Hampshire Alcohol Needs Assessment

FINAL

26.10.11
Acknowledgements

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List of abbreviations

ACSO  Accredited Community Safety Officers
ATR  Alcohol Treatment Requirement
AUDIT  Alcohol Use Disorders Identification Test
CQUIN  Commissioning for Quality and Innovation
DAAT  Drug and Alcohol Action Team
DASA  Defence Analytical Services and Advice
DES  Directly Enhanced Service
EBI  Extended Brief Intervention
HAPG  Hampshire Alcohol Partnership Group
HCC  Hampshire County Council
HES  Hospital Episode Statistics
HMP  Her Majesty’s Prison
HOMER  Hampshire Operational Model for Effective Recovery
IAS  Institute for Alcohol Studies
IBA  Identification and brief advice
IMD  Index of Multiple Deprivation
IOD  Integrated Officer Management
LAPE  Local Alcohol Profiles for England (published by NWPHO)
NDTMS  National Drug Treatment Monitoring Service
NI39  National Indicator 39 (hospital admissions per 100,000 for alcohol-related harm)
NOMS  National Offender Management Service
NTA  National Treatment Agency (for substance misuse)
NTE  Night Time Economy
NWPHO  North West Public Health Observatory
OASys  Offender Assessment System
OCU  Operational Command Unit
PCSO  Police Community Support Officers
PHSE  Personal Health and Social Education
RMS  Record Management System (Hampshire Constabulary)
SADQ  Severity of Alcohol Dependence Questionnaire
SARC  Sexual Assault Referral Centre

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Executive summary

1. Excessive alcohol consumption is a prevalent, costly and avoidable source of health and social harm in Hampshire, yet many of the negative consequences are insidious and not wholly attributable to alcohol, often leading to a failure to acknowledge the link.

2. Hampshire compares well to national and regional averages on indicators of alcohol-related health and social harm but there are notable exceptions and evidence of increasing health harm.

3. Around 20% of the Hampshire population are classed as ‘increasing risk drinkers’, 20% report binge drinking and nearly 4% are in the ‘higher risk’ drinking category. This equates to over 250,000 drinking above recommended levels, including over 40,000 higher risk drinkers.

4. Currently, over 15,000 hospital admissions are attributable to alcohol a year in Hampshire and rates are rising in all Local Authorities.

5. Alcohol harm is concentrated in the relatively deprived areas of Gosport, Havant and Rushmoor and reflects the pattern of health inequalities across Hampshire in related diseases, such as cardiovascular disease.

6. However, increasing risk drinking is prevalent across the county, particularly in the affluent areas of Hart and Fareham, and consequences are expected to escalate in all areas if consumption is not addressed.

7. The key priorities for Hampshire are to reverse the growth in alcohol-related hospital admissions across the county and to minimise the contribution of alcohol to health inequalities in Gosport, Havant and Rushmoor.

8. Much of the health burden from alcohol arises from its contribution to a wide range of common chronic conditions not wholly attributable to alcohol. Strategies to improve health must recognise that the key goal for Hampshire is a sustained reduction in excessive drinking, much of which is likely to be unrecognised by health service professionals and drinkers themselves.

9. Excessive alcohol consumption can lead to a wide range of physical and mental health difficulties including acute and chronic conditions, therefore a strategy of prevention and early intervention is expected to reduce demand across a broad range of clinical services.

10. Expanding the public health role of primary care clinicians will be key to controlling the impact and costs of alcohol; initial investment in developing an alcohol-conscious culture will be returned through the reversal of costly trends in long term care and hospital admissions.

11. Targeted action is also needed to address localised alcohol problems such as binge-drinking in Winchester, admissions in young people in the New Forest, crime in Havant and Basingstoke & Deane, and to reduce harm among high risk groups particularly offenders and the armed forces.

12. Specialist treatment services for alcohol should be provided in line with evidence-based recommendations for good practice; the aim to meet 15% of need is consistent with recommended levels of provision and a county-wide strategy to improve identification of harmful drinkers is needed to support achievement of this.

13. There is a link between the availability of alcohol and alcohol-related harm in Hampshire indicating the importance of licensing in improving public health and safety.

14. Alcohol-related crime remains an important source of avoidable social harm to the population of Hampshire but trend data shows recent improvements; resources are needed to continue this.
important work and to reverse increasing trends in health consequences in line with the achievements seen in crime

15. Alcohol has traditionally suffered from shortcomings in funding, ownership and evaluation, which must be overcome to succeed in reducing alcohol-related harm in Hampshire.
1. Background to alcohol misuse

1.1 Alcohol use and misuse

The amount of alcohol contained in a drink is measured in units, where one unit is equivalent to 10ml of pure alcohol. The Department of Health recommended daily limit for alcohol consumption for adults is no more than 3-4 units per day for men and no more than 2-3 units per day for women. There is no recommended safe level of alcohol consumption for children and pregnant women.

Example alcohol unit contents of typical drinks:
- A pint of 5% beer, lager or cider contains 2.8 units
- A can of strong white cider (7.5%) contains 3.8 units
- A large glass of wine (250ml) contains 3 units
- A bottle of wine contains 9 units
- A single measure of spirits (25ml) contains 1 unit
- A 700ml bottle of spirits contains 28 units
- A bottle of alcopops contains 1.4 units

Standard definitions of alcohol risk categories are summarised in Table 1.1 and are described below. Those who regularly drink above recommended limits are classified by the Department of Health as being at ‘increasing risk’ or ‘higher risk’ of suffering health consequences. These descriptors relate to the previously used terms ‘hazardous’ and ‘harmful’ drinkers respectively.

