Alcohol Task Group

Final Report

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FOREWORD

“Whose responsibility is it to change the way some of us drink?”

I would like to take this opportunity as Chairman of Health O&S to thank task group members and advisers for this excellent piece of work, which pretty accurately demonstrates the answer to that question.

Ultimately, of course, everyone must take personal responsibility but the recommendations here recorded and shared with our partners will be shown to be critical in the development of our first Alcohol Strategy. We cannot expect that all of the recommendations will be acted upon immediately but we know the task group is keen to keep all the ideas alive and the Health Overview & Scrutiny Committee pledges to re-visit the strategy frequently to monitor its success.

Councillor Nicola Urquhart
Chair of the Health O&S Committee

INTRODUCTION

I am pleased to introduce this scrutiny report, which reviews many aspects of alcohol consumption and their immediate and longer-term consequences for the people of this borough. The place of alcohol in enjoyable socialising, and its contribution to Richmond's vibrant leisure economy is clear. At the same time, reducing the health harms and antisocial behaviour associated with excess alcohol consumption can improve the well-being of all and address a considerable financial burden.

We have been fortunate in having the input of national organisations such as the Institute of Alcohol Studies and Alcohol Concern. I should like to thank them, and the Home Office, for taking the time to present and discuss matters with us. We have also benefited from the experience and knowledge of several people from organisations and businesses involved locally. I should like to thank them all for their time, and particularly Sgt Tom Knox who has contributed to most of our meetings and organised a police site visit.

Christian Scade of Democratic Services deserves our thanks for putting a huge amount of work into organising meetings and keeping us on track to meet a tight schedule. His work in pulling together such a wide range of evidence into this final report is greatly appreciated. I hope that all stakeholders will find it helpful, particularly in looking at the issues across the piece.

It will fall to Anne Lawtey, the Community Safety Partnership manager, to draw up the borough's alcohol strategy. We are grateful to her support of the scrutiny process and hope that these findings and recommendations will help inform the development of a robust strategy.

Cllr Liz Jaeger
Chair of the Alcohol Task Group

EXECUTIVE SUMMARY AND RECOMMENDATIONS

1. Alcohol plays an important part in our society and the majority of people drink sensibly. However, alcohol misuse is associated with health and social problems at the individual, family, community and public level. The Centre for Public Health at Liverpool John Moores University has published estimates of the percentages of adults reporting binge drinking in each London borough during 2000 -2002. The estimates figures suggest that Richmond upon Thames has the third highest rate of binge drinking in London.

2. Estimates in 2004 put the annual costs of excessive drinking – in terms of damage to health, crime and disorder, and loss of work productivity at around £20 billion per year in England and Wales.

3. In June 2007 the Government published *Safe Sensible Social: The next steps in the National Alcohol Strategy.* This outlines the Government's long term goal, which is to minimise the health harm, violence, crime and antisocial behaviour associated with alcohol, while ensuring that people are able to enjoy alcohol safely and responsibly.

4. A local alcohol strategy in Richmond upon Thames is currently being developed and will be published on the 1 April 2008. This will feed into the Community Safety Strategy and means input from this task group has been timely and the recommendations (if approved) will be incorporated into the strategy.

5. Alcohol is a cross cutting issue and partnership working will be crucial if the Richmond upon Thames Alcohol Strategy is to be a success. The task group looked at all areas of interest including education, health, economic, leisure and crime and disorder.

6. Suggestions for change have been put forward in all areas and it is hoped that these will be taken forward by stakeholders. The task group believe that the following recommendations should be given priority status:

    1. That all sources of relevant funding be identified as a matter of urgency as the funding available (and what it can be used for) will impact on other recommendations. (**Recommendation 1**)

2. That in order to prioritise future service delivery the collection and sharing of data needs to be improved by all in relation to alcohol. In particular, reliable quantitative data is needed for alcohol related attendances in primary care, in A&E and for hospital admissions to address the current data underestimates. This is essential for the alcohol burden to be reflected in the Council / PCT Joint Strategic Needs Assessment. **(Recommendation 21**)

3. That all stakeholders consider seriously the balance between the benefits and harm whenever considering issues relating to the supply and consumption of alcohol. (**Recommendation 33**)

4. That an alcohol coordinator be appointed to ensure the Richmond upon Thames alcohol strategy is delivered. (**Recommendation 34a and 34b**).

PART I – ROLE AND FUNCTION OF THE ALCOHOL TASK GROUP

BACKGROUND TO THE ALCOHOL TASK GROUP

7. At the meeting of the Overview and Scrutiny Co-ordinating Group on 23 July 2007 it was agreed to set up the Alcohol Task Group. At its initial meeting on 27 September 2007 the task group established the following terms of reference:

   a. To identify the advantages and disadvantages of alcohol use in Richmond upon Thames.

   b. To determine the size of problems associated with alcohol use in Richmond upon Thames

   c. To identify the controls, treatments and remedies currently used in Richmond upon Thames and assess their effectiveness in reducing alcohol related harm.

   d. To investigate other controls, treatments, remedies that could be used in Richmond upon Thames to help minimise the health harms, violence and antisocial behaviour associated with alcohol, while ensuring people are able to enjoy alcohol safely and responsibly.

   e. To make recommendations to Cabinet and the Community Safety Partnership and, where appropriate, other stakeholders, to develop an effective and efficient borough wide alcohol strategy ensuring Richmond upon Thames is ''safe, sensible, social''. (The Community Safety Partnership has a legal duty from 1 April 2008 to include an alcohol strategy in the Community Safety Strategy.)

   In all of the above, the task group agreed to focus on issues associated with: education / public information, health, crime, recreation, licensing, the night time economy and the economy in general. The task group also looked at how effectively relevant agencies worked together.

METHODOLOGY

8. In order to assist with the development of the local alcohol strategy the task group agreed it was important to gather evidence from a wide range of organisations. Members also decided it would be best to split the review up into sections covering all areas of interest including education, health, economic, leisure and crime and disorder. This allowed the task group to learn about cross cutting issues and ensure appropriate recommendations could be made. **Appendix A** outlines the issues discussed at each task group meeting.

9. The task group interviewed the following witnesses as part of their evidence gathering (in order of their appearance before the group): Anne Lawtey, Community Safety Partnership Manager; Dr Rachel Seabrook, Institute of Alcohol Studies; Sgt Tom Knox (Licensing); Esther Worboys, Twickenham Town Centre Manager; Barry Croft, Licensing Team Leader; Tom McAuley, Twickenham Pubwatch; Adrian Waterworth, Richmond Pubwatch; Eddie Piece, Richmond Pubwatch; Carl Morlese, Assistant Head of Streetscene; Chief Inspector Mike Kirby; Sgt Tony Lovegrove, Safer Neighbourhoods; Caroline Steenberg, Planning Officer; Rob Mitchener, Head of Licensing; Sue Rippon, Corporate Policy Consultant; Dave Smith, Head of Trading Standards; Angela Ivey, Principal Tourism & Marketing Manager; James Rowlands, Domestic Abuse Co-ordinator; Steve Howard, South Branch Chairman, Licensed Taxi Drivers Association; Robin Gillis, Public Carriage Office; Robert Dray, Senior Transport Planner; David Noakes, Community Safety Officer; Cllr Denise Carr, Cabinet Member for Adult Services, Health and Housing; Jonelle Patton, Joint Commissioning Manager, PCT; Sarah Darcy, Joint Commissioning Manager, PCT; Dr Anita Jolly, Consultant in Public Health Medicine, PCT; Rob Henderson, Head of Integrated Youth Support Services; Gill Hines, Health Education Consultant; Kathryn Ruth, Drugs and Education Co-ordinator; Ranjit Dhillon, Chief Executive, Addiction Support and Care Agency; Michael Carson, Anti-Social Behaviour and Alcohol Unit, Home Office; Cllr Williams, Cabinet Member for Communities and Richard Eason, RuT LGBT Forum and Co-chair of OutWest.

10. The task group commissioned Alcohol Concern to provide an option appraisal for the development of alcohol services in the borough. This piece of research

was carried out by Mike Ward and was considered by the task group on the 4 December 2007.

11. Members of the task group attended a variety of external alcohol related seminars / briefings and carried out their own research by, for example, meeting Dr Jenny Allen at the Cross Deep surgery, Twickenham, to find out more about the enhanced alcohol services provided by GPs. Sgt Tom Knox also organised a police site visit which allowed task group members to see how the night time economy was policed.

12. The task group used national figures (in various forms) to help them understand issues that needed to be addressed. Unfortunately, local figures were not always available. This meant that in many areas the task group was unable to determine the size of the problem in Richmond upon Thames. The task group feel that this has prevented them from making clearer recommendations and as a result have made some suggestions in relation to the importance of data collection / data sharing which they believe will help prioritise future service delivery. Further information about data collection / data sharing can be found under paragraphs 106 – 112.

13. The reports and minutes from all task groups meetings are listed under 'Selected Reading' at the end of this report.

ALCOHOL TASK GROUP MEMBERSHIP

- Councillor Liz Jaeger (Chair)
- Councillor Sally Cole
- Councillor Pamela Fleming
- Councillor Ben Khosa
- Professor Joe Collier
- Harvey Woolfe

PART II – FINDINGS

‘SAFE, SENSIBLE, SOCIAL'

The National Alcohol Strategy and Related Issues

14. ‘Alcohol is regarded as an important part of the European cultural tradition. It has a significant recreational role and, consumed in small quantities, can have health benefits for certain groups. Nevertheless, while alcohol is often a source of pleasure it is also the cause of significant individual, social and economic harm. Alcohol is an addictive drug and a major cause of illness such as liver cirrhosis, cancers, heart disease, and social problems including social exclusion, unemployment, homelessness, violence, disorder, health inequality, teenage pregnancy and accidents’ (Alcohol Concern: 2003).

15. ‘*Safe.Sensible,Social’*, the new Alcohol Harm Reduction Strategy for England, was announced by Government in June 2007. Michael Carson, Anti Social Behaviour and Alcohol Unit, Home Office, informed the task group (on 10 January 2008) that the long-term goal of the national strategy was to ‘minimise the health harms, violence and antisocial behaviour associated with alcohol, while ensuring that people are able to enjoy alcohol safely and responsibly’.

16. The government’s priorities set out in the document are: sharpened criminal justice for drunken behaviour, a review of NHS alcohol spending, more help for people who want to drink less, toughened enforcement of underage sales, trusted guidance for parents and young people, public information campaigns to promote a new ‘sensible drinking’ culture, public consultation on alcohol pricing and promotion and local alcohol strategies.

17. A local alcohol strategy in Richmond upon Thames is currently being developed and will be published on the 1 April 2008. This will feed into the Community Safety Strategy and means that input from this task group has been timely and the recommendations (if approved) will be incorporated into the strategy.

18. The task group agreed from the outset that it was important to develop a strategy which would manage the use and misuse of alcohol holistically with specific outcomes delegated and monitored appropriately by delivery bodies.

Working in Partnership in Richmond upon Thames

19. Whilst the work of the task group will help ensure that the local alcohol strategy covers all elements of '*Safe,Sensible,Social'* it's important to note that as a borough we have various parts of an Alcohol Harm Reduction Strategy already in place. These include:
    1. Licensing Policy (which includes a Cumulative Impact element)
    2. Controlled Drinking Zones in Richmond and Twickenham Town Centres;
    3. Designated Dispersal Zones in Richmond and Twickenham Town Centres;
    4. A range of treatment commissioned from a variety of providers
    5. Treatment and education provided by GPs as part of their general remit;
    6. A pilot programme rolled out within the Community Safety Unit, in September 2007, identifying how many Domestic Violence incidents involved alcohol;
    7. Health education provided to vulnerable and target groups (young people; expectant mothers; those with alcohol related illnesses);
    8. Police officers tasked to town centres on Friday and Saturday evenings in higher numbers than usual;
    9. Publicity campaigns about anti-social behaviour related to alcohol;
    10. Specific alcohol related offending programmes provided by Probation;
    11. A sub group of the Substance Misuse Planning Forum working on the health element of an Alcohol Harm Reduction Strategy as part of the overall Substance Misuse Treatment Plan for 2008/09.
20. The ministerial foreword to 'Safe.Sensible.Social' states that 'promoting a sensible drinking culture that reduces violence and improves health is a job for us all, not just the Government'. In Richmond, the following agencies are amongst those who will be involved in delivering the strategy:
    1. Community Safety Partnership
    2. Richmond and Twickenham Primary Care Trust

3. Alcohol treatment agencies (both voluntary and statutory)
4. GPs
5. Metropolitan Police
6. LBRuT Licencing
7. LBRuT Trading Standards
8. LBRuT Transport Planning
9. The Probation Service
10. Schools
11. Youth Services
12. Richmond Magistrates Court

Funding Sources

21. It is the government's view that the treatment and care for people with alcohol problems is a mainstream health and social care responsibility and therefore there is no ring-fenced money to fund alcohol services / initiatives. This is a significant concern not least because Caroline Flint, former Minister of State for Public Health, notes in '*Safe, Sensible, Social'* that alcohol abuse costs England and Wales £20 billion each year in damage to health and crime and disorder.
22. The task group believe that due to the wide range of issues associated with alcohol, money for services, and / or initiatives, will need to be sought from a number of sources. For example, whilst most of the money for alcohol treatment services is expected to come from PCT budgets, funding from social services, community safety and the police could also be used as appropriate.
23. A key driver of local spending priorities is the Local Area Agreement (LAA). Alcohol misuse is a cross-cutting issue, and a focus on reducing alcohol-related harm can bring benefit to all four areas of the LAA[1]. Public Service Agreement (PSA) 25 aims to reduce the harm caused by alcohol and drugs and contains indicators on reducing the number of people admitted to hospital for alcohol-related harm, and reducing the percentage of the public who perceive drunk or rowdy behaviour to be a problem in their area. PSA 14, which aims to 'increase the number of children and young people on the road to success', contains an indicator to reduce the proportion of 10-15 year-olds frequently drinking alcohol.

