

Jersey Alcohol Profile 2016

Statistics Unit

States 
of Jersey

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Jersey alcohol profile 2016

12 litres
of pure alcohol

The average alcohol consumption per person aged 15 or over



1 in 4 drinkers drink at potentially hazardous or harmful levels



Islanders drink, on average, a sixth (17%) less than a decade ago, in 2006



Since June 2000, alcohol prices have increased more than retail prices



Around **1 in 6** of all crimes were recorded as involving alcohol

People aged in their 40's and 50's



spend the most on wine at home* and spend the most on alcohol generally

*expenditure in off-license premises

In 2014-2016, there were **39 deaths** in Jersey related to the consumption of alcohol

these represent **2%** of all deaths.



During 2014-2016, there were **50 admissions** of children to hospital with an alcohol-specific condition

Summary

This report presents statistics and recent trends of alcohol use in Jersey.

Information presented in this report is based on data provided by States of Jersey departments, survey results and data processed by the Statistics Unit. Detailed information on the nature of sources and data handling are given in the Background Notes section of this report.

Key findings

In Jersey, in 2016:

- an average of 12 litres of pure alcohol was consumed per person aged 15 or over. The level of consumption is similar to that reported for 2014 and 2015
- alcohol consumption is around a sixth (17 per cent) less than a decade earlier, in 2006
- Jersey has a similar level of alcohol consumption (per person aged 15 or over) to France, Ireland and Poland but higher than Portugal and the UK
- one in eight (12 per cent) respondents to the Jersey Opinions and Lifestyle Survey reported that they never drink alcohol
- around a quarter (26 per cent) of drinkers were found to be drinking at potentially hazardous or harmful levels
- around two-fifths (39 per cent) of 16 to 34 year old drinkers reported drinking five or more units on a typical drinking day, exceeding the recommended daily limits for both males and females
- there were 470 referrals to the Drug and Alcohol Service for problematic drinking; of these two-thirds (65 per cent) were male
- almost 20,000 days of sickness and invalidity benefit were claimed for alcoholism in 2016

Over the period 2014 to 2016:

- there were 39 alcohol-related deaths (Office for National Statistics definition), representing 2 per cent of all deaths in Jersey. The most common alcohol-related death was alcoholic liver disease, accounting for two-thirds (64 per cent) of alcohol-related deaths during this period
- one in six (16 per cent) of all recorded crimes over the three-year period were recorded as involving alcohol

In 2017:

- between June 2000 and June 2017 the price of alcohol increased at a higher rate than retail prices generally (17 per cent greater)

Introduction

The States of Jersey Statistics Unit now provides population level health statistics.¹ This report is the latest in a series of reports which examines the effect of alcohol on Islanders' health. It covers topics such as drinking habits and behaviours among adults (aged 16 or over) and school children (aged 11 to 15), drinking-related ill health and mortality, pricing of alcohol, alcohol-specific hospital admissions and alcohol-related prices and expenditure. The report contains both previously published information and new analyses.

A number of States of Jersey Departments have provided data for this report, including the Health and Social Services Department, Social Security Department and the States of Jersey Police.

Comparisons are presented with data published by Public Health England (PHE), the UK Office for National Statistics (ONS) and NHS Digital. International comparisons on alcohol consumption are included using data published by the Organisation for Economic Co-operation and Development (OECD) and the World Health Organisation (WHO).

Comparisons made between different jurisdictions or between two time periods are tested for statistical significance. Only statistically significant differences have been described using terms such as 'higher', 'lower', 'increase' or 'decrease'.

For further details about the analysis, statistical testing and comparison sources, see the Background Notes section of this report.

¹ The analytical function of the Public Health Directorate's Health Intelligence Unit moved to the Statistics Unit in May 2017.

Alcohol consumption

The information presented in this section relates to drinking patterns of:

- resident adults (aged 16 or over)
- consumption by residents aged 15 or over (excluding visitors and seasonal workers) for international comparison

The Department of Health in England has recently updated the advice for alcohol consumption:²

Current advice (published January 2016):

The department advises:

- men and women should not regularly drink more than 14 units a week
- drinking should be spread over three or more days if regularly drinking as much as 14 units a week
- pregnant women should avoid alcohol altogether

Previous advice (prior to January 2016):

Drinking more than 2 to 3 units a day for women and 3 to 4 units a day for men was classified as drinking at increasing risk to health. Drinking twice this amount per day was classified as being at higher risk of alcohol-related harm.

To allow for the comparison over time this report uses ‘previous’ advice unless explicitly stated.

Alcohol consumption per resident person aged 15 or over

The Statistics Unit uses data from the Customs and Immigration Service on quantities of dutiable goods imported into the Island each year to produce a measure of pure alcohol consumption per resident person aged 15 or over. For further information on the methodology used, please see the Background Notes section of this report.

In 2016, total alcohol consumption was 12 litres of pure alcohol per person aged 15 or over.

² Department of Health (2016), UK Chief Medical Officers’ Alcohol Guidelines Review: Summary of the proposed new guidelines, published January 2016, www.gov.uk

Alcohol consumption 2016

12 litres
of pure alcohol

The average alcohol consumption per
person aged 15 or over



Jersey residents drink, on
average, a sixth (17%) less
than a decade ago, in 2006

On average, each year, Jersey
residents drink the equivalent of



400

large glasses
of wine

Or



530

pints
of beer

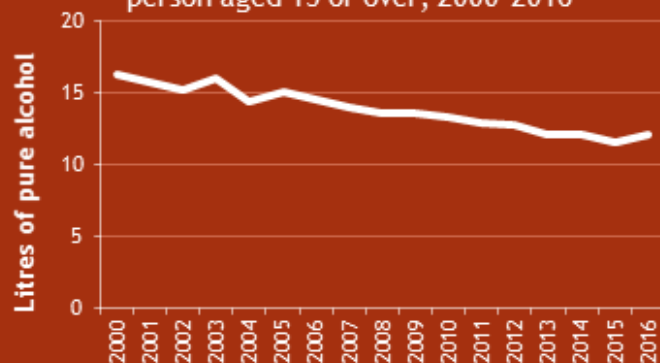
Or



30

litre bottles
of spirits

Average annual consumption of pure alcohol per
person aged 15 or over, 2000-2016



The latest figure available for the UK shows that in 2015 per capita consumption was 10 litres of pure alcohol per person aged 15 or over.³ The comparable figure for Jersey in 2015 was 2 litres higher, at 12 litres of pure alcohol per person aged 15 or over.

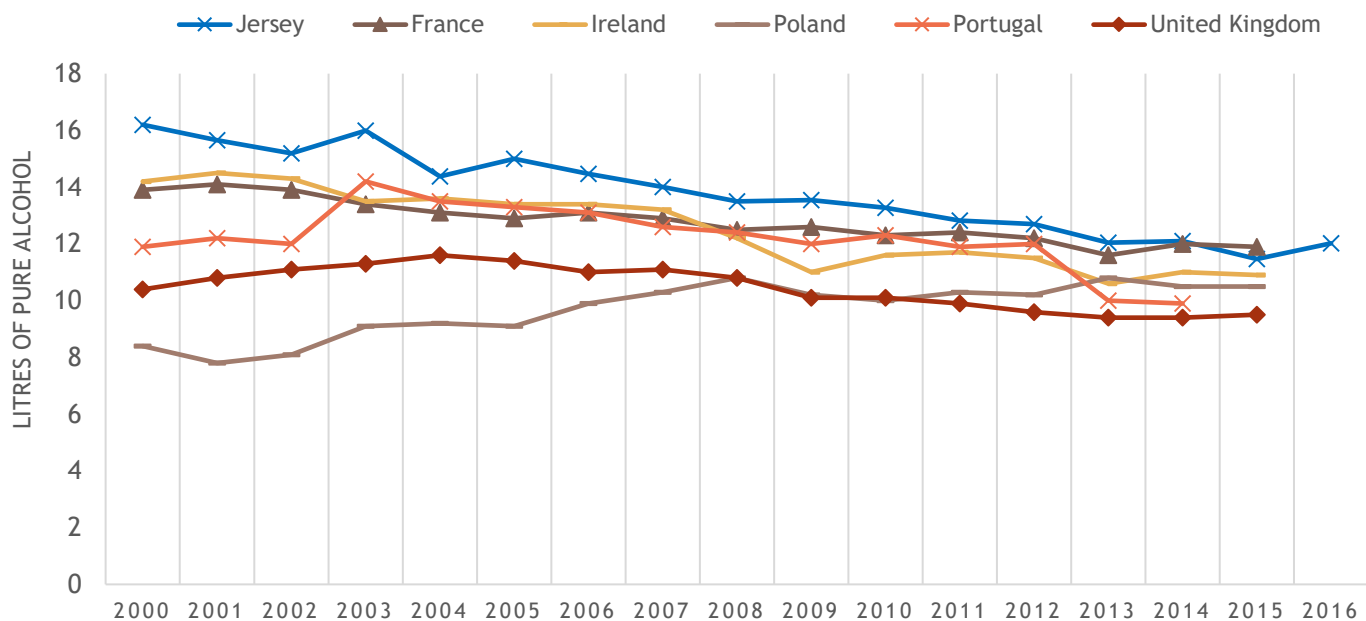
The World Health Organisation (WHO) estimates that in 2010 the worldwide total alcohol consumption was 6.2 litres of pure alcohol per person aged 15 years or older. Projections by WHO suggest this rose to 6.4 litres in 2016.⁴

Compared to European countries, per capita consumption of alcohol in Jersey is similar to that in France, Ireland and Poland but higher than in Portugal and the UK, as shown in Figure 1.

³ Tettenborn, Mark (August 2016), Statistical Handbook 2015, British Beer & Pub Association (BBPA), London, Brewing Publications Limited

⁴ World Health Organisation, World Health Statistics 2017: monitoring health for the SDGs, Sustainable Development Goals, available from apps.who.int

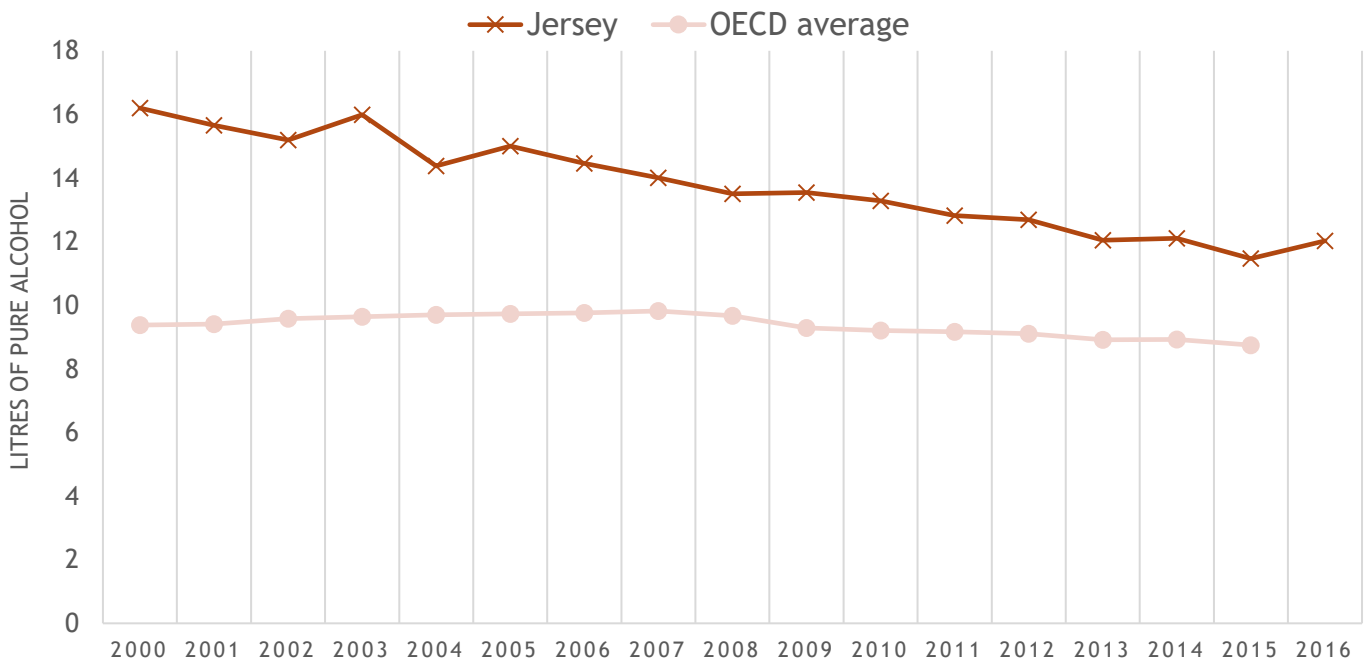
Figure 1: Alcohol consumption in Europe (per person aged 15 or over), 2000-2016



Source: Statistics Unit, OECD

Jersey consumes a greater quantity of alcohol per person aged 15 or over than the average for OECD countries,⁵ as shown in Figure 2.

Figure 2: Alcohol consumption compared to average of OECD countries (per person aged 15 or over), 2000-2016



Source: Statistics Unit, OECD

⁵ Organisation for Economic Co-operation and Development, Non-medical causes of health: alcohol consumption, updated 7 July 2015, available from www.stats.oecd.org

Self-reported drinking patterns

The principal source of data on the drinking behaviour of adults in Jersey is the Jersey Opinions and Lifestyle Survey (JOLS)⁶ (formerly the Jersey Annual Social Survey, JASS), conducted by the Statistics Unit. This is an annual survey covering adults aged 16 or over who are living in private households in the Island.

Self-reported drinking patterns 2016

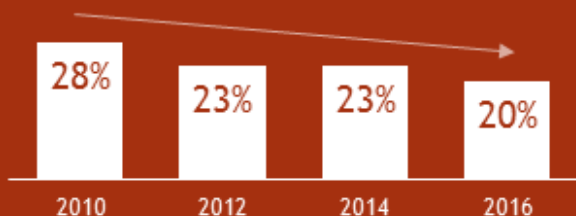


Over half of males (54%) drank 2 or more times a week



Two-fifths (39%) of females drank 2 or more times a week

Since 2010, the proportion of men drinking 4 or more times a week has slightly fallen



The proportion of women drinking 4 or more times a week has remained flat since 2010



26%
male drinkers



9%
female drinkers

exceed the recommended*
number of units per week

*based on new recommendations (max. 14 units a week)



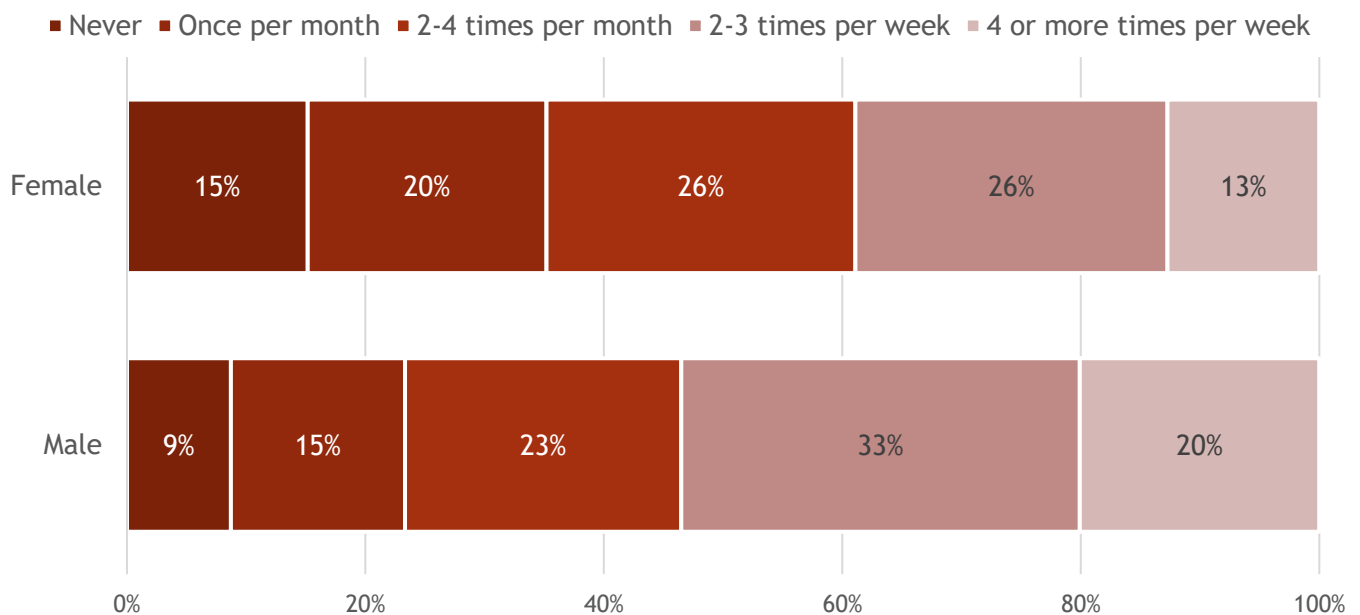
80% of drinkers
said they had
3 or more
drink-free days
in a typical week

Source: JASS 2010, 2012, 2014 and JOLS 2016

⁶ States of Jersey Statistics Unit, Opinion and Lifestyle Survey, published 30 November 2016, available from www.gov.je

Respondents to JOLS 2016 were asked about their drinking behaviours. Figure 3 shows that a greater proportion of males than females drink at least two or more times each week.

Figure 3: How often respondents drink alcohol, by sex 2016



Source: JOLS 2016

The JOLS 2016 survey also asked respondents about the amount of alcohol they drank on a typical drinking day, in terms of units of alcohol. Figure 4 shows one unit of different types of alcohol.