NHS Choices\(^1\) advises the public on recommended drinking levels and the potential consequences of regularly exceeding these levels. Regularly means most days of the week. Increasing-risk drinkers are defined as those who regularly drink above recommended limits: 22-50 units a week for men and 15-30 units for women. Increasing risk drinkers are at greater risk of developing alcohol-related illness compared to non-drinkers, including:

- Men are 1.8 to 2.5 times as likely to get cancer of the mouth, neck and throat; women are 1.2 to 1.7 times as likely
- Women are 1.2 times as likely to get breast cancer
- Men are twice as likely to develop liver cirrhosis, and women 1.7 times as likely
- Men are 1.8 times as likely to develop high blood pressure, and women are 1.3 times as likely

Higher-risk drinkers are defined as men who regularly drink more than 8 units a day or more than 50 units a week, and women who regularly drink more that 6 units a day or 35 units a week. Higher risk drinkers are at even greater risk developing alcohol-related illness than increasing risk drinkers, and the more they drink above the ‘higher risk’ thresholds the greater the risks. Compared to non-drinkers the health consequences of higher risk drinking may include:

- 3-5 times more likely to get cancer of the mouth, neck and throat
- 3-10 times more likely to develop liver cirrhosis
- Men could have four times the risk of having high blood pressure, and women are at least twice as likely to develop it
- Twice as likely to suffer from an irregular heartbeat
- Women are around 50% more likely to get breast cancer

\(^1\) http://www.nhs.uk/Livewell/alcohol/Pages/Effectsofalcohol.aspx
Binge drinking is defined as drinking twice (or more) than the recommended daily limit in a single drinking session, i.e. more than 8 units for a man or 6 units for a woman.

Dependent drinking is not defined purely in terms of consumption; alcohol dependence is characterised by persistent heavy drinking accompanied by some or all of a range of psychological, behavioural and physical features including difficulty controlling drinking despite evidence of harm, increased tolerance to alcohol and the presence of withdrawal signs and symptoms. Diagnosis is via assessment by a competent professional supported by validated tools such as the Alcohol Use Disorders Identification Test (AUDIT) and the Severity of Alcohol Dependence Questionnaire (SADQ). Moderately dependent drinkers do not typically experience withdrawal symptoms, or withdrawal symptoms are mild to moderate. Severely dependent drinkers do experience withdrawal symptoms, which are usually severe. Most severely dependent drinkers fall into a pattern of ‘relief drinking’, where they drink to avoid or counter withdrawal symptoms. Physical withdrawal symptoms can include hand tremors, sweating, nausea, visual hallucinations and seizures. Psychological withdrawal symptoms can include depression, anxiety, irritability, restlessness and insomnia.

Table 1.1 Reference table of alcohol risk categories

<table>
<thead>
<tr>
<th>UK descriptor of risk level</th>
<th>Recommended daily limit - Males</th>
<th>Recommended daily limit - Females</th>
<th>Definition</th>
<th>AUDIT score</th>
</tr>
</thead>
<tbody>
<tr>
<td>No/low Risk</td>
<td>No more than 3-4 units a day on a regular* basis</td>
<td>No more than 2-3 units a day on a regular* basis</td>
<td>Drinking within the Department of Health’s drinking guidelines and are at low-risk of harmful effects</td>
<td>0-7</td>
</tr>
<tr>
<td>Increasing risk</td>
<td>More than 3-4 units a day on a regular* basis</td>
<td>More than 2-3 units a day on a regular* basis</td>
<td>A pattern of drinking that increases the risk of harmful consequences for the user. Hazardous refers to patterns of use that are of public health significance despite the absence of any current disorder in the individual user.</td>
<td>8-15</td>
</tr>
<tr>
<td>Higher risk (previously ‘harmful’)</td>
<td>More than 50 units per week (or more than 8 units per day) on a regular* basis</td>
<td>More than 35 units per week (or more than 6 units per day) on a regular* basis</td>
<td>A pattern of use which is already causing damage to health. The damage may be physical or mental. Harmful drinkers show clear evidence of some alcohol-related harm.</td>
<td>16-19</td>
</tr>
<tr>
<td>Dependent</td>
<td></td>
<td></td>
<td>Dependence is characterised by behaviours previously described as ‘psychological dependence’, with an increased drive to use alcohol and difficulty controlling its use, despite negative consequences.</td>
<td>20-40</td>
</tr>
</tbody>
</table>

* Regular in this context means drinking at this sort of level every day or most days of the week; for weekly drinking, it refers to the amounts drunk most weeks of the year.
1.2 Harmful effects of alcohol

An overview of the evidence relating to the health and social effects of alcohol is provided by Babor and colleagues [1].

Alcohol leads to health and social harm via toxicity, intoxication and dependence: toxicity can lead to chronic disease, intoxication can cause acute social and health effects (such as unintentional injuries), and dependence can lead to chronic health and social problems. This highlights that neither intoxication nor dependence are needed for alcohol to damage health, and this characterises the ‘silent harm’ that alcohol imposes among people who are unaware that their drinking is causing or contributing to long-term health problems.

Alcohol contributes to a broad range of physical and mental health problems including cancers, cardiovascular disease, gastrointestinal disease, low birth weight, foetal alcohol spectrum disorder, depression, suicide, injury and death from accidents and assaults.

Health problems related to alcohol can be divided into conditions that are wholly attributable to alcohol (referred to as ‘alcohol-specific’) and conditions where alcohol is one among a range of possible causes (‘alcohol-related’). For alcohol-related conditions, ‘alcohol attributable fractions’ describe the proportion of cases in the population that can be attributed to alcohol, distinct from other possible causes. Alcohol-related conditions are sub-divided into acute and chronic conditions.

