Alcohol Misuse Select Committee Report

March 2008

Kent County Council

Contents

Foreword

Alcohol plays an important and complex part in our society and is often associated with cultural and symbolic meanings; it is a source of enjoyment, it helps people relax and is often used in celebrations. However, although most of us drink sensibly, alcohol misuse can result in several serious problems for individuals, families and the Kent community at large.

As this timely review shows, there are compelling reasons for dealing with alcohol misuse today. In England the consequences of alcohol misuse cost about £20 billion every year. But the costs that society has to bear are not just economic; binge drinkers are responsible for much alcohol-related violence and anti-social behaviour, and many people today believe that alcohol misuse is a major cause for concern. Importantly, excessive alcohol consumption can damage health in many ways, affecting people of all ages and representing a significant burden on the NHS.

Much can be done to deal with alcohol misuse through, for example, better identification and treatment of people with alcohol problems, better education and awareness about alcohol and its harmful consequences, and better prevention and control of alcohol-related crime and disorder. An integrated approach, with all the agencies dealing with alcohol misuse in Kent working together, can ensure the most effective results.

I am very grateful to all the people who have taken part in this review; without them, the production of this report would not have been possible.

Tackling alcohol misuse and its harmful consequences is the responsibility of us all. Together, we can change this “drinking culture” to make Kent a healthier, safer place to live.

David Hirst, Chairman of the Alcohol Misuse Select Committee.

Executive Summary

1.1. Committee Membership

1.1.1. The Committee consists of eight Members of Kent County Council (KCC): Five Members of the Conservative Party, Two Members of the Labour Party and one Member of the Liberal Democrat Party.

Mrs Ann Allen

Conservative Member for Wilmington

Mr David Brazier

Conservative

Member for Sevenoaks North East

Mrs Trudy Dean

Liberal Democrat

Member for Malling Central

Mr John Fullarton

Conservative Member for Broadstairs and Sir Moses Montefiore

Mr David Hirst

Conservative

Member for Herne Bay

Chairman

Mr Bill Newman

Labour

Member for Dover Town

Mrs Eileen Rowbotham

Labour Member for Dover North

Mrs Paulina Stockell

Conservative Member for Maidstone Rural West

1.2. Scene Setting

1.2.1. It is widely accepted that excessive consumption of alcohol is a growing social and public-health problem in the UK, with a marked increase in the numbers drinking regularly and to excess.

1.2.2. This is partly attributable to the fact that alcohol has become cheaper and more readily available. Also, patterns of drinking have changed – with alcohol misuse becoming more socially acceptable, and increasing numbers of women (particularly younger women) drinking excessive levels of alcohol.

1.2.3. Health problems that are known to be associated with excessive alcohol consumption include:

- brain damage;
- alcohol poisoning;
- cancer;
- liver disease (cirrhosis);
- circulatory disease;
- high blood-pressure;
- damage to the nervous system;
- mental-health problems;
- impaired reproductive health;
- elevated risk of sexually-transmitted infections (associated with more risky sexual behaviour); and
- trauma (associated with accidents and violence).

1.2.4. Drinking to excess is one of the leading causes of disease, injury, disability and premature death. The annual number of alcohol-related deaths in the UK more than doubled between 1991 and 2005 (when the figure was 8,386). It is estimated that some 17 million working days, costing £6.4 billion, are lost in the UK each year due to alcohol-related sickness absence. Alcohol misuse also contributes to health inequalities.

1.2.5. Some public-health interventions (such as breath-testing of drivers and legal restrictions on the sale of alcohol) are known to be effective in reducing alcohol-related harm.

1.3. Terms of reference

- To map out, in respect of the administrative County of Kent, on the basis of available evidence, the extent of alcohol misuse and the public-health implications of the issue.

- To consider what public health initiatives[1] might be undertaken to address alcohol misuse in Kent, having regard to national/government policies, and existing national and local best practice.

[1] The standard typology of public-health interventions is as follows: health protection; preventive medicine; health education; healthy public policy; community empowerment.

- To explore the possible role of collaborative working (with the 12 district authorities in Kent, local NHS Bodies, schools and other partners) in delivering initiatives on this issue.

- To explore programmes currently addressing the issue of alcohol misuse in primary and secondary schools in Kent.

- To take account of the work of the Kent Drug and Alcohol Action Team (KDAAT), and consider innovative ways of delivering alcohol related services.

- To consider the impact of alcohol misuse on NHS Accident and Emergency departments – with reference to pressure on services and assaults on NHS staff.

- To identify vulnerable groups where alcohol misuse is most prevalent and focus on action that KCC could take to reach those groups.

- To explore funding streams to support the implementation of initiatives on this issue.

- To make specific recommendations on this issue for Kent County Council and partner organisations.

1.4. Recommendations

Recommendation 1

The Alcohol Misuse Select Committee recommends that:

Kent County Council (KCC) establishes, in partnership with Kent Primary Care Trusts (PCTs), an independent task board which will carry out a comprehensive and systematic needs assessment of alcohol service provision in Kent. This review should investigate, quantify and evaluate the current level of need and the financial resources available in both East and West Kent; it should consider coordination, commissioning and provision mechanisms involved; it should assess the effectiveness of local alcohol treatment systems in all the four tiers of intervention, and it should explore opportunities for savings in order to maximise budget spend on service delivery. The Kent Drug and Alcohol Action Team (KDAAT) should produce an annual updating report indicating in the various areas of operation the number of individuals receiving treatment and the reasons for their referral. (Please refer to Sections 3.1 and Section 3.2)

Recommendation 2

The Committee recommends that the needs of all those individuals requesting assistance, especially those caring for dependants, should be assessed carefully, and that treatment should be prioritised according to the importance and urgency of each situation. (Section 3.2)

Recommendation 3

The Select Committee recommends that:

The outcomes of the needs assessment should inform the production of an overarching alcohol strategy for Kent. The production of the strategy, aiming at reducing the impact of alcohol misuse in Kent, should be lead by KDAAT. The strategy should address a variety of issues including treatment services, underage drinking, public awareness, alcohol-related crime and responsible retailing. It should clearly identify effective actions to be taken, together with responsibilities and accountability of all the agencies involved in the coordination, commissioning and provision of alcohol-related services. The strategy should include mechanisms that will evaluate and monitor the progress of its implementation, and it should encourage closer collaborative ties between all the agencies involved. (Section 3.1 and Section 3.2)

Recommendation 4

The Committee urges KCC to lobby Central Government to raise the priority and profile of the issue of alcohol misuse in the UK. KCC should press for an increase in funding to finance services dealing with alcohol misuse. This

pressure should be carried out through the influence of the Local Government Association (LGA), as well as through direct contact with Central Government agencies. (Section 4.1)

Recommendation 5

KCC should ensure that the distribution of financial resources for alcohol-related services is monitored, amongst other methods, through Local Area Agreement (LAA) structures and mechanisms. KCC should prioritise the allocation of resources for these crucial alcohol services, given their impact across so many other aspects of life. (Sections 4.1 and 4.2)

Recommendation 6

The Committee recommends that:

KCC establishes closer links with local academic institutions, such as the University of Kent, in order to deal with alcohol misuse. Work should be carried out with the European Institute of Social Studies (EISS) of the University of Kent, in an effort to attract European Union funding to finance alcohol misuse services in Kent. KCC should liaise with EISS to encourage the participation of both the alcohol industry and Kent-based agencies dealing with alcohol misuse in the EU Alcohol and Health Forum. Care should be taken to present the Forum with the many projects that the alcohol industry in Kent may initiate. (Section 4.2)

Recommendation 7

The Select Committee urges that the effectiveness of GPs in early identification and referral of alcohol misusers in Kent should be improved. All GPs in Kent should be strongly encouraged to attend special training that will help them identify alcohol misusers, especially those with dependants. (Section 5.1)

Recommendation 8

GPs and other primary care staff should increase the provision of "motivational brief interventions" and advice to individuals drinking excessively, but not yet experiencing major problems resulting from excessive consumption. Funding sources to finance these brief interventions should be identified by Kent Primary Care Trusts (PCTs). (Sections 5.1 and 5.2)

Recommendation 9

The Committee urges that KCC offers immediate intervention to support those with urgent needs, such as children mistreated by alcoholic parents, young carers of misusers and misusers suffering from alcohol withdrawal crises. If during assessment a parent is identified as in need of alcohol treatment, KCC

Social Services should ensure that support is provided to ascertain that the children are properly cared for. (Section 5.3)

Recommendation 10

It is paramount that additional temporary sheltered housing should be facilitated by KCC for individuals recovering from alcohol addiction, particularly those discharged from hospitals, prisons and residential alcohol treatment, in order to prevent relapse. (Section 5.4 and Section 8.1)

Recommendation 11

The Select Committee supports the promotion of a hard-hitting health campaign targeted at the young to increase their awareness and so reduce the damaging effects of alcohol. The Committee urges that this campaign should stress personal responsibility and self esteem, give information about sensible drinking and about the variety of alcohol- related services available in the County (Section 6.1)

Recommendation 12

In order to help those seeking support, the Select Committee recommends that:

1. **A logo, which facilitates the identification of all alcohol services in the County, is adopted. (Section 6.2)**

2. **The "alcohol" section in the KDAAT website is developed and expanded. (Section 6.2)**

Recommendation 13

KCC should produce a directory in hard copy of all alcohol-related services available in the County which includes all voluntary sector provision, to aid partners and clients to access help for individuals in crisis. (Section 6.2)

Recommendation 14

The Alcohol Misuse Select Committee recommends that:

More consistent Personal, Social and Health Education (PSHE), which includes effective alcohol education, should be delivered in both primary and secondary schools in Kent. PSHE accreditation for both teachers and nurses should be widely supported. The organisation and promotion of this training should be carried out by Schools Drugs Education Advisers through Local Children's Services Partnerships. The Kent PSHE Advisory Group should pay particular

attention to this recommendation when investigating young people's personal health and wellbeing in the County. (Sections 7.1 and 7.2)

Recommendation 15

The Committee recommends that the inclusion of persons recovering from alcohol addiction in the delivery of alcohol education in schools in Kent should be considered by Local Children's Services Partnerships. Guidance for schools will ensure that lessons delivered by outside speakers, including previous alcohol misusers, comply with a clear quality assurance framework. (Section 7.2)

Recommendation 16

The Committee commends that parents and Kent-based primary and secondary schools should work in partnership to promote legal, safe and sensible drinking. Schools should involve parents in their children's alcohol education by transferring learning about sensible drinking into the home. (Sections 7.2 and 7.3)

Recommendation 17

Successful initiatives dealing with other related health issues, such as drug misuse, drink driving and sexual health, should be explored for adaptation to the theme of alcohol misuse. KCC should support the delivery of these initiatives in tackling alcohol misuse. (Section 7.2)

Recommendation 18

The Select Committee commends and supports the work carried out by the Safer and Stronger Communities Group and its sub-group, in their effort to reduce alcohol-related crime linked to the night-time economy and to deal with domestic violence in Kent. It recommends that this work should be comprehensive, including the diversity of offences fuelled by alcohol misuse which are not necessarily of a violent nature. (Sections 8.1 and 8.2)

Recommendation 19

The Select Committee urges that:

Communication between agencies at county level and those at more local level should be enhanced. Better data sharing between organisations dealing with alcohol-related crime, such as the police and Crime Disorder Reduction Partnerships (CDRPs) should be secured. The sharing of best practice between Kent-based CDRPs in tackling alcohol-related disorder should be improved. Both Central Government and the alcohol industry should be encouraged to provide data and finance. (Section 8.2)

Recommendation 20

The Committee strongly recommends that the Kent-based alcohol misuse conference, including representatives of local authorities, CDRPs, KDAAT and the alcohol industry, is established. (Section 8.2)

Recommendation 21

The Alcohol Misuse Select Committee urges that:

All hospitals in Kent improve Accident and Emergency (A&E) data gathering on injuries resulting from alcohol-related violence. All A&E departments in Kent should be strongly encouraged to collect and share data with other agencies in order to pinpoint "hot spots" and sources of crime resulting from alcohol misuse, and should quantify accurately NHS costs of dealing with health consequences. (Section 8.2)

Recommendation 22

KCC should recommend that magistrates are provided by Her Majesty Court Service (HMCS) with training which will enable them to deal more effectively with alcohol-related crime. (Section 8.2)

Recommendation 23

The Select Committee supports the KCC Towards 2010 target 58 to work with off licence pub and club owners to reduce alcohol fuelled crime and disorder, anti-social behaviour and domestic abuse. In addition, we recommend that problems of drinking outside the curtilage of licensed premises should be addressed, and that KCC should seek to discourage the practices of discounting alcoholic drinks, charging high prices for soft drinks and other strategies that could promote irresponsible drinking by all retail outlets. (Sections 9.1, 9.2 and 9.3)

Recommendation 24

The Committee recommends that:

KCC supports, where appropriate and after other measures have been explored, the establishment of alcohol free areas and of Alcohol Disorder Zones, which can require premises failing to implement actions designed to reduce alcohol-related anti-social behaviour in their vicinity to contribute towards the cost of the additional policing necessary to suppress the disruption. Kent Police, Trading Standards and other appropriate agencies should increase their efforts to identify retailers who supply alcohol to under age persons and ensure that penalties are applied. (Sections 9.2 and 9.3)

Recommendation 25

The Committee recommends KCC to improve public knowledge of the rights to object to licence applications for the sale of alcohol and to call for license reviews if problems of public nuisance occur. Local experience of public nuisance was previously submitted via Parish Councils, and the Select Committee recommends that KCC engages the support of the Kent Association of Parish Councils to lobby Government to reinstate Parish Councils as consultees in license applications. (Sections 9.2 and 9.3)

Recommendation 26

The Select Committee urges KCC to engage and encourage Central Government to ensure that the rate of taxation of drinks increases proportionally with their alcoholic strength. A greater part of the additional revenue accrued from alcohol taxation should be re-invested for the prevention and treatment of alcohol misuse. (Section 10.1)

Recommendation 27

The Committee recommends that KCC supports Central Government's engagement of large supermarket chains encouraging them to review their alcohol marketing strategies, including "loss leader" discounting practices, and to ensure that alcohol is not sold to under-age customers. (Section 10.2)

Recommendation 28

The Committee commends that KCC encourages Central Government to make Personal, Social and Health Education (PSHE) a statutory subject with inspection by Ofsted (please refer to Appendix 4 for related recommendations in KCC PSHE report). (Section 10.3)

2. Background

2.1. Introduction

2.1.1. Alcohol plays a positive role in British society and is associated with important cultural and symbolic meanings. However alcohol is not an "ordinary commodity"; it is a legal drug whose toxic effects can be harmful for people's health and can fuel crime and anti-social behaviour.[2] The Alcohol Misuse Select Committee, in Kent County Council, has investigated the problem of alcohol misuse, some of its negative consequences, and some of the solutions. The Committee has produced this report of which recommendations can help tackle the issue of alcohol misuse and its consequences in Kent.

2.1.2. Alcohol misuse accounts for almost 10% of disease burden in England, surpassed only by tobacco and blood pressure.[3] The consequences of excessive alcohol consumption for individuals' health are numerous and diverse. They include intoxication, alcohol dependence, brain damage, breast cancer, mental ill-health and alcoholic liver disease.[4] [5] Up to 22,000 people die in England every year from causes attributable to alcohol misuse, and up to 150,000 hospital episodes are related to excessive alcohol consumption.[6] Within Europe, the UK has now the third highest proportion of 15 year olds (24%) who have been drunk 10 times or more during the past year. The average weekly consumption of alcohol reported by young people who drink aged 11-15 years doubled in the 1990s.[7]

2.1.3. In the KCC administrative area, according to NHS figures, the actual overall number of alcohol-specific hospital admissions in has almost doubled from 885 admissions in 1997-8 to 1,454 in 2006-7.[8]

2.1.4. Also, the number of adults in Kent undergoing treatment for alcohol misuse more than doubled from the period 2005-6 to 2006-7. Similarly, the number of young people in treatment increased from 115 in 2005-6 to 271 in 2006-7.[9]

2.1.5. Crime and anti-social behaviour are also strongly linked to alcohol misuse. Nearly half (46%) of all incidents of domestic violence in England are thought to be caused by offenders under the influence of alcohol.[10] Alcohol-related crime is linked to up to 70% of Accident and Emergency

[2] Babor, T. et al (2003) Alcohol: No Ordinary Commodity, Oxford, Oxford University Press.
[3] Department of Health (2005) Alcohol Needs Assessment Research Project (ANARP), London.
[4] Department of Health (2006) Alcohol, Health and Wider Social Impact, London.
[5] Department of Health (2007) Safe. Sensible. Social. The Next Step in the National Alcohol Strategy, London.
[6] Department of Health (2005) Alcohol Needs Assessment Research Project (ANARP), London.
[7] Department of Health (2007) Safe. Sensible. Social. The Next Step in the National Alcohol Strategy, London.
[8] NHS Wide Clearing Service (2207) Alcohol Specific Hospital Admissions for Local Authorities in Kent, 1997/8 – 2006/7.
[9] Kent County Council (2007) Alcohol Misuse Select Committee, 14 June 2007, Maidstone.
[10] Ibid.

(A&E) attendances.[11] Nearly half of all 10 to 17 year olds who drink at least once a week admitted to criminal or anti-social behaviour.[12]

2.1.6. In Kent, the number of adult arrests for drink offences increased from 5,732 in 2005-6 to 5,950 in 2006-7. The number of young people arrests has also substantially increased, from 278 in 2005-2006 to 403 in 2006-7.[13]

2.1.7. The economic costs incurred from the consequences of alcohol misuse in England are also concerning, amounting to around £20 billion every year. Most people in the Country think that drunken behaviour in a public place is a significant problem and 80% of people believe that more should be done to deal with alcohol misuse.[14]

2.2. Terminology

2.2.1. "**Alcohol misuse"** can be defined as "the use of a substance for a purpose not consistent with legal or medical guidelines". The term "misuse" is often preferred to "abuse" in the belief that it is less judgemental.[15]

2.2.2. The World Health Organisation (WHO) divides alcohol use disorders into three categories.

- **Hazardous drinking**: individuals drinking above recognised "sensible" levels but not yet experiencing harm. "hazardous" limits are defined as the consumption of 22-50 units per week for men, and 15-35 units for women.

- **Harmful drinking**: individuals drinking above recommended levels for sensible drinking and experiencing physical and/or mental harm. The weekly consumption associated with harmful drinking is of more than 50 units per week for men and of more than 35 units for women. Individuals categorised as Harmful drinkers have not yet developed alcohol dependence.

- **Alcohol dependence**: individuals drinking above sensible levels, experiencing an increased drive to use alcohol and difficulty controlling its use. Dependent drinking can be sub-divided into two categories; "moderate" dependence and severe dependence, traditionally known as "chronic alcoholism".[16] [17] [18]

[11] Department of Health (2006) Alcohol, Health and Wider Social Impact, London.
[12] Department of Health (2007) Safe. Sensible. Social. The Next Step in the National Alcohol Strategy, London.
[13] Kent County Council (2007) Alcohol Misuse Select Committee, 14 June 2007, Maidstone.
[14] Ibid
[15] Anderson, P. and Baumberg, B. (2006) Alcohol in Europe: A Public Health Perspective, Institute of Alcohol Studies, London.
[16] Department of Health (2005) Alcohol Needs Assessment Research Project (ANARP), London.
[17] Department of Health (2005) Alcohol Needs Assessment Research Project (ANARP), London.
[18] Sheehan, D. (2007) Choosing Health in the South East: Alcohol, South East Public Health Observatory (SEPHO).

2.2.3. "**Binge drinking**" is defined as the consumption of 8 or more units of alcohol for men and 6 or more units of alcohol for women during a single session (these are double the daily recommended limits of consumption).[19]

2.2.4. The effects that alcohol can have on individuals vary with factors such as age, health, weight, gender and diet.[20] Nonetheless, according to the 1995 "Sensible Drinking" report, the Government advises that "sensible drinking" is defined as the consumption of no more than 3-4 units of alcohol per day for men, and 2-3 units per day for women. The report also states that after an episode of heavy drinking individuals should refrain from drinking for 48 hours to allow the body to recover.[21]

2.2.5. Alcohol consumption is normally measured in "**units**". A unit of alcohol equals 10ml or 8 grams of pure alcohol (eg. ethanol). Generally one unit of alcohol corresponds to half pint of ordinary strength beer, a small glass of wine of 9% alcohol by volume (ABV), or one measure of spirits.[22]

2.2.6. The following table displays the unit strength of some common beverages.

Figure 1: Common alcoholic beverages and unit strength

Drink	Quantity	Units
Wine	125ml glass (9% ABV)	1
	125ml glass (11–12% ABV)	1.5
	175ml glass (11–12% ABV)	2
	75cl bottle (9–10% ABV)	6–7.5
	75cl bottle (11–12% ABV)	8–9
	50ml sherry, port, madeira, Vermouth, martini	1
Lager, beer and cider	330ml bottle (4–5% ABV)	1.5
	440ml can (4–5% ABV)	2
	440ml can (8–9% ABV)	3.5–4
	500ml can (1 pint), (4–5% ABV)	2–2.5
	500ml can (8–9% ABV)	4–4.5
	440ml can low alcohol beer (1.2% ABV)	0.5
Spirits	25ml pub measure (40% ABV)	1
Alcopops	300ml bottle of 'alcopop' (4–6% ABV)	1.3–2
	200ml bottle of 'alcopop' (13.5% ABV)	2.7

Source: Choosing Health in the South East (2007)

[19] Ibid
[20] Department of Health (2007) Safe. Sensible. Social. The Next Step in the National Alcohol Strategy, London.
[21] Ibid
[22] Sheehan, D. (2007) Choosing Health in the South East: Alcohol, South East Public Health Observatory (SEPHO).

2.3. A Historical Glance at Alcohol

2.3.1. Alcohol has provided a variety of functions for people throughout history, especially in religion and worship. Alcoholic drinks have served as sources of nutrients and for medical and antiseptic purposes.

2.3.2. It is not known when alcohol was first used, it was probably the result of a fortuitous accident that occurred tens of thousands years ago. However, the discovery of beer jugs in the late Stone Age suggests that intentionally fermented drinks existed in the Neolithic period, about 10,000 years ago. The earliest alcoholic beverages were probably made using berries and honey, and winemaking may have originated in the Middle East.

2.3.3. Alcoholic beverages were very important in ancient Egyptian religion: Osiris, the god of wine, was worshipped throughout the entire country. The Egyptians made at least 17 varieties of beer and 24 varieties of wine. Both beer and wine were offered to the gods.

2.3.4. Alcohol was also an important part of religious life in ancient China, where it was considered spiritual rather than material food. A Chinese imperial edict of around 1,116 BC stated that the use of alcohol in moderation was believed to be prescribed in heaven.

2.3.5. The first widespread alcoholic drink in ancient Greece was mead, a fermented beverage made of honey and water. However, by 1,700 BC wine was the most popular drink, and was used both for religious rituals and for hospitality. The Greeks were amongst the most temperate of ancient people in the consumption of alcohol.

2.3.6. Between the founding of Rome, in 753 BC and the third century BC the Romans used alcohol in moderation. However, after the Roman conquest of the Italian peninsula and the Mediterranean basin (509 to 133 BC) the traditional Roman values of temperance and frugality were gradually replaced by heavy drinking, degeneracy and corruption. Practices that promoted heavy drinking included drinking before meals on empty stomach, inducing vomit to be able to consume more food and wine, and drinking games.

2.3.7. Numerous developments in drinking habits occurred during the Middle Ages. Mead, rustic beers and wild fruit wines became increasingly popular, especially amongst Celts, Anglo-Saxons, Germans and Scandinavians. However, wine remained the most popular drink in Southern European countries. Monasteries became the repositories of the brewing and winemaking techniques developed in earlier times. Monks brewed virtually all beer of good quality, and by around the 13th century the use of hops and the consumption of ales became widespread in northern Europe. By the end of the millennium the most popular form of festivities in England were known as “ales”.

2.3.8. The most important development with regards to alcohol in the Middle Ages was probably the process of distillation. Albertus Magnus (1193-1280) was the first person clearly describing the process.

2.3.9. By the end of the Middle Ages the popularity of beer spread across England, France and Scotland. Brewers were officially recognised as a guild in England, and the adulteration of beer and wine were punishable with death in Scotland.

2.3.10. In the modern period consumption of alcohol in Europe was often high. In the 16th century the annual consumption of alcoholic drinks reached 100 litres per person. In Coventry, the average amount of beer and ale drank was 17 pints per person per week, compared to about 3 pints today. However, the consumption of spirits became widespread only in the 17th and 18th centuries. For example, gin consumption in England peaked in 1743, where a nation of six and a half million people drank over 18 million gallons of gin.

2.3.11. While drunkenness was still an accepted part of life in the 18th century, increasing industrialisation in the 19th century brought a change in attitudes, resulting from the need for a reliable and punctual workforce. Problems commonly associated with industrialisation, such as urban crime, poverty and high infant mortality, were also attributed to alcohol. [23]

2.4. The Cultural and Social Aspects of Alcohol

2.4.1. As just highlighted in the section above, alcohol has been an important part of social and spiritual life in Britain and elsewhere in the world for many centuries. Alcohol is associated with several aspects of British life: to help people relax, to seal business deals, to celebrate life events, to say goodbye to people, to forget, to manipulate people, to feel grown up and to belong. Importantly for the purpose of this review, alcohol can be used as a form of "self-medication", where people using it believe that it alters their feelings and helps them cope with situations they find difficult. [24] [25]

2.4.2. In Europe, distinctive cultural drinking patterns can be identified. There is a North-South gradient in terms of drinking behaviour, although not without exceptions.

2.4.3. **Beverage choices:** while southern European nations prefer wine, north European ones prefer beer. However, recent data suggests that the Spanish drink more beer than wine.[26]

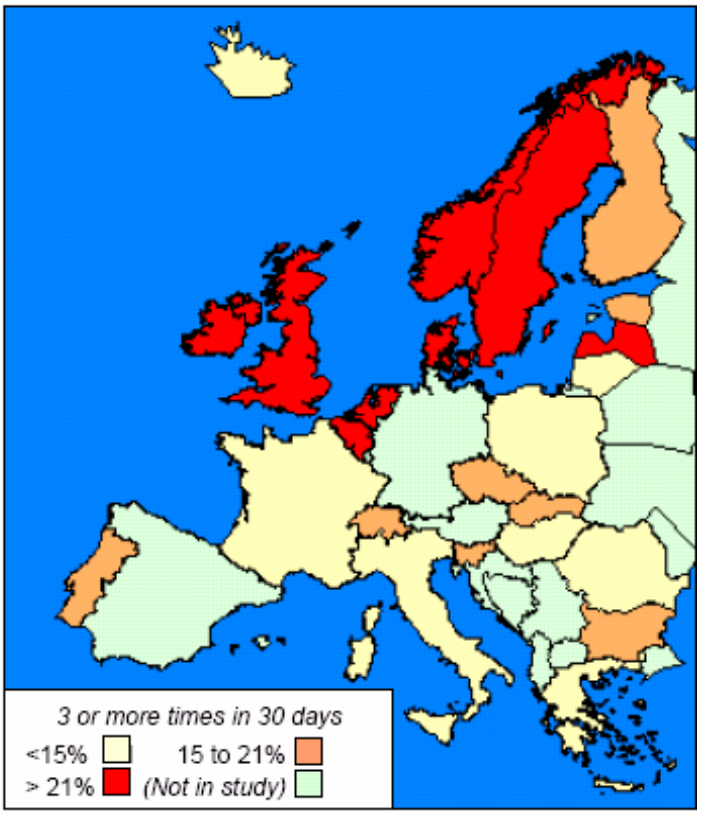
[23] Hanson, D. (1995) Preventing Alcohol Abuse: Alcohol, Culture and Control, Praeger, Wesport.
[24] Mental Health Foundation (2006) Cheers? Understanding the Relationship between Alcohol and Mental Health, London.
[25] Kent County Council (2007) Alcohol Misuse Select Committee, 27 June 2007, Maidstone.
[26] Mental Health Foundation (2006) Cheers? Understanding the Relationship between Alcohol and Mental Health, London.

2.4.4. **Drinking with meals:** it is widely believed that in Southern Europe drinking revolves around mealtimes much more than in the rest of Europe. While this evidence has some validity - especially in Italy, France and Portugal - there are exceptions. For example, Sweden has more people "only drinking when eating" than Spain.[27]

2.4.5. **Frequency of drinking:** southern Europeans drink alcohol more often than northern Europeans, and are much more likely to be daily drinkers.[28]

2.4.6. **Drunkenness and binge drinking:** binge drinking and drunkenness are much more common in northern European countries. Also, qualitative data suggests that the lack of self control associated with visible drunkenness tends to be suppressed in southern European youth culture.[29]

Figure 2: Binge Drinking in 15-16 Year old Students in Europe



Source: Institute of Alcohol Studies, Alcohol in Europe: A Public Health Perspective (2006)

2.4.7. Having highlighted the above cultural differences in Europe, it is perhaps also important to draw attention to the following general points.

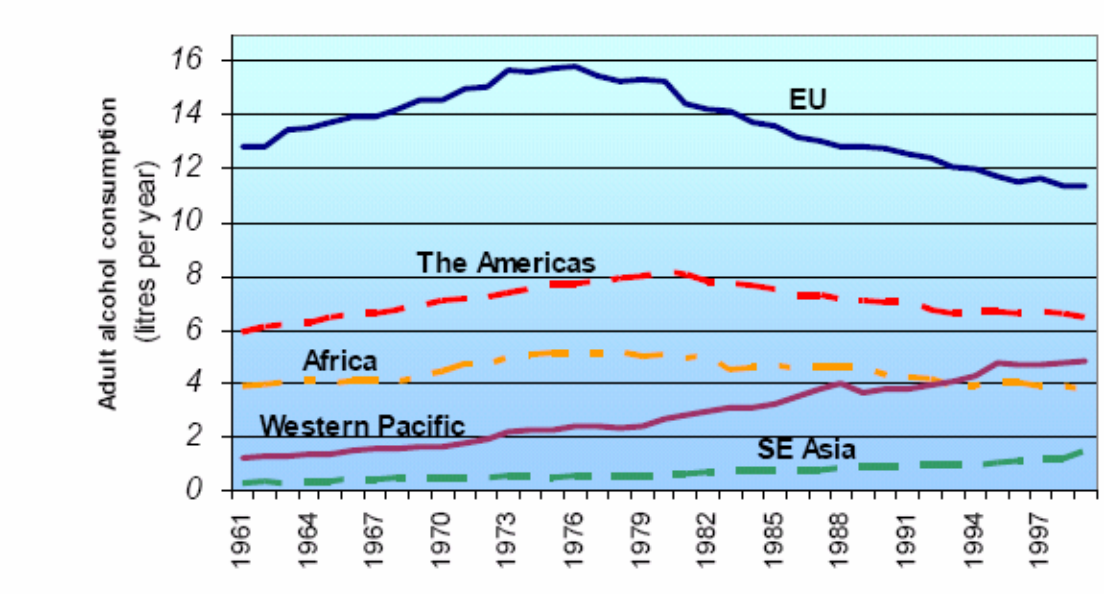
[27] Anderson, P. and Baumberg, B. (2006) Alcohol in Europe: A Public Health Perspective, Institute of Alcohol Studies, London.
[28] Ibid
[29] Ibid

Although *patterns* of alcohol consumption can differ in Europe, with excessive alcohol consumption the damage to people's health "still goes on".[30] Drinking takes place in a social context, which has a powerful influence both in the amount and patterns of drinking in the community.[31] Finally, many aspects of the British drinking culture, such as drinking and driving have changed.[32] The belief that drunkenness and anti-social behaviour are an accepted and intrinsic part of British culture can be challenged and changed.[33]

2.5. A Glance at Alcohol Consumption in Europe and in the Rest of the World

2.5.1. The European Union is the heaviest drinking region of the world, with an average of approximately 11 litres of pure alcohol consumed by each adult every year. This equals to an average level of two and a half times the rest of the world's average.[34] In fact this level is a considerable decrease from the peak level of 15 litres reached in the mid-1970s. Since then there has been a general plateau, in which rises in consumption in eastern and northern Europe were met by a consistent fall in southern Europe.[35] A degree of stability has also been reached in the Americas, the second highest-consuming region (with just under 7 litres), while, by contrast, consumption in south-east Asia and the western Pacific is rising.