[1] (i) Safer and Stronger Communities (ii) Children and Young People (iii) Healthier Communities and Older People (iv) Enterprise and Economic Development

Recommendation 1:

That all sources of relevant funding be identified as a matter of urgency as the funding available (and what it can be used for) will impact on other recommendations.

The Night Time Economy and Related Issues

24. The advantages and disadvantages of alcohol's impact on the night time economy are hotly contested issues. The task group examined the benefits and detrimental effects of drinking on the evening leisure culture in Richmond upon Thames and looked at options to manage the excesses of alcohol misuse.

25. The role of alcohol in the night time economy is summarised below:

National Perspective

- Pub and club industry turns over £23bn per year – equal to 3% of the UK's Gross Domestic Product
- 518,000 were employed in pubs and clubs in 2003
- Estimated that the average pub injects £73,000 per year into the local economy
- Planning Policy Statement (PPS) 6, Planning for Town Centres, encourages a pro-active plan-led approach to NTE issues in town centres, including diversification of uses, with tourism, leisure and cultural facilities which appeal to a wide range of age and social groups

London

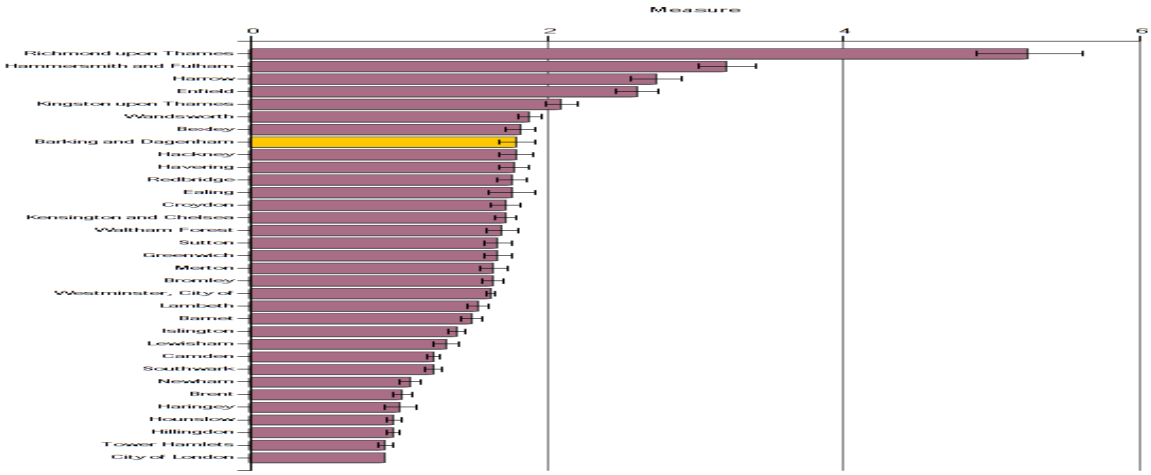
- 224,000 people employed in the dining, pub and entertainment industry in London. Alcohol consumption was worth £2.35bn to the London economy in 2002, dining was worth £15.5bn and theatres and cinemas £0.44bn
- Leisure spending as a whole in London is projected to increase by 26% 2001 - 2016. 'Casual' or 'leisure' dining will be a particular area of growth
- The NTE forms an important part of the social and cultural life of Londoners, enhances London's reputation as a world city and major tourist destination, and helps to develop London's creative industries. Pubs, clubs, bookshops, theatres, church halls, live music and other public venues are enormously important in providing access to grassroots cultural activity.
- Diversifying the night time economy is identified as an important issue.

Twickenham

- Identified under Mayor's Best Practice Guide as a cluster with "Specialist provision of more than local importance"
- Contains 4,410 sq m of bars and pubs, 4,470 sq m of cafes and restaurants and 1,550 sq m of take-aways
- Aug 2007 Survey found that 26% of the premises in the town are for Food and Drink (compared to 15% in July 1996)
- Contrary to expectation the NTE causes relatively few problems in Twickenham: some low-level Anti-Social Behaviour (ASB), night-time transport issues, and imbalance of licensed premises vs retail.
- Solutions employed: ASB - Code of Conduct, Radio Link, CCTV, Controlled Drinking Zone, Designated Dispersal Zone; Transport – Night Buses; Imbalance – Cumulative Impact Zone, Local Development Framework Core Policy for Twickenham Town Centre.

26. Many of the borough's attractions provide alcohol or sell it on their premises and benefit from the additional income it generates. The maximum number of employee jobs relating to alcohol in the borough is 8,600 or 12.9% of all jobs available locally. The proportion compares with 8.4% for all London and 8.1% for the UK and represents a significant element of the borough economy. (* Maximum because the total is agglomerated and includes a small number of jobs relating to campsites, travel agencies and libraries.) The bar chart below shows that Richmond employs 50% more people in bars than the next highest London borough.

Employees in bars - % of all employees
(source Local Alcohol Profiles for London)



Richmond is represented by the top bar of the chart, employing more than 5%

Licensing Policy

27. The Licensing Act 2003 requires licensing authorities to prepare, consult on, adopt and publish licensing policies at least every three years and to keep such policies under constant review, making revisions when appropriate. The new draft policy for 2008 to 2011 was formally launched for consultation on 3 September with a six week consultation period. This allowed the task group to consider the draft policy before it was published in January 2008.

28. The task group learnt that the four licensing objectives: prevention of crime and disorder; public safety; the prevention of public nuisance and the protection of

children from harm remained the key factors of consideration for any sub committee determining licence application. It was also noted that rightly or wrongly health was not one of the objectives under the Licensing Act 2003.

29. The task group were informed (in November 2007) of the proposed change as detailed in section four of the draft in relation to the two cumulative impact zones for the town centres of Richmond and Twickenham. These are being continued but the qualifying criteria has been relaxed so that not only pubs or bars are affected, as was the case in the initial policy, but all premises that seek a new or variation licence in the catchment areas. This will give the licensing committee greater control over proposed changes to existing licensed premises or those businesses that seek to enter the cumulative impact zones. The task group endorsed the (draft) licensing policy especially in relation to the cumulative impact assessment not least because residents and associations, such as the Richmond Society, have consistently raised concerns about antisocial behaviour in town centres when making representations.

Recommendation 2:

That any application to change A1 (retail shops) to A3 (restaurants and cafes), A4 (drinking establishments) or A5 (hot food takeaways) be given very careful scrutiny in centres where high numbers of restaurants and bars already exist. Planning and licensing committees should be provided with information on trends and cumulative impacts when such applications are heard.

30. In the past three years the Licensing Authority has received over 3000 representations, held over 220 hearings, processed around 750 premises license applications and issued over 1000 Temporary Event Notices. The Erskine Corporation were also commissioned to undertake research in 2005 and 2007 meaning that the authority has developed a good understanding of the impact that the licensed trade has had on the night time economy, particularly in Richmond and Twickenham town centres.

31. The most recent study undertaken by the Erskine Corporation in April 2007 found that between 2005 and 2007 there has been a modest but notable fall in the relative number incidents of crime, antisocial behaviour and nuisance recorded in the town centres of both Richmond and Twickenham. The incident peak in 2005 was at around 10.30-10.45pm is much less pronounced and has

been pushed back to around 11.45pm-midnight in both town centres. They observed considerably less rowdiness, such as shouting and screaming. However, though relatively small in overall volume, there was a notable increase in intimidation by a few users of both town centres. There has also been an increase in littering in Richmond and Twickenham.

Streetscene

32. The issue of littering and refuse collection was also raised by representatives of Richmond and Twickenham Pub Watch and following their police site visit (which included both town centres) the task group agreed that the appearance of high streets has a significant part to play in preventing anti-social behaviour and more attention should be focused on improving shop fronts and the street scene in all the shopping areas. In particular the task group recommends that refuse collection times should be co-ordinated so rubbish from shops is not left on the streets at night and wherever possible streets should be cleaned at night. This would also solve issues some residents have with early morning noise.

Recommendation 3: ***That the refuse collection times be co-ordinated so rubbish from shops is not left on the streets at night and wherever possible streets should be cleaned at night.***
Recommendation 4: ***That officers be asked to investigate whether there is any way through planning or licensing conditions or planning obligations that A3, A4 and A5 uses can ensure litter generated is minimised (through conditions not allowing take away food) or otherwise promptly removed from the street.***

Underage sales and related issues

33. The task group were informed that the Licensing Team were in discussion with the Youth Service with regard to research being done with under-age drinking

in the borough and what brings young people into the borough. Anecdotal evidence was that young people come into the borough because they felt safe and a number of witnesses informed the task group that Richmond was a destination of choice on Friday and Saturday nights for youngsters from many surrounding boroughs.

34. The legal provisions in the Licensing Act 2003 relating to underage sales are enforceable by either the Police or by trading standards. The generally agreed division of responsibility is for trading standards to concentrate their efforts in relation to ''off-sales'' and for the Police to focus on ''on-sales''. There are logical reasons for this:

- Trading Standards resources are stretched to the limit and there is no capacity to extend underage purchasing work to on-sales
- There are considerable difficulties in conducting underage sales operations at on-sale premises, including the protection from harm of the underage purchaser
- Considering the difficulties underage "stings" are not appropriate in on-sale premises. It is easier for the Police to enforce provisions by observation and tackling apparent underage purchasers and the seller. Trading Standards have no powers in respect of an illegal purchase (i.e. the purchaser commits an offence) and cannot therefore require their age details etc.
- Police can issue Fixed Penalty Notice, Trading Standards cannot.

35. Underage purchase operations are therefore difficult to organise and implement. Trading Standards need to comply with a Code of Practice agreed and endorsed by LACORS and the Dept of Media Culture and Sport. A typical operation involves three officers and one or two purchasers.

36. Despite these problems however, current test purchasing results show a sales rate of only 6%. This is down from a rate of around 40% in 2003/04. Whilst this improvement was welcomed the task group believe caution is needed when interpreting these figures as it could be the case that traders are getting used to the methods used. Therefore, the task group support any new imaginative initiatives to tackle problems associated with underage sales.

37. The task group also believe that training has an important role to play in selling alcohol responsibly. Whilst there is no legal requirement to train in relation to underage sales, if there is no adequate training / records of training in an establishment the licensee would be very unlikely to be able to establish a defence to an allegation of making illegal sales.

38. The evidence received from the Police and the Richmond and Twickenham Pub Watch schemes suggest that underage sales is more of a problem for ''off sales''. Underage drinking in pubs had been addressed by using stricter restrictions such as doormen checking entry and over 21 policies. However, whilst over 21 policies might have cut down the number of underage sales in pubs there were concerns that such policies might have contributed to the number of young people drinking outside. This was something the task group felt needed further investigation. The task group also felt that more needed to be done in relation to cutting irresponsible drinks promotions and suggested that the voluntary code for alcohol retailers in the borough be re-launched.

39. It is hoped that the recommendations below will lead to better understanding and allow stakeholders to respond accordingly.

Recommendation 5:

That research be conducted to establish:

(a) Who the users of the licensed sector are, how they 'come and go', how much they spend, and what their perceptions of the town centres are.

(b) Why adults come to town centres in Richmond upon Thames during the night time economy and where they come from

(c) Why under 18s come to town centres in Richmond upon Thames during the night time economy, where they come from and where they get their alcohol from.

(d) The pros and cons of over 21 policies at licensed outlets and the impact of 18-21 year olds drinking off-licence alcohol in the borough.

Recommendation 6:

That the voluntary code for alcohol retailers in the borough be re-launched with the wording checked for legal compliance, especially regarding competition regulations.

Recommendation 7:

That the local authority and police work with the industry and a local college to develop a module (NVQ / accredited scheme) for staff working in off-licences.

Recommendation 8:

That all staff selling alcohol in the borough be trained to ensure alcohol is always sold responsibly.

Transport Provision

40. Another issue of concern in relation to the night time economy was the provision of adequate and appropriate transport during the night time economy, especially in Richmond town centre. The task group gathered evidence from Richmond and Twickenham Pub Watch, the police, the licensed taxi drivers association, the Public Carriage Office and relevant council officers.
41. Across London there are 25,000 licensed Hackney Carriages (taxis) and 40,000 private hire vehicles. Within Richmond upon Thames there are 415 licensed hackney carriage drivers and 40 operating centres, for approximately 3,000 private hire vehicles. However, the Public Carriage Office explained that caution was needed when dealing with these figures as a number of firms worked across London meaning that the number of private hire vehicles operating in Richmond upon Thames was likely to be significantly less.
42. There is no central operating office in Richmond although the town centre is served by five operators who are located on the 'fringes'. Steve Howard, South Branch Chairman, LTDA, also suggested that the figure of 415 licensed hackney carriage drivers needed to be treated with caution as operationally this could differ significantly.
43. The general consensus amongst witnesses was that there were not enough taxis during the peak of the night time economy and it was felt that this had contributed to the anti-social behaviour witnessed in the town centres. The successful taxi schemes used in Kingston upon Thames were discussed by the task group which included marshalled taxi ranks (for hackney carriages) and minicab booking kiosks (for private hire vehicles).
44. However, if these schemes are to be developed in Richmond a number of issues need to be addressed including: town centre design / planning issues, funding, data collection to show there is demand and enforcement to ensure the scheme could operate successfully.

