

ALCOHOL HARM REDUCTION STRATEGY

2009-2012



Friday April 17th 2009

| Contents | Page |
|---|-------------|
| Foreword | 5 |
| Steering Group Membership | 6 |
| Executive Summary | 7 |
| Introduction | 13 |
| Dorset’s Harm Reduction Alcohol Strategy | 15 |
| Policy Context | 15 |
| Alcohol Harm in Dorset | 20 |
| Special Populations | 21 |
| Where we are now & where are the gaps? | 24 |
| Where do we need to get to – our Aims, Outcomes and Objectives | 33 |
| How we’re going to get there – Implementation | 37 |
| Monitoring, evaluation and review | 39 |

Foreword

Welcome to our new Strategy for Alcohol in Dorset.

As the Director of Public Health, part of my role is to highlight challenges to the health of our population. Traditionally this has been through a focus on the major diseases such as cancer and heart disease. However, part of my role is to look forward and recognise where the challenges lie – alcohol is most certainly one of those.



We have long recognised the fine line between the benefits of sensible alcohol consumption in a society and the damage to individuals and communities from the misuse of alcohol.

Efforts to limit this damage have been many and varied, including legislation to restrict access and taxation and price controls, and have not always achieved their desired result.

Most of us do drink sensibly, however the images of the damage resulting from alcohol misuse are becoming a disturbingly common feature of life in Britain in the year 2009.

The Strategy is timely in that it provides us with clear local information on the scale of the problem, and practical suggestions as to how we might respond.

This includes a better understanding of what behaviours cause harm etc., but importantly I would encourage us to see that it is an opportunity for all of us, and suggest that only by shifting all our attitudes now do we produce an environment and culture where we can minimise the damage from alcohol and maximise the benefits.

Finally my sincere thanks go to all those people who have contributed to the development of this report and in particular Emma Wilson for her unflagging enthusiasm and energy in leading the process.

A handwritten signature in black ink that reads "David Phillips".

Dr David Phillips
Director of Public Health

A wide range of agency representatives were consulted in the course of preparing the alcohol strategy, including senior staff and managers from Dorset County Council, Local District Councils, Dorset Police, NHS Dorset, Dorset Fire and Rescue, Dorset Youth Offending Team, Dorset Drug and Alcohol Action Team, Dorset Probation Service and Youth Services. Consultees were invited to identify current responses to alcohol-related harm in Dorset and any gaps in services that needed addressing by a formal consultation period and a Multi-agency Stakeholder event.

Steering Group Membership

| | |
|----------------------|---|
| Lee Bayliss | DAAT Co-ordinator – Dorset County Council |
| Jane Brennan | Service Improvement Manager – NHS Dorset |
| Andy Frost | Corporate Policy Officer – Community Safety – Dorset County Council |
| Des Gandy | Dorset Service User Forum |
| Ben Hargreaves | Detective Chief Inspector - Dorset Police |
| Trevor Heritage | Licensing Officer – Purbeck District Council |
| Ruth Howlett–Shipley | Deputy Director of Public Health – NHS Dorset |
| Bill Jaggs | Head of Regulatory Services – Dorset County Council |
| Joanna Joy | Administration Support – NHS Dorset |
| Rosie La Manno | Dorset Service User Forum |
| Patrick Myers | Strategic Joint Commissioning Manager – Children’s Services - Dorset County Council |
| Tina Ridge | Assistant Chief Officer – Probation Service |
| Andy Vickers | DAAT Co-ordinator – Dorset County Council |
| Emma Wilson | Health Programme Advisor – Harm Reduction – NHS Dorset |
| Kay Wilson-white | Community Safety Manager – Dorset County Council |

This report can be made available in other formats and languages. Please call Dorset PCT's **Patient Advice and Liaison Service** on **01305 361285** or email PALS@dorset-pct.nhs.uk to request a suitable format. For details of Trust services or patient information leaflets, please log on to www.dorset-pct.nhs.uk

Executive Summary

National Profile

Alcohol is a significant factor in our society. Used in moderation, it can be a source of enjoyment, celebration and relaxation, a positive part of our social and family lives. However whilst many of us use alcohol positively to enhance our lives, there is growing recognition of the physical, personal and social damage caused by the misuse of alcohol.

Alcohol Harm Reduction Strategy for Dorset

The Alcohol Harm Reduction Strategy for Dorset has been developed in accordance with the guidelines provided by the Government in the *Safe, Sensible, Social: Alcohol strategy local implementation toolkit*.

The role of the Strategy is to help coordinate the different activities undertaken by each local organisation to tackle alcohol related harm. Effective coordination at a local level will maximise efficiency and avoid duplication. However, when developing this strategy it is important to take into consideration the fact that each local organisation has its own priorities, drivers, delivery mechanisms and performance management structure. This strategy is a driver of activity and also the key means of coordinating joint working.

Consideration has also been given to the particular issues and vulnerabilities of young people and people from minority groups (e.g. Black minority ethnic people; lesbians, gay men, bisexuals and transgender people, people from different faith groups; older people; those with learning difficulties). This includes problems related to access, inclusion and cultural issues. Within this alcohol strategy the above issues will not be addressed separately but should be fully integrated within the three theme areas, as the strategic direction within Dorset County Council and NHS Dorset is already aimed toward addressing such inequalities.

A supporting document *Improving health services for alcohol misuse in Dorset – a systemic assessment of needs - 2006* was used to set out the direction of this strategy.

Alcohol Harm in Dorset

The National Statistics give an indication of the problems presented by alcohol misuse across the country. Similarly, a variety of local statistics show that alcohol misuse imposes a heavy economic, social and personal cost on the people of Dorset.

Local alcohol profiles for 2006/07 are available from the North West Public Health Observatory (appendix 1). They have been placed in localities for Dorset County with the South West and England data for comparison.

In October 2008 a Dorset lifestyle survey was undertaken by Market Research Group based at Bournemouth University, commissioned by Public Health Directorate – NHS Dorset, which included some questions about alcohol. 22,000 Dorset residents received a questionnaire, 6834 of which responded to the research within the field work period (31% response rate).

The aim of the survey was to collect information about the health status of the local population. It was designed to aid understanding of what services are needed to enable NHS Dorset to better plan and deliver local health services now and in the future.

The main findings were:-

- 70% of respondents reported drinking alcohol.
- 61% of respondents reported drinking their recommended units or less a week.
- Respondents most frequently reported drinking between 11 and 20 units per week (27%).
- On average respondents reported drinking the most on Saturdays (4.1 units) and the least on Mondays (1.9 units).
- The majority of respondents reported consuming one or more standard glass of wine (59%), 28% one or more single measure of spirits, 21% one or more pint(s) of normal strength beer and 19% one or more large glass of wine.
- 84% reported their alcohol consumption as typical for them.

Where do we need to get to – our Aims, Outcomes and Objectives

This Strategy identifies aims, outcomes and objectives that will set out a framework for action between the spring of 2009 and the spring of 2012.

Aim of the Strategy

The Alcohol Strategy aims to reduce the negative effects of alcohol on the population of Dorset, in relation to criminal activity, anti-social behaviour and physical and mental health as well as family welfare, whilst ensuring that the population of Dorset is able to enjoy alcohol safely and responsibly.

The Key Outcomes are:

| OUTCOMES | HOW THE OUTCOMES WILL BE MEASURED |
|---|--|
| 1. A reduction in Hazardous Drinkers in Dorset County. | Lifestyle Survey – Commissioned by Public Health NHS Dorset, Local/PCT Alcohol Profiles. |
| 2. A reduction in Harmful Drinkers in Dorset County. | Lifestyle Survey – Commissioned by Public Health NHS Dorset, Local/PCT Alcohol Profiles. |
| 3. An increase of 5% year on year for the life of the strategy of the numbers of individuals engaged into effective treatment. | HALO/NDTMS returns from treatment providers against a baseline to be established this year. Local measures for effective treatment i.e. care planned discharges, monitored by DAAT. |

| | |
|---|--|
| 4. Fewer incidents of alcohol related crime. | Police Statistics, Home Office data, Local/PCT Alcohol Profiles. |
| 5. Fewer accidents caused by alcohol. | Police Statistics, A&E Data, Acute Hospital Data, South West Ambulance data, Dorset Fire and Rescue Data. |
| 6. A reduction in alcohol related mortality. | Hospital Episode Statistics (HES), Local/PCT Alcohol Profiles. |
| 7. A reduction in the number of young people known to be drinking and causing harm to others. | Police Statistics, Youth Offending Team Data, Absenteeism for school – alcohol known cause, Tell-us Survey (Links with NI 115 LAA). |
| 8. A reduction in perceived perceptions of drunk or rowdy behaviour. | Police and Communities Together meetings, Lifestyle Survey, Local Authority Citizen panels, local media reports, Fear of Crime Survey. |

Objectives

The objectives are set out in three agreed themes:-

1. Prevention
2. Intervention/Treatment
3. Enforcement

Prevention

Objective 1:

Educate children and young people to stop/prevent them from harming themselves and others by making them aware of the risks of drinking to excess, through generic education, targeted education (young people at risk), Peer Education, Youth clubs, media and events.

Objective 2:

Improve systems of communication for parents regarding the risks of excess drinking and in influencing their children's drinking behaviour through the media, workplace education, and other settings (Children's Centres, Schools and Community).

