NHS
Bedfordshire

An Alcohol Strategy for Central Bedfordshire

2008-2011

6/01/2009

EXECUTIVE SUMMARY

1.1 National Context of the Alcohol Strategy for Central Bedfordshire

Alcohol plays an important and positive role in many aspects of British life. 90% of the adult population drink alcohol and for most of us its use is associated positively with our personal and social lives. However for a minority of drinkers the misuse of alcohol produces significant harm, impacting the individual, the family and the community.

HM Government's alcohol strategy "Safe Sensible Social" – June 2007 outlines 3 key delivery themes to address the misuse of alcohol. These are:

"First, we need to ensure that the laws and licensing powers we have introduced to tackle alcohol-fuelled crime and disorder, protect young people and bear down on irresponsibly managed premises are being used widely and effectively.

Secondly, we must sharpen our focus on the minority of drinkers who cause or experience the most harm to themselves, their communities and their families. These are:

• young people under 18 who drink alcohol, many of whom we now know are drinking more than their counterparts did a decade ago; and
• 18–24-year-old binge drinkers, a minority of whom are responsible for the majority of alcohol-related crime and disorder in the night-time economy;
• harmful drinkers, many of whom don't realise that their drinking patterns damage their physical and mental health and may be causing substantial harm to others.

Finally, we all need to work together to shape an environment that actively promotes sensible drinking, through investment in better information and communications, and by drawing on the skills and commitment of all those already working together to reduce the harm alcohol can cause, including the police, local authorities, prison and probation staff, the NHS, voluntary organisations, the alcohol industry, the wider business community, the media and, of course, local communities themselves."

1.2 Central Bedfordshire's Alcohol Strategy – Strategic Aims and Objectives

In seeking to reduce the harmful effects of alcohol misuse in Central Bedfordshire, the Central Bedfordshire Alcohol Strategy has adopted the key elements of the National Strategy. Central Bedfordshire's Alcohol Strategy will address the reduction of alcohol related harm via 3 blocks.

1. Children and Young People
2. Health
3. Community Safety

Each of these three blocks has a set of **overarching aims**, a set of **operational objectives** and related targets.

1.2.2. Strategic Aims and Objectives: Children's and Young People

Strategic Aims: 1. Reduce the number of Young People using Substances
Strategic Objectives: 1. To improve the quality and quantity of alcohol education in schools and colleges 2. To develop our approach to providing family focused services 3. To challenge and change the idea that drunken anti-social behaviour is acceptable or normal 4. To work with the industry to restrict the availability of alcohol 5. To continue to improve the quality of targeted and specialist treatment services
These strategic aims and objectives are linked to the following targets: PSA 25: Reduce the harm caused by Alcohol and Drugs PSA 14: Increase the number of children and young people on the path to success (including the proportion using substances)

Further information on this block is given in section 4.

1.2.3. Strategic Aims and Objectives: Health

Strategic Aims:

1. Effective prevention of alcohol misuse
2. Effective interventions to rehabilitate and minimise harm to those who misuse alcohol

Strategic Objectives:

1. Effective Prevention of alcohol misuse, including:
    - Working through community projects, schools and higher education establishments
    - Working with alcohol retailers
    - Sharing data to identify localities where alcohol-related harm is occurring
2. Effective interventions to rehabilitate and minimise harm to those who misuse alcohol, which should:
    - Be facilitated by a lead commissioner for alcohol, be well publicised and be included in a directory which has mandatory updates
    - Are tailored towards the MoCAM framework (Tiers 1 to 4) with clear referral pathways between each Tiers and agreed methods of assessment which tier is appropriate for each individual.
    - Develop the local set of priorities identified for each of four tiers
        - Tier 1 Includes brief interventions
        - Tier 2: Includes open access alcohol-specific facilities
        - Tier 3: Community-based, structured, care-planned alcohol treatment.
        - Tier 4: Alcohol specialist inpatient treatment and residential rehabilitation
    - Provide support to families and other significant others (including employers) of those affected

These strategic aims and objectives are linked to the following targets:

- NI 120: To reduce all-age all-cause mortality
- PSA 25: Reduce the harm caused by Alcohol and Drugs

Further information on this block is provided in section 5.

1.2.4. Strategic Aims and Objectives: Community Safety

Strategic Aims: 1. To reduce the levels of alcohol related violent crime 2. To reduce the percentage of the public who perceive drunk and rowdy behaviour to be a problem in their area
Strategic objectives: 1. To challenge and change the idea that drunken anti-social behaviour is acceptable or normal; 2. Increase the harm reduction opportunities for those arrested 3. To vigorously implement and action measures to reduce alcohol related crime and disorder 4. To target support to those most at risk of harm including the family harms that are associated with alcohol misuse through domestic violence and child abuse to reduce repeat incidents 5. To ensure that business and industry reinforce responsible drinking messages
These strategic aims and objectives are linked to the following targets: NI 30: Re-offending rate of prolific and other priority offenders NI 32: Repeat incidents of domestic violence PSA 23, Priority Action 1: Reduce the most serious violence, including tackling serious sexual offences and domestic violence PSA 25: Reduce the harm caused by Alcohol and Drugs

Further information on this block is given in Section 6.

1.3 Strategic Framework for Implementing the Strategy

Central Bedfordshire's Alcohol Strategy (2008-2011) will be delivered by an Alcohol Strategy Steering Group. The Alcohol Strategy Steering Group will be the coordinating reference group between the different agencies.

Central Bedfordshire's Alcohol Strategy will link to and support other partnership strategies in the local area including the Children and Young People's Plan and supporting annual drugs and alcohol plan.

1.4 Links to Sustainable Community Strategy

An Alcohol Strategy for Central Bedfordshire will ensure that alcohol harm is included in the highest level of priorities for the new areas of the Sustainable Community Strategy and the Local Area Agreement. Four out of the five themes in Bedfordshire's Local Area Agreement 2008-2011 include responsibility for specific elements of the Alcohol Strategy.

Growing our economy:

- To reduce alcohol-related unemployment
- To increase productivity
- To deliver a balanced Night Time Economy

Delivering good health and well-being:

- To reduce alcohol-related accidents and hospital admissions
- To promote sensible drinking

Raising the aspirations of our children and young people:

- To safeguard children from alcohol-related harm

Building cohesive, strong and safe communities:

- To reduce alcohol-related crime and antisocial behaviour
- To reduce the percentage of the public who perceive drunk and rowdy behaviour to be a problem in their area

The Alcohol Strategy for Central Bedfordshire will also contribute to the following targets in the Local Area Agreement 2008-2011:

NI120	All-age all cause mortality rates
NI 115	Substance misuse by young people
NI16	Serious acquisitive crime rate
NI30	Reoffending rate of prolific and other priority offenders
NI32	Repeat incidents of domestic violence

1.5 Implementation planning

Every year action plans will be developed to ensure that the strategy is successfully implemented. The following sections are the Action Plans for Children and Young People, Health and Community Safety relating to 2008-2009.

1.5.1 ACTION PLAN FOR CHILDREN AND YOUNG PEOPLE

Activity	Outputs and outcomes to be achieved	Lead partner	Resources	Deliverable date	Progress check
Concern that current education on alcohol may not be meeting needs of children in our schools	Conclude PHSE Audit and based on provisional findings instigate an urgent review of alcohol education in middle and upper schools.				
Parents are not fully conversant of the dangers to their children of alcohol consumption	Parents with children in middle and upper schools to be targeted about the danger of alcohol for their children				
Many parents are perceived as not taking responsibility for their children	Link to local parenting stakeholder groups. Monitor implementation of local parenting strategy and feedback progress to alcohol strategy groups				

Many young people drift into alcohol abuse because of boredom	To help young people to be channelled into activities which are of interest and relevant to them, and which will prevent disaffected young people from drinking alcohol				
An early intervention system for victims of domestic violence needed to ensure repeat incidents are quickly identified	Children at risk from repeat incidents of domestic abuse are identified quickly, and prevented from further abuse				
Preventing the sale of alcohol to those under the age of 18 and proxy sales	Further implementation of initiatives such as the one undertaken with Tesco in Flitwick which targets the sale of alcohol to under age drinkers and proxy sales				

1.5.2 ACTION PLAN FOR HEALTH

Activity	Outputs and outcomes to be achieved	Lead partner	Resources	Deliverable date	Progress check
Evaluation of community interventions to prevent alcohol misuse	Short report to be returned from each intervention including verifiable data on numbers of clients reached and resulting changes in attitudes and drinking behaviour				
Sharing data from A&E on the locations of alcohol-related incidents with police	Memorandum of understanding between A&E and police				
Updating information and links on Central Bedfordshire Borough Council and NHS Bedfordshire website and a directory of alcohol-related services	Page for alcohol-related information and links that is easily and intuititively navigable from the websites' homepage, providers obliged to inform commissioning organisations of any change in contact details within one week				

Appointing a lead commissioner for alcohol misuse services	In the first instance an agreed job description and lines of reporting				
Agreement on a screening tool for alcohol misuse (Tier 1 and above)	Providers to report aggregate de-duplicated statistics on the numbers with hazardous (or worse) scores amongst those screened				
Tier 1 interventions to be available to all in Bedford	Providers to report aggregate de-duplicated statistics on those given brief interventions				
Provision of Tier 2 outreach services or open access facilities to all areas currently not covered	Providers to report aggregate de-duplicated statistics on numbers seen including number of homeless people				
Ensuring black and ethnic minority services are not disadvantaged by current service arrangement	Providers mandated to report back on presence or absence of difficulties in reaching BME groups				
Referral of all appropriate cases into tier 3	Clear referral pathway for access to tier 3 facilities, aggregrate statistics on the numbers referred to tier 3.				

Increasing links to services for mental health and misuse of other drugs for appropriate clients	Referral pathways to be regularly refreshed (if the same as previous year, written confirmation from provider)				
Individual care plans for clients accessing tier 3.	Providers to show evidence to commissioners (eg anonymised case studies or proformas)				
Referral of all appropriate cases to Tier 4	Clear referral pathway for access to tier 4 facilities, aggregrate statistics on the numbers referred to tier 4				
Evaluation of tier 4 interventions (care)	Providers to provide verifiable data on numbers accessing residential treatment, and outcomes				
Evaluation of tier 4 outcomes (setting and aftercare)	Collated feedback from service users				
Tackling the links between alcohol misuse and the workplace	Providers to collate examples of successful return to employment as examples of successful practice				

Provision of support for under 10s who have household members affected by alcohol misuse	Providers to collect data on proportion and numbers of alcohol misusers with a household member under 10 in the first instance				

1.5.3 ACTION PLAN FOR COMMUNITY SAFETY

Activity	Outputs and outcomes to be achieved	Lead partner	Resources	Deliverable date	Progress check
Current initiatives aimed at tackling anti-social behaviour and alcohol consumption to be continued, and extended	More engagement needed with larger pub and restaurant chains at a corporate level so that they can contribute to reducing levels of alcohol abuse, underage drinking and anti-social behaviour				
More awareness raising needed of the dangers of alcohol abuse	To increase awareness raising amongst drinkers of the consequences of anti-social behaviour associated with alcohol, and the consequences should they choose to indulge in anti-social behavour				
A message about the dangers of alcohol abuse which also includes BME groups will ensure that the needs of these groups are met	To ensure “hard to reach” groups are included in publicity on alcohol abuse				
To help young people to be channelled into activities which are of	The provision of alternative venues for young people to stop them drinking alcohol because they feel				

interest and relevant to them, and which will prevent disaffected young people from drinking alcohol	there is little else to do				
An early intervention system for victims of domestic violence to ensure repeat incidents are quickly identified	To protect children and young people from repeat incidents of domestic violence				
"Safer Clubbing" scheme will combat street noise, and reduce the fear of crime within the wider community, as will the extension of the Safer Neighbourhood Teams	To reduce the fear of crime within the community				

