# Assessing and Addressing the Harms Caused by Alcohol to Individuals and Communities in East Sussex

## Final Version

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## Introduction

Alcohol takes a huge toll on all communities, East Sussex included. A single example from a local paper is illustration. *A drink-driver who killed a Robertsbridge mother-of-four as she walked home from a night out with her husband has been told he faces a jail sentence. Christine Fraser, 46, was hurled through the air and into the forecourt of a car dealership just yards from her home.*[1] A single alcohol related incident impacts on the criminal justice system, health services and families.

A group of partner agencies from the health, social care, criminal justice and local authority sectors in East Sussex commissioned this needs assessment from Alcohol Concern to identify the harm caused by alcohol to individuals and communities in the county, to assess current responses and to make recommendations about how best to address the harm. The work was carried out by Alcohol Concern's consultancy service.

Alcohol Concern has used the following approaches to develop this assessment of need:

| |
|---|
| Review of key documents |
| Meetings with specialist service providers |
| Meetings with non-specialist Tier 1 providers |
| Meetings with young people's services |
| Consultation with community groups |
| Meetings with specialist community safety and criminal justice system staff |
| Meetings with education / communication specialists |
| Meetings with the licensing staff |
| Consultation with service users and carers |
| Review of models from other areas |
| Meetings with commissioners |

In all 57 individuals were interviewed including service users and carers. In addition Alcohol Concern reviewed over 30 local reports such as the local Licensing Policies.

## National Requirements

Throughout this document we have indicated the national requirements on local partnerships with regard to alcohol. However, it should be noted that these are relatively few in number, although alcohol impacts on a number of other mandated areas e.g. domestic abuse.

# Section 1
# The extent of hazardous, harmful and dependent drinking in East Sussex

### 1.1 The Number of Hazardous, Harmful and Dependent Drinkers in East Sussex

There are two key sets of national data on the prevalence of alcohol problems.

- Office of National Statistics (ONS) general household survey data
- The Department of Health's Alcohol Needs Assessment Research Project (ANARP)

The *ONS general household survey* identifies the following six groups of drinkers (see Appendix 1 for definitions) and the national percentages in each group. The following table extrapolates these to East Sussex's adult population (16 and over) of (413,100):

| | |
|---|---|
| Non-drinkers (12% of population) | 49,572 |
| Low-risk drinkers (67.1%), | 277,190 |
| Hazardous drinkers (16.3%) | 67,335 |
| Harmful drinkers (4.1%). | 16,937 |
| Moderately dependent drinkers (0.4%) | 1653 |
| Severely dependent drinkers (0.1%) | 413 |

These figures can also be extrapolated to the individual boroughs and districts within the county.

| | Non drinkers 12% | Low Risk 67.1% | Hazardous 16.3% | Harmful 4.1% | Moderately Dep 0.4% | Severely Dep 0.1% |
|---|---|---|---|---|---|---|
| Eastbourne | 9,396 | 5,2539 | 12,762 | 3,210 | 313 | 78 |
| Hastings | 8,274 | 46,265 | 11,238 | 2,826 | 275 | 68 |
| Lewes | 9,210 | 51,499 | 12,510 | 3,146 | 307 | 76 |
| Rother | 8,769 | 49,033 | 11,911 | 2,996 | 292 | 73 |
| Wealden | 13,992 | 78,238 | 19,005 | 4,780 | 466 | 116 |

It has been argued by many in the alcohol field that these categories significantly underestimate the number of dependent drinkers.[2]

The *Alcohol Needs Assessment Research Project (2005)* used the ONS data but enhanced it with other research and comes up with a higher prevalence of problems and, in particular, dependency. This data is focused on the population from 16-64 (299,400 in East Sussex) and, therefore, under-represents the small but growing number of older problem drinkers.[3]

| | |
|---|---|
| Hazardous/Harmful drinkers (23%). | 68,862 |
| Dependent drinkers (3.6%) | 10,778 |

These national figures can be adjusted by using data on regional drinking patterns. The South East has the second lowest level of hazardous and harmful drinking but the fourth highest level of dependency (both out of the nine regions). When the South East Region figures are extrapolated to East Sussex the following picture emerges[4]:

| | |
|---|---|
| Hazardous/Harmful drinkers (19%) | 56,886 |
| Dependent drinkers (4%) | 11,976 |

Again these figures can be extrapolated to the individual boroughs and districts.

| | Hazardous/Harmful 19% | Dependent 4% |
|---|---|---|
| Eastbourne | 10,678 | 2,248 |
| Hastings | 10,250 | 2,158 |
| Lewes | 10,535 | 2,218 |
| Rother | 9,230 | 1,943 |
| Wealden | 16,283 | 3,428 |

Three other broad demographic factors currently impact on the level of drinking in an area and can be used to refine the projections:

- Ethnic make-up of the population. (Higher populations of people from black and minority ethnic communities reduce the overall level of drinking because these groups tend to drink less than white British, Irish and European communities.)
- Gender balance. (Men drink more than women so any bias to male populations will increase overall levels of drinking)
- Age range. (Younger adults drink more than older adults so a younger than average population may have higher levels of drinking)

The proportion of East Sussex's population from black and minority ethnic communities is relatively low: the white population is 96.1% of the total population.[5] This will slightly increase the number of problem drinkers in the county, because large ethnic minority communities drink less than white British communities.

Population estimates show that 241,337 (47.7%) of the county population is male and 264,892 (52.3%) is female.[6] Nationally, the position is 49.1% male to 50.9% women. This imbalance between males and females will reduce the rate of drinking in the county slightly because men drink more than women.

The age distribution of an area will also have an impact on the overall level of drinking. Older populations drink less than younger ones, so a population with an above average age level will be likely to have lower levels of drinking. East Sussex's population is older than the national average and this will again slightly reduce the overall impact of alcohol on the county.[7]

These population statistics do not suggest that the regional extrapolations above need to be significantly revised. However, these figures are all based on extrapolating national and regional data to the local population. The key question is whether the actual situation in the county reflects the extrapolated data. Does the county have a higher or lower than average level of alcohol problems?

One way of refining this data is to use the Government sponsored North West Public Health Observatory's data. The NWPHO provides fifteen statistical

indicators of adult alcohol related harm broken down by local authority area. Each indicator can rank the five local boroughs in comparison with the 354 local authorities in the country. The table below sets out the data.

| | **Borough rank out of 354 local authorities in England (1 lowest – 354 highest rate of problems)**[8] | | | | |
|---|---|---|---|---|---|
| | Eastbourne | Hastings | Lewes | Rother | Wealden |
| Male - Alcohol related months of life lost | Eastbourne ranks 334 out of 354 | 321 / 354 | 197/ 354 | 193/ 354 | 38/ 354 |
| Female - Alcohol related months of life lost | 352 / 354 | 141 / 354 | 75/ 354 | 145/ 354 | 67/ 354 |
| Male - Alcohol-specific mortality | 345 / 354 | 253 / 354 | 153/ 354 | 244/ 354 | 60/ 354 |
| Female - Alcohol-specific mortality | 306 / 354 | 72 / 354 | 58/ 354 | 28/ 354 | 21 / 354 |
| Male - Mortality from chronic liver disease | 336 / 354 | 257/ 354 | 117 / 354 | 244/ 354 | 28/ 354 |
| Female - Mortality from chronic liver disease | 210 / 354 | 71 / 354 | 107/ 354 | 19/ 354 | 30/ 354 |
| Male Alcohol-attributable mortality | 342 / 354 | 210/ 354 | 149/ 354 | 171/ 354 | 67/ 354 |
| Female -Alcohol-attributable mortality | 329 / 354 | 183/ 354 | 94/ 354 | 59/ 354 | 58/ 354 |
| Alcohol-specific hospital admission, under 18s | 295 / 354 | 344/ 354 | 174/ 354 | 288 / 354 | 213/ 354 |
| Male Alcohol-specific hospital admission | 293 / 354 | 346/ 354 | 162/ 354 | 255 / 354 | 72/ 354 |
| Female Alcohol-specific hospital admission | 301 / 354 | 344/ 354 | 259/ 354 | 231 / 354 | 122/ 354 |
| Male Alcohol-attributable hospital admission | 306 / 354 | 336/ 354 | 169/ 354 | 217/ 354 | 167/ 354 |
| Female Alcohol-attributable hospital admission | 301 / 354 | 325/ 354 | 167/ 354 | 215 / 354 | 159 / 354 |
| NI39 Alcohol related Hospital admissions | 325 / 354 | 327/354 | 139/354 | 199 / 354 | 172/354 |
| Alcohol related recorded crimes | 281 / 354 | 322/354 | 109/354 | 79/354 | 24/354 |
| Alcohol related violent offences | 312 / 354 | 327/354 | 124/354 | 69/354 | 25/354 |
| Alcohol related sexual offences | 296 / 354 | 331/354 | 112/354 | 180/354 | 15/354 |

Marked patterns emerge from this data. If the data was averaged across the county, East Sussex would appear close to the national average, however, this conceals distinct differences between boroughs. Hastings and,

particularly, Eastbourne have some of the highest rankings in the country for a number of indicators. For example, Eastbourne's Female - Alcohol related months of life lost ranking, is third highest in the country. Hasting's Male Alcohol-specific hospital admission is ninth highest in the country. Nine of Eastbourne's and ten of Hasting's rankings are among the top 50 in the country. On the other hand seven of Wealden's rankings are among the lowest 50 in the country.

Data from the Ambulance service confirms the picture of differential rates of problems within the county and reflects the pattern found in the NWPHO data of higher rates of problems in the coastal areas.

| L.A. | Major wards | Total Responses "Alcohol-related" | Rate/1,000 |
|---|---|---|---|
| **Eastbourne** | | **561** | **34** |
| | Devonshire Ward | 172 | 63 |
| | Meads Ward | 82 | 39 |
| | Upperton Ward | 106 | 61 |
| **Hastings** | | **485** | **32** |
| | Castle Ward | 143 | 98 |
| | Central St. Leonards Ward | 65 | 56 |
| | Old Hastings Ward | 43 | 49 |
| **Lewes** | | **307** | **23** |
| | Lewes Priory Ward | 39 | 35 |
| | Newhaven Denton and Meeching | 41 | 32 |
| **Rother** | | **284** | **26** |
| | Central Ward | 39 | 44 |
| | Eastern Rother Ward | 37 | 53 |
| **Wealden** | | **329** | **17** |
| | Crowborough North Ward | 25 | 33 |
| | Uckfield Central Ward | 23 | 37 |
| | Uckfield North Ward | 20 | 20 |
| Unknown | | **32** | |
| **E SUSSEX** | | **1998** | **27** |

Source: **EMERGENCY RESPONSES BY THE AMBULANCE SERVICE IN E SUSSEX – between 01/04/2008 and 30/09/2008, Public Health Department** ES Downs & Weald PCT[9]

This data highlights two key factors which need to be taken into account when planning any response to alcohol misuse in the county:

- East Sussex is part of a region which, despite having lower levels of hazardous and harmful drinking has significant numbers of dependent drinkers.
- Parts of the county have drinking patterns which are among the highest in the country.

These two factors need to drive any service structure which is developed locally.

### 1.2 National Alcohol Treatment Monitoring System

Since April 2008 alcohol services have been reporting data to the National Alcohol Treatment Monitoring System: part of the National Drug Treatment Monitoring System.

Data is now available on the first eleven months. The table below provides data on East Sussex, England, neighbouring areas and representative areas from around the country.

| | Population (,000) | NDTMS alcohol clients in treatment April 2008 – February 2009 | Rate per 1,000 of population |
|---|---|---|---|
| Bath & NE Somerset | 175.6 | 252 | 1.44 |
| Brighton & Hove | 251.4 | 599 | 2.38 |
| Devon | 740.8 | 1231 | 1.66 |
| East Riding | 330.9 | 529 | 1.60 |
| **East Sussex Downs & Weald Primary Care Trust** | | **210** | |
| **East Sussex (combined PCTs)** | **506.2** | **353** | 0.70 |
| **Hastings and Rother PCT** | | **243** | |
| Liverpool | 436.1 | 1197 | 2.74 |
| Manchester | 452 | 1764 | 3.90 |
| Oxfordshire | 632.0 | 651 | 1.03 |
| Surrey | 1,085.2 | 2071 | 1.91 |
| Swindon | 186.6 | 471 | 2.52 |
| Torbay | 133.2 | 403 | 3.03 |
| West Sussex | 770.8 | 1151 | 1.49 |
| England | 50,762.9 | 98058 | 1.93 |

East Sussex's total rate of referral is well below the national average, and below directly comparable areas such as Surrey, West Sussex and Oxfordshire.

It was recognised locally that the East Sussex NDTMS alcohol data reporting may be lagging behind what is actually happening and that some of the interventions such as brief interventions are not being recorded.[10] Sussex Partnership's nurses have only recently begun to report to NDTMS on alcohol. The Action For Change reporting to NDTMS has been slow to start, and there are still some aspects of their service which it has not been agreed should be reported i.e. extended brief interventions. Tier 4 data also needs to be included routinely. There is ongoing discussion with the commissioners about this reporting.[11] [12]

GPs are currently being asked to sign up to the Directed Enhanced Scheme and it is hoped that this data will be recorded on the NDTMS so that commissioners can monitor what is happening.[13]

In the future this data will become a useful source of information on alcohol problems and alcohol treatment systems. However, this system is so new that it is unwise to draw too many conclusions. Nonetheless, this data is consistent with a treatment system which is under-resourced or under-developed.

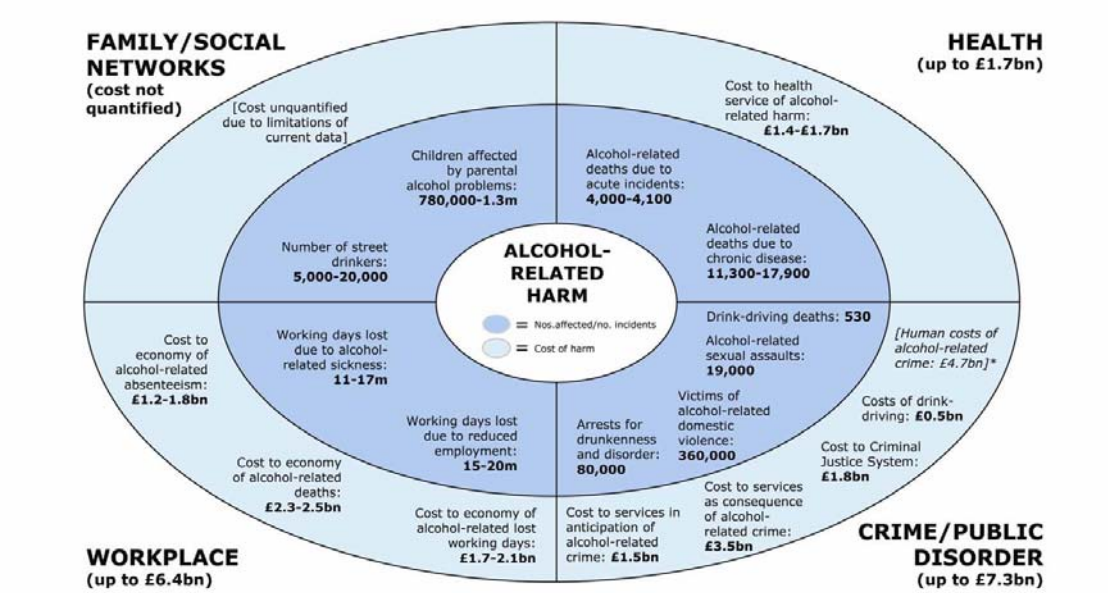
### 1.3 Interviews

All of the interviewees were asked for their comments on the impact of alcohol on the county, in order to determine whether local perception matched the national and regional data.

| |
|---|
| *The lower need is in the rural area; the coastal strip has higher need. It is not clear that there is greater need in the east e.g. Hastings than in the western part of the county e.g. Eastbourne.*[14] |
| *East Sussex has two aspects:*<br>• *the coastal areas, particularly, Hastings and then Eastbourne, but also Seaford and Newhaven.*<br>• *the rural areas which are much less problematic.*<br>*Hastings leaps out as being a significant area for alcohol in the regional context. However, the evidence for this is largely anecdotal but seems to be widely accepted. It may also be that we are starting to see the effects of the economic downturn in Hastings which is reducing alcohol consumption.*[15] |
| *Alcohol is pretty widespread. We see a lot in the context of violence and domestic abuse but also people who use it recreationally and then get into problems. Geographically Hastings and Eastbourne are the two key areas. Nowhere else is coming close.*[16] |
| *We are not receiving significant anecdotal reports of alcohol related problems coming through from housing providers.*[17] |
| *Borough Housing policy means that a significant number of "problem" families are housed in Newhaven social housing. This has produced some complex alcohol related problems.*[18] |
| *Most places of concern are likely to be in Eastbourne and Hastings.*[19] |
| *Hastings and Eastbourne are the main focus of concern; other towns are not having significant problems. In Hastings it is the town centre and the old town and St Leonards.*[20] |
| *Eastbourne is no different from many town centres – there will be problems but not a large issue that makes it different from other town centres.* [21] |
| *The main problem is created in the summer months when European students visit Eastbourne – local youths can create conflicts with them.*[22] |

### 1.4 Data on the Social, Health and Economic Impact of Alcohol on East Sussex

The table below, taken from *Models of Care for Alcohol Misusers,* indicates the costs of a wide range of harms related to alcohol. Local data is not available for any of these indicators. This section, therefore, extrapolates the national figures in this table to the local borough and district populations to provide an indication of alcohol's impact. As a result no conclusions or recommendations have been made on the basis of this data:




### 1.4.1 Health

| Effect | National Impact | Eastbourne | Hastings | Lewes | Rother | Wealden |
|---|---|---|---|---|---|---|
| Cost to health service of alcohol related harm | £1.4-1.7 billion per annum (mid-point £1.55bn) | £2,945,000 | £2,635,000 | £2,790,000 | £2,790,000 | £4,340,000 |
| Alcohol related deaths due to acute incidents | 4,000 – 4,100 per annum (mid-point 4050) | 15 | 7 | 7 | 7 | 11 |
| Alcohol related deaths due to chronic disease | 11,300 – 17,900 per annum (mid-point 14,100) | 51 | 24 | 25 | 25 | 39 |

### 1.4.2 Crime / public disorder

| Effect | National Impact | Eastbourne | Hastings | Lewes | Rother | Wealden |
|---|---|---|---|---|---|---|
| Human costs of alcohol related crime | £4.7 billion per annum | £16,920,000 | £7,990,000 | £8,460,000 | £8,460,000 | £13,160,000 |
| Costs of drink-driving | £0.5 billion per annum | £1,800,000 | £850,000 | £900,000 | £900,000 | £1,400,000 |
| Costs to criminal justice system | £1.8 billion per annum | £6,480,000 | £3,060,000 | £3,240,000 | £3,240,000 | £5,040,000 |
| Costs to services as | £3.5 billion per annum | £12,600,000 | £5,950,000 | £6,300,000 | £6,300,000 | £9,800,000 |

| | | | | | | |
|---|---|---|---|---|---|---|
| a consequence of alcohol-related crime | | | | | | |
| Costs to services in anticipation of alcohol-related crime | £1.5 billion per annum | £5,400,000 | £2,550,000 | £2,700,000 | £2,700,000 | £4,200,000 |
| Drink-driving deaths | 530 per annum | 2 | 1 | 1 | 1 | 1 |
| Alcohol-related sexual assaults | 19,000 per annum | 68 | 32 | 34 | 34 | 53 |
| Victims of alcohol-related domestic violence | 360,000 per annum | 1,296 | 612 | 648 | 648 | 1,008 |

### 1.4.3 Family and social networks

| Effect | National Impact | Eastbourne | Hastings | Lewes | Rother | Wealden |
|---|---|---|---|---|---|---|
| Children affected by parental alcohol problems | 780,100-1.3 million (mid-point 940,100) | 3,384 | 1,598 | 1,692 | 1,692 | 2,632 |
| Number of street drinkers | 5,000 – 20,000 | 45 | 21 | 23 | 23 | 35 |

### 1.4.4 Workplace

| Effect | National Impact | Eastbourne | Hastings | Lewes | Rother | Wealden |
|---|---|---|---|---|---|---|
| Cost to economy of alcohol related absenteeism | £1.2-1.8 billion per annum (mid-point £1.5bn) | £5,400,000 | £2,550,000 | £2,700,000 | £2,700,000 | £4,200,000 |
| Cost to economy of alcohol related deaths | £2.3-2.5 billion per annum (mid-point £2.4bn) | £8,640,000 | £4,080,000 | £4,320,000 | £4,320,000 | £6,720,000 |
| Cost to economy of alcohol related lost working days | £1.7-2.1 billion per annum (mid-point £1.9bn) | £6,840,000 | £3,230,000 | £3,420,000 | £3,420,000 | £5,320,000 |
| Working days lost due to alcohol related sickness | 11-17 million per annum (mid-point 14 million) | 50,400 | 23,800 | 25,200 | 25,200 | 39,200 |
| Working days lost due to reduced employment | 15-20 million per annum (mid-point 17.5 million) | 63,000 | 29,750 | 31,500 | 31,500 | 49,000 |

## 1.5 Young People and Alcohol

Compared to other European countries, the UK has the third highest proportion of 15-year-olds (24%) who have been drunk 10 times or more over the past year. There are strong links between high levels of youth alcohol consumption and other risk factors such as youth offending and teenage pregnancy, truancy, exclusion and illegal drug misuse.[23] As a result alcohol and young people is a major focus of the revised national alcohol strategy.[24]

There are indicators that drinking among young people in some parts of the county is above the national average. The key statistic about the impact of alcohol on under 18's comes from the NWPHO's data set (see Section1.1). This records alcohol specific hospital admissions for under 18s. Three of the five boroughs are in the highest 25% of authorities nationally, and the other two are average or above average. This suggests a rate of problems well above national average in Hastings, Eastbourne and Rother. Lewes and Wealden are closer to the national average; however, overall the county would be above average.

| | **Borough rank out of 354 local authorities in England (1 lowest – 354 highest rate of problems)**[25] | | | | |
|---|---|---|---|---|---|
| | Eastbourne | Hastings | Lewes | Rother | Wealden |
| Alcohol-specific hospital admission, under 18s | 295 / 354 | 344/ 354 | 174/ 354 | 288 / 354 | 213/ 354 |

Other data does support a picture of above average problems among young people. The young people's substance misuse needs assessment reports that GCSE achievement is worse than the national average.[26] The Joint Area Review found a significantly high number of under 20s with mental health and behavioural disorders.[27] Both of these can be linked statistically to alcohol misuse.

