Health and Social Services Public Health Directorate

Preventing harm caused by alcohol

A summary of evidence

January 2014

This document underpins the Council of Ministers' draft Alcohol and Licensing Strategy which is available for comment from 8 January 2014 to 24 March 2014.

The Economic Development Department has also produced a *Licensing Law policy paper* that also underpins the Council of Minister's strategy.

Both are available from www.gov.je/consult.

Introduction from Deputy Anne Pryke, Minister for Health and Social Services

Our vision is of a vibrant healthy community in which alcohol continues to be a part of our social and cultural lives. Where alcohol is regulated appropriately and its cost reflects both its social benefits and potential harm. It is a future where children and young people can meet without commercial pressure to drink alcohol, and where families and friends can enjoy evenings out without fear of antisocial behaviour fuelled by alcohol.

We have known for some time that alcohol consumption in Jersey is high when compared to other countries. Health research has shown that the more a population drinks, the greater the amount of harm caused to its society.

Promoting personal responsibility for sensible drinking is one approach to reducing harm caused by alcohol. But evidence shows that this cannot stand alone.

The department spends at least £2 million pounds a year dealing with hospital admissions for alcohol- attributed conditions. It is estimated that at least one life is lost in Jersey every year as a direct result of alcohol consumption, a tragic loss for family and friends, and a sad reflection on a society that is witnessing the continually escalating health and social costs of alcohol.

Even more disturbing is the scale of underage drinking among **some 12-15** year olds across our island, which makes it worryingly evident that we are not getting the balance between fun and harm quite right.

The Government of the States of Jersey has a key role in ensuring that everyone with a part to play in managing alcohol consumption does so in a way that promotes responsible and sensible drinking.

We need to be bold. We need to demonstrate strong leadership in creating the right environment and conditions for alcohol to exist as an acceptable, enjoyable and properly regulated element of social life. We need to be brave in making critical decisions on cost and we need to be flexible enough to manage accessibility in a way that protects our children and vulnerable people, but does not stifle our economy or our right to choice in our social lives.

These issues are all addressed in this Alcohol and Licensing Strategy, which will create a Licensing Law fit for the challenges of the 21st Century.

The key is to strike the right balance between tackling the harm caused by alcohol and acknowledging the positive benefits it can also bring, and we need your help to achieve that. I encourage you to support these efforts and to let us know what you think by submitting a response to the consultation on the Chief Ministers proposed Alcohol and Licensing Strategy. The responses you give will help us in creating a healthy, safe and bright future for our island.

Foreword from the Medical Officer of Health

Alcohol is the everyday name we use for the organic compound ethyl alcohol, or ethanol. A colourless, flammable liquid, it occurs naturally as the product of fermentation of sugar and yeast. It is also a psychoactive drug with addictive properties.

Alcohol has been a recreational drug since pre-history - a pleasurable social lubricant when used in moderation. However there is a lengthy and impressive catalogue of problems over the millennia:

- Problems with drunkenness are recorded in texts on Ancient Egypt
- The Ancient Babylonians needed a law to regulate drinking houses
- Ancient Romans worshipped Bacchus, the god of wine, in orgies
- There are warnings against the perils of alcohol in Ancient Greek literature
- Alcohol consumption by people of the Muslim religion was – and remains – banned by their prophet Mohammed
- In Britain's industrial revolution in the 1830's, alcoholism was rife – this was followed by the temperance movement: 'taking the pledge'.
- In the United States in the early 1900s, the corn surplus led to unprecedented per capita alcohol consumption. The 1919 National Prohibition Act resulted.
- In the UK and much of the Western world in the late 20th / early 21st century, alcohol-related harm including deaths began to increase, alongside shifting attitudes to public drunkenness and easy availability of cheap alcohol, notably through supermarkets.

Alcohol can cause wide ranging harms to health, from the acute effects of drunkenness (accidents, violence and injuries, alcohol poisoning, vomiting and aspiration, risky sexual behaviour) to the 60 or so medical conditions currently known to be linked with alcohol as a causal factor. Of these, most people are aware that excessive alcohol consumption over time often leads to chronic liver disease (cirrhosis). However it is less well recognised that alcohol is one of the most important causes of hypertension (high blood pressure), is strongly associated with obesity and is implicated as a causal factor in a large number of cancers, including mouth, throat, gullet, stomach, breast and liver cancers.

The effects of alcohol vary from person to person. Thinking of short-term effects, factors that affect how high a person's blood alcohol level reaches after consumption include age, weight, gender, genetic make-up, the type (% alcohol), amount and speed of drink consumed, and how much was eaten before drinking. It is thus impossible to make any reliable predictions about 'safe' levels of drinking to avoid exceeding the legal limit for driving.

The more chronic effects and serious harms that excess alcohol intake over time can generate are even more unpredictable. Everyone knows one or more people whose alcohol consumption is or was very high, well above recommended safer drinking levels, and yet they seem to be escaping serious health harms, or lived to a ripe old age. At some time in the future, genetic profiling may render it possible to identify which of us is more at risk than others of contracting certain medical conditions when exposed to relevant risk factors: and which of us may be able to take such 'risks' with lesser consequences. At present, drinking above the recommended limits and hoping for the best is no better than playing Russian roulette.

Alcoholic liver disease often has mild or no symptoms until the condition is well advanced. Deaths due to liver disease have doubled in the UK since 1986. Our own data does not go back as far as that, but currently our Standardised Mortality Ratio for liver disease deaths is 150[1] if we compared ourselves with the South West Region of England (where the population and environment has much in common with our own) and 129 when we compare with the England and Wales average. To explain, this is a statistical calculation where the average is calculated to a SMR of 100: so having a SMR of 150 tells us we are 50% above the SW Region average, and the 129 figure means we are 29% above the England and Wales average.

As explained later in this paper, our rates of alcohol-specific deaths (those due to conditions known to be caused specifically by alcohol, including liver disease) are approximately twice as high as the England rate: this is the equally the case for deaths in women as well as deaths in men. We also compare badly with our neighbours – second only to the North East and North West Regions of England – when we calculate alcohol-attributable hospital admissions. This is a measure of the impact of a wide range of conditions which evidence shows are wholly or partly caused by alcohol consumption. Alcohol and its consequences are having a serious and significant impact on the people of this island, and on our health services. It is time for renewed, and effective action to prevent more damage.