INFORMATION SUPPORTING THE ALCOHOL STRATEGY

2. ALCOHOL-RELATED HARM: DEFINING THE PROBLEM

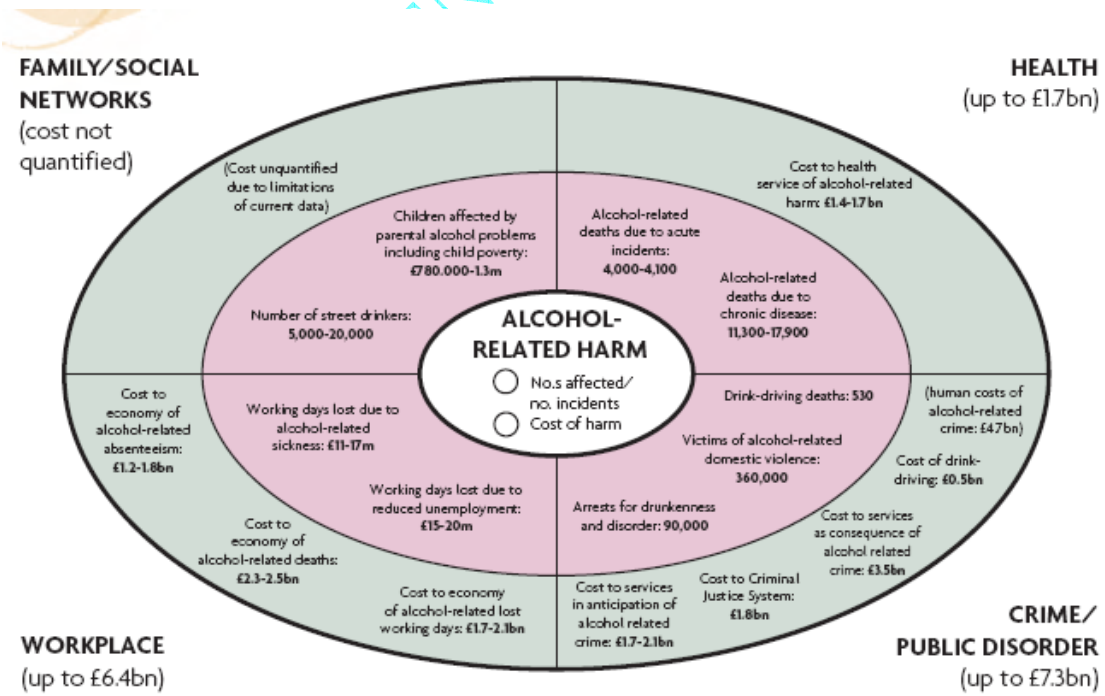
2.1 The Impact of Alcohol Related Harm in England

The following headlines, taken from the Alcohol Harm Reduction Strategy for England (2004) illustrate the nature and range and the impact of alcohol nationally:

• 1.2m violent incidents
• 360,000 incidents of domestic violence (around a third) which are linked to alcohol misuse;
• increased anti social behaviour and fear of crime – (61% of the population perceive alcohol-related violence as worsening);
• over 30,000 hospital admissions for alcohol dependence syndrome;
• up to 22,000 premature deaths per annum;
• at peak times, up to 70% of all admissions to accident and emergency departments;
• up to 1,000 suicides per year including accidental overdose;
• up to 17million working days lost through alcohol related absence;
• between 780,000 and 1.3m children affected by parental alcohol problems; and
• increased divorce - marriages where there are alcohol problems are twice as likely to end in divorce.

The Cabinet Office strategy unit analysis showed that in 2004 the cost of alcohol related harm was around £20 billion per year[1] The figure below is taken from the Alcohol Harm Reduction Strategy for England (2004) and details the breakdown of the cost of the misuse of alcohol:

Fig 1



[1] Rannia L, Costs of Alcohol Miuse, 2004, Cabinet Office

However over 1 million people are employed in hotels, pubs, bars, nightclubs in the UK. Furthermore the development of the evening economy, driven by the alcohol leisure industry, has supported a revival of many town and city centres across the country.

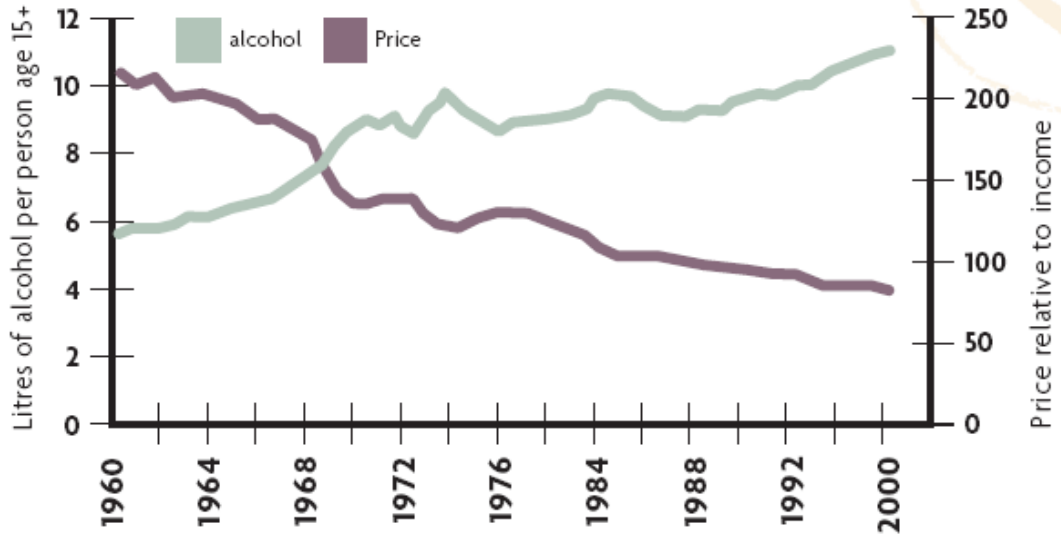
2.2 Factors Contributing to the Increase in Harm in England

The rise in alcohol related harm is a complex matter, influenced by an embedded relationship that exists in British society towards excessive drinking. There are three factors which have contributed to the increase in problematic harm now evident in our communities.

a) **Growth in availability**

The number of premises licensed to sell alcohol has grown significantly over the last 20 years. The growth in "On licensed" premises grew by 21% between 1980 and 2004 and 27% in "Off licensed" premises (IAS 2006). Increased availability promotes greater competition and there has been much greater promotional activity leading to price cutting to attract custom. While the price of alcohol generally increased by 24% during the period 1980-2003 the level of disposable income increased by 91% during the same period. This made alcohol 54% more affordable in 2003 than in 1980. The table below illustrates the changes in consumption compared to the level of the price of alcohol relative to include for the period 1960-2002.[2]

Fig 2



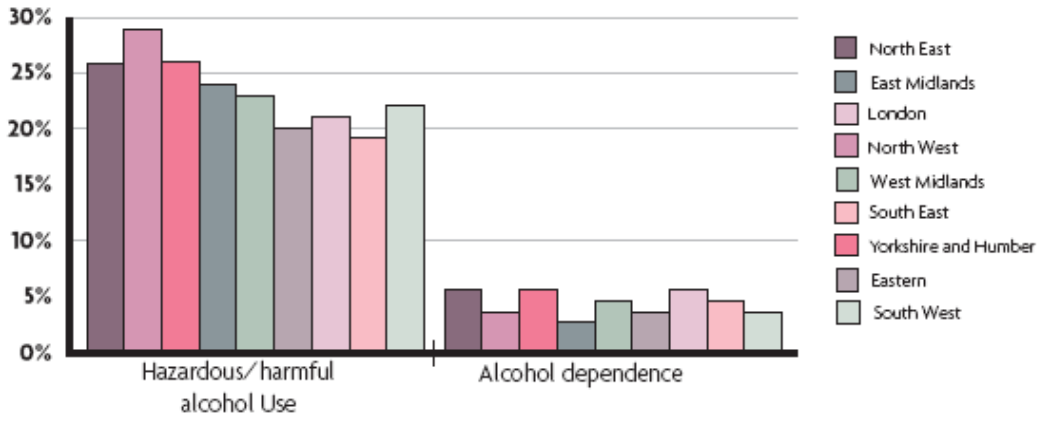
b) **Growth in alcohol consumption**

The national picture shows that the alcohol consumption doubled in the period 1960-2002. The Alcohol Needs Assessment Research Project (ANARP 2004) revealed that consumption at hazardous/harmful levels for adults in the East of England was

[2] Tighe, Consumption of Alcohol in the United Kingdom, 2003, Academy of Medical Sciences

below the national average (23%) at 18%, whilst the numbers of adults with alcohol dependence for the East of England is around 4%

Fig 3



c) Confusion over Units

In England, 90% of people drink alcohol, and most people have heard of units of alcohol and the sensible drinking messages. However, most people do not keep a check on the number of units they drink and may be drinking more than they think they are. *(Safe Sensible Social HM Government 2007)*

Many people have a limited understanding of the effects of alcohol, the hard excessive drinking can have on physical and mental health and what a unit of alcohol means and the relationship between units and glass sizes and the strength of different drinks. This leads to potential harm through lack of knowledge. The development of clear and accessible information about alcohol is crucial in establishing an informed and sensible drinking culture.

Surveys of public opinion in England and the UK as a whole suggest that alcohol is a major cause of concern. Typical findings of surveys including the following:

- Seven in 10 people think the UK would be a “healthier and better place to live” if the amount of alcohol consumed was reduced
- Most people perceive alcohol (78% of people) and tobacco (60%) to be more damaging to health than illegal drugs
- Most people (80% think that more should be done to tackle the level of alcohol abuse in society

3. DEMOGRAPHY OF CENTRAL BEDFORDSHIRE

At the time of writing this report, Central Bedfordshire comprises two local authorities, Mid Bedfordshire District Council and South Bedfordshire Bedfordshire District Council, which will become a unitary authority, Central Bedfordshire, on 1 April 2009.

For ease of reference, all demographic data that follows is currently split between South Bedfordshire and Mid Bedfordshire.

According to the 2001 Census figures, South Bedfordshire has a population of 112,637.[3] The area is split into three main towns; Dunstable, Houghton Regis and Leighton Buzzard and there are twenty rural parishes. The population of the towns and rural areas, is as follows:

30% Dunstable
14% Houghton Regis
30% Leighton Buzzard
26% live in the rural areas.

According to the OPNS mid year estimates for 2006, South Bedfordshire's population had increased to 117,000[4], and is projected to increase to 145,600 by 2021[5]. According to the 2001, Census figures, Mid Bedfordshire had a population of 121,024.[6] In 2006, the OPNS mid year estimates put this figure at 132,000[7], and the projected increase in population is set to increase to 143,900 by 2021.[8]

Mid Bedfordshire is predominantly rural, but has a number of larger market towns in Sandy, Biggleswade, Ampthill and Flitwick.

Indices of Deprivation 2007 for Super Output Areas[9]:

Ward name	2004 IMD	2007 IMD	Change
Parkside (South Beds)	8221	6713	-1508
Manshead (South Beds)	5771	6717	946
Parkside (South Beds)	8350	7549	-801
Tithe Farm (South Beds)	86665	8507	-158
Tithe Farm (South Beds)	10855	9739	-1116
Northfields (South Beds)	10802	10055	-749
Plantation (South Beds)	10353	10055	-298

[3] OPNS, 2001
[4] OPNS mid year estimates 2006
[5] *BCC Population Model, 2007 Provisional Forecast (subject to change).*
[6] OPNS, 2001
[7] OPNS mid year estimates, 2006
[8] *BCC Population Model, 2007 Provisional Forecast (subject to change).*

[9] Office of Public Sector Information (OPSI), 2007

Flitwick East (Mid Beds)	13671	10335	-3336
Sandy Pinnacle (Mid Beds)	11483	10860	-623
Planets (South Beds)	11417	12092	675

People living in areas of deprivation are more likely you are to suffer from health-related behaviours such as alcohol consumption, smoking, sexual health, and obesity. All of these factors contribute to health inequalities.