Figure 3: Alcohol Adult Consumption in Europe and the Rest of the World

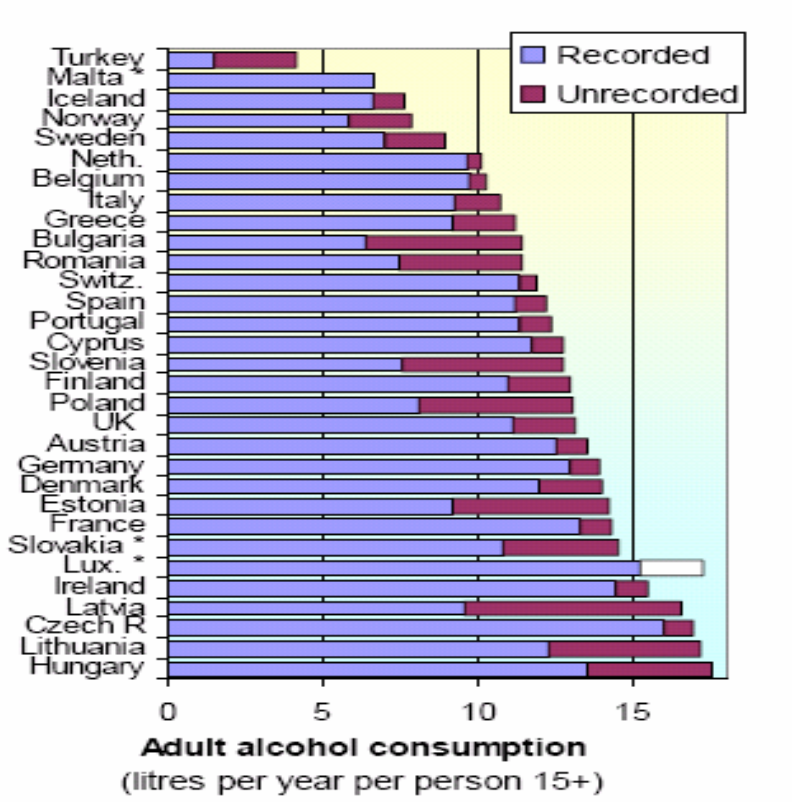


Source: Institute of Alcohol Studies, Alcohol in Europe: A Public Health Perspective (2006)

[30] Kent County Council (2007) Alcohol Misuse Select Committee, 10 July 2007, Maidstone.
[31] Raistrick, D., Heather, N. and Godfrey, C. (2006) Review of the Effectiveness of Treatment of Alcohol Problems, National Treatment Agency (NTA), London.
[32] Fox Anne (2007) Alcohol Misuse Select Committee, 14 September 2007, Maidstone.
[33] Department of Health (2007) Safe. Sensible. Social. The Next Step in the National Alcohol Strategy, London.
[34] Anderson, P. and Baumberg, B. (2006) Alcohol in Europe: A Public Health Perspective, Institute of Alcohol Studies, London.
[35] Ibid

2.5.2. Considering all forms of consumption – recorded and illicit – considerable variation can be found in the European Union (EU). For example, the recorded consumption in Luxembourg is two and a half times that of Malta. The level of consumption of the UK in relation to the rest of the EU is about average.[36]

Figure 4: Alcohol Consumption in Europe, 2002



Source: Institute of Alcohol Studies, Alcohol in Europe: A Public Health Perspective (2006)

2.6. Alcohol Consumption and Alcohol Misuse in England

2.6.1. In England 90% of the population drinks alcohol.[37] Conflicting evidence exists about the specific consumption of alcohol, although there is agreement that women and children's consumption has risen. Patterns of drinking are also changing, with more alcohol being bought from off-licenses and drunk at home, sometimes prior to a night out at the pub or club.[38]

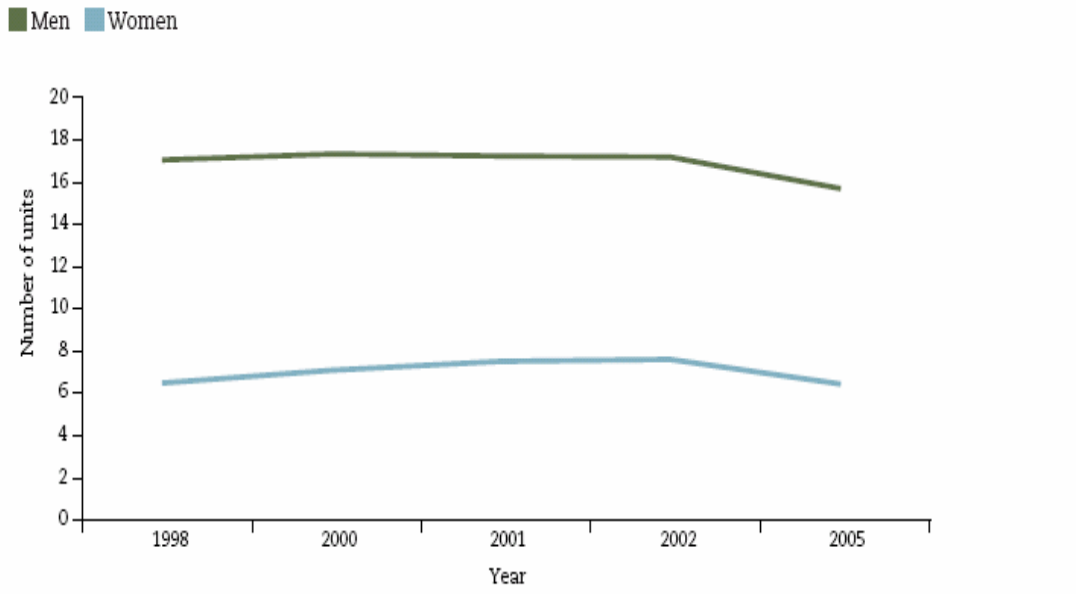
2.6.2. Evidence from Her Majesty Revenue and Customs (HMRC) data suggests that on average adults purchased the equivalent of 11.3 litres of pure alcohol per year. These figures are almost double the estimated values suggested by the General Household Survey (GHS) reported by the Office for National Statistics (ONS), indicating that the average adult drank 10.8 units of alcohol weekly in 2005 (5.6 litres of pure alcohol).[39]

[36] Ibid
[37] Department of Health (2007) Safe. Sensible. Social. The Next Step in the National Alcohol Strategy, London.
[38] Ibid
[39] Ibid

2.6.3. While ONS data suggests that consumption trends stabilised after 1980, HMRC excise data indicates a rise by 24% on "duty paid" clearances between 1995 and 2004 and a fall of 2% in 2005.

2.6.4. Based on self-reported data collected by the GHS, the majority of people aged 16 and over in the UK drinks at least once a week (64%). The proportion is higher for men (72%) than for women (57%). In 2005 the UK average weekly consumption of men reached about 15 units, while that of women was about 7 units.[40]

Figure 5: Average Weekly Alcohol Units by Gender



Note: Adult consumption, based on self-reported GHS data. Based on the self-reported data, the majority of people aged 16 and over in the UK drink at least once a week (64%). This figure is higher among men (72%) than women (57%).
Source: GHS 2005; ONS 2006.

Source: Department of Health (2007) Safe. Sensible. Social. The Next Step In the National Alcohol Strategy.

2.6.5. In the 1990s the average weekly consumption reported by young people aged 11-15 **doubled**, from an average of 5 units a week in 1990 to 10 units a week in 2000. Since 2001, the proportion of young people aged 11-15 who reported drinking has declined, from 46% to 38%.[41] However, those who are drinking are consuming more alcohol and more often.

2.6.6. While consumption levels of older adolescents have remained stable, those of younger people have steadily increased. In 2006, 11-13 year old boys who drank consumed on average 11.9 units per week, 6.4 more weekly units than in 2001. The 2006 amount exceeds the average weekly

[40] Ibid
[41] Ibid

amount drunk by adults. Young 11-13 girls drank 8.4 units a week in 2006, up 2.7 units since 2001.[42]

2.7. National Policies

2.7.1. Below are outlined some of the most central national drivers designed to tackle alcohol misuse and its consequences in England.

2.7.2. **The Crime and Disorder Act 1998 (as amended by the Police Reform Act 2002):** Primary Care Trusts (PCTs) became "responsible authorities". This power means that now they have the statutory responsibility to work in partnership with other responsible authorities, such as the police, fire, local authorities and bodies whose function is to tackle crime and anti-social behaviour.[43]

2.7.3. **The Licensing Act 2003:** In 2003 the Government announced a series of reforms to the licensing laws, which became operational in 2005. These reforms intended to provide:

- Flexible opening hours.
- Changes in the identity and accountability of the licensing authority.
- Strengthened protection for children and young people under the age of 18 from harm.
- The prevention of public nuisance.[44] [45]

2.7.4. **The Alcohol Harm Reduction Strategy for England (2004):** The Alcohol Harm Reduction Strategy for England is the most important policy devised by Government on alcohol and violence. The strategy includes a series of cross-agency measures aiming to:

- Tackle alcohol-related disorder and anti-social behaviour in town and city centres.
- Improve the health and treatment of people with alcohol-related problems.
- Promote social responsibility from the alcohol industry and retail sector.
- Improve alcohol education.[46]

2.7.5. **Choosing Health: Making Healthy Choices Easier (2004):** Choosing Health strengthened the role of Local Area Agreements (LAAs)

[42] Ibid
[43] Department of Health (2005) Alcohol Misuse Interventions, London.
[44] Ibid.
[45] Department of Health (2006) Alcohol, Health and Wider Social Impact, London.
[46] Ibid

and of Local Strategic Partnerships (LSPs) in an effort to encourage partnership work and delivery at local level. It builds on the measures set out by the Alcohol Harm Reduction Strategy and reinforces them by introducing:

- A national campaign designed to tackle the problem of binge drinking.
- A social responsibility scheme.
- Training for professionals.
- Pilot schemes on screening and brief interventions in primary and secondary health settings**.**
- Pilot schemes in criminal justice settings.
- Improvement of treatment services.[47]

2.7.6. **The Alcohol Needs Assessment Project (ANARP) (2005)** provided the first detailed picture of the level of need for alcohol services in the country. The project found that there is a high level of need in England, with about 38% of men and 16% of women aged 16-64 suffering from an alcohol misuse disorder (this equals to approximately 8.2m people). The assessment also reported that only about 63,000 people gain access to treatment every year, that is 1 out of 18 of the alcohol dependent population.[48]

2.7.7. **The Alcohol Misuse Intervention report (2005)** builds on ANARP and provides both compelling economic arguments for dealing with alcohol misuse and guidance for implementing additional interventions.[49]

2.7.8. **Safe. Sensible. Social. The Next Steps in the National Alcohol Strategy (2007)** reviews the progress since the Alcohol Harm Reduction Strategy for England and identifies further national and local action to achieve long-term reductions in alcohol-related ill health and crime. The next steps include:

- Sharpened criminal justice for drunken behaviour and intervention that will include conditional caution measures. Offenders will be offered advice and will be given information about the consequences of alcohol misuse.

- A review of the National Health Service (NHS) spending, that will inform more efficient investments in alcohol misuse prevention and treatment.

- More support for young alcohol misusers, including telephone helplines, interactive websites and support groups.

- Tougher enforcement of penalties to discourage underage sales of alcohol. This builds on the additional powers that local authorities and the police have been granted to prosecute and even close offending premises.

[47] Department of Health (2005) Alcohol Misuse Interventions, London.
[48] Department of Health (2006) Alcohol, Health and Wider Social Impact, London.
[49] Ibid.

- Guidance for parents and young people to help them make informed decisions about drinking.

- Publicity campaigns promoting sensible drinking.

- A public consultation to establish beyond doubt whether pricing and promotion encourage people to drink more.

- Local alcohol strategies. By April 2008 all Crime and Disorder Reduction Partnerships (CDRPs) - including members such as the police, local authorities, fire and rescue authorities and PCTs - will be legally required to have a strategy to tackle, amongst other aspects, alcohol-related disorder and misuse.[50]

2.8. Alcohol Misuse and Public Health

2.8.1. The main focus of the Select Committee's work is on the impact of alcohol misuse on public health. As mentioned above, alcohol plays an important role in social life, and it is often central to rituals marking key events such as births, weddings and deaths. Throughout history and across cultures alcohol is a common means to enjoy company and have fun.[51]

2.8.2. Cultural beliefs strongly influence the benefits – real and not – of alcohol. Sometimes these beliefs are so strong that people become visibly more sociable when they believe they have consumed alcohol when in fact they have not.[52]

2.8.3. Nonetheless, it appears that the consumption of alcohol in moderation can bring about various health benefits.

2.8.4. In terms of social well being, general population studies have found that alcohol consumption can lead to positive sensations and improved subjective health.[53]

2.8.5. In terms of neuropsychiatric conditions, light alcohol use can reduce the risk of vascular-caused dementia.[54]

2.8.6. Alcohol seems also to be beneficial against gastrointestinal, endocrine and metabolic conditions. For example, some evidence suggests that alcohol may reduce the risk of gallstones and, if consumed in low doses, of Type II diabetes.[55]

[50] Department of Health (2007) Safe. Sensible. Social. The Next Step in the National Alcohol Strategy, London.
[51] Anderson, P. and Baumberg, B. (2006) Alcohol in Europe: A Public Health Perspective, Institute of Alcohol Studies, London.
[52] Darkes, j. AND Goldman, M.S. (1993) Expectancy Challenge and Drinking Reduction: Experimental Evidence for a Mediational Process, Journal of Consulting and Clinical Psychology, 61,344-353.
[53] Anderson, P. and Baumberg, B. (2006) Alcohol in Europe: A Public Health Perspective, Institute of Alcohol Studies, London.
[54] Ibid
[55] Ibid

2.8.7. A positive relationship between alcohol consumption and a reduced harm from cardiovascular diseases also exists. For instance, low doses of alcohol consumption can decrease the risk of ischaemic stroke. In addition, one meta-analysis has estimated a 20% decreased risk of coronary heart disease (CHD).[56]

2.8.8. Some evidence also indicates that women who consume alcohol tend to have a higher bone mass than those who abstain.[57]

2.8.9. Finally, it appears that in older people small quantities of alcohol can reduce the risk of dying compared to those who do not drink.[58]

2.8.10. However, the impact of alcohol on well-being can also bring about a wide variety of negative consequences, which seem to exceed these benefits. These consequences are far-reaching, given that in England 38% of men and 16% of women aged 16-64 years have an alcohol use disorder, amounting to approximately 8.2 million people.[59]

2.8.11. In terms of **social well being**, the greater the amount of alcohol consumed, the greater the risk of harming social spheres such as home life, marriage, work, studies and friendships.[60] An investigation conducted by the National Society for the Prevention of Cruelty to Children (NSPCC) on their helpline calls, for instance, found that parental alcohol misuse is a factor in 23% of child neglect calls, 13% of calls about emotional abuse, 19% of calls about physical abuse and 5% of calls about sexual abuse.[61]

2.8.12. Also, alcohol misuse is related to **lower levels of productivity** and reduced employment. A census of alcohol services, for instance, reported that out of 10,000 people receiving help each day for their drinking problems, 36% were unemployed.[62]

2.8.13. Alcohol misuse can also result in intentional and unintentional **injuries**. A correlation exists between heavy consumption and the level of violence; the higher the intake of alcohol, the more severe the violence. For example, about half (46%) of incidents of domestic violence are thought to be associated to alcohol misuse.[63] A proportional relationship can also be found between alcohol consumed, the frequency of this consumption, and drink driving. **Drink driving** is still responsible for 7% of all accidents and for 17% of all deaths in road accidents in the country.[64]

---

[56] Ibid
[57] Ibid
[58] Ibid
[59] Department of Health (2005) Alcohol Needs Assessment Research Project (ANARP), London.
[60] Anderson, P. and Baumberg, B. (2006) Alcohol in Europe: A Public Health Perspective, Institute of Alcohol Studies, London.
[61] Department of Health (2005) Alcohol Misuse Interventions, London.
[62] Ibid
[63] Department of Health (2007) Safe. Sensible. Social. The Next Step in the National Alcohol Strategy, London.
[64] Department of Health (2005) Alcohol Misuse Interventions, London.

2.8.14. About 35% of all **A&E attendances** and ambulance calls in the UK are alcohol related. This figure peaks to 70% between midnight and 5 in the morning. In addition, 150,000 hospital admissions each year are alcohol-related, of which about 33,000 are due to liver diseases, and between 30,000 and 36,000 are people diagnosed with dependency problems.[65]

2.8.15. A direct correlation also exists between the quantity of alcohol drunk and **suicide**. For instance, between 15% and 25% of suicides, and 65% of suicide attempts in England, are related to problem drinking.[66]

2.8.16. In terms of **neuropsychiatric disorders**, a link can be found between alcohol misuse and anxiety and sleep disorders, depression, alcohol dependence, nerve damage, brain damage and cognitive impairment. For instance, over one in eight people with an anxiety disorder also misuses alcohol. In addition, the risk of alcohol dependence increases with the volume of alcohol consumed and with drinking large amounts in one session.[67]

2.8.17. Excessive alcohol consumption increases the risk of **gastrointestinal, metabolic and endocrine conditions** such as **liver cirrhosis**, pancreatitis, Type II diabetes, and gout.[68] About 4,500 deaths in England and Wales every year are associated with alcohol-related liver diseases – 90% more than the last decade.[69]

2.8.18. Nearly 5,000 **cancer deaths** every year in the UK are attributable to alcohol. The types of cancer that are more likely to be linked to alcohol are those of the mouth, larynx, oesophagus, liver and breast.[70]

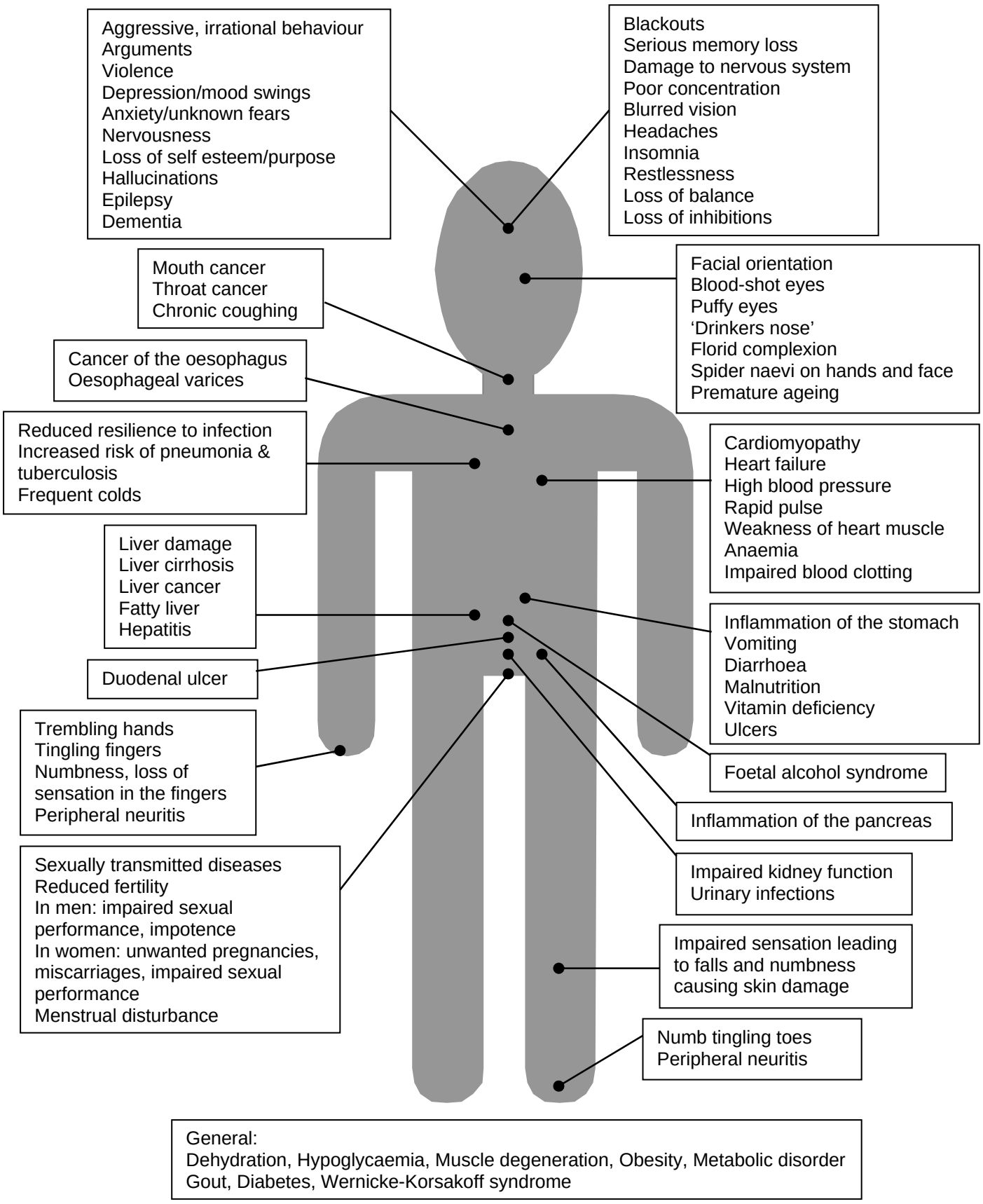
2.8.19. Heavy drinking can lead to a higher risk of **cardiovascular diseases** such as strokes, hypertension and irregularities in heart rhythms. For example, every year in the country 1,200 deaths due to stroke are associated to alcohol, together with 10% of deaths caused by alcohol-related hypertension.[71]

2.8.20. Finally, research shows that alcohol misuse can negatively affect pregnancies and can result in **unsafe sex and unintended teenage pregnancy**. 10% of children of alcohol-dependent mothers suffer from **foetal alcohol effects**.[72] Also, evidence shows that after consuming alcohol, one in seven 16-24 year olds have had unsafe sex, one in five have had sex they later regretted, one in ten have been unable to remember whether they had sex the night before, and 40% think they are more likely to have casual sex.[73]

---

[65] Ibid
[66] Ibid
[67] Anderson, P. and Baumberg, B. (2006) Alcohol in Europe: A Public Health Perspective, Institute of Alcohol Studies, London.
[68] Ibid
[69] Ibid
[70] Ibid
[71] Department of Health (2005) Alcohol Misuse Interventions, London.
[72] Ibid
[73] Social Exclusion Unit (1999) What's It All About, London.

Figure 6: Alcohol-Related Health Problems



Source: Alcohol Concern, Health Impacts of Alcohol, 2002

2.9. The Cost of Alcohol Misuse

2.9.1. Together with the direct impact of alcohol on public health, several monetary costs can be attributed to excessive alcohol consumption.

2.9.2. Alcohol consumption is certainly beneficial for the country's economy; the value of the alcoholic drinks market reaches more than £30 billion per annum and about 1 million jobs are estimated to be linked to it.[74] However, the consequences of alcohol abuse to health, crime and disorder, and loss of productivity at work, are costly.

2.9.3. According to the Alcohol Harm Reduction Strategy for England (2004), alcohol misuse in England costs approximately £20 billion a year.[75] The total healthcare annual cost alone related to alcohol amounts to £1.7 billion. Alcoholics and their families are heavier users of health care services than non-misusers of the same age and gender.[76] Specialist alcohol treatment expenditure is estimated to be about £217million.[77]

2.9.4. The cost of unemployment resulting from alcohol misuse is estimated to reach £1.9 billion per year.[78] In addition, overall lost productivity in England as a result of excessive consumption of alcohol amounts to £6.4 billion a year.[79]

2.9.5. Alcohol-related crime and disorder are thought to cost up to £7.3 billion a year.[80]

2.9.6. Conversely, and in addition to general social benefits, treatment of alcohol misuse can also result in monetary savings. For example, according to a recent study conducted by UKATT, for every £1 spent on treatment, the public sector saves £5.[81]

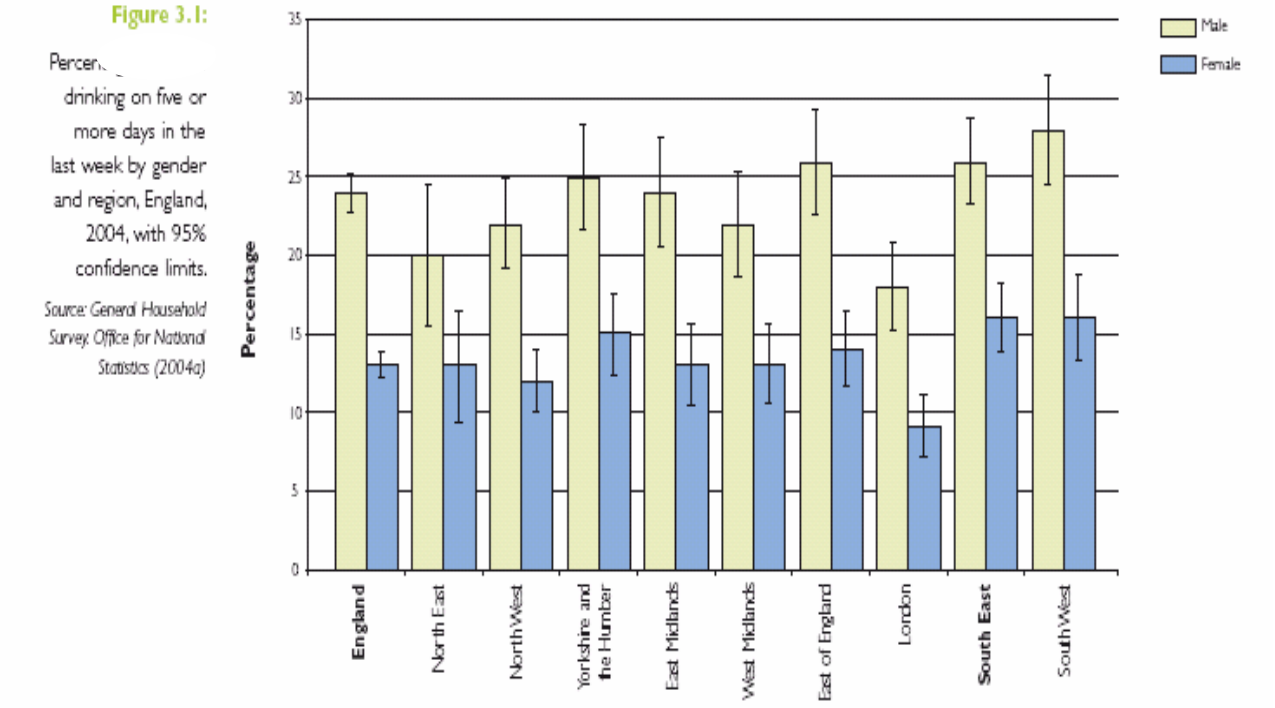
2.10. Alcohol Misuse in Kent and in the South East Region

2.10.1. It appears that concerning drinking patterns and alcohol-related consequences are emerging in Kent and in the South East, especially among women and young people.

[74] Prime Minister's Strategy Unit (2004) Alcohol Harm Reduction Strategy for England, London.
[75] Ibid
[76] Babor, T. et al (2003) Alcohol: No Ordinary Commodity, OUP, Oxford.
[77] Department of Health (2005) Alcohol Needs Assessment Research Project (ANARP), London.
[78] Department of Health (2007) Safe. Sensible. Social. The Next Step in the National Alcohol Strategy, London.
[79] Department of Health (2006) Alcohol, Health and Wider Social Impact, London.
[80] Ibid
[81] Department of Health/National Treatment Agency (2006) Models of Care for Alcohol Misusers (MoCAM), London.

2.10.2. The proportion of men (26%) and women (16%) in the South East who report drinking on five or more days in the last week is higher than in most other regions in England and is significantly higher than in London.[82]

Figure 7: Percentage of Adults Drinking 5 or More Days in the Last Week by Gender and Region, England, 2004.



Source: General Household Survey: Office for National Statistics (2004)

2.10.3. The average alcohol consumption by men in the South East has remained generally stable in the last decade, and in Kent these levels appear to be lower – but not significantly lower - than in other neighbouring sub-regions, such as Surrey and Sussex.[83]

2.10.4. However, it appears that the levels of consumption of women both in England and in the South East are steadily increasing. Also, the proportion of adults in the South East binge drinking at least one day a week has reached about 20% for men and about 9% for women. Although these rates are lower than those of other regions, they are higher than those of London and of the East of England.[84]

2.10.5. The number of both alcohol-specific and alcohol-related hospital admissions in both men and women in several Kent districts appears to be higher than both the average in the South East and in England (please refer also to Appendix 3).

2.10.6. In terms of alcohol-specific admissions – that is conditions in which alcohol is causally implicated in *all* cases – in 2004-5 the male hospital

[82] Sheehan, D. (2007) Choosing Health in the South East: Alcohol, South East Public Health Observatory (SEPHO).
[83] Sheehan, D. (2007) Choosing Health in the South East: Alcohol, South East Public Health Observatory (SEPHO).
[84] Ibid

admission rate for 100,000 persons was 234.78 for the South East and 305.81 for England. While in only one district (Thanet) the rate was higher than the English average, in seven districts (Canterbury, Dartford, Dover, Gravesham, Shepway, Swale and Thanet) it was higher than the South East average.[85]

2.10.7. Similarly, while the average rates for females in the South East and in England were 124.26 and 144.62 respectively, those in two districts (Shepway and Thanet) exceeded the national average, and those in seven districts (Ashford, Canterbury, Dartford, Dover, Shepway, Swale and Thanet) exceeded the South East average.[86]

2.10.8. The alcohol-specific admission rates for young people in Kent appear to be relatively higher than the adult counterpart. In 2004-5 the rate of under 18 male hospital admissions for alcohol-specific conditions was higher in five Kent districts (Ashford, Canterbury, Dartford, Shepway and Thanet) than in the England average (48.97 for 100,000 persons), and higher in six districts (Ashford, Canterbury, Dartford, Shepway, Swale and Thanet) than in the South East (46.44 for 100,000 persons). The rates for under 18 girls were higher in five districts (Ashford, Canterbury, Dartford, Shepway and Thanet) than in both England (58.51 per 100,000 persons) and the South East (58.14 per 100,000 persons). [87]

2.10.9. According to NHS figures, the actual overall number of alcohol-specific hospital admissions in the KCC administrative area has almost doubled from 885 admissions in 1997-8 to 1,454 in 2006-7.[88]

2.10.10. In terms of alcohol-related admissions – that is all those conditions where alcohol was a factor contributing to the admission – a similar picture emerges. The male hospital admission rate was higher in two districts (Shepway and Thanet) than the England average (826.07 per 100,000 persons), and it was higher in eight districts (Ashford, Canterbury, Dartford, Dover, Gravesham, Shepway, Swale and Thanet) than in the South East average (678.32 per 100,000 persons).[89]

2.10.11. The rate for females was higher in two districts (Shepway and Thanet) than in the English average (461.51), and it was higher in seven districts (Ashford, Canterbury, Dartford, Dover, Shepway, Swale and Thanet) than in the South East average (401.38 per 100,000 persons).[90]

2.10.12. The number of adults in Kent undergoing treatment for alcohol misuse more than doubled from the period 2005-6 to 2006-7. Similarly, the number of young people in treatment increased from 115 in 2005-6 to 271 in 2006-7.[91]

[85] NWPHO (2006) Local Alcohol Profiles for England, www.nwph.net/alcohol/lape.
[86] Ibid
[87] Ibid
[88] NHS Wide Clearing Service (2207) Alcohol Specific Hospital Admissions for Local Authorities in Kent, 1997/8 – 2006/7.
[89] Ibid
[90] Ibid
[91] Kent County Council (2007) Alcohol Misuse Select Committee, 14 June 2007, Maidstone.

Figure 8: Adults in Treatment in Kent, Alcohol, 2005/6 – 2006/7

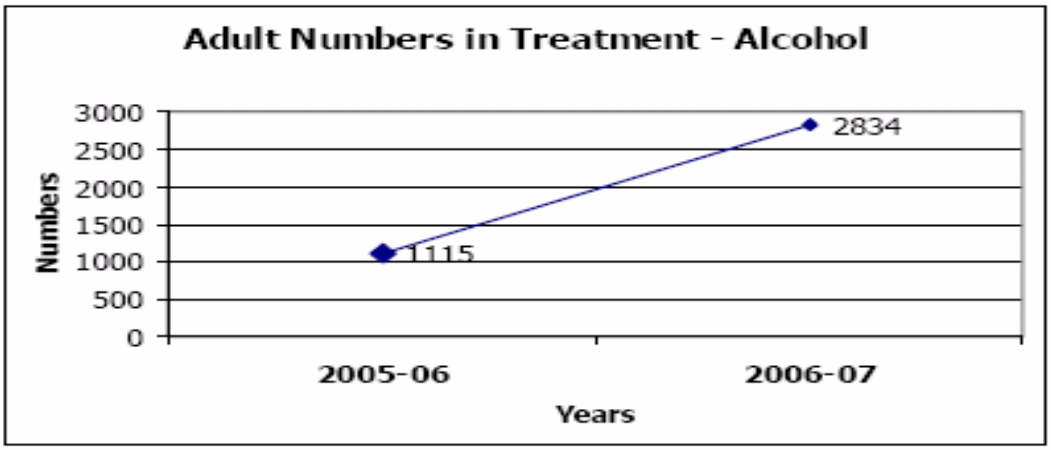
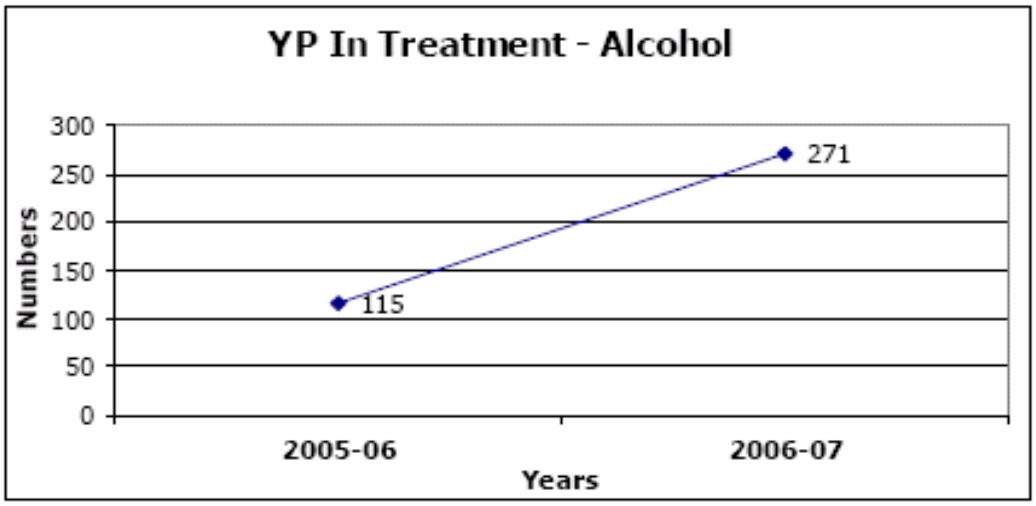


Figure 9: Young People in Treatment in Kent, Alcohol, 2005/6 – 2006/7



Source: KDAAT, Kent County Council.
Data: Business Information Unit Force Headquarters, Kent Police May 2007 for April 2006 –March 2007
KDAAT Provider Data April 2005-March 2006, April 2006–March 2007

2.10.13. In terms of the impact of alcohol misuse on the economy of the South East region, in 2005 about 4,400 people diagnosed with alcoholism claimed incapacity benefits or severe disablement allowances; this figure is substantially above the national average and is the fourth highest of the nine regions in England.[92]

2.10.14. The level of alcohol-related crime and violent crime in both Kent and the South East is lower than that in England as a whole.[93] However, the level of crime attributable to alcohol is higher in three Kent districts (Dartford, Gravesham and Thanet) than in the England average (10.45 per 1,000 persons), and higher in four districts (Dartford, Gravesham,

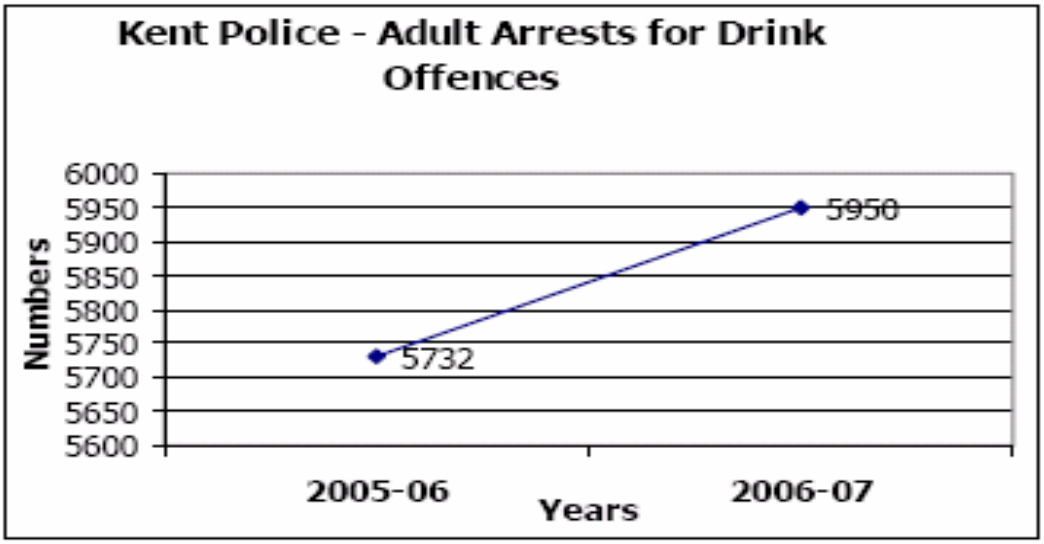
[92] Sheehan, D. (2007) Choosing Health in the South East: Alcohol, South East Public Health Observatory (SEPHO).
[93] Ibid

Swale and Thanet) than in the South East average (8.77 per 1,000 persons).[94]

2.10.15. Also, the level of alcohol-related violent crime is higher in three districts (Dartford, Gravesham and Thanet) than in the English average (7.33 per 1,000 persons), and is higher in five districts (Dartford, Gravesham, Shepway, Swale and Thanet) than in the South East average (6.42 per 1,000 persons).[95] The rate of sexual offences attributable to alcohol is the same or higher in seven districts (Ashford, Dartford, Gravesham, Maidstone, Shepway, Swale and Thanet) than in both the national and regional average (both 0.15 per 1,000 persons).[96]

2.10.16. The number of adult arrests in Kent for drink offences increased from 5,732 in 2005-6 to 5,950 in 2006-7. The number of young people arrests in Kent has also substantially increased, from 278 in 2005-2006 to 403 in 2006-7.[97]

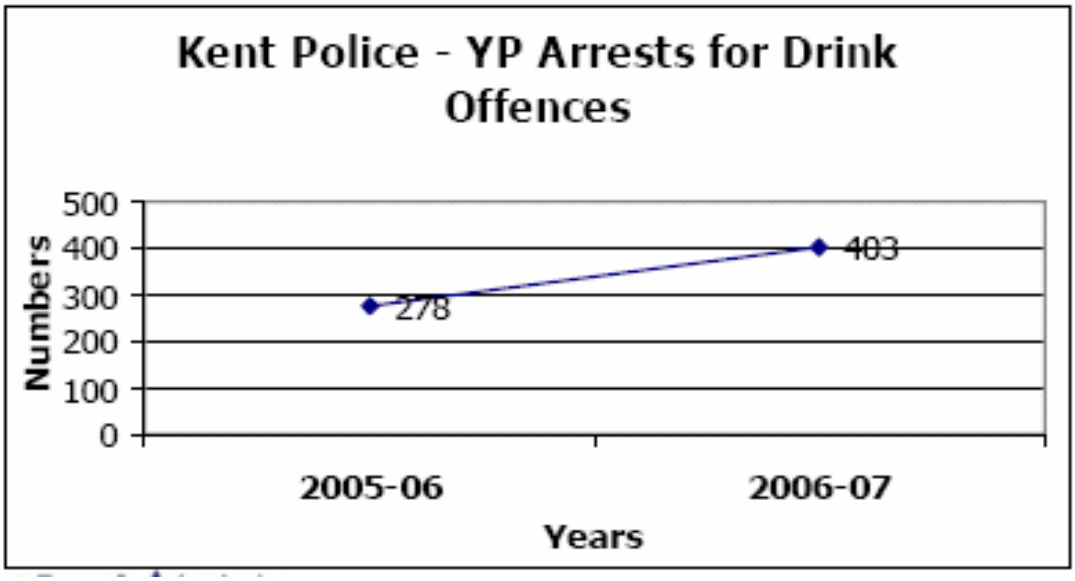
Figure 10: Adult Arrests for Drink Offences in Kent, 2005/6 – 2006/7.