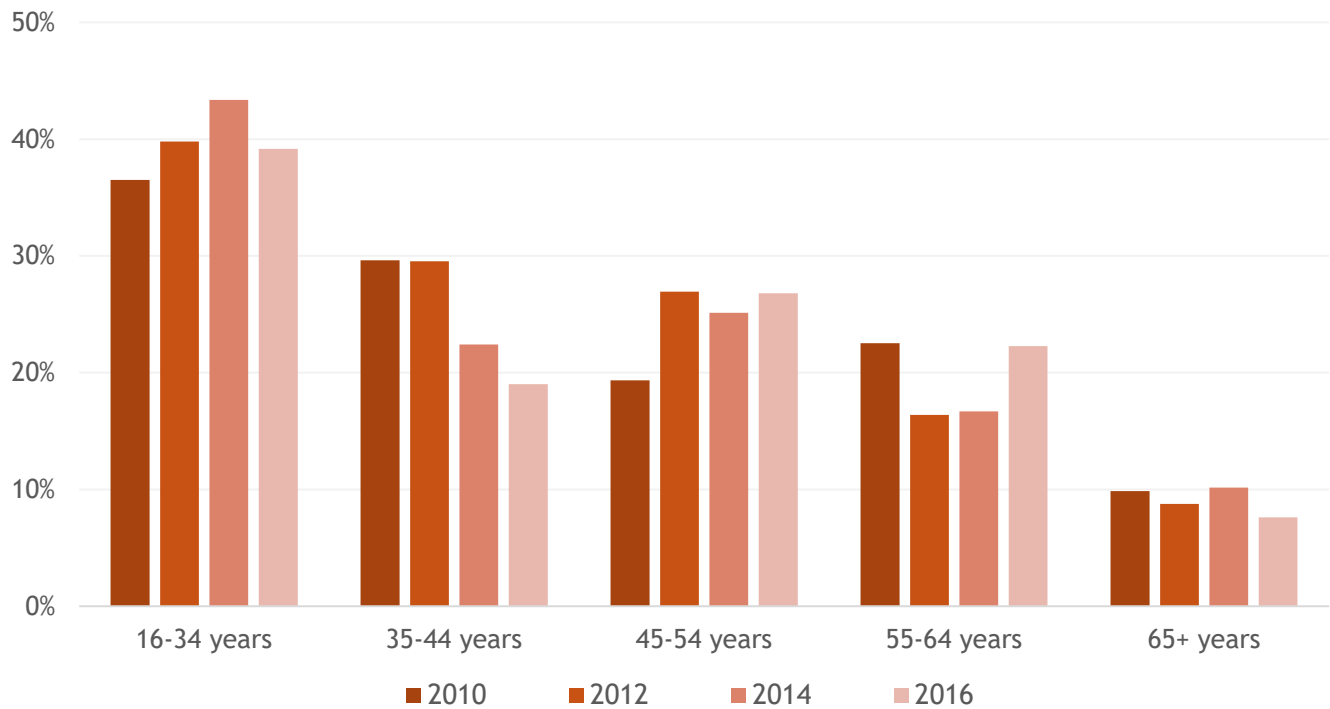
Figure 4: Alcohol Units



Around two-fifths (39 per cent) of 16 to 34 year old who drank alcohol reported usually drinking five or more units when they drank, exceeding the previously recommended daily limits for both males and females. This proportion decreased with age, with fewer than one in ten (8 per cent) of those aged 65 or over usually drinking five or more units.

Figure 5 shows the distribution by age group of those drinking five or more units on a typical drinking day, and how this has changed over the last seven years. The proportion of 35-44 year olds drinking five or more units on a typical day has decreased from 30 per cent in 2010 to 19 per cent in 2016, while the 45-54 age group saw an increase from 19 per cent in 2010 to 27 per cent in 2016.

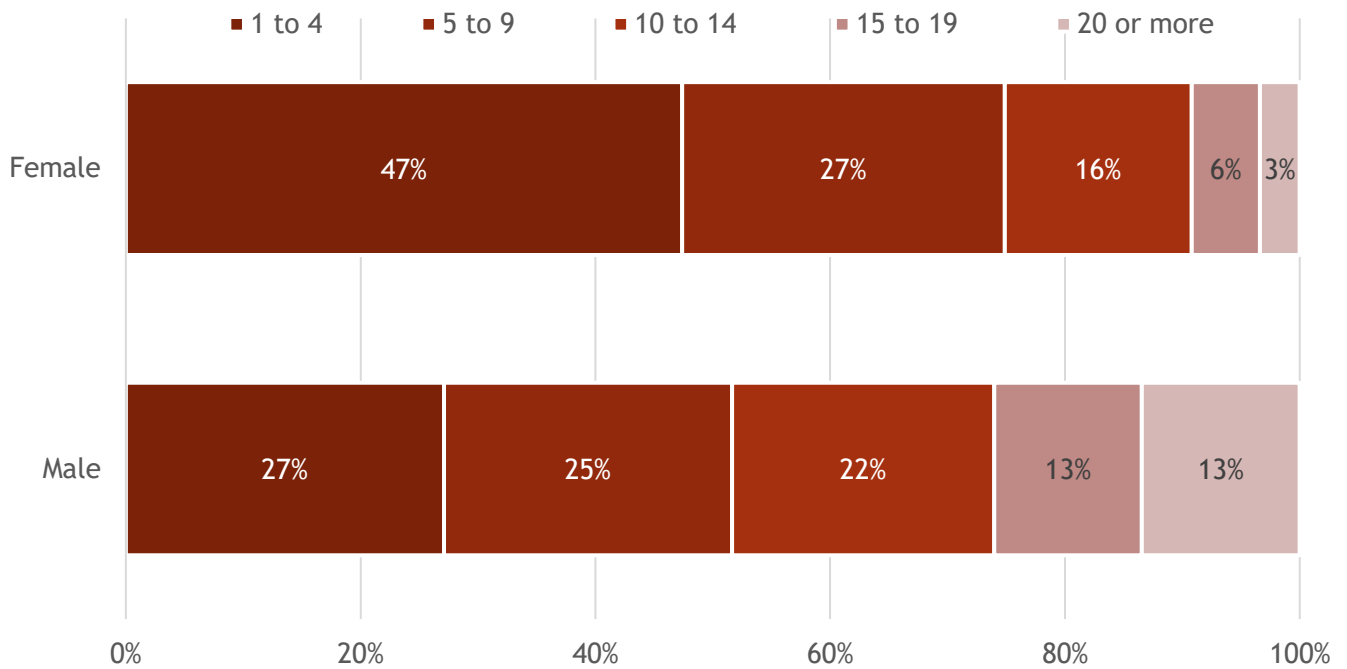
Figure 5: Units per typical drinking day; percentage of adults drinking 5 or more units, by age group



Source: JASS 2010, 2012, 2014 and JOLS 2016

The latest Department of Health in England guidelines recommend individuals drink no more than 14 units of alcohol per week and that these units should be spread over three or more days. The 2016 round of JOLS asked respondents how many units they drank in a typical week. Around a quarter (26 per cent) of male drinkers reported drinking more than 14 units in a typical week, thereby exceeding the recommendations. Around one in ten female drinkers (9 per cent) reported drinking more than 14 units in a typical week, as shown in Figure 6.

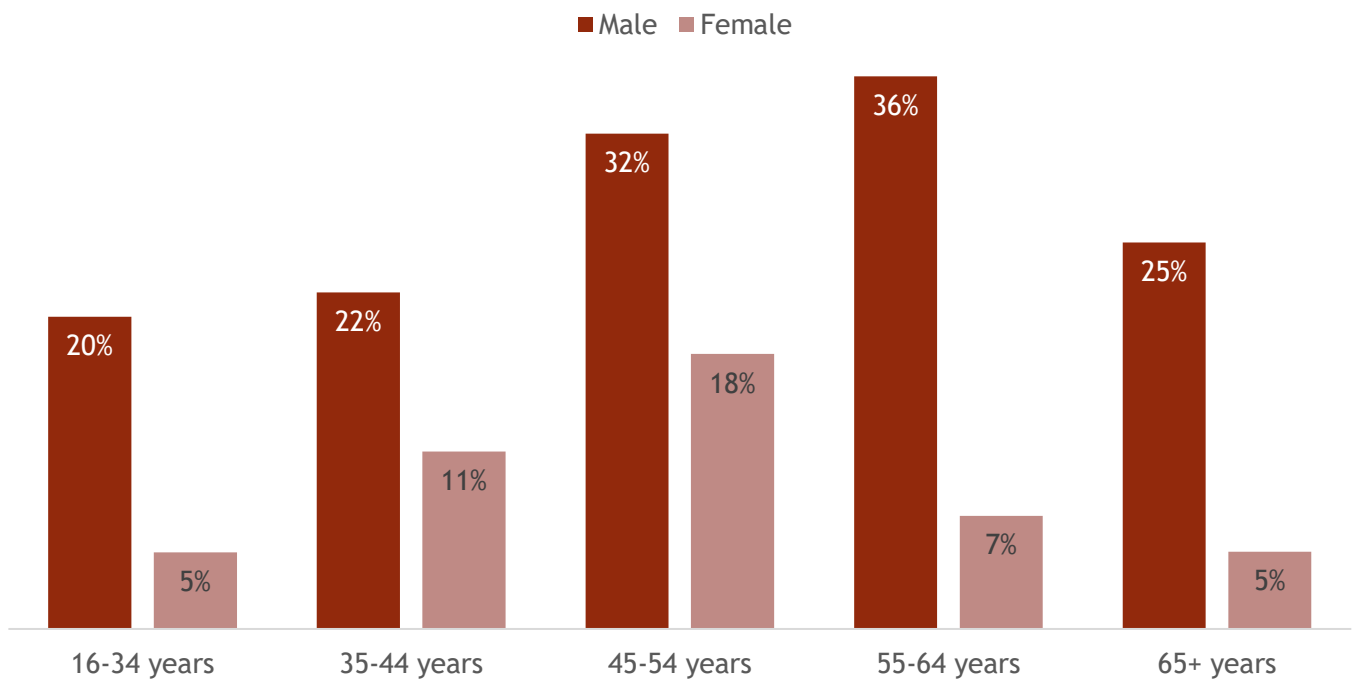
Figure 6: Units per typical drinking week, by sex, 2016



Source: JOLS 2016

Around one in three male drinkers between 45 and 64 years of age drank more than the recommended maximum level. The 45-54 year old age group had the greatest proportion of females drinking more than the weekly recommended maximum, as shown in Figure 7.

Figure 7: Proportion of drinkers drinking more than 14 units in a typical week, by age and sex



Source: JOLS 2016

The Department of Health in England recommendations also suggest having several drink-free days each week.⁷ Four-fifths (80 per cent) of drinkers reported having three or more drink free days in a typical week. In contrast, the proportion of those who reported having no drink free days in a typical week was 6 per cent.

A greater proportion of older drinkers, those aged 65 or over, reported having no drink free days (16 per cent) compared to around 1 per cent of those aged 16 to 44 years, and fewer than one in ten of those aged 45 to 54 years (8 per cent) and aged 55-64 years (9 per cent).

Of those drinkers who report drinking more than 14 units in a typical week, around four-fifths (82 per cent) said they had at least one drink free day.

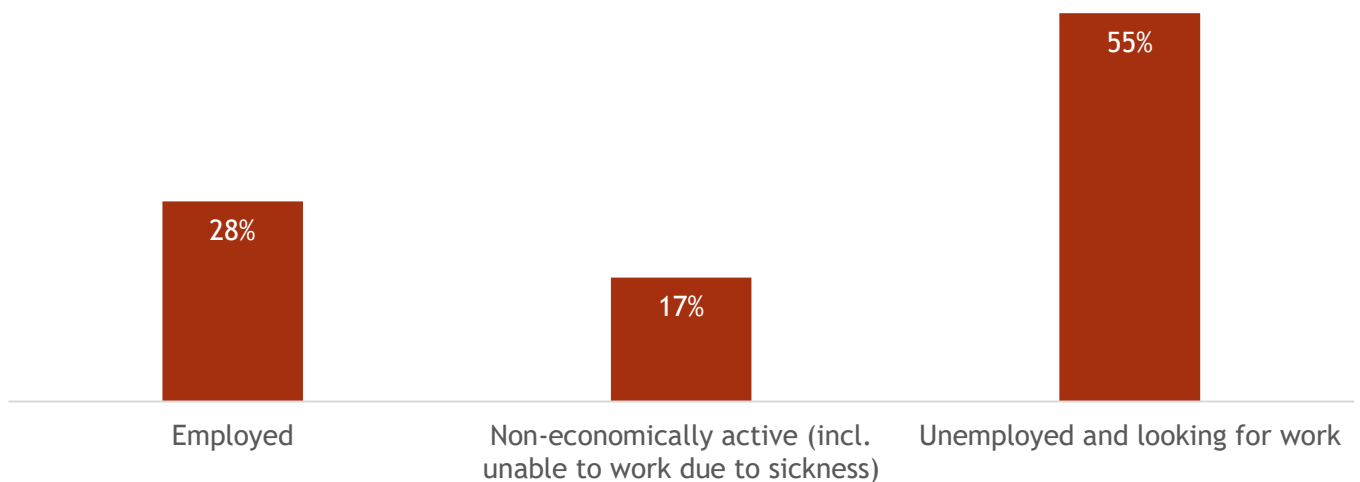
Other characteristics of drinkers

JOLS 2016 data can be used to look at differences in drinking patterns by other characteristics of the population:

- place of birth
 - three-fifths (60 per cent) of those born elsewhere in the British Isles and two-fifths (42 per cent) of Jersey born residents reported drinking at least twice a week. Around a quarter (27 per cent) of those born outside of the British Isles reported drinking at least twice a week
- occupation
 - the percentage of those who drink at least twice a week has decreased in all occupational groups since 2010. However, there remain differences between groups, with senior managerial (62 per cent) and technical (60 per cent) groups the highest, and routine (27 per cent) and clerical (29 per cent) the lowest
- smokers and non-smokers
 - around two-fifths of those who currently smoke also drink more than 5 units on a typical drinking day (40 per cent of daily smokers and 42 per cent of occasional smokers). This compares with around a quarter of ex-smokers (28 per cent of those who used to smoke daily and 25 per cent of former occasional smokers), and a fifth (20 per cent) of those who have never smoked
- economic activity
 - over half (55 per cent) of those unemployed and looking for work who drank reported that they drank five or more units on a typical drinking day, compared to 28 per cent of employed persons and 17 per cent of non-economically active respondents (Figure 8)

⁷ Department of Health (2016), UK Chief Medical Officers' Alcohol Guidelines Review: Summary of the proposed new guidelines, published January 2016, www.gov.uk

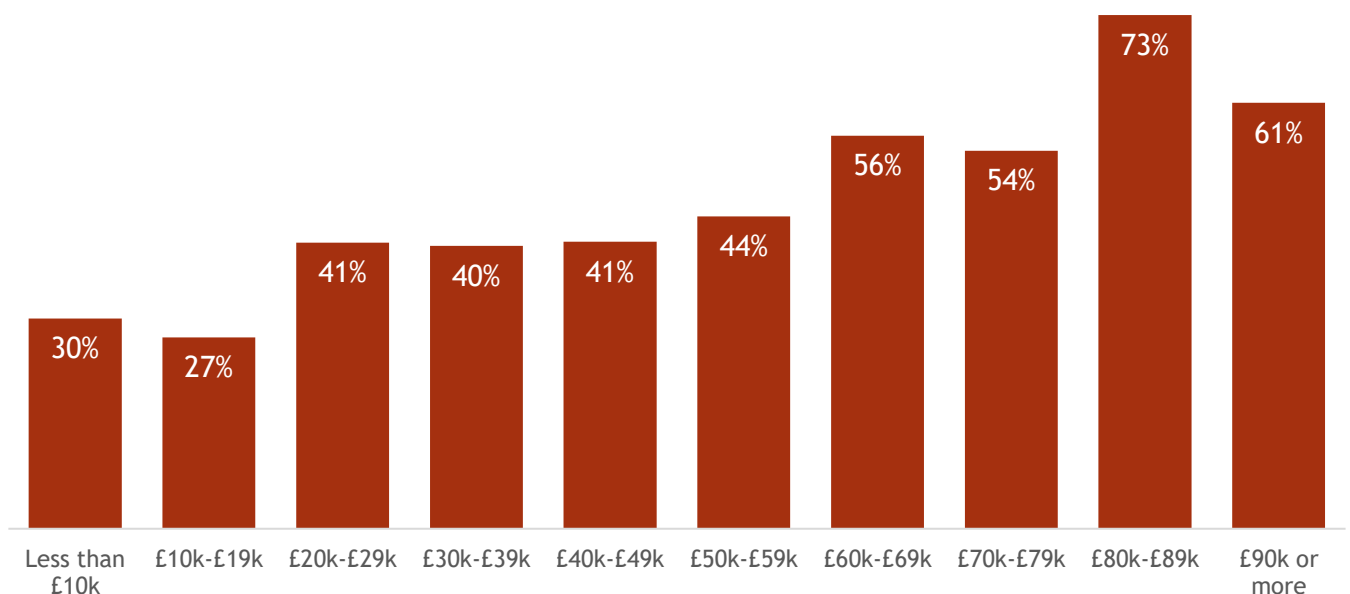
Figure 8: Percentage drinking five or more units on a typical drinking day, by employment group, 2016



Source: JOLS 2016

- household income
 - the proportion of those drinking at least twice a week in the top income bracket (£90,000 or more) was double that in the lowest income bracket (less than £10,000) (Figure 9)
 - the number of units drunk on a typical day did not show significant variation by household income, indicating that although those in higher income brackets may drink more frequently, when they do it is not necessarily at higher levels.

