher than England and the North-West. Admission rates for men in Wirral are almost double those for women in every year showed.

Source: Local Alcohol Profiles for England (LAPE), 2012
Notes: *For detailed explanation of alcohol attributable and alcohol specific, please see Glossary at end.*

There has been some fluctuation in male admissions but rates were still higher in 2010/11 than at any point in the five previous years. The trend of year on year increases in admissions in both males and females in England and the North-West is **not** replicated in Wirral. Locally, admission rates appear to have plateaued over the last 3 to 4 years. Although figures are still higher than England and the North-West, if regional and national figures continue to increase as Wirral stays static, the gap will close.

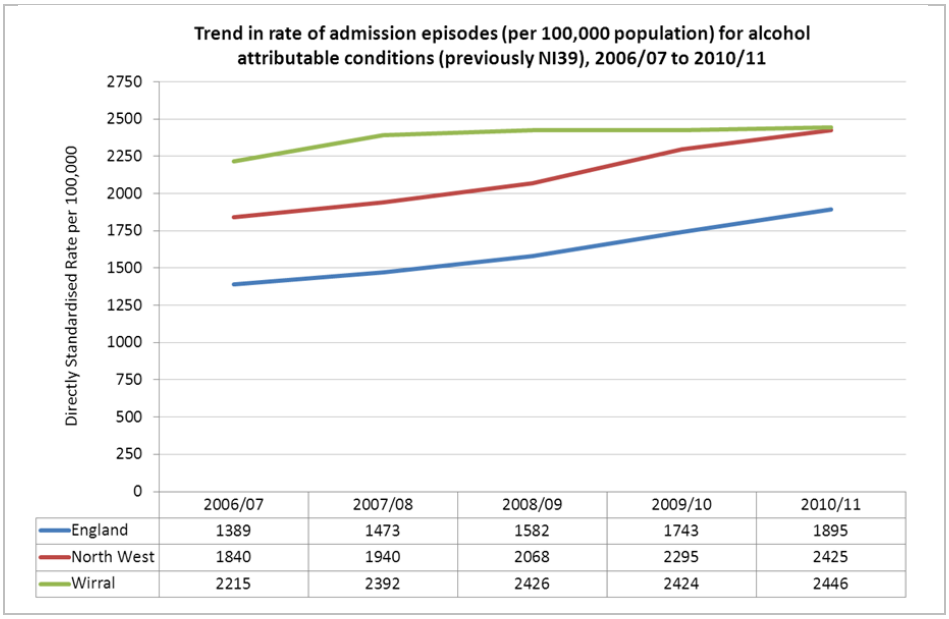
Figure 10.7d: Trend in hospital admissions for alcohol *specific* conditions by gender, directly standardised rates per 100,000 population for England, North-West & Wirral, 2006/07 to 2010/11



	England	North West	Wirral	England	North West	Wirral
	Females			Males		
2006/07	178.31	291.29	466.63	383.00	575.63	899.16
2007/08	192.97	312.03	536.31	391.39	596.85	1004.89
2008/09	192.47	315.60	492.52	390.18	611.89	942.76
2009/10	210.52	348.05	497.52	430.15	666.44	915.98
2010/11	225.01	363.48	464.62	450.90	695.85	930.71

As is the case for alcohol-attributable admissions, alcohol specific admissions are also higher in Wirral (for males and females) than either the North-West or England. Although rates appear to be levelling off in Wirral, admissions for both sexes were still around three times higher in Wirral in 2010/11 compared to England and the North-West (where rates do not appear to be levelling off as they are in Wirral). Admissions in men are almost double those of women (in Wirral, England & the North West overall).

Figure 10.7e: Trend in admission episodes (per 100,000 population) for alcohol attributable conditions (previously NI39), 2006/07 to 2010/11