Objective 3:

Educate adults, young people and children, particularly targeting those social groups known to consume greater amounts of alcohol and/or with a higher prevalence of alcohol related problems. Education needs to incorporate, increased knowledge of harm, life skills, improved confidence and self-efficacy and an understanding of values, particularly in relation to risk.

Intervention/Treatment

Objective 4:

Develop the capacity of health and other appropriate front line staff to deliver brief interventions to maximise the opportunity of the ‘teachable moment’, whilst identifying hazardous, harmful and dependent drinkers who may need sign posting to appropriate services in relation to the individual’s needs.

Objective 5:

Improve care pathways and the targeting of appropriate treatment and support in relation to people’s needs.

Objective 7:

Identify, at the point of arrest, the offender whose offending is alcohol-related, and refer them on for brief interventions and/or treatment.

Objective 8:

Provide co-ordinated, appropriate services to help people who have problems as a result of alcohol misuse, as well as their families or carers.

Enforcement

Objective 9:

Effective management and partnership co-ordination of alcohol related criminal incidents and anti-social behaviour, in order to prevent similar incidents in the future.

Objective 10:

Actively regulate the supply of alcohol to reduce alcohol misuse, but allow for age-appropriate and responsible drinking within healthy limits.

Objective 11:

Create safer environments in which people drink, both in private and in public.

Objective 12:

Effective management and co-ordinated partnership working of alcohol related accidents (Drink driving, etc), in order to prevent similar accidents in the future.

How we’re going to get there – Implementation

The limited central government funding allocated for alcohol services, in contrast to the substantial sums devoted to tackling drug misuse, makes it imperative to get right the framework and procedures which will steer the alcohol strategy over the next three years. However a successful alcohol

strategy will not be judged merely by its effect in three years but indeed over a much longer period, and progress will only be maintained if there is both a strong collective will to give alcohol misuse a high priority and a recognition of the importance of getting the systems right.

Monitoring, evaluation and review

The steering and implementation group is key to taking this strategy forward.

The strategy will mould the areas to be developed and priority schemes to be funded (alongside identifying coordinated opportunities for new funding) and developed.

This task will need be underpinned by joined-up commissioning. The steering and implementation group will organise annual needs assessment and the commissioning of services locally to meet these needs, using pooled resources to greatest effect.

With agreed targets in place within contracts, services can then be performance-managed to ensure clear, effective and positive outcomes for service users.

In this way the implementation of the strategy can be monitored and subject to continuous review. It can be continuously refreshed and evaluated to achieve ongoing relevance.

The contents of the strategy should be open to change in the light of new information, changes in funding regimes or new central government initiatives.

The links between the alcohol strategy and other relevant strategies should continue to be identified and made explicit. Those with the responsibility for drafting new strategies should be required to take account of the alcohol strategy when formulating future strategies.

1. Introduction

National Profile

Alcohol is a significant factor in our society. Used in moderation, it can be a source of enjoyment, celebration and relaxation, a positive part of our social and family lives. However whilst many of us use alcohol positively to enhance our lives, there is growing recognition of the physical, personal and social damage caused by the misuse of alcohol¹.



The 2007 *National Alcohol Strategy and Department of Health (2006)* guidance identify six main categories:

Low Risk drinkers – are drinking in a way that is unlikely to cause their self or others significant risk.

- Adult women should not regularly* drink more than 2-3 units a day
- Adult men should not regularly* drink more than 3-4 units a day
- Pregnant women or women trying to conceive should avoid drinking alcohol. If they do choose to drink, in order to protect the baby they should not drink more than 1-2 units of alcohol once or twice a week and should not get drunk.

*Regularly is defined as drinking every day or most days.

Hazardous drinkers – are drinking at levels over the low risk drinking limits, either regularly or through less frequent sessions of heavy drinking, but have so far avoided significant alcohol-related problems.

Binge drinkers – are drinking too much alcohol over a short period of time. This type of drinking typically leads to drunkenness and has immediate and short term risks to the drinker and those around them.

Harmful drinkers – are drinking above low risk levels, usually more than hazardous drinkers and show clear evidence of some alcohol-related health problems.

Moderately Dependent – are likely to have increased tolerance of alcohol, suffer withdrawal symptoms, and have lost some degree of control over their drinking. They may recognise they have a problem with drinking but do not have severe dependence.

Severely Dependent – may have withdrawal fits (delirium tremens: e.g. confusion or hallucinations usually starting between two or three days after the last drink); may drink to escape from or avoid these symptoms.

Patterns of drinking vary according to gender, age and other factors such as lifestyle and income. For example, men are more likely than women to drink more than 'sensible' amounts, while young people aged 16-24 are more likely to binge drink.

These categories can be used when assessing the level of need in a population as well as when assessing the gap between need and the provision of appropriate services. It is important to consider the various 'social harms' that may be consequences of any of the above categories of alcohol use (including violence, domestic abuse, road accidents incurred from drink-driving and the consequences of unprotected sex, including teenage pregnancy).

There are many reasons for prioritising work on reducing alcohol harm. The *National Audit Office (2008)*ⁱⁱ and *Choosing Health (2004)*ⁱⁱⁱ summarises these:

The financial burden of alcohol misuse is around £2.7 billion annually to the NHS and the total annual cost of alcohol misuse to the UK economy has been calculated by the Cabinet Office at up to 25.1 billion.

18% of the adult population (7.6 million) are drinking at hazardous levels.

7% (2.9 million) are showing evidence of harm to their own physical and mental health.

15,000-22,000 deaths and 150,000 hospital admissions each year are associated with alcohol misuse.

A quarter of children under 16 drink alcohol – on average around 10 units per week.

Over a million children in the UK are affected by parental alcohol problems.

Nearly half the victims of violent crime described their assailant as being under the influence of alcohol at the time.

Up to 17 million working days are lost annually due to alcohol-related absence.

About 2 in 10 male prisoners and 1 in 10 female prisoners reported that their drinking had caused injury to self or others in the year before coming into prison.

2. Dorset's Harm Reduction Alcohol Strategy

The Alcohol Harm Reduction Strategy for Dorset has been developed in accordance with the guidelines provided by the Government in the *Safe, Sensible, Social: Alcohol strategy local implementation toolkit*.

The role of the Strategy is to help coordinate the different activities undertaken by each local organisation to tackle alcohol related harm. Effective coordination at a local level will maximise efficiency and avoid duplication. However, when developing this strategy it is important to take into consideration the fact that each local organisation has its own priorities, drivers, delivery mechanisms and performance management structure. This strategy is a driver of activity and also the key means of coordinating joint working.



Consideration has also been given to the particular issues and vulnerabilities of young people and people from minority groups (e.g. Black minority ethnic people; lesbians, gay men, bisexuals and transgender people, people from different faith groups; older people; those with learning difficulties). This includes problems related to access, inclusion and cultural issues. Within this alcohol strategy the above issues will not be addressed separately but should be fully integrated within the three theme areas, as the strategic direction within Dorset County Council and NHS Dorset is already aimed toward addressing such inequalities.

A supporting document *Improving health services for alcohol misuse in Dorset – a systemic assessment of needs – 2006*^{iv} was used to set out the direction of this strategy.

3. Policy Context

3.1 National

In 2004, the Government published its first national alcohol harm reduction strategyⁱ. This strategy contained four key aims:

- To improve the information available to individuals to start the process of change in the culture of drinking to get drunk
- To better identify and treat alcohol misuse
- To prevent and tackle alcohol-related crime and disorder and deliver improved services to victims and witnesses
- To work with the industry in tackling the harms caused by alcohol

In June 2007, the Government published *Safe, Sensible. Social: the next steps in the National Alcohol Strategy*^v. It detailed the long term goal of the Government to minimise the health harm, violence, crime and anti-social behaviour associated with alcohol, while ensuring that people are able to enjoy alcohol safely and responsibly.

The three overarching goals of *Safe, Sensible, Social* are:

- To reduce the levels of alcohol-related violent crime, disorder and anti-social behaviour
- To reduce the percentage of the public who perceive drunk and rowdy behaviour to be a problem in their area
- To reduce chronic and acute ill health caused by alcohol, resulting in fewer alcohol-related accidents and hospital admissions

Safe, Sensible, Social sets out the steps the Government will take to achieve these goals. They include:

- Sharpening the criminal justice system for drunken behaviour, providing enhanced support and toughened penalties for those whose unsafe drinking leads to criminal behaviour
- Reviewing health service spending to ensure that appropriate and cost effective preventions and treatments are delivered
- Helping those who want to drink less by making information and support widely available
- Toughening enforcement of underage sales by ensuring that local authorities and police use their powers to clamp down on those who sell alcohol to children
- Providing credible guidance for parents and young people to help them make informed decisions about their drinking
- Rolling out public information campaigns to promote a culture of sensible drinking by highlighting the impact of alcohol misuse
- Consulting the public on the way alcohol should be promoted and its cost
- Ensuring that every local area has developed an alcohol strategy setting out how it will address the harms related to the misuse of alcohol.

