Department of Health

GOVERNMENT OFFICE FOR THE EAST OF ENGLAND

NHS National Treatment Agency for Substance Misuse

East of England Alcohol Conference Report

Cambridge, 10 March 2008

Alcohol in the East of England – Headlines

- Recent research across the region shows how to analyse national data down to ward level as a way to target scarce resources to alcohol hot spots
- During the period 2003/4 to 2005/6 over 1,500 under 18s were admitted to hospital beds as a result of alcohol– an even spread between males and females
- The East of England has the highest rate of alcohol consumption in 13 - 15 year olds; 12.6% compared to the national average of 8.2% (Health Survey England 2005)
- The number of offenders in the East of England with alcohol problems is close to the national average (48%)
- Alcohol-related harm is being addressed as a high priority in Local Area Agreements (LAAs)

Introduction

The East of England's second regional alcohol conference (the first took place in April 2006) was held at Robinson College in Cambridge. The primary aims of the event were to:

- Discuss the implications of the national alcohol strategy, *Safe.Sensible.Social*
- Share the learning emerging from ongoing alcohol pilot initiatives around the region
- Focus on new policy opportunities provided by the Public Service Agreement (PSA) target for Drugs and Alcohol

Over 150 delegates from the criminal justice system, the Government Office for the East of England (GO-East), local authorities, NHS trusts, Primary Care Trusts (PCTs), the voluntary sector and services for children and young people met to

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hear a range of invited speakers addressing the issues surrounding the regionalisation of the national strategy.

The conference was chaired by Sue Howl, GO-East's Regional Home Office Director, with presentations from:

Dr Simon Moore, Senior Lecturer, Cardiff University

David Sheehan, Development Manager, South-East Regional Public Health Group

Tony Oram, Strategy Manager, Norfolk Drug and Alcohol Team

Ziggy McDonald, Head of Alcohol Strategy Unit at the Home Office (HO)

Don Lavoie, Alcohol Policy Office, Department of Health (DH)

Pat Branigan, Director Cambridge Health Evaluation Consultancy (CHEC)

Malcolm Roxburgh, Information Manager, National Treatment Agency

Sue Howl opened the conference by emphasising the timeliness of the day's event in light of the new PSA. This is the first time that there has been such a joint agreement across government. She explained that today's alcohol challenges are key for public health and public order, with real impact on vulnerable people and consequences for individuals and the wider community – including crime and anti-social behaviour. Its effects can be seen in a number of different ways such as harm to the individual caused by liver disease; alcohol-related crime and disorder; domestic violence; alcohol-dependent parents and the impact on families.

Sue explained that alcohol was 'at the forefront of all our agendas', and that the national strategy is a joined-up strategy which gives us the opportunity to do a number of things, including:

- Ensure that laws and licensing powers protect young people
- Maintain a sharper focus on a minority of problem drinkers
- Shape an environment which actively promotes sensible drinking

Sue went on to describe the GO-East's role in the region as being key to galvanising regional support; networking local areas and feeding back to central government on future policy. Negotiating LAAs is enabling the government and local areas to work together on forming meaningful contracts. It is extremely encouraging to see that LAAs are prioritising alcohol. The most important challenge will be to ensure that they deliver.

- It was then time to move into the main presentations of the day.

An overview of the 'Cardiff model'

Dr Simon Moore, Senior Lecturer, Cardiff University gave an overview of the 'Cardiff model' for collecting data on alcohol-related violence in Emergency Departments (EDs) – or A&E – and sharing the data with community safety partners. The context for this initiative was low rates of recording of violent offences by the police – 23% compared with the numbers seen in hospital. Cardiff produced a list of 'essential ingredients' for collecting data in EDs and sharing it with partners. This should include victim age and gender; violence date and time; exact location; weapon. The results of collecting and sharing this data include a 60% decrease in assault injury in premises targeted by police and ED, compared with targeted policing alone.

In addition to having a system for recording data, two essential ingredients are: the prioritisation of violence as a key public health issue by the local public health service and city-wide or area-wide violence prevention group at senior level dedicated to continuous scientific violence prevention.

Sharing data across these agencies has resulted in a clear reduction in violence linked to licensed premises as policing plans are continually reviewed and tactics adapted in response to the data.