Figure 9: Percentage of adults drinking on two days a week or more, by household income level, 2016



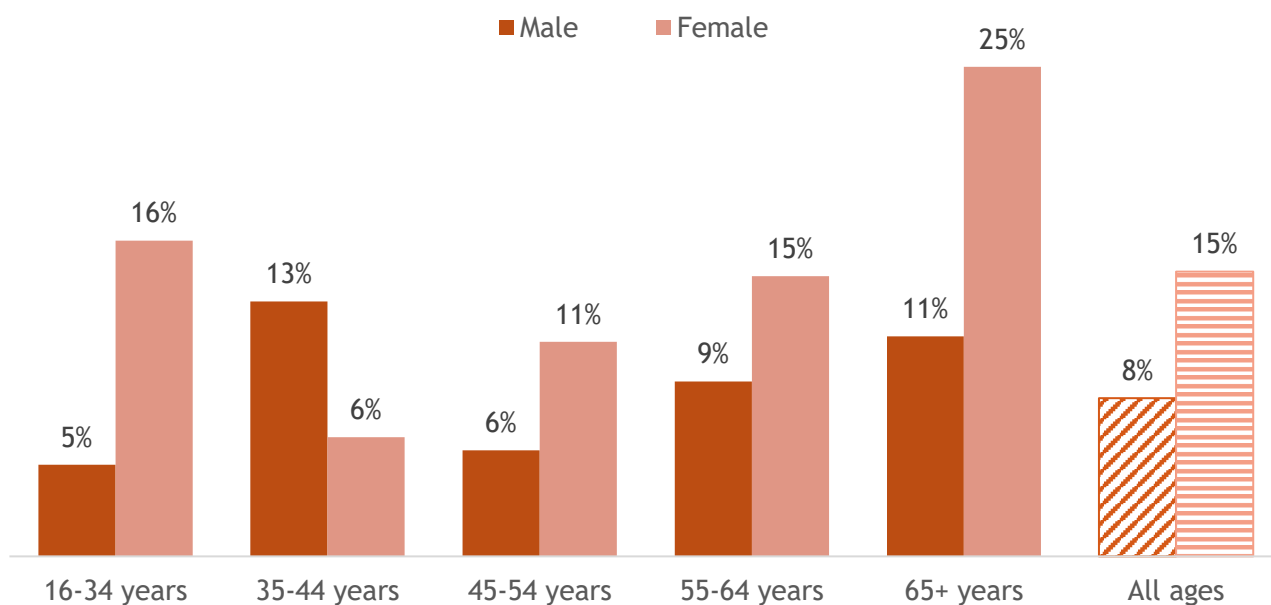
Source: JOLS 2016

Teetotalism

One in eight (12 per cent) of respondents to JOLS 2016 reported that they never drink alcohol (9 per cent of males and 15 per cent of females). This proportion has remained at a similar level since 2008.

The breakdown of those who never drink alcohol by age and sex is shown in Figure 10. Around one in four (25 per cent) females aged 65 years or over reported never drinking alcohol. In contrast, 5 per cent of males aged 16 to 34 years reported that they never drink alcohol.

Figure 10: Respondents who reported never drinking alcohol, by age and sex



Source: JOLS 2016

In Great Britain, one in five adults (21 per cent) reported that they do not drink alcohol.⁸

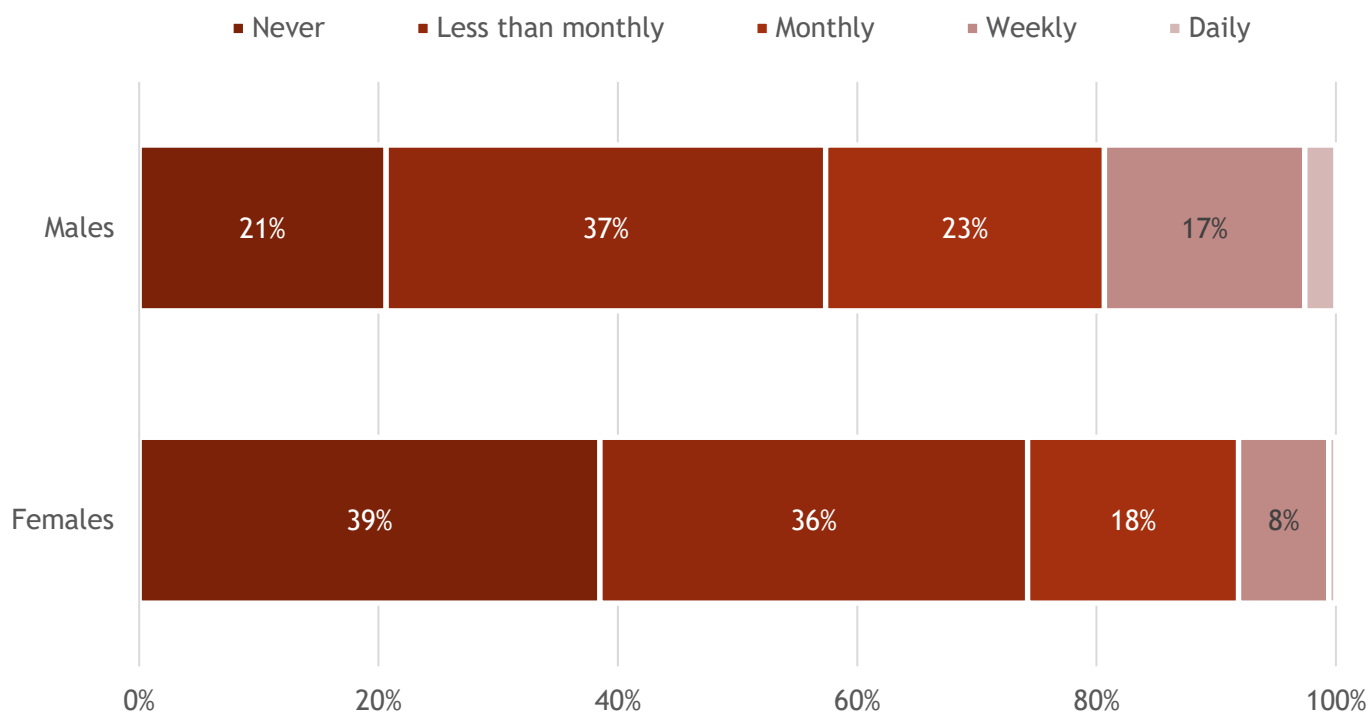
Binge drinking

In this report, the definition of binge drinking is based on the previous Department of Health in England alcohol drinking recommendations. Specifically, this concerns males who drink more than 8 units on one day (around four pints of normal strength beer or three-quarters of a bottle of wine) and females who drink 6 units or more on one day (around three pints of normal strength beer or two large glasses of wine).

⁸ Office for National Statistics, Adult drinking habits in Great Britain: 2005 to 2016, published 3 May 2017, available from www.ons.gov.uk

Figure 11 shows the binge drinking patterns as reported in JOLS 2016: 43 per cent of male drinkers and 26 per cent of female drinkers reported drinking at twice the recommended daily levels at least monthly.

Figure 11: Frequency of binge drinking, by sex (of those who drink alcohol)



Source: JOLS 2016

Younger age groups were more likely to binge drink than their older counterparts; 45 per cent of 16 to 34 year old drinkers reported binge drinking at least monthly, three times the proportion of drinkers aged 65 or over (15 per cent). A similar pattern of binge drinking was seen in Great Britain as reported by the Office for National Statistics.⁹

The proportion of male drinkers who binge drink at least monthly has risen over the last seven years, from 32 per cent of males in 2010 to 43 per cent in 2016, while the proportion of female drinkers who binge drink at least monthly has remained relatively flat over this period.

⁹ Office for National Statistics, Adults Drinking Habits in Great Britain: 2005 to 2016, published 3 May 2017, available from www.ons.gov.uk

Drinking and pregnancy

Details about alcohol consumption during pregnancy are collected by the Maternity Department as part of pre-natal checks.

Of those woman who gave birth in 2016:

- 95 per cent reported not drinking during pregnancy
- more than one in three (37 per cent) reported that they did not drink prior to getting pregnant
- those woman who said they drank during pregnancy reported drinking only occasionally

Hazardous or harmful drinking

Hazardous drinking, as defined by the WHO,¹⁰ is a pattern of alcohol consumption carrying risks of physical and psychological harm to the individual. **Harmful** drinking denotes the most hazardous use of alcohol, at which damage is likely. A potential outcome of harmful drinking is alcohol dependence.



Levels of harmful and hazardous drinking in Jersey have been derived from two data sources:

- the findings from JOLS 2016 where respondents were asked to answer a set of questions from a 4-item screening tool (FAST)¹¹
- data on referrals to the Drug and Alcohol Service has been analysed to provide information on problem drinkers and their use of the service.

¹⁰ Saunders J.B., Aasland O.G., Babor T.F., et al, Development of the Alcohol Use Disorders Identification Test (AUDIT): WHO Collaborative Project on Early Detection of Persons with Harmful Alcohol Consumption-II, *Addiction*, 1993;88791- 804

¹¹ Public Health England, Fast Alcohol Screening Test (FAST), Alcohol learning resources, available from www.alcohollearningcentre.org.uk

FAST

The Fast Alcohol Screening Test (FAST) is a 4-item screening tool designed to highlight potential hazardous or harmful drinking behaviours. It should be noted that a survey of the local household population is likely to under-represent alcohol dependent adults, who are more likely to be homeless or in an institutional setting. Moreover, problem drinkers who do live in private households may, like problem drug users, be less able or willing to participate in surveys.

Table 1: FAST Questions

FAST	Scoring system				
	0	1	2	3	4
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Only answer the following questions if your answer above is monthly or less					
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year

Scoring: A total of 3 or more indicates hazardous or harmful drinking

Source: Public Health England <http://www.alcohollearningcentre.org.uk/>

The 4-item test used in JOLS 2016 is unable to differentiate between hazardous and harmful drinking.¹² Table 2 shows the proportion of each age group and sex whose responses indicated that their drinking behaviour was potentially hazardous or harmful to their health.

¹² A 10-item screening test is required to differentiate between hazardous, harmful and dependent drinking; however, the 10-item screening test has not been included in the annual social surveys since 2010 due to the burden of such a large number of questions on respondents and the likely under-representation of dependent adults in the survey of local households.

Table 2: Percentage of hazardous or harmful drinkers (FAST score of 3 or more, excluding non-drinkers), by age and sex

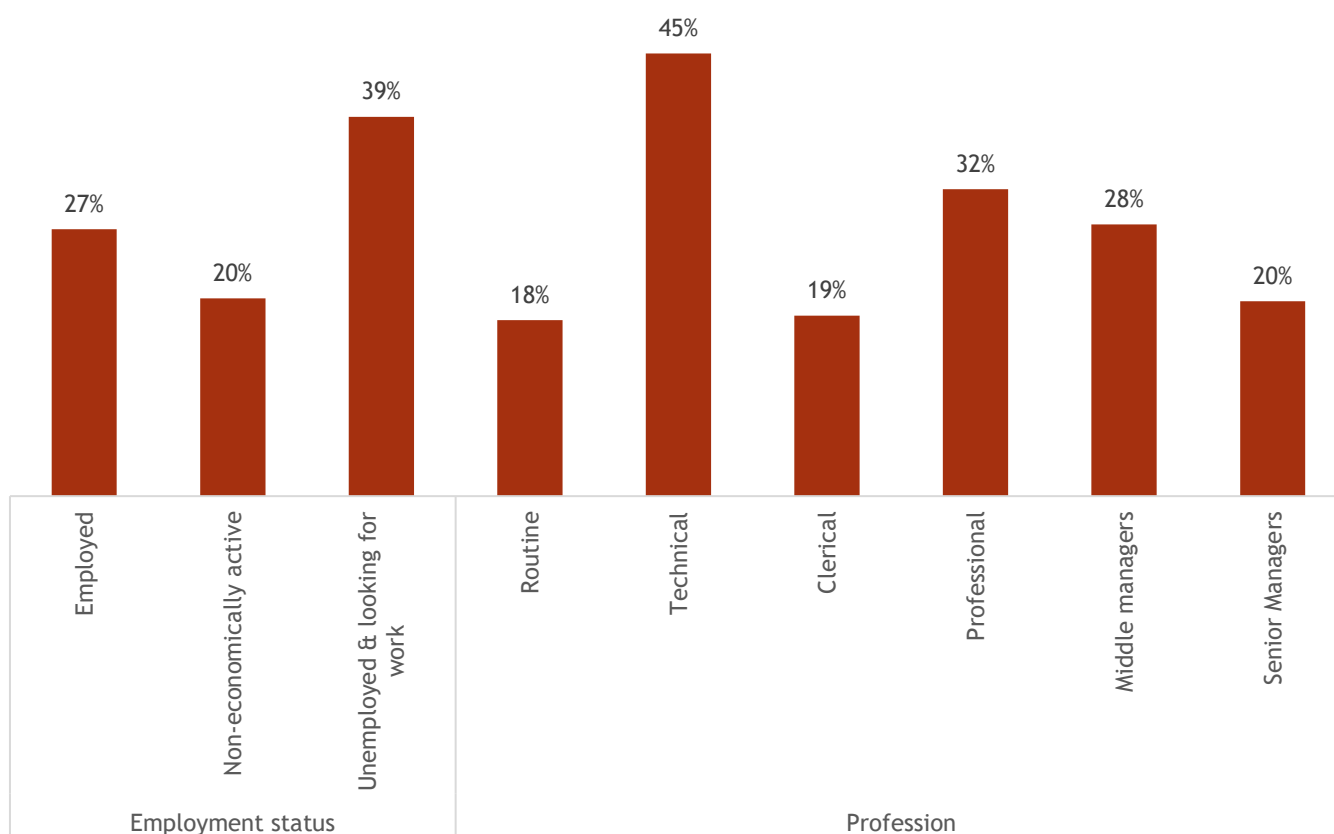
Age	Males (%)	Females (%)	All Persons (%)
16-34 years	48	25	38
35-44 years	28	17	22
45-54 years	31	22	27
55-64 years	32	10	21
65 years and older	17	2	10
16+ population	34	17	26

Source: JOLS 2016

Around one in four (26 per cent) resident adult drinkers were found to be drinking at potentially hazardous or harmful levels, with a higher proportion of males (34 per cent) than females (17 per cent).

A greater proportion of drinkers born in Jersey (32 per cent) or elsewhere in the British Isles (25 per cent) were found to be drinking at hazardous or harmful levels compared to those born elsewhere (11 per cent). There was little difference in the pattern of hazardous or harmful drinking by education level or by tenure, but a difference in employment status and profession was found as shown in Figure 12.

Figure 12: Percentage of hazardous or harmful drinkers (FAST score of 3 or more, excluding non-drinkers), by employment status and profession



Source: JOLS 2016

Notes: **Routine** work refers to routine, semi-routine, manual or service occupations, such as cleaners, security guards and receptionists. **Technical** professions refer to technical or craft occupations such as mechanics, plumbers and electricians. **Clerical** or intermediate occupations include, for example, secretaries, clerical workers and nursery nurses. **Professional** occupations (normally requiring a professional qualification) include scientists, accountants or social workers. **Middle or junior managers** refer to office managers, bank managers and publicans, for example. **Senior managers** (usually responsible for planning, organising and co-ordinating work) refer to chief executives or finance managers, for example.

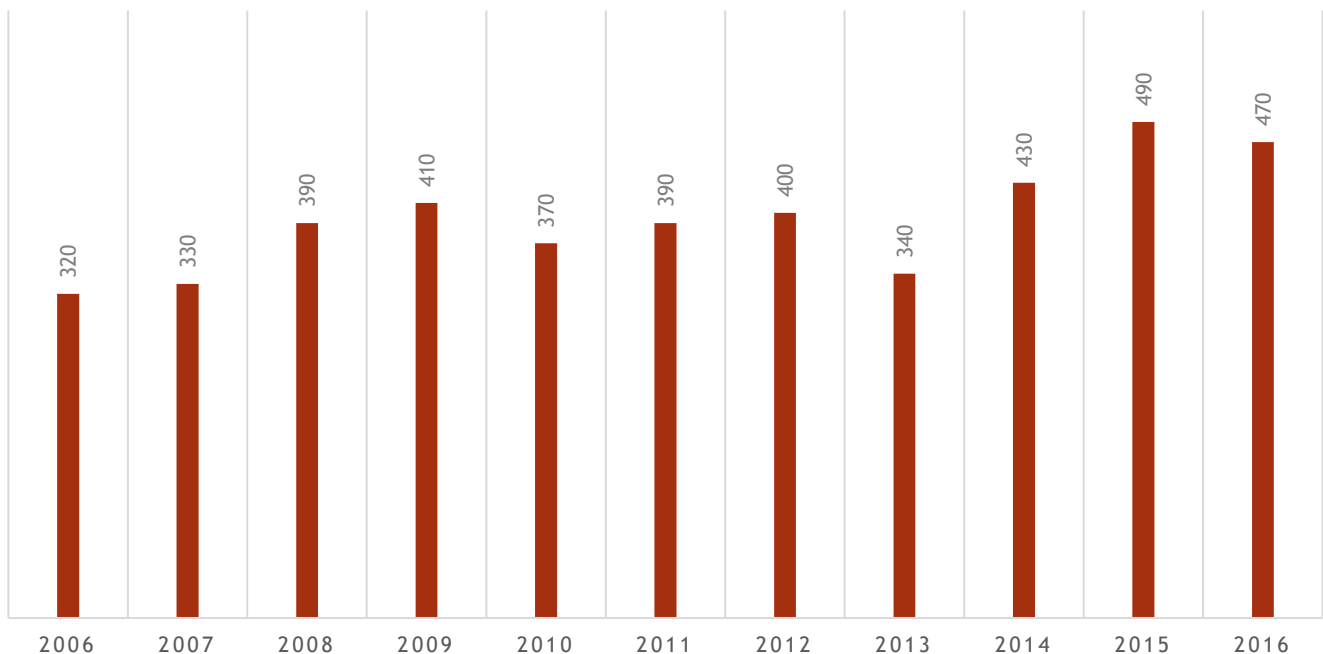
Using the results of JOLS 2016, it is estimated that around 21,000 resident adults have drinking behaviour that is potentially hazardous or harmful. Of these, around 14,000 are male and around 7,000 are female; the largest number of these being in the youngest age group, 16-34 years (6,000 males and 3,000 females).

Alcohol misuse

There were 640 people referred to the Drug and Alcohol Service in Jersey in 2016; of these 470 were for problematic or dependent drinking¹³ (73 per cent). The majority (450 referrals) were for alcohol treatment only, while around 20 were for alcohol problems alongside other substances.

The number of people seeking help for problems with alcohol has increased over the last 10 years, from around 320 in 2006 to 470 in 2016, as shown in Figure 13.