3.2 Legislation

In April 2008 three national indicators were established which specifically focus on alcohol, through which the Government will measure local progress in reducing alcohol-related harm. These are:

NI 39 Alcohol-harm related hospital admission rates

NI 41 Perceptions of drunk and rowdy behaviour as a problem

NI 115 Substance misuse by young people

In addition, reducing alcohol-related harm can make an important contribution to other national indicators, for example those relating to crime and community safety.

| | | |
|------------------|-----------------------------|--|
| Community Safety | PSA 23 | Reducing violent crime and disorder, especially assault with injury |
| Community Safety | Statutory Instrument SI1830 | That Crime and Disorder Reduction Partnerships (CDRP'S) have a strategy to tackle crime, disorder and substance misuse, including alcohol misuse |

The **Licensing Act 2003** came into force on 24th November 2005. The Act includes four licensing objectives, which all licensed premises are now required to meet:

- Prevention of crime and disorder
- Promotion of public safety
- Prevention of public nuisance
- Protection of children from harm

The act devolved licensing responsibilities to Local Authorities, made provision for flexible opening hours and set up a system of personal and premises licenses under the scrutiny of seven responsible authorities including Police, Trading Standards, Fire and Rescue Service and Local Safeguarding Children Boards.

The **Violent Crime Reduction Act 2006** provides additional powers to tackle alcohol-related violence in the night-time economy, including drinking banning orders, under which restrictions can be imposed on individuals who commit alcohol-related offences, and alcohol disorder zones, so that, in areas affected by significant alcohol-related crime and disorder, licensed premises can be required to contribute to the costs of managing the night time economy.



3.3 Policy and guidance

The *Department of Health* and the *National Treatment Agency for Substance Misuse*^{vi} have published a number of key documents to guide the commissioning of alcohol treatment services.

Models of Care for Alcohol Misusers (MoCAM)^{vii}, provides a framework for commissioning alcohol treatment services, and advises that a local treatment system should comprise four tiers of intervention:

- Tier 1:- Alcohol-related information and advice, screening, simple brief interventions and referral, provided by a range of generic services
- Tier 2: Open access, non-care planned, and alcohol specific interventions
- Tier 3: Community-based, structured, care planned alcohol treatment
- Tier 4: Alcohol specialist inpatient treatment and residential rehabilitation

The Alcohol Needs Assessment Research Project (ANARP) 2005^{viii} measured the gap between the demand for and provision of specialist alcohol treatment services at a national and regional level.

Alcohol Misuse Interventions: Guidance on developing a local programme of improvement^x provides guidance on developing and implementing local programmes to improve the care of hazardous, harmful and dependant

drinkers and identified £15 million of Government investment to improve the commissioning and delivery of alcohol treatment services.

*The Public Health White Paper Choosing Health*ⁱⁱⁱ outlined plans to pilot alcohol screening and brief interventions in primary care, Accident and Emergency and the Criminal Justice System. Working with the alcohol industry to develop an information campaign to reduce binge drinking and a voluntary social responsibility scheme for alcohol producers and retailers was also proposed.

*Reducing Alcohol harm: health services in England for alcohol misuse*ⁱⁱ – this report evaluates work by the Department of Health and the National Health Service to address the health effects of alcohol misuse.

Every Child Matters: Change for Children^x is the Government's vision for ensuring that agencies work together to protect and promote the well-being of children and young people. The Government's aim is for every child, whatever their background or circumstances, to have the support they need to:

- Be healthy
- Stay Safe
- Enjoy and achieve
- Make a positive contribution
- Achieve economic well-being



Department for Children, Schools and Families, Department of Health: Youth Alcohol Action Plan 2008^{xi} sets out what the Government will do to address drinking by young people in three main ways:

- Working with police and the courts to stop it, making it clear that unsupervised drinking by young people under-18 in public places is unacceptable;
- Recognising that drinking by young people in the home is clearly the responsibility of parents and families, but providing clearer health information for parents and young people about how consumption of alcohol can affect children and young people. The Action Plan announces that the Chief Medical Officer, Sir Liam Donaldson will produce clear guidelines for families;
- Working with the alcohol industry to continue the good progress made to reduce the sale of alcohol to under-18s but also in marketing and promoting alcohol in a more responsible way.

The National Institute for Health and Clinical Excellence (NICE)^{xii} is the independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health. NICE has 8 published guidelines related to alcohol issues:

- School-based interventions on alcohol.

- Interventions to reduce substance misuse among vulnerable young people.
- Sleep apnoea – continuous positive airway pressure (CPAP).
- Schizophrenia.
- Social and emotional wellbeing in primary education.
- Selective internal radiation therapy for colorectal metastases in the liver.
- Radiofrequency ablation for the treatment of colorectal metastases in the liver.
- Non-surgical reduction of myocardial septum.

NICE also has 4 guidelines in development:

- Alcohol dependence
- Alcohol use disorders – clinical management
- Personal, social and health education focusing on sex and relationships and alcohol education.
- Pregnancy and complex social factors.

3.4 Local Strategies, Plans, Assessments and Reviews that will link with the Harm Reduction Alcohol Strategy.

- Dealing with Alcohol, Drug and other substance misuse at work – NHS Dorset.
- Pan Dorset Harm reduction Strategy – Pan Dorset Harm Reduction Group.
- Dual Diagnosis Strategy, Development Plan and Implementation Plan – NHS Dorset, Dorset Drug and Alcohol Action Team.
- Children and Young People's Plan 2009-2012 - Dorset Children's Trust.
- DAAT Needs assessment.

3.5 Local Area Agreements linked with the Alcohol Harm Reduction Strategy.

Children and Young People

- NI 110 – Young people's participation in positive activities

Strong and Inclusive

- NI 4 - % of people who feel they can influence decisions in their locality

Children and Young People

- NI 115 – Substance misuse by young people

Education and Early Years

- Secondary school persistent absence rate

Strong and Inclusive

- NI 6 – Participation in regular volunteering

Health and Well-being

- NI 120 – All-age all cause mortality rate

Strong and Inclusive

- NI 2 - % of people who feel that they belong to their neighbourhood
- NI 23 – Perceptions that people in the area treat one another with respect and dignity

Safer Communities

- NI 20 – Assault with injury crime rate
- NI 32 - Repeat incidents of domestic violence
- NI 47 - People killed or seriously injured in road traffic accidents
- NI 15 - Serious violent crime rate
- NI 17 – Perceptions of anti-social behaviour
- NI 24 – Satisfaction with the way the police and local council dealt with antisocial behaviour
- NI 27 – Understanding of local concerns about antisocial behaviour and crime by the local council and police
- NI 41 – Perceptions of drunk or rowdy behaviour as a problem

4. Alcohol Harm in Dorset

The National Statistics give an indication of the problems presented by alcohol misuse across the Country. Similarly, a variety of local statistics show that alcohol misuse imposes a heavy cost – economic, social and personal cost on the people of Dorset.

4.1 Dorset

Dorset is a medium-sized County, with a smaller than average, sparsely distributed, rural population of approximately 400,000 people.

Dorset PCT covers the same geographical area as Dorset County Council, with boundaries from Lyme Regis in the West to Christchurch in the East, Portland in the South to Gillingham in the North.

It includes the urban conurbation of Weymouth and Portland, the seaside towns of Swanage and Lyme Regis, and the market towns of Bridport, Blandford, Dorchester, Sherborne, Shaftesbury, Sturminster Newton, Wimborne and Wareham.

Local alcohol profiles for 2006/07^{xiii} are available from the North West Public Health Observatory (appendix 1). They have been placed in localities for Dorset County with the South West and England data for comparison.

In October 2008 a Dorset lifestyle survey^{xiv} was undertaken by Market Research Group based at Bournemouth University, commissioned by Public Health Directorate – NHS Dorset, which included some questions about alcohol. 22,000 Dorset residents received a questionnaire, 6834 of which responded to the research within the field work period (31% response rate).

The aim of the survey was to collect information about the health status of the local population. It was designed to aid understanding of what services are needed to enable NHS Dorset to better plan and deliver local health services now and in the future.

The main findings were:-

- 70% of respondents reported drinking alcohol.
- 61% of respondents reported drinking their recommended units or less a week.
- Respondents most frequently reported drinking between 11 and 20 units per week (27%).
- On average respondents reported drinking the most on Saturdays (4.1 units) and the least on Mondays (1.9 units).
- The majority of respondents reported consuming one or more standard glass of wine (59%), 28% one or more single measure of spirits, 21% one or more pint(s) of normal strength beer and 19% one or more large glass of wine.
- 84% reported their alcohol consumption as typical for them.

4.2 Special Populations

There are also some groups in Society for whom alcohol misuse may be more of a problem. This may be because rates of alcohol misuse have potential to be higher than that in the resident population, as in the case of prisoners and the homeless^{iv}.

4.2.1 Children at risk due to parental drinking

Figures on the number of children who may be at risk of harm due to parental drinking are difficult to estimate accurately in Dorset. The only local data available relate to numbers of children on the child protection register where alcohol has been discussed as a factor at the initial case conference. This is shown in the table below. The data relates to initial case conferences only, and where alcohol or drug and alcohol use by parents has been discussed as a risk factor^{iv}.



Total number of case conferences and children at risk due to parental alcohol or alcohol and drug use, Dorset 2003-2005.

| | Initial conferences where drugs or alcohol are an issue | Total number of children | Children at risk due to parental alcohol use | Children at risk due to parental drug and alcohol use | Total at risk due to parental alcohol use |
|-----------|---|--------------------------|--|---|---|
| 2003-2004 | 52 | 112 | 56 | 27 | 83 |
| 2004-2005 | 53 | 107 | 36 | 41 | 77 |

4.2.2 Homelessness

Rough sleepers and homeless people are known to have high rates of use of illicit substances and alcohol. In Dorset approximately 70-85% are using alcohol regularly. The difficulty arises in estimating how many rough sleepers there are in Dorset. Local authorities are required to perform regular rough sleeper counts, but there is disagreement as to the accuracy of this exercise. In December 2005 the official rough sleeper count in Weymouth and Portland found 8 people met the Office for the Deputy Prime Minister's definition of a rough sleeper. Locally, providers of services put the figure at between 2 or 3 times that number^{iv}.

