Walsall NHS
Teaching Primary Care Trust

# Alcohol in Walsall:
## a public health perspective

**The 2007 Annual Report of the Director of Public Health**

Incorporates
Walsall Alcohol Needs Assessment and Walsall Alcohol Strategy

# Contents

# Foreword

In Public Health, it is customary to compare the drinking of alcohol with drug use. Walsall, with a quarter of a million residents, has around 12 to 15 drug related deaths per year. Heavy investment is made into helping drug users quit, by attracting them into treatment; especially heroin users. There may be relapses, but treatment is usually successful. The investment is justified, because Class A drug use can drive families into poverty, women into prostitution, children into care, and people into prison. Problematic drug use is often about fuelling a harmful illegal activity, mainly through the proceeds of crime. By comparison, there are at least 50 alcohol related deaths per year in Walsall, but funding for alcohol services is dwarfed by that for tackling drugs.

The alcohol issue is complex, partly because it is legal, at least for adults. Adding to the complexity of the public health message, moderate drinking is generally viewed as beneficial to health, largely by reducing cardiovascular disease. However, drinking can easily develop into an excessive habit or an addiction. Just as in drug use, alcohol dependency can destroy the family and person. There are strong associations with violent crime and with fatal road accidents. A large proportion of Walsall's residents drink above recommended safety limits; in many, silently developing fatal chronic liver disease. Added to this has been the emergence of binge drinking, especially in our youth and in our women. At one time, Walsall Town Centre was a 'No Go' area on a weekend night. The increasing culture of going out to get drunk defies belief.

There has been an unprecedented increase in alcohol related admissions to the Manor Hospital over the past five years, particularly in women and young adults, with at least 30 such admissions every year in under 16s. A recent Walsall alcohol needs assessment revealed a startling finding. While around 650 referrals were made to our two alcohol service providers in 2005-06, there were an estimated 8,000 heavy and 4,000 dependent drinkers of alcohol across the borough. Clearly, they are not being recognised. There is a desperate need for alcohol workers in primary care, to help the many residents with drinking problems. A 2005 survey showed that, among those who drink alcohol, 38% of men and 21% of women in Walsall binge drink, compared to the England average of 21% men and 9% women. In Walsall, alcohol misuse was associated with over 11,500 crime incidents in 2005/2006, mostly with violence. We have plans to introduce an alcohol arrest referral scheme, whereby offenders are enticed into treatment, similar to the existing Drug Intervention Programme. Among those offenders under probation, 37% had problematic alcohol use and 32% had violent behaviour related to drinking.

The alcohol problem has been neglected and under funded. We have patiently awaited the long overdue national strategy on alcohol and expect significant Home Office and Department of Health funding from this year. The public health White Paper Choosing Health also signalled out alcohol for special attention. This report then is a timely one and I sincerely hope it raises alcohol as a priority, at long last, among all health professionals and our partners across Walsall.

**Dr Sam Ramaiah**
Director of Public Health

February 2007

**DISCLAIMER The names of people used in this report to provide case studies bear no relation to the actual identity of Walsall residents.**

# Acknowledgments

My grateful thanks go to the many colleagues for their help in the production of this report, in particular to the Editorial Team of:

Dr Nick Pugh, supported by Andrew Hood, Neelam Sangrey, Mohammed Ramzan, and Graham Fee.

Special thanks go to:

Jan Stahlberg (Independent Consultant), who carried out the 2006 Walsall Alcohol Needs Assessment (replicated in Chapter 2), Dr Avtar Suri (Walsall GP Alcohol Lead), who facilitated collection of primary care data for this needs assessment, and David Bloomfield for Chapter 7 alcohol-related crime and disorder data.

Finally, thanks to the many colleagues, past and present, who have helped frame the contents of this report, and who have contributed to the work of the Walsall Alcohol Strategy Group or who attended the many meetings since September 2002:

Dr Avtar Suri, Diane McNulty, Claire Gallagher, Michelle Lawrence, Neelam Sangrey, Mohammed Ramzan, Andrew Hood, Rachael Humphreys, Karen Parsons, Ian Rose, Chris Smith, Lydia Hudson, Alistair Howie (Walsall Teaching PCT); Gerry Duffy, Annette Orton, Colette Naughton, Pat Reihill (Lantern House); Hugh Jobber, Colin Harrison (Addaction); Colin McNally (Walsall Alcohol Support Services); Shani Clarke (Destiny Project); Daren Garratt, Alan Jarvis, Angela Eley, Marcia Minott, Kathleen Rennie (Walsall DAAT); Gwyn Bevan, Lyn Reed, David Bloomfield, Dave Parish, Nozmul Hussain (SWBP); Neil Evans, Helen Turnbull (Vulnerability Group, SWBP); Neil Beechey, Peter Finch, Mark Hinton, Helen Turnbull, Andy Gilbert (West Midlands Police); Beverley Ashton, Alan Poole (ASB Officers); Joe Walker (Youth Service, ASB Unit), Chris Sprague, Lindsay Etheridge (Licensing Officers); Alan Husted, Pat Brown Richards (Probation); Bob Hook, Neil Harris, Roger Winter, Kish Patel, Paul Thomas, Don Campbell (Walsall MBC); Gemma Fisher (Trading Standards Service); Judith Sunley (Public Protection, Walsall MBC); Mark Rickard (MBC Traffic & Road Safety); Francis Doherty (Community Safety Units); Elaine Simpson, Sue Wedgewood (Education Walsall); Sheri Rogers (Walsall Domestic Violence Forum); Rosie Musson, Steve Foster, Ian McArdle (Dorothy Pattison Hospital); Karen Eccleston, Tracie Wilson, Denise Fraser, Sue Thorley, Dr Amanda Hughes, Mr David Bowden, Maureen Woodcock (Manor Hospital); Felicia Siebritz (Strategic Race Equality Partnership); Joanne Gutteridge (Black Country Cardiac Network); Richard Jaques (WalPOP); Max Vaughan, Bob Purser (Aquarius); Chris Wood (Arts into PSHE); Richard Clarke (MAP); Lynne Moriarty (Glebe Centre); and Tony Lloyd (Connexions).

**Design**
Walsall tPCT Communications Department.

**Published by**
Walsall Teaching Primary Care Trust, Jubilee House, Walsall WS2 7JL
Telephone 01922 618388, Fax 01922 618360.
This report is also available on the website:
www.walsall.nhs.uk/publichealth/publichealthhome.asp
Correspondence to:
nicholas.pugh@walsall.nhs.uk

# Introduction and Background to Alcohol Consumption

In November 2001, the Walsall Health Authority Directorate of Public Health produced a Walsall alcohol strategy document for distribution and consultation **(Pugh & Ramaiah 2001)**. It was largely informed by the work of Alcohol Concern, which had been campaigning for a national strategy for some time **(Alcohol Concern 1999)**. Also in 2001, the Annual Report of the Chief Medical Officer highlighted the increasing morbidity and mortality attributable to cirrhosis of the liver, drawing further attention to alcohol **(Department of Health 2001)**. No further action was taken during the first part of 2002, during which time an announcement on a national alcohol strategy had been expected. Finally, in July 2002, the Prime Minister requested his Strategy Unit to embark on a consultation process leading to a national strategy in 2004. This provided the necessary impetus to take forward a local consultation in Walsall on alcohol related problems.

Alistair Howie, the PCT Chief Executive, encouraged a meeting to establish a Walsall Alcohol Strategy Group, which convened in September 2002 with Nick Pugh, Gerry Duffy (Lantern House), Daren Garratt, Drug and Alcohol Action Team (DAAT) Coordinator, and Diane McNulty (PCT Health Development Manager) in attendance. A range of issues were discussed, including membership of the group. Two immediate decisions were taken:

- The Alcohol Strategy Group should be a time limited sub group of the DAAT Treatment Forum, accountable to the Walsall DAAT on progress.
- The launch of the Walsall strategy should be announced at the 2nd Annual Drug Conference (organised by the Walsall DAAT) later in September 2002.

In October 2002, Diane McNulty and Daren Garratt led a participatory exercise workshop at the Gorway Centre, Walsall, feeding back to the group in January 2003. The key conclusion was that the Alcohol Strategy Group would work to devise a local strategy based on the same basic design as Tackling Drugs to Build a Better Britain, defining aims and objectives around four principal areas **(Home Office 1998)**:

- Young people
- Communities: families and carers
- Treatment
- Crime and disorder

The group met again in February 2003 to consider any further alcohol related issues for incorporation into the strategy. Nick Pugh agreed to coordinate production of a draft report based on feedback from the workshop proceedings, and on crime and disorder feedback from Detective Inspector Neil Beechey of West Midlands Police. The report was circulated to all group members for perusal prior to a meeting in May 2003 to agree the strategy. This Walsall Alcohol Strategy document contained an Action Plan, that has since been updated, and is reflected in Chapters 3 to 7 of this report **(Pugh et al 2003)**.

The 2003 Action Plan helped in deciding the allocation of Health Action Zone funding for alcohol. Support was available to three main areas:

- An awareness campaign relating to personal health and safety
- A pump priming initiative to increase police intelligence in containing weekend drunken disorder and associated violence around Walsall town centre
- Introduction of an agency (Aquarius) to initiate brief interventions for problematic drinkers in the primary care setting.

It should be noted that the strategy and action plan was also informed by feedback from the 2002 Walsall 2nd Annual Drug Conference, where alcohol featured on the agenda.


The Prime Minister's cabinet office finally issued a document for widespread consultation during 2003, before releasing in March 2004 an Alcohol Harm Reduction Strategy for England **(PM's Strategy Unit 2004)**. This national strategy was widely criticised in lacking bite, certainly from the standpoint of central government, and in lacking the promise of significant dedicated funding for use at local level. The long awaited national strategy then resulted in the Walsall Alcohol Strategy Group next meeting in June 2004. However, there was very little appetite for forward planning, given the lack of promised government alcohol funding.

By the end of 2005, there were serious concerns around the issue of alcohol in the United Kingdom:

- Incidence and mortality rates from alcoholic cirrhosis continued to increase, and had finally overtaken those in France (and the EU average) – with particular concerns over increased frequency of chronic liver damage in younger drinkers and women.
- Binge drinking (heavy alcoholic consumption of around at least 8 to 10 units during a session of a few hours) continued to harm the young, and especially women, through the effects of poisoning, risk from accidents and violence, and the chance of developing a potentially lifelong dependency.
- Binge drinking continued to be responsible for flagrant public disorder and all the attendant threats to public safety; at the same time challenging the resources of the police, the criminal justice system, and local authorities.
- There was increasing evidence of chronic heavy drinking and binge drinking being strongly correlated with crime; and substantially more so than crime associated with drugs.

Despite this, Government showed little sign of introducing effective harm reduction measures such as: bans or controls on 'alcopops' type products, health warnings on alcoholic drinks (as in France), labelling of drinks and drink measures with units of alcohol, stricter or more flexible controls on licensing hours, zero tolerance to drink driving, etc.

In the face of government inaction, the Walsall Alcohol Strategy Group was nevertheless re-established in November 2005, with Nick Pugh continuing as Chair. There were several reasons for doing so:

1. Since the group last met in June 2004, the Safer Walsall Borough Partnership (SWBP) had been launched (October 2004) through the merger of the Walsall Drug and Alcohol Action Team (DAAT) and Crime and Disorder Reduction Partnership (CDRP). The newly formed Partnership, with its multi-agency way of working, was viewed as ideally placed to direct and oversee the Group.
2. An update was required on progress with the 2003 Action Plan and what future actions should be prioritised, modified, and introduced by the Group for consideration by the partnership and commissioning.
3. The Group needed to be made aware of existing and future funding relating to alcohol, eg Public Health's Choosing Health (Department of Health 2004), National Regeneration Fund, possibly increased Home Office pooled budget funding from April 2006; and how it could inform the commissioning group.
4. The Group needed updating on efforts to combat alcohol-associated problems in Walsall by the police, the criminal justice system, and the local authority.

5. Since last meeting in June 2004, local health agencies had moved on several alcohol fronts:

- Aquarius was appointed to lead on brief interventions and alcohol referrals in primary care (this agency has since withdrawn and Dr Avtar Suri aimed for Walsall to produce its own primary care alcohol workers).
- Dr Suri was appointed as Lead Walsall GP for alcohol, encouraging GPs to take up a new contract providing an enhanced service for alcohol (thus reducing pressures on existing alcohol service providers) and identifying GPs willing to undertake alcohol work as a specialised interest.
- WICAS (Walsall Integrated Community Alcohol Services) was formed (and chaired by Dr Suri) to promote integration of primary care alcohol services with our two providers (Lantern House and Addaction); following the model existing for drugs through the Shared Care scheme.
- The Destiny Project was established through the efforts of Colin McNally (and later Shani Clark), aiming at an effective peer support for problematic drinkers verging on dropping out of society.
- The Manor Hospital experimented with a Clinical Decision Unit that could help deal with problems of the acutely intoxicated, who frequently pose a challenge to the police, A&E departments, and public.
- Planning the implementation of a Health Needs Assessment (through NRF support; Dr Suri had made a start on assessment in primary care), and health awareness campaign, especially among our youth.

Significant progress was made during 2006, in anticipation of dedicated alcohol funding from the financial year 2007-2008. The Alcohol Strategy Group updated the 2003 version of the Walsall Alcohol Strategy, in particular the Action Plan presented in this report. Indeed, this report will be taken to represent a significantly expanded 2007 version of the Walsall Alcohol Strategy. At the time of writing, the following represent updates of the above pointers:

- There is a bid in place to seek new funding, through the Walsall tPCT Local Development Plan, to appoint four primary care alcohol workers, supported by four specialist GPs, each providing one session per week, and coordinated by the Lead Walsall GP for alcohol. This recommendation was recently upheld by the Walsall Alcohol Needs Assessment, presented in Chapter 2.
- WICAS will be revived once these appointments are in place, to integrate primary care work with that of our two alcohol service providers.
- In parallel with this, again based on need (and evidence elsewhere), the alcohol related crime agenda will be addressed by the Partnership (SWBP) supporting a bid to appoint Alcohol Arrest Referral Workers (see Chapter 7).
- The Destiny Project, and allied community groups, will require every encouragement and support in identifying funds.
- A more effective enforcement strategy to combat Town Centre alcohol related disorder (Chapter 7), coupled with the flexibility of the new licensing laws, has led to a lessening impact on the Manor Hospital (the pilot of a Clinical Decision Unit has been replaced by a new Integrated Assessment Unit to address alcohol related problems and admissions).
- The first phase of a Walsall Alcohol Needs Assessment has been completed by Jan Stahlberg, with primary care support from Dr Suri (Chapter 2).

## Definitions

**One unit** equals **8 grams** of alcohol and is roughly equivalent to half a pint of ordinary strength beer, a small glass of wine, a single measure of spirits, and a very small glass of sherry or fortified wine.

**Low-risk alcohol use** applies to occasional or regular moderate drinking within safe limits (men: not more than 21 units per week and not more than 4 units on any one day; women: not more than 14 units per week and not more than 3 units on any one day) and without adverse consequences on health or relationships with others. Some authorities would also recommend 1 to 2 alcohol-free days per week.

**Risky alcohol use** involves frequently exceeding safe limits and includes binge drinking. Adverse health effects may not always be present, but drinking bouts may be associated with violence, sexual abuse, other crimes, and accidents. Risk of serious harm and future dependence increases with frequency and amount of drinking.

**Binge drinking** is usually defined as consuming at least twice the safe daily limit (ie 8 units for men; 6 units for women), usually in a short space of time with the aim of getting drunk. This is associated with the above adverse effects, unprotected sex, and alcohol poisoning.

**Hazardous drinking** is consuming 22 to 50 units per week for men and 15 to 35 units per week for women. Often equates to risky alcohol use and/or binge drinking.

**Problem drinking** is associated with frequent or regular alcohol related consequences but does not meet the criteria for alcohol dependence.

**Harmful drinking** is consuming more than 50 units per week for men and more than 35 units per week for women. Often equates to problem drinking.

**Alcohol dependence** is a chronic condition characterised by excessive alcohol use, inability to reduce the amount consumed, adverse health effects, and breakdown of relationships with family members, work colleagues, and friends. It is associated with tolerance (needing to drink more to obtain the same effect), withdrawal symptoms, a pre-occupation with getting the next drink, and denial of problems with alcohol.

## The Public Health Impact of Alcohol

The morbidity and mortality attributable to alcohol is certainly not to the forefront of the British psyche. Social drinking is an integral part of life, and pubs are a familiar and traditional feature of the nation's landscape. Off licences are thriving, as are new city outlets such as wine bars and clubs. There is an increasing exposure to varieties of wines and beers from all over the world. Drinking at home is becoming the norm. There is no end to the seductive appeal of alcohol advertising and we do not completely understand drinking dynamics in our populations (Alcohol Concern 1999).

Other changes over time have conspired to prevent a rise in national alcohol consumption. We are becoming aware of the recommended upper units of alcohol. The Chancellor's budgets remind us that alcohol is not entirely good for our health. Few today cannot see drink and driving as a dangerous mix. However, our obsession with celebrity is regularly spiced with another idol making headlines on the alcohol front. All the more sensational if violence is a feature. Restrictions on alcohol sales are now a regular and accepted feature at large gatherings. It would appear that most people drink sensibly and responsibly. Even in the most seedy pub, most customers are no trouble. Only 5% or less can be unruly, and they tend to be the same people.

This tells us something. Problem drinkers of whatever background survive and take on another day. But they are not detected in primary care, where problem drinkers are twice as likely to visit their GP as the average patient. Around 20% of patients attending primary care are excessive drinkers, translating to at least one seen by a GP every day. Yet surveys suggest 65% of GPs see only up to six excessive drinkers in a year. This means GPs miss over 95% of their patients who are problem drinkers. This is an opportunity missed since brief interventions in primary care can alter drinking behaviour. Even those lasting 5-10 minutes can reduce alcohol consumption by up to 20%. Problem drinkers are often dismissed as weak-willed, perhaps explaining why alcohol services receive scant attention. Many argue that alcohol misuse is so pervasive that only primary care teams can suitably deal with it.

It is astonishing that Health Authorities, and then Primary Care Trusts, have been let off the hook for so long. One in 25 adults is alcohol dependent. Alcohol plays a pathogenic role in hypertension and liver disease. Deaths from alcohol-specific diseases rose 38% from 1992 to 1997, and keep on rising. Alcohol misuse directly affects many Department of Health priority areas such as primary care, coronary heart disease, mental health, hospital admissions and waiting lists, accidents, drug misuse, teenage pregnancy, and children's services. Why the apathy? The aim is not to preach temperance or send out unpopular messages. Sensible and responsible drinking is the order of the day, with incisive strategies that can impact on problem drinkers, on their health, and on the chaos they cause to their families, friends, and society.

**Are there any benefits to alcohol consumption?** There certainly appear to be many as evidenced by the majority of the population who drink moderately or well within the recommended limits. The physiological and psychological benefits are widely known and appreciated. There are also postulated benefits to heart function, provided consumption is sustained at a truly moderate level. Research continues to explore this area and establish safety levels.

## Coronary Heart Disease

- problem drinkers twice as likely to visit their GP than the average patient
- clinical depression and 65% of suicide attempts are linked to heavy drinking
- high alcohol consumption is closely linked to hypertension, a major risk factor for CHD and stroke
- weekend binge drinking is associated with the 3% excess deaths from CHD that occur on Mondays

**What are the harm mechanisms?** There are three main mechanisms. With the organised efforts of society and the public health approach, there is limited scope or opportunity for addressing the following two:

- Chronic high consumption leads to a tolerance that does not necessarily result in unruly behaviour or obvious inebriation, is not necessarily associated with dependence, but is frequently associated with chronic liver disease and cirrhosis.
- Dependence is a leading mental health issue and is characterised by serious physical signs of a withdrawal state if access to alcohol is denied. Dependent persons do not inevitably develop chronic liver disease and cirrhosis.

By contrast, there is much we can do to address the third mechanism:

- Intoxication. Harm is caused by drinking large amounts or drinking inappropriately and is associated with crime and public disorder, damage to family and social relationships, reduced productivity, and accidents. Binge drinking (large amounts on single occasions) is unfortunately common in the UK. Intoxication accounts for much of the workload of the NHS, the police, and the social services.

Note that by tackling intoxication, especially among the young, it would be possible to reduce entry into the first two mechanisms.

## Astonishing inaction on alcohol to date, given that:

- 1 in 25 adults is alcohol dependent
- alcohol plays a pathogenic role in hypertension and liver disease
- deaths from alcohol-specific diseases rose 38% from 1992 to 1997
- alcohol misuse directly affects many Department of Health priority areas and/or targets, eg
    1. primary care
    2. coronary heart disease
    3. mental health
    4. hospital admissions
    5. waiting lists
    6. accidents
    7. drugs
    8. teenage pregnancy
    9 children's services

**Who are particularly at risk of manifesting intoxication?** Health inequality certainly operates here since intoxication and alcohol dependency is more frequent among those in unskilled occupations. Young males are at particular risk of injury or death in alcohol related incidents. Heavy drinking is becoming more prevalent among girls and is more prevalent among those excluded from school.

**What current harm minimisation measures are in force?** These are well known and include drink driving regulations, trained bar and door staff, policing of entertainment areas, football match restrictions, high duty levels on alcohol, controls on advertising, proof of age schemes, prosecution of traders selling alcohol to under 18s, licensing of retail outlets, health advice on alcohol units, and drinking bans in the workplace.

**What other measures may be brought into force?** Sweden once experimented with jail and hard labour for drink and drive offences. This will not be introduced in the UK, but there may be a move towards zero tolerance whereby any amount of alcohol may incur an offence. Penalties may become harsher. France prints health warnings on their drinks. The UK government has still to ban alcohol advertising.

# Strategies to Combat the Alcohol Problem

Several strategies can make a significant difference at the local level.

## A. Gains that can be Achieved through Health Improvement and the Public Health Approach

Alcohol Concern has long been instrumental in submitting proposals to inform the national strategy **(Alcohol Concern 1999)**. It has also submitted a briefing for planners and commissioners in formulating health improvement programmes that incorporate strategies to combat alcohol **(Alcohol Concern 2001)**. A summary is produced below by way of key priority areas, evidence-based messages, and suggested actions. The content has been modified to focus on more realistic approaches that will particularly require the collaboration of primary care, hospitals, mental health, and the Drug and Alcohol Action Team (DAAT). This summary is still valid in 2007.

### Primary Care
### Mental Health
### Coronary Heart Disease

Primary care teams are ideally placed to identify patients with excessive and problem drinking, which is strongly linked with the priority areas of mental health and coronary heart disease.

- Problem drinkers are twice as likely to visit their GP than the average patient.
- Clinical depression and 65% of suicide attempts are linked to heavy drinking.
- High alcohol consumption is closely linked to hypertension, a major risk factor for coronary heart disease (CHD) and stroke.
- Weekend binge drinking is associated with the 3% excess deaths from CHD that occur on Mondays.

What can be done?

- Brief interventions in primary care can change drinking behaviour **(Bien et al 1993)**.
- NHS Direct and Walk in Centres can be equipped to deal with and advise on alcohol related problems.
- Primary care should access Alcohol Concern's Primary Care Alcohol Information Service. See next Section B.
- Within health improvement programmes, the role of alcohol misuse should be considered and addressed within the CHD and Stroke prevention policy.
- Within health improvement programmes, plans for implementing the Mental Health National Service Framework should reflect the need for effective alcohol services and for joint protocols involving mental health and primary care staff in covering the risk of suicide.

### Accident and Emergency
### Hospital Admissions
### Drug Services

Alcohol misuse is a major issue in relation to accidental injury and death, to hospital admissions, and to drug misuse.

- Alcohol is a major contributor to accidental death in up to 30% of all accidents and in 39% of fires.
- 50% of seriously admitted patients admitted through Accident and Emergency (A&E) have an alcohol related injury.
- 1 in 7 hospital admissions are alcohol related, particularly the short term effects of heavy drinking, eg accidents, violent episodes, self harm.
- Up to 50% of underage drinkers have tried illegal drugs compared to 17% of non drinkers.
- Up to 50% of drug misusers in treatment drink at excessive levels.

What can be done?

- Alcohol link workers in A&E have proved especially effective with people who do not have

chronic alcohol related problems (Bien et al 1993).

- Akin to the approach used in primary care to identify patients not previously known as problem drinkers, alcohol workers on wards can enable brief and effective interventions that can be followed up in the community.
- Once home, the identified problem drinker should have the support of primary care networks and should know the location of adequately provided alcohol services.
- DAAT plans should link to the health improvement approach to embrace alcohol misuse and utilise or expand the skills present in drug services to provide alcohol harm minimisation services that are sensitive to the needs of identified problem drinkers.
- Drug education initiatives in schools should also fully cover alcohol education.
- Alcohol services should develop strong links with smoking cessation programmes since smoking relapse is associated with drinking, and frequent drinkers are much more likely to be regular smokers.

### Hot Topics:

- Change the drinking patterns of the most problematic drinkers?
- Reduce alcohol consumption across the entire population?
- Costs to the NHS not only caused by dependent drinkers, eg huge burden on A&E departments due to accidents which are alcohol related
- Need for more training and information on alcohol-related problems for GPs and nurses

## Children's Services
### Teenage Pregnancy

Inclusion in the health improvement approach for these priority areas in relation to alcohol misuse will depend on a high level of integration with social services. Alcohol as a problem in young people arises not only from their own drinking but also from alcohol misuse by their parents. Alcohol plays a prominent role in teenage sex.

- 21% of 11-15 year olds now drink on a regular basis and the average weekly consumption rose from 5.3 to 9.9 units per week between 1990 and 1998.
- Alcohol related A&E admissions among under 15s are rising alarmingly.
- Nearly one million children live with at least one parent who misuses alcohol and heavy drinking by parents is a factor in up to 50% of child protection cases.
- The report on teenage pregnancy by the Social Exclusion Unit highlighted that after uncontrolled drinking, 1 in 7 older teenagers go on to have unsafe sex.
- A survey of 13 and 14 year olds found that 40% were drunk when they experienced first sexual intercourse.

What can be done?

- The Public Health and the Health Improvement concept needs to embrace many approaches referred to above, such as the identification within primary care of problem drinkers (which will include parents) as a significant first step, and the development through the DAAT of alcohol services that are geared towards children, in addition to schools education.
- Strategies on teenage pregnancy need to specifically include and address the issue of alcohol misuse.

Alcohol strategies also impact on other priority areas. Smoking has been referred to in association with drug and alcohol services. There are opportunities to support action on domestic violence following identification of problem drinkers in primary care and in hospital. Retirement, bereavement, and increasing isolation are all features of older people that can promote heavy drinking. Strategies for identifying and supporting problem drinkers in primary care can apply and be extended to residential homes.

## Why do some heavy drinkers develop the deadly alcoholic cirrhosis, and not others?

- Research initiatives are needed to increase our understanding of alcoholic liver disease, as summarised recently by Day (2000):
- Advanced alcoholic liver disease develops in less than 10% of heavy drinkers.
- The risk of disease increases with total alcohol intake, but also with daily versus weekend drinking, and drinking away from meal times.
- Obesity significantly increases the risk of all stages of alcoholic liver disease.
- Fatty liver plays a role in the pathogenesis of more advanced liver disease, probably by increasing the sensitivity of the liver to endotoxin and oxidative stress.
- Genetic factors play a role in susceptibility and results to date suggest to scientists that polymorphisms of cytokines and other immuno-regulatory genes may be most closely associated with disease risk.

## Wide variety of government roles, including

- **Provision of adequate information and education**
- **Regulating the drinks industry (to ensure it behaves responsibly)**
- **Protecting those who are vulnerable**
- **Ensuring treatment for those who need it (and their families)**
- **Preventing alcohol misuse causing harm to others**
- **Joining up provision/providing strategic direction**

## B. Gains that can be Achieved through the Organisation of Primary Care

Since primary care teams are ideally placed to identify excessive drinkers, the Department of Health supported Alcohol Concern in launching 10 demonstration projects. North-East Birmingham and Gateshead concluded that identification of problem drinkers was not a problem in primary care. Other projects focused on interventions and reported the success of utilising alcohol workers, spanning their roles in hospital and primary care. For example, North Southwark offered alcohol training for staff in seven GP practices, resulting in 25% of patients reducing their drinking and identifying most other patients for assessment through alcohol workers.
In the meantime, primary care can intervene effectively through an information service developed by Alcohol Concern, called the Primary Care Alcohol Information Service (funded by the Department of Health) that provides a telephone information line, fact sheets, and web pages aimed at sharing good practice with primary care workers (www.alcoholconcern.org.uk). The service:

- Provides an information line for primary care professionals on alcohol issues.
- Produces fact sheets about alcohol misuse prevention and treatment.
- Keeps track of research developments relating to alcohol and primary care.
- Disseminates examples of good practice in tackling alcohol misuse.
- Offers advice on partnership between primary care and alcohol services.
- Provides information about alcohol policy development in relation to primary care.
- Can demonstrate how alcohol misuse connects with local and national priorities.

Patients need to be asked about alcohol misuse otherwise problem drinkers will not be identified. There is a need for PCTs, Lead GPs or specialist primary care alcohol providers to develop protocols and guidelines on how to treat suspected and identified problem drinkers; also to develop guidelines on screening, interventions, referrals, and managing acute drinking problems. Alcohol Concern can provide advice in all these areas through their website. Further sources of information are the WHO collaborative project based in Tyneside and the Medical Council on Alcoholism, London.

### Our Favourite Drug

This is the title of a leading article in the British Medical Journal written by Dr Paton, the retired West Midlands clinician and authority on alcoholic liver disease. The author insists that local initiatives should be encouraged. The following is reproduced verbatim from his article **(Paton 2002)**:

" . . . Health professionals who work with alcohol misusers are not only frustrated by government inaction and lack of resources; they need guidance on priorities among the many challenging problems that confront them. Assuming that this will never come from government, *a way forward might be for primary care trusts to take alcohol agencies under their wing*. Since the classic study of **Tether and Robinson (1986)**, community owned services have been regarded as an ideal way of managing alcohol misuse, and in the early 1990s Alcohol Concern began setting up voluntary agencies with the help of government grants. Over 300 of these now cover most of the country and could form the core of local services. In time, it should be possible to supply each general practice and hospital with one or more alcohol workers or specialist nurses whose function would be to identify and treat problems and to support staff. Such a scheme has already been successfully pioneered in practices in Cornwall and in the accident and emergency department at St Mary's Hospital in London **(Patton et al 2002)**. No doubt we would have to beg a little more money: according to the latest figures (in 2001), government expenditure on treating alcohol problems is £1.1m (£291.1m on drug problems) – peanuts when set against the estimated £7bn that alcohol misuse costs society . . ."

**Principles:**

- **Need long-term strategic response to tackle alcohol misuse efectively**
- **Alcohol misuse is responsibility of individual drinker, but need to promote greater sense of responsibility and awareness of consequences**
- **Must balance individual freedom (own drinking behaviour) by agreed social constraints (not infringing rights of others)**
- **Since alcohol misuse can lead to addiction, personal capability may be undermined (hence important role for government)**

## C. Gains that can be Achieved through Interpretation of the New Licensing Laws at Local level, With the Co-operation of Local Authorities and the Police

A recent White Paper proposed major changes to our licensing laws, of which flexibility of pub opening hours is a small part (Home Office 2000). The key feature is that the licensing of persons to sell alcohol and the licensing of premises for the sale of alcohol would be separated, with responsibility for licensing shifting from the magistrates to the local authorities. Personal licensing would entail knowledge of licensing law and social responsibilities. Although a new offence of buying alcohol for someone under 18 years would be in force, children would at the discretion of the license holder be allowed access to licensed premises. Opening hours, noise levels, and safety would be set to meet local needs. Police would have stronger powers, including temporary closure of premises.

There are implications of these changes:

- Removal of permitted hours does not necessarily mean that alcohol consumption will increase since when opening hours were lengthened, this did not lead to such an increase and neither of alcohol related harm (Pinot de Moira & Duffy 1995).
- Buying alcohol on behalf of someone under age will need to be counteracted by more effective enforcement, but it may be that allowing children into licensed premises will help to de-glamourise alcohol, provided that children are not neglected while parents give all their attention to drinking.
- Personal licenses could help to ensure that landlords run safe drinking premises, and are being seen to do so.
- Pub and Club Watch schemes could be enhanced with trained door staff being a requirement in establishments according to a local star rating based on safety.
- Closing times could be coordinated and staggered.
- Busy areas could be served by cheap and safe public transport, high profile access to taxi cab hire, and the provision of secure overnight car parking.
- Measures could be taken to slow drinking through the promotion of low-alcohol drinks, discouragement of ‘happy hours’ and the serving of drink and food at tables.
- There should be measures to reduce heavy drinking episodes and so impact immediately on hospital bed availability, eg accident prevention strategies can organise community safety to avoid drink related violence in pubs by the training of bar staff and the use of toughened glasses, plastic bottles, and controlled removal of glassware.
- There is need to shift from the getting drunk culture to the continental café culture that sees people drinking and eating over several hours free from intoxication.
- Stronger police power is less drastic than the threat of license removal and could actually help to ensure that disorderly and unsafe drinking is tackled.
- Police stations can start an alcohol arrest referral scheme to link offenders into community alcohol teams.

In addition to the Safer Walsall Borough Partnership, Walsall has a well established Accident Prevention Group and this may be another forum in which to discuss strategies involving health, local authorities, and the police.

## Alcohol Harm Reduction Strategy for England (PM's Strategy Unit 2004)

(1) Four key pillars were identified:

- Better education and communication (addressing: information provided by the alcohol industry; education and young people; alcohol misuse in the workplace; and advertising)
- Improving health and treatment services (addressing: those with alcohol problems are identified and referred to the appropriate services; appropriate treatment is available; treatment for vulnerable groups covers all their related needs and problems, and adequate aftercare is available)
- Combating alcohol-related crime and disorder (addressing: crime, disorder and anti-social behaviour in towns and cities at night; under age drinkers; dealing with people who repeatedly commit alcohol-related offences; domestic violence; and drink driving)
- Working with the alcohol industry (addressing: promotion of good practice in product development, branding, advertising and packaging; a donation to an independent fund for community and national level projects designed to tackle alcohol related harm; promotion of good practice down the supply line)

(2) Four key harms were identified:

- Harms to health
- Crime and anti-social behaviour
- Loss of productivity at the work place
- Social harms, such as family breakdown

## Health

A key identified issue is that alcohol problems are not always identified and appropriate referral or treatment does not always occur. People with alcohol problems are likely to come into contact with a range of public institutions: Health services, Social services, Voluntary bodies, Police and the criminal justice system, Schools and educational institutions. Their problems may not be picked up for various reasons: eg absence of a clear identification process; lack of staff training to identify underlying problem of alcohol misuse; lack of knowledge as to whom to refer; lack of staff time; alcohol carrying a strong stigma. The Department of Health was urged to strengthen the emphasis on the importance of early identification of alcohol problems through communications with doctors, nurses and other health care professionals; also to work with the Home Office, the Department for Education and Skills and the National Treatment Agency (NTA) to develop guidance within the Models of Care framework on the identification and appropriate referral of alcohol misusers.

There is a risk that alcohol treatment for vulnerable groups might fail due to lack of co-ordination of treatment and services, since: a third of psychiatric patients with a serious mental illness also have a substance misuse problem; 25% of drug users also misuse alcohol; 50% of rough sleepers and other homeless people have problems with alcohol; some young people have complex multiple needs. Reducing alcohol related harm will need DAATs and PCTs operating within Partnerships, to ensure effective commissioning of alcohol prevention and treatment services, probably under guidance of the NTA; also ensuring a contribution to the Crime and Disorder Strategy.

## Alcohol Harm Reduction Strategy for England (PM's Strategy Unit 2004)

## Crime and Disorder

In reducing the harms caused by crime and disorder, key issues are:

- To reduce the number of incidents of alcohol-related violent crime and to change the perception that drunk and rowdy behaviour is increasing, as measured by the British Crime Survey.
- To reduce low-level disorder in the night-time economy and improve its diversity: measuring this both through the use of existing surveys and through the evaluation of the new Licensing Act.
- To monitor through existing statistics the extent to which under age drinking is being prevented and tackled.
- The Home Office will examine whether it is possible to measure a reduction in the number of repeat offences of domestic violence where alcohol is involved.
- To resume the downward trend in drink-driving incidents as measured in statistics produced by the Department of Transport.

Government will have a clear commitment to deliver an over-arching alcohol harm reduction strategy. This will be:

- Assessed against indicators of progress for the four key harms identified.
- Set against a clear baseline.
- Supported by better co-ordination of research.
- Regularly monitored.

### Flexibility to deliver at the local level

Local alcohol strategies will need to be developed. Government Offices will assist as required. Local partnerships already exist, which can form a focus for reducing the harms caused by alcohol misuse: Crime and Disorder Reduction Partnerships, Drug and Alcohol Action Teams, Criminal Justice Boards and Youth Offending Teams, Local Strategic Partnerships. DAATs and CDRPs need to integrate and work with PCTs to develop a responsible authority on alcohol related issues.

### How the strategy will be delivered at local level

Local agencies will work within existing chains of accountability to deliver outcomes. The CDRP will provide a forum for discussion, sharing good practice and co-ordination regarding the four key levers: Education and Community, Treatment, Community Safety, Working with the alcohol industry. CDRPs, including representation from the local PCT, will provide a co-ordinating body for agreeing local priorities and determining future direction. The Cabinet Office will not be seeking compulsory strategies from local authorities, but expects to see measures for tackling alcohol misuse embedded within existing strategic frameworks. Government Offices will work with areas that have identified particular issues.

**1 unit of alcohol =**

- half pint of ordinary strength lager/beer/cider (3.5% vol);
- 25ml pub measure of spirit (40% vol);
- a small glass of wine (9% vol).

Examples of alcohol units (per number of drinks) have been issued by the Portman Group, an organisation encouraging sensible drinking (www.portman-group.org.uk).

## Number of drinks

| | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| **Low alcohol lager**<br>1% vol; 275ml can | 0.3 | 0.6 | 0.8 | 1.1 |
| **Standard beer/lager**<br>3.5% vol; 1 pint | 2 | 4 | 6 | 8 |
| **Premium beer/lager**<br>5% vol; 1 pint | 2.8 | 5.7 | 8.5 | 11.4 |
| **Super strength lager**<br>9% vol; 440ml can | 4 | 7.9 | 11.9 | 15.8 |
| **Champagne, wine**<br>12% vol; 125ml glass | 1.5 | 3 | 4.5 | 6 |
| **Port**<br>20% vol; 50ml | 1 | 2 | 3 | 4 |
| **Sherry**<br>17.5% vol; 50ml | 0.9 | 1.8 | 2.6 | 3.5 |
| **Vermouth**<br>15% vol; 50ml | 0.8 | 1.5 | 2.3 | 3 |
| **Brandy/whisky**<br>40% vol; 25ml | 1 | 2 | 3 | 4 |
| **Rum/vodka/gin**<br>37.5% vol; 25ml | 0.9 | 1.9 | 2.8 | 3.8 |
| **'Alcopops'**<br>5% vol; 330ml bottle | 1.7 | 3.3 | 5 | 6.6 |
| **Regular cider**<br>5% vol; 1 pint | 2.8 | 5.7 | 8.5 | 11.4 |
| **Strong cider**<br>8.5%; 275ml bottle | 2.3 | 4.7 | 7 | 9.4 |

Current daily guidelines for sensible drinking are 2-3 units or less for females and 3-4 units or less for males. Refraining on one day should not mean excess on another. The British Liver Trust also encourages 2 alcohol-free days per week. Consume no more than 1-2 units once or twice per week when pregnant. No agreed definition of binge drinking but a consensus would agree 8 or more units in one session for men (6 or more in women).

# The Overall Size of the Alcohol Problem

Reference has already been made to the Chief Medical Officer's Annual Report **(Department of Health 2001)**, drawing attention to the increasing alcohol related mortality nationwide (Figures 1 and 2). The four updated figures below show the continued UK rise in alcoholic consumption (>21 units per week, men; >14 units per week, women) and related mortality, and deaths from chronic liver disease (largely alcoholic cirrhosis). Clearly this is a matter of serious concern.

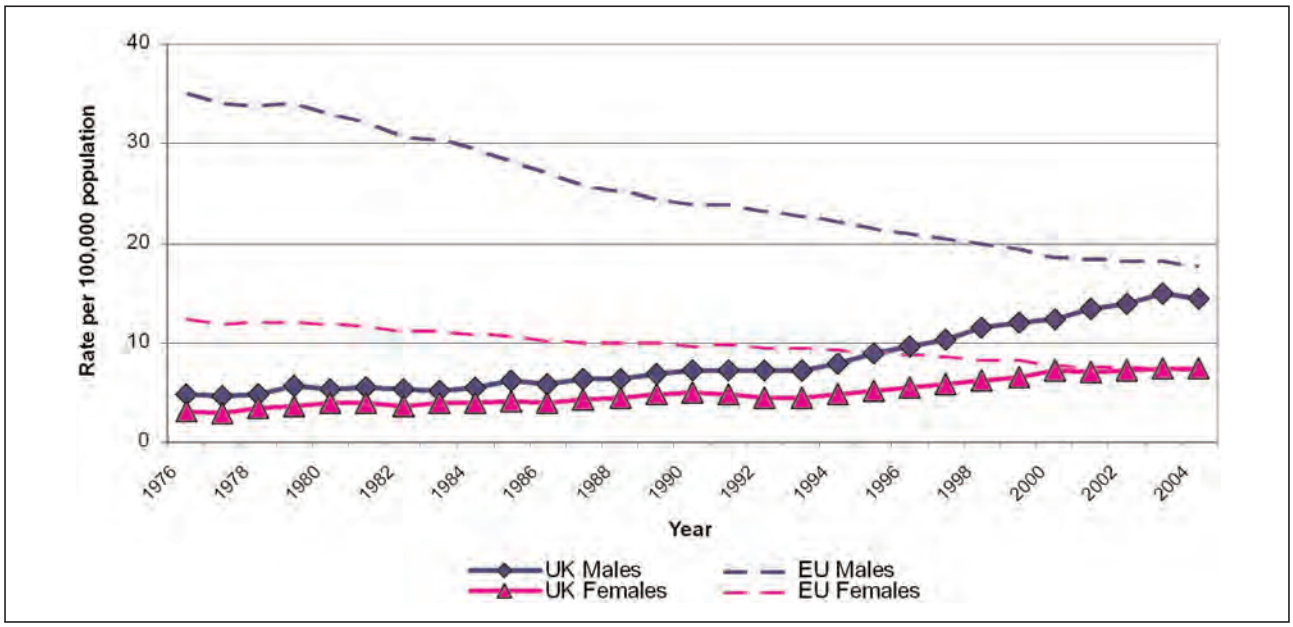



Figure 1. Mortality from chronic liver disease and cirrhosis, standardised rate per 100,000 population, all ages by gender, UK and EU, 1976-2004
(WHO, Health for All database, online version, 2006)

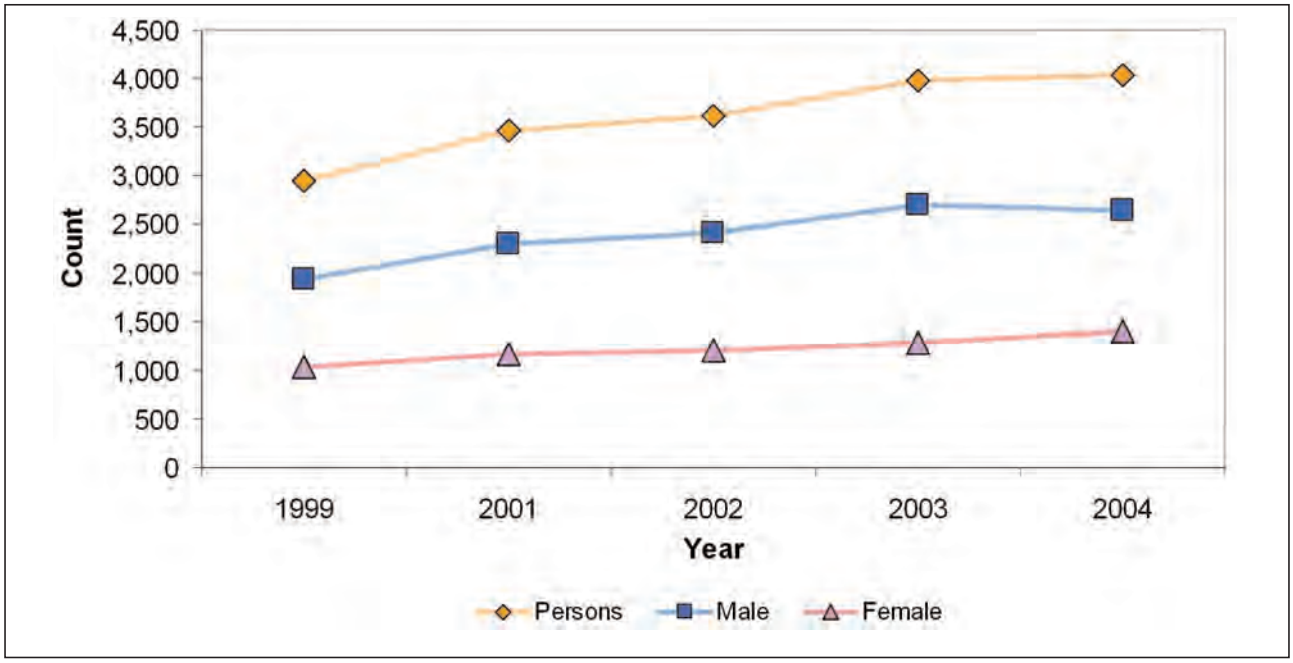



Figure 2. Deaths from alcoholic liver disease in England and Wales by gender, 1999 and 2001-2004
(ONS, Statistical Bulletin on Alcohol, 2006)

Figure 3 dramatically illustrates how the UK is moving in the opposite direction to other countries in the European Union; in particular France, which was once described as the alcoholic cirrhosis capital of Europe. Rates of mortality due to cirrhosis of the liver are an important indicator of population levels of alcohol harm. Total recorded alcohol consumption in Britain doubled between 1960 and 2002, giving rise to a need to examine and assess cirrhosis mortality trends. This prompted the recent work of Leon and McCambridge (2006). They calculated mortality rates for all ages and for specific age-groups (15-44 years and 45-64 years) for cirrhosis of the liver. Rates were directly age-standardised to the European standard population and compared with rates from 12 western European countries for the period 1955-2001. The findings were alarming for the UK, and Scotland in particular. Cirrhosis mortality rates increased steeply in Britain during the 1990s. Between the periods 1987-1991, and 1997-2001, cirrhosis mortality in men in Scotland more than doubled (104% increase) and in England and Wales rose by over two-thirds (69%). Mortality in women increased by almost half (46% in Scotland and 44% in England and Wales). These relative increases are the steepest in western Europe, and contrast with the declines apparent in most other countries examined, particularly those of southern Europe. Cirrhosis mortality rates in Scotland are now one of the highest in western Europe, in 2002 being 45.2 per 100,000 in men, 19.9 in women. Recommendations from this and other similar reports suggest that current alcohol policies and strategies in Britain should be assessed by the extent to which they can successfully halt the adverse trends in liver cirrhosis mortality. The situation in Scotland and many parts of England and Wales warrant particular attention.