This paper sets out further detail on the health harms of alcohol and Health and Social Services Department support for moving forwards together for better population health across government through developing activity as guided by the alcohol and licensing strategy currently out for consultation.

The joint government alcohol and licensing strategy is a first step to achieving our vision. A vision of a vibrant healthy community in which alcohol continues to be a part of our social and cultural lives. Where alcohol is regulated appropriately and its cost reflects both its social benefits and potential harm. It is a future where children and young people can meet without commercial pressure to drink alcohol and where families and friends can enjoy evenings without fear of anti-social behaviour fuelled by alcohol.

[1] 2008/9: Jersey Health Profile: Public Health Department

Executive Summary

'It is difficult to imagine that patterns of behaviour will alter dramatically until a vital message finally gets through – that although alcohol can be a friend as a personal pleasure and a social lubricant, used in excess it soon changes character and becomes the mortal enemy of individuals and society'

Chris Bright Editor Jersey Evening Post, 3rd March 2009.

It is widely recognised and increasingly apparent that the current level of alcohol consumption in Jersey causes harm. In 2003 the States of Jersey agreed an alcohol strategy which aimed to reduce the harm caused by alcohol. During the time of this Strategy the average per adult consumption levels of alcohol have fallen from 16 litres to 12.8 litres per adult population. These hard won reductions have been the result of coordinated action between different government departments such as Home Affairs, Treasury, Education Sports and Culture, Health and Social Services.

Despite this reduction, hospital spending is estimated at £2million a year for alcohol attributable conditions and the mortality from chronic liver disease is one-and-a-half times greater then the south west.

We are fortunate that the wider societal strategies to tackle excessive alcohol consumption are already known and have been implemented in other countries. Investment for a pathway of treatment and support services has already been identified as a priority in the Health and Social Services White Paper (2012). This strategy draws upon the national recommendations made by the National Institute of Clinical Excellence and the World Health Organisation with a focus on population approaches to reducing alcohol consumption and related harm. Service specifications for building on current alcohol services have been underway led by HSSD throughout 2013.

A comprehensive report in 2006 to the European Commission identified the most effective elements of alcohol policies to reduce the harm caused by alcohol. In general, the evidence is strong for the effectiveness of regulating alcohol availability and the use of alcohol taxes. Given the broad reach of these strategies, and the relatively low expense of implementing them, the expected impact of these measures on a society and its health is relatively high.

For example, most drink-driving countermeasures, such as reducing the legal limit of blood alcohol levels, received high ratings on effectiveness. Not only is there good research support for these programmes, but they also seem to be applicable in most countries and are relatively inexpensive to implement and sustain.

In contrast, the expected impact for school-based education and for public service messages about drinking is low. Although the reach of educational programmes is thought to be excellent (because of the availability of captive audiences in schools), the ability to change behaviour across a population is poor when compared to other measures.

The full range of interventions, as described above, is needed to achieve the greatest population impact. The approaches proposed in the alcohol strategy will attempt to balance what works with what's feasible within current resources and what would be publicly acceptable.

The recent Health Profile, completed by the Public Health Department, demonstrates in detail the breadth of harm caused by alcohol and provides the detailed baseline measures which will be used to measure the effectiveness of the health objectives outlined in the alcohol and licensing strategy.

Key States Departments have worked together on the principles which inform this prevention focused strategy and further involvement is anticipated as specific project plans and strategic activity are developed in due course.

Introduction

Alcohol has been an ever-present part of Jersey life. Records show that alcohol consumption has always been high in the Island. This may be because of greater disposable wealth brought about by the development of a more affluent society. Alcohol consumption is not bad in itself and it can be sensibly enjoyed. For the majority of people in the island who drink it, alcohol acts as a pleasant social lubricant that is enjoyed with friends without worry.

Alcohol sales are important to businesses such as hotels, restaurants and bars, which cater for the demand for alcohol by both residents and tourists. This sector of the economy employed around 5,050 people at the end of 2012 – about 9% of all workers[2]. Impots duty collected on alcohol came to £16.8 million pounds in 2012.

It is difficult to estimate all the costs associated with alcohol. Experts have different opinions of what costs should be included in any assessment. The best estimates from international research suggest the costs to society of harmful levels of alcohol consumption are likely to be between 1.3% - 2% of Gross Domestic Product (GDP), which for Jersey would equate to £45 – £70 million pounds per annum[3].

Background, and Progress to date

In 2003 the States of Jersey agreed a specific alcohol strategy which aimed to reduce the harm caused by alcohol. This document was part of broader efforts to improve community safety as set out in the Building a Safer Society Strategy. These hard won reductions have been the result of robust and successful partnership working between States departments, Voluntary Groups and representatives of licensed premises.

During the lifetime of the Alcohol Strategy there have been a number of ongoing initiatives that are likely, given the existing research evidence - to have contributed to this reduction such as;

- Regular drink driving campaigns
- Embedding alcohol education into the school curriculum
- Closer working between the States of Jersey Police and Licensees
- Support for innovative approaches (taxi marshal) to promote community safety
- Maintaining an annual increase in alcohol impot in most years of the strategy

Despite this progress, levels of alcohol consumption are still high. For example the European average alcohol consumption is 11 litres per capita compared to 12.8 in Jersey. Previously proposed actions (revision of the licensing law, harmonising the rate of impot on alcohol and reducing the level of permissible level of blood alcohol content when driving) have not yet been achieved so will be included in the new strategy.

The new Alcohol and Licensing Strategy for Jersey

The proposed new alcohol strategy builds on the success of previous strategies with revised objectives informed by new and emerging evidence for effectiveness in reducing the avoidable harm caused by alcohol. The emphasis is firmly on island wide prevention. Most recently the National Institute for Health and Care Excellence (2010) published guidance and made recommendations on preventing harmful drinking. This strategy draws upon these new recommendations. The Alcohol Strategy complements the current Health and Social Services White Paper, Caring for each other; caring for ourselves' with its emphasis on early intervention and pathways of care.