Both Districts share similar age profiles, with above average numbers of people in the 30 to 59 age category:[10]

Age Group	Mid Bedfordshire	South Bedfordshire	England and Wales
Under 20	25.86	26.48	25.1
20 to 29	10.69	10.52	12.6
30 to 59	45.70	44.24	41.5
60 to 74	11.81	12.65	13.3
75 and over	5.94	5.68	7.6

6.7% of South Bedfordshire's population is non-white, and 2.4% of Mid Bedfordshire's population is non white:[11]

Percentage of resident population in ethnic groups	Mid Bedfordshire	South Bedfordshire	England
White	94.63	93.34	90.9
Of which White Irish	0.95	1.70	1.3
Mixed	0.85	0.89	1.3
Asian or Asian British	0.74	1.02	4.6
Indian	0.52	0.75	2.1
Pakistani	0.08	0.08	1.4

[10] OPNS, 2001
[11] OPNS, 2001

Bangladeshi	0.04	0.02	0.6
Other Asian	0.10	0.17	0.5
Black or Black British	0.34	0.64	2.1
Caribbean	0.18	0.40	1.1
African	0.13	0.19	1
Other Black	0.03	0.05	0.2
Chinese or Other Ethnic Group	0.47	0.41	0.9

Although there is no direct evidence to suggest that any one ethnic group in Central Bedfordshire has a particular problem with alcohol misuse, research does suggest that many people from these communities feel reluctant to approach traditional services because these are often seen as insensitive to their needs. However, a survey into alcohol use by ethnic minority communities was carried out in 2001, by Aquarius for Alcohol Concern, amongst 1684 second or subsequent generation men and women in the Midlands,. It found that there were relatively high levels of drinking amongst black communities, and male Sikhs.[12] It may therefore be useful to ensure that any future community safety or health campaigns on alcohol include ethnic minorities in the target groups.

[12] Alcohol Concern's Factsheet *Alcohol drinking among Black and minority ethnic communities (BME) in the United Kingdom*

4. CHILDREN AND YOUNG PEOPLE

4.1 Strategic Aims, Objectives and Related Targets

Strategic Aims: 1. Reduce the Number of Young People using Substances
Strategic Objectives: **1. To improve the quality and quantity of alcohol education in schools and colleges** **2. To develop our approach to providing family focused services** **3. To challenge and change the idea that drunken anti-social behaviour is acceptable or normal** **4. To work with the industry to restrict the availability of alcohol** **5. To continue to improve the quality of targeted and specialist treatment services**
These strategic aims and objectives are linked to the following targets: PSA 25: Reduce the harm caused by Alcohol and Drugs PSA 14: Increase the number of children and young people on the path to success (including the proportion using substances)

4.2 National Data on Alcohol-Related Harm to Children and Young People

The Government's Alcohol Harm Reduction Strategy for England (Strategy Unit, 2004) states that:

"Young people under the age of 16 are drinking twice as much today as they did ten years ago, and report getting drunk earlier than their European peers. A number of issues surround alcohol misuse by young people, from specific health effects to alcohol-related crime, school exclusion and unsafe sex. As part of a long-term alcohol harm reduction strategy, it is vital that young people are educated to make responsible choices about their drinking behaviour"

Research quoted in the Strategy shows that:

- Prevalence of drinking alcohol in the last week has risen from 21% of 11-15 year olds in 1998 and 1999 to 24% in 2000 and 26% in 2001. Previously prevalence had decreased from 27% in 1996 to 21% in 1998.
- The increase in prevalence of drinking in the last week was more pronounced among 13-15 year olds than among 11-12 year olds
- The average amount drunk by 11-15 year-olds in 1990 was 0.8 units per week, rising to 1.6 units in 1998. Amongst 11-15 year-olds who drink, average consumption rose from 5.3 units in 1990 to 10.4 units in 2000, but fell in 2001 to 9.8 units.
- Among those who drank, boys drank an average of 10.6 units in 2001 compared with 8.9 units drunk by girls.

- Binge drinking is common among young people in the UK, with 56% of 15-16 year-olds having drunk more than five drinks on a single occasion in the last 30 days. 30% of this age group report this behaviour three or more times in the last 30 days

The Health Council of the European Union has expressed concerns about the following aspects of young people's drinking:

- Binge drinking and heavy drinking by young people
- Significant unsupervised alcohol consumption outside the family at an earlier age
- Increasing consumption by young girls
- Trend to consume alcohol with other drugs

A European study of drinking among 15-16 year olds (ESPAD) showed that UK figures for alcohol consumption were some of the highest in Europe alongside Ireland and Denmark:

1. 94% of 15-16 year olds have consumed alcohol at least once, with 47% having drunk alcohol at least 40 times compared to 20% of 15-16 year olds in France and 15% of the age group in Portugal
2. The UK also comes near the top of the list where consumption in the last 30 days is concerned, with 16% of 15-16 year olds in the UK having drunk more than 10 times in the last 30 days[13]

4.3 Youth and Alcohol Action Plan

Government policy on alcohol over the last 10 years has focussed on a number of measures in response to drinking by young people from education to enforcement. However, the Government believes there are five key reasons why more action should be taken on young people and alcohol, and these are:

1. Changes in recent years in how much young people are drinking, where and how they drink, and where they obtain alcohol
2. The negative impact of drinking by young people on short and long term health, and its contribution to crime and anti-social behaviour
3. Growing parental and public concern about teenage drinking
4. The lack of clarity in current law about the age at which alcohol can be purchased, and how much it is sensible to drink
5. No single, co-ordinated government approach to addressing young people's alcohol consumption

The Department of Children Schools and Families, the Home Office and the Department of Health produced a Youth Alcohol Action Plan in June 2008, which has the following five objectives:

Objective 1: Stopping young people drinking in public places

Objective 2: Taking action with industry on young people and alcohol

Objective 3: Developing a national consensus on young people and drinking

[13] Hibell B, 2000 *The 1999 European School Survey Project on Alcoohl and other Drugs* quoted in Alcohol Concern *Young People's Drinking* factsheet, March 2004

Objective 4: Establishing a new partnership with parents

Objective 5: Supporting young people to make sensible decisions

Alcohol related support and treatment provision for children and young people is underpinned by "Every Child Matters Change for Children: Young People and Drugs". This strategy outlines a joint approach between Drug Action Teams and Childrens' Services for the development of universal, targeted and specialist alcohol and drug services for young people. This includes ensuring that alcohol provision is build around the needs of vulnerable young people and that there is a focus on prevention and early intervention with those most at risk.

Objectives 3, 4 and 5 of the Youth Alcohol Action Plan already sit within the Children and Young Peoples Drugs-Alcohol Plan 2008-09, and the main responsibility for the implementation of Priorities 1 and 2 will form part of the Children and Young People's section of the Alcohol Strategy for Central Bedfordshire

4.4 Local Data on Alcohol-Related Harm to Children and Young People

- In a local survey in 2004, carried out by the Directorate of Public Health, 47% of 14-15 year olds in Bedfordshire reported having at least one alcoholic drink in the previous week. In 2006, a similar survey found the percentage of 14-15 year olds in Bedfordshire reporting having at least one alcoholic drink in the previous week had increased to 53%
- The Directorate of Public Health reported in 2007 that "estimates for Bedfordshire suggest that there are locally nearly 1900 young people aged under 19 who are dependent drinkers and over 7,700 drinking at hazardous/harmful levels"[14]

Alcohol related support and treatment provision for children and young people is underpinned by "Every Child Matters Change for Children: Young People and Drugs". This strategy outlines a joint approach between Drug Action Teams and Childrens' Services for the development of universal, targeted and specialist alcohol and drug services for young people. This includes ensuring that alcohol provision is build around the needs of vulnerable young people and that there is a focus on prevention and early intervention with those most at risk.

In Central Bedfordshire, it has been possible to use evidence from local health related behaviour 'Balding' survey (2006) to help estimate the prevalence of alcohol issues amongst young people in Mid and South Bedfordshire. The Balding survey, commissioned for Bedfordshire PCT, focussed on 1137 Year 8 and Year 10 pupils in upper and middle schools in Bedfordshire during the summer term in 2006. It asked pupils a number of health-related questions around nutrition and exercise, as well as use of drugs and alcohol. Pupils were asked about their alcohol use in the 7 days prior to the survey, and in Mid and South Bedfordshire where 531 pupils took part in the survey, the results were as follows:

	Year 8	Year 10
Alcohol use 7 days prior to survey	28%	66%
Any use on	17%	25%

[14] Public Health Report, *Health of Children and Young People in Bedfordshire,* Septermber 2007

one day		
Any use on more than one day	12%	41%
21 or more units consumed	0%	40%

Pre-mixed spirits, spirits and beer were the most popular drinks amongst the Year 10s .

The Balding survey follows on from a similar survey carried out in 2004, where 44% of pupils in Year 8 had at least one alcoholic drink in the week before the survey, but more pupils in Year 10 drank at least one alcoholic drink in the seven days before the survey in 2006 than in 2004. Furthermore, Year 8 and Year 10 pupils in Mid and South Bedfordshire are more likely to have drunk alcohol than their fellow students in the national data.[15]

In addition, the questionnaire from the School Improvement Service to seven upper schools in Bedfordshire[16], provides some useful data about young peoples' attitudes to alcohol, and how they are perceived by their peers: Pupils were asked to comment on the following statements:

- Drinking is never a good thing for anyone at any age.
- Drinking sensibly is ok for adults, but not for students my age.
- Drinking occasionally at my age is ok as long as it does not affect school work or other responsibilities.
- Occasional drinking at my age is ok even if it does affect school work and other responsibilities.
- Regular drinking at my age is ok if that is what the individual wants to do.

The Directorate of Public Health reported in 2007 that "estimates for Bedfordshire suggest that there are locally nearly 1900 young people aged under 19 who are dependent drinkers and over 7,700 drinking at hazardous/harmful levels"[17] This evidence is corroborated by the Eastern Region Public Health Observatory (ERPHO) which shows that people in younger age groups do appear to drink greater amounts of alcohol than any other age groups. Almost 30 per cent of males aged 16 to 24 were reported to drink more than 28 units per week, and 22 per cent of women aged 16 to 24 consumed more than 21 units per week. By means of comparison, the corresponding figures for those aged 75 or over, were 10 per cent of men and four per cent of women; less than a third of the alcohol consumed by their younger counterparts. The findings presented above may indicate that a large number of young people may be 'binge drinking' if they are consuming such large quantities on just one or two nights a week. The 'Am I Bothered?' survey provides some evidence to support that this might be the case. Pupils were asked to report how many

[15] Supporting the Health of Young People in Mid and South Bedfordshire, June 2006
[16] Survey commenced September 07 and is ongoing
[17] Public Health Report, *Health of Children and Young People in Bedfordshire,* Septermber 2007

alcoholic drinks (defined in units) they would consume at a party or social event. The findings presented in Fig. 1 detail the findings for 'yourself', and Fig. 2 presents the findings for perceptions of drinking patterns amongst 'Other students in your year'.

Fig. 1: How many alcoholic drinks do you consume at parties or other social occasions?