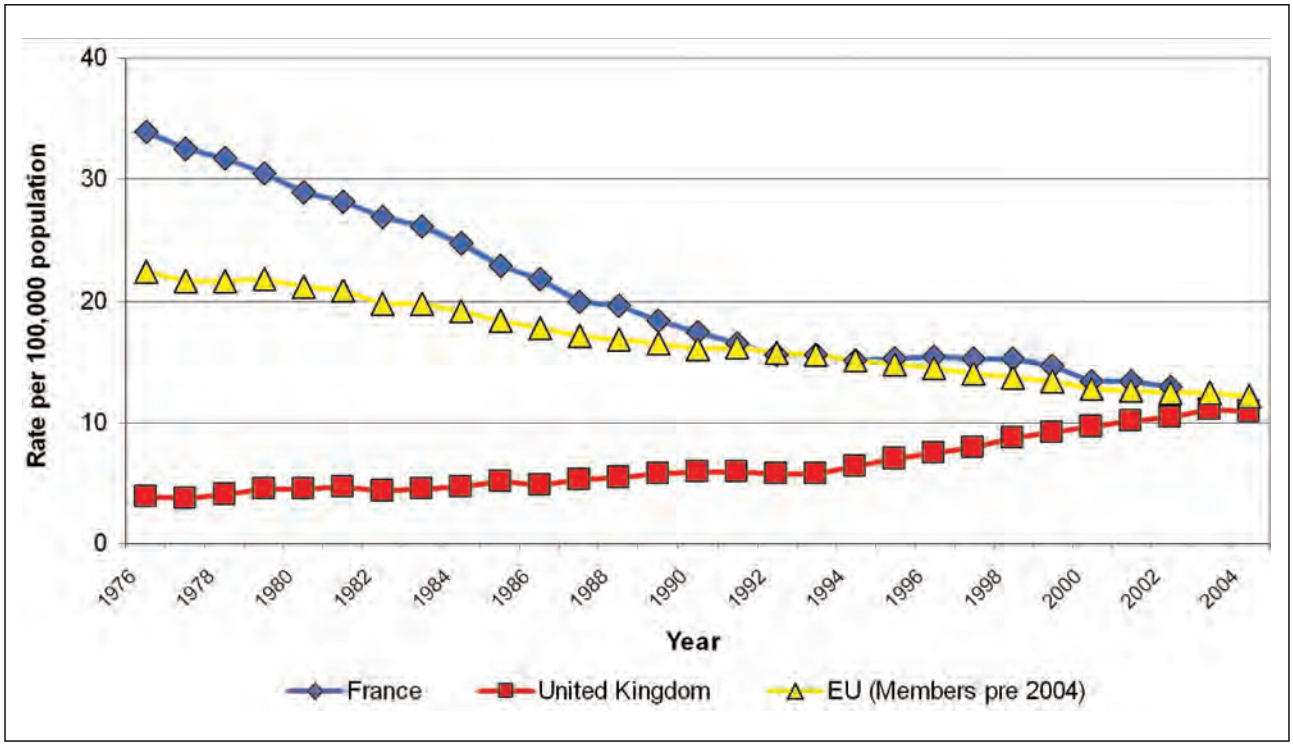



Figure 3. Mortality from chronic liver disease and cirrhosis, standardised rate per 100,000 population, all persons, all ages, France, UK and EU, 1976-2004
(WHO, Health for All database, online version, 2006)

Figure 4 again shows alarming rises, this time in excess alcohol consumption over the 14-year period from 1988 to 2002, especially so in young women **(Office for National Statistics 2004)**. However, it is good to see an improvement in the more recent 2005 data.

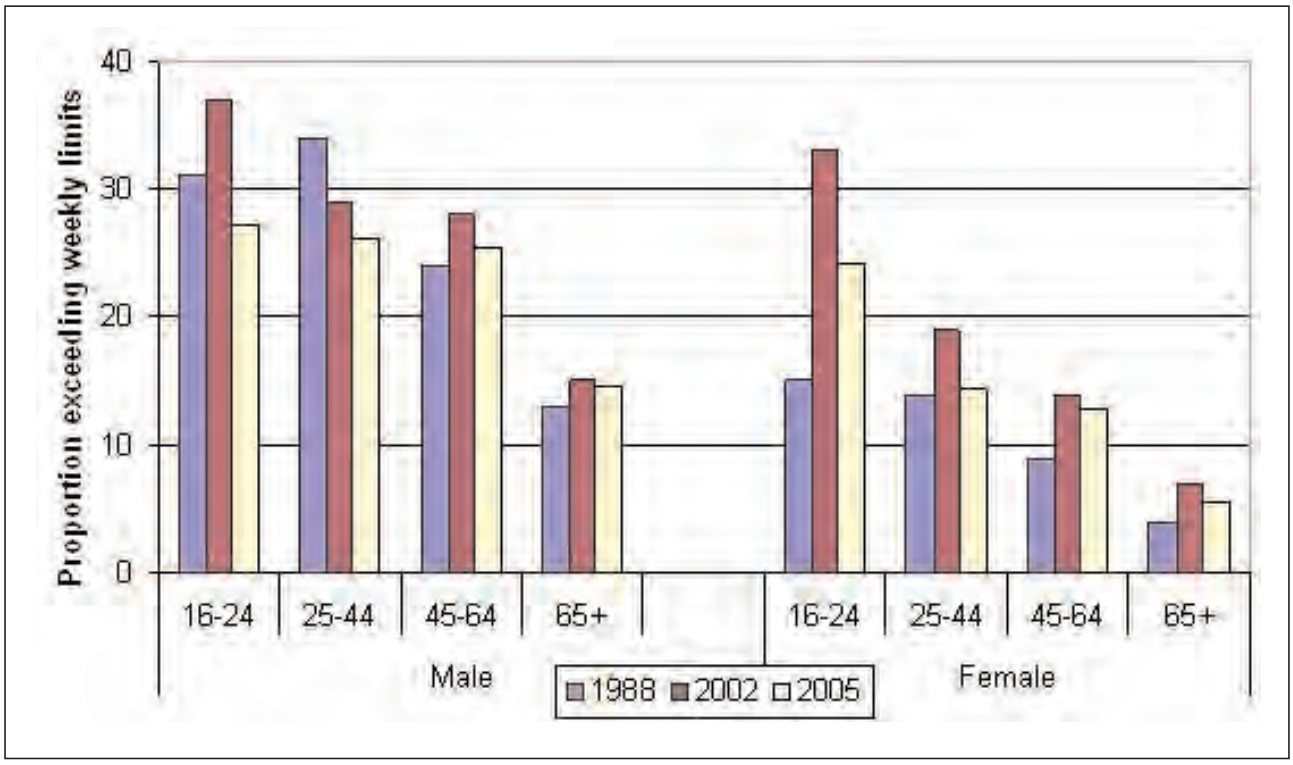



Figure 4. Proportion of people in the UK exceeding recommended drinking levels per week by age and sex, 1988 to 2005 (General Household Survey 2006)

In conclusion, the overall size of the alcohol problem in the UK is still a source of serious concern. At a time when deaths from circulatory disease and cancer are steadily decreasing, cirrhosis is fast emerging as a leading chronic disease, largely attributable to alcohol.

## New Alcohol Team for Walsall

**A new alcohol team, funded by the National Lottery and the NRF, started work at the Glebe Centre from January 2007. The new team comprises one alcohol worker and two alcohol support workers.**

**This new service is to be integrated with and is to be complementary to existing service provision within Walsall.**

# Information and Walsall Alcohol Needs Assessment

The previous chapter ended with a graphic display (Figures 1 to 4) of the increasing alcohol problem in the United Kingdom. While overall mortality is decreasing in Europe (Figure 3), there are other exceptions apart from Britain, Finland being one example. McKee (2006) is pessimistic that a European alcohol strategy will materialise. He states that " . . . alcohol related disease accounts for almost 8% of the overall burden of disease in Europe. One factor contributing to the current level of consumption is the single European market, testified to by the existence of vast retail outlets around Calais that thousands of British travellers visit each week. Yet the single market has implications that go far beyond this type of cross border trade. Countries such as Sweden and Finland had longstanding stringent controls on alcohol sales that restricted access to low cost alcohol. After they joined the European Union in 1995 they had to dismantle important parts of their policies, and over the next decade death rates from cirrhosis in Finland rose by 50%. The industry has also used the single market to justify attacks on labels being introduced in France to warn pregnant women of the hazards of drinking. Consequently, national health ministries widely recognise the need for European support to tackle the growing threat to health posed by the liberalisation of the alcohol sector . . ." He goes on to suggest that some elements of the alcohol industry have engaged in a massive and highly effective exercise to derail proposals for Europe wide public health action.

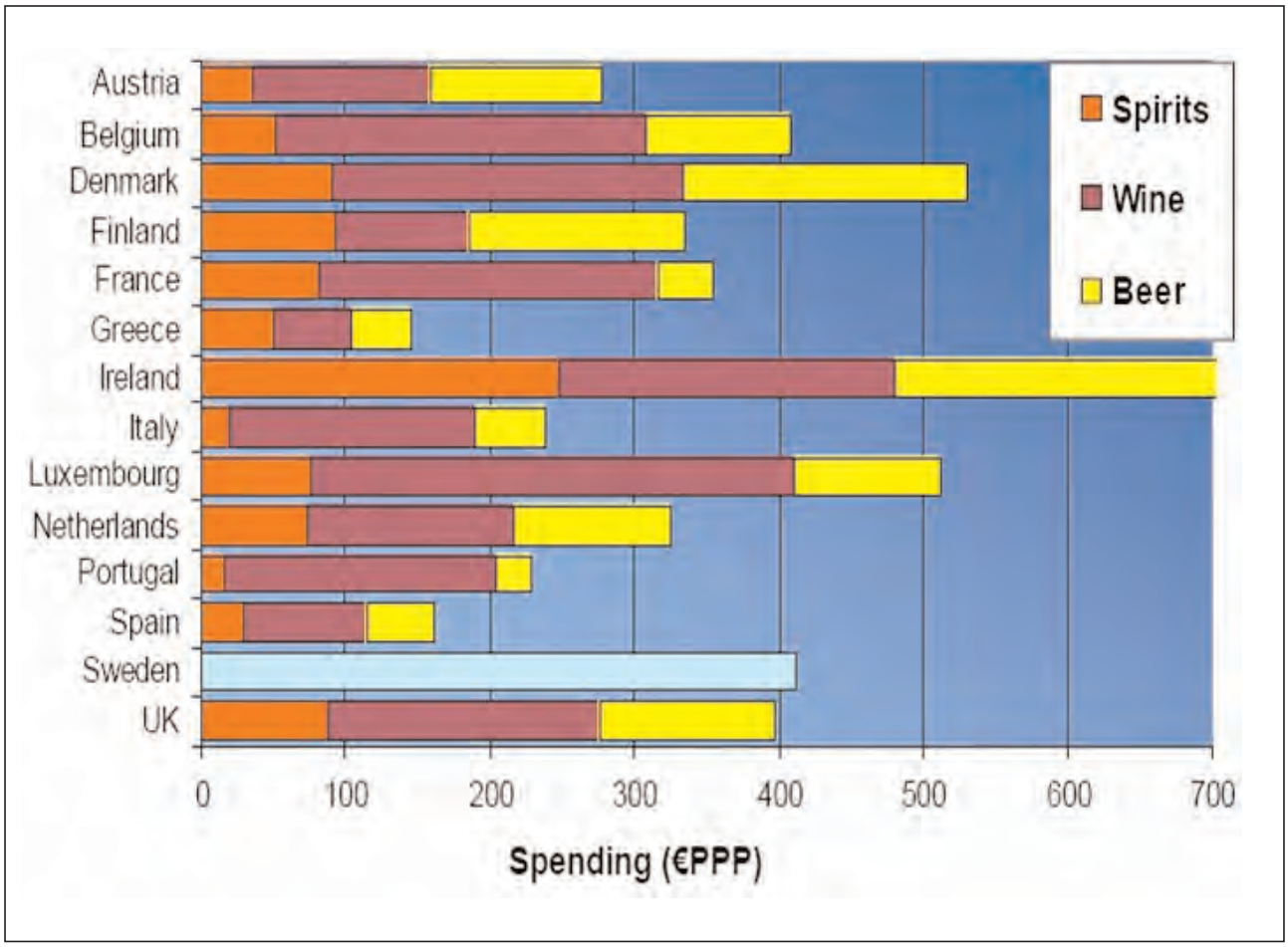



Figure 5. EU consumer spending on alcohol 1999: purchasing power parity (PPP) allows costs to be scaled by the relative prices in different countries

(Household Budget Survey 1999, Eurostat)

The UK has one of the highest levels of expenditure on alcohol in the EU, being among the top six (Figure 5). The figure excludes high Irish beer expenditure as this would distort the scale. Sweden had no beverage-specific data available. Figure 6 shows that in the EU: mortality is the largest single cost to society; crime is the largest group of costs to society; while treatment and prevention only constitute a small part of the costs **(Anderson & Baumberg 2006)**.


Figure 6. Health, social and economic costs in relation to alcohol, EU wide (The ASPECT Consortium 2004)

## The UK costs of alcohol related harm can be summarised:

- **Cost of alcohol misuse estimated at £20 billion per year**
- **30,000 admissions per year due to alcohol dependence**
- **An estimated half of all violent crimes and one third of domestic violence cases are linked to alcohol dependence**
- **17 million working days lost each year**
- **Human and emotional impact on victims of crime; between 780,000 and 1.3 million children affected each year by parents' alcohol use**

There are key sources of information on alcohol related issues in this country, down through to regional and local levels.

## National Alcohol Needs Assessment

The **Department of Health (2004)** recently published the findings of an alcohol needs assessment research project. The work was jointly conducted by the Section of Addictive Behaviour, St George's Hospital, London, Kable Ltd, and MORI Social Research Institute. They adopted the World Health Organization categorisation of alcohol use disorders:

- Hazardous drinking: people drinking above recognised sensible levels but not yet experiencing harm.
- Harmful drinking: people drinking above recognised sensible levels and experiencing harm.
- Alcohol dependence: people drinking above recognised sensible levels and experiencing harm and symptoms of dependence.

They defined the potential demand for health service resources as the estimated number of people in England with alcohol dependence who have consulted their GP in a year; derived from GP consultation rates in the Psychiatric Morbidity Survey **(Singleton et al 2001)**. The potential demand for specialist alcohol services was defined as the number of dependent drinkers per annum who access alcohol treatment in non-specialist services, such as medical or psychiatric services. This group make significant demands on health service resources. The actual demand for specialist alcohol services was defined as the number of dependent drinkers referred to alcohol services. Finally, the gap between need and service provision was expressed as the Prevalence-Service Use Ratio, which is the number in need of interventions divided by the number of people accessing specialist alcohol interventions.

Need estimates were primarily based on the Alcohol Use Disorders Identification Test (AUDIT) questionnaire **(Saunders et al 1993)**. AUDIT scores of 8-15 defined hazardous and harmful drinking, while an AUDIT score of 16 or more defined alcohol dependence. AUDIT is known to possess high sensitivity and specificity when used as a dependence screen in the general population **(Reinert & Allen 2002; Rumpf et al 2002)**. Supplementary data on alcohol consumed were obtained from the 2001 General Household Survey **(Office for National Statistics 2002)**, including measures of binge drinking (more than eight units in one day in the past week for men and six units or more for women), hazardous drinking (between 22 and 50 units per week for men and between 15 and 35 units per week for women) and harmful drinking (more than 50 units per week for men and more than 35 units per week for women).

Some 38% of men and 16% of women had an alcohol use disorder, equating to 7.1 million people in England. Within this there were 32% of men and 15% of women who were hazardous or harmful alcohol users (Figure 7). The overall prevalence of alcohol dependence was 3.6% (6% men and 2% women). There was a decline in all alcohol use disorders with age, with younger people showing a higher prevalence of both hazardous/harmful drinking and alcohol dependence than older people (Figure 8). Black and minority ethnic groups had a considerably lower prevalence of hazardous/harmful alcohol use, but a similar prevalence of alcohol dependence compared with the White population (Figure 9). There was considerable regional variation in the levels of alcohol related need, (as seen in Figure 10).

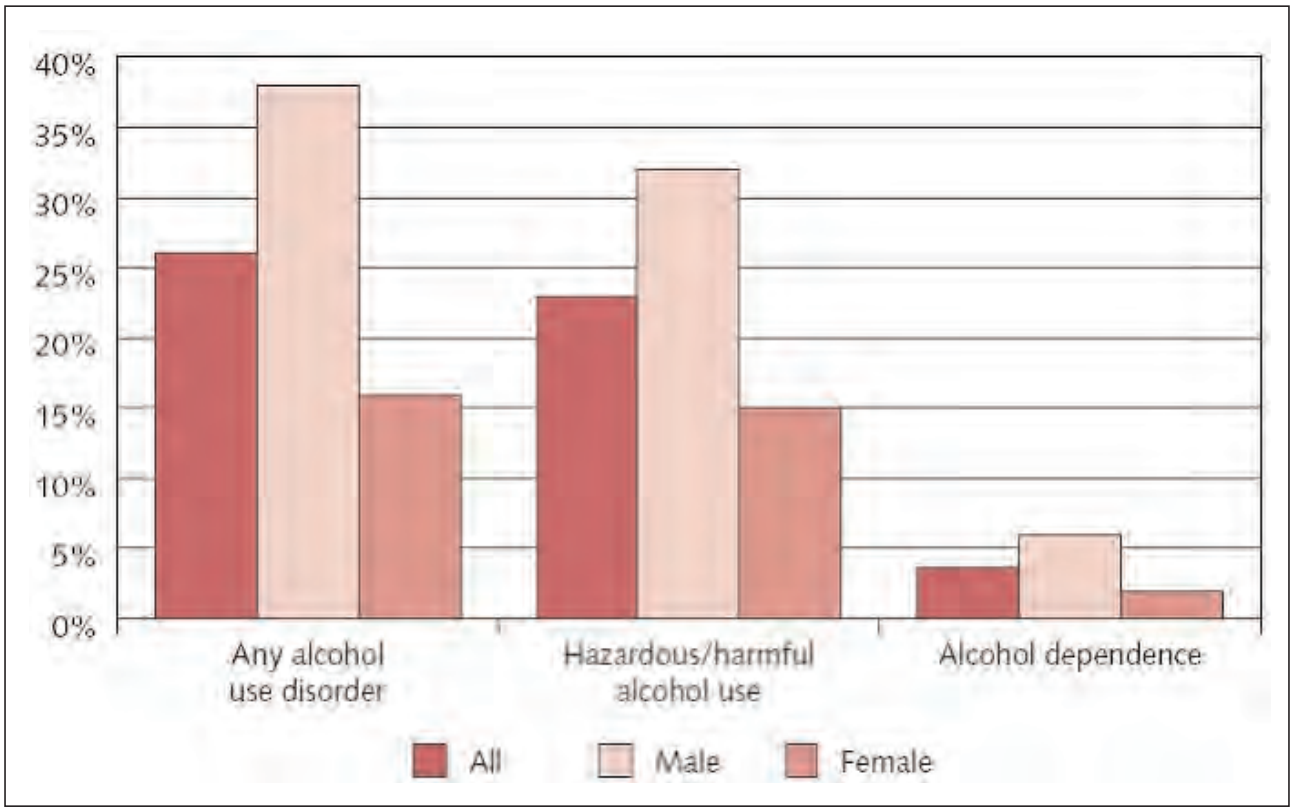



Figure 7. Percentage of people in England with an alcohol use disorder, by type and gender (2001)

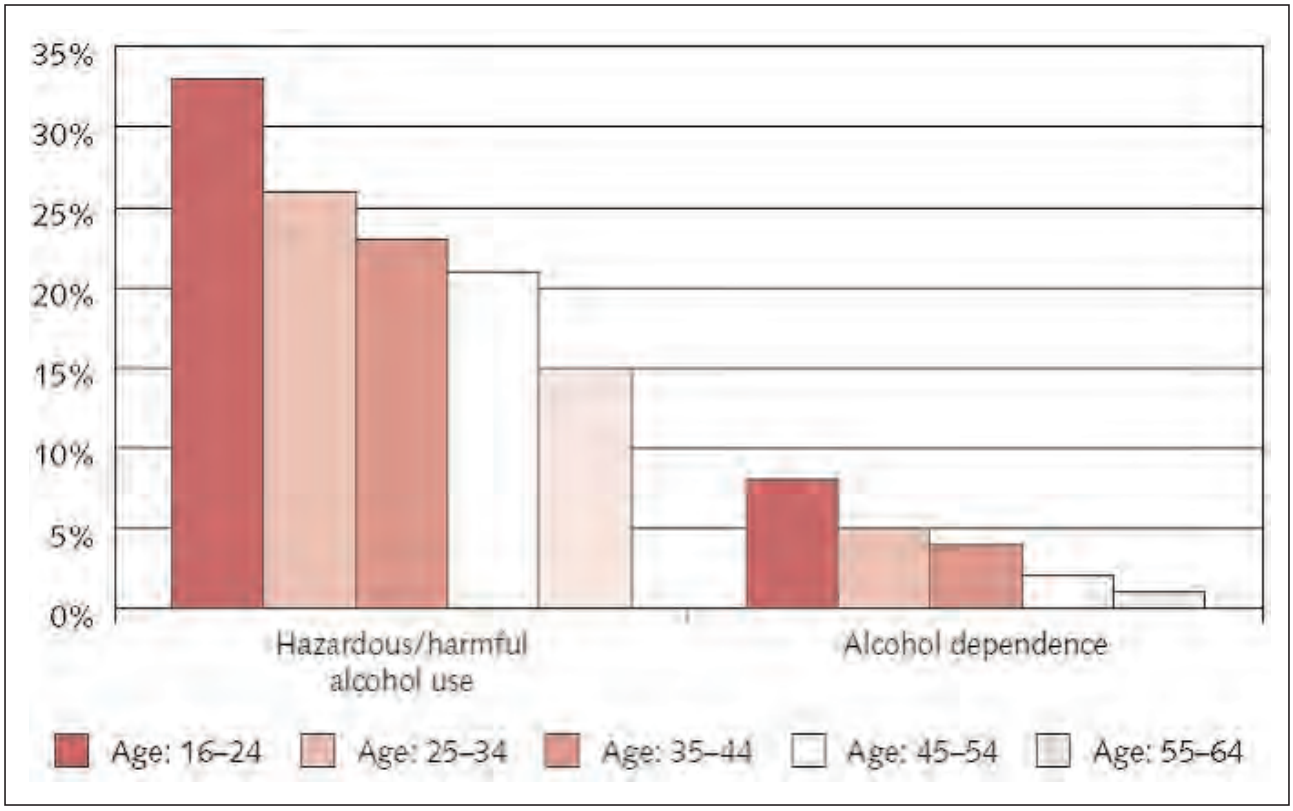



Figure 8. Percentage of people in England with an alcohol use disorder, by age (2001)

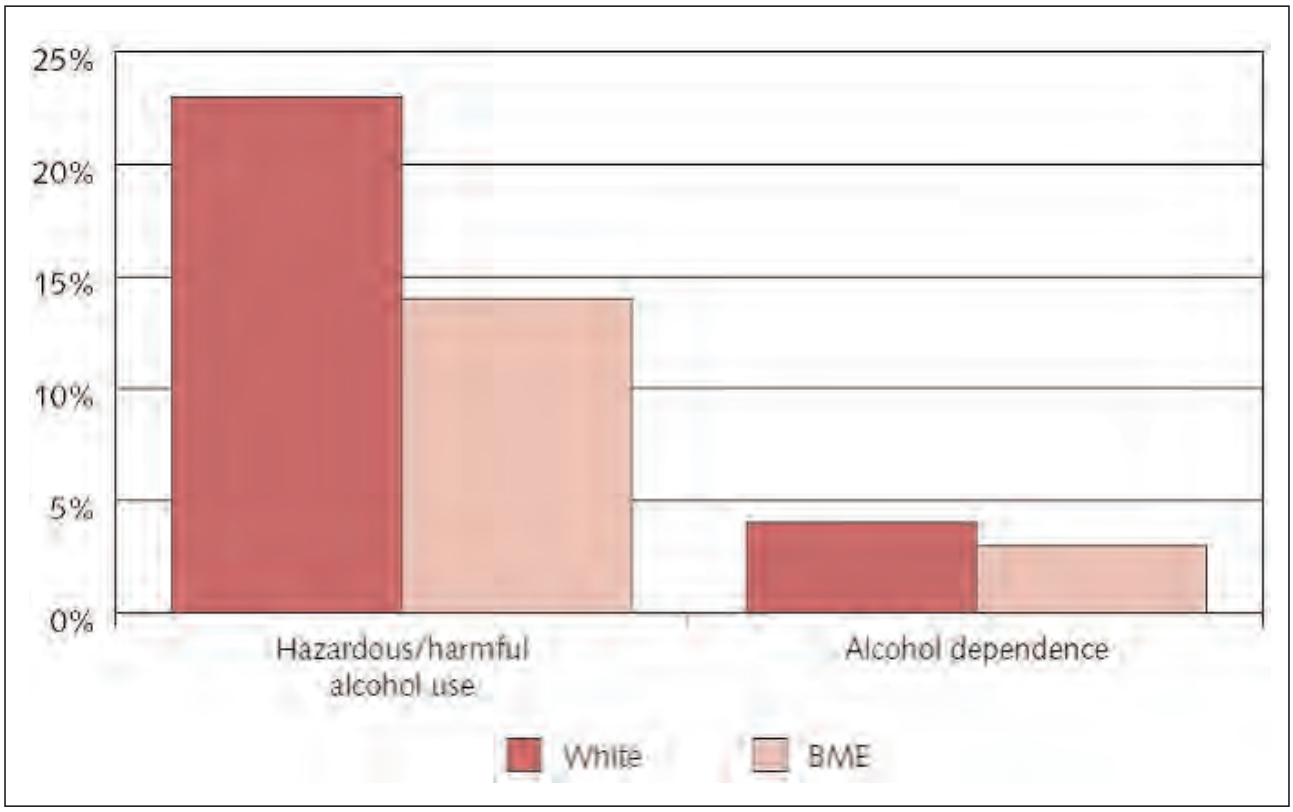



Figure 9. Percentage of people in England with an alcohol use disorder, by ethnicity (2001)

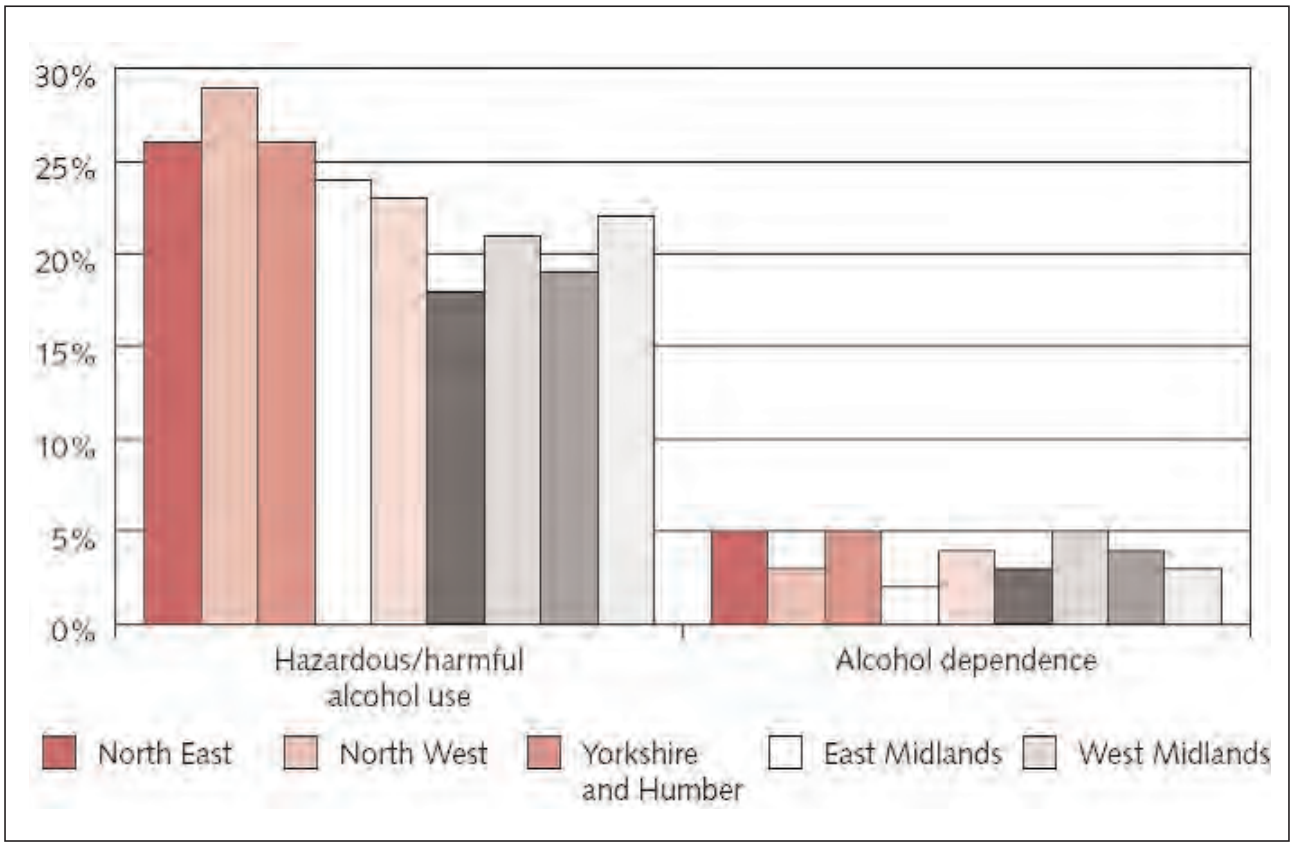



Figure 10. Percentage of people in England with an alcohol use disorder, by region (2001)

There were extremely low levels of formal identification, treatment, and referral of patients with alcohol use disorders by GPs (1 in 67 male and 1 in 82 female hazardous/harmful drinkers; 1 in 28 and 1 in 20 identified male and female dependent drinkers respectively). Younger patients were especially under-identified. Although 71% of alcohol use disorder patients identified by GPs were felt to need specialist treatment, the qualitative research suggested that many were not referred because of two main factors: perceived difficulties in access, usually through long waiting times for specialist treatment; and patient preference not to engage in such treatment. The study suggested that GPs limit demand for specialist services by low levels of routine enquiry about alcohol issues and finding alternatives to specialist treatment such as in-house interventions and referral to self-help groups such as Alcoholics Anonymous.

Responses from DAATs on specialist alcohol services showed availability of counselling (81%), inpatient detoxification (63%), specialist advice and information (60%), and day treatment (53%). DAAT professionals were aware of a very large gap between the provision of alcohol treatment and need or demand. They also believed that the harm resulting from alcohol misuse was far greater to both the individual and the community than the harm resulting from drug misuse. There was concern that the supply of alcohol needed to be tackled as much as demand, and that the alcohol strategy focuses more on reducing crime and disorder rather than addressing health and social care needs. There was also concern about the delay in action to improve services following publication of the national alcohol strategy. This has had a negative impact on professionals in the field who feel the strategy has raised expectations but has not produced the desired impact on services on the ground. The lack of specific targets in the alcohol strategy will hamper local action to develop alcohol initiatives.

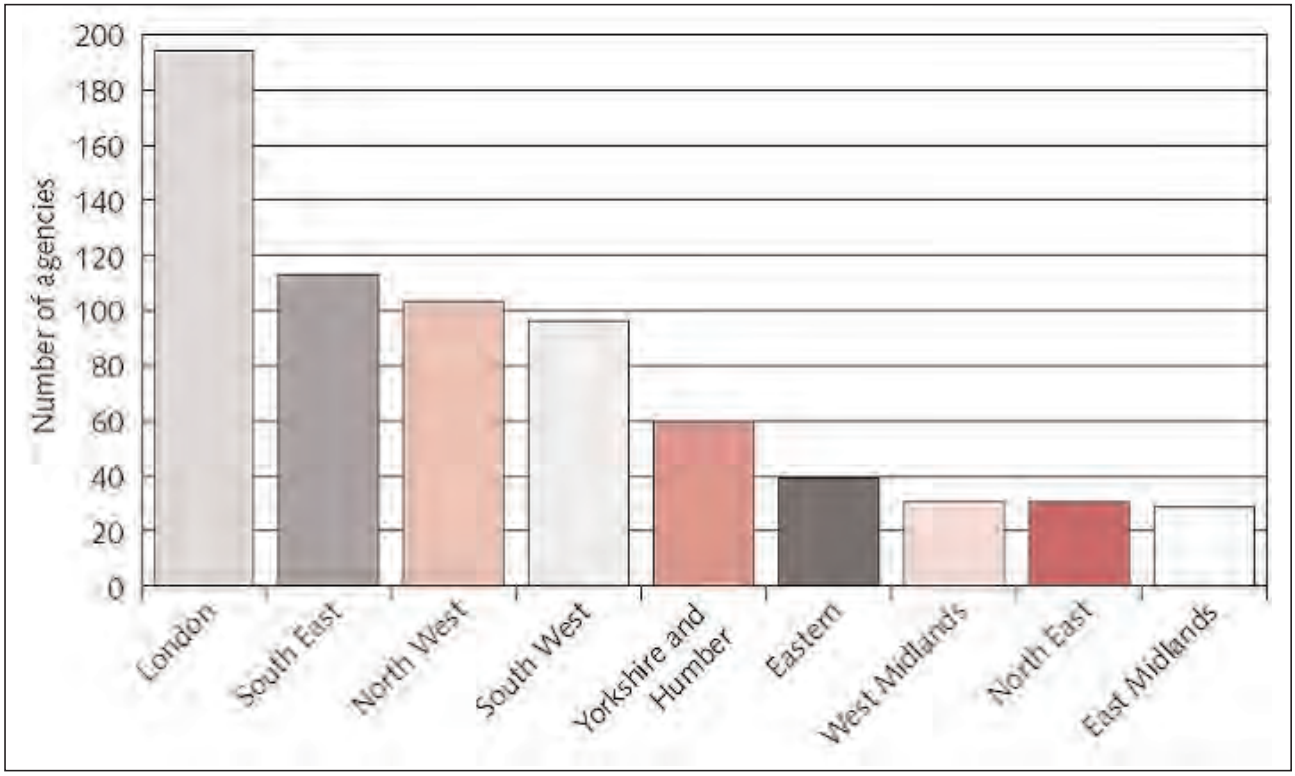



Figure 11. Distribution of alcohol treatment agencies by an alcohol needs assessment mapping exercise by region (n=696)

The study identified 696 agencies providing specialist alcohol interventions across England, with considerable regional variation in numbers; London having the largest and East Midlands the fewest (Figure 11). Nearly 69% of alcohol agencies were community based and 31% were residential services, the former providing advice, brief and psychological interventions. Clients with more severe alcohol dependence were the largest group of clients in both. The largest proportion of referrals to alcohol agencies were self-referrals (36%), followed by primary care (24%). Groups most commonly perceived to be poorly served by alcohol treatment services were women caring for children, homeless people, ethnic minorities and clients with dual diagnosis.

An estimated gap analysis across England provided a Prevalence-Service Use Ratio (PSUR) of 18; equating to 5.6% of the "in-need" alcohol-dependent population accessing treatment each year. Women were 1.7 times more likely to access alcohol treatment than men (PSUR: women 12; men 21). Figure 12 shows that there was considerable regional variation in PSUR from 1 in 102 (1% of alcohol dependent people accessing treatment in a year) in the lowest access region (North East) to 1 in 12 (8% of alcohol dependent people accessing treatment in a year) in the highest (North West). The figure shows that the West Midlands was a relatively high access region. The gap analysis also highlighted that more than twice as many people are referred for alcohol treatment than those who actually access treatment (2.7:1).

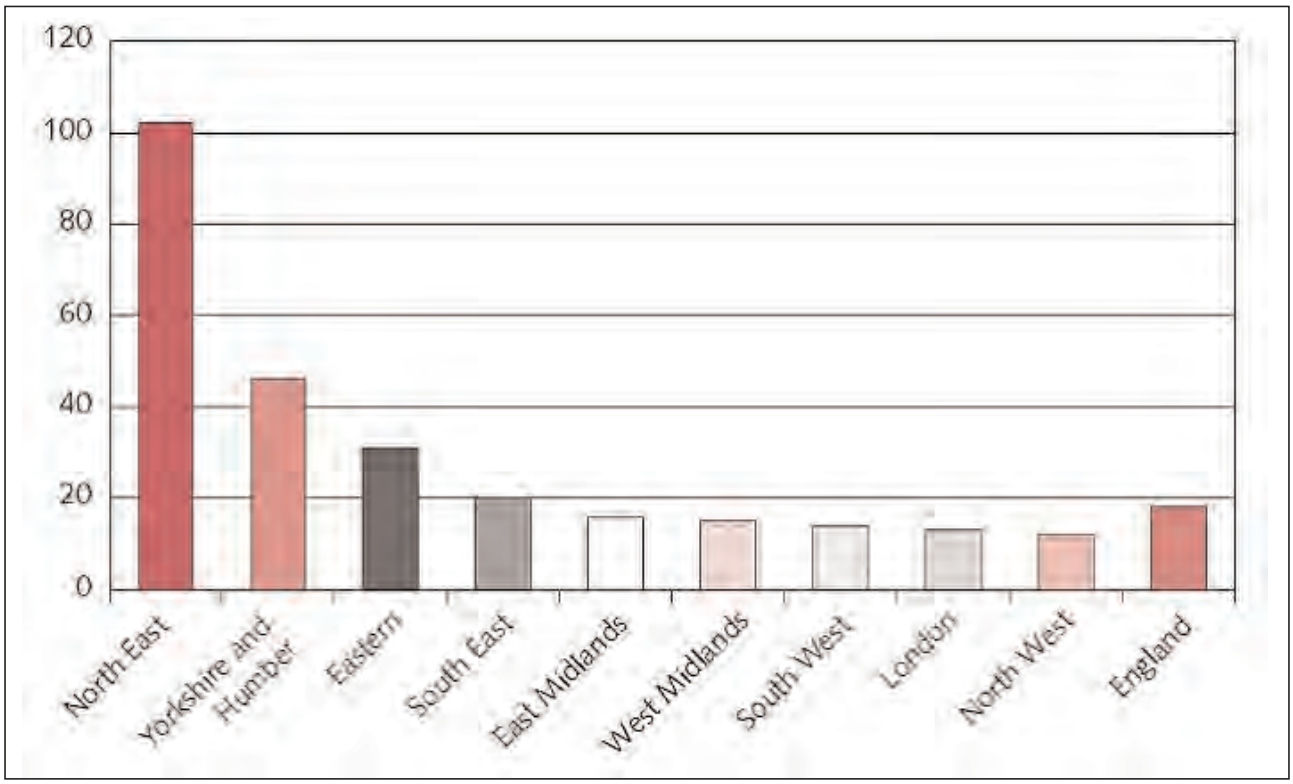



Figure 12. Prevalence service utilisation by region according to PSUR value

Key conclusions of the research were:

- There is a large gap between the need for alcohol treatment and actual access to treatment with only 1 in 18 (5.6%) alcohol dependent individuals accessing specialist alcohol treatment nationally per annum.
- Approximately a third of alcohol dependent individuals referred to treatment actually access treatment and since 36% of referrals are self-referrals, this suggests the need for greater public awareness initiatives (coupled with the need to address capacity to meet demand).
- There is a higher level of reported screening and intervention activity in primary care than previously studied and a higher level of confidence in dealing with alcohol problems, but there is still scope for improvement, with most GPs expressing the need for more training to deal with alcohol in primary care.
- There was a high level of satisfaction among GPs with specialist services, but a high level of difficulty in ensuring access, suggesting that increased capacity in alcohol services would lead to increased actual demand and access.
- While there was considerable scope for increased identification and referral to specialist care from generic services including primary care, general hospitals, mental health services, criminal justice agencies, and social services - again- it will be essential to ensure adequate capacity in specialist alcohol services to meet increased demand from initiatives to increase screening and referral.

## Three main harm mechanisms from alcohol:

### (1) CHRONIC HIGH CONSUMPTION

- Tolerance and no obvious inebriation
- Not necessarily any unruly behaviour
- Frequently associated with cirrhosis of the liver

### (2) DEPENDENCE

- Leading mental health disorder
- Signs of withdrawal if alcohol denied
- Cirrhosis does not inevitably develop

### (3) INTOXICATION (inc. binge drinking)

- Drinking large amounts, one session (eg 8-10 units)
- Associated with crime and disorder
- Damage to family, social relations
- Accidents and reduced productivity
- Tackling this in young may prevent entry into (1) or (2)

## What alcohol does to your body

Adapted from a Merck Pharmaceutical poster, Hayward Medical Communications 1999

### Brain damage
This is one of the most serious consequences of excessive alcohol consumption and the majority of chronic alcoholics will suffer a degree of brain damage (1).

### Heart disease
Drinking above the recommended limits is a common cause of high blood pressure, increasing risk of stroke and heart disease (2). Alcohol can also damage heart muscle, causing a condition known as cardiomyopathy (3).

### Cancer
Around 3% of all cancers can be attributed to alcohol (2): in particular, there is an increased risk of mouth and throat cancers (3) and probably also of breast cancer (4).

### Psychiatric disorders
High levels of anxiety, depressive illness, hallucinations and blackouts are associated with heavy drinking (3). The lifetime risk of suicide for alcohol-dependent individuals is about 60-120 times the suicide risk of the non-psychiatrically ill population (3).

### Liver disease
Alcohol problems are the most common cause of liver damage in the UK: 90% of heavy drinkers will have a fatty liver; around 40% will develop alcoholic hepatitis (inflammation of the liver), a potentially fatal condition; and 8-30% of drinkers with a 10-20 year history of daily heavy drinking will develop alcoholic cirrhosis, a deadly liver disease (3).

### Digestive problems
Peptic ulceration, gastritis, and acute and chronic pancreatitis are all associated with heavy drinking (3).

### Impaired mobility
Osteoporosis (brittle bones), gout (causes severe arthritis), muscle and nerve damage (causes limb weakness) can develop as a result of excessive drinking (3).

### Impotence
Men who are heavy drinkers have more sexual problems than men who do not (5).

(1) Rang & Dale (1991)
(2) Alcohol Concern (1997)
(3) Chick et al (1997)
(4) Bowlin et al (1997)
(5) Health Education Board for Scotland (1998)

## Local Alcohol Profiles for England

These were recently produced by the North West Public Health Observatory (2006), in association with the Centre for Public Health, Liverpool John Moores University. Routine data and intelligence were compiled from a range of sources, including the Department of Health and the Home Office. In this section, the information relating to Walsall is presented alongside that of the other Black Country boroughs, Birmingham, the West Midlands, and England.