Source: KDAAT, Kent County Council.

[94] NWPHO (2006) Local Alcohol Profiles for England, www.nwph.net/alcohol/lape.
[95] Ibid
[96] Ibid
[97] Kent County Council (2007) Alcohol Misuse Select Committee, 14 June 2007, Maidstone.

Figure 11: Young People Arrests for Drink Offences in Kent, 2005/6-2006/7.



Source: KDAAT, Kent County Council.

2.10.17. Finally, the number of alcohol-related deaths reported by KDAAT providers has considerably increased, from 2 in 2005-6 to 16 in 2006-7.[98]

2.11. KCC Targets and Objectives

2.11.1. In order to reinforce Government's commitments to tackle alcohol misuse and its adverse consequences, Kent County Council has developed its own initiatives, policies, objectives and targets.

2.11.2. In addition to the provision of alcohol-related services, which will be discussed later in the report, several initiatives and objectives are already in place in Kent. A selection of them is included below.

2.11.3. **Towards 2010** is a four-year strategy launched in 2006 whose objective is to reach wide goals through specific action plans. Target 50 of Towards 2010 includes the introduction of a hard-hitting public health campaign targeted at young people in order to increase their awareness about – amongst other things – the effects of alcohol misuse.[99]

2.11.4. This wide-ranging target also aims at reducing the damaging consequences of drugs misuse and of early or unprotected sex.[100] Its holistic approach to tackling all these aspects as part of the same package seems crucial because of the links between them. For example, according to the Models of Care for Alcohol Misusers (MoCAM) report, a quarter to one third of drugs misusers also misuses alcohol.[101] Also, the

[98] Ibid
[99] Kent County Council (2007) Towards 2010: Kent, Your County, Your Future, Our Promises to You, Maidstone.
[100] Ibid
[101] Department of Health/National Treatment Agency (2006) Models of Care for Alcohol Misusers (MoCAM), London.

influence of alcohol appears to be strongly correlated with a more limited use of contraception and with high levels of regret for having gone further sexually than intended.[102] [103]

2.11.5. Local Area Agreements (LAAs) are important mechanisms that bring health outcomes to the forefront of local community planning. They comprise a list of targets negotiated between Central Government and local authorities which local authorities have to meet.[104] From 2008 the role of LAAs, as set out in the White Paper Strong and Prosperous Communities (2006), will be strengthened, as LAAs will become the only mechanism where Government agrees targets with local authorities, and targets will be based on locally owned priorities rather than on national targets.[105]

2.11.6. The **Kent Local Area Agreement (LAA)** already includes targets and objectives aimed at dealing with alcohol-related problems. For example, it endeavours to reduce alcohol abuse (Outcome 16), to reduce the overall level of crime (Outcome 10), and to increase the proportion of people who believe Kent is a Safer County (Outcome 9).[106]

2.11.7. One of the main strands of the **KCC Supporting Independence Programme (SIP)**, which is linked to both the LAA and the Second Local Public Service Agreement (LPSA2), is dedicated to helping people with alcohol or substance addiction to move out of dependency and achieve greater independence.[107] In addition, the Programme has recently commissioned an independent researcher to explore the extent and effectiveness of alcohol-related services in Kent. The researcher will then produce a report, which is predicted to be completed by the end of 2007. The recommendations of the report will be presented to the Kent Drug and Alcohol Action Board, to the Alcohol Misuse Select Committee and to KCC Communities Directorate. [108]

2.11.8. The **Kent Healthy Schools Programme** promotes the health and well being of children and young people through a well planned school curriculum that encourages learning and healthy lifestyles choices. In order to gain healthy school status schools have to demonstrate, amongst other objectives, that they are delivering effective **PSHE**; alcohol education is one of the subjects of the PSHE programme (please see also Section 7.2 on PSHE).[109]

---

[102] Redgrave, K. and Limmer, M. (2005) It Makes You More Up for It. School Aged Young People's Perspectives on Alcohol and Sexual Health. Rochdale.
[103] Hosie, A. and Dawson, N. (2005) The Education of Pregnant Young Women and Young Mothers in England, University of Newcastle and University f Bristol, Bristol.
[104] Department of Health/National Treatment Agency (2006) Models of Care for Alcohol Misusers (MoCAM), London.
[105] Department of Health (2007) Safe. Sensible. Social. The Next Step in the National Alcohol Strategy, London.
[106] Kent County Council (2005) The Kent Local Area Agreement April 2005 – March 2008, Maidstone.
[107] Kent County Council (2006) Kent County Council Supporting Independence Programme. Report and Analysis 2, Maidstone.
[108] Kent County Council (2007) Alcohol Misuse Select Committee, 27 June 2007, Maidstone.
[109] Department for Education and Skills and Department of Health (2005) National healthy Schools Status: A Guide for Schools, London.

2.11.9. Finally, the aim of the Alcohol Misuse Select Committee review itself is to identify areas that may need improvement in an effort to reduce the negative impact of alcohol misuse.

2.12. A Multi-Agency Approach to Alcohol Misuse

2.12.1. Overwhelming evidence from both witnesses of Alcohol Misuse Select Committee hearings and general literature suggests that the most effective way to achieve all these aims and objective is by conducting an increasingly coordinated and concerted effort.[110] [111] [112] [113] [114] [115]

2.12.2. Several forms of multi-component collaboration aimed at dealing with alcohol misuse in Kent already exist. For example, Crime and Disorder Reduction Partnerships (CDRPs) including members from the police, local authorities, the probation service, health authorities, the voluntary sector are already working to deal with – amongst other aspects – alcohol-related crime and anti-social behaviour.[116]

2.12.3. Nonetheless, having analysed the evidence, Members of the Committee are convinced that more can be done to tackle alcohol misuse and its negative impact on diverse spheres of social life in Kent. The recommendations that will follow in this report reflect both the need for developing and expanding the work already performed by various partners and agencies in Kent, and the conviction that a holistic approach is necessary to tackle alcohol misuse in the County.

[110] Department of Health (2007) Safe. Sensible. Social. The Next Step in the National Alcohol Strategy, London.
[111] Department of Health/National Treatment Agency (2006) Models of Care for Alcohol Misusers (MoCAM), London.
[112] Vass, G. (2007) Dossier on Alcohol Harm from a European Perspective, European Institute of Social Services, University of Kent.
[113] Kent County Council (2007) Alcohol Misuse Select Committee, 28 June 2007, Maidstone.
[114] Kent County Council (2007) Alcohol Misuse Select Committee, 10 July 2007, Maidstone.
[115] Kent County Council (2007) Alcohol Misuse Select Committee, 10 September 2007, Maidstone.
[116] Kent County Council (2007) Alcohol Misuse Select Committee, 28 June 2007, Maidstone.

3. Needs Assessment and Overall Strategy

3.1. Coordination, Commissioning and Provision of Alcohol Services in Kent

3.1.1. As part of NHS provision, both commissioning of alcohol intervention and treatment are the general responsibility of local Primary Care Trusts (PCTs).[117]

3.1.2. In order to reflect a more devolved system of planning and performance for health and social care indicated in *National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/6 – 2007/8*, PCTs can determine local targets in response to local need without prescriptive guidance from the Department of Health (DH) or strategic health authorities (SHAs).[118]

3.1.3. This system sets out a series of principles PCTs should follow to ensure that their plans:

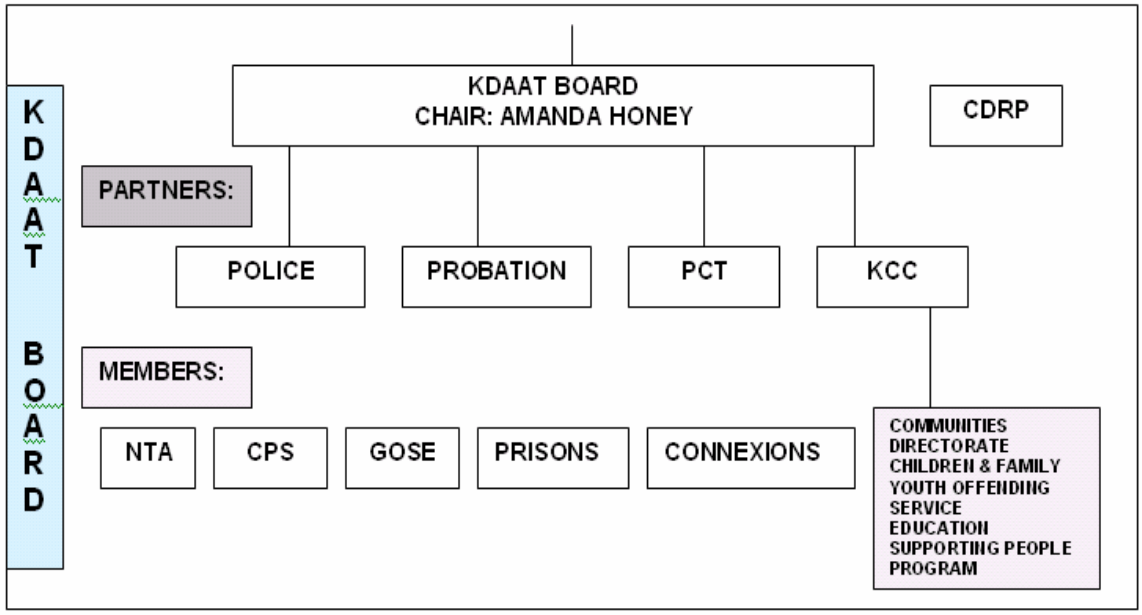
- Are in line with population needs.
- Address local service gaps.
- Deliver equity.
- Are evidence-based.
- Are developed in partnership with other NHS agencies, local authorities and other partners.
- Offer value for money.[119]

3.1.4. In Kent, the Kent Drug and Alcohol Action Team (KDAAT), set up in 1995, is the agency responsible for the specific management and commissioning of alcohol and drug-related treatment services across the County.[120]

3.1.5. This multi-agency team has the responsibility to report to a partnership board comprising senior officers representing all the local agencies concerned with alcohol and drug misuse. These agencies include Kent County Council, the police, the probation service, local NHS services and voluntary groups (see Figure 12 below). The statutory "observers" of KDAAT are the Government Office for the South East (GOSE) and the National Treatment Agency (NTA). [121]

[117] Department of Health/National Treatment Agency (2006) Models of Care for Alcohol Misusers (MoCAM), London.
[118] Ibid
[119] Ibid
[120] Kent County Council (2007) Alcohol Misuse Select Committee, 14 June 2007, Maidstone.
[121] Ibid

Figure 12: KDAAT Board Structure



Source: KDAAT, Kent County Council.

3.1.6. KDAAT includes two joint commissioning bodies; one for adult services and one for young persons. A four-tiered framework of provision helps organising the commissioning and provision of alcohol interventions. Although the structure of this framework is not rigid, it is generally organised as follows:

- **Tier 1:** alcohol-related information and advice; screening; simple brief interventions; referral. Tier 1 interventions include alcohol education at school, information on sensible drinking, simple brief interventions to reduce alcohol-related harm and referral of those with alcohol dependence for more intensive interventions.

- **Tier 2:** Tier 2 interventions include the provision of open access facilities and outreach providing, for example, alcohol-specific advice, information and support; extended brief interventions to help misusers reduce their alcohol consumption; assessment and referral of those with more serious alcohol-related problems.

- **Tier 3:** Tier 3 interventions include the provision of community-based specialised alcohol misuse assessment, and coordinated and care-planned alcohol treatments.

- **Tier 4:** Tier 4 interventions comprise provision of residential, specialised alcohol treatments which are care-planned and coordinated to ensure continuity of care and aftercare.[122] [123]

[122] Department of Health/National Treatment Agency (2006) Models of Care for Alcohol Misusers (MoCAM), London.
[123] Kent County Council (2007) Alcohol Misuse Select Committee, 14 June 2007, Maidstone.

3.1.7. The provision of the services commissioned by KDAAT is supplied by a variety of organisations – including voluntary and charity organisations - across the whole of Kent, including: The KCA (formerly known as the Kent Council on Addiction), Turning Point, The Kenward Trust, The East Kent Community Alcohol Service, The Pilsdon Community at West Malling, Connexions, Cyrenians and Emmaus. Below more details are provided on some of these organisations, whose representatives provided evidence to the Select Committee.

- The **East Kent Community Alcohol Service (EKCAS)**, with its headquarters at Mount Zeehan in Canterbury, is part of the Kent and Medway NHS and Social Care Partnership Trust. The mission of the Trust is "to provide a range of effective and high quality community based services to meet the agreed needs of local people".[124] [125]

- The **KCA** is a registered charity established in 1975. It employs over 200 people across Kent, Surrey and the London Boroughs of Greenwich, Bexley, Ealing and Bromley. The KCA's mission is to prevent or reduce the harms and costs arising from the misuse of alcohol and drugs, and to promote mental health and social inclusion. The KCA provides services at both Tier 2 and Tier 3, services for young persons, primary health care counselling and workforce training and development.[126] [127]

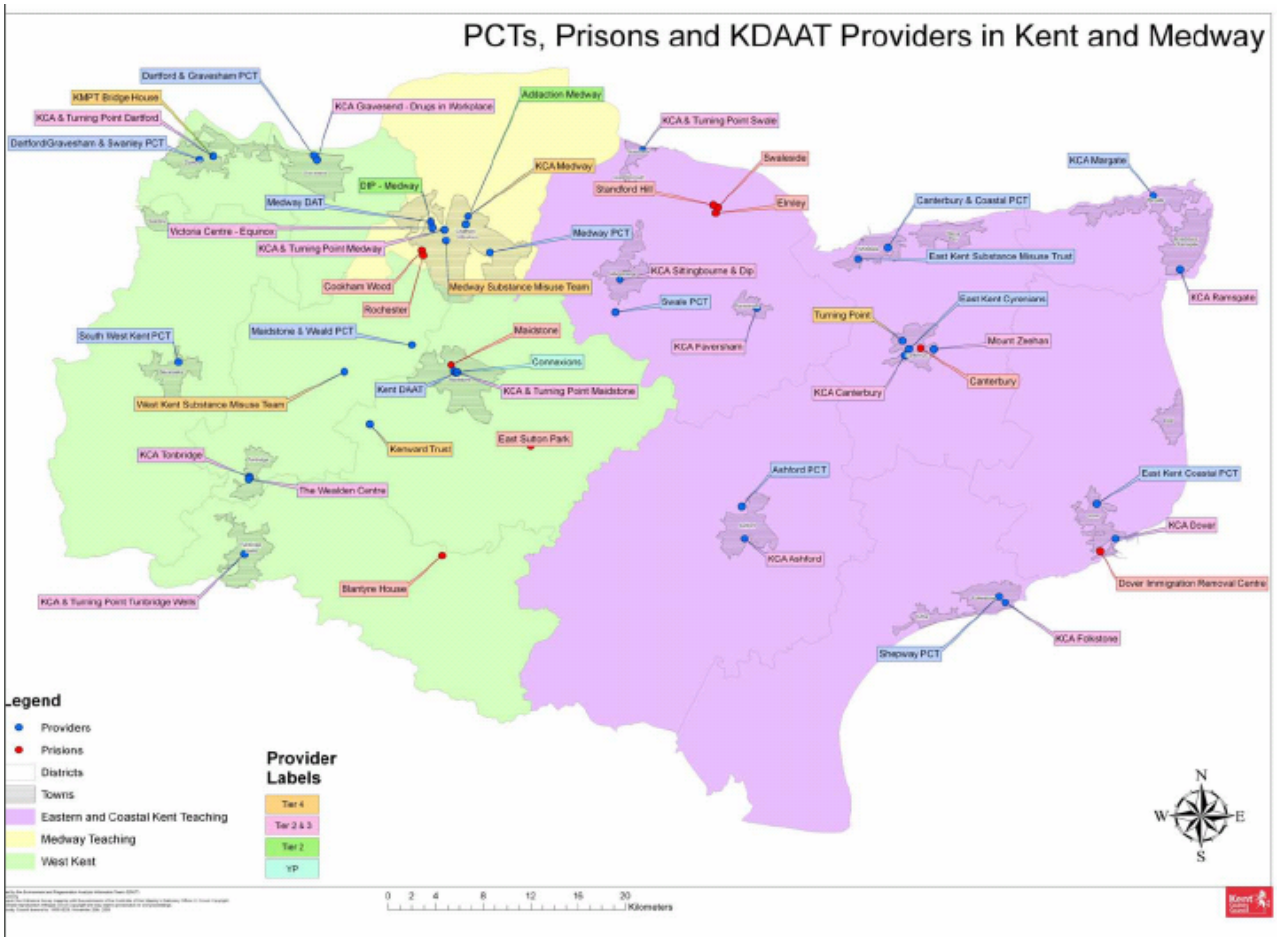
- The **Kenward Trust** is a registered Christian charity which, for nearly 40 years, has carried out a series of residential community and counselling services for the rehabilitation and long-term care of people with alcohol and drug misuse problems. The objective of the Kenward Trust is to enable clients to meet agreed goals to deal with their alcohol problems. The charity includes 10 residential rehabilitation centres in Kent and Sussex. Services provided include residential accommodation in a non-drink environment, individual and group counselling, aftercare by telephone, therapy programmes, assistance towards long-term accommodation and spiritual growth.[128] [129]

- The Pilsdon Communities are Christian charity organisations. The **Pilsdon Community at West Malling** moved into the former Ewell Monastery in 2004. The Community is a "dry house", in which the consumption of alcohol is forbidden to all its members. The aims of the charity are to offer shelter, hospitality and spiritual refreshment to all people in need.[130] [131]

[124] Kent and Medway NHS and Social Care Partnership Trust (2006) Eat Kent Community Alcohol Service: Information for Service Users.
[125] Kent County Council (2007) Alcohol Misuse Select Committee, 16 July 2007, Maidstone.
[126] Kent County Council (2007) Alcohol Misuse Select Committee, 10 July 2007, Maidstone.
[127] KCA website (2007) http://www.kca.org.uk/services.htm.
[128] Kenward Trust (2005) Policy and Induction Manual, Yalding,
[129] Kent County Council (2007) Alcohol Misuse Select Committee, 28 June 2007, Maidstone.
[130] Kent County Council (2007) Alcohol Misuse Select Committee, Visit to the Pilsdon Community at Malling, 20 July 2007.
[131] Pilsdon website (2007) http://www.westmalling.kentparishes.gov.uk/Pilsdon.

3.1.8. Figure 13 below illustrates the provision and location of alcohol services in Kent (for a larger picture see Appendix 3).

Figure 13: Provision of Alcohol Services in Kent



Source: KDAAT, Kent County Council.

3.2. Needs Assessment and Alcohol Strategy

3.2.1. Currently, developments aimed at producing an alcohol reduction strategy are being carried out in the two Primary Care Trust (PCT) areas in Kent: East and West Kent PCTs. However, although not required to do so, at the moment Kent lacks an overall alcohol strategy.[132] [133] An overall alcohol strategy can perhaps best underpin a systematic approach to help identify effective interventions and solutions to tackle alcohol misuse, coordinate a multi-agency system, and identify the responsibilities and accountability of all the agencies involved in the coordination, commissioning and delivery of alcohol services. Several authorities in England recognise the importance of an overall strategy, and 60% of Drug Action Teams (DATs) surveyed by ANARP reported having a strategy in place.[134]

[132] Department of Health (2005) Alcohol Needs Assessment Research Project (ANARP), London.
[133] Kent County Council (2007) Alcohol Misuse Select Committee, 27 June 2007, Maidstone.
[134] Department of Health (2005) Alcohol Needs Assessment Research Project (ANARP), London.

3.2.2. However, it appears that currently data that is necessary to inform the development of an alcohol strategy in Kent is limited; this, for example, makes it challenging to carry out comparison of project work to determine which initiatives are most effective in dealing with alcohol misuse in the County.[135]

3.2.3. Before developing a strategy the Committee urges that a needs assessment must be carried out. Several reasons can be presented.

3.2.4. According to the first ever national needs assessment concerning the levels of alcohol misuse in England – the Alcohol Needs Assessment Research Project (ANARP) – a "very large gap" exists between the provision of alcohol treatment and the demand for such treatment.[136]

3.2.5. The gap analysis estimated by ANARP shows that about 63,000 people access treatment per annum, providing a Prevalence Service Utilisation Ratio (PSUR) of 18. In other words, only one person in need of treatment out of 18 actually manages to receive treatment (5.6% of the in-need dependent population).[137]

3.2.6. ANARP estimated that in the South East region alone there are 184,000 dependent drinkers, of which 22,000 (about 12%) have been referred to treatment services and 9,000 (about 5%) have been assessed by treatment services. This data suggests that in the region only 1 person out of 20 in need receives alcohol services.[138]

3.2.7. Data gathering on children, elderly people and dependant people who are particularly vulnerable is especially important. Alcohol addiction is a "family illness", as the family organises its life around the misuser.[139] Almost 1 million children in the UK currently live in households with parents misusing alcohol.[140] [141]

3.2.8. Children whose parents suffer from alcoholism are six time more likely than children of non-misusers to experience verbal and physical aggression. Some are exposed to rage, violence and abuse on a daily basis.[142]

3.2.9. In Kent, it has been estimated that substance misuse (both for alcohol and drugs misuse) is a parental characteristic of over half the children (56.1%) on the child protection register.[143] Over 800 children are

[135] Kent County Council (2007) Alcohol Misuse Select Committee, 27 June 2007, Maidstone.
[136] Department of Health (2005) Alcohol Needs Assessment Research Project (ANARP), London.
[137] Ibid
[138] Sheehan, D. (2007) Choosing Health in the South East: Alcohol, South East Public Health Observatory (SEPHO).
[139] National Association of Children of Alcoholics (2007), http://www.nacoa.org.uk/codepend.
[140] Ibid
[141] Kent County Council (2005) Alcohol Misuse Select Committee, written evidence, 14 June 2007, Maidstone.
[142] National Association of Children of Alcoholics (2007), http://www.nacoa.org.uk/codepend.
[143] Kent County Council (2005) Alcohol Misuse Select Committee, written evidence, 14 June 2007, Maidstone.

currently on the protection register in the County.[144] The relationship between alcohol misuse and children is discussed in more detail in Chapter 5 and Chapter 7 of the report.

3.2.10. It is estimated that if a minimal level of access was provided (10%) 18,000 individuals would be helped. A good level of service (20%) would provide treatment to 36,000 people.[145] As ANARP estimated, in the South East region there are currently about 9,000 individuals suffering from alcohol dependency (about 5%) who have been assessed by treatment services.[146]

3.2.11. These figures provide an idea of the gap between demand and provision at national level; an accurate assessment in Kent, then, would help pinpoint more precisely the level of need in the County and provide data about the health requirements of Kent residents.

3.2.12. Exploring the level of alcohol service provision in Kent will also enable agencies to establish with precision how fairly services and other resources are distributed across the County. Evidence suggests that in Kent service provision in the East of the county is currently more established than in the West.[147] [148] [149] A health equity audit embodied in the needs assessment, then, can help identify service access inequalities and inform reactive strategic actions.

3.2.13. Finally, an important reason for determining accurately the level of need in the County is the potential financial savings that can be accrued by treating individuals in need. According to an analysis produced by the United Kingdom Alcohol Treatment Trial (UKATT) in 2005, for every £1 spent on alcohol treatment, the public sector saves £5.[150] This result is reinforced by the evidence provided by Dr Rake, who informed the Committee that individuals with alcohol problems tend to present themselves to their GPs 30 times more than non-misusers.[151] As the Director of the Kenward Trust, Mr Featherstone, pointed out, “the most expensive addict is the one who is not being treated”.[152]

3.2.14. The findings of current research on the level of service provision in Kent, commissioned by the Supporting Independence Programme (SIP), should prove very helpful in accurately assessing how far levels of need are being met.[153]

---

[144] Kent County Council (2005) Alcohol Misuse Select Committee, written evidence, 24 September 2007, Maidstone.
[145] Ibid
[146] Sheehan, D. (2007) Choosing Health in the South East: Alcohol, South East Public Health Observatory (SEPHO).
[147] Kent County Council (2007) Alcohol Misuse Select Committee, 10 July 2007, Maidstone.
[148] Kent County Council (2007) Alcohol Misuse Select Committee, 16 July 2007, Maidstone.
[149] Kent County Council (2007) Alcohol Misuse Select Committee, 16 July 2007, Maidstone.
[150] Department of Health/National Treatment Agency (2006) Models of Care for Alcohol Misusers (MoCAM), London.
[151] Kent County Council (2007) Alcohol Misuse Select Committee, 10 July 2007, Maidstone.
[152] Kent County Council (2007) Alcohol Misuse Select Committee, 16 July 2007, Maidstone.
[153] Kent County Council (2007) Alcohol Misuse Select Committee, 27 June 2007, Maidstone.

3.2.15. Having considered all the above issues, The Alcohol Misuse Select Committee puts forward the following recommendations.

Recommendation 1

The Alcohol Misuse Select Committee recommends that:

Kent County Council (KCC) establishes, in partnership with Kent Primary Care Trusts (PCTs), an independent task board which will carry out a comprehensive and systematic needs assessment of alcohol service provision in Kent. This review should investigate, quantify and evaluate the current level of need and the financial resources available in both East and West Kent; it should consider coordination, commissioning and provision mechanisms involved; it should assess the effectiveness of local alcohol treatment systems in all the four tiers of intervention, and it should explore opportunities for savings in order to maximise budget spend on service delivery. The Kent Drug and Alcohol Action Team (KDAAT) should produce an annual updating report indicating in the various areas of operation the number of individuals receiving treatment and the reasons for their referral.

Recommendation 2

The Committee recommends that the needs of all those individuals requesting assistance, especially those caring for dependants, should be assessed carefully, and that treatment should be prioritised according to the importance and urgency of each situation.

Recommendation 3

The Select Committee recommends that:

The outcomes of the needs assessment should inform the production of an overarching alcohol strategy for Kent. The production of the strategy, aiming at reducing the impact of alcohol misuse in Kent, should be lead by KDAAT. The strategy should address a variety of issues including treatment services, underage drinking, public awareness, alcohol-related crime and responsible retailing. It should clearly identify effective actions to be taken, together with responsibilities and accountability of all the agencies involved in the coordination, commissioning and provision of alcohol-related services. The strategy should include mechanisms that will evaluate and monitor the progress of its implementation, and it should encourage closer collaborative ties between all the agencies involved.

4. Funding Issues

4.1. Raising the Priority of the Issue of Alcohol Misuse

4.1.1. Despite growing concerns around the issue of alcohol misuse and the urgent need for increasing action to deal with it, it appears that the financial resources allocated by Central Government are inadequate.

4.1.2. One of the causes for this inadequate distribution seems to be the uneven allocation of resources in relation to other public health areas. For instance, alcohol budgets are poorly developed compared to those allocated to deal with obesity and smoking related issues.[154]

4.1.3. Perhaps more importantly, a discrepancy in this distribution exists also within substance misuse services. Extensive evidence shows that the funding allocated to drugs services is much greater than that allocated to alcohol services, despite the growing urgency to tackle alcohol misuse. The national budget for alcohol services is £95 million, while the annual spend on drugs services in 2005-6 amounted to £573 million.[155] This evidence is also reflected by a quantitative survey of Drug Action Team (DAT) professionals, in which 86% of respondents reported that their alcohol treatment budgets were much lower than their drug budgets.[156]

4.1.4. The concerns for this inequality in funding are exacerbated by the fact that in England about 1 in 15 people are dependent on alcohol, compared to only 1 in 50 people dependent on drugs.[157]

4.1.5. Two reasons for this financial disparity are the historical direction of funding to drugs rather than to alcohol, and the belief that drugs misuse is linked with fuelling HIV contagion and violent crime.[158] This perception diverges from the view of DAT professionals, who generally believe that the harm resulting from alcohol misuse is far greater to the individual and to the community than that resulting from drug misuse.[159]

4.1.6. This uneven resource allocation is reflected in the present budget issues facing KDAAT and other agencies providing alcohol services in Kent.

4.1.7. KDAAT receives its funding from five sources: about half of the funding is supplied by the National Treatment Agency (NTA) – a special health authority created by Central Government in 2001 to improve the

[154] Department of Health (2007) Safe. Sensible. Social. The Next Step in the National Alcohol Strategy, London.
[155] Sheehan, D. (2007) Choosing Health in the South East: Alcohol, South East Public Health Observatory (SEPHO).
[156] Department of Health (2005) Alcohol Needs Assessment Research Project (ANARP), London.
[157] Sheehan, D. (2007) Choosing Health in the South East: Alcohol, South East Public Health Observatory (SEPHO).
[158] Kent County Council (2007) Alcohol Misuse Select Committee, Visit to the Kenward Trust, 20 July 2007, Maidstone.
[159] Department of Health (2005) Alcohol Needs Assessment Research Project (ANARP), London.

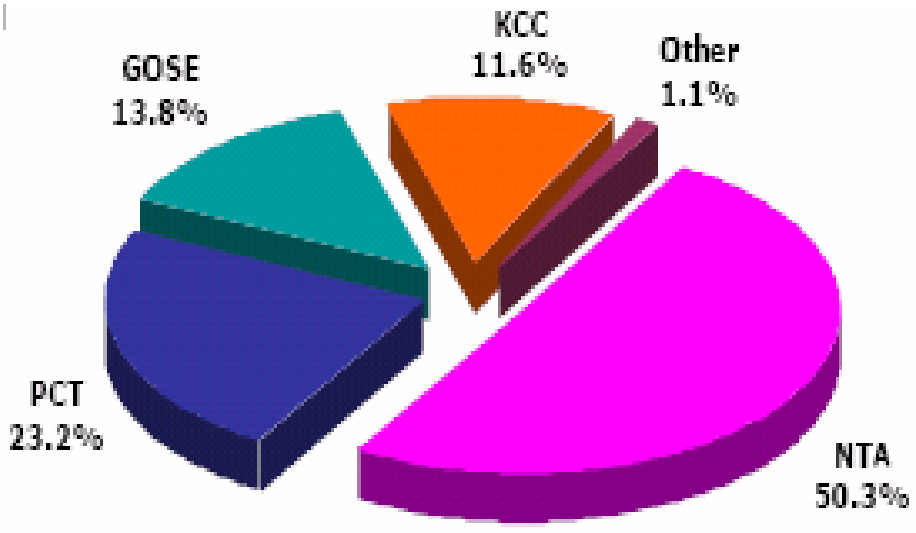
availability and effectiveness of treatment for drugs and alcohol misuse in England.[160] [161] The rest is provided by Primary Care Trusts (PCTs), the Government Office for the South East (GOSE), Kent County Council and other establishments.[162]

4.1.8. Part of Primary Care Trusts funding for alcohol services, and more specifically for alcohol screening and brief interventions, is financed by Choosing Health monies.[163] PCTs funding allocations are intended to cover areas including diet and obesity, stop smoking services, sexual health modernisation and alcohol interventions.[164]

4.1.9. For the 2007-8 period, the Choosing Health financial allocation to West Kent PCT was about £1,900,000. Of this sum, the funding the PCT allocated to alcohol services was £153,735.[165] The allocation to Eastern and Coastal PCT in the 2007-8 period was instead approximately £2,400,000.[166] The funding the PCT spent on alcohol services was about £231,000.[167]

4.1.10. In total, then, KDAAT receives 78% of its financial resources from Government. Figure 14 illustrates the origins and proportions of this funding.

Figure 14: KDAAT Funding Sources

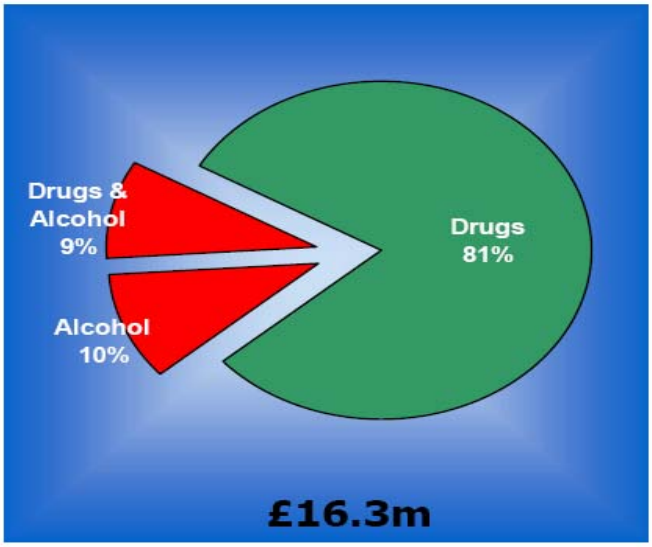


Source: KDAAT, Kent County Council

[160] Kent County Council (2007) Alcohol Misuse Select Committee, 14 June 2007, Maidstone.
[161] National Treatment Agency (NTA) (2007) http://www.nta.nhs.uk/about/default.aspx.
[162] Kent County Council (2007) Alcohol Misuse Select Committee, 14 June 2007, Maidstone.
[163] Kent PCTs (2007) PCT Survey – Freedom of Information Request.
[164] Department of Health (2004) Choosing Health: Making Healthy Choices Easier, London.
[165] West Kent Primary Care Trust (2007) Health Policy Board Meeting, 9 November 2007.
[166] Department of Health (2005)http://www.dh.gov.uk/en/PolicyandguidanceOrganisationpolicy/Financeandplanning/Allocations/DH_4104471.
[167] Kent PCTs (2007) PCT Survey – Freedom of Information Request.