Figure 1.1 shows all of the health conditions that are recognised as being wholly or partly caused by alcohol consumption.

Social harm arising from alcohol may be suffered by the drinker themselves or by those around them, and consideration of social harm should include both direct harm and indirect harm through the overall cost of alcohol to society since all resources consumed in the management of alcohol harm carry an opportunity cost to society.

The major categories of social harm arising from alcohol misuse are violence (including domestic violence, sexual violence and child abuse), family and relationship problems including disruption, divorce and neglect of children, a spectrum of difficulties at work from poor performance and absenteeism to dangerous practice and inability to maintain a job, financial problems, educational difficulties, crime, anti-social behaviour and damage to property.
Figure 1.1. Summary of health conditions attributable to alcohol

Conditions wholly-attributable to alcohol

- Alcohol-induced pseudo-Cushings syndrome
- Mental and behavioural disorders due to alcohol
- Nervous system degeneration due to alcohol
- Alcoholic polyneuropathy
- Alcoholic myopathy
- Alcoholic cardiomyopathy
- Alcoholic gastritis
- Alcohol liver disease
- Alcohol-induced chronic pancreatitis
- Ethanol poisoning
- Methanol poisoning
- Toxic effects
- Accidental poisoning by alcohol

Conditions partly attributable to alcohol - chronic

- Cancer of the breast, colon, larynx, lip, liver, oesophagus, oral cavity, pharynx, rectum
- Diabetes mellitus (type 2)
- Epilepsy
- Hypertensive diseases
- Ischemic heart disease
- Cardiac arrhythmias
- Heart failure
- Haemorrhagic stroke
- Ischemic stroke
- Oesophageal varices
- Gastro-oesophageal laceration-haemorrhage syndrome
- Unspecified liver disease
- Cholelithiasis (gallstones)
- Acute and chronic pancreatitis
- Psoriasis
- Spontaneous abortion

Conditions partly attributable to alcohol - acute

- Road traffic accidents - pedestrian and non-pedestrian
- Water transport accidents
- Air/space transport accidents
- Fall injuries
- Work/machine injuries
- Firearm injuries
- Drowning
- Inhalation of gastric contents/inhalation and ingestion of food causing obstruction to the airway
- Fire injuries
- Accidental excessive cold
- Intentional self-harm
- Assault
### 1.3 Interventions for alcohol misuse

In 2006, the Department of Health and the National Treatment Agency for Substance Misuse (NTA) published Models of Care for Alcohol Misusers (MoCAM), which described a tiered approach to alcohol interventions. This provides a valuable framework for planning a programme of services although commissioners will recognise that services should be structured to respond to service users’ needs rather than be restricted by pre-defined tiers.

A summary of the tiers is provided in Table 1.2. For a detailed description, readers are referred to the original document (Models of Care for Alcohol Misusers, Department of Health, 2006) and the accompanying document Review of the Effectiveness of Treatment for Alcohol Problems (NTA, 2006).

#### Table 1.2 Summary of alcohol intervention tiers (MoCAM, 2006)

<table>
<thead>
<tr>
<th>Tier</th>
<th>Interventions</th>
<th>Typical setting/provider</th>
</tr>
</thead>
</table>
| 1 - Identification of hazardous, harmful and dependent drinkers | Screening to identify misuse of alcohol  
Advice and brief interventions for hazardous/harmful  
Referral of dependent and harmful | Shared care with specialised alcohol services (i.e. to deliver alcohol specific components of generic services)  
Most will be delivered in settings not specific to alcohol e.g. primary care, A&E, police settings, homelessness services, occupational health services |
| 2 - Open access and outreach facilities | Advice and extended brief interventions  
Assessment and referral of those needing more structured intervention  
Advice on peer support groups such as alcoholics anonymous | May be delivered in specialist or non-specialist settings  
Partnership with tier 3 and 4 provision or link to non-alcohol services that provide tier 1 |
| 3 - Community-based specialist services and co-ordinated treatment programmes | Comprehensive substance misuse assessment, care-planning and monitoring  
May include prescribing interventions (e.g. community-based detox and others to reduce risk of relapse), structured psychosocial therapies, and liaison services (e.g. with services for mental health, housing, antenatal, etc) | Usually have own premises, services provided in community, peripatetic or home visit, some work maybe provided via primary care services (shared care and GP-led prescribing) |
| 4 - Residential specialised treatment and aftercare | Comprehensive treatment programme as tier 3 but in specialist in-patient facility | Specialist in-patient facility  
Shared care with those providing tier 1-3 |
NICE have published public health and clinical guidance relating to the prevention and management of alcohol misuse. Public health guidance consists of School-based interventions on alcohol (PH7, 2007) and Alcohol misuse disorders – preventing harmful drinking (PH24, 2010). Clinical guidance consists of Alcohol-use disorders: physical complications (CG100, 2010) and Alcohol dependence and harmful alcohol use (CG115, 2011).

Guidance relating to school-based interventions (PH7) aims to discourage alcohol use among children and young people, delay the age that drinking begins and reducing harm among those who do drink. Recommendations relate to a ‘whole school’ approach involving all school children and parents to increase knowledge of potential harm, explore attitudes, develop self-esteem, assertiveness, coping skills and awareness of the influence of the media, peers, parents and role models in relation to alcohol. Further recommendations concern partnership working between education and other agencies, and harm reduction among children and young people who may be drinking at harmful levels including the use of school-based advice and support services, referral for specialist services and involvement of other agencies as appropriate.