In general, data is more consistent with a picture of Hastings and Eastbourne as the areas with the more significant problems. Teenage pregnancy rates are above national average in Hastings and Eastbourne and below national average in the other three areas. This is consistent with higher rates of alcohol use by young people in the former areas.[28]

Crime data confirms this picture. Youth crime is one of the best indicators of alcohol related harm; in particular criminal damage is very closely linked with alcohol use and young people. The rate in each borough per 1000 population in 2007/8 is set out below.

| | Rate of criminal damage in each borough per 1000 population in 2007/8 |
|---|---|
| Eastbourne | 21.4 |
| Hastings | 25.5 |
| Lewes | 19.63 |
| Rother | 16.81 |
| Wealden | 10.89 |

The Young People's Specialist Substance Misuse Treatment - Needs Assessment 2007/08 provides data on the primary substance misused. [29]

**Primary substance by gender**

| | | Female | Male | Total |
|---|---|---|---|---|
| Primary substance | Heroin illicit | 8 | 1 | 9 |
| | Benzodiazepines | 1 | 0 | 1 |
| | Cocaine unspecified | 4 | 6 | 10 |
| | MDMA | 3 | 5 | 8 |
| | Nicotine | 0 | 1 | 1 |
| | Ketamine | 1 | 0 | 1 |

| | | | | |
|---|---|---|---|---|
| | Cannabis unspecified | 9 | 42 | 51 |
| | Cannabis | 58 | 165 | 223 |
| | Solvents unspecified | 4 | 6 | 10 |
| | Amyl nitrate | 0 | 1 | 1 |
| | Alcohol | 125 | 111 | 236 |
| | Steroids unspecified | 0 | 1 | 1 |
| Total | | 213 | 339 | 552 |

Overall, 236 (42.8%) young people declared alcohol as their primary substance; 125 (58.7%) females and 111 (32.7%) males misusing mainly alcohol. Comparative data was sought from other areas to put this figure in context. In Bournemouth and Poole 43% of YP reported alcohol as primary substance[30], in Nottinghamshire the figure was 42%.[31] This suggests that the county is in line with other areas. However, the borough by borough analysis shows some marked differences between areas.

This data is also available by borough and district.

**Table 14: Primary drug of young people in treatment by LA**

| | Eastbourne | Hastings | Lewes | Rother | Wealden | Total |
|---|---|---|---|---|---|---|
| Total | 194 | 177 | 59 | 66 | 56 | 552 |
| Alcohol | 50.5% | 33.8% | 33.8% | 51.5% | 42.8% | |

A higher percentage of young people reported misusing alcohol in Eastbourne, than Hastings. The number in treatment in Hastings is surprisingly low. None of the 552 individuals had previously been in treatment either in East Sussex or elsewhere. [32]

Two other data sources give a picture of the alcohol related behaviour of young people.

- The Health Related Behaviour Survey 2007 -
- The Tell Us questionnaire - The Tell Us questionnaire is an annual data collection tool that focuses on outcomes in the Every Child Matters agenda. A sample of Year 6, 8 and 10 students are asked for their answers to a range of questions that focus on health, staying safe and plans for their future. In 2007, 111,385 students across England were consulted.

The Health Related Behaviour Survey 2007 reported:

- 39% of the 3908 respondents had drunk alcohol within 7 days of the survey.
- 8% of girls and 6% of boys had consumed more than 14 units of alcohol.

- Of those that had drunk in the 7 days, 1 in 5 reported that they had been drunk at least once.
- 19% of young people had obtained their alcohol from a family member, 15% from a friend and 12% got someone to buy it for them.[33]

The Tell Us 3 survey September 2008 findings include:

- East Sussex has a better than national average rate of young people reporting no alcohol use
- East Sussex has a statistically significant, better than national average, reported delivery of alcohol advice and information
- East Sussex has a 1% worse than national average reporting of young people getting drunk once within the last 4 weeks[34]

Newspaper articles highlighted some level of concern about alcohol related harm among young people

Newspaper Article
People living at East Side in Newhaven say they are under siege from groups of up to 40 beer-drinking youths who fight and throw empty bottles around.
Now, after receiving a large number of complaints, particularly concerning the recreation ground, Newhaven police are to step up patrols in the area…One East Side resident, who did not want to be named for fear of reprisals, said the situation was so bad, younger children were afraid to play in their own back gardens…She said: 'Since the new play equipment arrived at the recreation ground last September, the group hanging round there has increased in number from about 10 to up to 40…
They are all drinking and most are in year 10 at school so we don't know where they are getting the alcohol from. They stay up there until midnight or 1am causing havoc – lots of noise and abuse the neighbours…
The kids that live round here can't use the park because they leave their rubbish, including glass, in there…The children whose gardens back on to the recreation ground can't play in their gardens because they get abuse from them.' [35]

Interviewees were asked for their views on alcohol use among young people.

| |
|---|
| *The Eastbourne and Hastings areas are more associated with alcohol and crime. However, from focus groups with young people we have done across the areas – the young people in rural areas have the same attitudes and in some way it is easier to drink in rural areas.* [36] |
| *Youth nuisance – in parks and gardens there do seem to be young people drinking. Community safety try and tackle it by bans I would like to see it being tackled by outreach.* [37] |
| *There is an increasing proportion of young people who are drinking and getting involved in anti-social behaviour and crime.* [38] |
| *The prevention message needs to come earlier and more strongly. That message came from young people themselves.* [39] |
| *The key problem is anti-social behaviour and criminal damage caused through youths' drinking.* [40] |

Alcohol use is clearly a significant issue for young people in the county; some evidence suggests that problems are above the national average in the county as a whole. In general, the data suggests that young people's patterns reflect adult patterns in that they are above the national average in the coastal areas and lower in the rural areas.

It should also be noted that a significant number of young people will be affected by the alcohol problems of their parents. Government data suggests that between 780,000 and 1,300,000 young people will fall into this category nationally. This equates to over 12,000 children locally. This number would be even higher if hazardous and harmful drinkers were included.

**1.6 18–24 Year-old Binge Drinkers**

The 18-24 year-old binge drinkers are identified as a group of particular concern in *Safe. Sensible. Social*. It is an artificial grouping. The heaviest consumers of alcohol are 16-24 year olds. However, this group does not disappear at age 24, many of the problems in this targeted group will also be seen in slightly older age groups.

These drinkers are unlikely to be dependent on alcohol and are most likely to fall into the category of hazardous, harmful or moderately dependent drinkers. The problems most associated with them will be those of violence, disorder and anti-social behaviour associated with the night time economy. Nonetheless some will be on course to develop severely dependent drinking patterns.

It is possible to extrapolate statistics about alcohol related harm to give a picture of the level of alcohol related harm in the young adult age groups. According to ANARP 33% of those in the 18-24 age group and 26% of those in the 25-29 age group will be hazardous/harmful drinkers. 8% of those in the 18-24 age group and 5% of those in the 25-29 age group will be dependent drinkers. These are national figures encompassing both males and females.

If extrapolated to the East Sussex population these would suggest the following pattern:

| | | Eastbourne | Hastings | Lewes | Rother | Wealden |
|---|---|---|---|---|---|---|
| 18-24 | Hazardous/ Harmful drinkers | 2277 | 1967 | 1736 | 1445 | 2330 |
| 18-24 | Dependent drinkers | 552 | 479 | 421 | 350 | 564 |
| 25-29 | Hazardous/ Harmful drinkers | 1794 | 1550 | 1368 | 1139 | 1836 |
| 25-29 | Dependent drinkers | 345 | 298 | 263 | 219 | 353 |

**1.7 Data Gathering**

In any area there will be a number of data sources that can potentially provide indications of local need. These include police, accident and emergency or

housing data. Significant efforts were made to access criminal justice, health and housing data on alcohol related harm. In general these efforts were not successful and it appeared that the data was either not available or not of sufficient priority.

A specific theme in the research was the need to access better data from Accident and Emergency services. A significant number of interviewees identified this gap. [41] [42] [43] [44] [45] [46] However, the PCT reported that this was being worked on and that an improvement in this area should also be one outcome of the hospital alcohol liaison post which is being developed. The needs assessment did receive data about A&E attendances, but it did not specifically identify alcohol as the cause of attendances. It showed the increased rate of attendances at A&E by 16-20 year olds on a Friday or Saturday night (10pm-5am) and the relationship with factors such as violence and accidents. This data includes ward of residence.[47] The Department of Health is currently working to include alcohol as a cause of A&E attendance in national data collection plans. The A&E departments in East Sussex have met with the regional alcohol lead and public health and the departments are keen to initiate more detailed alcohol reporting, as developed in Cardiff. This is now being looked into by the hospitals' IT department.

Police data recording was also criticised. Police officers who attend a crime should tick a box and this should show up in the statistics. However, this relies on alcohol being identified by officers. However, the Police have now agreed to address this in their new data system.[48] [49] [50]

Fire and ambulance service data was reported to have been either patchy or absent.[51] [52] [53] Again it was recognised that action needed to be taken in this area.[54]

Concern was also expressed about other datasets including:

- Anti-social behaviour;
- Housing data which does not demonstrate the link between alcohol, anti-social behaviour and maintaining tenancies;
- The recording of domestic violence incidents.[55]

In general there was an identified need to have more joined up work among agencies regarding data and information sharing.[56] [57] This area of work would be facilitated if the alcohol strategy established a data collection strategy. A sample strategy from another area is included at Appendix 2.

Appropriate action to tackle alcohol misuse should not be delayed by the need to develop data systems; however if the impact of the steps taken to tackle alcohol misuse is to be monitored over the years it will require the development of a better indicator set.

### 1.8 Summary

Extrapolations based on national and regional data suggest that the level of hazardous, harmful and dependent drinking in East Sussex will be as follows:

| | |
|---|---|
| Hazardous/Harmful drinkers (19%) | 56,886 |
| Dependent drinkers (4%) | 11,976 |

These figures can be extrapolated to the individual boroughs and districts.

| | Hazardous/Harmful 19% | Dependent 4% |
|---|---|---|
| Eastbourne | 10,678 | 2,248 |
| Hastings | 10,250 | 2,158 |
| Lewes | 10,535 | 2,218 |
| Rother | 9,230 | 1,943 |
| Wealden | 16,283 | 3,428 |

The North West Public Health Observatory provides data on a number of indicators such as alcohol-related hospital admissions, mortality, morbidity and crime. These allow a detailed look at drinking patterns in the county. Marked patterns emerge from this data. If the data was averaged across the county, East Sussex would emerge as close to the national average, however, this conceals distinct differences between boroughs. Hastings and, particularly, Eastbourne have some of the highest rankings in the country for a number of indicators. On the other hand Wealden has some of the lowest levels.

Other data such as accident and emergency admissions and interviewee comments confirm this pattern.

It should be noted, however, that even if the level of drinking matched the national average, alcohol consumption is at such a level in England that it will be a cause of harm everywhere, including apparently lower need areas such as Wealden. Significant numbers of people will have alcohol related hospital admissions or die as a result of alcohol related ill health. A large proportion of crime and anti-social behaviour will be alcohol related.

Alcohol misuse:

- Costs the local health service over £15.5 million pounds per year
- Costs the criminal justice system over £21 million pounds per year
- Leads to 368,000 working days lost from the workforce
- Leads to 222 sexual assaults per year

This data can be broken down borough by borough, for example:

| **Effect** | **National Impact** | **Eastbourne** | **Hastings** | **Lewes** | **Rother** | **Wealden** |
|---|---|---|---|---|---|---|
| Cost to health service of alcohol related harm | £1.4-1.7 billion per annum (mid-point £1.55bn) | £2,945,000 | £2,635,000 | £2,790,000 | £2,790,000 | £4,340,000 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Costs to criminal justice system | £1.8 billion per annum | £6,480,000 | £3,060,000 | £3,240,000 | £3,240,000 | £5,040,000 |

North West Public Health Observatory data in combination with crime, teenage pregnancy and survey data indicates that drinking among young people across the county is above the national average, although most problems are in the coastal areas. It should also be noted that 12,000 young people will be affected by the alcohol problems of their parents.

This data highlights three key factors which need to be taken into account when planning any response to alcohol misuse in the county:

- East Sussex is part of a region which, despite having lower levels of hazardous and harmful drinking has above average numbers of dependent drinkers.
- Parts of the county have drinking patterns which are among the highest in the country.
- Above regional levels of drinking among young people.

These three factors need to drive any service structure which is developed locally.

Since April 2008 alcohol services have been reporting data to the National Alcohol Treatment Monitoring System: part of the National Drug Treatment Monitoring System. This dataset is relatively new and its reliability is questionable; however, the county has a very low rate of reporting which might be consistent with poor service provision; however, it could be also consistent with poor data collection.

A clear local gap is good data on the extent of alcohol related problems. This needs to be improved. Many of the key sources of local data: Accident and Emergency, Police, Housing and Fire among others have systems which are either under-developed or under-reporting.

Appropriate action to tackle alcohol misuse should not be delayed by the need to develop data systems; however if the impact of the steps taken to tackle alcohol misuse is to be monitored over the years it will require the development of a better indicator set. This area of work would be facilitated if the alcohol strategy established a data collection strategy.

### 1.9 Recommendations

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|---|
| • All local agencies should ensure that their data systems can identify people whose presence in their service is directly, or in part, related to alcohol use and that this data is being collected, collated and reported to the DAAT. |
| • The Alcohol Strategy Group should develop a data collection strategy to focus and coordinate this work. |

# Section 2
# Diverse communities and particular groups

## 2.1 Women Drinkers

On average women drink less and are less likely to have an alcohol problem than men. However, the gap between the level of men's problem drinking and women's problem drinking is narrowing nationally. The number of women drinking above recommended guidelines has risen by over half in the last 15 years.[58]

As is usual across Britain, women outnumber men in the local population by 264,892 (52.3%) women to 241,337 (47.7%) men.[59] If the data from the ANARP on the national ratio of male to female drinkers is applied to the data on drinking in East Sussex the following picture emerges[60]:

| | Total | Males | Females |
|---|---|---|---|
| Hazardous/Harmful drinkers | (Ratio 32m:15f) | 38,731 | 18,155 |
| Dependent drinkers | (Ratio 6m:2f) | 8,982 | 2,994 |

The North West Public Health Observatory health dataset contains six indicators which are split into male and female datasets.[61]

| | **Borough rank out of 354 local authorities in England (1 lowest – 354 highest rate of problems)**[62] | | | | |
|---|---|---|---|---|---|
| | Eastbourne | Hastings | Lewes | Rother | Wealden |
| Male - Alcohol related months of life lost | Eastbourne ranks 334 out of 354 | 321 / 354 | 197/ 354 | 193/ 354 | 38/ 354 |
| Female - Alcohol related months of life lost | 352 / 354 | 141 / 354 | 75/ 354 | 145/ 354 | 67/ 354 |
| Male - Alcohol-specific mortality | 345 / 354 | 253 / 354 | 153/ 354 | 244/ 354 | 60/ 354 |
| Female - Alcohol-specific mortality | 306 / 354 | 72 / 354 | 58/ 354 | 28/ 354 | 21 / 354 |
| Male - Mortality from chronic liver disease | 336 / 354 | 257/ 354 | 117 / 354 | 244/ 354 | 28/ 354 |
| Female - Mortality from chronic liver disease | 210 / 354 | 71 / 354 | 107/ 354 | 19/ 354 | 30/ 354 |
| Male Alcohol-attributable mortality | 342 / 354 | 210/ 354 | 149/ 354 | 171/ 354 | 67/ 354 |
| Female -Alcohol-attributable mortality | 329 / 354 | 183/ 354 | 94/ 354 | 59/ 354 | 58/ 354 |
| Male Alcohol-specific hospital admission | 293 / 354 | 346/ 354 | 162/ 354 | 255 / 354 | 72/ 354 |
| Female Alcohol-specific hospital admission | 301 / 354 | 344/ 354 | 259/ 354 | 231 / 354 | 122/ 354 |
| Male Alcohol-attributable hospital admission | 306 / 354 | 336/ 354 | 169/ 354 | 217/ 354 | 167/ 354 |
| Female Alcohol-attributable hospital admission | 301 / 354 | 325/ 354 | 167/ 354 | 215 / 354 | 159 / 354 |

The NWPHO data presents a very varied picture. In Eastbourne women's alcohol related harms follow the male pattern of being well above the national average. However, in Hastings the picture is more varied with female rates being high for some indicators (e.g. alcohol specific hospital admissions) but strikingly low for others (e.g. mortality from liver disease). No discernible pattern emerges in the other three boroughs.

Neither adult nor young people's services had a gender breakdown which deviated markedly from national patterns. The Young People's Substance Misuse Service had a 61:39 male female average which is close to national norms.[63]

None of the interviewees identified anything exceptional associated with gender patterns, other than a perception that more young women are drinking and having problems.[64] [65]

The key question is whether women drinkers are being under-served or poorly served in the treatment system. In general, no evidence was found to support this position, however, the Action For Change open access system did cause concern with regard to women and other groups such as older people. One Action For Change worker commented that the open access waiting room can be "quite scary" with the presence of men under the influence of alcohol.[66] It is possible that there could also be drinkers outside the building which could deter women, in particular, from using the open access, especially women with a history of abuse by intoxicated men.

### 2.2 The Families of Drinkers

The drinker's family are often the forgotten people. While a great deal of attention is being focused on the drinker, the needs of the family can be missed. Their needs can be more acute than the drinker's. As one local carer said "you feel so desolate, you can't tell the rest of your family".[67]

The family may live in poor financial circumstances. The home life itself may be deprived both physically and emotionally. The strain of living with a drinker may lead to depression and other emotional problems. They may be the victims of physical or emotional abuse: both child abuse and domestic violence are strongly associated with alcohol misuse. The Government estimates that there are up to 1.3 million children affected by their parent's alcohol use in the UK.[68]

If only half the harmful and dependent drinkers in the county had just one "concerned other", that would still equate to over 12,000 carers.

The county has a well regarded Family Substance Misuse Service run by the Children's Services and hosted by the East Sussex Under 19's Substance Misuse Service. This works with people in the Safeguarding system.[69] It is a multi disciplinary team providing a specialist assessment and intervention service for those parents and children involved or at risk of involvement within the child protection system.[70] The programme works with about 90 families

per annum and about 30% of these have an alcohol problem.[71] The service has been recently reviewed and a report is available.[72] However, it was recognised that this service only touched the tip of the iceberg and that more was required to meet the needs, particularly of young carers who want:[73]

- More flexible services in terms of access and group times[74]
- More age appropriate literature.[75]

It was also positive to note that the East Sussex three-year Joint Commissioning Strategy for Carers' Services 2007/08 to 2009/10 inclusive recognises the needs of substance misusers: "East Sussex Safer Communities Team will ensure all relevant agencies across the county are able to signpost and provide advice and information to carers of substance misusers and will publicise a new specialist carers' support group that has been set up with Care for the Carers. The team will also collect data to inform planning for the future needs of carers of substance misusers."[76]

Action for Change provides some family interventions. A fortnightly significant others group has been running in Eastbourne for the last a year. Members talked about how valuable this group has been in supporting them. On average five people are coming to the group. One family have had a daughter of 29 who has died as a result of alcohol use.[77] However, the service felt that this provision was "woefully under-resourced" compared to the demand.[78] Eastbourne alone has access to this service. Action For Change is trying to raise funds for a one day per week carers' post.[79]

It was generally agreed that further investment is needed in families work.[80]

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| *I would like to see more services for significant other …it would be good to see investment in this area.*[81] |
| *There should there be a local public education campaign with special attention to carers' needs.*[82] |
| *Carers are reluctant to come forward for reasons of stigma, shame, confidentiality, not seeing themselves as "carers", involvement with the criminal justice system, fear, client resistance to carer involvement.*[83] |
| *We are building links with A&E departments to identify carers/family members of those admitted for alcohol related incidents.*[84] |
| *This organisation supports 4 young carers of alcohol misusing parents and believes that there are many more too ashamed or frightened to come forward for help and support – stigma, fear, shame*[85] |
| *Young carers support systems and needs should be better met*[86] |
| *Funding and commissioning for proper carers' support is a key gap.*[87] |

The East Sussex Commissioning Strategy for Adult Alcohol Misuse 2008/11 reported that "the Family SMS will continue to be invested in, subject to positive evaluation of performance."[88] However, no further investment in significant other work is identified.

One carer commented more negatively on the help available from services. It was felt that services ignored the significant other – "my wife was ill and harming herself but people wouldn't see me – people wouldn't talk to me because I wasn't her".[89] This issue of confidentiality and the role of the carer

needs further consideration, especially as the evidence suggests that care plans which involve carers are more likely to be successful.

Two other services were mentioned in this context. It was reported that there is also a Family and Carers Support Service in Hastings which covers alcohol, drugs and mental health. They come in to CRI and run open days.[90] It was also reported that a support group has been set up in Battle to help families who are caring for someone with foetal alcohol spectrum disorders (FASD). Action For Change has attempted to make contact with this service, with limited success.[91]

It was reported that this new service was set up after an increase in the number of families in Sussex caring for someone with FASD who were asking for help[92], however, neither Action For Change nor commissioners were aware of such an increase.[93] [94] No further evidence on the extent of FASD was identified. A training course introducing FASD has also been run in Hastings.[95]

### 2.3 People from Black and Minority Ethnic Communities

The county does not have a large black and minority ethnic population. The white population accounts for 96.1% of the total population of East Sussex, well above the national average.[96]

The general perception is that alcohol problems among BME communities do not represent a significant unmet need in the area. The views of eight people working with these communities were sought. Only one replied. This person did not identify significant problems among BME communities but recognised the possibility that such problems could exist in any community.[97]

In general it can be argued that improving the response to BME communities is not a high priority. The one are where this view might need to be adjusted is with the East European communities. The young people's needs assessment highlighted data which suggested that by 2008 there were around 1,300 people from the so called "accession countries" in the county. The 2006/07 adult needs assessment highlighted that the Eastern European population was expected to increase.[98] [99] One interviewee suggested that the county had the second largest Polish community in the South.[100]

In other parts of the country e.g. Nottinghamshire and Ealing, people from these communities have caused alcohol related problems. Such problems were not identified in East Sussex. The economic downturn may limit the size of this group of migrants and, therefore, limit problems; however, given the traditional patterns of heavy drinking associated with these communities it is important to identify these groups in monitoring service use.

Action For Change said that they do see some clients from Eastern Europe. They have staff with some of these languages so that does not represent a barrier. However, due to resources this group has not been specifically targeted. The same is true of travellers and other BME communities.[101]

The NDTMS records both nationality and ethnicity and Action For Change has inputted into this system since September 2008. Commissioners should monitor nationality data to ensure the situation remains unchanged.

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|---|
| *The proportion of BME clients is very small. We don't see East Europeans accessing the service – they are a very small proportion.*[102] |
| *We don't see many people from BME communities coming in.*[103] |
| *The figures for alcohol clients from BME communities are low but this reflects the size of the local non-white population. It is hoped that the plans to expand into general practice will improve access. The existing clinics are hard to access because they are in working time.*[104] |
| *A tiny proportion of clients are from BME communities but they are seeing more from Eastern Europe but they are not a major burden.*[105] |
| *Alcohol fuelled lewdness and rowdiness tends to go hand in hand with anyone from any community drinking to excess in my opinion - something which I have witnessed from many communities. I feel it would be unfair to highlight certain communities, as alcohol abuse and subsequent issues arising from this can be placed squarely at the door of most communities with the possible exception of (from what I myself have actually witnessed) Chinese, Japanese, Korean, Indian and Thai communities but that is not to say that alcohol problems do not occur within these groups also.*[106] |
| *I know there are alcohol related problems among the Eastern European Communities particularly the Polish and Russian males.* [107] |
| *There are low non-white groups in East Sussex. There is no evidence on East Europeans – hearsay would suggest there are groups in the area.*[108] |
| *East Sussex has seen an influx of, particularly Poles, but alcohol problems with this group are not showing up in either figures or anecdotal reports.*[109] |
| *This is not something that has been raised with him specifically. They do have an East European population but no negative connotations about alcohol use.* [110] |
| *There are statistically low numbers of people from black and minority ethnic communities and no problems have been identified…People from East European communities are mostly in employment.*[111] |
| *There are concerns regarding some Eastern Europeans who are supplying contraband alcohol/cigarettes.*[112] |
| *People from black and minority ethnic communities are a minimal problem -* [113] |
| *People from black and minority ethnic communities are not a problem*[114] |
| *We have had people coming in from these communities but it has not been highlighted as an issue locally.*[115] |

Particular information was sought on traveller communities in the county. Action For Change suggested that Hailsham was the main area for traveller communities. One interviewee reported that local housing policy in that area has located large number of "traveller" families on a particular estate thus concentrating alcohol related problems in that area. This produced a group with some prolific offenders and associated criminal and anti-social behaviours[116] However, travellers were not identified by anyone else as a significant client group, albeit that they have not gone out to seek them.[117]

## 2.4 Drug Users with an Alcohol Problem

It is recognised nationally that many drug misusers also have alcohol problems or develop problems once they give up drugs. The National Treatment Outcome Research Study found that 33% of those entering residential treatment or community methadone programmes were drinking at levels above those recommended as safe.[118]

Alcohol misuse represents a particular problem for drug misusers. It may increase the risk of relapse and overdose and will present serious problems for people who have hepatitis.