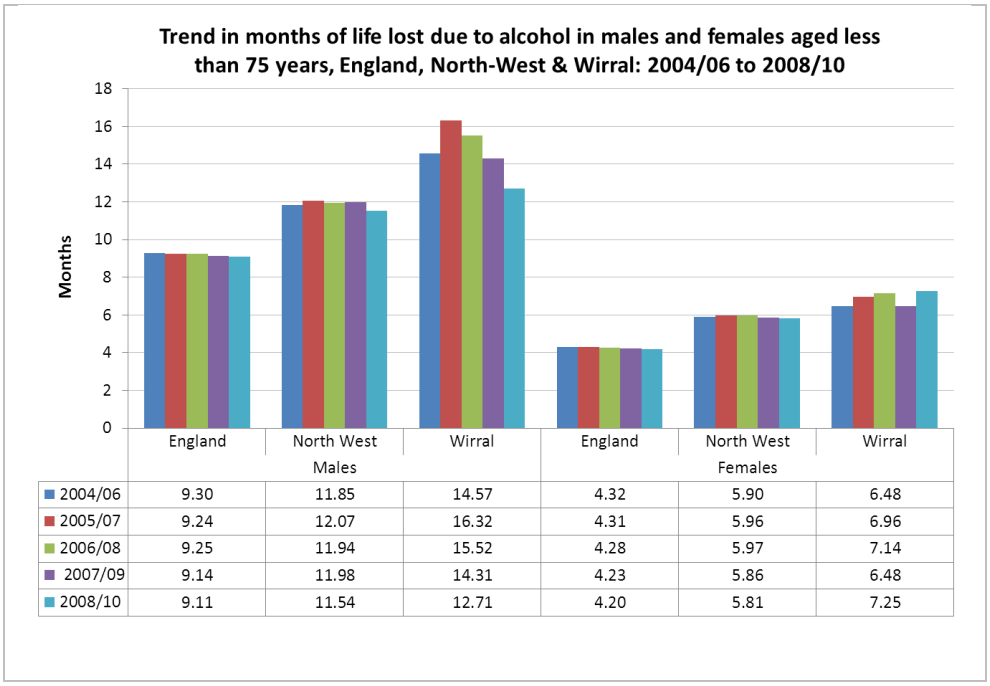
	2006/07	2007/08	2008/09	2009/10	2010/11
England	1389	1473	1582	1743	1895
North West	1840	1940	2068	2295	2425
Wirral	2215	2392	2426	2424	2446

Alcohol-attributable admission episodes appear to have plateaued in Wirral since 2007/08. This has closed the gap with the North-West, but rates were still significantly higher compared to England in 2010/11. Figure x also shows, the rate of alcohol-attributable admission episodes rose by just over 10% in Wirral between 2006/07 and 2010/11. The corresponding increases in the North West and England overall were 32% and 36% respectively.

Source: Local Alcohol Profiles for England (LAPE), 2012

Trend in Mortality

Figure 10.7f: Trend in Months of Life Lost (MML) due to alcohol, males and females aged less than 75 in England, North-West & Wirral, 2004/06 to 2008/08



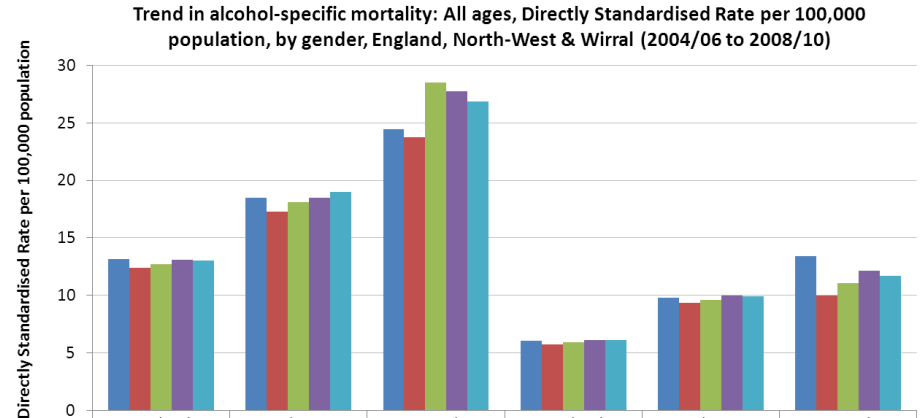
	Males			Females		
	England	North West	Wirral	England	North West	Wirral
2004/06	9.30	11.85	14.57	4.32	5.90	6.48
2005/07	9.24	12.07	16.32	4.31	5.96	6.96
2006/08	9.25	11.94	15.52	4.28	5.97	7.14
2007/09	9.14	11.98	14.31	4.23	5.86	6.48
2008/10	9.11	11.54	12.71	4.20	5.81	7.25

The data presented here give an estimate of the increase in life expectancy which could be expected if all alcohol-attributable deaths among those aged <75 were prevented. The chart shows that for males and females in Wirral, MLL was higher than both the North-West and England. Also, although MML for males has been falling since 2005/07, it still stands at over 1 year (12.71 months). For women, it reached the highest level in the last five years (7.25 years) in 2008-10.

Source: Local Alcohol Profiles for England (LAPE), 2012

Figure 10.7g below shows the trend in mortality (deaths) from alcohol specific conditions in Wirral, the North-West and England since 2004/06 to 2008/10 (the most recent time period figures are available for).

Figure 10.7g: Trend in alcohol specific mortality: All ages, Directly Standardised Rate per 100,000 population, by gender, England, North-West & England (2004/06 to 2008/10)