4.2.3 Prison Population

In Dorset there is a significant male prison population with over representation of black and minority ethnic people in some of the four prisons, for which NHS Dorset commission health services. There are roughly 2,000 prisoners at any one time being held in Dorset. Applying these proportions from the national survey data shows that there are significant needs in relation to alcohol misuse in the prison population. In a single year there are likely to be between 570 and 630 men in the prison estate who could well have significant needs in relation to alcohol misuse. Anecdotally approximately 10% of prisoners in Dorset are severely dependent on alcohol and require detoxification treatment whilst another 15-20% are hazardous/harmful alcohol misusers^{iv}.

4.2.5 Alcohol Misusers on substance misuse databases

Local data on people in Dorset with a drug and alcohol problem who have been treated by statutory services is submitted to the National Treatment Agency for Substance Misuse (NTA) via the National Drug Treatment Monitoring System returns, and it is people being treated for illicit drug misuse that are monitored in the main. Nonetheless, the database has some data relating to people treated for alcohol misuse as a main drug of misuse^{iv}.

4.2.6 Dual diagnosis of serious mental illness and alcohol misuse

The relationship between a serious mental disorder and alcohol misuse is complex in Dorset, as it is in the rest of England. The ongoing use of any substance can prolong the recovery of the individual's common mental health problem, and therefore a combined approach to treatment needs to be adopted. The education of primary care staff is an essential component in treating dual diagnosis in relation to the individual's needs^{iv}.

4.2.7 Domestic Violence and alcohol misuse

The term domestic violence covers a number of types of abusive behaviour including physical violence, psychological abuse and financial and sexual abuse. Women represent the largest group of victims with men as the perpetrators but men can also be abused and it is known that domestic

violence can occur between family members. What typifies domestic violence is that one person in a relationship has all the power and control over the other and victims are subjected to controlling and coercive behaviour by the perpetrator. Domestic violence often occurs in private and is associated with shame which makes it difficult for many victims to report it, particularly to the criminal justice agencies.

It is known that alcohol use or misuse is not causal in violent relationships – many men who drink and are violent to women are never violent to other people when drunk. However, it is generally believed that alcohol disinhibits an already abusive individual. This in itself can be very dangerous and presents an increased risk to the victim of being very badly hurt. Many men will use their drinking or alcohol “problem” as an excuse or justification for abuse and a small minority will be alcohol dependent. It is also known that many victims who have been subjected to abusive, controlling behaviour over a long period of time may end up using or abusing alcohol as a means of coping with the abuse and dulling the pain they feel. In summary, it is fair to say that alcohol is part of the pattern of domestic violence.

There is limited research information available on the links between alcohol and domestic violence. Some studies have found that women who report domestic violence are many more times more likely to misuse alcohol than women who do not report domestic violence. The most commonly reported finding is the association between drinking alcohol and being a perpetrator. National data from the British Crime survey 2003^{xv} found that domestic violence victims reported that 45% of perpetrators were under the influence of alcohol at the time of the assault.



In Dorset there is some evidence to show the links between alcohol and domestic violence. It is estimated that 30% of alcohol related assaults are linked to domestic violence and it is also known that in about 40% of domestic incidents attended by the police the perpetrator has been drinking.

Anecdotal information from domestic violence service providers suggests that alcohol is also an issue for victims. One outreach service reported that the numbers of clients with alcohol problems is increasing and that they had had five service users in 2008 with problems (two of whom had gone into recovery and no longer drank).

For victims, alcohol use or misuse can be problematic in that refuges and other services are often unable to support them due to safety concerns and that staff are not trained to deal with people in active substance misuse.

4.2.8 Teenage Pregnancy and alcohol misuse

The UK has the highest teenage pregnancy rate in Western Europe as well as one of the highest rates of alcohol use among teenagers in Europe. In Dorset, the rate of teenage conception for 15 to 17 year olds is lower on average (22.7 per 1,000 population in 2006, with 55% leading to termination)

than for the UK as a whole (40.7 per 1,000 population in 2006, with 48% leading to termination), however there are teenage conception hotspots across Dorset with rates in the top 20% of the UK^{xvi}.

Anecdotal evidence suggests that alcohol is often involved in teenage pregnancy; however there is a dearth of research that examines direct links between the two. It is more common for studies to explore the link between alcohol and risky sex, which is in turn a common risk factor in teenage conception. Studies have found that:

- young people under the influence of alcohol are less likely to use contraception
- many young people report that alcohol is the main reason they had sex, especially early sex or sex with someone they don't know
- young people are more likely to have sex they regret when under the influence of alcohol

The national Teenage Pregnancy Strategy aims to reduce teenage conception by 50% by 2010 from a 1998 baseline and each local authority or Primary Care Trust area has individual targets to contribute to this reduction. National strategies and guidance state very clearly that to succeed in reducing the rate of teenage conception, clear links need to be made between the use of alcohol and engaging in risky sex. A comprehensive needs analysis of teenage conception in Dorset is currently underway and the findings of this will link with this strategy.

5. Where we are now & where are the gaps?

The Needs assessment and consultations on which this strategy is based identified a wide range of activities which were already making a contribution to tackling problems of alcohol misuse in the county. It is by no means intended to be comprehensive as due to the complexity of current service provision there may be some services inadvertently overlooked. However, it does provide an overview of the main services currently on offer. The needs assessment also revealed a significant number of gaps in services which would need to be filled if the programme to reduce alcohol related harm is to be a comprehensive one.

5.1 Prevention

Schools in Dorset dedicate approximately 2-3 hours a term to specific lessons to alcohol use – this may be delivered by non specialist teachers. There has also been a shift within the healthy schools agenda for schools to focus on risk taking and consequences.

Life Education Dorset is a children's charity working with the community and schools to help children make vital healthy choices in life. Specially trained educators using mobile classrooms create a memorable environment to deliver a series of age appropriate health education programmes about the harmful effects and risks of eating badly, smoking, drinking alcohol and taking drugs.

Project Blitz, the award-winning project, aims to tackle the problem of alcohol related violent crime and anti social behaviour, through a 1 day programme of education, enforcement and support. The road show tours the majority of schools in Dorset and comprises a number of elements, including a showing of the play 'Last Orders', which is followed up by an alcohol workshop and a fire prevention and anti-social behaviour workshop. It is delivered by the 7 safer schools community teams involving Dorset Police, Youth Offending Team, Dorset Fire and Rescue and Dorset Trading Standards with involvement from SHADOWS and Solomon Theatre Company.

SHADOWS (Shire Alcohol and Drug Outreach Worker Service), is an outreach service set up for all young people under the age of 21 who live in the Dorset area. It aims to inform and educate about the realities and consequences of drug and alcohol use/misuse, so that hopefully wise choices can be made and problems avoided. SHADOWS works alongside the education service, providing input into drug and alcohol education, plus consultancy and support for pupils and teachers. SHADOWS also works in local Youth Information Centres and has links with the specialist prevention service (formerly ASSIST).

Solomon Theatre Company presents Last Orders in Schools to 11-14 year olds. The audience sees a cast of three re-enacting an evening of binge drinking. The play was developed by a team of doctors, police, teachers and actors to present a short drama that looks at the consequences of alcohol consumption by young people. Following the performance the audience then have the opportunity to interview the three characters in a "Jeremy Kyle" TV studio format. The young people discover the lessons they have learnt and are able to explore the issues in detail.

Youth Advisory Services play an important role in providing informal advice on a range of issues, and evidence in Dorset suggests concerns around alcohol form a significant proportion of the workload.

Public Health have appointed a Health Programme Advisor in Harm Reduction who is working in partnership with stakeholders to commission services to meet Dorset's need for alcohol services. Also Public Health are networking with the Crime and Disorder Reduction Partnership to make the Dorset population aware of the sensible drinking message via a local alcohol campaign whilst working with local pub watch groups and supermarkets supported by local media.



Know your colour launch
November 2008

Talking Shop is an interactive consumer education package run by Trading Standards. It brings the subjects of consumer rights, food and nutrition and anti social behaviour to life through role play via the internet. Talking Shop contributes to the National Curriculum for citizenship key stage 4. Pupils in small teams deal with real life situations. They are able to interact, via instant message, with Trading Standards professionals who have the knowledge and skill to provide instant feedback to queries. One scenario is anti-social behaviour and

underage sales, students have to organise a party for their social year. They come up against issues such as using fake ID to buy alcohol, hoax calls, graffiti and vandalism and bullying.

In Christchurch, the **MAYO** (Multi-Agency Youth Outreach) project is a successful collaboration between Dorset Police, Christchurch Borough Council, Christchurch Youth Service, and community outreach and advisory services: Shadows, Connexions, Ladders and Impact.

The main aim of the project is:

- To meet and engage young people 'where they are at' and encourage them to stay safe; be healthy; achieve and have their achievements recognised, make a positive contribution to their communities and with the previous four points in mind....enjoy life.

Dorset Health Scrutiny Committee review of Alcohol misuse and the risks to young people's health and behaviour - The Dorset Health Scrutiny committee is a watchdog on local NHS health services. From time to time they look at one particular health issue in more detail.