4.1.11. However, as Figure 15 below shows, 81% of the current total funding of KDAAT is spent exclusively on drugs services, followed by 10% exclusively for alcohol services and 9% for both.[168]Alcohol services are allocated in total 14% of the available budget.[169]

Figure 15: Proportion of Financial Resources Allocated to KDAAT



Source: KDAAT, Kent County Council.

4.1.12. Importantly, tackling alcohol misuse in Kent may become even more challenging given that, as KDAAT colleagues reported, Government funding to KDAAT has recently been cut by £0.5 million, and given that the allocation of financial resources for 2007-8 is still unclear.[170]

4.1.13. The consequences of this reduction clearly impinge on service provision. For example, as a result of these cuts the KCA lost one post aimed at providing preventative alcohol misuse measures for young people in Kent.[171] Members of the Committee expressed deep concern for the current – and potentially future – loss of financial support.[172]

4.1.14. The increasingly careful and effective management of existing resources, then, becomes crucial in order to ensure the existing provision of alcohol misuse services. As already mentioned in the report, the role of Local Area Agreements (LAAs) is becoming increasingly significant in local planning for agreeing locally shared objectives and strategies.[173] Amongst other mechanisms to monitor the distribution of alcohol-related resources, LAAs can then both help identify opportunities for

[168] Ibid
[169] Ibid
[170] Ibid
[171] Kent County Council (2007) Alcohol Misuse Select Committee, 10 July 2007, Maidstone.
[172] Ibid
[173] Department of Health (2005) Alcohol Misuse Interventions, London.

partnerships, and can help decide how local effort is organised and delivered.[174]

4.2. Funding Opportunities

4.2.1. Together with the challenge of raising the profile of alcohol misuse and of providing services of the existing quality despite a reduced budget, it is vital to identify other opportunities for potential funding.

4.2.2. One of the means for achieving this end, together with gaining a deeper understanding about alcohol misuse, its consequences and solutions, is to establish closer links with academic institutions, such as the University of Kent.

4.2.3. Collaboration between Kent County Council - and other establishments working to tackle alcohol misuse – and the University of Kent, already exists. For example, the University already has links with the East Kent Community Alcohol Service.[175] In addition, The University's European Institute of Social Services (EISS) has been instrumental in providing vital evidence for this Alcohol Misuse Select Committee review.[176]

4.2.4. The European Institute of Social Services is a department within the School of Social Policy, Sociology and Social Research at the University of Kent. The Institute has an established reputation in comparative research in international and public policy. Its aim is to support public sector and voluntary organisations through sharing knowledge of innovative practices adopted elsewhere in Europe, and by helping these organisations access European funding to support their programmes.[177]

4.2.5. Together with the central support that EISS can supply to KCC in order to explore funding opportunities, evidence from EISS included, amongst other items, information about the European Alcohol Health Forum. The Forum, set up in June 2007, is already made up of representatives of more than 40 organisations which are scheduled to meet twice a year. Its aim is to take action to protect European citizens – and young people in particular – from the harmful use of alcohol, and to prevent irresponsible commercial behaviour.[178]

4.2.6. The initiative emerges as a response to the fatalities caused by alcohol misuse in Europe. About 200,000 Europeans die each year as a consequence of alcohol misuse; more than a quarter comprises young men aged 15-29 years.[179]

---

[174] Department of Health (2007) Safe. Sensible. Social. The Next Step in the National Alcohol Strategy, London.
[175] Kent County Council (2007) Alcohol Misuse Select Committee, 16 July 2007, Maidstone.
[176] Vass, G. (2007) Dossier on Alcohol Harm from a European Perspective, European Institute of Social Services (EISS),University of Kent..
[177] University of Kent (2007) http://www.kent.ac.uk/eiss/about/index.html.
[178] Vass, G. (2007) Dossier on Alcohol Harm from a European Perspective, European Institute of Social Services (EISS),University of Kent..
[179] Ibid

4.2.7. In order to become a member of the Forum a business or a non-governmental organisation (NGO) has to present a concrete action plan which will spell out the actions the organisation will take to deal with alcohol misuse. This will enable the evaluation of successful initiatives, which will then be shared as best practice.[180]

4.2.8. Members of the Alcohol Misuse Select Committee expressed deep concerns about the reduction of funding to deal with alcohol misuse in Kent. The cuts of funding, together with the careful monitoring of existing resources and the opportunities for further financial support, present challenges that need addressing. The committee commends the following interventions.

[180] Ibid

Recommendation 4

The Committee urges KCC to lobby Central Government to raise the priority and profile of the issue of alcohol misuse in the UK. KCC should press for an increase in funding to finance services dealing with alcohol misuse. This pressure should be carried out through the influence of the Local Government Association (LGA), as well as through direct contact with Central Government agencies.

Recommendation 5

KCC should ensure that the distribution of financial resources for alcohol-related services is monitored, amongst other methods, through Local Area Agreement (LAA) structures and mechanisms. KCC should prioritise the allocation of resources for these crucial alcohol services, given their impact across so many other aspects of life.

Recommendation 6

The Committee recommends that:

KCC establishes closer links with local academic institutions, such as the University of Kent, in order to deal with alcohol misuse. Work should be carried out with the European Institute of Social Studies (EISS) of the University of Kent, in an effort to attract European Union funding to finance alcohol misuse services in Kent. KCC should liaise with EISS to encourage the participation of both the alcohol industry and Kent-based agencies dealing with alcohol misuse in the EU Alcohol and Health Forum. Care should be taken to present the Forum with the many projects that the alcohol industry in Kent may initiate.

5. Identification, Referral and Intervention

5.1. Identification and Referral Processes

5.1.1. As discussed above, only about 1 person out 20 in need of alcohol services receives them in the South East.[181] In part this can be explained by low levels of formal identification and referral of patients with alcohol use disorders by general practitioners (GPs) and other primary care staff.

5.1.2. According to the 2004 Alcohol Needs Assessment Research Project for England (ANARP), GPs formally identified approximately only 1 in 67 male and 1 in 82 female hazardous/harmful drinkers.[182] The formal identification rate by GPs for alcohol dependence was 1 in 28 for males and 1 in 20 for females respectively.[183] The largest proportion of referrals to alcohol services were found to be self referrals (36%), followed by GP and primary care referrals (24%)[184]

5.1.3. One of ANARP's conclusions is that "there is clearly considerable scope for increased identification and referral…".[185]

5.1.4. Several reasons have been put forward to explain lack of attention to excessive drinkers. In their survey in the English Midlands, Kaner et al. (1999) identified issues including:

- Lack of time amongst busy healthcare professionals.
- Lack of appropriate training to carry out screening and brief interventions.
- A belief that patients will not take advice to change their drinking behaviour.
- Lack of suitable screening and intervention material.
- The fear of offending patients by raising the issue of alcohol misuse.[186]

5.1.5. Together with these reasons evidence suggests that, more generally, a restricted budget affects the quality of local support services provision.[187]

[181] Sheehan, D. (2007) Choosing Health in the South East: Alcohol, South East Public Health Observatory (SEPHO).
[182] Department of Health (2005) Alcohol Needs Assessment Research Project (ANARP), London.
[183] Ibid
[184] Department of Health (2005) Alcohol Needs Assessment Research Project (ANARP), London.
[185] Ibid
[186] Kaner, E.et al (1999) A RCT of Three Training and Support Strategies to Encourage Implementation of Screening and Brief Alcohol Intervention by General Practitioners, British Journal of General Practice, 49, 699-703.
[187] Kent County Council (2007) Alcohol Misuse Select Committee, 28 June 2007, Maidstone.

5.1.6. Despite these challenges evidence shows that effective identification and referral processes are central to tackling alcohol misuse and that action should be taken. Some of the reasons are outlined below.

5.1.7. As already pointed out that there is a "very large gap" between the provision of alcohol treatment and the demand for such treatment.[188] In Kent, only 1 person out of 20 in need is offered alcohol services.[189]

5.1.8. Importantly, it appears that some sections of the population in need of treatment are less likely to be identified than others. For example, ANARP found that GPs tend to under-identify younger patients compared to older patients.[190]

5.1.9. But doctors may also fail to diagnose elderly people. According to the Royal College of Physicians, as many as 60% of elderly people who are admitted to hospital because of confusion, falls at home and heart failure, may have unrecognised alcohol problems.[191]

5.1.10. Affluent middle class professionals are another category that is under-identified.[192] As the new alcohol strategy – Safe. Sensible. Social. – points out, harmful drinkers over 35 years are especially prone to develop chronic health problems such as cirrhosis, hypertensions or heart diseases.[193]

5.1.11. Finally, effective identification and referral processes are important because some individuals in need of treatment need to be encouraged to inform their GPs that they need help. For example, many women do not seek help because they feel that if they admitted to have alcohol-related problems they would be stigmatised.[194]

5.1.12. One of the ways to improve identification processes is for GPs and other primary care staff to use screening questionnaires. Several types of questionnaires to help diagnose alcohol dependency are already available. The Alcohol Use Disorders Identification Test (AUDIT) was developed by the World Health Organisation (WHO). The test is now used in a range of settings worldwide and has been translated in all the major languages.[195]

5.1.13. AUDIT consists of ten items, comprising 3 questions on alcohol consumptions, 4 on alcohol-related problems and 3 on dependence symptoms. The test is intended to take two minutes to complete,

[188] Department of Health (2005) Alcohol Needs Assessment Research Project (ANARP), London.
[189] Sheehan, D. (2007) Choosing Health in the South East: Alcohol, South East Public Health Observatory (SEPHO).
[190] Department of Health (2005) Alcohol Needs Assessment Research Project (ANARP), London.
[191] Institute of Alcohol Studies (2007) Alcohol and the Elderly, St Ives.
[192] Kent County Council (2007) Alcohol Misuse Select Committee, 27 June 2007, Maidstone.
[193] Department of Health (2007) Safe. Sensible. Social. The Next Step in the National Alcohol Strategy, London.
[194] Kent County Council (2007) Alcohol Misuse Select Committee, visit to the Kenward Trust, 20 July 2007, Maidstone.
[195] Raistrick, D., Heather, N. and Godfrey, C. (2006) Review of the Effectiveness of Treatment for Alcohol Problems, National Treatment Agency for Substance Misuse (NTA), London.

although some evidence shows that it may take longer.[196] One version of the AUDIT questionnaire is shown below (see also Appendix 3).

Figure 16: The Audit Questionnaire

1. How often do you have a drink containing alcohol?

(0) Never	(1) Less than monthly	(2) 2-4 times a month	(3) 2-3 times a week	(4) 4 or more times a week	

2. How many units of alcohol do you drink on a typical day when you are drinking?

(0) 1-2	(1) 3 or 4	(2) 5 or 6	(3) 7, 8 or 9	(4) More	

3. How often do you have six or more units of alcohol on one occasion?

(0) Never	(1) Less than monthly	(2) Monthly	(3) Weekly	(4) Daily or almost daily	

4. How often during the last year have you found that you were able to stop drinking once you had started?

(0) Never	(1) Less than monthly	(2) Monthly	(3) Weekly	(4) Daily or almost daily	

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

(0) Never	(1) Less than monthly	(2) Monthly	(3) Weekly	(4) Daily or almost daily	

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

(0) Never	(1) Less than monthly	(2) Monthly	(3) Weekly	(4) Daily or almost daily	

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

(0) Never	(1) Less than monthly	(2) Monthly	(3) Weekly	(4) Daily or almost daily	

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

(0) Never	(1) Less than monthly	(2) Monthly	(3) Weekly	(4) Daily or almost daily	

9. Have you or someone else been injured as a result of your drinking?

(0) No	(2) Yes, but not in the last year	(4) Yes, during the last year	

10. Has a relative or friend or doctor or other health worker been concerned about your drinking or suggested you cut down?

(0) No	(2) Yes, but not in the last year	(4) Yes, during the last year	

Record total score here

If total score is 8 or over alcohol use disorder is very likely
Scores above 0 in questions 4-6 suggest either alcohol dependence or heading for alcohol dependence

Source: Review of the Effectiveness of Treatment for Alcohol Problems (2006), National Treatment Agency for Substance Misuse (NTA)

[196] Ibid.

5.1.14. The Fast Alcohol Screening Test (FAST) is a shorter version of AUDIT, and has been developed because in some medical settings AUDIT is sometimes considered too time consuming for widespread implementation (a larger picture is shown in Appendix 3).[197]

Figure 17: The FAST Questionnaire

Questions	Scoring system 0	1	2	3	4	Your score
How often do you have 8 (men)/ 6 (women) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Only answer the following questions if your answer above is monthly or less						
How often in the last year have you not been able to remember what happenned when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	

World Health Organisation 2001

Source: Department of Health (2007) Safe. Sensible. Social. The Next Step in the National Alcohol Strategy

5.1.15. Training to carry out effective screening and brief interventions can also help increase identification, referral and treatment of alcohol dependence. Authoritative evidence indicates that screening and brief intervention activity increases when GPs and nurses are adequately trained and supported for them.[198]

5.1.16. According to the Alcohol Harm Reduction Strategy for England (2004), little training on alcohol issues is provided to health professionals. Some doctors reported receiving alcohol training only one afternoon during the five years of their undergraduate studies.[199]

5.1.17. Also, evidence submitted to the Committee reports that in Kent only about 35 surgeries have undertaken this training.[200] Yet, research from ANARP found that GPs generally welcome the possibility of training on alcohol issues, expressing the preference for in-person rather than distance learning teaching.[201]

[197] Department of Health (2007) Safe. Sensible. Social. The Next Step in the National Alcohol Strategy, London.
[198] Raistrick, D., Heather, N. and Godfrey, C. (2006) Review of the Effectiveness of Treatment for Alcohol Problems, National Treatment Agency for Substance Misuse (NTA), London.
[199] Prime Minister's Strategy Unit (2004) Alcohol Harm Reduction Strategy for England, London.
[200] Kent County Council (2007) Alcohol Misuse Select Committee, 10 July 2007, Maidstone.
[201] Department of Health (2005) Alcohol Needs Assessment Research Project (ANARP), London.

5.2. Brief Interventions

5.2.1. The increase of brief interventions, then, seems to bring about substantial benefits.

5.2.2. Although sometimes there is confusion around the meaning of "brief intervention" as it is used as an umbrella term, this report will adopt the terminology used in the *Review of the Effectiveness of Treatment for Alcohol Problems*.[202] The Review makes the distinction between two types of interventions: simple brief interventions and extended brief interventions.

5.2.3. Simple brief interventions entail a 5 minute session in which hazardous or harmful drinkers receive information about alcohol and about the risk of medical and social problems resulting from alcohol misuse. Brief intervention should also include goal-setting and written self-help material for the patient to take away.[203]

5.2.4. Extended brief interventions typically take 20-30 minutes and may involve several sessions. This more sophisticated therapy generally involves tasks such as detailed self-monitoring of alcohol consumption, identification of high risk situations for excessive drinking, formulation of simple rules to limit consumption and feedback of blood test results.[204]

5.2.5. Although the majority of people in their "drinking careers" move out of problem drinking without accessing treatment services, the impact of brief interventions for those who access them can be very beneficial.[205]

5.2.6. A large body of evidence including at least 56 controlled trials shows that brief interventions reduce alcohol consumption to low-risk levels.[206] Alcohol and harmful drinkers receiving brief interventions are twice as likely to moderate their drinking 6 to 12 months after an intervention when compared to misusers receiving no intervention.[207]

5.2.7. Recent research also shows that brief interventions can reduce weekly drinking by between 13% and 34%, resulting in 2.9 to 8.7 fewer average drinks per week[208]

5.2.8. It has been estimated that if consistently implemented GP-based interventions would reduce problem drinking levels to low risk levels for 250,000 men and 67,500 women every year.[209]

---

[202] Raistrick, D., Heather, N. and Godfrey, C. (2006) Review of the Effectiveness of Treatment for Alcohol Problems, National Treatment Agency for Substance Misuse (NTA), London.
[203] Ibid
[204] Ibid
[205] Ibid
[206] Ibid
[207] Department of Health (2005) Alcohol Misuse Interventions, London.
[208] Ibid
[209] Ibid

5.2.9. Together with the above reasons, financial incentives also exist. The direct cost of a brief intervention was calculated in 1993 to be only £20. A recent WHO study estimated that the cost effectiveness of alcohol brief intervention is similar to that of smoking cessation interventions, with £1,300 and £1,200 respectively per year of ill-health or premature death prevented.[210]

5.3. Interventions for the Most Vulnerable People

5.3.1. Certain sections of the population – such as children of alcohol misusers, dependants in general and misusers suffering an alcohol withdrawal crisis - are particularly vulnerable to the negative consequences of alcohol misuse, and may need immediate help.

5.3.2. However, according to ANARP the average waiting time for assessment in England is 4.6 weeks.[211] The South East region is relatively efficient; indeed it is the one with the shortest wait, 3.3 weeks.[212]

5.3.3. Nonetheless, evidence submitted to the Committee suggests that sometimes support needs to be more immediate, because some clients may not return or because other dependants may be at risk. [213] [214] [215]

5.3.4. Alcohol addiction is a "family illness", as the family organises its life around the misuser.[216] Almost 1 million children in the UK currently live in households with parents misusing alcohol.[217] [218] Children whose parents suffer from alcoholism are six time more likely than children of non-misusers to experience verbal and physical aggression. Some are exposed to rage, violence and abuse on a daily basis.[219]

5.3.5. In Kent it has been estimated that substance misuse (both for alcohol and drugs misuse) is a parental characteristic of over half the children (56.1%) on the child protection register.[220] Over 800 children are currently in the protection register in Kent.[221]

5.3.6. The Substance Misusing Parent Project, carried out in the areas of Thanet and Dover in 2003-4, and independently evaluated by the University of Kent, found that the mean number of children that each

[210] Ibid
[211] Department of Health (2005) Alcohol Needs Assessment Research Project (ANARP), London.
[212] Ibid
[213] Kent County Council (2007) Alcohol Misuse Select Committee, 14 June 2007, Maidstone.
[214] Kent County Council (2007) Alcohol Misuse Select Committee, 27 June 2007, Maidstone.
[215] Kent County Council (2007) Alcohol Misuse Select Committee, 10 July 2007, Maidstone.
[216] National Association of Children of Alcoholics (2007), http://www.nacoa.org.uk/codepend.
[217] Ibid
[218] Kent County Council (2005) Alcohol Misuse Select Committee, written evidence, 14 June 2007, Maidstone.
[219] National Association of Children of Alcoholics (2007), http://www.nacoa.org.uk/codepend.
[220] Kent County Council (2005) Alcohol Misuse Select Committee, written evidence, 14 June 2007, Maidstone.
[221] Kent County Council (2005) Alcohol Misuse Select Committee, written evidence, 24 September 2007, Maidstone.

substance misuse parent had was 2.4, and that the mean age of these dependent children was 7.8 years. The gender proportion was even, with girls representing 51% of these children.[222]

5.3.7. According to the report *Hidden Harm: Responding to the Needs of Children of Problem Drug Users (2003)*, it is crucial that the needs of children of alcohol and drugs misusers are explored and assessed.[223]

5.3.8. The report maintains that, in their efforts to help these children, drug and alcohol agencies should ensure they carry out tasks such as: discussing with the client safety at home; liaising with the family's health visitor in the child's early years; ensuring that the child has received basic health checks and immunisation; assisting the parents to make sure that the child receives nursery, pre-school and school education, and liaising with the child protection team if there are concerns for the child's safety.[224]

5.3.9. The report concludes by pointing out that Drug Action Teams play a significant role in meeting the needs of children, and that additional resources will be needed in order to build capacity.[225]

5.3.10. Together with children of misusing parents, it should be ensured that alcohol misusers suffering an alcohol-related crisis also access immediate service provision.

5.3.11. A large body of evidence presented to Members of the Alcohol Misuse Select Committee shows that, when suffering an alcohol-related crisis, people need almost instant access to services.[226] [227] [228] Waiting two weeks can be fatal to someone experiencing alcohol withdrawals and needing urgent help. For example, an appointment for detoxification could be easily forgotten and missed if users are unable to manage their lives, and managing detoxification without medical supervision can be lethal. [229]

5.4. Aftercare

5.4.1. Another area of intervention that needs particular attention is that of aftercare. For some individuals alcohol dependence is a relapsing condition. They can quickly return to their previous drinking habits if

[222] Ibid
[223] Advisory Council on the Misuse of Drugs (2003) Hidden Harm: Responding to the Needs of Children of Problem Drug Users, London.
[224] Ibid.
[225] Ibid
[226] Kent County Council (2007) Alcohol Misuse Select Committee, 14 June 2007, Maidstone.
[227] Kent County Council (2007) Alcohol Misuse Select Committee, 27 June 2007, Maidstone.
[228] Kent County Council (2007) Alcohol Misuse Select Committee, 28 June 2007, Maidstone.
[229] Kent County Council (2007) Alcohol Misuse Select Committee, 27 June 2007, Maidstone.

continuing support is not provided, thus eroding the health and well-being gains from intervention.[230]

5.4.2. During and after treatment individuals may need support in several aspects of their lives, including avoiding the company of heavy drinkers, finding housing, finding employment, managing their personal finances and accessing training and education.[231]

5.4.3. Housing provision is perhaps particularly vital, as recovering alcohol addicts risk relapse if returned to the environment where they misused alcohol consumption or where alcohol misuse is prevalent.[232]

5.4.4. Although the amount of research on aftercare is not considerable, the findings are impressive. For example, in a study conducted by Ahles et al (1983) at one-year follow up, the rate of abstinence in the experimental group given aftercare was 40% compared to 11% of the control group.[233]

5.4.5. In Kent the Supporting People programme, amongst other things, helps individuals who misuse alcohol access stable accommodation. The benefits of the programme are several. For example, it decreases the risk of suicide and harm amongst vulnerable persons, it reduces rates of crime and crisis admissions to hospitals, and it enables people live more independently.[234]

5.4.6. Housing-related support is organised into two main categories; Accommodation-based Support - in which short and long term housing and support are delivered under one roof, and Floating Support – a short term service no longer than 2 years in which support is delivered in the user's own home.[235] Often housing-related support needs are met as part of a package of interventions to deal not just with alcohol misuse, but also with other issues, such as offending and homelessness.[236]

5.4.7. Specific residential treatment is provided by organisations such as Turning Point in Canterbury and the Kenward Trust at Yalding.[237]

5.4.8. The Kenward Trust for example offers a "second stage" programme for people who need additional time to re-organise their lives and to ensure that they would continue to abstain from alcohol (and drug) consumption. This stage can be in a shared accommodation for a period up to two years.[238]

---

[230] Department of Health/National Treatment Agency (2006) Models of Care for Alcohol Misusers (MoCAM), London.
[231] Ibid
[232] Kent County Council (2007) Alcohol Misuse Select Committee, 27 June 2007, Maidstone.
[233] Raistrick, D., Heather, N. and Godfrey, C. (2006) Review of the Effectiveness of Treatment for Alcohol Problems, National Treatment Agency for Substance Misuse (NTA), London.
[234] Kent County Council (2008) Alcohol Misuse Select Committee, written evidence, 11 January 2008, Maidstone.
[235] Ibid
[236] Ibid
[237] Kent County Council (2007) Alcohol Misuse Select Committee, 27 June 2007, Maidstone.
[238] Kent County Council (2007) Alcohol Misuse Select Committee, 28 June 2007, Maidstone.

5.4.9. At Turning Point people can live independently in supported housing for two years. The ages of the clients range between 24 to 55 years, with more men generally accessing the service.[239]

5.4.10. In total, there are approximately 100 places available for those leaving treatment for substance misuse problems (comprising support both for drug and alcohol misusers). More specifically, 46 are Accommodation-based units and 66 are Floating Support places.[240] [241] However, these figures can only provide an *indication* of the level of need and of service provision, as other services – such as services for the homeless – can still contain elements to deal with alcohol misuse.[242]

5.4.11. Nonetheless, witnesses have pointed out that currently in Kent the level of aftercare for alcohol misusers does not match that for drugs misusers.[243]

5.4.12. In addition, while some evidence suggests that funding for residential services currently matches demand, a greater body of evidence indicates a need for housing and aftercare services.[244] [245] [246] [247]

5.4.13. After the investigation of all these identification, referral, treatment and intervention services, Members of the Alcohol Misuse Select Committee urged that the following actions should be taken.

[239] Kent County Council (2007) Alcohol Misuse Select Committee, 16 July 2007, Maidstone.
[240] Kent County Council (2007) Alcohol Misuse Select Committee, 14 June 2007, Maidstone.
[241] Kent County Council (2008) Alcohol Misuse Select Committee, written evidence, 11 January 2008, Maidstone.
[242] Ibid
[243] Kent County Council (2007) Alcohol Misuse Select Committee, 14 June 2007, Maidstone.
[244] Kent County Council (2007) Alcohol Misuse Select Committee, 27 June 2007, Maidstone.
[245] Kent County Council (2007) Alcohol Misuse Select Committee, 14 June 2007, Maidstone.
[246] Kent County Council (2007) Alcohol Misuse Select Committee, 16 July 2007, Maidstone.
[247] Kent County Council (2007) Alcohol Misuse Select Committee, 27 June 2007, Maidstone.

Recommendation 7

The Select Committee urges that the effectiveness of GPs in early identification and referral of alcohol misusers in Kent should be improved. All GPs in Kent should be strongly encouraged to attend special training that will help them identify alcohol misusers, especially those with dependants.

Recommendation 8

GPs and other primary care staff should increase the provision of "motivational brief interventions" and advice to individuals drinking excessively, but not yet experiencing major problems resulting from excessive consumption. Funding sources to finance these brief interventions should be identified by Kent Primary Care Trusts (PCTs).

Recommendation 9

The Committee urges that KCC offers immediate intervention to support those with urgent needs, such as children mistreated by alcoholic parents, young carers of misusers and misusers suffering from alcohol withdrawal crises. If during assessment a parent is identified as in need of alcohol treatment, KCC Social Services should ensure that support is provided to ascertain that the children are properly cared for.

Recommendation 10

It is paramount that additional temporary sheltered housing should be facilitated by KCC for individuals recovering from alcohol addiction, particularly those discharged from hospitals, prisons and residential alcohol treatment, in order to prevent relapse.

6. Public Awareness

6.1. A Hard Hitting Campaign

6.1.1. Throughout the Review one of the main conclusions that Members of the Committee reached – reflecting one of the main conclusions of the new national strategy *Safe. Sensible. Social* – was the need for increased public awareness on alcohol misuse and its consequences.[248] People have the right to clear and accurate information in order to make sensible choices about their alcohol consumption.

6.1.2. A number of local and national campaigns raising awareness about alcohol-related issues, such as "Know Your Limits", "Walk Away" and "Carry the Can" have already been developed and implemented.[249] Indeed, some of them, such as the national "Know Your Limits" campaign, have been improved and upgraded to ensure a sustained promotion.[250]

6.1.3. This commitment to sustained promotion and awareness is also reflected at local level. One of the objectives of Kent County Council, as highlighted in *Towards 2010*, is to introduce a hard-hitting campaign aimed at young people to increase awareness and reduce the damaging effects of – amongst other aspects – alcohol.[251]

6.1.4. In order to inform this objective, the Committee identified a variety of specific aspects on which the campaign should focus.

6.1.5. Personal responsibility and self esteem are two aspects that needs addressing. Central government, the local authority, the police, the NHS, schools, voluntary organisations and the business community all have a central role to play in a holistic endeavour to tackle the issue of alcohol misuse.[252] But personal responsibility is important too.[253]

6.1.6. Individuals can contribute to tackling alcohol misuse and its alarming consequences in several ways. Everybody needs to be aware of the consequences of alcohol misuse for their health, families, children and friends. Everybody can promote sensible drinking and ensure that alcohol-related problems are dealt with in the community.[254]

6.1.7. Also, public opinion investigations indicate that the majority of the English population believes that the root of the problem lies in an English

[248] Department of Health (2007) Safe. Sensible. Social. The Next Step in the National Alcohol Strategy, London.
[249] Kent County Council (2007) Alcohol Misuse Select Committee, 28 June 2007, Maidstone.
[250] Department of Health (2007) Safe. Sensible. Social. The Next Step in the National Alcohol Strategy, London.
[251] Kent County Council (2007) Towards 2010: Kent, Your County, Your Future, Our Promises to You, Maidstone.
[252] Department of Health (2007) Safe. Sensible. Social. The Next Step in the National Alcohol Strategy, London.
[253] Ibid
[254] Ibid

"drinking culture", which ensures that drunkenness and related anti-social behaviour are tolerated.[255]

6.1.8. But, as the report already mentioned, many aspects of the British drinking culture, such as drink and driving have changed.[256] The belief that drunkenness and anti-social behaviour are an accepted and intrinsic part of British culture can be challenged and changed.[257]

6.1.9. Together with the promotion of personal responsibility and self esteem in an effort to discourage tolerance of drunkenness, the Committee identified the need to intensify the publicity of sensible drinking messages.

6.1.10. Although most drinkers in England (86%) have heard of the unit system to measure alcohol consumption, only 13% of people check the amount of units they drink.[258]

6.1.11. In addition, even if most people have heard of the unit system, they do not know what a "unit" means, and about the relationships between units, differing alcoholic strength and glass sizes.[259] This evidence showing confusion about units at national level was also reflected by evidence provided to the Committee by young people.[260]

6.1.12. Together with the specific need of improving unit awareness is the more general need to promote knowledge about the consequences of alcohol misuse, which have reached concerning levels in the country.[261] For example, the report already revealed that alcohol misuse accounts for almost 10% of disease burden in England, surpassed only by tobacco and blood pressure.[262]

6.1.13. Also, up to 22,000 people die in England every year for causes attributable to alcohol misuse, and up to 150,000 hospital episodes are related to excessive alcohol consumption.[263] The UK has now the third highest proportion of 15 year olds (24%) who have been drunk 10 times or more during the past year. The average weekly consumption of alcohol reported by young people who drink aged 11-15 years doubled in the 1990s.[264]

6.1.14. A final aspect requires that this public awareness campaign should also give information about the range of alcohol-related services currently available in Kent.

---

[255] Ibid
[256] Fox Anne (2007) Alcohol Misuse Select Committee, 14 September 2007, Maidstone.
[257] Department of Health (2007) Safe. Sensible. Social. The Next Step in the National Alcohol Strategy, London.
[258] Ibid
[259] Ibid
[260] Kent County Council (2007) Alcohol Misuse Select Committee, 2 July 2007, Maidstone.
[261] Kent County Council (2007) Alcohol Misuse Select Committee, 16 July 2007, Maidstone.
[262] Department of Health (2005) Alcohol Needs Assessment Research Project (ANARP), London.
[263] Department of Health (2005) Alcohol Needs Assessment Research Project (ANARP), London.
[264] Department of Health (2007) Safe. Sensible. Social. The Next Step in the National Alcohol Strategy, London.

6.1.15. Knowledge and identification of alcohol-related services offered in Kent can be enhanced. This, for example, can increase access to services and encourage an increase in self referrals. Indeed, according to ANARP, the majority of referrals to alcohol agencies in England are currently self referrals (36%).[265]

6.1.16. In addition, Members found that although a directory of alcohol-related services supplied in Kent already exists in the KDAAT website, this can be developed and publicised more widely.[266] For example, some professionals providing alcohol-related treatment in the County appeared to be unaware of the directory. Furthermore, a recent survey conducted on behalf of ANARP revealed that in England there were 43% more agencies providing specialist alcohol services than previously identified.[267]

6.2. Directory and Logo

6.2.1. It was suggested to the Committee that hard copies of the directory should be made available, that they should include all voluntary and charitable establishments as well as the statutory ones, and that they should be targeted as an aid to all professionals working in the field in the County. It seems vital to ensure that all these agencies are listed as at present over half of all provision is voluntary, one third is statutory (NHS) and 8% is supplied by the private sector.[268]

6.2.2. Finally, it was proposed to the Committee that it should recommend the adoption of one single logo for all alcohol-related services in Kent. This will facilitate the identification of one joined up recognisable service throughout the County.[269] Perhaps this initiative can prove particularly important for vulnerable sections of the population in need of urgent support, such as drinkers in a withdrawal crisis, children of alcohol-dependent parents and homeless people.[270] [271] [272] [273]

6.2.3. Members of the Alcohol Misuse Select Committee hope that the following recommendations will help Kent residents estimate their alcohol consumption, recall sensible drinking guidelines and locate more readily agencies providing alcohol-related services.

---

[265] Department of Health (2005) Alcohol Needs Assessment Research Project (ANARP), London.
[266] Kent County Council (2007) Alcohol Misuse Select Committee, written evidence, 18 July 2007, Maidstone.
[267] Department of Health (2005) Alcohol Needs Assessment Research Project (ANARP), London.
[268] Department of Health (2005) Alcohol Needs Assessment Research Project (ANARP), London.
[269] Kent County Council (2007) Alcohol Misuse Select Committee, visit to Mount Zeehan Centre, 18 July 2007, Maidstone.
[270] Kent County Council (2007) Alcohol Misuse Select Committee, 27 June 2007, Maidstone.
[271] Kent County Council (2007) Alcohol Misuse Select Committee, 14 June 2007, Maidstone.
[272] Kent County Council (2007) Alcohol Misuse Select Committee, 10 July 2007, Maidstone.
[273] Kent County Council (2007) Alcohol Misuse Select Committee, 10 July 2007, Maidstone.

Recommendation 11

The Select Committee supports the promotion of a hard-hitting health campaign targeted at the young to increase their awareness and so reduce the damaging effects of alcohol. The Committee urges that this campaign should stress personal responsibility and self esteem, give information about sensible drinking, and about the variety of alcohol related services available in the County.

Recommendation 12

In order to help those seeking support, the Select Committee recommends that:

1. **A logo, which facilitates the identification of all alcohol services in the County, is adopted.**

2. **The "alcohol" section in the KDAAT website is developed and expanded.**

Recommendation 13

KCC should produce a directory in hard copy of all alcohol-related services available in the County which includes all voluntary sector provision, to aid partners and clients to access help for individuals in crisis.