[2] States of Jersey Statistics Unit: Jersey in Figures 2011:
[3] Institute of Alcohol Studies: 2008: Economic Costs and Benefits Fact Sheet

The recent Health Profile, completed by the Public Health Department, demonstrates in detail the breadth of harm caused by alcohol and provides the detailed baseline measures which will be used to measure the effectiveness of the objectives outlined in this strategy.

Key States Departments, including Economic Development, Home Affairs and Treasury have worked together on the principles which inform this prevention focused strategy and further involvement has been committed to, as specific project plans are developed in due course.

The five keys objectives are:

1. to help reduce alcohol related crime and disorder
2. to better secure public safety
3. to help prevent public nuisance
4. to better protect and improve public health
5. to help protect children from alcohol related harm

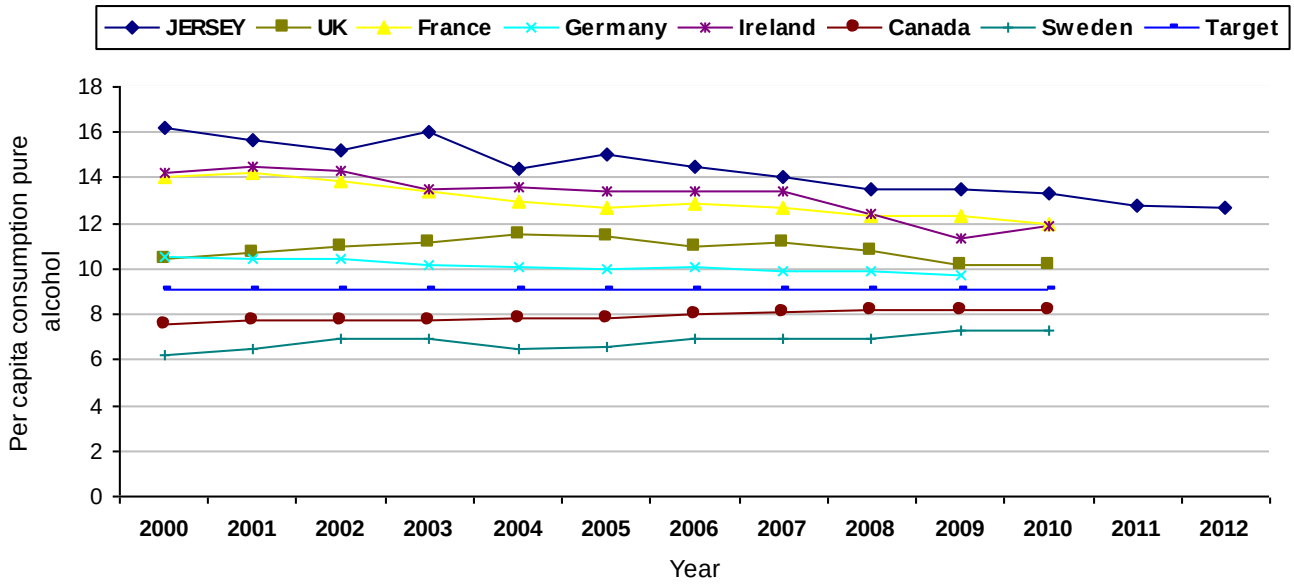
One of the key measures of success for these objectives will be year on year measure of per capita consumption of alcohol. Other measures will include self reported consumption and sources alcohol by young people as well as Alcohol and Drug Service referral and rates of alcohol attributable admissions.

Alcohol Consumption in Jersey – An Overview

Patterns of Consumption

In Jersey, we consume high levels of alcohol when compared to other countries. To benchmark against other jurisdictions, we calculate the average amount of pure alcohol consumed per person per year. In 2012, this was 12.8 litres (see figure 1 below). To put this number into perspective, this is roughly equivalent to about 130 bottles of wine per person per year which equates to 2-3 bottles per week; an average of 25 units per week for everyone aged 16 and over. Of course, the reality is more varied than this. We know from the Jersey Annual Social Survey that there are some people over 16 who don't drink alcohol at all: around 11%. So the average consumption among all alcohol drinkers is actually higher than the 13 litre overall average – and we all know some who consume considerably more than the average.

Figure 1: Alcohol Consumption per capita (litres of pure alcohol per 15+)



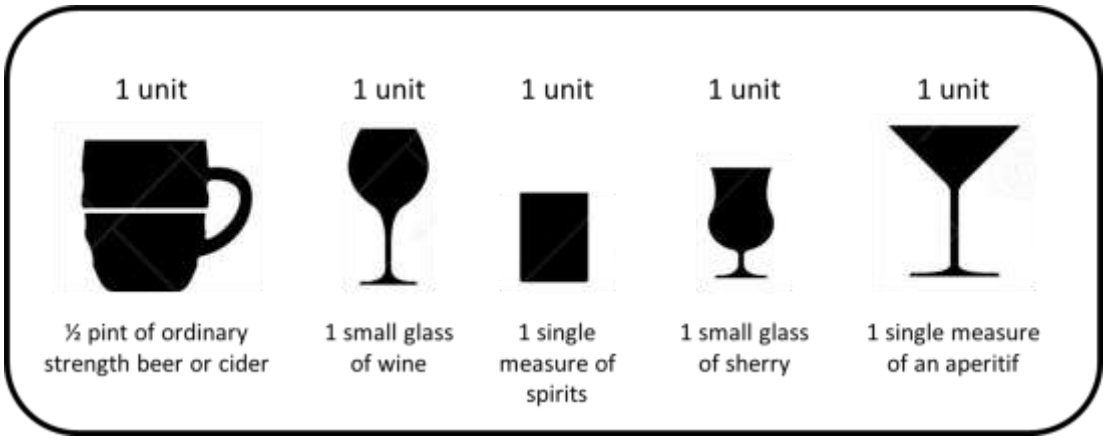
Source: Public Health Intelligence Unit

Approximately, 89% of the Jersey population (aged 16 or over) drink alcohol, which is equivalent to 73,000 people. The Department of Health guidance states that to lower the risk of detrimental health effects, men should not regularly drink more than 4 units per day and women should not regularly drink more than 3 units per day. Individuals who exceed the daily recommendations for their sex are considered to be drinking at *'increased risk'*. Men drinking in excess of 8 units per day and women drinking in excess of 6 units per day on drinking days are considered to be drinking at a level conferring *higher risk*.