Table 1 shows the percentage of adults aged 16 years and over who binge drank 2000-2002 (men: consumed 8 or more units of alcohol on the heaviest drinking day in the previous seven days; women: 6 or more units). The synthetic estimates are derived from a number of sources including the Health Survey for England data, Census 2001 and other administrative sources. It would appear that other regions in England have a greater binge drinking culture than that in the West Midlands

| | |
|---|---|
| Walsall | 14.9 |
| Birmingham | 14.7 |
| Dudley | 16.5 |
| Sandwell | 14.3 |
| Wolverhampton | 13.8 |
| West Midlands | 15.9 |
| England | 18.2 |

Table 1. Percentage adults binge drinking, 2000-2002

Reduced life expectancy attributable to alcohol was calculated from deaths under 75 years of age, and expressed as months of life lost (Table 2). Alcohol related mortality, based on a revised and expanded list of International Classification of Disease 10 codes, is shown in Table 3. Readers are directed to the original report for the details of methodology. In both Tables, Walsall men compare well to those from neighbouring areas, although conforming approximately to regional and national averages. Walsall women are marginally of greater concern.

| | Men | Women |
|---|---|---|
| Walsall | 10.7 | 6.2 |
| Birmingham | 12.6 | 5.1 |
| Dudley | 11.1 | 6.0 |
| Sandwell | 15.6 | 6.9 |
| Wolverhampton | 15.3 | 7.1 |
| West Midlands | 10.9 | 5.5 |
| England | 9.6 | 5.1 |

Table 2. Months of life lost attributable to alcohol, 2002-2004

| | Men | Women |
|---|---|---|
| Walsall | 52.8 | 31.7 |
| Birmingham | 66.3 | 29.0 |
| Dudley | 55.5 | 32.7 |
| Sandwell | 73.8 | 36.3 |
| Wolverhampton | 67.5 | 33.2 |
| West Midlands | 56.0 | 30.1 |
| England | 50.2 | 28.0 |

Table 3. Alcohol related mortality, per 100,000 population, 2004

Tables 4 and 5 present alcohol specific and alcohol related hospital admission data. Specific conditions include diseases such as alcoholic cirrhosis of the liver. Alcohol related admissions also include categories such as accidents, which are not specific. Again, ICD 10 codes were scrutinised, using a complex methodology. This time, rates for Walsall on both counts were significantly above the regional and national averages.

| | **Men** | **Women** |
|---|---|---|
| Walsall | 928 | 497 |
| Birmingham | 1071 | 546 |
| Dudley | 704 | 390 |
| Sandwell | 1023 | 519 |
| Wolverhampton | 825 | 463 |
| West Midlands | 782 | 437 |
| England | 826 | 462 |

Table 4. Alcohol related hospital admissions, per 100,000 population, 2004-05

| | **Men** | **Women** |
|---|---|---|
| Walsall | 370 | 162 |
| Birmingham | 441 | 159 |
| Dudley | 256 | 112 |
| Sandwell | 413 | 147 |
| Wolverhampton | 293 | 112 |
| West Midlands | 285 | 127 |
| England | 306 | 145 |

Table 5. Alcohol specific hospital admissions, per 100,000 population, 2004-05

Table 6 presents recorded crime related to alcohol. The recorded data included:

- Violence against the person
- Sexual offences
- Robbery
- Burglary
- Theft of a motor vehicle
- Theft from a motor vehicle.

| | Recorded total | Violence only |
|---|---|---|
| Walsall | 11.6 | 8.2 |
| Birmingham | 13.9 | 9.4 |
| Dudley | 8.4 | 5.6 |
| Sandwell | 10.1 | 6.5 |
| Wolverhampton | 12.3 | 8.4 |
| West Midlands | 10.1 | 7.2 |
| England | 10.5 | 7.3 |

Table 6. Alcohol related crime, per 1,000 population, 2005-2006

The Table presents total recorded crime from these six categories and that from violence only. Numerators and population denominators for categories of offences were obtained nationally from the Home Office for all of the Crime and Disorder Reduction Partnerships in England. Data are presented as crude rates. Walsall's rates are above regional and national averages.

## Policy on Alcohol Consumption

Standard health advice is that:

- Men should not drink more than 21 units per week and not more than 4 units on any one day
- Women should not drink more than 14 units per week and not more than 3 units on any one day
- Pregnant women or women planning a pregnancy should not drink at all, or at least make every effort to reduce the amount of alcohol consumed.

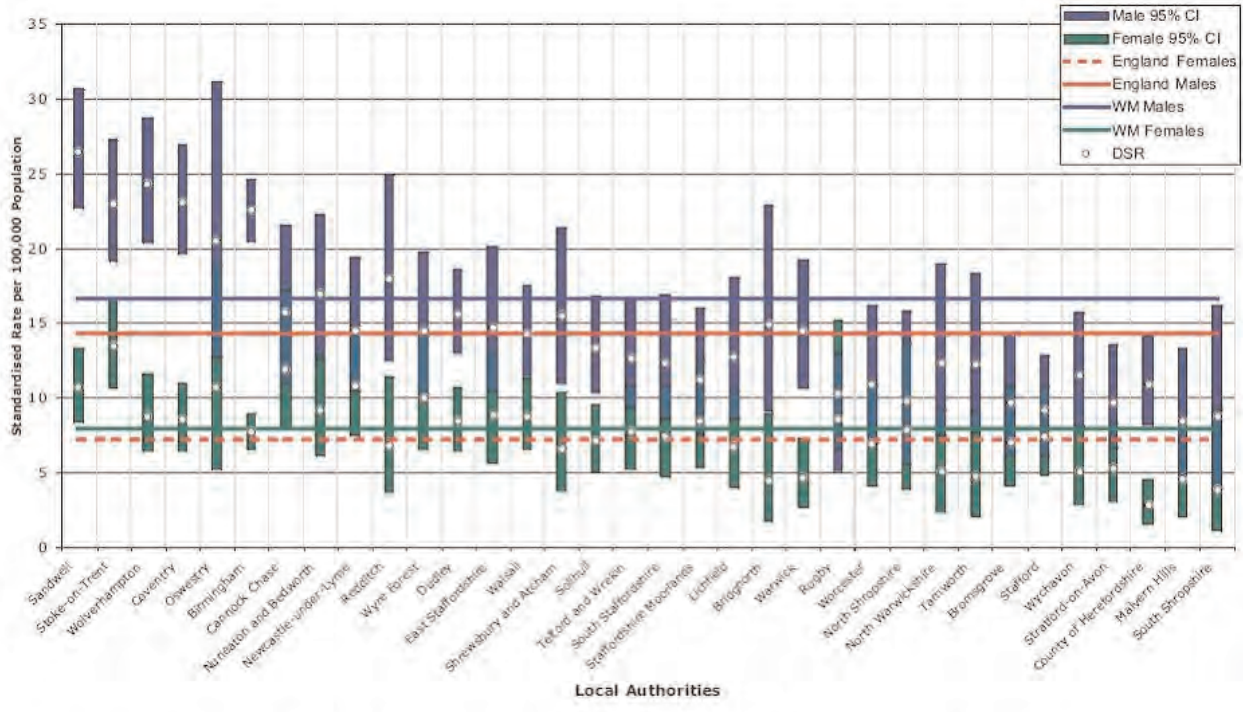
Government policy is to encourage and support sensible drinking, but this indicates the need to reduce alcohol misuse in the form of binge drinking and chronic over-consumption. It is NOT an endorsement of moderate drinking as the wisest or most healthy option. Indeed, abstinence is a valid personal choice and, given the addictive nature of alcohol, some would argue that it is the only sensible choice. At present, there is no Public Sector Agreement target related to alcohol harm reduction, although a clear strategy on alcohol will contribute to existing PSA targets on improving life expectancy, reducing inequalities and reducing crime and disorder.

# Alcohol in the West Midlands

The above title is the subject of a report, reviewing alcohol and alcohol services in the West Midlands, produced by the West Midlands Public Health Group (2006), in collaboration with the West Midlands Public Health Observatory. The following represent highlights from the report.

Alcohol occupies an important place in the social and cultural life of the UK. As many as 90% of adults in the UK drink, usually as an enjoyable and pleasurable accompaniment to food, entertainment, sport and other leisure pursuits. The alcohol industry is valued at more than £30 billion per annum, employing around one million people and contributing £8 billion in taxes. However, alcohol is implicated in 40% of all reported crime, and associated with 70% of stabbings and beatings, the broken beer glass being a most common weapon of assault. Alcohol related crime and anti-social behaviour costs the UK around £7.3 billion annually. Every year, 1 in 6 deaths on the road are related to drink-drive accidents. An estimated 1 million children are affected by parental alcohol problems. Marriages beset by such problems are twice as likely to end in divorce. Half of rough sleepers have problems with alcohol. Sickness absence due to alcohol results in £6.4 billion of lost production. The total cost of alcohol-related harm in England is around £20 billion per annum.

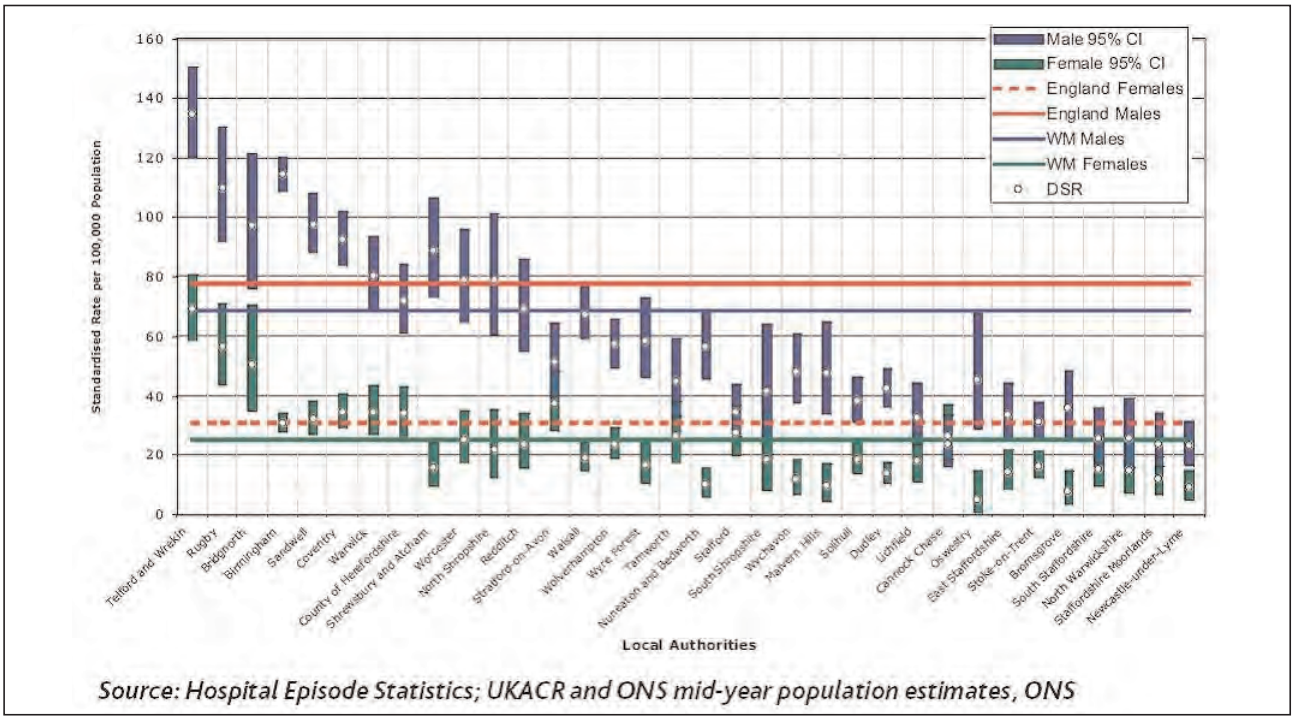
Of the Government Office Regions across England, the West Midlands comes about midway in terms of mean consumption (15.9 units per week for men and 7.2 for women) with the North East consuming the most and London the least amount of alcohol. The West Midlands is average also for the proportion of people exceeding advised daily limits of alcohol consumption. The West Midlands has the third highest alcohol related death rate, with dramatic inequalities: eg a four-fold variation in death rate between the affluent South Shropshire (6 per 100,000) and the deprived area of Sandwell (19 per 100,000).




*Source: PHO mortality files, ONS; UKACR and ONS mid-year population estimates, ONS*

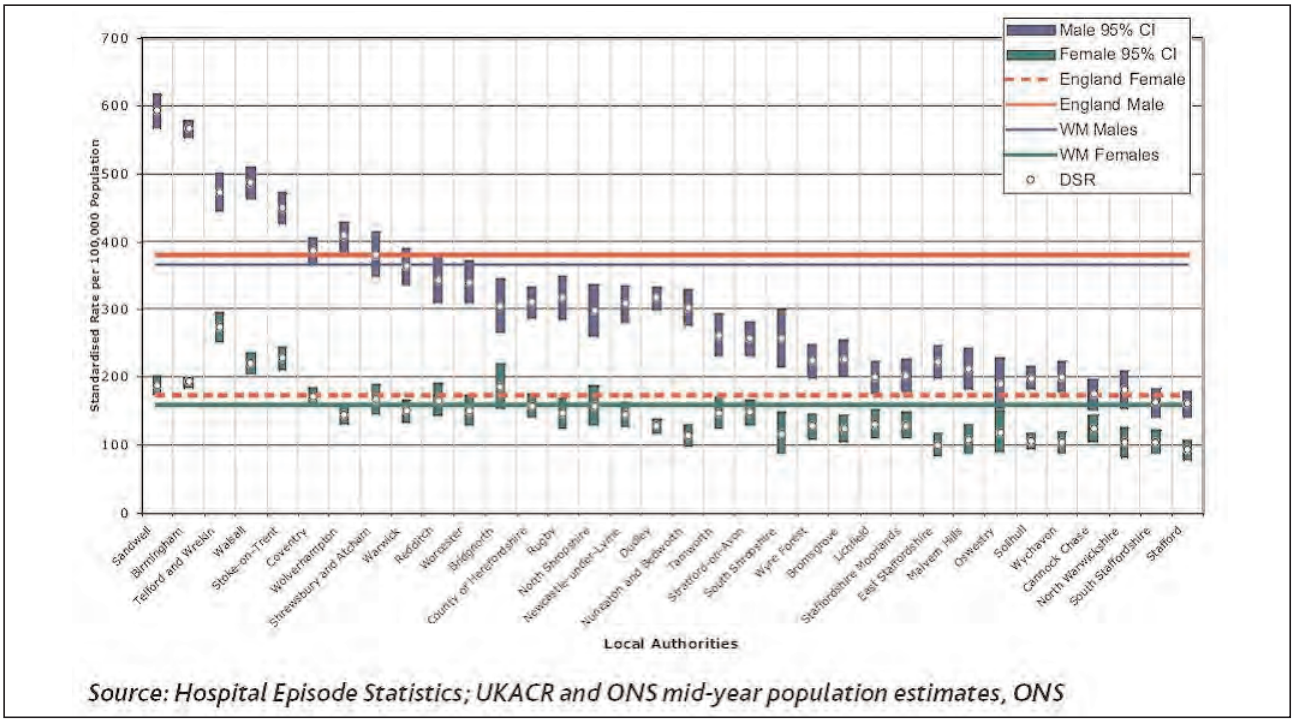
Figure 13. Direct standardised rate per 100,000 population for alcohol related mortality by gender and West Midlands Authority, all ages, 2000-2004

Figure 13 shows Walsall's alcohol related mortality in relation to other local authority areas in the West Midlands. Walsall is just below the regional average for males and just above that for females. For males especially, Sandwell, Stoke, Wolverhampton, Coventry, Oswestry and Birmingham have significantly higher rates. Figure 14 shows Walsall's alcohol related accident admissions compared to other areas and, again, they are around the regional average for both males and females. Birmingham, Sandwell and Coventry men again feature here as significantly higher than the regional average. Figure 15 shows alcohol related hospital admissions and this time, Walsall men and women feature prominently among the highest rates.




*Source: Hospital Episode Statistics; UKACR and ONS mid-year population estimates, ONS*

Figure 14. Direct standardised rate per 100,000 population for alcohol related accident admissions by gender and West Midlands Authority, all ages, 2000-2004




*Source: Hospital Episode Statistics; UKACR and ONS mid-year population estimates, ONS*

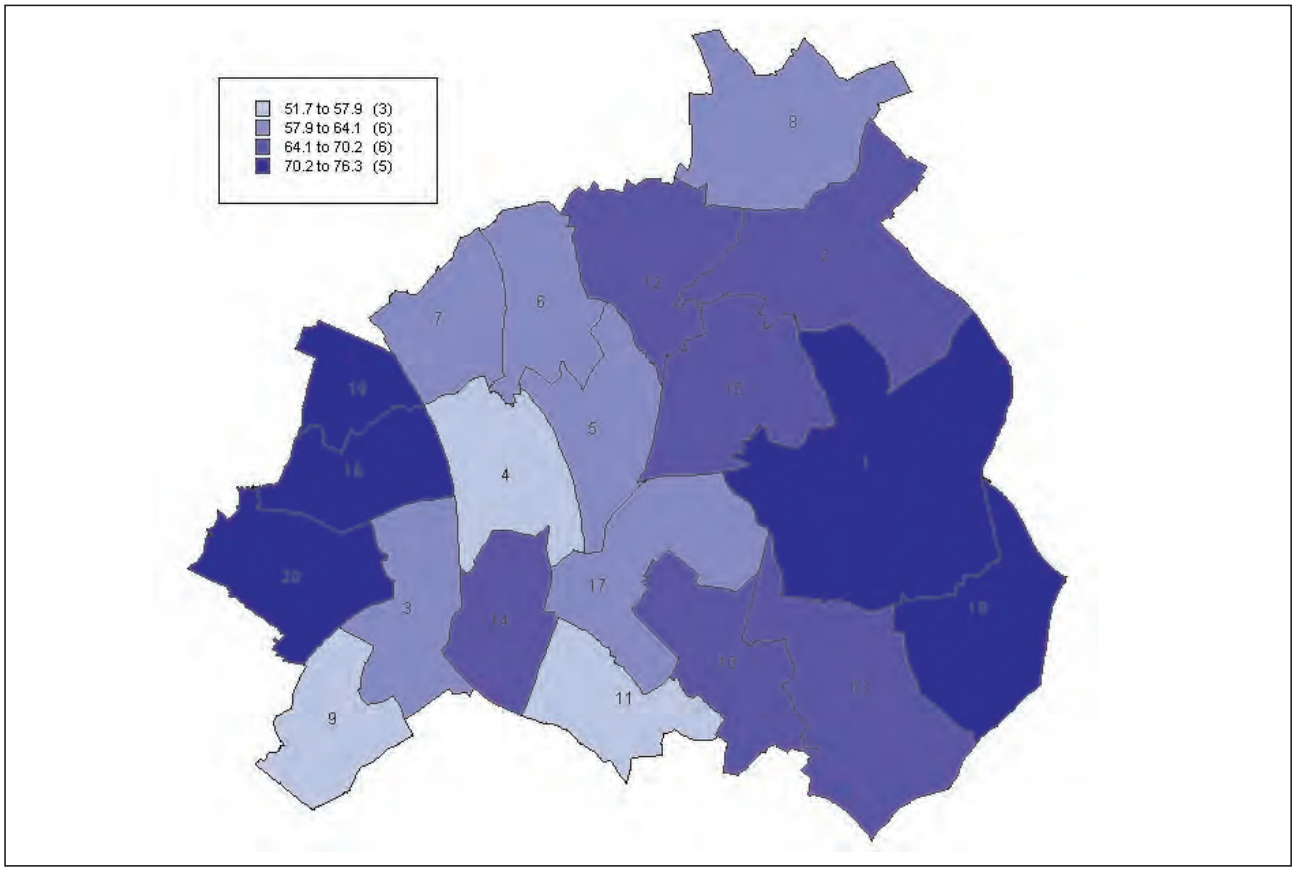
Figure 15. Direct standardised rate per 100,000 population for selected alcohol related admissions by gender and West Midlands Authority, all ages, 2000-2004

A survey of West Midland GPs showed that 60% frequently see patients with alcohol-related problems and 22% dealt with 20 or more patients with drink-related problems in the previous 6 months. Similar rates applied to social workers but 90% of probation officers frequently dealt with clients with alcohol-related problems. Most PCTs, including Walsall, had good arrangements in place for shared care between GPs and tier 2 or tier 3 alcohol services, the latter provided by Addaction Walsall and Lantern House respectively. Further information is provided in Chapter 6 on Walsall alcohol services, along with definitions of alcohol service tiers.

## West Midlands Regional Lifestyle Survey: Walsall

The West Midlands Regional Observatory completed the third in a series of lifestyle surveys in 2005, building on results from 1995 and 2001. The postal questionnaire sent to all districts in the West Midlands region included questions on general health, smoking, exercise, diet, alcohol, and various community and environmental issues. Analysis of the Walsall results of this survey have been used to produce a Public Health report in Walsall, of which the alcohol results are shown below.

In the 2005 survey, about 65% of respondents in Walsall said they drank alcohol. This was a slightly lower proportion than the regional average of 71%, and substantially lower than that reported in the 2001 survey when 84% of Walsall respondents said they drank alcohol. The estimated prevalence of drinking in 2005 equates to about 125,000 people aged 18 years and over. More Walsall men (76%) are drinkers than women (55%). Drinking prevalence is highest among young people and decreases with age. For example, over 76% of 18-24 year olds drink, falling to 46% in people aged 75 years and over. Map 1 illustrates the substantial variation in drinking prevalence across wards in Walsall. The pattern suggests a negative correlation with deprivation, with more people in affluent, more eastern, wards drinking and fewer in the more western deprived communities. More than 50% of the adult population in all wards drank alcohol. The highest prevalence (76%) was in Aldridge Central and South (1) and in Streetly (18) wards; the lowest rates were in Palfrey (11) and Darlaston South (9), with rates of 52% and 53% respectively.




Map 1. Proportion of adults drinking alcohol in Walsall by ward, 2005

Table 7 summarises respondents' reported frequency of drinking in the three lifestyle surveys from 1995 to 2005. The 1995 and 2001 survey questionnaires included scope for drinkers to respond that they drank less than once per week. However, this category was omitted from the 2005 questionnaire. Nevertheless, during the decade it can be seen that among those people who do drink, the frequency of drinking has increased across the board: more people are drinking on a few days per week and more are drinking everyday. Frequency of drinking among Walsall people in 2005 was similar to the pattern in the West Midlands, except that in Walsall there was a larger proportion drinking on only 1-2 days per week.

| | 1995 | | 2001 | | 2005 | |
|---|---|---|---|---|---|---|
| | Walsall | W.Mids | Walsall | W.Mids | Walsall | W.Mids |
| Less than once / wk | 29 | 30 | 25 | 26 | - | - |
| 1-2 days / wk | 38 | 38 | 38 | 36 | 47 | 42 |
| 3-4 days / wk | 17 | 17 | 18 | 19 | 29 | 28 |
| 5-6 days / wk | 7 | 6 | 8 | 9 | 12 | 12 |
| Every day | 9 | 9 | 11 | 10 | 12 | 12 |

Table 7. Percentage of adults in Walsall drinking by frequency, 1995-2005

The 2005 survey also indicates that:

- Women drink less frequently than men. For example, 55% of women were drinking on up to 2 days a week compared to 41% of men. Conversely, 14% of Walsall men were drinking alcohol every day compared to only 9% of women.
- Less frequent drinking (up to 2 days per week) was more prevalent in younger age groups (63% in 18-24 years olds compared to 38% in over 75 years) and more frequent drinking (every day) occurred as people get older (24% in 75 years and over compared to only 4% in 18-24 years olds).
- There was no substantial variation in frequency of drinking by ward across Walsall, although more frequent drinking occurred mostly in Rushall (15) and Aldridge & Walsall Wood (2) where 16% drank every day.
- Of the respondents who stated which type of drink they drank recently, the largest majority who drank draught beer products were men aged 25-34 years (17%). For alcopops, the most frequent drinkers were women aged 18-24 years (27%) and for spirits, men aged 25-34 years were the heaviest consumers (10%). Women aged 35-44 years were the most frequent drinkers of wine (14%).

Respondents who said they drank were asked to recall how much they had consumed in the past week. Table 8 highlights that drinking in excess of weekly sensible levels in Walsall had reduced marginally in 2005 for both men and women compared with a decade earlier, although there had been a marginal increase since 2001 among men. Among drinkers, 23% of men and 10% of women in Walsall were drinking in excess of sensible weekly levels. This is equivalent to about 14,000 men and 7,000 women in the total adult population of Walsall. In contrast to earlier surveys, drinking in excess of sensible levels in Walsall was lower than the West Midlands regional average in 2005.

| | 1995 | | 2001 | | 2005 | |
|---|---|---|---|---|---|---|
| | Walsall | W.Mids | Walsall | W.Mids | Walsall | W.Mids |
| Men | 25 | 24 | 20 | 21 | 23 | 26 |
| Women | 11 | 10 | 12 | 12 | 10 | 13 |

Table 8. Percentage of drinkers drinking alcohol in excess of sensible levels, 1995-2005

In order to determine levels of binge drinking, drinkers in 2005 were also asked to recall the most they had drunk in one session. About 38% of men and 21% of women drinkers could be classified as binge drinkers; equivalent to about 23,000 men and 14,000 women in Walsall. These rates are marginally higher than the regional averages of 36% for men and 19% for women. The pattern of binge drinking in Walsall is summarised in Figure 16. Drinking patterns by gender were very similar for all ages, with far fewer women binge drinking than men, with the exception of people aged 75 years and over, in whom a higher proportion of women binge drink. The largest group of male binge drinkers were in the 25-34 years category (55% of drinkers) but in the female population, the highest proportion of binge drinkers was among 18-24 year olds.

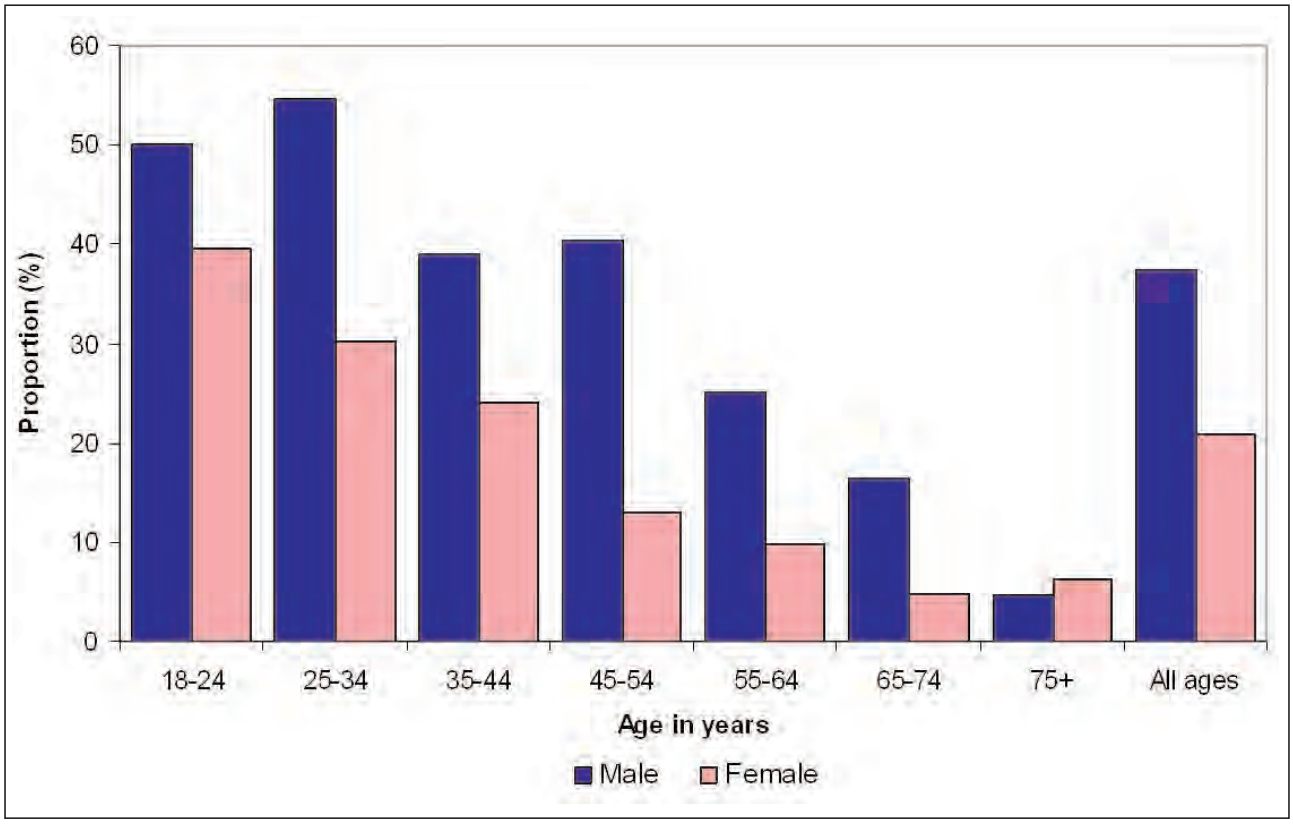
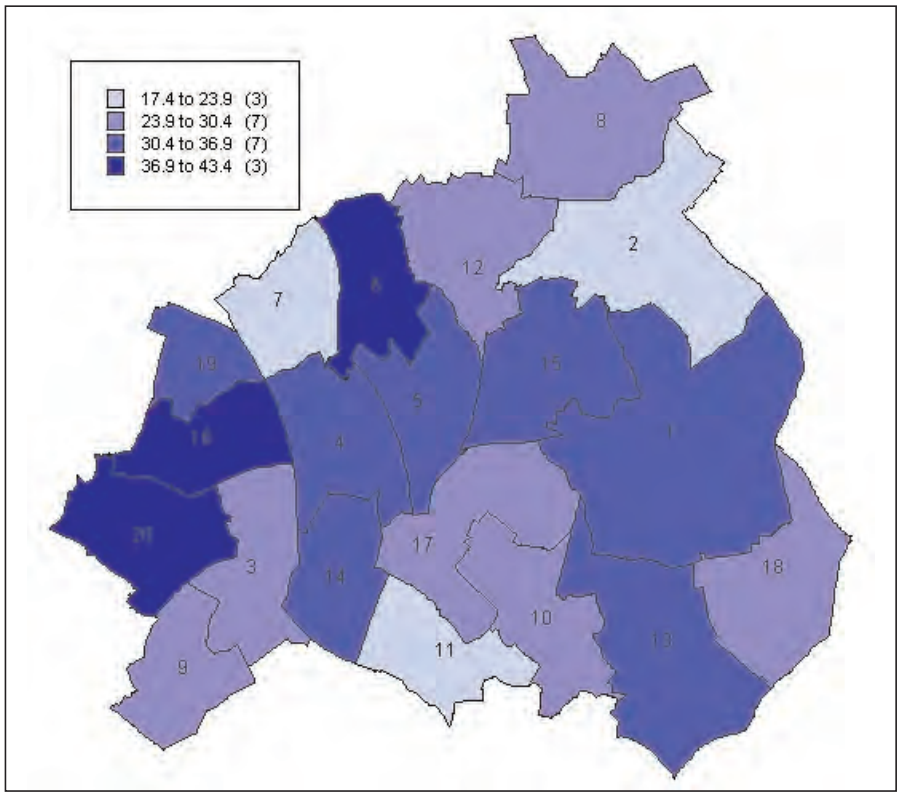
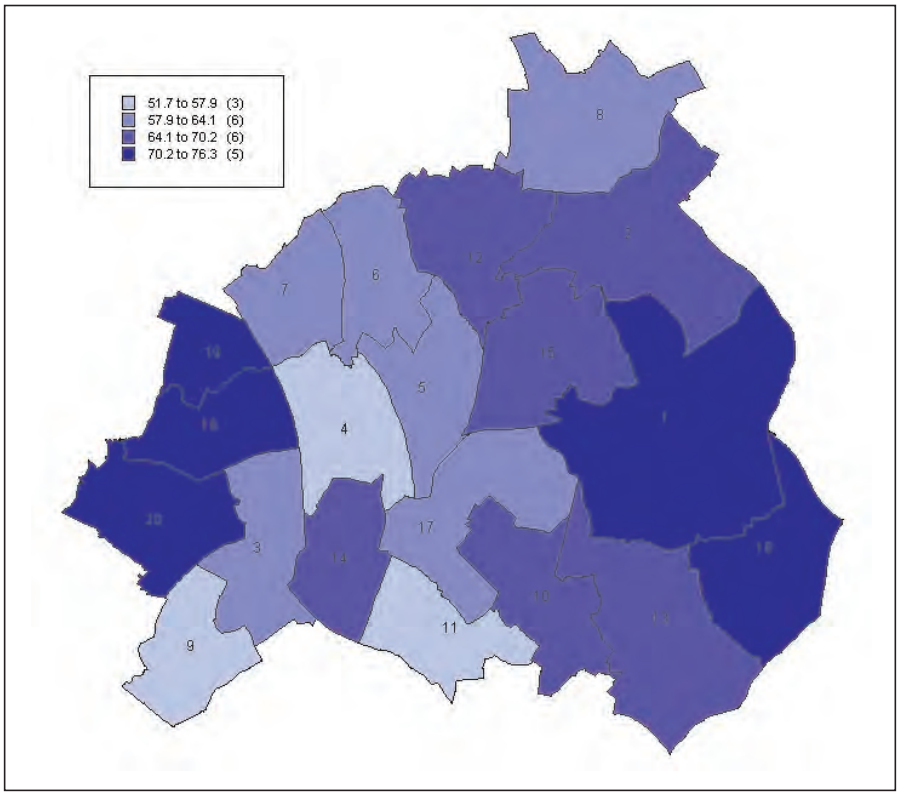



Figure 16. Percentage of Walsall drinkers binge drinking, by age and gender, 2005




Map 2. Percentage of drinkers binge drinking, by ward, 2005




Map 3. Percentage of respondents drinking, by ward, 2005

Map 2 shows that there was no clear geographical pattern of binge drinking across Walsall wards. Map 3 is a repetition of Map 1, as a comparison, to show the percentage of people drinking any amount of alcohol. The highest rates of binge drinking were in Bloxwich East (6) and Short Heath (16), at 43% and 42% respectively. The lowest rates were in Aldridge North & Walsall Wood (2) and Palfrey (11), at 17% and 21% respectively. By gender, St Matthews (17) had the most male binge drinkers (62%), while Birchills (4) and Bloxwich East (6) had the most binge drinkers among women (33%). Compared to overall prevalence of drinking (Map 3), there are some interesting findings. Aldridge North & Walsall Wood (2) had high levels of drinking prevalence yet the lowest proportion of binge drinking; while Bloxwich East (6) had high levels of binge drinking but lower levels of drinking prevalence. This may suggest a tendency towards binge drinking in Bloxwich East and towards moderate drinking in Aldridge North & Walsall Wood. By extrapolation, given Walsall's East to West deprivation divide, the general pattern may be for more affluent people to drink more moderately, while binge drinking is more likely in more deprived areas. This is partly supported by Figure 17, which correlates index of deprivation in Walsall against binge drinking among drinkers of alcohol. While binge drinking tends to decrease with affluence, quintile 4 (people from next to the least deprived Walsall areas) proved an exception, especially among men.

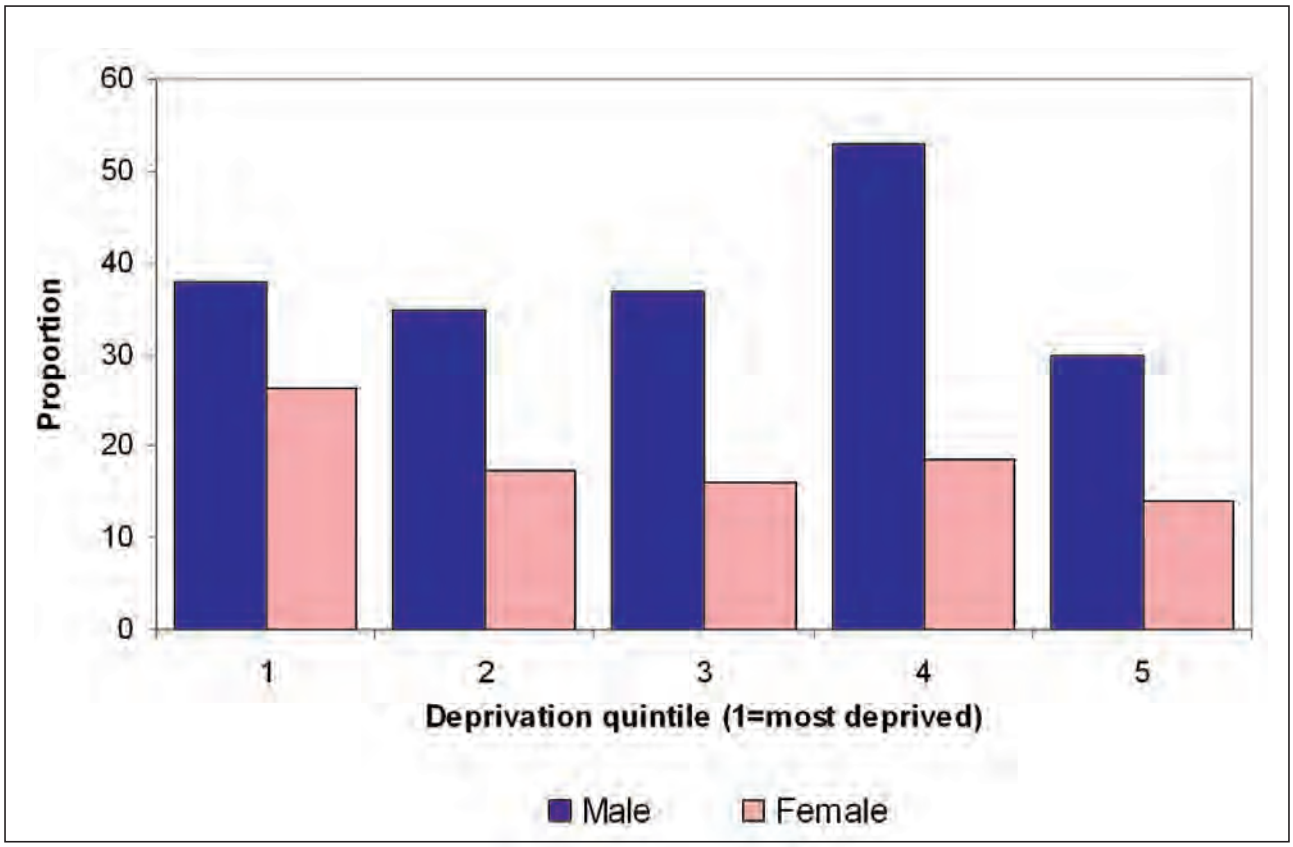



Figure 17. Percentage of Walsall drinkers binge drinking, by quintile level of deprivation, 2005

The 2001 survey revealed mass ignorance of the safe weekly limits for alcohol consumption among the Walsall population: only 12-13% of adults were able to identify correctly the safe weekly limits for men and women, while over 60% said they did not know what the safe limits were. Since 2001, there has been substantial activity to raise awareness of sensible drinking levels and there have also been widespread improvements in labelling of supermarket and off licence products by the display of alcohol unit content on bottles and cans. However, the 2005 survey did not include a question on knowledge of sensible drinking levels, and so there is no indication as to whether awareness has increased locally or regionally.

# Walsall Alcohol Needs Assessment

This was produced by Stahlberg (2006). What follows is a replication of the content of that report. The needs assessment is still a work in progress and will be revisited once funds and opportunity arise in the future.

## Hospital Admissions

Hospital admissions were based on a set of ICD 10 codes applied to three years of data at the Manor Hospital. Figure 18 shows that after two relatively steady years, admissions increased by 15% in 2003. This could indicate that increasing numbers are diagnosed with alcohol related conditions, or reflect improved awareness and recording of alcohol related causes for admission. Further analysis of 2004-2006 data would provide a better understanding of this trend.

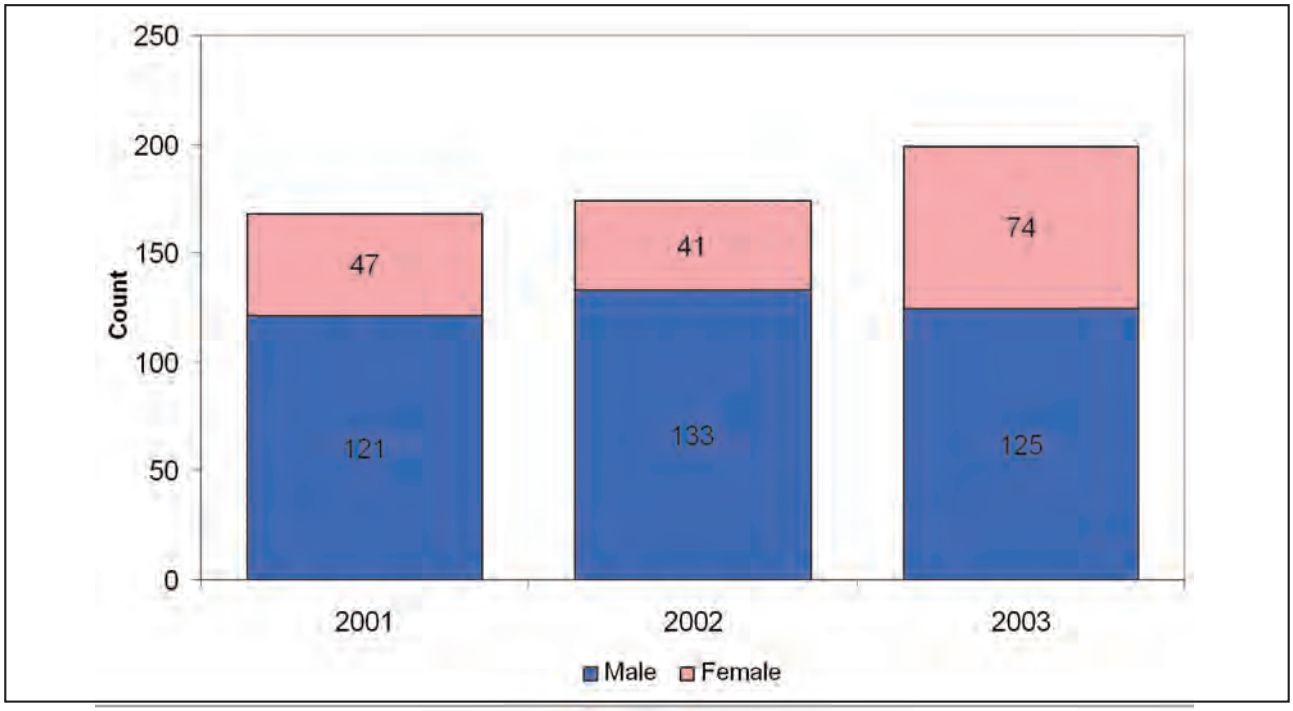



Figure 18. Admissions by year for alcohol related conditions in Walsall

Figure 18 also shows that a large majority of the admissions are men. There has not been a great difference in the overall number of male admissions. However, there was an 80% increase in female admissions between 2002 and 2003. The increase in admission numbers between 2002 and 2003 is therefore a result of the higher number of women admitted to hospital. Further analysis of the reasons for this increase is needed to understand if the cause is:

- One or more specific types of admissions
- Improved or changed recording practices
- A general sign that female admissions are increasing in numbers and/or as a proportion to male admissions.

Regardless of the reason, the increase should be noted with interest and to see if this finding can be correlated in any way with findings from other parts of the needs assessment.

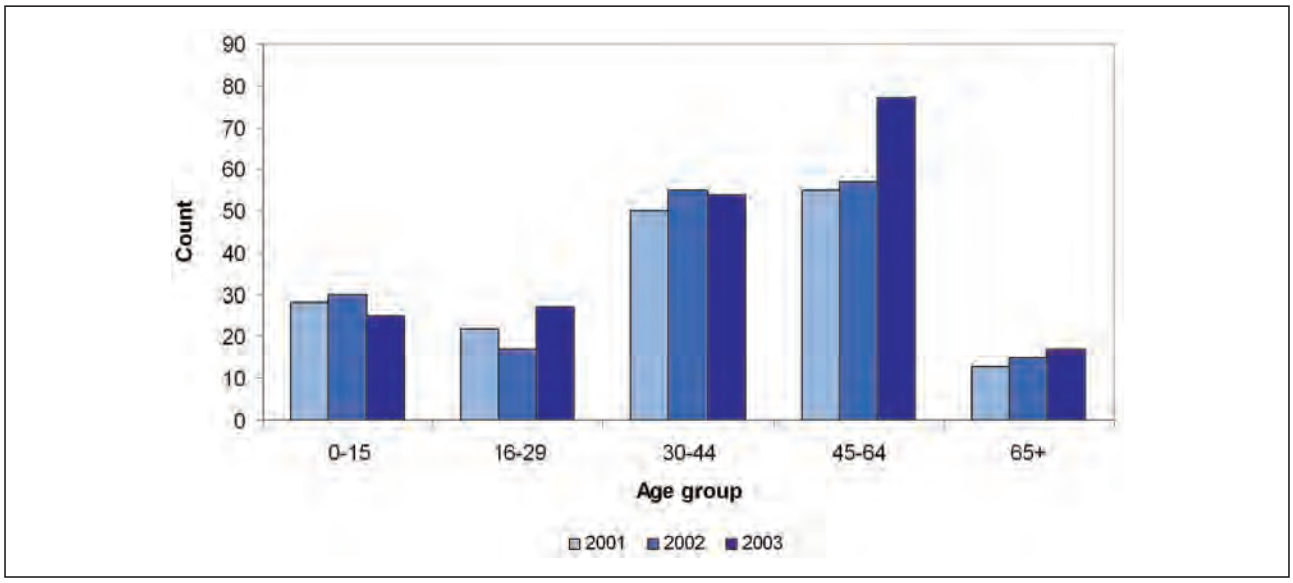



Figure 19. Age group breakdown of alcohol related admissions 2001-2003

The two age groups that highlight significant changes in admission levels are the 16-29 and 45-64 year olds (Figure 19). The older age group does not represent a major surprise as it could be a sign of increasing numbers presenting with various chronic symptoms. The increase in admissions between 2002 and 2003 for the 16-29 year olds should also be examined in further detail. Regardless of the reason for the increase, a 59% year on year increase indicates a level of concern that represents an ongoing trend of more alcohol related conditions emerging for this relatively young age group. The other striking issue is the relatively high number of admissions in the youngest age group of 0-15 years. Even though there is a variable trend in the number of admissions, there should be concern at this level of children and young people admitted to the Manor Hospital with conditions that are classified as alcohol related.