45. Robin Gillis from the Public Carriage Office explained that Transport for London had limited funds for taxi schemes at the moment and as a result money would have to come from elsewhere. Suggestions from the task group include looking at the option of part council / part police funding possibly via the Economic Development Fund. Another suggestion was the Initiatives Fund. The task group ask that all possible streams of funding be investigated. Either way, the Public Carriage Office would be happy to help develop a local scheme and this would not be dependent on Richmond receiving Transport for London funding.
46. Robin Gillis also informed the task group that from his experience (and best practice examples) if a scheme was developed in Richmond it would be best to start with a pilot to ensure it worked and was needed.
47. In terms of cost it was estimated that a taxi marshal rank would need two marshals costing between £25 and £35 per hour depending on experience / type of marshal employed. In relation to the private hire kiosk scheme Robin Gillis explained that this was a cheaper option and would be able to provide further cost information if required.
48. It was also agreed, by all stakeholders, that if the scheme was to be successful it would need the support of the local police.
49. The task group also noted that the Community Safety Team were promoting the '*Cab Wise'* scheme widely across the borough. This approach was fully endorsed by the task group.

Recommendation 9: ***That the Richmond town centre redevelopment plans be reviewed to ensure adequate and appropriate transport provision is made during the night time economy.***
Recommendation 10: ***That further investigations take place in relation to setting up a (pilot) marshalled taxi rank in Richmond (for hackney carriages) and a minicab booking kiosk (for private hire vehicles).***

Diversification of events

50. Evening entertainment options are being developed all the time and will, no doubt, continue to be so in the lead up to London 2012 Olympics.

51. *'NightVision'* a 2006 publication by the Civic Trust was used by the task group to look at ways to 'create town centres for all'. Research carried out by the Civic Trust shows there is 'widespread dissatisfaction with the choice, variety and style of venues and a feeling that the public realm has been abandoned to aggressive market forces – to the detriment of those with other interests or limited means. Whole sections of the community are not served by the very restricted range of venues normally on offer'.

52. The House of Commons Inquiry (The Evening Economy and the Urban Renaissance 2003) recommend that local authorities develop action plans that encourage non-alcohol centred evening activities: late opening shops, museums and galleries and the identification of events that have wider appeal to people of all ages. Research by the Civic Trust shows that 'policy makers and consumers want diversity in the evening economy. There is a received understanding that a balance or diversity of town centre land uses will make centres safer, more attractive and more sustainable in the long run.'

53. The task group believed that diversification of the night time economy would be extremely beneficial and suggested that the local alcohol strategy be used to help the borough achieve purple flag status (a new national accreditation scheme for town and city centres at night).

Recommendation 11a: ***That initiatives to develop a night time economy based on diversity be supported by the local alcohol strategy to help the borough achieve purple flag status.***
Recommendation 11b: ***That consideration be given to the appointment of a retail 'champion' or 'co-ordinator' who would promote, for example, evening opening of shops.***
Recommendation 11c: ***That consideration be given to piloting more cultural events, particularly on***

Richmond riverside, and sports activities.

A role for employers

54. Alcohol and drug misuse is a major issue affecting employers and employees in the UK. Problems caused by this misuse not only affect the health, safety and welfare of staff but also business productivity and profits.
55. Alcohol is known to be a major reason for workplace absence. Alcohol Concern suggests that up to 14.8 million working days are lost each year as a consequence of drinking, constituting between 3% and 5% of all absences.
56. The TUC, who represent people at work in Great Britain state in *Alcohol and Work: a potent cocktail* (2003) that 'one thing we…know is that the majority of people who have a drinking problem are in work, so work can be a key location for combating the harm that alcohol can cause'.
57. The task group acknowledged that the Council had a workplace alcohol, drug and substance misuse policy. The task group endorsed this and suggested that all employers in the borough have such a policy to support employees affected by alcohol.

Recommendation 12:

That the alcohol strategy promotes support for people who are affected by alcohol by for example encouraging all employers in the borough to have a work place alcohol policy.

Crime and Alcohol

58. ‘Research shows that alcohol is a factor in criminal behaviour. In the UK in 2003 nearly two-thirds of sentenced male prisoners (63%) and four-fifths of female sentenced prisoners (79%) admitted to hazardous drinking prior to imprisonment.’ (Alcohol Concern: 2007)

59. The British Crime Survey suggests that with the exception of 2003/04 the number of alcohol related violent offences has decreased every year since 1995. However the British Crime Survey shows that people are increasingly likely to think that alcohol disorder is a problem. The most popular concern of borough residents was identified as ‘people being drunk/rowdy in public places’ in the Metropolitan Police, Public Attitude Survey 2006/07.

60. Most alcohol related incidents occur on Friday and Saturday nights in Richmond and Twickenham town centres. 83% of borough assaults (between April to June 2007) were related to alcohol.

61. It is estimated that alcohol related crime costs the UK £7.3 billion per annum in terms of policing, prevention services, processing offenders through the criminal justice system and human costs incurred by victims of crime.’ (Alcohol Concern: 2007). The social and economic costs of alcohol related assaults are estimated to have cost the borough £8.1 million in 2006/07 (domestic abuse alone cost the borough £5.9 million).

62. The economic costs of alcohol in relation to crime and disorder matters were of significant concern to the task group and they looked at ways to reduce these costs.

63. Although the media have recently highlighted custody referral scheme in Plymouth as a national first, there have actually been several such schemes running for many years. The 2004 National Alcohol Harm Reduction Strategy reported that there were currently eight referral schemes with a specific focus on alcohol. Some of these based on arrest and others on bail conditions. The summary box below provides further information:

- **Alcohol Arrest Referral Scheme**: Where those arrested for alcohol related offences are bailed from the police station and required to contact the relevant agency in order to attend counselling.
- **Conditional Cautioning:** An offender who admits guilt is given a caution with

the condition they attend brief intervention appointments. Failure to do so can result in the case going to court.

- **Alcohol Treatment Requirement**: This provides an alcohol treatment option for people involved in the criminal justice system, as part of a community order given by the court.

64. The importance of arrest referral has been underlined by the advent of Conditional Cautioning. This was introduced by the Criminal Justice Act 2003 and allows, for the first time, for a condition that is conducive to restoration or rehabilitation to be attached to a police caution. Where the condition is not met, the offender may be charged and prosecuted with the original offence.

65. Arrest referral is an obviously beneficial pathway and the advent of Conditional Cautioning places a legal framework around such interventions. Despite the obvious benefits Sgt Tom Knox informed the task group that funding might be a barrier to developing such a scheme in Richmond upon Thames. It was also noted that due to strict funding criteria it wouldn't be possible to use the drug arrest referral programme to refer alcohol offenders. This inflexibility and the absence of an alcohol arrest referral scheme is a concern, especially for repeat alcohol offenders. Given the cost of not having such a scheme, the task group believe that the Police and Community Safety Partnership need to look at availability of funding to develop this in Richmond upon Thames. Alcohol Concern also suggested that PCT funds could be used for such a scheme.

Recommendation 13:

That stakeholders look more vigorously at maximising the income flow available to develop an alcohol arrest referral scheme in Richmond upon Thames.

66. A number of documents in relation to tackling problems associated with alcohol were also discussed by the task group. Sgt Tom Knox suggested that stakeholders should be encouraged to adhere to the Met Police 'Safe and Sound' document (www.nactso.gov.uk) and Counter Terrorism Protective Security Advice. This approach was endorsed by the task group and it was hoped that stakeholders would use this useful information.

67. The task group concluded that tackling alcohol related crime has lots of cross cutting themes and strategies such as; reduction in violent crime, harm minimisation, domestic violence, National Offending Management and the Every Child Matters agenda. It was agreed that all of these areas needed to be considered in the development of the forthcoming strategy.

Health Issues / Alcohol Services

68. Excessive alcohol consumption damages health. The box below lists alcohol-specific illness and alcohol-attributable illness.

Alcohol-specific illness
Methanol poisoning
Mental and behavioural disorders due to use of alcohol
Ethanol poisoning
Degeneration of nervous system due to alcohol
Alcohol-induced pseudo-Cushing's syndrome
Alcoholic polyneuropathy
Alcoholic myopathy
Alcoholic liver disease
Alcoholic gastritis
Alcoholic cardiomyopathy
Accidental poisoning by and exposure to alcohol

Alcohol-attributable illness
Accidental exposure to excessive cold
Acute pancreatitis
Air/space transport accidents
Alcohol-induced chronic pancreatitis, other chronic pancreatitis
Assault / Firearm injuries
Chronic liver disease
Diabetes mellitus
Drowning
Epilepsy and Status epilepticus
Fall injuries
Fire injuries
Gastric ulcer
Gastro-oesophageal laceration- haemorrhage syndrome
Heart failure / Stroke
Hypertensive diseases
Inhalation and ingestion of food causing obstruction of respiratory tract
Intentional self-harm/Event of undetermined intent
Ischaemic heart disease
Malignant neoplasm of breast
Malignant neoplasm of larynx
Malignant neoplasm of lip
Malignant neoplasm of liver and intrahepatic bile ducts
Malignant neoplasm of oesophagus
Malignant neoplasm of oral cavity and pharynx
Malignant neoplasm of other digestive organs
Malignant neoplasm of stomach
Oesophagael varices
Pneumonia and influenza
Psoriasis
Road Accidents / Water transport accidents / Work/machine injuries
Spontaneous abortion
Supra ventricular cardiac arrhythmias, atrial fibrillation and flutter
Tuberculosis

69. The Alcohol Needs Assessment Research Project (2004) identifies three categories of problematic alcohol consumption used to assess the level of need in the population. These are defined as:

    1. *Hazardous* drinking – drinking above sensible limits, but not yet experiencing harm (measured by consumption of between 22 and 50 units per week for males and between 15 and 35 units per week for females)

    2. *Harmful* drinking – drinking above recognised sensible levels and experiencing harm (measured by consumption of over 50 units per week for males and over 35 units per week for females)

    3. *Alcohol dependence* – drinking above recognised sensible levels and experiencing harm and symptoms of dependence.

70. 'Sensible drinking is drinking in a way that is unlikely to cause yourself or others significant risk or harm' (Safe.Sensible.Social: 2007). The Government advises that adult men should not regularly drink more than 3-4 units of alcohol a day and adult women should not regularly drink more than 2-3 units of alcohol a day. Binge drinking is defined as drinking too much alcohol (over 8 units a day for men and over 6 units a day for women) over a short period of time, e.g. over the course of an evening, and it is typically drinking that leads to drunkenness. Binge drinking has immediate and short-term risks to the drinker and to those around them.

71. On the 4 February 2008 Mr Eason addressed the Health Overview and Scrutiny Committee from the perspective of the local lesbian, gay, bisexual and trans (LGBT) community. LGBT people are believed to lead less healthy lifestyles: they have higher levels of alcohol consumption, are more likely to smoke and more likely to misuse drugs than heterosexual people. Mr Eason wanted to ensure that the local alcohol strategy addressed specific issues (outlined in **Appendix B**) to help reduce health inequalities for LGBT people. Mr Eason also mentioned the LGBT Health Summit (September, 2008) and suggested that the Council / PCT consider sending a delegate. The task group welcomed Mr Eason's contribution and officers confirmed that an Equality Impact Needs Assessment (EINA) would be carried out on the strategy once the drafting process had been completed.

72. No local survey data exists concerning the drinking habits of Richmond upon Thames residents. However, national survey data can be extrapolated to the local level to give an indication of the amount of alcohol consumption within the borough. The Centre for Public Health at Liverpool John Moores University has published estimates of the percentages of adults reporting binge drinking in each London borough during 2000 – 2002. The estimates figures suggest that Richmond upon Thames has the third highest rate of binge drinking in London. This is a concern.

73. Two sources of survey data are available: the General Household survey (GHS) and the Health Survey for England (HSE). Both surveys are recurrent and estimate the prevalence of different types of drinking behaviours in the English regions (Tables 1 and 2).

Table 1. Alcohol misuse prevalence estimates for men for London and the South East of England.

Data source	Prevalence Estimate					
	% hazardous drinking		% harmful drinking		% binge drinking	
	London	SE	London	SE	London	SE
HSE*	27.1	28.4	6.0	5.9	11.4	17.1
GHS**	21.1	22.2	4.8	4.8	12.5	13.9

*2000/02
**2005

Table 2. Alcohol misuse prevalence estimates for women for London and the South East of England.

Data source	Prevalence Estimate					
	% hazardous drinking		% harmful drinking		% binge drinking	
	London	SE	London	SE	London	SE
HSE*	15.9	19.3	2.3	2.3	4.6	6.1
GHS**	10.5	14.5	2.0	2.6	4.8	6.0

*2002/02
**2005

74. There is some difficulty in extrapolating these regional estimates to borough level as the local demography differs from the regional picture. The North West Public Health Observatory has produced estimates for hazardous, harmful and binge drinking for all English PCTs which are derived from data models that include national survey data and other socio-demographic data (Table 3).

Table 3: Hazardous, harmful and binge drinking – estimates

Area	% hazardous drinking	% harmful drinking	% binge drinking
LBRuT	21.0	4.3	18.4
London	18.8	5.1	15.4
England	20.1	5.0	18.2

Data source: North West Public Health Observatory

75. These estimates show that Richmond upon Thames has a higher prevalence of hazardous and binge drinking than London (though not statistically higher than the England average), but a lower prevalence of harmful drinking. The estimated number of Richmond upon Thames adults (aged 16 and over) who drink above sensible limits by drinking category is shown in Table 4.

Table 4: Estimated numbers of Richmond upon Thames residents who drink above the recommended levels.

Drinking category	Number of LBRuT residents*
Hazardous	29,982
Harmful	6,139
Binge	26,270

*based on GLA 2007 population projections as the denominator

76. **Table 5** gives the estimated prevalence and number of alcohol dependent drinkers within the borough.

