NHS Swindon and Swindon Borough Council

Adult Alcohol Needs Assessment
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PART 1: INTRODUCTION AND CONTEXT

1.1 The purpose of this document

The purpose of this document is to identify, record and make recommendations on alcohol related needs in Swindon. The document is owned by the Alcohol Steering Group’s Expert Group, who is responsible for ensuring that the recommendations are taken forward. This includes using the document to inform the development of Swindon's Alcohol Harm Reduction Strategy for Adults, 2010-12.

1.2 Aim and objectives of the needs assessment

The overall aim of this needs assessment is to identify, through analysis and the involvement of key stakeholders, what Swindon’s alcohol related health needs are and how well these are being met. This will in turn provide information to plan, negotiate and commission services that improve alcohol related health outcomes. The comprehensive analysis that is required to undertake a needs assessment will ensure that decision-making on how best to prevent and mitigate the impacts of alcohol use are based upon sound evidence.

In line with this overall aim, the objectives of the needs assessment are to:

- Synthesise intelligence to identify alcohol-related (met and unmet) needs in Swindon. This will require the following activities:
  - Building a profile of the health, social and economic impact of alcohol misuse on Swindon using key indicators such as the incidence and prevalence of alcohol related harm;
  - Assessing the impact of alcohol on diverse and target communities;
  - Base-lining current alcohol service provision in Swindon;
  - Identifying the likely demand for prevention (including treatment) services;
  - Incorporating stakeholder views on need into the process, allowing a deeper understanding of needs to be gained.
- Identify gaps between the need for and provision of alcohol services at the local level. This includes gaps in the coordination, commissioning and delivery of alcohol services in Swindon.
- Identify, using the evidence base, what works in promoting safe, sensible and social drinking.
- Identify which health needs are priorities for action in Swindon.
- Stimulate the involvement key stakeholders in the process, and their ownership of the outcomes.

1.3 Methodology

The NICE (2005) definition of a health needs assessment will be used (also used by the National Treatment Agency) to inform the methodology for this needs assessment; “A systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities”.
In this context “need” is defined as the ability to benefit from a policy or service intervention. There must also be capacity to meet needs within relevant alcohol prevention, treatment and recovery services. This needs assessment will therefore seek to make recommendations that could be implemented within the resources available.

The needs assessment will take into account gender, ethnicity and other diverse needs in the local population and any unmet needs from this perspective. The assessment will also be undertaken in accordance with the requirements of the national guidance on undertaking an equality impact assessment.

A range of health needs assessment methodologies have been suggested since the 1990s. These are:

- **Epidemiology and Research**: the collection, analysis and interpretation of data (both quantitative and qualitative) to generate hypotheses and answer them.
- **Corporate**: determining and balancing the views of a range of local and regional stakeholders, and building their commitment to the resulting action plans.
- **Comparative**: assessing existing provision against service standards, national targets and other comparable areas.

Each has its place in the comprehensive approach required to identify need and reduce harms associated with alcohol use, and so a combination of the three approaches will be used in this needs assessment. Combined, they provide a robust and systematic process for the production of a needs assessment, and in turn evidence based decision-making.

### 1.4 Sources of information

The information which has contributed to this needs assessment has been gathered from a number of sources:

- Review of key national and local documents.
- Review of the evidence base in what works to preventing and reducing alcohol use, focussing on harmful use.
- National and local data compiled by NHS Swindon, Swindon Borough Council (SBC) and Swindon’s Community Safety Partnership (SCSP).
- Data on service demand and delivery compiled by Swindon and Wiltshire Alcohol and Drug’s Service (SWADS).
- Feedback from adults engaged in alcohol treatment services (through focus groups).
- Feedback from professionals involved in the commissioning and/or delivery of alcohol related services (through one to one informal interviews and the “Big Debate” conference).
- Feedback from professionals involved in responding to the impacts if alcohol (through one to one informal interviews and the “Big Debate” conference). This includes professionals the Police, Probation, and licensing staff.
Feedback and direction from the Expert Group of the Alcohol Steering Committee’s Group.

1.5 Definitions and scope

Health needs

This needs assessment has been commissioned as a Health Needs Assessment. Whist the focus will therefore be on identifying and meeting health needs, factors that are related to alcohol use and health will also be explored (i.e. crime and community safety, families, unemployment etc.). This is in line with the Dahlgren and Whitehead (1991) model, which suggests that there are complex, multi-layered factors influencing behaviours such as drinking and which subsequently impact upon health.

Adults

This needs assessment has been commissioned to explore needs in adults only, which includes those people aged 19 years and above. A separate needs assessment has been conducted for children and young people (led by Swindon Borough Council). As it is important that children’s and adults alcohol services are joined up, the needs of young people that move from using services for children and young people to services for adults will also be identified. Identifying these “transition period” needs has taken place with the steering group conducting the needs assessment for children and young people.

Alcohol use

In order to explore alcohol use in Swindon it is useful to define the different levels and types of drinking, as they can have varying impacts on the individuals concerned and those around them. All types of alcohol use will be explored in this needs assessment, though the focus is on preventing drinking that causes harm to oneself and others. In line with the definitions developed by the Alcohol Needs Assessment Research Project (2005) and used in Safe Sensible and Social: The Next Steps in the National Alcohol Strategy (2007), drinking can be defined as follows:

Sensible drinking: drinking in a way that is unlikely to cause harm to one-self or others.

Hazardous drinking: drinking above recognised ‘sensible’ levels but not yet experiencing harm.

Harmful drinking: drinking above ‘sensible’ levels and experiencing harm to one-self and potentially harm to others.

Binge drinking: drinking over twice the daily guidelines in one day (8 units + for men and 6 units + for women) on at least one occasion in the last week. In this report, this level of drinking is also referred to as heavy drinking.
Other definitions used in relation to drinking are as follows:

**Alcohol dependence**: people drinking above ‘sensible’ levels and experiencing harm and symptoms of dependence\(^5\).

**Safe units**:  
- Women should not regularly drink more than 2-3 units of alcohol a day, and not more than 14 units in a week.  
- Men should not regularly drink more than 3-4 units of alcohol a day, and not more than 21 units in a week.  
- Pregnant women or women who are trying to conceive should avoid drinking alcohol. If women do choose to drink, to minimise the risk to the baby, they should not drink more than one to two units of alcohol once or twice a week and should not get drunk\(^6\).  

In the UK, a unit is defined as 8g of alcohol. This is equivalent to either 125ml (a small glass) of wine (at 9% strength), a half pint of ordinary strength beer, or one measure of spirits.

**Problem drinking**: drinking alcohol so as to cause problems with personal health, social well-being, family well-being, work, and/or crime and disorder  

**Alcohol-use disorders**: ICD-10 published by WHO in 1992 categorizes disorders related to alcohol use under four headings: acute intoxication due to use of alcohol, harmful use, dependence syndrome, and withdrawal state\(^7\).

**1.6 Context: why a needs assessment is required**

**The National Alcohol Strategy**

Alcohol has significantly moved up the national agenda since the launch of the Alcohol Reduction Strategy in 2004, and its renewal in 2007 with ‘Safe, Sensible, Social: The Next Steps in the National Alcohol Harm Reduction Strategy’ (2007)\(^8\). This sets out the Government’s ambition to achieve significant reductions in the harms and cost of alcohol misuse in England over the next 10 years. It identifies next steps which will build on the existing programme of work, and explains the importance of partnership working to prevent and reduce the impacts of alcohol-related use. It specifically focuses on the minority of drinkers who cause the most harm to themselves, their communities and their families. They are:  
- Harmful drinkers, many of whom do not realise that their pattern of drinking is causing harm to their health. Harmful drinkers include those causing harm to others.  
- Young people under 18 years who drink alcohol, many of whom are drinking more than young people did a decade ago.  
- 18–24-year-old binge drinkers, a minority of whom are responsible for the majority of alcohol-related crime and disorder.

Safe Sensible and Social (2007) and the Government’s Alcohol Needs Assessment Research Project (2005) encourage localities to inform their
Alcohol Strategy through the assessment of local need. Standards for Better Health (2004)\textsuperscript{9} and Models of Care (2006)\textsuperscript{10} also requires there to be a shared understanding of the local need for alcohol treatment based upon annual needs assessments.

Other drivers for an assessment of alcohol-related need are briefly described below:

**World class commissioning**

The Needs Assessment is a vital component of the commissioning cycle and framework. It highlights gaps in service provision, informs the development of initiatives to meet those gaps, and helps to ensure that current services are flexible enough to evolve in line with need. In addition it enables the DAAT to benchmark how it is meeting its strategic objectives and to prioritise future allocation of resources.

Organisational competencies 5 and 6 in the World Class Commissioning Vision (DH 2007)\textsuperscript{11} outline the requirement to manage knowledge, assess need, and prioritise investment based on a thorough understanding of need. High Quality Care for All (DH 2008)\textsuperscript{12} also states that all NHS commissioners will be held to account on the quality of health outcomes they achieve for the populations they serve, including the most vulnerable, excluded and those with complex needs. Needs assessments are important in informing quality alcohol-related outcomes.

**Evidence based commissioning**

The commissioning of evidence-based interventions requires information to be synthesised and summarised on both alcohol need and “what works” in preventing and reducing alcohol-related harm. Producing a summary of the evidence base is an important objective of a needs assessment.

**Joint Strategic Needs Assessment (JSNA)**

The Local Government and Public Involvement in Health Act (2007)\textsuperscript{13} created the requirement for Joint Strategic Needs Assessments (JSNA’s) to provide a firm foundation for commissioning that improves health and social care provision and reduces inequalities. It is expected that needs assessment’s that focus on particular areas, such as this one, will make a significant contribution to the JSNA.

**Community Safety Partnerships (CSPs)**

The statutory framework regulating Community Safety Partnership’s\textsuperscript{14} requires partnerships to include alcohol-related needs in their local strategic assessments. Reducing and preventing alcohol related harm is also a key priority for the Swindon Community Safety Partnership Executive Board.
PART 2: ALCOHOL - THE NATIONAL CONTEXT

2.1 Drinking behaviours among adults

All adults

In England the vast majority of people drink alcohol. In 2004 it was estimated that 90% of all adults drink alcohol – nearly 40 million people\textsuperscript{15}. In 2006, the UK ranked third highest across 25 EU member states for the number of drinks consumed in one sitting, with 24% of residents drinking five or more drinks on a day when they drink alcoholic beverages\textsuperscript{16}. In 2007, 73% of men and 57% of women reported drinking an alcoholic drink on at least one day in the previous week. 13% of men and 7% of women reported drinking on every day in the previous week\textsuperscript{17}.

In relation to the amount of alcohol that people drink, the majority of adults drink within the safe level of units. However, large numbers also drink above safe levels. In 2007, 41% of men and 34% of women drank over the safe levels (3-4 units for men and 2-3 for women) on at least one day in the previous week. With this, 25% of men reported drinking over 8 units and 16% of women reported drinking over 6 units on at least one day in the previous week. This equates to 25% of men and 16% of women engaging in heavy and binge drinking\textsuperscript{18}.

According to the national alcohol needs assessment published in 2005\textsuperscript{19}, 38% of men and 16% of women (age 16–64 years) are drinking above the low-risk or sensible levels. This is equivalent to approximately 8.2 million people in England, and about one in four people aged 16-64 years having an alcohol-use disorder. In terms of the levels that people drink to, we also know that in 2007:

- 33% of men and 16% of women (24% of adults) were classified as hazardous drinkers. This includes 8% of men and 2% of women estimated to be harmful drinkers, the most serious form of hazardous drinking, which means that damage to health is likely\textsuperscript{20}.
- 9% of men and 4% of women showed some signs of alcohol dependence\textsuperscript{21}.

In terms of time trends, between 1998 and 2006 the proportion of men drinking more than 8 units on at least one day of the previous week fell from 22% to 18%. Among women drinking more than 6 units on at least one day of the previous week, no such reduction over the same time period was seen. Between 1998 and 2008 the proportion of men drinking more than 21 units in an average week fell from 28% to 23%, and the percentage of women drinking more than 14 units a week fell from 15% to 13%\textsuperscript{22}. Since the introduction of improved methods to estimate units in 2006, however, there has been an increase in average weekly alcohol consumption for both men and women in the UK. This upward trend is more accurate of drinking levels over time. It is thought that previous trends underestimated the actual units
consumed because of gradual increases in wine drinking, alcohol content of wine, and average glass size.

**Young adults aged 18-24 years**

A report by the Joseph Rowntree Foundation (2009) found that there is a possible recent decrease in alcohol consumption amongst 16-24 year olds. The authors of the report are cautious about interpreting this as a convincing downward trend because variability in consumption between successive survey years is greater in this age group than any other. This age group also has the highest consumption if one compares prevalence or unit consumption across ages, so the often cited message that drinking is highest in young adults still holds.

**Older people**

In recent years there has been a small but steady increase in the amount of alcohol consumed by older adults. The trend is consistent across different surveys and different consumption measures. The report by the Joseph Rowntree Association speculates that it is likely to be the wealthier, better-off individuals, who are drinking more. They also suggest that those people in their 50’s and 60’s (the ‘baby boom’ generation), because of their experience of young adulthood at a time of great social change, may have more liberal and permissive attitudes to social activities such as drinking.

**Women**

The information already given on the prevalence and patterns of drinking among women suggests that women are less likely than men to drink and women who do drink consume less than men. However, a trend identified across several different surveys and different measures of alcohol consumption (i.e. General Household Survey, Omnibus survey, Health Survey for England and the Scottish Household Survey) shows a recent narrowing of the gender gap in the UK. This includes a narrowing of the gender gap in drinking at excessive and harmful levels. In relation to drinking during pregnancy, over half of mothers (54%) say that they drink alcohol during pregnancy.

**Ethnic differentials in alcohol use**

Lower rates of alcohol consumption are consistently reported amongst ethnic minority groups (as a whole) compared to people of White ethnicity. However, alcohol use patterns and the prevalence of alcohol-related problems vary among ethnic groups. There are marked differences between the drinking patterns of Caribbean and South Asian groups for example, and within the latter, Pakistanis, Bangladeshis and Muslims from elsewhere report very little drinking. Among the elements thought to account for these ethnic differences are religious factors, social and cultural factors such as drinking norms and attitudes and, in some cases, genetic factors.
The Swindon Black and Minority Ethnic Groups Health Care Needs Assessment (2009) suggests that alcohol dependency is a contributory factor to mental health illness amongst some African-Caribbean people. A recent study of alcohol consumption amongst ethnic minority groups in the UK (Becares et al. 2009) also concludes that despite the lower alcohol drinking rates of UK ethnic minority people (excluding Irish), events of racial discrimination expose ethnic minorities to unique stressors that elevate the risk for escapist drinking. The report suggests that ethnic minority people living in areas of high ethnic density will report less alcohol use relative to their counterparts, due to decreased experienced racism and increased socio-cultural norms.

2.2 Knowledge and attitudes to alcohol

In 2007 92% of men and 89% of women reported that they had heard of measuring alcohol in units. There was less knowledge of the recommended maximum daily intake. 35% of men and 47% of women had heard of units but said they didn’t know what the recommendations were for men, whilst 39% of men and 43% of women similarly knew about units but said they did not know the recommendations for women. According to the report Safe Sensible and Social (2007), few people are able to estimate accurately how much they drink, and only 13% of drinkers keep a check on the number of units they drink.

Alcohol is often considered an important part of the cultural fabric of the UK. In the 1990s it was reported that the UK is ambivalent towards alcohol, holding generally favourable attitudes whilst disapproving of problem drinking (Plant 1995). In recent years widespread public, media and political attention has been drawn to the range of problems associated with alcohol, and there is an emerging consensus that the UK has a major alcohol problem.

According to the 2007 Health Survey for England, 16% of men and 14% of women who had drunk in the last year said they would like to drink less. Although specifically about the views of people in Scotland, the Scottish Social Attitudes Survey (2007) reports some attitudes towards drinking that can to some extent be generalised to England:

- Although 81% agree that it is possible to enjoy a night out in the pub without drinking alcohol, 39% still think it is, in general, easier to enjoy social events if you have had a drink.
- People express different attitudes about different types of alcohol misuse. For example, while 94% believe that a ‘chronic’ drinker is ‘very likely’ to damage their health if their behaviour continues long-term, this falls to 47% with respect to a ‘binge’ drinker and just 35% for a ‘hazardous’ drinker (i.e. someone who drinks above recommended weekly limits).
- Young adults hold more ‘permissive’ attitudes towards ‘binge drinking’ and ‘getting drunk’, although 30-39 year-olds also appear to express less concern than older age groups about ‘hazardous’ drinking.
There is little evidence on attitudes towards drinking in England specifically. A survey of 6,869 people in the East of England\textsuperscript{33} can, however, be used to gain an indication of what people’s attitudes are to drinking in England. Key findings from the survey include:

- Those people drinking at increased or higher risk categories often underestimate the amount that they drink and the impact that such behaviour can have on their health and well-being.
- The majority of those drinking at increasing risk levels describe themselves as ‘moderate’ drinkers, indicating that this is perceived as not only socially acceptable, but also a normal level at which to drink.
- Younger drinkers (18 – 24 year olds) are more likely to say that their drinking habits are affected by peer pressure and are more likely to say that they drink to give them confidence.
- People are relatively unconcerned about their personal drinking habits, but acutely aware of the social impact that drinking has. Alcohol is seen as a problem, but it’s generally regarded as someone else’s.
- People are more likely to feel that the amount they drink is good for their health than bad (23%, compared to 17%). The majority of drinkers simply feel that the amount that they drink is neither good nor bad for their health (58%).
- For those people that have had concerns about their drinking habits, the most common causes for concern are health related. The extent to which each of these concerns affects different sub-groups varies: women tend to be more concerned about putting on weight, men more concerned about developing health problems, and younger people (aged 18-24 years) are more concerned about the amount of money they spend on alcohol than developing health problems.

The knowledge and attitudes that young people have towards drinking alcohol are also important to highlight, as today’s young people are tomorrow’s adults. A study by the Joseph Rowntree Foundation found the following about knowledge and attitudes towards drinking among 14-17 year olds in two towns in England\textsuperscript{34}:

- Most of the young people reported positive reasons for getting drunk. The most frequently cited motivation was increased confidence in social and sexual situations. Other motivations included getting drunk to ‘escape’ and forget problems, to achieve a ‘buzz’, and for ‘something to do’.
- Getting drunk was widely seen as normal and acceptable. The young people reported the important influence of friends, ranging from actual peer pressure to the less overt, although more common, ‘peer guidance’. They also reported the respect and image associated with getting drunk as a motivating factor.
- The young people attributed ‘risky’ drinking to harmful outcomes in a variety of ways. Accounts of alcohol leading to a loss of inhibitions, impaired judgement, and complete loss of control were reported. Using alcohol as an excuse for socially unacceptable behaviour was apparent.
2.3 Trends in alcohol spending and sales

There has been an increase in the volume of alcohol consumed over the last 35 years in the UK, rising from 7.4 to 10.9 litres of pure alcohol per person aged at least 15 years from 1971 to 2006 (JRR 2009). The type of alcoholic beverage consumed in the UK has changed over time, with a small decrease in beer consumption and increases in wine, cider, coolers/flavoured alcoholic beverages (FABs) and spirits consumed (JRR 2009).

Average weekly expenditure on alcohol purchases has changed little overall from 1986 to 2006, averaging between about £15 and £17 a week per household. After a slight increase from 1995 to 2000, weekly expenditure decreased slightly in the subsequent years. In contrast, the percentage of alcohol expenditure as a proportion of total expenditure has decreased (Food Expenditure Survey (FES) classification at 2006 prices. Between 1980 and 2005 household disposable income increased by 97 per cent in real terms, making alcohol 62 per cent more affordable in 2005 (National Statistics, 2007).

In the UK, between 1971 and 2006, there has been an increase in alcohol sales made through off-trade premises (off-licences and supermarkets, etc.) and an increase in alcohol consumed at home (Safe Sensible and Social 2007). There has been a corresponding decrease in on-trade sales, such as at pubs, clubs, and restaurants.

2.4 The impacts of drinking: Alcohol related harms

There are many people who will drink at levels which are safe and sensible. However, we also know that there are a large number of people that drink at levels which are unsafe. Alcohol consumption is associated with a broad range of health, social and economic problems, at individual, family and societal level (Klingemann and Gmel 2001).

Impacts on health and wellbeing

Mortality and life expectancy

Life lost from mortality due to alcohol is increasing. Alcohol-related deaths have more than doubled since 1979, and more people are dying at a younger age (Safe Sensible and Social 2007). Mortality and reduced life expectancy is attributable to alcohol in the following ways (all data is for 2005 and taken from the 2008 report on Alcohol Attributable Mortality and Hospital admissions by Jones et al., unless specified):

- In 2007, in England, there were 6,541 deaths directly related to alcohol, an increase of 19% since 2001. Of these alcohol related deaths, the majority (4,249) died from alcoholic liver disease.
- Each man in England dying from an alcohol-attributable cause loses an average of 20.2 years and each woman loses an average of 15.1 years.
4.4% of male deaths were alcohol attributable compared to 2.0% of female deaths.