All alcohol related admissions were categorised by Walsall's wards. While Figure 20 depicts the names of the wards, Map 4 is more helpful in showing the location of residence of people admitted to the Manor Hospital. The conclusion from both is that the areas with a high proportion of communities of South Asian origin have the highest count and concentration of admissions. With anecdotal evidence supporting the view that there is a hidden problematic alcohol use among some of Walsall's ethnic minority population (especially among the Punjabi and/or Sikh communities), the high number of admissions would warrant a more in-depth investigation into the type of admissions and the ethnic origin. It would also be of help for further analysis to look at the spread of admissions from the two wards of Palfrey and Pleck. These further investigations would qualify the nature and location of the problematic alcohol use. It is also important to find out whether this profile has changed over time. The resulting answer could contribute towards engaging the communities in question in discussion about alcohol related issues, and about which interventions could be put in place to halt and reduce the level of alcohol related admissions.

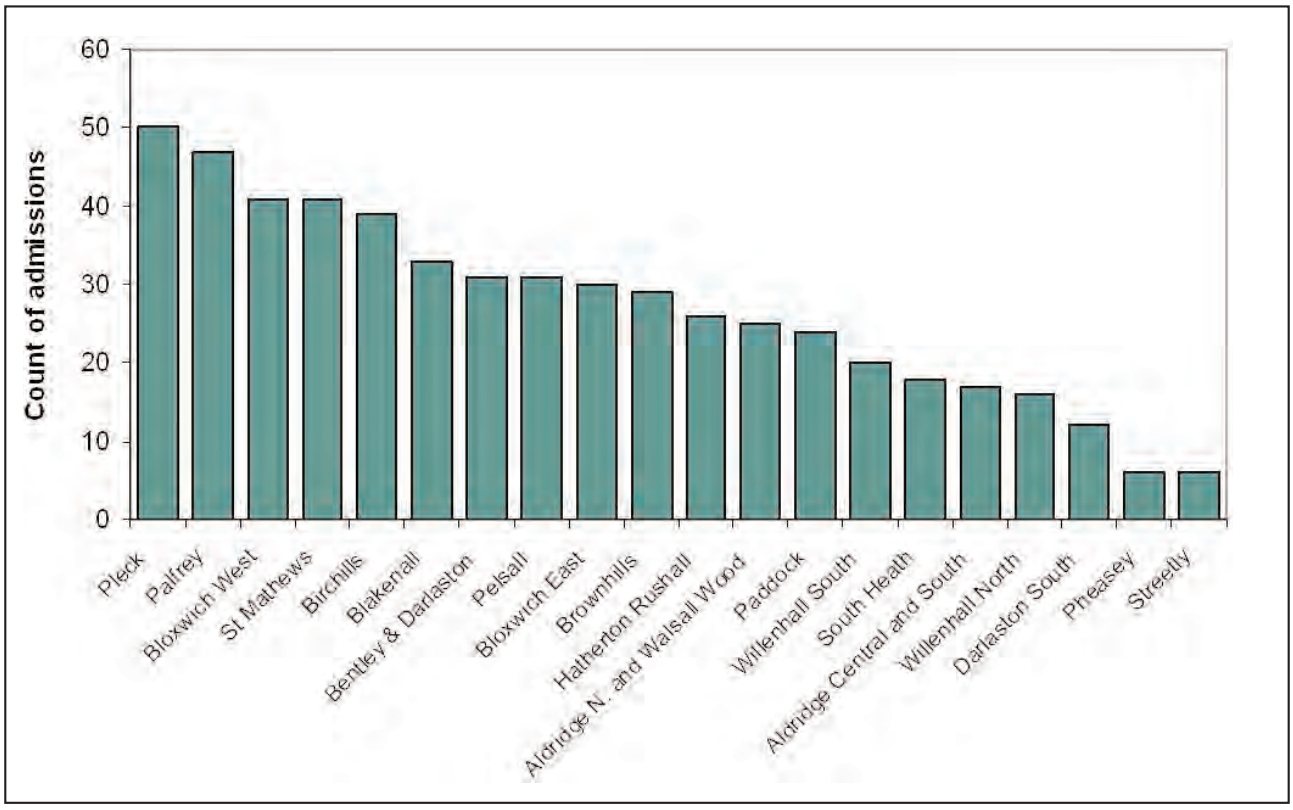
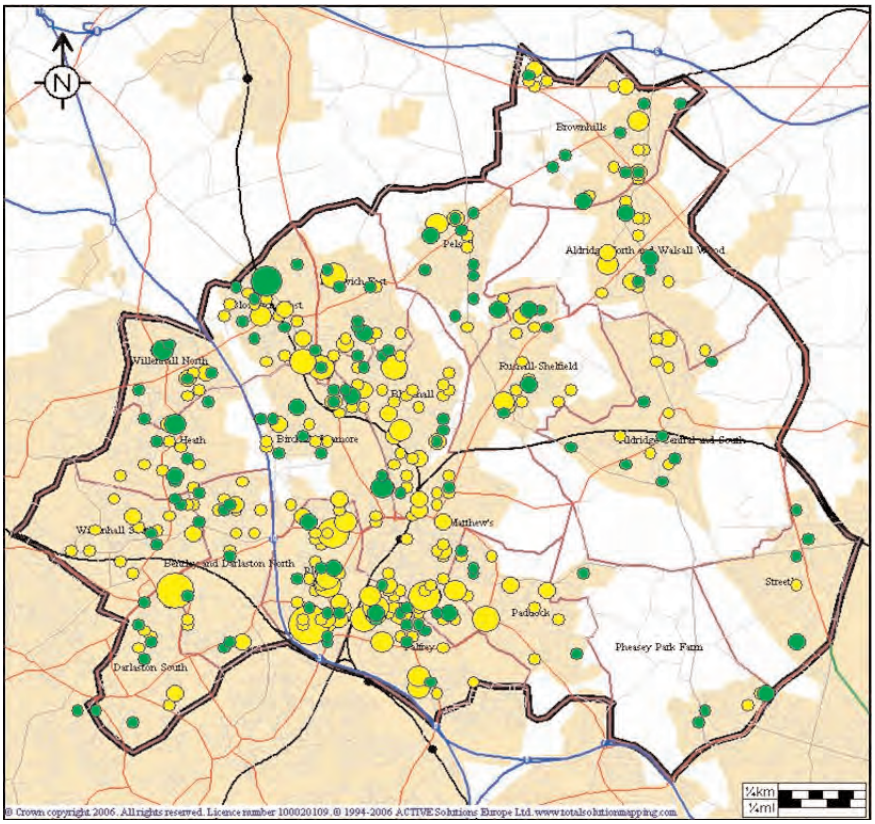



Figure 20. Admissions of Walsall residents to Manor Hospital by Ward for alcohol related conditions, 2001-03




| Key | Sex | Count |
|---|---|---|
| | Male | 379 |
| | Female | 162 |

Map 4. Male and female (all ages) emergency alcohol admissions to Walsall Manor Hospital, 2001-2003

Concentrations of admissions become more apparent when they are mapped out. The greatest concentration still forms just outside the town centre in the Caldmore, Palfrey and Pleck areas. This raises issues about the causes. Drinking in South Asian communities and a possible correlation with the other health, crime and socio-economic problems faced in the area should be the key priorities of concern. The split according to the deprivation/wealth boundaries is also more apparent in Map 4. There are three distinct areas emerging with different levels of admissions:

(1) Aldridge Central, Aldridge South and Streetly, showing relative few emergency admissions
(2) Aldridge North, Brownhills and Pelsall
(3) Palfrey, Pleck, Bloxwich, Blakenall, Birchills, Willenhall, and Darlaston

The concentration of admissions around the Blakenall New Deal for Communities (NDC) area strengthens the notion about a correlation between deprivation and alcohol related harm. One of the interesting elements to note about the NDC data is that the admissions are spread out throughout the whole area and not just confined to a particular neighbourhood. The built environment and the way that estates and densely inner city communities function could be key factors, along with shopping behaviours, drinking behaviours and population dynamics. There may also be contributing factors such as whether an area is primarily 'lived in' (Blakenall) or whether there are other issues that affect the data, such as visitors and through traffic of people or vehicles (Caldmore, Palfrey, Pleck).

Peer groups and/or gang related behaviour in communities could also have an influence on the way that admissions occur, in patterns that identify certain parts of communities. There is, for example, a significant effect of high streets and parks on the way that groups of people drink and bring their behaviour into the community. On occasion, these behaviours lead to alcohol related injuries or medical emergencies: ie the younger age groups 0-29 years accounted for 52 admissions (26%) in 2003. These environmental factors will be explored in more detail in the section about Local Neighbourhood Partnerships.

The caveat to the mapping of the admissions data (Figure 20 and Map 4) is that outlying areas in the West and East of Walsall would take emergency admissions to either New Cross Hospital, Wolverhampton (eg people living in Willenhall and Darlaston) or Good Hope Hospital in Sutton Coldfield (eg people living in South Aldridge and Streetly). Admissions to these hospitals of people with residence within the Walsall tPCT boundary would provide an even more accurate account of the profile, eliminating any doubt that there are hidden admissions figures that would alter the way that the data leads to the findings as outlined above.

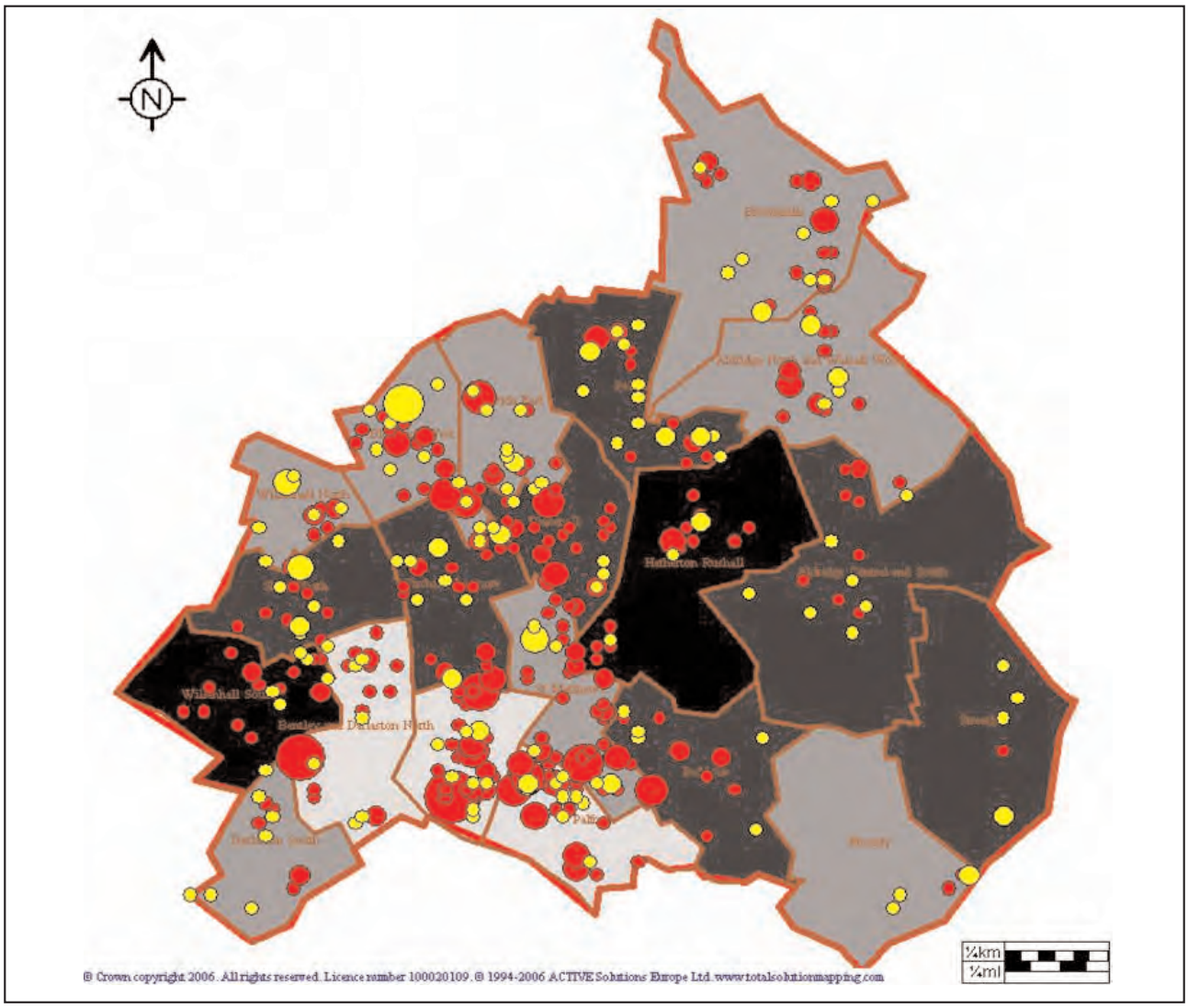
The admissions data raise a couple of unresolved questions that would be useful to investigate further:

- The age profile of admissions in the various areas. This could, for example, help to highlight specific issues that need targeting in certain areas, even with low numbers of admissions.

- The ethnicity profile of admissions in the third group of trends identified above (Palfrey, Pleck, Bloxwich, etc). This could again highlight hotspot areas where particular concerns would lead to action plans based on small or large communities throughout Walsall.

Map 5 provides an interesting contrast between self reported drinking and actual alcohol related emergency admissions to hospital. When comparing the admissions data with the self reported drinking levels from the 2005 West Midlands Lifestyle Survey, discrepancies emerge over the way that people assess their own drinking and the way that the actual levels of problematic drinking manifests themselves in harmful behaviour, such as alcohol related emergency admissions. The areas where there is higher incidence of admissions match with areas where adults have reported low drinking levels (lighter shaded areas). A good example of this contrasting picture is Palfrey, Pleck, and Bentley/Darlaston North. Conversely, the areas where adults are reporting higher drinking levels do not show corresponding high levels or admissions.

This is a good depiction of how perceptions clash with what is actually taking place in and around people's lives. There is a complex set of belief and perception triggers that affect the way that people report their drinking. Peer pressure/preference, word of mouth, media, perception of the community in which people live are just some of the likely factors that affect how people are likely to count up their daily and weekly alcohol consumption.




Activity Key: Alcohol admissions coloured by gender (sized by geo-group)

| Key | Count | Description |
|---|---|---|
| | 379 | Male |
| | 162 | Female |
| | 541 | Total |

Activity Key: Prevalence and excess drinking by ward (%)

| Key | Lower % | to | Upper % |
|---|---|---|---|
| | 0.0 | to | 9.5 |
| | 9.6 | to | 12.7 |
| | 12.8 | to | 15.9 |
| | 16.0 | and | over |

Map 5. Prevalence of excess drinking by ward and hospital admissions in Walsall, 2001-03 by gender

## Mortality

A list of ICD 10 codes was used as a basis for counting the number of alcohol related deaths. The main source for this list, the Alcohol Statistical Bulletin 2004, set out mortality as a key indicator of harm to society caused by long term problematic alcohol drinking behaviours. During the course of the needs assessment process, information came to light that Dr Keith Williams, Director of Public Health, Coventry Teaching PCT had presented mortality data at a National Treatment Agency seminar in 2005. He had compared alcohol related deaths with drug and smoking related deaths. The comparison had been made as an illustration of the £1 million that Coventry had invested in alcohol prevention and treatment services. The Coventry mortality data showed approximately 700 deaths related to smoking, 70 related to alcohol and 7 related to drugs. The ratios that these figures display are comparable to the Walsall data during the period 2002-2004 (Figure 21).

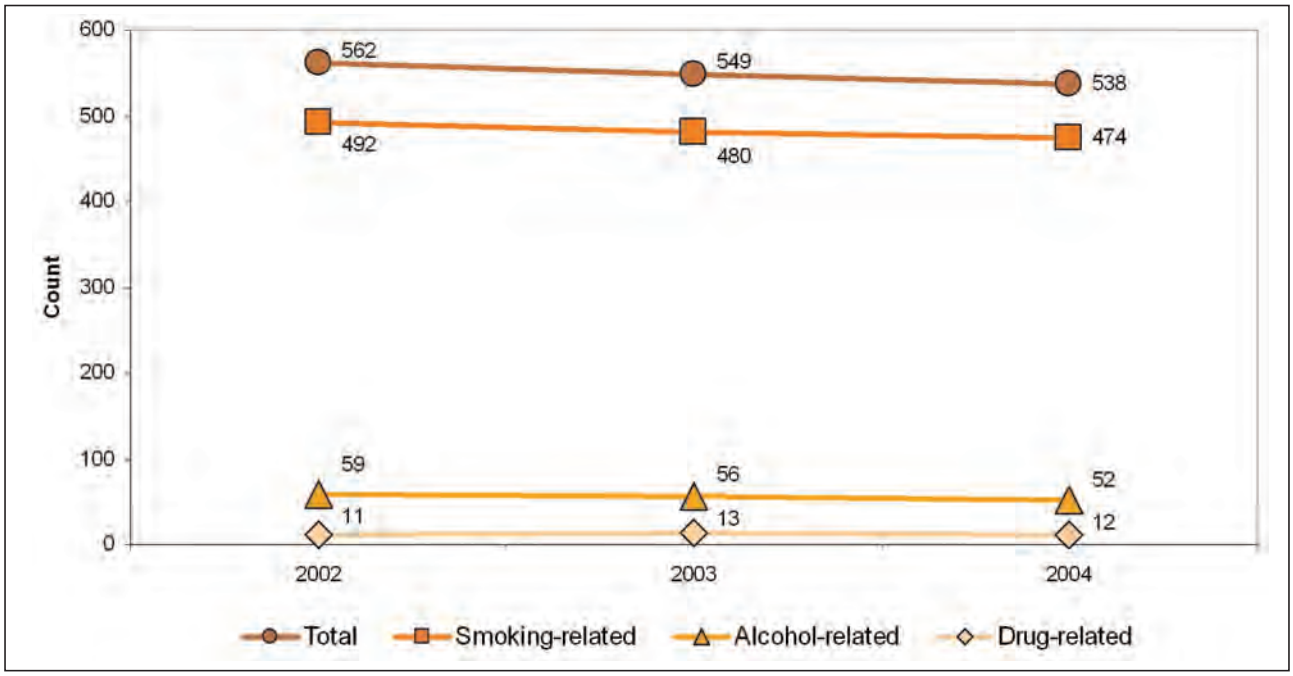



Figure 21. Smoking, alcohol and drugs related mortality data for Walsall recorded by ICD 10 codes.

Figure 22 shows that the 2005 figure for alcohol related deaths in Walsall increased again to 58. This increase was caused by male deaths, as female deaths reduced during the period between 2004 and 2005. There are, therefore, three things to note:

- After a couple of years of reduced number of alcohol related deaths, levels have again reached just below the number seen in 2002
- The proportion of male alcohol related mortality has gone through the same trend of initial reduction with a stark increase of 41% in numbers between 2004 and 2005, to reach the 2002 level
- Female mortality has remained relatively stable with a single spike during 2004.

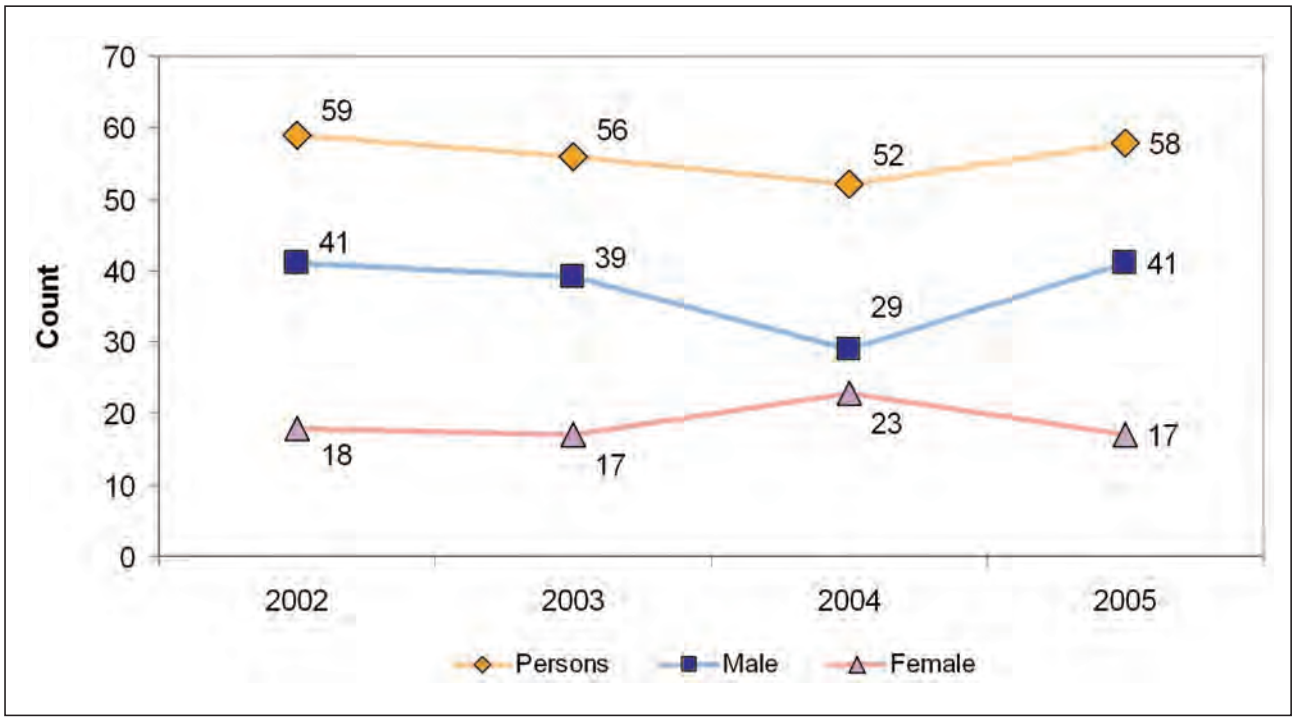



Figure 22. Alcohol related mortality data by gender, 2002-2005

Based on the previously cited evidence from a European Union research study **(Anderson & Baumberg 2006)** that mortality accounts for the single highest cost to society, it provides a good foundation to the argument for increased investment in alcohol related services in Walsall. The argument on this one account should be particularly strong given the lower mortality figure for drugs.

## Primary Health Care Data

The alcohol related patient data from four general practices in Walsall was the result of replicating the work previously piloted at Birchills Health Centre by Dr Avtar Suri, Walsall's Lead GP for Alcohol. The purpose was to establish the pattern of alcohol consumption among targeted general practices and health centres across Walsall. Data would describe how patients of different ages and gender had estimated their drinking behaviour. There were three drinking levels defined for this study (see Glossary): Social/moderate, heavy and dependent. Nine general practices were asked to take part in the pilot study. These nine practices were chosen from surgeries with high Quality Outcome Framework scores. The sample of general practices was also a selection of single practices and large health centres. There was also a spread of practices in deprived and affluent areas. Four general practices submitted data for 2005 and 2006. The total patient population covered by the four practices was 14,100. It was therefore a relatively large sample covering 5.6% of Walsall's total population of 252,800. The figures below are all based on 2005 data, as this provided the best foundation for the analysis of drinking levels among the patient population. With this large and relatively representative sample, it was also possible to calculate overall estimated numbers of drinking levels for Walsall. This would provide a significant first look into how many potential users there could be of the various forms of interventions provided by prevention and treatment services.

Figure 23 shows that there are higher proportions of female drinkers for the age groups covering 12 to 49 years than is the case for male drinkers. This trend is reversed beyond the age of 50 years, where men are noted for a higher proportion of drinking. This could indicate a generational shift in drinking pattern, with younger females more likely to drink than their male counter parts.

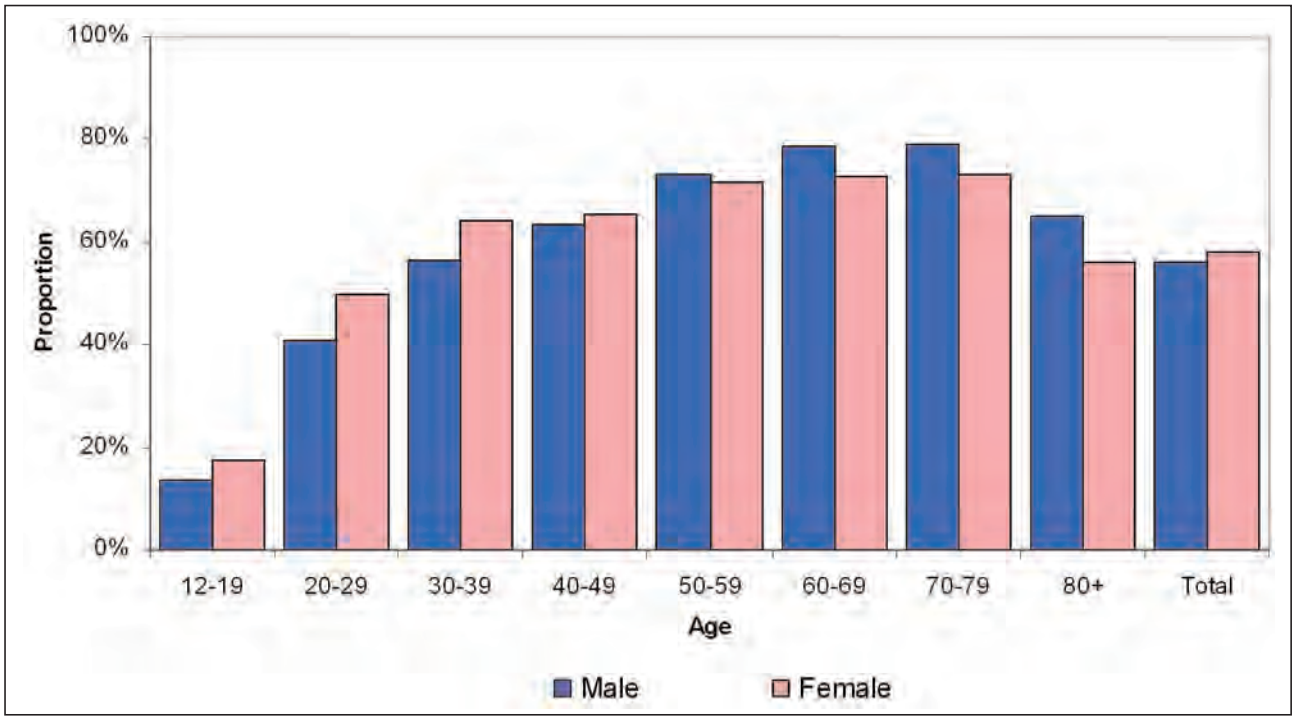



Figure 23. Proportions of all people drinking alcohol, by age and gender

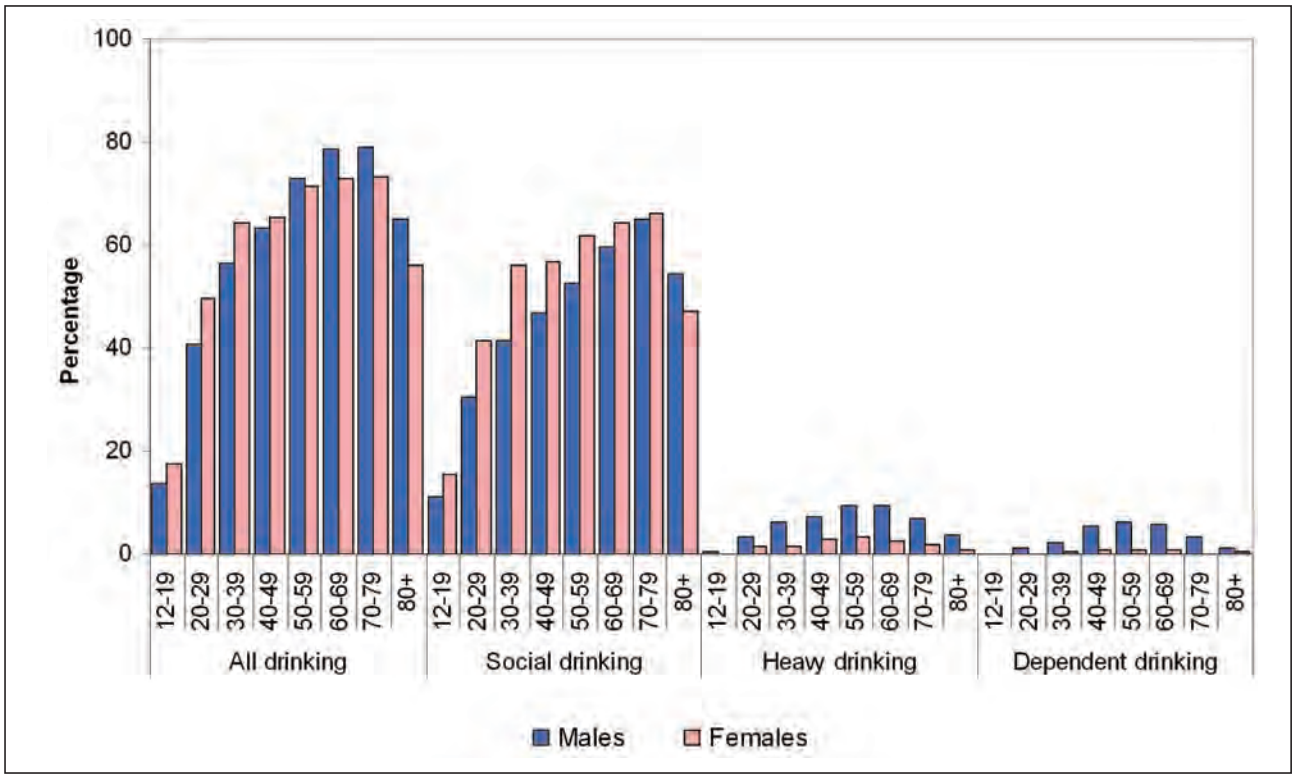



Figure 24. Profile and proportions of drinkers in the four-practice sample

Bearing in mind Figure 23, it is noted in Figure 24 that most of the drinking by females is social/moderate. There are significantly higher proportions of women that drink socially than the men. This is the case for all age groups apart from those over 80 years. There are, on the other hand, significantly higher proportions of men than women that drink at heavy or dependent levels (Figure 24). Based on the data collated for 2005 and 2006, there were significant findings around the changes in heavy drinking levels for male and female patients in the four-practice sample (Figure 25). The changes were statistically small, but the fact that the increases for the female patients were across all age groups is significant enough to monitor the trend to see if it continues. There were also increases in heavy drinking levels for men. Emerging trends for higher proportions of younger men aged 20-29 and 30-39 years should be of particular concern if this were to continue. This upward trend is especially stark in the spike experienced in the male 50-59 years category.

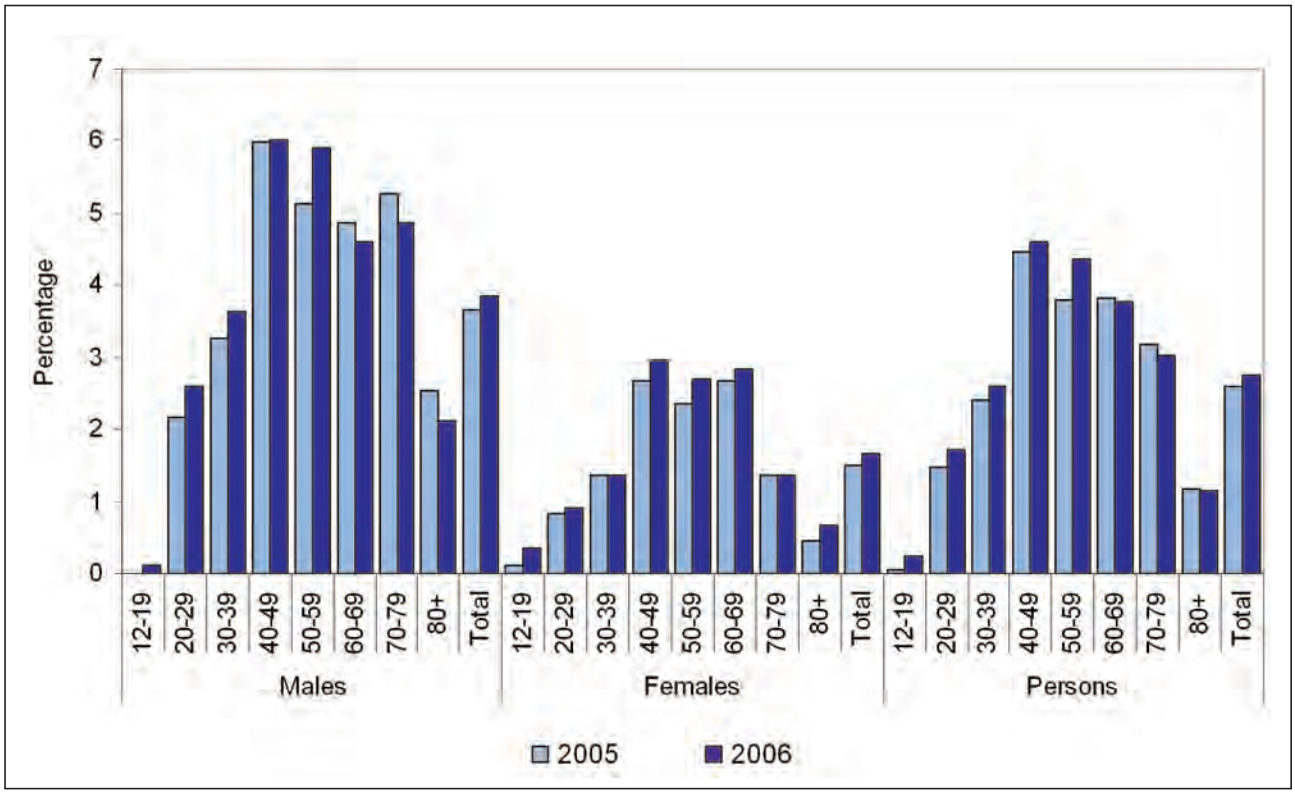



Figure 25. Proportions of males, females and persons drinking heavily by age, 2005 and 2006

With very low percentages of males and females that drink at dependent levels, the changes from 2005 to 2006 cannot be seen as statistically significant. This is seen in Figure 26. Nevertheless, there are upward changes in a couple of the male age categories (40-49 years and 60-69 years). It is also a significant finding that there is no evidence of any major reductions in the proportions of dependent drinking. The problem therefore seems to have been maintained at the same level throughout 2005 and 2006. Figure 26 shows these very low percentages for dependent drinkers, although percentages in males are far higher than those in females.

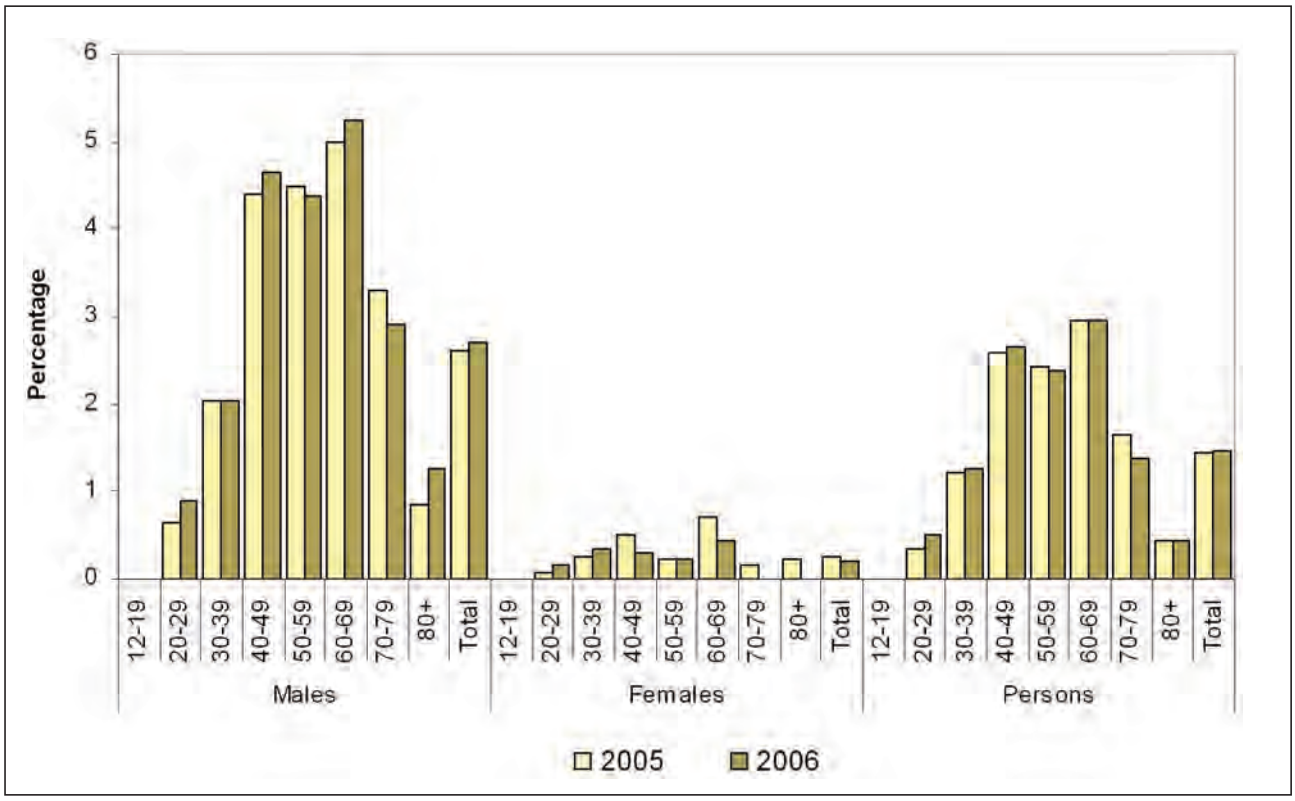



Figure 26. Proportions of males, females and persons drinking dependently by age, 2005 and 2006

With such a large sample of alcohol related data (on 14,100 patients), drawn from representative communities in Walsall, there was enough reliable data to estimate the total numbers of drinkers in Walsall. This is shown in Figure 27, providing an approximate prevalence of the various drinking levels and providing a guide for the potential users of Tiers 1 to 4 services in Walsall **(Department of Health 2006)**.

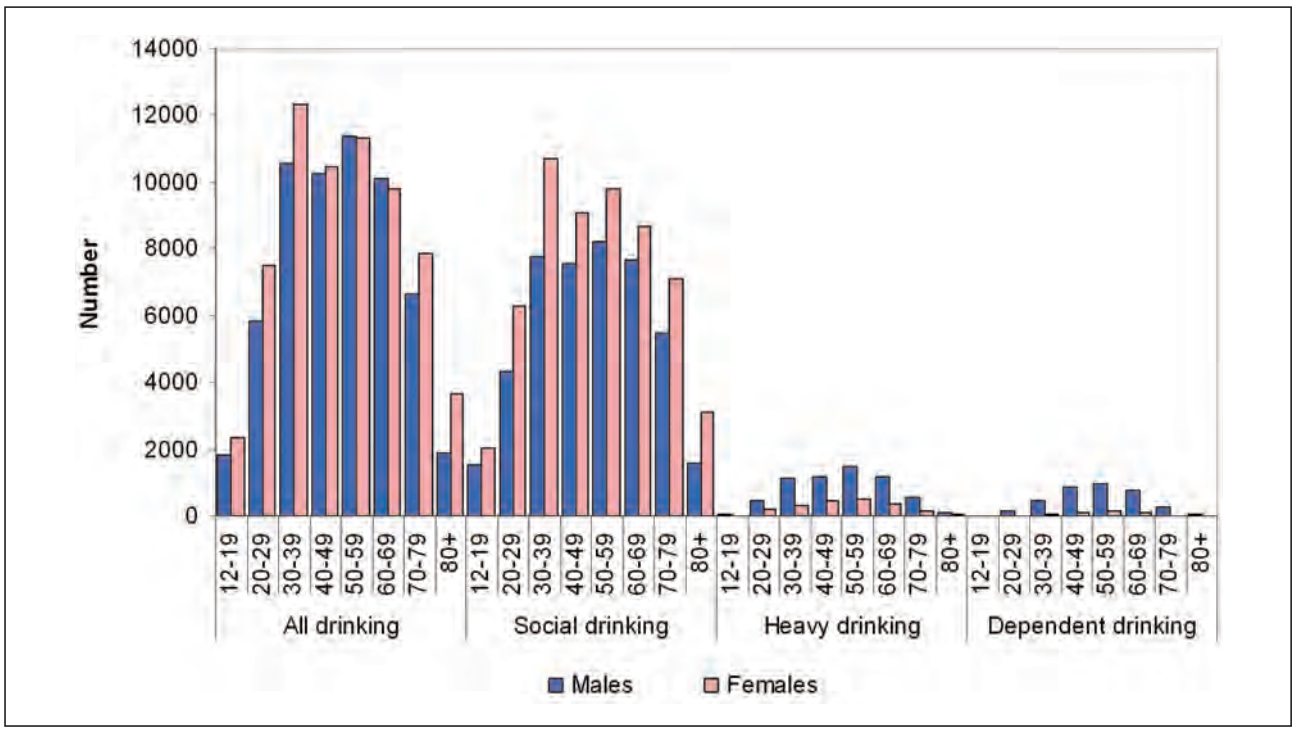



Figure 27. Estimated numbers of drinkers in Walsall by volume, age and gender, 2005.

A summary of the analysis of drinking levels by age are shown below:

- The majority of all female and male drinkers are concentrated among the age groups spanning 30-69 years.
- All female drinking peaks at the age group 30-39 years.
- All male drinking peaks at the age group 50-59 years.
- Social female drinking peaks at the age group 30-39 years.
- Male social drinking peaks at the age group of 50-59 years.
- Male heavy drinking peaks at the age group 50-59 years (but with high levels at age groups 30-39, 40-49 and 60-69 years).
- Female heavy drinking peaks at age group 50-59 years (but with high levels at age groups 30-39, 40-49 and 60-69 years).
- Male dependent drinking peaks at age group 50-59 years (but with high levels at the age group either side of this).
- Female dependent drinking peaks at age group 50-59 years (but with high levels at the age group either side of this).
- All female age groups show higher number of social drinkers than males.
- All male age groups show higher number of heavy and dependent drinkers than females.
- There are significant numbers of young drinkers (12-19 years), with more female drinkers than males drinkers.
- There are a high number of young female social drinkers in the age groups spanning 12-39 years compared to male social drinkers.

For the purpose of the initial assessment of need, the key focus should be on the estimated levels for heavy and dependent drinkers (Table 9). With a total of 8,134 heavy and 3,927 dependent drinkers in Walsall, these numbers show that the size of problematic drinking is much higher than the numbers of individuals that are known to alcohol specific services at the present time. Even with adjustment for incidents of inaccurate self reporting, the figures are pitched at a level that will not change dramatically, especially given the high sample of patient data involved in the work. The estimated numbers also highlight the fact that there are many people currently registered with general practitioners that are unlikely to be known as heavy or dependent drinkers, and so are unavailable for appropriate GP or specialist service intervention. A comparison of this disparity is carried out in a later section following an analysis of the 4-year trend of service users accessing specialist service providers.

| Heavy | | | Dependent | | |
|---|---|---|---|---|---|
| **Male** | **Female** | **Total** | **Male** | **Female** | **Total** |
| 6109 | 2025 | 8134 | 3468 | 459 | 3927 |

Table 9. Total estimated numbers of male, female and persons at heavy and dependent drinking levels in Walsall

Figures 28 and 29 show the proportion of men and women in each category of drinking levels. It is estimated that:

- There are more female than male drinkers (including data from all categories).
- There are more female than male social drinkers
- here are more male than female heavy and dependent drinkers.