The Dorset Health Scrutiny Committee identified the topic of alcohol misuse and the risks to young people's health and behaviour as an area of concern that it wished to investigate further when drawing up its work programme for April 2008 to March 2009. This concern was in recognition that when young people drink they take risks that impact on them, their families, the wider community and the key agencies that are supporting young people in Dorset. A full scrutiny review was started in June 2008 and will conclude in the spring of 2009. The aim of the review is to achieve the following:

(A) To make a difference to the extent alcohol is misused by young people in Dorset by ensuring that:

- a. Education on alcohol is comprehensive and covers the whole range of consequences of alcohol misuse and challenges young people's misconceptions.
- b. A range of mechanisms exist within Dorset to divert young people away from alcohol misuse and its related consequences.
- c. A range of early and co-ordinated interventions are initiated when a young person comes into contact with any service as a result of an alcohol related event.
- d. The availability of alcohol to under 18's is reduced as far as possible.

(B) To achieve an understanding of:

- e. The different environments and the extent to which under 18's in Dorset drink, to include socio- economic factors, urban and rural differences, age, ethnicity and gender.

- f. The risks young people are exposed to through drinking. This will include risks to general health, sexual health and engaging in antisocial behaviour, violence and potentially dangerous sexual behaviour.

The progress made by agencies in delivering preventative work in relation to national and local (LAA) targets the reduction of harm caused by alcohol.

The final report of the scrutiny review will contain a number of recommendations, for relevant bodies and organisations which the Dorset Health Scrutiny Committee will want to see action on. The Committee will monitor progress made against these recommendations on a regular and ongoing basis.

Gaps

- No intelligence about what schools are doing on drug and alcohol education.
- No consistency and coordination of drug and alcohol programmes within the school environment.
- Lack of evidence surrounding alcohol education in Learning Centres (PRU's).
- No rolling programme after Blitz has presented to the school.
- Lack of training and resources within schools to provide correct information regarding alcohol.
- No generic message given out in the county of Dorset regarding low risk drinking for all age groups.
- No statutory provision of consistent education or training around identifying alcohol problems.
- No local leaflets specifically focusing on young people and alcohol misuse, including underage sales.
- Lack of clear information for both young people and parents about the risks associated with drinking alcohol.
- Lack of resources to develop SHADOWS into schools and for outreach activities also to give brief intervention to young people who are already misusing alcohol, especially in areas of need (Weymouth and Portland) 4.5 workers for the whole of Dorset.
- No community projects in the west, south and north of Dorset which mirror MAYO Christchurch project.

5.2 Intervention/Treatment

Health settings are among the most important settings in which to identify problem drinkers. This is because most people visit their GP at least once a year, and alcohol misusers are also likely to present to general practice more often than non-misusers. However, previously unidentified alcohol misusers may also present to A&E Departments as well as to criminal justice settings such as Youth Offending team, the probation service and the police.

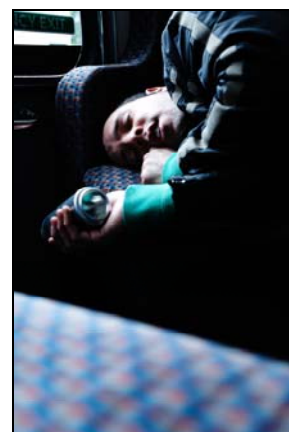
In Dorset General Practitioners routinely enquire about alcohol consumption as part of new patient registrations. However, the degree to which people report their drinking habits accurately at new patient checks is unknown. Despite most of the resident population visiting their GP within a year, it is clear that many people with alcohol misuse disorders also go undiagnosed in primary care. The extent to which local GP's in Dorset are confident in dealing with alcohol misuse also varies.

The **Dorset Youth Offending Team (YOT)** works with young people in Dorset (ages 10-17) who have committed offences. All cases are screened for their alcohol use. If problems are identified an internal referral is made to the YOT's health team, which consists of 3 registered nurses and a psychologist. The health workers undertake a comprehensive assessment on all referrals. The health team delivers Tier 3 and Tier 2 alcohol treatment, and supports other team members in the delivery of Tier 1 interventions, using a range of information and treatment resources, and a motivational interviewing approach to encourage behaviour change.

Arrest Referral Scheme is one of a series of Criminal Justice Interventions that seek to identify problem substance misusing offenders in the Criminal Justice System (CJS) and refer them to treatment. The aim is that a dedicated substance misuse worker, working in police custody cells, makes contact with substance-misusing arrestees and refers them to appropriate treatment aiming to reduce their substance misuse related offending. Involvement with the scheme is voluntary and it is not an alternative to prosecution or due process. Being focused on the point of entry to the CJS, this initiative aims to identify and help problem substance misusing offenders as early as possible.

Treatment Services

In addition to the above there is a range of non-statutory and statutory partners in Dorset that provide services for young people and adults who misuse alcohol. Almost without exception these are services for drug and alcohol misusers rather than dedicated alcohol misuse services. Generally, services for people who are seeking help and advice to control their drinking are provided by non-statutory dedicated drug and alcohol agencies that have charitable status, although they may be commissioned by NHS Dorset or DCC as part of the statutory response to problems. These agencies may also provide some treatment, in the form of structured counselling. One exception to this is **Alcoholics Anonymous (AA)** a fellowship of people affected by alcohol that advocates an abstinence-based approach to treatment. AA sits outside of the statutory response to alcohol misuse problems, but plays an important role in helping many (an unknown number due to anonymity) drinkers remain free from alcohol misuse. Specialist treatment services are generally provided by multi-disciplinary teams delivered by NHS mental health organisations. Highly specialist and inpatient detoxification services for alcohol misuse are



provided by NHS mental health inpatient units around Dorset.

EDAS – The Essential Drug and Alcohol Service manages the ADCAP project across Dorset. This is a locality based relapse prevention service for those in recovery from their substance misuse problem. It is an abstinence based service commissioned by the Drug and Alcohol Action team and offering one to one and group work treatment.

EDP – Are commissioned to offer open access provision in localities across Dorset. Often based from drop in centres, they offer harm reduction advice, information, motivational interventions and signposting to treatment services.

Statutory Treatment Services - Dorset services for alcohol misusers are generally provided on an East/West basis. People over the age of 18 requiring treatment who live in the West and North of the County are assessed and treated by the **Community Alcohol and Drugs Advisory Service (CADAS)**. In the East people over the age of 18 are assessed and treated by the **South East Dorset Community Drug and Alcohol Team (SEDCDAT)**. In both the East and West of the County there is agreement that work within these agencies should be provided by integrated drug and alcohol teams, comprised of substance misuse workers, not split into separate teams for drugs and alcohol. The fact that many clients are poly drug and alcohol users means it is important to focus on both.

CADAS (Genesis) in Weymouth began as a harm reduction service in response to HIV/AIDS with input from sexual health services. Its remit today is drug and alcohol harm minimisation.

Specialist Prevention Treatment Service is provided by Dorset County Council. The service for young people has five work streams, including one for young people who require treatment for substance misuse problems. The service sees young people between the ages of 10 and 21 years, with the main age group 14-15 years old. It will also see young people who have drug and/ or alcohol using parents. The specialist prevention team will see young people on a case by case basis at a range of rural locations, including people's homes, schools and youth centres.

Referrals come via a range of sources, including schools, GP's, Social services and self-referrals. There are also good links with CADAS and SEDCDAT.

The **Dorset Service User Forum** raises awareness by using the experience and knowledge of service users, from across Dorset and to make sure the service user voice is heard. The forum engages with service users locally to listen to their concerns, whilst ensuring communication is sustained between service users, service providers, the Drug and Alcohol Action Team and the National Treatment Agency.

The **Dorset Drug and Alcohol Action Team (DAAT)** is a statutory partnership of the Police, County Council, NHS Dorset, Probation, local Prisons and service users.

A small staff team act as the officers supporting the partnership based in the Colliton Annexe next to County Hall. They operate as part of the County Council's Drug Action and Community Safety Team recognising the links to crime associated with substance misuse.

Their key role is as commissioners of services for people with substance misuse problems, attempting to minimise the negative impact on individuals, their families and communities through the misuse of substances. Each year they draft treatment plans for adults, young people and the local prisons. These plans reflect the goals the DAAT have set for the year ahead and throughout the year they continuously review their implementation.

The DAAT has supported the establishment of a service user forum for substance misuse in Dorset. The Forum represents service users in giving feedback on the effectiveness of our services and is available to support, and advocate for, a service user.

Gaps

- Lack of intelligence surrounding young people and the extent alcohol is abused in Dorset.
- No generic brief intervention information packs, sign posting or a referral system in all health care settings including GP's, A&E Departments, Occupational Health Departments, pharmacies and Outpatient Departments.
- Need for training to identify harmful and hazardous drinking and to provide brief interventions in front line settings e.g.: Outpatients, Pre-assessment Units, Schools, Children's Ward in the acute hospital.
- Lack of identification of A&E attendees for alcohol misuse and co-ordinated support across services and community settings, through agreed pathways of care, to ensure appropriate brief interventions support and referral is provided.
- Lack of funds, resources and coordination for specific alcohol treatment and rehabilitation in relation to individuals needs.
- Lack of coordinated alcohol commissioning with agreed targets and performance management in place based upon annual needs assessments and underpinned by agreed sustainable funding streams.
- Clearer identification of services with the prison environment.
- Clearer identification of individuals with a dual diagnosis in the primary care setting.
- Very limited provision and choice for Tier 4 treatment for under 18s (It is rarely needed, but important when it is and using adult provisions may not be appropriate).