Figure 13: Referrals to the Drug and Alcohol Service for problems with alcohol, 2006-2016



Source: Drug & Alcohol Service

Of those referred for alcohol problems, two-thirds (65 per cent) were male; the 40-49 year old age group comprised the greatest proportion of referrals (28 per cent). Around two-thirds (67 per cent) of 2016 referrals for alcohol problems had been seen before by the service. The majority of those referred for alcohol problems had been referred by professionals working in health and social services (52 per cent); around two-fifths (38 per cent) had self-referred to the Service.

¹³ The Drug and Alcohol Service is available to anyone who would like help with their alcohol consumption; this includes people who have approached the service themselves as they require help to cut down rather than stop drinking, they wish to stop drinking altogether or those who have been referred by medical or other professionals.

Hospital admissions due to alcohol consumption

This section presents information on completed hospital admission episodes (referred to here as hospital admissions) with diseases, injuries and conditions that can be attributed to alcohol consumption.

There are a number of measures of alcohol-attributable hospital admissions available; only alcohol-specific hospital admissions have been included in this report:¹⁴

Alcohol-specific hospital admissions

admissions due to conditions where alcohol is causally implicated in all cases of the conditions (those conditions wholly attributable); for example, alcohol-induced behavioural disorders and alcohol-related liver cirrhosis. The alcohol-attributable fraction (AAF) is 1.0 (100 per cent of cases are considered to be caused by alcohol).

AAFs take account of patient sex, age and diagnosis to estimate the number of admissions attributable to alcohol consumption. For further information on the methodology used, see the Background Notes section of this report.

Alcohol-specific hospital admissions

In 2016, there were 770 admission episodes to the Jersey General Hospital for a condition that was wholly attributable to alcohol (AAF equal to 1.0). This latest number of such admission episodes is 150 fewer than the previous year (920 in 2015) and the lowest number of episodes seen in the last five years, since 2012. The majority of admissions were male (72 per cent) and the largest number of admission episodes were for persons aged 55-64 years, as shown in Figure 14.

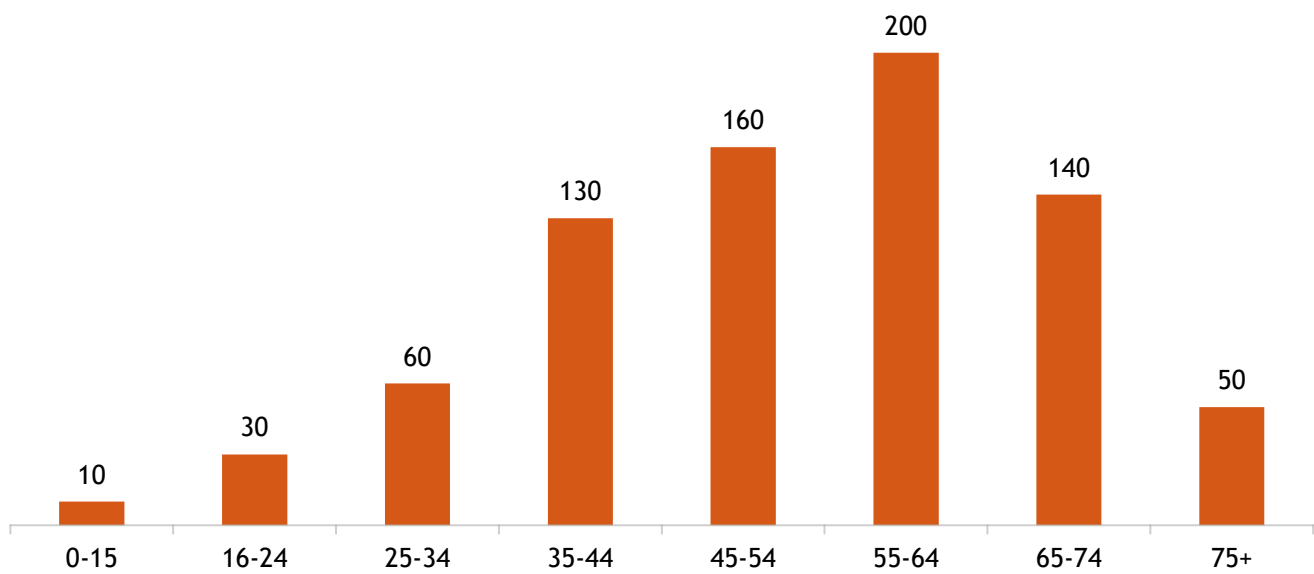
The alcohol-specific hospital admission age standardised rate for Jersey was 747 per 100,000 population for calendar year 2016. The rate for hospital admissions of males was significantly higher than that for females. However, the latest rate for males was significantly lower than the previous four years whereas the female rate has remained flat over this period.

Public Health England publish figures for England based on financial years; for 2015-16 the alcohol specific age standardised hospital admissions rate was 583 per 100,000, with English regions ranging from 246 to 1,681 per 100,000.¹⁵ Comparisons with the PHE indicators are shown in Appendix 1.

¹⁴ A small number of episodes for 2016 were yet to be coded at time of publication. This is unlikely to affect those episodes for alcohol specific admissions, although these should still be treated as provisional. It was deemed more likely that these uncoded admissions may impact on the broader measures of alcohol-hospital admissions which is why they have not been included in this report.

¹⁵ Public Health England, Local Alcohol Profile 2017, published 3 May 2017, available from www.lape.org.uk

Figure 14: Alcohol-specific hospital admission episodes to Jersey General Hospital, 2016*



*Numbers rounded to nearest 10

Source: Statistics Unit

The number of admission episodes (770) in 2016 related to 480 individuals. A similar pattern of gender and age distribution was seen when individuals were considered rather than episodes, with the majority being male (70 per cent) and the largest number being for persons aged 55-64 years.

Deaths related to alcohol consumption

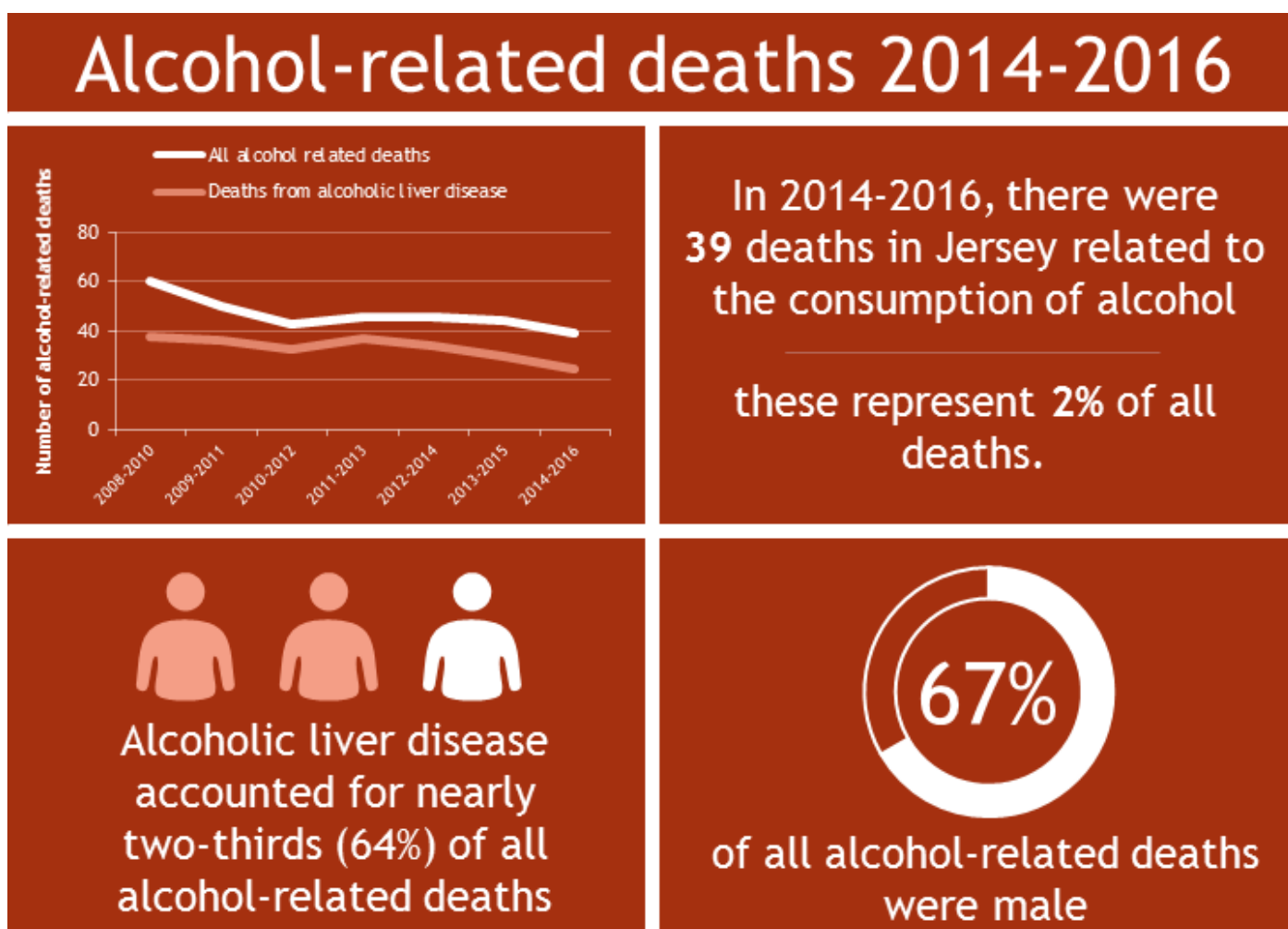
Alcohol consumption can be related to deaths from certain types of disease, such as cirrhosis of the liver, and in some cases may be associated with other causes of death, such as strokes.

There are two measures of deaths due to alcohol consumption currently used in the UK;

- the first is the National Statistics definition of alcohol-related deaths¹⁶ used by the Office for National Statistics (ONS). This definition only includes those causes regarded as being the most directly related to alcohol consumption, as well as certain liver diseases, even when alcohol is not specifically mentioned on the death certificate
- the second measure is that produced by Public Health England (PHE) which also includes all conditions which are considered to be partially caused by alcohol, such as cancer of the mouth

For comparative purposes, both measures have been used to analyse deaths in Jersey linked to alcohol consumption and are presented alongside UK data calculated using the same methodology.

Alcohol-related deaths (Office for National Statistics measure)



¹⁶ Office for National Statistics, Alcohol-Related Deaths in the United Kingdom registered in 2016, published 7 November 2017, available from www.ons.gov.uk

The number of alcohol-related deaths for 2014-2016 (39 deaths), is similar to that reported for the previous three-year period, 2011-2013 (46 deaths) and lower than that reported six years ago, 2008-2010 (60 deaths).

Alcohol-related deaths were responsible for around 500 years of potential life lost¹⁷ (YOLL) over the three-year period, 2014-2016, (400 years of male life and 100 years of female life).

Age-standardised rates (ASRs) can be used to compare mortality rates of different jurisdictions. The 2014-2016 alcohol-related mortality rate for Jersey is 14 per 100,000 population. The latest available data for the UK shows that in 2016, the alcohol related death rate was similar, at 15 per 100,000 population.¹⁸

The Jersey ASR for males for the period 2014-2016 was 18 per 100,000, similar to the 2016 rate for England of 19 per 100,000.¹⁹

Alcohol-attributable deaths (Public Health England measure)

Public Health England (PHE) report alcohol deaths²⁰ using several definitions which aim to capture the wider burden of alcohol consumption on population health and health service use. These definitions include conditions where alcohol is the direct cause of all cases (alcohol-specific or wholly-attributable conditions), as well as conditions where alcohol is causally implicated in some, but not all, cases of the outcome (alcohol-related or partially-attributable conditions).

Jersey alcohol-specific mortality, chronic liver disease mortality and alcohol-related mortality (the broader measure of deaths attributable to alcohol, as shown in the infographic) are similar to the average for England. Alcohol-attributable mortality indicators for Jersey have remained essentially flat since 2008, as shown in Table A2 and Figure A2 in Appendix 1.

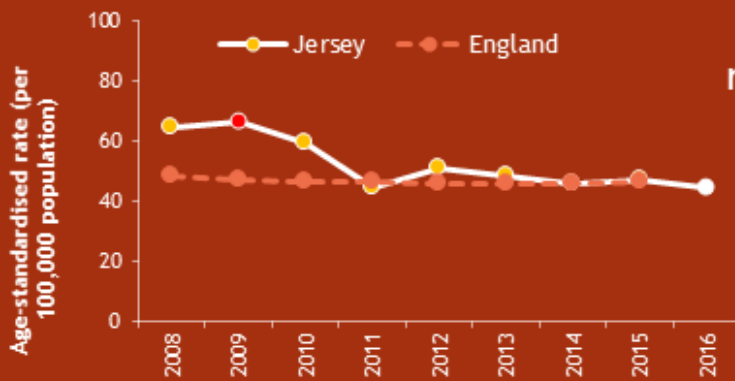
¹⁷ Years of Life lost (YOLL) is a measure of premature mortality that quantifies the years **not** lived by individuals who die under 75 years of age (an arbitrary cut off used to enable comparisons). For more information, see Background Notes.

¹⁸ Office for National Statistics, Alcohol-Related Deaths in the United Kingdom registered in 2016, published 7 November 2017, available from www.ons.gov.uk

¹⁹ Due to the relatively small number of deaths, annual and female rates have not been calculated for Jersey.

²⁰ Public Health England, Local Alcohol Profile 2017, published 3 May 2017, available from www.lape.org.uk

Alcohol-attributable deaths 2016



The Jersey rate for alcohol-related deaths (PHE measure)* is similar to the England average

Significance compared with England average

- Significantly worse
- Not significantly different
- Significantly better
- Significance not tested

* PHE alcohol-related deaths* measure

30



Annual numbers of alcohol-related⁺ deaths

15



(PHE measure)

Half of alcohol-related⁺ deaths are due to cancers linked to alcohol consumption

⁺Alcohol-related deaths refer to deaths from wholly- and partially-attributable conditions

Liver disease

Liver disease accounts for around 20 premature deaths a year in Jersey.²¹ There are three primary risk factors: alcohol, obesity and viral hepatitis infections. For the purposes of this report, mortality rates that consider all liver diseases and alcoholic liver disease are compared to comparable Public Health England rates. For the detailed comparisons and graphs, see Appendix 1.

The premature mortality rate for liver diseases in Jersey (19 per 100,000 population) was similar to the English average (18 per 100,000) for 2014-2016. For alcoholic liver disease, the premature mortality rate was also similar to that of the English average. There has been essentially no change in the rate of premature death for liver disease or alcoholic liver disease in Jersey since 2010, as shown in the Figure A3 in Appendix 1.

A report released by the Statistics Unit in September 2017 considered the number of currently registered GP patients recorded on disease registers for long-term conditions and the projected numbers of people with these conditions over the next 10 and 20 years.²² The report showed that in 2016 there were some 800 people on the disease register for chronic liver disease. This number is projected to increase to around 900 by 2026.

²¹ States of Jersey Statistics Unit, Premature Deaths 2013-2015, published 28 March 2017, available from www.gov.je

²² States of Jersey Statistics Unit, Disease Projections 2016-2026, published 14 September 2017, available from www.gov.je

Alcohol-related crime

Data on alcohol-related crime was provided by the States of Jersey Police.²³

Alcohol-related crime 2016



Around 1 in 6 of all crimes were recorded as involving alcohol



Over 140 drink-drive incidents were recorded by the States of Jersey Police



More than 100 domestic assaults involving alcohol were recorded in 2016

Around a quarter of offences against the person in 2014-2016 involved alcohol



A total of 2,905 crimes were recorded in 2016, giving a crude rate of 28 crimes per 1,000 population. Table 3 gives the number of crimes recorded over the three-year period 2014-2016, along with the proportion of those where alcohol was recorded as being involved. For more information on crime statistics in Jersey see Background Notes.

Around one in six (16 per cent) of all crimes recorded over the latest three-year period, 2014-2016, had alcohol involvement. Around a quarter (27 per cent) of recorded offences against the person had alcohol involved; this category includes common assault, grave and criminal assault and indecent assault. More than two-fifths (44 per cent) of recorded assaults on police and prison officers had alcohol involvement.

²³ Some crime figures can be affected by campaigns run by the Police, such as efforts focused on public order offences or licensing enforcement, as well as the reporting and recording of crimes, therefore time series data are not presented here.

Table 3: Offences recorded by the States of Jersey Police, 2014-2016

Type of Crime	Total Offences	Proportion recorded as involving alcohol (%)
Acquisitive crime	2,300	8
Burglary	500	4
Offences against property	1,600	9
Offences against the person	3,800	27
Drug offences	700	12
Other offences	300	16
Total offences	9,100	16

**Numbers rounded to nearest 100*

Source: States of Jersey Police

Domestic violence

In 2016, there were nearly 1,000 domestic violence incidents reported to the States of Jersey Police. Of these, around 300 were domestic violence assaults. More than two-fifths (44 per cent) of these assaults were recorded as having alcohol involvement, as recorded by the officer attending the scene. It is likely that this proportion represents an underestimate since incidents where no suspect or offender is present are not recorded as involving alcohol.