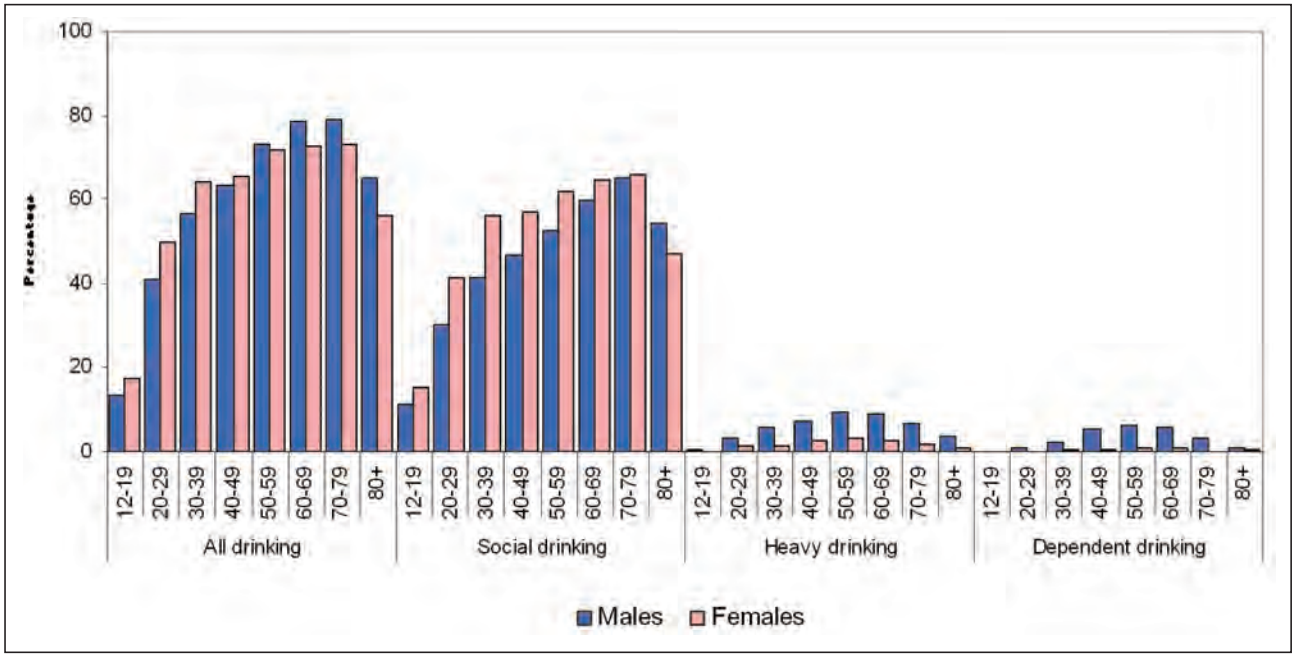



Figure 28. Estimated percentage prevalence of drinking and drinking levels by age group and gender, 2005

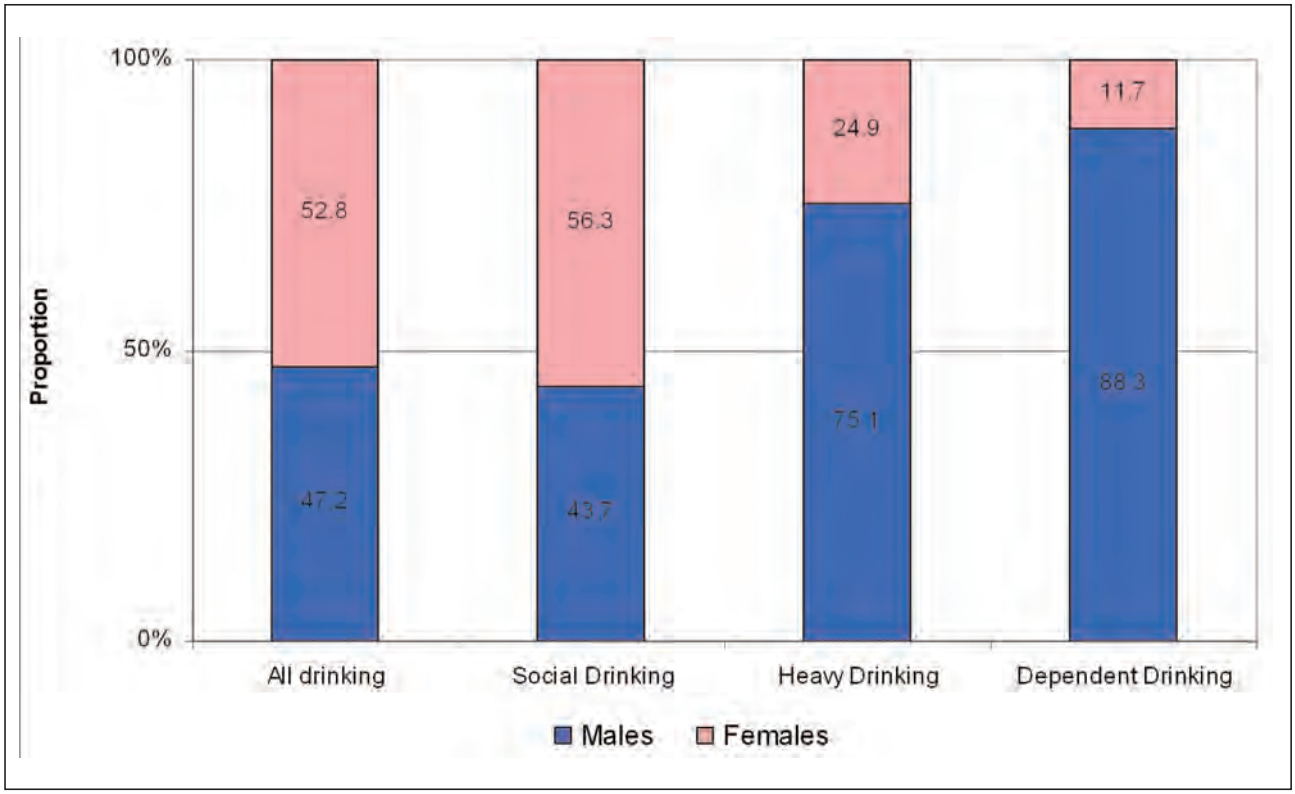
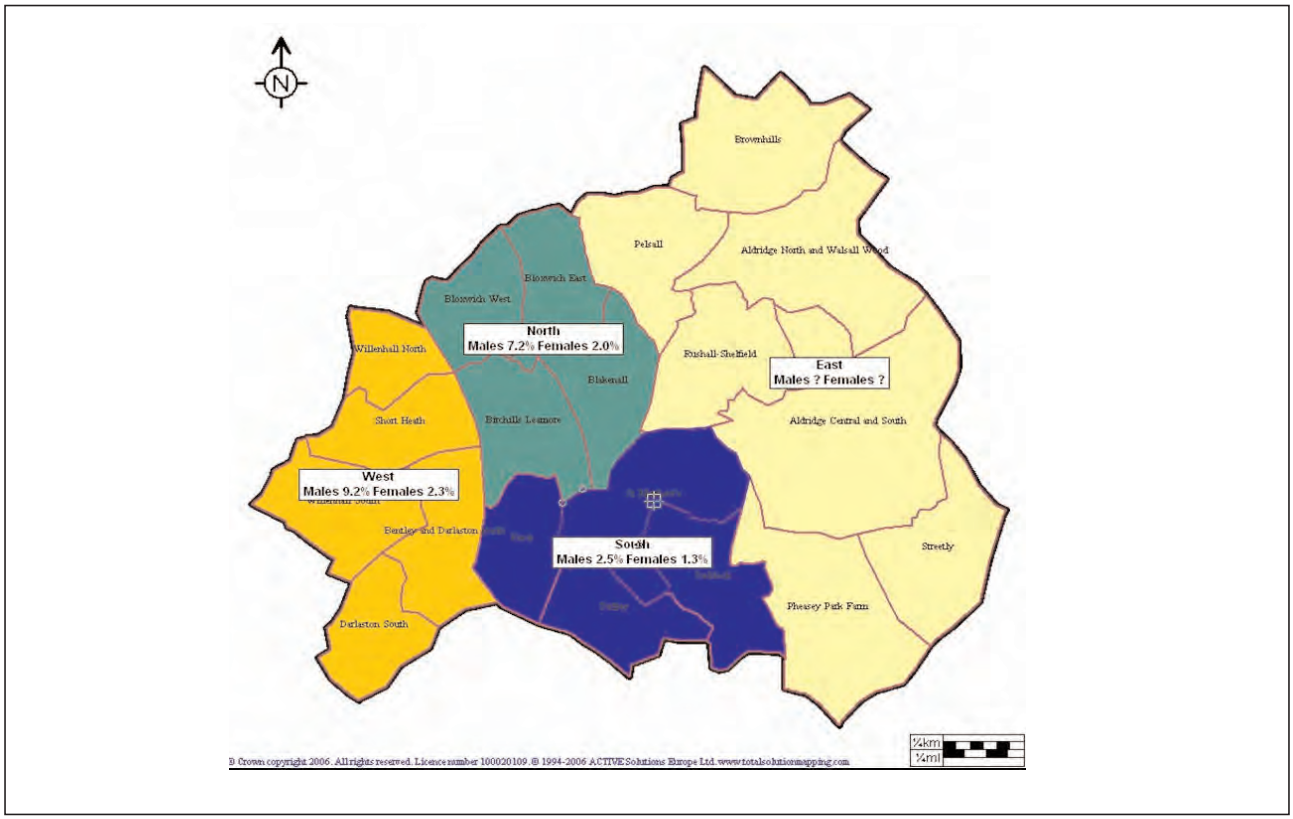



Figure 29. Total drinkers and drinking levels by gender (%), 2005

With primary care data available for three sector areas in Walsall, it is noticeable that there are differences in the patterns emerging (Map 6). Data from more general practitioners is needed to ascertain whether the indicated proportions reflect the whole area or are specific to the four individual practices currently taking part in the data collection pilot. However, the high total number of patients included in the sample allows a level of confidence that findings are indicative of the overall pattern for the area, although a number of issues need to be raised at this stage:

- The North and West sectors emerge as having the highest proportion of male heavy drinkers. The West sector currently shows the highest proportion of heavy drinking males (9.2%). In both areas, female heavy drinkers are around 2% of the total female patient base.
- It is again noticeable that self reported drinking levels to general practitioners in the South sector are very low. This matches the finding from the West Midlands Lifestyle survey.
- With inadequate data levels available from the East sector, it has not been possible to set any levels for this area. One of the recommendations for future action would therefore be to ensure that general practices from this area contribute to the data collection.




Map 6. Proportion of males and females drinking heavily by Walsall Primary Care sector area, 2005

## Specialist Alcohol Treatment Provider Data

Over the three years from 2002/03 to 2005/06, there was an increase of 19% in referrals to Lantern House, Walsall's Tier 3 level alcohol provider service. However, the increase has not been constant (Figure 30). The depicted peaks and troughs of service provision are not likely to be an indication of a lesser need for services but a sign of restriction on service provision due to factors such as lack of funding or problems in recruiting staff to meet needs for services. The dip in service provision between 2003/04 and 2004/05 coincided with the Aquarius contract for providing alcohol specific services in primary care settings. Since this contract was withdrawn, Lantern House has again shown an increase in referrals. Placing an alcohol worker in selected general practices throughout Walsall could also have affected the referral numbers. Female referrals have been maintained at a fairly constant level, while the male referrals mirror the overall increase with a reduction in numbers between 2003/04 and 20004/05.

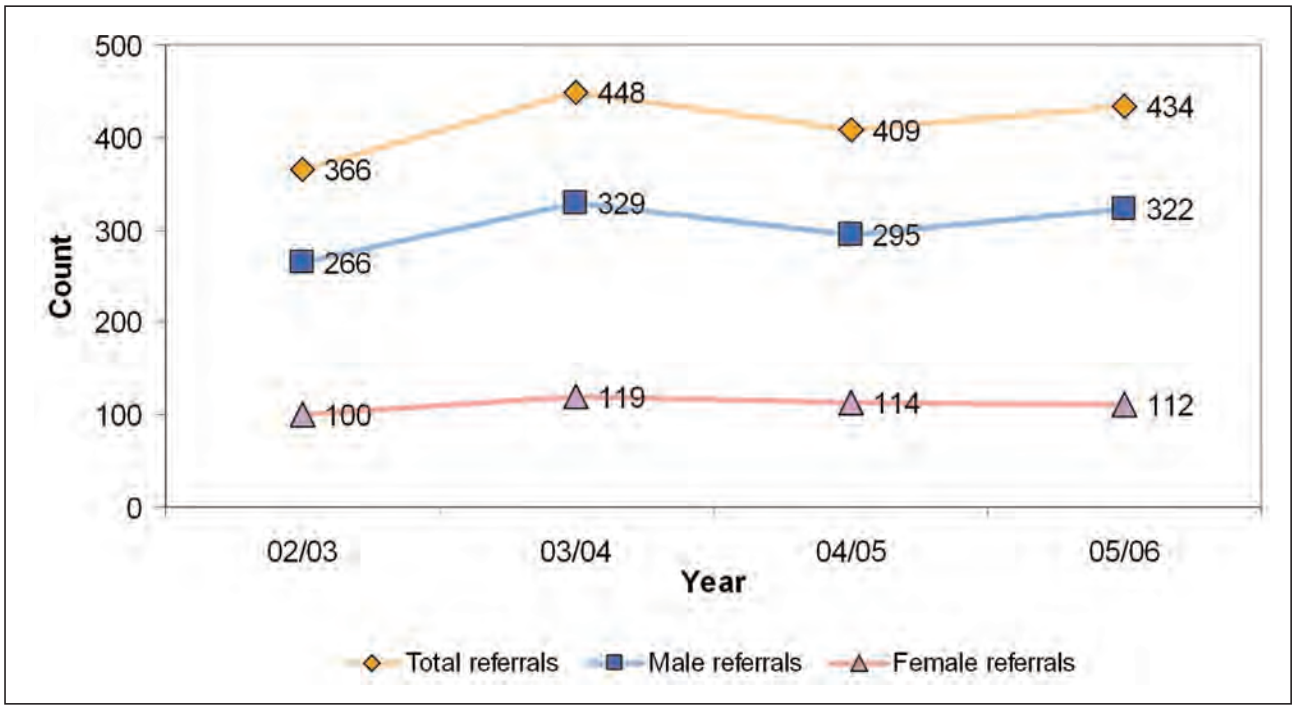



Figure 30. Lantern House alcohol treatment referrals

Referrals to Addaction (Tiers 2 and 3 level alcohol provider) increased by 111% between 2002/03 and 2005/06 (Figure 31). Female referrals reflect a 129% increase, with male referrals showing an upward trend over the period of 105%. Most of this increase took place between 2002/03 and 2003/04. This increase could reflect staffing levels, increased self referrals or an association with the arrest referral scheme for drug users. Either way, the reasons for the stark increase should be examined in detail. It would also be relevant to see if those referral trends had been maintained throughout the period or changed in any way. The reduction in referrals in the mid period again coincided with the Aquarius contract.

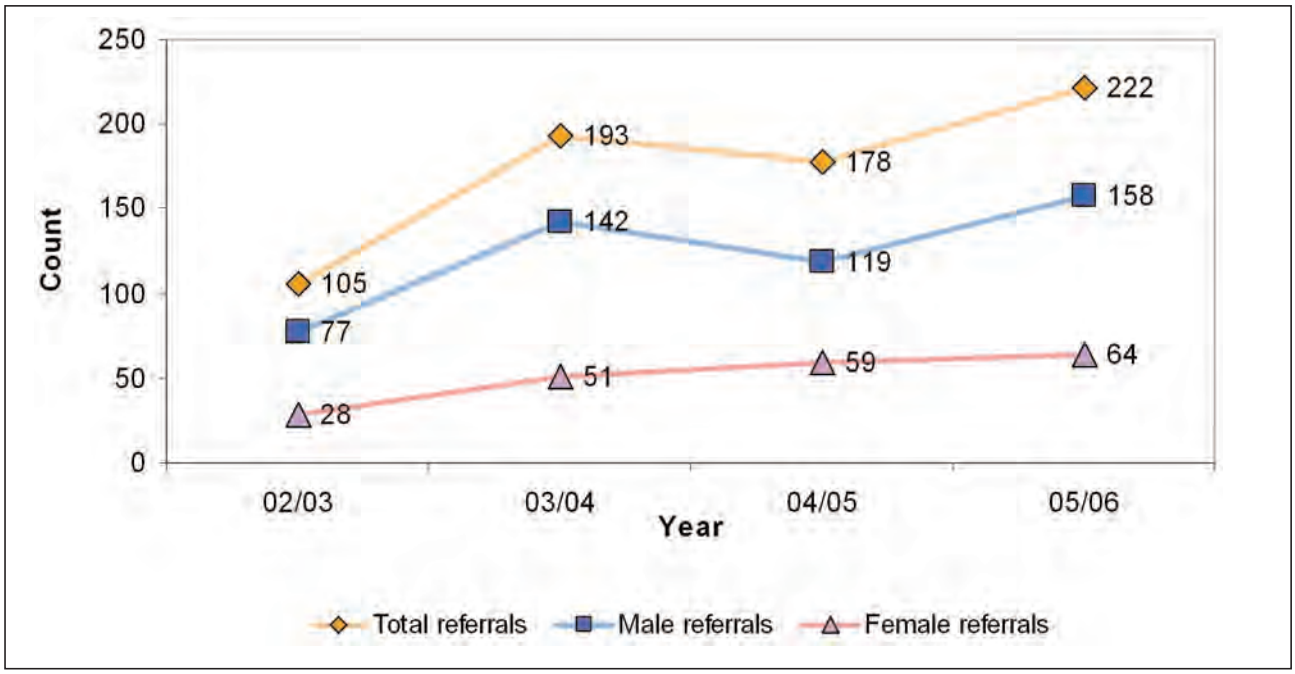



Figure 31. Alcohol related referrals (alcohol as primary drug) to Addaction

Figure 32 is arguably the most telling one in the Walsall needs assessment. The estimated number of heavy and dependent drinkers was discussed in the previous section (Table 9). These numbers are compared to the number of people that access specialist alcohol services at Lantern House and Addaction. There is a stark contrast between the estimated figures and the people currently accessing services. The total of 702 referrals to specialist services contrasts to the 3,927 that is estimated to be in need of targeted intervention, most likely at Tier 3 level. Another estimated 8,134 people are in need for intervention at Tiers 2 or 3 for their heavy drinking levels. There is no information on how many people receive interventions by their GP. However, even if these numbers were included, they would be unlikely to meet the total estimated 12,061 heavy or dependent drinkers in need of some kind of intervention or treatment programme. This represents nearly 5% of Walsall's population.

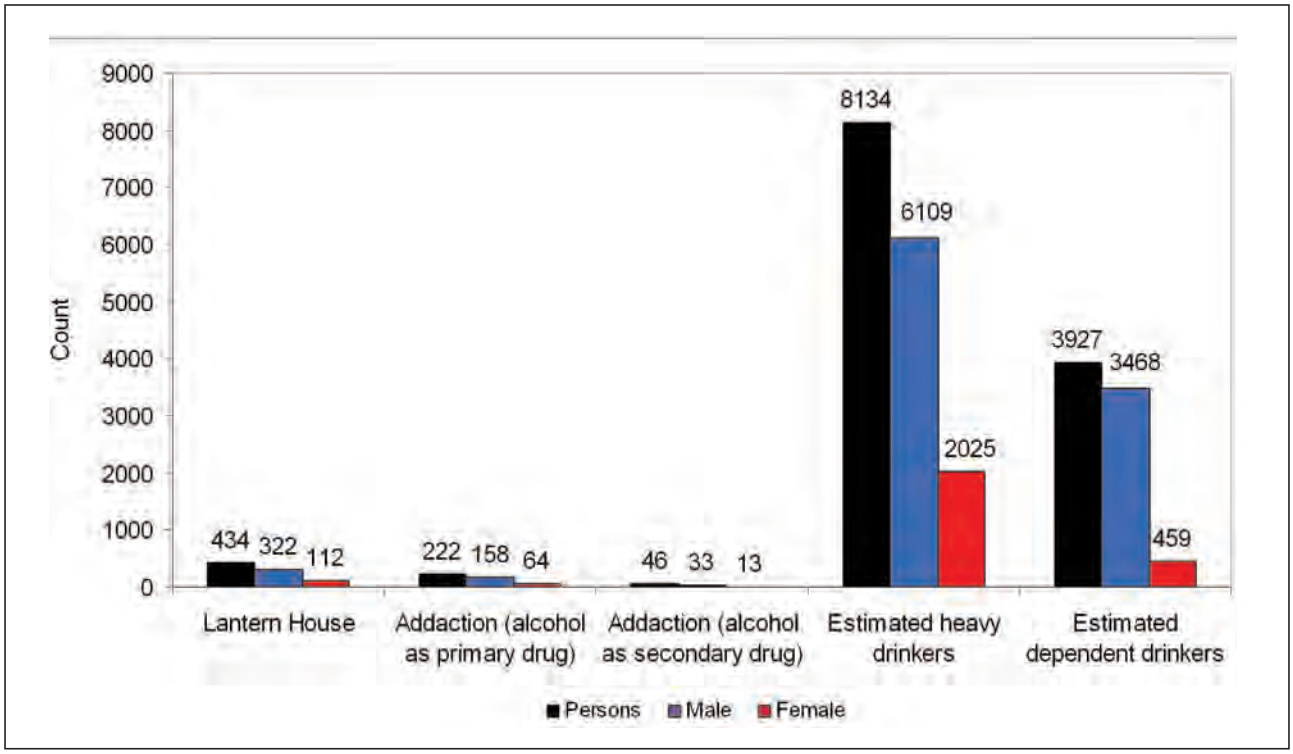



Figure 32. Estimated numbers of heavy and dependent drinkers compared with specialist service users, 2005

## Binge Drinking

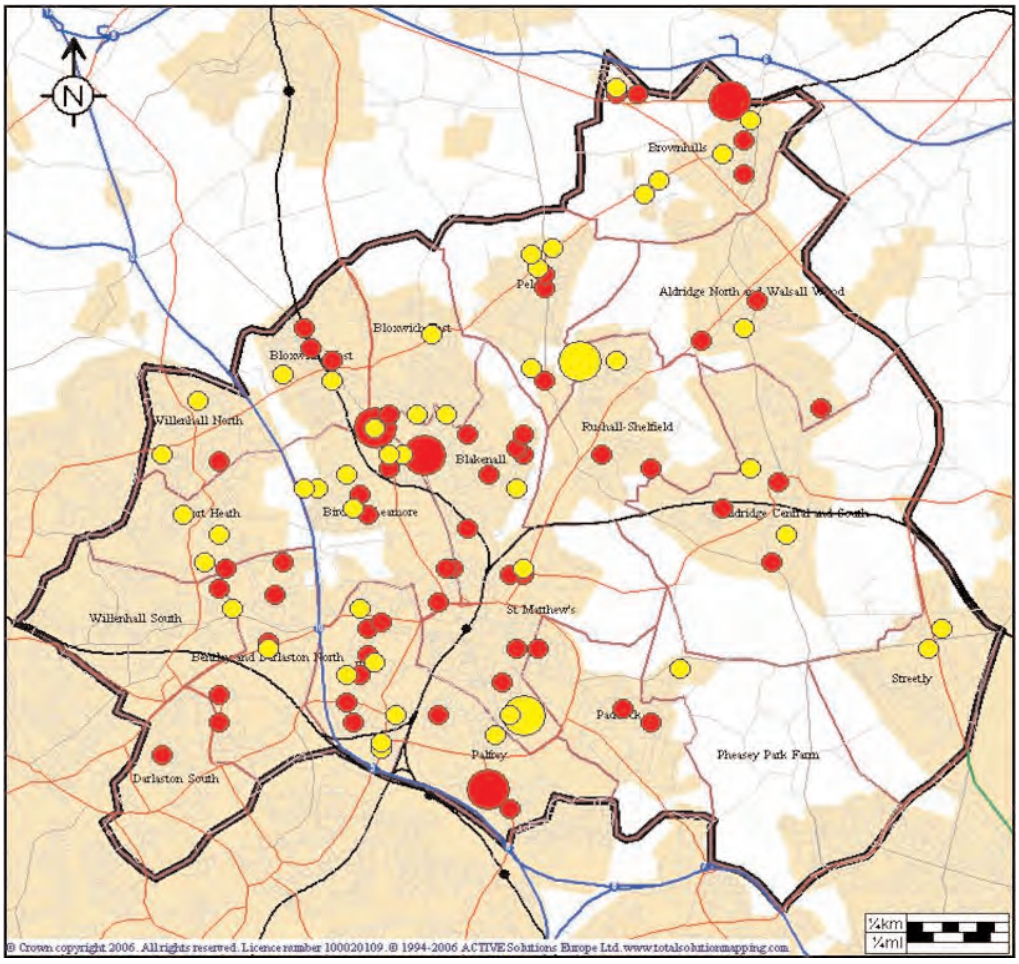
Among those who drink alcohol, there is a slightly higher prevalence of men binge drinking in Walsall (38%) compared to the West Midlands (36%). The prevalence in Walsall is much higher than the England average where 21% of male drinkers were binge drinking. The same pattern is repeated for women (Table 10). The difference in drinking levels in Walsall compared to the England average is an indication of the level of problems that have been identified throughout the needs assessment.

| | Walsall | West Midlands | England |
|---|---|---|---|
| Male | 38 | 36 | 21 |
| Female | 21 | 19 | 9 |
| Person | 30 | 28 | - |

Table 10. Proportion of adult drinkers who were binge drinking in Walsall, West Midlands and England, 2005

More detailed analysis from the Regional Lifestyle Survey, as demonstrated earlier in this chapter, shows little difference in level of male binge drinking in relation to deprivation. Women in the most deprived socio-economic group show a slightly higher proportion of binge drinking. Another important finding is that men in the higher middle class group report the highest level of binge drinking. This could indicate a particular drinking behaviour linked to higher income earners and stresses associated with middle to senior managerial levels, self employed persons and their equivalent. Some would speculate that young men living in higher middle class areas engage in different drinking behaviours, than is the case for the more deprived areas, although this trend is not replicated for men in the least deprived category. These findings suggest a break with the convention that the most deprived areas account for the most health, crime and socio-economic related problems; an issue that should be subject to further investigation. There is a higher prevalence of binge drinking in younger age groups. With just over 50% of young male drinkers between 18 and 34 years showing binge drinking behaviour, the other noticeable consumption levels relate to young women aged 18-24 years. This matches the increasing body of research across UK showing that young women increasingly account for a greater proportion of the binge drinking culture, particularly during the traditional Friday and Saturday nights out in the town centre.

## Children and Young People




| Key | Sex | Count |
|---|---|---|
| ● | Male | 64 |
| ● | Female | 49 |

Map 7. Males and females under 20 years: emergency admissions (alcohol) to Walsall Manor hospital, 2001-2003

Map 7 illustrates that there are different concentrations of hospital admissions for young people (under 20 years of age) than is the case for other adults. Admissions are more spread throughout the Borough. There are still concentrations, but they are located in parts of the Borough that are notorious for under age drinking and anti-social behaviour. In particular, the high number of admissions from the Blakenall New Deal area stands out. Areas such as Alumwell, Leamore, Willenhall, Chuckery, Pelsall and Brownhills also show significant clusters of young people admitted to hospital as emergency cases. There are also isolated single location clusters around Shelfield High School (young females) and Palfrey (young males). Again, these are signs that peer groups gather around familiar areas and engage in high levels of drinking behaviour and/or binge drinking, with a high risk of accidents or violent behaviour as a result. The apparent low level of admissions from parts of the east of the borough may reflect that some young people from these areas are admitted over boundary to Good Hope Hospital rather than Walsall Manor Hospital.

| Estimated alcohol use among young people in Walsall aged 12-19 years. | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | All drinking | | Social Drinking | | Heavy Drinking | | Dependent Drinking | |
| Age | M | F | M | F | M | F | M | F |
| 12-13 | 57 | 89 | 38 | 89 | 0 | 0 | 0 | 0 |
| 14-15 | 362 | 338 | 297 | 280 | 0 | 0 | 0 | 0 |
| 16-17 | 514 | 688 | 429 | 592 | 0 | 9 | 0 | 0 |
| 18-19 | 773 | 1042 | 643 | 926 | 29 | 0 | 0 | 0 |

Table 11. Estimated alcohol use among young people in Walsall aged 12-19 years

*N.B. Estimates are based on self-reported alcohol use in 4 general practices across Walsall, 2005*

Table 11 shows estimated numbers of young people aged 12-19 years and levels of drinking. Most drink socially. There is a predictable increase in numbers of young people drinking as they get older. The largest percentage change is between 12-13 and 14-15 years (535% for males and 280% for females), with a subsequent doubling of the number of young people drinking, and a levelling off in percentage increase in the last year. Young women are estimated to drink a lot more than young males. There is a doubling of numbers drinking sociably. The percentage increase for social drinking in males is less than those shown for the females. Emerging findings suggest that there are small numbers of female heavy drinkers, and significantly higher numbers of late teenage young men with high drinking levels. The caveat to all this is that data for younger age groups is less reliable than for older age groups. Youth are less likely to be entirely truthful about health issues such as drinking, smoking and drug use. While young people may be keen to impress peers with their drinking, they are more likely to underestimate their drinking when asked by health professionals such as GPs. Given that young people will be aware of the legal age limit of 18 years for purchasing drinks, they will be less likely to reveal the volume and regularity of their drinking, particularly if asked for their drinking behaviour in front of parents.

## Youth Offending Service

Figure 33 shows that there has been a steady increase in alcohol referrals between 2002/03 and 2005/06. With the proportion of new alcohol referrals peaking at 59% in 2003/04, this has since reduced to 45% in 2005/06. These figures do not depict the level of intervention needed for the various cases. Further analysis of the data would provide more information about the number of young offenders that had received health education, counselling or other more intensive treatment interventions. There are sufficient numbers of alcohol related referrals to undertake some further analysis on the gender, age and residence of the young people concerned. This would further improve the understanding about the changes in the profile of young people committing alcohol related offences. It would be particularly interesting to see if the findings matched those of the residence of emergency admissions for under 20 year olds.

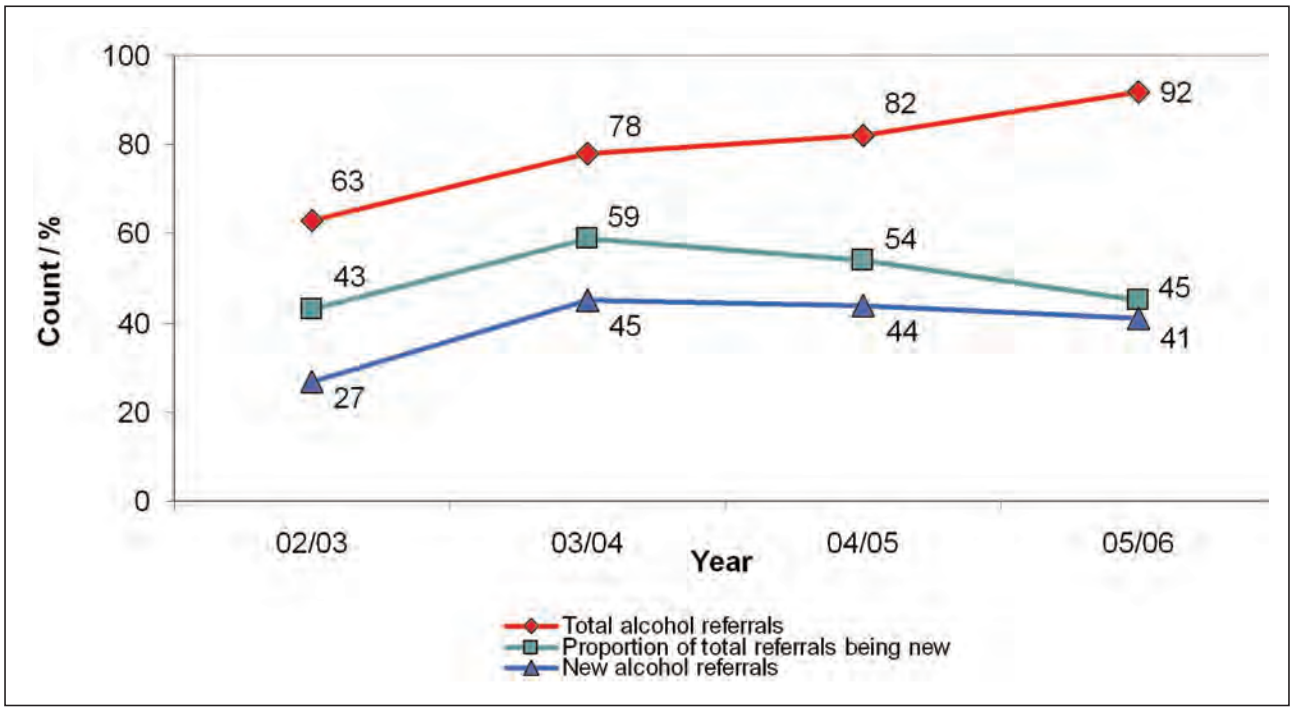
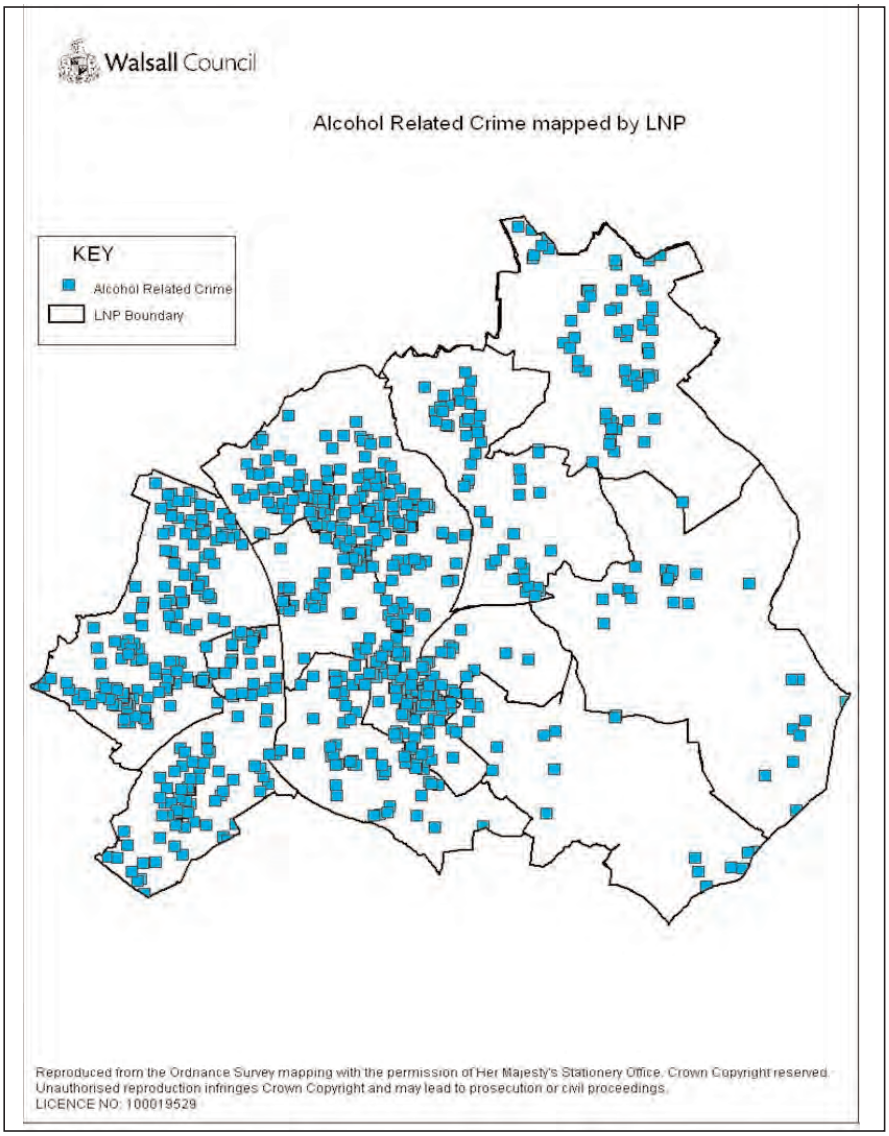



Figure 33. Referrals to the Youth Offending Service Substance Misuse Worker

## Crime and Anti-social Behaviour

The Walsall Town Centre is one of the main areas for arrests for alcohol related offences. Map 8 shows a cluster in the centre, confirming that the Town Centre economy accounts for a large amount of police activity. Other arrest clusters can be found in the district town centres and the Blakenall New Deal for Community (NDC) Area, the latter accounting for 70 alcohol related arrests over the period. Willenhall and Darlaston also show a high proportion of the overall arrests in the Borough. Other centres affected by alcohol related crime are Pelsall and Brownhills. Aldridge also features but on a lesser scale. Streetly alcohol related arrests are less concentrated around one specific area, such as a high street, but show that problems also occur in this relatively affluent area. The number of arrests are likely to have underestimated the actual size of alcohol related crime, one reason being lack of awareness in applying 'alcohol markers' to appropriate crime incidents.

Most of the recorded arrests depicted in Map 8 related to violence or incidences where individuals clearly had been under the influence. At present, we do not have reliable data on alcohol related crime. Available data already presented in Table 6, under the section on Local Alcohol Profiles in England, translates to approximately 3,000 recorded alcohol-related crime incidents in Walsall per year. However, even if a more accurate number of crimes were recorded, it is highly likely that the current concentrations would remain the same. The insight that more accurate figures would facilitate, relates to a more accurate understanding of the funding and human resource requirements needed to provide effective interventions aimed at reducing crime, and the associated effects in the neighbourhoods and district town centres where alcohol related crime is most prevalent.




Map 8. Alcohol related arrests January 2003to March 2006 by Local Neighbourhood Partnerships

Work is required to obtain further local information on alcohol related crime and anti-social behaviour from the Probation Service, Licensing and Trading Standards, and Customs and Excise.

NOTE: More recent data and information on alcohol-related crime and disorder is presented in Chapter 7, showing a more than trebling the number of reported incidents compared to previous years. The more recent data in Chapter 7 has been presented by David Bloomfield and Gwyn Bevan of the CDRP component of the Safer Walsall Borough Partnership.

# Summary of Walsall's Action Plan on Alcohol

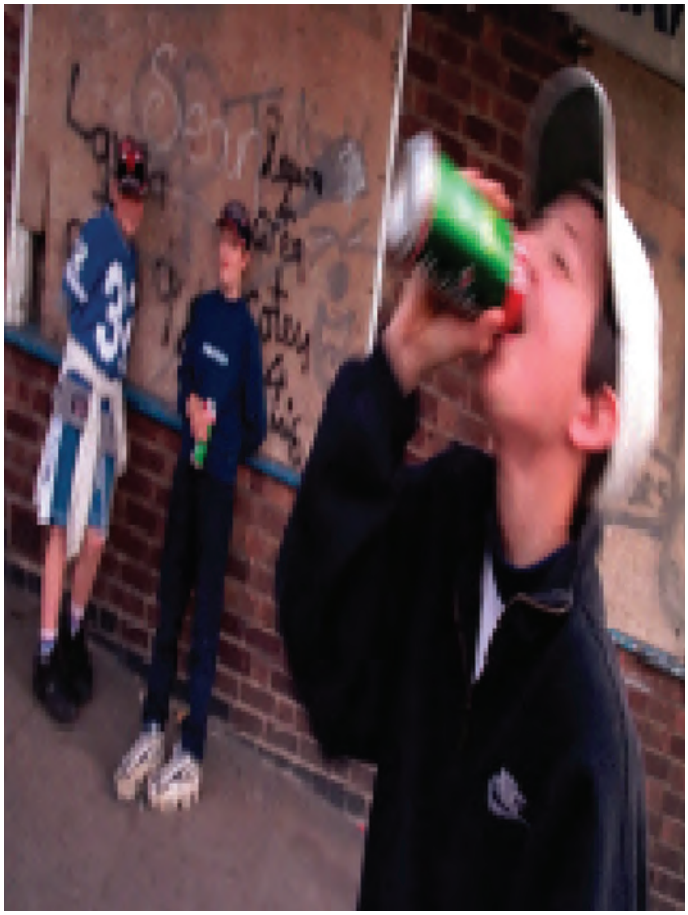
This is an update of the Action Plan produced in 2003, as part of the Walsall Alcohol Strategy. The update then followed wide consultation by numerous partners across Walsall, and was coordinated by Walsall's Alcohol Strategy Group.

Despite the publication of the national alcohol strategy in 2004 (Prime Minister's Strategy Unit 2004), there has been concern and disappointment at the subsequent level of government funding for alcohol related problems in British society. However, this situation is expected to change for several reasons, including:

- Significant government funding (from the Home Office through to the Drug and Alcohol Action Teams – the DAATs, and from the Department of Health) is expected to materialise from 2007, with a monitoring of treatment services by the National Treatment Agency (NTA)
- The explosion of binge drinking, particularly in town centres, continues unabated and, with it, the enduring impact on crime and disorder
- The public health White Paper Choosing Health (Department of Health 2004) singled out alcohol for special attention and, again, the new national enhanced services programme for Primary Care singles out alcohol for uptake by GPs with a special interest
- Rates for alcohol consumption and chronic liver disease are soaring, in contrast to most of the rest of Europe.

Accordingly, the Alcohol Strategy Group recently reconvened early in 2006 and is responsible for this updated Action Plan. The plan is divided into four sections:

1. Alcohol and young people in Walsall
2. Alcohol and communities in Walsall
3. Alcohol treatment services in Walsall
4. Alcohol and crime and disorder in Walsall.



These four sections form the basis for the subsequent four chapters. This report in its entirety effectively doubles up as an updated Walsall Alcohol Strategy.

One important action is not referred to and is common to all four sections. This action relates to our lack of robust and comprehensive information relating to alcohol at the local level. Walsall is certainly not alone in this. Accordingly, a needs assessment was undertaken with the aim, crucially, of identifying gaps in service provision across the borough. The findings of this needs assessment were presented in the previous chapter. However, more work is still required and especially in the Crime and Disorder area, although a start has been made, as presented in Chapter 7. This report serves as a baseline for substantial activity that can be expected from 2007.

An overall summary of the Action Plan from all four sections is presented below from the standpoint of what we are doing well at present to where we need more action, inevitably requiring developments that will demand considerable government funding. Many would also argue that government needs to do more on policy.

## What we are doing well
### (but further effort still required)

1. Raising awareness of alcohol and safe drinking in schools, youth clubs and the communities through dedicated staff and campaigns
2. Applying the proof of age scheme
3. Tackling problematic drinking through a peer advocacy approach (pilot phase)
4. Ban on drinking alcohol in all public places
5. Targeting off licences supplying under age youths with alcohol
6. Controlling alcohol-fuelled disorder and violence in the Town Centre.

## Where we need more action
### (but usually dependent on more resources and/or a stronger prioritisation)

1. More alcohol workers, especially in primary care and specialist services
2. Government funding to enable the development of specialist alcohol services and their integration with alcohol services (and community detoxification) within Primary Care through GPs with a Special Interest (GPswSI)
3. Funding a dedicated alcohol arrest referral scheme (possibly on the Dudley model).
4. Greater priority accorded to alcohol in the national schools curriculum
5. Strengthening the Pub Watch scheme and the tackling of drinks promotions
6. Stronger alcohol links into the Teenage Pregnancy strategy
7. Implementing alcohol-specific integrated care pathways for problem drinkers
8. Targeting awareness and intervention among disadvantaged groups
9. Stronger links between the Manor Hospital and the tPCT to address the role of alcohol in coronary heart disease, mental health, elderly care, falls and stroke prevention, accident prevention
10. Funding to develop an in-patient and rehabilitation (detox) centre, and more dedicated alcohol services within the Manor Hospital.

## Expected developments

1. Increasing influence of Health Promotion (Choosing Health agenda), a new Healthy Schools Lead (Walsall) and two recently appointed Licensing Officers
2. Increasing influence of the Destiny Project and Walsall Alcohol Support Services, but dependent on securing funds
3. Appointment of a DAAT Alcohol Coordinator and stronger influence of SWBP's Vulnerability Group to address the inequalities agenda
4. Recommendation to introduce alcohol problem services in the workplace
5. Identifying and supporting perpetrators of domestic abuse within families, by addressing underlying alcohol related issues clearly and with treatment interventions
6. Appointment of a Consultant Psychiatrist with an interest in substance misuse
7. NTA Models of Care guidance (2006) and Government alcohol funding (2007).

## What Government needs to do

1. Increase the tax on alcohol, especially drinks such as alcopops
2. Tackle drinks advertising and drinks promotions
3. Clear labels on drinks (eg units, health warnings, etc)
4. Accord alcohol a priority at a funding level so far accorded drug misuse
5. Move towards a zero tolerance to drinking and driving.

# Action Plan: Alcohol and Young People in Walsall

During the Walsall Teaching PCT conference on Choosing Health to tackle health inequalities in Walsall in March 2006, there was a workshop on alcohol. Ten issues were raised by a variety of interested Walsall stakeholders as requiring priority attention. Four were not specific to young people (alcohol units awareness; alcohol cultural issue; alcohol coping strategies; effects of alcohol on the foetus). The remaining six issues were specifically raised as relevant to young people and alcohol:

1. It is not all about alcopops-type drinks, and possibly reducing consumption by selective taxation and/or retail price adjustment, since there is a widespread misuse of cheap strong ciders (eg 2L bottles of 9% White Lightning).
2. Trading Standards has an increasing role in curbing under-age drinking.
3. Similarly the Proof of Age scheme (Walsall is 3rd best performer in England) has an increasingly important role.
4. In the Criminal Justice System, alcohol problems now easily exceed those associated with drug use, and especially among excluded children.
5. An alarming 'ladette culture' among young Walsall women.
6. Drink-associated motor cycle accidents among young Walsall men.