5.3 Enforcement

Pubwatch Schemes are an initiative in Dorset to promote a sensible attitude to alcohol and drinking, leading to a relaxed and safe environment in local licensed premises. The idea is that by working



together local authorities, police and licensees can make pubs and clubs in Dorset even safer which is good for licensees, their customers, Dorset businesses and local residents. Areas in Dorset where pub watch schemes are being implemented are Weymouth, Dorchester, Bridport, and Sherborne.

Blitz 3 targets offenders who are found guilty of, or who admit to, offences of an anti-social or violent nature when under the influence of alcohol. The scheme operates in association with Pubwatch and repeat offenders can expect to receive a civil ban.

Dorset Police are one of 8 'Responsible Authorities (RA)', the other 7 listed below;

- Environmental Health Authority
- Health and Safety Authority
- Trading Standards
- Planning Design and Control Services
- Child Protection
- Dorset Fire Authority
- Marine and Coastguard Agency

The police will follow an intelligence led approach in partnership with the other RA & our communities across Dorset to ensure licensed venues (on & off licenses) promote the four licensing objectives;

1. Prevention of Crime & Disorder
2. Public safety
3. Protection of children
4. Public Nuisance

The police & Local Authorities will identify venues / areas that pose the greatest risk in relation to crime & disorder. This will allow licensing authorities the ability to exercise more caution & conditions when issuing licenses or undertaking a review hearing.

The police have a responsibility to enforce the law but will work closely with venues offering support & advice to ensure alcohol is retailed in a responsible manner & increase the level of trust & confidence in Dorset police within the licensing trade & our communities.

In exceptional circumstances Police will utilise their formal powers under the Licensing Act 2003 when one or more of the licensing objectives are undermined.

Crime and Disorder Reduction Partnerships

The Western Dorset Crime and Disorder Reduction Partnership (CDRP) cover the areas of both West Dorset District and Weymouth and Portland borough. Some of the projects that have been set up in partnership include an anti

social behaviour team, the Closed Circuit Television (CCTV) scheme and an arrest referral scheme.

The Eastern Dorset Crime and Disorder Reduction Partnership (CDRP) approach has been to work with existing community groups as well as establishing new community action groups in other parts of the district to help strengthen communities. The Eastern Dorset CDRP includes Christchurch Borough Council, East Dorset, North Dorset and Purbeck District Councils.



The partnerships meet four times a year, with several sub-groups that meet more frequently, working on key issues such as anti-social behaviour, burglary, CCTV, Domestic Violence, vehicle crime, violent crime and hate crime.

Wimborne Minister Prohibition of Drinking in the Streets – In March 2000 the bylaw was introduced on the streets of Wimborne Minister. During the evening Wimborne attracts large numbers of people, this is due to the popularity of the town as a venue for socialising and to the presence of one of only two drop in centres in the District. The bylaw remains an effective tool for the Police who have enforced it even through events such as the annual folk festival and New Year festivities.

Designation Orders for Dorchester, Bridport and West Bay – the effect of the orders is that since the 31st March 2007 it is offence if a person fails to comply with a request from a uniformed Police Community Support Officer to stop drinking any intoxicating liquor and/or fails to hand over to the officer any containers of such liquor in the designated area. It is an arrestible offence, which carries with it a maximum level 2 on the standard scale (currently £500) if convicted.

Trading Standards have a responsibility to enforce the laws which cover the sale of certain goods to people who are too young to buy them. Regular test purchasing exercises are carried out using volunteers aged about 15. These volunteers will try to buy alcohol, cigarettes, fireworks or similar, and if they are successful then the retailer may be cautioned or prosecuted.

Proof of age cards are provided free of charge by Trading Standards to school age children in Dorset. They also operate a “Responsible Retailers” scheme which tells retailers what their responsibilities are and how to make sure they do not sell to people under age.

Weymouth Street Pastors - Street Pastors in Weymouth Town Centre were launched in June 2008. Street Pastors is a church-based initiative where a small team walks the streets of the town in order to help those who are vulnerable within the night-time economy of the pubs and clubs scene. The Street Pastors come alongside people in time of need to listen, care and offer practical help towards making the vulnerable safe.

SSCT (Safe Schools and Communities Team), a partnership between Dorset Police and Dorset Youth Offending Team (YOT) works with police Safer Neighborhood Teams and other partners in the community to:

- Target anti-social behaviour issues such as truancy, alcohol/substance misuse, and bullying
- Arrange and facilitate restorative meetings and interventions
- Provide advice, materials and equipment to enhance engagement with young people through schools and other forums
- Run cyber safety programmes for parents, pupils and teachers to increase awareness of the risks associated with internet use

Gaps

- No Pubwatch scheme in some areas of Dorset, where there may be a need.
- Lack of intelligence surrounding activities of night time economy.
- Proof of age cards not mandatory.
- Lack of a scheme for off licenses that mirrors the Pubwatch scheme.
- Lack of publicity to identify excellent licensees and to give a positive picture of good publicans.
- Lack of intelligence of A&E alcohol incidents related to violent crime.

6. Where do we need to get to – our Aims, Outcomes and Objectives

This Strategy identifies aims, outcomes and objectives that will set out a framework for action between the spring of 2009 and the spring of 2012.

6.1 Aim of the Strategy

The Alcohol Strategy aims to reduce the negative effects of alcohol on the population of Dorset, in relation to criminal activity, anti-social behaviour and physical and mental health as well as family welfare, whilst ensuring that the population of Dorset are able to enjoy alcohol safely and responsibly.

6.2 The Key Outcomes are:

| OUTCOMES | HOW THE OUTCOMES WILL BE MEASURED |
|---|--|
| 1. A reduction in Hazardous Drinkers in Dorset County. | Lifestyle Survey – Commissioned by Public Health NHS Dorset, Local/PCT Alcohol Profiles. |
| 2. A reduction in Harmful Drinkers in Dorset County. | Lifestyle Survey – Commissioned by Public Health NHS Dorset, Local/PCT Alcohol Profiles. |
| 3. An increase of 5% year on year for the life of the strategy of the numbers of individuals engaged into effective treatment. | HALO/NDTMS returns from treatment providers against a baseline to be established this year. Local measures for effective treatment i.e. care planned discharges, monitored by DAAT. |

| | |
|---|--|
| 4. Fewer incidents of alcohol related crime. | Police Statistics, Home Office data, Local/PCT Alcohol Profiles. |
| 5. Fewer accidents caused by alcohol. | Police Statistics, A&E Data, Acute Hospital Data, South West Ambulance data, Dorset Fire and Rescue Data. |
| 6. A reduction in alcohol related mortality. | Hospital Episode Statistics (HES), Local/PCT Alcohol Profiles. |
| 7. A reduction in the number of young people known to be drinking and causing harm to others. | Police Statistics, Youth Offending Team Data, Absenteeism for school – alcohol known cause, Tell-us Survey (Links with NI 115 LAA). |
| 8. A reduction in perceived perceptions of drunk or rowdy behaviour. | Police and Communities Together meetings, Lifestyle Survey, Local Authority Citizen panels, local media reports, Fear of Crime Survey. |

6.3 Objectives

The objectives are set out in three agreed themes:-

1. **Prevention**
2. **Intervention/Treatment**
3. **Enforcement**

An overarching common objective to cover all three themes has been agreed and needs to be taken into consideration for each action identified:-

Utilise the experience and expertise of service users

6.3.1 Prevention

Rationale:

One of the National Strategy's three focus areas is young people under 18 (and especially those aged 11-15 years). The government has developed guidance for young people and their parents on the harm associated with alcohol abuse.



Initial findings from the National Institute for Clinical Excellence (NICE)^{xii} evaluation of the effectiveness of schools-based alcohol interventions (November 2007) suggest that programmes which begin in early childhood and which combine schools-based curriculum intervention with parental education targeting problem behaviour (including alcohol misuse) are the most likely to have long-term effects on heavy and patterned drinking behaviours.

The Government's update to the National Alcohol Harm Reduction Strategy^v for England demonstrates that, despite a broad public awareness of the harms that alcohol can cause to self and others if drunk in excess, a detailed understanding of the extent and seriousness of these harms is generally lacking. An accepted culture of heavy drinking, to which many 13 and 14 year

olds have already been introduced, is taking an increasing toll on community health, and is now so deeply entrenched that only a sustained educational programme, targeting a wide range of age-groups, is likely to increase understanding and thus change behaviour.

Objective 1:

Educate children and young people to stop/prevent them from harming themselves and others by making them aware of the risks of drinking to excess, through generic education, targeted education (young people at risk), Peer Education, Youth clubs, media and events.

Objective 2:

Improve systems of communication for parents regarding the risks of excess drinking and in influencing their children's drinking behaviour through the media, workplace education, and other settings (Children's Centres, Schools and Community).

Objective 3:

Educate adults, young people and children, particularly targeting those social groups known to consume greater amounts of alcohol and/or with a higher prevalence of alcohol related problems. Education needs to incorporate, increased knowledge of harm, life skills, improved confidence and self-efficacy and an understanding of values, particularly in relation to risk.

6.3.2 Intervention/Treatment

Rationale:

Early screening and referring people showing signs of misusing alcohol to appropriate sources of support and treatment is crucial in reducing longer-term harm. One concern is that increased screening may lead to unsupportable demands on treatments services. However, the majority of those assessed are likely to need only a 'brief intervention' – concise information and advice, ideally provided shortly after the individual has experienced an incident or accident and is more likely to be responsive.