Opportunities are also taken for brief advice on alcohol, or 'motivational interviewing' with individuals in hospital trauma and outpatient clinics at the time of suture or plaster removal.

The NHS role in alcohol harm reduction in the community

David Sheehan, Development Manager, South-East Regional Public Health Group discussed the role the NHS can play in relation to alcohol-harm reduction in the community. The estimated annual burden of alcohol on health services is £1.7b - higher than for smoking or class A drugs.

A number of key partners need to be working together to tackle community violence where alcohol is a key factor – licensing committee; drinks industry; emergency departments (EDs) and health staff; staff working with children and young people; local authorities; voluntary and community sector; police and the Local Strategic Partnership.

The South-East region has been incrementally adopting the Cardiff model, and David reiterated the importance of recording assault type and location. It is equally important to create a dialogue between the NHS and community safety colleagues and to identify early adopter sites.

25 of the 33 emergency departments across the south-east have signed up to developing a local data sharing model over the last two years. ED reception staff need to be trained and supported in collecting the data and Crime and Disorder Reduction Partnerships (CDRPs) need to feed back directly to NHS staff the positive impact the system is having on violent crime.

A&E data sharing in the East of England

Tony Oram, Strategy Manager, Norfolk Drug and Alcohol Team presented some emerging results from three East of England pilot projects on implementing A&E data sharing – Cambridge; Norwich; Peterborough – funded by the Home Office Crime and Drugs Team in the region.

The Cardiff model is central to the pilots. In addition Norwich used the Paddington Alcohol Test (PAT) for four weeks over Christmas and New Year 2007 when people accessing A&E could be referred for brief advice where necessary.

The findings appear similar to those of Cardiff and the South-East. Hot spots for alcohol-related assaults were identified and more effective targeting for licensing enforcement and patrols resulted. In Norwich over the four week period, just over 5,000 people attended A&E. Just over 400 of these were alcohol-related. 287 took the PAT test, and just over 100 had a significant risk score. 16 were then referred for brief advice but none attended. Follow on calls showed that brief motivational interviews were considered inappropriate as those identified were ‘entrenched drinkers’ needing immediate access to mainstream services.

A key lesson learned was the importance of targeting brief advice and locating a wide range of staff to deliver it in different settings.

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The general lessons from the pilots so far are that it is technically feasible and cost effective to introduce the Cardiff model. The IT system can be built quickly and cheaply, and there are genuine public health and safety benefits. Pitfalls include short-term funding and tight timescales. To be successful in the long-term this process has to be built into the mainstream business of the A&E and community safety partners.

The national alcohol strategy

Ziggy McDonald, Head of the Alcohol Strategy Unit at the Home Office (HO) then talked in his keynote speech about the national strategy, *Safe. Sensible. Social*. Although violent crime has fallen, half of victims believe the offender was under the influence of alcohol. One fifth of violent crimes are committed in or around pubs and clubs. Over three-quarters of people are concerned about generally drunken and disorderly behaviour among British people – the ‘English drinking culture’.

Measures of success will include overturning these perceptions; reducing hospital admissions for alcohol-related chronic and acute ill-health and reducing the frequency and quantity of alcohol consumed by young people. The long-term goal of the alcohol strategy is to:

> ‘Minimise the health harms, violence and anti-social behaviour associated with alcohol while ensuring that people are able to enjoy alcohol safely and responsibly.’

By April 2008 every CDRP *should* have a local alcohol strategy. Local action will be backed up nationally by a ‘Tackling Underage Sales of Alcohol Campaign’ (TUSAC). A ‘Know Your Limits’ campaign will start in May and a public order campaign in June. A&E data sharing is seen as vital. The Department of Health (DH) is looking into the links between price, promotion and harm. The HO has commissioned a review of pubs clubs and shops on responsible sales.

Following the review of the Licensing Act 2003, HO will change the law on persistent sales of alcohol to children; moving from three sales down to two as the point at which licenses will be withdrawn. Acceptable behaviour contracts will be used for young people drinking in public, and brief advice offered.

The outcomes set out in *Safe. Sensible. Social* are captured in several PSAs. For example PSA 14 Children and Young People on the path to success; PSA 23 Safer Communities and PSA 25 Drugs and Alcohol. These are underpinned by key indicators relating to alcohol.