In Jersey 52% of adults knew the correct daily recommended maximum sensible alcohol intake for men, 63% were able to recall the correct daily recommended maximum amount for women. Approximately 20% over-estimated the recommended maximum daily units for men whilst slightly fewer (12%) over-estimated the recommended maximum daily units for women. Respondents who over estimated the daily recommended limits were also found to be more likely to consume alcohol at above the recommended limits[4].

A Unit of alcohol is 10 millilitres of pure alcohol. It is the amount of alcohol in a standard measure of spirits, a small glass of wine with 11% alcohol, or half a pint of 4% alcohol beer, lager or cider. If wine is stronger or in larger glasses, or if the other drinks have higher alcohol levels, each drink contains proportionately more Units. For example a 250 ml glass of 13% alcohol wine contains 3 Units.

Figure 2: What is a Unit?



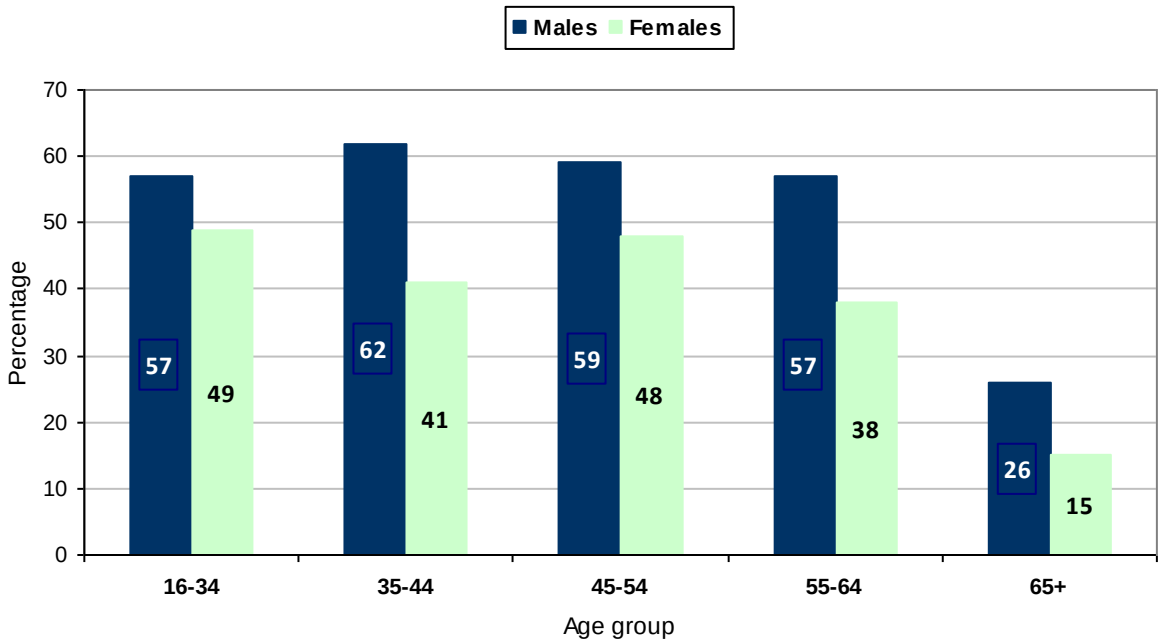
Source: Department of Health:

Self-reported levels of alcohol Units consumed in the Jersey Annual Social Survey (2010) suggests that 7,212 men and 5,405 women are drinking at a level of increased risk. Figure 3 below shows the percentage of men and women who are exceeding the recommended upper limit on at least one day of the week. In addition it is estimated that approximately 4,000 people are dependent on alcohol[5]. Given the widespread misunderstanding about what constitutes a unit of alcohol, these figures may well be considerable underestimates of true consumption.

Anecdotal evidence from representatives of the licensed trade and emergency services would suggest that much of the consumption is around the weekend. So called 'binge drinking', especially amongst young adults, is a concern with rapid consumption of strong drink over a short period of time, resulting in increasing numbers attending the hospital's Emergency Department needing treatment for acute intoxication, falls and injuries that are resulting from fights.

[4] States of Jersey Statistics Unit: 2008: Jersey Annual Social Survey
[5] Revised 2010 population estimates based on 2011 census

Figure 3. Percentage exceeding the recommended upper limit on at least one day of the week



Source: Jersey Annual Social Survey 2010

When comparing alcohol consumption behaviour to other countries with high population consumption such as England; the patterns of drinking show similarities (Figure 4). The known incidence of health risks resulting from alcohol (such as increased risk of cardio vascular disease, cancers such as liver and breast cancer, gastrointestinal disease such as liver cirrhosis, pancreatitis, and other conditions including type II diabetes, and neuro psychiatric conditions such as depression and anxiety), increase dramatically for men who exceed 7/8 drinks per occasion and for women who exceed 5/6 drinks per occasion.

Figure 4: Comparison of Men and Women in Jersey and England consuming alcohol at increased and higher levels of risk (2010)

	2010 England	**2010 Jersey**
Men over 4 units	41%	39%
Men over 8 units	23%	18%
Women over 3 units	28%	32%
Women over 6 units	14%	10%

Source: Public Health Intelligence Unit: 2012

Impact of Alcohol Misuse on Hospital Services

We know that continuing high levels of consumption across the population have led to high levels of demand for hospital services. Around 7% of the adult population have been injured or injured someone else as a result of their drinking, with nearly three-quarters of such occurrences during the twelve months prior to the survey. Friends, doctors and health workers have been sufficiently

worried about the drinking of 6% of the population to advise them to cut down on their consumption[6].