NICE prevention guidance (PH24) relates to the prevention of harmful drinking. Recommendations include national-level interventions to reduce demand through minimum alcohol pricing, revising licensing legislation to restrict availability and revising advertising codes of practice. Local measures include use of local alcohol-related harm data to inform licensing policy and enforcement of licensing conditions. Recommendations relating to the commissioning of services advise commissioning of opportunistic screening and brief interventions as well as planning for a likely increase in demand for specialist services as a result of screening. Routine opportunistic screening using validated tools (e.g. AUDIT) is recommended or targeting of high risk groups if resources do not support routine screening. Brief advice is recommended for adults identified by screening, and extended brief advice for 16-17 year olds identified by screening and for adults who do not respond to brief advice. Referral for specialist treatment is recommended for those who do not respond to extended brief advice as well as dependent drinkers and those who have severe effects or co-morbidity. Formal evaluation of services to ensure adherence with evidence-based practice and cost-effectiveness is also highlighted as a key responsibility of commissioners.

Guidance relating to the clinical management of physical complications of alcohol misuse (CG100) describes recommended management of acute alcohol withdrawal, Wernike’s encephalopathy, liver disease and pancreatitis including the intensity of care, when to refer, appropriate professionals and recommended medication.

Recommendations relating to the clinical management of harmful and dependent drinking (CG115) describe the identification and diagnosis of harmful and dependent drinking, the principles of a person-centred care approach, specialist assessment and management including appropriate use of community-based and in-patient withdrawal, psychological therapies and medication.

1.4 Policy context

The major national public policies and resources for guiding practice related to alcohol are summarised in Figure 1.2. Figure 1.3 summarises strategies in place in Hampshire.
Figure 1.2 Summary of major national alcohol policies and resources 2005-present

**Alcohol Needs Assessment**
Research Project, DH
Prepares information at a national and regional level to highlight the range of alcohol use disorders in the population and the range services currently available, including gaps in services and regional variations in access.

**MoCAM, DH**
Models of care for alcohol misuse (MoCAM) provides best practice guidance for local health organizations and their partners in delivering a planned and integrated local treatment system for adult alcohol misusers.

**Safe, Sensible, Social**
HM Government
Joint alcohol strategy from the Department of Health and the Home Office. The document sets out clear goals and actions to promote sensible drinking and reduce alcohol-related harm.

**Alcohol Attributable Fractions**
Alcohol attributable fractions provide an indication of the public health effects of alcohol. Fractions are derived from the most recent population estimates of alcohol consumption data in England and the best risk estimates extracted from the published literature.

**Local Routes, DH**
Good practice guidance on the development of integrated care pathways for people with alcohol.

**Alcohol Misuse Interventions, DH**
2005
Guidance on developing local programmes for screening and brief interventions and guidance on treatment for dependent drinkers.

**Review of the Effectiveness of Treatment for Alcohol Problems, NTA**
2006
Review of the evidence on alcohol interventions, enables local services and partnerships to assess current provision and plan developments to meet the needs of their population.

**School-based alcohol interventions, NICE**
2007
Guidance is aimed at teachers, school governors and practitioners with health and wellbeing as part of their remit. Working in education, local authorities, the NHS and the wider public voluntary and community sectors. The recommendations focus on encouraging children not to drink, delaying the age at which they start drinking and reducing the harm it can cause among those who do drink.

**Alcohol Use Disorders: Preventing Harmful Drinking, NICE**
2008
Guidance for government, industry, the NHS and all those whose actions affect the population’s attitude to – and use of – alcohol. The guidance identifies how government policies on alcohol could be used to combat harm. Recommendations for practise cover licensing and identifying and helping people with alcohol-related problems.

**Signs for Improvement, DH**
2009
Guidance for commissioners to assist them in commissioning interventions to reduce alcohol-related harm.

**Clinical management, NICE**
2010
Guidance for the government, industry, the NHS and all those whose actions affect the population’s attitude to – and use of – alcohol. The guidance identifies how government policies on alcohol could be used to combat harm. Recommendations for practice cover licensing and identifying and helping people with alcohol-related problems.

**Harmful and dependent, NICE**
2011
This clinical guideline offers evidence-based advice on the diagnosis, assessment and management of harmful drinking and alcohol dependence in adults and in young people aged 10–17 years.
Figure 1.3  Summary of local alcohol strategy documents 2006-present

Hampshire Alcohol Strategy 2006-2009  
AKA ‘Ten Point Plan’

Hampshire DAAT  
Summary of the local and national context and the work needed to reduce alcohol related harm in Hampshire.  
Accompanied by a separate action plan.

2006

2007

Force Alcohol Strategy 2007-9  
Hampshire Constabulary  
This document sets out the strategy that Hampshire Constabulary will employ to deal with alcohol related anti-social behaviour and violence.

2008 Strategic Review of Substance Misuse Services Development Plan  
Hampshire DAAT  
This review aims to ensure the coordinated development of a robust commissioning strategy for drug and alcohol. It provides an analysis of all funded drug and alcohol services delivered in Hampshire taking account of evidence of met and unmet need. The outcome of the review is a commissioning strategy which will inform substance misuse service provision.

2008

2009

Hampshire Local Area Agreement (LAA)  
2008 - 11  
This three year agreement between local partners and central government describes the priorities and targets for the area:  
Safer communities - Reduce alcohol related public violence  
Health and wellbeing - tackle alcohol abuse  
Targets - 1120 Assault with Injury crime rate; 1139 Alcohol harm related Hospital admissions.