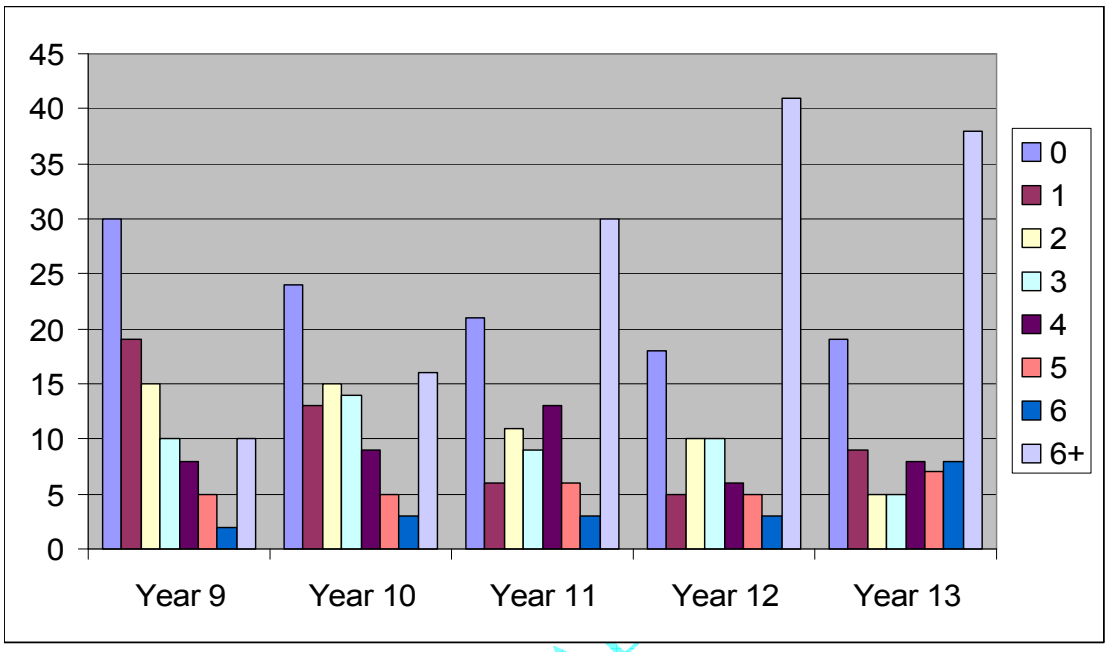
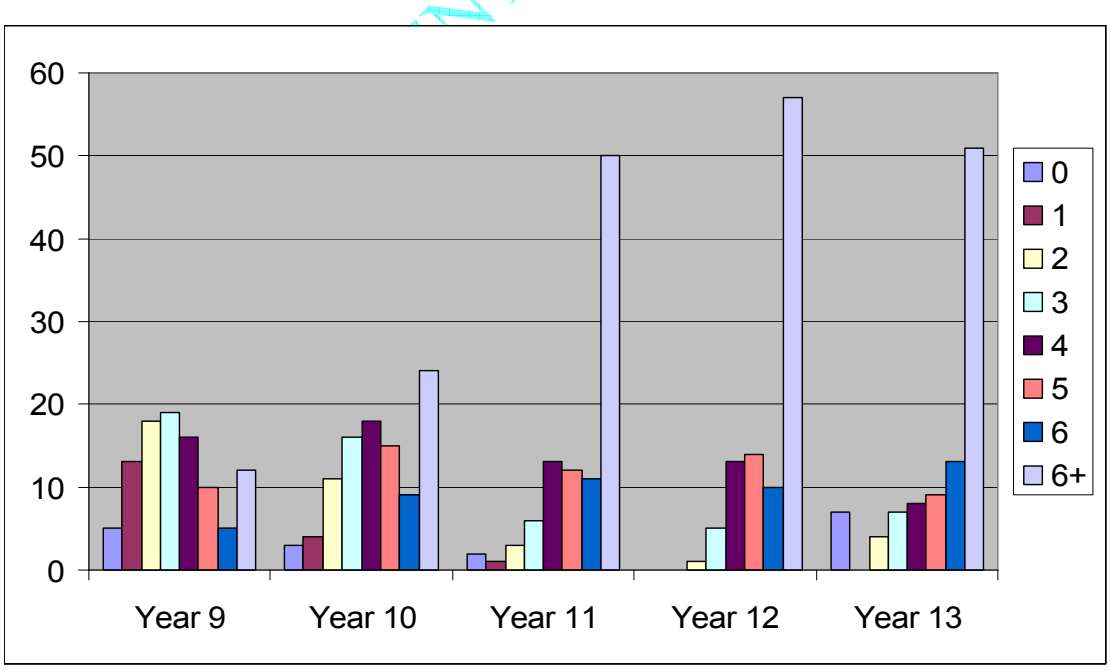


Fig 2: How many alcoholic drinks do you think other students in your year consume at parties or other social occasions?



The *Alcohol Harm Reduction Strategy* quantifies binge drinking as 8 units for men, and 6 units for women, and it is therefore concerning to learn that young people age 17+ regularly consume 6+ units of alchol at social events. "If we apply the average of these percentages to the total number of pupils across Bedfordshire, we can assert

that **there are an estimated 5179 pupils who may be binge drinking** and thereby benefit from universal and targeted services. Some may require alcohol treatment interventions depending on the harmful and hazardous nature of their alcohol consumption."[18]

The survey also reports that four per cent of respondents claimed that they had been hospitalised as a result of alcohol once in the last year, and three per cent more than once. Again applying this percentage to all Year 9 to 13 pupils in Bedfordshire reveals that **943 young people may have been taken to hospital as a result of alcohol, and for a further 706 this may have occurred more than once**.[19] This is likely to suggest a need for alcohol treatment interventions amongst this cohort of young people.

4.5 Anti-social behaviour

Although "young people hanging around" is recorded as a community quality of life concern, this is not a category of anti-social behaviour in itself. Surveys have shown that the public in Bedfordshire continue to perceive that some of the causes of anti-social behaviour directly relate to young people, specifically:

- Teenagers hanging round the streets
- Inadequate provision of activities and facilities for young people
- Parents not taking responsibility for their children

The important issues are:

- How to protect young people from becoming victims of crime and anti-social behaviour by providing safe localities for them to use in their leisure time that do not put them at risk of harm and do not bring them into conflict with other residents
- Reducing the likelihood of young people becoming involved in crime and anti-social behaviour by working with those most at risk
- Reducing the misuse of drugs and alcohol by young people

Alcohol is now a bigger issue than drugs across the county in terms of the night time economy, public order, and binge drinking (see Health section for Binge drinking figures for Bedford). In a scope study of alcohol services in Bedfordshire carried out by Doyle Training and Consultancy in September 2006, data for the county shows that there are 7,768 under 19 year olds drinking at hazardous/harmful levels and 1881 dependent drinkers.

4.6 School

At present 61% of schools in Bedfordshire have reached national healthy schools standard and in Bedfordshire are the fastest improving authority in the region. Schools both deliver drugs/alcohol services as part of science and PSHE and

[18] *Alcohol Needs Assessment,* p. 55 Perpetuity Research & Consultancy International, July 2008

[19] This figure may appear to be high. However, the erpho report 'Alcohol use in the East of England estimates that there were almost 22,500 alcohol related admissions in 2002/3. Indeed, it may well be an underestimation as young people may not attribute an incident such as a fall requiring hospital treatment to alcohol consumption. For a full copy of this report see: http://www.erpho.org.uk/Download/Public/13545/1/erpho%20Risks%20&%20Determinants%206_Alcohol%20use.pdf

drugs/alcohol services can be referred to using Common Assessment Framework processes. 1-2-1 support group works is in middle and upper schools and is targeted in areas with identified drugs/alcohol issues. There is an ongoing baseline PHSE audit of schools and this will help to inform the action plan for next year. Nevertheless, the recent Alcohol Needs Assessment found that there will still cause for concern about the standard of education on alcohol in schools:

"Geographically the findings from the school pilot survey suggest that the patterns of drinking are similar in schools across the county, and although some professionals were aware that alcohol education is delivered and addressed in PSHE and through Healthy Schools, there were some concerns regarding the consistency of these programmes. In the words of one interviewee:

Not all young people will receive alcohol education sessions. All schools will include alcohol in their drug sessions but you don't know how good the quality of the training is.

Some local workers suggested that the key messages that alcohol education should be conveying were not getting through to young people and that by the age of 18 years old; some young people were drinking hazardously and harmfully, yet they were not aware of, or at least did not recognise the dangers of their drinking habits. Data suggests that young people are binge drinking and indeed albeit the minority they are drinking above the adult weekly recommended number of units. This could have significant implications on the health and well-being of young people and requires attention.

Delivering a programme of universal alcohol education in schools was considerably important to a number of local stakeholders who felt that the current delivery of alcohol education was patchy and lacking in capacity. A number of comments were made to suggest that alcohol services did not currently have the capacity to deliver alcohol education in schools. This was seen as a disservice to young people in Bedfordshire.

In light of this, the need for a continuum of alcohol education in schools was announced by one interviewee who made the following remark:

It is okay to have one session with a specialist agency but you have to have availability to do that for Year Nine and Ten, backed up by education by the school and then in Year Eleven.

As well as offering universal alcohol education programmes in schools some professionals insisted that additional targeted work was needed with disaffected young people who were potentially at a higher risk of developing alcohol problems. Young people in temporary accommodation, looked after children and school excludees were reported to be at a higher risk of alcohol misuse in comparison to the general population of young people in Bedfordshire, and therefore these cohorts of children and young people may benefit from more intensive targeted education programmes. It is important to note that there may be additional cohorts of young people at an increased risk of developing alcohol misuse problems in Bedfordshire, those mentioned here are confined to those raised by this sample of local stakeholders.

There was a general understanding and appreciation amongst those consulted that although the willingness to deliver education and prevention programmes was

evident amongst local professionals, the overall lack of funding and capacity limited their ability to put in place a package of comprehensive education and prevention services.

In order to gather information on the level of knowledge of alcohol units amongst alcohol service users, those consulted were asked if they were aware of the recommended weekly alcohol consumption in units/amounts. The majority of respondents were either incorrect or did not know this figure. Clearly there is a need for further work with service users to reinforce the safer drinking message. The recent national campaigns may also be beneficial in raising awareness of the safe drinking limits; however there will be a need for a full evaluation of these advertisements to measure their impact.

Those who commented on the provision of services for young people were concerned about the gap in provision for 16 to 24 year olds. Young people in this age category were reported to neither fit into young people or adult services and this was a concern. The importance of early intervention and prevention for this age group was highlighted.

One professional was of the opinion that the drinking culture amongst young people needed to be challenged using positive activities:

You need to go out and engage with alcohol users, there is a culture among young people; it is more about let's go out and do something positive rather than alcohol. A positive activity is money better spent than hard line education programmes. I have not seen any evidence of successful alcohol programmes"[20]

4.7 Home

The importance of offering alcohol education programmes to parents was also recognised, however parents were regarded as difficult to engage in alcohol education programmes that were often packaged as drug awareness sessions. Some stakeholders believed that there may be benefit in being more creative when developing drug awareness sessions in schools for parents so as not to stigmatise parents who choose to attend. This may potentially be one of the reasons why uptake is currently so low.

"Parents not taking responsibility for their children" is one of the community perceptions of why young people engage in anti-social behaviour, and this was a factor highlighted by the judge in the Robert Barrington Gill case where the judge said:

"There are elements here of parental control or lack of it"[21]

There is evidence to suggest that some parents are unaware of the amount of alcohol their children consume. Many parents are very happy to attend meetings arranged by schools to highlight the problems of drug misuse amongst young people but similar meetings to discuss alcohol abuse do not meet with the same attendance rates. Many parents also seem unconcerned that their children meet at home to consume alcohol before going out.

[20] *Alcohol Needs Assessment,* p.77-78 Perpetuity Research & Consultancy International, July 2008
[21] Bedford Today, 16 September 2008

However, many people express concern at the numbers of unsupervised young people who hang around in areas such as shopping centres, or parks, and engage in anti-social behaviour, much of it alcohol related.

4.8 Taking action with the drinks industry and alcohol:

According to the Balding Survey from 2006,[22]in Mid and South Bedfordshire,. 1% of pupils in Year 8 had bought alcohol from an off-licence that should sell only to over-18s, and this figure had risen to 14% of Year 10 pupils.

Current initiatives in Mid and South Bedfordshire to prevent the sale of alcohol to under age drinkers include:

- Reduction in the supply of alcohol to those under age through Trading Standards/Police enforcement exercises, supported by trader advice;
- Bedfordshire Rural Communities Charity to provide training to village hall committees on drug awareness, licensing laws, vandalism etc.