In 2010 it was estimated that there were 2,372 hospital admissions specifically or partially attributable to alcohol. Males (68%) were more likely to be admitted than females (32%) for alcohol attributable conditions or consequences[7].

In order to compare Jersey with other regions in England alcohol attributable hospital admissions are used. This is a statistical method of calculating the number of admissions for certain conditions linked to alcohol, and the proportion of that type of admission which are caused by alcohol. This shows that the Jersey Hospital was above the national average and third highest overall. (Figure 5)

Figure 5.Rates of alcohol attributable hospital admissions per 100,000 (EASR) 2010/2011

North East	2,600
North West	2,429
London	1,915
South East	1,458
South East Coast SHA	1,567
South Central SHA	1,338
South West	1,757
England	1,898
Jersey 2010*	**2,065**

Source: Jersey HIU; Compendium of Population Health Indicators.

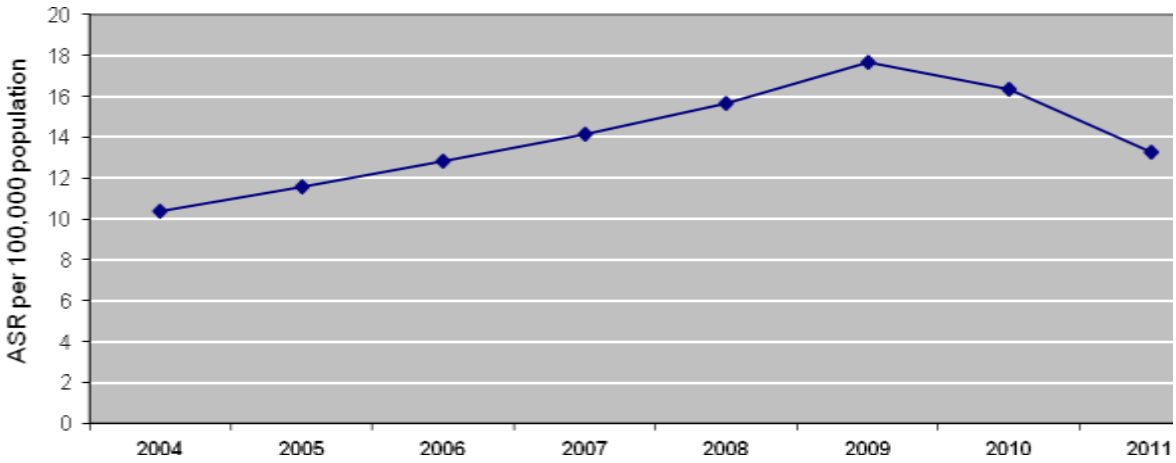
* Jersey data does not include consultant episodes for private patients or from Orchard House, Sandybrook or the Limes

Source: 2011 census and 2010 Jersey Annual Social Survey

Currently, there are on average 273 (2009 – 2011) years of life lost every year due to premature death from alcohol in Jersey. Alcohol accounts for around 2% of all deaths in our Island. Jersey experiences 30-50% more deaths than would be expected from chronic liver disease when compared with England & Wales[8]. Most, but not all cases of chronic liver disease are caused by excessive alcohol consumption. The death rate from chronic liver disease in men is about one and a half times higher in Jersey when compared with England & Wales. Death rates caused specifically by alcohol have risen between 2005 – 2009, with a small reduction in 2010 (Figure 6).

Figure 6. *Alcohol specific death rate (three year rolling age standardised rate).*

[6] States of Jersey Statistics Department: 2010: Jersey Annual Social Survey
[7] Admission with alcohol specific primary diagnosis
[8] Jersey Public Health Department: Jersey Health Profile 2008/9



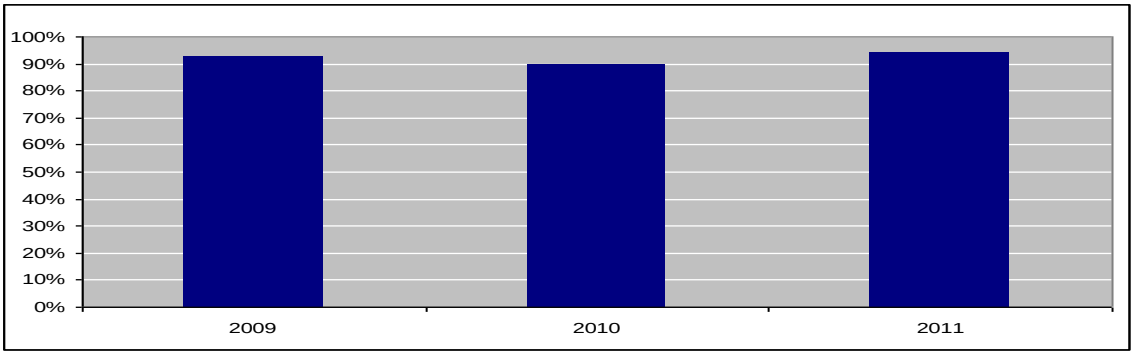
Source: Public Health Intelligence Unit (2012)

The Wider Impact of Alcohol Misuse

We know that alcohol addiction is a problem and can seriously affect people's lives, and whilst it is hard to gauge the true extent of the problem, recent surveys suggest that at least 5% to 12% of people have some issues with alcohol use. Although almost everyone (99%) has "never needed an alcoholic drink in the morning to get over a heavy drinking session", 5% have failed to do what was expected of them because of their drinking in the past year, 14% (almost one in every six) had a feeling of guilt or regret after drinking and the same proportion of people have been unable to remember what happened the night before[9].

Alcohol is a factor in the majority of violent street crimes and public order offences in Jersey and is the major contributory factor in most evening arrests. It is also a significant factor in domestic violence. In 2011, just over 90% of all evening street violence arrests involved alcohol, and this figure has been consistently high in previous years (figure 7).