2009 Strategic Review of Community Safety: Alcohol Misuse in Hampshire  
DAAT, PCT, Community Safety  
Covers the criminal justice elements contained within the Alcohol Ten Point Plan, ie under-age drinking and reducing alcohol related anti-social behaviour, the night-time economy and enforcement activity. Assessment of current provision and future needs.

2010

2011
1.5 Aims and objectives of this needs assessment

The aims and objectives of this needs assessment are as follows:

1. Describe the profile of alcohol harm in Hampshire
   a. Summarise the epidemiology of alcohol misuse and harm in Hampshire and how it compares to other populations
   b. Identify main harms and highlight groups at risk of greatest harm or inequality
   c. Describe trends in alcohol harm in Hampshire

2. Identify existing services for reducing alcohol harm in Hampshire

3. Establish priority areas for improvement
   a. Identify gaps between best practice and current provision in Hampshire
   b. Obtain stakeholder views of needs and priorities related to alcohol harm

4. Make recommendations for Hampshire’s 2011-14 Alcohol Strategy
2. Alcohol consumption and harm in Hampshire

2.1 Epidemiology of alcohol misuse

The North West Public Health Observatory (NWPHO) produce Local Alcohol Profiles for England (LAPE) annually [2]. Estimates for alcohol consumption are local area synthetic estimates based on national survey and local area level data. However, people may be drinking more than they realise or report: the amount of alcohol sold is roughly double the self-reported consumption\(^2\), which does not include alcohol where duty is not paid such as home-made alcohol and that purchased abroad for personal consumption [3].

2.1.1 Prevalence of alcohol consumption

In Hampshire, 19% of the population are increasing risk drinkers, 18% are binge drinkers and 4% are higher risk drinkers. Figures 2.1 to 2.3 show the levels within each Local Authority area, and how this compares to the average for England, the South Central region and the South East Coast region.

Figure 2.1 Increasing risk drinking in Hampshire

\(^2\) HMRC 2005 data indicated that 11.3 litres of pure alcohol were purchased per adult over the year, whereas self-reported consumption (General Household Survey, 2005) was equivalent of 5.6 litres of pure alcohol over the year
Figure 2.2 Higher risk drinking in Hampshire

Higher risk drinking

Source: NWPHO, LAPE 2010  
Data relates to: 2005  
N.B. Confidence intervals not available for regional averages

Figure 2.3 Binge drinking in Hampshire

Binge drinking

Source: NWPHO, LAPE 2010  
Data relates to: 2007-8
2.1.2. Numbers drinking above recommended levels

Using the prevalence data shown above, an estimated 256,613 people drink above recommended levels and 192,460 are binge drinking.

Table 2.1 Mid-year population estimates† and percentage estimates of alcohol consumption among population over 16 years‡

<table>
<thead>
<tr>
<th>Mid-year population 2009 aged over 15 years</th>
<th>Increasing risk</th>
<th>Higher risk</th>
<th>Binge drinking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value</td>
<td>Lower</td>
<td>Upper</td>
<td>Value</td>
</tr>
<tr>
<td>Hampshire</td>
<td>1,063,900</td>
<td>20.18</td>
<td>18.51</td>
</tr>
<tr>
<td>Basingstoke and Deane</td>
<td>132,400</td>
<td>20.70</td>
<td>18.91</td>
</tr>
<tr>
<td>East Hampshire</td>
<td>91,400</td>
<td>20.31</td>
<td>18.64</td>
</tr>
<tr>
<td>Fareham</td>
<td>93,300</td>
<td>21.34</td>
<td>19.62</td>
</tr>
<tr>
<td>Gosport</td>
<td>66,200</td>
<td>21.57</td>
<td>19.78</td>
</tr>
<tr>
<td>Hart</td>
<td>73,700</td>
<td>21.97</td>
<td>20.09</td>
</tr>
<tr>
<td>Havant</td>
<td>97,300</td>
<td>18.77</td>
<td>17.27</td>
</tr>
<tr>
<td>New Forest</td>
<td>148,900</td>
<td>18.44</td>
<td>17.01</td>
</tr>
<tr>
<td>Rushmoor</td>
<td>74,600</td>
<td>21.08</td>
<td>19.18</td>
</tr>
<tr>
<td>Winchester</td>
<td>93,500</td>
<td>19.22</td>
<td>17.65</td>
</tr>
</tbody>
</table>

†Mid-year population estimates for 2009, ONS; ‡Source: NWPHO, LAPE 2010; Data relates to: 2005

Table 2.2 Estimated number of drinkers in Hampshire and Local Authorities

<table>
<thead>
<tr>
<th>Increasing risk</th>
<th>Higher risk</th>
<th>Binge drinking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean estimate</td>
<td>Lower 95% CI</td>
<td>Upper 95% CI</td>
</tr>
<tr>
<td>Hampshire</td>
<td>214,695</td>
<td>196,928</td>
</tr>
<tr>
<td>Basingstoke and Deane</td>
<td>27,407</td>
<td>25,037</td>
</tr>
<tr>
<td>East Hampshire</td>
<td>18,563</td>
<td>17,037</td>
</tr>
<tr>
<td>Eastleigh</td>
<td>20,129</td>
<td>18,446</td>
</tr>
<tr>
<td>Fareham</td>
<td>19,910</td>
<td>18,305</td>
</tr>
<tr>
<td>Gosport</td>
<td>14,279</td>
<td>13,094</td>
</tr>
<tr>
<td>Hart</td>
<td>16,192</td>
<td>14,806</td>
</tr>
<tr>
<td>Havant</td>
<td>18,263</td>
<td>16,804</td>
</tr>
<tr>
<td>New Forest</td>
<td>27,457</td>
<td>25,328</td>
</tr>
<tr>
<td>Rushmoor</td>
<td>15,726</td>
<td>14,308</td>
</tr>
<tr>
<td>Test Valley</td>
<td>18,831</td>
<td>17,261</td>
</tr>
<tr>
<td>Winchester</td>
<td>17,971</td>
<td>16,503</td>
</tr>
</tbody>
</table>
2.1.3. Patterns within Hampshire

Levels of increasing risk and binge drinking are close to England and South East averages and several local authorities are over: increasing risk drinking is highest in Hart, the least deprived of our local authorities (and least deprived in England), followed by Gosport, Fareham and Rushmoor; higher risk drinking is most prevalent in Gosport, Havant and Rushmoor; binge drinking is highest in Winchester, Gosport and Basingstoke and Deane.