Estimated prevalence (%) of dependent drinkers*	Estimated numbers of dependent drinkers
3.6%	5,140

*Data Source: ANARP 2005.

77. The task group commissioned Alcohol Concern to provide an option appraisal for the development of alcohol services in the borough. This was a brief piece of work undertaken in November 2007 and was carried out by Alcohol Concern's consultancy service based on desk research. The report focused on brief interventions at tier 1 (non-specialist services which see substance misuse), tier 2 (open access substance misuse services) and tier 3 (structured community based substance misuse services). The report was discussed by the task group on the 4 December 2007 and was an important document in terms of identifying options / recommendations for service development in Richmond upon Thames.

Alcohol Related Attendance in Primary Care

78. Patients with an alcohol use disorder present to primary care services with a range of physical conditions that are caused at least in some part by their alcohol misuse. It is less common for an individual to present complaining solely of alcohol consumption. Subsequently alcohol use disorders are detected to a varying degree within general practice. This is documented in the national Alcohol Needs Assessment Research Project 2005 which found extremely low levels of formal identification, referral and treatment of patients with an alcohol use disorder as recorded in the national General Practice Research Database (GPRD). Qualitative data suggests that GPs do not enquire about alcohol use disorders at least in part because of the perceived lack of availability of onward treatment services.

79. Until very recently several Richmond upon Thames PCT GPs provided an enhanced alcohol service to their patients. GPs in 13 of the 31 local practices were contracted to undertake alcohol interventions which, if necessary, lead to referral to agencies such as the local alcohol counselling service.

80. A snap shot of one medium sized practice (list size 5442) within the PCT found that out of 4419 adults aged 16 and over, 543 (12%) were recorded as having an alcohol consumption above the weekly recommended limits. A further breakdown showed that 357 men (17% of the total registered adult male practice population) drank between 21 and 42 units/week and 72 (3%) drank above 42 units/week. For female patients, 186 (8% of the total registered adult female practice population) drank between 14 and 28 units/week and 31 (1%) drank above 28 units.

81. Richmond and Twickenham PCT informed the task group that the enhanced alcohol service was comprised of two elements: GP screening via an agreed audit tool: and subsequent brief interventions and a counselling provided at the practice by an Addiction and Care Agency (ASCA) counsellor. In 2006 / 07 the cost of this enhanced service was £159,420.

82. Dr Jenny Allen from the Cross Deep surgery, Twickenham, informed the task group that screening of patients and 'brief interventions' was carried out by GPs at the practice (as one might hope for at most surgeries) However, what made the Cross Deep service an enhanced service was the presence of a worker from ASCA. Any patients identified by the GPs as harmful / dependent drinkers

though the GPs screening were referred to the ASCA worker so there was shared care within the surgery.

83. ASCA was established in 1990 as a counselling service for alcohol clients, although it now also provides drug treatment. ASCA is not a drop-in service but provides a day programme offering counselling, group work and complementary therapies and a woman's service which include assessment, counselling and childcare issues. ASCA received £239,093 of funding in 2006/07 – this is made up on £190,093 from the NHS and £49,000 from the local authority.

84. It was agreed that 'shared care' was an important part of the enhanced service but unfortunately due to the low uptake with regard to the ASCA counselling it was agreed (by both the PCT and ASCA) that the service wasn't providing value for money in its current form. As a result, the PCT would be working with practices and ASCA to monitor activity to inform the development of an enhanced service in 2008/09. In the meantime all new referrals will be sent to ASCA and patients will be invited to attend counselling at Lower Mortlake Road for the remainder of the 2007/08 financial year.

85. Despite these concerns Alcohol Concern recommended that consideration be given to developing an enhanced alcohol service in Richmond upon Thames. The task group agree and believe this is a 'health justice' issue as without an enhanced service, flexibility and local provision for patients is removed.

Recommendation 14:

That an enhanced GP service be rolled out across the borough which considers both treatment and prevention during 2008/09.[2]

Brief Interventions at tier 1

86. It is a key principle of the government's new alcohol strategy that tier 1 professionals such as primary care or social services do not need to refer everyone with an alcohol problem to specialist services. Brief interventions can change the drinking patterns of people who are developing alcohol related problems. If there is anything to suggest that s/he may be a hazardous, harmful

[2] Please refer to the section on 'possible funding sources' for further information.

or dependent drinker further questions should be asked to determine whether this is actually the case.

87. If alcohol related harm is identified workers can offer brief interventions consisting of advice and information about alcohol's effects and strategies for reducing harm. If a person has a more engrained problem then referral should be made to tier 2 or tier 3 services.

88. In 2006 the Department of Health published the *Review of the effectiveness of treatment for alcohol problems* (see www.nta.nhs.uk). This sets out evidence on the effectiveness of screening and brief interventions.

89. The *Review* identifies a number of screening tools. These include very brief systems such as the CAGE tool (four questions). This only takes a minute to complete and has been widely used in clinical practice. The items are easy to remember and can be administered orally by a practitioner.

1. Have you ever felt you should cut down on your drinking?
2. Have people annoyed you by criticising your drinking?
3. Have you ever felt bad or guilty about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye opener)?

A more extensive questionnaire is the WHO's AUDIT tool (10 questions). An alternative, briefer, tool is the FAST screening tool which is a cut down version of the well-evaluated AUDIT.

90. Once the problem drinker has been identified, there is evidence that brief interventions carried out by the tier 1 worker are effective in reducing alcohol consumption among hazardous and harmful drinkers to low-risk levels. Research has shown that the effects of brief interventions persist for periods up to two years after intervention and perhaps as long as four years. The *Effectiveness Review* is a good source of information.

91. After hearing evidence from Alcohol Concern, ASCA and the PCT the task group agreed that more needed to be done in terms of brief interventions at tier 1. One pilot scheme that will start in 2008 will see a full time alcohol specialist nurse based in the A&E department at the West Middlesex Hospital who will offer brief intervention (30-45 minute motivational interview) to patients who

attend A&E with an alcohol related illness / injury. However, the task group suggest that tools such as CAGE, AUDIT or FAST should be used by all frontline professionals including GPs, social workers, school nurses, housing officers and the police. The actual or perceived lack of onward treatment services should not inhibit such screening.

Recommendation 15:

That more be done in terms of brief interventions at tier 1. Screening tools such as CAGE, AUDIT or FAST should be more widely used by a range of frontline professionals including GPs, A&E, social workers, school nurses, housing officers and the police.[3]

Tier 2 and Tier 3 models

92. The core of any alcohol treatment system will be its tier 2 and tier 3 services. The Department of Health's *Model of Care for Alcohol Misuse* (MoCam) defines these services as:

- Tier 2 Open access substance misuse services
- Tier 3 Structured community-based substance misuse services

93. MoCAM says that tier 2 embraces interventions which offer simple and swift access to help with the aim of engaging and retaining them in treatment and care. These include: advice, information and referral services for drinkers, their families and carers; easy access or drop-in facilities that include services to reduce alcohol related harm and self-help groups such as Alcoholics Anonymous and Al-Anon.

94. Tier 3 covers: community detoxification; access to inpatient detoxification or residential rehabilitation; a care package with a care coordinator. The services offered may include: care planned counselling, structured day programmes etc.

95. However, although the tier label separates these services out, they must be firmly linked together as a system of care. It is also important to note that a single service can offer both tier 2 and tier 3 interventions. This is particularly

[3] Please refer to the section on 'possible funding sources' for further information.

common in the alcohol field where many voluntary sector agencies offer both advice and information and one to one psycho-social interventions.

96. Richmond upon Thames currently has specialist treatment services in relation to tier 2 and tier 3 that include the *Single Person Emergency Accommodation in Richmond* (SPEAR) the DAIS Tier 2 drop in centre and ASCA. The DAIS Tier 2 drop in centre was launched in October 2007. This pilot project, funded by the drug pool treatment budget, is fully endorsed by the task group.

97. Alcohol Concern's research work identified a number of ways of providing tier 2 and tier 3 services. At the most basic level the choice is most likely to be between:

- A single service providing both tier 2 and tier 3 services. Barking and Dagenham is cited as a good practice example by Alcohol Concern.
- Separate services providing the tier 2 and tier 3 elements. Bolton is cited as a good practice example by Alcohol Concern.

98. However, within both of these models there are likely to be many variations and options. The specifications for these best practice examples were discussed by the task group at their meeting with Alcohol Concern.

99. The numbers of patients who received treatment in specialist alcohol services within Richmond upon Thames for 05/06 are shown below:

Numbers in specialist treatment services

Service Provider		**Numbers in treatment 05/06**
Richmond Community Drug and Alcohol Team (RCDAT)		203
Addiction Support and Care Agency (ASCA)	Day programme	105
	Counselling programme	164
	Women's service	18
Single Person Emergency Accommodation in Richmond (SPEAR)		48
TOTAL		538

100. The task group pointed out that the 5/600 people identified seemed to be a very small proportion of the estimated number of harmful drinkers at 5/6000 and a still smaller proportion of the estimated number of hazardous and binge drinkers.

Recommendation 16: ***That the best practice contract specifications supplied by Alcohol Concern be compared to current contracts and used in the future if appropriate.***
Recommendation 17: ***That the movement from tiers 1 to 2, 2 to 3 be as seamless as possible.***
Recommendation 18: ***That the capacity of tier 2 and tier 3 services be monitored to ensure the treatment system works as a whole.***

Substance Misuse Models

101. As part of their investigations the task group looked briefly at other substance misuse models such as smoking cessation models. It was agreed that further investigation by the PCT would be advantageous to determine synergies in service delivery.

Recommendation 19: ***That the PCT look at substance abuse models more generally to determine synergies in delivery***

Family Members

102. Family members can experience as much physical or mental ill-health as a result of their loved one's drinking as a drinker. The self-help group Al-Anon can be an invaluable form of help. MoCAM says very little about the needs of family members. However, many parts of the country make services available for family members. In the Bolton model Alcohol and Drugs Services (a voluntary sector alcohol and drug service based in the North West) provide support for family members.

103. In many other areas it is the expectation that the voluntary sector / tier 2 service will help family members. For example in Surrey, Surrey Alcohol and Drug Advisory Service provides one to one help for problem drinkers and family members. The same is true for Kent Council on Addiction (a voluntary sector service). The Barking and Dagenham service specification includes family work as an integral part of the service.

104. However, some areas have established separate family services. In Nottinghamshire 'Hettys' and WAM (What About Me) are separate services which meet the needs of family members and the children of substance misusers respectively. A WAM service has also been set up in Sheffield.

105. Alcohol Concern note that there is no guidance as to which is the best approach. However, both the areas with specialist services have populations four times larger than Richmond. For a smaller area integrating family work into the mainstream alcohol contract is probably most appropriate. Alcohol Concern believe that this would not impose any significant extra cost on the contract.

Recommendation 20a: ***That support for family members be picked up in service contracts in tier 2.***
Recommendation 20b: ***That where there is no close (family) support other types of support be made available for drinkers.***

Data Collection / Data Sharing

106. The task group used national figures (in various forms) to help them understand issues that needed to be addressed. Unfortunately, local figures were not always available, especially in relation to health. For example, qualitative data suggests that GPs do not enquire about alcohol use disorders possibly because of the perceived lack of availability of onward treatment services and no local survey data exists concerning the drinking habits of Richmond upon Thames residents. In short, there are significant gaps in the information collected (and shared) by various stakeholders.

107. Up to 35% of all A&E attendances nationwide may be alcohol related. The Prime Minister's Strategy Unit in 2003 found that in A&E departments at peak times: 41% of all attendances were positive for alcohol consumption; 14% of attendees were intoxicated; 43% were identified as problematic drinkers after screening and 70% of attendances between midnight and 5am are alcohol related.

108. Richmond upon Thames does not house an acute hospital trust and residents access two local providers in neighbouring boroughs – Kingston Hospital and West Middlesex University Hospital. Annually Richmond upon Thames residents are responsible for approximately 16,000 A&E attendances in each unit.

109. **Number of A&E attendances in 2006/07 where the reason for attendance was recorded as 'apparently drunk' and / or the diagnosis on discharge was 'alcohol'**

Hospital	Number of attendances in people aged under 16	Number of attendances in people aged over 17
Kingston	19	77
West Middlesex	Awaiting data	Awaiting data

110. The task group were advised by the PCT that the table above underestimates the number of alcohol related A&E attendances. This is because there are many attendances where alcohol has directly contributed to the patient's morbidity, but this is not always recorded on the hospital coding system. Common alcohol related reasons for attending A&E include fits, psychiatric disorders, collapse, head injury, vomiting, assaults, falls, chest pain, abdominal pain and wounding. Current data collection systems do not routinely record whether patients presenting with the above conditions have alcohol misuse as an underlying cause of their ill health and therefore it is impossible to estimate the alcohol related workload from routine data sources.

111. The problems highlighted above meant that in many areas the task group were unable to determine the size of the problem in Richmond upon Thames. The task group felt that this has prevented them from making clearer

recommendations and as a result have made some suggestions in relation to the importance of data collection / data sharing which they believe will help prioritise future service delivery.

112. Michael Carson from the Home Office noted that data collection / data sharing needed to be developed across the country and suggested making contact with Dave Sheehan, Department of Health, who has done a significant amount of research in relation to data collection. The task group agreed that the PCT should make contact with the Department of Health to look at ways of developing the model locally. The 2008-2011 government spending review and the resulting PSAs are the first to contain indicators on alcohol. Therefore, the collection of accurate data will be even more important in the future.