Evening street violence

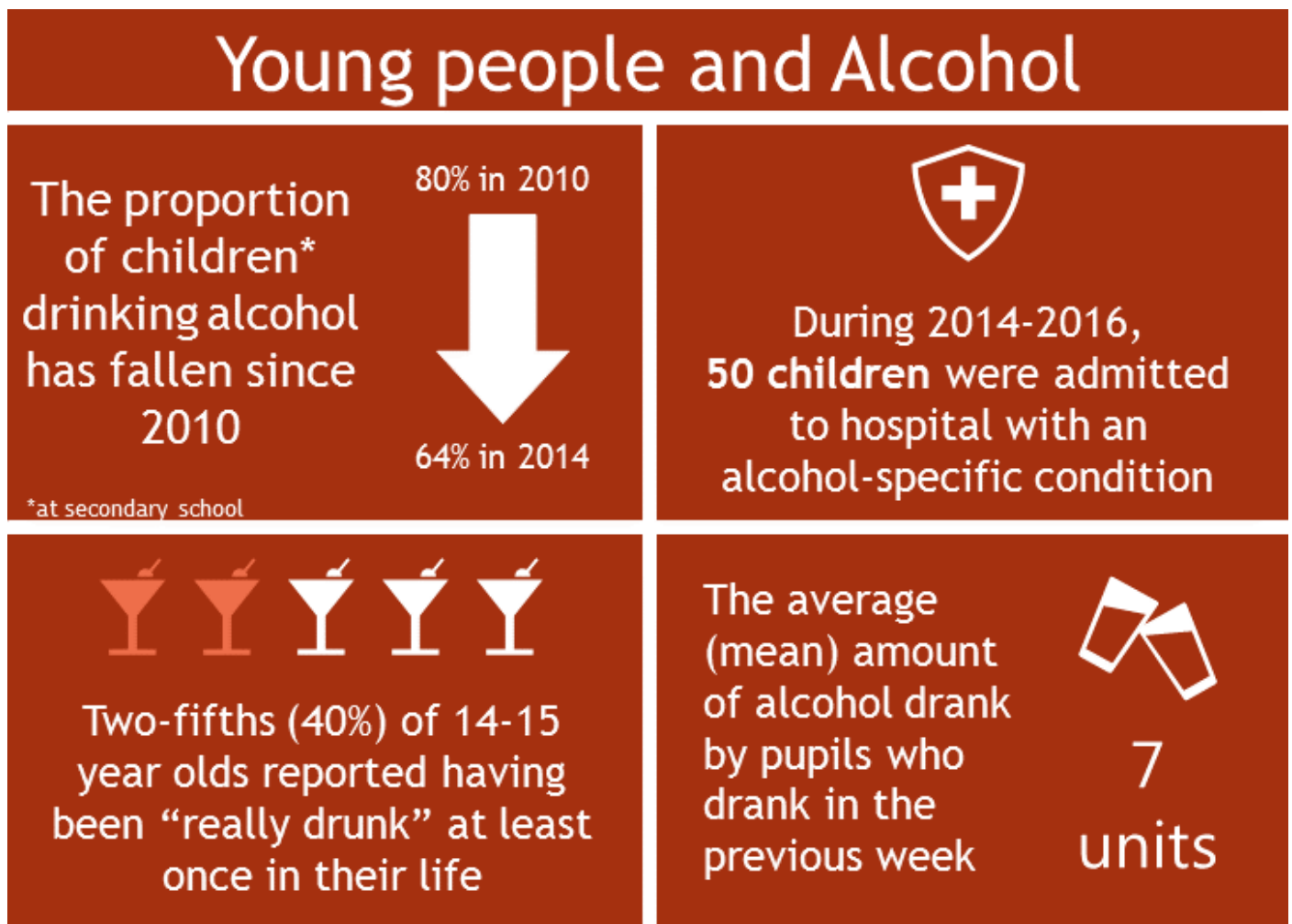
The number of recorded incidents of evening street violence has reduced from more than 300 in 2012 to around 200 in 2016. In the latest year, around 90 incidents were recorded as involving alcohol by the officer at the scene.

Drink-driving

140 drink-driving incidents were recorded by the States of Jersey Police in 2016; 30 involved a road traffic collision or hit and run incident. The majority of drink-drive incidents in 2016 were committed by males (73 per cent); half (52 per cent) were committed by 31-50 year olds (males and females).

Young people and alcohol

The information presented in this chapter relates to drinking patterns of children in Jersey. Two main sources of information are used to describe drinking patterns and the effects of alcohol use by children. The first source is a survey of school children,²⁴ which asks children about their health and lifestyle behaviours. This survey was last run in 2014 and data presented in the last 2014 alcohol profile. The second source is hospital admission data, taken from the Hospital computer system and analysed by the Statistics Unit. For further information on both of these sources, please see the Background Notes section of this report.



Drinking among children

The 2014 Young People’s Health and Lifestyle survey report²⁵ contains information on the drinking behaviour of children aged 12-15 in secondary schools in Jersey.

²⁴ States of Jersey Public Health Intelligence Unit, A picture of Health Jersey 2014: Reflections on the health and lifestyle of young people ages 10-15 years, published 2 March 2015, available from www.gov.je

²⁵ States of Jersey Public Health Intelligence Unit, A picture of Health Jersey 2014: Reflections on the health and lifestyle of young people ages 10-15 years, published 2 March 2015, available from www.gov.je

The key findings for 2014 were:

- around half (52 per cent) of 12-13 year olds report having never drunk alcohol, decreasing to one in five (20 per cent) of 14-15 year olds. These proportions have increased since 2010, when 30 per cent of 12-13 year olds and 9 per cent of 14-15 year olds reported having never drunk alcohol
- boys were more likely to have drunk alcohol in the 12-13 age group, while equal proportions of girls and boys had drunk alcohol in the older age group (14-15 years)
- 1 in 6 (16 per cent) of 14-15 year olds had drunk alcohol in the seven days prior to the survey. This proportion has declined steadily since 1998, when 54 per cent of pupils in this age group reported drinking in the previous week, to 40 per cent of pupils in 2006 and 36 per cent in 2010
- the proportion of young people who reported they drank in the previous seven days continues to be lower than in the UK and lower than in Guernsey
- around three-fifths (62 per cent) of pupils who drank alcohol in the last week did so on one day only
- pupils who drank in the previous week drank a mean of 7 units of alcohol. In England this figure was 8 units of alcohol
- cider was drunk by the greatest percentage of young people in the seven days prior to the survey, followed by spirits and beer. The top three drinks consumed were (in descending order): spirits, wine and cider by girls and cider, beer and spirits by boys
- two-fifths (40 per cent) of 14-15 year olds reported having been “really drunk” at least once in their life

For more information on the drinking habits of young people in Jersey, see the report ‘*A picture of Health Jersey 2014: Reflections on the health and lifestyle of young people ages 10-15 years*’.²⁶ The next round of the school survey is scheduled to run in 2018.

Under 18 hospital admissions due to alcohol consumption

Over the period 2014-2016, there were 50 episodes of children under 18 admitted to hospital with a primary or secondary diagnosis for an alcohol-specific condition. The number of episodes related to 40 individuals, with the number of admission episodes per person varying from one to three. Females accounted for a greater number of episodes (30) than males (20). The number of episodes has remained essentially flat since 2012.

The crude rate of hospital admission for Jersey is 79 per 100,000 population aged under 18 for the latest period (2014-2016). Comparable figures to the Public Health England indicators can be found in Table A1 and Figure A1 in Appendix 1. The Jersey rate is significantly higher than the English average (37 per 100,000) for the same period.

²⁶ States of Jersey Public Health Intelligence Unit, *A picture of Health Jersey 2014: Reflections on the health and lifestyle of young people ages 10-15 years*, published 2 March 2015, available from www.gov.je

Social Security expenditure

This section presents information provided by the Social Security Department on claims relating to alcoholism.

There are three types of sickness benefit provided by the Social Security Department for Jersey residents.

- short term incapacity allowance (STIA) is usually authorised by GP's and paid to working age claimants who satisfy the necessary contribution conditions for periods of incapacity lasting between 2 and 364 days.
- long term incapacity allowance (LTIA) is an assessed allowance for working age persons who satisfy the necessary contribution conditions and have a long term loss of faculty. Claimants may continue to work while receiving this allowance.
- invalidity benefit (INV) is no longer available to new claimants, due to the introduction of LTIA in 2004, but continues to be paid to those individuals who were in receipt of the benefit prior to LTIA being introduced. Invalidity benefit does not allow claimants to undertake work whilst claiming.

Expenditure on benefits due to alcoholism

Figures are presented for claims made for which the illness reported is alcoholism. Such figures are likely to be an underestimate of the number of people claiming benefit for alcoholism, since an alternative diagnosis (such as depression) may be recorded in some cases rather than the explicit code for alcoholism.

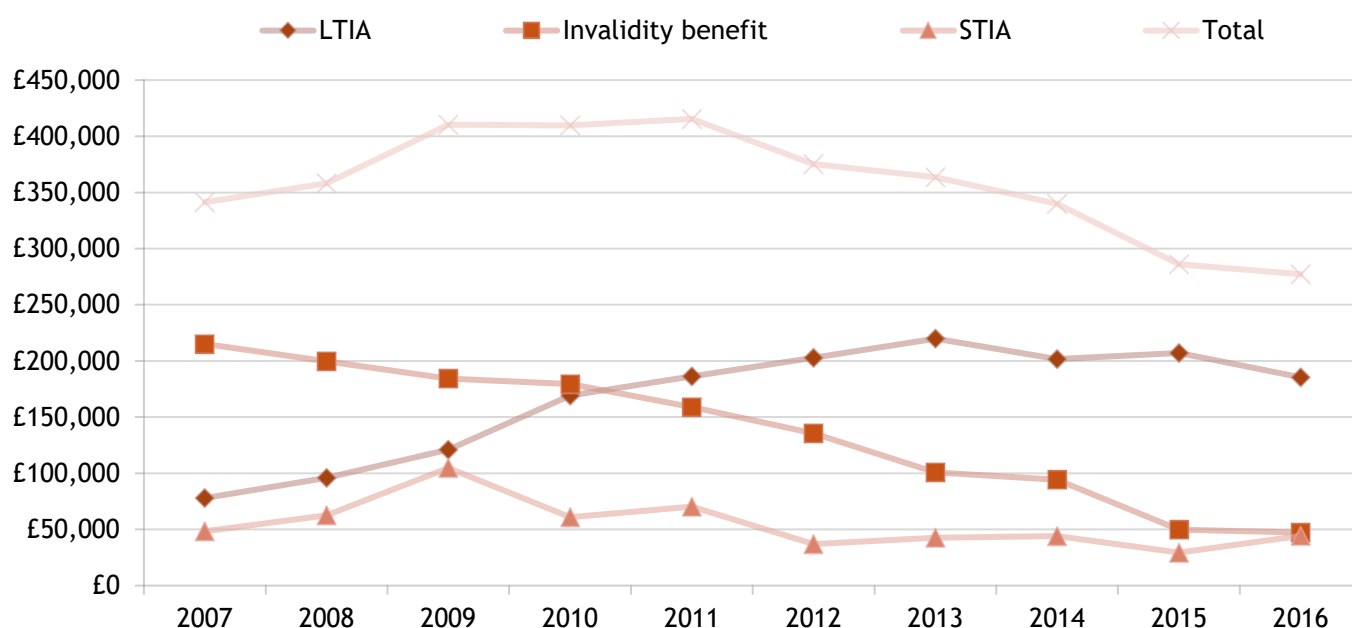
In 2016:

- a total of £277,200 was paid out by Social Security for alcoholism, comprising: £185,500 for LTIA; £47,300 for Invalidity benefit; and £44,400 for STIA claimants
- the total paid out in 2016 was 3 per cent lower than that paid out for claims due to alcoholism in the previous year 2015 (£286,100), which had been a 16 per cent decrease on the 2014 figure (£339,900)
- over the last three years, 2014-2016, the average annual number of claims for alcoholism for LTIA was 45, for invalidity benefit was 7 and for STIA was 21; the number of claims representing a small proportion of the number claims for each benefit annually (1 per cent or less)
- claims for LTIA for alcoholism covered 15,900 days, although claimants may still be working. STIA claims for alcoholism covered almost 2,000 days, with claimants not working during this

time. A total of 19,600 days were claimed for alcoholism in 2016 for STIA, LTIA and invalidity benefit

- between 2007 and 2011, the number of claims, expenditure and days claimed for alcoholism doubled for LTIA; since 2011, the level of each has remained essentially flat (Figure 15)
- the number of claims for invalidity benefit has decreased by around three-quarters since 2007, largely as a result of this benefit no longer accepting new claimants. The number of claims for STIA has remained essentially flat over the same period

Figure 15: Expenditure⁺ on STIA, LTIA and INV* for alcoholism, 2007-2016



Source: Social Security Department

⁺Nominal expenditure (i.e. not adjusted for inflation)

* LTIA was introduced in 2004, with invalidity benefit no longer accepting new claimants from this time.

The total expenditure by the Social Security Department on benefits relating to alcoholism has decreased by more than £138,300 since 2011.

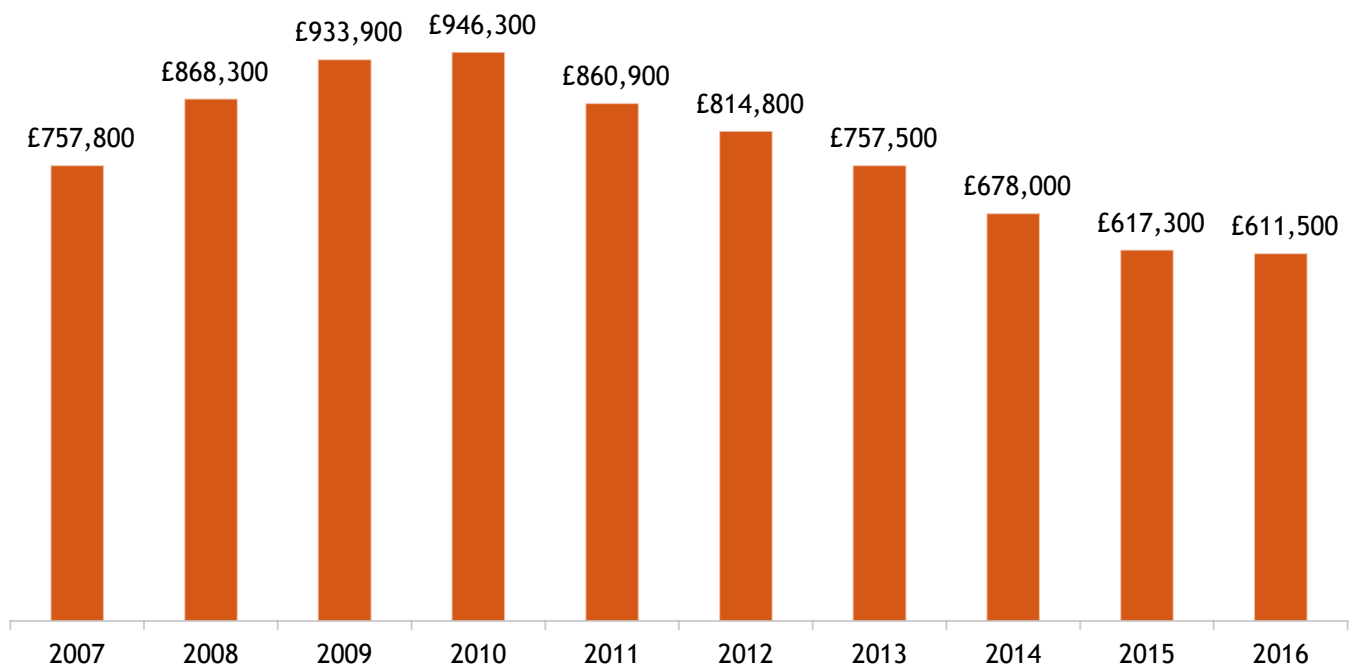
Expenditure on benefits due to alcohol-related sickness and ailments (including alcoholism)

Alcohol-related sickness and ailments are defined by the Social Security Department as alcoholism, detox, drug and substance dependency and liver disease (from all causes including alcohol) and cirrhosis.

Social Security Department data for alcohol-related sickness and ailments show that for 2016:

- £611,500 was paid for a total of 164 claims
- this latest total is similar to that for the previous year (2015), 10 per cent lower than two years previously, 2014 (£678,000), and is the lowest expenditure for a decade (Figure 16)
- over half of claims (57 per cent) for alcohol-related sickness and ailments were for LTIA
- a total of 42,500 days were claimed in 2016 for alcohol related sickness: 19,600 for alcoholism; 3,000 for detox; 12,800 for drug and substance dependency; and 7,200 for liver disease (from all causes including alcohol) and cirrhosis

Figure 16: Expenditure* on alcohol-related sickness and ailments, 2007-2016



*Nominal expenditure (i.e. not adjusted for inflation)

Source: Social Security Department

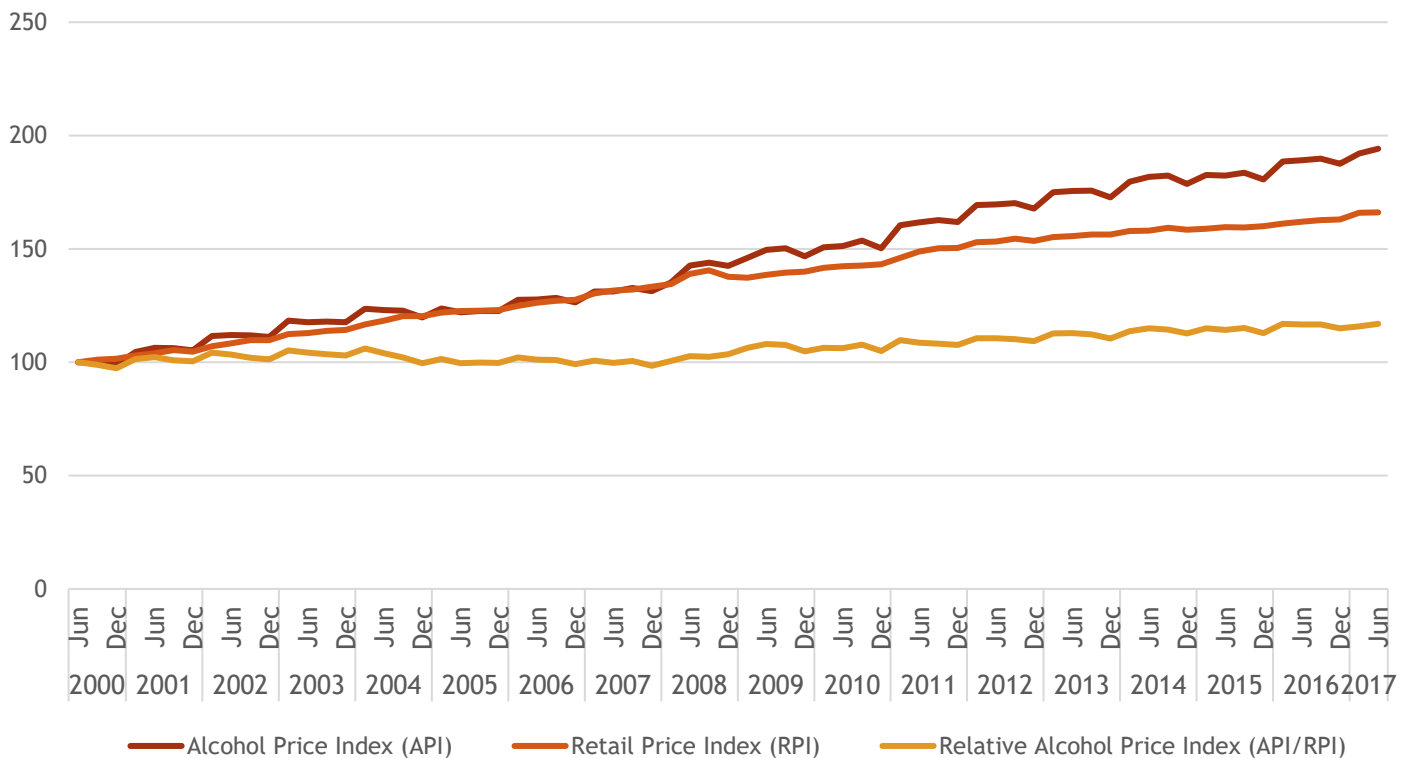
Retail prices

Data compiled by the States of Jersey Statistics Unit enables analysis of the price of alcohol over time. Three indices are considered here:

- the all-items Retail Prices Index (RPI) - the main inflation measure in Jersey, compiled using a representative ‘basket’ of over 500 separate goods and services
- Alcohol Price Index (API) - the group level index of the RPI relating to a ‘basket of alcoholic drinks’ priced by the Statistics Unit and provides a representative measure of the price of alcohol
- Relative Alcohol Price Index - defined as API/RPI and provides an indicator of how the average cost of alcohol has changed in relation to prices overall

Between June 2000 and June 2017, the price of alcohol in Jersey has increased by 17 per cent more than retail prices generally. Figure 17 shows how prices have changed since June 2000 (an arbitrarily chosen base quarter), increasing essentially in line with inflation prior to 2008 since when alcohol prices have increased at a faster rate than retail prices.