Table 2.3  Rank of Hampshire alcohol indicators among all 326 Local Authorities in England†

<table>
<thead>
<tr>
<th></th>
<th>Increasing risk</th>
<th>Higher risk</th>
<th>Binge drinking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basingstoke &amp; Deane</td>
<td>233</td>
<td>101</td>
<td>192</td>
</tr>
<tr>
<td>East Hampshire</td>
<td>215</td>
<td>49</td>
<td>153</td>
</tr>
<tr>
<td>Eastleigh</td>
<td>209</td>
<td>61</td>
<td>158</td>
</tr>
<tr>
<td>Fareham</td>
<td>251</td>
<td>74</td>
<td>84</td>
</tr>
<tr>
<td>Gosport</td>
<td>255</td>
<td>226</td>
<td>200</td>
</tr>
<tr>
<td>Hart</td>
<td>260</td>
<td>7</td>
<td>97</td>
</tr>
<tr>
<td>Havant</td>
<td>99</td>
<td>165</td>
<td>35</td>
</tr>
<tr>
<td>New Forest</td>
<td>73</td>
<td>26</td>
<td>54</td>
</tr>
<tr>
<td>Rushmoor</td>
<td>246</td>
<td>133</td>
<td>91</td>
</tr>
<tr>
<td>Test Valley</td>
<td>213</td>
<td>41</td>
<td>165</td>
</tr>
<tr>
<td>Winchester</td>
<td>137</td>
<td>3</td>
<td>243</td>
</tr>
</tbody>
</table>

†A rank of 1 is the best Local Authority in England and a rank of 326 is the worst

Table 2.4 Hampshire Local Authority alcohol indicators ranked†

<table>
<thead>
<tr>
<th></th>
<th>Increasing risk</th>
<th>Higher risk</th>
<th>Binge drinking</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>New Forest</td>
<td>Winchester</td>
<td>Havant</td>
</tr>
<tr>
<td>2</td>
<td>Havant</td>
<td>Hart</td>
<td>New Forest</td>
</tr>
<tr>
<td>3</td>
<td>Winchester</td>
<td>New Forest</td>
<td>Fareham</td>
</tr>
<tr>
<td>4</td>
<td>Eastleigh</td>
<td>Test Valley</td>
<td>Rushmoor</td>
</tr>
<tr>
<td>5</td>
<td>Test Valley</td>
<td>East Hampshire</td>
<td>Hart</td>
</tr>
<tr>
<td>6</td>
<td>East Hampshire</td>
<td>Eastleigh</td>
<td>East Hampshire</td>
</tr>
<tr>
<td>7</td>
<td>Basingstoke and Deane</td>
<td>Fareham</td>
<td>Eastleigh</td>
</tr>
<tr>
<td>8</td>
<td>Rushmoor</td>
<td>Basingstoke and Deane</td>
<td>Test Valley</td>
</tr>
<tr>
<td>9</td>
<td>Fareham</td>
<td>Rushmoor</td>
<td>Basingstoke and Deane</td>
</tr>
<tr>
<td>10</td>
<td>Gosport</td>
<td>Havant</td>
<td>Gosport</td>
</tr>
<tr>
<td>11</td>
<td>Hart</td>
<td>Gosport</td>
<td>Winchester</td>
</tr>
</tbody>
</table>

†A rank of 1 is the best and a rank of 11 is the worst
2.2 The health impact of alcohol misuse

NWPHO LAPE provide annual statistics on morbidity and mortality related to alcohol. The data are derived from local data with ‘alcohol attributable fractions’ applied for conditions known to be caused wholly or partly by alcohol consumption. Morbidity data excludes those who do not seek treatment.

The rates presented in Figures 2.4, 2.5, 2.7, 2.9, 2.10 and 2.11 apply age and sex-specific rates observed in the local population to a standard population (European Standard Population), to allow comparison between areas without bias caused by differences in the age and sex composition of each Local Authority area.

2.2.1 Mortality from alcohol

Deaths from alcohol in Hampshire are comparable to rates in the South East and South Central regions and highest among males in all areas. Within Hampshire, Gosport has the highest rates of death from alcohol, in both males and females, but the difference between Gosport and other Local Authorities is markedly greater for alcohol-specific deaths. Rates of alcohol-attributable deaths among females do not vary materially across the county.

Figure 2.4 Alcohol-attributable mortality in Hampshire, all ages

Source: NWPHO, LAPE 2010      Data relates to: 2008
Figure 2.5 Alcohol-specific mortality in Hampshire, all ages

Alcohol-specific mortality

Mortality per 100,000 population (directly standardised rate)

Source: NWPHO, LAPE 2010  Data relates to: 2006-8 (3-year moving average)

Figure 2.6 Mortality from land transport accidents involving a car, bicycle, pedestrian or train

Mortality from land transport accidents attributable to alcohol

Mortality per 100,000 population (directly standardised rate)

Source: NWPHO, LAPE 2010  Data relates to: 2006-8 (3-year moving average)
Applying the rates shown in Figures 2.4, 2.5 and 2.11 to the population of Hampshire shows that over a period of a year, 327 deaths and 15,171 hospital admissions in Hampshire were attributable to alcohol in 2008.