The National Treatment Agency published "Promoting safer drinking – A briefing paper for drug workers" in 2004.[119] This recommends that drug workers should be able to identify and assess problem drug users with patterns of hazardous, harmful or dependent drinking, offer them advice, brief interventions and refer on if required. Drug agencies should have policies in place to cover this, leaflets and materials available for clients and staff trained to deliver interventions.[120]

Local drug services confirmed that most drug clients come with a potentially problematic pattern of drinking, albeit they may not be dependent. Most drug users also drink. It was estimated that probably about 25% substitute heroin or crack use with alcohol.

Alcohol and cocaine use is also being identified, particularly in the pub and club culture. Services are seeing more such clients coming through. For example, after Christmas CRI received a higher number of such referrals, but this may be cyclical. It is reported that most of these people are employed and may be beginning to have problems at work or are experiencing psychological problems. It was suggested that while this was not a large problem, it is growing.[121]

The key question is whether drug users with an alcohol problem are identified and offered interventions. The evidence suggested that they are fairly well served. A wide swathe of Sussex Partnership Trust staff have been trained to do screening and brief interventions.[122] In the voluntary sector the view was also that staff have the skills to deal with it.[123] Commissioners also felt drug services could deal with this client group.

On the inpatient side, most bed places are being used by drug users who are alcohol dependent.[124] They have three beds for detoxification in East Sussex and another 0.5 beds in Brighton. The majority of detoxifications are to do with alcohol.[125]

The East Sussex Commissioning Strategy for Adult Alcohol Misuse 2008/11 says that "for the most complex cases, and people who are experiencing problems with both alcohol and drug misuse, delivery of the service will be coordinated by the specialist substance misuse service."[126]

Action For Change reported that they were being referred drug users with an alcohol problem and have "quite a few people on methadone".[127] Given the guidance that drug services should be able to work with this group, and the resource pressure on alcohol services, this would seem to be an area where drug service should be clearly taking the lead responsibility.

### 2.5 Lesbian, Gay, Bisexual and Trans-sexual People

It has been argued that either lifestyle or underlying emotional issues may encourage lesbian, gay, bisexual or trans-sexual people (LGBT) to drink above the national average. However, some members of these communities argue that this is simply stereotyping and that drinking patterns among LGBT communities reflect the national pattern. No evidence was identified either way on this issue. There is no reason to think that this client group is under-served.[128] [129]

### 2.6 Alcohol Problems among Older People

People over 65 drink significantly less than younger age groups; however, simple demographics suggest that the number of people over 65 with alcohol problems will grow over time. The number of older people is rising and the drinking pattern of each successive generation of over 65s has been increasing steadily since the Second World War.

East Sussex has a population over 65 which is above the national average and the trends suggest that this pattern will increase.

It is interesting to note that in Kent, Adult Services have recently identified this as an issue of concern.[130] However, views on the extent of problems were mixed. Over 100 local older people's services were contacted by email to seek views on this issue (see Appendix 3). However, the response was very poor. This could be interpreted as suggesting a lack of problems, but in reality it probably points up a knowledge gap.

Comments from the interviewees and the email survey highlighted the varied views on this issue.

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| *We come across them from time to time and would like to go out and target this group but resources are the issue.*[131] |
| *This is an issue that needs exploring…but again it is not clear how it is manifesting itself.* [132] |
| *We do have issues with the use of alcohol by our clients – in many cases file notes suggest to visit in the morning before the person has drunk too much – or else to visit later as they will not get up until late. It can also cause problems with aggression which they do not themselves perceive as aggression.*<br><br>*The abuse is mainly related to depression and lack of social contact in the case of older people, although people who have always been alcoholics then become old as alcoholics. There are also issues around the older clients not wanting to admit the problem and trying to hide it and in some cases getting aggressive with the support worker if the subject is touched on.* |

| |
|---|
| *Very little information on alcohol abuse is aimed at older people although Age Concern are very good – the majority of generic material is aimed at drinking too much socially, in public etc. which is more of a problem for young drinkers. Where older people are perceived as alcoholics it is as homeless people not as retired homeowners.*[133] |
| *I have made some enquiries about this issue but with little response.*[134] |
| *As an Outreach Worker in Lewes and the surrounding rural areas, out of the 80 families I have met over the past 18 months there is only 1 where alcohol was an issue and a possible cause of his dementia…There seems to be no support for his drinking problems at all.*[135] |
| *I feel there may be a population of hidden older drinkers.*[136] |
| *This is a big and unrecognised issue, it has not been well researched…Had a meeting with older peoples service who felt that alcohol was all the older people had.* [137] |
| *We do have issues around the feelings of older people about young drinkers – this is mainly related to drinking in public and congregating in public areas.*[138] |
| *There are no apparent problems among older people.*[139] |
| *Services in Eastbourne don't lend themselves to being accessed by older people.*[140] |
| *This is a big problem with many slips, trips and falls caused by this group's use of alcohol.*[141] |

Action For Change do not specifically target the over 65 age group, but do see clients from this age group. They have also done some training with older people's service.[142] It was pointed out that, as with women (2.1 above), older people might find it quite intimidating to come in to the open access waiting room.[143]

It should be noted that the Joint Commissioning Strategy for Older People 2007-2010 mentions alcohol albeit in a limited way. The Time of Our Lives Strategy Improving and promoting quality of later life in East Sussex 2008-2011 does not mention it at all.

Although there is no convincing data to suggest that alcohol problems among older people are a key local issue, simple demography and the growth of the over 65 population suggests that this is an area that merits further exploration. The Older People's Partnership Board has established a Promoting a Healthy Old Age steering group to lead action on older people's quality of life, wellbeing, engagement and prevention.[144] This could provide a framework for further work on alcohol use among older people.

### 2.7 Alcohol Related Dementia

National concern is growing about the number of people who are suffering alcohol related dementias such as Korsakoff's Syndrome. Although numbers will be small in any given area, each client can have significant needs. Local data on alcohol related dementia was not identified, but this is the experience in most parts of the country. A few interviewees in treatment services were able to identify people with alcohol related dementia.[145] [146] [147]

This issue is not considered in the Commissioning Strategy and this research could not identify a protocol or pathway for managing alcohol related dementias. It was made clear that the community care panel for substance misusers was not responsible for funding these clients.[148] [149] [150]

**2.8 Non-changing Drinkers**

National statistics indicate that 40-60% of clients who enter alcohol treatment services will drop out within as little as a couple of sessions.[151] Those most likely to disengage will be the most risky and vulnerable clients among the substance misusing population. These risky and vulnerable groups will include: those with criminal justice histories[152], personality disorder[153], and / or mental illness.[154]

Models of Care for Alcohol Misusers (see below section 6) recognises that not all drinkers will achieve positive change after their first encounter with treatment services. It will, therefore, be necessary to plan for multiple alcohol treatment episodes.[155] It is often a specific concern of Tier one services that specialist alcohol services do not work well with difficult to engage substance misusers.

Alcohol Concern's *Commission on the Future of Alcohol Services* recommends that: "The network of alcohol services needs to have the ability to reach out and maintain engagement with, at the least, those who are identified as posing the greatest level of risk. Not all services will need to have this capacity but appropriate services must exist in the local area. These services will include assertive outreach, floating support, wet services and services for brain damaged drinkers". Many in this client group will be street drinkers and people who are marginally housed such as "sofa surfers".[156] [157]

This group is of particular concern in the context of the Action For Change open access entry system. It is specifically acknowledged that this system tests client motivation and is designed to reduce non-attendance at appointments by ambivalent clients. However, this will not give workers the chance to motivate or even assess more ambivalent clients and clients who are pointed in Action For Change's direction but who do not attend remain unidentified. Although it should be noted that, Action For Change will help people who they are told cannot attend the drop-in.[158]

The Commissioning Strategy does not directly address this issue but it does attempt to provide easier access via primary care[159] and commissioners noted that the issue of non-engagement was being tackled in the drugs field through encouraging the use of text and telephone reminders.[160]

Others identified this as an issue of concern.

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|---|
| *Carers are invariably living with individuals who do not want to change.*[161] |
| *A newspaper article identified that there was a high drop-out rate of people who came for treatment but did not continue with it, probably due to the length of the wait.* [162] |
| *This is not an issue that had been discussed locally.*[163] |

A model of service provision is provided by the Omni outreach team in Surrey (part of Surrey Alcohol and Drug Advisory Service) which takes referrals from Tier 3 services of clients who have been assessed as high risk or vulnerable and who have disengaged from services. This team seeks to re-engage such clients.

This is an important group of clients and their needs should not be ignored. East Sussex should develop a protocol or care pathway for services to follow in meeting the needs of this group.

### 2.9 Homeless Problem Drinkers

Homeless and marginally housed problem drinkers were an area of concern to a number of interviewees.[164] [165] [166] [167] [168] It was recognised that alcohol contributes to the loss of homes and relationship breakdown with the consequent loss of accommodation and increases the likelihood of poor treatment outcomes. There was also recognition of the need to provide a response to these issues.[169] [170]

A number of interviewees raised concerns about the local response to problem drinkers with housing problems.

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| *Homelessness is a big problem in Eastbourne and Hastings. More so in Hastings. They say there isn't a homelessness problem but there is lots of sofa surfers etc. The count in November was 0.*[171] |
| *Housing and homelessness Yes it is regularly reported on. Eastbourne has a team that works on this and drinking is a factor in this. Most hostels and halfway houses have a no drinking rule. So this is an identifiable group.* [172] |
| *Supporting People are not receiving significant anecdotal reports of alcohol related problems coming through from their providers*[173] |
| *Over the last few months I have been working alongside a social worker who has years of experience of mental health care in our part of East Sussex. One of his burning passions is to ensure that we provide a quality service for people who are suffering with alcoholism and homelessness.…One of the gaps that he has rightly identified in service provision locally is a temporary place for homeless men and women with alcohol use problems to go to live in order to receive support and beat their illness.*[174] |
| *There are people with significant complex problems but the homeless counts come up with low numbers. They may well be hidden homeless – sofa surfers. But you can't find out the data from housing needs officers.*[175] |
| *The main housing provider has not specifically raised alcohol and anti-social behaviour as an issue.*[176] |
| *A big concern is having the appropriate level of support for people.* [177] |
| *Street homelessness and street drinking is a particular problem in the Hastings area.*[178] |
| *Hastings has 250-300 Street drinkers, it is still a big problem as they are "only" moved out of the centre of the town into nearby parks and shelters.*[179] |
| *There are very few street drinkers in Hastings it is not a real problem here.*[180] |
| *Street drinking is becoming a problem – groups that congregate, begging and anti-social behaviour.*[181] |

| |
|---|
| *Not homelessness but street drinkers who are managed through enforcement powers.*[182] |
| *Feels that there may be up to 20 people street homeless at any one time.* [183] |
| *Is street homelessness and street drinking a problem in the area? Yes, very much so.*[184] |
| *At the Salvation Army Citadel in Eastbourne, 80 people show up at their two food evenings. 30-40 have been drinking and some are very inebriated.* [185] |

However, action is being taken on this. There are ongoing discussions about the link between rough sleeping and street drinking and issues about anti social behaviour at the borough and district level.[186]

The East Sussex Commissioning Strategy for Adult Alcohol Misuse 2008/11 includes two items targeting homelessness:

- During 2007/8 a new 'floating housing support' service will be tendered for adults suffering from substance misuse.[187]
- Staff who provide housing related support across all care groups should be required to demonstrate competence in screening and brief interventions.[188]

A number of services were identified who provide outreach or accommodation support to drinkers:

- *Oasis Christian Outreach* works to find people on the streets and in the community with drug and alcohol dependencies. It carries out telephone interviews and can take people to a Nottingham rehabilitation centre within 48 hours.[189] [190]
- Carr Gomm provides a floating support service for 30 people with alcohol problems.[191]
- Heatherdene Limited provides 5 units of supported accommodation for people with mental health problems including people with alcohol problems. [192]
- Kenward Trust run The Malthouse providing support to people with alcohol and drug problems. [193]
- There is a Homeless Health Team in Hastings.[194]
- Action For Change has an outreach worker in Eastbourne who holds a clinic at the Salvation Army Citadel in Eastbourne and attempts to engage drinkers into treatment. This post was funded by Pfizer for one year but is not likely to continue in the future.[195]
- Supporting People identified 72 people with a primary or secondary alcohol problem in units funded by Supporting People.[196]

The most significant problem is the lack of statistics. It was stated that housing services do not keep statistics on the role of alcohol as a cause of housing problems.[197] [198]

Housing, homelessness and street drinking are clearly significant issues in some parts of the county, but action is also being taken to address the issue. It is not possible to argue that this should be a high priority issue for action. The key areas for work are:

- Building up a statistical database on this issue; and
- Monitoring the impact of the activity proposed in the commissioning strategy.

### 2.10 Victims and Perpetrators of Domestic Violence

The 2004 national alcohol strategy recognises "the nature of the links between alcohol misuse and domestic violence" and the need to "address those links in public policy and in the design of local services."[199] Research suggests that alcohol contributes to between one third and a half of domestic violence incidents.[200]

The national cost of domestic violence to criminal justice, health, social, housing and legal services as well as the economy amounts to more than £5.7 billion a year. The cost to the NHS for physical injuries is around £1.2 billion a year. Physical injuries account for most of the NHS costs, but mental health care is estimated at an additional £176 million.[201] This equates to a cost of £50-60 million pounds locally.

Domestic violence was recognised as an important issue locally, although no-one suggested that it was more of an issue then anywhere else in the country.[202] [203] [204] The police have seen alcohol as a factor in 37% of domestic violence incidents.[205] It was reported that there has been an increase of a third in domestic violence over the rolling year.[206] Nonetheless it is clear that, as in most parts of the country, there is insufficient data on the relationship between alcohol and domestic violence.[207] It will be important to ensure that agencies such as the police and A&E are capturing this link in their data.

At a strategic level the county has a Community Safety Agreement. The Agreement identifies the priorities for East Sussex Partners to work on over the year. Alcohol is mentioned throughout the document. References to alcohol being a factor in domestic violence is highlighted in both the violent crime (p29) and alcohol section (p42).

There are services for people who are experiencing domestic violence. Interestingly CRI, which also runs drug services, runs domestic violence services in Eastbourne and Hastings.[208] However this service only works with victims.[209]

The only service for perpetrators is the IDAP which is run by Probation and can only be accessed via the criminal justice system.[210] Alcohol is addressed on the course, but it is not seen as the cause of the violence but rather as a disinhibitor. However, IDAP is not an alcohol rehabilitation programme, and drinkers would need to go to other services for help.[211] There is also a waiting list for the service.[212]

A number of interviewees agreed that perpetrator programmes for those not on an order and particularly a programme which addresses alcohol use would be an important development.[213] [214] [215] [216]

The Multi-Agency Risk Assessment Conference (MARAC) is a relatively recent process for the multi-agency management of the risks associated with domestic violence. This system is operational in East Sussex and it is positive to note that Action for Change is on the MARAC[217]

Domestic abuse is not limited to partner abuse. a variety of forms of abuse including elder abuse and teenagers abusing parents as well as abuse in same sex partnerships and women abusing men. All of these can be linked to alcohol. vulnerable adults' provision. One worker identified a man in his 70s who was drinking and making himself vulnerable by asking young people to buy more alcohol for him. [218] This highlights the need to make links between vulnerable adult arrangements and alcohol services. It was positive to note that Action For Change have addressed this training issue. [219]

**2.11 Unemployment**

Research does not suggest a greater average consumption by those in unemployment, it is clear that problem drinking does impact upon an individual's ability to work productively and maintain a job. Alcohol problems contribute to problems at work and levels of unemployment. A census of alcohol services conducted by Alcohol Concern in 1997 found that of the 10,000 people receiving help for their drinking problems each day 36% were unemployed.

It is likely, therefore, that while deprivation per se will be a partial indicator of alcohol problems, higher levels of unemployment are also an indicator of higher levels of alcohol problems.

Information was sought on this issue locally from Job centre Plus. They recognised that this was an area of concern but no data was available to confirm the size of the link.[220]

**2.12 Summary**

Both **women and men** have patterns of drinking which reflect the variety of drinking levels found across the county: high levels of drinking in the coastal areas to much lower levels in the rural areas. If national data on the national ratio of male to female drinkers is applied to the data on drinking in East Sussex the following picture emerges:

| | Total | Males | Females |
|---|---|---|---|
| Hazardous/Harmful drinkers | (Ratio 32m:15f) | 38,731 | 18,155 |
| Dependent drinkers | (Ratio 6m:2f) | 8,982 | 2,994 |

The key question is whether women are under-represented or under-served in treatment services, need specific educational messages, or need to be better targeted by community safety initiatives. The key area of concern was that the Action For Change open access services may disadvantage women who may feel intimidated by drunken men.

If only half the harmful and dependent drinkers in the county had just one "concerned other", that would still equate to over 12,000 carers. It is quite

clear that there is an under-provision of services for **carers and family members.** This is being addressed partially through the Family Substance Misuse Service and some limited work by Action For Change, but this is only touching the edges of this huge area of need and further investment is needed. Commissioners should include addressing carers' needs in future specifications for Tier 2 alcohol services.

A local support group has been set up in Battle to help families who are caring for someone with **foetal alcohol spectrum disorders**. It was reported that this new service was set up after an increase in the number of families in Sussex caring for someone with FASD who were asking for help. However, no other evidence of such an increase was found. Commissioners should explore whether further work is required on this issue.

Overall, there was no evidence that **black and minority ethnic communities** represent an area of unmet need. The county has a population of **people from Eastern Europe** and in some parts of the country these populations have been associated with alcohol related problems. This is not obviously the case in East Sussex.

No evidence was found to either prove or disprove the existence of above average levels of alcohol problems in the **lesbian, gay, bisexual, and trans-sexual community**.

Most drug users also drink. It was estimated locally that probably about 25% of people in drug services substitute heroin or crack use with alcohol. Services and commissioners were aware of the needs of **problem drug users who also had alcohol problems**. These clients are being referred into Action For Change for help, when they could be managed by drug services. This is placing a further burden on alcohol services.

No figures exist to confirm the scale of alcohol problems among **older people**. Population data suggests that this will become a more important issue over time. Local alcohol services were interested in developing a response, however, capacity is too limited to readily allow this. In the absence of a well-developed alcohol service, this issue will need to be viewed as a lower priority and re-considered in the medium term.

Although there are no reliable local statistics on **alcohol related dementias,** cases were emerging in treatment services and other services. What is clear locally is that there is a need to resolve pathways into care for this group.

**Clients who fail to engage** with services present a particular problem. National statistics indicate that as many as 40-60% of clients who enter alcohol treatment services will drop out within as little as a couple of sessions. There is also evidence that the most risky and vulnerable clients will be more likely to disengage than the rest of the substance misusing population. It would be useful for clear guidance to be developed on how to respond to clients who enter alcohol services but seem resistant to change or are unwilling to engage.

Alcohol problems among people with **housing problems** were recognised to be an important issue. However, services are being provided to meet some of this need. Again the biggest gap is the lack of local data on the exact nature of the links between the two issues. Action is being taken in this area within the Commissioning Strategy and it will be important to monitor how this impacts on the problem.

**Domestic violence** is a vital local issue. It was recognised that victims may also have problems with alcohol. A key problem is the lack of adequate data. However, there are no specific services for perpetrators or victims with alcohol problems. This represents an important local gap.

### 2.13 Recommendations

| |
|---|
| • Commissioners should re-consider the open access entry system currently used by Action For Change because it runs the risk of women and older people being intimidated by drunken men. |
| • Commissioners should routinely monitor client nationality. |
| • Commissioners should ensure that as many drug users with alcohol problems as possible are being worked with in drug services rather than being referred into alcohol services. |
| • Commissioners should include addressing carers' needs in future specifications for Tier 2 alcohol services. |
| • Commissioners should view the needs of older people with alcohol problems as a lower priority in the short term but this theme should be re-considered in the medium term. |
| • Commissioners should clarify pathways for people with alcohol related dementias and the numbers of people with such conditions should be carefully monitored. |
| • Commissioners should develop clear guidance on how to respond to clients who enter alcohol services but seem resistant to change or are unwilling to engage. |
| • Housing services should gather better data on the relationship between housing problems and alcohol use. |
| • Commissioners should explore whether further work is required on foetal alcohol spectrum disorder. |
| • The Police should gather reliable data on the number of incidents of domestic violence which are related to alcohol misuse. |
| • Commissioners should develop services which target perpetrators and victims of domestic violence who also have problems with alcohol. |

# Section 3
# Young people

### 3.1 National Requirements at Local Level

National guidance offers a framework for the response to young people's alcohol and drug misuse.

Government guidance clearly sets out how alcohol and drug education should be delivered in schools. [221] This emphasises that:

- the lead role in such education lies with the teachers within the school and not external contributors.
- preventing alcohol and drug misuse is important but it should be set in the context of a wider skills focused education covering a range of personal, social and health education.

"Teachers should always maintain responsibility for the overall drug education programme. External contributors should not be used as substitute teachers, nor should they constitute the entirety of a school's drug education programme. When working directly with pupils they should add a dimension to the drug education programme that the teacher alone cannot deliver."[222]

The national strategy is also clear about what works. In the context of education it emphasises: alcohol and drug education programmes delivered by teachers trained to use normative, life-skills based approaches, and supported by wider communications campaigns and by parental and community involvement.[223]

Other national documents impact on the planning of the response to young problem drinkers. These include the Youth Alcohol Action Plan and Hidden Harm.

Universal, schools alcohol and drug education should be primarily teacher led and set in the context of a wider programme of Personal, Social and Health Education.

Beyond universal education it is vital that generic young people's services are able to respond appropriately to young people's substance misuse. The youth service, schools, Connexions, children's social care, the Youth Offending Team and other such services should be able to identify, advise, support and refer young substance misusers.

The question is how much responsibility should lie with generic services and how much should lie with specialist services? In the ideal circumstances as much of young people's substance needs would be dealt with by generic young people's services as is possible. This has several advantages:

- Young people's substance misuse is addressed in an holistic context rather than tackled in isolation in a specialist service and specialist intervention is best delivered as part of a holistic package involving other agencies as appropriate;
- Young people with a range of problems avoid the risk of being labelled as "substance misusers";
- Young people do not have to move from service to service to find help.