7. Alcohol Misuse and Young People

7.1. Young People and Alcohol Misuse

7.1.1. Alcohol consumption amongst the young section of the population in the UK is particularly concerning. Young people under the age of 16 drink twice as much today as they did about ten years ago, and report getting drunk earlier than their European peers.[274] The UK has one of the highest rates of excessive alcohol consumption amongst young people in Europe, with 29% of 15 to 16 year olds reporting to have been drunk 20 times or more in the past year.[275] Alcohol misuse amongst young people may lead to several adverse consequences, including specific health problems, alcohol-related crime, unsafe sex, academic impairment due to possible damage to the hippocampus and alcohol dependency in later life.[276] [277]

7.1.2. Several reasons have been presented to explain why young people drink. They include:

- To socialise with their peers, "having a laugh".
- Peer pressure, pressure from the media.
- Affordable prices and availability.
- A more tolerant attitude from society.
- The influence from parents' drinking habits and attitudes.
- "Nothing else to do".
- Most young people see drinking alcohol as more acceptable than smoking cigarettes or cannabis.[278] [279] [280] [281]

7.1.3. Young people's drink preferences have changed over the last decade, with a higher proportion drinking spirits and alcopops. Also drink preferences appear to be gender-related. Boys are more likely to drink beer, lager, cider than girls (89% of boys compared with 59% of girls),

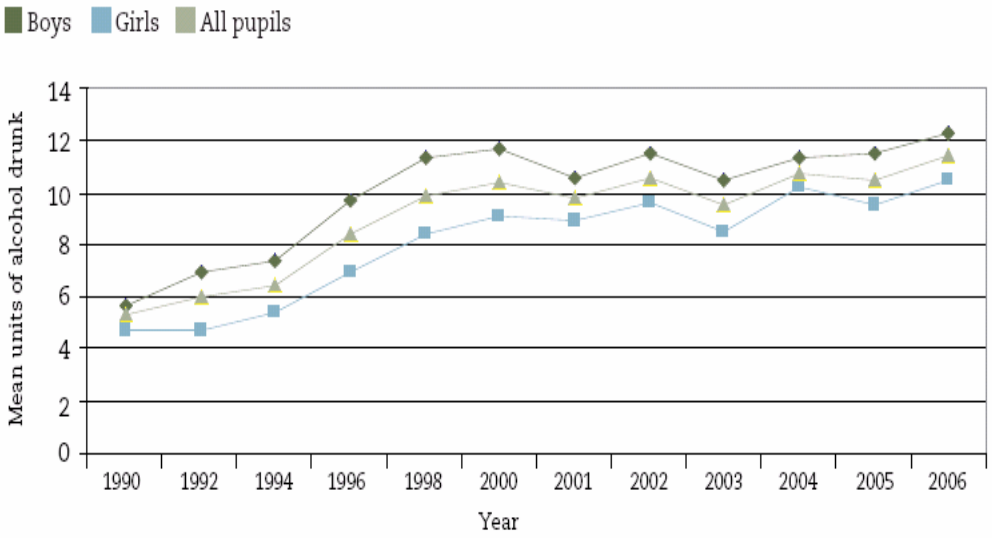
[274] Prime Minister's Strategy Unit (2004) Alcohol Harm Reduction Strategy for England, London.
[275] Sheehan, D. (2007) Choosing Health in the South East: Alcohol, South East Public Health Observatory (SEPHO).
[276] Prime Minister's Strategy Unit (2004) Alcohol Harm Reduction Strategy for England, London.
[277] Kent County Council (2008) Alcohol Misuse Select Committee, written evidence, 8 January 2008, Maidstone.
[278] Kent County Council (2007) Alcohol Misuse Select Committee, 2 July 2007, Maidstone.
[279] Kent County Council (2007) Alcohol Misuse Select Committee, 14 June 2007, Maidstone.
[280] Department of Health (2007) Safe. Sensible. Social. The Next Step in the National Alcohol Strategy, London.
[281] Alcohol Concern (2006) Acquire: Alcohol Concern Quarterly Information and Research Bulletin, Autumn 2006.

while girls are more likely to drink wine (54% compared with 33%) and alcopops (71% compared with 59%).[282]

7.1.4. Evidence of young people's drinking patterns, and of problems resulting from excessive alcohol consumption, suggests that drinking amongst young people in the UK is a matter of concern.

7.1.5. Among young people aged 11-15 years who drink, the average weekly consumption has doubled from 5.3 units in 1990 to 10.5 units in 2005.[283] The frequency of drinking has also increased, with the proportion of young people drinking at least once a week rising from 13% in 1990 to 17% in 2005.[284]

Figure 18: Average Alcohol Consumption among 11-15-Year Old Pupils in England Who Drank in the Last Week, 1990-2006



Source: Fuller, E. (2007) Drug Use, Smoking and Drinking Among Young People in England: Headline Figures. Health and Social Care Information Centre.

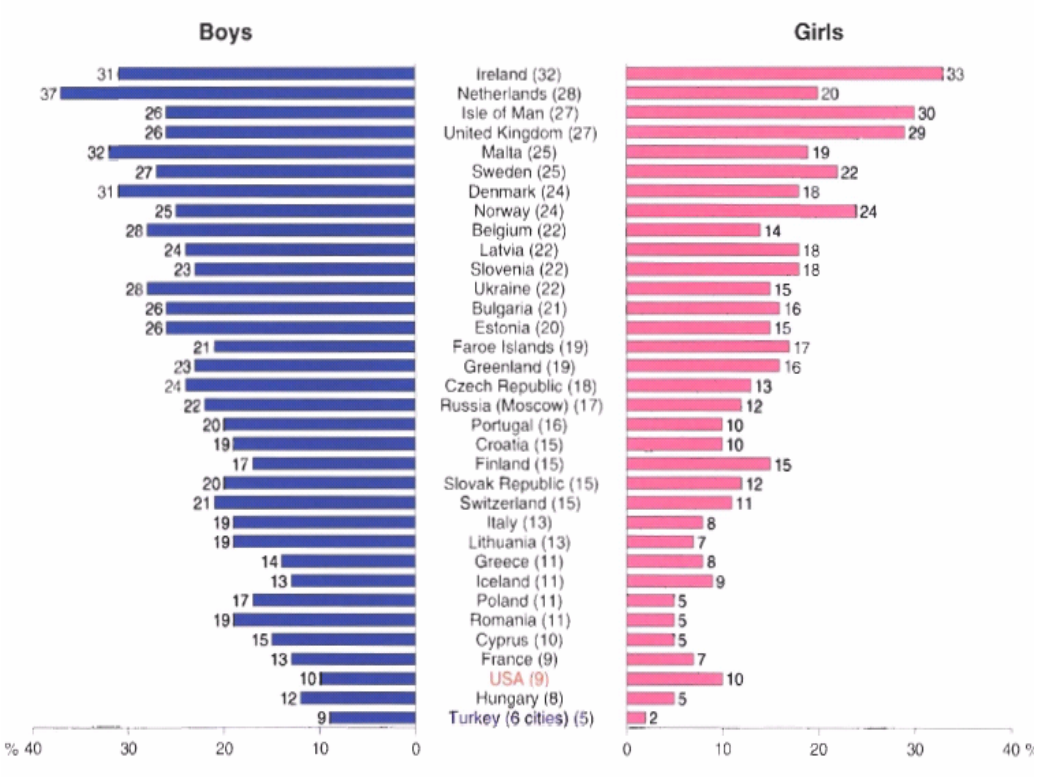
7.1.6. Alcohol misuse amongst girls is particularly alarming. The gap between drinking consumption between young male and young female adolescents is narrowing; the proportion of girls drinking at least once a week has increased from 12% in 1990 to 16% in 2005, compared to a rise of 15% to 17% for boys.[285]

7.1.7. Binge drinking in the UK was described by the Prime Minister in 2006 as "the new British disease".[286] The European School Survey Project on Alcohol and Other Drugs (ESPAD) (2003) found that the proportion of British young people aged 15-16 years binge drinking is one of the

[282] Office for National Statistics (ONS) (2005) Drug Use, Smoking and Drinking Among Young People in England 2005, ONS, London.
[283] Ibid
[284] Ibid
[285] Office for National Statistics (ONS) (2005) Drug Use, Smoking and Drinking Among Young People in England 2005, ONS, London.
[286] Mental Health Foundation (2006) Cheers? Understanding the Relationship between Alcohol and Mental Health, London.

highest in Europe (27%). The Survey also found that the proportion of binge drinking among girls is now higher than that of boys, with 29% of girls who drink reporting to have binge-drunk 3 or more times during the last week compared to 26% of boys.[287]

Figure 19: Proportion of 15-16 Year Old Boys and Girls Who Reported Binge Drinking 3 Times or More during the Last 30 Days, 2003

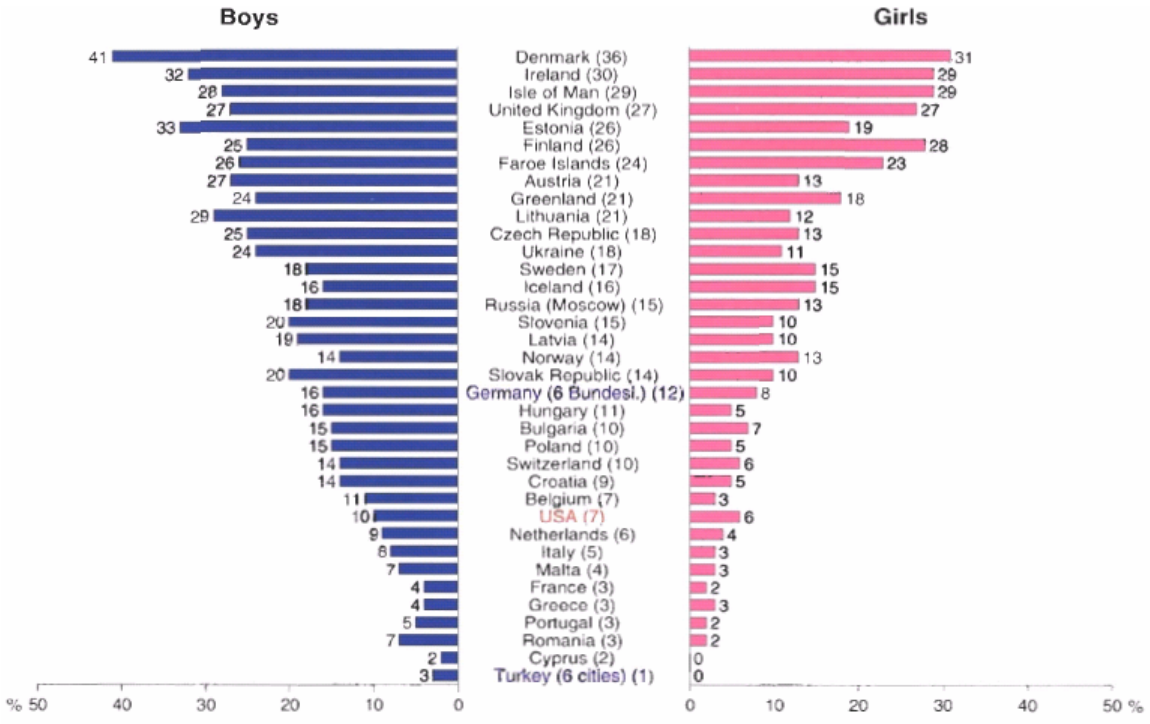


Source: The European School Survey Project on Alcohol and Other Drugs (ESPAD), 2003

7.1.8. One of the highest levels of drunkenness during one's lifetime is also reported by British teenagers, with 27% stating to already have been drunk at least 20 times or more in their lifetime.[288] About 35% of teenagers in the UK admit having been drunk at the age of 13 years.[289]

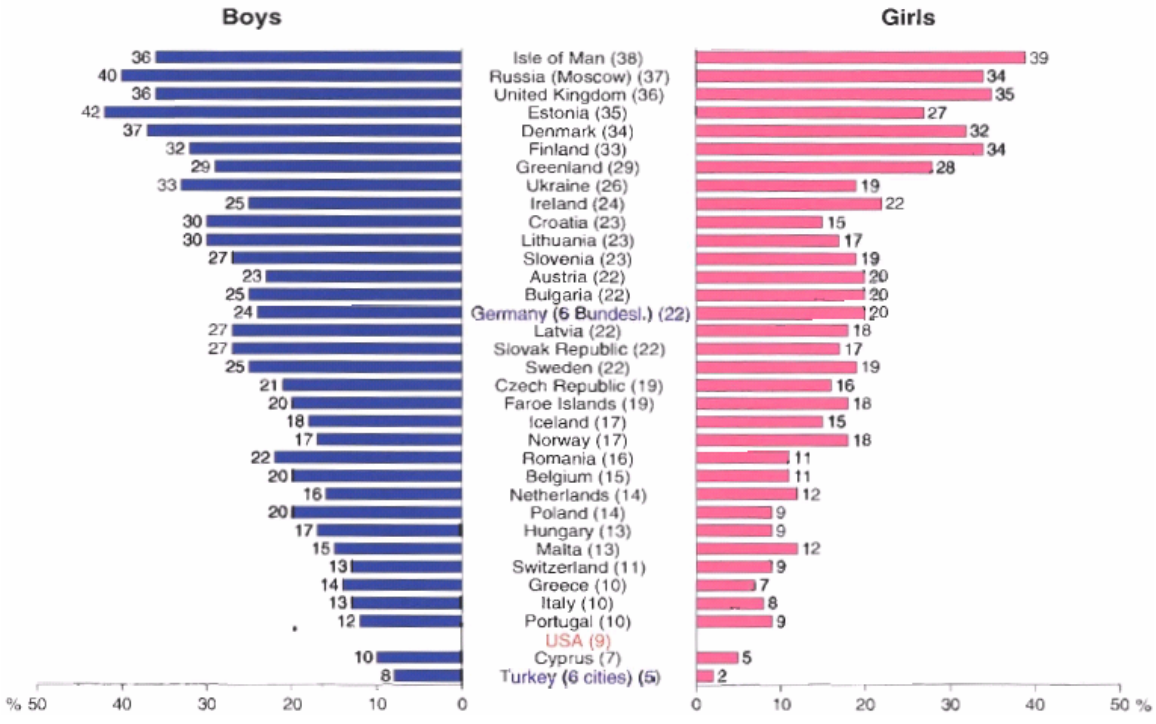
[287] Alcohol Concern (2006) Acquire: Alcohol Concern Quarterly Information and Research Bulletin, Autumn 2006.
[288] Ibid
[289] Ibid

Figure 20: Proportion of 15-16 Year Old Boys and Girls Who Have Been Drunk 20 Times or More in Lifetime, 2003



Source: The European School Survey Project on Alcohol and Other Drugs (ESPAD), 2003

Figure 21: Proportion of Boys and Girls Who Have Been Drunk at the Age of 13 or Younger, 2003.



Source: The European School Survey Project on Alcohol and Other Drugs (ESPAD), 2003

7.1.9. According to a survey produced by the British Medical Association (BMA) in 2003, regular heavy drinking and binge drinking are associated with several problems affecting young people, such as physical and mental problems, anti-social behaviour, violence and poor school performance.[290]

7.1.10. In relation to health, the burden caused by intoxication is relatively higher in young people than in the rest of the population.[291] In 2004/5 7,579 under 18 year olds in Britain were admitted to hospital for alcohol-related injuries. This figure represents a 21% increase from the period 2000/1.[292]

7.1.11. In Kent, the number of young people treated in hospitals for alcohol-related injuries rose from 115 in 2005/6 to 271 in 2006/7 (see Figure 9).[293]

7.1.12. Intoxication among young people is more dangerous than for adults, as young people experience coma at lower blood alcohol levels and can develop hypoglycaemia, hypothermia and breathing difficulties.[294] Some evidence also shows that alcohol misuse can affect brain development.[295]

7.1.13. Deaths from liver cirrhosis amongst 25 to 34 year olds have risen; this is thought to be a consequence of a rise in drinking from an earlier age.

7.1.14. With regards to crime and anti-social behaviour, underage drinking and drunken behaviour are perceived as real problems by the public.[296] Nearly half of young people aged between 10 and 17 years who drink once a week or more admitted to have committed disorderly or criminal behaviour.[297]

7.1.15. Amongst young people aged 18-24 years, those who binge drink are far more likely to have committed criminal or anti-social behaviour during or after drinking (63%) than other regular drinkers of the same age (34%).[298]

[290] British Medical Association (2003) Adolescent Health, BMA Board of Science and Education, London.
[291] Alcohol Concern (2006) Acquire: Alcohol Concern Quarterly Information and Research Bulletin, Autumn 2006.
[292] Ibid
[293] Kent County Council (2007) Alcohol Misuse Select Committee, 14 June 2007, Maidstone.
[294] Alcohol Concern (2006) Acquire: Alcohol Concern Quarterly Information and Research Bulletin, Autumn 2006.
[295] Alcohol Concern (2006) Acquire: Alcohol Concern Quarterly Information and Research Bulletin, Autumn 2006.
[296] Department of Health (2007) Safe. Sensible. Social. The Next Step in the National Alcohol Strategy, London.
[297] Ibid
[298] Ibid

7.1.16. This age group accounts for a third of all offences and a quarter of all violent offences reported in England in 2006, despite representing only 6% of the population analysed.[299]

7.1.17. In Kent the number of young people arrested for committed alcohol-related offences increased from 278 in 2005/6 to 403 in 2005/6 (see Figure 11).[300]

7.1.18. Together with the above alcohol-related problems among young people, there are other concerns over the close relationships between alcohol and unsafe sex, sexually transmitted infections (STIs), illicit drugs use, poor educational performance and school exclusion.

7.1.19. Evidence shows that after consuming alcohol, one in seven 16-24 year olds have had unsafe sex, one in five have had sex they later regretted, one in ten have been unable to remember whether they had sex the night before, and 40% think they are more likely to have casual sex.[301] Given that the UK has the highest teenage pregnancy rate in Western Europe, these figures are a matter of serious concern in relation to unwanted pregnancies and STIs including HIV.[302] [303]

7.1.20. The link between alcohol consumption and illicit drug use is also very strong. One study reported that over half of "weekly drinkers" admitted having used illicit drugs compared to 1 in 15 non-drinkers.[304] In addition, a recent national survey on smoking, drinking and drug use showed that recent alcohol use was the strongest predictor of recent cannabis use.[305]

7.1.21. When mixing alcohol and drugs, their effects are also often compounded, presenting unknown and increased health risks. For instance, researchers have found that when drinking alcohol and taking cocaine together, the liver combines them and produces a third substance, Cocaethylene, which both intensifies the euphoric effects of cocaine and increases the risks of liver damage sudden death.[306] [307]

7.1.22. Finally, evidence shows that alcohol misuse has an impact on school performance. For example, a European study concluded that there is a strong correlation between alcohol consumption and school performance, with alcohol misuse being both the cause and the result of school failure.[308]

---

[299] Ibid
[300] Kent County Council (2007) Alcohol Misuse Select Committee, 14 June 2007, Maidstone.
[301] Social Exclusion Unit (1999) What's It All About, London.
[302] Department for Education and Skills (2006) Teenage Pregnancy Next Steps: Accelerating the Strategy to 2010, Nottingham.
[303] Alcohol Concern (2006) Acquire: Alcohol Concern Quarterly Information and Research Bulletin, Autumn 2006.
[304] Ibid
[305] Ibid.
[306] National Institute on Drug Abuse (2008) website: http:/www.nida.nih.gov/Infofacts/cocaine.
[307] Release (2008) Drugs. The Law and Human Rights, website: http://www.release.org.uk/html/~drug_menu/cocaine.php.
[308] Settertobulte, W. et al (2001) Drinking Among Young Europeans, WHO, Copenhagen.

7.1.23. Alcohol is also a factor in school suspensions and exclusions. A 2003 study commissioned by the Youth Justice Board reported that around 14% of children in the country were excluded from school for drinking alcohol in the premises.[309]

7.2. Young People and Alcohol Education

7.2.1. Several issues and consequences, then, surround young people and alcohol misuse. As part of the long-term alcohol harm reduction strategy, it is important that young people are educated to make responsible choices about their drinking behaviour.[310]

7.2.2. Although some evidence suggests that school-based alcohol education programmes are unlikely to deliver large benefits, other evidence suggests that good quality alcohol education, delivered by competent people, can be effective.[311] [312] [313] [314]

7.2.3. More specifically, good alcohol education should be delivered consistently; it should both provide accurate information and be interesting, and should be part of a multi-component, combined approach.[315] [316] [317]

7.2.4. Good alcohol education is important for a variety of reasons. Even if scientific reviews have shown that school-based alcohol education has positive but modest effects on alcohol consumption, they also point out that it has a large influence on knowledge and attitudes towards alcohol.[318] Given the importance of alcohol in British culture and society – and the need for a cultural shift in drinking behaviour – providing young people with empowering information is essential.[319]

7.2.5. In addition, prevention and early intervention are clearly more desirable approaches, before excessive drinking produces dependence that makes treatment challenging.[320] Evidence suggests that people who develop alcohol dependency later in life often start drinking before the age of 14 years.[321]

---

[309] Youth Justice Board (2003) Youth Survey 2003: Research Study Conducted for the Youth Justice Board, January to March, MORI, London.
[310] Prime Minister's Strategy Unit (2004) Alcohol Harm Reduction Strategy for England, London.
[311] Babor, T. et al (2003) Alcohol: No Ordinary Commodity, Oxford, Oxford University Press.
[312] Kent County Council (2007) Alcohol Misuse Select Committee, 10 July 2007, Maidstone.
[313] Kent County Council (2007) Alcohol Misuse Select Committee, 10 July 2007, Maidstone.
[314] Department for Education and Skills (2004) Drugs: Guidance for Schools, London.
[315] Kent County Council (2007) Alcohol Misuse Select Committee, 10 July 2007, Maidstone.
[316] Ibid
[317] Fox Anne (2007) Alcohol Misuse Select Committee, written evidence, 14 September 2007, Maidstone.
[318] Mental Health Foundation (2006) Cheers? Understanding the Relationship between Alcohol and Mental Health, London.
[319] Ibid
[320] Raistrick, D., Heather, N. and Godfrey, C. (2006) Review of the Effectiveness of Treatment of Alcohol Problems, National Treatment Agency (NTA), London.
[321] Kent County Council (2007) Alcohol Misuse Select Committee, 14 June 2007, Maidstone.

7.2.6. Alcohol education is already a statutory requirement of the National Curriculum Science Order, representing the minimum delivery requirement. However, schools are expected to extend alcohol education provision through the non-statutory framework for Personal, Social and Health Education (PSHE).[322]

7.2.7. PSHE helps children in both primary and secondary schools develop their knowledge, skills, attitudes and understanding about alcohol.[323] In addition, PSHE programmes include education on sexual health and drugs misuse, contributing as a package in tackling these issues as stated in Towards 2010.[324]

7.2.8. The delivery of education on those topics as a coordinated package is crucial given that, as the report already mentioned, strong links exist between alcohol misuse, the use of illicit drugs and unsafe sexual activity.[325] [326]

7.2.9. The recent KCC select committee report on PSHE and Children's Health already identified some of the current challenges affecting the effective delivery of PSHE in the County.[327]

7.2.10. One of the consequences of the lack of statutory status is that the delivery of PSHE remains typified by general vagueness and inconsistency. On average PSHE is allocated one of the lowest teaching time in the country – about 2.5% in years 7 to 9; some schools do not provide PSHE at all.[328] Although it is challenging to include regular PSHE lessons within an already "squashed" curriculum, Ofsted maintained that not providing PSHE in any form is "untenable".[329]

7.2.11. Together with the inconsistent delivery of PSHE, it appears that the subject is affected by a shortage of specialist, accredited teachers. Although free PSHE certification courses for both teachers and nurses are available, with lessons about alcohol and its negative effects being delivered by Schools Drugs Education Advisers, many members of staff are reluctant to take on those courses because PSHE is considered "content heavy" and not as desirable as other subjects in terms of career development.[330]

7.2.12. However, as the report points out, it is perhaps precisely because some aspects of PSHE are "content heavy" and because it is important to provide accurate information about alcohol that untrained teachers and nurses should specialise by obtaining the certificate.[331] Also, Ofsted

[322] Prime Minister's Strategy Unit (2004) Alcohol Harm Reduction Strategy for England, London.
[323] Ibid
[324] Kent County Council (2007) PSHE/Children's Health Select Committee Report, KCC, Maidstone.
[325] Social Exclusion Unit (1999) What's It All About, London.
[326] Alcohol Concern (2006) Acquire: Alcohol Concern Quarterly Information and Research Bulletin, Autumn 2006.
[327] Kent County Council (2007) PSHE/Children's Health Select Committee Report, KCC, Maidstone.
[328] Ibid
[329] Ibid
[330] Ibid
[331] Ibid

reports that the quality of PSHE teaching by specialist teachers remains considerably better than that of non-specialist ones.[332]

7.2.13. The specialist knowledge acquired, the report indicates, should be organised and disseminated through the collaboration of schools located in the same geographical area. [333] Indeed, evidence suggests that in Kent specialist teachers are already cascading their knowledge to other colleagues within the same grouping of schools.[334]

7.2.14. It has been suggested to Members of the Committee that, together with specialist teachers and nurses, it may be beneficial if people recovering from alcohol dependence were also involved in the delivery of alcohol education. They have personally experienced the adverse effects of alcohol dependence and can be particularly convincing in teaching pupils that it is not glamorous or sensible to misuse alcohol.[335]

7.2.15. Guidance will be issued to schools, stressing the importance that lessons delivered by *any* outside speaker – including ex alcohol misusers – must comply with a clear quality assurance framework. This framework requires, for example, that matters such as confidentiality and responsibility for behaviour management are in place.[336]

7.2.16. In addition to PSHE, other initiatives can be promoted to educate children and young people in Kent about alcohol and its consequences.

7.2.17. Central Government is encouraging sensible drinking and increased alcohol awareness through its national "Know Your Limits" campaign. The campaign targets binge drinkers in particular, emphasising the physical and criminal consequences of alcohol misuse.[337]

7.2.18. Also, the "Think" national campaign adopts graphic images of the injuries that drink driving can cause in order to discourage such behaviour.[338]

7.2.19. One initiative in Kent is a peer-education schools drama competition for young people on the theme of alcohol and drug misuse. Young people have the opportunity to participate in a competition in which they write a short play about the issues involved and perform in a play. The finalists have the opportunity to perform their play in the Hazlitt Theatre in Maidstone in front of an invited audience.[339]

7.2.20. It was also suggested that successful initiatives adopted to deal with other issues – which sometimes are related to alcohol misuse – can be adapted to the theme of alcohol misuse. For example, "A Licence to

[332] Ibid
[333] Ibid
[334] Kent County Council (2007) Alcohol Misuse Select Committee, 14 June 2007, Maidstone.
[335] Kent County Council (2007) Alcohol Misuse Select Committee, 27 June 2007, Maidstone.
[336] Kent County Council (2008), written evidence, 18 February 2008.
[337] Department of Health (2007) Safe. Sensible. Social. The Next Step in the National Alcohol Strategy, London.
[338] Ibid
[339] Kent County Council (2007) Alcohol Misuse Select Committee, 10 July 2007, Maidstone.

Kill?" is a successful project which has been adopted in Kent and Medway to discourage drink driving. The initiative, set in a theatre, involves showing to 16 to 18 year old pupils a film of a crash which has been recreated in the local area, and the dynamics that follow the accident. All those who were involved both directly and indirectly in the accident, such as the driver, police officers and ambulance staff who arrived on the scene of the accident, give their vivid accounts of the event, rendering the experience both realistic and effective for pupils.[340] [341]

7.3. Parents and Alcohol Education

7.3.1. Parents play a central role in the provision of alcohol education to children and young people. Children's drinking attitudes and behaviours are initially shaped by their families; parents act as role models and can control and support their children drinking patterns.[342] Parents can instil in children a "socially competent drinking behaviour".[343]

7.3.2. By contrast, low parental support and control, heavy parental drinking and attitude that condone alcohol misuse are likely to result in heavy drinking by young people.[344] One witness reported to the Committee that he observed parents condoning and even encouraging their 12 year old child's drinking behaviour by claiming "my child can hold his alcohol".[345] Alcohol misuse by parents can even lead to verbal and physical harm to their children; one third of all domestic violence in the country is alcohol-related.[346]

7.3.3. The law allows parents and young people to decide when young people can consume alcohol.[347] Nonetheless, young people are drinking alcohol at a younger age and those who drink are consuming larger quantities than ever before.[348] Parents are the most common source of alcohol provision to young people, supplying 48% of the alcohol obtained by underage drinkers.[349] [350]

7.3.4. As one witness observed, even if primary and secondary schools provide good alcohol education, the teaching may be ineffective if children receive contrasting messages from significant role models such as their parents. [351] It is important, then, that parents are engaged in the

[340] Kent County Council (2007) Alcohol Misuse Select Committee, visit to the Kenward Trust, 20 July 2007, Maidstone.
[341] Kent and Medway Safety Camera Partnership (2007), A License to Kill?, http://www.kmscp.org/ltk/.
[342] Alcohol Concern (2006) Acquire: Alcohol Concern Quarterly Information and Research Bulletin, Autumn 2006.
[343] Ibid
[344] Ibid
[345] Kent County Council (2007) Alcohol Misuse Select Committee, visit to the Kenward Trust, 20 July 2007, Maidstone.
[346] Department of Health (2007) Safe. Sensible. Social. The Next Step in the National Alcohol Strategy, London.
[347] Ibid
[348] Ibid
[349] Ibid
[350] Kent County Council (2007) Alcohol Misuse Select Committee, 2 July 2007, Maidstone.
[351] Kent County Council (2007) Alcohol Misuse Select Committee, 27 June 2007, Maidstone.

provision of effective alcohol education to their children and in promoting sensible drinking.

7.3.5. Given the potential negative consequences of alcohol misuse, children and young people need both support and education that enable them to make informed and sensible choices about their drinking behaviour. The Alcohol Misuse Select Committee, after having considered the evidence, commends the following actions.

Recommendation 14

The Alcohol Misuse Select Committee recommends that:

More consistent Personal, Social and Health Education (PSHE), which includes effective alcohol education, should be delivered in both primary and secondary schools in Kent. PSHE accreditation for both teachers and nurses should be widely supported. The organisation and promotion of this training should be carried out by Schools Drugs Education Advisers through Local Children's Services Partnerships. The Kent PSHE Advisory Group should pay particular attention to this recommendation when investigating young people's personal health and wellbeing in the County.

Recommendation 15

The Committee recommends that the inclusion of persons recovering from alcohol addiction in the delivery of alcohol education in schools in Kent should be considered by Local Children's Services Partnerships. Guidance for schools will ensure that lessons delivered by outside speakers, including previous alcohol misusers, comply with a clear quality assurance framework.

Recommendation 16

The Committee commends that parents and Kent-based primary and secondary schools should work in partnership to promote legal, safe and sensible drinking. Schools should involve parents in their children's alcohol education by transferring learning about sensible drinking into the home.

Recommendation 17

Successful initiatives dealing with other related health issues, such as drug misuse, drink driving and sexual health, should be explored for adaptation to the theme of alcohol misuse. KCC should support the delivery of these initiatives in tackling alcohol misuse.

8. Alcohol Misuse, Crime and Anti-Social Behaviour

8.1. The Impact of Alcohol-Related Crime and Disorder

8.1.1. The vast majority of the population in the UK enjoy alcohol without causing harm. However, a minority of people who drink put themselves and others at risk. Alcohol misuse is strongly linked to violence and disorder and contributes to driving people's fear of crime. [352]

8.1.2. According to the Alcohol Harm Reduction Strategy for England (2004), 61% of the population perceive alcohol-related violence as worsening.[353]

8.1.3. Over half of reported drunken or anti-social behaviour is attributed to young people.[354]

8.1.4. In England nearly half of all 10-17 year olds who drink at least once a week admitted to some sort of crime or antisocial behaviour; about a fifth of them admitted that they had been involved in a fight during or after drinking.[355]

8.1.5. In 2006, young people aged 18-24 years accounted for a third of all offences and a quarter of all violent offences in the country, despite representing only 6% of the population analysed.[356]

8.1.6. Around half of all incidents of domestic violence (46%) are thought to be related to alcohol.[357] About 1 million children live in families where one or both parents misuse alcohol.[358] A survey showed that parental alcohol misuse was one aspect in 23% of child neglect calls, 13% of calls about emotional abuse, 19% of calls about physical abuse and 5% of calls about sexual abuse.[359]

8.1.7. In 30% of all sexual offences, 33% of burglaries and 50% of street crime, offenders have been found to be drunk.[360] About half of all violent crimes (1.2 million incidents) are alcohol-related. 63% of men and 39% of women coming to prison were classed as hazardous drinkers in the year leading up to custody.[361]

8.1.8. In Kent, the total population of the County's prisons is 3,558, of which 3,465 are men and 93 are women. According to the Counselling Assessment Referral Advice and Throughcare (CARAT), although the number of individuals who have been identified and recorded as having

[352] Prime Minister's Strategy Unit (2004) Alcohol Harm Reduction Strategy for England, London.
[353] Ibid
[354] Department of Health (2007) Safe. Sensible. Social. The Next Step in the National Alcohol Strategy, London.
[355] Ibid
[356] Ibid
[357] Ibid
[358] Department of Health (2005) Alcohol Misuse Interventions, London.
[359] Ibid
[360] Ibid
[361] Ibid

an alcohol problem in Kent is 451, it is estimated that as much as 50%, or about 1,500 convicts, suffers from alcohol misuse.[362]

8.1.9. Data from 2004 shows that drink driving was associated with 5% of all road accidents and with 18% of all road fatalities.[363]

8.1.10. Up to 35% of all A&E attendances and ambulance costs (about £0.5 billion) may be attributed to alcohol misuse. The proportion of alcohol-related attendances can reach 70%.[364]

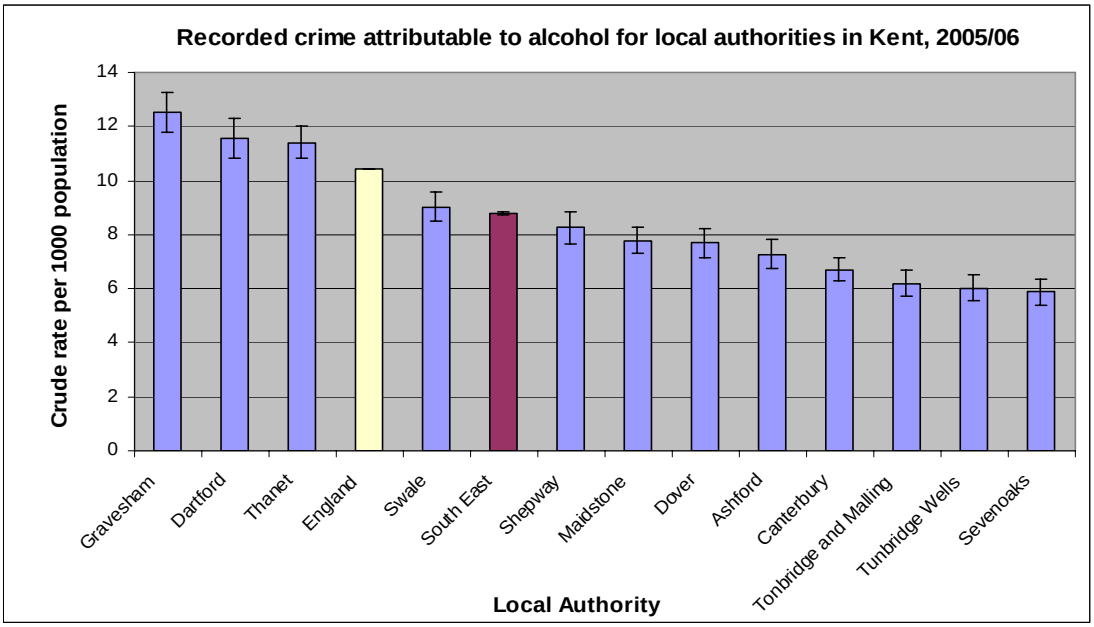
8.1.11. The number of NHS staff experiencing violence or abuse from patients has remained relatively stable between 2003 and 2006; 31% experienced violence in 2006, 30% in 2005, and 32% in 2003 and 2004.[365] [366]

8.1.12. In 2004-2005, in England, NHS staff in acute hospitals experienced 11,428 physical assaults; ambulance staff experienced 1,329 assaults.[367]

8.1.13. In the South East the rate of crime is lower than the average rate for England.[368] However, the level of crime attributable to alcohol is higher in three Kent districts (Dartford, Gravesham and Thanet) than in the England average (10.45 per 1,000 persons), and higher in four districts (Dartford, Gravesham, Swale and Thanet) than in the South East average (8.77 per 1,000 persons) (please see Appendix 3 for a larger picture). [369]

[362] Kent County Council (2007) Alcohol Misuse Select Committee, written evidence, 15 January 2008.
[363] Department of Health (2005) Alcohol Misuse Interventions, London.
[364] Ibid
[365] Healthcare Commission (2006) National Survey of NHS Staff 2005: Summary of Key Findings, London.
[366] Sheehan, D. (2007) Implementing Emergency: Department Data Sharing to Reduce Alcohol-Related Violence, Second National Alcohol Conference, Government Office for the South East, Guilford.
[367] Ibid
[368] Sheehan, D. (2007) Choosing Health in the South East: Alcohol, South East Public Health Observatory (SEPHO).
[369] NWPHO (2006) Local Alcohol Profiles for England, www.nwph.net/alcohol/lape.