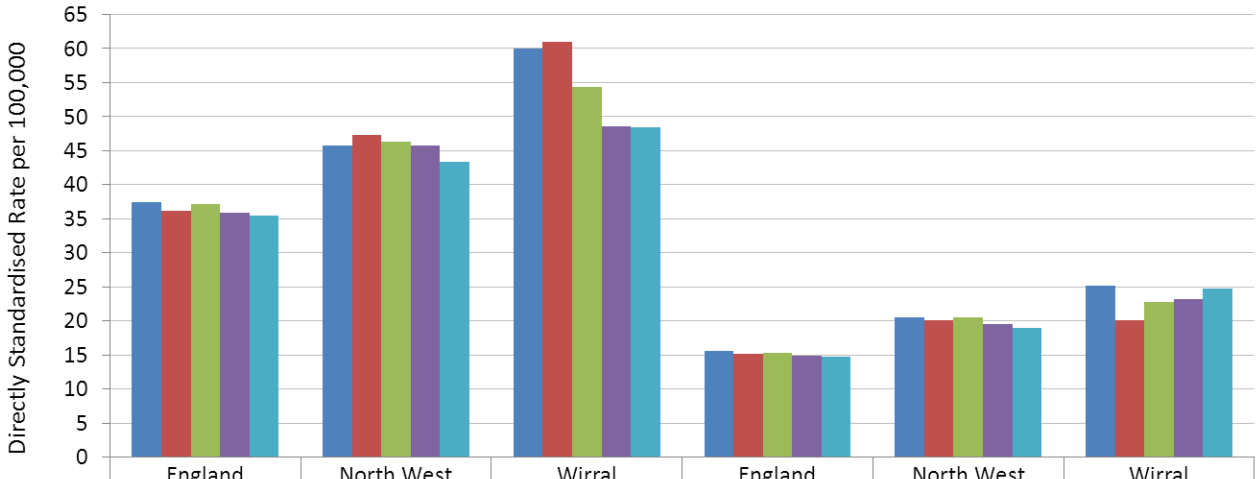


	England	North West	Wirral	England	North West	Wirral
	Males			Females		
2004/06	13.16	18.51	24.41	6.04	9.82	13.40
2005/07	12.38	17.30	23.76	5.75	9.34	9.96
2006/08	12.71	18.09	28.49	5.92	9.61	11.04
2007/09	13.12	18.51	27.76	6.12	9.98	12.12
2008/10	13.06	19.01	26.83	6.12	9.93	11.70

As Figure 10.7g shows, mortality from alcohol specific causes in Wirral was higher than both England and the North West (in both males and females) for every year shown here. Men have roughly twice the rate of mortality of women in Wirral (also true of England and the North-West). The upward trend appears to have levelled off in Wirral for females and has actually decreased slightly for males for each of the last three years (although is still double the England rate).

Source: Local Alcohol Profiles for England (LAPE), 2012

Figure 10.7h: Trend in alcohol-attributable mortality, all ages, by gender, rate per 100,000, England, North-West & Wirral, 2006-10



	England	North West	Wirral	England	North West	Wirral
	Males			Females		
2006	37.43	45.68	60.02	15.52	20.54	25.12
2007	36.13	47.32	60.95	15.18	20.11	20.14
2008	37.11	46.36	54.35	15.28	20.58	22.75
2009	35.86	45.73	48.61	14.87	19.57	23.27
2010	35.48	43.42	48.45	14.70	19.02	24.80

Source: Local Alcohol Profiles for England (LAPE), 2012

As Figure 10.7h shows, alcohol-attributable mortality amongst men in Wirral is currently higher than both England and the North-West averages.

Having said this, there has been a marked fall in alcohol-attributable mortality amongst men in Wirral between 2006 and 2010. This is bringing Wirral men more into line with national and regional averages.

Amongst women, the picture is slightly different. As is the case for Wirral men, alcohol-attributable mortality amongst women in Wirral is currently higher than both England and the North-West averages. Unlike the picture for men however, the trend is pointing to year on year increases.

This is against a national and regional picture of slight reductions in alcohol-attributable mortality amongst women. The trend in alcohol-attributable mortality amongst women in Wirral appears to have risen every year since 2007, meaning that the gap between Wirral and England and the North-West for alcohol-attributable mortality is widening.

Key trend messages

- **Rates of alcohol-related violent crimes appears to be reducing, whilst alcohol related sexual crime appears to be increasing over time in Wirral**
- **Rates of alcohol-attributable admissions appear to have plateaued for the last three years amongst women in Wirral. There is more fluctuation for men, with a rise in 2010/11 after three years where the trend appeared to be decreasing**
- **Alcohol-specific admissions peaked in 2007/08 for both men and women in Wirral, and since then have fluctuated with no clear trend apparent**
- **Months of life lost due to alcohol is falling in men, but not women. It was 16 months in 2007/08 for men, but had reduced to 12 by 2010/11. This was still higher than the North-West and England averages for men**
- **Months of life lost due to alcohol in women has shown a slight increase since 2006/07 in Wirral and has remained higher than England and the North-West**
- **The upward trend in alcohol-specific mortality appears to have levelled off in Wirral for females in 2008/10, after three years of consecutive rises**
- **Amongst men, alcohol-specific mortality has actually decreased slightly for each of the last three years (although it is still double the England rate)**
- **Alcohol-attributable mortality appears to be falling for men, mirroring the national and regional picture**
- **Alcohol-attributable mortality in Wirral women does not appear to be following the falling national and regional trend however. It has risen for each of the last three consecutive years**