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Local strategies should reflect local priorities, and the new alcohol toolkit should be used to help with strategy development.

Department of Health policy

Don Lavoie from the DH Alcohol Policy Team gave the second keynote speech. Whilst 90% of people in England drink alcohol, only 13% keep a tab on their drinking. Drinking over years can cause stroke; Coronary Heart Disease; liver disease. The Office for National Statistics estimates that up to 10m people drink above low-risk, or sensible levels.

The national strategy's goal is not to prohibit fun, but to minimise risk-taking behaviour. Key target groups include binge drinkers; harmful drinkers; young people under 18; parents and pregnant women who are advised to avoid alcohol. Alcohol should be prioritised in LAAs. Identification and brief advice (IBA) should be implemented in a variety of settings like A&E facial injury clinics. Treatment services also play a vital role. Look at care pathways – what are the access problems and what can be done about them locally?

In the East of England a Regional Alcohol Steering Group (RASG) was established in February 2008, supported by a Delivery Group. A Drug and Alcohol Pathway Group, chaired by the National Treatment Agency (NTA) ensures appropriate services for substance-misusing offenders.

At the national level, the campaigns referred to earlier are all intended to promote a culture of sensible drinking. DH also wants to provide more help for people who want to drink alcohol, whilst emphasising the responsibility of individuals.
In summary – we can make our country a healthier, safer place to live, but only if we all work together. We must forge a clearer national understanding of what is and isn't acceptable drinking behaviour and act to reduce the harm caused by alcohol to individuals, families and communities.

Alcohol in the East of England – need, impact and plans

Pat Branigan, Director Cambridge Health Evaluation Consultancy, (CHEC) then shared the emerging findings of a HO-funded scoping study carried out by his consultancy on alcohol need, impact and plans across the region. The study looked at existing data regionally, locally and at ward level and made a strategic assessment of activity – what is going on, and what is good practice?

The North West Public Health Observatory has produced data on alcohol for each region, but not at ward level. However, through a process of matching and ranking using the Index of Multiple Deprivation 2007 data (IMD) and the grouping system used for census data, it was possible to first hypothesise which ward types would be associated with greatest risk and then test this using IMD data sets. This gave ward level results.

The greatest concentration of 'hot spots' for binge drinking was found in Cambridge, followed by Norwich; Luton; Colchester; Welwyn Hatfield and Bedford – perhaps a combination of student and/or military-dominated communities?

From the Primary Care Trust (PCT) perspective, Joint Strategic Needs Assessments need more time to focus, but will provide opportunities to fine-tune the detail. For CDRPs there are problems relating to data generation, and therefore over-reliance on police statistics. But LAAs are looking promising in selecting the right indicators to tackle alcohol. For example. by prioritising domestic violence; alcohol-related hospital admission rates; assault with injury crime rate.

National Drug and Alcohol Monitoring System (NDTMS)

Malcolm Roxburgh, Information Manager, National Treatment Agency, presented information about the new national data recording system on alcohol users in treatment – the National Drug and Alcohol Monitoring System (NDTMS). This is an extension of the existing national data system for drug users, and will underpin the PSA. It is overseen by a cross-government board. The system will look at tier three and four service users – heavily dependent drinkers, rather than those likely to benefit from IBA.

Once the data is collected it can be used by commissioners to look at services. The Healthcare Commission can use it to assess local performance. Drug and Alcohol Action Teams (DAATs) can use it for trend data.
www.ndtms.org/dams/

Expert Panel

An expert panel was convened by Sue Howl during the conference plenary session in the afternoon. The panel comprised speakers plus Dr Adrian Boyle,

A&E Consultant Addenbrooke's Hospital, Cambridge and Dr Anne McConville, Deputy Director, Public Health Directorate, alcohol lead for the Directorate. Key points covered were:

- The Pooled Treatment Budget (PTB) can be used where individuals have corresponding drug and alcohol problems. In limited situations it can be used on alcohol where an area is meeting all its other drugs targets. There are no plans for a dedicated PTB for alcohol.
- There are no technical or ethical reasons to prevent data sharing as long as there are local data sharing arrangements and protocols for anonymising and disaggregating data. The new national alcohol data sharing system will for the first time clearly demonstrate the level of need and demand.
- The recently-established Regional Alcohol Steering Group has decided not to extend its remit to illicit drugs, in order to maintain its focus on alcohol.
- The need for resources to treat alcohol dependency and severe alcohol-related damage was acknowledged as a key issue in its own right. There is a risk of it getting lost in dual diagnosis; for example of mental health problems.
- Product labelling with unit contents is improving. The spring campaign will focus on understanding units; not drinking alcohol during pregnancy or when trying to conceive; recognition of the Drink Aware Trust logo and sensible drinking messages using recommended daily units.
- Ministers are keen to have a dialogue with the drinks and supermarket industries on product placement, promotion and labelling. However alcohol regulation has to be treated carefully if we are not to see a boom in hazardous home-made alcohol.

Workshops

A series of parallel workshops ran during the morning:

- Violent Crime Project (Harlow)
- Hospital Admissions
- Data
- Identification and Brief Advice (IBA)
- Domestic Violence
- Tackling Violent Crime (TVC
- Under-Age Sales.

Reducing alcohol-related violent crime project
Facilitator: Paul Howell, Essex Police

The County was funded by the HO Crime & Drugs Team in the region to carry out a project targeting ten alcohol-misusing offenders in Harlow town centre. A multi-agency approach was adopted to develop a scheme aimed at reducing the number of alcohol-related incidents of violent crime and anti-social behaviour, offering perpetrators a fast-track route into treatment where possible.

The project involved identifying the best care pathways for this group, taking account of social needs. Taking an individualised approach to clients was successful, using motivational interviewing and IBA.

This proved to be a very different group to class A drug users in terms of needs. The project gave a great insight into behaviours in relation to poly-drug use. For example, alcohol being taken as a personal (legal) reward for managing other drugs. In terms of group behaviour, members gravitate to individuals who had money; for example welfare benefits in order to fund group drinking sessions. Local agencies need to provide interventions and treatments in non-threatening environments; for example the homeless unit in Harlow was seen by the target group as ‘safe’. Negative points included not enough time to profile the group fully in terms of health; social and criminal justice issues.

Tackling alcohol-related hospital admissions
Facilitator: Daniel Harry and David Cooper, Norfolk DAAT

Cambridge, Norwich and Peterborough were funded by the HO Crime & Drugs Team in the region to develop pilot projects aimed at reducing the number of

alcohol-related hospital admissions and offering people a route into treatment, building on the Cardiff model described in the plenary session.

Norwich found the Cardiff data module not user-friendly, and in need of amendment. However, introducing the Cardiff data screens had been very low cost – around £800-£900. A key learning point was that the triage point in A&E is key to reaching 'missing populations' that could have benefited from IBA. It proved difficult for busy A&E staff to give brief advice as part of core delivery. Other hospital settings may be more appropriate. But engaging with A&E departments was seen as only one component of the way forward on alcohol. For example, there is a need to tackle domestic drinking.

The results of the pilot projects are now being reviewed and next steps planned. For example work with GPs on screening; brief interventions and referral; training for staff in IBA; work with A&E and Ambulance Trust on triage in the night time economy; doing analysis of alcohol-related hospital admissions; longitudinal cohort studies of repeat attendees; communications campaigns.

Data analysis
Facilitators: Pat Branigan and Elaine Ellis, Cambridge Health Evaluation Consultancy (CHEC)

CHEC had been commissioned by the HO Crime & Drugs Team in the region to carry out a mapping exercise on alcohol-related harms and activity across the region. They gave an overview of available data sources, covering alcohol-related crime, health and young peoples' issues and described their emerging findings.

Local Authorities (LAs) were ranked according to alcohol-related indicators, including health and crime. Using the same methodology to look at both health and crime scores, Norwich was top (worst) each time, with Great Yarmouth second. A group of LAs in addition to these scored highly in terms of binge drinking, crime and longer-term health impacts – Harlow; Ipswich; Peterborough; Southend; Fenland; Stevenage; Cambridge and Watford.

The study found that alcohol issues are much broader than community safety. The key issues emerging from the workshop were set out by Pat in his plenary presentation.