While these are being addressed by the Action Plan, it is clear that Government and the drinks industry still has much to do. The Action Plan in relation to young people is presented below.

## Responsibilities of the drinks industry:

- Producing and marketing good quality and safely packaged products
- Ensuring that these products are properly labelled and responsibly marketed
- Ensuring that alcohol should not be sold to under age or drunk people
- Adhering to guidelines on responsible promotional activity and management of drinking premises
- Working with those seeking to minimise harm caused by alcohol misuse
- Acting as a good employer and training staff

## Education and communication (an issue for Government):

- Mixed messages on alcohol and confusion about the dangers and probabilities of harm
- Sensible drinking message ineffective, despite high level of unit awareness
- Mistake to focus alcohol messages exclusively around health
- Advertising deliberately targets young people and portrays drinking in a glamorous context
- Strong case for more effective regulation of alcohol advertising(possibly statutory regulation)

# Alcohol and Young People in Walsall

## Action

| Subject | Progress and Comments |
|---|---|
| **Education**<br>(Education Walsall, Drug and Alcohol Action Team - DAAT, Neighbourhood Regeneration Fund - NRF) | |
| • Include alcohol training programmes for teachers and other professionals working with young children and youth | • Alcohol workshops underway in secondary schools (2 hour work sessions delivered to 3,000 children in 2005/06)<br>• Alcohol training programmes delivered through Youth Clubs, including awareness raising of the impact of problematic drinking on families |
| • Include alcohol education as a specific target in the Personal, Social and Health Education (PSHE) agenda through the National Healthy Schools Scheme | • Currently awaiting the appointment of a Healthy Schools Lead for Walsall, following which alcohol can be accorded a higher priority<br>• Alcohol education is included in guidelines to improve Healthy Schools standards, but there needs to be a renewed schools priority (currently, 60% of Walsall schools participate)<br>• Arts and education into PSHE in relation to alcohol is being addressed by the GLUG campaign |
| **Awareness**<br>(DAAT, Walsall Teaching Primary Care Trust - PCT) | |
| • Provide information on the effects and consequences of alcohol to young people and parents in Walsall from a variety of sources and media presentations | • This is specifically being addressed by a Pelsall project (supporting parents and young people), which could be expanded to other areas |
| • Address the issue of parents supplying alcohol to their children | • Much alcohol awareness is already being achieved through the education approach (above), but there is scope for involvement of the PCT (Health Promotion's Choosing Health agenda)<br>• DAAT alcohol awareness raising is continually being addressed in community settings across the borough |

| | |
|---|---|
| **Enforcement**<br>(Police, Walsall Metropolitan Borough Council – MBC, Customs and Excise) | |
| • Extend the proof of age scheme across the Walsall borough and advise licensed premises to demand it | • There are mixed results; the proof of age scheme is going to apply a more robust application through Training Standards |
| • Ban drinks promotion schemes within licensed premises across Walsall that specifically target young people | • A consistent and more robust application to tackle drinks promotion will be enabled through the recent appointment of two Licensing Officers (one attached to each Police OCU) |
| • Advice (going along with enforcement) at some premises associated with brawling or large crowd gatherings may include the use of plastic containers (not glass or bottles) at peak times | • The Pub Watch scheme needs to be extended, although this is a voluntary initiative that may not be applicable to all premises |
| • Reduce the supply of contraband or illegally imported alcoholic drinks | • Tackling supply of "street liquor" is a national initiative with mixed results |
| **Links with other strategies**<br>PCT, Education Walsall) | |
| • Walsall's Sexual Health Strategy recognises the strong links between excessive alcohol consumption and teenage pregnancy, along with sexually transmitted infections, and will further bolster education and awareness | • There is scope for involvement of the PCT (Health Promotion's Choosing Health agenda)<br>• Restrictions on time in delivering the PSHE agenda has resulted in sex, drugs and alcohol education sometimes being removed or accorded lower priority – an issue that needs remedial action |

## GLUG

Much more than Arts into PSHE, GLUG is a life-skills approach to alcohol education, devised to support Healthy Schools. It is an innovative 4 book multi-media action work pack, supported by a teaching road show, for ages 7 to 11 years. With the aid of the teachers' manual, PSHE Educators can rapidly self-skill in the use of a range of imaginative, flexible and fun approaches to preventive work with younger children. GLUG is bright, lively and coolly streetwise, allowing children to examine issues in a safe and attractive learning environment. These include: risk, choice, personal and community safety, relationships, self esteem, parenting and empowerment.

The GLUG Project is recognised as a best practice health education resource by many agencies, including Alcohol Concern and DrugScope. The GLUG road show has hit Walsall's Primary Schools since 2005, aiming to:

- Deliver a highly effective Preventive Alcohol Education Lesson to large audiences (up to 250) of children aged 7 to 11 years
- Skill teachers, support staff, governors and parents in the most up to date approach to prevention on alcohol
- Enable schools to extend and revisit their PSHE alcohol and drugs work through use of the GLUG work pack

GLUG is led by Chris Ward, a drugs education specialist (glug1@tiscali.co.uk) and further information is available on: www.glug-alcohol-education.co.uk.

## Walsall Youth Arts projects: binge drinking

There is no agreed definition of binge drinking but a consensus would suggest 8 or more units in one session for men (6 or more in women).

Walsall Youth Arts have already worked with many youths to discuss issues around binge drinking in a creative way. Beer mats with information on safe drinking levels have gone out to local pubs across the borough.

One project targeted young people attending Darlaston Youth Club. Most present admitted to drinking, mainly vodka and alcopops. The group created collages for poster artwork, adding slogans and text that might have an effective way of imparting knowledge on the dangers of binge drinking. Another project at Pelsall Youth Club again showed that vodka and alcopops were favoured drinks among the young, with large amounts drank at weekends among friends. The group again created collages for posters, but initial interest tended to wane. The projects at least elicited surprise among most youth that they were excessive in their drinking, created an awareness of recommended weekly units of safe drinking levels, and urged in some a review of their drinking habits.

## Trading Standards and the New Licensing Act

The new Licensing Act became operative in Walsall from July 2005. From November 2005, Trading Standards took over as the Licensing Authority, replacing procedures that went through the courts. Trading Standards is now the issuing authority in consideration of all Walsall drinks premises and landlords. There is the perception of a new informal and 'permissive' approach to issuing licenses, which are then easily revoked from gathering evidence. This new approach, which is 'controlled' and intensive, is already seen as effective in contributing to the effort of reducing crime and disorder. Trading Standards is viewed as applying a more robust application of the proof of age scheme and is strongly supportive of voluntary initiatives such as Pub Watch.

Trading Standards is a division, along with Environmental Health and Bereavement Services, of the Local Authority's Public Protection Unit (formerly Environmental Health and Consumer Services). As well as licensing, it is also responsible for Consumer Advice and Taxi Licensing. Dr Judith Sunley, the Head of Public Protection, is keen to collect data on alcohol related incidents, such as:

- Casualty incidents and other health indicators
- Referrals to substance misuse teams
- Links to teenage conceptions.

The impact of alcohol education through schools is a complex issue, since the family and community play such an important role. Research suggests the potential of a Strengthening Families Programme, where a good school-based alcohol education is integrated with a broader community intervention (Spoth et al 2001). In short, we cannot leave education on alcohol entirely to schools and there is arguably a strong need for a more integrated educational approach in Walsall.

Recently, the drinks industry has been more active in adopting social responsibility standards for the production and sale of alcoholic drinks in the UK. A variety of organisations have been promoting such standards, including the British Beer & Pub Association, the Federation of Licensed Victuallers Associations, Scotch Whisky Association, Wine and Spirit Trade Association, and The Portman Group; the latter being particularly active in promoting sensible drinking (Portman Group 2006). Initiatives include:

- Promoting the sensible drinking message
- Marketing drinks, packaging, units awareness
- Promoting code of practice
- Preventing under-age purchases
- Preventing the sale to intoxicated customers
- Rules on drinks advertising
- Dispersal policy by the Bar, Entertainment and Dance Association.

Locally, the British Beer & Pub Association (Midland Counties) has been active in Walsall, through meetings with Police, who are particularly concerned with young people accessing drinks from supermarket stores and other retail outlets. Clearly, these initiatives will have an impact on alcohol in Walsall young people.

## Action on alcohol: impact on government targets

Excessive alcohol consumption affects many organ systems and action will impact on many NHS targets:

- Reducing mortality rate (through effects on liver and heart disease, stroke, accidents, suicide, and cancer)
- Reducing waiting times in Accident & Emergency (especially at weekends)
- Reducing hospital admissions (especially repeated admissions)
- Indirectly improving diet.

There are further impacts on health as part of Local Area Agreements (LAA):

- Reducing mortality rate as already stated
- Increasing life expectancy (through a direct impact on averting chronic liver disease, especially cirrhosis)
- Reducing health and social deprivation (effect on behaviour and social downward drift)
- Reducing homelessness and associated health risks (eg tuberculosis)
- Reducing infant mortality rate (effect on low birth weight).

Finally, action on alcohol strongly impacts through the LAA Pillar on:

- Reducing alcohol related crime.

## Community Binge Drinking Project for Walsall 2006

The concern of alcohol abuse and binge drinking was identified during the Walsall Health Action Zone's final year in 2006, in line with the government White Paper, Choosing Health (2004). It was agreed to develop a campaign in each of the four HAZ localities of Walsall to raise awareness of binge drinking and of the amount of units of alcohol local people should not be exceeding each day. There was a need specifically to engage young people in Walsall, due to the growing problem of the binge drinking culture which has often led young people to crime related activities and vulnerability to sexual assault.

## Beer Mat Project

The North, South and West HAZ commissioned Walsall tPCT to design a beer mat for use as a communication tool. The aim of the Beer Mat project was to raise awareness of the daily alcohol unit limit for both men and women. The beer mats were sent out to all of the local pubs situated in the North, West and South of Walsall.


## *Young People Binge Drinking Poster - R U Bingin?*

The South HAZ commissioned Walsall Creative Development Team to develop a project that would engage and raise awareness amongst young people of issues around binge drinking. The R U Bingin? Project was an Arts into Health alcohol awareness project engaging 20 young people at Pelsall Youth Centre, Darlaston Youth Project and Walsall Youth Arts to creatively explore issues surrounding binge drinking. The local young people produced designs for a possible Don't Bing Drink poster and other promotional material which would appeal to young people and promote messages to reduce the amount of alcohol intake. This resulted in a poster campaign targeting secondary schools and youth clubs in the Borough. The initiative focused on raising awareness of the physical, emotional and psychological risks and effects of alcohol, short and long term effects around binge drinking and encouraging young people to be more aware of alcohol units. The project was managed by Walsall Council's Creative Development Team and delivered in partnership with Walsall tPCT, Walsall Youth Service and Walsall Youth Arts.

## Darlaston Youth Project - Walsall Youth Arts

Three sessions with young people were held at Darlaston Youth Project, aiming to discover young peoples' thoughts on drinking. Most of the young people present admitted to drinking, mainly vodka and alcopops drinks. One young man said that he drank mainly beer but sometimes he drank tequila slammers with his aunt. The group created two large collages with images, colours and fonts that they thought would appeal to other young people and that would work on a poster design. The following week they started to paint ideas for their posters. They also used a camera to try out different poses that might work on their design. The final week again combined painting, computer design and photography. The young people continued with their paintings of their poster designs and also used the digital camera to photograph bottles brought in as props. Some worked on the computer to review their images and to combine photos into a poster artwork. Others looked at how slogans might work on the posters and what text could be added.

## Pelsall Youth Club

Two sessions were held at Pelsall Youth Club. The first week engaged with six young people in total. They drank mainly alcopops and vodka; quite large amounts, mostly at the weekend with their friends. They worked to create a large scale collage of imagery for poster designs that they felt was appealing to young people.

## Walsall Youth Arts

Art worker Claude Chambers worked with five young people aged 17 to 23 years. Discussions brought up many surprises for the young people who took part. One young woman was astonished that she was drinking double the recommended limit for a week on a regular basis. The group developed a story idea and dialogue language of young people. This was scaled into a storyboard for the R U BINGIN? Poster materials. One young person with knowledge of Photoshop created the visuals and came up with the general design and layout of the poster. He then used software called 'Comic Life' to make the finished cartoon poster.

## Binge Drinking Calendar

East HAZ took the approach to address binge drinking in schools in the Borough through the approach of a calendar card and year planner with splashed on health messages. A pilot study was undertaken at WALCAT College. Hard hitting images were used on the front of the card, with information highlighting the dangers of binge drinking. More than 12,000 calendar cards were delivered to schools and a prize draw was also held where a local school pupil won £50 in sports vouchers. Over 90% who had returned the evaluation form for the prize draw responded positively in finding the information useful.

The entire community project approach has made some young people review their drinking habits and binge drinking. One poster was exhibited at the Youth Exhibition "Me Myself & I" at the Chameleon Gallery, Walsall in May 2006. The poster has had lots of positive comments from professionals and young people, and has been distributed to all secondary schools, youth clubs and health centres in the Borough. There have also been ideas to develop the poster into a Bus Campaign. Health messages of the dangers of excessive drinking were also promoted within the workshops and there is a possibility to produce draw string bags with two poster designs on the bag to be given to school leavers with relevant information on the dangers of binge drinking put within them.

# Alcohol and Young People in Walsall

What we are doing well (but further effort still required)

1. Raising awareness of alcohol related problems in schools and youth clubs
2. Applying the proof of age scheme

Where we need more action (but usually dependent on more resources and/or a stronger prioritisation)

1. More priority accorded to alcohol (drugs and sexual health) in the national schools curriculum,
   ideally supported by an integrated family and community approach
2. Expand raising alcohol awareness at community level among young people and parents
3. Strengthen the Pub Watch scheme and the tackling of drinks promotions
4. Stronger alcohol links into the Teenage Pregnancy strategy

Expected developments

1. Appointment of a Healthy Schools Lead for Walsall
2. Stronger involvement of Health Promotion (Choosing Health agenda)
3. Increasing influence of two recently appointed Licensing Officers

What Government needs to do

1. Increase the tax on alcohol, especially drinks such as alcopops
2. Tackle drinks advertising and drinks promotion
3. Clear labels on drinks (eg units, health warnings, etc)
4. More resources through schools

# Action Plan: Alcohol and Communities in Walsall

On average, each problem drinker adversely affects at least two other people. Many of these are children living with a problem drinking parent. However, direct services for children and other non-drinking family members have been slow to develop and have been given insufficient attention. This is why the advent of the Destiny Project and the Walsall Alcohol Support Services are so important for the borough's residents. This priority deserves every support initiative, that has so far been sadly lacking.

Family members (of problematic drinkers) are often non-drinkers or at least drink sensibly. Sometimes the long standing stress that they are subjected to may result in them developing their own drinking problems. They often suffer negative experiences, including violence, poverty and social isolation (Velleman 2000). Psychological and physical morbidity often occurs in the spouse and children of problem drinkers (Vellemann & Orford 1999), while family and financial breakdowns are all too common. Children of problem drinkers are also likely to display antisocial behaviour, and may be predisposed to substance misuse, as well as leaving home and marrying earlier than their peers (Velleman 2000). Shame, embarrassment, fear of disclosure and family loyalty are some factors that make it difficult for children to disclose problems associated with parental alcohol use (Brown 1988). A spouse may likewise hide a problem drinker. Health and social services may actually exacerbate the problem, since they are becoming increasingly specialised (Weir & Douglas 1999). For example, if there is a specialised focus on child and protection issues, the drinking parent and other family members may be excluded professionally; they may be isolated and still not receive any help. At worst, the child may be removed from the family. Hence the need for specialised alcohol support services. Good models have been developed in the primary care setting (Copello et al 2000), in addition to support offered to specialised alcohol providers. The model is based on five key steps:

- Listening to the family member and assessing the situation
- Providing advice and information
- Exploring ways of responding or coping
- Exploring appropriate social support
- Referral as necessary.

There are many examples of effective support services across the country, one being the Family Alcohol Service (FAS), established as a result of a partnership between the NSPCC and the Alcohol Recovery project in London. This type of service, as envisaged by the Destiny Project and by the Walsall Alcohol Support Services, aims to support the treatment of drinking people and parents, as well as providing systemic family and child intervention and support. Crucially, this type of support service provides an effective liaison with health, social services, education, probation, and alcohol services.

# Alcohol and Communities in Walsall

## Action

| Subject | Progress and Comments |
|---|---|
| **Awareness**<br>(PCT, Destiny Project, Walsall Alcohol Support Services)<br><br>• Launch campaigns on Safe Drinking Limits and reasons why people drink to excess, be they ignorance of limits, ranging through to dependence on alcohol (this includes utilisation of the advocacy role of organisations such as Connexions, etc)<br><br>• Reduce the stigma of excessive alcohol consumption within Walsall communities, increase the numbers of problem drinkers accessing treatment, and raise awareness of the devastating effect of problematic drinking on families and society | • Safe drinking has been taken up by the Health Promotion team, who could also liaise with the Portman Group, an organisation encouraging sensible drinking<br><br>• There is need to deliver clearer and precise messages, in language geared to the various target audiences<br><br>• Problematic drinking is within the remit of a recently formed group, the Destiny Project, which adopts a peer advocacy approach to identify and support people in need |
| **Intervention**<br>(Lantern House, Destiny Project, Primary Care, Walsall Alcohol Support Services)<br><br>• Develop alcohol-specific integrated care pathways for problem drinkers, promoting them among families and carers | • Currently being developed by Lantern House (Walsall's Tier 3 community drug and alcohol provider service) in association with Primary Care and support groups such as the Destiny Project |
| **Targeting specific groups**<br>**1** (DAAT, MBC, PCT, Destiny Project, Walsall Alcohol Support Services)<br><br>It is necessary to raise an AWARENESS and INTERVENTION approach among diverse groups. They include:<br><br>• the homeless and destitute<br>• the elderly, lonely, and bereaved<br>• victims of domestic violence<br>• victims of family breakdown<br>• ethnic minority groups<br>• pregnant women | The DAAT intends to strategically lead on this work through the appointment of an Alcohol Coordinator<br><br>• There is a need to link up with, eg Social Services and Age Concern; Housing; work on Domestic Violence and BME (Black Minority Ethnic groups) projects; national service framework (NSF) for the elderly<br><br>• Some work is beginning, eg there already exists a Black Country holistic approaches project addressing alcohol and BME communities |

| | |
|---|---|
| **2** (Safer Walsall Borough Partnership – SWBP)<br><br>A remit of SWBP's Vulnerability Group is to address issues such as repeated domestic violence, BME victimisation, and other issues identified by communities (alcohol misuse has been identified as an area that is affecting most vulnerable people and families)<br><br>Efforts need to ensure that the alcohol issue is incorporated into a variety of programmes that address such diverse groups, in order to enhance health and reduce crime | The Partnership intends to raise the awareness of alcohol misuse among vulnerable groups, through engagement, consultation and empowerment of communities by:<br><br>● Local Safer and Stronger Community Panels meeting every two months (there will be Panels in each of the nine borough neighbourhoods, plus one for the Town Centre)<br><br>● Such meetings (augmented by special neighbourhood events) are open and accessible to communities, most of which demand stronger efforts on safety in particular |
| **Links with other programmes to raise awareness** (PCT, Manor Hospital)<br><br>Excessive alcohol consumption needs to be addressed by:<br><br>● NSFs on coronary heart disease, mental health, & the elderly<br>● programmes on stroke prevention<br>● programmes on accident prevention | ● The recent appointment of a Consultant Psychiatrist with an interest in Substance Misuse will promote action around mental health<br><br>● The Walsall GP Lead on alcohol will aim to promote engagement with alcohol issues through the Quality and Outcomes Framework (QOF) in Primary Care<br><br>● Alcohol awareness within other programmes will be promoted through eg the Falls Programme, Manor Hospital clinical governance group, Black Country cardiac network, Walsall Accident Prevention Group |

## Black Country Cardiac Network

This network is part of a nationwide initiative, having a cardiologist as a national lead. There is GP and practice nurse involvement, with quarterly meetings to agree work plans to achieve service improvements, mostly geared to National Service Frameworks and NICE guidance. There is a focus on primary prevention, and strong links with stroke teams and diabetes networks. Primary prevention has taken on a new priority with the advent of the Public Health White Paper Choosing Health, since of high relevance to preventing cardiac disease is action on smoking, physical activity, obesity and alcohol. Specific information on safe drinking limits is now available to all cardiac patients, and cardiac nurses now undergo specific alcohol training. There is now a place for brief interventions to deal with excessive or problematic drinking, so that the identification of cardiac patients who need help is an integral part of the overall assessment process. There are areas of cardiac work where alcohol plays an important role, such as: the cause of some cardiac arrhythmias and cardiomyopathies, and the links with clinical depression after cardiac events.

The network has been concerned with the development of a new service, which began in April 2006: the Primary Prevention of Coronary Heart Disease Service. This programme follows a pathway whereby Lifestyle Advisors and clinicians working in Primary Care support information for assessing cardiovascular risk and signposting to intervention for lifestyle changes. The intention is to target patients aged 40-50 years, who have no existing heart disease or diabetes, and have no record of BMI. These patients are then sent a population survey form, and those with a BMI of 30 or above are invited for a lifestyle assessment by the Service team. Most identified patients are seen within their own practice by a Lifestyle Advisor, who will share information directly with the GP. Questions on alcohol consumption are included as part of the assessment, and a brief intervention may follow.

## Vulnerable groups:

- Children of problem drinkers are at risk
- Wide range of vulnerable groups need alcohol services to serve a diverse population
- These groups have multiple needs that also need to be addressed (close inter-agency working)
- Need to build on good partnership work being done by Drug and Alcohol Teams (DATs) and Crime and Disorder Reduction Partnerships (CDRPs)
- Need for more and consistent funding

# Black and Minority Ethnic Issues and Alcohol

This has been referred to in a previous Director of Public Health Annual Report, Minority Communities Matter **(Walsall Teaching PCT 2005)**. In that report, there was reference to an audit of Walsall's African and African-Caribbean communities **(Harris et al 1999)**. The audit showed that these communities were more likely to have lone parents, have chronic illness, live in the most deprived wards, live in rented accommodation, be unemployed, and lack training opportunities - all factors associated with alcohol problems. Among these communities, there was also concern about the quality of care for Mental Health inpatients, which will include problematic drinkers, and about those discharged back into the community. The report made specific reference to rates of alcohol consumption being highest among Walsall White and Caribbean men, but lower among South Asian men (substantially lower among Pakistani and Bangladeshi men). For example, the 2000 Walsall Asian Lifestyle Survey showed the proportion of people who said they drank alcohol when questioned in 1995 and again in 2000: respectively Indian 30%, 40%; Pakistani 2%; 5%; Bangladeshi 2%; 0%. Clearly there are reporting problems but the differences are clear. There was an important observation among Indian groups in that Sikh men are generally reported to have very high rates of alcohol consumption. These cultural differences are significant, and we have already seen in Chapter 2 the unexpectedly high rates of alcohol related hospital admissions from the wards of Palfrey and Pleck, which contain high concentrations of South Asian people. Other sources have also pointed to problematic drinking among people of Sikh or Punjabi background.

Dr Avtar Suri, Walsall's Lead GP on Alcohol, has observations on Punjabi and other issues in relation to alcohol:

- They were among the first migrants from India, usually from a village background and usually taking up labouring jobs. The majority had started drinking home brewed alcohol in their native village from ages 13 to 14 years onward. In the UK, they tended to gather in various pubs to socialise and drink in excess. Indeed, excessive drinking is very much the norm at most social occasions, such as weddings, birth of a child (especially male), birthdays, anniversaries, diwali, holi, and vaisakhi festivals. There is now a trend for young teenage South Asians to start drinking in competition with peer groups from the White population.
- Walsall GPs are otherwise seeing: a direct correlation between excessive drinking and social deprivation; increasing numbers of female drinkers, especially bingers; understated self reporting of alcohol consumption; increasing numbers of heavy drinkers among business people, teachers, doctors, and nurses; and younger people with alcohol related chronic liver disease.
- £1 spent on alcoholics saves £5 otherwise spent on hospital care, crime costs, etc.

## Streakers Fined

Reports of British tourists behaving badly abroad have been all too familiar. For example, the Sunday Times in August 2006 reported three men fined 800 Euros each and sentenced to a month in jail after a streaking incident in the rowdy Malia resort of Crete, Greece. The previous month, 10 Britons were held after a mob of up to 50 wrecked Malia's hospital in a drunken rampage following a series of stabbings in the town.

# Quotes

Pleck resident " . . . In Punjabi communities, drinking signifies manliness and strengthens their male identity, so the more tolerant to alcohol, the more of a man that person is considered to be. This is particularly noticeable at celebrations and parties. It is considered rude not to drink at an event such as this and refusing drink could offend the host. Economic factors are also to blame. Many Punjabi males still occupy low status and low paid jobs. For this reason, alcohol is used to cope with the stresses of a low income. For those who have developed successful businesses, the stress of managing this often leads to alcohol misuse. I do think that drinking is part of the Punjabi culture and one way of addressing this issue is to run a few educational and awareness campaigns targeted at this community . . ."

Ex Pleck resident " . . . Many Punjabi men that drink alcohol do so because it is readily available and its use is socially accepted by male migrants wherever they have settled. People start consuming alcohol at an early age and therefore get addicted. From what I know, alcohol is excessively drunk at times of stress, and this often leads to domestic violence. Alcohol is also used or seen as a nerve calming substance during the loss of a loved one. I don't think drinking is a cultural thing but has been adopted into life as a means of socialising among male members. It is a part of entertainment at parties and social gatherings. However, having said that, not all Punjabi Sikhs consume alcohol. A large percentage of Sikh men are pure vegetarians and teetotallers . . ."

Palfrey resident " . . . Alcohol is a problem now in the Punjabi community. Those individuals who start drinking alcohol find it very hard to stop and it is certainly not good for health. Back in my day when the main source if income came from labour work it was normal to go for a pint in our local. Nowadays, if it's a celebration its like - bring the drink out; if it's a birthday - bring the drink out; if it's weddings - bring the drink out; if it's Christmas - bring the drink out. There is just too much alcohol available now. People don't go to pubs anymore. The thing is, the ones that drink, drink a lot. The new generation don't sit with the older ones. They have their own groups. Back in my day there was only a handful of people at weddings but now literally hundreds attend and there is plentiful free alcohol on offer to the guests . . ."

PCT Health Professional " . . . The pattern of drinking from my experience has shifted. Very rarely do I see someone 'legless' at a function. Due to status and self respect, men are controlling their bingeing; well probably still bingeing, but not to the point of making fools of themselves and their family. However, the younger generation are being exposed to vast amount of free alcohol, and therefore the cultural acceptance of drinking in Punjabi communities encourages youngsters to start early. The Punjabi celebration culture is spreading across different South Asian communities. It is not unknown for Gujerati families to have similar celebratory functions. Drinking is common across all religions and cultures. I have friends from all south Asian groups and they do drink alcohol. Obviously some for religious reasons only do so without the knowledge of family. There is not an issue for Asian men that wives and partners are drinking, whereas at one time it was unacceptable. Finally, Asian communities do not recognise or seek help for alcoholism; they do not recognise it as a problem . . ."

## The Reverend Pete Wilcox

The reverend has been working on a project for people drinking excessively on a Friday night in the Walsall town centre, deploying volunteers from different church groups. From 10pm to 2am they provide hot and cold non-alcoholic drinks outside St Paul's, The Crossing in a safe and quiet environment for those who over consume alcohol. Advice and counselling is at hand for a range of alcohol related issues, including domestic violence, as well as health promotion literature. The scheme has been previously piloted in Coventry.

## The market:

Should the alcohol industry be at the heart of the strategy?

Need more affordable soft drinks

Need alternative entertainment for those who do not wish to drink

Restrict bad practices such as 'happy hours' and 'all you can drink' offers

# Alcohol and Communities in Walsall


### What we are doing well (but further effort still required)

1. Raising awareness of Safe Drinking Limits through campaigns
2. Tackling problematic drinking through a peer advocacy approach, with support to families and children (Destiny Project and Walsall Alcohol Support Services)

### Where we need more action (but usually dependent on more resources and/or a stronger prioritisation)

1. Implementing alcohol-specific integrated care pathways for problem drinkers
2. Targeting awareness and intervention among disadvantaged groups
3. Stronger links between the Manor Hospital and the tPCT to address the role of alcohol in coronary heart disease, mental health, elderly care, falls and stroke prevention, accident prevention

### Expected developments

1. Stronger involvement of Health Promotion (Choosing Health agenda)
2. Increasing influence of the Destiny Project but will require significant funding
3. Appointment of a DAAT Alcohol Coordinator and stronger influence of SWBP's Vulnerability Group to address the inequalities agenda
4. Appointment of a Consultant Psychiatrist with an interest in substance misuse

### What Government needs to do

1. Increase the tax on alcohol
2. Tackle drinks advertising and drinks promotion
3. Clear labels on drinks (eg units, health warnings, etc)
4. Accord alcohol a priority at a funding level so far accorded drug misuse

# Action Plan: Alcohol Treatment Services in Walsall

Alcohol workers operating in specialist services have long been a cornerstone in delivering care to people referred for problematic drinking, often associated with alcohol dependency. Many referred people have physical and psychological morbidity, usually having a long history of contact with one or more of the following: primary care and acute services, mental health services, social care services, and the criminal justice system. Some people self refer, but mostly they are referred from the other points of contact. Alcohol workers rely a great deal on the cooperation of primary care professionals and on various support services, such as the Destiny Project in Walsall, and value the support of voluntary groups such as Alcoholics Anonymous. Typically, alcohol workers are stretched to capacity and are under resourced, often having to follow up their patients in the primary care setting. This is a distraction and consumes a considerable amount of time that should be devoted to care in the specialist setting, which in Walsall is principally based at Lantern House. In many respects, they need to focus their energies on the most problematic drinkers and, as a result, should mainly deal with the tip of an iceberg. A far larger group of drinkers remain below the surface as a considerable problem in the community, as we saw in Chapter 2 in the section on the Walsall Alcohol Needs Assessment. This group should be dealt with for the most part within primary care, led by specialist GPs with an interest and supported by their own alcohol workers. By this means, the capacity problems being experienced within specialist services can be addressed. However, it is very important that both cadres of alcohol workers operate very closely together, ideally coming under the same management structure, and operate also with alcohol or link workers beginning to emerge in acute services. Usually there are strong links between alcohol workers within specialist services and professionals working in mental health, social services, and the criminal justice system. The advent of Primary Care Alcohol Workers has thus been seen as a necessity, not only from Walsall's experience and needs assessment, but from considerable evidence elsewhere.

## Primary Care Alcohol Workers

### Description

This service existed in Walsall until the beginning of 2005, when the provider Aquarius withdrew because of capacity problems within its organisation. The work of two Aquarius-trained Primary Care Alcohol Workers was further supervised by the Alcohol GP Lead, Dr A Suri, who was funded as part of this service. Accordingly, there is currently a significant local service gap.

The aim of the service is to identify problematic drinkers within the community through an evidenced based brief interventions approach in the primary care setting (later extending to the Accident & Emergency department) and deliver the appropriate care, if necessary with direct referral to local specialist providers (principally Lantern House and Addaction).

The key objectives of the Primary Care Alcohol Workers are to:

- Develop and maintain alcohol treatment services in primary care settings in collaboration with GPs and key professionals
- Undertake comprehensive assessments of the health, social care and criminal justice related needs of service users and make plans to meet those needs
- Identify areas of risk and ensure the safety of staff, service users and those affected by a service user's drinking
- Provide specialist advice on the effects of alcohol use and dependence through education and training to relevant professionals and service users.

In many ways, the role of Primary Care Alcohol Workers are akin to Key Drug Workers operating as part of the successfully implemented Shared Care Scheme now operating within primary care in Walsall.

### Addressing need

Around 20% of patients attending primary care are excessive drinkers but surveys suggest 65% of GPs see only up to 6 excessive drinkers in one year, which is an opportunity missed since brief interventions in primary care can alter drinking behaviour (those lasting 5-10 minutes can reduce consumption by 20%). As already seen, the effectiveness and recommendation of the primary care approach has been endorsed by the:

- Chief Medical Officer's Annual Report 2001 on chronic liver disease
- Walsall Alcohol Strategy 2003 (informed by wide consultation)
- Alcohol Harm Reduction Strategy for England 2004
- Public Health paper Choosing Health 2005

The Walsall Alcohol Needs Assessment 2006, in Chapter 2 of this report further endorses the recruitment of primary care alcohol workers.

### Benefits of change

It is proposed to evaluate the benefits of the primary care approach once the baseline health needs assessment has been completed. It will be possible to identify the proportion of problematic drinkers (who present in the primary care setting) who have benefited from interventions (including referral for specialist care) but who otherwise would have remained unrecognised and continued with excessive drinking. Other evaluation criteria can be introduced (eg number of referrals, outcomes, absenteeism rates). Many of the benefits of change will need to be assessed over a 3 to 5 year time scale. In addition to addressing population needs and health gain, this service can be expected to impact on crime, especially in high deprivation areas. Further evaluation criteria can be applied through the Criminal Justice system.

### Impact upon other services

This service improves and pro-activates the relationship between primary care and specialist alcohol services. Referrals become not only more appropriate but alcohol services are spared clients who increasingly can be dealt with competently in the primary care setting (certainly as enhanced services are developed), including that of community detoxification. This service is an essential component of modernisation and makes it possible for the care pathway developed by Lantern House to have a better chance of success. In addition, this service makes it possible to establish more effective links with Accident & Emergency and with the Criminal Justice system. There is clear research evidence to show effective partnership and whole system gains.

## Brief Interventions

Rapid identification of problem drinkers (taking a rapid standardised alcohol history) and brief interventions in primary care (and other settings such as A&E), with advice on appropriate drinking (+/- onward referral to alcohol treatment providers) is proving highly effective.

Detoxification, using gradually reducing doses of chlordiazepoxide (Librium), can also be arranged in the community setting, as well as in hospitals and by specialist services.

## Alcohol dependency

Affected people are in need of constant help and motivation, family and community support. They are deserving of a non-judgemental approach and benefit from peer support groups. For example, Alcoholics Anonymous is successful in sustaining many alcohol dependent people.

## Alcohol Service Tiers

**0 Preventive services:** inform about the effects of alcohol and risks of misuse.

**1 General services:** working with a wide range of clients (eg primary care) but can provide brief interventions, screening and referral to alcohol treatment services.

**2 Open access alcohol treatment services:** providing accessible alcohol specialist services for a wide range of alcohol misusers referred from a variety of sources, including self-referrals. There are minimal requirements on alcohol misusers to receive services. But there is frequent referral to Tier 3.

**3 Structured community based alcohol services:** providing structured programmes of care, including cognitive behavioural therapy, motivational interventions, structured counselling, community detoxification, day care, and aftercare programmes for alcohol misusers leaving residential rehabilitation or prison.

**4a Residential alcohol specific services:** aimed at those with a high level of need, including inpatient alcohol detoxification or stabilisation. Requires higher level of user commitment, after first ensuring careful assessment and preparation to maximise readiness and compliance.

**4b Highly specialised residential services:** that are not alcohol specific, such as liver units and forensic units for mentally ill offenders.

**Problem drinkers of whatever background are generally not detected and not helped**

**Problem drinkers are twice as likely to visit their GP (but they are missed)**

**Around 20% of patients attending primary care are excessive drinkers (ie at least one seen per GP per day), BUT**

**Surveys suggest 65% of GPs see only up to 6 excessive drinkers in one year (or, GPs miss over 95% of patients who are problem drinkers)**

**An opportunity missed since brief interventions in primary care can alter drinking behaviour (those lasting 5-10 minutes can reduce consumption by 20%)**

**Problem drinkers dismissed as being weak-willed – hence why alcohol services receive scant attention**

**Many argue that only primary care teams can suitably deal with alcohol misuse (in a global sense)**

## Brief Intervention Guidelines

There are many approaches to brief interventions on alcohol, that can be used in any setting (but typically in primary care or hospital). The following is an example:

1. Does the patient know the recommended safe limits for alcohol (2-3 units a day for women and 3-4 units a day for men)?
2. Advise not to drink up to these limits on a daily basis and to include some alcohol free days in the week.
3. Give explanation of alcohol units and ideally supply relevant literature.
4. Explore ways that patient may reduce drinking, eg shandy instead of beer, alternating alcoholic and soft drinks, etc.
5. Refer patient to GP/Practice Nurse for follow-up on recommendations made, or directly to an Alcohol Provider service (literature giving details of self referral to such a service may be more effective) when consumption is excessive (eg over 50 units per week and/or dependent, problematic drinking).

## Questionnaires used in brief interventions

**The AUDIT (Alcohol Use Disorders Identification Test) questionnaire is often quoted as a gold standard for use in very busy medical settings. The FAST (Fast Alcohol Screening Test) has been developed from the AUDIT, and is quicker and just as effective. Two other fast questionnaires are the Paddington Alcohol Test and the CAGE. The CAGE questionnaire is typically used if consumption exceeds 50 units of alcohol per week, or if drinking is problematic or dependent.**

- **Have you ever thought you ought to cut down your drinking?**
- **Has anyone ever annoyed you by criticising your drinking?**
- **Have you ever felt guilty about your drinking?**
- **Have you ever had to have an 'eye-opener' – ie a drink first thing in the morning?**

**Two or more positive answers suggest that drinking may be causing problems. For many people, these are issues that occurred in the distant past, but with advancing age and coping strategies, may not be issues that relate to the present or recent past. If the score is positive for a possible risky or harmful level of drinking, advise on the following options:**

- **Do nothing but give time for the patient to reflect and demonstrate a change in drinking behaviour**
- **Advise patient to reduce consumption, providing fact sheets and supportive literature material (many people succeed)**
- **Suggest consultation with the GP**
- **Suggest self-referral to a Drug Provider service**
- **Refer urgently to the GP, if there is severe dependency, for detoxification.**

## Brief Interventions in Primary Care and Accident & Emergency

Brief interventions have been successfully delivered nationwide to identify problematic drinkers and intervene appropriately. To date, this has been delivered sparingly because of a lack of dedicated government funding. This approach is usually delivered in the Primary Care setting but has also been successfully implemented in Accident & Emergency departments and on acute hospital wards. Brief interventions were introduced in Walsall, until recently, by the provider Aquarius who also deliver their work elsewhere in the region. However, they later withdrew because of uncertainty over funding but have left behind a model for delivery of the approach.

There is much evidence for the effectiveness of brief interventions, including a recent meta-analysis showing its impact among people with alcohol problems who are not seeking treatment **(Moyer et al 2002)**. There is much support for its use by GPs **(Kaner et al 1999)** and practice nurses **(Lock & Kaner 2004; Coulton 2006)**. Nurses are interested in screening and brief intervention and many are willing to incorporate this approach into practice, and so contributing to decreasing the health and social costs of excessive alcohol consumption in the population **(Heather 2004)**. Recently, its effectiveness has been confirmed for use in A&E departments **(Crawford et al 2004)**. It is important for screening to be brief as well as effective. The FAST questionnaire can be completed in 12 seconds, and was consistently reliable when sensitivity and specificity were tested against AUDIT as the gold standard **(Hodgson et al 2003)**. Of patients identified by FAST to be harmfully using alcohol: 77% would be happy to receive alcohol education material, 46% would welcome a 5 minute discussion with a nurse, and 25% would accept three counselling sessions from a nurse. FAST questionnaire is terminated after question one for over 60% of people (identifies >60% as either harmful user or not).

FAST questions identify hazardous, problem and severely dependent drinkers, opening the door for targeted health promotion and treatment.

## Clients Referred to Addaction Walsall

Addaction is a Tier 2 level provider of drug and alcohol services, where people can typically self refer for confidential advice and care. More problematic users can be referred on to Lantern House, which provides Tier 3 level services (that includes medical inputs and access to residential or psychiatric care). The following Addaction data from 2005 to 2006 provides some background to clients referred with alcohol as a primary substance problem -

- Gender: male 73%; female 27%
- Principal age groups: 15-24 years 14%; 25-34 years 27%; 35-44 years 32%
- Referral sources: self 37%; arrest referral 26%; GP 10%; probation 3%
- Ethnicity: White 82%; Indian 7%; Irish 2%
- Outcomes: still attending 33%; onward referral 14%; left treatment 10%.

# Alcohol Treatment Services in Walsall

## Action

| Subject | Progress and Comments |
|---|---|
| **Organisation, policies and guidelines**<br>(DAAT, Lantern House, Primary Care, Addaction) | |
| • Expand the Walsall DAAT remit to embrace alcohol issues in the local and national strategy | • Following the publication of the national alcohol strategy in 2004, the DAAT has prepared for dedicated government funding (expected in 2007) with a variety of pilot initiatives referred to in this Action Plan |
| • In line with Models of Care, develop alcohol-specific integrated care pathways that support the coordination of alcohol treatment and effective management of care across drug and alcohol treatment services and general health, social and other care | • A national consultation on Models of Care for alcohol, led by the National Treatment Agency (NTA), has been completed and was published in June 2006<br>• The Models of Care guidance, already developed for drug services, will further advise and inform the alcohol-specific integrated care pathways being developed by Lantern House, in association with Primary Care in particular<br>• Addaction (Walsall's Tier 2 community drug and alcohol provider service) contributes to these pathways |
| • Develop GP guidelines for patient management and appropriate onward referral | • The key approach in Primary Care is the rapid identification of problematic drinkers, followed by brief interventions incorporating appropriate management<br>• GP guidelines are being developed by the Walsall GP Lead on alcohol and will require implementation through GPswSI (GPs with a special interest), provided by enhanced alcohol services in Primary Care from 2007 (see below) |
| **Primary Care**<br><br>There is potential for Primary Care to play a key role in community addiction services (already being developed for drug misuse through the Shared Care scheme), associated with two major shifts:<br>(1) towards the rise of GPswSI and (2) towards a nurse-led NHS, with nurses having prescribing rights, wider responsibilities and better pay for greater skills. Thus, there is need to: | |
| • Appoint a GP coordinator of alcohol treatment across Walsall practices, with increasing responsibilities as services develop | • A Walsall GP Lead on alcohol is already in place |

| | |
|---|---|
| • Designate and fund GPswSI in alcohol across the borough | • GPswSI in alcohol will be taken forward by the GP Lead on alcohol through the Primary Care Development Board, to develop enhanced services for alcohol from 2007 (in the meantime, it is proposed to identify four Primary Care centres, one for each Walsall sector, each to provide one GP session per week devoted to alcohol related problems) |
| • Pilot specialised training for practice nurses across the borough in order to assist screening, brief interventions and rapid access to treatment | • Until recently, specialised training for practice nurses was provided by the Aquarius Project through two primary care alcohol workers (this will now be taken forward by two extra alcohol workers, provided by Lantern House) |
| • Consider Alcohol Concern's Primary Care Information Service input into Walsall practices | • The Alcohol Concern service has yet to be implemented and awaits the above developments in Primary Care |
| • Develop a holistic multi-disciplinary Community Alcohol Detoxification and Aftercare Team (supported by GPwSI) that will provide social care and health care, and address issues such as housing, relationships, employment and other preventative issues | • Again, detoxification and aftercare awaits significant funding of planned developments in Primary Care, backed up by a total of at least eight alcohol workers based from Lantern House, and supported by other agencies such as Addaction, with strong links to the work of the Alcohol Coordinator (above) and community staff (eg the Destiny Project). At least eight GPswSI will eventually need to operate from primary care venues across Walsall. |
| Specialist services | |
| • Improve arrangements for the discrete counselling of health and other professionals | • Will include planned arrangements for expanding Lantern House premises |
| • Pursue approved recruitment of a Consultant Psychiatrist with an interest in substance misuse | • Recruitment has recently been made |
| • Explore the possibility of developing a local specialist in-patient and rehabilitation (detox) centre | • This will require significant funding, likely at a later date (to be promoted by the Consultant Psychiatrist) |
| Acute services | |
| • Pilot specialised training for nurses in the Manor Hospital's Accident & Emergency (A&E) Department and on key wards, in order to assist screening, brief interventions and rapid access to treatment | • Work has already begun in these areas, utilising existing staff resources (significant progress awaits dedicated alcohol funding from 2007) |
| • Support this pilot exercise with the appointment of alcohol link nurses at the Manor | • There is need for two alcohol link nurses: one operating within the Manor and the other shared with the community |
| • Provide a 'wet centre' where inebriated people raising medical concerns may be observed | • The Manor's Integrated Assessment Unit (an adjunct of A&E, whereby patients can be observed and monitored for a limited period) is being utilised for difficult alcohol related problems (eg the triad of drowsiness, inebriation and head injury) |
| • Improve the security to attending patients and A&E staff from alcohol-fuelled disorder | • A CCTV system has been installed in the A&E foyer, with a warning that anti-social behaviour orders (ASBOs) may be invoked |

## Drugs and Alcohol Today Conference, London, April 2006-11-27

Lord Adebowale, Chief Executive of Turning Point, emphasised that substance misuse must include alcohol and until we do, there is a massive imbalance. Echoed by Srabani Sen, Chief Executive of Alcohol Concern, who felt the poor relation in a field dominated by funding for drugs. There is continued bafflement at the lack of priority, politically on alcohol. No money, mechanism or drivers for alcohol strategy.