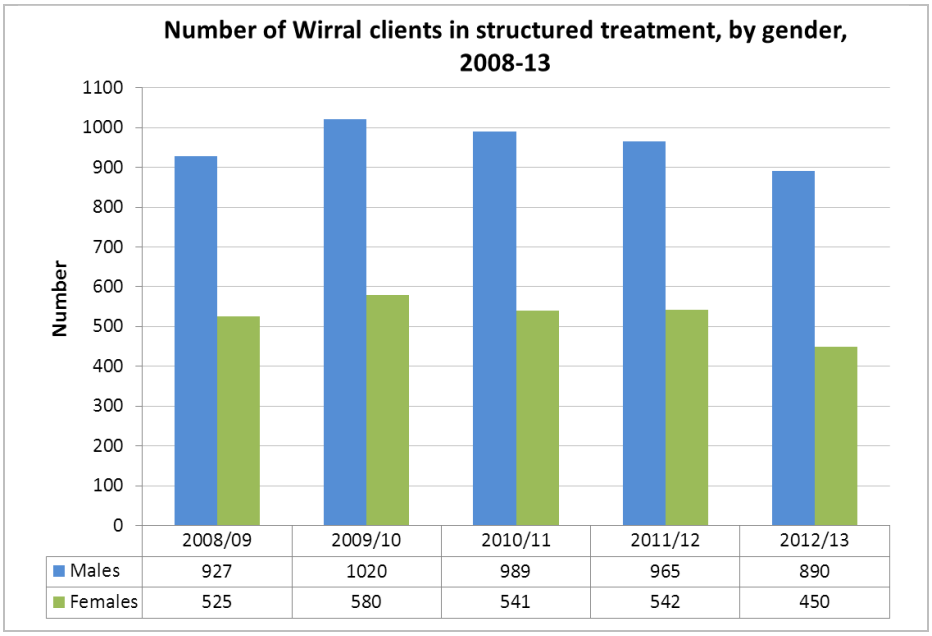
10.8 Current activity and services

Adults in Structured Treatment

In Wirral during 2012/13, there were 1,340 people in contact with structured treatment in Wirral, two-thirds of who were male. This equates to a crude rate of 5.13 per 1,000 population, compared to the England average of 2.5 per 1,000.

Wirral ranked higher (10th) than all of the other Merseyside authorities including Knowsley (12th), Halton (13th), Liverpool (16th), Sefton (24th) and St. Helens (53rd) for the number of clients in structured treatment in 2012/13. This indicates that Wirral has a high level of need for alcohol treatment and is being relatively successful in engaging with people and getting them into treatment.

Figure 10.8a: Numbers in structured treatment from 2008/09 to 2012/13 by gender



	2008/09	2009/10	2010/11	2011/12	2012/13
Males	927	1020	989	965	890
Females	525	580	541	542	450

The numbers shown in the chart 10.8a equate to a crude rate of 5.13 per 1,000 population, the 10th highest in England (the highest was Blackpool at 7.75 per 1,000). The England average was 2.5 per 1,000. Wirral ranked higher than all of the other Merseyside authorities including Knowsley (12th), Halton (13th), Liverpool (16th), Sefton (24th) and St. Helens (53rd). This indicates that Wirral has a high level of need for alcohol treatment and is being relatively successful in engaging with people and getting them into treatment.

Source: National Alcohol Treatment Monitoring System, 2012. www.ndtms.net

Characteristics of individuals in treatment

In Wirral, during 2012/13, the most common age group for individuals in contact with structured alcohol treatment services was 40-49 (50%). 10% were aged 18-29 years and 7% were aged over 60.

The most common route into structured alcohol treatment in Wirral in 2011/12 was self, family or friends referral route (34%), followed by General Practitioner's (GPs) (25%) and Mental Health services (15%). Referrals from GPs have increased for the second year running.

In 2011/12, there were 873 discharges from treatment, a slight decline on the previous year, however although there were less discharges the outcomes for clients leaving treatment were much more favorable. Sixty percent of individuals leaving alcohol structured treatment in 2012/13 did so in a planned way compared to just 57.6% in 2010/11 and 54.5% in 2009/10.

Alcohol Screening

AUDIT Alcohol Screening

The Alcohol Use Disorders Identification Test (AUDIT) is a simple screening tool used to identify people at risk of developing alcohol problems. A score of 0-7 is sensible drinking (low risk); 8-15 is hazardous drinking (increased risk); 16-19 is harmful drinking (high risk); and a score of 20 or more is dependent drinking.

Tables 10.8a and 10.8b below show the number of AUDIT screens carried out in Wirral between 2008/09 and 2012/13 by gender and drinking categorisation of those classed as at-risk.

Table 10.8b: Number of AUDIT screens by gender, 2008/09 to 2012/13

Year	Male	Female	All
2008/09	873	885	1,758
2009/10	2,453	3,031	5,484
2010/11	4,825	5,519	10,344
2011/12	4,422	5,603	10,025
2012/13	5,891	4,926	10,817
Total all years	**18,464**	**19,964**	**38,428**

Source: Alcohol Treatment Monitoring Service, LJMU, 2013

As the table shows there was an increase in the number of males screened of 33.2% and a decrease in the number of females screened of 12.1% over the same period.