Alcohol attributable deaths also varied by age, and although the highest number of deaths were seen in older age groups, young adults were disproportionately affected by their alcohol use. Among 16-24 year old males, 26.6% of all deaths were estimated to be attributable to alcohol consumption compared to 1.4% among those aged 75 and over.

In those aged less than 35 years, deaths were most likely to occur from the acute consequences of alcohol consumption, in particular, intentional self-harm and road traffic accidents.

Beyond the age of 35, liver cirrhosis, malignant neoplasm of the oesophagus and breast, and hypertensive diseases were the most common causes of death attributable to alcohol.

For malignant neoplasm, hypertensive diseases, and acute and chronic pancreatitis, male deaths were evenly distributed across all four categories of alcohol consumption examined, whereas female deaths were found to be more attributable to lower levels of alcohol consumption (1-19 g/day).

For ischaemic and haemorrhagic stroke, and unspecified liver cirrhosis the majority of deaths were attributable to alcohol consumption exceeding 40 g/day.

Between 16 and 41% of suicides are thought to be attributable to be alcohol. Among men who present to hospital following an episode of deliberate self harm, 50% regularly drink excessively and about 23% are dependent on alcohol.

**Morbidity**

As well as contributing to mortality and reduced life expectancy, alcohol is a major cause of disease and injury and contributes to increased morbidity. Every organ, system and tissue in the human body can be damaged by unsafe alcohol-use. This damage comes from either acute use or chronic use. Some of the key harms that both acute and chronic use can cause are as follows:

- **Acute intoxication**: Prevalence peaks in those under 20, and tails off after the age of 40, reflecting the heavy single-occasion drinking patterns most common among young drinkers.
- **Accidents**: This includes road traffic accidents. In 2005 it was estimated that 6% of road casualties and 17% of all road deaths occurred when someone was driving over the legal limit for alcohol (Safe Sensible and Social 2007).
- **Miscarriage**: Drinking more than 2 units of alcohol a week when pregnant can increase women’s likelihood of miscarriage.
- **Liver disease**: Excessive alcohol consumption is a major cause of liver disease. Liver cirrhosis is found in one in five heavy drinkers. Age-specific rates of mortality from liver disease explicitly attributed to alcohol have risen by about 90% over the past decade.
- **Cancers**: Alcohol is associated with higher risks of many cancers, including cancers of the oral cavity, pharynx, larynx and oesophagus.
Cancers at other sites, such as the liver, stomach, pancreas, colon, and rectum are also associated with alcohol consumption. Drinking alcohol increases the risk of breast cancer in women, though the magnitude of the risk is small and the mechanism unclear.

- **Mental health**: Alcohol consumption is associated with a range of negative consequences for mental health. Heavier drinking can contribute to anxiety and depression and can accelerate or uncover a predisposition to the development of psychiatric disorder (including psychosis).
- **Other disorders**: Alcohol is also associated with gastrointestinal, cardiovascular, neuropsychiatric, maternal and perinatal conditions, foetal alcohol syndrome, and injuries (from intentional assaults or self infliction).

**Burden on healthcare resources**

- In 2007/08 there were 863,300 alcohol related admissions to hospital. This is an increase of 69% since 2002/03 when there were 510,200 alcohol related admissions. 40
- In 2007/08 62% of alcohol related admissions were for men. Among both men and women there were more admissions in the older age groups than in the younger age groups. 41
- The most common reasons for hospital admission in males and females were hypertensive diseases, mental and behavioural disorders due to use of alcohol, and cardiac arrhythmias. 42
- Mental and behavioural disorders due to use of alcohol, were the leading cause of alcohol-related admissions in males under the age of 55. 43
- In England in 2007, there were 134,429 prescription items for drugs for the treatment of alcohol dependency prescribed in primary care settings or NHS hospitals and dispensed in the community. This is an increase of 31% since 2003 when there were 102,741 prescription items. 44

**Impacts on children and families**

Parental influence and drinking habits play an important role in shaping drinking behaviours in young people (e.g. Wood et al. 2004). In a survey by the NHS Health and Information Centre (2009) pupils are more likely to drink if they live with other people who do, and if they believe that their parents are tolerant of their drinking. 1 The proportion of young pupils who drunk alcohol in the last week increased from 5% of those who live in non-drinking households to 31% of those who live with three or more people who drink alcohol for example. 53% of all young people reported that their parents did not mind them drinking as long as they don’t drink too much, and less than half (46%) reported that their families disapprove of them drinking alcohol. 80% of pupils who said that their parents would disapprove, have never drunk alcohol. 1 A literature review by the Joseph Rowntree Foundation in 2009 supports the

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1 Information was obtained from 7,798 pupils in 264 schools throughout England in the autumn term of 2008.
finding that parents influence their children’s attitudes towards drinking. It finds that children’s intentions to drink alcohol are significantly related to parental drinking practices; the more parents drink, the more likely children are to express an intention to drink.

Government estimates that between 780,000 and 1.3 million children are affected by parental alcohol problems (Cabinet Office Strategy Unit, 2004). Problematic alcohol use by a parent can affect their quality of parenting, and in turn affect the child’s attitudes and behaviours (increased risk of aggressive behaviour towards others, emotional problems etc). Strong links have also been found between parental alcohol use and child maltreatment, especially when drinking is harmful or hazardous. A number of studies also show that being maltreated as a child is associated with marked increases in the risk of hazardous or harmful drinking in later life (WHO 2006).

**Impacts on community safety**

According to the 2008/09 British Crime Survey, victims believed their offender(s) to be under the influence of alcohol in nearly half (47%) of all violent incidents, similar to the level in the 2007/08 survey (46%). This is equivalent to 973,000 incidents. Victims believed the offender(s) to be under the influence of alcohol most frequently in reported incidents of stranger violence (62% of incidents). Victims believed the offender(s) to be under the influence of alcohol in 38% of reported domestic violence incidents.

18-24 year olds that binge drink are responsible for the majority of alcohol-related crime and disorder. 63% of 18–24-year-old binge drinkers admit to committing criminal or disorderly behaviour before or after drinking (Safe Sensible and Social 2007). In 2005/06 17% of all violent incidents were committed in or around pubs or clubs (Safe Sensible and Social 2007), the majority on Friday or Saturday nights.

Longer-term trends show there have been decreases since 1995 (with the exception of 2003/04) in the number of violent incidents believed by victims to involve offender(s) under the influence of alcohol. This is in the context of the overall fall in the number of violent crimes. Despite this decrease, people perceive alcohol related disorder to be more of a problem (Safe Sensible and Social 2007). More than half of people (53%) thought that alcohol was one of the major causes of crime, although a much smaller proportion (8%) thought it was the main cause of crime in Britain today (BCS 2008/09).

**Impacts on housing**

Harmful alcohol consumption can be one of the trigger factors leading to a lack of housing and subsequent homelessness for some people. Of those people that are homeless, people that live on the street (“rough sleepers”) are particularly vulnerable to alcohol misuse problems, and are more likely to die from unnatural causes such as alcohol poisoning than the general population. In a report by Shelter (2007), alcohol and drugs are highlighted by service
users as an important contributor to both losing housing and worsening health.

In general, homeless people with alcohol (and possibly other e.g. drug use, mental health needs) problems face particular difficulties in finding accommodation and support to meet their needs. Those who also experience mental health problems can have particularly severe difficulties in finding somewhere to stay and/or appropriate support services.

Impacts on employment

Alcohol can impact upon a person’s employment in a number of ways, including impairment of skills and performance, reduced attendance at work, increased sickness absence and possibly unemployment. Dependence clearly increases the risk of becoming unemployed, but equally being unemployed may increase the risk of alcohol dependence. Up to 17 million working days are lost annually due to alcohol-related absence and 20 million working days lost annually due to alcohol-related reduced employment (Institute of Alcohol Studies 2009\(^5\)). Binge drinkers are at higher risk of unemployment, and chronic drinkers are at some risk of higher unemployment, but earn more as their ranking rises until, and if, their drinking becomes unsustainable (IAS 2009). In the UK, around 50,000 people claim incapacity benefit because of drink problems (Information Directorate mid 2005 population estimates).

Impacts on the economy

The National Social Marketing Centre estimated that the total annual societal cost of alcohol misuse in England to be £55.1 billion (based on 2003 prices)\(^5\). This includes:

- £21 billion cost to individuals and families/households (e.g. loss of income, informal care costs)
- £2.8 billion cost to public health services/care services
- £2.1 billion cost to other public services (e.g. criminal justice system costs, education and social services costs)
- £7.3 billion cost to employers (e.g. absenteeism)
- £21.9 billion in human costs (DALYs).

In 2008 the Department of Health estimated that the cost of alcohol related harm to the NHS in England is £2.7 billion in 2006/07 prices\(^5\). A breakdown of these costs is given in the table below.

<table>
<thead>
<tr>
<th>NHS activity</th>
<th>Estimated Cost (Millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital inpatient and day visits</td>
<td></td>
</tr>
<tr>
<td>- Directly attributable to alcohol misuse</td>
<td>167.6</td>
</tr>
<tr>
<td>- Partly attributable to alcohol misuse</td>
<td>1,022.70</td>
</tr>
<tr>
<td>Hospital outpatient visits</td>
<td>272.4</td>
</tr>
<tr>
<td>Accident and emergency visits</td>
<td>645.7</td>
</tr>
<tr>
<td>Ambulance services</td>
<td>372.4</td>
</tr>
<tr>
<td>NHS GP consultants</td>
<td>102.1</td>
</tr>
</tbody>
</table>
### 2.5 Vulnerable groups

Heavier drinking is associated with engaging in other “risky” behaviours such as drug taking and unprotected sex. This is partly because alcohol impairs people’s judgement and lowers their inhibitions to participating in such behaviours. As well as people being vulnerable to the direct impacts of alcohol, they are then vulnerable to other harms such as sexually transmitted and/or communicable (e.g. Hepatitis B through sharing of needles) diseases.

Heavy alcohol (and other risky behaviours) is a risk factor for many other problems, including poor mental health, unemployment, and homelessness. A report by Shelter in 2007\(^5\) for example, stated that 31% of the homeless people they questioned cited drug and alcohol problems as a reason for their being on the street. People with such problems tend to lead chaotic lifestyles and there is a need to ensure that their alcohol use and needs are recognised so that support in other areas is effective.

People who take drugs are also likely to use alcohol, though not necessarily to harmful levels. Research suggests that (early) alcohol use can be a risk factor for drug taking, but there is also some evidence to suggest that drug use can lead to increased alcohol use. Where alcohol is used with drugs, it can increase the harmful effect of the drug. A report by the NTA in 2007\(^6\) for example, found that the combined use of heroin and alcohol increases the risk of overdose. Alcohol concentrations, even those associated with mild intoxication, appeared to lower the amount of heroin required to fatally overdose by as much as a half.

There is some consensus within the literature that there is heavier drinking among lesbians and gay men, though is very little evidence for this and further research is required.

The Indications of Public Health in the English Regions Report (2007)\(^7\) classifies individuals into “lifestyle” groups and highlights particular communities that have (additional) alcohol issues. These include the most deprived lifestyle group, ‘Urban Challenge’, who are typically unemployed, low-income older smokers, and have four to fifteen times greater alcohol-specific mortality. They also have four to ten times greater alcohol-specific admission to hospital than the most affluent groups. Whilst most lifestyle groups tend to show levels of alcohol-related harms in line with the level of deprivation experienced in their location, one group, ‘New Starters’, always show higher levels of harm than would be expected from deprivation alone. These areas are characterised by young, highly qualified but not very well off people. Since they are already experiencing significantly high levels of
mortality, life lost and admission to hospital due to alcohol use their location and prevalence in local communities should be used as a warning sign of where alcohol-related issues are likely to worsen in the future.

2.6 Gap between need and service utilisation

In 2005 the Alcohol Needs Assessment Research Project (ANARP)\(^{58}\) estimated that there is a large gap between the need for alcohol treatment and actual access to treatment with only approximately 1 in 18 (5.6%) alcohol dependent individuals accessing specialist alcohol treatment nationally per annum. In North America, an access level of 1 in 10 (10%) alcohol dependent individuals entering treatment per annum is regarded as a 'low' level of access, 1 in 7.5 (15%) 'medium' and 1 in 5 (20%) 'high' (ANARP)\(^{59}\).
PART 3: PROFILE OF SWINDON

3.1 Total population and population estimates

In 2006 Swindon had a population of 192,500 people, and 144,200 of these people were aged 20 years or above. In October 2005 the number of people registered with a GP in Swindon was 201,382, although approximately 11,000 of these lived outside of NHS Swindon boundaries.

At ward level, mid year population estimates stated that in 2007 Abbey Meads had the highest population whilst Ridgeway had the lowest. The 2007 mid year population estimates for all wards in Swindon are given in the graph below.

Figure 3.1: Resident Population Estimates - Swindon Primary Care Trust by Ward

Source: Office for National Statistics © Crown Copyright 2009: 2007 mid year population estimates at ward level.

There are wide variations in the demographic composition of wards within Swindon. Abbey Meads for example has a high proportion of children aged 0-4 and people aged 25 to 44 years compared to Swindon’s overall demographic profile, whilst Blunsdon has a higher proportion of people aged...
45 years and above. The graphs below highlight the age and gender differences between these two wards.

**Figure 3.2:** Resident Population Estimates for Abbey Meads

![Bar chart showing age distribution for Abbey Meads]

**Source:** Source: Office for National Statistics © Crown Copyright 2009: 2007 mid year population estimates at ward level

**Figure 3.3:** Resident Population Estimates for Blunsdon

![Bar chart showing age distribution for Blunsdon]

**Source:** Source: Office for National Statistics © Crown Copyright 2009: 2007 mid year population estimates at ward level
NHS Swindon and Swindon Borough Council estimate that between 2001 and 2016 the overall resident population change in Swindon will be an increase of 23%. In absolute terms this is an increase of approximately 40,000 people. Between 2010 and 2030 it is estimated that Swindon’s population will increase by 18.7%, which is higher than the national average. Preliminary indications from the model used to predict population trends suggest there will be increases in the numbers of people in their twenties, in later middle age and early old age, as well as in pre-school children and in people age 90 years or more. Projections for population growth across different age groups are summarised in the table below.

Table 3.1: Population projections for NHS Swindon, 2010 to 2030.

<table>
<thead>
<tr>
<th>Age group</th>
<th>2010</th>
<th>2020</th>
<th>2030</th>
<th>Percentage increase</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2010 to 2020</td>
</tr>
<tr>
<td>0-19</td>
<td>49.1</td>
<td>52.1</td>
<td>55.1</td>
<td>5.8%</td>
</tr>
<tr>
<td>20-44</td>
<td>72.9</td>
<td>75.4</td>
<td>79.6</td>
<td>3.3%</td>
</tr>
<tr>
<td>45-64</td>
<td>49.8</td>
<td>56.5</td>
<td>56.4</td>
<td>11.9%</td>
</tr>
<tr>
<td>65+</td>
<td>28.4</td>
<td>36.1</td>
<td>46.6</td>
<td>21.3%</td>
</tr>
<tr>
<td>All Ages</td>
<td>200.3</td>
<td>220.3</td>
<td>237.8</td>
<td>9.1%</td>
</tr>
</tbody>
</table>


3.2 Ethnic Profile

Swindon has a diverse ethnic profile, with at least 105 different languages spoken in the town. The 2001 Census (the next national Census will take place in 2011) shows that the largest ethnic groups other than White British (91% of residents) were White Minority Ethnic (4%) and Asian or Asian British (2% or 3,837 people). The White Minority Ethnic Group includes those of Irish, Polish, Portuguese, and Italian heritage, and growth in this group over recent years is possibly a result of migration from new Eastern European EU member states. Other ethnic groups include Indian, African-Caribbean, Pakistani, and those of Bangladeshi heritage. Almost 5% of the population was recorded within a ‘non-white’ ethnic category, which equates to approximately 8,642 people.

The graph below shows the estimated percentage of people in ethnic groups other than “White British” for each ward in Swindon in 2001. This indicates that ward’s such as Central (21%) and Eastcott (15.2%) had significantly higher percentages of non White British ethnicities compared to wards such as Blunsdon (4.4%) and Highworth (3.3%).
The 2008 Swindon Super Survey indicates that the majority of people from Black and Minority Ethnic (BME) groups are living in the Neighbourhood Renewal areas of Swindon. These are areas that have been identified (using the Indices of Multiple Deprivation) as areas with the highest levels of deprivation. They are therefore high priority for health promotion and prevention (and related) work. The response rates to Swindon’s Super Surveys tend to be low (can be as low as 35%), and so generalisations from the results to the whole population may be not very accurate.

Using ONS mid-year population estimates, central government estimates, and extrapolating census data, NHS Swindon and Swindon Borough Council have estimated the number of people within ethnic and BME groups for 2007 and the average annual growth between 2002 and 2008. These estimates are given in the table below. These estimates indicate that there was population growth across all ethnic and BME groups between 2002 and 2008, and that growth was highest in the Asian and Black communities. Growth was lowest in the White (including Irish and Other White) community.

Table 3.2: Population estimates for Swindon by Ethnic Group

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Year</th>
<th>Absolute Change</th>
<th>Average annual growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>White: Irish &amp; Other White</td>
<td>7,500</td>
<td>9,400</td>
<td>1,900</td>
</tr>
<tr>
<td>Mixed</td>
<td>2,100</td>
<td>3,000</td>
<td>900</td>
</tr>
<tr>
<td>Asian</td>
<td>4,200</td>
<td>6,500</td>
<td>2,300</td>
</tr>
<tr>
<td>Black</td>
<td>1,400</td>
<td>2,200</td>
<td>800</td>
</tr>
<tr>
<td>Chinese and Other</td>
<td>1,800</td>
<td>2,700</td>
<td>900</td>
</tr>
</tbody>
</table>
### Ethnic Group

<table>
<thead>
<tr>
<th>Population by BME and non-BME¹</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total BME</strong></td>
<td><strong>17,000</strong></td>
</tr>
<tr>
<td><strong>Total BME (excluding Irish)</strong></td>
<td><strong>14,700</strong></td>
</tr>
<tr>
<td>% <strong>Total BME</strong></td>
<td><strong>9.11</strong></td>
</tr>
<tr>
<td>% <strong>Total BME (exc Irish)</strong></td>
<td><strong>7.88</strong></td>
</tr>
</tbody>
</table>

¹The BME estimate definition follows the Commission for Racial Equality and Equality & Human Rights Commission to include all categories other than “White British”.

### 3.3 Diversity

#### Sexual orientation

According to the 2001 Census, 94% of Swindon residents are heterosexual and 6% lesbian, gay or bisexual. It is estimated that numbers will have increased across all groups between 2001 and 2008, but that the proportion of lesbian, gay and bisexual residents remained the same (6%).

**Table 3.3: Population by Sexual Orientation**

<table>
<thead>
<tr>
<th>Sexual orientation</th>
<th>2001</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>% of population</td>
<td>Number</td>
</tr>
<tr>
<td>Lesbian, Gay &amp; Bisexual</td>
<td>10803</td>
<td>6.00%</td>
<td>11370</td>
</tr>
<tr>
<td>Heterosexual</td>
<td>169248</td>
<td>94.00%</td>
<td>178130</td>
</tr>
<tr>
<td>Total</td>
<td>180051</td>
<td></td>
<td>189500</td>
</tr>
</tbody>
</table>

#### Traveller communities

The South West Public Health Observatory published a report on the health of travellers in 2002. This report identified 85 gypsy caravans in Swindon in July 2001, areas of potential health need, and a number of ethnical issues on inclusion. A later needs assessment, commissioned by SBC and Wiltshire County Council (Gypsy and Traveller Accommodation Needs Assessment) in 2006, estimated that there were 40 authorised and 10 unauthorised traveller households living in Swindon. Although the focus of the needs assessment was accommodation needs, it did highlight that those travellers living on authorised sites were much more likely to be registered with a general practice (96%) compared to those on unauthorised sites (24%).

#### Asylum seekers

Research was carried out in Swindon during 2003/04 to identify the needs of young asylum seekers in the town. It concluded that it may not be appropriate to set up targeted services for this group, but that they are less likely to be able to access mainstream services, and require support to promote integration. In particular

- better access to health services
- improved multi-agency co-ordination to address all their needs
• improved communication, education and training for asylum seekers and practitioners is required

The Joint Strategic Needs Assessment (2008) highlighted that there are asylum seekers in Swindon schools from Kosovo, Afghanistan, Nigeria, Iran, Turkey, Somalia, Russia, Palestine, Guinea, Lebanon, Congo, Albania, Eritrea, Kenya and Zimbabwe.

Religion

People practice a range of religions in Swindon. The 2001 Census data and 2007 and 2008 mid year estimates of people’s religious practices are highlighted in the table below.