Table 2.5 Number of deaths and hospital admissions due to alcohol in 2008

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Basingstoke and Deane</td>
<td>28.6</td>
<td>9.7</td>
<td>1,464.1</td>
</tr>
<tr>
<td>East Hampshire</td>
<td>21.4</td>
<td>7.9</td>
<td>1,181.4</td>
</tr>
<tr>
<td>Eastleigh</td>
<td>24.6</td>
<td>5.3</td>
<td>1,235.9</td>
</tr>
<tr>
<td>Fareham</td>
<td>17.3</td>
<td>5.2</td>
<td>1,323.4</td>
</tr>
<tr>
<td>Gosport</td>
<td>20.4</td>
<td>10.1</td>
<td>1,262.9</td>
</tr>
<tr>
<td>Hart</td>
<td>12.9</td>
<td>3.0</td>
<td>1,053.6</td>
</tr>
<tr>
<td>Havant</td>
<td>23.2</td>
<td>7.4</td>
<td>1,778.6</td>
</tr>
<tr>
<td>New Forest</td>
<td>36.2</td>
<td>11.5</td>
<td>1,702.9</td>
</tr>
<tr>
<td>Rushmoor</td>
<td>19.1</td>
<td>7.0</td>
<td>1,837.7</td>
</tr>
<tr>
<td>Test Valley</td>
<td>20.1</td>
<td>5.2</td>
<td>1,146.0</td>
</tr>
<tr>
<td>Winchester</td>
<td>22.7</td>
<td>7.8</td>
<td>1,184.9</td>
</tr>
<tr>
<td><strong>Hampshire total</strong></td>
<td>246.4</td>
<td>80.1</td>
<td><strong>15,171.2</strong></td>
</tr>
</tbody>
</table>

1NWPHO most recent published rates applied to HCC estimate of 2010 population (gender specific estimates)
Figure 2.8 shows the estimated increase in life expectancy that would be expected if all deaths related to alcohol were prevented in those under 75 years.

**Figure 2.8 Months of life lost due to alcohol in Hampshire**

![Months of life lost due to alcohol](image)

Source: NWPHO, LAPE 2010    Data relates to: 2006-8 (3-year moving average)

### 2.2.2 Morbidity from alcohol

Person-specific hospital admissions indicate the number of people affected by conditions wholly or partly attributable to alcohol, shown in Figures 2.9 and 2.10 respectively. National Indicator 39 (NI39) measures the total number of admissions, including repeated admission of the same individual, as a measure of the impact of alcohol on health services. The number of admissions derived from these rates are show above in Table 2.5.

As with deaths, data show that hospital admissions related to alcohol among adults are comparable between Hampshire and the South East and South Central regions, and are greatest among males in all areas. Within Hampshire, the relatively deprived areas of Gosport, Rushmoor and Havant show the highest rates of admission although NI39 statistics show that Hart and Fareham, where increasing risk drinking is prevalent, have the next highest rates of admission.

Data relating to claimants of incapacity benefit where alcohol is the main reason, show that Hampshire has a lower rate than South East and South Central regions. Within Hampshire the observed pattern is similar to morbidity and mortality with Gosport, Havant and Rushmoor showing the highest rates.
Figure 2.9 Number of persons admitted for alcohol-specific conditions in Hampshire, all ages

Alcohol-specific hospital admission

Source: NWPHO, LAPE       Data relates to: 2008/9

Figure 2.10 Number of persons admitted for alcohol-attributable conditions in Hampshire

Alcohol-attributable hospital admissions (persons admitted)

Source: NWPHO, LAPE       Data relates to: 2008/9
Among under 18 year olds, only the rate of admission for conditions wholly attributable to alcohol is recorded due to absence of evidence for estimating alcohol attributable fractions for other conditions. This indicator shows a different pattern, with the New Forest showing the highest rate, followed by Rushmoor and Eastleigh. The data presented are crude rates and the population aged 10-19 years in the New Forest is large, however this does not completely explain the findings as Table 2.6 shows the rate of events per 1,000 persons aged 10-19 years remains high in the New Forest compared to other areas. Figure 2.13 also shows that the relatively high rate in the New Forest has been observed in previous years and 2.14 shows high levels of hospital attendance by school-aged children in the New Forest Local Authority.
Figure 2.12  Number of persons under 18 years admitted for alcohol-specific conditions

Alcohol-specific hospital admission under 18 years

Source: NWPHO, LAPE
Data relates to: 2008/9
Table 2.6  Under 18 alcohol-specific hospital admissions per 1,000 population aged 10-19 years

<table>
<thead>
<tr>
<th>Total population aged 10-19 years¹</th>
<th>Number of alcohol-specific hospital admissions in persons under 18 years (2006/7-2008/9)²</th>
<th>Number of events per 1,000 persons aged 10-19 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basingstoke &amp; Deane</td>
<td>19,600</td>
<td>48</td>
</tr>
<tr>
<td>East Hampshire</td>
<td>15,000</td>
<td>17</td>
</tr>
<tr>
<td>Eastleigh</td>
<td>15,200</td>
<td>49</td>
</tr>
<tr>
<td>Fareham</td>
<td>13,500</td>
<td>31</td>
</tr>
<tr>
<td>Gosport</td>
<td>9,600</td>
<td>23</td>
</tr>
<tr>
<td>Hart</td>
<td>11,600</td>
<td>14</td>
</tr>
<tr>
<td>Havant</td>
<td>14,400</td>
<td>35</td>
</tr>
<tr>
<td>New Forest</td>
<td>20,300</td>
<td>89</td>
</tr>
<tr>
<td>Rushmoor</td>
<td>11,300</td>
<td>42</td>
</tr>
<tr>
<td>Test Valley</td>
<td>14,600</td>
<td>39</td>
</tr>
<tr>
<td>Winchester</td>
<td>15,900</td>
<td>27</td>
</tr>
</tbody>
</table>