Figure 22: Recorded Crime Attributable to Alcohol in Kent, 2005/06

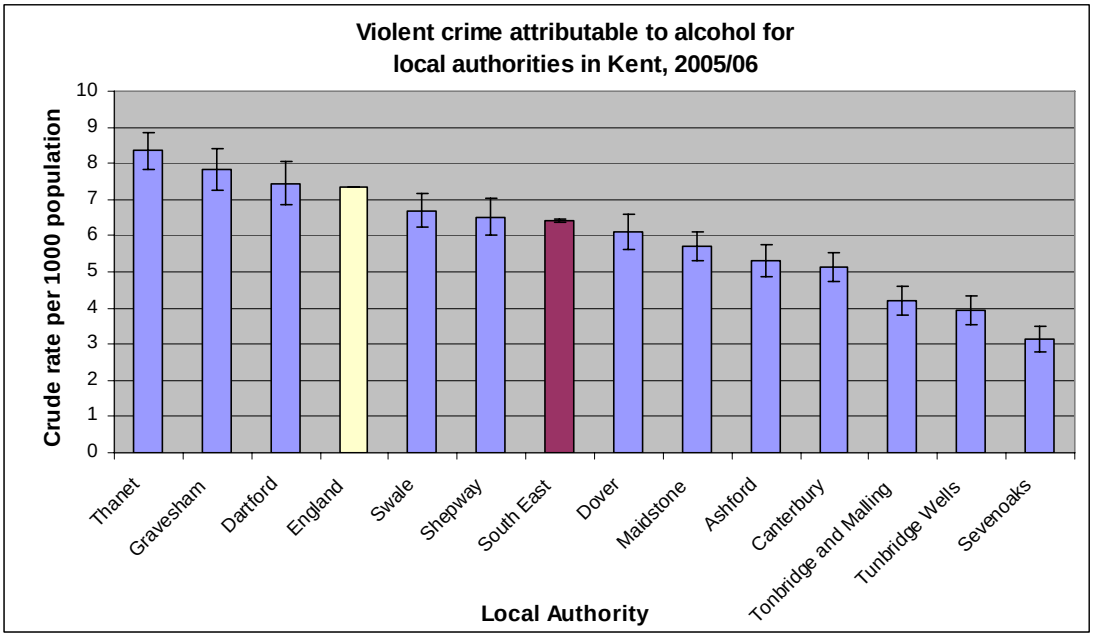


Source: Local Alcohol Profiles for England, NWPHO

8.1.14. Also, the level of alcohol-related violent crime is higher in three districts (Dartford, Gravesham and Thanet) than in the English average (7.33 per 1,000 persons), and is higher in five districts (Dartford, Gravesham, Shepway, Swale and Thanet) than in the South East average (6.42 per 1,000 persons).[370] The rate of sexual offences attributable to alcohol is approximately the same or higher in seven districts (Ashford, Dartford, Gravesham, Maidstone, Shepway, Swale and Thanet) than in both the national and regional average (both 0.15 per 1,000 persons) (see Appendix 3 for larger pictures).[371]

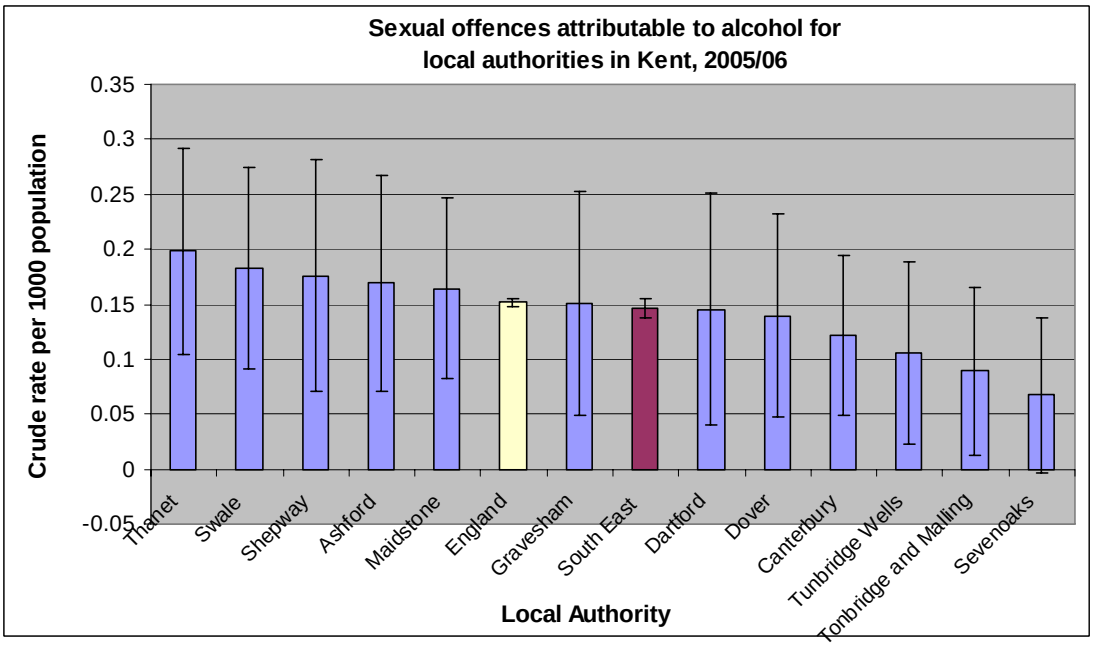
[370] Ibid
[371] Ibid

Figure 23: Violent Crime Attributable to Alcohol in Kent, 2005/6



Source: Local Alcohol Profiles for England, NWPHO

Figure 24: Sexual Offences Attributable to Alcohol in Kent, 2005/6



Source: Local Alcohol Profiles for England, NWPHO

8.1.15. The number of adult arrests in Kent for drink offences increased from 5732 in 2005-6 to 5950 in 2006-7. The number of young people arrests in Kent in this period has also substantially increased, from 278 in 2005-2006 to 403 in 2006-7.[372]

[372] Kent County Council (2007) Alcohol Misuse Select Committee, 14 June 2007, Maidstone.

8.1.16. The level of anti-social behaviour can be measured in part by using data on the serving of Penalty Notices for Disorder (PNDs), although this data can also reflect different approaches adopted by different police authorities in dealing with the issue. The South East rate of alcohol-related PNDs (59.4%) is considerably higher than the English average (46.8%); Kent has the second highest rate of PNDs in the region (71.3%).[373]

8.1.17. Section 17 of the Crime and Disorder Act 1998, then amended by the Police and Justice Act 2006, states that responsible authorities must consider crime and disorder and the misuse of substances, including alcohol, in the exercise of all their duties, activities and decision making; all policies and strategies must include a consideration of their impact on crime and disorder.[374]

8.2. Tackling Alcohol-Related Crime in Kent

8.2.1. Several local organisations, such as Kent County Council, the Kent Police, the Kent Community Safety Partnership and Local Crime and Reduction Partnerships (CDRPs) are committed to dealing with alcohol-related crime. A wide variety of initiatives are already in place in the county to deal with the issue.[375]

8.2.2. The Kent Community Safety Partnership between KCC and Kent Police was set up in 2001. Some of the initiatives introduced through the Partnership in order to meet the policing and safety needs of Kent residents included additional resources to provide a highly visible uniformed presence, and the addition of Community Wardens and Partnership Police Community Support Officers (PCSOs).[376]

8.2.3. Crime and Disorder Reduction Partnerships (CDRPs) were established following the 1998 Crime and Disorder Act. They involve a variety of agencies including the police, local authorities, the probation service, health authorities, the voluntary sector, local businesses and residents.[377] It is the legal duty of CDRPs to identify local crime and disorder sources and to take joined-up action to deal with them.[378]

8.2.4. Kent Police is highly involved in tackling alcohol-related crime. At strategic level, for example, the Kent Police Drug and Alcohol Strategy informs and assists Kent Police and its partners in the reduction of drug and alcohol misuse, and ensures the delivery of national alcohol and drug misuse strategies.[379]

---

[373] Sheehan, D. (2007) Choosing Health in the South East: Alcohol, South East Public Health Observatory (SEPHO).
[374] Kent County Council (2006) Section 17 Crime and Disorder Act: What It Means to You, Maidstone.
[375] Ibid
[376] Kent County Council (2006) Section 17 Crime and Disorder Act: What It Means to You, Maidstone.
[377] Home Office (2007)http://www.crimereduction.gov.uk/partnerships2.htm.
[378] [378] Kent County Council (2006) Section 17 Crime and Disorder Act: What It Means to You, Maidstone.
[379] Kent Police (2007) Area Operations: Drug and Alcohol Strategy, Kent Police.

8.2.5. A series of more specific initiatives reflect the strategic commitment of the Kent Police and of other local partner agencies, such as Trading Standards.

8.2.6. Penalty Notices for Disorder (PNDs) entail the issuing of fixed fines of £80 to individuals exhibiting disruptive behaviour. [380]

8.2.7. "Conditional Cautioning" referral schemes aim to provide an alternative to prosecution where the offending is alcohol-related, and where offenders must attend sessions to learn about the consequences of alcohol misuse.[381]

8.2.8. In "meet and greet" tactics, officers patrol targeted night-time "hot spots" to provide reassurance for the public and to deter crime.[382]

8.2.9. The "safer socialising" scheme awards certificates to those businesses selling alcohol in the night-time economy that demonstrate high standards of management and operation.[383]

8.2.10. The Alcohol Intervention Support Programme (AISP), commissioned by KDAAT and delivered by the Kenward Trust, aims to divert young people from substance misuse through education and awareness.[384]

8.2.11. Finally, two more measures include the distribution of "spikies", which are applied to bottles to prevent the spiking of drinks in pubs and clubs, and the "Pub Watch" scheme, which involves the exchange of intelligence between businesses, the police and other agencies in order to identify "hot spots"[385].

8.2.12. The commitment of Kent County Council to deal with alcohol-fuelled offences is reflected, for example, in the Section "Stronger and Safer Communities" and in several targets of the Towards 2010 strategy. The objective of Target 57, for instance, is to support Kent Police and to work with CDRPs to strengthen police presence in problem areas. Target 58 instructs to work with off-licences, pubs and clubs to reduce alcohol-related crime and antisocial behaviour. Target 60 requires KCC to support young people in order to reduce the risk of them offending.[386]

8.2.13. Also, the Kent Agreement - which comprises the Local Area Agreement (LAA) and the Local Agreement Phase 2 (LPSA2) – brings together Kent "partners" to tackle, amongst other things, problems with a link to alcohol in the County. One of the central tasks of the Safer and Stronger Communities Group is to oversee the targets in the Kent Agreement and to recommend specific actions to meet desired

[380] Kent County Council (2007) Alcohol Misuse Select Committee, 28 June 2007, Maidstone.
[381] Department of Health (2005) Alcohol Misuse Interventions, London.
[382] Kent County Council (2007) Alcohol Misuse Select Committee, 28 June 2007, Maidstone.
[383] Action Against Business Crime (2007) http://www.brc.org.uk/aabc/safersocialisingaward.htm.
[384] Kent County Council (2007) Alcohol Misuse Select Committee, written evidence, 20 June 2007, Maidstone.
[385] Kent County Council (2007) Alcohol Misuse Select Committee, 28 June 2007, Maidstone.
[386] Kent County Council (2007) http://www.kent.gov.uk/council-and-democracy/.

"outcomes". Outcomes 9, 10, 11 and 12 are all aimed at reducing crime and at making Kent a safer place to live.[387]

8.2.14. In order to meet these targets, for example, the Safer and Stronger Communities Group includes a sub-group - the Kent and Medway Domestic Violence Strategy Group – whose objective is to develop domestic abuse services and projects in Kent.[388] Importantly, the focus on violent and other crimes associated to the night-time economy also remains a high priority for the Safer and Stronger Communities Group.[389] [390]

8.2.15. Members of the Alcohol Misuse Select Committee commend the work of the Safer and Stronger Communities Group and urge that the Group makes sure to tackle a diversity of alcohol-related offences, which are not necessarily of a violent nature.

8.2.16. The Committee also insists that communication and cooperation between all agencies involved in dealing with alcohol misuse in Kent is enhanced. As the report indicated above, several initiatives involving different local organisations are currently taking place in the county. Indeed, more schemes can be mentioned to illustrate co-operation and information sharing processes. For example, Kent Police, KDAAT and Eastern and Coastal Kent PCT are currently collaborating in a pilot scheme for the east of Kent which entails offering alcohol counselling and treatment to offenders with potential alcohol problems.[391]

8.2.17. Other programmes demonstrate multi-level partnership working between countywide and more local organisations. For example, the "Three Strikes" scheme includes Kent Police, Dover District Council, Dover CDRP, the Dover Partnership and other local agencies, and involves penalties such as the issuing Anti-Social Behaviour Orders (ASBOs) after a third arrest for alcohol-related offences.[392] [393]

8.2.18. However, evidence submitted to Members of the Committee suggests that communication and collaborative mechanisms between all the agencies involved can be maximised.[394] For example, a witness suggested that CDRPs and the Kent Partnership should look at ways to better connect the District level CDRPs and the county Stronger, Safer Community Partnership.[395] Also, a representative of the alcohol industry

[387] Kent County Council (2005) The Kent Agreement, Maidstone.
[388] Kent County Council (2007) Kent Partnership: Safer and Stronger Communities Group, Meeting on 11 October 2007, Maidstone.
[389] Ibid
[390] Kent County Council (2005) The Kent Agreement, Maidstone.
[391] Kent County Council (2007) Alcohol Misuse Select Committee, written evidence, 20 June 2007, Maidstone.
[392] Kent County Council (2007) Alcohol Misuse Select Committee, 28 June 2007, Maidstone.
[393] See also "Three Strikes" leaflet.
[394] Kent County Council (2007) Alcohol Misuse Select Committee, written evidence, 18 September 2007, Maidstone.
[395] Ibid

maintained that more involvement and collaboration with the alcohol industry was needed at localised level.[396]

8.2.19. Accident and Emergency (A&E) data gathering and sharing could also be improved. In Kent projects already exist, involving the pooling of A&E data collected from questionnaires, with the objectives both of gaining a better understanding of the dynamics of alcohol misuse and of using productively that intelligence to combat alcohol misuse.[397]

8.2.20. This exercise can prove very useful in dealing with alcohol misuse and crime resulting from it given that, as already indicated above, a large proportion of A&E attendances are related to alcohol misuse.[398]

8.2.21. However, good evidence identifies the need for improving intelligence and support action in relation to A&E data. For example, it was suggested that PCTs, Hospital, Ambulance and Mental Health Trusts in Kent could all enhance their record of alcohol-related violent crimes and share this information to enable Kent CDRPs to produce their crime audits and community safety strategies. [399] [400]

8.2.22. Nonetheless, this need for increased and accurate data collection to assess the impact of initiatives and to combat alcohol misuse is not exclusive to Kent, and exists at national level too.[401]

8.2.23. Another initiative that could be developed in order to strengthen cooperative links is a conference on alcohol and the night-time economy including representatives of all the CDRPs in the County and representatives of KDAAT.[402]

8.2.24. Finally, another area that the Alcohol Misuse Select Committee identified after the exploration of the issue of alcohol misuse and its relation to crime is the role of sentencing in containing the problem.

8.2.25. The large majority of alcohol-related offenders are not habitual offenders. However, some of them are arrested regularly; about 20% of those arrested for committing alcohol-related offences have already been convicted four or more times.[403]

8.2.26. Several forms of health and education intervention are available to the justice system to promote behavioural change. For example, courts can attach an Alcohol Treatment Requirement (ATR) to a community order, so that alcohol dependent offenders must receive intensive care

[396] Kent County Council (2007) Alcohol Misuse Select Committee, 19 June 2007, Maidstone.
[397] Kent County Council (2007) Alcohol Misuse Select Committee, written evidence, 20 June 2007, Maidstone.
[398] Department of Health (2005) Alcohol Misuse Interventions, London.
[399] Kent Police (2007) Area Operations: Drug and Alcohol Strategy, Kent Police.
[400] Kent County Council (2007) Alcohol Misuse Select Committee, written evidence, 18 September 2007, Maidstone.
[401] Department of Health (2005) Alcohol Needs Assessment Research Project (ANARP), London.
[402] Kent County Council (2007) Alcohol Misuse Select Committee, written evidence, 18 September 2007, Maidstone.
[403] Prime Minister's Strategy Unit (2004) Alcohol Harm Reduction Strategy for England, London.

treatment.[404] Also, the National Probation Service (NPS) offers – amongst other substance misuse schemes – a Drink Impaired Drivers (DID) programme designed for drink drivers.[405]

8.2.27. However, processes for referring more habitual alcohol-related offenders are considered less effective, as these offenders will continue to cause harm to themselves and to society at large, and will continue to absorb criminal justice time and resources.[406]

8.2.28. It is the view of the Committee – and it is also stated in both the main national drivers, the Alcohol Harm Reduction Strategy for England (2004) and Safe. Sensible. Social. The Next Steps in the National Strategy (2007) – that intoxication does not relieve individuals of responsibility for their actions.[407] [408] Indeed, it is asserted that alcohol should be taken into account as an aggravating factor when sentencing.[409]

8.2.29. As the Alcohol Harm Reduction Strategy indicates, it is crucial that magistrates and sentencers are made aware of the variety of health and education interventions that are available as part of a sentence. It is also vital to they are made aware that tougher approaches are necessary against habitual offenders and against more serious alcohol-related offences. Magistrates could be provided by Her Majesty Court Service (HMCS) with training which will supply information on the variety of interventions available to them, and which will give support to deal more effectively with recidivism and more serious alcohol-related offences.

8.2.30. Alcohol misuse is the cause of two major problems in England; it can cause harm to people's health and it can result in crime and anti-social behaviour. Having largely dealt with the consequences and some possible solutions of alcohol misuse in relation to the health aspect, Members of the Alcohol Misuse Select Committee make the following recommendations to deal with the aspect of alcohol-related crime.

[404] Department of Health (2007) Safe. Sensible. Social. The Next Step in the National Alcohol Strategy, London.
[405] Ibid
[406] Prime Minister's Strategy Unit (2004) Alcohol Harm Reduction Strategy for England, London.
[407] Prime Minister's Strategy Unit (2004) Alcohol Harm Reduction Strategy for England, London.
[408] Department of Health (2007) Safe. Sensible. Social. The Next Step in the National Alcohol Strategy, London.
[409] Ibid

Recommendation 18

The Select Committee commends and supports the work carried out by the Safer and Stronger Communities Group and its sub-group, in their effort to reduce alcohol-related crime linked to the night-time economy and to deal with domestic violence in Kent. It recommends that this work should be comprehensive, including the diversity of offences fuelled by alcohol misuse which are not necessarily of a violent nature. (Sections 8.1 and 8.2)

Recommendation 19

The Select Committee urges that:

Communication between agencies at county level and those at more local level should be enhanced. Better data sharing between organisations dealing with alcohol related crime, such as the police and Crime Disorder Reduction Partnerships (CDRPs) should be secured. The sharing of best practice between Kent-based CDRPs in tackling alcohol related disorder should be improved. Both Central Government and the alcohol industry should be encouraged to provide data and finance.

Recommendation 20

The Committee strongly recommends that the Kent-based alcohol misuse conference, including representatives of local authorities, CDRPs, KDAAT and the alcohol industry, is established.

Recommendation 21

The Alcohol Misuse Select Committee urges that:

All hospitals in Kent improve Accident and Emergency (A&E) data gathering on injuries resulting from alcohol-related violence. All A&E departments in Kent should be strongly encouraged to collect and share data with other agencies in order to pinpoint "hot spots" and sources of crime resulting from alcohol misuse, and should quantify accurately NHS costs of dealing with health consequences.

Recommendation 22

KCC should recommend that magistrates are provided by Her Majesty Court Service (HMCS) with training which will enable them to deal more effectively with alcohol-related crime.

9. Alcohol Misuse, the Alcohol Industry and Social Responsibility

9.1. Alcohol Misuse and the Alcohol Industry

9.1.1. Today consumers have an extensive and unprecedented choice in purchasing alcohol. In the UK today there is a wide range of on-licensed businesses, including public houses, bars and restaurants. There is also a wide range of off-licensed retail outlets selling alcohol, from small corner shops to large supermarkets.[410]

9.1.2. Recent years have witnessed the transformation of the night-time economy in British cities and towns; large, branded "warehouses" belonging to national or international chains have replaced older pubs.[411]

9.1.3. The consumption of alcohol is certainly beneficial for the country's economy; the value of the alcoholic drinks market reaches more than £30 billion per annum, and about 1 million jobs are estimated to be linked to it.[412]

9.1.4. Against this background, as the report has indicated, the excessive consumption of alcohol is becoming a matter of concern in the country. Everybody is responsible and can have a role to play in combating this problem and in ultimately changing the "drinking culture", including the alcohol industry.[413]

9.1.5. Many establishments in the alcohol industry recognise the importance of social responsibility in the way they promote and sell their products. However, more work can be done to deal with the issues of under-age drinking, binge drinking, alcohol-related crime and alcohol misuse in general.[414]

9.2. The Licensing Act (2003) and the Violent Crime Reduction Act (2006)

9.2.1. The Licensing Act (2003) was implemented in 2005 and added more powers both to better regulate the sale of alcohol and to deal with irresponsible businesses.[415]

9.2.2. Several additional powers have been introduced with the Act. They include:

---

[410] Department for Culture, Media and Sport, Office of the Deputy Prime Minister and the Home Office (2005) Drinking Responsibly: The Government's Proposals, London.
[411] Anderson, P. and Baumberg, B. (2006) Alcohol in Europe: A Public Health Perspective, Institute of Alcohol Studies, London.
[412] Prime Minister's Strategy Unit (2004) Alcohol Harm Reduction Strategy for England, London.
[413] Department of Health (2007) Safe. Sensible. Social. The Next Step in the National Alcohol Strategy, London.
[414] Department for Culture, Media and Sport, Office of the Deputy Prime Minister and the Home Office (2005) Drinking Responsibly: The Government's Proposals, London.
[415] Department of Health (2007) Safe. Sensible. Social. The Next Step in the National Alcohol Strategy, London.

- Additional authority to the police to close down disorderly premises.

- Empowerment to the police and residents to ask for reviews of licences where crime and anti-social behaviour occur.

- Increased fines and potential licenses' suspensions for fuelling anti-social behaviour.

- Increased penalties for underage sale of alcohol.

- Prosecution for breach of licensing conditions.[416]

9.2.3. These additional powers introduced by the Licensing Act have been accompanied by other initiatives in the Violent Crime Reduction Act (2006), such as:

- Alcohol Disorder Zones, and the right to allow the police and local authorities to charge licensed premises for the cost of additional enforcement.

- Banning of individuals causing disruption in a locality for 48 hours.

- Banning by the police or trading standard officers of the sale of alcohol for 48 hours, if premises continue to sell alcohol to people under the age of 18 years.

- Fast-track reviews, recommended by the police, against licences associated with serious offences.

- Drinking banning orders from named premises for individuals responsible for disorderly conduct, from 2 months to 2 years.

9.2.4. This new law has changed the responsibility for licensing from the Magistrate Courts to the 13 local District Council licensing authorities in Kent.[417]

9.2.5. Licensed premises, following the Licensing Act, have now to undertake one or more of the following licensable activities (which are now covered by only one licence):

- The sale of alcohol by retail for consumption on or off the premises.

- The supply of alcohol by or on behalf of a qualifying club.

- The supply of hot food or drinks between 11pm and 5am.
- The provision of regulated entertainment.[418]

[416] Ibid
[417] Kent County Council (2007) Alcohol Misuse Select Committee, 10 September 2007, Maidstone.
[418] Ibid

9.2.6. Both enforcement and administrative authorities, and the trade, must now promote the four licensing objectives, namely: prevention of crime and disorder; public safety; prevention of public nuisance and protection of children from harm.[419]

9.2.7. This commitment is reflected, for example, in Target 58 of the Towards 2010 strategic document, which requires KCC to work with off-licences, pubs and clubs to reduce alcohol-related crime and antisocial behaviour.[420]

9.2.8. It is estimated that currently in Kent there are approximately 6,000-7,000 licensed premises, of which 5,000 are licensed to sell or supply alcohol. About 45%-50% of premises submitted applications to extend their opening hours (normally by 2 or 3 hours a day).[421]

9.2.9. Also, there are now in the county 57 licensed establishments open 24 hours a day, comprising 35 supermarkets and stores, 14 hotels and 8 late night venues.[422]

9.3. The Alcohol Industry and Social Responsibility

9.3.1. Many businesses in the alcohol industry are already working to promote responsible practices in the manufacture and sale of alcohol. For example, the Portman Group – which includes representatives from the business industry – produced a "Code of Practice on the Naming, Packaging and Promotion of Alcoholic Drinks", which discourages excessive consumption and the glamorising of alcoholic drinks. The Code is supported by virtually the whole alcohol industry in the country.[423]

9.3.2. The British Beer and Pub Association published *Point of Sale Promotions: Standards for the Management of Responsible Drinks Promotions Including Happy Hours (2005)*, which provide guidance to support responsible retailing.[424]

9.3.3. Other widespread initiatives include "Challenge 21" (please see Figure 25 below), in which retailers can ask anyone appearing to be under 21 to produce a valid form of identification, such as a passport or a driving license, to prove that they are 18 or older.[425] "Best Bar None" is an award initiated voluntarily by local businesses and is given to those on-licenses demonstrating responsible management.[426]

---

[419] Ibid
[420] Kent County Council (2007) http://www.kent.gov.uk/council-and-democracy/.
[421] Ibid
[422] Ibid
[423] Department of Health (2007) Safe. Sensible. Social. The Next Step in the National Alcohol Strategy, London.
[424] British Beer and Pub Association (2005) Point of Sale Promotions: Standards for the Management of Responsible Drinks Promotions Including Happy Hours, BBPA, London.
[425] Department of Health (2007) Safe. Sensible. Social. The Next Step in the National Alcohol Strategy, London.
[426] Ibid

Figure 25: The Challenge 21 Poster

Source: British Beer and Pub Association

9.3.4. More locally, several licensed premises in Kent have joined the "Safer Socialising" scheme as part of the Safer Town Partnership, and many employ licensed door-staff who are trained in drug recognition.[427]

9.3.5. Both the Kent-based company Shepherd Neame and the Wetherspoon pub chain, amongst other schemes aimed at promoting sensible drinking, make use of mystery shoppers to test socially responsible behaviour of the staff in its pubs.[428] [429]

9.3.6. However, despite this endeavour both at national and local level, some businesses still act irresponsibly and illegally. For example, the national Alcohol Misuse Enforcement Campaign found that 45% of on-licences and 35% of all off-licenses targeted sold alcohol to young people under the age of 18 years.[430] Another survey found that 14% of underage drinkers were successful in purchasing alcohol more than 11 times.[431]

9.3.7. In Kent last year Trading Standards performed 151 test purchases, and found that in about a third of them alcohol was sold to underage people.[432]

9.3.8. In addition, there are other aspects of the bar environment that can lead to problems. These include: serving practices that can encourage intoxication, such as discounting and other price promotions; aggressive approaches at closing time by bar staff and by the police; the inability of staff to manage problematic situations; loud music and general characteristics of the environment that can lead to crowding.[433] [434] [435]

9.3.9. The consequences of these irresponsible practices are serious. In 2005/6, about a fifth (17%) of all violent offences in England was committed in or around pubs or clubs.[436]

9.3.10. The broadening of practices such as responsible beverage service (RBS) programmes can help promote responsible behaviour in licensed premises. They focus on attitudes, knowledge and skills of people serving alcohol. The main objective of these programmes is to prevent intoxication and underage drinking, for example by discouraging "pushing" drinks and suggesting food or slowing service.[437]

---

[427] Kent County Council (2007) Alcohol Misuse Select Committee, written evidence,20 June 2007, Maidstone.
[428] Kent County Council (2007) Alcohol Misuse Select Committee, 19 June 2007, Maidstone.
[429] Kent County Council (2007) Alcohol Misuse Select Committee, 19 June 2007, Maidstone.
[430] Department for Culture, Media and Sport, Office of the Deputy Prime Minister and the Home Office (2005) Drinking Responsibly: The Government's Proposals, London.
[431] Department of Health (2007) Safe. Sensible. Social. The Next Step in the National Alcohol Strategy, London.
[432] Kent County Council (2007) Alcohol Misuse Select Committee, 10 September 2007, Maidstone.
[433] Babor, T. et al (2003) Alcohol: No Ordinary Commodity, Oxford, Oxford University Press.
[434] Kent County Council (2007) Alcohol Misuse Select Committee, 19 June 2007, Maidstone.
[435] Department of Health (2007) Safe. Sensible. Social. The Next Step in the National Alcohol Strategy, London.
[436] Ibid
[437] Babor, T. et al (2003) Alcohol: No Ordinary Commodity, Oxford, Oxford University Press.

9.3.11. But the importance of these responsible serving practises is not just limited to the environment within the premises. Licensed businesses can also be held partly responsible for anti-social, drunken behaviour occurring outside the curtilage of their premises, in the streets.

9.3.12. According to evidence received, individuals who sell alcohol inside the premises can also be found accountable for alcohol consumed outside the premises.[438]

9.3.13. Drinking alcohol in the streets is considered a problem; indeed the British Medical Association (BMA) is working to make this behaviour illegal.[439]

9.3.14. Two forms of intervention that could be adopted in Kent are Designated Public Place Orders and Alcohol Disorder Zones.

9.3.15. Where particular areas have been identified as experiencing anti-social behaviour, the police and local authorities can pinpoint them through Designate Public Place Orders, which give the police powers to confiscate alcohol containers within them. As of 2005, 130 authorities in England used these measures.[440]

9.3.16. Under the Anti-Social Behaviour Act (2003) local authorities and the police have also the power to disperse disruptive individuals and send home young people under the age of 16. In addition, between January and September 2004, 400 anti-social behaviour areas were designated countrywide.[441]

9.3.17. In Kent two alcohol free areas have been established, one in Broadstairs Harbour, the other in Canterbury.[442] However, currently no evidence is available to show whether these schemes are effective.[443]

9.3.18. Building on these initiatives, Alcohol Disorder Zones, designated by local authorities and the police, incorporate a number of licensed premises. The premises involved are given the opportunity to carry out a series of interventions to reduce anti-social behaviour. Premises which fail to implement these actions will be required to contribute towards the cost of the additional policing required to suppress the disruption.[444]

9.3.19. A final action that can be taken in order to promote social responsibility and deter anti-social behaviour, is to broaden residents' knowledge about their powers to object to and review licence applications.

---

[438] Kent County Council (2007) Alcohol Misuse Select Committee, 10 September 2007, Maidstone.
[439] Kent County Council (2007) Alcohol Misuse Select Committee, 28 June 2007, Maidstone.
[440] Department for Culture, Media and Sport, Office of the Deputy Prime Minister and the Home Office (2005) Drinking Responsibly: The Government's Proposals, London.
[441] Ibid
[442] Sheehan, D. (2007) Choosing Health in the South East: Alcohol, South East Public Health Observatory (SEPHO).
[443] Ibid
[444] Department for Culture, Media and Sport, Office of the Deputy Prime Minister and the Home Office (2005) Drinking Responsibly: The Government's Proposals, London.

9.3.20. Both “responsible authorities” and “near neighbours” can object or ask to revoke a license to sell alcohol. “Responsible authorities” include the Police, Trading Standards authorities, the Fire Authority, and Health and Safety and Social Services departments.[445]

9.3.21. Those defined as “near neighbours” differ from case to case, depending on the location of the premises seeking the license. In a city, near neighbours are those residents living within approximately 200 yards from the premises; in a village setting, near neighbours could be the population of the whole village.[446]

9.3.22. It appears that not many members of the public in Kent are aware that they can oppose the application or review of a license to sell alcoholic beverages. Perhaps this can be partly explained by the fact that legislation that conferred these new powers is recent, from 2003, and has not yet become public knowledge.[447]

9.3.23. Having considered all the above issues, Members of the Committee recommend the following:

[445] Kent County Council (2007) Alcohol Misuse Select Committee, 10 September 2007, Maidstone.
[446] Ibid
[447] Ibid

Recommendation 23

The Select Committee supports the KCC Towards 2010 target 58 to work with off licence pub and club owners to reduce alcohol fuelled crime and disorder, anti-social behaviour and domestic abuse. In addition, we recommend that problems of drinking outside the curtilage of licensed premises should be addressed, and that KCC should seek to discourage the practices of discounting alcoholic drinks, charging high prices for soft drinks and other strategies that could promote irresponsible drinking by all retail outlets.

Recommendation 24

The Committee recommends that:

KCC supports, where appropriate and after other measures have been explored, the establishment of alcohol free areas and of Alcohol Disorder Zones, which can require premises failing to implement actions designed to reduce alcohol-related anti-social behaviour in their vicinity to contribute towards the cost of the additional policing necessary to suppress the disruption. Kent Police, Trading Standards and other appropriate agencies should increase their efforts to identify retailers who supply alcohol to under age persons and ensure that penalties are applied.

Recommendation 25

The Committee recommends KCC to improve public knowledge of the rights to object to licence applications for the sale of alcohol and to call for license reviews if problems of public nuisance occur. Local experience of public nuisance was previously submitted via Parish Councils, and the Select Committee recommends that KCC engages the support of the Kent Association of Parish Councils to lobby Government to reinstate Parish Councils as consultees in license applications.

10. Engaging Central Government

10.1. Alcohol Misuse, Taxation and Pricing

10.1.1. Some of the forms of intervention that can help tackle alcohol misuse in Kent and in the country at large require the engagement of Central Government, either because the support of Government is vital for their successful implementation or because they must be enforced through national legislation.

10.1.2. The vital support that Government can play can be illustrated by the issues discussed in the "funding" chapter of this report; the role of Central Government is critical in raising the profile of the issue of alcohol misuse and in providing additional funding to finance alcohol-related services in Kent.