Figure 17: Relative alcohol price index: 2000 to 2016



Source: Statistics Unit

Household Expenditure

The Statistics Unit runs a Household Spending and Income Survey (HSIS) approximately every five years. The most recent round of the survey ran for twelve months from April 2014 to April 2015. For more information on household spending, see the States of Jersey Statistics Unit Report *Jersey Household Spending Survey 2014/15*²⁷ available from www.gov.je

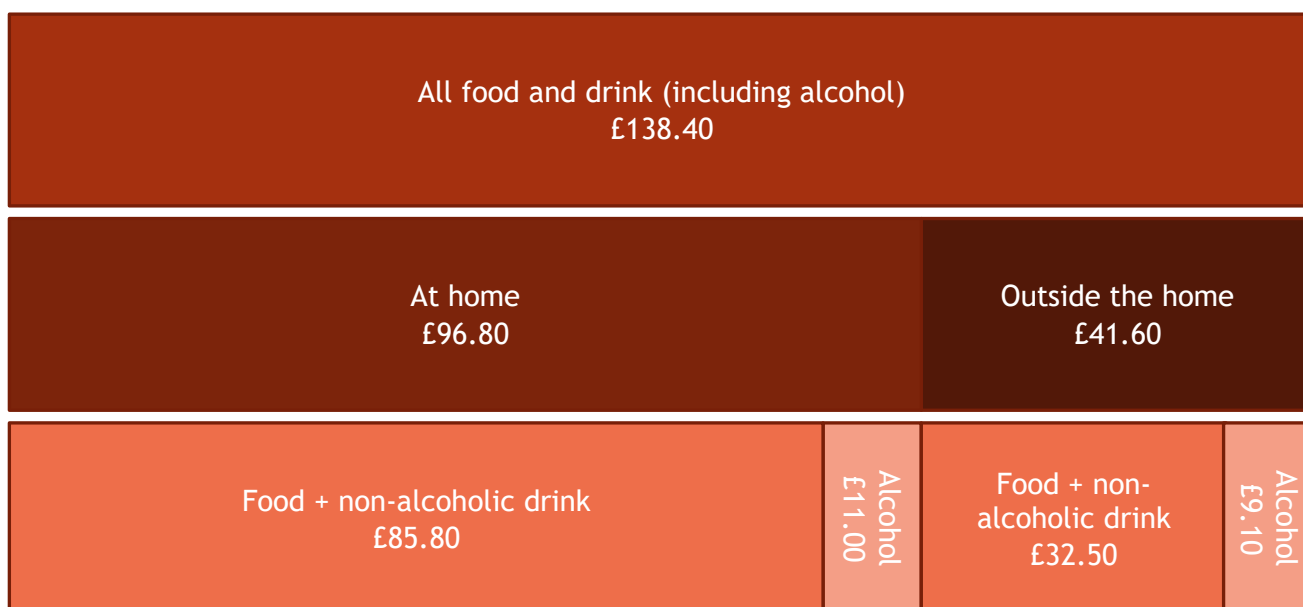


Overall household expenditure on alcohol

In 2014/2015, households in Jersey spent an average of £138 per week on food and drink both at home and outside of the home, including alcoholic drinks. Of this total, £20 per week (15 per cent) on average was spent on alcohol (either off premises or in licensed premises), as shown in Figure 18.

²⁷ States of Jersey Statistics Unit, Jersey Household spending 2014/15, published 27 May 2016, available from www.gov.je

Figure 18: Average household food and drink expenditure per week, 2014/15



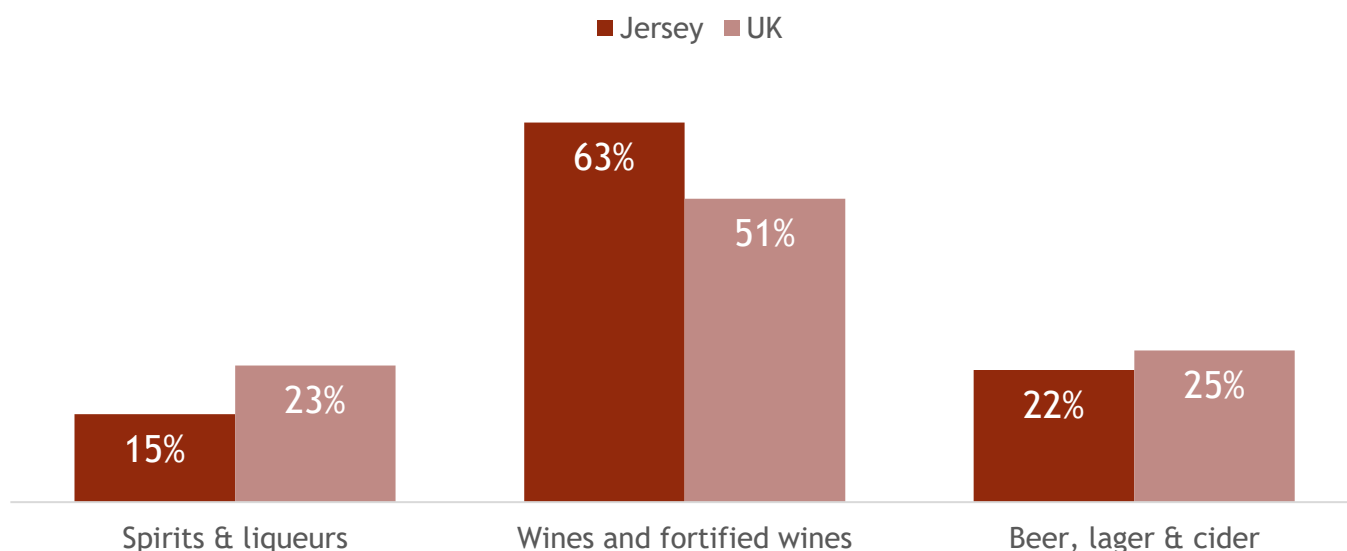
Source: Jersey Household Spending Survey 2014/15

Expenditure by alcohol type

Wine constitutes the greatest expenditure on alcohol in off-licensed premises in Jersey, with an average weekly household spend of £6.90, compared to £1.60 on spirits and liqueurs and £2.40 on beer, lager and cider.

Wine accounts for 63 per cent of the household alcohol expenditure in off-licensed premises in Jersey, compared to 51 per cent in the UK (Figure 19). Spirits and liqueurs account for a lower percentage of expenditure in Jersey than in the UK, while the proportion of alcohol expenditure on beer, lager and cider is similar.

Figure 19: Proportion of alcohol expenditure in off-licensed premises by drink type



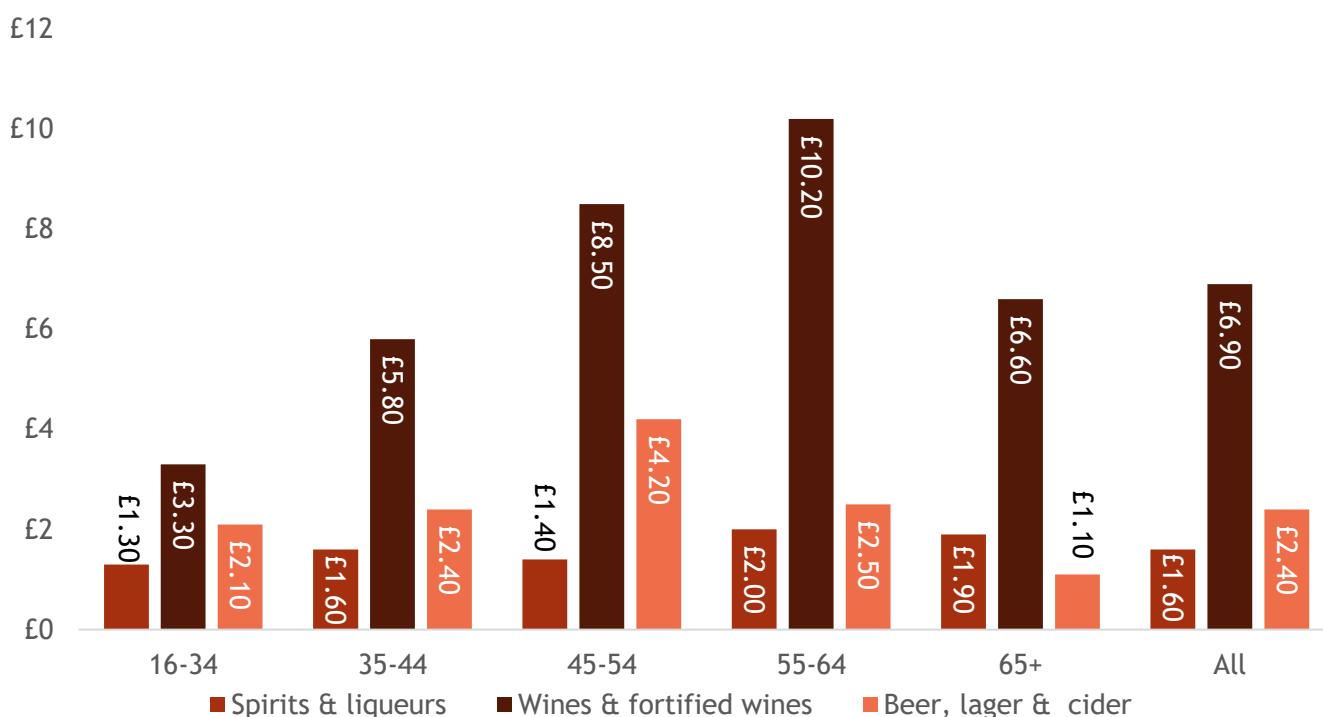
Source: Jersey Household Spending Survey 2014/15 and ONS Family Spending 2015

Household expenditure by age, income and tenure

Households in Jersey where the head of household is in the 45-54 year-old age group spent the most on alcohol (average of £27 per week). The next oldest age group, 55-64 year-olds, spent slightly less (£25 per week) but a greater proportion of this was drinking at home (off-premises), rather than drinking out in licensed premises. Expenditure on alcohol was lowest for the 65 or over age group, at £16 per week. 16-34 year-old's are the only group that spend more on alcohol in licensed premises than at home.

Figure 20 shows average expenditure for alcohol consumed at home by alcohol type and age of the head of household.

Figure 20: Expenditure per week on alcohol consumed at home (in off-licensed premises) by age group of head of household

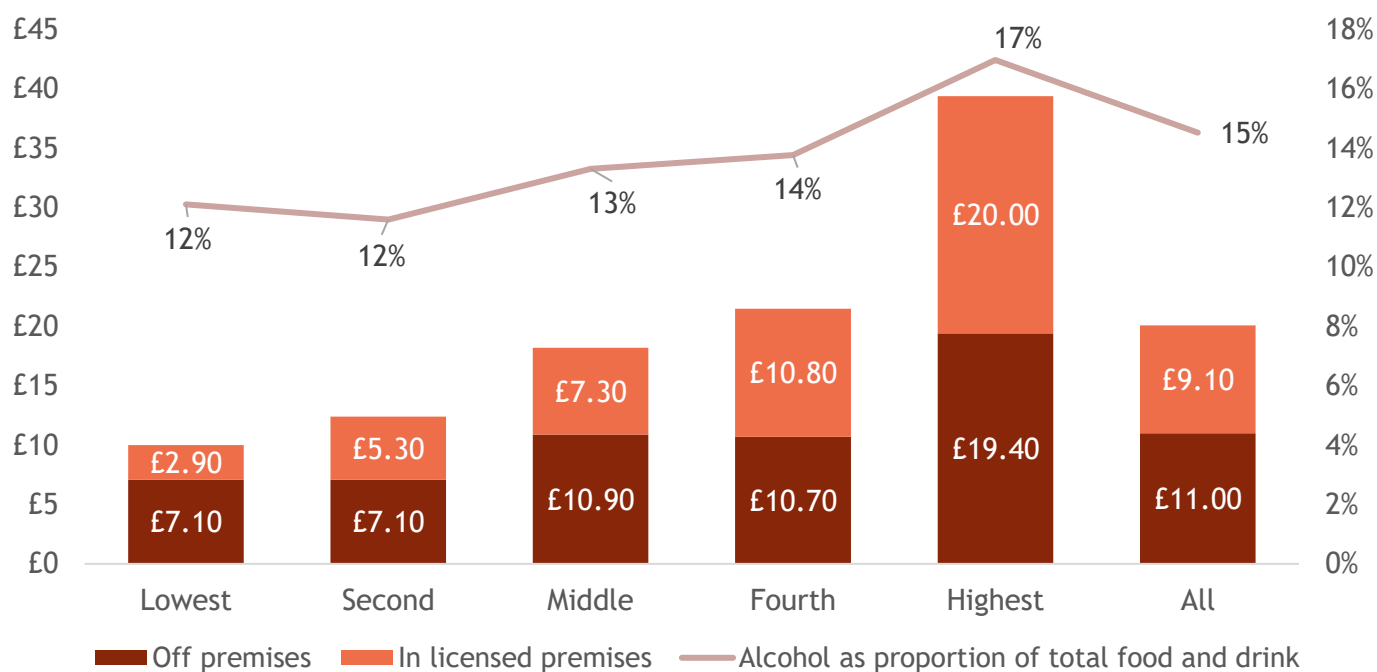


Source: Jersey Household Spending Survey 2014/15

Differences in expenditure were also seen by household income quintile²⁸ (non-equivalised), with households in the highest income quintile spending the most on alcohol and the highest proportion of their food and drink expenditure on alcohol (Figure 21).

²⁸ If every household were ordered according to its income, from the lowest to highest, the first 20 per cent of households represent the "first income quintile" of households - i.e. those households which have the lowest income. The second income quintile is the next 20 per cent of households, and so on up to the fifth income quintile, which corresponds to the 20 per cent of households with the highest income.

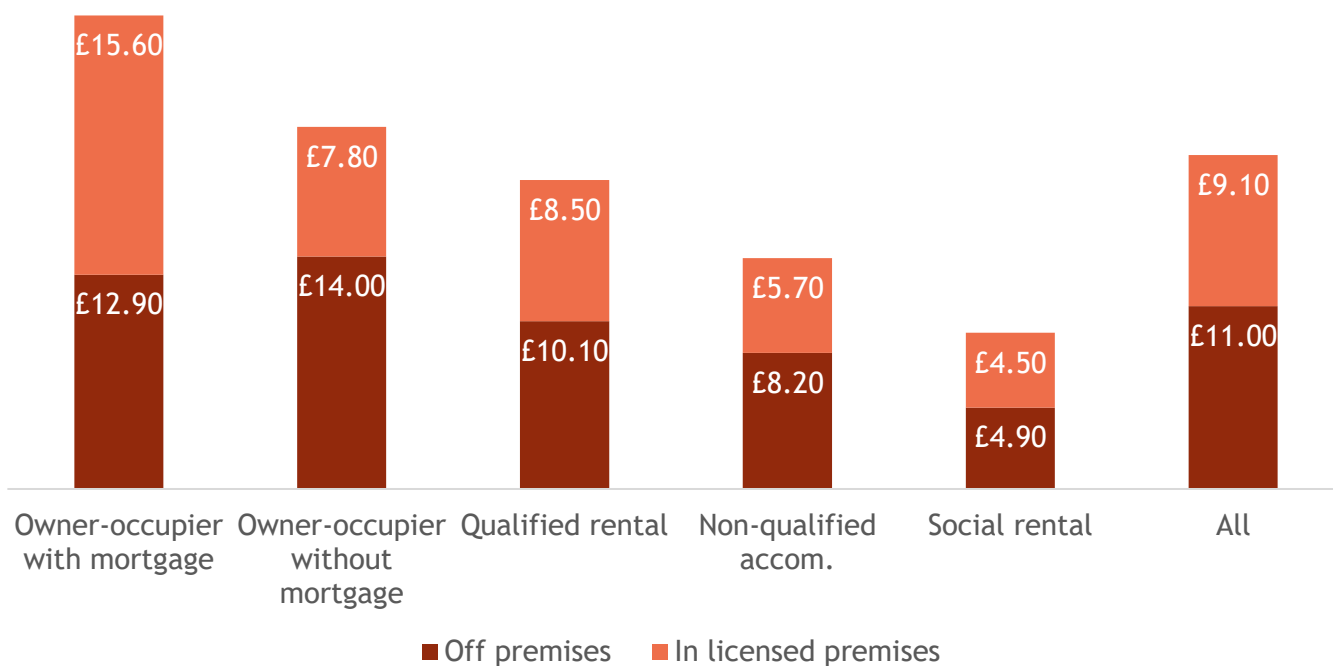
Figure 21: Expenditure per week on alcohol by income quintile



Source: Jersey Household Spending Survey 2014/15

Expenditure on alcohol varied by tenure, with owner-occupiers spending three times more per week (£28.50) than those living in social rental households (£9.40) as shown in Figure 22.