Table 10.8c: Outcome of AUDIT screens: categorisation of at-risk drinkers, 2008/09 to 2012/13

Year	Males			Females		
	% Hazardous	% Harmful	% Dependent	% Hazardous	% Harmful	% Dependent
2008/09	20.4%	4.0%	7.1%	14.1%	1.6%	3.2%
2009/10	26.4%	4.6%	13.7%	21.6%	3.0%	6.4%
2010/11	24.2%	3.7%	17.6%	18.7%	2.6%	8.1%
2011/12	22.4%	4.3%	11.4%	17.2%	1.8%	4.8%
2012/13	16.5%	4.7%	28.3%	13.4%	3.2%	14.7%

Source: Alcohol Treatment Monitoring Service, LJMU, 2013

In Wirral during 2012/13, 10,817 AUDIT screenings were undertaken. Following a decrease in 2011/12 from the previous financial year, the proportion of males categorised as dependent drinkers increased substantially from 11.4% to 28.3%, an increase of 251%. Likewise the number of females categorised as dependent drinkers increased from 4.8% to 14.7%, an increase of 306%. Those identified as drinking hazardously or harmfully has stayed relatively stable, with a slight decrease in Hazardous for both males and females and more prominent increase for female Harmful drinkers, albeit from low numbers to begin with.

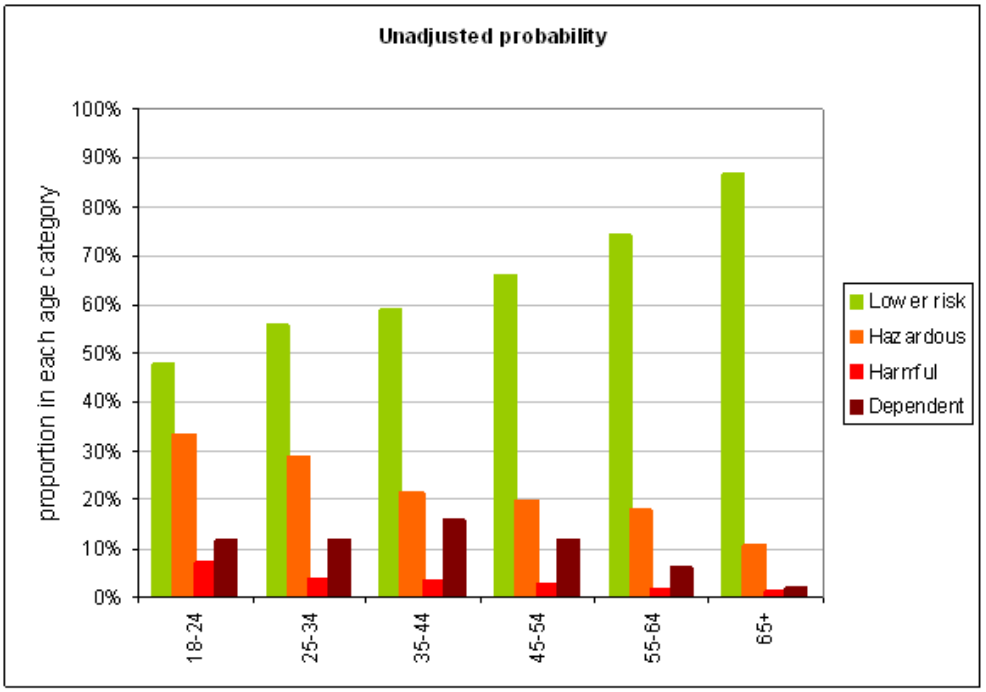
These increases are likely to be due to better targeting of clients for screening by alcohol services.

In addition to AUDIT screening, there were **8,439 additional screens** carried out to ascertain the number of at risk drinkers in the population in Wirral in 2012/13. This increased the total number of screens carried out in Wirral to 19,256 for the year.

Identification and Brief Advice (IBA) screening analysis

The programme of screening has dynamically developed since 2008, with the involvement of several different providers at different time points. These providers have tended to target different categories of drinkers, as well as engaging different age groups and different sexes.

Figure 10.8d: Proportion of screened drinkers in each category of drinking behavior, by age band



Source: NHS Research and Development Team, 2011

Further analysis showed that the proportion of lower risk drinkers identified increases with age, where hazardous and harmful drinking reduces. Dependent drinkers are most often identified amongst 35-44 year olds. After adjustment (i.e. controlling for sex, time of screen and type of screening provider), 18-24 year olds screened were still most likely to be harmful or hazardous drinkers and 35-44 year olds remained most likely to be dependent drinkers.