<table>
<thead>
<tr>
<th>Religious practice</th>
<th>2001 Census</th>
<th>Mid 2007 estimate</th>
<th>Mid 2008 estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buddhist</td>
<td>510</td>
<td>530</td>
<td>540</td>
</tr>
<tr>
<td>Christian</td>
<td>126157</td>
<td>133520</td>
<td>135930</td>
</tr>
<tr>
<td>Hindu</td>
<td>1000</td>
<td>1030</td>
<td>1040</td>
</tr>
<tr>
<td>Jewish</td>
<td>127</td>
<td>140</td>
<td>150</td>
</tr>
<tr>
<td>Muslim</td>
<td>1851</td>
<td>1900</td>
<td>1940</td>
</tr>
<tr>
<td>Sikh</td>
<td>1013</td>
<td>1060</td>
<td>1080</td>
</tr>
<tr>
<td>Other</td>
<td>647</td>
<td>680</td>
<td>690</td>
</tr>
<tr>
<td>No Religion</td>
<td>34437</td>
<td>35620</td>
<td>36240</td>
</tr>
<tr>
<td>Declined to Disclose</td>
<td>14309</td>
<td>15000</td>
<td>15290</td>
</tr>
<tr>
<td>Total</td>
<td>180051</td>
<td>189480</td>
<td>192900</td>
</tr>
</tbody>
</table>

3.4 Socio-economic status

ACORN provides one way of assessing deprivation by combining demographic and lifestyle information. According to this measure in 2008, Swindon had lower levels of people that were “wealthy achievers” or in the “urban prosperity band” than the UK average. Swindon had higher levels of people that were “comfortably off” or who had “moderate means”, and lower levels of people that were “hard pressed”.

In the rankings of the 354 English districts and unitary authorities, Swindon is not within the most deprived 50 local authorities in any of the rankings. However, within Swindon there are extremes of high and low levels of deprivation as the table indicates below.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>UK</td>
<td>24.80%</td>
<td>12.10%</td>
<td>28.00%</td>
<td>13.70%</td>
<td>20.60%</td>
</tr>
<tr>
<td>Swindon</td>
<td>21.10%</td>
<td>5.10%</td>
<td>41.10%</td>
<td>14.90%</td>
<td>17.80%</td>
</tr>
</tbody>
</table>

Source: ACORN March 08
The index of multiple deprivation is a score that combines levels of deprivation from the following 7 domains:

- Income (22.5%)
- Employment 22.5%
- Health Deprivation and Disability (13.5%)
- Education Skills and Training (13.5%)
- Barriers to Housing and Services (9.3%)
- Crime (9%)
- Living Environment (9.3%)

In 2007, Swindon’s wards had the following deprivation scores, with Penhill having the highest level of deprivation and Shaw and Nine Elms the lowest.

### Table 3.6: Index of Multiple Deprivation 2007 by Ward

<table>
<thead>
<tr>
<th>Ward</th>
<th>IMD 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Penhill</td>
<td>47.6</td>
</tr>
<tr>
<td>Parks</td>
<td>43.0</td>
</tr>
<tr>
<td>Walcot</td>
<td>31.8</td>
</tr>
<tr>
<td>Gorse Hill &amp; Pinehurst</td>
<td>31.2</td>
</tr>
<tr>
<td>Central</td>
<td>24.7</td>
</tr>
<tr>
<td>Moredon</td>
<td>21.5</td>
</tr>
<tr>
<td>Toothill &amp; Westlea</td>
<td>17.8</td>
</tr>
<tr>
<td>St Phillip</td>
<td>15.9</td>
</tr>
<tr>
<td>Dorcan</td>
<td>15.8</td>
</tr>
<tr>
<td>Eastcott</td>
<td>15.7</td>
</tr>
<tr>
<td>Western</td>
<td>14.9</td>
</tr>
<tr>
<td>Freshbrook &amp; Grange Park</td>
<td>12.3</td>
</tr>
<tr>
<td>Wroughton &amp; Chiseldon</td>
<td>11.3</td>
</tr>
<tr>
<td>Blunsdon</td>
<td>11.0</td>
</tr>
<tr>
<td>St Margaret</td>
<td>9.9</td>
</tr>
<tr>
<td>Highworth</td>
<td>9.5</td>
</tr>
<tr>
<td>Covingham &amp; Nythe</td>
<td>8.6</td>
</tr>
<tr>
<td>Ridgeway</td>
<td>8.2</td>
</tr>
<tr>
<td>Old Town &amp; Lawn</td>
<td>7.8</td>
</tr>
<tr>
<td>Haydon Wick</td>
<td>6.8</td>
</tr>
<tr>
<td>Abbey Meads</td>
<td>5.7</td>
</tr>
<tr>
<td>Shaw &amp; Nine Elms</td>
<td>5.5</td>
</tr>
</tbody>
</table>


**Other socio-economic indicators**

According to the 2008 Swindon Super Survey 60% of residents reported that they were employed, 11% reported that they were not employed, 5% that they were permanently sick or had a disability, and 25% that they were retired. Of those that were not employed, 3% were unemployed and seeking work to start a job.
In September 2009 the number of households claiming Jobseeker’s Allowance in was 6,143, which is 5.1% of the workforce. The highest number of claimants were in the Penthill ward (10.5%). The number of children living in workless households in Swindon has increased with the recent economic downturn.

According to the 2001 census, the percentage of lone parent households with dependent children is higher than the South West regional average though lower than the England average.

*Table 3.7:* Profile of lone parent households with dependent children

<table>
<thead>
<tr>
<th>Region</th>
<th>Lone parent households: With dependent children</th>
<th>% Lone parent households: With dependent children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Swindon</td>
<td>4,351</td>
<td>5.80</td>
</tr>
<tr>
<td>England</td>
<td>1,311,974</td>
<td>6.42</td>
</tr>
<tr>
<td>South-West Region</td>
<td>113,037</td>
<td>5.42</td>
</tr>
</tbody>
</table>

*Source:* Census 2001
PART 4: ALCOHOL - THE LOCAL CONTEXT

4.1 Drinking behaviours among adults

According to the 2008 Swindon Super Survey, 16% of residents in Swindon never drink alcohol, 23% drink occasionally (once a month or less), 22% drink 2-4 times a month, 25% 2-3 times a week and 13% 4 or more times a week. From this data it is not possible to identify what percentage of Swindon residents are drinking above unsafe levels and who is drinking to harmful or hazardous levels. However it is possible to infer that no more than 13% of residents are drinking above “safe levels”, though the Super Survey is likely to underestimate safe drinking levels because it captures residents self reported alcohol levels only. In addition, it is possible that those people choosing not to respond to the Super Survey are heavier drinkers than those who responded.

In terms of time trends, between 2006 and 2008 the percentage of people reporting that they never drink alcohol decreased, whilst for the other categories percentages increased or decreased marginally.

Table 4.1: How often people drink alcohol in Swindon

<table>
<thead>
<tr>
<th>Question: How often, if ever, do you have an alcoholic drink?</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Swindon &amp; Shrivenham %</td>
<td>NRA %</td>
<td>Swindon &amp; Shrivenham %</td>
</tr>
<tr>
<td>Never</td>
<td>18</td>
<td>25</td>
<td>17</td>
</tr>
<tr>
<td>Occasionally (once a month or less)</td>
<td>23</td>
<td>28</td>
<td>21</td>
</tr>
<tr>
<td>2 to 4 times a month</td>
<td>21</td>
<td>20</td>
<td>23</td>
</tr>
<tr>
<td>2 to 3 times a week</td>
<td>23</td>
<td>15</td>
<td>25</td>
</tr>
<tr>
<td>4 or more times a week</td>
<td>13</td>
<td>11</td>
<td>14</td>
</tr>
</tbody>
</table>

Source: 2008 Swindon Super Survey

According to the Super Survey, in 2008 most people that responded to the survey stated that they did not consume any alcohol in the week prior to the survey. Although when people did drink, they consumed lower levels of units, 9% of people stated that they consumed 5 or 6 units and 9% 7 or more units in the previous week. It is not possible to infer how many males are binge drinking (e.g. 8 units or above) as the questionnaire falls short of asking whether respondents drank 8 or more units in any day in the last week.
Table 4.2: How many units of alcohol people in Swindon drank in the last week

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th></th>
<th>2008</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Swindon &amp; Shrivenham</td>
<td>NRA</td>
<td>Swindon &amp; Shrivenham</td>
<td>NRA</td>
</tr>
<tr>
<td>None</td>
<td>21</td>
<td>32</td>
<td>24</td>
<td>35</td>
</tr>
<tr>
<td>1</td>
<td>16</td>
<td>16</td>
<td>18</td>
<td>16</td>
</tr>
<tr>
<td>2</td>
<td>18</td>
<td>16</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>3</td>
<td>14</td>
<td>11</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td>4</td>
<td>11</td>
<td>7</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>5 or 6</td>
<td>10</td>
<td>8</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>7 or more</td>
<td>10</td>
<td>10</td>
<td>9</td>
<td>7</td>
</tr>
</tbody>
</table>

Source: 2008 Swindon Super Survey

The North West Public Health Observatory produces local alcohol profiles for England. This is based on the National Alcohol Indicator Set and includes Swindon. They estimated the following about drinking behaviours in Swindon in 2009:

- 20% of residents aged 16 years and over report engaging in hazardous drinking, defined as consumption of between 22 and 50 units of alcohol per week for males, and between 15 and 35 units of alcohol per week for females.
- 4.9% of residents aged 16 years and over report engaging in harmful drinking, defined as consumption of more than 50 units of alcohol per week for males, and more than 35 units of alcohol per week for females.
- 16.1% of adults in Swindon consume at least twice the daily recommended amount of alcohol in a single drinking session and so engage in binge drinking.
- Although there are variations in the proportion of people who engage in these drinking behaviours in Swindon compared to the South West and England, the differences between are not statistically significant.

4.2 Knowledge and attitudes to alcohol

No recent local surveys or research are available on the knowledge and attitudes of Swindon residents to alcohol. The East of England region has however conducted robust research on drinking knowledge and attitudes, which although are not specific to Swindon, can be generalised to Swindon residents to some extent. This is on the basis that the demographic profile of the research is fairly representative of Swindon (i.e. represents male and female English residents, all age groups above 18 years, and ethnic minority groups), and on the logic that drinking attitudes and knowledge across England are likely to be similar. The key aim of the research, which was conducted by Ipsos MORI in 2008/09, was to develop a deeper understanding of people’s attitudes towards drinking in response to increasing concerns over its impact on the nation’s health. The key findings of the research are as follows:
Perceptions of drinking behaviours:
- Those people who are drinking at increased and higher risk levels often underestimate the amount that they drink and the impact that such behaviour can have on their health and well-being. This has long-term implications for public health and service provision.
- The majority of those drinking at increasing risk levels describe themselves as ‘moderate’ drinkers, indicating that this is perceived as not only socially acceptable, but also a normal level at which to drink.

Motivations for drinking:
- Drinking patterns and motivations for drinking vary a great deal by age. Younger people (aged 18-24 years) show a tendency to ‘binge drink’, with many drinking heavily on a few concentrated occasions during the week. Older drinkers are more likely to drink on a regular basis and though they tend to drink fewer units, they do so more often.
- Younger drinkers are more likely to say that their drinking habits are affected by peer pressure and are more likely to say that they drink to give them confidence. Is this an accurate reflection of their motivations, or does it just indicate that younger people are more likely to admit that these factors influence their drinking?
- Ethnic minority respondents are also more likely to agree that they feel under pressure from their peers to drink more than they’d like (19%, compared to 10% overall).

People’s concerns about alcohol consumption
- People are relatively unconcerned about their personal drinking habits, but acutely aware of the social impact that drinking has. Alcohol is seen as a problem, but it's generally regarded as someone else’s. Similarly, people are relatively unconcerned about its effect on their health, but there is more awareness of the pressures that alcohol consumption puts on public services.
- Where people have concerns, women tend to be more concerned about putting on weight, men more concerned about developing health problems and younger people are more concerned about the amount of money they spend on alcohol.

People’s views on reducing their alcohol consumption
- Only a small proportion of drinkers indicate that they want to cut down the amount that they drink. Of those, different methods are likely to be more effective with some groups than others.
- Over a quarter of those who do wish to cut down say that more information on alcohol packaging could help them to do so. Similarly, men wanting to cut down are more likely than women to list advice from their GP as an effective measure, perhaps linked to the fact that men who are concerned about the amount they drink are more likely to cite health-concerns as a factor than are women.
- Half of all those who participated in the survey said that their GP was their preferred source of information.
GP surgeries were a less popular source of information among ethnic minority respondents (32% listed them as a preferred source of information, compared to 49% of white respondents). Schools and colleges, youth and social clubs, and pubs and clubs were all prioritised above GP surgeries as preferred sources of information among ethnic minority respondents.

4.3 The impacts of drinking: Alcohol related harms

Impacts on health and wellbeing

Mortality and life expectancy

Mortality can be entirely related to alcohol (alcohol-specific) or influenced only in part by alcohol (alcohol-attributable). In Swindon there were 31 male and 17 female alcohol-specific deaths between 2005 and 2007 (see table below). The alcohol-specific mortality rate was lower in Swindon than both the South West region and England, though the differences are not statistically significant. In Swindon there were 31 male and 13 female alcohol-attributable deaths in 2007 only (see table below). The alcohol-attributable mortality rate was higher for males in Swindon that the South West, but again the differences could have arisen by chance and are not statistically significant.

In terms of time trends, the alcohol-attributable morality rate for males and females in Swindon was lower in 2007 compared to 2001. However, the alcohol-specific mortality rate for males and females in Swindon was higher in 2007 than it was in 2001, and so increased overall.

Table 4.3: Alcohol related mortality in Swindon, the South West and England

<table>
<thead>
<tr>
<th>Area</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Rate per 100,000</td>
</tr>
<tr>
<td>Alcohol-specific mortality for period 2005-2007</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swindon</td>
<td>31</td>
<td>11.1</td>
</tr>
<tr>
<td>South West</td>
<td>968</td>
<td>11.6</td>
</tr>
<tr>
<td>England</td>
<td>9899</td>
<td>12.71</td>
</tr>
<tr>
<td>Alcohol-related mortality for 2007</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swindon</td>
<td>31</td>
<td>30.1</td>
</tr>
<tr>
<td>South West</td>
<td>1027</td>
<td>33.7</td>
</tr>
<tr>
<td>England</td>
<td>10,027</td>
<td>36.1</td>
</tr>
</tbody>
</table>

Source: 2009 Alcohol Profiles, North West Public Health Observatory

There were 32 male and 24 female deaths due to chronic liver disease in Swindon in the years 2005 to 2007 (see table below). The mortality rate for chronic liver disease for men was lower in Swindon than in England and the South West. The mortality rate for chronic liver disease for women was higher in Swindon than in both the South West and England. However, all differences are not statistically significant.
Table 4.4: Mortality from chronic liver disease in Swindon, the South West and England between 2005 and 2007

<table>
<thead>
<tr>
<th>Area</th>
<th>Men</th>
<th></th>
<th></th>
<th>Women</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Rate per 100,000</td>
<td>Number</td>
<td>Rate per 100,000</td>
<td></td>
</tr>
<tr>
<td>Swindon</td>
<td>32</td>
<td>11.30</td>
<td></td>
<td>24</td>
<td>7.23</td>
</tr>
<tr>
<td>South West</td>
<td>1014</td>
<td>11.70</td>
<td></td>
<td>558</td>
<td>5.55</td>
</tr>
<tr>
<td>England</td>
<td>10,928</td>
<td>13.79</td>
<td></td>
<td>6293</td>
<td>7.13</td>
</tr>
</tbody>
</table>

Source: 2009 Alcohol Profiles, North West Public Health Observatory.

In terms of life expectancy, the average man in Swindon loses about 7 months of life due to alcohol-use disorders. The average woman loses about 3 and half months of life.

Hospital admissions and burden on health care resources

Hospital admissions can also be entirely related to alcohol (alcohol-specific) or are influenced only in part by alcohol (alcohol-attributable). Thus, all admissions for alcoholic liver disease, mental/behavioural disorders due to alcohol and alcoholic poisoning are alcohol-specific. However, admissions for accidents, assaults, road traffic accidents, certain cancers, heart disease, and spontaneous abortion, for example, can be attributed to alcohol for a proportion of, but not all, cases.

In Swindon, there were 746 alcohol-specific hospital admissions for people aged 18 years and above between 1st April 2008 and 31st July 2009. This is according to the data from the Secondary Users Service (SUS). Of the 746, 502 were male and 244 were female. A breakdown of the age of those that were admitted is given in the table below. This shows that alcohol-specific admissions are highest in middle aged residents, and particularly high in those in their late 30s, 40s and early 50’s.

Table 4.5: Alcohol-specific admissions in Swindon by age group between April 2008 and July 2009

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>Number</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 – 24</td>
<td>63</td>
<td>8</td>
</tr>
<tr>
<td>25 – 31</td>
<td>79</td>
<td>11</td>
</tr>
<tr>
<td>32 – 38</td>
<td>93</td>
<td>12</td>
</tr>
<tr>
<td>39 – 45</td>
<td>162</td>
<td>22</td>
</tr>
<tr>
<td>46 – 52</td>
<td>118</td>
<td>16</td>
</tr>
<tr>
<td>53 – 59</td>
<td>103</td>
<td>14</td>
</tr>
<tr>
<td>60 – 67</td>
<td>85</td>
<td>11</td>
</tr>
<tr>
<td>68 – 75</td>
<td>22</td>
<td>3</td>
</tr>
<tr>
<td>75 +</td>
<td>21</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>746</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Secondary Users Service (SUS)

According to the 2009 Alcohol Profiles prepared by the North West Public Health Observatory, the alcohol-specific admission (standardised) rate (for those aged 18 years and above) in Swindon is higher than the South West average, but (statistically) significantly better than the national average.
In Swindon, there were 6,082 alcohol-attributable hospital admissions for people aged 18 years and above between 1st April 2008 and 31st July 2009. Again, this is according the data from the Secondary Users Service (SUS).

In this analysis, all alcohol attributable admissions with an attributable fraction score between 0.2 and 0.999 were included (1 would be equal to an alcohol-specific admission). The 2009 Alcohol Profiles include a smaller range of alcohol attributable admissions. In their analysis there were 1,045 alcohol-attributable male admissions per 100,000 of the population and 611 female admissions per 100,000 of the population in 2008/09. These profiles indicate that alcohol-attributable admissions (for those aged 18 and above) in Swindon are higher than the South West average but (statistically) significantly better than the national average.

Alcohol-attributable admissions in Swindon increased between 2003/04 and 2006/07 for both makes and females, and then decreased slightly in 2007/08 as indicated by the graphs below.

**Figure 4.1:** Alcohol-attributable hospital admissions for males and females per 100,000 of the population.

Source: 2009 Alcohol Profiles, North West Public Health Observatory.

**Table 4.6:** Alcohol-specific and alcohol-attributable admissions in the financial year 2008-2009 for Swindon, the South West and England.

<table>
<thead>
<tr>
<th>Alcohol-specific hospital admissions</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rate per100,000</td>
<td>Rate per100,000</td>
</tr>
<tr>
<td>Swindon</td>
<td>287.3</td>
<td>131.7</td>
</tr>
<tr>
<td>South West</td>
<td>305.6</td>
<td>149.8</td>
</tr>
<tr>
<td>England</td>
<td>305.8</td>
<td>144.6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Alcohol-related hospital admissions</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rate per100,000</td>
<td>Rate per100,000</td>
</tr>
<tr>
<td>Swindon</td>
<td>827.2</td>
<td>481.5</td>
</tr>
<tr>
<td>South West</td>
<td>829.3</td>
<td>468.9</td>
</tr>
<tr>
<td>England</td>
<td>826.1</td>
<td>461.5</td>
</tr>
</tbody>
</table>

Source: 2009 Alcohol Profiles, North West Public Health Observatory.
A study of 1025 attenders at the Accident and Emergency Department in Great Western Hospital in Swindon in 2006 gave the following results:

- On average, 19% of all attendances were related to alcohol-use disorders.
- Much higher figures can be experienced at peak attendance times, with up to 60% of attendances being alcohol related.
- Men were three times more likely to attend with an alcohol-related problem than were women.
- Young people under 30 were also more likely to attend for alcohol-related problems than those older.
- People presented with a broad range of alcohol-related conditions such as falls psychiatric disturbances, and assaults.
- Many of the alcohol-related attendances pose a significant drain on departmental resources.

Swindon situation for accidents where alcohol is a contributory factor

Between 1st October 2008 and 30th September 2009 there were 462 road traffic accidents in Swindon. These caused 595 casualties, 4 of which were fatal, 89 of which were serious, and 502 of which were slight. Of all collisions, 13 involved the driver being impaired by alcohol, and 7 involved pedestrians being impaired by alcohol.

Table 4.7: Road traffic collisions and casualties in Swindon where alcohol impairment is a contributory factor. Period 01/10/2008 to 30/09/2009.

<table>
<thead>
<tr>
<th>Collisions in which the Officer has attributed impairment by alcohol to one or more drivers as a contributory factor.</th>
<th>Fatal</th>
<th>Serious</th>
<th>Slight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of collisions</td>
<td>1</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Number of casualties</td>
<td>1 (25% of all fatal casualties)</td>
<td>8 (9% of all serious casualties)</td>
<td>8 (2% of all slight casualties)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Collisions in which the Officer has attributed impairment by alcohol to one or more pedestrians as a contributory factor.</th>
<th>Fatal</th>
<th>Serious</th>
<th>Slight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of collisions</td>
<td>0</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Number of casualties</td>
<td>0</td>
<td>2 (2% of all serious casualties)</td>
<td>5 (1% of all slight casualties)</td>
</tr>
</tbody>
</table>

Source: Swindon & Wiltshire Road Collision and Casualty Statistics, 2008/09. Received on request.