Recommendation 21: ***That in order to prioritise future service delivery the collection and sharing of data needs to be improved by all in relation to alcohol. In particular, reliable quantitative data is needed for alcohol related attendances in primary care, in A&E and for hospital admissions to address the current data underestimates. This is essential for the alcohol burden to be accurately reflected in the Council / PCT Joint Strategic Needs Assessment.***[4]
Recommendation 22: ***That A&E departments share with the police data about where drunken patients bought their last drink,*** [5]

Possible Funding Sources

113. In both 2006-7 and 2007-8 PCTs received an Alcohol Interventions Allocation to improve local alcohol services. Richmond and Twickenham PCT received over £45, 000 under this allocation. It is believed that this funding will continue in the future. This could be a source of funds for either a primary care scheme or an accident and emergency scheme and could be used in relation to **recommendations 14, 15 and 21 and 22**.

[4] Please refer to the section on 'possible funding sources' for further information.
[5] Please refer to the section on 'possible funding sources' for further information.

114. It is the government's view that the treatment and care for people with alcohol problems is a mainstream health and social care responsibility. Therefore, beyond the Alcohol Interventions Allocation there is no dedicated pot of money for alcohol services. However, in relation to **recommendation 14** Alcohol Concern suggested that '*Choosing Health Money'* could be used to roll this out across GP surgeries in the borough. The task group understand though presentations to Health O&S that the Choosing Health Budget for 2008/09 is £1.1 million and it's recommended that a greater proportion of this money is allocated to alcohol treatment services.

115. A key document that will affect the relative prioritisation of competing funding needs is the Local Area Agreement. Alcohol misuse is a cross-cutting issue, and a focus on reducing alcohol-related harm can bring benefit to all four areas of the LAA. Public Service Agreement (PSA) 25 contains an indicator focused on reducing the trend in alcohol related hospital admissions.

116. The table below gives the 2006/07 funding for alcohol services in Richmond upon Thames.

Service	**2006 / 2007 Funding**
RCDAT	£1,012,046 (for drugs and alcohol)
ASCA	£239, 093 (£190,093 NHS; £49,000 LA)
GP enhanced alcohol service	£159,420
SPEAR	£79,040 (for drugs and alcohol)
TOTAL	**£1,489,599**

117. The actual amount of funding available for alcohol services is considerably less than specified above because most of the money identified funds both alcohol and drugs services.

118. In view of the limited funding available for alcohol services the task group suggested that resources could be shared with neighbouring authorities / PCTs and asked stakeholders to investigate further.

Recommendation 23:

That contact be made with neighbouring authorities / PCTs to maximise opportunities to work together and share resources in terms of alcohol service development.

Youth Offending, Education and Public Information

119. Drug and alcohol education and prevention is not about trying to convince young people never to drink, its broad aims are to help young people think about and look at the whole picture so as to make sensible and informed choices.

120. There is a social and cultural acceptance to drinking in Britain, which can't be hidden nor ignored from young people who are themselves growing ever closer towards greater independence. The ''just say no'' approach to drug education has proven not to work. It is important therefore not to play up the exciting sides to drinking, nor however to play it down, but rather to explore the whole picture.

121. Two PSA targets relate to alcohol – PSA 14 and PSA 25. PSA 14 relates more specifically to young people and has five indicators:

    1. Reduce the percentage of 16-18 year olds not in education, employment or training
    2. More participation in Positive Activities
    3. Reduce the proportion of young people frequently using illicit drugs, alcohol or volatile substances
    4. Reduce the under-18 conception rate
    5. Reduce the number of first-time entrants to the Criminal Justice System aged 10-17.

122. During their investigation the task group learnt that there is a lot already in place to meet these targets. These can be split up into the following broad areas (1) Education and Prevention in Schools (2) Education and Prevention Outside of Schools (3) Work with Parents and (4) looking within these broad areas to identify and refer children and young people at risk of harm from alcohol misuse. Further information about education and prevention and youth offending and alcohol misuse can be found in **Appendices C & D.** These briefing papers allowed the task group to have an informed discussion with Rob Henderson, Head of Youth Support; Gill Hines, Healthy Schools Co-ordinator and Kathryn Ruth, Drugs and Education Co-ordinator and helped the task group make recommendation in this important area.

Recommendation 24a:

That throughout the borough, schools provide a robust alcohol education

programme within Personal, Social and Health Education and similar arrangements made for the wider school community, including private schools.
Recommendation 24b: ***That alcohol theme days be used by all schools to ensure alcohol isn't forgotten about as part of Personal, Social and Health Education.***
Recommendation 25a: ***That the Cabinet Member for Children's Services and Education takes a lead on alcohol education ensuring it takes place in each school year with a particular focus given in years 6, 7 and 8.***
Recommendation 25b: ***That communication between primary and secondary schools be improved in relation to alcohol education.***
Recommendation 25c: ***That primary and secondary schools share information associated with alcohol harm and relevant stakeholders work through any resulting issues to ensure children don't 'slip through the net' of services.***
Recommendation 26: ***That alcohol coordinators be appointed in every school.***
Recommendation 27: ***That stakeholders promote opportunities for young people to meet up and socialise responsibly and safely without pressure to drink.***
Recommendation 28: ***Drugs, smoking and alcohol outreach work be developed to meet and target young people across the borough with harm reduction information around safer drinking.***

Recommendation 29: ***That a peer-led alcohol education campaign by and for young people be developed to counteract the popular images of alcohol.***
Recommendation 30: ***Improve awareness of the social implications of adult role modelling on younger people.***
Recommendation 31: ***That a more robust strategy be developed in relation to engaging parents in alcohol education so as to encourage confidence in talking with, rather than at, their children about alcohol and safer drinking.***
Recommendation 32: ***That the capacity of Young People's Drug and Alcohol Support be increased to provide tier 2 alcohol education to targeted young people, for example, in Pupil Referral Service, secondary schools and special schools.***

Economic Costs and Benefits

123. For most adults drinking alcohol is part of a pleasurable social experience, which causes no harm to themselves or others. For some people though, alcohol misuse is responsible for causing serious damage to themselves, their family and friends and to the community as a whole. **Appendix E** provides a useful summary of the private and external costs and benefits of alcohol use/misuse.

124. The Institute of Alcohol Studies estimate that the social costs of alcohol are normally estimated to be between 1% and 3% of GDP. **Appendix F** summarises the overall costs of alcohol misuse in England as of September 2003.

125. In this context, alcohol has significant costs not only for the individual but also for the whole economy. The potential savings to individuals, households, businesses and the public sector from effective measures to minimise harm from alcohol misuse could therefore be large. However, estimating these costs is a methodological challenge, given the difficulty of quantifying the degree of causality between alcohol misuse and its negative consequences. Nevertheless, cost estimates of this kind are potentially a valuable source of information for policy makers.

126. The task group tried to establish the economic costs and benefits of alcohol in Richmond upon Thames but this hasn't been possible. On the costs side, LBRuT's portion of the estimated national £20 billion cost is some £60 million simply based on our population share.

127. As part of the review Public Health Consultants from Richmond and Twickenham PCT were asked to use the Cabinet Office document *'Alcohol Misuse: How much does it cost'* (Sept 2003) to see whether it was possible to quantify all local healthcare costs associated with alcohol misuse.

128. The Cabinet Office document is a complex piece of health economic analysis which estimates gross, national, external costs due to alcohol misuse. The analysis is based on assumptions of health care use across a range of alcohol misuses, based on prevalence estimates of alcohol misuse derived from literature. The costs are derived by estimating the extent to which individuals who misuse alcohol and have alcohol-attributable illnesses consume health

services across the whole health economy (primary, secondary and specialist services).

129. Richmond and Twickenham PCT informed the task group that to replicate this work locally would be a huge undertaking and the following difficulties would be encountered:

    1. The assumptions used in the national study, such as prevalence levels and healthcare use, may not apply locally.

    2. Local data is incomplete (e.g. A&E data) and in some respects difficult to get hold of (GP data).

130. Dr Anita Jolly, Consultant in Public Health Medicine, suggested that the best that could be done would be to find out the total NHS expenditure for 2000/01 (the study year) and to calculate the proportion of that annual cost that the study estimated was spend on treatment of alcohol misuse (£1.5 billion mid-estimate). This proportion could then be applied to the total Richmond and Twickenham PCT budget for 2007 / 2008 to give an estimation of the total Richmond and Twickenham PCT spend on alcohol misuse. However, the PCT warn that this figure would have to be viewed with extreme caution because:

    1. The PCT would be applying historical data to current expenditure

    2. The PCT know from more recent mortality and morbidity data that the burden of alcohol-related illness is less in Richmond upon Thames than the England average and therefore the assumptions used in the national study would be an overestimation of local healthcare costs i.e. the proportion of total healthcare costs spent on alcohol misuse within the borough is likely to be less than the proportion spent on alcohol misuse nationally.

    3. The Cabinet Office study findings are estimates and not precise costs.

131. The task group were disappointed that they were unable to establish the economic costs of alcohol in Richmond upon Thames but it has become clear that whatever figures you use the costs associated with alcohol are too big to ignore.

CONCLUSION

132. Understandably, dealing with alcohol-related violence and anti social behaviour has been a higher priority for the public and relevant authorities than addressing the health harms resulting from excess alcohol consumption. Drunk and rowdy behaviour and criminality is a far more immediate and public problem than hidden and longer-term health harms. These priorities are reflected in the requirement that the borough's alcohol strategy should feed into the community safety strategy, rather than into a community health strategy.

133. A great deal is already being done to remedy anti social behaviour, including the recent introduction of controlled drinking zones, and the changes to the licensing policy. While not wishing in any way to underplay concerns regarding anti social behaviour, the situation does appear to be getting under better control (see paragraph 31). We should therefore use the new requirement for an alcohol strategy as an opportunity to focus concerns more on health harms.

134. We very much hope that the health and education issues discussed in this report will be addressed in public health programmes especially given the new emphasis nationally on preventative treatment.

Recommendation 33:   ***That all stakeholders consider seriously the balance between benefits and harm whenever considering issues relating to the supply and consumption of alcohol.***
Recommendation 34a: ***That Cabinet supports the idea that a senior member of the Local Strategic Partnership be appointed as a champion for the strategy.***
Recommendation 34b: ***That the first task of the 'champion' be to look at how best to establish an alcohol co-ordinator post to ensure the Richmond upon Thames alcohol strategy is delivered. This should include consideration of:***

- ***how the post is funded***
- ***how the co-ordinator will work across a range of organisations***
- ***what outcomes are to be achieved.***

TABLE OF RECOMMENDATIONS

Rec. No.	Recommendation	For action by:
1	That all sources of relevant funding be identified as a matter of urgency as the funding available (and what it can be used for) will impact on other recommendations.	Cabinet / PCT
2	That any application to change A1 (retail shops) to A3 (restaurants and cafes), A4 (drinking establishments) or A5 (hot food takeaways) be given very careful scrutiny in centres where high numbers of restaurants and bars already exist. Planning and licensing committees should be provided with information on trends and cumulative impacts when such applications are heard.	Cabinet
3	That the refuse collection times be co-ordinated so rubbish from shops is not left on the streets at night and wherever possible streets should be cleaned at night.	Cabinet
4	That officers be asked to investigate whether there is any way through planning or licensing conditions or planning obligations that A3, A4 and A5 uses can ensure litter generated is minimised (through conditions not allowing take away food) or otherwise promptly removed from the street.	Cabinet
5	That research be conducted to establish: (a) Who the users of the licensed sector are, how they 'come and go', how much they spend, and what their perceptions of the town centres are. (b) Why adults come to town centres in Richmond upon Thames during the night time economy and where they come from (c) Why under 18s come to town centres in Richmond upon Thames during the night time economy, where they come from and where they get their alcohol from. (d) The pros and cons of over 21 policies at licensed outlets and the impact of 18 – 21 year olds drinking off-license alcohol in the borough.	Cabinet
6	That the voluntary code for alcohol retailers in the borough be re-launched with the wording checked for legal compliance, especially regarding competition regulations.	Cabinet
7	That the local authority and police work with the industry and a local college to develop a module (NVQ / accredited scheme) for staff working in off-licences.	Cabinet / Police
8	That all staff selling alcohol in the borough be trained to ensure alcohol is always sold responsibly.	Cabinet
9	That the Richmond town centre redevelopment plans be reviewed to ensure adequate and appropriate transport	Cabinet

Rec. No.	Recommendation	For action by:
	provision is made during the night time economy.	
10	That further investigations take place in relation to setting up a (pilot) marshalled taxi rank in Richmond (for hackney carriages) and a minicab booking kiosk (for private hire vehicles)	Cabinet
11a	That initiatives to develop a night time economy based on diversity be supported by the local alcohol strategy to help the borough achieve purple flag status.	Cabinet
11b	That consideration be given to the appointment of a retail 'champion' or 'co-ordinator' who would promote, for example, evening opening of shops.	Cabinet
11c	That consideration be given to piloting more cultural events, particularly on Richmond riverside, and sports activities.	Cabinet
12	That the alcohol strategy promotes support for people who are affected by alcohol by for example encouraging all employers in the borough to have a work place alcohol policy.	Cabinet
13	That stakeholders look more vigorously at maximising the income flow available to develop an alcohol arrest referral scheme in Richmond upon Thames.	Cabinet Police / PCT
14	That an enhanced GP service be rolled out across the borough which considers both treatment and prevention during 2008/09.	PCT
15	That more be done in terms of brief interventions at tier 1. Screening tools such as CAGE, AUDIT or FAST should be more widely used by a range of frontline professionals including GPs, A&E, social workers, school nurses, housing officers and the police. (The actual or perceived lack of onward treatment services should not inhibit such screening)	PCT
16	That the best practice contract specifications supplied by Alcohol Concern be compared to current contracts and used in the future if appropriate.	PCT
17	That the movement from tiers 1 to 2, 2 to 3 be as seamless as possible.	PCT
18	That the capacity of tier 2 and 3 services be monitored to ensure the treatment system works as a whole.	PCT
19	That the PCT look at substance abuse models more generally to determine synergies in delivery.	PCT
20a	That support for family members be picked up in service contracts in tier 2.	PCT
20b	That where there is no close (family) support other types of support be made available for drinkers.	PCT
21	That in order to prioritise future service delivery the collection and sharing of data needs to be improved by all in relation to alcohol. In particular, reliable quantitative data is needed for alcohol related attendances in primary care, in A&E and for hospital admissions to address the current data underestimates. This is essential for the alcohol burden to be accurately reflected in the Council / PCT	PCT / West Middlesex University and Kingston Hospitals