4.9 Gap Analysis and Areas for Development:

The main gaps that have emerged to date from this section are as follows:

- That there is concern amongst professionals that the current provision of alcohol education around PSHE in schools is not adequate
- That many parents are not engaging in increasing concerns about younger people and their consumption of alcohol
- Many parents are not taking responsibility for the alcohol-related anti-social behaviour of their children
- That many young people engaging in anti-social behaviour, which may be associated with alcohol, come from areas of social deprivation, and will suffer health inequalities. Many of these young people may engage in anti-social behaviour simply out of boredom, and more needs to be done to channel this boredom into more productive activities
- There have been localised initiatives in South and Mid Bedfordshire aimed at off licences where sales to young people have been identified as a problem including work to prevent proxy sales. Further engagement needs to taken with the large pub retailers with regard to combating under age drinkers
- Although there have been successes by both police and trading standards in prosecuting off licence retailers who sell alcohol to under age drinkers, it would prove a useful warning to those retailers who break the law if they were “named and shamed” by local media

Gap analysis	Areas for development
Concern that current education on alcohol may not be meeting needs of children in our schools	Conclude PSHE Audit and based on provisional findings instigate an urgent review of alcohol education in middle and upper schools.
Parents are not fully conversant of the dangers to their children of alcohol consumption	To target parents of children in middle and upper schools in South and Mid Bedfordshire about the need to be more

[22] Supporting the Health of Young People in Mid and South Bedfordshire, June 2006

	aware of the effects of alcohol and offer focused parenting courses (eg. Speakeasy & Drug Proof Your Kids)
Many parents are perceived as not taking responsibility for their children	Link to local parenting stakeholder groups. Monitor implementation of local parenting strategy and feedback progress to alcohol strategy groups
Many young people drift into alcohol abuse because of boredom	Link to IYSS agenda. To develop affordable activities in and around the area aimed at younger people
There have been localised initiatives in South and Mid Bedfordshire aimed at off licences where sales to young people have been identified as a problem including work to prevent proxy sales. This work has been targeted and intelligence and has included close working with large supermarkets and chains who are able to sell alcohol at discount prices.	This tailored response needs to continue where problems are identified alongside active engagement with local stakeholders to develop a sustainable and effective approach across Central Bedfordshire.
Further engagements needs to be taken at a corporate level with the large pub chains	To engage large pub chains at a corporate level with ensure that engagement with local initiatives has the support at the highest level, and is not left to individual pub managers
More high profile successes by police and trading standards who successfully prosecute off licence retailers who sell alcohol to under age drinkers	To “name and shame” off licence retailers in the media

5. **HEALTH**

5.1 Strategic Aims, Objectives and Related Targets

Strategic Aims:

1. Effective Prevention of alcohol misuse
2. Effective interventions to rehabilitate and minimise harm to those who misuse alcohol

Strategic Objectives:

1. Effective prevention of alcohol misuse, including:
    - Working through community projects, schools and higher education establishments
    - Working with alcohol retailers
    - Sharing data to identify localities where alcohol-related harm is occurring

2.Effective interventions to rehabilitate and minimise harm to those who misuse alcohol, which should:

- Be facilitated by a lead commissioner for alcohol, be well publicised and be included in a directory which has mandatory updates
- Are tailored towards the MoCAM framework (Tiers 1 to 4) with clear referral pathways between each Tiers and agreed methods of assessment which tier is appropriate for each individual.
- Develop the local set of priorities identified for each of four tiers
    - Tier 1 Includes brief interventions
    - Tier 2: Includes open access alcohol-specific facilities
    - Tier 3: Community-based, structured, care-planned alcohol treatment.
    - Tier 4: Alcohol specialist inpatient treatment and residential rehabilitation
- Provide support to families and other significant others (including employers) of those affected

These strategic aims and objectives are linked to the following targets:

- NI 120: To reduce all-age all-cause mortality
- PSA 25: Reduce the harm caused by Alcohol and Drugs

5.2 Key Documents Supporting the Health Section of Central Bedfordshire 's Strategy

The Government's *Alcohol Strategy Local Implementation Toolkit* (2008) identifies health as one of the three major blocks that are vital to an alcohol strategy (the other two being community safety and children and young people)[23]. Within the health section, the toolkit recommends that a local alcohol strategy should contain the following elements:

- Increasing awareness of alcohol units, the sensible drinking message, and of the health risks caused by alcohol misuse
- Identifying hazardous and harmful drinkers and providing brief advice
- Providing effective, evidence-based interventions and treatment for harmful and dependent drinkers, at a level of intensity that is appropriate for their individual needs
- Tackling the overlap of alcohol misuse with the misuse of drugs other than alcohol
- Reducing the impact of alcohol misuse in the workplace and examining and tackling the links between alcohol misuse and unemployment
- Collecting and sharing data

Moreover, several extensive literature reviews have recently been completed:

- *Review of the effectiveness of treatment for alcohol problems* (Raistlick D et al, National Treatment Agency, November 2006)
- *Effective and Cost-effective Measures to Reduce Alcohol Use In Scotland*: *An Update to the Literature Review* (Ludbrook A et al, Scottish Executive, January 2005)

In addition:

- The *Alcohol Needs Assessment* (Perpetuity Research, July 2008) was recently carried out for Bedfordshire. Its findings were presented in October 2008 and it identifies a number of local priorities that have arisen from consultation with stakeholders and service users in Bedfordshire.
- *Models of Care of Alcohol Misusers* (MoCAM) was a joint publication produced by the Department of Health and National Treatment Agency in June 2006. The Department of Health recommends that MoCAM be used as a commissioning framework. Nevertheless, there are effective measures that are not explicitly part of the MoCAM framework that also need incorporating into our local strategy.

Each of the above documents uses a slightly different classification system for programmes that aim to prevent and treat alcohol misuse. Central Bedfordshire 's strategy for reducing harm to health merges these documents into a single coherent strategy. For the sake of consistency, this strategy will use MoCAM framework for the treatment section (section 5.4)

[23] What to include in a local alcohol strategy. Alcohol Strategy Implementation Toolkit pp17-25.

5.3 Effective prevention of alcohol misuse

Alcohol Strategy Local Implementation Toolkit recommends that a cross-cutting strategy should aim to increase awareness of alcohol units, the sensible drinking message, and of the health risks caused by alcohol misuse.

The Department of Health recommends that:

- Men should not regularly drink more that 3-4 units of alcohol per day
- Women should not regularly drink more than 2-3 units of alcohol per day
- Pregnant women or women trying to conceive should avoid drinking alcohol. If they do choose to drink, to protect the baby they should not drink more than 1 to 2 units of alcohol once or twice a week.

There is evidence that poor knowledge of units is a factor in the harm from alcohol that is currently seen in Bedfordshire. For example, in the *Alcohol Health Needs Assessment*, only 2 out of 11 service users questioned knew what the recommended number of units was for their gender.

In addition to the results of the local health needs assessment, it is estimated that a significant minority of Bedfordshire adults drink to levels that are 'hazardous' or 'harmful'[24]:

Figure 2.1: Estimates of hazardous and harmful drinkers by current Local Authority				
Local Authority	Drinking to hazardous levels (Men: 22-50 units) (Women: 15-35 units)		Drinking to harmful levels (Men: 50+ units) (Women: 35+ units	
	Number of people (over 16s)	Percentage of over 16s	Number of people (over 16s)	Percentage of over 16s
Bedford	21,466	18%	5,456	5%
Mid Bedfordshire	20,317	20%	3,914	4%
South Bedfordshire	18,051	20%	3,978	4%

Clearly, therefore, there is greater scope for improving knowledge and drinking behaviours within Central Bedfordshire. In 2006, central government re-launched the '*Know Your Limits'* campaign which aimed to reinforce the above the recommendations.

[24] NWPHO from Health Survey for England, Hospital Episode Statistics, Office for National Statistics mid-year population estimates and mortality data and the Census of Population 2001

Changing drinking behaviour however is however a very challenging task. For example, the literature review for the Scottish Executive (it was not part of the NTA review) examined the available evidence on prevention programmes.[25] They found that 'Mass media campaigns had some effect on knowledge and attitudes but little on behaviour'. This supported by other recent literature reviews[26] [27]. A large spend on a campaign 'telling people to drink sensibly' may not be the best use of resources at present because the evidence suggests that it will not cut down on harmful drinking.

The following actions are supported by evidence, and form our local priorities for prevention:

- The Scottish Executive literature review said there was a need for further research into community interventions. They did give a limited number of examples of successful projects. For example, one US project (Project Northland) combined education and community-based intervention targeted at 11-14 year olds. After 3 years, students in the intervention sites had lower rates of alcohol use. Community and educational interventions can therefore form an important part of Central Bedfordshire's drive to tackle alcohol misuse, but these would have to be monitored carefully as published studies have varied in their results.
- Another featured community intervention was the Community Trials Project. In this study the intervention managed to make retail outlets in intervention sites half as likely to sell alcohol to an apparent minor. Part of the action plan is therefore to liaise with retailers to follow this successful example.
- In the 'Cardiff model' the A&E shared data with other agencies on where alcohol-related injuries took place, enabling them to identify hotspots where alcohol-related harm was occurring.
- Material on 'What help is out there' should people run into difficulty should be disseminated. The Department of Health recommends that organisations such as Central Bedfordshire Council and NHS Bedfordshire should make use of health promotion opportunities that arise within schools and healthcare centres (including keeping information on websites updated and refreshed)

[25] Effective and Cost-Effective Measures to Reduce Alcohol Misuse in Scotland: An update to the Literature Review. Ludbrook et al, 2005.
[26] Hill L. Alcohol health promotion via mass media: The evidence on effectiveness. Eurocare Conference, Warsaw 2004
[27] Babor T, Caetano S, Casswell et al. Alcohol: No ordinary commodity. Research and Public Health. Geneva, 2004.

5.4 Effective interventions to rehabilitate and minimise harm to those who misuse alcohol.

5.4.1 Local Data on Alcohol-Related Harm to Health

Regularly drinking more than the recommended number of units over a long period can lead to complications such as:

- Certain types of cancer, especially breast cancer
- Memory loss, brain damage or even dementia
- Increased risk of heart disease and stroke
- Liver disease, such as cirrhosis and liver cancer
- Stomach damage
- Potentially fatal alcohol poisoning

Alcohol often causes deaths at younger ages than many of the other major killers. It is estimated that if all alcohol-attributable deaths in those aged under 75 were prevented, the average life expectancy in Mid Bedfordshire would rise by 5.6 months for men and 2.8 for women. In South Bedfordshire, without alcohol-attributable deaths, the average life expectancy would rise by 10.7 months for men and 1.5 for women.

In total, there were 52 male and 33 female deaths attributable to alcohol in Central Bedfordshire in 2004-2005. According to the UK Statistics Authority, the national alcohol-related death rate has 'almost doubled' since 1991[28].

Alcohol-related illness also has a significant impact on our local services. In 2005/6 there were 1440 admissions attributable to alcohol in Mid Bedfordshire or South Bedfordshire residents. This figure does not include attendances at Accident and Emergency that do not result in an admission to hospital.

5.4.2 Models of Care for Alcohol Misusers

Given the scale of the problem described in the previous section, it is vital that the services provided to Central Bedfordshire residents are supported by evidence of effectiveness and cost-effectiveness. It is also clear that the level of harm caused by alcohol varies between affected individuals. Services must therefore be configured to meet each level of need with an appropriate intensity.

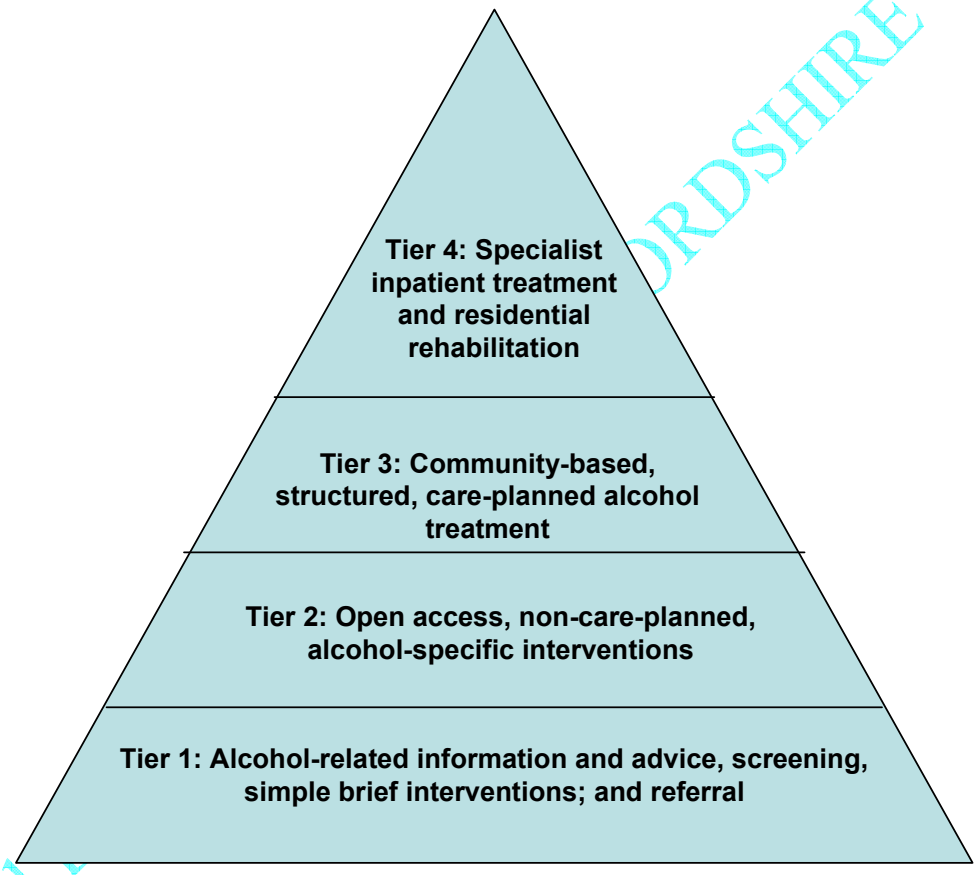
Models of Care for Alcohol Misusers suggests that interventions for alcohol misuse should be classified in four tiers, with Tier 4 being the interventions that should be provided by those most severely affected (see figure 2.1).