Figure 7: Proportion of arrests for violence & disorder involving alcohol intoxication 2009 - 2011



Source: States of Jersey Police (2011)

Many of the mental and physical functions that we depend on to drive safely are affected when we drink alcohol. In Jersey the alcohol limit for drivers is 80mg of alcohol per 100ml of blood, 35mg per 100ml of breath or 107mg per 100ml of urine. In most other European countries, the limit is less, usually 50mg per 100ml of blood. In Jersey around 200 people a year are charged with drunk in charge of a vehicle. Approximately 52% of those charged were over double the permitted

[9] States of Jersey Statistics Unit: Jersey Annual Social Survey 2010

limit. Between 10%-30% of these offences were found following a road traffic accident[10]. Some countries have schemes that are linked to drink-drive convictions to identify and help problem drinkers. The applicability of these in a Jersey context should be explored.

Impact of Alcohol on Children and Young people

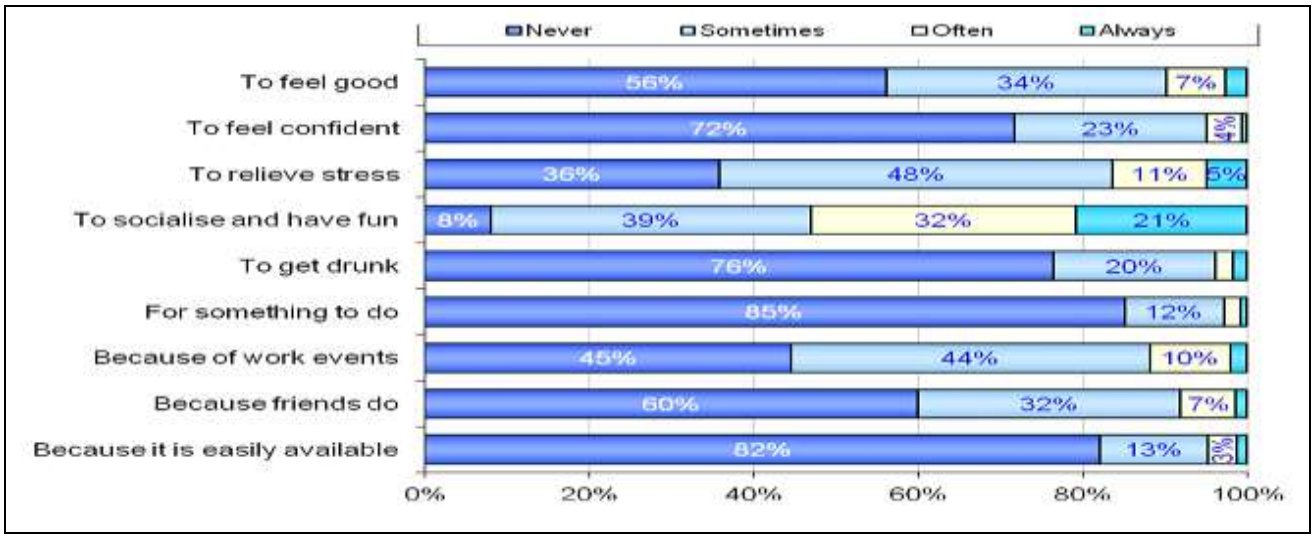
Drinking at an early age can cause serious health problems, both in the short and long term. The healthiest option is for children to have an alcohol free childhood. In general children are emotionally less able to cope with the effects of drinking alcohol; and their level of maturity means they are more likely to engage in risky behaviour as a result of drinking. For example a recent audit by Brook (Jersey) found that over half of young girls requesting emergency contraception reported drinking alcohol prior to sexual activity.

The Health Related Behaviour Survey of Children (2010) shows that 11% of young people aged between 14-15 years old are drinking alcohol regularly. Research has shown that exposure to alcohol advertising is commonly associated with the onset of drinking among young people and increased consumption among those who already drink. Tightening regulation on advertising has been recommended by the National Institute for Health and Care Excellence as part of a preventative approach.

Reasons for Drinking

There are many and varied reasons why people like to drink alcohol. When asked almost two thirds of people reported drinking alcohol to relieve stress at least sometimes[11]. Around a quarter said they drank with the intention of getting drunk at least sometimes whilst work events also had an influence on consumption (see Figure 8). Not surprisingly children and young people described similar reasons for drinking alcohol with socialising and having fun with friends being the biggest influence on consumption[12].

Figure 8: Reason for Drinking Alcohol



Source: States of Jersey Statistics Unit

[10] Figures from States of Jersey Police: 2012
[11] States of Jersey Statistics Unit: Jersey Annual Social Survey 2010.
[12] Public Health Department: 2011: A Picture of Health in Jersey: 2010

What we drink

In Jersey, nearly half of people who drink alcohol said that they mostly drink wine[13]. The second most popular drink was normal strength beer or lager or cider (see Figure 9). The table below shows whilst normal strength beer or lager is the most preferred drink for 16 to 24 year olds, as people get older beer becomes less commonly chosen as the preferred drink and wine begins to become the most favoured drink with 70% of 55 to 64 year olds mostly drinking wine compared with only 25% of 16 to 24 year olds; While two-fifths (43%) of *men* preferred to drink normal strength beer, lager or cider, and the same proportion (43%) preferred wine, only one in ten (10%) *women* preferred to drink normal strength beer, lager or cider compared to over two-thirds (69%) who preferred to drink wine.

Figure 9: Type of alcohol consumed by Age Group

Type of alcoholic drink	16 – 24 yrs	25 – 34 yrs	35 – 44 yrs	44 – 54 yrs	55 - 64 yrs	65 - 74 yrs	75+ yrs	All ages
Strong beer /lager /cider	2	9	6	4	3	2	2	**5**
Normal strength beer /lager /cider	41	30	26	26	18	17	13	**26**
Wine	25	48	61	62	70	68	68	**56**
Alco-pops	9	1	0	1	0	0	0	**2**
Spirits	23	12	5	5	7	7	11	**10**
Sherry	0	0	0	1	0	4	4	**1**
Low alcohol drinks	0	0	1	1	1	3	1	**1**
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Access to Alcohol

The availability of alcohol within a population has been shown to increase its consumption. There are 560 licensed premises in Jersey (385 'on'; 175 'off') in relation to which 701 different type of alcohol licences are held with many premises holding multiple licences depending on the nature of their business[14]. Previous Medical Officer of Health Reports[15] point to a higher number of actual outlets in Jersey licensed to sell alcohol when compared to populations of similar size and characteristics in the South West and UK (Figure 10 below).