Above all, the majority of substance users would not need a specialist service. However, the monitoring and recording of the impact of this low threshold work in generic services would need to be available.

Nationally, this model represents the ideal not the actual. Generic services are not fully taking on this role and specialist services are either undertaking work with young people or are supporting generic services to undertake this work.

The precise role of, and specification for, young people's substance services can only be determined when commissioners have decided what role they expect generic young people's workers to play. Are specialist services simply the preserve of Tier 3[1] referrals? Are they required to provide "consultancy" support to generic services? Or are they expected to go into generic services and offer Tier 2 responses?

The 2008 National Drug Strategy underlines the importance of Tier 3 young people's substance misuse services. It specifically recommends making this treatment more effective by:

- "developing the workforce, improving access and developing a more outcome based approach;
- improving transitional arrangements for those transferring from young people's to adult services;
- strengthening links between young people's treatment and mental health services;
- supporting and involving young people and their parents and carers more in the planning and process of treatment for young people, and involving carers' and users' groups in the design and planning of treatment services. Where no such groups exist, we will encourage local areas to establish them."[224]

The NTA report: *The role of CAMHS and addiction psychiatry in adolescent substance misuse services* recommends CAMHS services should be centrally involved in the provision of services to young substance misusers.[225]

At the highest level of intervention, each area will require a pathway into detoxification and residential care. However, in most areas it would be expected that these two services would be used rarely.

Two key questions face commissioners:

- To what extent do local universal education and Tier 3/4 services meet these standards?
- What should the balance be between generic services and specialist services in the delivery of substance misuse interventions at Tier 1 / 2?

[1] Tier 1 and 2 services are universal responses and more specialist responses in universal settings such as youth clubs. Tier 3 and Tier 4 services are specialist substance misuse provision for young people with substance misuse problems

Tackling underage drinking will also require a number of other approaches. The following table summarises a baseline of good practice.

| | | |
|---|---|---|
| Enforcement Trading standards | – | Is there a vigorous campaign to prevent underage sales or sales to adults who are supplying young people? |
| Enforcement Police patrols | – | Are areas known to be used by underage drinkers being assertively policed? |
| Enforcement Confiscation | – | Are police using confiscation powers? |
| Anti-social Behaviour | | Is there a graduated programme which, having identified problematic underage drinkers, moves through clear stages of warning, offering help and negotiating voluntary contracts before imposing an ASBO? |
| ASBOs | | Do ASBOs encourage treatment as well as control behaviour? |
| Exclusion zones | | Are exclusion zones being used to target areas used by young drinkers and is consideration being given to the negative effects of zones e.g. will young people be pushed to drink in more dangerous locations e.g. derelict buildings? |

It will never be possible to eliminate underage drinking and alcohol use entirely. However, a borough, district or county which has used all of these levers in a coordinated way will have done as much as can be expected to control this problem.

### 3.2 Universal Services: General

A great deal of work has been undertaken to ensure that universal services are identifying and intervening appropriately with young substance misusers. All vulnerable young people's workers in East Sussex attend a level 1 and/or level 2 substance misuse training programme delivered by specialist service personnel. This is compulsory for the vulnerable young people's services.[226] Teenage pregnancy staff have also been trained in working with alcohol issues.[227]

At the centre of this system is the Young People's Substance Misuse Service. The service has clear care pathways for referrals with the full range of universal services including Connexions, Schools, Youth Service, YOT, CAMHS and other such settings.[228] Referral pathways were also reported to be well embedded with GPs.[229] There is considerable local confidence in this system which one interviewee suggested was "Very robust – the best in the UK!"[230]

Referrals to specialist young people's treatment confirm this picture to some extent, as is shown in the table below.

**Referral source into treatment by LA**[231]

| | Eastbourne | Hastings | Lewes | Rother | Wealden | Total |
|---|---|---|---|---|---|---|
| Youth Offending Team | 66 | 49 | 17 | 17 | 9 | 158 |
| Education service | 61 | 69 | 13 | 18 | 19 | 180 |
| Pupil referral unit | 2 | 2 | 0 | 0 | 0 | 4 |
| Other | 23 | 24 | 10 | 16 | 5 | 78 |
| Self | 9 | 9 | 3 | 3 | 9 | 33 |
| Social Services | 10 | 5 | 4 | 3 | 4 | 26 |
| Connexions | 10 | 8 | 3 | 4 | 2 | 27 |
| Looked After Children | 3 | 3 | 1 | 1 | 3 | 11 |
| Drug service statutory | 2 | 0 | 3 | 0 | 0 | 5 |
| Syringe exchange | 1 | 0 | 0 | 0 | 0 | 1 |
| Psychiatry | 3 | 3 | 2 | 0 | 2 | 10 |
| GP | 2 | 0 | 3 | 3 | 2 | 10 |
| Drug service non-statutory | 2 | 0 | 0 | 0 | 0 | 2 |
| Arrest referral/DIP | 0 | 1 | 0 | 0 | 0 | 2 |
| A&E | 0 | 4 | 0 | 1 | 1 | 6 |
| | 194 | 177 | 59 | 66 | 56 | 552 |

A wide range of services are referring into the specialist service. 28.6% of the referrals to the service were through the YOT and 32.6% through Education services.[232] However, there are gaps. The number of referrals from A&E is low (with 4 in Hastings, 1 in Wealden and 1 in Rother). This is a concern, given the NWPHO data showing high numbers of young people presenting as alcohol related hospital admissions.[233]

To tackle the problem of young people with alcohol problems in hospital, a campaign encouraging young people to 'know their limits' is being introduced by the PCT at the A&E department of the Eastbourne District General Hospital in February.[234] However, hospital services can also access a crisis response service in the specialist team via a duty clinician system.[235]

### 3.3 Schools

The general impression was that schools were geared up to tackling substance misuse among young people. Each secondary school has a designated substance misuse worker from the Young People's Substance Misuse Service that will work as part of the "team around the school".[236]

All Pupil Referral Units receive a specific worker service and targeted prevention sessions each academic year. All Secondary Schools where substance related exclusion occurs receive a specific assessment/ case work

service within five working days.[237] 32.6% of Young Peeople's Substance Misuse service referrals were derived from education sources such as schools, behaviour support or education welfare services. 65 substance related exclusions occurred during the year and 61 received a timely service, delivered as part of an education reintegration plan (the parents of four young people refused to accept a service).[238]

Drugs and alcohol education is included in schools' PHSE teaching[239] [240] with both teachers and school nurses delivering sessions.[241] 88% of schools have "Healthy Schools" status.[242] Some external speakers are also coming in to school e.g. Police officers and Connexions workers.[243] [244]

Other initiatives were also identified.

| |
|---|
| *The Safer Hastings Partnership brought a touring theatre company to the town to educate students about the dangers of alcohol abuse and binge drinking.*[245] |
| *Robertsbridge Community College hosted a dance theatre workshop and performance by the Somerset-based theatre company Pretty Good Girl last Friday. Twenty-six Year 11 GCSE drama students took part in a very strenuous two hour workshop based on the themes to be seen in the performance later that day. They learnt how to deliver strong, thought-provoking movements, based on the theme of teenage binge drinking.*[246] |

Nonetheless, problems were identified. The Young People's Needs assessment reported that "Alcohol prevention messages and communication strategies re access to services require urgent review in conjunction with Health Improvement colleagues."[247]

Other interviewees focused on the time pressures on the PHSE curriculum[248] and the need to ensure that appropriate emphasis is placed on the delivery of alcohol education throughout the PHSE curriculum.[249]

### 3.4 Youth Service

The Youth Service has a referral protocol with specialist services[250] [251] and the specialist service delivers level 1 and 2 training to youth workers throughout County services.[252] A number of interviewees identified gaps in the availability of diversionary activities for young people in the county.[253] [254] [255] [256]

### 3.5 Child and Adolescent Mental Health Services (CAMHS)

The CAMHS team provides mental health support for children and adolescents with alcohol problems as part of a more complex set of mental health problems. They report that demand for their service is increasing. [257]

The CAMHS service appears to be well integrated in to the young people's treatment system:

- In a report to the NTA it was stated that "Further work is to be completed in relation to a bolt on drug and alcohol screening within mental health screening. CAMHS are leading on creating a general screening/referral tool to be used in the hospitals, substance misuse

related admissions will be part of the new screening protocols with A&E and Paediatrics)."[258]

- There is a care pathway for substance misusers, but there is also a specialised co-morbidity pathway being developed. [259]
- They are part of a planned multi agency data collection and information sharing system which will cover Children's Services, acute hospital and CAMHS.

### 3.6 Social Care / Looked After Children

Good work appears to have been undertaken within the Looked After system. As with other local universal services, there are referral pathways with the East Sussex Under 19's Substance Misuse Service. In the case of Looked After Children the pathway uses statutory assessment and review tools.[260]

The most striking piece of evidence is the number of young people with substance misuse identified and reported to the government in the OC2 framework. This framework monitors a range of activity in the Looked After system. To date, 74 young people 'looked after for at least 12 months' were identified as having a substance misuse issue. 63 (85.1%) of these individuals received an intervention for their substance misuse issue and 4 young people declined an intervention.[261] This is a rate of identification that is much higher than in many other areas. For example the comparable identification figure in the very needy borough of Lambeth was 12.

Work is being undertaken to integrate substance misuse processes with the CAF and to fully integrate the substance misuse agenda within Children's Services. CAF compliance and lead professional roles will be audited in substance misuse services.[262]

Other initiatives include:

- Targeted Prevention Programmes within local Children Homes and one to one work via LAC services.[263]
- Training for foster carers and residential staff.[264]
- The specialist service utilises the same electronic recording system as vulnerable Children's Services, this incorporates a direct link to Contact Point.[265]

### 3.7 Youth Offending Team (YOT)

The YOT sees significant numbers of young substance misusers. During the period 01/10/2007 – 30/09/08 the Youth Offending Team completed 2,352 ASSETs (assessments). Of these, 1,507 scored 1 or more for substance misuse; indicating the use of alcohol and/or drugs in their offending profile.[266] [267]

Substance Misuse Workers from the Young People's Substance Misuse Service have been based within the Youth Offending Team since April 2000. Interventions are also available as custodial throughcare options or as licence conditions. Workers from the Young People's Service can also attend Prevent and Deter and Priority and Prolific Offender meetings to advise and provide swift responses to those identified as requiring an intervention.[268] [269]

Level 1 and 2 training has been given to all YOT workers and 98% of young people who were supervised by the YOT were screened for substance misuse during the first three quarters of 2007/08.[270] [271] [272] [273] The effectiveness of the links between the services is demonstrated by the fact that 28.6% of the specialist service's clients came from the YOT.

Interviewees were positive about the effectiveness of the YOT specialist service link.[274]

### 3.8 Young People's Arrest referral

East Sussex is a pilot area for young people's arrest referral and a service began operation on 1st April 2009.[275] The proposal for this scheme identified three elements of service provision that will be undertaken by the service:

- delivering services in the custody suite upon arrest and at follow up appointments;
- delivering preventative services as early as possible to young people using alcohol or involved in anti social behaviour;
- attending the five Prevent and Deter meetings across the county to ensure the "tracking" by all agencies of those young people who come into contact with the arrest referral service.[276]

However, it is too early make any judgements about the effectiveness of this service.

### 3.9 Connexions

The primary role of Connexions is to support young people in making a transition into adult life e.g. through overcoming barriers at an educational level. This role can include tackling crime, teenage pregnancy and alcohol and drug problems. This suggests a more extended role in helping young people with alcohol problems.

The local Connexions service is run by CRI.[277] Two Connexions Intensive Personal Advisers deliver services as part of the Under 19's Substance Misuse Service to young people in treatment, they are also line managed within the Under 19's Service. All other connexions advisers, in schools as well as in the community, receive level 2 training and record substance misuse activity and referrals on their database: ASPIRE.[278]

### 3.10 Housing and Homelessness

A number of interviewees identified homelessness and housing problems among young people as a significant issue.[279] [280] [281] However, it was also reported that action is being taken to address these issues: in particular via the Young People's Specialist Service and the under 16s Housing Scheme.[282] [283] [284] An under-19s young homeless worker is attached to the specialist team.[285]

### 3.11 Young People's Substance Misuse Services

The county's main young people's substance misuse is the East Sussex Under 19's Substance Misuse Service. This is a Local Authority led multi-disciplinary team that is fully integrated within Children's Services. The

service is recognised nationally, regionally and locally as a model of good practice in delivering substance misuse services to young people, both in commissioning practice and service design and delivery. [286]

It delivers Tier 2-4 drug and alcohol interventions to local young people, who are affected by substance misuse. This includes an assessment and case work function as well as direct access to a range of specialist interventions delivered by a multi-disciplinary team of workers. The service also hosts a Family Substance Misuse Service (see above 2.2).[287]

Personnel within the Young Person's element of the service include
0.1 CAHMS Consultant Psychiatrist
0.4 Psychiatrist (Substance Misuse Lead)
0.5 Clinical Lead Nurse Specialist RMN
1.0 YOT Clinical Nurse Specialist RMN
1.0 Substance Misuse Nurse RMN
1.0 Vulnerable Young Persons Nurse Specialist RGN
0.4 Psychologist (Counselling/Forensic Psychology)
7.0 Caseworkers
2.0 Connexions Intensive Personal Advisor's
1.0 Senior practitioner
1.0 Administrator
1.0 Practice Manager

The staff team is directly employed by a number of different agencies such as Health, Action For Change and the Local Authority Children's Services. Practitioners are then seconded to the specialist service where they are directly accountable to their appointed line manager within the team and work to an approved integrated management protocol.[288] [289]

Specialist assessment clinics are delivered across the county within targeted young people's services. Two assessment clinics are delivered weekly within the Youth Offending Team in the East and West of the county. Clinical services are delivered from Youth Access Centres across the county.[290]

The service reports to a Performance Management Group that is chaired by the joint lead of the Children's Services Commissioning Team. It has senior representation from YOT, Education, Police, Health and the Drug and Alcohol Action Team. Interviewees were uniformly positive about the young people's service.

| |
|---|
| *…an excellent service for young people which sees very high numbers of young people with alcohol problems…the service is pivotal.*[291] |
| *Are alcohol services appropriate to the needs of problem drinkers? Yes – Under 19 Substance Misuse Team.*[292] |
| *Rapid access to under 19s' substance misuse service.*[293] |
| *Are local alcohol services well advertised? Yes – Under 19 Services particularly.*[294] |
| *Under 19s service is well advertised.*[295] |
| *Under 19s are well serviced, but adults not.*[296] |
| *Are alcohol services appropriate to the needs of problem drinkers? For under* |

| |
|---|
| *19s, yes: adult services sparse.*[297] |
| *Care pathways well developed include schools.*[298] |

An analysis of the numbers of under 19 Tier 3 clients reported to the National Drug Treatment Monitoring System per 1000 of the population was undertaken. The per capita analysis allows for the differences in the size of the population of young people which is not available from the NDTMS website itself. The per capita rate of referral for England as a whole is 1.6. The rate for East Sussex is 3.4. This is consistent with the positive comments received about the service locally and nationally.

### 3.12 Tier 4 Services

Although the need will occur only rarely, it is important that all local areas have referral pathways into alcohol detoxification and residential rehabilitation for young people.

The young people's substance misuse needs assessment describes Tier 4 provision as follows: "The Under 19's SMS provides access to Tier 4 services. The service uses Tier 4 inpatient mental health services where a co-existing mental health problem exists. Only where there is not a co-existing mental health need would the Tier 4 admission be within local authority looked after children's services for under 16's with Tier 3 intensive support for the placement. Under 16's inpatient detoxification provision has been accessed within paediatric services or for the 16 plus alcohol inpatient detoxification via Eastbourne clinic, with an individually tailored contract and Tier 3 "in reach" support in every instance. Decision making regarding Tier 4 provision is currently being made using the joint children services and health "complex case planning" process. The specialist young people's service places approximately one alcohol inpatient detoxification and two dual diagnosis cases to residential provision per year."[299]

This system appears fairly well-established; however, a couple of interviewees still felt that there was a gap in this area:

| Which are the key gaps in the local alcohol services? |
|---|
| *An in-patient treatment detoxification for young people who do not have a diagnosable mental health problem.* [300] |
| *Support and help, in-patient services for young people with severe alcohol dependency.* [301] |

Other interviewees suggested that the system was effective and adequate to meet the needs.[302] [303] [304] [305]

### 3.13 Transitions

The transition between young people's and adult services is a significant concern nationally. This concern is reflected locally. The Young People's Substance Misuse Needs Assessment reports that: "Retention of 19-22 year olds is poor compared to retention in young people's services. The drop out rate from treatment is higher in the adult treatment sector."[306]

Nonetheless measures are in place to address this issue. The Young People's Substance Misuse Needs Assessment reports that: "The adult substance misuse services operate a shared transition policy with the Under 19's SMS for 19 years plus. The policy does work well, problems relating to transfer are few and usually only relate to the intensity of the care co-ordination service that is required. However, if mental health is a significant feature of service user need transfer to mental health services for a CPA function and accommodation support can be difficult to achieve. However, the new Early Intervention in Psychosis Service should address some of these issues as it will cater for 16-25 years and the U19's clinical staff will act as a spoke of this service for those with a dual diagnosis aged 18 or below."[307]

Generally interviewees confirmed this and reported that there was monitoring of the number of clients coming through[308] [309]; however, it should be noted that one manager in adult services was not aware of a protocol.[310]

Action For Change has part-time 16-25 year old young people's workers.[311] These work as part of the Pulse service and are focussed on YP moving into adult services. The worker can undertake three-way handovers with the specialist young people's service. However, this has a limited geographical focus and the worker interviewed felt that there was significant unmet need in this age group.[312]

### 3.14 Trading Standards and Test Purchasing

Trading standards departments are responsible for overseeing retail sales of alcohol to minors. This is an important power for controlling underage drinking, especially drinking in public places.

The evidence suggested that use is being made of test purchasing powers by both the Police and Trading Standards.[313] [314] [315] [316] An example is Rother Police who have run Operation Quench during school holidays targeting the sale of alcohol to young people.[317] Proof of Age schemes are being used and publicised across the county.[318] [319] [320] [321] It was reported that this work is multi-agency but there was a critical comment about multiple visits to the same premises by different agencies.[322]

Interviewees expressed concern about two other issues

- proxy purchasing[323] [324] [325] and
- the need for improved education for parents.[326] [327]

Particular concern was expressed about the introduction of self service check outs and the likelihood that this will lead to increased proxy purchases.

Newspaper Report
A teenager stole almost £12 worth of wine from Thresher after a member of staff refused to sell him alcohol. Freddy Reed-French, 19, of Stockleigh Road, St Leonards, was recognised by her as someone she regularly turned away because of his age…Prosecutor Claire Prodger said: "The member of staff on this occasion said she could not serve him alcohol without ID…"He then left

the store with two bottles of wine." The offence, which happened on March 2, was caught on CCTV and reported to police.[328]

### 3.15 Tackling Street Drinking

It is important to ensure that appropriate action is taken to challenge and control the behaviour of young people consuming alcohol in public places.

The Young People's Substance Misuse Service has been piloting the delivery of a partnership response aimed at targeting under age drinking within Eastbourne and Hastings. This service necessitates a police response to those young people who are stopped in public for the first time with alcohol entailing their return home to parents/carers with service information. On the second occasion their details are passed to the Young People's Substance Misuse Service and a letter is sent to their parents offering a targeted intervention. On the third occasion an Acceptable Behaviour Contract is proposed with a requirement to undertake an assessment and meet the treatment / intervention recommendations from this.[329] [330] [331]

Within Hastings area this dovetails with an outreach project that delivers a "hotspot" response to areas identified by the police and community groups where young people are congregating and consuming alcohol. These "hotspots" are visited by Young People's Substance Misuse Service staff and youth workers who jointly deliver information and advice, harm minimization and brief interventions around alcohol and personal safety. What has become apparent from this service experience is that many young people require a more pro-active response to disengaged parents, often with substance misuse needs of their own. The outreach service currently lacks the capacity to respond to this area of need.[332]

### 3.16 Summary

There are indicators that drinking among young people in some parts of the county is above the national average. The key statistic about the impact of alcohol on under 18's comes from the NWPHO's data set (see Section1.1). This records alcohol specific hospital admissions for under 18s. Three of the five boroughs are in the highest 25% of authorities nationally, and the other two are average or above average. This suggests a rate of problems well above national average in Hastings, Eastbourne and Rother. Lewes and Wealden are closer to the national average; however, overall the county would be above average.

| | **Borough rank out of 354 local authorities in England (1 lowest – 354 highest rate of problems)**[333] | | | | |
|---|---|---|---|---|---|
| | Eastbourne | Hastings | Lewes | Rother | Wealden |
| Alcohol-specific hospital admission, under 18s | 295 / 354 | 344/ 354 | 174/ 354 | 288 / 354 | 213/ 354 |

The response to alcohol misuse among young people is very good. The county has a well-developed and well thought of Young People's Substance Misuse Service. Tier 1 services such as schools, the youth service,

children's services, the YOT and Connexions have all developed a response to substance misuse.

A great deal of work has been undertaken to ensure that universal services are identifying and intervening appropriately with young substance misusers. All vulnerable young people's workers in East Sussex attend a level 1 and/or level 2 substance misuse training programme delivered by the specialist service personnel.

At the centre of this system is the Young People's Substance Misuse Service. The service has clear care pathways for referrals from the full range of universal services including Connexions, Schools, Youth Service, YOT, CAMHS or other such settings. There is considerable local confidence in this system which one interviewee suggested was "Very robust – the best in the UK!"

The system of education in schools, i.e. teacher led, Personal Social and Health Education (PSHE) focused and occurring across all four key stages, matches national guidance. The general impression was that schools were geared up to tackling substance misuse among young people. Each secondary school has a designated substance misuse worker from the Young People's Substance Misuse Service that will work as part of the "team around the school". Pupil Referral Units receive a specific worker service and targeted prevention sessions each academic year. Drugs and alcohol education is included in schools' PSHE teaching and 88% schools have "Healthy Schools" status.

Nonetheless, problems were identified. Interviewees focused on the time pressures on the PSHE curriculum and the need to ensure that appropriate emphasis is placed on the delivery of alcohol education throughout the PSHE curriculum.

Universals services such as the Youth service, Connexions and the YOT all have clear pathways with the specialist service and have received training in working with substance misusers. The rate of identification in the Looked After Children system is particularly good.

Beyond the treatment and care system good work is being undertaken to tackle underage sales and target street drinking; however a number of interviewees identified three key gaps:

- The availability of diversionary activities for young people in the county.
- Proxy purchasing and
- The need for improved education for parents.

### 3.17 Recommendations

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| • Commissioners should ensure that sufficient time is available in the PHSE curriculum to address alcohol. |
| • The county, borough and district councils should develop plans to provide more diversionary activities for young people in the county. |
| • Police, Licensing and Trading Standards should run education |

| |
|---|
| • Police, Licensing and Trading Standards should run education campaigns targeting parental responsibility for their children's drinking. |

# Section 4

# Public Education

### 4.1 National Requirements at Local Level

No national standard exists for the amount of public education that should be undertaken in an area, nor is there a requirement to undertake alcohol public education at the local level.