Swindon situation for specific diseases where alcohol is a contributory factor

The table below highlights how many admissions there were for certain conditions where alcohol was a contributory factor and in some cases the primary contributor. Admissions where alcohol is a (primary) contributory factor are particularly high for cardiovascular disease and cancers, though alcohol also contributes to other conditions such as chronic disorders, liver disease, intoxication, and other acute events (e.g. due to violence and incidents).
Table 4.8: Admissions by condition, where alcohol is a contributory factor and where it is the primary diagnosis, for the period 2008/09.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Admissions where it is a contributory factor</th>
<th>Admissions where it is the primary diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Disorders</td>
<td>731</td>
<td>309</td>
</tr>
<tr>
<td>Liver Disease</td>
<td>177</td>
<td>65</td>
</tr>
<tr>
<td>Cardiovascular Disease</td>
<td>6792</td>
<td>1713</td>
</tr>
<tr>
<td>Mental Health</td>
<td>584</td>
<td>113</td>
</tr>
<tr>
<td>Cancer</td>
<td>1942</td>
<td>1717</td>
</tr>
<tr>
<td>Foetal Alcohol Syndrome</td>
<td>Information not available</td>
<td>Information not available</td>
</tr>
<tr>
<td>Toxic effects of alcohol</td>
<td>102</td>
<td>4-5</td>
</tr>
<tr>
<td>Acute</td>
<td>147</td>
<td>135</td>
</tr>
<tr>
<td>Suicides</td>
<td>Information not available</td>
<td>Information not available</td>
</tr>
</tbody>
</table>


Impacts on children and families

In Swindon, 88 of the 123 clients in contact with the adult treatment provider for alcohol misuse between 1 April 2008 and 31 March 2009 were parents. Of those that were parents the vast majority had children living with them. As has already been highlighted, parental drinking behaviours and attitudes is associated with increased hazardous and harmful drinking in (their) children later on in life, and so Swindon should be looking to target such families for preventative work.

Table 4.9: Adults in treatment at Swindon Alcohol & Drugs Service (SWADS) between 01/04/08 and 31/03/09 who are parents, and their parental status.

<table>
<thead>
<tr>
<th>Primary Problem Drug</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>123</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parental Status</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>All the children living with client</td>
<td>4</td>
</tr>
<tr>
<td>Children Living with Client</td>
<td>84</td>
</tr>
<tr>
<td>Client Pregnant</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>35</td>
</tr>
</tbody>
</table>

Source: SWADS, Swindon.

Impacts on community safety

Alcohol-attributable crime

The 2009 Alcohol Profiles data set provides information on a range of alcohol-attributable crimes, based on local information. According to this data, in 2008/09 there were 1,594 recorded crimes that were attributable to alcohol. Of these alcohol attributable crimes, 1190 were violent crimes and 28 were sexual crimes (see table below). The rates of alcohol-attributable crime and were higher in Swindon than in the South West, and higher than England for violent crime and sexual crimes. The differences between Swindon and England are not statistically significant, though the differences in all alcohol attributable crime and alcohol attributable violent crime between Swindon and the South West are statistically significant.
Table 4.10: Alcohol attributable crime in Swindon for the financial year 2008/2009.

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Rate per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alcohol attributable crime</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swindon</td>
<td>1,594</td>
<td>8.21</td>
</tr>
<tr>
<td>South West</td>
<td>36,786</td>
<td>7.10</td>
</tr>
<tr>
<td>England</td>
<td>43,964</td>
<td>8.61</td>
</tr>
<tr>
<td><strong>Alcohol attributable violent crime</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swindon</td>
<td>1,190</td>
<td>6.13</td>
</tr>
<tr>
<td>South West</td>
<td>27,604</td>
<td>5.33</td>
</tr>
<tr>
<td>England</td>
<td>310,928</td>
<td>6.09</td>
</tr>
<tr>
<td><strong>Alcohol attributable sexual crime</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swindon</td>
<td>28</td>
<td>0.15</td>
</tr>
<tr>
<td>South West</td>
<td>617</td>
<td>0.12</td>
</tr>
<tr>
<td>England</td>
<td>6,263</td>
<td>0.12</td>
</tr>
</tbody>
</table>

Source: 2009 Alcohol Profiles, North West Public Health Observatory.

Alcohol needs identified by the Probation Service

The Offender Assessment System (OASys) is an advanced, and research based, offender assessment for identifying the factors associated with offending related behaviour. Introduced into the National Probation service in 2003, it has now become the core offender assessment system for both the Probation and Prison services. The majority of offenders receiving custodial sentences of more than 12 months and those receiving community sentences will all be assessed at some point during their sentence using OASys. The OASys assessment consists of three main sections; Factors influencing likelihood of reoffending (Accommodation, ETE, Alcohol Misuse etc), a risk of harm assessment and management plan, and a sentence planning section. By completing the assessment, a Probation Officer is able to identify the issues likely to increase the offenders risk of reoffending as well as the factors that need to be addressed in order to reduce their risk of harm levels.

Offenders are typically assessed using OASys at the start of their community sentence or, if they have been released from custody, at the start of their licence. This assessment is then reviewed at a minimum of 16 week intervals throughout their contact with the Probation service, or sooner if their circumstances change. A final termination assessment is completed at the end of the offenders sentence to review the progress made in the reduction of factors likely to contribute to further offending. The information below is taken from OASys assessments completed at the start of community sentence/licence between April 2008 and March 2009.

Extent of Alcohol Misuse in Adult Offenders: In 2008/09, 48% of offenders entering probation supervision in Swindon had alcohol misuse as an identified factor related to their offending. This equates to a total of 320 offenders. During the same period, 52 Community Sentences with an Alcohol Treatment Requirement were made by the courts. This reflects a potentially unmet need of 84% in Swindon.

Of those who had alcohol identified as a factor relating to their offending…
Demographics: 5% were female, 92% were of white ethnicity, and 45% were aged 25 years and under.

Current alcohol use as a problem: 68% identified current levels of alcohol use as problematic.

Binge drinking or excessive use of alcohol in last 6 months: 83% in had engaged in binge drinking in the past 6 months.

Frequency and level of alcohol misuse in the past: Offenders past frequency and levels of alcohol misuse was a concern in 93%.

Motivation to tackle alcohol misuse: 56% of offenders had moderate to high levels of motivation to address their alcohol misuse.

Violent behaviour related to alcohol use at any time: In 87% of cases in, alcohol misuse had been related to violent behaviour in the past.

Other Offending Factors and Alcohol Misuse: The most common other factor associated with their offending was “Thinking and behaviour” (69%), and the second most common need was “Employment, Education and Training” (56%).

Antisocial behaviour

Complaints about anti-social behaviour (ASB), and anti-social behaviour orders, are community safety indicators where alcohol has an attributable influence. In Swindon, between 1st November 2008 and 31st October 2009 there were 12,097 reports of ASB made to the Police. 75% (9,072) of the reported ASB related to rowdy or inconsiderate behaviour, and 3% (408) of reports referred to drunken behaviour or drinking directly. As people reporting ASB are not currently asked whether they think drinking is involved in the ASB, the 3% figure only represents those that offered this information and is much lower than we would expect it to be. Map A highlights where the 408 ASB incidents reporting drunken behaviour took place.

51% (6,224) of ASB incidents in Swindon were reported during “night time economy” hours, and so between 7pm and 7am (see map 2). It is likely that the majority of these incidents involved alcohol. As the maps below highlight, ASB occurs throughout Swindon, though particular hot spots are the Town Centre and Neighbourhood Renewal areas. ASB reports quoting “Drink(ing)” or “Drunk(en)” are concentrated in the Town Centre, Old Town and Eldene (see map 3).

Between October 2008 and November 2009 10 interim antisocial behaviour orders and 3 full orders were given to people living in Swindon. The 3 full orders were specifically alcohol related, and involved street drinkers.
**Figure 4.2:** Anti-social behaviour reported in Swindon.

**Figure 4.3:** Night time anti-social behaviour reported in Swindon town between 7pm and 7am, with hot spots highlighted.
Figure 4.4: Anti-social behaviour reported in Swindon town, with hot spots highlighted: Town Centre, Old Town and Eldene

Impacts on housing situation

Data from Swindon’s St. Luke’s Day Centre indicates that between April and September 2009 9% (16) of people attending were rough sleepers and 18% (32) were sofa surfing. A further 27% (48) were in temporary accommodation, and 11% (19) were in Local Authority housing. Of those attending the day centre it was recorded that 28% (49) had alcohol issues and needs. Many other issues and needs were also identified including drugs, emotional, mental health, and learning difficulties. Swindon’s Rough Sleeper Panel estimates that 95% of those sleeping rough have alcohol and drugs issues. Although from this data it is not possible to say that drinking caused people’s housing (i.e. rough sleeper) status, it is possible to infer that alcohol plays a role in contributing to and/or compounding people’s lack of permanent housing.

In a Service User and Stakeholder Survey conducted by Swindon Borough Council in 2007, people that were homeless or roofless identified the following as contributors to their housing situation:
- Lack of affordable accommodation.
- Family and relationship breakdown.
- Drug/alcohol problems (and lack of accommodation for people with these problems).
- Behavioural/mental health problems.

4.4 Vulnerable groups with alcohol needs

There are a number of groups of people that can be referred to as “vulnerable” because they have other needs (that impact upon their health) in addition to their alcohol needs. Where local data is available on the numbers of vulnerable people with alcohol needs this is stated. The data is generally on those that are already in contact with alcohol treatment services. In reality, there will be many more vulnerable people with alcohol needs (who are unknown to services) and so the figures below do not reflect total need. Some people will also have multiple needs, and so will fall into more than one vulnerable group.
Drug users: Of the (approximately) 220 adults attending SWADS for treatment between 1st April 2008 and 28th February 2009, 38 were also drug users. The majority of those that were drug users used cannabis (47%), 16% used cocaine, 13% heroine and 3% crack.

People with mental health issues: Of the (approximately) 220 adults attending SWADS for treatment between 1st April 2008 and 28th February 2009, 8% (17) were referred from mental health services and so will have mental health as well as alcohol (and possibly other) needs.

Rough sleepers and sofa surfers: Swindon’s Rough Sleeper Panel estimates that 95% (15) of rough sleepers have alcohol as well as housing needs. The majority of rough sleepers and sofa surfers with alcohol needs are male and single. Of the (approximately) 220 adults attending SWADS for treatment between 1st April 2008 and 28th February 2009, the majority (885) did not have housing problems. 8 people were identified as having housing problems, 7 of which were urgent.

Financially dependent on the State: Of the (approximately) 220 adults attending SWADS for treatment between 1st April 2008 and 28th February 2009, 35% (78) were unemployed and 5% (10) were economically inactive.

Victims and perpetrators of domestic violence: There are clear links between the misuse of alcohol and domestic violence. According to Swindon’s Domestic violence Strategy (2009 – 2012) in 2008/09 2,844 incidents of domestic violence were reported to Wiltshire police. In 2007/08 23% of all reported violent crime and 30% of serious woundings and assaults could also be attributed to domestic violence. Not all cases of domestic violence are reported on the basis of the national statistics that one in four women and one in six men will experience domestic violence at some point in their lives, 23,250 women, 15,500 men could potentially be victims of domestic violence in Swindon.

People with Korsakoff’s Syndrome: Korsakoff’s syndrome can cause symptoms such as amnesia, limited ability to converse with others, lack of insight and apathy, and can be caused by chronic alcoholism. There are a number of people with Korsakoff’s syndrome resident in Swindon (figures unavailable).

Those aged under and around 18 years: In 2008/09 at least 84 children were adversely affected by parental alcohol misuse in Swindon. Swindon’s Children and Young People’s Alcohol Needs Assessment (2009) highlighted the following young people as being particularly vulnerable to alcohol and drug misuse:
- Young offenders
- Children looked after by the local authority
- Young homeless people
- Children excluded from school
- Children who truant from school
- Young people who have been sexually exploited through prostitution
- Children of drug and alcohol users.
Family conflict and breakdown has been identified as one of the most significant factors in increasing vulnerability in children and young people.

**Carers and families of those who have alcohol problems:** Those that care for someone who misuses alcohol (and/or drugs) are at increased risk of being a victim of violence and abuse, and are vulnerable to isolation, emotional and financial difficulties.
PART 5: LOCAL SERVICE PROVISION

5.1 Models of Care for Alcohol Misusers (MoCAM)

Models of care for alcohol users (Department of Health 2006) sets out best practice guidance for commissioning and delivering a planned and integrated local system of alcohol interventions. MoCAM is predicated on the basic concept that local areas should provide a treatment system, rather than a range of different loosely co-ordinated interventions. Key elements to the treatment system are:

- A four-tiered system of treatment provision (see table below) with an expectation that every local area should provide access to services at every tier.
- Integrated care pathways – that every individual should receive a triage assessment at their first point of contact with the treatment system and then be directly matched to the most appropriate intervention without having to undergo repeated assessments.
- Care planning and co-ordination – putting the service user at the centre of a negotiated, clear care planning process which ensures continuity of care and a focus on outcomes.

### Table 5.1: The four-tiered system of alcohol treatment and its key components

<table>
<thead>
<tr>
<th>Tier 1: Mainstream</th>
<th>Tier 2: Mainstream or Specialist</th>
<th>Tier 3: Community specialist</th>
<th>Tier 4: Residential specialist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open access or outreach</td>
<td>Comprehensive assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Targeted screening</td>
<td>Brief alcohol interventions and treatment</td>
<td>Care planned and co-ordinated treatment</td>
<td>Inpatient managed withdrawal and psycho-social treatment</td>
</tr>
<tr>
<td>Information and brief advice</td>
<td>Triage assessment and referral</td>
<td>Managed withdrawal</td>
<td></td>
</tr>
<tr>
<td>Referral</td>
<td>‘Shared care’</td>
<td>Psycho-social treatments</td>
<td>Residential rehabilitation</td>
</tr>
<tr>
<td>Mutual aid groups e.g. Alcoholics Anonymous</td>
<td></td>
<td>Structured day programmes</td>
<td></td>
</tr>
</tbody>
</table>

5.2 Mapping current alcohol service provision in Swindon

By mapping existing services available in Swindon against the 4 tiers detailed in MoCAM, the range of services and level of service capacity available can be easily identified. It also enables a comparison to be made between service provision and capacity and identified need, which is analysed further in the next chapter.

From the tables below it is clear that the range of tier 1 to 4 alcohol treatment services are being provided in Swindon. Tier 1 and 2 treatment services are
being provided in a range of settings, though more could be done to develop and enhance provision in some settings; notably in pharmacy and domestic abuse service settings. Further exploration of the quality and range of service provision in settings such as primary care and social care would also be helpful in identifying further gaps in the provision of alcohol care and treatment. Tier 3 and 4 interventions are provided in a more limited number of settings, as would be expected for these levels of specialist services. However, consideration should be given to exploring opportunities to provide specialist treatment in further community and outreach settings.

See sections 5.3 to 5.6 for descriptive information about tier 1-4 service provision in Swindon.
Table 5.2: Current service provision in Swindon in the 4 tiers detailed in MoCAM. “Y” indicates that services are provided in a particular setting.

<table>
<thead>
<tr>
<th>TIER 1 INTERVENTIONS</th>
<th>Settings currently delivered in</th>
<th>Minimum Tier 1 alcohol interventions:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Specialised alcohol service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>General practice</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pharmacies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A &amp; E</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other hospital departments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MH services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social services department</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Homeless services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Police settings</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vocation and unemployment services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Domestic abuse services</td>
<td></td>
</tr>
</tbody>
</table>

1. **Alcohol advice and information**
   - Specialised alcohol service: Y
   - General practice: Y
   - Pharmacies: Y
   - A & E: Some - not contract dependent on individual worker
   - MH services: Y - Older peoples services, Children’s
   - Social services department: Y
   - Homeless services: Y
   - Police settings: Y – Job centre plus
   - Vocation and unemployment services: Y
2. **Targeted screening and assessment for those drinking in excess of sensible drinking and those who may need alcohol treatment**
   - Specialised alcohol service: Y
   - General practice: Y
   - Pharmacies: Y – unplanned detox
   - A & E: Y
   - MH services: ?
   - Social services department: Y – Hostels. Not in SBC housing
   - Homeless services: Y
   - Police settings: Y
   - Vocation and unemployment services: To be introduced
   - Domestic abuse services: Y
3. **Provision of simple brief interventions for hazardous and harmful drinkers**
   - Specialised alcohol service: Y
   - General practice: Y
   - Pharmacies: Y
   - A & E: ?
   - MH services: ?
   - Social services department: Y – Hostels. Not in SBC housing
   - Homeless services: Y
   - Police settings: Y
4. **Referral of those requiring more than simple brief interventions for specialised alcohol treatment**
   - Specialised alcohol service: Y
   - General practice: Y
   - Pharmacies: Y though dependent on who on duty
   - A & E: Y
   - MH services: ?
   - Social services department: Y
   - Homeless services: Y
   - Police settings: Y
   - Vocation and unemployment services: Y
   - Domestic abuse services: Y
5. **Partnership/shared care with specialised**
   - Specialised alcohol service: Y – but currently
   - General practice: Y
   - Pharmacies: Y
   - A & E: ?
   - MH services: Don’t but should!
   - Social services department: Y
   - Homeless services: Y
   - Police settings: Y
   - Vocation and unemployment services: Y
   - Domestic abuse services: Y
alcohol treatment services, e.g. to provide specific alcohol treatment interventions within generic services.

<table>
<thead>
<tr>
<th>TIER 2 INTERVENTIONS</th>
<th>Settings currently delivered in</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Specialist alcohol services</td>
</tr>
<tr>
<td>Tier 2 interventions include open access facilities and outreach targeting alcohol misusers, which provide:</td>
<td></td>
</tr>
<tr>
<td>Alcohol-specific information, advice and support</td>
<td>Y</td>
</tr>
<tr>
<td>Extended brief interventions and brief treatment to reduce alcohol-related harm</td>
<td>Y</td>
</tr>
<tr>
<td>Alcohol-specific assessment and referral of those requiring more</td>
<td>Y</td>
</tr>
<tr>
<td>Part of Tier 3</td>
<td>Settings currently delivered in</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Partnership or ‘shared care’ with staff from Tier 3 and Tier 4 provision, or joint care of individuals attending other services providing Tier 1 interventions</strong></td>
<td><strong>Specialist alcohol services</strong></td>
</tr>
<tr>
<td><strong>Mutual aid groups, e.g. Alcoholics Anonymous</strong></td>
<td>Y</td>
</tr>
<tr>
<td><strong>Triage assessment, which may be provided as part of locally agreed arrangements.</strong></td>
<td>Y</td>
</tr>
</tbody>
</table>

**TIER 3 INTERVENTIONS**

<table>
<thead>
<tr>
<th>Tier 3 alcohol interventions:</th>
<th>Setting currently delivered in</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care planning and review</strong> for all those in structured treatment, often with regular key working</td>
<td>Y</td>
<td>Y</td>
<td>Y - for children</td>
<td>Y – but not focused on alcohol</td>
</tr>
<tr>
<td>Session</td>
<td>Status</td>
<td>Notes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>--------</td>
<td>---------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community care assessment and case management of alcohol misusers</td>
<td>Y</td>
<td>Y - for children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A range of evidence-based prescribing interventions, in the context of a package of care, including community-based medically assisted alcohol withdrawal (detoxification) and prescribing interventions to reduce risk of relapse</td>
<td>Y</td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A range of structured evidence-based psychosocial therapies and support within a care plan to address alcohol misuse and to address co-existing conditions, such as depression and anxiety, when appropriate</td>
<td>Y</td>
<td>Y – some but not evidence based nec.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Structured day programmes and care-planned day</td>
<td>Y</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
care (e.g. interventions targeting specific groups)

Liaison services, e.g. for acute medical and psychiatric health services (such as pregnancy, mental health or hepatitis services) and social care services (such as child care and housing services and other generic services as appropriate).