Fig 10: Rate of licensed premises per 10,000 population

Jersey 2010	On-licences	Off- licences	Total
Number	404	179	583
Rate per total population	44.0	19.5	63.5
Rate per total peak population	37	16.4	53.4
England 2003/04	21.2	8.7	29.9
Southwest 2003/04	27.8	9.7	37.5

[13] States of Jersey Statistics Department: 2008 Jersey Annual Social Survey.
[14] Figures from Economic Development Department
[15] Annual Report of the Medical Officer of Health: 2009/10 Chapter 4 Health Statistics: Public Health Department

Differences v England	*x2.1*	*X2.2*	*x2.1*
v Southwest	*x1.6*	*X2.0*	*x1.7*

Source: South West Public Health Observatory, 2008

In a recent case study of the Liberation Square area in St Helier, it was estimated that there was a licence capacity for approximately 5,380 people across only seven streets[16]. Having high levels of accessibility and opportunity to consume alcohol has been shown in other countries to increase consumption. A best practice policy would support specific conditions being applied to licensed premises in high density areas, for example limiting the time period a retailer is permitted to sell alcohol where there are already significant numbers of existing retailers selling alcohol.

Figure 11: Licensed Capacity by Street (2011)

Locality	**Seated**	**Standing**	**Total**
Mulcaster Street	140	440	580
Esplanade	-	230	230
Bond Street	42	108	150
Wharf Street	-	410	410
Liberation Street	800	730	1530
Caledonian Place	50	185	235
Weighbridge	1345	900	2245
Total	2377	3003	5380

Source: Public Health Department: 2011

Within the Alcohol and licensing strategy, there are plans to introduce an Alcohol and Licensing Policy group. It will be the responsibility of this group to provide annual policy guidance to the Licensing Assembly who are responsible for the determination and issuing of licences to sell alcohol. The purpose of this guidance will be to ensure that the overall treatment of liquor licences shall be seen to be transparent, fair, consistent, reasonable and in accordance with strategic objectives. Should a body of local evidence indicate that the density of licences is linked to any increases in crime, disorder nuisance, deteriorating public health or harms to young people it is envisaged that the policy group will be responsible for considering such concerns and where appropriate providing recommendations both generally and specifically to the Licensing Assembly.

The Price of Alcohol

There is research evidence that shows that the amount of alcohol drunk by the population as a whole[17], as opposed to by particular groups in the population, is driven in part by price, availability and promotion. Or, to put it simply, the more outlets there are selling cheap alcohol, the more a population is likely to drink overall.

There is also research that suggests that young people and problem drinkers are particularly price-sensitive and their consumption of alcohol is affected by how much it costs[18]. Research also shows

[16] Public Health Department: 2011: Responding to Alcohol Density, A Case Study:

[17] Anderson.P, Baugman.B: 2006: Alcohol in Europe, A Public Health Perspective. A Report for the European Commission: Institute of Alcohol Studies

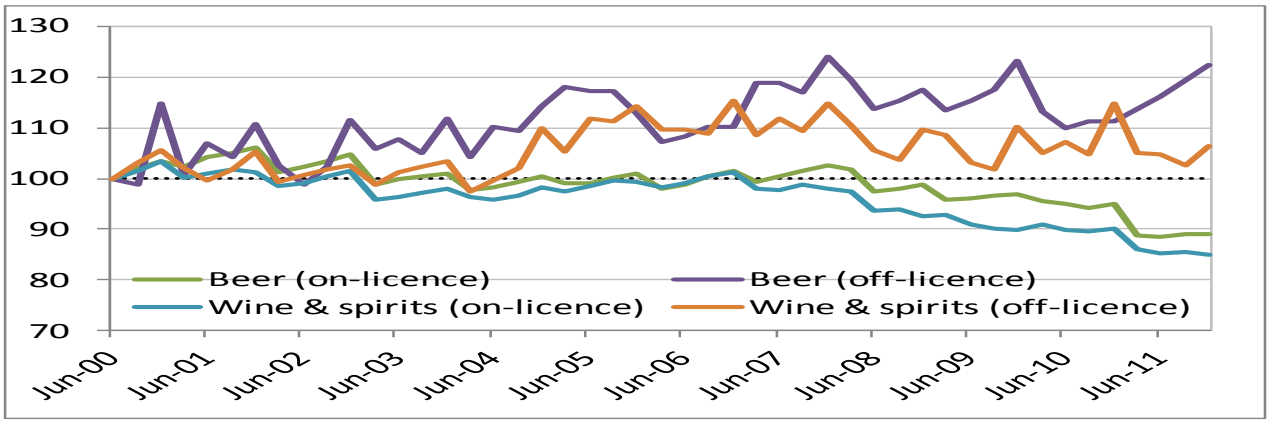
[18] Estimates taken from the University of Sheffield: 2008: Independent Review of the Effect of Alcohol Pricing and Promotion: Part B; School of Health & Related Research: 1980: Independent Review of the effects of alcohol pricing and promotion, A summary of the evidence to accompany a report on phase 1 systematic reviews. University of Sheffield.

that when alcohol is cheaper more is consumed and more harm results; when alcohol becomes more difficult to access, less is consumed and less harm results[19].

Locally we know that since 2000 alcohol sold in off-licences has become more affordable whereas on-licence alcohol became less affordable over the same period, particularly since 2008 (Figure 12).

Anecdotal evidence would suggest that there has been a change in drinking patterns toward increased drinking at home and away from drinking in on-licensed premises. Whilst national survey data support this viewpoint, no local survey information is available to support the extent of this trend in Jersey. More work needs to be done in understanding the nature and extent of price differences between alcohol sold from different premises.

Figure 12: Alcohol affordability, Jersey on and off licence 2000-2011



Source: Statistics Unit and Economics Unit calculations

There are three distinct approaches that can be taken to address alcohol price including adjustments to taxation through impot duties, implementing a minimum unit price and addressing price and bulk promotions.