It is important to note (and this is emphasised by the Department of Health) that the four tiers refer to the intervention themselves, not the providers. Thus, it is possible that a provider might provide interventions for more than one tier (especially Tiers 2 and 3). Equally, a provider that provides interventions for more than one tier must ensure and demonstrate that the clients are not managed using a tier that is more or less intensive than their individual needs provide.

[28] Alcohol related deaths continue to rise. Office for National Statistics. Published online 25th Jan 2008.

Feedback from members of the East of England Regional Alcohol Steering group have noted that areas that have had most tangible success in tackling alcohol misuse have appointed lead commissioners dedicated to alcohol-related services and this has also been recommended in the Alcohol Needs Assessment. It is also clear from MoCAM that referral between the different tiers of interventions would need to be well coordinated, and to this end there must be a directory of alcohol misuse services that has mandatory updates (when there has been no change to contact details, 'no change')

Figure 2.1: Stepped alcohol treatment as recommended by Models of Care for Alcohol Misuse



5.4.3 Tier 1: Alcohol-related information and advice, screening, simple brief interventions and referral

Evidence from both literature reviews for the National Treatment Agency (NTA) and the Scottish Executive has shown that identifying hazardous and harmful drinkers and giving them brief targeted advice can be effective and cost effective. Some stakeholders who responded to the Alcohol Health Needs Assessment also recommended that a universal screening tool be implemented within Bedfordshire.

At present, there is no data available on how many people in Central Bedfordshire who present with a non-alcohol related problem are screened or alcohol misuse disorders, even in areas where their prevalence may be higher (Accident and Emergency departments, for example).

Several screening tools for alcohol misuse are currently available. The choice of screening tool should be agreed between front-line staff and commissioners to ensure that time and training needs are met. The AUDIT (Alcohol Use Disorders Identification Test) is a tool is recommended by both the NTA and Scottish Executive literature reviews and the World Health Organisation as being effective. In its full form AUDIT has ten questions, but it has the advantage that if the answers to the first three questions do not indicate alcohol misuse the remaining questions can be omitted[29].

It is also worth noting that AUDIT has a scoring system that helps what intensity of intervention might be required, with 8-15 indicating a likely need for brief intervention (as per tier 1), 16-19 extended brief intervention (as per tier 2) and 20+ referral to specialist service (as per tiers 3 and 4). Thus this screening tool may also help alcohol misuse services to place clients in the correct tier, and aggregate data on how many people score within each range can help to refine commissioning arrangements.

Having identified hazardous and harmful drinkers, there is good evidence to suggest that brief interventions are both effective and cost-effective.

The counselling strategy used in brief interventions has been summarised as FRAMES[1]:

- **F**eedback review problems experienced because of alcohol
- **R**esponsibility patient is responsible for change
- **A**dvice advise reduction or abstinence
- **M**enu provide options for changing behaviour
- **E**mpathy use empathic approach
- **S**elf-efficacy encourage optimism about changing behaviour

Both the NTA land Scottish Executive literature reviews found evidence of effectiveness in primary care and accident and emergency settings. They also found the brief intervention to be effective whether given by a nurse or a doctor. Economic modelling was performed, which included the cost of overheads, training, screening, assessment and the brief intervention itself. The authors concluded that the cost per life year saved is in the range £1446-£2628 if no savings in resource use are taken into account. If resource savings (eg by reduced admissions and accident and

[29] Screening and Brief Interventions for Alcohol Problems in Healthcare, 2nd Edition. World Health Organisation

emergency attendances) are considered then the benefits exceed the costs by £21.81 per patient.

In terms of the provision of Tier 1 interventions within Central Bedfordshire the following are local priorities:

- The agreement of an appropriate screening tool
- The introduction of a brief intervention programme where this is not already provided.
- The development of monitoring arrangements, including data collection, to assess the numbers seen by and the impact of brief interventions.

5.4.4 Tier 2: Alcohol-related information and advice, screening, simple brief interventions and referral

MoCAM recommends that Tier 2 interventions include provision of open access facilities and outreach that provide:

- Alcohol-specific information, advice and support
- Extended brief interventions and brief treatment to reduce alcohol-related harm. Extended brief interventions typically take 20–30 minutes to deliver and can involve a small number of repeat sessions (between 3 and 12).
- Alcohol-specific assessment and referral of those requiring more structured alcohol treatment
- Partnership or 'shared care' with staff from Tier 3 and Tier 4 provision,or joint care of individuals attending other services providing Tier 1 interventions
- Mutual aid groups
- Triage assessment, which may be provided as part of locally agreed arrangements.

In terms of the provision of Tier 2 interventions within Central Bedfordshire the following are local priorities:

- The NTA literature review recommends that those who have reached harmful levels of drinking (more than fifty units per week for men, more than thirty-five units for women) should receive brief interventions.
    - According to the *Alcohol Needs Assessment*, there are potentially 5,456 people aged over 16 in Central Bedfordshire who would fall into this category.
    - It is noted that the AUDIT screening tool, which was also recommended in the *Alcohol Needs Assessment*, has a scoring system that would identify clients who were likely to benefit from extended brief intervention.
- In terms of open access and outreach, the NTA literature review did not provide a detailed discussion of whether they were effective or cost-effective. However:
    - In the *Alcohol Needs Assessment* stakeholders fed back that homeless people were a priority for outreach services. It is noted that homeless people with alcohol problems in Central Bedfordshire may not always be apparent as they are accessing services in Luton.
    - Black and ethnic minority groups were felt by stakeholders in *Alcohol Needs Assessment* to be underrepresented amongst service users.

The NTA review recommends 'that mainstream services would necessarily continue to be major providers for ethnic minorities and it was recommended that staff in these agencies be trained in the skills and sensitivity needed to identify and work with all minority groups.' Services provided for those who may misuse alcohol must therefore be culturally competent.

5.4.5 Tier 3: Community-based, structured, care-planned alcohol treatment

According to MoCAM, Tier 3 interventions include:

- Comprehensive substance misuse assessment
- Care planning and review for all those in structured treatment, often with
- Regular keyworking sessions as standard practice
- Community care assessment and case management of alcohol misusers
- A range of evidence-based prescribing interventions, in the context of a package of care, including community-based medically assisted alcohol withdrawal (detoxification) and prescribing interventions to reduce risk of relapse
- A range of structured evidence-based psychosocial therapies and support within a care plan to address alcohol misuse and to address co-existing conditions, such as depression and anxiety, when appropriate
- Structured day programmes and care-planned day care (e.g. interventions targeting specific groups)
- Liaison services, e.g. for acute medical and psychiatric health services (such as pregnancy, mental health or hepatitis services) and social care services (such as child care and housing services and other generic services as appropriate).

Tier 3 interventions are normally delivered in specialised alcohol treatment services with their own premises in the community.

In terms of the provision of Tier 3 interventions within Central Bedfordshire the following are local priorities:

- According to *Alcohol Needs Assessment*, however, 'the perception was that there was a higher level of need for in-patient detox than community detoxes'.
    - The NTA literature review however gave evidence showing non-residential rehabilitation to be effective, and more cost-effective than residential rehabilitation, so Tier 3 community-based planned care of alcohol-misusers still have an important role and Central Bedfordshire Council and NHS Bedfordshire are committed to them.
    - In light of the above perception, there instead needs to be clearer criteria for referral out of tier 3 into residential tier 4 services. One such set of criteria is presented in next section dedicated to tier 4 services.
- The *Alcohol Needs Assessment* recommended that as regards liaison services:
    - 'Additional work to be done on treatment pathways for those with mental health problems'.
    - The *Alcohol Strategy Implementation Toolkit* recommends 'tackling the overlap of alcohol misuse with the misuse of drugs other than alcohol' and this in the *Alcohol Needs Assessment* this was identified as an area that required further development.

- A formal process of service evaluation, including:
    - Ensuring that clients do receive individual care plans
    - Monitoring the numbers of clients who come through tier 3 services

5.4.6 Tier 4: Alcohol specialist inpatient treatment and residential rehabilitation

Tier 4 interventions include:

- Comprehensive substance misuse assessment, including complex cases when appropriate
- Care planning and review for all inpatient and residential structured treatment
- A range of evidence-based prescribing interventions, in the context of a package of care, including medically assisted alcohol withdrawal (detoxification) in inpatient or residential care and prescribing interventions to reduce risk of relapse
- A range of structured evidence-based psychosocial therapies and support to address alcohol misuse
- Provision of information, advice and training and 'shared care' to others delivering Tier 1 and Tier 2 and support for Tier 3 services as appropriate.

The following are priorities for the provision of Tier 4 interventions within Central Bedfordshire :

- The development of clear referral guidelines for referral into tier 4 interventions, given the high level of need that was expressed by those who feed back to the *Alcohol Needs Assessment* The NTA literature review put forward a protocol developed by Melnick *et al* [30] for referring into residential services.
    - Service users with a low-risk pattern of drug use are directed towards non-residential treatment; those with a high-risk pattern enter the next assessment point
    - Service users with more than one year of abstinence in the last four or a drug history of less than four years are referred for non-residential treatment; the remainder go on to the third point
    - Those with high–risk social factors (living arrangements, peer involvement with drugs, criminal behaviour) are recommended for residential treatment; the remainder move on to the last point
    - Those in need of rehabilitation (education, training or work skills insufficient to earn a living) are referred to residential treatment; the remainder are referred to non-residential treatment.
- A regular and formal process of service evaluation for inpatient or residential treatment, which includes:
    - Appropriateness of referrals
    - The care provided
    - The setting in which it is delivered
    - The aftercare thereafter

[30] Melnick, G., De Leon, G., Thomas, G. & Kressel, D. (2001). A client-treatment matching protocol for therapeutic communities. Journal of Substance Abuse Treatment, 21, 119–128.

5.4.7 Provision of support to families and other significant others of those affected

Support to significant others is not a formal part of the four tiers of intervention in MoCAM, but is mentioned in other sources. The following are priorities for development in Central Bedfordshire :

- *Alcohol Strategy Implementation Toolkit* recommends that one element of an alcohol strategy should be 'reducing the impact of alcohol misuse in the work place' and 'examining and tackling the link between alcohol misuse and unemployment'. Many organisations already have existing policy in this regard, and those without one should be encouraged to develop one.
- In addition, the sections on 'Including Family and Friends in Treatment' in the National Treatment Agency Review clearly argue for their involvement, for example in encourage alcohol misusers to engage with treatment.
- The *Alcohol Needs Asssessment* has also identified that children under the age of 10 who have a household member who is suffering from alcohol problems require further support.