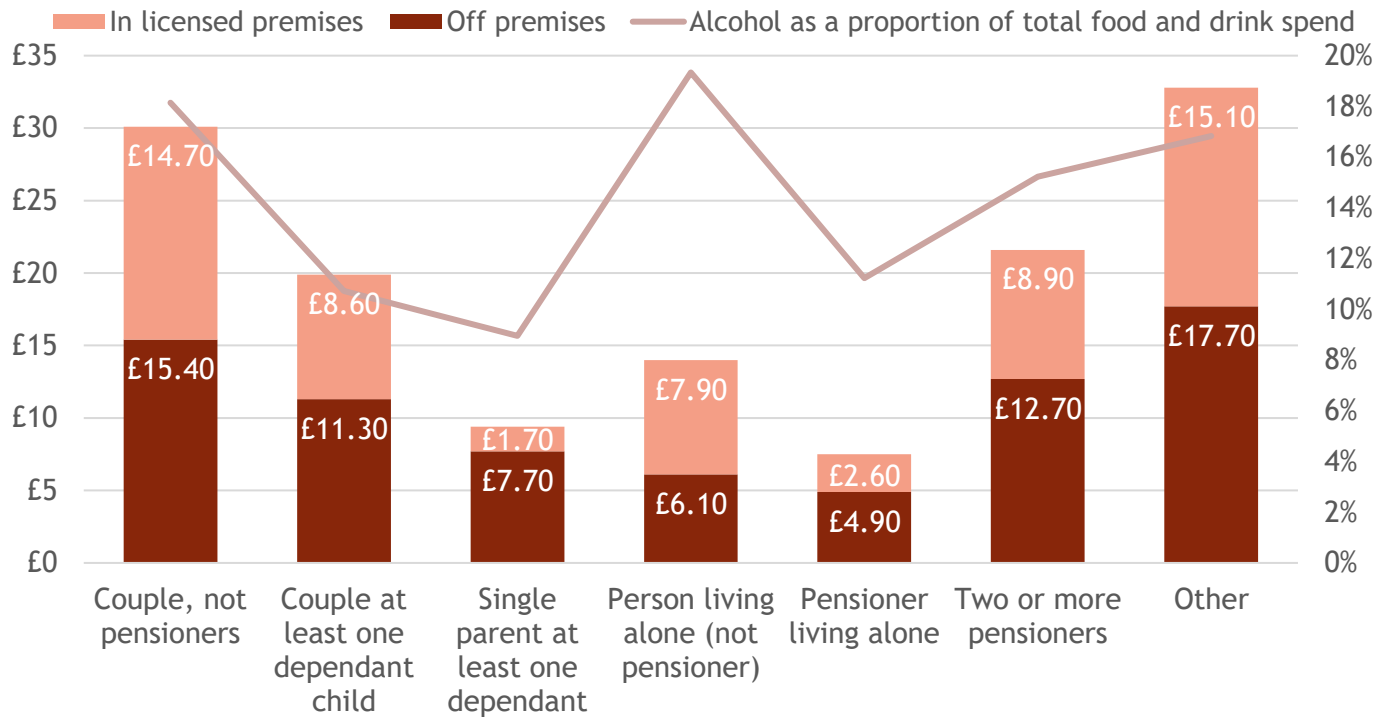
Figure 22: Expenditure per week on alcohol by housing tenure



Source: Jersey Household Spending Survey 2014/15

Figure 23 shows the distribution of expenditure on alcohol by household type. With the exception of households with ‘other structures’, couples of non-pensionable age spent the most on alcohol.

Figure 23: Expenditure per week on alcohol by household type



Source: Jersey Household Spending Survey 2014/15

Definitions and glossary of terms

Age standardised rates

An age standardised rate is the rate of events that would occur in a population with a standard age structure if that population were to experience the age-specific rates of the subject population (e.g. Jersey). The age groups used are 0 to 4, 5 to 9,...85 to 89, 90+ years. The 2013 European Standard Population has been used to calculate the standardised rates in this report. The same population is used for males, females and all persons and rates are expressed per 100,000 population.

Alcohol-specific conditions

Alcohol-specific conditions include those conditions where alcohol is causally implicated in all cases of the condition;²⁹ for example, alcohol-induced behavioural disorders and alcohol-related liver cirrhosis. The alcohol-attributable fraction is 1.0 since it is considered that all cases from such conditions are caused by alcohol.

Alcohol-related conditions

Alcohol-related conditions include all alcohol-specific conditions, plus those where alcohol is causally implicated in some but not all cases of the outcome, for example hypertensive diseases, various cancers and falls. The attributable fractions for alcohol-related outcomes used here range from between 0 and less than 1.0. For example, the alcohol-attributable fraction for mortality from pneumonia among males aged 75 or over is 0.10 because the latest epidemiological data suggest that 10 per cent of pneumonia cases among this population are due to alcohol.³⁰

Confidence Intervals

A confidence interval gives an indication of the likely statistical uncertainty around a value that has been calculated. A confidence interval indicates the range within which the true value for the population as a whole could be expected to lie, taking natural random variation into account. Confidence intervals should be considered when interpreting results.

²⁹ See Jones L and Bellis MA (2014m *Updating England-specific alcohol-attributable fractions*, Liverpool: Centre for Public Health, Liverpool John Moores University

³⁰ Public Health England, Local Alcohol Profiles for England 2015 User Guide, published 2 June 2015, available from www.lape.org.uk

Conditions

Acute - symptoms appear and change or worsen rapidly.

Chronic - develops and worsens over an extended period of time.

Crude Rates

A crude rate refers to the number of events per 1,000 or 100,000 population.

Drinking frequency

Binge drinking - males are considered to have binged if they drank more than eight units of alcohol on one day and females if they drank more than six units. These are double the recommendation, from the Department of Health in England,³¹ for the amount of units to consume on one day.

Frequent drinking - this is classified as those who drink on five or more days in a week.

Teetotal

Teetotalers are those who say that they do not drink alcohol at all.

Years of Life Lost (YOLL)

Years of life lost is a measure of premature mortality which is used to compare the mortality experience of different populations for all causes of death and/or particular causes of death by quantifying the number of years **not** lived by individuals who die under a given cut-off age. The most frequently used cut-off age is 75, this having been set as an age that everyone can be expected to reach.

³¹ Based on Department of Health recommendations prior to January 2016, for more information on the changes to recommendations see: Department of Health (2016), UK Chief Medical Officers' Alcohol Guidelines Review: Summary of the proposed new guidelines, published January 2016, www.gov.uk

Background notes

Data sources

The following data sources have been used in this report:

- Alcohol consumption figures use data supplied by Customs and Immigration on volumes of alcohol imported into the Island, alongside population figures generated by the Statistics Unit, data on the number of seasonal workers in the Island each year and information from Visit Jersey (and the Tourism department prior to 2015) on the number of visitors each year
- Deaths data is compiled by the Statistics Unit from notifications and registrations reported by parish registrars to the Superintendent Registrar as required by the Marriage and Civil Status (Jersey) Law 2001. Coding of cause of deaths of Jersey residents is undertaken by the Office for National Statistics on a quarterly basis, classified using the International Statistical Classification of Diseases, Injuries and Causes of Death (tenth revision, ICD-10).
- The Jersey Opinions and Lifestyle Survey (JOLS) is a voluntary postal and internet survey run by the States of Jersey Statistics Unit. The survey is sent to more than 3,000 randomly selected households each year, and has a high response rate of around 46 per cent. Statistical weighting techniques are used to compensate for different patterns of non-response from different sub-groups of the population. The result is that the survey results can be considered broadly accurate and representative of Jersey's resident population. As with all sample surveys, there is an element of statistical uncertainty, typically around ± 2.5 percentage points for proportions relating to the overall population. For further details see www.gov.je/JOLS.
- Data on the drinking behaviours of young people in Jersey is taken from the The Young People's Health and Lifestyle Survey (formally known as the Health Related Behaviours Survey) which is run in schools by the States of Jersey Health Intelligence Unit. The latest round ran in 2014, and the questionnaire was carried out with students in all primary schools with the exception of schools for children with special need requirements) across the Island at ages 10-11 years (school year 6) and in all secondary schools across the Island at 12-13 years (school year 8) and 14-15 years (school year 10). A total of 2,675 students completed the survey, representing an 86 per cent response rate. The survey questions cover a range of health topics including family background and home life through to specific health issues such as diet, physical activity, drugs, alcohol, smoking and wellbeing. With the survey methodology used there is 95% confidence that the sample percentages accurately represent the whole population percentage to ± 2 percentage points. For further information please see the report on www.gov.je
- Household expenditure on alcohol was taken from the Statistics Unit report on the Jersey Household Spending Survey 2014/15, available from www.gov.je. A total of 1,278 randomly selected households took part in the survey, representing a response rate of 45 per cent. The survey spanned a twelve-month period to capture different spending patterns throughout the year, for example typically higher and different expenditure in the run-up to Christmas. Regular

spending (e.g. housing costs, fuel and memberships) and infrequent purchases (e.g. furniture and vehicles) were collected through a face-to-face interview. In addition, each adult household member kept a spending diary for two weeks to capture day-to-day spending. More than 170,000 individual purchases were used to compile the spending report, for further information Jersey Household Spending Survey 2014/15 available from www.gov.je

- The Social Security Department have provided information on the number of sickness benefit claims made to their department. For further information see www.gov.je
- Data on hospital admissions is taken from the hospital computer system TRAK which was implemented in June 2011. Admissions data are classified using the International Classification of Diseases (ICD-10); each admission can have up to 20 diagnosis fields which provide the reasons why the patient was admitted to hospital. These diagnosis fields are used in the analysis of alcohol-specific hospital admissions in this report
- Data on the number of people currently living with chronic liver disease is collected from the General Practice Central Server (GPCS), a computer system introduced into all general practice (GP) surgeries in Jersey in 2013. Data taken from the GPCS are taken from specific disease registers which are generated as part of the Jersey Quality Improvement Framework which incentivises GPs to accurately record patients that meet a set of disease-specific criteria as being on a particular disease register. As such, the quality of this data is deemed to be greater than those indicators and disease registers for which GPs are not incentivised to record
- Data on substance misuse has been provided by the Drug and Alcohol service on the number of referrals received each year. For further information about the service see www.gov.je
- Details on alcohol-related crime have been provided by the States of Jersey Police. These figures can be affected by campaigns being run by the Police and are reliant on officers recording when alcohol has been involved. Figures for Jersey have not been compared on a like-for-like basis to English crime figures due to differences in the legal systems and recording mechanisms. For further information on Jersey crime statistics see jersey.police.uk
- The Retail Prices Index (RPI) and the group level data for Alcoholic Drinks, as measured quarterly by the Statistics Unit, has been used to analyse changes in the price of alcohol in comparison to retail prices overall. The Alcohol Price Index, used to derive the relative alcohol price index, relates to a 'basket of alcoholic drinks' and is used to measure the average change in price of alcoholic drinks bought by an average household in Jersey. For further information see www.gov.je/inflation

Comparisons

Comparisons to other jurisdictions are presented in this report to enable benchmarking and comparison with trends being seen elsewhere. Data is extracted from published reports from the Office for National Statistics, Public Health England, NHS Digital, OECD and WHO.

Timeliness

The data presented in this report refers to 2016 data or earlier periods if national comparison data for 2016 is not currently available. Data for retail prices is presented to June 2017 as this was available at time of publication.

Methods

Per capita consumption of alcohol

Information supplied by Customs and Immigration on volumes of alcohol imported into the Island is divided by the population aged 15 or over (excluding visitors and seasonal workers) to generate a measure of the amount of pure alcohol consumed in litres in a calendar year per resident person. Conversion factors used to estimate the amount of pure alcohol are: beer and cider, 5 per cent; wine, 12 per cent; and spirits, 20 per cent.

Measures of mortality

Age-standardised rates have been calculated using the number of deaths occurring each year as the numerator and the mid-year population estimate for that year as the denominator. The rates have been standardised using the 2013 European Standard Population. The directly age-standardised rates adjust for differences in age and sex structures between populations to allow comparisons across time and place.

Annual mortality rates for Jersey are calculated using the average of the two corresponding end-year population estimates as published by the States of Jersey Statistics Unit. The resulting estimate of the mid-year population assumes that half of births, deaths and migration occurs in the first half of the calendar year.

Potential years of life lost (YOLL) estimates the number of years a person would have lived had they not died prematurely. It is based on the assumption that every individual could expect to live until the age of 75 and premature death before that age may be preventable.

Alcohol-attributable fractions used to calculate alcohol-related mortality and hospital admissions

Attributable fraction values are the proportion of a health condition or external cause that is attributable to the exposure of a specific risk factor (such as alcohol) in a given population. Attributable fractions are used in this report to estimate the number of deaths and hospital admissions that are related to alcohol consumption. The population attributable fraction calculation assumes a causal association between risk factor and outcome, meaning that the attributable fraction can also be viewed as the expected proportional reduction in cases of an outcome arising in the population as a result of removing the exposure, in this case, alcohol. For further information on the methodology see www.nhsdigital.nhs.uk.

Alcohol attributable fractions (AAFs) are used to calculate the number of hospital admissions attributable to alcohol. In March 2017, PHE, in response to user feedback, replaced indicators on numbers of people admitted to hospital due to alcohol with indicators measuring admission episodes instead. The aim of this

change was to show the impact on services that admissions due to alcohol have. As such, the indicators in this report have been updated to reflect the change in methodology and are therefore not comparable with previous versions of the alcohol profile.

Accuracy and reliability

All figures have been independently rounded to the nearest integer; this is because small numbers are more susceptible to natural variation. Percentages may not add up to 100 per cent due to rounding.

The data covers all deaths of residents living in Jersey on- and off-Island. A small number of inquests may still be outstanding for deaths occurring in calendar year 2016; therefore, numbers here should be treated as provisional. All death numbers have been independently rounded to the nearest 10, to reflect the provisional nature of these statistics at time of publication.

When the observed total number of deaths is fewer than 10, mortality rates are not calculated, as there are too few deaths to calculate directly standardised rates reliably. This is an update on previously published recommendations by PHE.

Data recorded on the GP central server is reliant on GPs and practice staff to accurately record activity occurring in their individual practices. The Statistics Unit has access, through a data sharing agreement, to the central server to allow statistical information to be monitored. This information is anonymised and as a result the data cannot be interrogated to look for errors or duplicates, therefore figures presented here should be treated with caution. The accuracy and reliability of this data is expected to improve as data is further shared and interrogated and as coding of the data improves.

Information on hospital admission episodes for 2016 should be treated as provisional due to a small number of outstanding episodes that are yet to be coded by the Clinical Coding team. This number is known to be less than 200 general medical episodes.

Confidence intervals and statistical significance

Confidence intervals have been used in this report to compare Jersey mortality rates and hospital admission rates with those of England. Confidence intervals are a measure of the statistical precision of an estimate and show the range of uncertainty around the estimated figure. The confidence interval indicates the range within which the true value for the population as a whole can be expected to lie, taking natural random variation into account.

Comparisons between rates or over time have been statistically tested to determine whether differences are likely to be statistically significant or the result of natural random variation. Only those differences deemed as statistically significant have been described in this report using terms such as 'increase', 'decrease', 'higher' or 'lower'.

Data quality and completeness

A quality assurance process includes checks on data completeness, comparison to previous year data, comparisons to previous data for the same cohorts and investigation of any large changes.

The data quality and completeness of data extracted from the GP central server cannot be assured; however where variation between GP practices is identified, this is fed back to individual surgeries for further checks. Figures are also compared to previous years figures and large changes are investigated.

The number of deaths may differ from previously published figures due to the inclusion of data from inquests which can take up to 18 months to complete and register. Data on deaths of Jersey residents that occur outside of the Island may also result in a delay in registering the death with the Superintendent Registrar. This means that total deaths in a given year should be treated as provisional.