Mortality in individuals in contact with structured drug and/or alcohol treatment

Between 2005/06 and 2010/11, there were 168 deaths reported to the National Drug Treatment Monitoring System (NDTMS) involving individuals from Wirral who had been in structured drug and/or alcohol treatment. The misuse of illicit drugs and/or alcohol accounted for 74% of deaths, whilst alcohol alone accounted for 30% of deaths (note that this is crossover in these figures).

Deaths fluctuated between 2007/08 and 2010/11, as routine monitoring was expanded in 2008/09 to collect data on clients receiving specialist alcohol treatment interventions. Prior to this, NDTMS only monitored individuals in specialist drug treatment. Consequently, the change in the number of confirmed deaths may not be as a result of real increases, but may be due to improvements in the accuracy of agency monitoring systems and cooperation with national audits, along with an increase in the number of individuals attending treatment during this period.

Effectiveness and cost-effectiveness of treatment services

Despite alcohol interventions requiring a large proportion of public sector spending, there are actually few economic studies looking at the cost effectiveness of alcohol interventions, particularly alcohol treatment. One reason for this may be that alcohol costs and outcomes fall across many different sectors like health, crime, employment, family, making the burden of data collection very high. Most studies show that treatment is cost effective compared to a ‘do-nothing’ alternative, regardless of approach.

Wirral is unusual in that an economic evaluation of alcohol services in Wirral has been carried out (in 2013, report available early 2014) which concentrated on alcohol identification and brief advice, specialist alcohol services, residential detox, shared care, aftercare, the hospital substance misuse nurse. It also touched on other interventions such as helping people back into work.

The review highlighted various points such as success rates appeared to be better in people aged over 50 and numbers of younger people in services were low compared to the estimated number of problem drinkers in the population. It also recommended that the number of men screened, the conversion rate (from screening to brief intervention) and referral into services where necessary all need to increase. Overall, all of the local alcohol services examined were found to be cost effective, either in producing long term cost savings, increasing quality of life and life expectancy, or both.

Current activity and services key messages

- **The rate of people in structured treatment in Wirral is more than double the England average (5.3 per 1,000 compared to 2.5 per 1,000). Wirral also had higher rates than the other Merseyside authorities in 2012/13**
- **The number of people in structured treatment in Wirral has reduced every year since 2009/10**
- **Half of those in treatment in 2012/13 were aged 40-49 and two-thirds were men**
- **The number of people screened using AUDIT has increased every year since 2008. In 2011/12, 10,025 were AUDIT screened in Wirral.**
- **More women were screened than men in 2011/12 (56% of those screened were women compared to 44% men)**
- **Although more women were screened, analysis of screening outcomes found that men were twice as likely as women to be dependent or harmful drinkers.**
- **Dependent drinkers were most often identified amongst 35-44 year olds, whilst 18-24 year olds were the most likely to be harmful or hazardous drinkers**
- **Economic analysis of current alcohol treatment services in Wirral found that they were generally cost-effective, whilst making recommendations on changes which may improve effectiveness further. The report will be available shortly.**

10.9 Local views

Community Alcohol Profile survey 2013

An annual survey into the views of Wirral residents on the impact of alcohol on their neighbourhood is conducted in Wirral. The survey consists of two sections, one for responses from residents aged over 18, and one for those aged under 18. The survey results for 2013 have not yet been written up, but should be available by December 2013. Please contact Bev Dajani on 0151 606 2000 for more details.

Views of Alcohol Service Users

In July 2011, Wirral Drug and Alcohol Action team conducted a survey of alcohol service consisting of five questions:

1. What factors encouraged you to access services?
2. How were you signposted to services?
3. Why did treatment work for you?
4. What would you change, if anything, about current alcohol service provision?
5. What can be done to discourage young people from drinking alcohol?

The surveys were given out at the following locations: Archway centre, ARCH Conway Street, Alcohol Clients Treatment Involvement Forum (ACTIF) and the Social Partnership. In total, 65 questionnaires were completed by service users throughout the Borough.

Q1: What factors encouraged you to access services?
The two main factors cited were the desire for a healthier lifestyle, and a recognition that they wanted and were ready for help. Family life was also a strong factor. Other factors mentioned included declining health, hospital stays, the Birchwood Detoxification Unit and mental health issues. One person stated that services were easily accessible, while for one other, abstinence was a reason for entering treatment.

Q2: How were you signposted to services?
The majority of respondents were signposted into services through the Social Partnership. This, however, should be interpreted with caution as the Partnership was one of the main outlets for the surveys and it is therefore reasonable to assume this does not reflect the true picture of the whole treatment system. Arrowe Park Hospital and Birchwood were the second most common signposting organisations, which reflect some of the reasons given above as to why individuals accessed services. Many of the other services within the alcohol treatment system were also cited, such as; Wirral Alcohol Service, ARCH, Spider GPs and Alcoholics Anonymous (AA). Some respondents also stated that friends had signposted them to services.