Rec. No.	Recommendation	For action by:
	Joint Strategic Needs Assessment.	
22	That A&E departments share with the police data about where drunken patients bought their last drink,	West Middlesex University and Kingston Hospitals / Police
23	That contact be made with neighbouring authorities / PCTs to maximise opportunities to work together and share resources in terms of alcohol service development.	Cabinet / PCT
24a	That throughout the borough, schools provide a robust alcohol education programme within Personal, Social and Health Education and similar arrangements made for the wider school community, including private schools.	Cabinet
24b	That alcohol theme days be used by all schools to ensure alcohol isn't forgotten about as part of Personal, Social and Health Education.	Cabinet
25a	That the Cabinet Member for Children's Services and Education takes a lead on alcohol education ensuring it takes place in each school year with a particular focus given in years 6, 7 and 8.	Cabinet
25b	That communication between primary and secondary schools be improved in relation to alcohol education.	Cabinet
25c	That primary and secondary schools share information associated with alcohol harm and relevant stakeholders work through any resulting issues to ensure children don't 'slip through the net' of services'.	Cabinet
26	That alcohol coordinators be appointed in every school.	Cabinet
27	That stakeholders promote opportunities for young people to meet up and socialise responsibly and safely without pressure to drink.	Cabinet
28	Drugs, smoking and alcohol outreach work be developed to meet and target young people across the borough with harm reduction information around safer drinking.	Cabinet
29	That a peer-led alcohol education campaign by and for young people be developed to counteract the popular media images of alcohol.	Cabinet
30	Improve awareness of the social implications of adult role modelling on younger people.	Cabinet
31	That a more robust strategy be developed in relation to engaging parents in alcohol education so as to encourage confidence in talking with, rather than at, their children about alcohol and safer drinking.	Cabinet
32	That the capacity of Young People's Drug and Alcohol Support be increased to provide tier 2 alcohol education to	Cabinet

Rec. No.	Recommendation	For action by:
	targeted young people, for example, in the Pupil Referral Service, secondary schools and special schools.	
33	That all stakeholders consider seriously the balance between benefits and harm whenever considering issues relating to the supply and consumption of alcohol.	Cabinet
34a	That Cabinet supports the idea that a senior member of the Local Strategic Partnership be appointed as a champion for the strategy.	Cabinet / LSP
34b	That the first task of the 'champion' be to look at how best to establish an alcohol co-ordinator post to ensure the Richmond upon Thames alcohol strategy is delivered. This should include consideration of: • how the post is funded • how the co-ordinator will work across a range of organisations • what outcomes are to be achieved.	

SELECTED READING

Alcohol Harm Reduction Strategy for England (AHRSE)
www.cabinetoffice.gov.uk/**strategy**/downloads/su/**alcohol**/pdf/CabOffce%20**Alcohol**Har.pdf

Safe Sensible Social – The Next Steps in the National Alcohol Strategy
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_075218

Models of Care for Alcohol Misuse (MOCAM)
www.dh.gov.uk/prod_consum_dh/idcplg?IdcService=GET_FILE&dID=28613&Rendition=Web

Alcohol Needs Assessment Research Project (ANARP)
http://www.dh.gov.uk/prod_consum_dh/idcplg?IdcService=GET_FILE&dID=5841&Rendition=Web

2004 Home Office research into young people and alcohol
http://www.homeoffice.gov.uk/rds/pdfs06/r277.pdf

Highs and Lows 2
http://www.london.gov.uk/mayor/health/drugs_and_alcohol/docs/highs-lows2.pdf

Economic Costs and Benefits – Institute of Alcohol Studies Fact Sheet
www.ias.org.uk

Alcohol misuse: How much does it cost? (Cabinet Office – 2003)
http://www.cabinetoffice.gov.uk/upload/assets/www.cabinetoffice.gov.uk/strategy/econ.pdf

Drinking places: Where people drink and why (Joseph Rowntree Foundation – 2007)
http://www.jrf.org.uk/bookshop/details.asp?pubID=935

Night Vision: Town Centres For All (Civic Trust – 2007)
http://www.civictrust.org.uk/publications/Nightvision_report.pdf

Managing the Night Time Economy – Best Practice Guidance (GLA – 2007)
http://www.london.gov.uk/mayor/strategies/sds/docs/bgp-nte/bpg-nighttime-economy.pdf

London's Night Time Economy (GLA – 2005)
http://www.london.gov.uk/assembly/reports/econsd/night-time-econ.pdf

Expecting 'Great Things'? The Impact of the Licensing Act 2003 on Democratic Involvement, Dispersal and Drinking Cultures. (University of Westminster – 2007)
http://www.ias.org.uk/cci/cci-0707.pdf

Alcohol Strategies

Preston Alcohol Harm Reduction Strategy
http://www.prestonalcoholstrategy.co.uk/index.php?option=com_frontpage&Itemid=1

Tackling Alcohol Misuse in Westminster 2006 – 2009
http://www3.westminster.gov.uk/docstores/publications_store/Westminster%20Alcohol%20Strategy%202006-09.pdf

Toolkits

http://www.localalcoholstrategies.org.uk/index.php

http://www.alcoholconcern.org.uk/files/20040706_102033_LAS%20Summary%20national%20PDF.pdf

Task Group Agenda Papers

Meeting 1 – Scoping / Background Information – 27 September 2007

- Terms of Reference / Membership
- The Scrutiny Review Process
- The National Alcohol Strategy and Related Issues
- Working in Partnership in Richmond upon Thames
- Assessment of Alcohol Related Harm in Richmond upon Thames (2004)

Meeting 2 – Licensing, the Night Time Economy and Related Issues – 11 Oct 2007

- (Draft) Licensing Policy 2008 - 2011
- The role of alcohol in the night time economy
- Best Bar None / Safer Socialising
- Street Scene, Parks and Open Spaces
- Transport Issues
- Draft Work Plan

Meeting 3 – The Economy, Alcohol and Trading Standards – 5 November 2007

- Briefing Paper

Meeting 4 – Crime and Alcohol – 13 November 2007

- 'An overview and analysis of Alcohol related incidents in the London Borough of Richmond upon Thames'

Meeting 5a – Marshalled Taxi Ranks / Minicab Booking Kiosks – 4 December 2007

- 'Partnership Excellence Awards 2007' - information about the successful schemes used in Kingston upon Thames.

Meeting 5b – Health Issues / Alcohol Services – 4 December 2007

- A briefing on the health effects and treatment services in the London Borough of Richmond upon Thames
- Option Appraisal for Alcohol Service Development (Alcohol Concern)

Meeting 6 – Youth Offending, Education and Public Information – 6 December 2007

- Education and Prevention: promoting a culture of sensible drinking
- Youth Offending and Alcohol Misuse

APPENDICES

Appendix A	**Timetable of meetings**
Appendix B	**LGBT Notes from Health OSC**
Appendix C	**Education and Prevention Briefing**
Appendix D	**Youth Offending and Alcohol Misuse Briefing**
Appendix E	**Summary of the private and external costs and benefits of alcohol use/misuse**
Appendix F	**Summary of the overall costs in England as of September 2003**

Appendix A – Timetable of Meetings

Date	Witnesses	Issues discussed
27 Sept 2007	Dr Rachel Seabrook, Institute of Alcohol Studies, Sgt Tom Knox, Esther Worboys, Twickenham Town Centre Manager and Barry Croft, Licensing Team Leader.	Scoping / Background Information
11 Oct 2007	Adrian Waterworth, Richmond Pubwatch, Eddie Piece, Richmond Pubwatch, Carl Morlese, Assistant Head of Streetscene, Sgt Tom Knox, Barry Croft, Licensing Team Leader, Anne Lawtey, Community Safety Partnership Manager, Chief Inspector Mike Kirby, Sgt Tony Lovegrove, Safer Neighbourhoods, Caroline Steenberg, Planning Officer, Esther Worboys, Twickenham Town Centre Manager, Rob Mitchener, Head of Licensing and Tom McAuley, Twickenham Pubwatch.	Licensing, the night time economy and related issues
5 Nov 2007	Sgt Tom Knox, Sue Rippon, Corporate Policy Consultant, Dave Smith, Head of Trading Standards, Anne Lawtey, Community Safety Partnership Manager, Rob Mitchener, Head of Licensing, Adrian Waterworth, Richmond Pubwatch, Eddie Piece, Richmond Pubwatch and Angela Ivey, Principal Tourism & Marketing Manager	The Economy, Alcohol and Trading Standards
13 Nov 2007	Sgt Tom Knox, Anne Lawtey, Community Safety Partnership Manager, and James Rowlands, Domestic Abuse Co-ordinator.	Crime and Alcohol
23 Nov 2007	Sgt Tom Knox	Police Site Visit – Policing the Night Time Economy
4 Dec 2007	Steve Howard, South Branch Chairman, LTDA, Robin Gillis, Public Carriage Office, Robert Dray, Senior Transport Planner, David Noakes, Community Safety Officer, Sgt Tom Knox.	Marshalled Taxi Ranks / Minicab Booking Kiosks

4 Dec 2007	Cllr Carr, Cabinet Member for Adult Services, Health and Housing, Mike Ward, Alcohol Concern, Janelle Pattern, Joint Commissioning Manager, PCT, Sarah Darcey, Joint Commissioning Manager, PCT and Dr Anita Jolly, Consultant in Public Health Medicine, PCT.	Health Issues
6 Dec 2007	Rob Henderson, Head of Integrated Youth Support Services, Gill Hines, Health Education Consultant, Kathryn Ruth, Drugs and Education Co-ordinator.	Youth Offending, Education and Public Info
10 January 2008	Ranjit Dhillon, *Chief Executive, ASCA.*	Meeting with ASCA - Addiction Support and Care Agency
10 January 2008	Michael Carson, Anti-Social Behaviour and Alcohol Unit, Home Office, Sgt Tom Knox, Cllr Williams, Cabinet Member for Communities and Anne Lawtey, Community Partnership Manager.	Findings / Recommendations
21 January 2008	Anne Lawtey, Community Safety Partnership Manager.	Draft Report

APPENDIX B

Notes for Richmond upon Thames Health OSC Meeting, Mon 4 February 2008

I am Richard Eason, an Officer of the Richmond upon Thames LGBT Forum and Co-chair of OutWest. I am speaking from the perspective of the local LGBT communities. It is estimated that about 10% of London's population is Lesbian, Gay, Bisexual or Transgender, this equates to 15-20 thousand people in this borough – a significant minority group!

Whilst we welcome the Task Group's Report and the opportunity to comment on it, we are disappointed that it does not recognise or address specific issues related to reducing health inequalities for LGBT people.

Firstly I'd like to quote some findings from the Department of Health's Briefings on LGBT Health:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078347

- we are believed to lead less healthy lifestyles: we have higher levels of alcohol consumption, are more likely to smoke and more likely to misuse drugs than heterosexual people.

- Researchers have pointed to the lack of social spaces for LGBT people apart from pubs and clubs. They suggest that LGBT people have been obliged to use the 'scene' and to fit in with a drinking culture.

- There is also an association between harassment in the workplace and alcohol problems for lesbian and bisexual women in comparison with heterosexual women

- Some of us may use alcohol and tobacco as coping mechanisms in dealing with homophobia. Homophobia may also lower self-esteem and undermine a person's ability to avoid pressures to drink.

- Lesbian and bisexual young women are at increased risk of a number of alcohol-related behaviours compared with heterosexual women. They more likely to have had episodes of binge drinking in the past year, and they report a higher average number of alcoholic drinks usually consumed when drinking.

- Among adult lesbian and bisexual women, abstention rates were found to be lower, and they were more likely to report alcohol-related social consequences and alcohol dependence, and to have sought help in the past for an alcohol problem.

- The greatest difference in alcohol use patterns appears amongst women in the 26–35-year-old age range. Lesbian and bisexual women were more likely to have higher levels of alcohol consumption, both in frequency and quantity.

Secondly there are specific characteristics of the our participation in the Night Time economy

- The scarcity of LGBT venues means we travel more to visit pubs and clubs. This borough has only one gay pub, people travel from throughout the borough and neighbouring boroughs to visit that venue. Residents also travel out of the borough to visit venues in Kingston, Ealing and Central London.

- We are likely to use public transport to travel quite long distances, often late at night and after consuming alcohol. Many of us, especially young LGBT people cannot afford to use taxis, therefore have to rely on public transport, especially night buses.

- All this makes us more vulnerable to crime, including homophobic violence and abuse on the streets and on public transport.

Additionally there are specific issues concerning Alcohol, LGBT people and

- Sexual health
- Mental health and
- Domestic abuse

We would like the Task Group to consider all these matters and ensure that the resulting actions are inclusive and equitable for the 10% LGBT minority in this borough.

Thank you, any questions?

Appendix C

Alcohol Strategy – Education and Prevention Briefing
Promoting a culture of sensible drinking

Advantages and disadvantages of alcohol use in Richmond upon Thames

Drug and alcohol education and prevention is not about trying to convince young people to never drink, its broad aims are to help young people think about and look at the whole picture so as to make sensible and informed choices.