6. COMMUNITY SAFETY

6.1 Strategic Aims, Objectives and Related Targets

Strategic Aims:

3. To reduce the levels of alcohol related violent crime
4. To reduce the percentage of the public who perceive drunk and rowday behaviour to be a problem in their area

Strategic objectives:

- to challenge and change the idea that drunken anti-social behaviour is acceptable or normal;
- Increase the harm reduction opportunities for those arrested
- to vigorously implement and action measures to reduce alcohol related crime and disorder
- to target support to those most at risk of harm including the family harms that are associated with alcohol misuse through domestic violence and child abuse to reduce repeat incidents
- to ensure that business and industry reinforce responsible drinking messages

These strategic aims and objectives are linked to the following targets:

NI 30: Re-offiending rate of prolific and other priority offenders
NI 32: Repeat incidents of domestic violence
PSA 23, Priority Action 1: Reduce the most serious violence, including tackling serious sexual offences and domestic violence
PSA 23, Priority Action 3: Tackle the crime, disorder and antisocial behaviour issues of greatest importance in each locality, increasing public confidence in the local agencies involved in dealing with these issues
PSA 25: Reduce the harm caused by Alcohol and Drugs

6.2 Links with Crime and Antisocial Behaviour

6.2.1 Areas of Concern Identified by the 2004 Alcohol Harm Strategy

Drinking is strongly linked to crime, disorder and anti-social behaviour. According to the Alcohol Harm Reduction Strategy for England 2004 (AHRSE) the areas of concern for most people included:

- Alcohol-related disorder and anti-social behaviour in towns and cities at night
- Under-age drinking
- Crime, disorder and anti-social behaviour - often caused by repeat offenders
- Domestic violence
- Drink-driving

6.2.2. Alcohol-related disorder and anti-social behaviour in towns and cities at night

The British Crime Survey found that 47% of violent crime is alcohol related and at peak times over half the admissions to A&E are alcohol related, often as a result of alcohol-related fighting or accidents after closing hours.

People who visit pubs and bars three or more evenings per week are over twice as likely to be the victims of violence, compared to those who rarely visit pubs or bars. Over half of alcohol- related violence between strangers and acquaintances occurs in or around pubs, clubs or discos; 70 per cent of these incidents took place on weekend evenings[31].

6.2.3. Under-age drinking

See Children and Young People section

6.2.4 Crime, disorder and anti-social behaviour

The relationship between alcohol and offending is intricate, and causal relationships between alcohol and offending include offences which occur because the offender has consumed alcohol, typically public disturbance, violence and domestic violence. Contributory relationships include drinking to facilitate an offence (Dutch courage) or used to excuse offending behaviour. Co-existing relationships include acquisitive offences to maintain habit (ie shoplifting for alcohol). In particular alcohol misuse is associated with anti-social behaviour and public disorder, violence, injury, victimisation, domestic violence, sexual assaults and road traffic accidents.

(a) Street Drinking

In 1996 a Mental Health Foundation report said the average street drinker is likely to be *'a white unemployed man aged 35 or older; who is probably homeless and sleeping rough or in temporary accommodation; who may be alcohol dependant, certainly often drunk, and who may also be using controlled drugs; perhaps also suffering from psychiatric disorders.often in poor state of health.at risk of arrest for public drunkenness offences, begging and other minor public order offences, and at risk of being the victim of assault.'* Recently, the picture of the classic street drinker has changed to include a wider diversity of cultural and ethnic backgrounds. For

[31] Strategy Unit, 2003

example, street drinkers are younger and often have serious substance misuse problems.

Though street drinking is often seen as a threat to public safety and appears regularly in surveys around public perception of crime and safety, there is little real evidence to substantiate this. However, the presence of intoxicated, possibly rowdy and unkempt groups of people in public places can foster a sense of a danger for many members of the public - especially the elderly. Street drinkers are not necessarily homeless; they may choose to drink outside for a number of reasons.

(b) Anti-social behaviour

Anti-social behaviour includes a range of problems such as noisy neighbours, vandalism, litter and youth nuisance - all of these have associations with drinking. In 2003, nearly a quarter of people canvassed by the British Crime Survey (22%) perceived a high level of disorder in their local area - an increase from 2001.[32]

6.2.5. Domestic violence

Domestic violence involves any act or threat of physical, emotional, mental, psychological, financial or sexual abuse in the context of a current or past intimate relationship. Unlike other alcohol related crime, it is largely hidden with only a percentage of incidents reported to the police. However, almost one in four women are estimated to have been assaulted by a partner since the age 16. Rates of alcohol misuse are significantly higher among perpetrators than in the general population according to the Strategy Unit's Interim Analytical Report for the national alcohol strategy (2003). The same report gives a figure of 360,000 (around a third) reports of alcohol related domestic violence per year.

There is not just a connection between alcohol and the perpetrators of domestic violence; many victims use alcohol as a form of self-medication, a coping mechanism. Also, perpetrators may use their partners' drunkenness as an excuse for their own aggression.

There is one further area which must be included in the Alcohol Strategy for Central Bedfordshire and this is:

6.2.6. Community safety and the physical environment

The term 'environment' encompasses a range of issues from 'green issues' such as pollution and waste management through land use to 'the built environment' ie housing, businesses etc. It includes open spaces and public spaces, buildings including housing estates and private property, footpaths, public highways, businesses and shops, public transport and public amenities eg toilets, phone boxes. In local surveys, the creation and maintenance of a pleasant, clean environment is generally second only to crime in the list of residents' concerns.

With few exceptions, Local Authorities are responsible for the local environment. Local Authorities aim to create/maintain a safe and clean environment for local residents, which in turn is an important factor in achieving objectives on economic regeneration, crime reduction and a healthy community. Many Local Authorities now

[32] Strategy Unit, 2003

employ street wardens, town centre managers and street population coordinators, particularly in known 'hot spots'.

Alcohol has an effect on many aspects of the local environment, including:

- Consequences of overindulgence in alcohol such as urination and vomiting in public places
- Cans, bottles and other alcohol-related paraphernalia
- Alcohol-related criminal damage (vandalism)

To assess how national concerns about alcohol abuse are shared by people in the Central Bedfordshire area, we need to look at the local situation.

6.3 Local Situation

6.3.1 Alcohol-related disorder and anti-social behaviour in Central Bedfordshire:

Alcohol is a bigger issue than drugs across Central Bedfordshire in terms of the night time economy, public order, binge drinking and the levels of criminal damage and anti-social behaviour. Although both Mid Bedfordshire and South Bedfordshire do not have the attendant problems of the night economy associated with Bedford, there are a number of “hotspots” related to alcohol abuse in both Districts, and measures are being taken through the local Community Safety Partnerships to deal with these:

- The Criminal Damage Working Group in Mid Bedfordshire has Identified hotspots in Flitwick, Biggleswade and Stotfold with problems of anti-social behaviour associated with alcohol, and the group has been working with the police on “Operation Columbus” which has confiscated alcohol from local youths
- Mid Beds Safe – the Mid Bedfordshire Community Safety Partnership has been working with the Beds Safe Anti-Social Behaviour Reduction Co-ordinator
- There are “No Alcohol Designated Zones” in Flitwick, Stotfold, Cranfield, Sandy and Ampthill, and a number of Alcohol Ban areas in South Bedfordshire

Using data provided by Bedfordshire Police, and analysed using GIS to identify alcohol and drug-related crime hotspots from January 2003 to June 2004, the following alcohol-related incidents were recorded:

Town/Village	Number of alcohol related offences
Dunstable	1009
Houghton Regis	242
Leighton Buzzard	402
Linslade	122
Toddington	44

Dunstable’s total represented 52% of the total number of alcohol related offences for South Bedfordshire during the period, followed by Leighton Buzzard with 21% of the total number. In June 2008, a South Beds Safe Co-ordinator was appointed, and has introduced a Pub Safe Scheme in Leighton Buzzard, similar to that in Bedford. A radio link scheme is now a major part of the Pub Safe Scheme, which provides communication between pubs and clubs in Leighton Buzzard about people causing trouble, and who can be prevented from entering other pubs. The BAND scheme, again similar to that in Bedford, now has now been introduced, and 27 pubs and

clubs in Leighton Buzzard are signed up to the Pub Safe Scheme. There is also an ongoing project to promote "safe" travel with licensed taxis and private hire vehicles, as well as how to help licencees identify forged £20 notes. Good liaison with licensees in the Leighton Buzzard means that issues of concern are being identified on a regular basis. Funding permitting, it is hoped that similar schemes can now be introduced into Dunstable.

6.3.2 Crime, Disorder and Antisocial Behaviour in Central Bedfordshire

Alcohol related crime figures, 2005-2006, Mid and South Bedfordshire		
	Mid Bedfordshire	**South Bedfordshire**
All Recorded crime - Number attributable to alcohol	564	946
Recorded crime attributable to alcohol / 1,000 pop	4.44	8.29
Violence against the person - Number attributable to alcohol	327	605
Violent crime attributable to alcohol / 1,000 pop	2.57	4.89
Sexual Offences - Number attributable to alcohol	11	15
Sexual Offences attributable to alcohol / 1,000 pop	0.08	0.13

The all recorded crime figure, attributed to alcohol, is comparatively low compared to that of Bedford during the same period where there were 1400 crimes recorded. However, many people from both South and Mid Bedfordshire do travel by train to Bedford to go to the pubs and clubs in the town. It may well be that a proportion of those crimes can be attributed to people living outside the Bedford area.

Bedfordshire as a whole has a lower level of violent crime that the most similar force (MASF) average. In extreme cases, alcohol related disorder can lead to tragic consequences, as in the Robert Barrington Gill case in December 2007, thrown into the River Ouse in Bedford by two local youths for refusing to give them his bank card and pin number. As he jailed the pair for murder, Judge John Bevan laid responsibility for the tragedy with the pubs and clubs in Bedford, but also with the families:

"There are elements here of parental control or lack of it. The parents and grandparents, according to Luddington and Downes, also plied them with drink and they must have know that these two were liable to be aggressive in drink"

"If premises like that put financial gain ahead of the appalling damage they do to youngsters, in particular Robert Gill, they should have a feeling of shame about the events of Boxing Day in Bedford."[33]

The Bedfordshire Best Value General User Survey 2006/07 indicated that the biggest issue for all Bedfordshire residents was parents not taking responsibility for their children (63%), with people being drunk/rowdy in public places felt to be the most important concern of 26% of local residents. Whilst anti-social behaviour is not always associated with alcohol, it is contributory factor, and leads to the increased fear of crime by the community as a whole. For example, in 2007 the Blue Light Survey analysed 2021 responses from members of the public across Bedfordshire, and identified the following concerns:

	Mid Bedfordshire	South Bedfordshire
Anti-social behaviour type		
	Teenagers hanging around on the streets (23%)	Teenagers hanging around on the streets (25%)
	Speeding vehicles (14.2%)	Noise nuisance (18.1%)
	Vehicle related nuisance (11.9%)	Speeding vehicles (11.2%)
	Noise nuisance (11.7%)	Vehicle related nuisance (9.6%)
	Rubbish or litter lying around (9.4%)	Rubbish or litter lying around (7.8%)

6.3.3. Street drinking in Central Bedfordshire

Street drinkers can be divided into two groups:

- Those individuals who may have a dual alcohol/drugs-related diagnosis, and who are classified as "rough sleepers", and who may choose to drink alcohol in the street
- Those individuals, usually younger people, who congregate in groups and whose drunken and rowdy behaviour is seen as a potential threat to local residents.

In 2006/2007, Bedfordshire Police Anti Social Behaviour incident data recorded 394 incidents of street drinking in Bedfordshire (including Luton). From this total, there were 83 incidents in South Bedfordshire, and 38 in Mid Bedfordshire. Despite having the lowest number of incidents overall, Biggleswade was identified was a particular "hotspot" for incidents of street drinking.

The trend in 2007/2008 for incidents of street drinking recorded 362 incidents in Bedfordshire (including Luton) to September 2008. The majority of incidents occurred in Bedford (137), with Mid Bedfordshire having the least number (26).