Workshop participants discussed the findings and considered data gaps; what should be measured and next steps. There was particular interest in understanding the method used to identify hot spots in order to take a more

evidence-based approach, and ways for data analysts across the region to network.

Identification and brief advice (IBA)
Facilitator: Don Lavoie

Don described the work that the DH is doing to help roll out a national programme of brief advice on alcohol for individuals with concerns from April 2008. This will include setting up support systems for frontline staff in healthcare and other settings, such as criminal justice. There have been 56 control trials over the past 30 years, but there are still gaps in the evidence base for alcohol IBA. It is still not routinely offered in criminal justice settings, and its efficacy with young people is unknown.

Definitions of 'brief advice' vary from a series of 6, down to one or two sessions. A research programme, 'Screening and Interventions Programme' (SIPs) for sensible drinking has been set up with a large academic consortium based on three clustered randomised control trials – Primary Care; A&E; Criminal Justice. There is also a small arrest referral pilot, and a further pilot to be offered in probation.

A healthcare collaborative will be set up to support frontline staff in implementing IBA, building on consultation with a sample of its potential users and using existing networks where possible.

Domestic Violence
Facilitator: Karen Bailey, the Greater London Domestic Violence (DV) Project

Karen presented data on DV and substance misuse, including alcohol. A study from the U.S.A reports that 60% of women accessing drug or alcohol services report current or previous domestic abuse. Alcohol misuse among DV perpetrators may be up to 7 times higher than in the general population. HO research on DV offenders has shown that 73% had used alcohol prior to the offence, with 48% seen as alcohol dependent. A number of studies have found that the perpetrator's use of alcohol; particularly heavy drinking, was likely to result in more serious injury to the partner than if they had been sober.
It was acknowledged that changing the culture takes time. For example, up until 1991 it was legal for a man to rape his wife.

Alcohol in DV is often used as part of 'deviancy disavowal' – 'I'm only violent when I'm drunk'. There is still a lack of research in this area.

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Tackling Violent Crime (TVC)
Facilitator: Christine Graham, Fieldworker with the HO TVC Programme

Christine gave an overview of the links between alcohol and violent crime, with particular reference to night time economy. 46% of violent offences are alcohol-related, according to the British Crime Survey. The absolute number of violent offences including alcohol has fallen over the past decade but the proportion of total violent offences involving alcohol has increased.

Research from the West Midlands has shown very limited overlap between victims and offenders (1.5%). Around 40% of offenders had no previous criminal involvement. Victims and offenders are predominantly male.

The HO TVC Programme has been running since 2004 to trial new ideas and develop good practice in tackling alcohol-related violence and DV.

Examples of good practice include taxi marshals; polycarbonate glasses; fixed penalty notices; street angels/pastors; safe corridors; night buses; alcohol exclusion zones; accredited door staff.

There are a number of national resources available to support local work. For example, *Saving Lives. Reducing Harm. Protecting the Public*, HO Action Plan; and an *Effective Practice in the Night Time Economy* DVD.

Workshop participants discussed local successes and challenges. In West Suffolk, for example, fixed penalty notices have been used early evening to reduce low level crime, and have also been found to reduce more serious violent crime later in the evening.

Under-age sales, *Think 21*
Facilitator: Charlotte Wilson, Cambridgeshire County Council Trading Standards Service

Charlotte leads the successful St Neots *Think 21* pilot which forms part of the County Community Alcohol Partnership (CAP). The CAP encourages alcohol retailers to sign up to a commitment to restrict the sale of alcohol products to over 21 year olds.

The workshop focused on the underage consumption of alcohol through partnership in Cambridgeshire. This project aims to deliver cultural change;

reduce harm to society and victims (including young drinkers) and challenge and change public perceptions.

The ‘drivers’ include delivering better outcomes; more effective use of resources and pressure from communities and businesses. The ‘barriers’ include the silo nature of the public sector; the huge range of organisations with an interest but no clear lead; funding.

Partners include retailers; Local Authorities; schools; police; voluntary sector providers; local community.

Achievements to date include reduced litter and crime; improved public perceptions and reduced fear of crime; culture change and better reputation.

Theatre Group

Immediately after lunch the Ipswich-based 'Red Rose Chain' Theatre Group performed one act from its play 'Strictly Body and Soul'; soon to be made into a film and DVD for schools. The company addresses issues with young people such as bullying; teenage parenting; substance misuse.