Addressing price through impot duty

At present duty[20] is calculated according to the type of alcoholic drink and to some extent its alcoholic strength. So for example the duty on spirits is much higher than other alcoholic drinks. However, there are examples where the duty per unit of alcohol is higher for lower strength alcoholic drinks than higher strength alcoholic drinks. Equalisation of duty across types of alcohol could support a more balanced approach to taxation based on the potential harm of alcohol strength.

For illustrative purposes, if the rate of duty on alcohol was set at the currently level charged for spirits; the price of beer, cider and wine would increase by between 5% and 20% while the price of spirits would not change. For example there would be a 25p increase on a pint of beer, 90p increase on a bottle of medium strength wine and a 75p increase on a four pack of lager. It is estimated this would increase government revenue from impot duty from £17million to £26million[21] which in turn would help government address some of the known social costs of alcohol consumption. It is estimated that there would be an approximate 6% reduction in consumption

[19] Alcohol Public Health Research Alliance (AMPHORA) 2012, The AMPHORA manifesto on Alcohol.
[20] Impots is French for tax or duty. By virtue of the Customs and Excise (Jersey) Law 1999 duty means any duty imposed by this Law on goods imported into, exported from or grown , produced or manufactured in the Baliwick and includes both customs and excise duty.
[21] Figures from States of Jersey Economics Unit

which would be equivalent to an average of 0.8 litres of pure alcohol per person. This reduction is likely to be gradual and seen over time.

Addressing price through a minimum unit cost

A minimum unit price is where there is a set price per unit of alcohol which must be charged by the retailer. The stronger the alcohol content, the more units contained within the beverage the higher the minimum price. Retailers would be legally required to ensure their prices for all alcoholic drinks were above the set minimum price. The increased revenue raised would go to the retailer. The effect would be to stop the amount that alcohol is used in loss leader promotions.

Accordingly to the research for the Department of Health it was estimated that increasing price per unit to 45p would lead to a 4.5% reduction in consumption, increasing by 50p would lead to 6.9% reduction and 60p to 12.8% reduction [22,23]. The research points particularly to reductions in young people's consumption as this group are price sensitive. Further impacts of the projected population consumption based on a 50p minimum unit price suggested the following benefits:

- Alcohol related deaths would fall by about 60 in the first year and 318 by year ten of the policy
- A fall in hospital admission of 1,600 in year 1, and 6,500 per year ten of the policy
- A fall in crime volumes by around 3,500 offences per year
- A financial saving from harm reduction (health, employment, crime etc) of £942m over ten years.

There are similarities and differences between the England and Jersey alcohol market therefore caution should be taken when applying the potential impacts to Jersey.

Other approaches working with retailers to voluntarily support responsible promotions should also be considered.

All the evidence suggests we need to review and strengthen a strategic approach to price. The National Institute for Health and Care Excellence in 2010[24] concluded, making alcohol less affordable is the most effective way of reducing alcohol-related harm. There is extensive international and national evidence (within the published literature and from economic analyses) to justify reviewing policies on pricing to reduce the affordability of alcohol.

Framework for Action

Evidence based Policy – A Summary of what works

We are fortunate that the wider societal solutions to excessive alcohol consumption are already known and have been implemented in other countries. The WHO-sponsored report 'Alcohol – No Ordinary Commodity' was first published in 2003 by Thomas Babor[25] (USA) and 14 other alcohol researchers from New Zealand, UK, Canada, Australia, Finland, Switzerland, Sweden, and Norway. The report describes recent advances in alcohol research with the purpose to guide actors in the policy field towards more efficient strategies to prevent alcohol problems. The table below lists the ten policy options they identified that stand out as 'best practises'.

[22] Estimates taken from the University of Sheffield: 2008: Independent Review of the Effect of Alcohol Pricing and Promotion: Part B.

[23] School of Health & Related Research: 1980: Independent Review of the effects of alcohol pricing and promotion, A summary of the evidence to accompany a report on phase 1 systematic reviews. University of Sheffield.

[24] National Institute for Health and Care Excellence 2010, Alcohol-use disorders: preventing harmful drinking

[25] Babor T. 2003. Alcohol. Oxford: Oxford University Press

Ten Best Practices
• Minimum legal purchasing age
• Government monopoly of retail sales
• Restrictions on hours and/or days of sale
• Outlet density restrictions
• Alcohol taxes
• Sobriety spot-check points (drunk driving)
• Lowered BAC limits (blood alcohol concentration, drunk driving)
• Administrative licence suspension following drink driving charges
• Graduated limits for drinking and driving for novice drivers
• Brief interventions for hazardous drinkers

In 2009 the World Health Organisation published a review of the most effective and cost effective alcohol policies which reduce alcohol related harm[26]. The review built on previous work in this area. In general, evidence of effectiveness was strong for the regulation of alcohol availability and the use of alcohol taxes. Given the broad reach of these strategies, and the relatively low expense of implementing them, the expected impact of these measures on public health is relatively high.

Most drink-driving counter measures received high ratings of effectiveness. Not only is there good research support for these programmes, but they also seem to be applicable in most countries and are relatively inexpensive to implement and sustain.

In contrast, the expected impact is low for school-based education and for public service messages about drinking. Although the reach of educational programmes is thought to be excellent (because of the availability of a captive student audience), the population impact of these programmes is poor. Similarly, while feasibility is good, cost–effectiveness and cost–benefit are poor when compared to other measures.

Treatment and early intervention strategies have, at best, medium effectiveness, because at a population level, their impact is limited, as specialised treatment for alcohol problems can benefit only the relatively small fraction of the population who come into treatment. While treatment provision is an obligation of a humane society, its effect on the actual drinking problem rates of the population at large is limited.

The fullest range of interventions is <u>necessary</u> to achieve the greatest population impact. No one intervention is <u>sufficient.</u> The interventions proposed in the new alcohol strategy attempt to balance what works, with the likely feasibility and acceptability of island-wide implementation.

[26] World Health Organisation Europe: 2009: Evidence of the Effectiveness and Cost Effectiveness of Interventions to reduce alcohol-related harm: World Health Organisation European Regional Office