Q3: Why did treatment work for you?
The most popular reason given was that it provided people with a structure and filled their time. Respondents also recognised that the opportunity to talk about their issues with other people who have had similar experiences aided their treatment process. The intense one-to-one work carried out by the Social Partnership was recognised as having an impact on their treatment, along with being given the tools by services to stop drinking and remain sober. Individuals also cited having the motivation themselves and being ready to change as other factors which aided treatment. Only two individuals said that treatment did not work for them.

Q4: What would you change if anything about current alcohol service provision?
Over a third of those stated that they would not change anything about current provision in the Borough. However, a number of respondents suggested that services could be made more accessible; that the government should put more funding into alcohol treatment; and that it should be possible to have a longer detoxification period. More time with skilled staff that had previous experiences of alcohol misuse themselves was also important, along with more outreach provision.

Q5: What can be done to discourage young people from drinking alcohol?
The response was that young people need more education relating to the physical and emotional effects of alcohol. There was a consensus for better use of Personal Health and Social Education (PHSE) lessons in schools, with sessions provided by recovering users to speak to young people about their own experiences seen as potentially valuable. It was suggested that advertising glamorising drinking was contributing to young people's drinking behaviours; and that stricter advertising regulation may help in preventing young people from drinking, in addition to the introduction of a minimum pricing.

10.10 National and local strategies

The following national documents are relevant to this chapter, see below:

- The Government's Alcohol Strategy (March 2012)
- An evidence based alcohol strategy for the UK (March 2013)
- Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. NICE clinical guideline 115 (2011)
- Alcohol-use disorders: diagnosis and clinical management of alcohol-related physical complications. NICE clinical guideline 100 (2010)
- Alcohol-use disorders: preventing the development of hazardous and harmful drinking. NICE public health guidance 24 (2010)
- Interventions in schools to prevent and reduce alcohol use among children and young people. NICE public health guidance 7 (2007)

10.11 Targets

Public Health Outcomes Framework (PHOF) alcohol targets

Wirral's overarching target has been to reduce alcohol related hospital admissions (previously known as NI39). This was a national target set out in the government's 2008-11 public service agreement which has now been included in the Public Health Outcomes Framework (PHOF) from now until 2015/16. Alcohol related hospital admissions are seen as a barometer of alcohol problems in the population. Wirral has had some success in curbing the increase in alcohol related admissions; in 2007/08 Wirral was sixth highest out of 151 PCT areas in England, whereas in 2011/12 they ranked 32nd out of 151 areas. This means Wirral have moved from being in the 5% worst performing areas, to now being outside of the worst 20%. Indicators in the new Public Health Outcomes Framework relevant to alcohol are:

- Alcohol-related admissions to hospital
- Mortality from liver disease
- Successful completion of drug treatment
- People entering prison with substance dependence issues who are previously not known to community treatment
- Take up of the NHS Health Check programme by those eligible (which will include screening for alcohol misuse from 2013).

A 2% stretch decrease upon the increasing trend in admissions has been set. Adjusting the performance to follow the new pattern of alcohol related admissions has resulted in a performance target of 2,355 for year 2013/14.

Wirral Council Corporate Plan 2013/14

One of the three priority targets adopted by Public Health for inclusion into the Wirral Council Corporate Plan for 2013/14 is the alcohol related admissions PHOF target (see above).

Wirral Health & Wellbeing Strategy (2013)

The same target (reducing alcohol admissions) has also been set as one of 3 health related priority areas in Wirral Council's 2013/14 Health & Wellbeing Strategy for Wirral.

10.12 Performance

How Wirral performs on the Public Health Outcomes Framework indicators is shown on at-a-glance spine charts on the Instant Atlas section of this site.

Data is constantly updated whenever new information becomes available and the atlas allows users to compare Wirral to both England and the North-West on all of the below alcohol related targets:

- Alcohol-related admissions to hospital (significantly higher than England in 2010/11)
- Mortality from liver disease (significantly higher than England in 2009/11)
- Successful completion of drug treatment (this is split into opiate users and non-opiate users; both indicators were higher than England for the calendar year of 2011, only significantly so for opiate users, for non-opiate users, no significant difference with England)
- People entering prison with substance dependence issues who are previously not known to community treatment (method of calculation of this indicator is yet to be determined nationally as of October 2013)
- Take up of the NHS Health Check programme by those eligible (not significantly different to England in 2011/12)

It is important to note that the information in brackets after each of the indicators above gives the situation as of October 2013. Information is updated periodically on our PHOF Instant Atlas and may change, so please check the Atlas for the most current information.