10.1.3. Taxation and pricing of alcoholic beverages are the two most common forms of national intervention that states adopt to control alcohol-related problems.[448] Indeed, they are the most effective methods for reducing alcohol misuse and its consequences.[449]

10.1.4. The impact of price changes on the consumption of alcohol has been investigated more than any other potential policy measure. A large body of evidence shows that an increase in price leads to a decrease in consumption and vice versa.[450]

10.1.5. Economists use the term "elasticity" to measure how much price changes affect the consumption of alcohol and its resulting harms. When alcohol is described as "price elastic", the proportion of change in the consumption of alcohol is greater than the proportion of price change. When alcohol is referred to as "price inelastic", the proportional change in the amount of alcohol consumed is less than the percent change in price.[451]

10.1.6. Studies conducted in Britain, as well as in Australia, Canada, Finland, New Zealand, Norway and Sweden, have shown that the demand for wines and for spirits in particular is generally more price elastic than that for beer. It was demonstrated that by raising the price of beer by 10%, beer consumption would fall by only 3.5%. With an increase in the price of wine by 10%, its consumption level would drop by 6.8%. By increasing the price of spirits by 10%, spirits consumption would fall by 9.8%.[452]

10.1.7. According to research conducted at European level, by raising the price of alcohol by 10% within the EU's 15 wealthiest states, it is

[448] Babor, T. et al (2003) Alcohol: No Ordinary Commodity, Oxford, Oxford University Press.
[449] Kent County Council (2007) Alcohol Misuse Select Committee, written evidence, 13 June 2007, Maidstone.
[450] Anderson, P. and Baumberg, B. (2006) Alcohol in Europe: A Public Health Perspective, Institute of Alcohol Studies, London.
[451] Ibid
[452] Ibid

estimated that every year 9,000 people could be saved, and 13 billion euros could be generated.[453]

10.1.8. Evidence also indicated that taxation on spirits is relatively low when compared to diluted beverages such as beer.[454]

10.2. Alcohol Misuse and Supermarkets' Sale Promotions

10.2.1. Another area which needs the support of Central Government in pricing, involves the Government's engagement of large supermarket chains.

10.2.2. Evidence submitted to the Select Committee indicates that today supermarkets, rather than pubs, are the establishments selling the largest quantity of alcohol in the UK.[455]

10.2.3. Although the alcohol industry has produced guidelines promoting social responsibility in the production and sale of alcohol in the UK[456], evidence suggests that some of the strategies adopted by large supermarket chains do not reflect these standards.

10.2.4. For instance, some witnesses expressed concerns to the Committee over strong discounting and "loss leading" strategies employed by some supermarket chains. The price of alcohol in supermarkets can be 5 times lower than in pubs; this is partly the result of loss leading measures aimed at attracting clients.[457]

10.2.5. The adoption of these strategies can be detrimental for smaller, local businesses in the alcohol industry.[458] Importantly, good evidence suggests that nowadays in Britain young people buy large amounts of low-priced alcohol from supermarkets and become intoxicated in their homes.[459] [460] [461]

10.2.6. Although price promotions are a legitimate way of encouraging sales, many in the alcohol industry are concerned about deep discounting and loss leading tactics. The alcohol industry's voluntary codes already dissuade promotions that encourage people to consume more alcohol than they otherwise would have done.[462]

---

[453] Department of Health (2006) Alcohol, Health and Wider Social Impact, London.
[454] Kent County Council (2007) Alcohol Misuse Select Committee, 10 July 2007, Maidstone.
[455] Kent County Council (2007) Alcohol Misuse Select Committee, 14 June 2007, Maidstone.
[456] Department of Health (2007) Safe. Sensible. Social. The Next Step in the National Alcohol Strategy, London.
[457] Kent County Council (2007) Alcohol Misuse Select Committee, 19 June 2007, Maidstone.
[458] Kent County Council (2007) Alcohol Misuse Select Committee, 19 June 2007, Maidstone.
[459] Kent County Council (2007) Alcohol Misuse Select Committee, 10 September 2007, Maidstone.
[460] Kent County Council (2007) Alcohol Misuse Select Committee, 10 September 2007, Maidstone.
[461] Kent County Council (2007) Alcohol Misuse Select Committee, 2 July 2007, Maidstone.
[462] Department of Health (2007) Safe. Sensible. Social. The Next Step in the National Alcohol Strategy, London.

10.2.7. The Government is aware of these concerns and is already exploring some of the issues involved. For example, the Competition Commission is already investigating the issue of loss leading and its effects on competition. Kent County Council can support such investigations to ensure that sales promotions will not have detrimental effects on the residents of Kent.[463]

10.3. Personal, Social and Health Education as a Statutory Subject

10.3.1. Finally, as the report discussed above, alcohol education is already a statutory requirement of the National Curriculum Science Order, representing the minimum delivery requirement. However, schools are expected to extend alcohol education provision through the non-statutory framework for Personal, Social and Health Education (PSHE).[464]

10.3.2. The report also explained that PSHE programmes include education on sexual health and drugs misuse, and can therefore contribute to tackling holistically these issues at strategic level, as stated in Towards 2010.[465]

10.3.3. However, the lack of statutory status can negatively impact on the effectiveness of PSHE teaching. For instance, the delivery of PSHE remains typified by inconsistency, as the subject is often neglected in order to leave more space for statutory subjects.[466] [467]

10.3.4. In addition, the lack of statutory status of PSHE dissuades teachers from gaining specialist knowledge in the subject, which would in turn lead to its more effective delivery.[468] A statutory Personal, Social and Health Education curriculum and accredited examination at GCSE level would result in a more effective alcohol education, and would promote change in the drinking culture among young people.

[463] Ibid
[464] Prime Minister's Strategy Unit (2004) Alcohol Harm Reduction Strategy for England, London.
[465] Kent County Council (2007) PSHE/Children's Health Select Committee Report, KCC, Maidstone.
[466] Kent County Council (2007) PSHE/Children's Health Select Committee Report, KCC, Maidstone.
[467] Ibid
[468] Ibid

Recommendation 26

The Select Committee urges KCC to engage and encourage Central Government to ensure that the rate of taxation of drinks increases proportionally with their alcoholic strength. A greater part of the additional revenue accrued from alcohol taxation should be re-invested for the prevention and treatment of alcohol misuse.

Recommendation 27

The Committee recommends that KCC supports Central Government's engagement of large supermarket chains encouraging them to review their alcohol marketing strategies, including "loss leader" discounting practices, and to ensure that alcohol is not sold to under-age customers.

Recommendation 28

The Committee commends that KCC encourages Central Government to make Personal, Social and Health Education (PSHE) a statutory subject with inspection by Ofsted (please refer to Appendix 4 for related recommendations in KCC PSHE report).

Appendix 1

Evidence

Oral Evidence

Thursday, 14 June 2007

- **Angela Slaven,** Director of Young Offenders' Services and KDAAT
- **Hud Manuel,** Finance Manager, KDAAT
- **Karen Sharp**, Commissioning Manager for Young Persons' Services, KDAAT
- **Lola Triumph**, Strategic Head of Commissioning (Adults), KDAAT

Tuesday, 19 June 2007

- **Jonathan Neame**, Chief Executive, Shepherd Neame
- **Martin Rawlings,** Director of Pub and Leisure, British Beer and Pub Association
- **Stuart Moore,** General Manager, South East, J D Wetherspoon plc

Wednesday, 27 June 2007

- **Nick Moon,** Social Inclusion Officer, Supporting Independence Team, KCC, and **Richard Jacklin,** researcher into alcohol and drug service provision in Kent
- **Simon Southworth,** Team Leader, Substance Misuse Team, KCC
- **Meradin Peachey,** Director of Public Health for Kent (a joint appointment by KCC and Primary Care Trusts)

Thursday, 28 June 2007

- **Inspector Jerry Prodger,** Substance Misuse Team, Kent Police
- **Caroline Davis**, Head of Strategic Partnerships, Eastern and Coastal Kent PCT
- **Godfrey Featherstone,** Director, Kenward Trust

Monday, 2 July 2007

- **Kent Youth County Council (KYCC) representatives**

Tuesday, 10 July 2007

- **Dr Mark Rake**, Founder of Kent Council on Addiction (now KCA) and **Neil Hunt,** Director of Research, KCA

- **Claire Goulding,** Operations Manager, Sunlight Centre, KCA

- **Allan Foster**, Lead Curriculum Advisor, and Subject Advisor for PSHE, KCC, **Carol Tomlinson**, Joint Commissioning Officer, KCC, and **Kate Craib**, School Drug Education Advisor, KCC

Monday, 16 July 2007

- **Bill Reading,** Manager, East Kent Community Alcohol Service

- **Peter Gates**, Service Users' Team, Kent Drug and Alcohol Action Team, with **Nick Collier,** ex Service User

Monday, 10 September 2007

- **Roger Vick,** Commercial Health Manager, Canterbury City Council

- **Clive Bainbridge**, Director of Community Safety and Regulatory Services, Kent County Council

Written Evidence

- **Clive Bainbridge**, Director of Community Safety and Regulatory Services, Kent County Council
- **Sajda Banaras**, Scrutiny Support Officer, Corporate Strategy, Hartlepool Borough Council
- **Kate Bearder**, Researcher, Overview & Scrutiny Team, City of Wakefield
- **Dr Marie Beckett**, Acting Medical Director, Clinical Director Acute & Emergency Medicine, East Kent Hospitals NHS Trust
- **Paul Blackmore**, Budget Officer, KDAAT, Kent County Council
- **Caroline Davis**, Head of Strategic Partnerships, Eastern and Coastal Kent PCT
- **Allan Foster**, Lead Curriculum Adviser, Adviser for PSHE, Advisory Service Kent, Kent County Council
- **Prof Nick Heather** , Emeritus Professor of Alcohol & Other Drug Studies
- **Stephie Lavis**, Senior Place Officer, Place Directorate, GOSE
- **Dr Mark Rake**, Founder of Kent Council on Addiction (now KCA)
- **Bill Reading**, Manager, East Kent Community Alcohol Service
- **Phil Sadler**, Alcohol Strategy Coordinator, Public Health Department, Liverpool PCT
- **Don Shenker,** Director of Policy and Services, Alcohol Concern
- **Sarah Spencer**, Senior Public Health Information Analyst, Kent & Medway Health Informatics Service
- **Michael Thompson**, Head of Communications and External Affairs, The Portman Group
- **Carol Tomlinson**, Joint Commissioning Officer, Kent County Council
- **Gillian Vass**, European Institute of Social Services (EISS), University of Kent.
- **Jackie Wardle**, Chief Executives, Derbyshire County Council

Visits

- Wednesday 18 July 2007, Visit to **Mt Zeehan Centre**, East Kent Community Alcohol Service Canterbury

- Friday 20 July 2007, visit to the **Kenward Trust**, Yalding

- Friday 20 July 2007, visit to the **Pilsdon Community**, West Malling

- Tuesday 5 February 2008, visit to the **Marlowe Academy**, Ramsgate.

Appendix 2

Glossary of Terms and Abbreviations

ADZ: Alcohol Disorder Zone

A&E: Accident and Emergency

AISP: Alcohol Intervention Support Programme

ANARP: Alcohol Needs Assessment Research Project

ASBO: Anti-Social Behaviour Order

ATR: Alcohol Treatment Requirement

AUDIT: Alcohol Use Disorders Identification Test

BMA: British Medical Association

CDRP: Crime and Disorder Reduction Partnership

CHD: Coronary Heart Disease

DAAT: Drug and Alcohol Action Team

DAT: Drug Action Team

DfES: Department of Education and Skills

DH: Department of Health

EISS: European Institute of Social Studies

EKCAS: East Kent Community Alcohol Service

EU: European Union

FAST: Fast Alcohol Screening Test

GHS: General Household Survey

GOSE: Government Office in the South East

GP: General Practitioner

HMCS: Her Majesty Court Service

KCC: Kent County Council

KDAAT: Kent Drug and Alcohol Action Team

KYCC: Kent Youth County Council

LA: Local Authority

LAA: Local Area Agreement

LGA: Local Government Association

LPSA: Local Public Service Agreement

LSP: Local Strategic Partnership

MoCAM: Models of Care for Alcohol Misusers

NGO: Non-Governmental Organisation

NHS: National Health Service

NPS: National Probation Service

NSPCC: National Society for the Prevention of Cruelty to Children

NTA: National Treatment Agency

OFSTED: Office for Standards in Education

ONS: Office of National Statistics

PCT: Primary Care Trust

PND: Penalty Notices for Disorder

PSA: Public Service Agreement

PSHE: Personal, Social and Health Education

PSUR: Prevalence Service Utilisation Ratio

RBS: Responsible Beverage Service

SEPHO: South East Public Health Observatory

SHA: Strategic Health Authority

SIP: Supporting Independence Programme
STD: Sexually Transmitted Disease

STI: Sexually Transmitted Infection

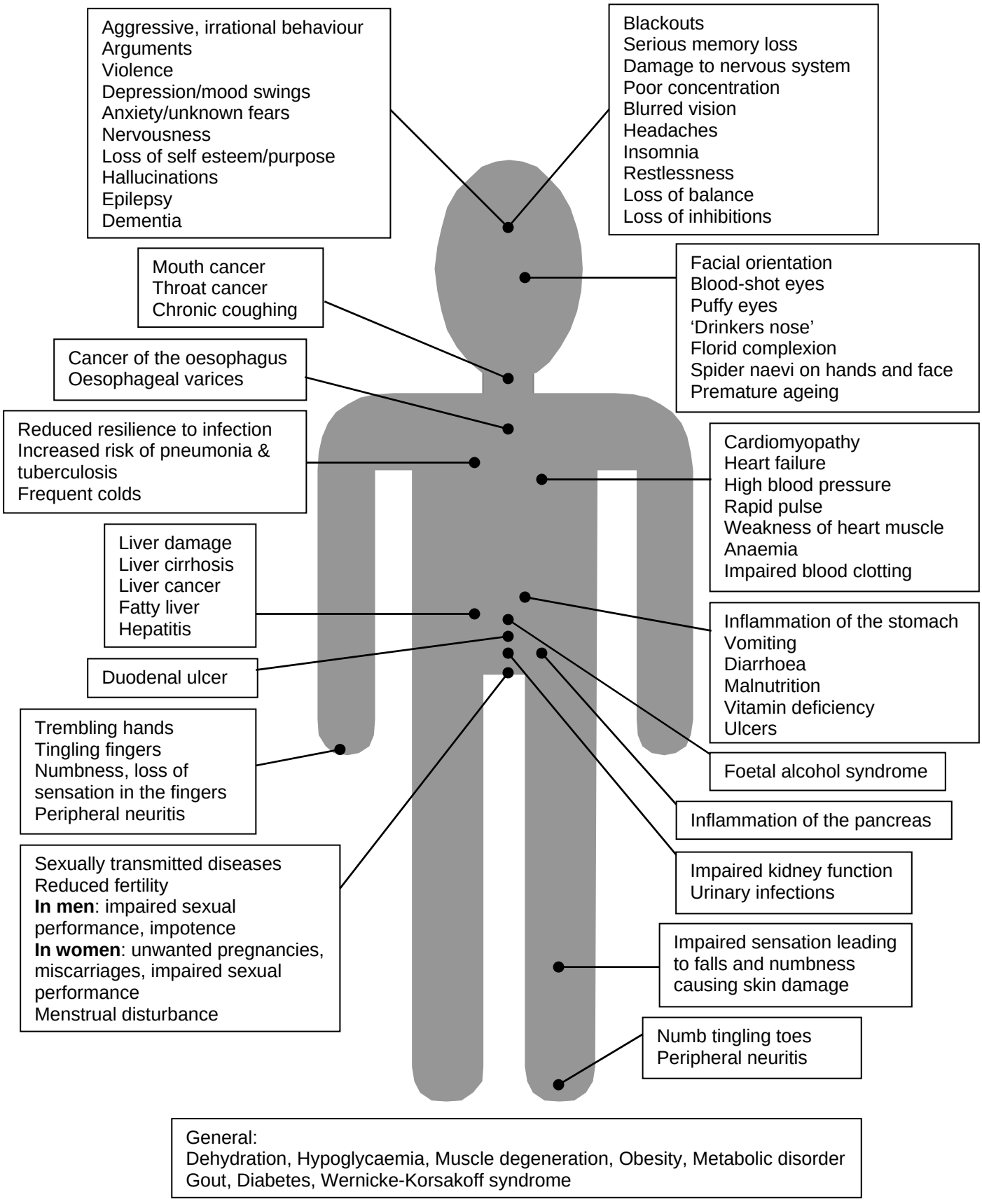
UKATT: United Kingdom Alcohol Treatment Trial

WHO: World Health Organisation

Appendix 3

Pictures, Tables and Charts

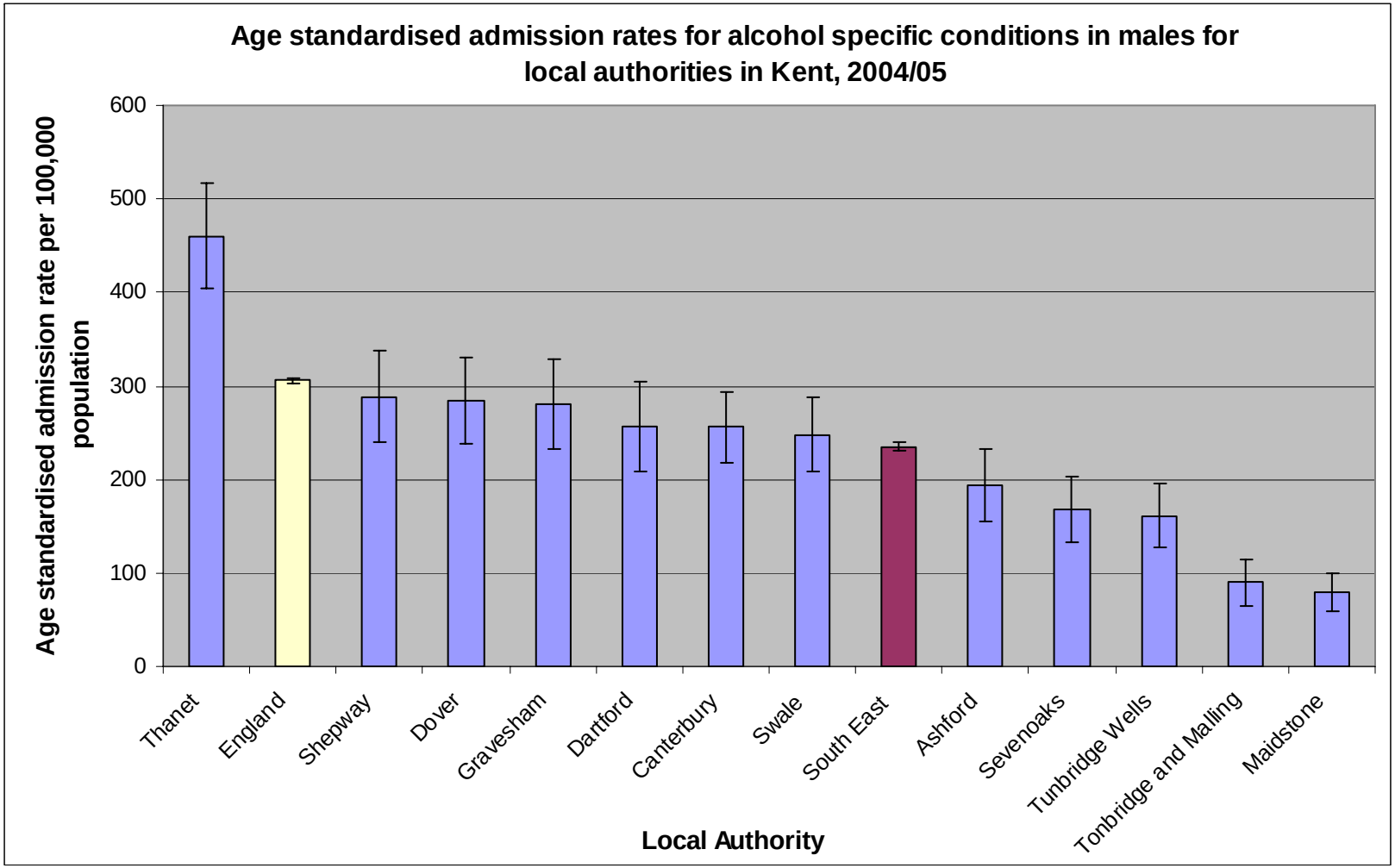
Alcohol Related Health Problems

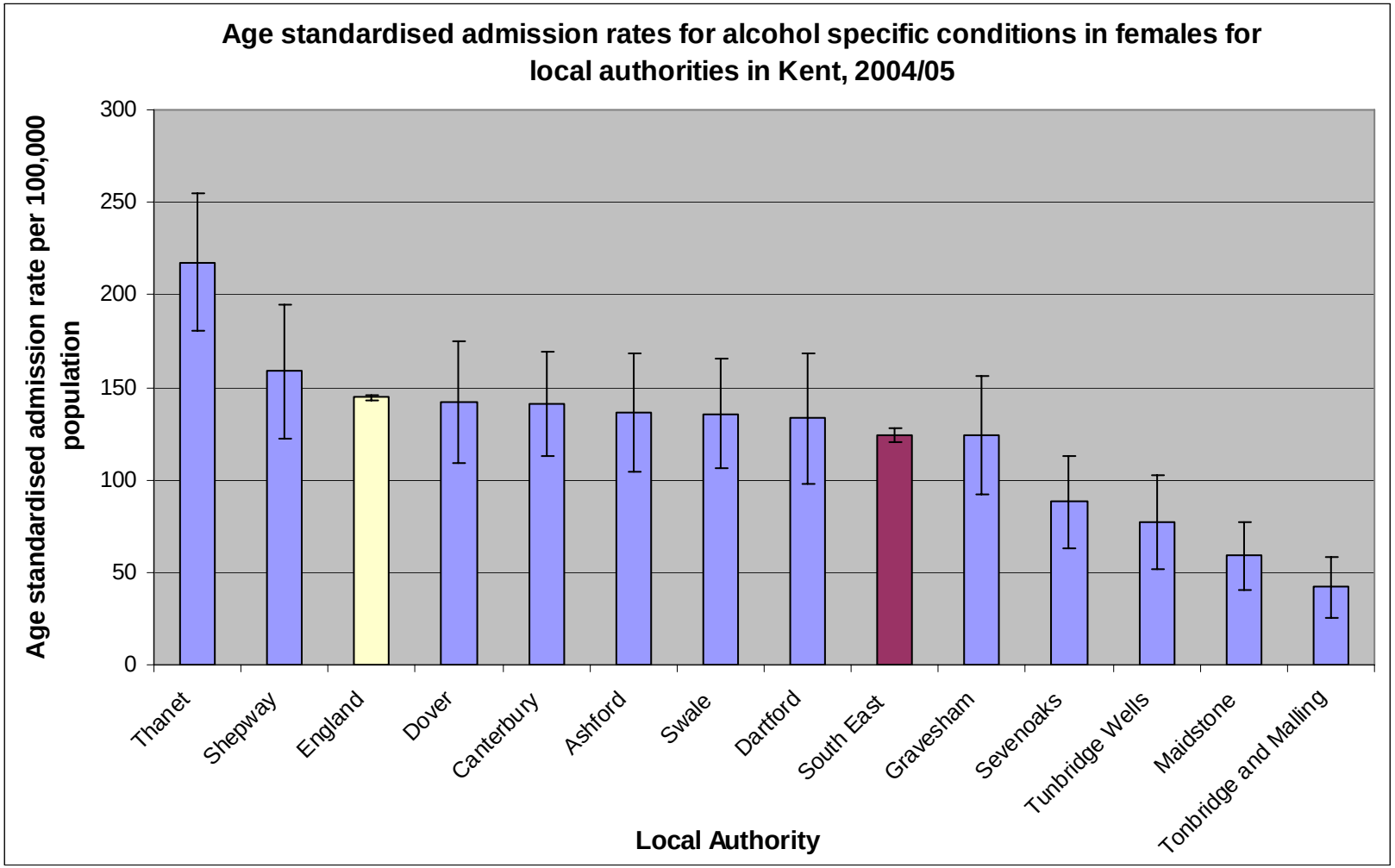


Source: Alcohol Concern, Health Impacts of Alcohol, 2002

Alcohol specific* hospital admissions for local authorities in Kent, 2004/05
Source: Local Alcohol Profiles for England, NWPHO (www.nwph.net/alcohol/lape)

Local Authority	Male hospital admission - number of alcohol specific conditions	Male hospital admission for alcohol specific conditions / 100,000 population	Lower 95% confidence limit	Upper 95% confidence limit	Female hospital admission - number of alcohol specific conditions	Female hospital admission for alcohol specific conditions / 100,000 population	Lower 95% confidence limit	Upper 95% confidence limit
Ashford	100	193.53	155.02	232.05	76	136.30	104.72	167.88
Canterbury	183	256.07	218.13	294.01	102	141.36	113.11	169.61
Dartford	112	256.20	208.44	303.96	56	133.10	97.75	168.45
Dover	149	284.47	237.75	331.18	78	141.89	109.33	174.45
Gravesham	131	280.40	232.06	328.75	60	123.99	92.13	155.85
Maidstone	59	79.56	59.11	100.01	42	58.99	40.75	77.23
Sevenoaks	97	168.16	133.74	202.59	49	87.95	62.61	113.28
Shepway	138	288.61	239.28	337.94	79	158.57	122.48	194.66
Swale	154	247.66	208.15	287.16	85	135.89	106.51	165.27
Thanet	276	460.56	404.66	516.45	139	217.39	180.27	254.51
Tonbridge and Malling	52	89.96	65.23	114.68	27	42.19	25.61	58.78
Tunbridge Wells	85	161.08	126.48	195.68	39	76.89	51.33	102.45
South East	9614	234.78	230.05	239.50	5156	124.26	120.80	127.72
England	77377	305.81	303.65	307.98	37173	144.62	143.13	146.11

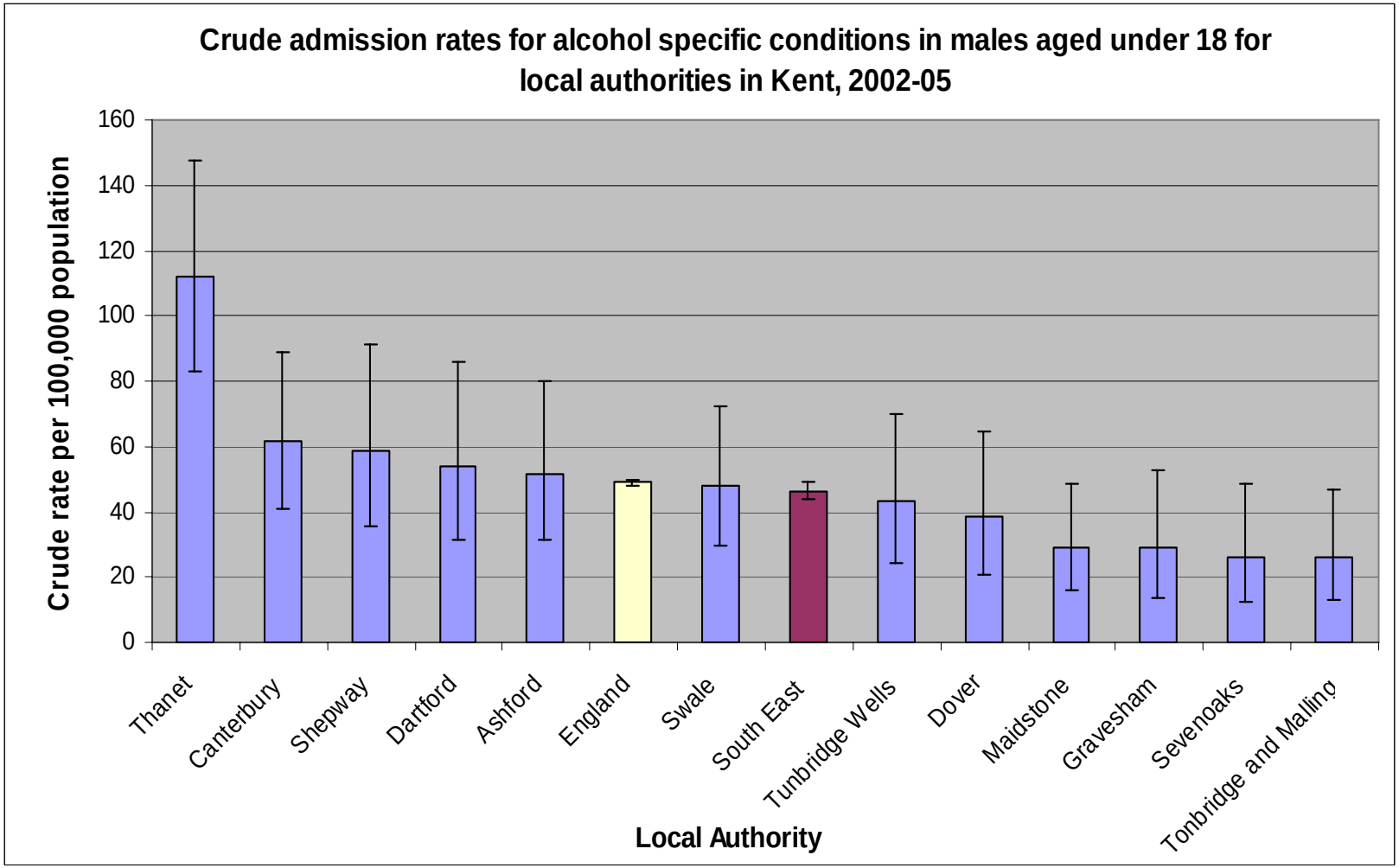

Age standardised admission rates for alcohol specific conditions in males for local authorities in Kent, 2004/05
Age standardised admission rate per 100,000 population
600
500
400
300
200
100
0
Thanet
England
Shepway
Dover
Gravesham
Dartford
Canterbury
Swale
South East
Ashford
Sevenoaks
Tunbridge Wells
Tonbridge and Malling
Maidstone
Local Authority

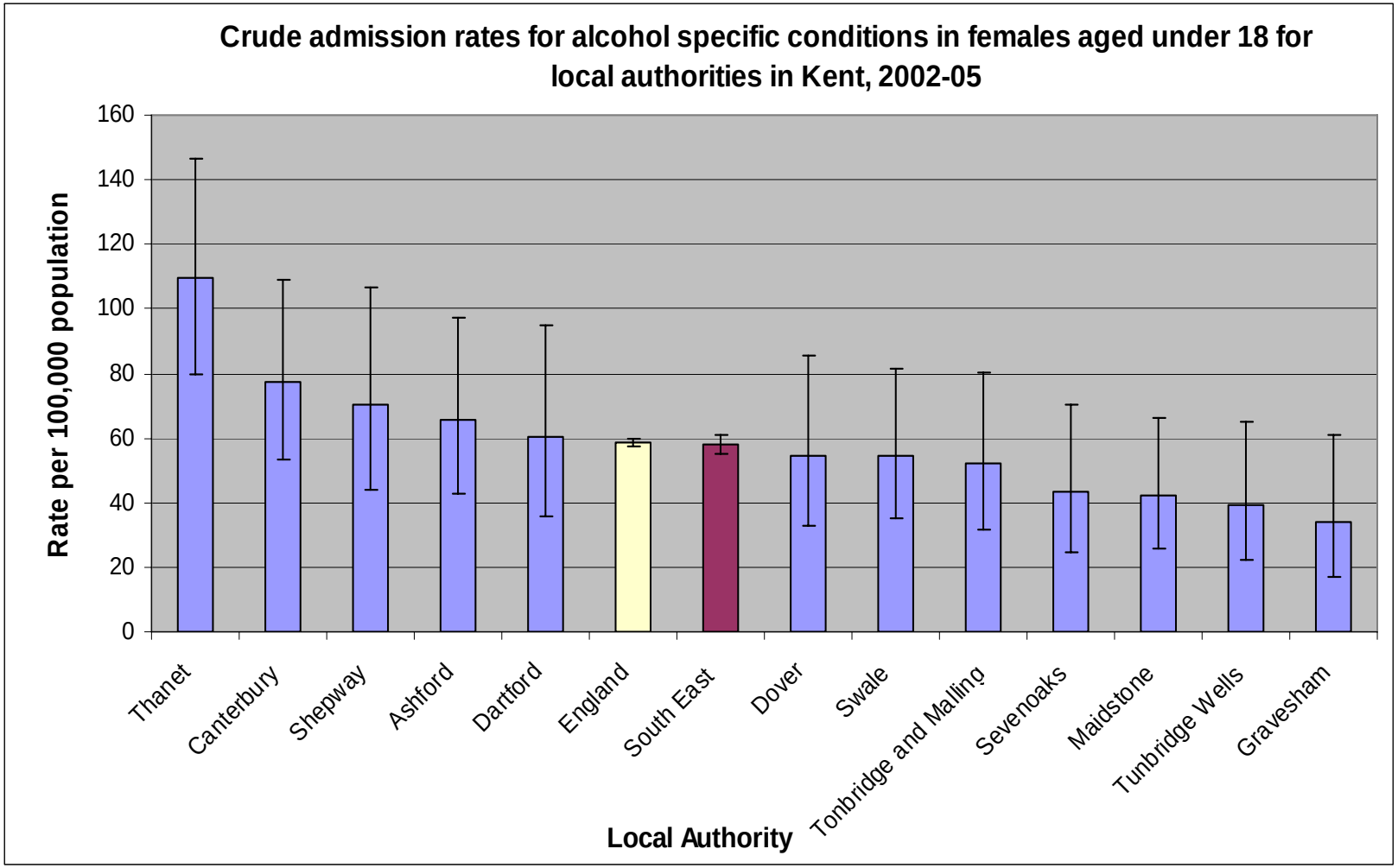

Age standardised admission rates for alcohol specific conditions in females for local authorities in Kent, 2004/05
Age standardised admission rate per 100,000 population
300
250
200
150
100
50
0
Thanet
Shepway
England
Dover
Canterbury
Ashford
Swale
Dartford
South East
Gravesham
Sevenoaks
Tunbridge Wells
Maidstone
Tonbridge and Malling
Local Authority

Alcohol specific* hospital admissions for under 18's for local authorities in Kent, 2002-05

Source: Local Alcohol Profiles for England, NWPHO (www.nwph.net/alcohol/lape)

Local Authority	Male hospital admission - number of alcohol specific conditions	Male hospital admission for alcohol specific conditions / 100,000 population	Lower 95% confidence limit	Upper 95% confidence limit	Female hospital admission - number of alcohol specific conditions	Female hospital admission for alcohol specific conditions / 100,000 population	Lower 95% confidence limit	Upper 95% confidence limit
Ashford	20	51.76	31.62	79.92	25	65.81	42.60	97.14
Canterbury	28	61.46	40.85	88.82	33	77.53	53.37	108.86
Dartford	6	53.83	31.36	86.17	14	60.11	35.63	94.99
Dover	28	38.39	20.99	64.41	35	54.77	32.98	85.51
Gravesham	13	28.75	13.79	52.87	14	34.06	17.00	60.94
Maidstone	7	28.93	15.82	48.53	5	42.45	25.56	66.29
Sevenoaks	49	26.35	12.64	48.45	50	43.42	24.82	70.50
Shepway	18	58.63	35.30	91.54	11	70.31	44.07	106.43
Swale	47	47.73	29.91	72.26	60	54.64	35.01	81.29
Thanet	8	111.96	83.11	147.58	14	109.64	79.98	146.68
Tonbridge and Malling	30	26.31	13.13	47.07	40	51.92	31.72	80.18
Tunbridge Wells	9	42.98	24.57	69.78	5	39.35	22.03	64.90
South East	480	46.44	43.94	49.05	575	58.14	55.25	61.14
England	3134	48.97	47.96	50.00	3717	58.51	57.37	59.66