The 2004 national alcohol strategy included a series of measures aimed at achieving a long term change in both attitudes to irresponsible drinking and behaviour itself. These included:

- making the "sensible drinking" message easier to understand and apply;
- targeting messages at those most at risk, including binge and chronic drinkers;
- providing better information for consumers, both on products and at the point of sale;
- providing alcohol education in schools that can change attitudes and behaviour;
- providing more support and advice for employers; and
- reviewing the code of practice for TV advertising to ensure that it does not target young drinkers or glamorise irresponsible behaviour.

The revised national strategy proposes public information campaigns to promote a new sensible drinking culture: "A new generation of publicity campaigns will mark a paradigm shift in the ambition and impact of public information about alcohol. The 'Know Your Limits' campaign will continue to develop and expand, acting as a call to action to promote sensible drinking and highlighting the physical and criminal harm related to alcohol misuse."[334] However, none of this is mandatory at the local level.

This problem is compounded by the fact that there is no reliable evidence of effectiveness of public alcohol education.[335] Alcohol Concern argues that the public has a right to information, especially in the context of large marketing spends by drinks companies and *Safe Sensible Social* is supportive of public awareness work.[336] As a result, decisions on how best to use public education should be taken in the context of a clear agreement and strategy on the use of such approaches.

In the same way there is no national requirement to undertake workplace initiatives.

### 4.2 Public Education

A wide range of public education initiatives were identified during the research.

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| *Eastbourne licensing team do training sessions about alcohol at the university freshers' week covering alcohol and safety and nuisance.*[337] |
| *The Safer Pubbing and Clubbing Group (a DAAT sub-group) have run safer clubbing, drinking in the sun, campaigns using posters on bus shelters etc.*[338] |
| *A substantial Sussex-wide Christmas Anti Drink-Drive awareness campaign to warn of the dangers of drink driving was launched at Heathfield Fire Station in November 2008. Promoted by the Sussex Safer Roads Partnership (SSRP), the launch triggered a package of road safety messages aimed at improving* |

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| *road safety over the festive period.*[339] |
| *Work is being done on proxy purchasing. The police have just done a radio advert on this.*[340] |
| *There was a Christmas drink-drive campaign under the Lewes CDRP banner, and education and advice to parents of juveniles "arrested" for alcohol related incidents In pubs and clubs there are Drinkaware/Drinkline posters in toilets.*[341] |
| *Information in Police custody suites, local initiatives in pubs and clubs – "beer goggles" and a recent feature in Hastings Observer.*[342] |
| *Rother Police have undertaken Operation Relay: Christmas Drink/Drive Campaign.* [343] |
| *The PCT do things via the Safer Pubbing and Clubbing Group.*[344] |
| *A Fire and Rescue Service campaign about smoking at home included information about not drinking.*[345] |
| *Trading Standards has an underage sales coordinator and they do public education.*[346] |
| *A booklet of alcohol advice for parents and young children and short films on TV screens around town. There has also been a recent full page advert in the Hastings Observer re alcohol harms and units; dink-drive campaign at Christmas 2008.*[347] |
| *There is a planned campaign via the alcoho –related crime prevention sub-group with leaflets and posters linked into "Know your limits".*[348] |
| *Work on local radio about alcohol and sexual health / teenage pregnancy.*[349] |
| *Information to new intakes of students in tertiary education.*[350] |

In particular, the Public Health Department covering the two PCTs has two health promotion specialists who cover work with Tier 1 substance misuse services. One of these workers focuses on alcohol. There is an SLA for this post with the DAAT which sets out what the role should encompass: Tier 1 training and public education work. As a result the focus of this work is on targeting hazardous and harmful drinkers. The health promotion specialist is also involved in various public education Initiatives. These tend to be partnership-based events such as Safer Clubbing or Have fun Stay safe which ran at Christmas.[351]

Nonetheless interviewees felt that more could be done on the public education front.[352] [353] [354]

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|---|
| *More could also be done on safer pubbing and clubbing.*[355] |
| *Are the big organisations like county council and police doing all they can to communicate about alcohol to their staff?* [356] |
| *There should be more public education – in conjunction with poster campaigns, Police and Trading Standards Department.*[357] |
| *Yes more education.*[358] |
| *Yes there should be a local public education campaign working through the DAAT.*[359] |
| *Hastings would support more public education.*[360] |
| *There should be a campaign related to carers and de-stigmatising in its approach.*[361] |

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| *There should be a campaign supported by local TV and other media.*[362] |

The East Sussex Commissioning Strategy for Adult Alcohol Misuse 2008/11 says that the county will "take up and reinforce national campaigns locally, ensuring that local campaigns provide ready access to information about how to get help locally." [363]

The key question is whether alcohol public education and communication work is covered by a single multi agency strategy which identifies how much should be invested, ensures there is minimal duplication and maximum reinforcement of messages.

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|---|
| *Ad hoc work is being done but no sustained work about alcohol.* [364] |
| *I feel that activity should be badged together and have more impact.*[365] |
| *The Police have just done a radio advert but the county did not necessarily know about it – because it is SussexPpolice. There is also the problem of CDRPs doing their own things.*[366] |

It was reported that East Sussex did not have such a strategy.[367] One interviewee felt that the county was 60% of its way there but a key missing element was a strategic framework. Kent Action on Alcohol Steering Group has developed a multi-agency alcohol communication strategy.[368] This is attached at appendix 4.

### 4.3 Local Advertising of Alcohol Services

18 community locations were visited (e.g. GP surgeries, libraries and pharmacists) to see if alcohol information and particularly alcohol service information was on display. The table below summarises the results.

| **Venue** | **Material** |
|---|---|
| Job Centre Plus Offices | No |
| Eastbourne Library | No |
| Aliiance Pharmacy Eastbourne | No |
| Boots Pharmacy Lewes | No |
| Police Station Lewes | No |
| CRI waiting room | There was only a photocopied AFC leaflet in the CRI waiting room. |
| GP practice, Hastings | No |
| Police Station Uckfield | No |
| Police Station Newhaven | No |
| Custody Suite Eastbourne | No |
| Council Offices Lewes | No |
| CAB Office Uckfield | No |
| Council Offices Hastings | No |
| Hastings Library | No |
| Lewes Library | No |
| Mental Health Centre | Yes Action For Change Information |

| | |
|---|---|
| Newhaven | |
| Community Centre, Newhaven | No |
| Eastbourne Borough Council Offices | Temporary display about health which included government leaflet - no local information |
| | |

The general picture was confirmed in the interviews.

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| *Publicity about local alcohol services requires development.*[369] |
| *Local alcohol services are not well advertised.*[370] |

Action For Change recognised this problem but were wary of such a campaign at present because of the demand it would place on a very stretched service.[371]

### 4.4 Workplace

The workplace represents a good location for targeting alcohol harm reduction messages and making links into appropriate help for those with problems.

The largest local employers are the statutory bodies: for example, East Sussex County Council which already has a good alcohol policy. However, the big gap is the large number of small businesses in the county.[372]

Action is being taken. A workforce development manager works across the three Sussex DAATs and has promoted the development of drug and alcohol policies in the workplace.[373]

The East Sussex Commissioning Strategy for Adult Alcohol Misuse 2008/11 recognises the importance of this area of work: "The partnership will work with local public sector employers to support workplace alcohol policies. [374]

- Promoting alcohol-focused communications campaigns;
- disseminating the advice for 'harmful' drinkers described in the national strategy (anticipated in August 2008);
- providing guidance about information and training that enables managers and support staff to screen for alcohol problems and provide brief interventions and referral when appropriate;
- considering how managers and supervisors might benefit from any training provided locally as part of the strategy."[375]

### 4.5 Summary

A wide range of public education initiatives were identified during the research. These were undertaken by a large number of agencies. Nonetheless interviewees felt that more could and should be done on the public education front.

The East Sussex Commissioning Strategy for Adult Alcohol Misuse 2008/11 says that the county will "take up and reinforce national campaigns locally,

ensuring that local campaigns provide ready access to information about how to get help locally." [376]

However, any future work on alcohol public education and communication should be covered by a single multi agency agreement which identifies how much should be invested, ensures there is minimal duplication and maximum reinforcement of national messages.

Local alcohol services are not well advertised. Action For Change recognised this problem but were wary of such a campaign at present because of the demand it would place on a very stretched service.

Action is being taken to increase the number of employers with workplace alcohol policies.

### 4.6 Recommendations

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| • Commissioners should ensure that public education is undertaken within the context of a clearly agreed strategic approach which balances the limited evidence of effectiveness against the need to ensure that the public receive clear messages to balance advertising from the alcohol industry. This strategy should ensure the appropriate advertising of alcohol services. |
| • Commissioners should ensure that local alcohol services are well advertised. |

# Section 5
# Crime and Anti-Social Behaviour

## 5.1 Tackling Alcohol Related Crime and Disorder

Managing the impact of drinking on crime and anti-social behaviour will involve policing and community safety measures as well as the appropriate application of the powers in the Licensing Act 2003. This section provides an overview of the steps taken in the county. Related issues such as domestic violence and alcohol treatment in the criminal justice system are dealt with in other parts of this report.

A key piece of context for this section is a general fall in violent crime in the county: it was suggested that acquisitive crime is the bigger problem now. Some interviewees felt that the economic downturn was having a noticeable impact on the night-time economy. "People are cutting back on discretionary spending." However, this does run the risk of moving problems into people's homes in terms of either domestic abuse or uncontrolled parties. The recession may also have the effect of reducing the price of alcohol.[377]

## 5.2 National Requirements at Local Level

A number of national requirements exist in this part of the response to alcohol. For example, *Safe Sensible Social* requires all local authorities to have a strategy which addresses the crime and disorder impact of alcohol.[378]

Licensing activity is clearly bound by a significant legislative framework, including the need to have a Licensing Policy and the requirement to enable affected parties to make representations and reviews. However, none of this specifies the need to consider the impact of alcohol on health or wider social care issues in an area.

The key national framework is the Public Service Agreement and in particular NI39 which targets a reduction in alcohol related hospital admissions. At one level this is a health target, but admissions will clearly be affected by violence, disorder and the level of accidental harm related to alcohol. Other targets also relate to alcohol e.g.

| |
|---|
| NI15 Serious violent crime rate |
| NI17 Perceptions of anti-social behaviour |
| NI20 Assault with injury crime rate |
| NI41 Perceptions of drunk or rowdy behaviour as a problem |

Other areas of national guidance and policy make links to alcohol. For example:

- Guidance on the use of Anti-Social Behaviour Orders made it clear that alcohol related behaviour was appropriate for such an order.[379]
- The Penalty Notice for Disorder scheme introduced as part of the Criminal Justice and Police Act 2001 has several of the penalties relating specifically to alcohol misuse and being drunk and disorderly.[380]
- Drinking Banning Orders which will be introduced in summer 2009 and will allow police and local authorities to stop a person entering premises if they have been involved in criminal or disorderly conduct under the influence of alcohol. Breach of an order, which can last up

to two years, can lead to a fine of up to £2,500. The orders are focused on people whose drinking has been identified as a factor in their disorderly conduct.[381]

Other national frameworks such as the MARAC, could have a bearing on alcohol problems but do not make this explicit.

London based Stella Project has published a wide range of guidance on alcohol and domestic abuse. (http://www.gldvp.org.uk)

A number of research papers have been published, and the Mayor of London has published a best practice guide, on managing the night-time economy. However, no single national guidance exists.[382]

A significant change to the situation is likely in the near future. The Home Office has opened consultation on the forthcoming mandatory licensing code of practice intended to address irresponsible retailing of alcohol and associated crime and disorder. The proposals set out a number of new requirements detailed in the main consultation document '*Safe. Sensible. Social. Selling alcohol responsibly*'. The new code of practice has four key areas:

- mandatory licensing conditions that will apply to licensed premises
- a requirement to display alcohol unit content and health related information
- discretionary local licensing conditions that can be applied to groups of two or more premises in any local area that have been clearly linked to alcohol-related nuisance and disorder
- statutory guidance to support the conditions and requirements, maximising the positive impact of the code, and good practice guidance.

The mandatory licensing conditions are expected to receive the most attention given that up to eight compulsory requirements can be brought in under the proposals that will impact on how pubs and clubs and the off-trade sell alcohol. The proposals include a number of key conditions:

1. Banning irresponsible promotions such as 'all you can drink'
2. Banning irresponsible practices such as alcohol being directly dispensed into customers mouths
3. Ensuring smaller measures (but not glass sizes) are made available
4. Ensuring the availability of free tap water
5. Ensuring online retailers have robust age-verifications systems
6. Ensuring point of sale information such as unit information and health guidelines are visible to all customers.[383]

Other proposed legislation includes the Policing and Crime bill: putting people first. Part 3 of the Bill contains provisions intended to reduce alcohol misuse by amending police powers to deal with young people drinking alcohol in public. There are also provisions that will raise the maximum penalties for those premises that sell alcohol to young people and those people who refuse to stop drinking in public when instructed to by the police. There are also

provisions to allow the Secretary of State to create, through secondary legislation, mandatory licensing conditions relating to alcohol.[384]

### 5.3 Tackling Crime and Anti-social Behaviour

The starting point for any work to reduce crime and anti-social behaviour is to be able to identify patterns and hotspots. Interviewees were unanimous that this was happening across the county and the strategic intelligence assessment has a chapter on alcohol related crime.[385]

| |
|---|
| *We have some very good hot-spotting data on violent crime and a top ten licensed premises that we are targeting.*[386] |
| *There is good knowledge of the key risk locations through data, information and intelligence.*[387] |
| *Information is shared between the Police and anti-social behaviour officers.*[388] |
| *PCSOs and anti-social behaviour officer provide good knowledge of the key risk locations / hotspots.*[389] |
| *There is an awareness of the crime and anti-social behaviour issues that alcohol can cause and the impact that this has on people across the town. This cuts across young people and the older generation.*[390] |
| *Eastbourne has a proactive programme of visits, risk assessments and town centre monitoring.* [391] |
| *There is good identification. The Police do constant problem profiling and there is an assessment across the county. The neighbourhood policing teams support this. We have looked at the top 10 streets for violent crime in the county e.g. Terminus Road in Eastbourne.*[392] |
| *There is good knowledge of the key risk locations.*[393] |
| *There is good and improving intelligence from CDRPs.*[394] |
| *Yes – collated through Police, CSOs intelligence and by licensing authority*[395] |
| *Yes – through CSP, Police, Council and CSO's.*[396] |

As stated in section 1, the key information gap was felt to be data from A&E units on the location of alcohol- related incidents.[397] However, it was reported that the PCT is working on this.[398]

It was also reported that significant efforts had been made to manage alcohol related crime, disorder and anti-social behaviour. *"There have been significant reductions in violent crime over the last 3 years. Operation Marble is the bespoke programme that we have for the town centres - e.g. early evening policing to pre-empt problems…We have also tried many of the other things which have been suggested for managing problems e.g. street pastors, safe havens."*[399]

Across the county many examples were found of initiatives taken to manage problems.

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| *Tackling alcohol related crime and anti-social behaviour is a key element of the Community Safety Plan for 2008/11: enforcement of licensing powers, reducing crime anti-social behaviour linked to alcohol, tackling under-age drinking and reducing domestic violence.*[400] |
| *In Hastings the Council will target problem and high-risk premises. Inspections* |

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| *of premises will be on a risk-assessed basis. This is in partnership with the Police and the Fire and Rescue Service.*[401] |
| *Eastbourne's Licensing Policy identified conditions which may be imposed on premises including: maximum occupancy limits, the use of close circuit television, the use of shatterproof drinking vessels and bottles, measures or restrictions placed on alcohol sales to prevent binge drinking and promote 'sensible drinking,' as well as polices to promote safer socialising.*[402] |
| *Lewes has licensing conditions targeting bottles etc.*[403] |
| *Rother also has licensing conditions targeting radio links schemes and bottle bans, toughened glasses.*[404] |
| *Powers to designate areas as no drinking zones have been used in Hastings, Lewes and Eastbourne.*[405] |
| *There is good security in the town centre pubs.*[406] [407] |
| *The use of a safe haven bus in Eastbourne.*[408] [409] |
| *Operation Blitz – dedicated Policing that goes directly to trouble spots…seizures of alcohol from young people who are then taken home to parents.*[410] |
| *The "Columbus" scheme that focuses on the "protection" of foreign students during summer months.*[411] |

**5.4 Transport**

Late night transport can cause problems in town centres as people try to leave after a night's drinking. Ranzetta Consulting's report for the Safer Hastings Partnership flagged up funding for transport as one of the things that could be done to improve safety in the night-time economy.[412] Concern was also expressed about a shortage of taxis, for example, in Eastbourne.[413] On the other hand, in the smaller towns and rural areas, it was felt there are few dispersal problems.[414] [415]

Various initiatives have been taken to address this area.

| |
|---|
| *Hastings Licensing Policy says that the Licensing Authority will arrange for protocols with Sussex Police to achieve the swift and safe dispersal of people from the town centre to avoid disorder and disturbance…and that the Authority wants to encourage taxi, private hire and bus services to work at night in the area to help with the safe and timely transportation of people away from the town centre. It will also encourage licence holders to provide transport home for their customers.*[416] |
| *Hastings has a late bus service although it was unclear whether this was all year round. Eastbourne tried a bus service but it didn't work.*[417] |
| *Over Christmas 2008 there was investment in taxi marshalling in key locations. Taxi numbers have been put on leaflets which also advertise bus and train timetables.*[418] |
| *In Hastings and Eastbourne, there have been moves to de-restrict taxi licences to improve availability of transport away from night-time economy.*[419] [420] [421] |

**5.5 Cumulative Impact**

Under the Licensing Act 2003, a saturation zone or cumulative impact zone can be declared by a local authority where the concentration of licensed

premises in an area is leading to problems. Once declared, although licensees can apply and licences may be granted, the assumption will be that no new licences will be granted within the zone.

Hastings have agreed to saturation zones in three areas:

- Hastings Town centre
- Old Town
- Central St Leonards[422]

Eastbourne has a zone around Grand Parade. This was evidenced through consultation with partners and looking at current evidence on crime and disorder. [423] No evidence was found of a need for zones in other areas of the county.

**5.6 Working with the Licensed Trade**

A key theme of the 2004 national alcohol strategy was encouraging a responsible attitude within the licensed trade. This remains a key issue both locally and nationally.

Pubwatch schemes provide an effective measure for keeping troublemakers from licensed premises. They involve a partnership between pubs and clubs within an area to provide an early warning system of the presence of individuals or groups likely to cause trouble. They can also involve communication between the police and licensees, and involve bar and door staff in providing early warning of instances of disorder. Information about individuals banned from local establishments can be circulated.[424]

In general much work has been done in this area. Pubwatch or Nightwatch schemes cover most of the county.[425] [426] [427] [428] [429] The Eastbourne Nightwatch scheme includes pubs, taxis and other night-time establishments.[430] However, there was concern that attendance at the Eastbourne meetings was poor.[431]

Multiple interviewees reported that the Police have undertaken test purchasing in on-licences.[432] [433] The police generally felt that there is good security in the town centre pubs.[434] [435]

A newspaper article highlighted an example of good practice by licensed premises staff.

Newspaper Article

A mother was caught drink driving at Tesco in Bexhill after a tip-off from store staff. Johanne Wojcik, 32, of Silvester Road, Bexhill, was refused service at the shop when she wanted to buy alcohol as she was believed to be too drunk. "She went into the store and tried to buy alcohol but was refused service because she was believed to be drunk." The defendant got into her car and police were called by staff from Tesco. [436]

The original National Alcohol Strategy recommended that pubs and clubs provide reasonably priced soft drinks, run designated driver schemes, make

free water available on all bars and make information available about alcohol.[437]

No evidence was found that this area of work had been tackled. When asked, most interviewees pointed to the use of safe glasses as the main response to improving safety in licensed premises.[438] [439] [440] [441] [442] [443]

However, there have been proactive moves on pricing issues e.g. one bar was promoting free vodka for females. A public outcry about this led to action. Joint police / local authority work has been challenging bars on happy hours.[444]

Best Bar None is a national scheme which sets standards for the management and operation of local licensed premises. Licensees can win awards for their practice under the scheme. The government has encouraged these schemes but it is fair to note that questions have been raised about the impact of these schemes in areas such as Croydon.[445] Locally it was reported there have been "bits and pieces of that work – it has ebbed and flowed e.g. safer socialising", however, it was reported that this was either not happening or not a local priority at present.[446] [447] [448]

Training bar staff to deal with the challenges of alcohol related problems is a technique which has been used internationally including Scotland and Wales. It has received less attention in England. Training would help staff to understand the law, the effects of alcohol, and particularly to have the skills to refuse service to drunken people. Such schemes were reported to be in place in the county.[449] [450] [451] [452] [453]

### 5.7 The Licensing Act 2003 - Representations and Reviews

It is assumed by the Licensing Act that an application for a new or varied licence will be granted unless "representations" have been made about the licence. Representations are essentially objections but specifically need to show that the licence application will not be in line with the four licensing objectives. In the same way a licence will remain in force unless a review is sought by an interested party.

Representations and reviews can be sought by the identified "Responsible Authorities" such as the police but can also be made by affected members of the public and local businesses. These represent a powerful tool for making an impact on licensing in an area.

It is clear that reviews have been used to tackle irresponsible licensees. The key question is whether members of the public are being encouraged to use these powers.[454]

The DCMS Guidance to the Licensing Act 2003 says that "Licensing authorities should consider providing advice on their websites about how any interested party can make representations to them." However, local authorities could undertake a specific initiative to educate local residents' associations, business associations and the public in general about how to

make a representation about licensed premises. Each area should develop a widely distributed information leaflet for the public and local businesses on how to make representations under the Licensing Act.[455]

Social inequality and social exclusion can impact on the number of representations and reviews. Evidence exists that areas of social exclusion will have lower levels of representations than more affluent areas. People in such areas may need more encouragement and support to make legitimate representations.[456]

The websites of the five local authorities were reviewed to see how they publicise the use of these rights.

| | |
|---|---|
| Hastings | There are formal details on how to make a representation or seek a review but not a more public friendly statement.<br><br>The Licensing Policy[457] contains information on how it will deal with the situation where applicants feel intimidated about giving personal details. |
| Wealden | There is a form for making a complaint against a licensed premises but nothing spec on representations and reviews |
| Eastbourne | There is a section on make representations but no effort apparently made to make it particularly accessible |
| Rother | There is a form for representations and reviews and advice on reviews but it is not particularly user friendly. |
| Lewes | Limited advice on making representations or seeking reviews. |

**5.8 Licensing Policy**

Each of the borough and district councils is required to have a Licensing Policy. The current policy runs from 2008 to 20011. Each of the five policies was reviewed to see whether the policies linked across to the health agenda and whether there are any performance indicators to measure the impact of the policy.

| | |
|---|---|
| Hastings | One of six Principles is to reduce alcohol misuse<br><br>There are no Performance Indicators.[458] |
| Eastbourne | The strategy recognises the need to link with tourism strategy but is weaker on how it will take into consideration local alcohol strategies.[459]<br><br>There are no Performance Indicators. [460] |
| Lewes | Does not mention the need to link to alcohol strategies / health strategies.[461]<br><br>There are no Performance Indicators. [462] |
| Rother | Does not mention the need to link to health strategies on section on strategic links.[463]<br><br>There are no Performance Indicators.[464] |
| Wealden | Does not mention the need to link to health strategies on |

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| | section on strategic links.[465]<br><br>There are no Performance Indicators.[466] |

**5.9 Summary**

Managing the impact of drinking on crime and anti-social behaviour will involve policing and community safety measures as well as the appropriate application of the powers in the Licensing Act 2003.