There is a social and cultural acceptance to drinking in Britain, which can't be hidden nor ignored from young people who are themselves growing ever closer towards greater independence. The "just say no" approach to drug education has proven not to work, because, if it is so bad why are people doing it? It is important therefore not to play up the exciting sides to drinking, nor however to play it down, but rather to explore the whole picture, the good and the bad and figure out what it means to be "safe and sensible".

Assessment of the effectiveness of controls and treatments currently used in reducing alcohol related harm, looking specifically at education and prevention work with young people and parents

As outlined in "Safe. Sensible. Social.", the National Alcohol Strategy, to reduce the harms from alcohol in Britain there needs to be a cultural shift in how we perceive alcohol and how young people perceive us, being clear as a society as to what it means to drink safely and responsibly.

The two Government PSA Targets which relate to more safe and sensible drinking are:

PSA 14: Increasing the number of young people on the path to success

PSA 25: Reduce the harm caused by Alcohol and Drugs

PSA 14 relates more specifically to young people and has five indicators:

1. Reduce the percentage of 16-18 year olds not in education, employment or training (NEET)

2. More participation in Positive Activities

3. Reduce the proportion of young people frequently using illicit drugs, alcohol or volatile substances

4. Reduce the under-18 conception rate

5. Reduce the number of fist-time entrants to the Criminal Justice System aged 10-17

Appendix C

What is already in place and happening within Richmond Borough to meet these targets and indicators around education and prevention? We can look broadly at three areas: Education and Prevention in Schools, Education and Prevention Outside of Schools, Work with Parents, and looking within these broad areas at the protocols to identify and refer children and young people at risk of harm from alcohol misuse.

Education and Prevention in Schools

Richmond Borough is comprised of 12 secondary and special needs schools and 41 primary schools. Each school is responsible for meeting national educational standards to raise awareness of the risks and harms of alcohol misuse.

Within the Curriculum

Some requirements within the curriculum are statutory, e.g. looking at how alcohol affects the body in Science, and some are non-statutory e.g. having a timetabled PSHE (Personal Social and Health Education) programme in place which can help build on better decision making skills and challenging attitudes and assumptions.

Drug Education is not just for secondary schools, but starts in primary schools and should be delivered cross phase, from Key Stage 1 to Key Stage 4 and cross curricular, i.e. not just taught in one subject but spiralled throughout.

Alcohol education can be taught to a very high level with skilled tutors and active learning techniques or skimmed over and not taught with any depth or lasting impact. Ultimately it is down to how the school decides to cover the issues. There is national guidance with the DCSF (DfES/0092/2004) and QCA (Qualifications and Curriculum Authority) which schools are advised to follow.

The LEA Drug Education Coordinator is employed to help support, provide guidance and monitor drug and alcohol education within Richmond borough. The level of education standards has greatly improved in the last five years with greater awareness of the issues, due in part to the implementation of such schemes as Healthy Schools and the ECM agenda. There is still a long way to go. Most children and young people enjoy drug and alcohol education, however with the pressures on statutory schools to fulfil more rigorous academic standards then ever the non-statutory requirements can get squeezed out.

PSHE is now timetabled into almost every secondary school in Richmond Borough, and within most primary schools. Having a dedicated teaching time for this subject is an important aspect in delivering effective alcohol education, as well as encouraging staff to access additional training to deliver classes in an active learning style. Drug and alcohol education must however be pushed as a crucial aspect from senior leadership within Children's Services for schools to actively take this on board.

Appendix C

School Drug Policies

Each school, both secondary and primary should have an up-to-date school drug and alcohol policy which outlines the school rules, drug or alcohol related incident protocol, and the timetabled curriculum for drug and alcohol education. Richmond Borough has adopted LEA key performance indicators around school drug policies within the Children and Young People's Plan. The KPI is under the Be Healthy SubGroup stating that 100% of Healthy Schools should have a schools drug policy in place which is updated every three years. It is each school's as well as the LEA's responsibility in making sure schools have and adheres to their updated policies.

Healthy Schools

The National Healthy Schools Award supports best practice within drug and alcohol education. It is awarded to schools who fulfil requirements covering four themes, two of which are related to alcohol education: PSHE and Emotional Health and Well Being.

There is a Healthy Schools partnership group who is responsible for quality assurance around the scheme. The partnership is made up of borough representatives within the PCT, LEA, and voluntary sector, including the LEA Drug Education Coordinator.

The partnership group meets once a term to discuss issues and host a once a term ECM forum for all Richmond Borough schools PSHE and Healthy Schools Coordinators. The Healthy Schools partnership group is overseen by the lead school inspectorate and reports into the Be Healthy SubGroup.

It is through this group that there is quality assurance within practice, and gaps in CPD or training and support needs are identified if a school is failing to meet its obligatory requirements as a Healthy School or working towards Healthy School Status.

Pastoral Support and Multi-Agency Teams

Each secondary school has a host of outside professionals who support pupils with learning, behavioural and emotional difficulties. These professionals are overseen by the pastoral support system within each school and usually coordinated by the deputy head teacher responsible for child protection or the SENCO Coordinator.

Multi-agency teams, where they exist, meet anywhere from weekly to once every half term, and can be comprised of: learning mentors, school nurse, Connexions Personal Advisors, Education Welfare officers, counsellors, and the LEA substance misuse worker. The aims of the group are to identify pupils which need additional support and provide a coordinated care plan. It is within these forums that children or young people who are identified with alcohol or drug related needs can be referred to the Young People's Drug and Alcohol

Support substance misuse worker, who can see pupils inside or outside of school.

Education Outside of School

When looking at education it is important to consider not just education within school but all of the good education which is happening outside of the school.

Youth Service and Detached Work

The Youth Service is a universal service open to every young person who lives or goes to school within Richmond Borough. The youth service has a broad capacity of providing generic open clubs as well as more targeted youth service provisions.

There are 6 youth clubs throughout Richmond Borough who provide a service for up to 3,000 young people within the borough. The Youth Service adheres to an overarching Curriculum in which alcohol and drug education are a component part. There is currently for instance a rolling six week programme at each youth club for detached drug and alcohol education during open club nights with the Detached Drug Project youth worker.

Outreach Work

Another aspect of youth work is outreach and detached youth work in which qualified youth workers go to where young people hang out. This could be in the parks, along the river, graveyards, and high streets etc., e.g. one popular place is the skate park in Hampton Wick.

Information and harm reduction tips are disseminated through informal conversation and dialogue within settings which are on young people's terms. It is a proven effective way of reaching young people who are otherwise hard to reach through the more structured services such as schools and colleges.

YOT

The Youth Offending Team has a dedicated Substance Misuse Worker who will carry out a set amount of sessions with every young person who has been identified with drug and alcohol related needs when entering the criminal justice system.

Depending on need this can either be a brief harm reduction intervention looking at reducing risk and providing educational information, longer term psychosocial interventions, or sometimes can result in a referral for more long term psychotherapeutic support within the Young People's Drug and Alcohol Support team.

Sorted4.Info Website for young people, parents, and professionals

Richmond Borough in partnership with Kingston Borough has recently redesigned a local drug and alcohol website for young people, parents and professionals. This website which is aimed at giving young people factual information and harm reduction guidance around drugs and alcohol as well as a virtual tour of young people's services within Richmond and Kingston, also has a portal for parents looking for information, and professionals.

The website will be having its soft launch by December 07 and public launch by Spring 2008. It is hoped that the site will be accessed by young people in schools through drug and alcohol research projects, at youth clubs and in a young person's own time when needing support and information.

The parents' site is aimed at parents who want basic information around the effects and risks of drugs and alcohol as well as tips on how best to talk to their children about the issues.

The professionals' site will lay out best practice and protocols in dealing with young people at risk of harm from alcohol and drug misuse, as well as policy guidance and resources such as downloadable referral forms or lesson plans for teachers.

Work with Parents

Good communication within the home between parents and their children is one of the most effective ways to reduce harm around alcohol related issues. Helping parents feel more confident and able to talk to their children should be a key aim within any Alcohol Strategy.

Another aspect of working with parents is the targeted work with parents whose drinking is causing risk to the well being of their children. This can be a clear indicator in early identification of children who may be prone to higher risk taking behaviour later on.

<u>Partnership work with the Parenting Coordinator</u>

One method of delivery of drug and alcohol education and awareness for parents within Richmond is through partnership work with the borough's Parenting Coordinator. This happens through Parenting Groups, in one-to-one sessions, or Parenting Events, e.g. a pre-xmas festive evening is being hosted for parents and their children to look at the issues of drugs and alcohol together.

Parents are referred to the parenting groups from Social Services, ART, the YOT or schools, when it is felt that the parent could benefit from additional parenting support. The groups run for eight sessions, one of which is a drug and alcohol component, looking at the risks of drugs and alcohol and how best to talk to their children about the issues.

<u>Young Mums and Dads Group with Youth Service Connexions PAs</u>

These groups are held for all young mothers and fathers between 16 and 24 as a support group to help build confidence, learn life skills, openly talk about things such as what it means to drink responsibly to reduce risk and build resilience in parenting. There are planned drug and alcohol focused workshops in the new year with one of the borough's substance misuse workers. The young mums group meets in Whitton which is a hot spot area for Richmond Borough.

Parents Evenings within Schools

Parent evenings are provided by Young People's Drug and Alcohol Support LEA Drug Education Coordinator for schools to offer as parent evenings, looking at the effects of alcohol and drugs, why young people take risks, and how best to support them. There have been a handful of schools who have taken up this offer, three of which have been secondary schools. We are hoping that every secondary school and some primary schools will offer this on a once yearly basis.

Protocols to Identify and Refer Children and Young People at Risk of Harm from Alcohol Misuse

Some protocols are in place in alignment with Every Child Matters and Hidden Harm initiatives, which can refer young people to the Young People's Drug and Alcohol Support for therapeutic support or brief drug and alcohol education interventions if more appropriate.

- There is a good level of working practices for services to refer into the Young People's Drug and Alcohol Support, where there are weekly allocations and care planning meetings. There are presently a high volume of referrals anywhere from two to four a week. Current capacity is full, however no waiting list exists as of yet. The team are hoping to acquire a new worker in the spring. Referrals come from Social Services, Schools, GPs, CDAT, Social Inclusion, YISP, YOT, CLA or Leaving Care Team, Parents or self referrals. There is a good working relationship between professionals.
- There are a range of trainings delivered to professionals which incorporates screening and referral procedures.
- A new training has been planned around the Hidden Harm agenda, looking at appropriate referrals of children from families where there is alcohol misuse.
- There is continuous work with schools in having clearer referral protocols and pathways and an integrated multi-agency support programme.
- There is increasing partnership work with the Community Drug and Alcohol Team in working with Hidden Harm, e.g. the children from families who are accessing treatment where there is substance misuse.

Other controls/treatments that could be used in Richmond upon Thames to help minimise the health harms, violence and antisocial

behaviour associated with alcohol, while ensuring people are able to enjoy alcohol safely and responsibly

When looking at alternative controls, the good practice already happening within Richmond Borough must be acknowledged. In many instances improvements for the local alcohol strategy will be about building and moving forward the existing practices. A few alternative controls that aren't in place, within a young people's agenda, could be looked at, some of which have been highlighted below.

The borough could work in partnership with established bodies to create more young people friendly, alcohol free zones, to prevent young people feeling under pressure to drink or to behave anti-socially. Although the borough has a strong youth service, healthy socialising within the community rather than being pushed to the outskirts of it, needs to be encouraged. Providing 'grown-up' and safe places to go, such as cafes or restaurants that have a 'youth-night' or late-night young people friendly zones, can help young people learn to meet others, develop relationships and socialise in increasingly 'adult' ways, to encourage their development on the path to becoming responsible young citizens.

The borough could take a stronger approach in campaigning to both adults and young people in the borough with a safer drinking and "know your limits" campaign. Many young people are influenced by media and what is seen as the acceptable norm. Putting together a campaign strategy which includes the views of young people and uses creative techniques such as peer education, drama, the arts and music are all ways to engage young people onto the platform to help this issue be more widely acknowledged and addressed.

There could be greater support from management on strategic levels so that the work on the ground can be more effective and long lasting. Partnership work within Children's Services needs to be encouraged more actively with joint working agreements around a shared agenda. Schools for example need to be encouraged to place drug and alcohol education higher on their agenda with a coordinated approach of delivery that includes parents as well as the wider school community. This push needs to come from higher strategic management within the Education Department rather than left to be delivered sporadically in a "too little and too late" manner.

Recommendations (for discussion and development) to Cabinet and the Community Safety Partnership and, where appropriate, other stakeholders, to develop an effective and efficient borough wide alcohol strategy

1. Greater awareness of the social implications of adult role modelling on young people today and further dialoguing of the issues with young people

2. More stringent requirements for schools and head teachers to provide a more robust alcohol education programme within PSHE and the wider school community, i.e. compulsory staff and governor training if dealing with or teaching drug and alcohol related issues

3. An inclusive alcohol strategy that provides opportunities to young people to meet up and socialise responsibly and safely without pressure to drink

4. To further develop drugs and alcohol outreach to meet and target young people across the borough with harm reduction information around safer drinking

5. Development of a peer-led alcohol education campaign by and for young people, to counteract popular media images of alcohol being cool and attractive

6. A more robust strategy around engaging parents with the issues so as to encourage confidence in talking *with*, rather than at, their children about alcohol and safer drinking

7. Enhanced partnership working on the issue of safer drinking, for example with Extended Schools and Family Support Centres

8. Increasing capacity of Young People's Drug and Alcohol Support to provide tier 2 alcohol education to targeted young people, for example in the PRS, secondary schools and special schools

APPENDIX D

ALCOHOL STRATEGY SCRUTINY TASK GROUP

DATE: **6 DECEMBER 2007**

REPORT OF: **ROBERT HENDERSON**

SUBJECT: **YOUTH OFFENDING AND ALCOHOL MISUSE**

WARDS: **ALL**

1. Summary

The Youth Offending Team works with young people aged 8 -17 to both prevent them from offending in the first instance and then re-offending once they have entered the criminal justice system.