## Accident and Emergency Hospital Admissions

- alcohol is a major contributor to accidental death in up to 30% of all accidents and 39% of fires
- 50% of seriously admitted patients through A&E have an alcohol related injury
- 1 in 7 hospital admissions are alcohol related, particularly the short term effects of heavy drinking, eg accidents, violent episodes, self harm

## Manor Hospital (Walsall Hospitals NHS Trust)

Walsall's hospital services are increasingly geared up to dealing with alcohol related admissions, with a particular focus of expertise in Accident and Emergency (A&E), on the Integrated Assessment Unit (IAU), and on Jay Ward (which includes patients with liver disease). The IAU is a 52-bedded unit, with side wards, that opened in April 2006; providing a suitable location for the observation of people with categories of alcohol related acute disorder. A standard brief interventions approach uses the St Mary's Hospital Fast Questionnaire. There is excellent signposting to Lantern House and Addaction, along with the provision of leaflets; with strong links to Annette Norton at Lantern House and to the Destiny Project. A 'See and Treat' area in A&E is utilised for alcohol related injuries.

A well developed Alcohol Withdrawal policy is based on national guidelines (Royal College of Physicians 2001), whereby patients are categorised by severity of withdrawal, and assigned to treatment schedules based on standard and moderate detoxification using chlordiazepoxide or severe detoxification starting with IV lorazepam. The intoxication protocols define the level of consultant involvement. There is now a far greater awareness of aftercare and appropriate onward referral. There is urgent need for at least one F Grade Alcohol Link nurse that can oversee patients with alcohol related disorders moving between the above three main locations within the Manor, but other wards also contain patients that have potential problems with alcohol. Two such nurses are required, the second having a focus on linking with key agencies in the community; this includes the Mental Health Trust as well as GPs and the two alcohol service providers.

Security within A&E and on the wards is now more professional and effective, with the threat of ASBOs being invoked as a last resort since December 2005. There is intelligent use of the Manor's Zero Tolerance Policy and Restraint Policy. CCTV surveillance has served as a useful deterrent to antisocial behaviour. However, one increasing problem (again raising issues of staff capacity) is the rising workload from police assessments for those in custody.

## Comment on Other Services

**Lantern House** and **Addaction** respectively provide excellent Tier 3 and Tier 2 specialist alcohol services in Walsall, but capacity is an issue. This is especially the case with Lantern House, currently under resourced with three alcohol workers. As mentioned above, the appointment of alcohol workers to work in primary care and closely liaise with Lantern House will considerably relieve the situation. Other support is also vital, such as the Destiny Project referred to in Chapter 5. Some clients are encouraged to go to Alcoholics Anonymous, where self-help is a key philosophy. This organisation supports itself entirely from donations of their members and so costs nothing. However, it does not suit everybody and there is a need for a variety of services. Alcohol Concern, being a national body that coordinates the work of the voluntary sector, is an excellent source of information and advice for both the public and professionals.

The Box referring to the **Manor Hospital** shows that alcohol problems are receiving increasing attention. As expected, funding is a constraint. Many would argue that funding by PCTs for alcohol services could be well used in emergency departments, where nearly a third of overall attendances are alcohol related and more than two thirds may be so after midnight **(Touquet & Paton 2006)**. The Manor rightly uses the St Mary's Hospital, London test since the emergency department team at that hospital has over the past 12 years carried out a pragmatic randomised controlled trial **(Crawford et al 2004; Williams et al 2005)**, showing that routine clinical staff can be trained to detect potential alcohol problems by using the evolving one minute Paddington alcohol test in patients with certain defined conditions **(Patton et al 2004)**, and that they can then offer brief advice. However, this hospital also has the on-site support of a PCT-funded alcohol worker, available for brief intervention and any necessary referral. This worker also has an important role in educating and supporting staff, as part of an approach shown to be cost effective **(Barrett et al 2006)**. It is not only emergency departments that are taxed by alcohol problems since numerous studies have highlighted their frequency among patients in hospital wards (Pirmohamed et al 2000). It is suggested that all general hospitals should have a senior consultant with an interest in alcohol **(Royal College of Physicians 2001)**.

Chronic liver disease is a grim outcome of excessive drinking over many years, and Chapter 1 shows that the age of onset is falling. The region is well served with specialised units experienced in treatment, including a liver unit in Birmingham where transplantation is possible. However, severe forms of alcoholic hepatitis still carry a 50% early mortality, while the treatment for cirrhosis is largely supportive in dealing with complications. Abstinence is key at this time, and certainly indicated to recover maximum remaining liver function if transplantation is being considered. Many patients with alcoholic cirrhosis wonder about their own plight, when other people they know well, who may have drunk to greater excess, remain free of disease. There is still some uncertainty over susceptibility to alcoholic cirrhosis, although genetic factors certainly operate. Daily dose of alcohol and length of time is fundamental, with increases in both increasing disease risk. However, an Italian study showed that less than 10% of people drinking at least 12 units of alcohol a day developed alcoholic liver disease, suggesting other factors must be important; these include the pattern of drinking, such as drinking outside meal times as opposed to entirely with meals, and drinking daily as opposed to in binges at weekends **(Bellentani et al 1997)**. Diet is another important factor, since in a study of over 1,500 heavy drinkers, obesity was the best predictor of alcoholic liver disease; probably because the severity of a fatty liver is a forerunner to end stage chronic disease **(Naveau et al 1997)**.

All clinically trained professionals should be alert to the presence of thiamine deficiency in people with alcohol problems. This often manifests as Wernicke's encephalopathy and should be suspected in any patient with a history of alcohol misuse who shows ophthalmoplegia, ataxia, acute confusion, memory disturbance, hypotension, hypothermia, coma or drowsiness. This condition can be missed, in which case many patients will die or will be left with a permanent Korsakoff's psychosis, often requiring residential care. Missing cases can invite litigation. Primary care should be alert to this possibility, while drug service providers and emergency departments are alert through protocols, as a failsafe for clinical suspicion. Certainly there should be a low threshold for making a presumptive diagnosis and all patients undergoing alcohol withdrawal should be offered prophylactic treatment with parenteral B-complex vitamins **(Cook et al 1998)**.

## Alcohol and Pregnancy

The Royal College of Obstetricians and Gynaecologists (2006) has updated its standards on improving women's health in relation to alcohol consumption and the outcomes of pregnancy. The foetal alcohol syndrome has attracted a lot of recent attention. Key points from the document include the following:

- There is an increasing body of evidence suggesting harm to the foetus from alcohol consumption during pregnancy. While the safest approach may be to avoid any alcohol intake during pregnancy, it remains the case that there is no evidence of harm from low levels of alcohol consumption, defined as no more than one or two units of alcohol once or twice a week.
- Binge drinking in pregnancy may be particularly harmful and specific advice to young men and women should make this clear. Advice on the risk of harm to an unplanned pregnancy, as well as the risk of sexually transmitted disease, should be widely available.
- In antenatal clinics, effort should be made to improve objective history taken about alcohol and other substance abuse, to attempt to identify the high-risk group of women with problem drinking or other behaviour that can be harmful to the foetus.
- It is quite likely that many cases of foetal alcohol spectrum disorder (FASD) are being missed and training in the recognition of this disorder and the availability of tertiary referral for confirmation of the diagnosis should be made more widespread in the UK through community and hospital based paediatric clinics.

Issues around alcohol and pregnancy are being addressed in Walsall, especially in the specialist service and hospital setting, but we clearly need to do more work on creating awareness among younger people in particular and among professionals in primary care.

Walsall does not have its own Tier 4 inpatient specialist alcohol provider unit, to meet the demands of stabilisation, assisted withdrawal, and other specialist needs. However, we need to be sure that Walsall patients referred to units outside the borough are receiving good quality of care. At least the move to a models of care approach, addressed in Chapter 8, will provide some assurance to our commissioners and referring specialists. In the meantime, the **Specialist Clinical Addiction Network (2006)** has recently produced a report of what inpatient services of the future should look like. The recent appointment of our own consultant psychiatrist with an interest in substance misuse offers the possibility of a local holding inpatient facility, or at least an improved liaison with the specialist units outside the borough on whom we are reliant.

## Alcohol Treatment Services in Walsall

### What we are doing well (but further effort still required)

1. The introduction of the rapid identification of problematic drinkers, followed by brief interventions incorporating appropriate management (pilot action)
2. Planning for a holistic multi-disciplinary Community Alcohol Detoxification and Aftercare Team (supported by GPswSI)
3. Establishing an Integrated Assessment Unit at the Manor Hospital, that has the potential for expansion of services in the management of acute alcohol related incidents

### Where we need more action (but usually dependent on more resources and/or a stronger prioritisation)

1. Government funding to enable the development of specialist alcohol services and their integration with alcohol services (and community detoxification) within Primary Care, provided through alcohol workers
2. Funding to enable the development of GPswSI in alcohol to implement services integration with alcohol worker support
3. Funding to develop an in-patient and rehabilitation (detox) centre
4. Again, funding to enable more dedicated alcohol services within the Manor Hospital (responding to alcohol related ill health)

### Expected developments

1. Government funding is expected from 2007
2. Appointment of a Consultant Psychiatrist with an interest in substance misuse
3. Recommendation to introduce alcohol problem services in the workplace

### What Government needs to do

1. It is all about a commitment to promised adequate funding, at least from 2007, and at a funding level so far accorded drug misuse
2. Tackle drinks advertising and drinks promotion
3. Clear labels on drinks (eg units, health warnings, etc)

# Action Plan: Alcohol and Crime and Disorder in Walsall

The relationship between alcohol and offending is complex **(Pemanen 1981)**, and may be: **causal**, where alcohol is directly and causally related to offending; **contributory**, where alcohol is one of many factors that can lead to offending, the exact role depending on individual, cultural, social and situational factors; or **co-existing**, where drinking and offending occur together, with a common cause. The British Crime Survey **(Kershaw et al 2000)**, a general household survey, provides some useful information on the relationship:

- In 40% of violent crimes, victims perceived the offender to be inebriated.
- The most common location for violence between strangers is in or around pubs or clubs on a weekend evening.
- Those frequently visiting pubs or wine bars are more than twice as likely to be victims of violence than those not visiting.

It should be noted that this survey is based on victim perceptions, a source of bias. However, a survey of prisoners in England and Wales showed that 63% of male sentenced prisoners (39% female) and 58% of male remand prisoners (36% female) were classified as hazardous drinkers, based on an AUDIT 8+ score **(Singleton et al 1999)**. Again, another source of bias given that inebriated offenders may not be representative of all offenders since they are more likely to be arrested, but general population surveys correct for this. For example, Youth Lifestyle Surveys in England and Wales showed that 15% of 12-17 year olds had been involved in drinking-associated antisocial behaviour **(Harrington 2000)** and among 12-21 year old males, regular drinkers were three times more likely to be serious or persistent offenders, with alcohol among 22-33 year old men being associated with violent offending; the latter only being associated in females among 12-15 year olds **(Flood-Page et al 2000)**. While the relationship is clear, it is certainly complex.

It is of interest to note that the Probation Service can be traced back to 1876, when the Church of England Temperance Society appointed Police Court Missionaries to reclaim those whose offending resulted from inebriation. While the service today is much broader, it continues to work with large numbers of offenders who experience problems with alcohol. However, the Probation Service has no specific remit to look for alcohol problems and is under intense pressure to produce reports; while offenders are reluctant to volunteer alcohol-related information that may be detrimental to their cause. It is clear that here is a situation, as in primary care and in hospitals, that is crying out for identification of problem drinkers through brief interventions, and perhaps a start can be made through alcohol arrest referral, considered later in this chapter for consideration in Walsall. We need an entire new mindset in getting at the root of the alcohol problem, first by recognising it and at least attempting to deal with it through treatment.

Alcohol consumption significantly contributes both to a wide range of offences in Walsall Borough and to an enjoyable night out. These are the conflicting realities that make this issue so complex and underline why work in this field needs to be carefully balanced, so much so that Government has introduced a new RESPECT agenda which is all about working together to create a society where we treat others as we would like to be treated, with binge drinking a priority. There is little doubt that alcohol is routinely thought to be an underlying causal factor for the rise in crime and disorder in the UK and media coverage of the issue would certainly lead us to this conclusion, with Police statistics purporting to show that approximately 70% of all violent crime is alcohol related. Walsall proves to be no exception and alcohol is the main driver of the increase in crime not only in the Town Centre but across the Borough as a whole.

Locally, the Partnerships Strategy addresses alcohol related crime through two key crime areas: Violent Crime and Criminal Damage, respectively 6,422 and 5,203 offences in Walsall 2005/2006. This represented a staggering 43% of borough crime. In economic terms, using Home Office cost of crime data, alcohol related crime cost Walsall Borough in 05/06, £114.85 million for Violence Against the Person and £2.65 million for Criminal Damage (please refer to Figure 6 in Chapter 2 to appreciate the enormous comparative costs accruing from violence against the person). Figure 34 shows that alcohol related crime substantially increased from 2004 to 2005.

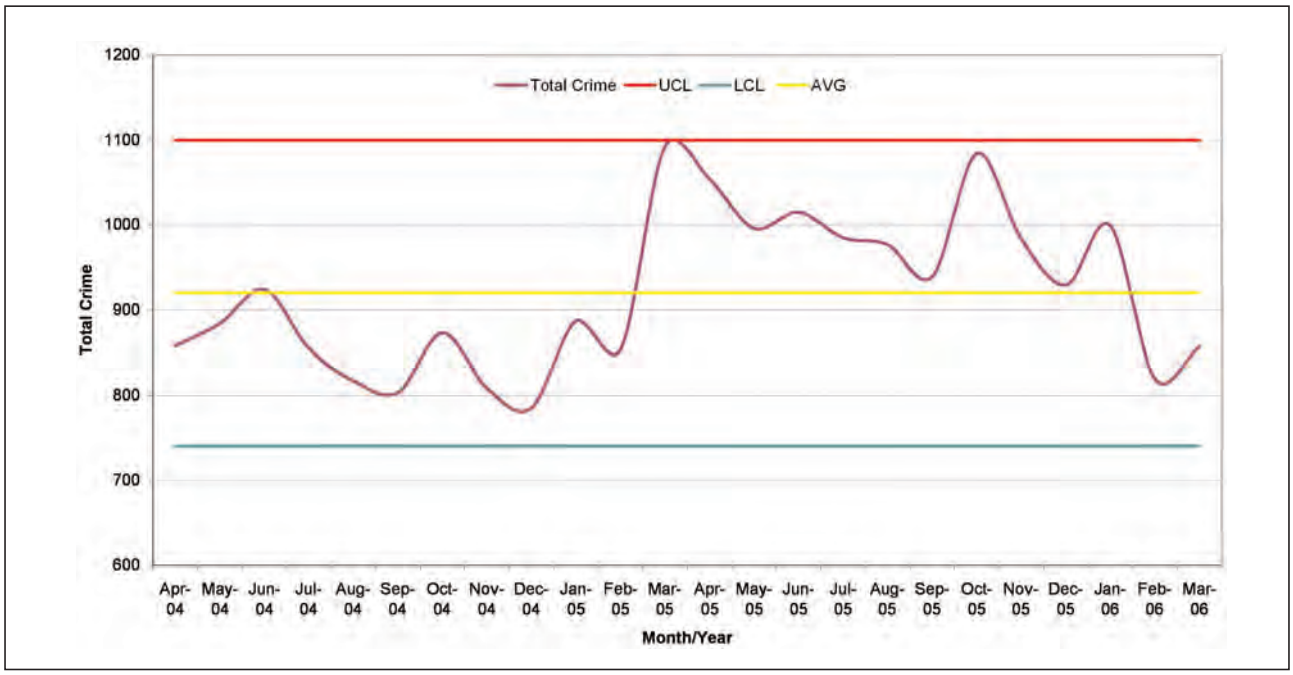



*Figure 34. Alcohol related crime in Walsall, 2004 to 2006*

The Borough's alcohol related crime has operated within its control limits with the only breach occurring in March/April 2005 when it briefly exceeded the upper limit. One must note that the levels of crime have been elevated when compared to 2004 levels and have demonstrated levels close to the upper control limit on several occasions. The period 05/06 has seen a 5% increase in Alcohol Related Crime compared to the previous year, with over 11,500 offences being committed. Since the strategy target for 05/06 was set at 9077 offences, the Partnership is exceeding the target by 28%.

A number of themes arise. For example, Reducing Crime is a Public Service Agreement, whereby it is necessary to reassure the public and reduce the fear of crime. Since alcohol related crime accounts for 43% of Borough Crime, the issue of drinking is high on the public agenda. Indeed, the greater media interest in alcohol fuelled crime, combined with recent government policy to introduce 24 hour drinking, has brought the alcohol and crime debate to the fore. Reducing violent crime, reducing antisocial and loutish behaviour are key priorities of Walsall's residents, with 64% expressing vandalism and graffiti and deliberate damage to vehicles, dwellings and properties as being a major problem in their area; 63% have expressed that youths hanging around and intimidating individuals is also a major problem for them. Rubbish and litter is seen as a further major problem for 60% of Walsall's residents, and this is intrinsically linked to vandalism, graffiti and other damage related offences. Combating alcohol-related crime cannot be the responsibility of the criminal justice system alone; input is also required from community organisations, including police, local authorities, health services, schools and probation.

## Violence

There is a wealth of evidence of a strong relationship between alcohol intoxication and aggressive and violent behaviour that comes from crime statistics, studies of offenders, studies of general population cohorts and studies of aggression. A substantial amount of the relationship between alcohol use and crime is related to shared factors, such as social disadvantage and deviant peer affiliations. Nevertheless, when these confounding variables are controlled, a significant relationship remains between alcohol misuse and crime, particularly violent crime. The suggestion is that alcohol misuse and violent offending arise via a similar route, since the antecedent risk factors are highly similar, but that there is also a direct cause and effect between alcohol misuse and violent offending. Of particular concern are the male perpetrators of domestic violence, who exhibit similar traits to generally violent men.

## Town Centre Violence

Violence is more likely to happen where people are grouped together, particularly if others are also drunk and of an aggressive disposition. Violence most commonly occurs in and around city centre licensed premises and entertainment venues, especially where young men gather and drink heavily on weekend nights. Not only is the assailant likely to be intoxicated, but so is the victim of violence, where the probability of both the assailant and the victim being intoxicated is high. However, as intoxicated people are less able to ignore threats or prevent escalation of conflict, this effect may be multiplicative in a group of drinkers. It is this reason why over 90% of all arrests in a town/city centre between 23:00-03:00 hours are drink related.

In the UK, around 60% of male prisoners and almost 40% of female prisoners are hazardous drinkers, as measured by the Alcohol Use Disorders Identification Test (AUDIT), compared with around 30% male and at most 10% female general hospital patients. We also know that offending is more prevalent in heavy drinkers, and population studies show that, as alcohol consumption increases, so does violent offending. Many arrestees are drunk, and a sizeable proportion of offenders admit to a relationship between their drinking and offending. Many factors are common to the development of both drinking and delinquency, for example low IQ, poorer families, larger families, family discord, and poor family management practices.

Action policies most effective in preventing this disorder are those targeting the environmental aspect conducive to violence, which Walsall had addressed through a Town Centre Management Policy. The British Crime Survey shows that alcohol related assaults between strangers and acquaintances tends to happen within the night time economy (Kershaw et al 2000). Around 50% of assaults take place in or around pubs and clubs, with 70% taking place at weekend evenings. Most other incidents take place in public places, such as entertainment facilities or public transport. More than 50% of incidents left the victim with some form of injury; more than 20% of incidents involved some form of weapon, most notably a glass or bottle; and more than 50% of incidents were not reported to the police.

**Walsall Town Centre has shown a dramatic rise in population since the millennium, with 2005 showing a five fold rise on the levels recorded in 2000. This is attributable to the thriving night time economy with the capacity for Walsall's nightclubs rising from a maximum occupancy of just over 2,000 to in excess of 10,000.**

## Factors Associated with Violence

Crime survey data (Kershaw et al 2000) showed that stranger and acquaintance assault was significantly higher among men than women, with the highest risk being 16-29 year old males. There were an estimated 188 incidents of alcohol-related stranger assault and 130 incidents of acquaintance assault per 10,000 men in 2000. The respective figures for women were 32 per 10,000 and 68 per 10,000. There was a pattern of falling victimisation rates with age in both genders, with the strongest correlation among 16-20 year-olds. Rates of alcohol-related victimisation were highest among adults who were single, followed by those cohabiting with a partner. Rates were also higher among those who did not live with children under the age of 16 years. Adults who were classified as unemployed had far higher rates of alcohol-related assault than those in employment/self-employed. Personal drinking patterns were strongly associated with the risk of becoming an alcohol-related assault victim. Individuals drinking three or four days a week had the highest rates of victimisation, with this consumption incorporating the culture of visiting pubs and night clubs regularly. The incident rate of alcohol-related stranger and acquaintance assault is lowest among those living in rural areas. Highest is among those in inner-city areas, closely followed by those in urban areas. Deprivation and alcohol consumption also show a positive correlation, as does tobacco usage and deprivation.

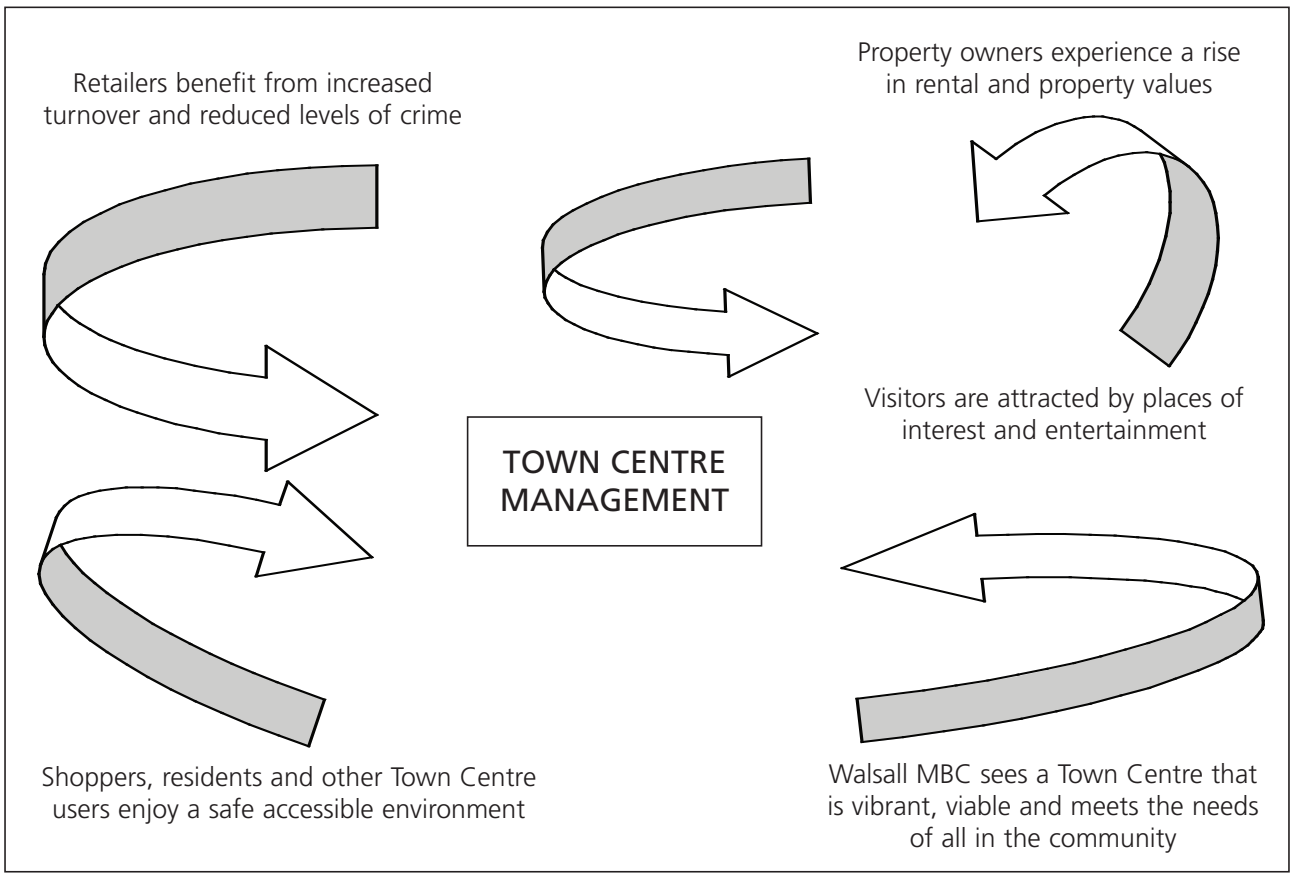
The most common type of force used in alcohol-related assaults was punching or slapping. Two-thirds of stranger incidents involved punching or slapping, as did just over a half of acquaintance incidents. Grabbing and pushing was also relatively common, followed by kicking. In a fifth of incidents the perpetrator had a weapon which they threatened to use, most commonly a drinking glass or a bottle. On average, approximately 20% of all Violent Crime can be attributed to Domestic Violence. The Domestic Violence Forum that operates in Walsall has highlighted that alcohol compounds violence in the home and can be a contributory factor in many domestic incidents.

It is inevitable that Walsall Town Centre attracts a great deal of attention in terms of end of week and weekend leisure activity, and especially in relation to drinking. Town centre issues in relation to alcohol are of course relevant to other centres across the borough, and so what follows also has general application.

## The Management of Walsall Town Centre

Walsall Town Centre has been developing over recent years and many exciting opportunities lie ahead such as the Town Wharf scheme up to Wolverhampton Road and the new Ring Road project. In terms of crime and community safety, those opportunities pose challenges and the need to consider more "secure by design" retail crime type initiatives. While the growth of the night time economy has boosted the town economically, the associated increase in levels of violence and disorder are an unwelcome side effect.

A more holistic approach, both in philosophy and at a tactical level, is needed; one that engages a broader partnership of key stakeholders. A strategy is required that shows broader aspirations, expertise and the deployment of resources to create a more joined-up plan to meet the needs of all who use the Town Centre.




A Town Centre Management framework should work by creating natural partnerships and producing networks that allow mutual achievement of objectives. Partners should co-operate by sharing their commercial, social, environmental and management skills. The key stakeholders, in addition to Walsall MBC and the retailers, should include restauranteurs, leisure operators, service providers, police, education, health, voluntary and community sectors.

Working groups could be established in a way that gives people the opportunity to directly influence change in Walsall Town Centre. Each group should have priorities that reflect a more holistic approach to town centre management than in the past. The following structure is offered as an example:

| Group | Membership | Priorities |
|---|---|---|
| Development group | Town centre shops<br>Head of Economic Development, Walsall Metropolitan Borough Council (MBC)<br>Head of Planning, Walsall MBC<br>Safer Walsall Borough Partnership (SWBP) | The local plan<br>Town Wharf Development<br>Ring Road development<br>Crime and Community Safety |
| Retail group | Shopping centre forum<br>Chamber of Commerce<br>Head of Planning, Walsall MBC<br>SWBP | Safe shopping awards<br>Peddlers<br>Beggars<br>Antisocial Behaviour Orders (ASBOs)<br>Tidiness and graffiti<br>Crime and Community Safety |
| Night time economy group | West Midlands Police<br>Pub/Club Watch representatives<br>Shopping centre forum<br>West Midlands Travel<br>Walsall MBC – planning marketing leisure, tourism, street pride, licensing<br>SWBP<br>Taxis | Safety, crime and disorder, alcohol<br>New licensing laws<br>Transport<br>Watch schemes<br>Research and best practice |
| Transport/Access group | Walsall College<br>West Midlands Travel<br>CEN - disability forum<br>Walsall MBC – planning, licensing, tourism<br>West Midlands Police | Safe routes in and out<br>Siting of taxi ranks and street Food vendors<br>Physical access to premises (safety) and compliance with DDA<br>Co-ordinated time-tabling |

## Fort Alice

In May 2004, the policing of Walsall Town Centre was addressed and a revised model adopted in the form of Operation Fort Alice. This operation focused greatly on the high visibility policing of identified hotspots with an impetus towards early intervention and reducing the potential for escalation of incidents into more serious violent crime. It involved officers patrolling key locations on foot and making greater use of the more minor public order offences of Section 4 and Section 5 of the Public Order Act 1986 (Abusive and Threatening Behaviour).

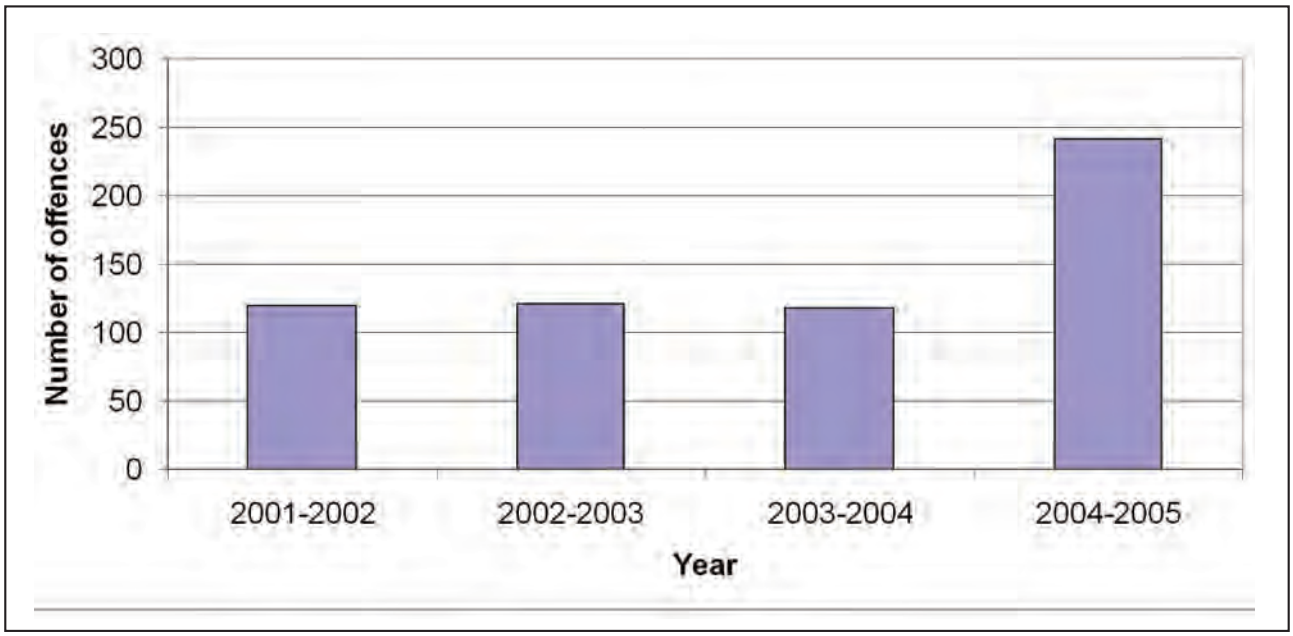



Figure 35. Walsall Town Centre night time (9pm to 5am) abusive and threatening behaviour offences, 2001 to 2005

Of the 3,434 crimes committed in Walsall Town Centre in 2004/05, 809 offences **(23.6%)** were attributed to violent crime. In Walsall Borough, of the 26,359 offences that occurred in 2004-05, 5,338 consisted of offences of violence against the person. In 2004/05, violent crime in Walsall Town Centre therefore accounted for 15.2% of all violent crime in the Borough. Of these 809 violent crimes, 587 **(73%)** were committed between 21.00hrs and 05:00hrs, and have intrinsic links with alcohol fuelled violence and the night time economy. There has been a steady increase in the number of violent offences committed in Walsall Town Centre, and consequently an increase in the number of violent offences committed between 21:00hrs and 05:00hrs (Figure 35).

There has also been a significant increase in the number of reported incidents of Section 4 and Section 5 of the Public Order Act 1986, with the number of offences in 2004-2005 accounting for **41.2%** of total night time violent crime, as opposed to **24.6%** in 2003-2004. The new policy of early intervention is directly responsible for this increase, as officers are using the lower level public order offences to deal with incidents that would typically escalate without intervention. This has resulted in a significantly higher number of detections of violent offences committed in Walsall Town Centre due to the interventional nature of Fort Alice. Figure 36 demonstrates how the number of detections has risen from the previous years, giving a detection rate of approximately 70% during the period of operation.

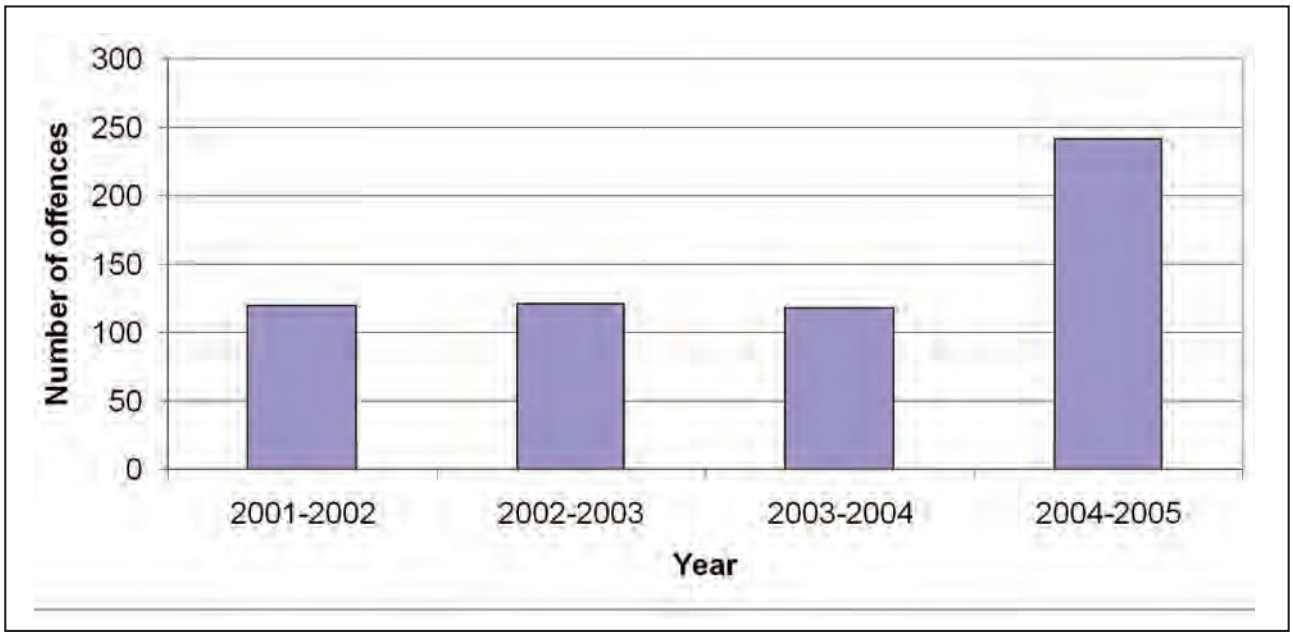



Figure 36. Walsall Town Centre night time violent offences and detections, 2001 to 2005

Operation Fort Alice has made significant headway into reducing potential violent crime, which is obviously a difficult statistic to demonstrate. However, the intensive nature of the Town Centre policing (approximately 10 officers per night may be policing up to nearly 10,000 Town Centre users) means that officers need to show more tolerance in dealing with lower level crime to maximise the effect of high visibility interventional policing. Therefore, officers use powers of arrest under Section 4 and Section 5 Public Order Act in prevention of more serious offences being committed rather than minor infringements. The large increase in Section 4 and Section 5 offences (double those of 2003-2004) is indicative of a large number of more serious offences being prevented and deterred, and accounts for 41.2% of all violent crime in the peak times.

## Crime, disorder and alcohol; ways of reducing the problem:

- City planning
- CCTV and street lighting
- Higher visibility policing
- Better late night transport
- Better coordination between alcohol and criminal justice agencies
- Better funding of these agencies

## Reducing Public Drunkenness

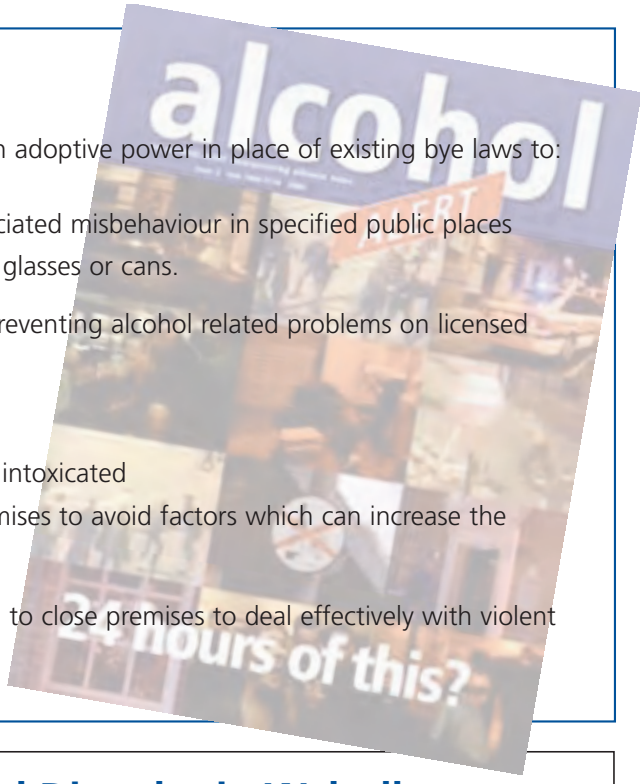
1. Consideration of primary legislation to provide an adoptive power in place of existing bye laws to:

   - Prevent alcohol consumption and associated misbehaviour in specified public places
   - Allow the police to seize open bottles, glasses or cans.

2. More widespread adoption of good practice in preventing alcohol related problems on licensed premises, including:

   - Exclusion of troublemakers
   - Refusal to sell alcohol to those already intoxicated
   - Good design and management of premises to avoid factors which can increase the potential for disorder.

3. Tough new powers for the police to enable them to close premises to deal effectively with violent and disorderly behaviour.




## Alcohol and Crime and Disorder in Walsall

### Action

| Subject | Progress and Comments |
|---|---|
| ACT is Action on Crime Together, comprising a partnership of Walsall's Police, Probation, PCT, Black Country Chamber, Council for Voluntary Service, MBC, and Fire Service. ACT has produced its crime and disorder reduction strategy 2002-2005, and specifically lists anti-social behaviour as a leading priority. Among 5 actions to address this are: | All this work has now been taken forward by the **Safer Walsall Borough Partnership (SWBP)**, which has an overarching mission to deliver community safety |
| • Campaigns to tackle alcohol abuse and under age drinking (note that a Young Persons officer is already in place) | • There are now two Young Persons officers (one for each Police OCU), working in collaboration with the two licensing officers |
| **Enforcement**<br>• Experimental prohibition of alcohol in certain zones at certain times, to be first tested in the Arboretum and town centre, and then other areas (resource dependent)<br>• Develop Proof of Age scheme in the town centre, and extend to other areas through liaison with the MBC and links with concerned groups (eg Connexions) | • There is now a ban on drinking alcohol in all public places, enforced by two anti-social behaviour (ASB) officers<br>• In force and ongoing |

| | |
|---|---|
| • More proactive work in identifying and dealing with off licences supplying under age youths with alcohol | • Ongoing and supported by a targeted approach using a mobile CCTV |
| • Explore possibility of developing a Wet Centre to deal with drunk and disorderly people following arrest, so reducing police distraction at peak periods | • There is little need for this (see also the Manor's Integrated Assessment Unit in Chapter 6) since the advent of the Town Centre police operation, Fort Alice (see text) |
| **Prevention** | |
| • Insist on use of less dangerous alternatives to glassware by designated venues at certain times, requiring the cooperation of the drinks industry for maximum effect | • This to be considered at venues associated with brawling, and to be taken up by the two licensing officers |
| • Promote awareness of unattended drinks to reduce the targeting of females for intended rape | • There is increasing awareness of this issue, assisted by backs of toilet doors posters, etc and the increasing issue of anti-spiking bottle tops |
| There is an urgent need to address alcohol-fuelled disorder and violence during weekend nights, and especially in the Town centre, eg: | The police operation, Fort Alice, has been a success. It is an ongoing exercise that thrives on early intervention and self policing by all partners involved in the collaboration. This success has to be judged against the fact that in 2002, around 2,000 people entered the Town Centre during a weekend night; compared to 10,000 in 2005. Crime and disorder figures might have increased (and this includes better reporting), but certainly not fivefold. The operation has impacted on several actions: |
| • Continue work with the SWBP's Delivery Group (formerly the Crime Focus Group), that includes town centre managers, to coordinate closing times at key locations with taxi provision, timing arranged through the Black Cab Association (BCA), and the use of marshals on 2-3 AM buses | • Better policing has precluded the need for marshals, coupled with the positive impact of more flexible and staggered licensing hours |
| • Working with Centro and the BCA, provide marshals to supervise taxi queues, and secure driver and public safety | • This has been achieved and is an ongoing programme |
| • Extend surveillance of trouble hotspots, and potential ones such as late closing fast food outlets, through use of CCTV | • Achieved |
| • Provide numerous and appropriate waste bins within prohibition zones to allow the permanent disposal of bottles and glasses seized by police | |
| • Pilot the use of UV sensitive smart water to spray troublemakers provided that light detectors are in place at most pub and club premises to enable door staff to prevent entry and re-entry | • This has not been deemed necessary following the installation of a large group of trained and coordinated door staff (identity and fingerprinting technology may follow) |
| • Liaise with Highways departments to prevent traffic-related incidents at certain premises, if necessary through temporary road closures | • In place and ongoing |

| | |
|---|---|
| • Test and introduce staggered opening and closing time arrangements, along with closing down soft drinks and coffee periods, taxi pre-booking, etc to reduce crowding and risk of disorder | • Was in place and now the new licensing laws have enabled more effective controls |
| • Introduce the intelligence interview for arrestees to identify premises serving already inebriated customers | • This has been supplemented by the intrusive supervision of licensed premises (eg following the inebriated person into a public house) |
| **Existing initiatives**<br><br>Build on the success of existing initiatives and learn from their experience, eg:<br><br>• Pub Watch scheme and CCTV arrangements<br>• Improved provision and governance of door staff<br>• Improved landlord responsibility and better licensing<br>• Advertising initiatives to reduce street crime<br>• Fixed Penalty Scheme<br><br>All will attract future local or enhanced support to ensure success.<br><br>National campaigns, eg at Christmas | All these initiatives have been advanced further. Of note are the following:<br><br>• Door staff are now professionally trained (non-contact control as well as martial arts), licensed and registered by the Security Industry Authority<br><br>• Initiatives such as Crimestoppers and Walsall Against Night-times Disorder (WAND) are supported by the police, who encourage the public to phone anonymously in reporting disorder (Tel. nos. widely available on cards with approved Taxi nos. on reverse)<br><br>• Fixed (£80) penalties are in force |
| **Probation and Tier 2 service provision**<br><br>Further strengthen Addaction's current arrangements for drug arrest referral to cover certain types of alcohol user. Addaction has an approach to target heavy recreational drug users in particular, eg direct first arrests for drunk and disorderly conduct into Tier 2 treatment (two Arrest Referral Workers already in post to initiate such an approach, inc Saturday afternoon and Sunday early morning sessions). In the pipeline are also detached outreach workers (NACRO) and ASB Coordinator posts (all now in post). | • There is need to strengthen any existing alcohol arrest referral scheme, possibly on the Dudley model (the courts can compel anyone on a second disorder offence to comply with the scheme – experience showed that 50% never came to attention again)<br><br>• Through a programme to identify and support perpetrators of domestic abuse within families, there is scope to address alcohol issues more clearly |

## Action on Under Age Drinking

Key approaches are:

1. Rigorous enforcement of the legislative provisions set out in the Licensing Acts of 1964 and 1988 to prevent the sale of alcohol to under 18s.
2. The provisions of the Confiscation of Alcohol (Young Persons) Act 1997 to be widely used to reduce the incidence of under age drinking and associated nuisance in public places.
3. More widespread use of Proof of Age schemes to restrict under 18s' access to alcohol in licensed premises.
4. Establish whether more can be done to strengthen alcohol education for young people and adults.

## Preventing Alcohol Related Violence

Keys to this are:

1. Targeting hotspots associated with alcohol related crime and disorder.
2. Greater use of information sharing schemes, such as Pub Watch, to keep troublemakers out of pubs and clubs.
3. Supporting bar staff and door supervisors to help reduce incidents of disorder on licensed premises.
4. More widespread use of toughened drinking glasses in pubs and bars, and refusal to sell beer in bottles.

## Alcohol Arrest Referral Scheme

**This is urgently needed in Walsall, to reduce alcohol related re-offending and other alcohol related harm. When offenders have been arrested, and alcohol is deemed to have been a contributory factor to an offence (associated with victimless crimes), then an offer is made to attend an alcohol assessment programme running over two sessions. Acceptance would entail signing a card (as in a caution, admitting guilt) and being bailed out on condition of attending for assessment. If attendance is confirmed and offenders comply with recommendations identified by counsellors, then bail is cancelled and no further action is taken against them. The facts are recorded to update a Police Custody System. These facts could later be used in court should alcohol related crimes re-occur. An offender failing to opt for this scheme is placed before the court, where refusal to do so is notified to the magistrates.**

**For more serious offences such as violent crime and criminal damage, offenders are charged and placed before the courts. However, they may still opt for the scheme, and this fact is reported to the courts for consideration. Sometimes, mental health problems or personality disorders are manifest, in which case arrest referral personnel may also seek other specialist advice. This scheme is enjoying success in Dudley and would appear to help reduce alcohol related re-offending.**

## Alcohol Arrest Referral

There has been an evaluation of the scheme operating in Dudley, which provides useful information for developing a similar scheme in Walsall, ie similar population size and a waterfront development:

- Scheme A is available to all adult prisoners who indicate an intention to plead guilty, with the exception of those charged with drink drive offences (where a separate scheme is available), and those arrested for breach of the peace (who must be dealt with at the first available court appearance)

- Scheme B operates when a not guilty plea is indicated, or when the offender is cautioned at the police station, or when a fixed penalty notice is issued. The custody officer can offer the opportunity of self-referral to Aquarius, an organisation that provides trained alcohol workers.