The starting point for any work to reduce crime and anti-social behaviour is to be able to identify patterns and hotspots. Interviewees were unanimous that this was happening across the county. It was also felt that efforts had been made to manage alcohol related crime, disorder and anti-social behaviour. Across the county many examples were found of initiatives taken to manage problems.

Various initiatives have also been taken to address late night transport problems in town centres as people try to leave after a night's drinking.

Under the Licensing Act 2003, a cumulative impact zone can be declared by a local authority where the concentration of licensed premises in an area is leading to problems. Once declared, although licensees can apply, the assumption will be that no new licences will be granted in that area. There are saturation zones in Eastbourne and Hastings. No evidence was found of a need for zones in other areas of the county.

A key theme of the 2004 national alcohol strategy was to encourage a responsible attitude within the licensed trade. This remains a key issue both locally and nationally. Pubwatch and Nightwatch groups exist across the county; however, there was concern that attendance at the Eastbourne meetings was poor. Server training was reported to be in place locally.

It was reported that nothing is being done to develop designated driver schemes, the provision of water and cheaper soft drinks, or information on alcohol at the point of sale in local licensed premises.

Boroughs and districts in East Sussex have used review powers to challenge the poor management of licensed premises. However, there is no monitoring of the pattern of representations and reviews made about licensed premises under the Licensing Act. This is important because there is national concern that people from more socially excluded areas may be making less use of their rights than people from other areas.

The borough and districts all have licensing policies; however, they contain no measures against which to assess its impact and effectiveness and in most cases do not link across to the health agenda.

### 5.10 Recommendations

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| • The licensed trade in the county should take a responsible attitude to the sale of alcoholic drinks by working to develop designated driver schemes, the provision of water and cheaper soft drinks, or information on alcohol at the point of sale. |
| • The Licensing Authorities should monitor and report on the pattern of representations and reviews to ensure that social exclusion or language skills are not a barrier to people using their rights under the Licensing Act. |
| • The Licensing Authorities should develop a set of measures against which to measure the effectiveness of Licensing Policies. |
| • The Licensing Authorities should ensure that future Licensing Policies should make clear links to the health agenda. |

# Section 6
# Treatment services

## 6.1 Introduction

In June 2006 the Department of Health's National Treatment Agency published *Models of Care for Alcohol Misuse* (MoCAM).[467] This document has the force of a National Service Framework in the health service and provides a standard to judge the adequacy of the range of local services. [468]

MoCAM divides services into four Tiers*:*

- Tier 1 Non-specialist services which see substance misusers e.g. social services and primary care;
- Tier 2 Open access, low threshold, substance misuse services;
- Tier 3 Structured community-based substance misuse services;
- Tier 4 In-patient and residential substance misuse services.

The services required under each tier are set out in the following sections.

The effectiveness of alcohol services has been studied on both sides of the Atlantic and there is clear evidence that the types of therapies used by alcohol services do have positive outcomes for clients. The UK Alcohol Treatment Trial and Project Match both showed that although no one treatment is more effective than any other, the range of treatments available do elicit change, albeit not for every client. In 2006 the Department of Health published the *Review of the effectiveness of treatment for alcohol problems*.[469] This provides an extensive evidence base on the effectiveness of alcohol services.

The *Review* also has evidence that brief interventions are effective in reducing alcohol consumption among hazardous and harmful drinkers to low-risk levels. Research has shown that the effects of brief interventions persist for periods up to two years after intervention and perhaps as long as four years.

A Health Development Agency Evidence Review also reports that there is review-level evidence that heavy drinkers receiving brief interventions are twice as likely to moderate their drinking six to 12 months after an intervention when compared with drinkers receiving no intervention.[470]

As yet no alcohol care pathways deriving from Models of Care for Alcohol Misuse have been developed for east Sussex; however, a working group is looking at this issue.[471]

## 6.2 National Requirements at Local Level

National frameworks on providing treatment for alcohol problems are largely guidance and opportunities rather than requirements. For example, the Department of Health's *Operating framework for the NHS in England 2009/10: High quality care for all* says that:

"Hospital admissions for alcohol-related conditions are at a worrying level. When reviewing their local priorities, PCTs should consider the longer-term benefits of their activity as well as the direct impact they can have, for example, on alcohol services. The Government's alcohol strategy, Safe, Sensible, Social: The next steps in the National Alcohol Strategy set out local and national action to reduce alcohol-related ill-health and crime. The recent consultation on possible further action will also be of interest to those PCTs who have included alcohol within their operational plan. PCTs who have not

included alcohol within their plan should consider if developments in alcohol services could contribute to other identified priorities."

The one area where there is a clear requirement is on the Directed Enhanced Scheme. This national scheme makes a payment to GPs of £2.33 for each new patient screened for alcohol use. It is a requirement on PCTs to offer this scheme to GPs in their area.[472]

In addition, alcohol services are now required to report anonymised client statistics to the National Drug Treatment Monitoring System.

In the future there are proposals that people with alcohol problems will face having their benefits docked if they do not attend treatment; however, the impact of these ideas is yet to be determined.[473]

Beyond these requirements, a significant number of frameworks and guidance have been published. These include:

- Models of Care for Alcohol Misuse (see above 6.1)[474]
- Treatment Effectiveness Review (see above 6.1)[475]
- Royal Pharmaceutical Society's *Community pharmacy and alcohol-misuse services* which looks at the opportunities for pharmacists to work with problem drinkers.[476]
- The Local Enhanced Scheme for Alcohol which permits (but does not require) PCTs to agree contracts with GPs for alcohol related activity.
- NI 39 (see 5.2 above) which targets a reduction in alcohol related hospital admissions.

More recently the Department of Health has encouraged the roll out of Identification and Brief Advice for problem drinkers in Tier 1 settings, especially primary care. Again this is not mandatory but has been supported by the development of a wide range of support materials which are published on the alcohol learning centre website (www.alcohollearningcentre.org.uk). In particular the Department of Health has recently published guidance on commissioning identification and brief advice training.

### 6.3 Capacity versus Demand in the Alcohol Treatment System

Only a small proportion of the people who have alcohol problems will seek help at any one time. The *Alcohol Needs Assessment Research Project* suggests that 10% of the in-need population accessing services each year would be a low level of access. 20% would be a high level of access.[477] [478] [479]
This data indicates that it would be reasonable to expect between 2,500 and 5,000 people to access services in the county each year (i.e. 10% to 20% of the approximately 25,000 harmful and dependent drinkers). At present numbers are well below the bottom of these two figures.

### 6.4 Tier 1 Non-substance Misuse Specific Services which See Substance Misusers

Many people experiencing alcohol-related harm can change their drinking after brief and motivational interventions that can be provided in non-substance misuse specialist Tier 1 services.

The people who will benefit from brief interventions are essentially the hazardous and harmful drinkers: that will equate to 69,000 people i.e. 23% of the local 16-64 population.

It is likely that the majority of these people will be seen by someone in the health, social care, housing or criminal justice sectors each year. Therefore, MoCAM says that a range of Tier 1 staff will need to be trained to:

- Identify and assess levels of need;
- Refer on to appropriate services when required;
- Educate clients about alcohol and its effects;
- Offer brief advice;
- Undertake motivational interviewing;
- Use harm reduction approaches.

Two Tier 1 services are singled out for specific attention:

- Primary care, and
- Accident and Emergency.[480]

Local work has been undertaken or is planned at Tier 1. The East Sussex Commissioning Strategy for Adult Alcohol Misuse 2008/11 identifies the following:

- Identification and brief advice training programme targeted at primary care staff.[481]
- Using the 'Choosing Health' allocation for alcohol to appoint two locality-based Alcohol Intervention Specialists, one based in Eastbourne and one based in Hastings.[482]
- Part of the 'Choosing Health' allocation will be used to establish a 'grants' programme that will seek bids from target organisations and teams for the resources needed to develop an ongoing programme of brief intervention skills training.[483]
- All contracts or service level agreements should include 'screening and brief interventions for alcohol misuse' as a staff competence requirement for provider organisations working with relevant care groups, vulnerable or disadvantaged people.[484]

The county has two health promotion specialists who cover work with Tier 1 substance misuse services. One of these focuses on alcohol. There is a service level agreement for this post with the DAAT which sets out that the role should encompass: Tier 1 training and public education work. As a result the focus of this work is on targeting hazardous and harmful drinkers.[485] [486] As yet the impact of this post has not been evaluated.[487]

Over the last nine months the post has trained 167 professionals in a series of tailored one and two day training programmes. For example a recently agreed training programme with A&E staff will run in slots at 8am and 8pm to accommodate shift patterns. [488] Other agencies trained include

- Housing
- Police[489] [490] [491]
- Prison
- Job Centre Plus[492] [493].
- Local Authority staff
- Maxio-facial staff [494]

The response to the work of these posts was positive.[495] [496]

Other Tier 1 services also reported that they had had alcohol training. Probation staff will know about screening and brief advice and extended brief interventions e.g. working on drink diaries and the cycle of change.[497] All mental health staff are to be trained in the use of screening tools e.g. FAST or the AUDIT and in brief interventions including motivational strategies and health education.[498] [499] CRI do brief alcohol interventions albeit they are primarily a drug service.[500] Action For Change deliver a range of training on an ad hoc basis e.g. for social service staff. This work is usually response led.[501] They are also doing training for ATR staff.[502]

The health promotion specialist is reported to be keeping a log of who has been trained, however, this has not yet been reviewed to see if the right groups have been targeted.[503]

The most important target group for brief intervention work is primary care. Some work has been undertaken but this area appears too be under-developed at present. The PCT is encouraging the use and roll-out of the Directed Enhanced Scheme which screens new patients. However, the success of this may be limited by the low national level of payment.[504] Action for Change is also commissioned to deliver GP training across the county.[505] Some interviewees had either had negative experiences with GPs or felt that there was professional and medical resistance to this client group.[506]

The two Health Improvement workers are rolling out training in the A&E units in Eastbourne and Hastings and they want to expand training into related areas such as gastroenterology. The key concern in A&E is about any increased workload in such busy settings.[507] An Action for Change post working across the A&E in Eastbourne and Lewes prison was funded opportunistically by Pfizer. The hospital work is at still an early stage[508], however, they have found it difficult to access space in the hospital.[509] [510]

It has also been highlighted that the data on A&E is very poor. They have not adopted the data recording system being used in other parts of the South East;[511] however, commissioners are going to ask the PCT to progress this.[512]

In developing the Tier 1 response a number of issues need to be noted:

- In February 2009 the Department of Health published an e-learning tool on the Alcohol Learning website (www.alcohollearningcentre.org.uk). This was launched in the middle of the research for this report and as a result some interviewees were not aware of it.[513] [514] It is important that commissioners use the opportunity to promote the elearning tool as a cost-effective way of rolling out identification and brief advice training.
- In developing this response it is important to ensure that Tier 2 and 3 services are developed in a way that supports the growing outflow from Tier 1, otherwise systems will become choked.
- A significant amount of identification and brief advice training is occurring in the county. However, this appears uncoordinated.[515] [516]

### 6.5 Tier 2 Open Access Services & Tier 3 Structured Community-based Services

MoCAM says that people with alcohol related problems require the following local Tier 2 interventions which offer simple and swift access to help with the aim of engaging and retaining them in treatment and care:

- advice, information and referral services for drinkers, their families and carers;
- easy access or drop-in facilities that include services to reduce alcohol related harm;
- self-help groups such as Alcoholics Anonymous and Al-Anon.

MoCAM also recognises that recovering problem drinkers require aftercare. This is seen as a possible role for Tier 2 services. Low threshold specialist services should also offer assistance to family members and other carers.[517]

Tier 3 services are structured services usually accessed via an appointment and an assessment. Such services encompass one to one psycho-social interventions, structured day programmes and community detoxification.

Tier 2 and Tier 3 services in East Sussex are provided by Action For Change, a third sector agency, and two nurses employed by the local NHS Trust who provide community detoxification.[518]

There was a general sense of dissatisfaction with the structure of local alcohol services both from the services themselves and other stakeholders.

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| *Alcohol has always been a bit of an also ran service. It has never had its own dedicated money – unlike drugs. Alcohol has never benefited from that. What has grown up has been the result of piecemeal bids. Under the circumstances they have done the best they could.* [519] |
| *They feel that they are in limbo with Action For Change. They are not satisfied but they are doing what they were asked; however it is not doing what is required in terms of the commissioning strategy.*[520] |
| *There is not enough of an alcohol treatment system locally.*[521] |
| *They have a historic pattern of treatment services which they wish to recommission this year. There is better service delivery in East than in the West and they want to get that in harmony across the county.*[522] |
| *By and large alcohol services have been a bit of a Cinderella service. I think* |

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| *that there is now a realisation that alcohol is a harmful drug and more will to address it now and to work in partnership.*[523] |
| *If they make a referral they will just say ask them to drop in. They have someone on an ATR who has been waiting two months for services. CRI commented that they will refer to Action For Change but because of the waiting time people won't go there.*[524] |
| *Further intervention strategies and Tier 2 and 3 treatments are needed.*[525] |
| *Few accessible services across East Sussex. They are currently confined to Eastbourne and Hastings.* [526] |
| *Not enough accessible services available across the County that recognise or take into consideration its rurality…More effective links required between referrer and provider services.*[527] |
| *Action for Change is not local; services are only in Hastings and Eastbourne.*[528] |
| *We need accessible, locally based alcohol treatment services with drop-ins and shop front information services open two or three times each week.*[529] |
| *There are few services available and then they are Eastbourne and Hastings centred.*[530] |
| *Inadequate provision, non-existent in some areas.*[531] |
| *Local third sector provider under-funded.*[532] |
| *Need greatly improved communications and co-operation among agencies.*[533] |
| *"Next to none" – no services commissioned for past 4 years.*[534] |
| *No services available in the area – Hastings and Eastbourne centric.*[535] |
| *Under 19s are well serviced, but adults not.*[536] |
| *Comprehensive accessible Tier2/3 adult services.*[537] |
| *Adult services are sparse.*[538] |

Perhaps the most telling criticism of the current system came from service users at CRI. A recent service user group meeting commented that the restricted access at Action For Change was a problem and they would like wider access. The service users reported that they were concerned by the limited number of open access services. It was also commented that if someone drops in, there can be no-one to see them and that there is a long waiting time for alcohol counselling.[539]

Action For Change deliver a Tier 2 / 3 service across the whole of East Sussex and are the only such service in the county.[540] They have two main bases: Eastbourne and Hastings. Clinics and counselling sessions are also run from a number of other different sites around the county e.g. GP practices (although not as many as they would wish), community health centres or local hospitals. Locations include Seaford, Uckfield, Newhaven, Rye, Bexhill and Battle. They cover most of the small semi-urban areas. It was reported that they need more venues. Aspirations to deliver services at GP practices are not being met because of a lack of space in surgeries.[541]

The entry into the treatment system is via Action For Change's Tier 2 open access clinics – these are the only port of call for people with alcohol problems in the county. The service does not take referrals - they expect someone to turn up at the nearest clinic. Two clinics per week are held in

each of the Eastbourne and Hastings offices. Elsewhere they are held on a fortnightly basis. Each clinic is 2 hours.[542]

The clinics have three sorts of clients: [543]

- New referrals[544]
- Repeat attenders waiting for interventions[545]
- Significant others.[546]

Appointments are 15 minutes in length. This is the point at which people first receive information about the service. They complete an assessment form, and then the case goes to a multi-disciplinary meeting. If needed they would then have a comprehensive assessment from either the nurses or Action For Change who could do a non clinical comprehensive assessment.[547]

They then offer a number of options. These include six sessions of extended brief interventions consisting of 50 minute weekly sessions.[548] They can also offer 12 weeks of structured counselling at 50 minutes per week.[549] They work with both controlled drinking and abstinence.

They also have a group programme in Hastings (but not Eastbourne). This is not structured day care – but includes a detoxification preparation group and a post detoxification group, relapse management, lifeskills and healthy eating. These meet weekly offering five themed groups each week. There is no wait for group programmes.[550] [551]

Long waits exist for structured counselling: it can be months but the service is hoping to bring this down. In Eastbourne the waiting time is 6 months because of staffing problems.[552] They are training new counsellors but are also hindered by venues.[553]

For extended brief interventions the wait in some rural areas can be high. The instruction from commissioners is that these clients should now be offered a place at an urban clinic and if they do not take it they will have to wait.[554]

Action For Change offers a number of other services:

- A detached care project working with street drinkers in Hastings.
- A significant other support program. This is a weekly group and one to one counselling.
- The services of a clinical psychologist who works with very complex cases where psychological interventions are appropriate. She also does supervison and training. This is currently four sessions per week. The post is employed by the Partnership Trust but Action For Change pay for it.
- A post working with the homeless in Eastbourne but this is on short term funding and may not continue.
- A 30 hour per week post across the A&E in Eastbourne and Lewes prison.
- The local ATR program for the Probation Service.

- Three staff doing Tier 2 work in the county councils young people's services.
- Two part time posts in the PULSE project which targets 16-25 year olds.[555]

Overall Action For Change has 30 staff: 20 part time and 10 full time. The agency receives about £460,000 from the PCTs and local authorities via the DAAT. In addition they have a contract with the Probation Service and separate funding for the young people's work from the County Council and Comic Relief.[556]

Action For Change is not the only Tier 3 service. The county also has two alcohol liaison nurses and a social worker plus input from a psychiatrist. These are part of the Sussex Partnership Trust.[557] The main function of the nurses is to provide community detoxifications: the social worker focuses on community care funding.[558]

One nurse covers Hastings and Rother, the other covers Eastbourne Lewes and Wealden.[559] Many of the alcohol liaison nurse clients come via Action For Change but they also take referrals from GPs and the CMHT, but not self-referrals. Action For Change is the biggest referrer.[560]

Each worker receives 4-6 referrals per week on average and about 50% of these become community detoxifications. Although the main role is to look at people for detoxification they will also work with clients with mental health problems.[561] At present there are waiting times of up to five weeks for people who want a detoxification.[562] The data in section 1 on the numbers of dependent drinkers highlights this as an important gap.

Disulfiram and acamprosate is available. The nurses like to use acamprosate with all detoxifications to reduce cravings. A local consultant is also looking at running an antabuse (disulfiram) clinic.[563]

The key problem is that there are only two alcohol nurses, who cover a large area so it is difficult to access them. As a result clients disengage or GPs are doing unsupervised detoxifications. [564]

Action For Change felt that a good multidisciplinary system operates across these services. There are two meetings per week at which the nurses and the Action For Change staff meet to discuss clients.[565]

A number of specific gaps in the range of services were identified:

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| *The nurses would like an ambulatory detoxification service running two weeks in Eastbourne and the next two weeks in Hastings and seeing 6-8 clients a fortnight.* [566] [567] |
| *The main gaps are to do with quantity. If we had more resources we would be able to offer a more comprehensive service.*[568] |
| *We would like to be able to offer more open access facilities.* [569] |
| *The entry system into the system is not the best… would prefer a system where people access services through primary care and access specialist* |

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| *services in primary care services.* |
| *The service users speak highly of the service but the environment is not great.*[570] |

Change is now proposed to the treatment system. In April 2008, the DAAT published the health and social care commissioning strategy for adult alcohol misusers. The strategy describes a step-change in the way services are delivered.[571] The aim is to unpick what they currently have and re-develop it with upto £1 million of new investment in 2009-10.[572]

The commissioning strategy aims to address the rurality of the county by delivering primary care based alcohol services instead of the current system. The resources currently invested in Action For Change and some new resources will be used to redesign the service. It is recognised that GP practices will not be available or suitable in every area; in this case services will be delivered elsewhere.[573]

This model will also not help people who are street homeless, prisoners or people who are using A&E as their first port of call.[574]

The East Sussex Commissioning Strategy for Adult Alcohol Misuse 2008/11 outlines further commissioning intentions:

- The treatment services directly commissioned by the partnership will continue to provide information about local '12 step' or other 'mutual aid' groups, as appropriate. Key workers will be expected to facilitate access. [575]
- The partnership will provide practical support to local 'self-help' and '12-step' or 'fellowship' groups seeking to establish themselves or extend their reach. [576]
- The financial resources currently available are not sufficient to provide the service developments. [577]
- The focus for expanding 'Tier 3' interventions will be the development of a new service that is based in primary care settings. The new service will need to be procured through a competitive tender process. [578]
- There will be close links and care pathways with 'crisis' services including the [mental health] crisis resolution home treatment team, out of hours services in general practice and accident and emergency services[579]
- 'Aftercare' or 'extended case monitoring' will routinely be provided to ensure people who access treatment are followed-up at 3, 6 and 12 months. [580]
- Information about alcohol-only structured treatment to be recorded using the 'Orion' database. [581]
- The partnership will need to agree a reporting framework for the performance indicators included in the commissioning strategy, to include the Vital Sign (VSC26) and National Indicator (NI 39) 'rate of alcohol related hospital admissions per 100,000'[582]

### 6.6 Dual Diagnosis Services

A significant proportion of problem drinkers will also have a mental health problem. This combination is associated with high levels of suicide, self-harm and violence to others and makes clients difficult to engage in services or treat effectively. Alcohol services will need to have both training in this area and specific protocols with local mental health services about the referral and management of this client group. These protocols will need to be written within the framework of the Department of Health's *Dual Diagnosis Good Practice Guide* which was published in 2002.

Sussex Partnership NHS Trust has a Policy on the Management of people with a Dual Diagnosis of Mental Health and Substance Misuse which sets out principles to work to, including treatment and discharge planning in community and inpatient services.[583] [584] [585]

All mental health staff are to be trained in the use of screening tools and brief interventions including motivational strategies and health education.[586]

The general sense from interviewees was that dual diagnosis was a problem area, but that the situation was beginning to improve.

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| *Dual diagnosis provision is a huge gap. There is a dual diagnosis group set and this is starting to improve things. But getting people to attend mental health services is a problem. This is an area that could be improved. There are problems of people being batted back with they need to address their substance misuse.* [587] |
| *They have a Dual Diagnosis Network. There is a tendency for busy mental health teams to push away intoxicated clients. The commissioners have said very clearly that dual diagnosis is part of the bread and butter work in mental health services. Therefore they are saying you will work together and help this with a dual diagnosis network. However, the meetings are dominated by substance misuse workers rather than mental health workers and more substance misuse workers attend.* [588] |
| *Hopes it is getting better but have felt very angry in the past. Clients dumped by mental health services who won't see clients who are drinking.* [589] |
| *Trust has a policy not to ping people back and forward between services. Feel there is still further work to be done in Eastbourne about improving practice at the local level. Things are working much better in Hastings.* [590] |

### 6.7 Tier 4 – Inpatient Detoxification

While community detoxification is the preferred route, a small number of dependent drinkers will require a greater level of supervision because of the risk of delirium tremens or withdrawal fits, because they have some complicating medical or psychiatric condition, because of unsuitable living circumstances or because they have not responded positively to previous community detoxifications. Inpatient places in a dedicated unit will be needed so that these clients can be withdrawn safely.

The county has three beds for substance misuse detoxification in East Sussex and another 0.5 beds in Brighton reserved for more complex cases.[591] The

majority of detoxifications are for alcohol.[592] The view, expressed by many interviewees was that this provision is simply inadequate.