10.13 Key gaps in knowledge and services

The aspects below should be considered in future work with partners:

- To explore if there is an impact of illegal alcohol availability in Wirral
- To review to what extent and possible implications of Foetal Alcohol Spectrum Disorders (FASD) in Wirral
- Data on revenue from alcohol sales in Wirral, current and historically and assessing how the picture formed compares to other data such as hospital admissions
- More detailed information on the benefits and costs associated with the night time economy
- To consider the impact that limiting the extent to which alcohol is advertised locally might have
- Wirral has higher rates of wholly attributable alcohol admissions (compared to partially attributable admissions). What this might mean is unclear.
- Economic evaluation of Wirral treatment services identified that there is currently no national benchmarking data on the costs of alcohol treatment. This means it is difficult to know whether local treatment service costs represent good value or not, compared to other areas (although services were assessed as being cost effective compared to a 'do nothing' alternative)
- Economic evaluation also identified a number of points, one of which was the lack of availability of raw NDTMS (National Drug Treatment Monitoring Service) data. This could be a rich data source and would enable the matching up clients between different services (in order to understand more about the typical journey clients take between services)

10.14 What is coming on the horizon?

It now appears unlikely that the current Coalition government will take national action on issues such as minimum pricing for alcohol or availability, despite evidence (see section 10.3) suggesting both of these strategies would be very effective at reducing alcohol related harm.

10.15 What does the research suggest as further actions?

An evidence based alcohol strategy for the UK (March 2013) maintains that the evidence is clear: the most effective way to reduce the harm from alcohol is to reduce the affordability, availability and attractiveness of alcohol products. The report states that limiting the damage once people are drunk, dependent, ill or dying is not enough and early intervention to reduce consumption across the entire population is necessary. They propose this should be done using the 'four Ps' of the marketing – price, product, promotion and place, claiming that as these are used by alcohol producers and retailers to increase their sales of alcohol, they could also be used by government to reduce alcohol sales, alcohol consumption and alcohol-related harm. In addition to these population-level approaches, many more targeted measures are needed. Early intervention by health and social care professionals is an important and underexploited opportunity to prevent problems developing and stronger drink driving measures are also required.

The local economic analysis - Cost Effectiveness of Alcohol Treatment Services (2013) highlighted various issues such as numbers of younger people in services being low compared to the estimated number of problem drinkers in the population and made various recommendations. They include increasing the number of men screened, increasing the conversion rate (from screening to brief intervention) and increasing referrals into services where necessary. The full report is expected to be available in early 2014.

A cost effectiveness review on alcohol conducted by Liverpool Public Health Observatory in 2010 provided evidence on primary, secondary and tertiary prevention interventions concluded that numerous cost-effective alcohol prevention initiatives are in place. According to the NICE costing report the interventions that would have the greatest resource implications are:

- Minimum price per unit of alcohol - with a resulting reduction in hospital admissions that could yield a potential health saving of around £80.3 million;
- Screening adults in primary care - long-term savings expected to be significant; and

- Brief interventions in primary care - providing brief advice to more people could potentially result in large savings.

Other examples of cost-effective interventions include:

- Increasing the proportion of dependent drinkers who are treated with brief counselling packages (e.g. motivational or social network therapy); and
- Employing alcohol health workers in Accident and Emergency and acute hospital clinics to work with non-dependent and dependent drinkers.

Links

- NW Cost of Alcohol Report 2012 links to Wirral report
- Wirral Cost of Alcohol Methodology 2013
- Wirral Cost of Alcohol Report 2013 from PHE and Drinkwise
- An evidence based alcohol strategy for the UK (March 2013) University of Stirling on behalf of the British Liver Trust and the Alcohol Health Alliance UK
- Alcohol Needs Assessment for Wirral conducted by LJMU in 2012
- Cost-effectiveness review on alcohol conducted by Liverpool University in 2010

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Glossary

Hazardous drinking: is a pattern of consumption associated with a high risk of psychological or physical problems in the future. The Scottish Intercollegiate Guidelines Network (SIGN) guideline defines hazardous drinking as regular consumption of 5+ units per day for men, and 3 for women (SIGN, 2003).

Harmful drinking: is a pattern of drinking that is already causing damage to physical or mental health. Harmful drinkers often already show clear evidence of harm by experiencing, for example, gastrointestinal complications, insomnia or falls. They typically consume more than hazardous drinkers and above recommended levels.

Dependent drinking: is characterised by psychological dependence, often with an increased drive to use alcohol and difficulty controlling its use. Symptoms of dependence including impaired control or a subjective experience of a compulsion to drink are experienced. In the extreme, it is associated with physical withdrawal symptoms upon cessation.

SMR: A ratio of the observed number of deaths in a population, relative to the expected number of deaths in that population. It is calculated by dividing the observed number of deaths by the expected number of deaths for Wirral. Ratios above 100 indicate that the number of events observed was greater than expected; whilst ratios below 100 that it was lower (England average is always 100).

Alcohol specific conditions (or wholly attributable): include those conditions where alcohol is implicated in *all* cases of the condition (e.g Alcohol Liver Disease is alcohol specific and has an Alcohol Attributable Fraction of 1, because no cases would arise without alcohol).

Alcohol attributable conditions (or partially attributable): Alcohol-attributable conditions include all those where alcohol is causally implicated in some but not all cases of the condition, for example, hypertensive diseases, various cancers and falls. The attributable fraction for alcohol-attributable conditions ranges from between greater than zero and less than one. For example, the Alcohol-Attributable Fraction for assault is 0.27.

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