This report highlights current data and key service provision and issues, as they relate to youth offending and alcohol

All comments are made within the context that whilst alcohol is experienced as a major factor in offending behaviour and anti social behaviour, there is no dedicated post within the youth offending team to address it, no government funding and no local or national performance indicators. For a small borough with a local priority in respect of alcohol misuse and crime, the national focus on substance misuse has not been helpful

2. Recommendation

It is recommended that Overview and Scrutiny note this report and look to identify key gaps in service delivery including both prevention and intervention and look to possible solutions in addressing these gaps.

3. Purpose of Report going to Scrutiny Committee

To assist Overview and Scrutiny Committee in having a comprehensive understanding of issues as they relate to young people and to support them in making key recommendations in addressing these.

4. Details

4.1 Context

The national context is that alcohol misuse is on the increase in relation to young people.

Information from the Drug Education forum states that there are two cultures working in tandom – the majority of young people are not drinking but the minority are drinking more.

Over and above this in the last 4 years average consumption of the average 15 year old male per week has risen from 10- 14 units and for females from 6 to 11 units. Younger age groups are also drinking more and their unit intake, particularly of 11-13 year olds is rising faster than the 15 year old cohort.

4.2 Local context

This picture analysed below is reflected within the youth offending team – alcohol is an increasing risk and associated factor in offending, particularly violent offences and is more likely to be associated with female offending patterns.

Richmond Youth Offending Team work with approximately 200 young people per year from early intervention through to working with young people in custody and beyond. Approximately 80% are male and 20% female, although at both the preventative end and high community penalty end, females are far more representative suggesting that they are both more likely not to re-offend but that when they do they are also more likely to be high risk offenders. Approximately 18% of offenders are from BME groups, representative of the 10-178 population. No significant differences are noticeable in the BME cohort as it relates to alcohol.

The Team is a multi agency service involving professionals from the Police, Probation, Connexions, CAMHS, Drug Action Team and the Council. The YOT also a range of other services including mentoring, parenting courses, mediation conferences t0o tackle bullying in schools and an in school targeted group work programme. The YOT is one of the highest performing YOTS in the country and the lowest funded in London.

4.3 Young offenders and alcohol

In terms of typically alcohol related offences numbers in the last 12 months would include

Violence against the person –	56
Criminal Damage	56
Robbery	48
Public Order offences	84

(Drugs offences involved 32 separate offences)

33.3% of female young people offending in the last quarter committed alcohol related offences - 24 of young women received court ordered sentences in the 6 months – 8 of these related to alcohol related offences.

From an analysis of our current 55 Court Ordered and community and custodial sentences the following picture emerges

- Four young people are in custody, one female. 3 offences involved grevious bodily harm and one other Robbery. All the offenders had consumed large quantities of alcohol. Of the last 6 females to receive a

custodial sentence, 100% had committed an offence aggravated by alcohol. One has received rehabilitation.

- In relation to our national assessment tool, of the 55 young people the average assessment of risk of offending in relation to alcohol is 1.5 for males and 1.45 for females, where 0 is low and 4 is high.

- 17 of total sample (about 1/3) had alcohol as an aggravating and contributory factor to their offence. 58% of these were male and 42% female

- Out of total male population at the YOT 22.73% of young men who offend had alcohol as an aggravating or contributory factor to their offending

- Out of female population at YOT 90.9% had alcohol as an aggravating or contributory factor to their offending

- From the above sample it appears that whilst alcohol is definitely a contributory factor to offending it appears to be far greater for that of the female population. It is important to note that whilst the above information demonstrates the propensity of young people to offend whilst consuming alcohol it does not necessarily reflect their use of alcohol as a whole.

- Interventions offered form the substance misuse worker are far higher than one would think from the above data primarily because during assessment it becomes prevalent that the young person has been abusing alcohol, even if it has not been a factor to their index offence.

- Interventions offered in the form of substance misuse to young people out of current young people sampled for this data was 36 out of the 55 young people, representing a figure of 65.45% of young people who receive some form of intervention from the substance misuse worker. Over 80% will include work in relation to alcohol

- 27 young people seen by the substance misuse worker are male- 75%. 61% of males within the Youth Offending team current community sentence caseload have or are receiving substance misuse/ alcohol input.

- 9 - 25% of all young people receiving an intervention pertaining to alcohol and drugs is female. However 81.8% of all girls who are active cases open to the YOT have either received or are receiving substance misuse and alcohol intervention.

- This suggests again that whilst the female representation is relatively low as a proportion of all young offenders they appear to have greater needs and issues in relation to alcohol.

Interventions that the YOT are currently offering–

- Binge drinking group session – one off session looking at harm reduction and affects of binge drinking.

- One to one sessions delivered by Substance misuse worker:

- Girls group for young women at risk of or early stages of crime/ anti social behaviour – alcohol and drugs are a key theme to a programme focused on building self esteem and improving confidence and family relationships

- Parenting Groups – 4 groups currently operating to a range of levels of need – all address alcohol and drugs and support young people

- Delivery of Tier 2/3 young women and alcohol 4 – week group

- Delivery of tier 2 – targeted harm reduction and awareness

- Delivery of tier 3 – Structured care plan over number of weeks. This is delivered in the form of one to one sessions and home visits. A systemic approach to look at alcohol - looking at problematic alcohol use not only the cause of problems but rather the symptom of wider issues.

- Residentials with the drugs team, currently running twice a year.

Future plans include:

Currently plans are in place to offer complimentary therapy to young people at Tier 3, such as homeopathy and acupuncture at Richmond Royal and this is being negotiated with the PCT.

Integrated Youth support services will be offering a range of preventative and targeted services in the 5 priority wards – Youth Workers, Connexions Personal Advisors, Extended School Coordinators, Adolescent Resource Team workers, Youth Offending Team workers, Substance Misuse workers will be working within a locality based network, creating a virtual to team to ensure the needs of the local community are being addressed. This will allow for easier access to advice and guidance as well as more specialists services. Addressing alcohol and related issues will be a priority in each ward.

Undertaking a local needs analysis of alcohol and substance use among young people involving 1000 school pupils and focus on targeted groups – by April 2008

The Common Assessment Framework is being launched in April 2008 – this is a process which attempts to identify young people with additional needs and problems at the earliest stage and provide intervention swiftly

4.4 Conclusions

National good practice messages suggest that

- Alcohol is on the increase for a minority of young people but this increase is serious. (Drug Education Forum)

- Alcohol is not sufficiently high up enough on School curriculum

- Education delivery on alcohol is too knowledge base and does not address real life issues for young people – low self esteem, peer groups

- Parents lack confidence in addressing alcohol issues with young people and knowing what is acceptable, responsible and safe

- Parents often have alcohol issues themselves

- There should be dedicated workforce, with a specific budget alongside collective professional responsibility to address the issues confidently

- Action should be based on evidence and research

Local issues in relation to youth crime and alcohol suggest

- Serious crime has a close relationship to alcohol misuse, particularly among female offenders.
- Violence and robbery are most likely to have alcohol as an aggravating factor
- There is relatively local priority given to alcohol misuse, particularly when compared to substance misuse
- There are no local performance indicators or specific budget – substance misuse workers absorb alcohol misuse in their brief
- Issues in relation to alcohol are not being detected earlier enough and there are insufficient interventions at the earliest stages
- There is little expertise across the workforce in relation to alcohol misuse

Key gaps include

- Good needs analysis on issue locally of alcohol misuse and hidden harm of alcohol using parents
- Coherent prevention strategy
- Strategic framework to address levels of need from Tier 1-4
- Training for workforce particularly in Schools
- Addressing sale of alcohol to young people.

5. Contacts

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Chart 7 Private and external costs and benefits of alcohol use/misuse

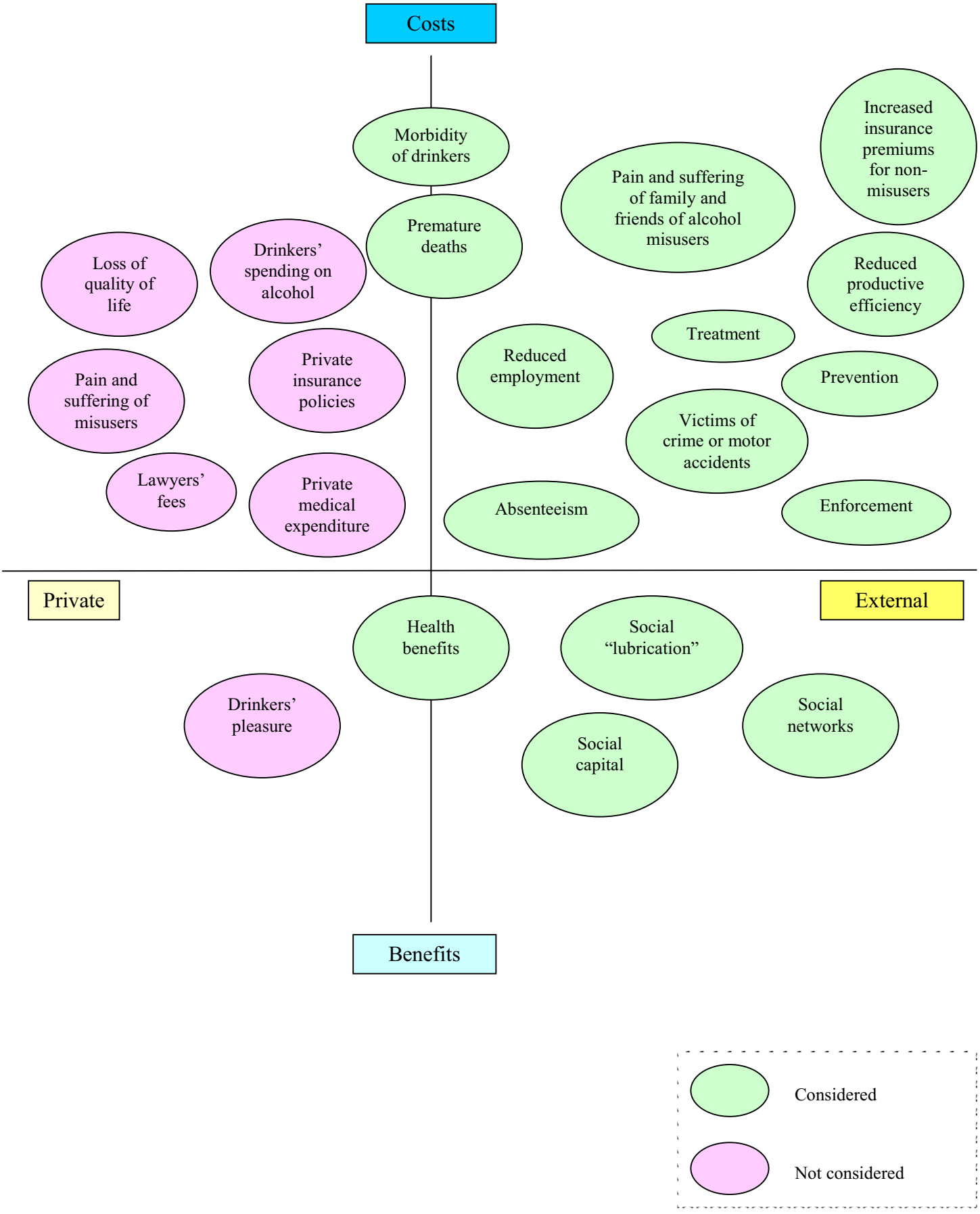

Table 40 Overall Costs of Alcohol Misuse (£ millions)		
	First Estimate	Second Estimate
Health Care Costs		
Hospital inpatient (&day) visits		
Directly attributable to alcohol misuse	126.2	126.2
Partly attributable to alcohol misuse	344.2	399.8
Hospital outpatient visits	222.8	445.6
Accident and emergency visits	305.2	305.2
Ambulance services	205.0	205.0
Practice nurse consultations	19.1	19.3
NHS GP consultations	27.8	48.7
Laboratory tests	N/A	N/A
Dependency prescribed drugs	1.6	1.6
Other health care costs	35.3	35.3
Specialist treatment services	96.2	96.2
Workplace and Wider Economy Costs		
Lost output due to absenteeism	1,213.6	1,785.9
Lost output due to reduced employment	1,726.1	2,153.7
Lost output due to reduced employment efficiency	N/A	N/A
Lost output due to premature death	2,254.3	2,481.8
Costs of alcohol-related and alcohol specific crime		
Criminal Justice System costs		
Alcohol specific offences	29.9	29.9
Alcohol-related offences	1,720.4	1,720.4
Property/health and victim services	2,521.2	2,521.2
Costs in anticipation of crime (alarms etc)	1,494.6	1,494.6
Lost productive output of victims	969.8	969.8
Emotional impact costs for victims of crime	4,678.6	4,678.6
Drink driving		
Criminal Justice System costs	77.3	77.3
Cost of drink-driving casualties		
Lost output		
Serious casualties	33.8	33.8
Slight casualties	25.9	25.9
Medical and ambulance		
Serious casualties	20.5	20.5
Slight casualties	11.0	11.0
Human costs		
Serious casualties	232.8	232.8
Slight casualties	123.8	123.8
TOTAL COSTS	**18,517.1**	**20,044.0**