A particular area of concern is the identification of parents with substance misuse problems and the impact this has on their children. National research shows that living within a family where one or both parents are misusing alcohol often results in behavioural problems and low school outcomes whilst also increasing the risk of the child starting drinking at an earlier age.

However, analysis from the United Kingdom Alcohol Treatment Trial suggests that for every £1 spent on alcohol treatment, the public sector saves £5ⁱ.

Objective 4:

Develop the capacity of health and other appropriate front line staff to deliver brief interventions to maximise the opportunity of the ‘teachable moment’, whilst identifying hazardous, harmful and dependent drinkers who may need sign posting to appropriate services in relation to the individual’s needs.

Objective 5:

Improve care pathways and the targeting of appropriate treatment and support in relation to people’s needs.

Objective 7:

Identify, at the point of arrest, the offender whose offending is alcohol-related, and refer them on for brief interventions and/or treatment.

Objective 8:

Provide co-ordinated, appropriate services to help people who have problems as a result of alcohol misuse, as well as their families or carers.

6.3.3. Enforcement

Rationale:

The links between alcohol misuse and crime – and especially between binge drinking and violent crime and disorder – are well-established, and borne out by some of the statistics quoted in the introduction to this strategy.

Behaviours that can be unleashed by excessive drinking, whether in the town centre or in the privacy of people’s homes, can have a damaging impact on individuals, families and communities; an effective strategy to reduce this damage requires a concerted and co-ordinated effort by the Crime and Disorder Reduction Partnership in Dorset.

The role of licensees and their staff in reducing irresponsible and illegal use of alcohol is critical if personal and social harm is to be reduced. Many local licensees are already fulfilling their legal and social obligations but Trading Standards confirm that over a quarter of off licensees are still being found selling alcohol to under-18s and there is concern about proxy purchasing by parents and other adults. There is an inherent tension between commercial considerations and the need to support safe levels of consumption. Staff, particularly those who are younger and less experienced, may also lack the skills and confidence to challenge those attempting to drink under-age or when they are already drunk. Further training and support is needed to enable them to fulfil the legal requirements of their work.

Objective 9:

Effective management and partnership co-ordination of alcohol related criminal incidents and anti-social behaviour, in order to prevent similar incidents in the future.

Objective 10:

Actively regulate the supply of alcohol to reduce alcohol misuse, but allow for age-appropriate and responsible drinking within healthy limits.

Objective 11:

Create safer environments in which people drink, both in private and in public.

Objective 12:

Effective management and co-ordinated partnership working of alcohol related accidents (Drink driving, etc), in order to prevent similar accidents in the future.

7. How we're going to get there – Implementation

The limited central government funding allocated for alcohol services, in contrast to the substantial sums devoted to tackling drug misuse, makes it imperative to get right the framework and procedures which will steer the alcohol strategy over the next three years. However a successful alcohol strategy will not be judged merely by its effect in three years but indeed over a much longer period, and progress will only be maintained if there is both a strong collective will to give alcohol misuse a high priority and a recognition of the importance of getting the systems right.

Wherever possible, existing services, structures and post-holders should be used to steer the implementation of the strategy.

- Strategy co-ordination is key to effective implementation of the strategy and therefore serious consideration needs to be given to the most effective way of ensuring that this key role is of appropriate status and standing amongst partner organisations.
- An implementation planning group will be formed by the lead partners of each action in order to take the actions forward.
- Accountability for the achievement of the aims and objectives of the strategy should be clearly identified, with the nominated lead, for each of the actions, for non-delivery or slippage.

- Service users, both adults and young people, should be in a position to influence the course of the strategy, give feedback on its implementation and contribute to decisions about any changes in direction.
- Robust business cases and project plans should be developed at an early stage to enable the implementation of services, projects and plans. Business cases should demonstrate innovation, service redesign and robust financial planning.

8. Monitoring, evaluation and review

The steering and implementation group is key to taking this strategy forward.

The strategy will mould the areas to be developed and priority schemes to be funded (alongside identifying coordinated opportunities for new funding) and developed.

This task will need be underpinned by joined-up commissioning. The steering and implementation group will organise annual needs assessment and the commissioning of services locally to meet these needs, using pooled resources to greatest effect.

With agreed targets in place within contracts, services can then be performance-managed to ensure clear, effective and positive outcomes for service users.

In this way the implementation of the strategy can be monitored and subject to continuous review. It can be continuously refreshed and evaluated to achieve ongoing relevance.

The contents of the strategy should be open to change in the light of new information, changes in funding regimes or new central government initiatives.

The links between the alcohol strategy and other relevant strategies should continue to be identified and made explicit. Those with the responsibility for drafting new strategies should be required to take account of the alcohol strategy when formulating future strategies.

9. References

- i** National Alcohol strategy (2004) – Department of Health, Home Office, Department for Education and Skills, Department for Culture, Media and Sport.
- ii** Reducing Alcohol Harm: health services in England for alcohol misuse (2008) – National Audit Office.
- iii** Choosing Health: Making healthy choices easier (2004) -Department of Health.
- iv** Improving health services for alcohol misuse in Dorset – a systemic assessment of needs (2006) – Sam Crowe Public Health Specialist Trainee.
- v** Safe, Sensible, Social – National Alcohol Strategy the next steps (2007) - Department of Health, Home Office, Department for Education and Skills, Department for Culture, Media and Sport.
- vi** Multiple publications - National Treatment Agency (2004 – present).
- vii** Models of care for alcohol misusers (MoCAM) (2006) – Department of Health.
- viii** Alcohol Needs Assessment Research Project (ANARP): The 2004 national alcohol needs assessment for England (2005) -Department of Health; University of London. St George's. Division of Mental Health. Section of Addictive Behaviour; Kable Limited; MORI Social Research Institute.
- ix** Alcohol Misuse Interventions: Guidance on developing a local programme of improvement (2005) – Department of Health.
- x** Every Child Matters: Change for Children – Department of Health.
- xi** Alcohol Action Plan (2008) – Department for Children, Schools and families, Department of Health.
- xii** Multiple publications(2004 – present) - National Institute for Health and Clinical Excellence.
- xiii** Local Alcohol Profiles (2006/07) - www.nwpho.org.uk/alcohol

- xiv** Lifestyle Survey (2008) - Market Research Group - Bournemouth University
- xv** British Crime Survey
- xvi** Alcohol and Teenage Pregnancy (2002) - Alcohol Concern.

Appendix 1

Data from www.nwpho.org.uk/alcohol

2006/07 Data for Alcohol Related Issues

DEFINITION: Confidence Intervals or limits (CI) are used to give a range of values within which there is a degree of certainty that the values are correct, and to assess if the values are significantly different from that of the reference population. This range is required as there is likely to be some variation that occurs by chance. (A small number of events or a small sample population will tend to produce wide confidence intervals i.e. a large difference between the upper and lower confidence limits – which you will see in some of these graphs showing alcohol data). These graphs show 95% confidence intervals which means we can be 95% certain that the real value will fall somewhere between the values of the two confidence limits 95 times out of 100.

Under 18 Hospital Admissions due to alcohol-specific conditions (1)

| Local Authority | Hospital admissions due to alcohol-specific conditions for persons under 18 years. Crude rate per 100,000 under 18 population | Lower 95% CI | Upper 95% CI |
|-----------------------|---|--------------|--------------|
| Christchurch | 69.5 | 40.5 | 111.4 |
| East Dorset | 69.3 | 48.0 | 96.8 |
| North Dorset | 61.0 | 40.6 | 88.2 |
| Purbeck | 109.1 | 73.0 | 156.6 |
| West Dorset | 73.9 | 53.7 | 99.2 |
| Weymouth and Portland | 148.4 | 112.7 | 191.9 |
| South West | 81.2 | 78.1 | 84.4 |
| England | 72.5 | 71.6 | 73.5 |

Alcohol specific hospital admissions – males (2)

| Local Authority | Male hospital admission for alcohol-specific conditions. DSR per 100,000 population | Lower 95% CI | Upper 95% CI |
|-----------------------|---|--------------|--------------|
| Christchurch | 258.6 | 186.7 | 347.3 |
| East Dorset | 145.1 | 107.3 | 190.9 |
| North Dorset | 155.3 | 114.5 | 205.4 |
| Purbeck | 288.9 | 220.1 | 371.4 |
| West Dorset | 282.0 | 230.9 | 340.3 |
| Weymouth and Portland | 462.0 | 390.3 | 542.8 |
| South West | 337.4 | 330.2 | 344.6 |
| England | 369.0 | 366.6 | 371.4 |

Alcohol specific hospital admissions – females (3)

| Local Authority | Female hospital admission for alcohol-specific conditions. DSR per 100,000 population | Lower 95% CI | Upper 95% CI |
|-----------------------|---|--------------|--------------|
| Christchurch | 88.6 | 51.1 | 141.1 |
| East Dorset | 80.3 | 53.2 | 114.8 |
| North Dorset | 120.6 | 85.0 | 165.3 |
| Purbeck | 204.1 | 145.4 | 277.7 |
| West Dorset | 157.9 | 121.4 | 201.0 |
| Weymouth and Portland | 219.4 | 169.3 | 279.1 |
| South West | 170.3 | 165.2 | 175.5 |
| England | 176.1 | 174.5 | 177.8 |