Contact details

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Cyril Le Marquand House

St Helier

JE4 8QT

PublicHealthStatistics@gov.je

Appendix 1: Public Health England comparable indicators

Alcohol-specific hospital admission indicators

Table A1: Hospital admission indicators (PHE measure)

Indicator	Period	Jersey rate	Jersey 95% CI	England rate	England 95% CI	England best/lowest	England worst/highest
Admission episodes for alcohol-specific conditions (age-standardised rate per 100,000 population)							
All persons	2015/16 & 2016*	747	(695, 802)	583	(581, 585)	197	1,681
Male	2015/16 & 2016*	1,083	(994, 1,179)	812	(809, 816)	259	2,441
Female	2015/16 & 2016*	419	(365, 479)	367	(364, 369)	130	1,015
Admission episodes for alcohol-specific conditions - Under 18s (crude rate per 100,000 population)							
All persons	2014-16*	78.5	(57.5, 104.7)	37.4	(36.7, 38.0)	10.8	115.1
Male	2014-16*	57.6	(33.6, 92.3)	29.4	(28.6, 30.2)	6.0	104.6
Female	2014-16*	99.7	(66.8, 143.2)	45.8	(44.8, 44.7)	15.7	126.3

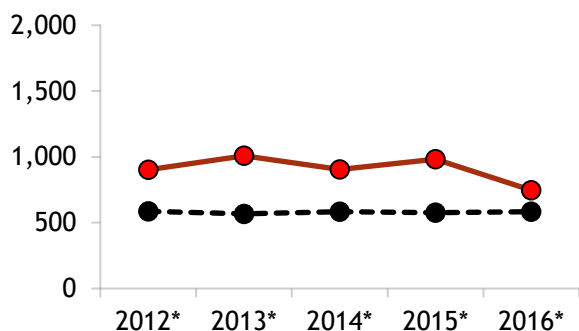
Source: Jersey Statistics Unit and Public Health England

*Jersey data is for calendar years, whereas English data is for financial years

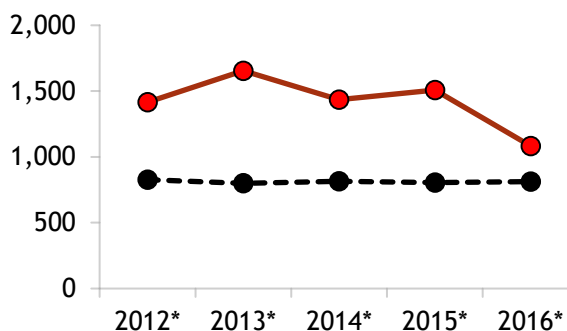
Figure A1: Hospital admission indicators (PHE measure)

Admission episodes for alcohol-specific conditions (age-standardised rate per 100,000 population)

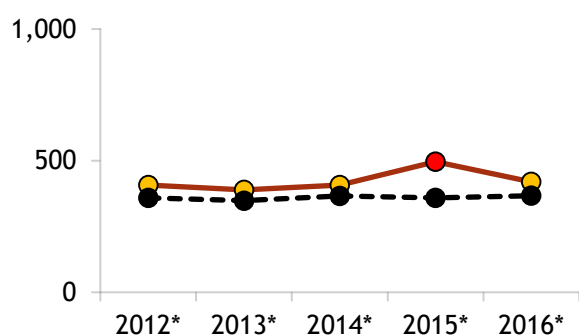
All persons



Male

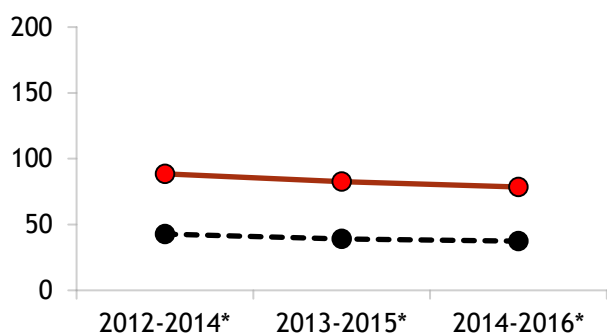


Female

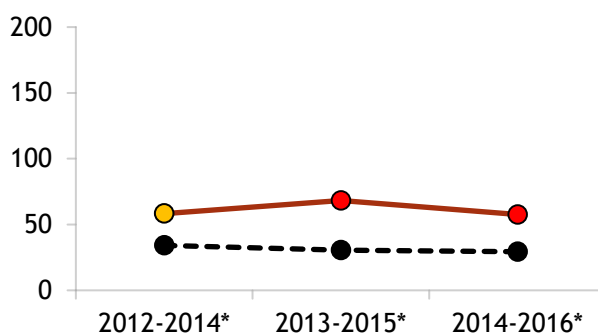


Admission episodes for alcohol-specific conditions - Under 18s (crude rate per 100,000 population)

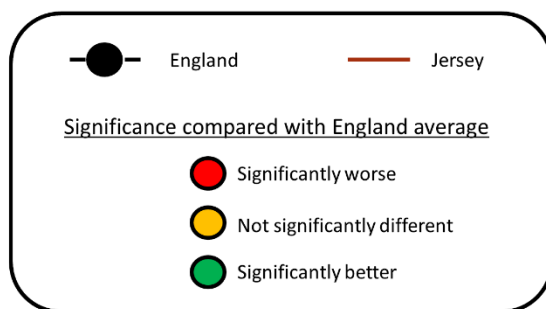
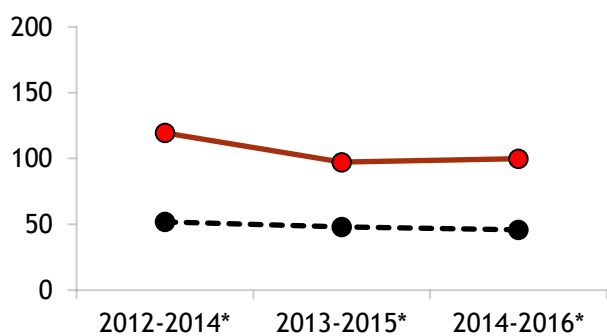
All Persons



Male



Female



Source: Jersey Statistics Unit and Public Health England

*Jersey data is for calendar years, whereas English data is for financial years

Alcohol mortality indicators

Table A2: Mortality indicators (PHE measure)

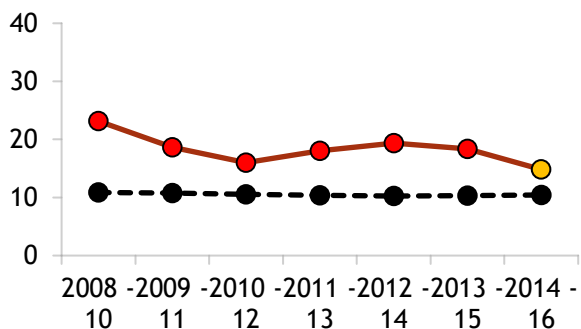
Indicator	Period	Jersey rate	Jersey 95% CI	England rate	England 95% CI	England best/lowest	England worst/highest
Alcohol-specific mortality (age-standardised rate per 100,000 population)							
All persons	2014-16	14.8	(10.5, 20.3)	10.4	(10.3, 10.6)	3.9	28.6
Male	2014-16	21.7	(14.4, 31.6)	14.2	(14.0, 14.5)	5.6	38.5
Female	2014-16	8.2	(4.0, 14.7)	6.8	(6.7, 7.0)	2.2	19.3
Mortality from chronic liver disease (age-standardised rate per 100,000 population)							
All persons	2014-16	11.9	(8.0, 17.0)	12.0	(11.8, 12.2)	5.5	31.5
Male	2014-16	15.0	(8.9, 23.5)	15.7	(15.5, 16.0)	6.3	42.2
Female	2014-16	8.5	(4.2, 15.3)	8.5	(8.3, 8.7)	3.7	21.0
Alcohol-related mortality (age-standardised rate per 100,000 population)							
All persons	2016	44.4	(31.9, 59.9)	46.0	(45.5, 46.6)	27.3	86.0
Male	2016	60.8	(38.9, 88.3)	66.3	(65.3, 67.4)	42.1	124.2
Female	2016	29.7	(16.3, 47.8)	28.8	(28.2, 29.4)	17.5	51.2

Source: Jersey Statistics Unit and Public Health England

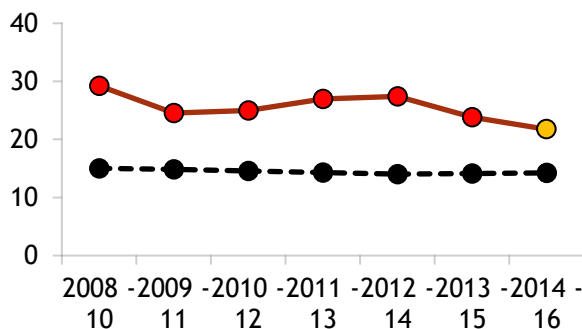
Figure A2: Mortality indicators (PHE measure)

Alcohol-specific mortality (age-standardised rate per 100,000 population)

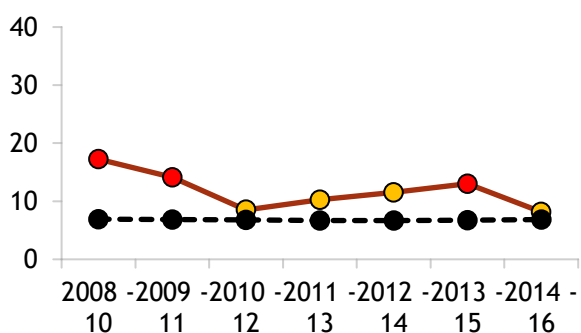
All persons



Male

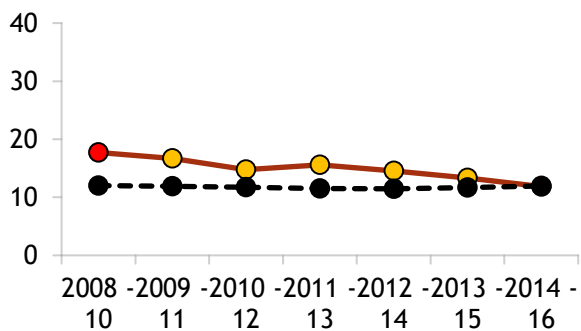


Female

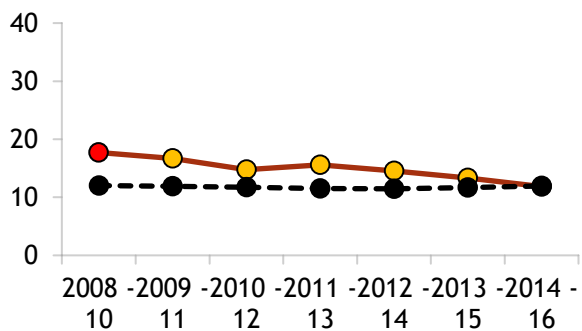


Mortality from chronic liver disease (age-standardised rate per 100,000 population)

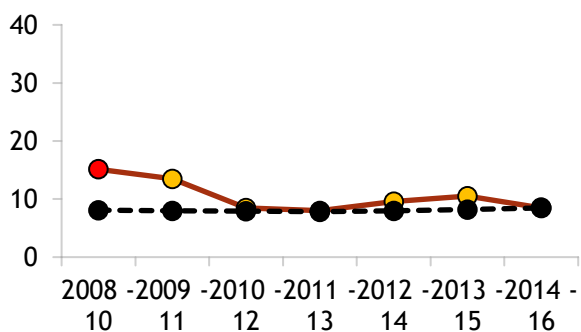
All Persons



Male

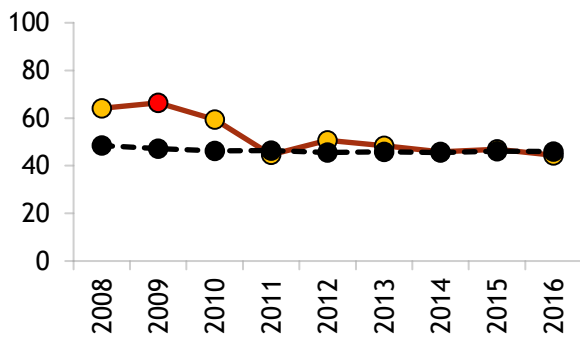


Female

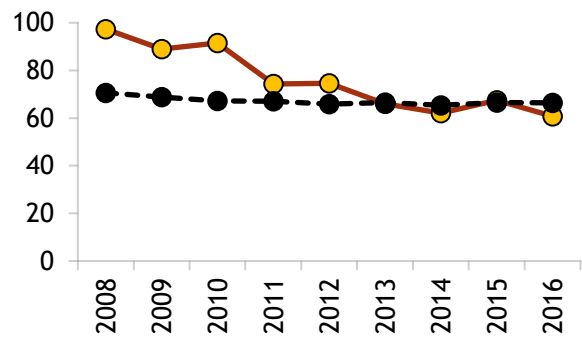


Alcohol-related mortality (age-standardised rate per 100,000 population)

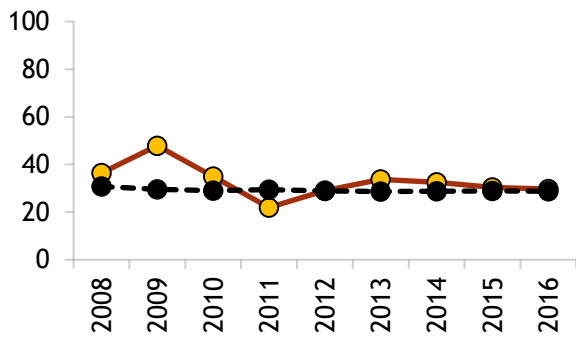
All Persons



Male



Female



England
 Jersey

Significance compared with England average

- Significantly worse
- Not significantly different
- Significantly better

Source: Jersey Statistics Unit and Public Health England

Liver disease indicators (including all liver disease and alcoholic liver disease)

Table A3: Liver disease indicators (PHE measures)

Indicator	Period	Jersey rate	Jersey 95% CI	England rate	England 95% CI	England best/lowest	England worst/highest
Under 75 mortality rate from liver diseases (age-standardised rate per 100,000 population)							
All persons	2014-16	18.8	(13.9, 24.9)	18.3	(18.0, 18.5)	9.8	44.7
Male	2014-16	24.0	(16.2, 34.2)	23.9	(23.6, 24.3)	8.5	56.8
Female	2014-16	13.8	(8.1, 21.9)	12.8	(12.6, 13.1)	5.6	32.7
Under 75 mortality rate from alcoholic liver disease (age-standardised rate per 100,000 population)							
All persons	2014-16	9.0	(5.7, 13.5)	8.8	(8.7, 9.0)	2.9	26.7
Male	2014-16	13.7	(8.1, 21.7)	11.8	(11.5, 12.0)	4.0	34.9
Female	2014-16	-	-	6.0	(5.8, 6.2)	2.0	18.5

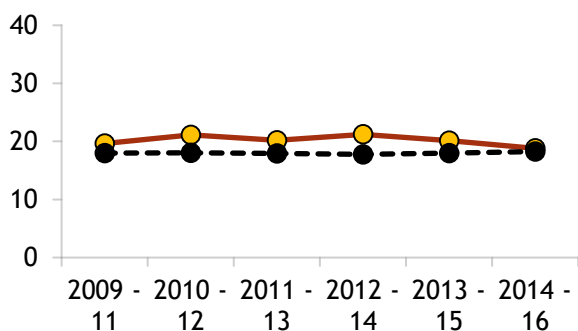
Source: Jersey Statistics Unit and Public Health England

- There are two few deaths to calculate directly age standardised rates reliably

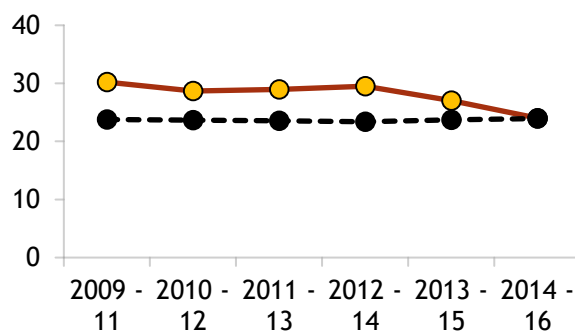
Figure A3: Liver disease indicators (PHE measures)

Admission episodes for alcohol-specific conditions (age-standardised rate per 100,000 population)

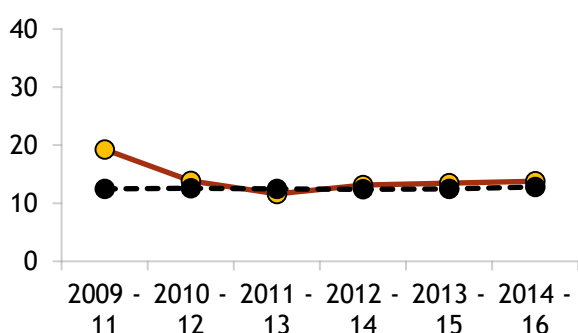
All persons



Male

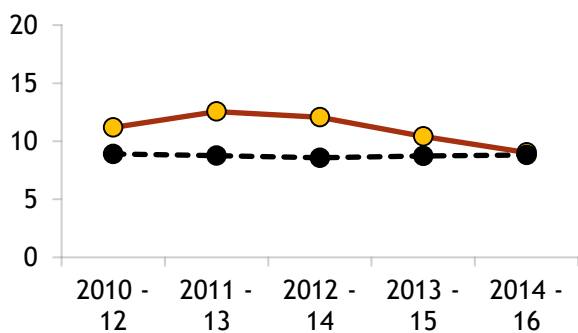


Female

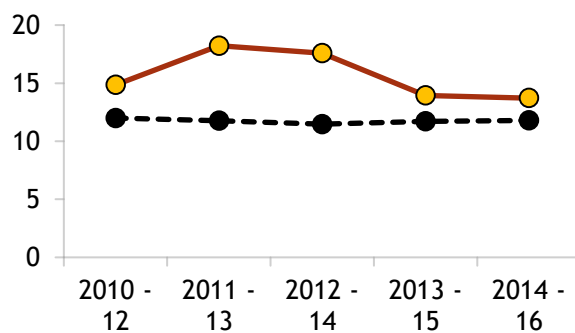


Under 75 mortality rate from alcoholic liver disease (age-standardised rate per 100,000 population)

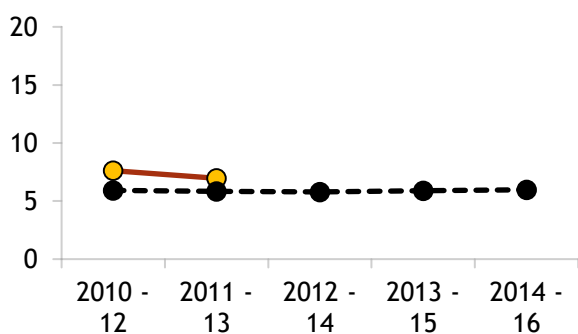
All Persons



Male



Female*



Source: Jersey Statistics Unit and Public Health England

* Data for the last three time periods not published as there are two few deaths to calculate directly age standardised rates reliably