<table>
<thead>
<tr>
<th></th>
<th>Y</th>
<th>Y</th>
<th>Y - for children</th>
<th>Y/ N</th>
</tr>
</thead>
</table>

**TIER 4 INTERVENTIONS**

Tier 4 interventions – in-patient or residential care

<table>
<thead>
<tr>
<th>Tier 4 alcohol interventions:</th>
<th>Settings currently delivered in</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist alcohol services</td>
<td>Y</td>
</tr>
<tr>
<td>Outreach services</td>
<td>Y</td>
</tr>
<tr>
<td>GPs</td>
<td>Y</td>
</tr>
<tr>
<td>A &amp; E</td>
<td>Y</td>
</tr>
<tr>
<td>Other hospital departments</td>
<td>Y</td>
</tr>
<tr>
<td>MH services</td>
<td>Y</td>
</tr>
<tr>
<td>Social services</td>
<td>Y</td>
</tr>
<tr>
<td>Homelessness services</td>
<td>Y</td>
</tr>
<tr>
<td>Police settings</td>
<td>Y</td>
</tr>
<tr>
<td>Vocation and unemployment services</td>
<td>Y</td>
</tr>
<tr>
<td>Domestic abuse services</td>
<td></td>
</tr>
</tbody>
</table>

Comprehensive substance misuse assessment, (including complex cases when appropriate)
<table>
<thead>
<tr>
<th>for Tier 4 services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Care planning and review for all inpatient and residential structured treatment</td>
<td>Y</td>
</tr>
<tr>
<td>A range of evidence-based prescribing interventions, in the context of a package of care, including medically assisted alcohol withdrawal in inpatient or residential care and prescribing interventions to reduce risk of relapse. A range of structured evidence-based psychosocial therapies and support to address alcohol misuse.</td>
<td>Y</td>
</tr>
<tr>
<td>Provision of information, advice and training and 'shared care' to others - delivering Tier 1 and Tier 2 and support for Tier 3 services as appropriate.</td>
<td>Y</td>
</tr>
</tbody>
</table>
5.3 Tier 1 alcohol services in Swindon: non-alcohol misuse specific services which see alcohol misusers

Many people experiencing alcohol-related harm can change their drinking after brief and motivational interventions that can be provided in non-substance misuse specialist Tier 1 services. Staff are trained to achieve the following objectives from their contact with alcohol misusers:

- Identify and assess levels of need
- Refer on to appropriate services when required
- Educate clients about alcohol and its effects
- Undertake brief interventions
- Undertake motivational interviewing
- Use harm reduction approaches

Primary care:

All general practices in Swindon provide general advice on alcohol prevention and signposting and referral to specialist services. Since April 2008, the Department has funded a Directed Enhanced Service (DES) to pay GP practices to undertake alcohol screening. If a patient is identified as drinking at increased or high risk, the general practice will deliver brief advice and refer them to specialist services as appropriate. The DES only applies to newly registered patients and so its impact is limited. There will however be an opportunity to use the new Health Checks to screen existing patients between the ages of 40 and 75 years on their alcohol use, as recommended in Section 5.10.

Acute care:

Two Alcohol Liaison Nurses have recently been appointed to work at the Great Western Hospital to screen people attending or admitted to hospital, provide advice and refer them to specialist alcohol services as appropriate. They will act as a key link between acute and primary and community based services, and so help to improve the referral pathway to community provision. The intention is for screening to be initially implemented in the Emergency Department and the Gastroenterology ward, and then be rolled out across the hospital. The Alcohol Liaison Nurse model is already being used in Liverpool, where they found that it has helped to prevent unnecessary admissions and has encouraged better patient education and links with other services.

In addition to the service provided by the Alcohol Liaison Nurses, Great Western Hospital will deliver unplanned inpatient detoxification where people present as an emergency case. GWH also provides specialist liver, general medical and surgical services to treat people suffering from the disease consequences of alcohol-use.

Key gap: Lack of Tier 1 service provision in Pharmacies. There are opportunities to deliver Tier 1 provision under the existing pharmacy contract e.g. pharmacies have responsibilities around the provision of information and advice, referral of customers to other services, and delivering public health
campaigns. An audit of provision in general practice would be helpful to aid identification of further gaps and where and how general practice provision could be enhanced (and to include some tier 2 and 3 services).

5.4 Tier 2 alcohol services in Swindon: Open access alcohol misuse services

Swindon & Wiltshire Alcohol & Drugs Service (SWADS)

Current specialist (adult) alcohol treatment services in Swindon are largely provided by Swindon and Wiltshire Alcohol and Drugs Service. SWADS is a voluntary agency, which is commissioned by Swindon’s Drug & Alcohol Action Team (DAAT – and other?). SWADS provides the following Tier 2 services:

Information, support and advice: Provision of information, advice and professional support by telephone or at SWADS.

Alcohol Assessment Clinic: Takes place three times a week. It is a drop in clinic (no referral required) that aims to identify treatment needs and enable people quick and easy access to treatment.

Drop in support group: A drop in clinic that offers advice and support to people that want to make contact with alcohol treatment services but (would) struggle to regularly attend a structured programme.

Brief intervention clinic: A drop in clinic that provides brief advice and signposting to appropriate SWADS and/or other services.

Aftercare: Aftercare is provided on a wide spectrum of issues, including resettlement advice and relapse prevention to support people in maintaining their abstinence from alcohol.

Meaningful activities: SWADS encourages those with alcohol problems to participate in activities such as art, as a way of encouraging them to re-engage and develop new interests.

Swindon Carers Centre

Swindon Carer’s Centre (in partnership with SWADS) runs a support group for family members and friends of people with alcohol problems. Meetings are currently held once a month.

Other self-help groups

Alcoholics Anonymous operate a number of self help groups in Swindon, at different locations and at different times of the week. People can also access alcohol misuse support through Cocaine Anonymous and Narcotics Anonymous. Due to the different cultures of the groups, each one tends to attract a different demographic (e.g. Alcohol Anonymous in Swindon tends to attract older people, and Narcotics Anonymous younger people).
Al-Anon offers help and support to family members of alcoholics and open meetings are held in Swindon every week mornings at Park South Community Centre and at Broadgreen Community Hall.

**Key gap/s:** Lack of provision of tier 2 services or referral pathways into tier 2 services from some settings, including domestic violence settings. Unclear what level of interventions are being provided in social service settings, or if there are good referral pathways from those settings. Need for further treatment capacity in the community setting, including through primary care, specialist facilities, and assertive outreach.

### 5.5 Tier 3 alcohol services in Swindon: Structured community-based alcohol misuse services

**Swindon & Wiltshire Alcohol & Drugs Service (SWADS)**

SWADS provide a range of Tier 3 services as follows:

**Group programme:** The group programme supports people at different stages of their drinking and progress towards giving up alcohol (or harm minimisation). It consists of the following groups:

- **Drop In Support Group:** The support group meets daily, Monday to Friday. The group is for anyone who has concerns about their alcohol use. This service offers support with drinking, safer drinking limits and harm minimisation. Clients do not have to be abstinent to attend this group.
- **Structured Support Group:** The Structured Support Group meets daily. The group aims to support clients as they experience the changes that accompany a decision to give up alcohol. This Group is the most intense phase of the programme and includes process work and skills modules to help clients to consolidate their new sense of identity and develop a ‘tool-kit’ of alternative coping strategies. It also includes building the skills and confidence needed in ‘life after SWADS’.

**Community detox:** Work with clients GP to monitor and provide support whilst medication is being administered. Clients who wish to access this service must be engaged in ongoing or subsequent treatment through the Group Programme or one to one counselling.

**One to one counselling:** One to one counselling is available to anyone who has been through the Joint Assessment Clinic followed by a SWADS Full Assessment. The one to one counselling service is also available for partners and carers of substance misusers.

**One to one appointments:** Appointments can be made by the Alcohol Arrest Referral Workers for SWADS to meet with adults that have been arrested and are misusing alcohol. The appointments take place at Gablecross Police Station. Alcohol Arrest Referral Workers can refer people to tier 2 and 3 services.
Auricular acupuncture clinic: Acupuncture clinics are provided weekday afternoons (excluding Wednesdays) and are open to clients and members of the public – no assessment required.

Outreach clinics: SWADS did attend GWH for hospital assessments, though this ceased since the recruitment of the Alcohol Liaison Nurses at GWH. SWADS delivers home assessment for any service user that is unable to attend the centre due to infirmity, agoraphobia and other disability issues. SWADS has also been commissioned (by Swindon Carers) to run a group meeting at the Carers Centre in Wood Street to support carers of people who misuse.

Culverly court, delivered through Threshold Housing Link

Culverly Court provides emergency accommodation to single homeless men who have issues that trigger and exacerbate homelessness such as alcohol and drug misuse. Appointments are offered to give advice and support on alcohol misuse.

Key gap: Lack of comprehensive (specialist) outreach clinic provision in community settings such as general practice, and fairly low levels of outreach to certain vulnerable groups such as the homeless and/or roofless (i.e. could take services to settings such as Amethyst House). Some services limited in terms of their capacity to provide treatment in the community setting.

5.6 Tier 4 alcohol services in Swindon

Inpatient detoxification

There is no inpatient detoxification service in Swindon. Where detoxification is required and funded, Swindon DAAT commission’s services from Providers outside of Swindon. Which service is commissioned is dependent on the needs of the client, though Providers in the past have included BranchLea Cross in Cheltenham (for clients with complex needs), Broadreach House in Plymouth, and Clouds House in Salisbury.

Residential rehabilitation

Where residential rehabilitation is approved, Swindon DAAT commissions services from Gloucester House. Gloucester House is a residential rehabilitation centre for people with alcohol and drug addictions, managed by The Salvation Army. It is currently for men only.

Gloucester House runs Primary and Secondary Programmes. The Primary Programme is for a minimum period of 12 weeks and includes the following interventions:

- Interpersonal Groups
- Teaching Sessions
- Introduction to the Twelve Step Programme
- Occupational Therapy
- Weekly one-to-one sessions with a key-worker. The secondary programme is a further opportunity for development for those who have satisfactorily completed the Primary Programme. This stage usually lasts for 3 to 6 months and is less structured.

The Old Apple Yard, delivered through Threshold Housing Link

The Old Apple Yard provides supported accommodation for homeless people with alcohol and/or drug problems. It offers 4 bed spaces for men and women. The Old Apple Yard is delivered through Threshold, a local charity that provides emergency, short-medium and long-term accommodation to single homeless people.

Key gap: Lack of inpatient detoxification service in Swindon and/or options for detoxification beds close to Swindon. Few residential rehabilitation beds for women in Swindon.

5.7 Dual diagnosis services

A significant proportion of problem drinkers will also have mental health problems. This combination is associated with high levels of suicide, self-harm and violence to others and can make clients difficult to engage in services or treat effectively.

In Swindon there are three outreach workers that work with people that are particularly vulnerable to having alcohol, mental health and other problems. A part-time Community Mental Health Nurse (CMHN) works with Swindon’s homeless community, including those drinking on the streets. The CMHN delivers information and advice, and supports clients in accessing health services (largely delivered at Carfax NHS Medical Centre) and alcohol services at SWADS. Two Outreach Workers are employed through Threshold Housing Link. The Outreach Workers work with the homeless community, and refer clients to the CMHN or services as appropriate. The Outreach workers also work closely with residents at Amethyst House, which provides bed and breakfast to 4-5 previously homeless people with a long history of chronic alcohol misuse.

Key gap: Lack of integrated care for those with mental health and alcohol problems. People misusing alcohol are not (comprehensively) able to access mental health care and support.

5.8 Services in the criminal justice system

There are a number of ways in which alcohol services can offer treatment and care to people involved in the criminal justice system. The interventions that Swindon currently uses are as follows:
Alcohol Arrest Referral Scheme

Swindon has been successful at gaining grant funding from the Home Office to be one of 8 localities piloting the Alcohol Arrest Referral Scheme. Under the Scheme, individuals arrested and charged with alcohol-related offences are interviewed by one of two full time alcohol workers’ (at Gablecross Police Station). The alcohol workers’ assess the individual’s drinking behaviour, the health risks of their drinking, and provide advice on reducing their alcohol consumption. The individual is then referred to one or more alcohol treatment sessions (e.g. at SWADS) as appropriate. Funding for the Scheme is due to end between March and October 2010.

Conditional Cautioning

Conditional Cautioning provides offenders the option of attending rehabilitation services instead of facing court proceedings. In the case of offending linked to alcohol, the condition is that the individual attend brief alcohol interventions. Non compliance will result in prosecution for the original offence. Further interventions are offered to the individual where they wish to engage in alcohol services further.

Swindon’s Alcohol Arrest Referral Scheme aims to achieve 5 conditional cautions each month, though progress in delivering this target has been delayed.

Alcohol Treatment Requirements

Alcohol Treatment Requirements (ATR) can be given by Magistrates to individuals that have committed an alcohol-related offence. This requires the individual to attend alcohol treatment services. SWADS has the contract with Probation to deliver ATRs in Swindon.

Designated Public Place Orders (DPPOs)

DPPOs are areas where it is an offence to drink alcohol after being requested by a police officer not to do so. The police have the power to require the surrender of alcohol and containers in these circumstances and those who fail to comply are liable to arrest. In Swindon the following areas are designated as DPPOs: Town Centre, Broad Green, Farringdon Road Park area, Haden Wick and Abbey Meads. Consultation is currently taking place on whether Cavendish Square should be designated a DPPO area.

Probation

Probation plays an important role in giving individuals on their case load advice and information about alcohol misuse, and in linking them with alcohol treatment services such as SWADS. Probation also monitors attendance at treatment services where attendance is part of an Alcohol Treatment Requirement or Conditional Order.
Key gap: There is no managed wet and/or dry house provision for street drinkers who are given a DPPO to be signposted to, and from where they could access health and related support.

5.9 Activities focussing on primary prevention

So far, this chapter has outlined services in place to treat people that are misusing alcohol, either to reduce their consumption and the harms they are causing to themselves (and possibly others), or to support them in becoming abstinent. Services that encourage people not to misuse alcohol (i.e. drink above safe levels) in the first place are crucial. By preventing the development of alcohol misuse, the harms caused by alcohol to individuals, families and the wider Swindon community can be substantially reduced.

This "primary prevention" approach is being delivered in Swindon in the following ways…

Provision of education and information
- A Young People’s Education Worker works with young people to educate them about alcohol use and misuse. This is important in encouraging young people not to take up drinking at unsafe levels, and in encouraging young people already experimenting with alcohol to either not drink or drink at safe levels.
- Information about alcohol and the associated harms are communicated to Swindon residents using a range of media, including local newspapers, radio and posters.
- Activities to engage the public in a debate about alcohol are planned under the “Big Debate” programme.

Training for staff on prevention
- Multi-agency training takes place on alcohol related harm for people working with children, young people and families, and adults.

Working with industry
- Work is taking place with off-licenses to reduce under-age purchasing of alcohol (through the test-purchasing programme) and irresponsible alcohol promotions.
- Swindon’s Crime Prevention Initiative Partnership (SCRIP) is working to reduce alcohol-related anti-social behaviour and criminal activities in the town centre.
- Work is ongoing with area managers (responsible for company policy) of pub and club chains to encourage the promotion of sensible drinking, and to increase use of polycarbonate glasses.
- Work is taking place with Door Staff at bars and pubs to engage them in providing intelligence to the Police on people that are being drunk and disorderly, and on how to handle incidents involving alcohol effectively.
- The NightVision Project is working to develop Swindon’s night time economy into an environment that is welcoming, clean and safe for all, encourages good movement and transportation of people, offers a choice and range of entertainment and activities, and is a stimulating and vibrant.
**Key gap:** A coherent communications and social marketing plan to target messages to key target audiences does not exist.

**5.10 Ongoing service development**

There are a number of additional services that are due to be implemented in the oncoming 6 months:

- **Health Checks (by general practice)** - All people between 40 and 75 years who have not had a stroke of been diagnosed with heart disease, diabetes of kidney failure will be invited (once every five years) to have a check to assess their risk getting these conditions. They will also be given support and advice to help them reduce or manage their risk. Questions about their alcohol consumption has been included as a local requirement within the Health Check, which provides an excellent opportunity to identify alcohol needs, provide brief advice, and refer people to specialist services as appropriate.

- **Multi-disciplinary meetings** that focus on meeting the needs if clients with complex and multiple needs. This is to help reduce complex cases being ‘bounced’ between services, and ensure that all their needs are appropriately met.

- **Referring individuals** that have committed an alcohol related offence to the Brief Intervention Clinic at SWADS as a pre-sentencing option. Discussion is currently underway with the Courts on this.
6.1 Estimation of numbers of people that misuse alcohol

In order to better understand alcohol-related needs in Swindon, it is important to estimate the numbers of people that misuse alcohol, or are at increasing risk of misusing alcohol. This will help inform whether Swindon has the range of services and capacity to meet their needs, and in turn inform future service planning and commissioning.

There is no definitive population based evidence on the numbers of adults requiring treatment for alcohol misuse. Research has focused on identifying vulnerability factors that contribute to the development of alcohol misuse and the prevalence of alcohol taking in large populations or samples. Even in those groups identified as being vulnerable to developing alcohol misuse problems, or who frequently use alcohol, not all will need specialist misuse treatment.

According to the North West Public Health Observatory (NWPHO) alcohol profiles, Swindon has the following number of hazardous, harmful and binge drinkers:
- Hazardous: 32,320
- Harmful: 7,870
- Binge drinkers: 25,856

These estimations are based upon the 2005 mid-year percentage of the population aged 16 years and over who report engaging in these drinking behaviours, and Swindon’s 2009 resident population projection (the latter compiled by NHS Swindon). In these estimations “hazardous” is defined as consumption of between 22 and 50 units of alcohol per week for males, and between 15 and 35 units of alcohol per week for females. “Harmful” is defined as consumption of more than 50 units of alcohol per week for males, and more than 35 units of alcohol per week for females.

The proportion of people drinking to these levels can be compared to the South West SHA population, England and Milton Keynes, which has a comparable population to Swindon. Although there are variations in the proportion of people who engage in these drinking behaviours in Swindon compared to the South West, Milton Keynes and England, the differences between them are not statistically significant.

Table 6.1: Estimate of the percentage of people engaging in different drinking behaviours by area.

<table>
<thead>
<tr>
<th>Area</th>
<th>[Mid 2005] Synthetic estimate of % of the population aged 16 years + who report engaging in drinking behaviour</th>
<th>Lower 95% CI</th>
<th>Upper 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hazardous drinking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Region</td>
<td>Harmful drinking</td>
<td>Binge drinking</td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>------------------</td>
<td>----------------</td>
<td></td>
</tr>
<tr>
<td>Swindon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>South West</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milton Keynes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>England</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Region</th>
<th>Harmful drinking</th>
<th>Binge drinking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Swindon</td>
<td>4.87</td>
<td>16.0</td>
</tr>
<tr>
<td>South West</td>
<td>4.45</td>
<td>15.3</td>
</tr>
<tr>
<td>Milton Keynes</td>
<td>4.80</td>
<td>17.5</td>
</tr>
<tr>
<td>England</td>
<td>5.03</td>
<td>18.0</td>
</tr>
</tbody>
</table>

**Source:** 2009 Alcohol Profiles, North West Public Health Observatory

A Ready Reckoner tool has also been developed by the Department of Health's Alcohol Learning Centre (ALC) to help localities estimate the number of drinkers in their area, and to help predict the likely impact of increasing alcohol interventions and treatment. According to this tool, Swindon has the following number of drinkers, by drinking type:

- Increasing risk drinkers: 30,228
- Higher risk drinkers: 7,357
- Dependent drinkers: 4,046
- Binge drinkers: 24,232

If the following interventions were *not* introduced in Swindon between 2009/10 and 2011/12, the Reckoner tool predicts that hospital admissions for alcohol will continue to increase as suggested in the chart below.

- Alcohol Specialist Nurse (ASN) in A&E and acute hospital clinics working with non-dependent drinkers
- Alcohol Health Worker in acute hospital working with dependent drinkers
- Increasing the proportion of dependent drinkers treated with motivational or social network therapy (UKATT)
- Screening for problem drinkers in general practice followed by brief intervention
As in Swindon, it is expected that there will be developments in service provision across all four areas (i.e. Alcohol Liaison Nurses are in place in the Acute Trust), the following impacts on hospital admissions can be expected.

**Figure 6.1:** Hospital admissions with none of the additional interventions (see above)

**Figure 6.2:** Hospital admissions with an increase in the interventions (see above)
6.2 Gap analysis

One of the ways in which alcohol-related needs can be identified is by comparing the number of people potentially needing treatment with the numbers accessing (and using) services. This then highlights whether there is a gap between service need and provision, and how big a gap there is. As well as comparing the numbers of people needing and using services, it is also useful to analyse who is accessing services so that we can try and identify if some groups are over or under represented in treatment services.

Number in need of alcohol treatment compared to numbers in treatment

The gap analysis conducted by the Alcohol Needs Assessment Research Project 2004 (ANARP) identified that in England, the number of alcohol dependent individuals accessing treatment per year is approximately 63,000. This provides a Prevalence Service Utilisation Ratio (PSUR) of 18, which means that 1 in 18 (or 5.6%) of the in-need alcohol dependent population are accessing alcohol treatment per year. The Prevalence-service utilisation ratio for the South West (based on estimated need) is 14.3, which means that 1 in 14 people are accessing alcohol treatment per year.

In Swindon the number of new alcohol dependent individuals accessing Tier 2 and 3 treatments at SWADS (the main service provider) in the financial year 2008/2009 was 308. This provides a Prevalence Service Utilisation Ratio (PSUR) 13, which means that 1 in 13 (or 7.6%) of the in-need alcohol dependent population are accessing alcohol treatment at SWADS per annum. This does not include additional people accessing Tier 2 services provided by self-help groups such as Alcoholics Anonymous, or Tier 3 services provided at Culverly Court and so the percentage of people accessing treatment will be higher. If the number of all alcohol dependent individuals accessing Tier 2 and 3 treatments as SWADS is used, the Prevalence Service Utilisation Ratio (PSUR) is 7, and so 1 in 7 of the in-need population are accessing treatment each year.