[33] Bedford Today, 16 September 2008

Most of the dates where there were high numbers of street drinking incidents took place at the weekend, starting on Friday evening, and throughout Saturday and Sunday. The day of the week trends also confirm high numbers recorded on a Monday or a Tuesday as well. Most incidents occur between 6 pm and 9 pm, and the majority of incidents take place during the warmer months in spring and summer in 2006, and summer and autumn in 2007.

6.3.4. Domestic violence in Central Bedfordshire

Figures for April to September 2007 show that there were 354 incidents of domestic violence in Mid Bedfordshire, and 718 in South Bedfordshire, with 38% and 46% of these being repeat incidents respectively.

Domestic violence impacts on anti-social behaviour, drug and alcohol issues, criminal damage and youth offending, and although data is not available to support these links in Central Bedfordshire, over the last 18 months, the county as a whole has progressed from being a poor performing county with less than minimal service provision for victims and perpetrators of domestic violence, and now meets 10 out of 11 BVPI 225 requirements. The LAA target of increasing the number of incidents to the police has also been exceeded, and with the launch of a local help line, has the potential to reduce repeat incidents of domestic violence. The Independent Domestic Violence Advisor (IDVA) service also has the potential to reduce repeat victimisation as victims are better supported.

6.4. Gap Analysis and Areas for Development in Central Bedfordshire

- Although Mid and South Bedfordshire do not have the problems associated with the night time economy in Bedford town centre, both Community Safety Partnerships are nevertheless wholly committed to tackling alcohol abuse in their areas. It has been difficult to find figures which show the impact these initiatives are having in combating this problem, and it is too early to say what impact the introduction of a Pub Safe Scheme is having on alcohol related crime and disorder in Leighton Buzzard. There are two areas which might be developed here:

    1. Engagement with local agencies, such as the Community Safety Partnerships, by the larger pub retailers at a corporate level, instead of leaving this to pub managers at a local level
    2. A strong message to go out to all those using pubs and clubs in Mid and South Bedfordshire that rowdy and drunken behaviour is not acceptable, and of the consequences drinkers face if they continue to indulge in unacceptable behaviour

- For many people in the community, younger people hanging around with nothing to do only increases fears of intimidation and crime. More needs to be done to encourage young people not to drift into using alcohol and anti-social behaviour. This could be done by providing young people with alternative, meaningful, and alternative activities.
- Ensure that any targeted publicity on alcohol includes ethnic minority groups in Central Bedfordshire
- With regard to domestic violence and alcohol, an early intervention system identified on repeat incidents including the provision of information about how to get violent people into services.

- More “Safer Clubbing” schemes to reduce the incidents of street drinking, and extension of the Safer Neighbourhood Schemes. This will reduce street noise, and reduce the fear of crime within the wider community.

Gap Analysis	Areas for Development
Current initiatives aimed at tackling anti-social behaviour and alcohol consumption to be continued, and extended	More engagement needed with larger pub and restaurant chains at a corporate level so that they can contribute to reducing levels of alcohol abuse, underage drinking and anti-social behaviour
More awareness raising needed of the dangers of alcohol abuse	A strong message from all partners involved in managing the night time economy in Mid and South Bedfordshire to be distributed around pubs and clubs
To ensure "hard to reach" groups are included in publicity on alcohol abuse	A message about the dangers of alcohol abuse which also includes BME groups will ensure that the needs of these groups are met
The provisions of alternative venues for young people to stop them drinking alcohol because they feel there is little else to do	To develop affordable activities in and around alcohol "hotspots" aimed at younger people
An early intervention system for victims of domestic violence to ensure repeat incidents are quickly identified	To protect children from abusive parents
To reduce the fear of crime within the community	Continuation and extension of the Safer Neighbourhood Schemes in Central Bedfordshire

Appendix A: Tiers 1 to 4 as featured in Models of Care for Alcohol Misusers

Tier 1 interventions: alcohol-related information and advice; screening; simple brief interventions; and referral	
Definition	Tier 1 interventions include provision of: identification of hazardous, harmful and dependent drinkers; information on sensible drinking; simple brief interventions to reduce alcohol-related harm; and referral of those with alcohol dependence or harm for more intensive interventions.
Interventions	• Commissioners need to ensure that a range of generic services provide as a minimum the following Tier 1 alcohol interventions: • Alcohol advice and information • Targeted screening and assessment for those drinking in excess of • DH guidelines on sensible drinking and for those who may need alcohol treatment • Provision of simple brief interventions for hazardous and harmful drinkers • Referral of those requiring more than simple brief interventions for specialised alcohol treatment • Partnership or 'shared care' with specialised alcohol treatment services, e.g. To provide specific alcohol treatment interventions within the context of their generic services.
Settings	• Tier 1 interventions can be delivered by a very wide range of agencies and in a range of settings, the main focus of which is not alcohol treatment. For example: Primary healthcare services; acute hospitals, e.g. A&E departments; psychiatric services; social services departments; homelessness services; antenatal clinics; general hospital wards; police settings, e.g. custody cells; probation services; the prison service; education and vocational services; and occupational health services. • Such interventions can also be provided in highly specialist non-alcohol specific residential or inpatient services, which have service users with high levels of alcohol-related morbidity who may require care plans and support to facilitate their access to alcohol-specific provision. Examples include: specialist liver disease units, specialist psychiatric wards, forensic units, residential provision for the homeless, and domestic abuse services.
Competency	This is provision that depends on at least minimal skills in alcohol misuse identification, assessment and interventions. Those delivering Tier 1 provision may require the following competences from the Drugs and Alcohol National Occupational Standards (DANOS): • AA1 Recognise indications of substance misuse and refer individuals • to specialists • AF1 Carry out screening and referral assessment • AH10 Carry out brief interventions with alcohol users • AB2 Support individuals who are substance misusers • AB5 Assess and act upon immediate risk of danger to substance misusers.

Tier 2 interventions: open access, non-care-planned, alcohol-specific interventions	
Definition	Tier 2 interventions include provision of open access facilities and outreach that provide: alcohol-specific advice, information and support; extended brief interventions to help alcohol misusers reduce alcohol-related harm; and assessment and referral of those with more serious alcohol-related problems for care-planned treatment.
Interventions	Tier 2 interventions include open access facilities and outreach targeting alcohol misusers, which provide: • Alcohol-specific information, advice and support • Extended brief interventions and brief treatment to reduce alcohol-related harm • Alcohol-specific assessment and referral of those requiring more structured alcohol treatment • Partnership or 'shared care' with staff from Tier 3 and Tier 4 provision, or joint care of individuals attending other services providing Tier 1 interventions • Mutual aid groups, e.g. Alcoholics Anonymous • Triage assessment, which may be provided as part of locally agreed arrangements.
Settings	Tier 2 provision may be delivered by the following agencies, if they have the necessary competence, and in the following settings: • Specialist alcohol services • Primary healthcare services • Acute hospitals, e.g. A&E and liver units • Psychiatric services • Social services • Domestic abuse agencies • Homelessness services • Antenatal clinics • Probation services and the prison service • Occupational health services.
Competency	Tier 2 interventions require competent alcohol workers who should have basic competences in line with DANOS, including those required for Tier 1. Competency can also depend on what cluster of services is provided. Front-line staff would normally have competence in motivational approaches and brief interventions. Those providing interventions at Tier 2 may require the following competences from DANOS: • AB2 Support individuals who are substance users • AB5 Assess and act upon immediate risk of danger to substance users • AF2 Carry out assessment to identify and prioritise needs • AG1 Plan and agree service responses which meet individuals' • identified needs • AH10 Carry out brief interventions with alcohol users.

Tier 3 interventions: community-based, structured, care-planned alcohol treatment	
Definition	Tier 3 interventions include provision of community-based specialised alcohol misuse assessment, and alcohol treatment that is care co-ordinated and care-planned.
Interventions	Tier 3 interventions include: • Comprehensive substance misuse assessment • Care planning and review for all those in structured treatment, often with regular keyworking sessions as standard practice • Community care assessment and case management of alcohol misusers • A range of evidence-based prescribing interventions, in the context of a package of care, including community-based medically assisted alcohol withdrawal (detoxification) and prescribing interventions to reduce risk of relapse • A range of structured evidence-based psychosocial therapies and support within a care plan to address alcohol misuse and to address co-existing conditions, such as depression and anxiety, when appropriate • Structured day programmes and care-planned day care (e.g. interventions targeting specific groups) • Liaison services, e.g. for acute medical and psychiatric health services (such as pregnancy, mental health or hepatitis services) and social care services (such as child care and housing services and other generic services as appropriate).
Settings	• Tier 3 interventions are normally delivered in specialised alcohol treatment services with their own premises in the community (or sometimes on hospital sites). • Other delivery may be by outreach (peripatetic work in generic services or other agencies, or domiciliary or home visits). • Tier 3 interventions may be delivered alongside Tier 2 interventions. • Some of the Tier 3 work is based in primary care settings (shared care schemes and GP-led prescribing services), but alcohol specialist-led services are required within the local systems for the provision of care for severe or complex needs and to support primary care. • The work in community settings can be delivered by statutory, voluntary or independent services providing care-planned, structured alcohol treatment.
Competency	Tier 3 services require competent drug and alcohol specialised practitioners who should have competences in line with DANOS. The range of competencies required will depend on job specifications and remits. Those delivering Tier 3 interventions may require a wide range of competencies from Key Area A in DANOS and many of the competences from Area AH, depending on the type of alcohol treatment provided. Medical staff (usually addiction psychiatrists and GPs) will require different levels of competence, depending on their role in alcohol treatment systems and the needs of the service user, with each local system requiring a range of doctor competences (from specialist to generalist) in line with joint guidance from the Royal Colleges of General Practitioners and Psychiatrists, *Roles and responsibilities of doctors in the provision of treatment for drug and alcohol misusers*, summarised in the National Treatment Agency for Substance Misuse briefing document *Roles and responsibilities of doctors in the provision of treatment for drug and alcohol misusers*.

Tier 4 interventions: alcohol specialist inpatient treatment and residential rehabilitation	
Definition	Tier 4 interventions include provision of residential, specialised alcohol treatments which are care-planned and co-ordinated to ensure continuity of care and aftercare.
Interventions	Tier 4 interventions include: • Comprehensive substance misuse assessment, including complex cases when appropriate • Care planning and review for all inpatient and residential structured • treatment • A range of evidence-based prescribing interventions, in the context of a package of care, including medically assisted alcohol withdrawal • (detoxification) in inpatient or residential care and prescribing interventions to reduce risk of relapse • A range of structured evidence-based psychosocial therapies and support to address alcohol misuse • Provision of information, advice and training and 'shared care' to others delivering Tier 1 and Tier 2 and support for Tier 3 services as appropriate.
Settings	Specialised statutory, independent or voluntary sector inpatient facilities for medically assisted alcohol withdrawal (detoxification), stabilisation and assessment of complex cases. Residential rehabilitation units for alcohol misuse. Dedicated specialised inpatient alcohol units are ideal for inpatient alcohol assessment, medically assisted alcohol withdrawal (detoxification) and stabilisation. Inpatient provision in the context of general psychiatric wards may only be ideal for some patients with co-morbid severe mental illness, but many such patients might benefit from a dedicated addiction specialist inpatient unit. Those with complex alcohol and other needs requiring inpatient interventions may require hospitalisation for their other needs (e.g. pregnancy, liver problems) and this may be best provided for in the context of those hospital services (with specialised alcohol liaison support).
Competency	Inpatient and residential interventions providing medically assisted alcohol withdrawal (detoxification) and specialist assessment and stabilisation would normally require medical staff with specialist competence in substance misuse (rather than generalist GPs). The level of specialised medical staff competence required will depend on the types of service provided and the severity of the service users' problems. Addiction specialist competences will be needed for inpatient units for severe and complex problems. Suitably competent GPs can provide support to some units for patients with less complex needs. Staff in residential rehabilitation units that are registered care homes will need to meet relevant social care national occupational standards. Hospital-based services will also be required to meet practitioner standards for independent or NHS hospitals. Those delivering Tier 4 interventions may require a wide range of competences from Key Area A in DANOS, and in particular many of the competences from Area AH 'Deliver healthcare services, depending on the alcohol treatment provided'. All staff working in all residential settings are advised to demonstrate competence against DANOS at both manager and practitioner levels.