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| *There is just not enough of it. It runs out very quickly especially at Tier 4. More people would benefit from detoxification.* [593] |
| *I wish there was adequate access to inpatient detoxification. In Hastings there is one bed in the Woodlands unit – but this is dependent on a mental health bed being available. In Eastbourne they use the Department of Psychiatry. There is meant to be two beds but the situation is more difficult than in Hastings.*[594] |
| *The impact is that clients wait or end up in a general hospital bed because they become an acute problem. Clients may also be disappearing because of the waits.* [595] |
| *Not enough alcohol detox beds – there is a ridiculous amount of waiting and beds are being offered and then withdrawn.*[596] |

The data on dependent drinkers outlined in section 1 emphasises the importance of this gap.

The East Sussex Commissioning Strategy for Alcohol Misuse 2008/11 addresses this problem.

- The existing arrangements [for inpatient detoxification] will be re-provided on a single site in Sussex, with double the capacity of the existing service. The service will be commissioned on a sub-regional basis in partnership with West Sussex and Brighton and Hove, with a specific number of bed-days allocated for East Sussex residents. [597]
- The physical location of a tier 4 specialist inpatient service is likely to be more easily accessible for coastal residents because of proximity and transport links. [598]

### 6.8 Tier 4 – Residential Rehabilitation

Residential rehabilitation services are not a specifically local service. It is acceptable for a particular authority not to have a residential service within its boundary. The key question is whether local people can access the national range of services.

The NHS and Community Care Act (1990) transferred resources formerly held by the Department of Social Security to the control of local authorities. These so-called “community care” funds are the main funds used to purchase residential care, although they can be used to purchase any service (other than health care) which will meet the client’s assessed need.

Social services departments have a legal duty to offer clients who require it a full individual assessment of need. This will determine who has access to the community care funds.

The messages about community care funding in the county were confused.

Most people seeking community care funding in East Sussex would come via Action For Change and then be referred to the social worker. Other referrals could come via the detoxification nurses as a follow-up to inpatient

detoxification, direct referrals from statutory social care services e.g. adult services, prison or from hospital services such as gastroenterology.[599] [600] Treatment service providers did understand how to get clients into residential rehabilitation.[601] [602]

Client need is then judged against the national Fair Access to Care Services eligibility criteria. In East Sussex people meeting the critical or substantial levels will be funded.[603] [604]

The decision on funding is taken via a panel which includes practitioners, a finance officer, and social services managers. Final authority lies with a senior manager in the local authority. Leaflets are available to describe this system to clients.[605] [606] [607] The community care budget sits with the local authority and is topped up from the DAAT.[608] [609]

The same system is used to assess and fund drug users. In some areas of the country the number of drug users placed far outstrips the problem drinkers. That is not the case in East Sussex at present. It was suggested that recently alcohol has been having a disproportionate share of the budget because this group of clients are more likely to be critical than drug users.[610]

Care management is also taken on by the social worker. Clients in rehabilitation units are always visited for reviews. It is felt that this is important in encouraging retention. Prior to entry, the social worker tries to encourage client choice through the use of travel warrants which let clients visit places before entry. Clients' needs and wishes e.g. family issues or desire for a 12 step programme are also accommodated where possible.[611]

The county does not have any block contracts for residential rehabilitation, all places are spot-purchased. Alcohol clients, however, are commonly using places such as the Kenward Trust in Kent, ANA in Portsmouth or Jigsaw in Bournemouth.[612]

Some interviewees suggested that the assessment process is quite swift; however, there was contradictory evidence.

It was reported that the demand for community care does outstrip the available resources. In accordance with the law, people who meet the criteria at a time when funds are not immediately available are put on a pending list.[613] [614]

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| *We can make an appointment for a client to see a social worker. They may have to wait a long time but will eventually get it. One man waited 3-4 weeks and that was the quickest I have known others have had to wait a year.* [615] |
| *Prison CARAT workers can't get residential rehabilitation for alcohol only…not sure that there is funding.*[616] |
| *Most complex clients who fit the community care protocol – have to demonstrate that community resources are not sufficient – but people who go in do stay the course.* [617] |
| *They have to wait a very long time to get in to res rehab.* [618] |
| *Access to rehab is a long process. The client has an assessment from a* |

*social worker and then the case goes to panel but can be problematic, there can be a six month to a year wait for rehab. They can only get a smooth transition by setting detoxification around access to rehabilitation.* [619]

The East Sussex Commissioning Strategy for Alcohol Misuse 2008/11 proposes to change this system The partnership will move from the current arrangements for 'spot purchasing' all residential rehabilitation services to a combination of 'block contract' and 'preferred provider' arrangements.[620] This is a potentially retrograde step which, unless there is an increase in the budget, will have the effect of restricting client choice. It should be noted that client choice is a legal requirement under the Community Care Act and restrictions on choice could fall foul of a legal challenge.

### 6.9 Services in the Criminal Justice System

There are a number of models of how alcohol services can offer treatment and care to people involved in the criminal justice system. These include:

- Arrest referral in the custody suite or court,
- Prison based work,
- Alcohol Treatment Requirements sentencing those appearing before the courts in to treatment.

### 6.10 Arrest Referral and Conditional Cautioning

Although a pilot young people's arrest referral project has been set up (see 3.8), there is no arrest referral scheme for adults.[621] The East Sussex Commissioning Strategy for Adult Alcohol Misuse 2008/11 states that they will consider establishing the feasibility of introducing alcohol arrest referral and conditional cautioning schemes at Eastbourne and Hastings Interview and Detainee Handling Centres.[622] It should also be noted that such interventions will require the development of Tier 2 and 3 services.

Conditional cautioning is also being rolled out. They are still monitoring the impact of this. There is again a problem with waits. Clients will go to Action For Change but as this has only just started it is too early to make any judgement.[623]

### 6.11 Alcohol services in the Prison System

HMP Lewes is a male local Category B prison. It holds both remanded and convicted adult prisoners, as well as young offenders on remand. It serves the courts of East and West Sussex. Responsibility for providing and commissioning healthcare services within HMP Lewes lies with East Sussex Downs and Weald Primary Care Trust.[624] The prison has about 700 inmates and only a minority come from East Sussex itself. It was estimated that 34% of prisoners come from East Sussex and Brighton and Hove combined.[625]

The prison's Healthcare Needs Assessment for 2008 contains some useful estimates of the numbers of prisoners with substance misuse or alcohol dependence prior to entering the prison. It is estimated that on average 390 will have an audit score of 8 or above implying that they are hazardous, harmful or moderately dependent drinkers. A further 30 will have an AUDIT score over 32 suggesting physical dependence.

The clinical services in the prison are able to offer a Librium based detoxification, plus vitamin therapy and some brief interventions. On average the clinical services are referred 30 problem drinkers per month. These people will have been identified on arrival during a primary health screening with a nurse. This screening routinely looks at issues related to alcohol misuse. However, this process will not help those people who are in the hazardous and harmful categories or possibly who have only psychological dependence.[626]

Usually prisoners have community detoxification in their cells but some go on to the hospital wing.[627] At present a new wing is being built for the clinical services. This will allow them to provide psycho-social interventions to drinkers which they are unable to do at present because the drinkers are on various different wings. [628]

The CARATs team, as is the case nationally, is not funded to work with problem drinkers, however, they will assess them and will definitely work with those who are polydrug users. In the last 6 months they have assessed 30 people with alcohol problems of whom between a quarter and a third came from East Sussex.[629] They also have basic alcohol awareness from CARATS on a one-to-one basis.[630]

Alcoholics Anonymous (AA) come into the prison. Cocaine Anonymous is starting but will also take problem drinkers.[631] An Action For Change prison worker is also coming in.[632] [633] The latter post does link work visiting as part of release planning.[634] This post gets a large numbers of referrals. In January alone there were 21 and 43 across the first three months of 2009. This means there is now a waiting list to see the worker.[635]

The key concern is that there is not a good pathway from prison to alcohol services. The prison can phone AA to get a sponsor to meet people off the train but if people are to be referred to Action For Change they have to go to the local drop-in sessions.[636] The prison would like to see more service for drinkers.[637] [638] [639]

### 6.12 Alcohol Treatment Requirements (ATR)

Action For Change run the ATR program for East Sussex Probation, which is being well used. They have worked with probation since 1996 and their work was adjusted 18 months ago to become an ATR programme.[640] [641]

It was reported to be working satisfactorily. The Probation Service has had partnership reviews and was happy with it.[642] However, there is still a waiting list to see the ATR worker.[643] If the client needs medical interventions they go to the nurse, which will again entail waits.[644]

### 6.13 Probation

Probation has no specific in-house courses on alcohol.[645] They have been delivering the national Offender Substance Abuse Programme (OSAP) which is directed at the heavy end of substance use but this is about to stop

because it is not getting very good results.[646] In general Probation Officers will do a basic assessment of alcohol use and if a problem is identified they will be referred to partner agencies for more in-depth work.[647]

### 6.14 Summary and Discussion of the Local Alcohol Treatment System

It is impossible to argue that the local alcohol treatment system is adequate. None of the interviewees suggested anything other than that this was a system that needed a radical overhaul.

The current system has a number of failings:

- A need to further develop brief interventions, particularly in primary care,
- A Tier 2 / 3 service which appears to have developed in a very piecemeal way,
- An open access entry system to Tier 2 / 3 which may disadvantage many clients,
- Long waiting lists for one to one interventions,
- An inequitable distribution of alcohol services across the county,
- A clear lack of both community and inpatient detoxification,
- Confusion over the adequacy of the residential rehabilitation system,
- A lack of a clear aftercare system.

No-one blamed the services themselves. They were generally seen to be struggling to deal with a huge problem with inadequate resources.

Commissioners also recognise almost all of these problems (perhaps with the exception of the residential rehabilitation question) and in the Commissioning Strategy have made a significant effort to address the problems.

However, it is the view of this report that the plans are not adequate to address the problem. The plans have good features, for example:

- The need to improve inpatient detoxification has been recognised.
- The need to expand the financial resources available to provide new services.
- The development of aftercare services.

Nonetheless, there are still gaps:

- 69,000 people, essentially the hazardous and harmful drinkers, could benefit from identification and brief advice.
- National data indicates that it would be reasonable to expect between 2,500 and 5,000 people to access services in the county each year but the numbers coming to services is well below that.
- The level of community detoxification provision is clearly inadequate in an area with higher levels of dependence and two boroughs which have some of the highest level of alcohol related morbidity and mortality in the country.

The plan for primary care provision appears to be only a partial answer to the problems identified. It is readily acknowledged that this approach has problems: some people will not readily make use of such a system and in

some areas it may be hard to identify locations. However, the more fundamental problem is that this approach appears to be one which is suited to the rural areas of the county but is far from appropriate for areas such as Eastbourne and Hastings which have levels of problems which are closer to those found in areas such as Wigan or Bolton.

In the opinion of this report it would, therefore, be more appropriate to have a service structure which incorporated three elements:

- A Tier 3 community alcohol team with an increased number of nurses and other medical input to provide an adequate service to the number of clients who are likely to require detoxification. This service might also provide a brief structured input to those who have been detoxified. For example, in Bolton the Tier 3 service provides a four to six week post detoxification programme of groupwork and one to one interventions, before assisting clients to transfer into an extended Tier 2 service offering an aftercare groupwork programme. At least two further nurses would be needed to bring the team to a size which is comparable to those found in areas of similar need.
- A primary care based Tier 2 programme of triage assessment and one to one interventions based in primary care services in the smaller communities and rural areas. This service can link people into the Community Alcohol Team for comprehensive assessment.
- One or two fixed base enhanced Tier 2 services serving the high need areas on the coastal strip. Given the level of need in these areas it appears justifiable to replicate the approach found in other high need urban areas. These services would provide a clear focus for the provision of alcohol services in the area and could provide a base from which the Community Alcohol Team could provide clinics. This service would provide triage assessment, brief and extended brief interventions, gatekeep access to the Community Alcohol Team and then provide a programme of groupwork and one to one support for clients who need ongoing or aftercare support.

This report will not take a view on whether this service should be built on the basis of the existing Action For Change service or built on a re-tendered service using, in part, the resources currently invested in that service. However, what is clear is that the entry system needs to change. Clients should be able to access triage assessment through an appointment system with clear timescales for speed of access. For example the Tier 2 triage service in Bolton (an area of high need serving a population of 260,000) has a fixed base, an appointment entry system and a requirement to undertake triage with one week. A flowchart map is included at appendix 5.

In addition to these major changes there are a number of other required changes, some of which are already envisaged by the Commissioning Strategy:

- A strategic approach to the rollout of brief interventions across Tier 1 workers with a key focus on primary care, perhaps through the use of Local Enhanced Services as well as the Directed Enhanced Service.

- Dissemination of the Alcohol Learning Centre's elearning tool to train Tier 1 workers.
- The development of care pathways for prisoners.

The East Sussex Commissioning Strategy for Alcohol Misuse 2008/11 proposes to change this system. The partnership will move from the current arrangements for 'spot purchasing' all residential rehabilitation services to a combination of 'block contract' and 'preferred provider' arrangements.[648] This is a potentially retrograde step which, unless there is an increase in the budget, will have the effect of restricting client choice. It should be noted that client choice is a legal requirement under the Community Care Act and restrictions on choice could fall foul of a legal challenge.

Above all, it is clear that both the level of need and the inadequacy of current provision demand the investment of additional resources in the treatment system. This will be essential simply to meet the demand which will be generated by Tier 1 initiatives such as Conditional Cautioning, identification and brief advice, Alcohol Treatment Requirements, prison pathways and work in Accident and Emergency units, as well as the pent up demand suggested by the data on alcohol related harm and the waiting times for existing provision.

### 6.15 Recommendations

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| • Commissioners should invest in an expanded and coordinated programme of screening and brief advice training in Tier 1 services. |
| • Commissioners should continue to support Local Enhanced Service schemes to provide alcohol brief interventions in primary care. |
| • Commissioners should disseminate the Alcohol Learning Centre's elearning tool to train Tier 1 workers. |
| • Commissioners should develop an enhanced Tier 2 service offering triage, advice and information, extended brief interventions, as well as aftercare groupwork. |
| • Commissioners should ensure that the enhanced Tier 2 service is offered from fixed bases in the high need coastal areas and primary care clinics in the rural areas. |
| • Commissioners should invest the equivalent of at least two new posts in the Community Alcohol Team to begin to allow it to meet the excess of demand over supply. This team should take on community detoxification and some post detoxification groupwork prior to the clients being referred back to the enhanced Tier 2 service. |
| • The county should examine the provider concerns about the difficulty of accessing the community care process. |
| • Commissioners should reconsider the proposal to move from the current 'spot purchasing' of residential rehabilitation services to a combination of 'block contract' and 'preferred provider' arrangements because of the restriction this will place on client |

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| choice. |
| • Commissioners should ensure the development of a care pathway from the prison system into alcohol treatment. |

# Section 7
# Strategy

## 7.1 National Requirements at the Local Level

Safe Sensible Social requires all local authorities to have a strategy which addresses the crime and disorder impact of alcohol. "Local communities are best placed to tackle local problems, including alcohol-related disorder. By April 2008, all Crime and Disorder Reduction Partnerships (CDRPs) – comprising the police, local authorities, police authorities, fire and rescue authorities and primary care trusts in England, and civil society organisations – will be required by law to have a strategy to tackle crime, disorder and substance misuse (including alcohol-related disorder and misuse) in their area."[649]

The Department of Health has published a Joint Strategic Needs Assessment (JSNA) core dataset - a list of indicators that can assist partners in preparing their JSNA, with detailed information on each indicator. The dataset takes into account the National Indicator Set and Vital Signs and provides 'a good foundation that can be supplemented with local data and information.' The link to alcohol is small, but nonetheless there is a recognition of a role for alcohol in the JSNA.[650]

However, no other requirements specifically relate to alcohol in the strategic domain.

## 7.2 Strategy

East Sussex has a well-developed strategic framework for the response to alcohol. In 2006 the East Sussex Drug and Alcohol Action Team launched their first Alcohol Harm Reduction Strategy and convened an Alcohol Steering Group to oversee the implementation of the Strategy.[651]

The East Sussex Drug and Alcohol Action Team (DAAT) is the multi-agency partnership that oversees drug and alcohol issues. The DAAT includes Hastings and Rother Primary Care Trust, East Sussex Downs and Weald Primary Care Trust, East Sussex County Council, District and Borough Councils, Sussex Police, Sussex Probation, HMP Lewes and providers and users of services. The DAAT involves a wide range of stakeholders through a number of special interest groups.[652]

New Terms of Reference have just been developed for the Alcohol Strategy Group. Membership includes Hastings and Rother Primary Care Trust, East Sussex Downs and Weald Primary Care Trust, East Sussex County Council, District and Borough Councils, Sussex Police, Sussex Probation, HMP Lewes and providers and users of services; however, there is no user or carer representative.[653] [654] [655] [656] The PCTs also have an identified lead commissioner for alcohol.[657] [658]

Other related groups include:

- The DAAT Young People's group.[659]
- The county licensing officers group. (It should be noted that much of the implementation of the Licensing Act was done jointly across the five local authorities).[660]

- An alcohol pathways meeting which is looking at the alcohol treatment pathway.[661]

A new county alcohol strategy is in the process of development. The DAAT has published a health and social care commissioning strategy for adult alcohol misusers. This describes a step-change in the way services are delivered from April 2008 to March 2011.[662]

The specific alcohol strategic structure appears well-developed and interviewees commented positively.

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| *There is good partnership working; it is research based and all agencies are trying to see what they can do.*[663] |
| *I think it works satisfactorily. The group has wide membership including police, probation, domestic violence, trading standards and licensing. The group meets quarterly, but it hasn't got the same oomph as drugs because it does not have the money.*[664] |
| *Alcohol commissioning strategy is very good.*[665] |

While the local structure around alcohol is positive, it is also important to ensure that that structure does not operate in isolation. Is alcohol referenced in other health, local authority and community safety strategies? Is there support for the strategy at the very highest levels?

The situation is mixed.

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| *There is not a consistent message across strategies.*[666] |
| *Most frustrating thing is the lack of organisation from on high…Lack of coordination around agendas.*[667] |
| *Yes the recommendations of different strategies are in harmony with each other.*[668] |
| *Alcohol is referenced in other areas e.g. workforce activity, young people's activity.*[669] |
| *Not sure there is enough senior level sign up yet.*[670] |

It is reported that the response to alcohol is included within the East Sussex Community Safety Agreement and the DAAT is chaired by East Sussex County Council's Director of Policy and Communications which, it is argued, demonstrates support at a high level.

Overall, alcohol appears to feature in some strategies and not in others. For example, the community safety strategies reflect alcohol satisfactorily.[671] It was also positive to note that the East Sussex three-year Joint Commissioning Strategy for Carers' Services 2007/08 to 2009/10 inclusive recognises the needs of substance misusers.[672] Young people's strategies such as:

- CAMHS Strategy 2006/07
- Teenage Pregnancy Action Plan 2207/08[673]
- Young Carers Strategy 2006
- NEET Reduction Strategy 2007/08
- Youth Offending Team Plan 2007/08[674]

all appear to include alcohol related elements.

East Sussex has a single ' sustainable community strategy' named 'Pride of Place' this is the overarching ' plan of plans' and is signed up to by all the statutory, private and voluntary sector agencies involved in the East Sussex Strategic Partnership. It provides a long term vision for East Sussex and identifies 9 thematic areas.

Alcohol is mentioned in two of the key thematic chapters. In the chapter on Community Safety one of the key tasks identified is to "reduce the harm caused by drugs and alcohol misuse" and in the Health and Wellbeing chapter, another key task is "reduce teenage pregnancy and reduce self-harming lifestyles: obesity, smoking, alcohol and substance misuse." There are other key tasks that, whilst not directly mentioning alcohol, would help to deliver on the alcohol agenda.

A countywide action plan is being developed for Pride of Place and the key issue under community safety that needs to be addressed in a cross cutting way is to "Develop a strategic and cross cutting approach to tackling the causes and effects of alcohol misuse."

However there also identifiable gaps:

- The Alcohol Strategy group is a sub- group of the DAAT, but the DAAT doesn't report to any specific group.[675]
- The county has not signed up to alcohol LAA targets.[676]
- Older people's strategies only make passing reference to alcohol. [677]

One interviewee hoped that the new alcohol strategy would provide impetus to develop high level buy in.[678]

### 7.3 User and Carer / Significant Other Involvement

As with the overall strategic framework the involvement of service users presented a mixed picture. A DAAT officer is responsible for the over-arching service user framework; however there is no user involvement at the DAAT or alcohol strategy group level.[679] [680] A number of groups and initiatives were identified:

| |
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| *CRI have a service user group that meets monthly and they are also trying to engage carers.*[681] |
| *Action For Change has an active service user function.*[682] |
| *The Young People's Substance Misuse Service has consulted young people as part of needs assessment, service development, communications and staff recruitment. A service user consultation group meets quarterly.*[683] |
| *There is a user involvement steering group overseen by the DAAT which has an alcohol user on it.*[684] [685] |
| *The DAAT have a good feedback rate from the NTA service user survey and receive better returns from Action For Change than other providers.* [686] |
| *CAMHS has a user group which includes carers and parents.*[687] |
| *The YOT has a service user group which was established six months ago.* |

Carer / significant other involvement in the alcohol field was less well developed.[688] However, Action For Change has appointed a carers' co-ordinator who will be working to develop carers' group attendance and outreach, information and empowerment. [689]

### 7.4 Learning Lessons from Inquiry Processes

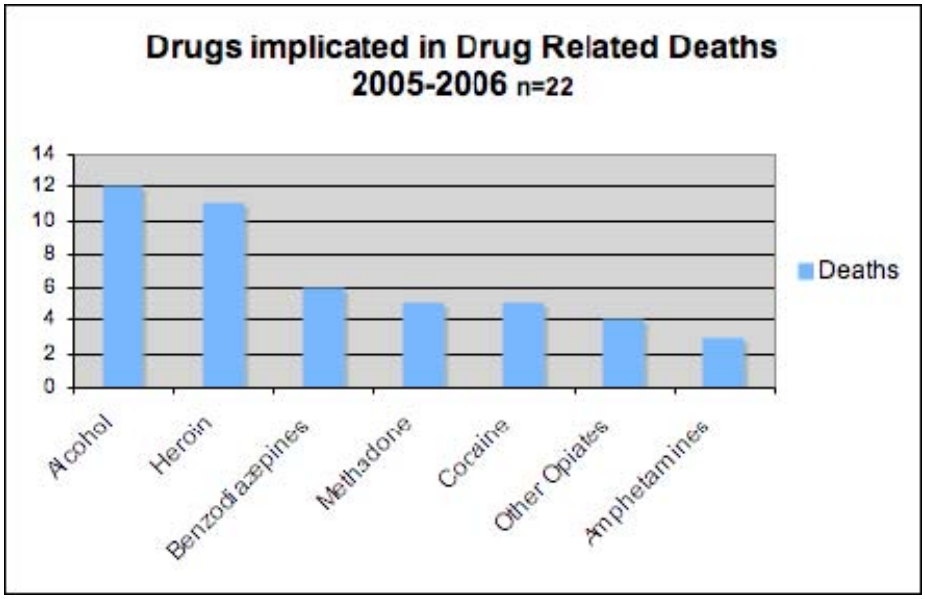
It is important to learn lessons about the adequacy of care for problem drinkers from local critical incidents. A number of acts of violence or self-harm will be subject to inquiry processes e.g.