Comparative to England and the South West, Swindon is therefore encouraging more people in need of specialist treatment services to access and use these services, though there is still a sizeable gap between numbers needing and accessing treatment. In the UK there is currently no agreed level of service provision required to provide an appropriate level of service. According to a North American model of appropriate levels of access, however, an access level of 1 in 10 (10%) alcohol dependent individuals entering treatment per annum is regarded as a ‘low’ level of access, 1 in 7.5 (15%) ‘medium’ and 1 in 5 (20%) ‘high’ (ANARP)\textsuperscript{66}. At these levels, Swindon is providing a low level of access. There are opportunities to increase the numbers accessing treatment through new initiatives being introduced to identify people with alcohol needs (i.e. the Alcohol Liaison Nurses, Health Checks and Brief Interventions), though there is unlikely to be enough capacity in the existing system to meet increased demand. This will need to be monitored.
Profile of those in treatment

Age

On the basis that 9% of men and 4% of women are estimated to show signs of alcohol dependency, of those accessing specialist treatment services one would expect approximately 69% to be men and 31% women. In 2008/09 366 males and 150 females were in tier 2 or 3 treatment with SWADS, which is equivalent to 71% males and 29% females. This suggests that the expected ratio of men and women are accessing treatment services at SWADS and no gender is (significantly) under represented.

Of those in treatment at SWADS, 62% are between the ages of 30 and 49 years. This is not surprising given that generally, people in these age groups drink more regularly than younger age groups, and Swindon has a high proportion of residents that are of working age (higher than the England average). Although people that are 18-24 years tend to be the heaviest drinkers as a single age group, we wouldn’t expect them to be highly represented in specialist treatment services because the majority will “grow out” of their drinking behaviours. Those that don’t will contribute to the higher numbers seen in the 25-29 years and upwards age groups. There is quite a sharp decrease in those in treatment after the age of 49 years, suggesting that those in their 50s may be under-represented in treatment services. There are also small numbers in treatment over the age of 60 years (and particularly 65 years and over), which suggests these age groups are under-represented.

Table 6.2: Numbers of people in treatment as at 30/09/2008, by age group.

<table>
<thead>
<tr>
<th>Age</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 and under</td>
<td>9</td>
<td>1.8%</td>
</tr>
<tr>
<td>19</td>
<td>11</td>
<td>2.1%</td>
</tr>
<tr>
<td>20 – 24</td>
<td>34</td>
<td>6.6%</td>
</tr>
<tr>
<td>25 – 29</td>
<td>45</td>
<td>8.7%</td>
</tr>
<tr>
<td>30 – 34</td>
<td>77</td>
<td>14.9%</td>
</tr>
<tr>
<td>35 – 39</td>
<td>86</td>
<td>16.7%</td>
</tr>
<tr>
<td>40 – 44</td>
<td>78</td>
<td>15.1%</td>
</tr>
<tr>
<td>45 – 49</td>
<td>80</td>
<td>15.5%</td>
</tr>
<tr>
<td>50 – 54</td>
<td>47</td>
<td>9.1%</td>
</tr>
<tr>
<td>55 – 59</td>
<td>31</td>
<td>6.0%</td>
</tr>
<tr>
<td>60 +</td>
<td>18</td>
<td>3.5%</td>
</tr>
</tbody>
</table>

Source: Alcohol Information Report, 2008/09 Quarter 4. Submitted by SWADS.

Ethnicity

Of those in treatment at SWADS the majority are White British (93%), as one would expect. The largest BME group in treatment are White Irish (1.6%) followed by Other White (1.2%) communities such as those from East Europe. This is again not surprising given that they are the largest BME communities in Swindon. There is no one in treatment in some ethnic groups (White and
Black African, Mixed, Pakistani, Bangladeshi and Chinese), suggesting that there is likely to be some under-representation of these groups in treatment services. However, as drinking alcohol will be avoided for religious and cultural reasons in some of these groups, numbers can be expected to be lower. Anecdotally, it has been suggested that black groups may be under-represented in treatment services, though the proportion in treatment in 2008/09 was roughly equal to the proportion of black residents (as a percentage of the total population) in Swindon, suggesting that it is what one would expect.

Place of residency

As at the 17th November 2009, 20% of those receiving treatment at SWADS attended informally and did not give details of their residency to the service. Of the 80% of clients where place of residency was recorded, 308 residents lived in Swindon and 38 lived outside the Borough.

By mapping where all 346 people attending treatment live, it is possible to identify potential patterns and/or gaps in service uptake based on residency. The maps are not included in this document to protect the confidentiality of those attending treatment, though the key finding is that the highest residential density (20%) of SWADS clients live within walking distance (1KM) of the Treatment Centre. Whilst one would expect needs for alcohol to be high in a central town/city area, where deprivation is generally high, 20% is a high proportion, and indicates that access to the service is an enabler for them, but could also be a barrier to those living further away. Anecdotally, this is supported by the views of stakeholders, who state that there is a need for more community outreach across Swindon. By overlaying the National Indices’ of Deprivation Health and Disability scores, we can also see that two of Swindon’s Lower Super Output Areas with the worst health and disability scores currently have no one in treatment. These are:
- Freshbrook (South and West) and
- Pinehurst South and Gorse Hill

Eldene Central and Liden North West, (alcohol ASB hot spots) also have very low treatment participation.

Number in treatment with additional needs

Of those in alcohol treatment at SWADS in 2008/09, 77 (15%) a minority of people people were also using drugs. The majority of those using drugs were using Cannabis (57%), followed by Cocaine (14%). 19 (25%) of those using drugs were also using a second drug, most commonly Cannabis and Crack, followed by Heroin.
Table 6.3: Number of people in alcohol treatment in 2008/09 using drugs (as a second and third presenting substance), by drug.

<table>
<thead>
<tr>
<th>Substance</th>
<th>Second</th>
<th>Third</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin</td>
<td>1.2%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Methadone</td>
<td>0.4%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Other opiate</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Benzodiazepine</td>
<td>0.2%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Amphetamine</td>
<td>0.8%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Cocaine</td>
<td>2.1%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Crack</td>
<td>1.4%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Hallucinogens</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>0.0%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Cannabis</td>
<td>8.5%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Solvents</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Major Tranquiliser</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Anti-depressants</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Other drug</td>
<td>0.4%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Poly drug</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>N/A</td>
<td>85.1%</td>
<td>96.3%</td>
</tr>
<tr>
<td>Misuse free</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>


Referral pathways and service provision

Referral to treatment

Between April 2008 and February 2009 there were 225 referrals to Tier 3 services at SWADS. The referral source with the highest proportion of referrals was “self” (99) followed by referral by general practitioners (75). There were 16 referrals from mental health services/professionals, and 6 from drug services. Referrals from other sources were fairly low, though it is expected that more referrals will be made through the Arrest Referral Scheme and the Alcohol Liaison Nurses based at GWH in the future. Additional referrals should also be expected (and planned for) from general practice, with the introduction of Health Checks (where people are asked questions about their alcohol consumption) next year.
**Figure 6.3:** Referrals to Tier 3 treatment at SWADS by referral source between April 2008 and February 2009.


**Waiting Times**

Between April 2008 and February 2009 there was one month (May 2008) when the wait for psychosocial interventions was an average of 9.6 weeks, but apart from this, waiting times for all services were low, and usually within a day or two. In the last quarter of 2008/09 the average waiting times for tier 1 and tier 2 treatment are 0.5 weeks or below.

**Table 6.4:** Waiting times for interventions in weeks for quarter 4 in 2008/09

<table>
<thead>
<tr>
<th>Treatment type</th>
<th>Number of valid waiting times</th>
<th>Average waiting times</th>
<th>Longest wait in a modality / intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community prescribing</td>
<td>8</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Structured psychosocial</td>
<td>38</td>
<td>0.3</td>
<td>2.0</td>
</tr>
<tr>
<td>intervention</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Structured day programmes</td>
<td>4&lt;5</td>
<td>0.3</td>
<td>1.0</td>
</tr>
<tr>
<td>Other structured treatment</td>
<td>72</td>
<td>0.5</td>
<td>10.0</td>
</tr>
</tbody>
</table>


**Exit status**
The vast majority of people using treatment services exited treatment in a planned way, and with the mutual agreement of all parties. The highest number of unplanned exits occurred in the structured psychosocial intervention (36 people) and the structured day programmes (39 people).
6.3 What we can infer from this information

From the quantitative information contained in this chapter it is possible to infer the following:

- Swindon does have high levels of people that are drinking to hazardous and harmful levels, and who are binge drinking, though drinking levels are not (significantly) different to levels for England, the South West or in Milton Keynes (a comparable area).
- There is a gap between the number of people needing tier 2 and tier 3 treatment services and the numbers accessing treatment. The gap in Swindon is smaller than the English average, though the level of access is still low compared to need. This has implications for how people are identified and referred for treatment, and treatment capacity.
- There is likely to be under-representation of people in their 50s and those aged 65 years and over in tier 2 and 3 treatment services.
- There is likely to be under-representation of some ethnic groups in tier 2 and 3 treatment services.
- There is under-representation of people from some (e.g. more deprived) areas in Swindon in tier 1 and 2 treatment services.
- Access to tier 1 and 2 treatment services is biased towards those within walking distance of the SWADS building. It is good that those that live near to SWADS are accessing it, but further community outreach is required to ensure access is not a barrier to those living outside the town centre.
Referral to tier 1 and 2 treatment services is working well in some areas (e.g. from general practice), though could be improved in other areas.

Waiting times for tier 1 and 2 treatment services are low, also indicating that there is capacity to treat more people.

The vast majority of people’s exit from tier 1 and 2 treatment services is planned, though there is scope to reduce unplanned exit in psychosocial and structured day programme services.

However, there are many things that we cannot infer from this information alone, and which we need to be aware of. We do not know for example, the sexual orientation of those using services (or not), or whether traveller communities and asylum seekers are represented in treatment services. As younger binge drinkers are less likely to access tier 2 and 3 treatment services, it is also difficult to analyse the gap between their needs and service provision. In the future, it would be useful for SWADS to identify the numbers of service users with mental health needs so that gaps and needs can be better quantified.

Further analysis of time trends will be able to be undertaken in the future, once NDTMS reporting for alcohol is more established (reports currently go back to April 2007).
PART 7: LOCAL VIEWS ON ALCOHOL RELATED NEEDS

7.1 View of professionals

Professionals from a range of organisations involved in preventing and/or reducing alcohol related harms were asked for their views on alcohol in Swindon. Methods used to obtain views were one to one interviews, (expert) group meetings, and email and telephone discussions.

The views presented in this section represent those of professionals in the following organisations:
- Community Safety Partnership, including representatives from:
  - Drug and Alcohol Action Team
  - Information Team
  - Domestic violence
- Swindon Borough Council, including representatives from:
  - Children & Young People’s Services
  - Housing Services
- NHS Swindon, including representatives from:
  - Public Health
  - Information Team
  - Commissioning
- Swindon & Wiltshire Alcohol and Drugs Services (SWADS)
- Swindon Carers Centre
- Great Western Hospital, A & E Department
- General Practice
- Police, including licensing
- Probation

What is going well in preventing and reducing alcohol harms in Swindon

There was general optimism from professionals on Swindon’s progress in preventing and reducing alcohol related harm, and in the last 18 months in particular. Many felt that alcohol was higher up the agenda, both nationally and locally. Specific services or developments in Swindon that were highlighted as positive were:
- The joint working approach between organisations.
- Links between the commissioners and providers.
- SWADS services provision, including:
  - Referral pathway into SWADS from GP practices.
  - Open Access support service.
  - Community detoxification service.
- Carfax NHS Medical Centre service provision.
- Arrest referral system.
- Recruitment of Alcohol Liaison Nurses in Great Western Hospital.
The harms that alcohol is causing to Swindon’s residents

The alcohol related harms that professionals viewed as affecting Swindon, corresponded with those highlighted by the quantitative analysis of needs described in chapter 3. The harms that were highlighted most often were as follows:

- Alcohol related mortality and morbidity.
- Antisocial behaviour.
- Violent behaviour and harm to others.
- Negative impacts on families and carers.
- Impacts on vulnerable groups of adults.
- Impacts on employment and personal finances.

Groups of people in Swindon with alcohol-related needs, and whom require further attention

When asked whether there were groups of people in Swindon that required further attention with regards to their alcohol needs, the following groups were highlighted by professionals:

- People with mental health as well as alcohol needs. It is felt that these individuals are currently being “bounced” between different services. Currently, Mental Health Services refer people to SWADS so that their alcohol needs are met, though SWADS then finds it challenging to meet their alcohol treatment needs because of their mental health problems.
- People drinking at home that are not in contact with services, and whom services subsequently do not know about. This is thought to include middle aged men and women who do not consider their drinking to be harmful (to themselves or others), and older drinkers who find it difficult to access services.
- Those aged under and around 18 years who are drinking, and often binge drinking. This includes young people who are at risk of becoming dependent drinkers in the future, and who should be targeted for preventative work.
- Certain hard to reach BME groups, though further work is required to identify which groups may require targeting.
- Those who are homeless and roofless. This includes street drinkers who are moved out of town centre areas if they are drinking (under Dispersal Orders), but not offered an alternative safe place to drink. It also includes homeless women who have particular difficulties accessing rehabilitation services locally as the main service provider (Gloucester House) is for men only.
- Carers and families of those who have alcohol problems.
- Perpetrators and victims of domestic violence.
- Those that are present to health services with other but related health problems e.g. Hepatitis C and liver problems.
Gaps in current service provision and local issues:

There are number of gaps in service provision and local issues that were highlighted as needing to be addressed. These are as follows:

**Inpatient detoxification facilities:**
There is currently no inpatient detoxification service in Swindon. Where detoxification is required and funded, places are commissioned from Providers outside of Swindon, usually from BranchLea Cross in Cheltenham (for clients with complex needs), Broadreach House in Plymouth, or Clouds House in Salisbury. Great Western Hospital currently only provides inpatient detoxification to patients presenting as an emergency. Although some professionals felt that further resources were required to fund places in the specialist services outside Swindon, most felt that there was a need for further resources and the establishment of a local inpatient detoxification facility (i.e. one option would to commission beds from Great Western Hospital). However, the expressed need for an inpatient detoxification facility was balanced with the view that if more resource was made available to enhance treatment capacity in the community, including community detoxification, this would reduce the need for inpatient detoxification beds.

**Inpatient rehabilitation:**
It was felt that there is a lack of inpatient rehabilitation services within the locality for women, and that the inequity between places for men and women should be addressed (the main local services provider, Gloucester House, is for men only).

**Wet/dry House for street drinkers:**
Many professionals felt that a wet and dry house for street drinkers should be established to ensure that they have the option of drinking in a safe, warm and clean environment. A wet/dry house model that is managed and which provides access to alcohol advice and treatment services was favoured above a wet house model that provides a safe environment to drink only. It was thought that less street drinkers are accessing SWADS, and so advice and treatment services, since the removal of the Rocks seating area in the town centre.

**Further treatment capacity in the community setting (including primary care)**
Some professionals expressed the need to do more to meet people's alcohol needs in the community setting, which would in turn help to prevent and reduce acute and emergency admissions. Three key ways of meeting people's alcohol needs in the community setting were identified:

1. Ensuring comprehensive and enhanced primary care provision, which enables more people to receive care and treatment with their primary care provider i.e. general practice.
2. The provision of a specialist clinical community service, which takes care to those with alcohol needs, including the provision of community detoxification.
3. The provision of community outreach by services, to ensure that high risk drinkers in particular, have their treatment needs identified and
met. Although SWADS currently does provide outreach services in some general practices, there was a view that this should be extended to all general practices, the Homeless Day Centres (to attend on a regular basis), Amethyst House (housing homeless people with chronic alcohol dependency), and other community services/facilities. SWADS could potentially access 30 students to undertake placements with them, each providing around 4 hours of outreach work per week.

It was also highlighted that as Swindon is taking positive action to identify resident’s alcohol needs (i.e. through increased brief interventions), there is a need to ensure that there is enough treatment capacity in the system to meet their needs.

**Joined-up care for people with mental health and alcohol needs:**
As already highlighted, there are service gaps in meeting the needs of those with mental health and alcohol problems. Swindon DAAT is currently taking steps to address this, through use of regular multi-disciplinary meetings to jointly case manage those with mental health and alcohol needs.

**Strengthened referral pathways:**
Although some referral pathways are established and effective, others are under-utilised. Swindon Carers Centre for example, has never received a referral from general practice. When attending the Tier 3 group programmes at SWADS no service users had heard of Swindon Carer’s Centre and were interested to hear more about it. It was suggested that all services that identify a person with an alcohol need should routinely ask them if they have a family and/or carers and if so, give them information about Swindon Carer’s Centre. Other referral pathways that need to be strengthened are those from Inclusion and DHI (to SWADS), those from mental health services (to treatment services), those from domestic violence services, services in contact with sex workers, services in contact with the unemployed and people with financial difficulties (i.e. Job Centre’s Plus, Citizen’s Advice Bureau), and voluntary organisations (in addition to Swindon Carer’s Centre). In order to ensure that referral pathways are clear and transparent to all professionals it is suggested that they are mapped and made readily available (e.g. on the web).

**Strengthened partnership work with young people’s services:**
It was suggested that there needed to be closer partnership working with young people’s services to ensure that services are more joined up in addressing the needs of both parents who misuse alcohol and their children. This was a gap also identified by Swindon’s Children and Young People’s Substance Misuse Needs Assessment. By ensuring that families are targeted, important early prevention work can be achieved with young people who are at risk of becoming problem drinkers in the future.

**Training:**
It was felt that there is a gap around training on alcohol and domestic violence. It is felt that further training would encourage more referrals of perpetrators (and victims) of domestic violence into treatment services.
Counselling for families and carers:
Swindon’s Carer’s centre currently runs a support group for families and carers of people that misuse alcohol, though it is thought that counselling would provide further benefits.

Strengthened alcohol discharge policy and attitudes of staff at GWH
A number of stakeholders stated that there is a need to encourage culture change amongst staff at the GWH to improve attitudes towards people misusing alcohol. Stakeholders also felt there is a need to strengthen discharge policy, to ensure that those misusing alcohol are referred to and/or met by SWADS and/or other appropriate services on discharge.

Roll out of brief interventions and referral to treatment services across Great Western Hospital:
It is intended that brief intervention, advice and referral to treatment services will be rolled out by the Alcohol Liaison Nurses from A&E and the Gastro-ontology wards to other wards in the hospital. This is highlighted as a current gap in service provision, but one which will be addressed.

Gaps and local issues with regards to Swindon’s “approach” to preventing and reducing alcohol-related harm

Focus on primary prevention:
It was suggested that there could be more of a focus on primary prevention (i.e. though earlier targeted community based interventions) to supplement the focus on treatment. Some discussion took place in the expert group about the need to target younger (vulnerable) people to ensure that they do not become problem drinkers in their late 20s and 30s. There could be a focus on those neighbourhoods with the highest identified need.

Approach and location of the DAAT
Although the location of the DAAT in the Community Safety Partnership does have certain benefits, it also has disadvantages. These include fewer opportunities to mainstream alcohol into all healthcare commissioning areas, and less opportunity to use a public health (rather than criminal justice) approach to identifying and tackling alcohol related needs. Some felt that there was a need to “supplement the focus from Criminal Justice after the fact to Health before the fact”. There is also scope for greater joint work and communication between different partners involved in preventing and reducing alcohol-related harm, including between NHS Swindon and Great Western Hospital. A number of professionals felt that it would be useful to have the roles and responsibilities of all organisations (in tackling alcohol harm) clarified.

Key priorities to address needs in Swindon:
The following were regarded as key priorities to address the needs of people misusing alcohol in Swindon. All were raised by different professionals on a number of occasions:

- Increase in inpatient detoxification facilities locally and further resources to fund places. However, this need could be
negated/reduced if there was improved treatment capacity, including detoxification facilities, in the community setting.

- Improved treatment capacity in the community setting, including more comprehensive and enhanced primary care provision, further specialist clinical treatment (including community detoxification), and community outreach services.
- Improved referral pathway and joined up care for those with mental health and alcohol problems.
- A managed wet/dry house that provides a safe environment for homeless and/or roofless people to drink in, and which has links with services so that alcohol needs can be identified and treated.
- Strengthened partnership working with young people’s services to ensure that services are more joined up in addressing the needs of both parents who misuse alcohol and their children (a focus on “families”).

Views of professionals gained through Swindon’s Big Debate

The views of a wide range of professionals on alcohol-related issues were captured during Swindon’s Big Debate, held in September 2009. Key issues that were raised by professionals in response to a series of questions (posed during the debate) are outlined on the next page.

Q. What issues do we face in Swindon from alcohol?

Health-related issues
- Alcohol related illness
- Strain on health service resources
- Cost to the local economy of alcohol related illness

Community safety issues
- Alcohol fuelled anti-social behaviours
- Domestic abuse, street violence, criminal damage, sexual assault/rape
- Exclusion of public from town centre (to avoid unsafe areas)
- Fear specific places such as the bus station

Issues specific to the night time economy and behaviours of those selling alcohol
- Geography – clusters of pubs/bars can increase the amount of drunk people in small areas, and in turn increase the likelihood of antisocial and violent behaviours
- Pubs and clubs motivated by profit rather than responsibility to encourage safe levels of drinking
- No accountability of bars/clubs for outcomes associated with drunken behaviour of their patrons
- Saturation of licensed premises
- Reputation of town centre (as an unsafe place) because of certain bars/pubs
- Cheap alcohol available in large amounts
• Appeal of alco-pops to young people

Issues related to drinking attitudes, cultures and behaviours
• Culture of heavy drinking in Swindon
• Increase in home drinking
• Peer pressure encourages people to drink

Other issues:
• Financial and family problems related to alcohol misuse

Q. What are the barriers to change? What is stopping us from reducing alcohol harm in Swindon?

Health-related issues
• 4 hour target in the Emergency Department of GWH
• Brief interventions should be provided more widely – by housing associations etc.