After the performance the audience engaged with the actors through a short question and answer session about the three characters who had acted out a number of key issues relating to alcohol. These included under-age drinking socially; living with an alcohol-dependent parent; peer pressure; alcohol in the workplace and sources of advice.

Next Steps and Closing Remarks

Dr Anne McConville brought the conference to a close by pulling together a number of thoughts from the day and next steps.

1. The issue of lack of data on alcohol, a key issue at the previous conference, has been progressed considerably through the data-sharing pilots.

2. The workshop sessions reminded us of the importance of only collecting data when we can do something useful with it.

3. Data should be used to support licensing decisions and to support licensees in complying with the law.

4. The A&E pilots are showing signs of success, and can be seen as a valuable tool in dealing with some of the challenges presented by the night time economy.

5. There is a need for clear pathways for alcohol identification and brief advice for individuals, including access to extended brief interventions and further treatment.

6. PCTs and CDRPs need to increase their levels of collaboration.

7. 12-13 year olds experimenting with alcohol and drinking regularly are a real concern for our region. Early 'drinking careers' have implications for longer-term health.

8. Appropriate, effective alcohol treatment services need to be commissioned.

9. Work is needed with the 'NHS as a responsible corporate citizen' in relation to alcohol – a paper going to the Strategic Health Authority Board later this month will set out priorities of its role with regard to reducing alcohol related harm.

10. We need to take advantage of social marketing and communication to amplify the messages from the Spring campaigns referred to by the keynote speakers

The Regional Alcohol Steering Group will consider ways to address these and other issues.

See Annex A for an overview of delegate conference evaluation forms.

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Annex A

Report on evaluation

The evaluation of the conference was generally positive, although only just over a quarter of delegates returned their evaluation forms.

- All of the speakers' presentations evaluated very positively, with ratings of 7 to 9 out of 10. The workshops had slightly more variable results, ratings ranging from 4 - 9 out of 10. The theatre group was rated 7 - 8 out of 10 and the Expert Panel 8 - 9 out of 10.

- In terms of the most helpful and interesting aspects of the day, the A&E data sharing pilots were considered practical and helpful.

- Some delegates were clearly looking for straightforward advice and information about what to do on alcohol and how to do it.

- The networking opportunity provided by the day was found to be very useful.

- How and where to target brief interventions was found to be helpful – see box below for some delegate quotes on helpful aspects of the day:

Explanation of the priority alcohol is achieving on a regional basis. Explanation of how we need to consider the performance indications for targets within LAA
The importance of evidence based interventions and data collection. The impact of violence on resources within health. Partnership working to address under age sales.
Ideas for rapid assessment and Brief Interventions in various settings. Concerned about emphasis on hospital admissions, not health care attendances (in climate of re-provision of hospital services)
Particular forms in Brief Interventions and alcohol related admissions = excellent
I thought that overall the government's strategy and concerns over long term health etc came over very well in a subject area that is very complex

- On what would help further, some delegates said:

How local authorities can practically implement local (and co-ordinated) alcohol strategies.
Funding Resources to address alcohol issues to quickly be put in place
Make all the presentations available electronically (i.e. post on web)

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Help with us collating data and analysing it into useful formats
More links to implement guidance within local alcohol strategy toolkit.
More contact with GO i.e. alcohol work. No-one had informed me of the alcohol steering group

- A selection of further general quotes from delegates:

Disappointed there was no input from licensed trade, alcohol industry, crown prosecution service or East of England Ambulance Service Quality of handouts not clear Should make all handouts available to all delegates not just those attending specific workshops
Was expecting 'workshops' to be interactive
Event geared towards health practitioners making some elements (i.e. data recording – NTA) less relevant
I would like to see more on best practice schemes. This was quite heavily focused on health who are usually the weakest link in partnership work; hopefully today will have inspired them to begin leading in some areas of this work.
Would have been good to have move on front line delivering – best practice. Too much on health data collection
Useful and interesting day, unfortunate weather. Probably too much on the agenda especially given the late start.
Very useful conference – well done and thank you. There is much to do: alcohol intrudes or affects so many aspects of modern life. But we must all have made the first few steps.