Hospital admissions for alcohol related harm. (NI39) (4)

| Local Authority | Hospital admission for alcohol-related harm. All persons DSR per 100,000 population | Lower 95% CI | Upper 95% CI |
|-----------------------|---|--------------|--------------|
| Christchurch | 967 | 877 | 1058 |
| East Dorset | 745 | 690 | 800 |
| North Dorset | 1088 | 1014 | 1163 |
| Purbeck | 1187 | 1092 | 1282 |
| West Dorset | 1065 | 1000 | 1130 |
| Weymouth and Portland | 1347 | 1262 | 1431 |
| South West | 1315 | 1305 | 1324 |
| England | 1384 | 1381 | 1387 |

Alcohol related recorded crimes (5)

| Local Authority | Recorded crime attributable to alcohol. Crude rate per 1000 population | Lower 95% CI | Upper 95% CI |
|-----------------------|--|--------------|--------------|
| Christchurch | 5.01 | 4.38 | 5.71 |
| East Dorset | 3.10 | 2.74 | 3.50 |
| North Dorset | 3.81 | 3.35 | 4.30 |
| Purbeck | 5.13 | 4.49 | 5.84 |
| West Dorset | 4.93 | 4.49 | 5.39 |
| Weymouth and Portland | 11.86 | 11.04 | 12.73 |
| South West | 7.67 | 7.59 | 7.74 |
| England | 9.20 | 9.18 | 9.23 |

Alcohol related violent crimes (6)

| Local Authority | Violent crime attributable to alcohol. Crude rate per 1000 population | Lower 95% CI | Upper 95% CI |
|------------------------|--|---------------------|---------------------|
| Christchurch | 4.09 | 3.52 | 4.73 |
| East Dorset | 2.20 | 1.90 | 2.54 |
| North Dorset | 2.85 | 2.46 | 3.28 |
| Purbeck | 3.86 | 3.31 | 4.48 |
| West Dorset | 3.80 | 3.42 | 4.21 |
| Weymouth and Portland | 10.38 | 9.61 | 11.20 |
| South West | 5.70 | 5.63 | 5.76 |
| England | 6.53 | 6.50 | 6.55 |

Alcohol related sexual offences (7)

| Local Authority | Sexual offences attributable to alcohol. Crude rate per 1000 population | Lower 95% CI | Upper 95% CI |
|------------------------|--|---------------------|---------------------|
| Christchurch | 0.11 | 0.04 | 0.26 |
| East Dorset | 0.07 | 0.03 | 0.16 |
| North Dorset | 0.09 | 0.03 | 0.19 |
| Purbeck | 0.08 | 0.02 | 0.21 |
| West Dorset | 0.09 | 0.04 | 0.17 |
| Weymouth and Portland | 0.14 | 0.07 | 0.27 |
| South West | 0.12 | 0.11 | 0.13 |
| England | 0.13 | 0.13 | 0.13 |

Mortality from land transport accidents due to alcohol (8)

| Local Authority | All persons mortality from land transport accidents attributable to alcohol. DSR per 100,000 population | Lower 95% CI | Upper 95% CI |
|------------------------|--|---------------------|---------------------|
| Christchurch | 1.86 | 0.26 | 3.46 |
| East Dorset | 2.54 | 1.12 | 3.96 |
| North Dorset | 2.88 | 1.48 | 4.30 |
| Purbeck | 1.32 | 0.01 | 2.63 |
| West Dorset | 1.67 | 0.72 | 2.63 |
| Weymouth and Portland | 1.95 | 0.74 | 3.17 |
| South West | 1.90 | 1.77 | 2.03 |
| England | 1.83 | 1.79 | 1.87 |

Hazardous drinking - synthetic estimates (9)

| Local Authority | Synthetic estimate of the percentage of the population aged 16 years and over who report engaging in hazardous drinking | Lower 95% CI | Upper 95% CI |
|------------------------|--|---------------------|---------------------|
| Christchurch | 17.8 | 16.5 | 19.2 |
| East Dorset | 19.1 | 17.6 | 20.6 |
| North Dorset | 19.9 | 18.3 | 21.4 |
| Purbeck | 20.4 | 18.8 | 22.0 |
| West Dorset | 19.1 | 17.6 | 20.6 |
| Weymouth and Portland | 19.0 | 17.4 | 20.5 |
| South West | 19.6 | 18.0 | 21.2 |
| England | 20.1 | 18.4 | 21.8 |

Harmful drinking - synthetic estimates (10)

| Local Authority | Synthetic estimate of the percentage of the population aged 16 years and over who report engaging in harmful drinking | Lower 95% CI | Upper 95% CI |
|------------------------|--|---------------------|---------------------|
| Christchurch | 3.68 | 3.34 | 4.02 |
| East Dorset | 3.53 | 3.20 | 3.86 |
| North Dorset | 4.04 | 3.62 | 4.47 |
| Purbeck | 4.08 | 3.68 | 4.49 |
| West Dorset | 3.84 | 3.48 | 4.21 |
| Weymouth and Portland | 4.58 | 4.10 | 5.05 |
| South West | 4.45 | 3.98 | 4.92 |
| England | 5.03 | 4.50 | 5.57 |

Binge drinking - synthetic estimates (11)

| Local Authority | Synthetic estimate of the percentage of the population aged 16 years and over who report engaging in binge drinking | Lower 95% CI | Upper 95% CI |
|------------------------|--|---------------------|---------------------|
| Christchurch | 13.5 | 11.4 | 15.8 |
| East Dorset | 13.1 | 11.3 | 15.2 |
| North Dorset | 14.9 | 12.9 | 17.1 |
| Purbeck | 14.2 | 12.4 | 16.3 |
| West Dorset | 13.7 | 11.9 | 15.8 |
| Weymouth and Portland | 15.8 | 13.8 | 18.0 |
| South West | 15.3 | 13.7 | 17.0 |
| England | 18.0 | 17.4 | 18.6 |

| Footnotes | Definition |
|-----------------------|---|
| Alcohol-specific | Conditions that are wholly related to alcohol (e.g. alcoholic liver disease or alcohol overdose). A list of alcohol-attributable conditions with their ICD-10 codes and associated attributable fractions can be found at: http://www.nwph.net/nwpho/publications/AlcoholAttributableFractions.pdf |
| Alcohol-attributable: | Alcohol-specific conditions plus conditions that are caused by alcohol in some, but not all, cases (e.g. stomach cancer and unintentional injury). For these latter conditions, different attributable fractions are used to determine the proportion related to alcohol for males and females. A list of alcohol-specific conditions with their ICD-10 codes can be found at: http://www.nwph.net/nwpho/publications/AlcoholAttributableFractions.pdf |
| CHART 1 | Persons admitted to hospital due to alcohol specific conditions (under 18s, persons), crude rate per 100,000 population. Numerator counts of between 1 and 5 have been suppressed (indicated as *). (NWPHO from Hospital Episodes Statistics 2004/05-2006/07 and Office for National Statistics mid-year population estimates 2004-2006). Does not include attendance at A&E. |
| CHARTS 2 & 3 | Persons admitted to hospital due to alcohol-specific conditions (all ages, male/female), directly standardised rate per 100,000 population. Numerator counts of between 1 and 5 have been suppressed (indicated as *) (NWPHO from Hospital Episodes Statistics 2006/07 and Office for National Statistics mid-year population estimates 2006). Does not include attendance at A&E. |
| CHART 4 | NI39: Hospital Admissions for Alcohol Related Harm: directly age and sex standardised rate per 100,000 population, 2006/07. (Department of Health using Hospital Episode Statistics and Office for National Statistics mid-year population estimates). |
| CHARTS 5 & 6 & 7 | Alcohol-related recorded crimes, crude rate per 1,000 population. (NWPHO from Home Office recorded crime statistics 2007/08). Attributable fractions for alcohol for each crime category were applied, based on survey data on arrestees who tested positive for alcohol by the Strategy Unit. |
| CHART 8 | Estimated number of deaths attributable to alcohol from land transport accidents (ICD-10: V01-V89) (all ages, persons) directly standardised rate per 100,000 population (standardised to the European Standard population). (NWPHO from Compendium of Clinical and Health Indicators, National Centre for Health Outcomes Development 2004-06 pooled and Office for National Statistics mid-year population estimates). The Strategy Unit's alcohol-attributable fraction was applied to obtain the estimates. |
| CHART 9 | Mid-2005 synthetic estimate of the proportion (%) of the population aged 16 years and over who report engaging in hazardous drinking, defined as consumption of between 22 and 50 units of alcohol per week for males, and between 15 and 35 units of alcohol per week for females. (NWPHO from Health Survey for England, Hospital Episode Statistics, Office for National Statistics mid-year population estimates and mortality data and the Census of Population 2001). Two local authorities (City of London and Isles of Scilly) have been omitted so authorities have been ranked from 1 to 352. |
| CHART 10 | Mid-2005 synthetic estimate of the proportion (%) of the population aged 16 years and over who report engaging in harmful drinking, defined as consumption of more than 50 units of alcohol per week for males, and more than 35 units of alcohol per week for females. (NWPHO from Health Survey for England, Hospital Episode Statistics, Office for National Statistics mid-year population estimates and mortality data and the Census of Population 2001). Two local authorities (City of London and Isles of Scilly) have been omitted so authorities have been ranked from 1 to 352. |
| CHART 11 | Synthetic estimate of the proportion (%) of adults who consume at least twice the daily recommended amount of alcohol in a single drinking session (that is, 8 or more units for men and 6 or more units for women). Estimates originally produced for the Department of Health (2003-2005). Two local authorities (City of London and Isles of Scilly) have been omitted so authorities have been ranked from 1 to 352. |