Community safety issues
• Policing of bye-laws in Swindon – enforcement not taking place.

Issues specific to the night time economy and behaviours of those selling alcohol
• Happy hours in bars/pubs/clubs encourage binge drinking
• Too many incentives for young people to drink
• Competition (offers) between licensed premises to attract customers
• Lack of engagement with licensed premises
• High cost of soft drinks in pubs/clubs/bars
• Not serving tap water
• Drink industries attitude to marketing and sponsorship
• Low cost of alcohol and special offers
• Underage sales

Issues related to drinking attitudes, cultures and behaviours
• Young people go out with the intention to get drunk
• Older people often don’t want to admit the extent of their use
• Attitudes passed on by parents
• Hanging around streets acceptable to youth.

Other issues:
• Financial pressures - Lack of resources to tackle issues as a whole
• Not enough information and awareness of alcohol related harms.
• Who will lead the change
• Legislation
• Lack of joint working
• Glamorised advertising e.g. in cinemas
• Lack of education and social skills
• Linked to drug use.
Lack of social outlets and alternative activities, and places to buy non-alcohol drinks
Lack of information

7.2 View of those misusing alcohol

Views of adults in alcohol treatment services

The views of people misusing alcohol were gained through attendance at a SWADS Drop in Support Group (where people do not have to be abstinent) and the Structured Support Group (for those who are abstinent). The following themes emerged with regards to what they perceived to be the local issues and needs and gaps in current service provision.

SWADS services greatly appreciated
All service users were very positive about SWADS and their experience at SWADS. Key words used to describe their perception of SWADS were friendly, safe, accepting, non-judgemental, supportive. Service users liked the fact that they weren’t labelled as “alcoholics” at SWADS.

Community outreach services
Service users agreed that one of the most difficult things about accessing treatment services was willing themselves to walk through the door at SWADS. This to service users is a huge step, not to be underestimated. Once inside they felt safe and supported. Service users felt that making this first step may be easier if SWADS could be accessed in services that they visit on a more “normal” basis (i.e. general practice), at least for the initial access.

Joined up care
Some service users felt that different services were not always very joined up, and that this could have helped them to access alcohol treatment services sooner. One described how they had attended A&E for alcohol misuse a number of times and no advice or support had been given. Most thought that their GP had been helpful, and in the majority of cases said that their GP had referred them to SWADS (though they are may be recorded as self referring because they often “turn up” at SWADS rather than being formally referred).

One stop shop for information on alcohol
Although service users were familiar with the services provided at SWADS and those by Alcohol Anonymous, they tended not to be aware of any other services or where they would look for information about alcohol and alcohol services (apart from at SWADS). They also tended not to be sure how different services were linked and how people can be referred one to another. They suggested that use of media such as newspapers and a website where people could find all information on alcohol services in Swindon would be useful.

Support of families and carers
For most of the service users it was apparent that their family and/or friends were very important in supporting them through their alcohol misuse, and
encouraging them to access treatment in the first place. A number described how family members had referred them to SWADS and taken them to their first (and sometimes subsequent) appointments at SWADS. This highlights the important role that family members and friends take, though also highlights how those without a support network may be particularly vulnerable to not accessing services.

**Social and leisure activities**

Service users who attended the Drop in Support Group and so were not abstinent, felt that a lack of money and leisure opportunities meant that they found it difficult to distract themselves from drinking. They agreed that this could be because they weren't aware of leisure facilities that were free or cheap to use.

### 7.3 Views of carers and families

The views of family members and carers of people with alcohol problems are crucial to take into account. It is often family members and carers that encourage those misusing alcohol to reduce their consumption and/or to seek help from treatment services. The following qualitative feedback from three carers (of family members with alcohol problems) highlights some of the alcohol related harms and issues that they think need addressing in Swindon.

<table>
<thead>
<tr>
<th>Case study 1:</th>
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<tbody>
<tr>
<td>B is distressed about her son who lives with her. He is 29 and drinks every day to the point of vomiting. He started drinking when he was 15 and left home at 18. He was divorced due to drinking at 22. He has lived at home with mum since. He subsequently lost his employment due to drink. He isolates himself, is depressed and neglects himself. He experiences psychotic episodes and has been sectioned. He says he hates drinking and sometimes stays sober for a couple of weeks following withdrawal at home. He has no structured daily activities, no social network or any role. There has been global erosion of his life through alcohol and the onset of mental health problems. He is being supported by a Community Psychiatric Nurse and he is now considering change. The impact on B is the contraction of her social functioning. The house smells of vomit so she can't have any friends around. She feels distressed and stressed. Exhausted by trying to bring about change, she has reached the stage of trying to get on with life regardless of son's use. Work distracts her. Service issues are as follows: lack of rapid entry into community treatment (there is a recognised 2 week 'window') when son seeking change, lack of response and/or funding for residential rehabilitation.</td>
</tr>
</tbody>
</table>
Case study 2:
D's parents found out 3 years ago that their 23-year-old daughter has Aspergers Syndrome. The daughter has been in contact with mental health services since experiencing difficulties at school at the age of 15/16 when she started to self harm. She continues to self harm and also has an alcohol problem.

Binge drinking has fuelled increased incidents of violence in the parental home where she still lives most of the time. The violence is directed towards herself, towards her parents and at times the family pets. The daughter's black and white thinking about people, services and events leaves her socially isolated, angry and unoccupied. Her Aspergers means that she lives with a low threshold of stress, high emotion and she will often over-react to events without understanding what the consequences really are. Alcohol helps her to overcome her communication and social impairments but continued drinking leads to aggression and violence.

Both parents are at the end of their tethers - exhausted and needing support for themselves and for their daughter. The father drinks to cope and mum is constantly 'rescuing' her daughter out of fear for her safety. Neighbours and the police are increasingly involved and there are crisis happening every weekend.

Service issues are as follows: lack of understanding of Aspergers syndrome across all agencies; alcohol services need to be flexible - possibly outreach service - to help clients with complex needs.
PART 8: WHAT WORKS IN REDUCING ALCOHOL-RELATED HARMs

The 2007 alcohol needs assessment gave a very thorough overview of the evidence base for what works in reducing alcohol related harms. This is still relevant and in line with the Department of Health Review of the effectiveness of treatment for alcohol problems. An updated version of the 2007 overview is given below.

8.1 Alcohol initiatives in England

There are many examples of good practice alcohol harm prevention and reduction initiatives in England. The Hub of Commissioned Alcohol Projects and Policies (HubCAPP) is an online resource, which provides access to learning about some of these local initiatives. If taking learning from these initiatives, the robustness of the evaluation (which varies) should be assessed.

Initiatives can be searched by the following project type:
- Alcohol health worker
- Education
- Enforcement
- Identification and brief advice
- Prevention
- Research
- Social marketing
- Specialist treatment.

The portal can be accessed at: http://www.hubcapp.org.uk/home.htm

8.2 Education, information, and communication

Education and campaigns
Evidence shows that neither education nor public campaigning about alcohol generally have much effect on the way in which a society views or consumes alcohol. A recent review concluded that only a tiny number of credible educational programmes had actually reduced young people’s drinking. The social and psychological factors that mainly influence young people are family and other social pressures, including the drinking habits of their peers and role models.

Social marketing
Although mass campaigns may not have much effect of alcohol consumption, three recent reviews of the evidence base suggest a causal link between alcohol marketing and youth drinking behaviour (Anderson et al. 2009, Smith and Foxcroft, 2008 and Meier et al. 2008). The Department of Health also promotes social marketing as a useful tool in contributing to the prevention of harmful drinking, and have commissioned a new social marketing toolkit for
higher risk drinkers (to be launch in March 2010). The toolkit will detail a social marketing best practice approach and include guidance on how to use new segmentation and evaluation tools.

**Unit labelling and health warnings**

Although unit labelling of alcohol containers is widely practised, and is intuitively desirable because it allows individual drinkers to monitor their own consumption, it is unclear to what extent these are observed and acted upon. Robust data demonstrating effectiveness are lacking. The American initiative to place health warnings on alcohol containers has demonstrated some potential success, but not a reduction in actual harm resulting from alcohol use. These types of public health intervention demonstrate only marginal effectiveness in isolation, and may be better combined into a unified and co-ordinated strategy.

### 8.3 Health and treatment services

**National Treatment Agency Review of the Effectiveness of Treatment for Alcohol Problems, 2006**

The National Treatment Agency commissioned a review of the effectiveness of treatment for alcohol problems which was published in 2006. The review has informed its guidance on developing a local programme for improvement and its Models of Care project. It is a detailed digest of the published research evidence on alcohol treatment and a vital resource for users, commissioners, service providers, and researchers. It draws on the Mesa Grande project and three published systematic reviews.

The review concludes that securing clarity of a drinking goal is important before starting treatment since abstinence and moderation goals call for different treatment approaches. They also stress the importance of involving family and friends in treatment, which will improve the chances of successful treatment. The review concludes that a stepped-care approach to alcohol treatment is needed with screening to detect the type of drinker. The type of treatment depends on the type of alcohol-use disorder: Hazardous drinkers should be given information, advice, and counselling in primary care. Harmful drinkers should be given less intensive (than specialist) treatments in primary or specialist care. Problem drinkers should be referred to a specialist. It clear that diagnosing psychiatric co-morbidity alongside alcohol-use disorders is crucial, as is the provision of the range of services to tackle associated mental health needs.

**Screening for alcohol problems**

Need to use a screening tool

Service providers and commissioners should consider using a suitable screening instrument to detect alcohol misuse. The AUDIT tool is a screening instrument of good sensitivity and specificity for detecting hazardous and harmful drinking among people not seeking treatment for alcohol problems. The AUDIT tool should be considered as the screening instrument of first choice in community settings.
There are possible benefits to targeted-screening as compared to whole population-screening. The FAST tool is a rapid and efficient screening tool for detecting alcohol misuse in the A&E setting. The PAT tool has been developed to fit with the demands of very busy A&E departments and is a quick and efficient screening tool in this setting. Both the T-ACE and TWEAK are superior screening instruments for detecting alcohol misuse among pregnant women than the MAST or CAGE. The FAST offers a rapid and efficient way of screening for hazardous and harmful alcohol consumption that can be used in a variety of settings. Other tools are the AUDIT-C and AUDIT-PC and the 5-Shot Questionnaire.

Clinical history and physical examination can be used to detect harmful drinking and practitioners should be aware of such indicators. Reliance on informal methods of screening may miss the majority of hazardous drinkers without obvious signs of alcohol-related harm.

Assessment and measuring treatment outcomes

Type of instrument

There are many instruments with good psychometric properties that can be combined to construct an assessment package; packages should also be suitable for outcome ratings. The reliability and validity of assessment packages have not been independently examined (other than one meta-analysis on the ASI) and so the evidence to support standard assessment packages is fairly weak. Measures that will be useful for routine clinical use can often be taken from major clinical trials. However there is ample scope to mix different scales for agencies to create a preferred package drawing on commonly used assessment tools.

Service user feedback will be useful in improving the assessment process. Providers will need to identify the practitioner skills required to undertake assessments.

Monitoring treatment outcomes

Routine evaluation of treatment outcomes is feasible but requires follow-up staff and access to statistical advice. Reporting clinically significant change is a strict test of outcome, which gives a good indication of improvement meaningful at an individual level. There is logic to undertaking follow-up at three months and 12 months after entering treatment and then again annually.

Brief interventions

Hazardous and harmful drinkers

Evidence suggests that hazardous and harmful drinkers receiving brief interventions were twice as likely to moderate their drinking 6 to 12 months after an intervention when compared to drinkers receiving no intervention. A recent systematic review confirmed brief intervention trials can reduce weekly drinking by between 13% and 34%, resulting in 2.9 to 8.7 fewer mean drinks per week with a significant effect on recommended or safe alcohol use. If consistently implemented, GP-based interventions would reduce levels of drinking from hazardous or harmful to low risk levels for 250,000 men and 67,500 women each year. Eight hazardous or harmful drinkers need to
receive brief interventions in order for one to reduce their drinking to low risk levels. There is good evidence that when GPs and nurses are adequately trained and supported for this work, screening and brief interventions activity increase.

**Heavy drinkers**
Evidence shows that heavy drinkers who receive a brief intervention are twice as likely to cut their alcohol consumption as heavy drinkers who receive no intervention.

**Women**
There is evidence that extended brief interventions (several visits) in primary care settings for women decreased alcohol intake by an average 51g per week.

**College students**
Brief interventions have been shown to reduce the level of alcohol consumption and associated problems over two years among college students who were drinking excessively.

**Emergency department attenders**
Attendance at an A&E department may help someone accept they have a problem with alcohol-use disorders that they would otherwise deny. In one study 202 patients were seen by an alcohol health worker and assessed or counselled. 71 of the patients seen were followed up after 6 months. 65% of these reported a reduction in alcohol intake and the mean reduction was 43%. Patients who received a brief intervention following visits to a London accident and emergency unit had made on average 0.5 fewer repeat visits in the following 12 months compared to those in a control group and had lower levels of alcohol consumption.

**Nurse-led community service**
The nurses in the alcohol services lifestyle team in the Liverpool area are moving the focus of alcohol-related care from hospital to the community, and providing a seamless service across primary and secondary care. The team’s work focuses on prevention as much as treatment, and includes everything from brief intervention clinics for problem drinkers to chronic disease management for alcohol-dependent patients. The clinics take place in GP surgeries and hospital outpatient departments, and aim to reduce alcohol-related harm and improve health and social functioning among hard-to-reach populations. People are referred to the clinics by GPs and A&E staff as well as via social services and the criminal justice system. Evidence from the clinics is extremely positive – 96% of patients say that talking to an Alcohol Specialist Nurse helped their alcohol use, with significantly lower alcohol consumption recorded after six months. The team can assess, treat and discharge five hospital inpatients and five A&E patients each day.

**Less intensive (than specialist) treatments for harmful drinkers**
The authors of the NTA Review of Treatments conclude that there is no best treatment/intervention or “treatment of choice” for people with alcohol...
problems. Rather a range of effective treatments for different kinds of client in different settings is needed. There is limited evidence for matching clients to treatments. Selection of which treatment to offer depends on clinician preference, client choice and availability of trained and enthusiastic therapists. Four effective kinds of less intensive treatment were identified:

- Basic treatment scheme
- Condensed cognitive-behavioural therapy
- Brief conjoint therapy
- Motivational Enhancement Therapy (MET)

Less intensive treatment, particularly MET, is suggested for the initial step in a stepped-care programme in specialist agencies.

**Alcohol-focused intensive specialist treatment for problem drinkers**

The authors of the NTA Review of Treatments identify several effective Cognitive Behaviour Therapy modalities:

- Community Reinforcement Approach
- Social Behaviour & Network Therapy (from UKATT)
- Behavioural Self-control Training
- Coping/Social Skills Training
- Cognitive-behavioural Marital Therapy
- Relapse Prevention
- Forms of Aftercare

**Non-alcohol-focused specialist treatment**

**Family interventions**

Problem drinking may be a “symptom” of some other problem, for example difficulty coping with life generally or family dysfunction. Having a rewarding and full life can be a protection from problem drinking. Families and friends benefit from involvement in treatment, whether or not it is alcohol focused. The strongest evidence available supports the use of cognitive behavioural couple and family therapies. Family interventions require suitably trained staff but they can be delivered in a variety of settings, including primary care.

Coping skills training for the spouse or partner of problem drinkers is effective. There is a choice of effective treatments for couples, either together or alone. Family interventions are important because they are the most likely to benefit the whole family, irrespective of how well the person with the drinking problem may be doing. Social therapies have a strong evidence base. Family interventions should be available in all service delivery tiers at appropriate levels of complexity. Staff require particular competences.

In 2003 (what was then) the Social Care Institute for Excellence published guidance on working with families with alcohol, drug and mental health problems. Their conclusions and recommendations were about the organisation of services in a locality. They included:

- Social services departments and their partner agencies should conduct audits to estimate the nature and extent of the impact of families with mental illness, drug and alcohol misuse on people’s workloads.
- Information and recording systems should be developed to support effective services to families.
• Budget allocations need to reflect the extent and nature of the work. Currently, drug and alcohol budgets grossly underestimate actual costs and expenditure.

**Social skills training**
The effectiveness of social skills training may have been overestimated because early studies made comparisons against treatments that were less effective than now. Social skills training can be matched to need, whether this is very specific in individuals who otherwise function well or for individuals scoring high on sociopathy. Care planning for relapse prevention might be expected to include an assessment of social skills deficits. For a problem drinker, becoming involved in activities that just make you feel good can be important, as can getting involved in skills learning, which may or may not be directly linked to drinking. Treatment agencies should have maintenance stage interventions, such as social skills training, within their repertoire. Staff require particular competences.

**Counselling**
Rogerian methods of counselling are less about specific therapies and more about how to deliver therapy, or to optimise therapist characteristics. Client-centred therapy is effective but less so than a specific structured therapy that is equally well delivered. Self-esteem continues to hold importance as a concept of relevance to addictions, but there is a lack of specific self-esteem therapies.

**Complementary therapies**
Complementary therapies should be part of a more comprehensive treatment package, rather than as standalone interventions.

**Detoxification and pharmacological enhancements to treatment**

**Detoxification setting**
Each provider should have in place detoxification care pathways that offer guidance on the use of different settings. Detoxification requires skilled staff. Hospitalisation for alcohol detoxification is indicated only when withdrawal is likely to be complicated. Community-based detoxification for treatment of uncomplicated alcohol withdrawal can be delivered in the home, on an outpatient or day patient basis, or within a supported residential facility.

**Preparation for detoxification**
Preparation for detoxification with the client is crucial. This should include:

- Giving information about the nature of withdrawal symptoms and what to expect during detoxification
- Assessing the stage of change and refreshing care plans accordingly
- A decision on where detoxification will be undertaken – at home, in hospital or in a community setting
- A discussion of any practical issues, such as childcare arrangements, time off work and travel
- The identification a friend, relative or agency staff to provide support
- Arrangements for follow-up, including a discussion of whether the service user wishes to take disulfiram or other medication post-
detoxification

- Planning daily activities for the weeks immediately after detoxification.
- High dose parenteral thiamine is an effective treatment for Wernicke’s encephalopathy. Consideration should be given, as a harm reduction measure, to prescribing vitamin supplements at any stage where nutritional deficiencies are likely.

Relapse prevention
Disulfiram taken supervised is an effective component of relapse prevention strategies. Both naltrexone and acamprosate as anti-craving medications show minor positive effects in relapse prevention when used in conjunction with psychosocial interventions.

Service user groups, family and friends can all provide essential support for people during community-based detoxification and as part of a relapse prevention package, including supervision of medication.

Self-help and mutual aid
Self-help manuals based on cognitive behavioural principles are an effective and cost-effective adjunct or alternative to formal treatment among alcohol misusers with mild to moderate dependence. Self-help manuals or correspondence courses can be effective when delivered through the post to media recruited alcohol misusers. Community-level mail interventions as part of a public health approach show promise, but more research is needed on the effectiveness of a personalised and motivationally based type of intervention.

Alcoholics Anonymous
It would be more accurate to describe AA as a way of life than a form of treatment. Several components of AA seem supported (recovering alcoholics as therapists, peer-led self-help therapy groups, teaching the 12-Step process, doing an “honest inventory”). There are good reasons to believe it is helpful to particular kinds of individual. AA appears to be effective for those alcohol misusers who are suited to it and who attend meetings regularly. AA is a highly cost-effective means of reducing alcohol-related harm. Not all alcohol misusers find the AA approach acceptable.

Other 12-Step therapies
Mutual aid groups, including 12-Step and other less-spiritual approaches, are an effective means of getting support both during treatment and as aftercare. Commissioners and providers must understand local mutual aid groups and how to work harmoniously with them.

Psychiatric co-morbidity
The permutations of co-morbidity disorders are numerous, so there are benefits from adopting a single integrated therapy, probably rooted in cognitive behavioural techniques. Treatment of people with alcohol-use disorders who also have psychiatric co-morbidity, especially pharmacotherapy, is likely to be complex and there are benefits in having a
single and constant treatment provider.

Theoretical considerations and some research data point to preferring an integrated or shared care service model for psychiatric co-morbidity. There needs to be clarity at a local level as to which service providers have the expertise to treat different diagnostic categories of psychiatric co-morbidity and a description of care pathways.

**8.4 Alcohol treatment pathways**

*Local routes: guidance for developing alcohol treatment pathways, 2009*

This guidance provides good practice advice on the development of integrated care pathways for people with alcohol problems, or what are referred to as alcohol treatment pathways (ATPs).