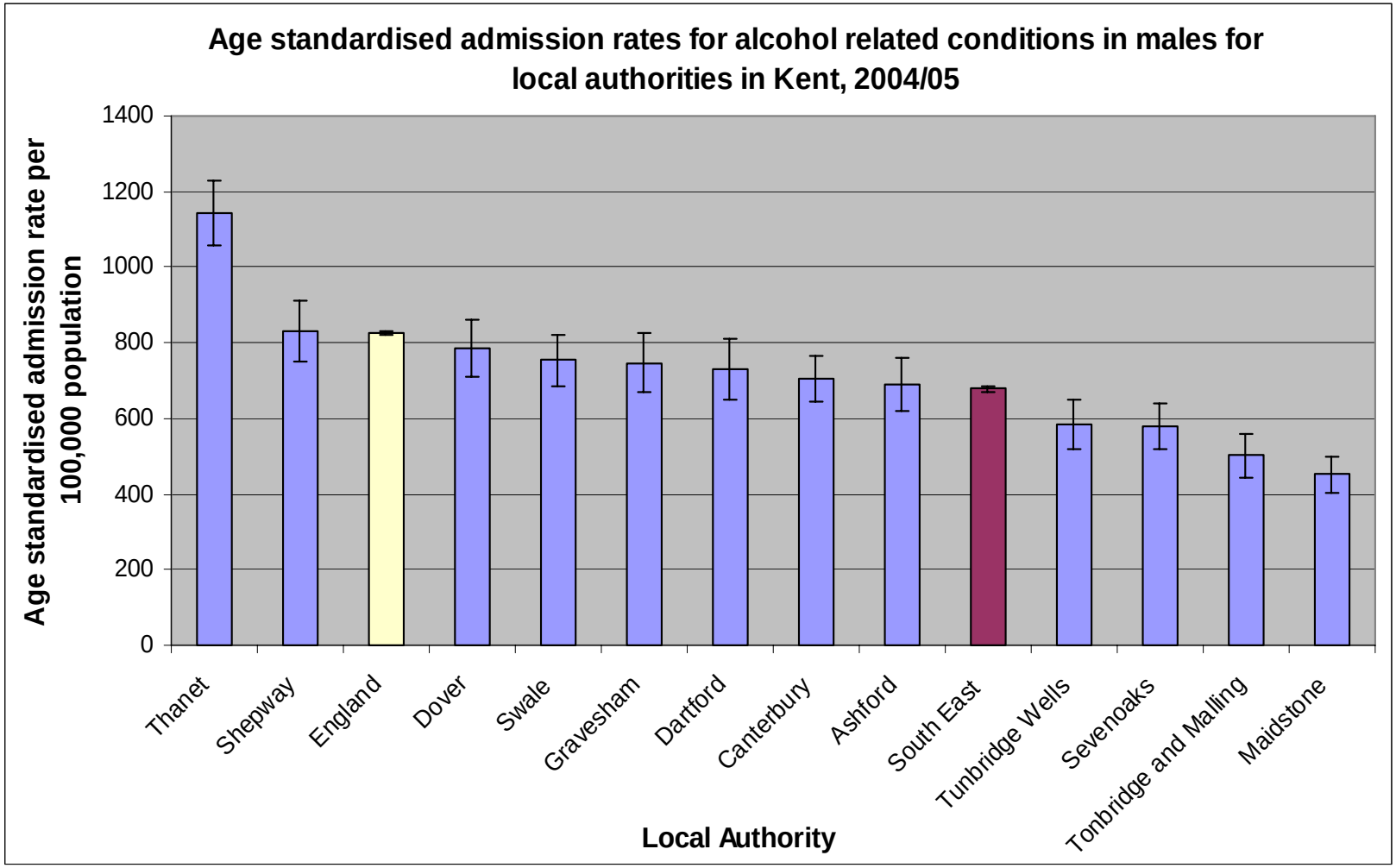

Crude admission rates for alcohol specific conditions in males aged under 18 for local authorities in Kent, 2002-05
Crude rate per 100,000 population
160
140
120
100
80
60
40
20
0
Thanet
Canterbury
Shepway
Dartford
Ashford
England
Swale
South East
Tunbridge Wells
Dover
Maidstone
Gravesham
Sevenoaks
Tonbridge and Malling
Local Authority

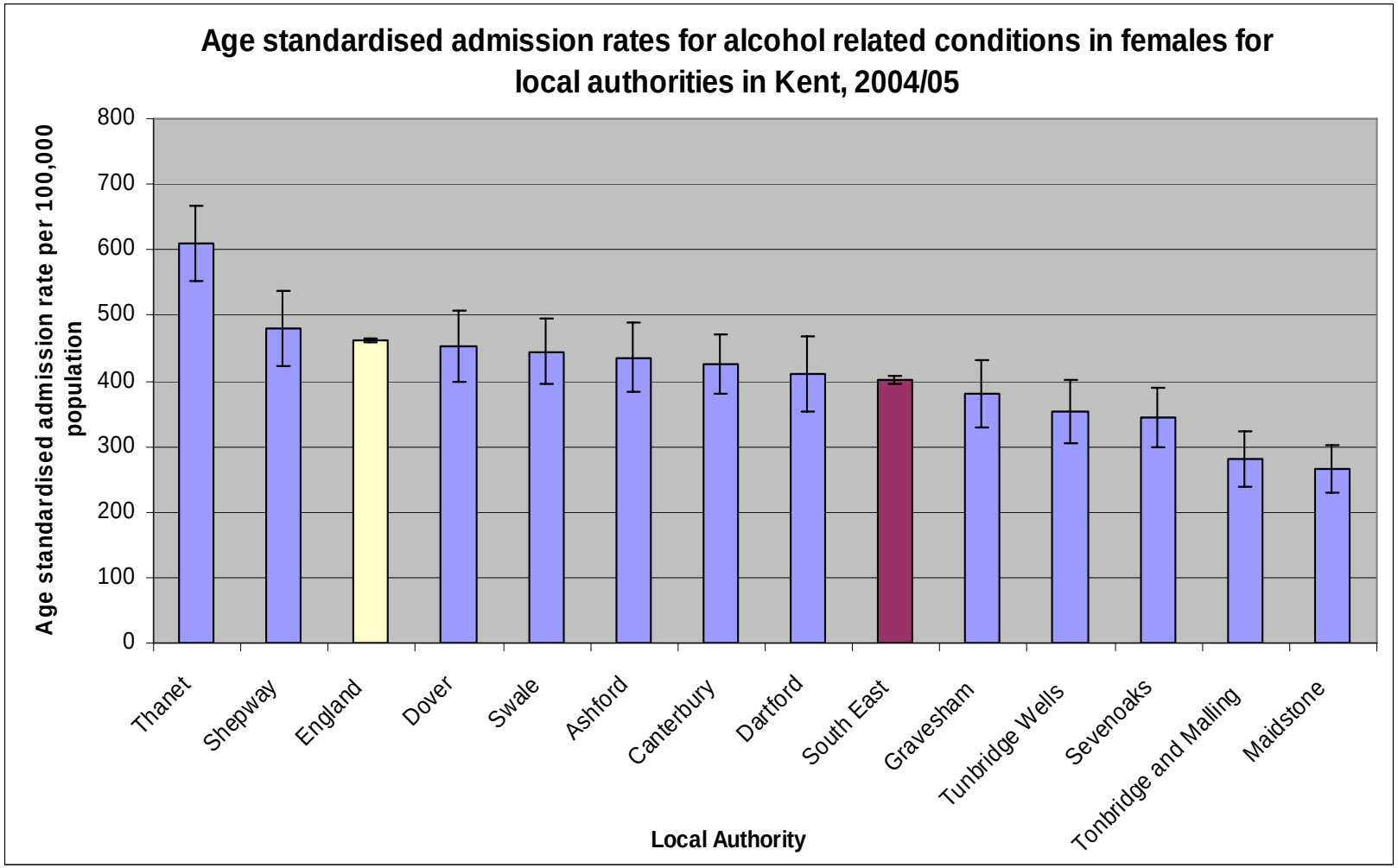

Crude admission rates for alcohol specific conditions in females aged under 18 for local authorities in Kent, 2002-05
Rate per 100,000 population
160
140
120
100
80
60
40
20
0
Thanet
Canterbury
Shepway
Ashford
Dartford
England
South East
Dover
Swale
Tonbridge and Malling
Sevenoaks
Maidstone
Tunbridge Wells
Gravesham
Local Authority

Alcohol related* hospital admissions for local authorities in Kent, 2004/05

Source: Local Alcohol Profiles for England, NWPHO (www.nwph.net/alcohol/lape)

Local Authority	Male hospital admission - number attributable to alcohol	Male hospital admission attributable to alcohol / 100,000 population	Lower 95% confidence limit	Upper 95% confidence limit	Female hospital admission - number attributable to alcohol	Female hospital admission attributable to alcohol / 100,000 population	Lower 95% confidence limit	Upper 95% confidence limit
Ashford	388	688.15	618.00	758.29	303	435.30	382.46	488.14
Canterbury	547	704.98	643.76	766.20	438	426.55	381.09	472.00
Dartford	325	731.19	651.01	811.38	219	410.41	352.59	468.22
Dover	456	785.87	711.09	860.64	332	452.30	397.64	506.96
Gravesham	363	745.81	668.15	823.46	233	380.24	327.82	432.66
Maidstone	342	450.85	402.39	499.32	240	266.57	230.25	302.89
Sevenoaks	355	579.71	517.36	642.07	262	343.90	297.48	390.31
Shepway	449	829.81	749.71	909.91	344	479.62	421.41	537.84
Swale	490	753.67	686.20	821.15	340	444.29	394.07	494.50
Thanet	790	1143.01	1058.84	1227.19	560	609.38	551.25	667.51
Tonbridge and Malling	290	501.14	442.18	560.10	203	280.42	238.90	321.94
Tunbridge Wells	321	582.28	517.36	647.20	249	353.40	304.13	402.67
South East	29490	678.32	670.46	686.18	21544	401.38	395.54	407.23
England	217938	826.07	822.57	829.57	147025	461.51	458.99	464.03

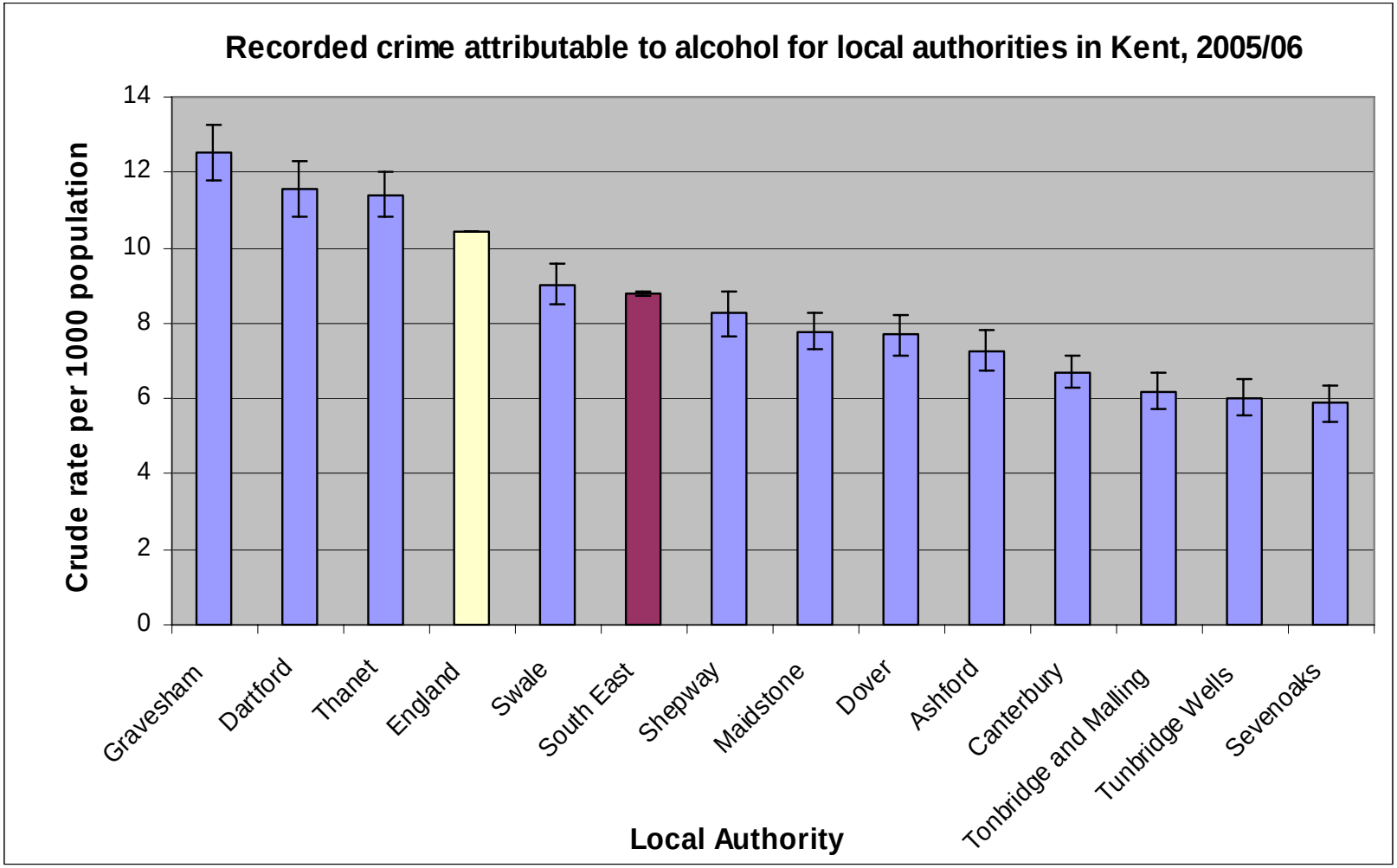

Age standardised admission rates for alcohol related conditions in males for local authorities in Kent, 2004/05
Age standardised admission rate per 100,000 population
1400
1200
1000
800
600
400
200
0
Thanet
Shepway
England
Dover
Swale
Gravesham
Dartford
Canterbury
Ashford
South East
Tunbridge Wells
Sevenoaks
Tonbridge and Malling
Maidstone
Local Authority

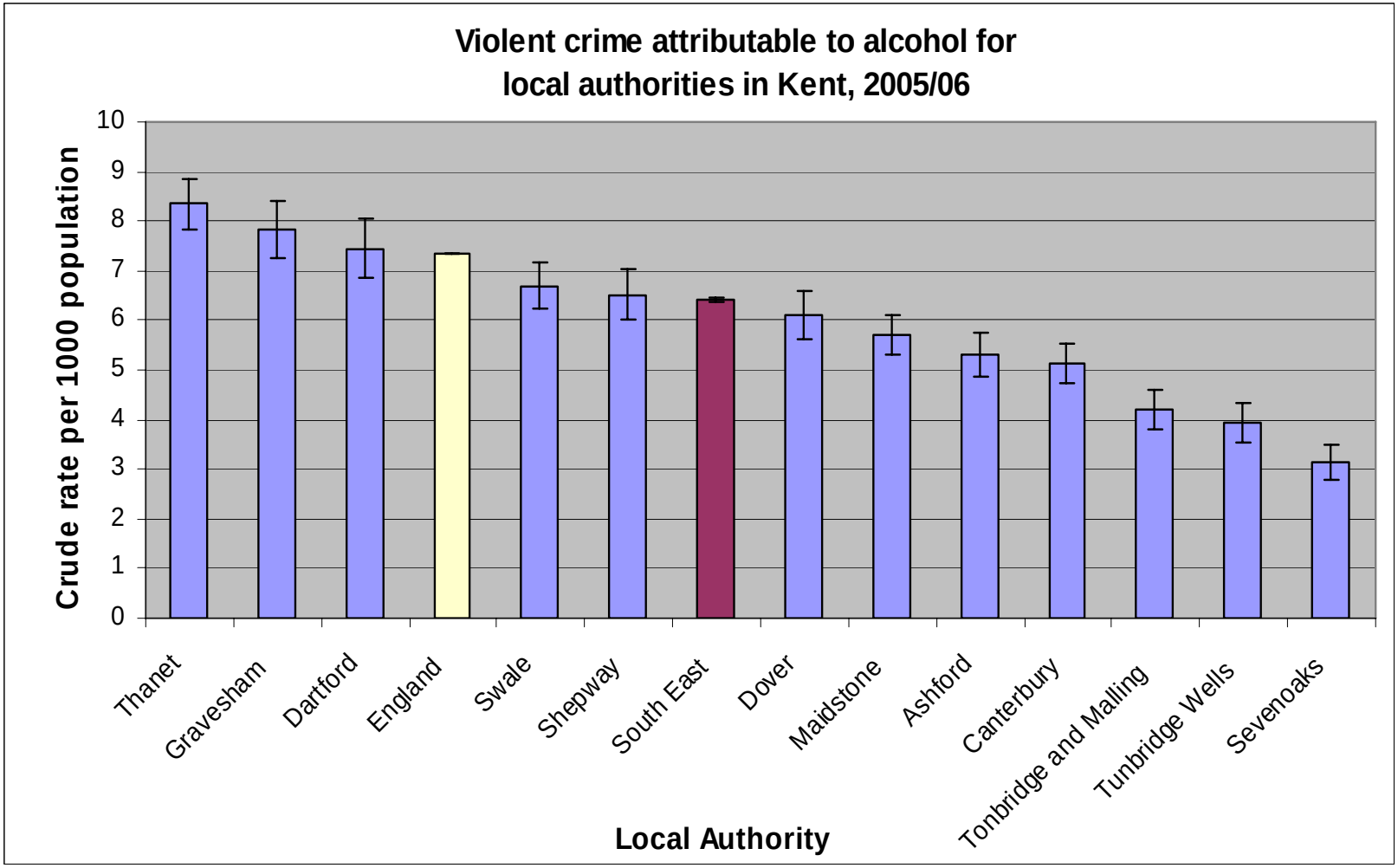

Age standardised admission rates for alcohol related conditions in females for local authorities in Kent, 2004/05
Age standardised admission rate per 100,000 population
800
700
600
500
400
300
200
100
0
Thanet
Shepway
England
Dover
Swale
Ashford
Canterbury
Dartford
South East
Gravesham
Tunbridge Wells
Sevenoaks
Tonbridge and Malling
Maidstone
Local Authority

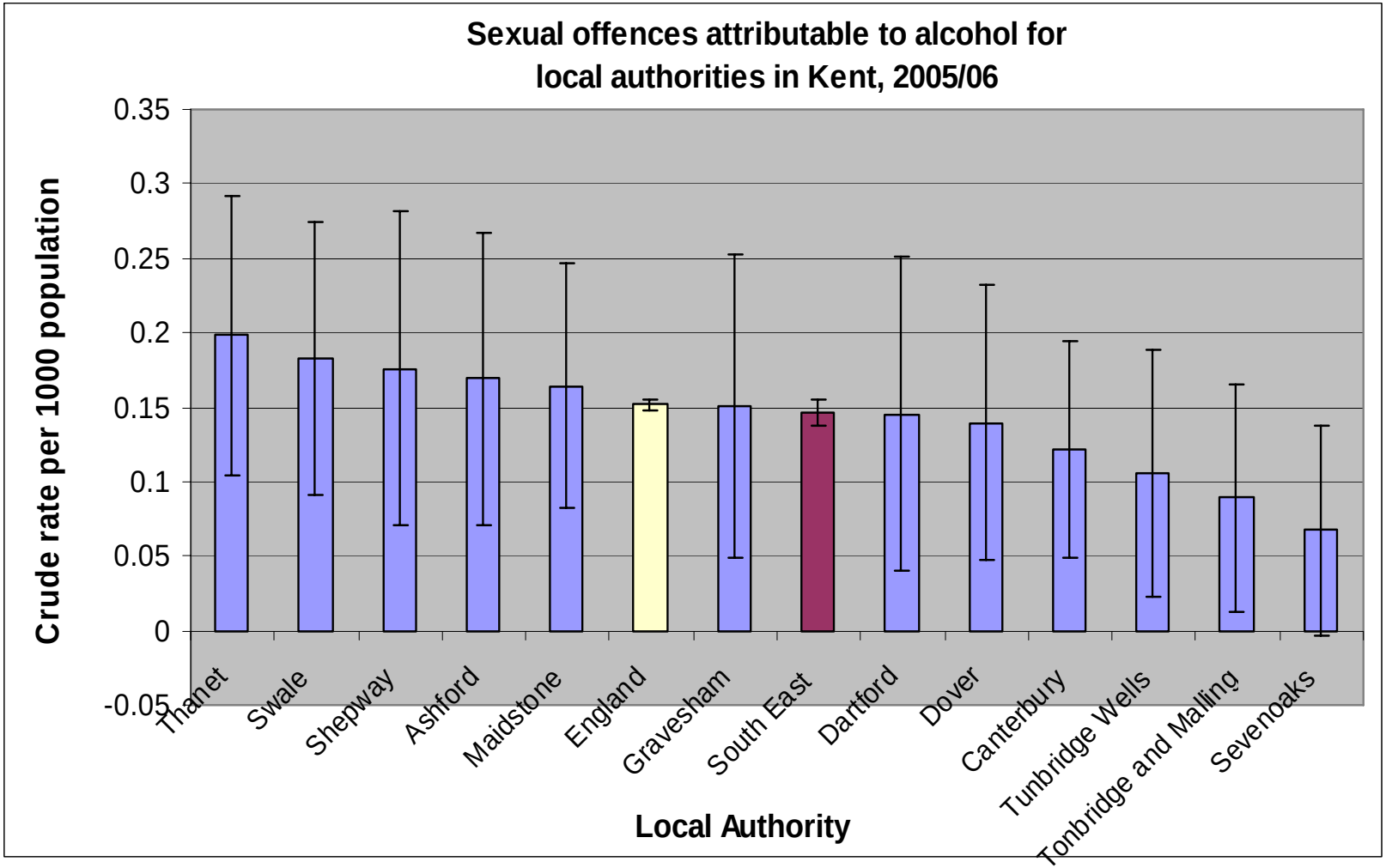
Alcohol related crime* for local authorities in Kent, 2005/06

Source: Local Alcohol Profiles for England, NWPHO (www.nwph.net/alcohol/lape)

Local Authority	All Recorded crime - Number attributable to alcohol	Recorded crime attributable to alcohol / 1,000 pop	Recorded crime attributable to alcohol LCL / 1,000 pop	Recorded crime attributable to alcohol UCL / 1,000 pop	Violence against the person - Number attributable to alcohol	Violent crime attributable to alcohol / 1,000 pop	Violent crime attributable to alcohol LCL / 1,000 pop	Violent crime attributable to alcohol UCL / 1,000 pop	Sexual Offences - Number attributable to alcohol	Sexual Offences attributable to alcohol / 1,000 pop	Sexual Offences attributable to alcohol LCL / 1,000 pop
Ashford	784	7.28	6.78	7.80	573	5.32	4.89	5.77	18	0.17	0.10
Canterbury	950	6.71	6.29	7.15	727	5.13	4.77	5.52	17	0.12	0.07
Dartford	1001	11.56	10.86	12.29	645	7.45	6.89	8.05	13	0.15	0.08
Dover	817	7.70	7.18	8.24	646	6.09	5.63	6.58	15	0.14	0.08
Gravesham	1189	12.53	11.83	13.26	743	7.82	7.27	8.40	14	0.15	0.08
Maidstone	1109	7.78	7.33	8.25	815	5.72	5.33	6.12	23	0.16	0.10
Sevenoaks	649	5.88	5.44	6.35	345	3.13	2.81	3.48	7	0.07	0.03
Shepway	816	8.25	7.69	8.83	646	6.53	6.03	7.05	17	0.18	0.10
Swale	1140	9.04	8.52	9.57	844	6.69	6.24	7.15	23	0.18	0.12
Thanet	1460	11.42	10.84	12.01	1067	8.35	7.85	8.86	25	0.20	0.13
Tonbridge and Malling	687	6.20	5.75	6.68	466	4.21	3.83	4.60	10	0.09	0.04
Tunbridge Wells	636	6.03	5.57	6.51	417	3.95	3.58	4.35	11	0.11	0.05
South East	71155	8.77	8.71	8.84	52060	6.42	6.36	6.47	1186	0.15	0.14
England	523666	10.45	-	-	367075	7.33	-	-	7590	0.15	0.15


Recorded crime attributable to alcohol for local authorities in Kent, 2005/06
Crude rate per 1000 population
14
12
10
8
6
4
2
0
Gravesham
Dartford
Thanet
England
Swale
South East
Shepway
Maidstone
Dover
Ashford
Canterbury
Tonbridge and Malling
Tunbridge Wells
Sevenoaks
Local Authority


Violent crime attributable to alcohol for local authorities in Kent, 2005/06
Crude rate per 1000 population
0
1
2
3
4
5
6
7
8
9
10
Thanet
Gravesham
Dartford
England
Swale
Shepway
South East
Dover
Maidstone
Ashford
Canterbury
Tonbridge and Malling
Tunbridge Wells
Sevenoaks
Local Authority


Sexual offences attributable to alcohol for local authorities in Kent, 2005/06
Crude rate per 1000 population
0.35
0.3
0.25
0.2
0.15
0.1
0.05
0
-0.05
Thanet
Swale
Shepway
Ashford
Maidstone
England
Gravesham
South East
Dartford
Dover
Canterbury
Tunbridge Wells
Tonbridge and Malling
Sevenoaks
Local Authority

The AUDIT Questionnaire

11. How often do you have a drink containing alcohol?

(0) Never	(1) Less than monthly	(2) 2-4 times a month	(3) 2-3 times a week	(4) 4 or more times a week	

12. How many units of alcohol do you drink on a typical day when you are drinking?

(0) 1-2	(1) 3 or 4	(2) 5 or 6	(3) 7, 8 or 9	(4) More	

13. How often do you have six or more units of alcohol on one occasion?

(0) Never	(1) Less than monthly	(2) Monthly	(3) Weekly	(4) Daily or almost daily	

14. How often during the last year have you found that you were able to stop drinking once you had started?

(0) Never	(1) Less than monthly	(2) Monthly	(3) Weekly	(4) Daily or almost daily	

15. How often during the last year have you failed to do what was normally expected from you because of drinking?

(0) Never	(1) Less than monthly	(2) Monthly	(3) Weekly	(4) Daily or almost daily	

16. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

(0) Never	(1) Less than monthly	(2) Monthly	(3) Weekly	(4) Daily or almost daily	

17. How often during the last year have you had a feeling of guilt or remorse after drinking?

(0) Never	(1) Less than monthly	(2) Monthly	(3) Weekly	(4) Daily or almost daily	

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

(0) Never	(1) Less than monthly	(2) Monthly	(3) Weekly	(4) Daily or almost daily	

19. Have you or someone else been injured as a result of your drinking?

(0) No	(2) Yes, but not in the last year	(4) Yes, during the last year	

20. Has a relative or friend or doctor or other health worker been concerned about your drinking or suggested you cut down?

(0) No	(2) Yes, but not in the last year	(4) Yes, during the last year	

Record total score here

If total score is 8 or over alcohol use disorder is very likely
Scores above 0 in questions 4-6 suggest either alcohol dependence or heading for alcohol dependence

Source: Review of the Effectiveness of Treatment for Alcohol Problems (2006), National Treatment Agency for Substance Misuse (NTA)

The FAST Questionnaire

Questions	Scoring system 0	1	2	3	4	Your score
How often do you have 8 (men)/ 6 (women) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Only answer the following questions if your answer above is monthly or less						
How often in the last year have you not been able to remember what happenned when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	

Source: Department of Health (2007) Safe. Sensible. Social. The Next Step in the National Alcohol Strategy

Appendix 4

Personal, Social and Health Education (PSHE) Report, Kent County Council

Recommendations Related to Alcohol Misuse Select Committee Report:

Recommendation 9

The Committee recommends that all schools in Kent work towards Healthy Schools validation by March 2009, through a process which is all inclusive to parents and governors. (Section 5.4, p55 and Section 5.5, p57)

Recommendation 10

The Committee strongly recommends a strategy for a more consistent and systematic Personal, Social and Health Education (PSHE) delivery, that is coupled with more robust assessment and monitoring methods, and that is adopted in all primary and secondary schools in Kent. (Section 5.6, p58)

Recommendation 12

That PSHE certificates for both teachers and nurses be widely promoted and supported. That each school cluster in Kent has a PSHE lead and each secondary school in Kent has at least one PSHE certified teacher. That PSHE awareness be raised through a countywide multi-agency conference, which includes all the decision makers, by March 2008. (Section 5.6, p58)

Recommendation 13

The Committee strongly urges the County Council to press Government to make PSHE statutory and therefore part of the core curriculum, thereby ensuring that a selection of PSHE lessons are duly observed during inspections by Ofsted. (Section 5.2, p50)

Recommendation 15

The Committee recommends that school governors ensure that strong and consistent sex and relationships education within a PSHE framework is delivered. That SRE be taught appropriately from primary school and by specialist teachers. (Section 6.4, p69)

References

Action Against Business Crime (2007)
http://www.brc.org.uk/aabc/safersocialisingaward.htm.

Advisory Council on the Misuse of Drugs (2003) Hidden Harm: Responding to the Needs of Children of Problem Drug Users, London.

Alcohol Concern (2006) Acquire: Alcohol Concern Quarterly Information and Research Bulletin, Autumn 2006.

Anderson, P. and Baumberg, B. (2006) Alcohol in Europe: A Public Health Perspective, Institute of Alcohol Studies, London.

Babor, T. et al (2003) Alcohol: No Ordinary Commodity, Oxford, Oxford University Press.

British Beer and Pub Association (2005) Point of Sale Promotions: Standards for the Management of Responsible Drinks Promotions Including Happy Hours, BBPA, London.

British Medical Association (2003) Adolescent Health, BMA Board of Science and Education, London.

Department for Culture, Media and Sport, Office of the Deputy Prime Minister and the Home Office (2005) Drinking Responsibly: The Government's Proposals, London.

Department of Health (2005) Alcohol Misuse Interventions, London.

Darkes, j. AND Goldman, M.S. (1993) Expectancy Challenge and Drinking Reduction: Experimental Evidence for a Mediational Process, Journal of Consulting and Clinical Psychology, 61,344-353.

Department for Education and Skills and Department of Health (2005) National healthy Schools Status: A Guide for Schools, London.

Department of Health (2005) Alcohol Needs Assessment Research Project (ANARP), London.

Department of Health (2006) Alcohol, Health and Wider Social Impact, London.

Department for Education and Skills (2006) Teenage Pregnancy Next Steps: Accelerating the Strategy to 2010, Nottingham.

Department of Health (2007) Safe. Sensible. Social. The Next Step in the National Alcohol Strategy, London.

Department of Health/National Treatment Agency (2006) Models of Care for Alcohol Misusers (MoCAM), London.

Hanson, D. (1995) Preventing Alcohol Abuse: Alcohol, Culture and Control, Praeger, Wesport.

Healthcare Commission (2006) National Survey of NHS Staff 2005: Summary of Key Findings, London.

Home Office (2007)http://www.crimereduction.gov.uk/partnerships2.htm.

Hosie, A. and Dawson, N. (2005) The Education of Pregnant Young Women and Young Mothers in England, University of Newcastle and University f Bristol, Bristol.

Institute of Alcohol Studies (2007) Alcohol and the Elderly, St Ives.

Kaner, E.et al (1999) A RCT of Three Training and Support Strategies to Encourage Implementation of Screening and Brief Alcohol Intervention by General Practitioners, British Journal of General Practice, 49, 699-703.

KCA website (2007) http://www.kca.org.uk/services.htm.

Kent and Medway NHS and Social Care Partnership Trust (2006) Eat Kent Community Alcohol Service: Information for Service Users.

Kent and Medway Safety Camera Partnership (2007), A License to Kill?, http://www.kmscp.org/ltk/.

Kent County Council (2005) The Kent Local Area Agreement April 2005 – March 2008, Maidstone.

Kent County Council (2006) Kent County Council Supporting Independence Programme. Report and Analysis 2, Maidstone.

Kent County Council (2006) Section 17 Crime and Disorder Act: What It Means to You, Maidstone.

Kent County Council (2007) http://www.kent.gov.uk/council-and-democracy/.

Kent County Council (2007) PSHE/Children's Health Select Committee Report, KCC, Maidstone.

Kent County Council (2007) Towards 2010: Kent, Your County, Your Future, Our Promises to You, Maidstone.

Kent Police (2007) Area Operations: Drug and Alcohol Strategy, Kent Police.

Kenward Trust (2005) Policy and Induction Manual, Yalding,

Mental Health Foundation (2006) Cheers? Understanding the Relationship between Alcohol and Mental Health, London.

National Association of Children of Alcoholics (2007), http://www.nacoa.org.uk/codepend.

NHS Wide Clearing Service (2207) Alcohol Specific Hospital Admissions for Local Authorities in Kent, 1997/8 – 2006/7.

NWPHO (2006) Local Alcohol Profiles for England, www.nwph.net/alcohol/lape.

Office for National Statistics (ONS) (2005) Drug Use, Smoking and Drinking Among Young People in England 2005, ONS, London.

Pilsdon website (2007) http://www.westmalling.kentparishes.gov.uk/Pilsdon.

Prime Minister's Strategy Unit (2004) Alcohol Harm Reduction Strategy for England, London.

Raistrick, D., Heather, N. and Godfrey, C. (2006) Review of the Effectiveness of Treatment of Alcohol Problems, National Treatment Agency (NTA), London.

Redgrave, K. and Limmer, M. (2005) It Makes You More Up for It. School Aged Young People's Perspectives on Alcohol and Sexual Health. Rochdale.

Settertobulte, W. et al (2001) Drinking Among Young Europeans, WHO, Copenhagen.

Sheehan, D. (2007) Choosing Health in the South East: Alcohol, South East Public Health Observatory (SEPHO).

Sheehan, D. (2007) Implementing Emergency: Department Data Sharing to Reduce Alcohol-Related Violence, Second National Alcohol Conference, Government Office for the South East, Guilford.

Social Exclusion Unit (1999) What's It All About, London.

University of Kent (2007) http://www.kent.ac.uk/eiss/about/index.html.

Vass, G. (2007) Dossier on Alcohol Harm from a European Perspective, European Institute of Social Services, University of Kent.

Youth Justice Board (2003) Youth Survey 2003: Research Study Conducted for the Youth Justice Board, January to March, MORI, London.

Acknowledgements

We would like to thank all the professionals, academics, young people, specialist agencies, representatives of the alcohol industry and officers who have taken part in this review. We are indebted to all those who have provided essential information and guidance. We would like to express our gratitude to all the people who, every day, work hard to deal with the issue of alcohol misuse and with its adverse consequences.

The Alcohol Misuse Select Committee

December 2007