The evaluation showed that out of a total 558 referrals, 367 made contact with treatment services (66%), of which 300 came from scheme A and the remaining 67 from the scheme B. Of those who made contact, 185 (46%) from scheme A completed two sessions and 28 (18%) from scheme B. In total, 38% completed two sessions. There were 50 in total (41 from A and 9 from B) who went on to engage in further work with the core service. This appears to be a relatively small number, the reason being that a number of people were lost to the schemes because they were dealt with in court on their first appearance, either prior to or after attending the first appointment.

In the initial stages in Dudley, referrals to the scheme were much slower than had been anticipated, and it was recognised that there were some custody officers who seemed to be unaware of the existence of the scheme or who were unwilling to refer cases. The problem was highlighted during one of the regular steering group meetings and remedial action in the form of additional briefing sessions was put in place. It was deemed that the steering group should contain representatives who are sufficiently senior in the organisation, to ensure that when remedial action is required, it can be sanctioned with the minimum of delay. Scheme A did not involve a bail condition. Indeed, evaluation revealed that the bail condition is almost certainly relevant, because the nature of the bail release process gave the impression that attendance was compulsory, even when it was not mentioned as a condition of bail.

The evaluation of the Dudley scheme contains several suggested areas of good practice that Walsall could benefit from:

- The principles of the scheme should be firmly focussed on motivational interviewing and the brief intervention would involve two 1-hour sessions.
- Clear criteria would need to be established at the beginning of the project as to what constitutes an alcohol related offence.
- Drink driving offences should not figure in the scheme as there is ample evidence to suggest that it is not appropriate to offer brief interventions to drink drivers.
- The two tiered type of intervention is recommended since this would ensure a more holistic offer of interventions to the largest possible effective group, including those who become victims of violence as a result of their alcohol abuse.

It will be necessary to bring the magistrates court on board with regard to whatever sort of scheme eventually emerges in Walsall. In an ideal scenario, magistrates would be informed by defence solicitors of an individual's attendance at an arrest referral scheme, and asked to consider explicitly acknowledging participation in the scheme when sentencing. In practice, both in Dudley and Worcester (where arrest referral has also been piloted), the reality has been that neither the scheme nor the individual's action plan (drawn up at the two sessions) were mentioned or taken into consideration in court. It is difficult to envisage a successful outcome to the scheme if we cannot come up with a carrot to go along with the other aspects of the interventions.

## Operation Alcohol, Cardiff

Some 10 years ago, Professor Jonathan Shepherd, Professor of Maxillo-facial Surgery at the University Hospital in Cardiff complained about the very high frequency of gruesome injuries sustained by alcohol-fuelled fights and brawling around weekend evenings. Much of the mindless violence was a cause of significant morbidity and recurring mortality, very often resulting from glassings and attacks with knives and bottles. He insisted that this was a public health issue and that much could be achieved through prevention.

He was right. At peak times, an Accident Department near a weekend hotspot could have as many as 9 out of 10 patients visiting as a result of an alcohol-related incident. It led in Cardiff, and later elsewhere in the country, to initiatives that included:

- No glassware being served after 9 pm at certain venues on certain nights
- No bottles also being passed over after 9 pm; plastic containers and bottles being used instead
- Certain venues associated with brawling to be patrolled and well-lit
- Car parking to be made secure; customers to be encouraged to take taxis
- Wider use of CCTV and general clean up of venue premises, especially to tackle litter
- Staggered closing hours.

In Cardiff, staff were drafted in at the Accident Department to take the name of the pub or club where an incident occurred, what weapons were used, the number of assailants, whether this was a repeat attack, whether the police were called, etc. This type of work actually led to the creation of Partnerships, where the NHS provide vital information to enforcement. Here, it is important for the police to be aware of the emergence of hotspots, and how to deal with them.

Time has since moved on and there are other initiatives in place to build on the earlier good work:

- New licensing laws
- Better control of potential flashpoints through trained bar staff and security
- Identification card systems and Proof of Age schemes
- Pub Watch schemes
- More subtle police surveillance and intelligence.

# Alcohol and Crime and Disorder in Walsall

What we are doing well (but further effort still required)

1. Campaigns to tackle alcohol abuse and under age drinking
2. Ban on drinking alcohol in all public places
3. Targeting off licences supplying under age youths with alcohol
4. Controlling alcohol-fuelled disorder and violence in the Town Centre (Fort Alice police operation), especially considering the fivefold increase in night time population from 2002 to 2005
5. Professionally trained and registered door (and bar) staff
6. Crimestoppers and Walsall Against Night-times Disorder (WAND)

Where we need more action (but usually dependent on more resources and/or a stronger prioritisation)

1. Further strengthening and expansion of existing initiatives
2. Funding a dedicated alcohol arrest referral scheme (possibly on the Dudley model), with at least 2.5 alcohol/counselling workers
3. Identifying and supporting perpetrators of domestic abuse within families, by addressing underlying alcohol related issues more clearly and forcibly with treatment interventions

Expected developments

1. Implementation of the NTA Models of Care guidance (2006) should draw increased attention to the need for alcohol intervention programmes
2. More dedicated Government funding on alcohol is expected from 2007

What Government needs to do

1. It is all about a commitment to promised adequate funding, at least from 2007, and at a funding level so far accorded drug misuse
2. Towards a zero tolerance to drinking and driving
3. Random roadside testing to reduce drinking and driving
4. Tackle drinks advertising and drinks promotion
5. Clear labels on drinks (eg units, health warnings, etc)

# Models of Care and Other Alcohol Related Guidance

This chapter is based around Models of Care for Alcohol Misusers (MoCAM), which provides best practice guidance for local health organisations and their partners in delivering a planned and an integrated local treatment system for adult alcohol misusers **(Department of Health 2006)**. It is informed by Models of Care for the treatment of adult drug misusers **(National Treatment Agency 2002)**, which had drug treatment as its primary focus, but was acknowledged to be highly relevant for alcohol service provision. MoCAM is supported by Department of Health guidance Alcohol misuse interventions: guidance on developing a local programme of improvement **(Department of Health 2005)**. Also relevant and supporting MoCAM are Review of the Effectiveness of Treatment for Alcohol Problems **(National Treatment Agency 2006)** and Alcohol Treatment Pathways **(National Treatment Agency 2006)**. The effectiveness document is especially compelling in suggesting, from recent studies, that alcohol treatment has both short and long-term economic benefits. Provision of alcohol treatment to 10% of the dependent drinking population within the UK would reduce public sector resource costs by between £109 million and £156 million each year. Furthermore, analysis from the UK Alcohol Treatment Trial suggests that for every £1 spent on alcohol treatment, the public sector saves £5.

MoCAM identifies four main categories of alcohol misusers who may benefit from some kind of intervention or treatment:

- Hazardous drinkers
- Harmful drinkers
- Moderately dependent drinkers
- Severely dependent drinkers.

These categories enable broad mapping across levels of need and against the range of provision required. The first two groups usually require advice and brief interventions to meet their needs. Moderately dependent drinkers can often be managed effectively in the community, including medically assisted alcohol withdrawal. However, they may also be better suited to specialist treatment. It is important for commissioners to understand that there cannot be any precise mapping of categories to tier of provision required; also that an individual may drift between categories. Severely dependent drinkers usually have serious and long-standing problems, and may require inpatient assisted alcohol withdrawal. They may have special needs or complex problems.

Complex problems include people with dual diagnosis, usually co-existing mental health needs. Pregnancy is an increasingly important co-existing health condition requiring immediate attention (see Chapter 6). Other people presenting challenges are older people, those with learning disabilities, or with social and housing problems. Domestic abuse is also complex in relation to alcohol, either in a victim or perpetrator. While not usually a complex problem, it is important to cater for diversity and address Black and Minority Ethnic groups appropriately.

A particularly important group are drug misusers, a third of whom also misuse alcohol. Experience has shown that most drug services have little or no impact on drug service users' drinking behaviour, despite around a half having identified alcohol problems. These people should be offered treatment for both, the ideal being to have a combined service, to reduce the need for referral. It is important for service users to have management of alcohol misuse clearly identified for action as part of the formal care plan for drug misuse. A further justification for this lies in the fact that up to 40% of drug users in treatment may be positive for hepatitis C infection; the significance being that alcohol use and misuse is the single biggest contributory factor to those with hepatitis C developing fatal liver disease.

PCTs are involved in the commissioning of alcohol interventions and treatment, and now conform to a framework to ensure best practice **(Department of Health 2004)**, so that services:

- are in line with population needs
- address local service gaps
- deliver equity
- are evidence based
- are developed in partnership with other NHS bodies, local authorities and other partners
- offer value for money.

This clearly puts into perspective why Walsall needed an alcohol needs assessment, as presented in Chapter 2, with crime based information presented in Chapter 7. Tiers of interventions (Chapter 6) provide a framework for commissioning but, as already emphasised above, they are not intended to be a rigid blueprint for provision. Those delivering any tier of service require competencies set out in the Drugs and Alcohol National Occupational Standards **(DANOS 2002)**. The following provides a brief account of what should be commissioned in local alcohol treatment systems.

**Tier 1 interventions: alcohol-related information and advice; screening; simple brief interventions; and referral.**
These can be delivered in a very wide range of settings, the main focus of which is not alcohol treatment, eg primary care, Accident & Emergency, psychiatric services, social services, homelessness services, antenatal clinics, hospital wards, custody cells, probation services, the prison service, educational services, and occupational health services. Examples of generic services include the following:

- alcohol advice and information
- targeted screening, assessment and brief interventions
- referral for specialised treatment
- partnership or shared care with specialised treatment services.

Needs assessment and action planning for Alcohol in Walsall has already identified brief interventions in primary care, with a move towards shared care, as a top priority; this along with alcohol arrest referral. The latter would demand screening, assessment and brief interventions in the police custody setting and, as suggested in Chapter 7, within the probation service. A start has already been made in A&E, hospital wards and antenatal clinics, but more resources are required.

**Tier 2 interventions: open access, non-care-planned, alcohol-specific interventions.**
These may be delivered by: specialist alcohol services, primary care, hospitals, and the above services listed in Tier 1, but are dependent on people with the necessary competence being in place. They are particularly required to help misusers reduce alcohol-related harm. Examples of interventions include:

- all Tier 1 interventions but with a more informed alcohol focus
- mutual aid groups, such as Alcoholics Anonymous
- triage assessment, usually as part of locally agreed arrangements.

All the above Tier 1 Walsall comments apply, especially on brief interventions, shared care and alcohol arrest referral. Addaction is a dedicated Tier 2 level provider, with links and arrangements, particularly involving Lantern House and enforcement. Lantern House, despite being a Tier 3 provider, is also an open access facility. The Destiny Project in Walsall is an example of a mutual aid group, in need of support.

**Tier 3 interventions: community-based, structured, care-planned alcohol treatment.**
These are normally delivered in specialised alcohol treatment services with their own premises in the community, and alongside Tier 2 interventions. Some Tier 3 work is based in primary care (shared care schemes). Interventions include:

- comprehensive assessment, planning and management
- prescribing interventions and medically assisted alcohol withdrawal
- psychosocial services and structured day programmes
- liaison with medical, psychiatric, social care, child care and housing services.

This is working well in Walsall, with Lantern House leading on Tier 3 work but, as seen in Chapter 6, badly under-resourced. Part of the problem here lies in the lack of shared care arrangements with primary care and, again, this falls back to the high priority of requiring alcohol workers, supported by GPs with a special interest (GPswSI). Addaction supports Lantern House, especially in liaison with the police and probation services and, yet again, the gap in service provision is the other high priority of alcohol arrest referral to ensure the necessary support. Medical staff will require different levels of competence **(National Treatment Agency 2005)**.

**Tier 4 interventions: alcohol specialist inpatient treatment and residential rehabilitation.**
These are specialised inpatient facilities for medically assisted alcohol withdrawal (detoxification) and stabilisation; they include residential rehabilitation units. Other complex needs requiring hospitalisation are associated with liver disease and sometimes pregnancy. In Lantern House, we have excellent liaison with Tier 4 service providers; something that will improve further with the recent appointment of a psychiatrist with an interest in substance misuse. As referred to in Chapter 6, a document describing the future of specialist inpatient services provides useful standards for commissioning **(Specialist Clinical Addiction Network 2006)**. Manor Hospital's midwifery section has provision for dealing with alcohol problems, with a specially trained midwife, although this expertise needs expanding to the rest of the team. The hospital's gastroenterology department expertise in liver disease was strengthened by the appointment of a consultant with a special interest in hepatology.

For all tiers of service, quality criteria for providing an evidence-based alcohol treatment service are available in two documents dealing with standards and commissioning: Quality in Alcohol and Drug Services (QuADS) produced by **Alcohol Concern/DrugScope (1999)**, and Commissioning Standards by the **Substance Misuse Advisory Service (1999**).

## Standard Detoxification

The following is typically used for medically assisted withdrawal from alcohol using chlordiazepoxide (Librium):

| Day | 08.00-09.00 | 13.00-14.00 | 18.00-19.00 | 22.00-23.00 |
|---|---|---|---|---|
| **1** | 20mg | 20mg | 20mg | 20mg |
| **2** | 20mg | 10mg | 20mg | 20mg |
| **3** | 20mg | 10mg | 10mg | 20mg |
| **4** | 10mg | 10mg | 10mg | 20mg |
| **5** | 10mg | 10mg | 10mg | 10mg |
| **6** | 10mg | | 10mg | 10mg |
| **7** | 10mg | | | 10mg |
| **8** | | | | 10mg |

This is used for minimal to moderate withdrawal (and may be used in the community setting); a different regime is used for moderate withdrawal, starting with 30mg.

For more severe withdrawal, parenteral (usually IV) lorazepam may be used as an inpatient, under the supervision of a doctor experienced in this type of critical care. All patients are usually also given 100mg thiamine orally twice daily and vitamin B compound. Patients requiring moderate to severe detoxification may require treatment by the parenteral route and also lactulose 10ml thrice daily. Patients may have ascites or liver failure and require haloperidol; also required for severe psychosis. Seizures may occur and require appropriate therapy.

It is important for service providers to develop integrated care pathways, as outlined by the National Treatment Agency (2006). These will, for example, provide arrangements for detoxification (see Box), and may refer to criteria for preventing relapse, such as the use of disulfiram (Antabuse). As a general or overall comment, it will be to the benefit of services and users if commissioners start to recommend the use of outcome measures. These may include:

- reduction of alcohol consumption (abstinence or moderation goal)
- reduction in alcohol dependence
- amelioration of alcohol-related health problems (eg liver disease, nutrition, psychological problems)
- amelioration of alcohol-related social problems (eg family matters, avoidance of criminal activity)
- improvement in health and social functioning.

Measureable goals can be agreed. However, it should be recognised that collecting and monitoring data will in itself require extra resources.

It is to be expected that, as with the commissioning of drug interventions and treatment, the NTA will be closely monitoring the PCTs, DAATs and Partnerships when Government funding for alcohol finally materialises in a substantive and continued manner. It is just as well that Walsall has made a good start with its own local alcohol strategies and with its own alcohol needs assessments. In the meantime, it would be fitting if the major priority areas identified in this report receive the necessary attention by the tPCT, the DAAT and the SWBP during 2007-2008.

# Conclusions and Recommendations

The Walsall Alcohol Strategy has evolved since 2001, when it was developed in line with recommendations made by Alcohol Concern, a major player in urging the government to act on the nationwide alcohol problem. The strategy was then developed further following consultation among key partners across the borough, and today it is consistent with the national strategy and it is further informed by a needs assessment at national, regional and local levels, as well as by an evidence base and models of care guidance. This Director of Public Health annual report is an unusually long one because it:

- Essentially represents an updated Walsall Alcohol Strategy, 2007
- Incorporates a first version of a Walsall Alcohol Needs Assessment, 2006.

As with any strategy, aims are usually met by development of an action plan. As detailed in Chapters 4 to 7 of this report, and summarised in Chapter 3, the Walsall Action Plan on alcohol has been updated to reflect the input of the key partners during 2006, together with recent needs assessments (Chapter 2) and guidance (Chapter 8).

The recommendations of this report on alcohol in Walsall largely represent the key issues that need to be addressed from the Action Plan. They are actions that need to be taken up at the local level. There are many and they are wide ranging. Since they are going to be dependent on new sources of government funding, on new initiatives, and on a redistribution or shifting in emphasis of existing resources, a prioritisation is in order. The following recommendations reflect an agreed priority list that is derived from key actions necessary to address alcohol in Walsall:

**(1)** Develop specialist alcohol services in Walsall further, including their integration with alcohol services (and community detoxification) within Primary Care, provided through alcohol workers; this will need to be supported by funding to enable the development of GPs with a Special Interest in alcohol.

> **Currently being supported by an interim National Regeneration Fund allocation, with a request for continued funding through the Walsall tPCT Local Development Plan.**
>
> **The concept of brief interventions is so important in identifying alcohol problems that it should be extended beyond health settings into other situations, eg social services, probation, enforcement (see Appendix for FAST screening).**

**(2)** Introduce and develop a dedicated Alcohol Arrest Referral scheme.

> **Currently being supported by an interim National Regeneration Fund allocation, with a request for continued funding through the SWBP.**

**(3)** Implement alcohol-specific integrated care pathways for problem drinkers; supported by an increasing role for agencies such as the Destiny Project, which is in urgent need of funding and support.

> **Priority for the SWBP.**

**(4)** Give more priority to alcohol in implementing the national schools curriculum, ideally supported by an integrated family and community approach; collaborating with existing programmes to expand alcohol awareness raising at community level among young people and parents.

> **Priority for Education Walsall and the SWBP.**

**(5)** Appoint a DAAT Alcohol Coordinator and provide a stronger influence of SWBP's Vulnerability Group to address the inequalities agenda.

> **Priority for the SWBP.**

**(7)** Further strengthen and expand existing initiatives:

- the Pub Watch scheme and the tackling of drinks promotions
- campaigns to tackle alcohol abuse and under age drinking
- ban on drinking alcohol in all public places
- targeting off licences supplying under age youths with alcohol
- controlling alcohol-fuelled disorder and violence in the Town Centre (Fort Alice police operation), especially considering the fivefold increase in night time population from 2002 to 2005
- professionally trained and registered door (and bar) staff
- Crimestoppers and Walsall Against Night-times Disorder (WAND).

Priority for Walsall MBC and the SWBP.

**(8)** Identify and support perpetrators of domestic abuse within families, by addressing underlying alcohol related issues more clearly and forcibly with treatment interventions.

Priority for the SWBP.

**(9)** Develop an in-patient and rehabilitation (detoxification) centre in Walsall.

Priority for Walsall tPCT.

**(10)** Develop stronger links between the Manor Hospital and the tPCT to address the role of alcohol in coronary heart disease, mental health, elderly care, falls and stroke prevention, accident prevention; and stronger alcohol links into the Teenage Pregnancy strategy – both requiring (A) a stronger involvement of the tPCT Health Promotion division (Choosing Health agenda), and (B) funding to enable more dedicated alcohol services within the Manor Hospital (responding to alcohol related ill health).

Priority for Walsall tPCT and the Manor Hospital

## Heavy drinking kills twice as many people as in 1991

Alcohol made the national headlines yet again in November 2006 with the release of data from the Office for National Statistics. Key points picked up by the media:

- In 1991 a total 4,144 men and women died from drink-related illness in Britain but by 2005 the total had leapt to 8,386; actual fatal effects were far higher because the data does not include deaths from cancer, violence or accidents linked to drinking.
- Binge drinking by teenagers in the past two decades is contributing to early deaths before middle age, particularly in people aged between 35 and 54 years.
- Adjusting for inflation and other economic factors, alcoholic drinks are estimated to be 54% cheaper on average than they were in 1980.
- Drink-related hospital admissions in England have reached record levels, eg those for alcoholic liver disease more than doubled in a decade, reaching 34,000 in 2004-05, while alcoholic liver disease deaths increased by 37%. Admissions for alcoholic poisoning increased to 21,700 from 13,600 over the same ten years.

# Alcohol Screening Tests

**CAGE** stands for Cut down, Annoyed, Guilty, Eye opener and its questionnaire **(Mayfield et al 1974)** includes items such as guilt related to heavy drinking and taking alcohol first thing in the morning. It is a screening test for people with heavy as well as dependent drinking. The **AUDIT** (Alcohol Use Disorders Identification Test) includes questions about the frequency and quantity of alcohol consumption and, like the CAGE, assesses hazardous and harmful as well as dependent drinking **(Barbor et al 1989)**. The AUDIT questionnaire is useful in community as well as hospital settings, consisting of 10 questions taking less than two minutes to complete. AUDIT was developed in a WHO study **(Saunders et al 1993)** and validated across six countries. While the AUDIT is useful and robust, there is need for an even shorter test, for use in A&E and other settings where time pressure is a major factor, and one which can be scored in seconds. This led to the **FAST** questionnaire **(Hodgson et al 2003)**. For more information, see **Health Development Agency (2002)**.

## Fast Alcohol Screening Test (FAST)

This questionnaire consists of just four items, can be self-completed or administered by a health or other professional, can take less than 20 seconds to complete, has a high reliability, and is most useful in initiating a brief intervention in hazardous drinkers.

For the following questions please circle the answer which best applies.

**1 drink = ½ pint of beer or 1 glass of wine or 1 single spirits**

**1** MEN: How often do you have EIGHT or more drinks on one occasion?
WOMEN: How often do you have SIX or more drinks on one occasion?

| Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
|---|---|---|---|---|

**2** How often during the last year have you been unable to remember what happened the night before because you had been drinking?

| Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
|---|---|---|---|---|

**3** How often during the last year have you failed to do what was normally expected of you because of drinking?

| Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
|---|---|---|---|---|

**4** In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

| No | Yes, on one occasion | yes, on more than one occasion |
|---|---|---|

Score questions 1 to 3: 0, 1, 2, 3, 4; Score question 4: 0, 2, 4
The minimum score is 0; the maximum score is 16
The score for hazardous drinking is 3 or more.

# References


Alcohol Concern (1997). *Measures for measures: a framework for alcohol policy.* London: Alcohol Concern.

Alcohol Concern (1999). *Proposals for a national alcohol strategy.* London: Alcohol Concern.

Alcohol Concern/DrugScope (1999). *Quality in Alcohol and Drug Services (QuADS).* London: Alcohol Concern.

Alcohol Concern (2001). *Getting alcohol into HImPs: a briefing for planners and commissioners.* London: Alcohol Concern.

Anderson P, Baumberg B (2006). *Alcohol in Europe: a public health perspective* (a report for the European Commission). European Commission: Brussels.

Barbor TF, de la Fuente JR, Saunders J, Grant M (1989). AUDIT: *The Alcohol Use Disorders Identification Test: guidelines for use in primary health care.* Geneva: World Health Organization.

Barrett B, Byford S, Crawford MJ, *et al.* Cost-effectiveness of screening and referral to an AHW in alcohol misusing patients attending an AED: a decision-making approach. *Drug and Alcohol Dependency 2006;* **81**: 47-54.

Bellentani S, Saccoccio G, Costa G, *et al.* Drinking habits as co-factors of risk for alcohol induced liver damage. The Dionysos Study Group. *Gut* 1997; **41**: 845-50.

Bien TH, Miller WR, Tonigan JS. Brief interventions for alcohol problems: a review. *Addiction* 1993; **88**: 315-35.

Bowlin SJ *et al.* Breast cancer risk and alcohol consumption: results from a large case-control study. *International Journal of Epidemiology* 1997; **26**: 915-23.

Brown S (1988). *Treating adult children of alcoholics: a developmental perspective.* New York: John Wiley.

Chick J, Godfrey C, Hore BD et al (1997). *Alcohol dependence: a clinical problem.* London: Mosby-Wolfe Communications: 29-33.

Cook CC, Hallwood PM, Thomson AD. Vitamin deficiency and neuropsychiatric syndromes in alcohol misuse. *Alcohol and Alcoholism* 1998; **33**: 317-36.

Copello A, Templeton L, Krishnan M, Orford J, Velleman R. A treatment package to improve the primary care services for
relatives of people with alcohol and drug problems. *Addiction Research* 2000; **8**: 471-84.

Coulton S, Drummond C, James D, *et al.* Opportunistic screening for alcohol use disorders in primary care: comparative study. *British Medical Journal* 2006; **332**: 511-14.

Crawford MJ, Patton R, Touquet R, *et al.* Screening and referral for brief intervention of alcohol-misusing patients in an emergency department: a pragmatic randomised controlled trial. *Lancet* 2004; **364**: 1334-39.

DANOS (2002). *Skills for health.* London: Drugs and Alcohol National Occupational Standards.

Day CP. Who gets alcoholic liver disease: nature or nurture? *Journal of the Royal College of Physicians London* 2000; **34**: 557-562.

Department of Health (2001). *The Annual Report of the Chief Medical Officer of the Department of Health (Liver cirrhosis: starting to strike at younger ages).* London: Department of Health.

Department of Health (2004). *Choosing health: making healthy choices easier* (Public Health White Paper). London: Department of Health.

Department of Health (2004). *Alcohol needs assessment research project (ANARP): the 2004 national alcohol needs assessment for England.* London: Department of Health.

Department of Health (2004). *National standards, local action: health and social care standards and planning framework* 2005/06-2007/08. London: Department of Health.

Department of Health (2005). *Alcohol misuse interventions: guidance on developing a local programme of improvement.* London: Department of Health.

Department of Health (2006). *Models of care for alcohol misusers* (MoCAM). London: Department of Health.

Flood-Page C, Campbell S, Harrington V, Miller J (2000). Youth crime: findings from the 1998/1999 Youth Lifestyle Survey. *Home Office Research Study* 209. London: Home Office.

Harrington V (2000). Underage drinking: findings from the 1998-99 Youth Lifestyle Survey. *Home Office Research Findings* 125. London: Home Office.

Harris C, Hassan E, Roach P (1999). *Audit of needs: African and African Caribbean communities of Walsall.* Centre for Research in Ethnic Relations, University of Warwick.

# References


Health Development Agency (2002). *Manual for the Fast Alcohol Screening Test (FAST): fast screening for alcohol problems.* London: Health Development Agency.

Health Education Board for Scotland (1998). *So you want to cut down your drinking? A self-help guide to sensible drinking*. Edinburgh: Health Education Board for Scotland.

Heather N, Dallolio E, Hutchings D, et al. Implementing routine screening and brief alcohol intervention in primary health care: a Delphi survey of expert opinion. *Journal of Substance Use* 2004; **9**: 68-85.

Hodgson RJ, John B, Abbasi T, et al. Fast screening for alcohol misuse. *Addictive Behaviour* 2003; **28**: 1453-63.

Home Office (1998). *Tackling drugs to build a better Britain.* London: Stationery Office.

Home Office (2000). *Time for reform: proposals for the modernisation of our licensing laws.* London: the Stationery Office.

Kaner EF, Lock CA, McAvoy BR, et al. A randomised controlled trial of three training and support strategies to encourage implementation of screening and brief alcohol intervention by general practitioners. *British Journal of General Practice* 1999; **49**: 699-703.

Kershaw C, Budd T, Kinshott G, et al (2000). The 2000 British Crime Survey: England and Wales. *Home Office Statistical Bulletin* 18/00. London: Home Office.

Leon DA, McCambridge J. Liver cirrhosis mortality rates in Britain from 1950 to 2002: an analysis of routine data. *Lancet* 2006; **367**: 52-56.

Lock CA, Kaner EF. Implementation of brief alcohol interventions by nurses in primary care: do non-clinical factors influence practice? *Family Practitioner* 2004; **21**: 270-75.

Mayfield D, McLeod G, Hall P. The CAGE questionnaire: validation of a new alcoholism instrument. *American Journal of Psychiatry* 1974; **131**: 1121-23.

McKee M. A European alcohol strategy: will the opportunity be missed? *British Medical Journal* 2006; **333**: 871-72.

Moyer A, Finney JW, Swearingen CE, et al. Brief interventions for alcohol problems: a meta-analytical review of controlled investigations in treatment-seeking and non-treatment-seeking populations. *Addiction* 2002; **97**: 279-92.

National Treatment Agency for Substance Misuse (2002). *Models of care for the treatment of adult drug misusers* (MoCDM). London: National Treatment Agency.

National Treatment Agency for Substance Misuse (2005). *Roles and responsibilities of doctors in the provision of treatment for drug and alcohol misusers* (Royal College of General Practitioners and Royal College of Psychiatrists). London: National Treatment Agency.

National Treatment Agency for Substance Misuse (2006). Review of the effectiveness of treatment for alcohol problems. London: National Treatment Agency.

National Treatment Agency for Substance Misuse (2006). *Alcohol treatment pathways: guidance for developing local integrated care pathways for alcohol.* London: National Treatment Agency.

Naveau S, Giraud V, BorottoE, *et al.* Excess weight risk factor for alcoholic liver disease. *Hepatology* 1997; **25**: 108-11.

North West Public Health Observatory (2006). *Local alcohol profiles for England.* Alcohol Research Unit, Centre for Public Health, Liverpool John Moores University. www.nwph.net/alcohol/lape.

Office for National Statistics (2002). *Living in Britian: results from the General Household Survey* 2001. London: Stationery Office.

Office for National Statistics (2004). Living in Britain: *results from the general Household Survey* 2003. London: Stationery Office.

Paton A. Our favourite drug. *British Medical Journal* 2002; **324**:1410.

Patton R, Crawford M, Touquet R. Emergency departments are well placed to identify alcohol misuse problems. *British Medical Journal* 2002; **324**: 300-1.

# References


Patton R, Hilton C, Crawford MJ, Touquet R. The Paddington alcohol test: a short report. *Alcohol and Alcoholism* 2004; **39**: 266-68.

Pemanen K (1981). Theoretical aspects on the relationship between alcohol use and crime. In: Collins JJ (Ed). *Drinking and crime.* New York: Guilford Press, 1-69.

Pinot de Moira A, Duffy J. Changes in licensing laws in England and Wales and alcohol related mortality. *Addiction Research* 1995; 3: 151-164.

Pirmohamed M, Brown C, Owens L, et al. The burden of alcohol misuse on an inner city general hospital. *Quarterly Journal of Medicine* 2000; 93: 291-95.

Portman Group (2006). *Promoting responsible drinking.* www.portmangroup.org.uk.

Prime Minister's Strategy Unit (2004). *Alcohol harm reduction strategy for England.* London: Prime Minister's Strategy Unit.

Pugh RN, Ramaiah S (2001). Walsall *Alcohol Strategy.* Walsall Health Authority.

Pugh RN, McNulty D, Garratt D, Beechey N (2003). *Walsall Alcohol Strategy.* Walsall Teaching Primary Care Trust.

Rang HP, Dale MM (1991). *Pharmacology,* 2nd edn. London: Churchill Livingstone: 887-88.

Reinert DF, Allen JP. The Alcohol Use Disorder Identification Test (AUDIT): a review of recent research. *Alcoholism: Clinical and Experimental Research* 2002; 26: 272-79.

Royal College of Obstetricians and Gynaecologists (2006). *Alcohol consumption and the outcomes of pregnancy.* London: RCOG Statement No. 5.

Royal College of Physicians (2001). *Recommendations for a coherent alcohol strategy for hospitals: alcohol, can the NHS afford it?* www.rcplondon.ac.uk/pubs/books.

Rumpf H-J, Hapke U, Meyer C, John U. Screening for alcohol use disorders and at-risk drinking in the general population: psychometric performance of three questionnaires. *Alcohol and Alcoholism* 2002; 37: 261-68.

Saunders JB, Aasland OG, Babor TF, et al. Development of the Alcohol Use Disorder Identification Test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol consumption. *Addiction* 1993; **88**: 791-804.

Singleton N, FarrellM, Meltzer H (1999). *Substance misuse among prisoners in England and Wales.* London: Office for National Statistics.

Singleton N, Bumpstead R, O'Brien M, et al (2001). *Psychiatric morbidity among adults living in private households,* 2000. London: Office for National Statistics.

Specialist Clinical Addiction Network (2006). *Inpatient treatment of drug and alcohol misusers in the National Health Service* (Final Report of the SCAN Inpatient Treatment Working Party). scan@nta-nhs.org.uk.

Spoth RL, Redmond C, Shin C. Randomised trial of brief family interventions for general populations: adolescent substance use outcomes for four years following baseline. *Journal of Consulting Clinical Psychology* 2001; **69**: 1-15.

Stahlberg J (2006). *Walsall alcohol needs assessment.* Walsall Teaching Primary Care Trust.

Substance Misuse Advisory Service (1999). *Commissioning Standards: drug and alcohol treatment and care.* London: Substance Misuse Advisory Service.

Tether P, Robinson D (1986). Preventing alcohol problems: *a guide to local action.* London: BMA, Tavistock.

Touquet R, Paton A. Tackling alcohol misuse at the front line. *British Medical Journal* 2006; **333**: 510-11.

Velleman R, Orford J (1999). *Risk and resilience: adults who were the children of problem drinkers.* London: Harwood.

Velleman R (2000). *The importance of the family*. In: Cooper D (Ed.). *Alcohol use.* Edinburgh: Radcliffe Medical Press.

Walsall Teaching PCT (2005). *The 2005 Annual Report of the Director of Public Health: minority communities matter.* Department of Public Health Medicine, Walsall Teaching Primary Care Trust.

Weir A, Douglas A (1999). *Child protection and adult mental health: conflict of interests?* Oxford: Butterworth-Heinemann.

West Midlands Public Health Group (2006). Rao J, Kemm J. Alcohol in the West Midlands: a review of alcohol and alcohol services in the West Midlands. www.go-wm.gov.uk/gowm/PublicHealth.

Williams S, Brown A, Patton R, *et al.* The half life of the teachable moment for alcohol misusing patients in the emergency department. *Drug and Alcohol Dependency* 2005; **77**: 205-8.

**Abstinence** Total avoidance of alcohol.

**Aftercare programmes** Support provided following discharge from a programme of treatment. It may include rehabilitation or be planned following a period of rehabilitation. The nature of support can be wide ranging and include services that support client physical, emotional, psychological, social and welfare needs.

**Alcohol Arrest Referral** Referral, assessment, treatment and rehabilitation of offenders with alcohol related problems. Clients may be referred from or assessed in custody suites or given bail on condition of attending an appointment with an alcohol worker. Alcohol workers may provide input into pre-sentence reports. Offenders may be referred to an Alcohol Related Offenders group as a condition of a Community Rehabilitation Order.

**Alcohol assessment** To identify alcohol misuse problems, immediate risks and assess appropriate onward referral (Level 1 assessment).

**Alcohol dependence** Drinking above recognised sensible levels and experiencing harm and symptoms of dependence. A chronic condition characterised by excessive alcohol use, inability to reduce the amount consumed (despite being aware of the need to reduce alcohol use), adverse health effects, and breakdown of relationships with family members, work colleagues, and friends. It is associated with tolerance (needing to drink more and more to obtain the same effect), withdrawal symptoms, a pre-occupation with getting the next drink, and denial of problems with alcohol.

**Alcohol screening** To detect excessive drinking through the use of brief questionnaire screening tools such as CAGE, AUDIT and FAST or recognising certain social, psychological and physical presentations as indirect indicators of excessive drinking.

**Alcohol specific semi-structured residential care** Such as half-way houses or semi-supported accommodation.

**Alcohol unit** See unit.

**Alcoholic** Generally refers to a person who has alcohol dependence.

**AUDIT** Alcohol Use Disorders Identification Test (screening questionnaire). See brief interventions.

**Binge drinking** Consuming at least twice the safe daily limit (ie 8 units for men; 6 units for women), usually in a short space of time with the aim of getting drunk. This is associated with violence, sexual abuse, other crimes, accidents, unprotected sex, and alcohol poisoning.

**Brief interventions** Rapid identification of problem drinkers (taking a rapid standardised alcohol history, usually using a brief questionnaire) and brief actions (interventions) in primary care (or other settings such as A&E), by way of advice on appropriate drinking, and possibly onward referral to alcohol treatment providers.

**CAGE** See FAST and brief interventions.

**Care planning and management** Systems that facilitate access to services that are client-centred and not determined by modalities provided by a particular agency. The services should provide a programme of integrated and coordinated health and social care, maximise client retention and minimise drop-out from the alcohol treatment system.

**Community care assessment, care management and coordination** Assessment of individual alcohol related needs and how these are to be addressed through a structured programme of community based provision. The programme should be agreed with the client and managed by a Care Coordinator responsible for coordinating the individual's care on behalf of all agencies and services involved.

**Control of Street Drinking/Byelaws** The 1990 byelaw: Consumption of Intoxicating Liquor in Designated Places. Use of byelaw prohibiting drinking in designated areas to control public disorder, rowdy and anti-social behaviour.

**Crime and Disorder Reduction Partnerships (CDRPs)** Crime and Disorder Act 1998 and also known as community safety partnerships. Alcohol related crime and disorder is one of the issues that CDRPs can address.

**Dependence** See alcohol dependence.

**Dependent drinking** Heavy drinking but the overriding criterion is the presence of dependence (see alcohol dependence), not the volume of alcohol consumed.

# Glossary

**Detoxification** Medically assisted withdrawal from alcohol, frequently using a scheduled programme of gradually decreasing doses of a sedative or tranquilizer such as chlordiazepoxide (Librium).

**Drop-in** Interventions provided through services that do not require clients to have a high level of commitment to structured programmes or complex assessments.

**FAST** Fast Alcohol Screening Test, that has been developed from the AUDIT questionnaire (see above); quicker and just as effective. Two other fast screening tools are the Paddington Alcohol Test and the CAGE. See brief interventions.

**Harmful drinking** Consuming more than 50 units per week for men and more than 35 units per week for women. Also, drinking above recognised sensible levels and experiencing harm, but not symptoms of dependence. Often equates to problem drinking.

**Hazardous drinking** Consuming between 22 and 50 units per week for men and between 15 and 35 units per week for women. Also, drinking above recognised sensible levels but not yet experiencing harm. Often equates to risky alcohol use and/or binge drinking.

**Heavy drinking** Tends to equate to harmful drinking but can also equate to long term, consistent or steady hazardous drinking; drinking above safe or sensible drinking levels or limits.

**Inpatient detoxification and stabilisation services** May be provided through generic services such as psychiatric wards or specialist alcohol misuse units. Assisted alcohol withdrawal may be offered to stabilise clients by prescribing medication such as chlordiazepoxide (Librium).

**Licensee training programmes** Training programmes which meet the syllabus requirements of the National Licensee's Certificate for on-license, off-license and part IV establishments. Sometimes required by Licensing Magistrates as a condition of being granted a license to sell intoxicating liquor.

**Local alcohol related needs** This includes needs relating to health promotion, needs of individuals with alcohol related difficulties, people affected by other people's drinking, and the needs of communities (eg crime prevention).

**Low-risk alcohol use** Occasional or regular moderate drinking within safe limits (men: not more than 21 units per week and not more than 4 units on any one day; women: not more than 14 units per week and not more than 3 units on any one day) and without adverse consequences on health or relationships with others.

**Moderate drinking** See low-risk alcohol use.

**Motivational and brief interventions** Minimal intervention techniques such as advice and information, provided to excessive drinkers who are not experiencing serious associated problems. Motivational interviews are also seen as a form of brief intervention to assess client readiness to engage in treatment and/or provide counselling in preparation for further treatment.

**Outreach** A method of delivering interventions in settings external to a service's usual site. The purpose of outreach may be to deliver interventions to clients not accessing site-based services or facilitate their access to site-based services.

**Paddington Alcohol Test** See FAST and brief interventions.

**Problem drinking** Associated with frequent or regular alcohol related consequences but does not meet the criteria for alcohol dependence.

**Pub Watch** A local communication network between licensees and police which provides all parties with an early warning system to prevent escalation and spread of trouble.

**Recommended units or limits** See low-risk alcohol use.

**Residential alcohol crisis services** These may offer interventions such as detoxification or relapse prevention in a crisis situation. They may provide open access as well as taking formal referrals from other agencies.

**Residential co-morbidity services** Services that address two concurrent disorders. For example, mental health and alcohol misuse difficulties.

**Risky alcohol use** Frequently exceeding safe limits and includes binge drinking. Adverse health effects may not always be present, but drinking bouts may be associated with violence, sexual abuse, other crimes, and accidents. Risk of serious harm and future dependence increases with frequency and amount of drinking.

**Safe drinking or limits** See low-risk alcohol use.

**Screening** (and questionnaire) See brief interventions.

**Sensible drinking** See low-risk alcohol use.

**Shared care treatment or support via Primary Care** Community based treatment under GP supervision with support from a specialist alcohol service.

**Social drinking** See low-risk alcohol use.

**Specialist alcohol assessment** Level 2 (triage): to identify treatment or care needs, client readiness to engage in treatment and the need for more comprehensive assessment and care coordination. Level 3 is a comprehensive alcohol misuse assessment.

**Specialist alcohol screening** To identify specific alcohol related needs following initial screening to detect excessive drinking.

**Specialist residential alcohol rehabilitation programmes** A range of interventions provided on a residential basis, following a period of treatment, to assist client return to and cope with day-to-day living.

**Structured care planned counselling and therapies** A range of planned counselling/therapy/social support, provided in the community to improve client psychological and social health.

**Structured community based detoxification** Planned interventions provided in the community to support client withdrawal from physical dependence on alcohol.

**Structured day programmes** Interventions provided through day facilities that offer a structured programme of care.

**Throughcare** The process by which individual clients access and proceed through the range of services and interventions that meet individual need in a comprehensive way.

**Tier 0 (Preventive) services** Inform about the effects of alcohol and risks of misuse.

**Tier 1 (General) services** Working with wide range of clients (eg primary care) but can provide brief interventions, screening and referral to alcohol treatment services.

**Tier 2 (Open access alcohol treatment) services** Providing accessible alcohol specialist services for a wide range of alcohol misusers referred from a variety of sources, including self-referrals. There are minimal requirements on alcohol misusers to receive services, but there is frequent referral to Tier 3.

**Tier 3 (Structured community based alcohol) services** Providing structured programmes of care, including cognitive behavioural therapy, motivational interventions, structured counselling, community detoxification, day care, and aftercare programmes for misusers leaving residential rehabilitation or prison.

**Tier 4 services** Either alcohol specific (4a) or highly specialised, non-specific (4b).

**Tier 4a (Residential alcohol specific) services** Aimed at those with a high level of need, including inpatient alcohol detoxification or stabilisation. Requires higher level of user commitment, after first ensuring careful assessment and preparation to maximise readiness and compliance.

**Tier 4b (Highly specialised residential) services** Not alcohol specific, such as liver units and forensic units for mentally ill offenders.

**Treatment under Community Rehabilitation Order** Community based alcohol treatment for offenders misusing alcohol under a Community Rehabilitation Order.

**Unit** (of alcohol) Equals 8 grams of alcohol and roughly equivalent to half a pint of ordinary strength beer, a small glass of wine, a single measure of spirits, and a very small glass of sherry or fortified wine.

# Abbreviations

| | |
|---|---|
| **A&E** | Accident and Emergency |
| **ASB** | Antisocial behaviour |
| **ASBO** | Antisocial Behaviour Order |
| **BME** | Black and Minority Ethnic (refers to groups, communities) |
| **BMI** | Body mass index (measure of body weight, obesity) |
| **CCTV** | Closed circuit television (security surveillance) |
| **CDRP** | Crime and Disorder Reduction Partnership |
| **CHD** | Coronary heart disease |
| **DAAT** | Drug and Alcohol Action Team |
| **GPswSI** | General Practitioners with a Special Interest (eg in alcohol) |
| **HA** | Health Authority |
| **IAU** | Integrated Assessment Unit |
| **ICD** | International Classification of Disease |
| **MBC** | Metropolitan Borough Council |
| **NDC** | New Deal for Communities |
| **NHS** | National Health Service |
| **NICE** | National Institute for Clinical Excellence |
| **NRF** | National Regeneration Fund |
| **NSF** | National Service Framework |
| **NSPCC** | National Society for the Prevention of Cruelty to Children |
| **NTA** | National Treatment Agency |
| **OCU** | Operational Command Unit (of police) |
| **PCT** | Primary Care Trust |
| **PSA** | Public Service Agreement (usually in relation to targets) |
| **PSHE** | Personal, Social and Health Education |
| **QOF** | Quality and Outcomes Framework (in primary care) |
| **SHA** | Strategic Health Authority |
| **SWBP** | Safer Walsall Borough Partnership |
| **tPCT** | Teaching Primary Care Trust |
| **WalPOP** | Walsall Persistent Offenders Programme |
| **WHO** | World Health Organization |
| **WICAS** | Walsall Integrated Community Alcohol Services |