The guidance concludes that the process of development of ATPs requires effective communication between all agencies, team members and other stakeholders involved. This includes obtaining consensus on inclusion criteria, on the agreed roles and responsibilities, on the optimal means of inter- and cross-agency working, and on the evidence of best practice. These all contribute to an effective final tool that supports the more explicit and effective delivery of care.

The guidance advises that alcohol treatment pathways should be:
- agreed and developed locally, taking account of local service configuration and priorities;
- evidence-based;
- client-focused; and
- agreed and championed so as to ensure ownership by managers, practitioners and the key stakeholder who can influence success.

Further information on specific ATPs, including for those with mental health needs and for those who are homeless, should be sought at [http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_110422.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_110422.pdf)

**8.5 Community safety and criminal justice**

*Enforcing the Existing Law*

The UK has a number of laws that apply to aspects of alcohol consumption that cause concern in bars. These relate to issues such as serving alcohol to children, serving people who are intoxicated, alcohol-impaired driving, antisocial, and aggressive or violent behaviour.

Selling and serving alcohol to minors is major problem in Britain. A nationwide police exercise during 2004 involved ‘sting operations’ in 1,825 licensed premises. This detected the illegal sale of alcohol to children in 650 of these establishments. Altogether 51% of the on-licences (bars) and 32% of the off-licences examined were selling to underage individuals.86
Many of the public order and associated problems linked with alcohol occur in and around bars and clubs. The police have taken a lead in attempting to moderate such problems and have recently been active in cities such as Cardiff (the Tackling Alcohol-Related Street Crime (TASC) project) and Manchester.

A local experiment was carried out by the police in Torquay in the early 1980s. Much of the trouble was focused in and around harbour-side bars from rowdy holiday-makers in the summer. Local police visited these bars and explained that they would be vigilant in enforcing the law in relation to permitted opening hours and serving intoxicated patrons and underage young people. They offered to help deal with troublesome patrons and reminded bar staff of what laws were related to good bar management. This advice was followed up with frequent, regular visits to bars in the target area by uniformed officers. This policy was enforced for a year. During this experimental period there was a 20% fall in recorded offences in Torquay. The police in Sussex subsequently followed up the Torquay venture with a similar initiative of their own. They reported that this achieved a worthwhile reduction in alcohol-related crimes.

Local Community Action
Tackling Alcohol-Related Street Crime (TASC) was set up in Cardiff in July 2000. This venture involved a “focused dialogue between the police and members of the licensed trade.” TASC involved the following elements:
- measures aimed at improving the quality and behaviour of door staff
- attempts to influence licensing policy and practice
- measures aimed at publicising the problem of alcohol-related violent crime
- targeted policing operations directed at crime and disorder ‘hot spots’
- a cognitive behavioural programme for repeat offenders
- a training programme for bar staff (‘Servewise’)
- a programme of education about alcohol for school-aged children
- support for victims of alcohol-related assaults attending hospital.

This exercise resulted in the following mixed outcomes: “A comparison of the first 12 months after the launch of the project with the previous 12 months indicated an overall decrease of four per cent in incidents involving alcohol-related assaults. This occurred despite a ten per cent increase of in-licensed premise capacity in central Cardiff. During the same period, incidents of violence against the person rose elsewhere in South Wales. … Virtually all the rise in disorder was accounted for by one street in Cardiff, which had the densest concentration of pubs and clubs and several newly opened premises … Overall, the TASC project was most successful in terms of targeted work with individual premises.”

TASC might have been far more productive if not inhibited both by local licensing policy and the national trends of cheaper and more readily available alcohol. Local licensing policy appears to have been working in a way that had probably damaged the prospects of TASC achieving major positive results.

Legal
The reduction in drink-driving and subsequent injury and death that has been
achieved in many areas of the developed world is one of the success stories of alcohol-harm control. This is most likely to be due to a combination of laws that forbid driving when intoxicated, and that also impose substantial punishments on offenders, coupled with changes in the social acceptability of driving while drunk. There is good evidence that the effectiveness of legislation is related to the perceived chance of being caught and punished. This is a further example of harm reduction achieved through multiple modalities and a shift in the attitude of the population as a whole. Changing attitudes is one of the most effective ways of changing behaviour in society but is difficult to do.

Responsible beverage services (RBS) are brought about usually through educational programmes for serving staff. They appear to be most effective when they are coupled with activities that reinforce existing legal controls for the vulnerable groups and persons driving under the influence of alcohol. The enforcement of existing regulations and legal controls has been studied in several contexts. Self-regulation, though widely advocated by industry, has little evidence to support its effectiveness in practice. This is hardly surprising since there are often commercial conflicts between the desire to run a profitable business and the regulation of alcohol sale, undermining the willingness of sales managers to engage in harm reduction strategies.

Partnership working between government and industry has shown some promise, but is again most effective when backed by regulatory enforcement. In the UK, targeted police action in areas of high alcohol-related crime and disorder has been shown to reduce the rates of crime and public drunkenness. Such initiatives appear to be improved by partnership working between health care and policing, both in data collection and community intervention. A “carrot and stick” approach has been successfully adopted in some areas to improve the practice of those responsible for selling alcohol.

Advertising
The evidence on the effect of advertising on alcohol consumption is not clear. Countries with broadcast advertising bans had lower levels of alcohol consumption. However the cumulative results of a recent meta-analysis failed to demonstrate that advertising bans were effective as an alcohol-reduction policy.

Making Bars Safer
Bar environment
There is a connection between the nature of a bar (its appearance, amenities and management) and the levels of heavy drinking and aggression that occur in and near it. A pioneering study of Vancouver bars indicated that aggression was linked to grubby, poorly-maintained, and unattractive décor. The researchers reported that poor physical bar environment gives patrons their first cue about what type of behaviour might be tolerated. They also concluded that swearing, sexual activity among patrons, sexual competition, prostitution, drug use and dealing, male rowdiness, and male roughness or bumping were associated with aggressive bar-room behaviour.
Australian research has shown that poor bar hygiene was associated with aggression. Graham and Homel have concluded that aggression in bars is associated with poor ventilation and smoky air, poor access to the bar, high noise levels, and crowding.

Some bars attract a lot of people who are ‘high risk’ in relation to heavy drinking. These individuals include those in their late teenage years and in their early twenties. Recent social changes now mean that young women often drink heavily and get involved in disorder and aggression. It has been shown that the identified risk factors in bars include groups of males who are strangers, the presence of underage girls, drunken people with money to spend, and an ‘anything goes’ atmosphere.

**Training bar staff**

It is important that bar staff should reduce aggression, not provoke it. Bar staff vary considerably in their ability to curb aggression. There has been some evidence that door attendants or “bouncers” have sometimes been the cause of aggression in the past.

**Safety glasses**

There is evidence that the use of toughened or safety glasses in bars is helpful in reducing accidental and non-accidental glass injuries. Safety glasses generally do not shatter into dagger-like shards when broken. They crumble into fragments rather like car windscreens. They are also more durable than non-safety glass. Glasses are often used as weapons in bar fights and have inflicted many serious and disfiguring facial injuries. The value of safety glass has been extended in Taunton, where shops in the town centre have been fitted with this type of glass in their windows.

### 8.6 Supply and pricing

**Licensing**

An obvious approach to preventing alcohol-related problems is to limit the general availability of alcohol. This can be done by limiting the number of locations in which alcohol can be obtained, limiting the times at which alcohol is available, or both. In most countries this is achieved through a licensing system. There is reasonably strong evidence that restrictions on the availability of alcohol modestly reduce alcohol consumption, but have a greater impact on the short term harms (such as accidents and violence) resulting from alcohol use. For this reason recent changes in the UK licensing laws have proved particularly controversial.

**Tax**

Large scale social interventions have the potential to yield considerable benefit, but are difficult to study and require popular consent. Another approach to reducing population consumption is to increase the cost of alcohol, usually by increasing taxation. Strong evidence supports this as a way of reducing the consumption of alcohol within a target population, but the extent to which it modifies the behaviour of the heaviest drinkers (and therefore those most at risk) is less clear. As a policy the effects of
increased taxation are complex, and may not be popular with a large section of society.

8.7 Future evidence base

The National Institute of Clinical Excellence (NICE) are in the process of developing three pieces of guidance relating to alcohol use disorders. Each piece of guidance will focus on a different element of the care pathway, from the prevention and early identification of alcohol use disorders through to the clinical management of acute alcohol withdrawal and alcohol related liver disease and pancreatitis. The third piece of guidance will focus on the management of alcohol dependence and psychological interventions. The three pieces of guidance are outlined below:

- **Part 1 - Public health guidance**: Alcohol use disorders in adults and young people: prevention and early identification (publication expected May 2010) - Centre for Public Health Excellence (CPHE) at NICE.
- **Part 2 - Clinical guideline**: Alcohol use disorders in adults and young people: clinical management (publication expected May 2010) - National Collaborating Centre for Chronic Conditions (NCC-CC)
- **Part 3 - Clinical guideline**: Alcohol use disorders: management of alcohol dependence (publication expected January 2011) - National Collaborating Centre for Mental Health (NCC-MH).
PART 9: RECOMMENDATIONS

9.1 Recommendations of the 2007 Alcohol Needs Assessment

28 recommendations were identified by the Alcohol Needs Assessment undertaken in 2007 (see Appendix A). These focused on six key areas:

- Local service gaps
- Population needs
- Developing local capacity and capability
- Developing the workforce
- Offering value for money
- Partnership

These recommendations have been addressed through the 2008-2010 Swindon Harm Reduction Strategy, and significant progress has been made. This updated needs assessment has identified the importance of continuing to consolidate and develop any outstanding recommendations to meet local need.

9.2 Recommendations of this needs assessment

Families and children

- As well as focussing on individual treatment, there should be a focus on reducing the impacts and harms of alcohol on the whole family, and especially where parents have children living with them.
- Adults misusing alcohol that enter any general or specialist treatment service should be asked if they have family members that they live with. As a minimum, information and advice should be given on services available for families to access (e.g. Swindon Carer’s Centre). Links should also be made with Children’s Services so that prevention and treatment work can be targeted at (vulnerable) families with children.
- Consideration should be given as to whether a Family Therapist should be reinstated in Swindon (this resource was decommissioned approximately 4 years ago).
- In line with the recommendations of the 2009 Young Person’s Alcohol and Drugs Needs Assessment, the See the Adult, See the Child protocol incorporating the hidden harm agenda should be fully implemented.

Prevention and treatment services

- An options appraisal should be undertaken to determine the most effective and efficient way of meeting resident’s detoxification needs, including consideration of inpatient and community detoxification facilities. Ideally, detoxification facilities should be provided locally so that people receive the treatment they need within their own community.
- Capacity to provide treatment in the community setting should be increased, which will help to meet the expected increase in demand for treatment (as more people are identified through brief interventions), and prevent and reduce acute and emergency (alcohol specific and
related) admissions. Options for increasing treatment capacity in the community setting should include building comprehensive and enhanced primary care provision, the provision of further specialist clinical community facilities, and further outreach services. Opportunities within existing general practice and pharmacy contracts to deliver (locally enhanced) alcohol services should be maximised.

Referral pathways
- Although some referral pathways are strong (i.e. general practice to SWADS), others are under utilised and not visible to professionals and clients that should be using them. In order to strengthen referral pathways and maximise their use, all referral pathways should be mapped out so that it is clear what alcohol services are available in Swindon and which services different agencies should be referring to. This should be disseminated and communicated to all agencies, with training where appropriate.
- Referral pathways that require particular attention are as follows:
  - Mental health referrals to/from SWADS: To ensure that people with mental health and alcohol dependency needs are supported by both services in a coordinated and integrated way.
  - GWH to specialist alcohol services: To ensure that people admitted to hospital with alcohol related needs are referred to SWADS and other appropriate services. Links with specialist services should ideally be made prior to discharge so that more vulnerable adults can be met by a SWADS worker (or another appropriate worker) before/at discharge.
  - Inter-service referral between Drugs and Homeless Initiative (DHI) and SWADS: To ensure greater integrated care for people misusing alcohol and drugs.
  - General and specialist alcohol treatment services to Swindon Carer’s Centre: To ensure more families of people misusing alcohol are aware of and receive support from Swindon Carer’s Centre where they choose to.
  - Domestic violence settings to/from specialist alcohol services: To ensure that victims of domestic violence are signposted to specialist services where they require it.
  - Social services settings to/from specialist alcohol services: To ensure that referral pathways are clear to all professionals and service users and utilised.
- There also needs to be a greater focus on ensuring that potentially vulnerable groups such as sex workers are routinely referred to specialist services where they have a need.

Vulnerable adults with specific needs
- Delivery of services to people with mental health and alcohol problems should be reviewed to ensure that both their mental health and alcohol needs are not treated in isolation, but managed and addressed in a coordinated and integrated way. Rather than having two different services deliver mental health and alcohol treatment, it is recommended that both services jointly develop and deliver a holistic programme that addresses both of their needs together. To the client,
this would mean getting combined mental health and alcohol addiction treatment from the same team.

- As the establishment of a Wet/Dry House for street drinkers in Swindon has been considered for some time, it is recommended that a formal decision is made as to whether this should be supported. If it is supported, it should be a managed centre that has links with alcohol (and other) services so that treatment needs can be identified and met where possible.
- As street drinkers are being dispersed throughout Swindon through Dispersal Orders and through the removal of areas such as the Rocks (seating), greater efforts should be put into assertive outreach to ensure that they are identified and given support to access alcohol (and related) services.

Training and workforce development

- Professionals already employed in the community and in contact with people that may be misusing alcohol should be trained to be able to identify alcohol problems and offer brief advice and signposting to specialist services. This includes Youth Workers, those working at Refuges, Shelters and Day Centres.
- The Alcohol Liaison Nurses will be responsible for rolling out training on alcohol across Great Western Hospital. This should include promoting culture change across the hospital to promote more positive attitudes towards those with alcohol problems.
- Consideration should be given to the employment of a Community Specialist Alcohol Nurse who could fulfil roles such as supporting the training of professionals in the community, and offering specialist advice to patients, other care professionals and voluntary agencies.

Awareness raising and preventative work with communities

- Links with the social marketing programme (both nationally and locally) should be made to fully utilise their resources on how best communications and social marketing could be applied to prevent and reduce alcohol related harms in Swindon. A comprehensive communications and social marketing plan to target messages to key audiences should be established.
- The Big Debate should be used as an opportunity to engage residents in discussion around alcohol. Events should be taken to communities and target locations that people come into contact with on a day to day basis (supermarkets, community pharmacists etc.).
- Work with children’s services should continue to take place to ensure that vulnerable young people receive support to deter them from misusing alcohol in the future.
- Existing community health champions could be valuable in communicating key messages around alcohol to communities.
- To help communicate and disseminate information, a substance misuse (drugs and alcohol) website should be set up that acts as an information hub for clients (children and adults), families, carers and professionals. This should include information on services in Swindon,
contact details, referral pathways, resources, and plans and strategies. Examples of information hubs in other areas can be found at the following websites:
- http://www.oxfordshiredaat.org/
- http://www3.hants.gov.uk/education/dat.htm
- http://www.essexdrugaction.org.uk/ Essex
- http://www.bucksdaat.co.uk/ Buckinghamshire
- http://www.suffolkdaat.org.uk/ Suffolk

Agreed and coordinated data set to monitor and analyse need
- As information related to alcohol is currently held by a number of different agencies, this can mean that there are gaps in what information is collected, monitored and utilised to inform strategies and action around alcohol. To ensure information is fully utilised, it is recommended that a comprehensive data set is agreed, which all agencies feed into, and which is held and monitored by the DAAT. The objectives of the data set would need to be agreed to ensure that there was added value, though there are numerous opportunities for using information to inform social marketing strategies, the targeting of outreach services to particular communities, and so on.
- The expected increase in referrals to specialist services such as SWADS, as a result of new interventions (i.e. Alcohol Liaison Nurses, Brief Interventions and Health Checks in general practice), should be estimated. This will help to inform whether or not existing specialist services have the capacity to meet anticipated increased future demand.

Partnership work and roles and responsibilities
- Partnership work should be strengthened through the following steps:
  - Mental health to be represented at Alcohol Steering Groups.
  - Links to be strengthened with Job Centre Plus and agencies in contact with those in financial difficulties that may have alcohol problems e.g. Citizens Advice Bureau.
  - Links to be strengthened with other community services that may be able to support communications and advice around alcohol e.g. community pharmacists (currently an opportunity to feed into the community pharmacy needs assessment).
- Roles and responsibilities of agencies should be defined to ensure that all professionals are clear on how they and others contribute to joint meetings such as the Alcohol Steering Group. This will also help to ensure that there is continuity in how an agency contributes if there is a change in personnel.

Approach to alcohol prevention and harm reduction
- Consideration should be given as to whether the benefits of locating the DAAT within NHS Swindon would outweigh the disadvantages of not being located in the Community Safety Partnership. If the approach Swindon wishes to take to preventing and reducing alcohol related harm is a public health (rather than criminal justice) approach, then arguably the DAAT would be best placed in NHS Swindon.
Appendix A

Recommendations of the 2007 Alcohol Needs Assessment

Immediate practical steps that the Community Safety Partnership and the PCT can take

The Community Safety Partnership and the PCT should:

1. support the lead PCT commissioner
2. identify local champions to support implementation, such as a Community Safety Partnership lead, hospital consultant, regional public health lead, a substance misuse consultant, a GP with a specialist interest, voluntary services worker, and service users
3. establish a project support or network group
4. task the Director of Public Health (DPH) to be a key contributor by steering this important programme at a local authority, PCT and SHA level in discussion with Directors of Commissioning and Performance
5. ask the DPH and Director of Commissioning to support local alcohol commissioners (who may already be employed as Joint Commissioners).

Local service gaps

The Community Safety Partnership and the PCT should:

6. assess current provision and levels of investment for screening and brief interventions and services for dependent drinkers across the local health and social care and criminal justice economies.
7. check whether screening and brief interventions are offered to hazardous and harmful drinkers who attend;
   a. primary care as a new registration or with a pre-existing condition where alcohol may contribute to the harm, or are perceived by the GP as being at an increased risk of developing health conditions because of excessive drinking;
   b. other hospital health care settings; for example STD clinics or fracture clinics;
   c. a non-NHS service for example, in a criminal justice setting
8. act collaboratively to secure services and service improvement when specialist service provision would benefit from this.

Population needs

The Community Safety Partnership should:

9. work in partnership to assess further local needs, current
investment and provision of screening and brief interventions and services for dependent drinkers across the local health, social care and criminal justice pathways and to consider the different needs and priorities within each community.

10. take account of different needs and inequalities within the hazardous, harmful and dependent drinkers population for geographical area, socio-economic group, ethnicity, gender, disability, age, faith, and sexual orientation, on the basis of a systematic programme of health equity audit and equality impact assessment. This should address issues of race equality.

**Equity**

The PCT and its partners should:

11. commission a health equity audit to identify how fairly services or other resources are distributed for the health needs of different groups. By using evidence on inequalities to inform decisions on investment, service planning, commissioning and delivery, health equity audits can help organisations address inequalities in access to services and in health outcomes, such as the inequalities experienced by black and minority ethnic groups.

12. apply these common equity criteria when implementing screening, brief interventions and support for hazardous, harmful and dependent drinkers.

**Developing local capacity and capability**

The PCT should

13. appoint and train an Alcohol Intervention Specialist(s) (G or H Grade Nurses or equivalent) with responsibility for co-ordinating and implementing arrangements for screening, the provision of information and brief interventions within settings determined locally, and identifying pathways to specialised treatment.

14. publish a guide to local services

15. use opportunities available within the new General Medical Services (GMS) contract to deliver enhanced services and a range of models of prevention to meet need

16. use core and flexible contracts for people requiring planned hospital care to support the flow of funds to alternative providers where patient choice and/or capacity demands dictate

17. agree explicit criteria for referral and treatment thresholds and trigger points within service level agreements and contracts. This includes involving service users more directly in decisions about interventions and treatment

18. have appropriate contracting and monitoring arrangements in place at PCT level to ensure that sustainable interventions and services are commissioned and that local monitoring
arrangements identify the impact on identified areas of NHS service demand and access.

Developing the workforce

The PCT should:

19. ensure that Local Delivery Plans contain robust workforce plans are in place to support delivery of national alcohol strategy through increases in the size of the workforce, roll-out of new ways of working and improvements in workforce productivity

20. use the changes arising from the new GP and consultant contracts, Agenda for Change and the extra capacity available from new independent sector providers to improve services for alcohol–use disorder

21. use the opportunities from the national commitment to lifelong learning and skills enhancement for staff at all levels to improve services for alcohol–use disorder.

22. engage with the programme to deliver the workforce elements of Choosing Health

Offer value for money

The PCT should

23. match provision with assessed need and ensure best value
24. ensure existing contracts, particularly with NHS Trusts, identify alcohol costs within larger contracts to facilitate this
25. re-negotiate when practicable existing contracts to improve services
26. consider new providers.

Partnership

The PCT should:

27. ensure that sustainable partnership with the local authority, other local partners, service users and service providers, including those from the independent sector and voluntary organisations to achieve successful modernisation and improvement

28. can with the local authority and other partners set local targets and timescales to implement screening, brief interventions and treatment for hazardous, harmful and dependent drinkers with indicators for progress monitoring.
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