- Part 8 Child Death Inquiries;
- Internal Serious Untoward Incident (or Critical Incident) Inquiries in mental health services (covering homicides, suicides, violent acts and serious self harm);
- Independent mental health homicide inquiries;
- Police or coroner's investigations;
- Inquiries into homicides which are related to domestic violence.

Many of these may involve significant levels of alcohol misuse as a contributory or causative factor and the reports may highlight specific failings in the local response to problem drinking.[690] [691]

A well-developed drug death review process has been developed in East Sussex. A drug related death steering group meets quarterly to discuss any deaths. This is chaired by the Joint Commissioning Manager. Alcohol does come into this process.[692] The two most recent confidential inquiries into drug related deaths showed that alcohol was implicated. It should be noted that the East Sussex Coroner advises the DAAT of each drug related death but not deaths where only alcohol is implicated in the death. [693]

The report into the Confidential Inquiries in to Drug-Related Deaths that occurred in East Sussex during 2005 and 2006[694] highlighted the following relationship between the identified deaths and different substances used.



Given the salience of alcohol in these figures it is surprising that this issue is not addressed in any form in the whole document, save for one mention in relation to an A&E recommendation from the previous report.[695]

The Trust has a Serious Untoward Incident group which the joint commissioner for Mental Health attends. This post also supervises the substance misuse commissioner which creates a link.[696]

The DAAT should keep the lessons from such inquiry processes under review.

### 7.5 Summary

The overall view of the strategic approach in the county was summarised in a single comment: "There is good partnership working; it is research based and all agencies trying to see what they can do." Good evidence was found of both solid partnership and appropriate strategic frameworks.

While the local structure around alcohol is positive, it is also important to ensure that that structure does not operate in isolation. Alcohol is not routinely referenced in other strategies e.g. older people's strategies.

Some strides have been made to develop user involvement; however, commissioners should consider user and carer / significant other representation on the Alcohol Strategy Group.

A number of local inquiry and review processes offer the chance to learn lessons about the local response to alcohol misuse. These include serious untoward incident inquiries in the Trust and Part 8 inquiries in children's services. Commissioners should ensure that lessons from inquiry processes which relate to alcohol misuse are fed into the treatment and commissioning system.

### 7.6 Recommendations

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| • Commissioners should ensure that alcohol is routinely referenced in all relevant strategies. |
| • Commissioners should consider user and carer / significant other representation on the Alcohol Strategy Group. |
| • Commissioners should ensure carer / significant other involvement in planning and strategic processes. |
| • Commissioners should ensure that lessons from inquiry processes which relate to alcohol misuse are fed into the treatment and commissioning system. |

## Appendix 1 National Extrapolations of Alcohol Related Harm

The consultation draft of the National Treatment Agency's *Models of Care for Alcohol Misusers* (MOCAM) offers a way of assessing the likely number of problem drinkers in an area. According to MOCAM the *ONS general household survey (2001)* identified that[697]:

- Most of the adult population of England are either non-drinkers (12%) or low-risk drinkers (67.1%), who drink within the Department of Health's guidelines and suffer no harmful effects.
- 16.3% of the population (6.4 million) are *hazardous drinkers*, with no apparent problems but taking risks with their longer-term health through regular excessive drinking or intermittent sessions of heavy drinking.
- A further 4.1% (1.6 million) are *harmful drinkers*, who are already experiencing physical, social or psychological ill-effects from their drinking but are not severely dependent.
- Less than 0.4% of the population (about 140,000 men and 20,000 women) are *moderately dependent drinkers* with significant drinking problems.
- Less than 0.1% of the population (less than 20,000 men and 10,000 women) are *severely dependent drinkers* who have a wide range of alcohol-related problems. Some are drinkers with complex problems, such co-existing physical or mental health needs, poly-drug dependence and social problems.

**Appendix 2**

## The XXX Alcohol Strategy Group
## Data Monitoring Strategy

**Aim:** The aim of the Strategy Group is to reduce the harmful impact of alcohol in XXX

**Objective:** To ensure that decisions about how to tackle alcohol related harms are based on accurate data about the local impact of alcohol and the effectiveness of various responses to it.

**Approach:** Data collection on alcohol's impact is at a very early stage of development both locally and nationally. The number of potential measures is huge but at the moment few of these are being gathered and analysed in a consistent and regular way. Therefore, an early task of the Alcohol Strategy Group is to agree a set of indicators which will provide a measure of the impact of alcohol on XXX in a way which allows the Group to measure the effectiveness of the response to it.

**Implementation**
The Alcohol Strategy Group will establish a sub-group to develop an appropriate and robust set of data measures and ensure they are monitored and adjusted as necessary.

**Potential measures:**
A range of measures are offered for consideration across the various strands of the national / local alcohol strategy. This section has identified a mix of existing data *(e.g. NDTMS data)*, data which is readily available but not collected *(e.g. data on reviews)* and data which would require significant development *(e.g. A&E data)*.

**Prevention/ Education**

- The number of schools offering alcohol education as part of PSHE programmes *(annual survey of a selection of schools)*
- Percentage level of adult and young people's awareness of various key indicators such as units and limits. drink/drive law, the availability of help for a problem and the public's rights under the Licensing Act *(annual sample survey)*
- The percentage of a random sample of 50-100 public venues in xxx such as libraries, health centres, A&E units, police stations and pharmacies which display information about alcohol *(annual survey)*

**Treatment**

- The number of treatment places at each tier across xxx *(DAAT data)*
- The take up of treatment places across xxx *(NDTMS data)*
- The diversity of those using treatment places *(NDTMS data)*

**Community Safety**

- The number of offences related to the misuse of alcohol across xxx e.g. the Police measure which is part of the Policing Plan: the number of drug/alcohol related offences in the Night Time Economy
- The number of A&E attendances related to alcohol *(to be developed)*
- The number of licensed premises visited in test purchasing operations and / or the number/percentage of premises where offences were disclosed *(Trading Standards data)*

**Licensing**

- Percentage level of awareness of the public's rights under the Licensing Act **or** Percentage level of public awareness of the Licensing Act *(annual sample survey)*
- The number of reviews sought across the county *(data from licensing authorities)*
- The number of reviews and representations sought by the public across xxx *(data from licensing authorities)*
- The percentage of a random sample of 50 licensed premises in xxx which display educational information about the negative impacts of alcohol, safe units and limits or offer designated driver schemes *(annual sample survey).*
- Measure of the amount of information disseminated by the group to the licensed trade as part of the action plan.
- The percentage of a random sample of 50 licensed premises in the county which have an inappropriate drinks promotion *(annual sample survey).*

## Appendix 3 – Agencies Contacted in the Older People's Research

annmorrissey@ashwoodhome.freeserve.co.uk, Nightnurse83@yahoo.co.uk, sue.ludlow@anchor.org.uk, p.sri@talktalk.net, helenab@chaseleytrust.org, dmcmeekin1@aol.com, claremonthouse@f2s.com, potterde@bupa.com, longworthhouse@tiscali.co.uk, info@berrypomeroy.org.uk, blatchingtonhouse@ahle.co.uk, ocallaja@bupa.com, bannowretirement@hotmail.com, Camelot1@btconnect.com, avalon.nursing@btconnect.com, caroline-house@tiscali.co.uk, natasha@oldhastingshouse.co.uk, maureen@sxhousing.org.uk, emma.ashton@mha.org.uk, Sandhurstcare1@aol.com, lauriston@schealthcare.co.uk, stdominics@asterhealthcare.co.uk, Normanhurst@btinternet.com, dudwell@barchester.com, holycrossnursingunit@tiscali.co.uk, hcpriory@tiscali.co.uk, gill.al-metrami@eastsussex.gov.uk, Marlowehouse@btopenworld.com, info@excelle.co.uk, leolyn@new-meronden.co.uk, holmesdalehouse@v21.me.uk, pillowatrick@aol.co.uk, sabreenelzayat@yahoo.co.uk, jodenney21@hotmail.com, enquiries@warrendrive.com, maureen@sxhousing.org.uk, info@harecombe.fsbusiness.co.uk, care@candlelightcare.co.uk, shareandcareagency@yahoo.co.uk, mariabolton@btconnect.com, info@abacuscarekentsussex.co.uk, care@carecompany.biz, manager@consultuscare.com, calmtime@fsmail.net, care@cooksbridgecare.co.uk, marie@hccltd.fsnet.co.uk, homelife@btopenworld.com, help@live-incomfort.co.uk, info@esf-online.org, chairman@esf-online.org, health@esf-online.org, mooshtikoi@yahoo.co.uk, allyson.kirk@aceastsussex.org.uk, LewesVillagesOutreach@alzheimers.org.uk, stayingput.wealdenlewes@anchor.org.uk, info@esda.org.uk, mail@bbch.co.uk, socialcaredirect@eastsussex.gov.uk, penny@woolgar684.freeserve.co.uk, getwellstaywell@wrvs.org.uk, hoflewes@aol.com, dgreameglen@aol.com, ritawatson@hotmail.com, meridianforum@aol.com, sallybutler6@msn.com, Samantha_Bickerstaff@yahoo.co.uk, ivy@ivywe.eclipse.co.uk, enquiries@nifinaraltd.com, lynn@Inghamhouse.co.uk, tdrnathan@hotmail.com, shormanl@bupa.com, Rob@blackman.force9.co.uk, Paul.Piercy@cumberlandcourt.co.uk, dagmarwilliams@btinternet.com, office@saint-margarets.co.uk, jchinapyel@hotmail.com, enquiries@ashberrycourt.co.uk, maureen@sxhousing.org.uk, trsamy@btinternet.com, Paul.Piercy@cumberlandcourt.co.uk, Malcolm.f.kay@btopenworld.com, l.crisford@nabs.org.uk, parkbeck@regalcarehomes.com, arden@angelhealthcare.co.uk, ashridgehouse@hotmail.com, shobowale@doctors.net.uk, birchholt1@yahoo.co.uk, enquiries@crollgroup.co.uk, northcornercarehome@googlemail.com, info@mullions.co.uk, roclynsresthome@hotmail.co.uk, stg@anh.org.uk, heather.wilson@eastsussex.gov.uk, claydon@caringhomes.org, beechesresthome@aol.com, cresthouse@tiscali.co.uk, stpetersgrange@beeb.net, robert.millen2@btinternet.com, devarajah@tiscali.co.uk, whitegates.kpc@btopenworld.com,

jmiles@angelhealthcare.co.uk, highpat@bupa.com, smcarey@btinternet.com, wealdhall@aol.com, heatherdene01@btconnect.com, hartfieldhouse1@aol.com, lynda.dewhurst@talk21.com, thomcaro@bupa.com, gyan@lineone.net, melvenia.stdavids@hotmail.co.uk, dawn.owasil@tesco.net, fred.bramble@lineone.net, dee@thornburycare.co.uk, sthelens@house124.wanadoo.co.uk, enquiries@glottenhammanorrobertsbridge.co.uk, greenacrecarehome@tesco.net, admin@inglewoodcare.co.uk, office@hardwickhouse.fsbusiness.co.uk, BREEL990@aol.com, enquires@kindcare.co.uk, info@HankhamLodge.com, cdham@hotmail.com, reception@pentlow.co.uk, berirvin@aol.com, graham@qach.fsnet.co.uk, sowerbya@bupa.com, roland@richardson6596.freeserve.co.uk, pl.finn@tesco.net, barbara.clark@peasmarshplace.co.uk, normanhurst@btinternet.com, Shona2@onetel.com, maureen@sxhousing.org.uk, geoffreyrobertclark@yahoo.co.uk, natashaedwards76@msn.com, mountside2@aol.com,

Dear Colleague

I am the senior consultant from Alcohol Concern, the national agency on alcohol misuse, who has been asked to undertake an alcohol needs assessment for the county on behalf of the PCTs, East Sussex DAAT and their partners. A key phase of this process is to seek information from key stakeholders. I am, therefore, writing to ask if you would take the time to answer the four brief questions below about the local impact of alcohol on older people. All information received will be treated in the strictest confidence.

- To what extent is the use of alcohol causing problems for the older clients you work with?
- If there are problems – what kind of problems are you seeing (including problems caused to your clients by other, younger, drinkers?
- In your view are services available to help older people who develop alcohol problems?
- What else should be done to tackle alcohol problems among older people?

If you would like to talk to me directly please let me know.

I look forward to hearing from you and thank you in advance.

Yours

Mike Ward
Senior Consultant
Alcohol Concern
07775 743324

**Appendix 4**
**The Kent Action on Alcohol Steering Group**
**Communication Strategy**

**Aim:** The aim of the KAASG Communication Strategy is to reduce the harmful impact of alcohol in the county of Kent by ensuring that the population of Kent is aware of:

- the Government's guidance on units and limits
- the harmful impact of drink-driving
- the potential harms from hazardous, harmful and dependent drinking
- the sources of help for people experiencing alcohol related harms
- the sources of help for the family members of hazardous, harmful and dependent drinkers
- how reviews and representations can be made under the Licensing Act
- the action being taken to tackle alcohol related harm in the county

**Objectives:**

- To coordinate educational / public awareness activities and the messages that they give to ensure that they have maximum impact.
- To develop an annual programme of educational / public awareness activities which use of a variety of media ranging from the internet and text messaging to newspapers, posters and public events to reach the public.
- To ensure that young people and their families are being targeted with appropriate information.
- To establish an annual county budget to support alcohol communication work with contributions from a range of agencies including the alcohol industry in Kent.

**Approach**

In achieving its aim the KAASG will:

- Ensure that all information is factual and only resorts to "shock tactics" where they are clearly justified.
- Seek constantly for evidence of the effectiveness of its work.
- Attempt to integrate alcohol information into other campaigns such as nutrition advice.
- Work cooperatively with others seeking to use the media to promote health / community safety / licensing messages.
- Wherever possible link local campaigns to national alcohol campaigns in a manner that ensures maximum impact.

**Actions**

1. The KAASG will establish a Communications sub-group which will consider engaging other members who could usefully contribute to this agenda e.g. public health, education or youth work membership.
2. The KAASG will identify a lead officer to take responsibility for chairing the sub-group, reporting back to the main group and taking forward the work of the sub-group.
3. The sub-group will seek to establish a budget for education / public awareness work with contributions from a range of agencies including the alcohol industry.
4. The sub-group will develop an annual timetable of alcohol awareness work to ensure there is no duplication and maximum impact.
5. The sub-group will develop, and agree the use of, a common logo / style for local alcohol awareness materials to ensure the benefits of repeated public recognition.
6. The sub-group will ensure that there are two high profile public alcohol education / awareness campaigns each year.
7. The sub-group will ensure that the websites of all public bodies consider containing links to relevant alcohol education materials or materials themselves.
8. The sub-group will ensure that there is a quarterly press release to the local media on an aspect of the impact of alcohol in Kent or the response to alcohol related harm.
9. The sub-group will review the available alcohol awareness materials being used in the county and make recommendations for the development of a consistent approach, covering the full range of issues and with the maximum impact.
10. The sub-group will ensure that alongside crime and health messages, the public is made aware of how reviews on Licensed premises are made under the Licensing Act.
11. The sub-group will use some of its funding to encourage the development of new approaches to raising alcohol awareness
12. The sub-group will develop an approach to the evaluation of the impact of public education / awareness materials e.g. levels of awareness of units and limits.

**Outcome Measures**

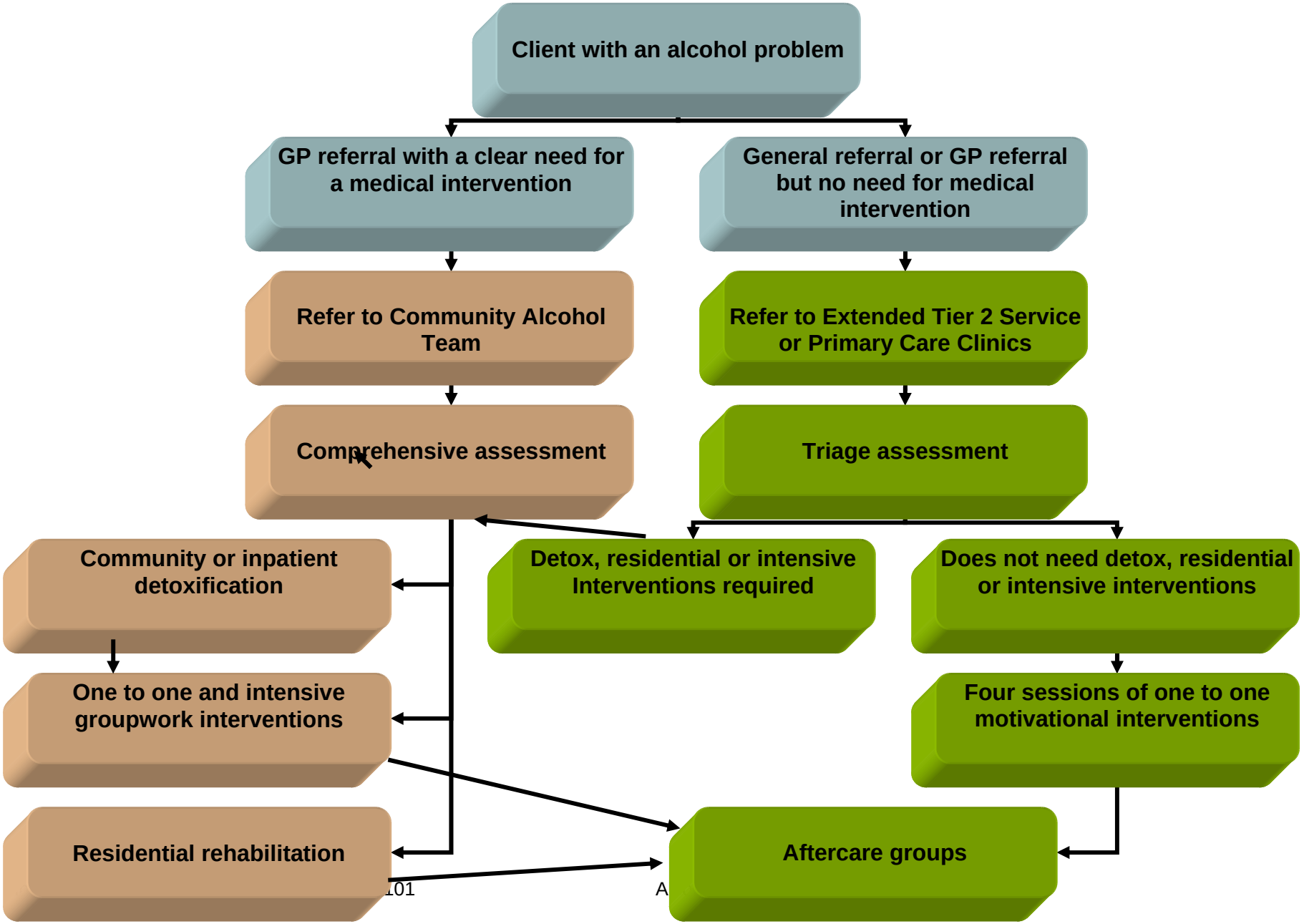
The education and public awareness work will need outcome measures. These will be couched in terms of percentage level of public awareness of various key indicators such as:

- Units and limits
- Drink/drive law
- The availability of help for a problem
- The public's understanding of the Licensing Act

The KAASG could ask an independent agent to visit 50-100 public venues in the county such as libraries, health centres, A&E units, police stations and pharmacies and see how many display information about alcohol.

Baselines and methods of gathering the data will need to be developed by the sub-group and be included in the KAASG's data monitoring strategy.

## Appendix 5 – Care Pathway for Proposed Service


Client with an alcohol problem
GP referral with a clear need for a medical intervention
General referral or GP referral but no need for medical intervention
Refer to Community Alcohol Team
Refer to Extended Tier 2 Service or Primary Care Clinics
Comprehensive assessment
Triage assessment
Community or inpatient detoxification
Detox, residential or intensive Interventions required
Does not need detox, residential or intensive interventions
One to one and intensive groupwork interventions
Four sessions of one to one motivational interventions
Residential rehabilitation
Aftercare groups

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[392]Interviewee 7
[393] Interviewee 14
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[395] Interviewee 24
[396] Interviewee 16
[397] Interviewee 3
[398] Interviewee 3
[399] Interviewee 3
[400] Interviewee 25
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[402] Eastbourne Licensing Policy 2008-11
[403] Lewes Licensing Policy 2008-11
[404] Rother Licensing Policy 2008-11
[405] Interviewee 12
[406] Interviewee 21
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[415] Interviewee 21
[416] Hastings Licensing Policy 2008-11
[417]Interviewee 7
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[424] Alcohol Harm Reduction Strategy for England – Cabinet Office – 2004 – p.51
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[426] Interviewee 14
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[447] Interviewee 24

[448] Interviewee 16
[449] Interviewee 6
[450] Interviewee 14
[451] Interviewee 13
[452] Interviewee 24
[453] Interviewee 16
[454] Interviewee 3
[455] DCMS Guidance to the Licensing Act 2003
[456] See for example South Tyneside Borough Council
[457] Hastings Licensing Policy 2008-11
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[467] National Treatment Agency – Models of Care for Alcohol Misusers – Department of Health - 2006
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[470] Mulvihill C. et al - Prevention and reduction of alcohol misuse - Evidence briefing - Health Development Agency - 2nd edition, March 2005
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The Statement of Financial Entitlements (Amendment) Directions 2009 has been published, enabling the introduction of payment mechanisms for the new five clinical directed enhanced services including the alcohol DES (see section 7H). It:..... requires each PCT to establish (if it had not already done so), operate and, as appropriate, revise an Alcohol Related Risk Reduction Scheme for its area. ..... As part of its Alcohol Related Risk Reduction Scheme, a PCT must offer to each contractor in its area the opportunity to enter into arrangements in respect of the period up to and including 31st March 2010, thereby affording the contractor a reasonable opportunity to participate in the Scheme during that period. However, before entering into any such arrangements, the PCT must satisfy itself of the matters set out in direction 3(2)(a) and (b) of the DES Directions [basically the contractor needs to be equipped ie trained to do it properly].

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[481] East Sussex Commissioning Strategy for Adult Alcohol Misuse 2008/11
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[487] Interviewee 7
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[492] Interviewee 21
[493] Interviewee 21
[494] Interviewee 44
[495] Interviewee 4
[496] Interviewee 2
[497] Interviewee 11
[498] Interviewee 2
[499] Sussex Partnership NHS Trust - Policy on the Management of people with a Dual Diagnosis of Mental Health and Substance Misuse -
[500] Interviewee 1
[501] Interviewee 5
[502] Interviewee 5
[503] Interviewee 2
[504] Interviewee 2
[505] Interviewee 5
[506] Interviewee 18
[507] Interviewee 2
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[509] Interviewee 2
[510] Interviewee 52
[511] Interviewee 7
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[514] Interviewee 2
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[517] National Treatment Agency – Models of Care for Alcohol Misusers – 2006
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[567]Interviewee 1
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[581] East Sussex Commissioning Strategy for Adult Alcohol Misuse 2008/11
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[583] Sussex Partnership NHS Trust - Policy on the Management of people with a Dual Diagnosis of Mental Health and Substance Misuse -
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[590] Interviewee 2
[591] Interviewee 57
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[593] Interviewee 4
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[601] Interviewee 5

[602] Interviewee 56
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[682] Interviewee 5
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