¹ONS mid-year population estimate 2009  ²From NWPHO, based on HES data

Figure 2.13  Trends in alcohol-specific hospital admission in under 18 year olds

Trends in under 18s alcohol-specific hospital admissions

Source: NWPHO, LAPE

Figure 2.14 is a density map of the number of school aged children visiting Southampton University Hospitals Trust (SUHT) in relation to alcohol consumption by home post code. Data shown relate to residents of Hampshire PCT area only (Southampton City PCT area is shown in grey). This highlights the high rate of events among young people in parts of the New Forest Local Authority, however these data are only available from the acute Trust in Southampton so do not represent the county-wide picture and may partially reflect geographical bias in relation to proximity to Southampton hospital.
Figure 2.14 Density map of school-aged children attending SUHT in relation to alcohol by home post code (January 2009-May 2011)
Analysis of Acute Trust attended for alcohol-related admission reveals that Portsmouth Hospitals NHS Trust are the main provider of acute services for Hampshire residents (Figure 2.15). All acute healthcare providers are included where the total number of admissions in the period January to December 2010 is greater than 500. Hampshire PCT refers to the former provider arm of Hampshire PCT. Figure 2.16 shows admissions to each Acute Trust by Local Authority residence.

Figure 2.15 Alcohol-related hospital admissions of Hampshire residents by Acute Trust

Source: Secondary Uses Service (SUS)                Data relates to: Jan-Dec 2010
Figure 2.16 Acute Trust attended for alcohol-related admission, by Local Authority of residence

Acute Trust attended for alcohol-related admission, by Local Authority of residence

Alcohol-related admissions (Jan-Dec 2010)

Source: Secondary Uses Service(SUS)  
Data relates to: Jan-Dec 2010
2.2.3 Analysis of health conditions related to alcohol

Analysis of acute, chronic and mental health conditions related to alcohol is provided by NWPHO and presented in Figures 2.18-2.23. Condition groupings used by NWPHO are shown in Appendix A. Data are presented that estimate both the numbers and age-specific rates of admissions in each Local Authority for the conditions that contribute most to the burden of illness. Numbers provide understanding of the scale of the issue for health service planning and rates provide insights into the distribution of disease among the population, to help target interventions.

Data show that hypertensive diseases are by far the biggest contributor to alcohol-attributable hospital admissions, contributing around 40% of all admissions. Cardiac arrhythmias and alcohol-specific mental health conditions are also significant contributors. Further analysis of the biggest contributors reveal that the highest numbers of admissions for hypertensive diseases and mental health conditions are seen in Gosport, Havant and Rushmoor among both males and females, but a different pattern for cardiac arrhythmias, where by far the highest numbers are seen in the New Forest. However, these data are not standardised and Figures 2.22 to 2.23 reveal that when presented as rates per head of population in broad age bands, it can be seen that the New Forest has relatively favourable rates of both hypertensive diseases and cardiac arrhythmias and Rushmoor stands out as having a significantly higher rate than other areas for both conditions. NWPHO do not provide data for alcohol specific mental illness by Local Authority.

The conditions that contribute most to alcohol related hospital admissions show a strong male bias and a steep age gradient.
Figure 2.18  Conditions contributing to alcohol-attributable hospital admissions

Number of hospital admissions (NI39) attributable to different groups of conditions

Source: NWPHO, LAPE       Data relates to: 2008/9

Figure 2.19  Distribution of admissions for alcohol-related hypertensive diseases

Hypertensive diseases contribution to NI39 by gender and local authority

Source: NWPHO, LAPE       Data relates to: 2008/9
Figure 2.20 Distribution of admissions for alcohol-related cardiac arrhythmias

Cardiac arrhythmias contribution to NI39 by gender and local authority

Source: NWPHO, LAPE  Data relates to: 2008/9

Figure 2.21 Distribution of admissions for alcohol-specific mental illness

Alcohol-specific mental conditions contribution to NI39 by gender and local authority

Source: NWPHO, LAPE  Data relates to: 2008/9
Figure 2.22 Rates of admission for alcohol-related hypertensive diseases, by age group

Source: NWPHO, LAPE and ONS 2009 population estimates
Data relates to: 2008/9
(Hart data suppressed by NWPHO due to small numbers in one or more age bands)

Figure 2.23 Rates of admission for alcohol-related cardiac arrhythmias, by age group

Source: NWPHO, LAPE and ONS 2009 population estimates
Data relates to: 2008/9
(Hart data suppressed by NWPHO due to small numbers in one or more age bands)
2.2.4 Other health service use related to alcohol

Ambulance use

All incidents involving the following list of conditions are recorded as potentially alcohol-related to overcome the need for a subjective judgement at each pick-up: Assault/Sexual Assault, Choking, Convulsions/fitting, Haemorrhage/Laceration, Overdose/Poisoning, Psychiatric/Suicide Attempt, Traumatic Injuries, Unconscious/Fainting. Figure 2.24 shows the number of pick-ups that may be related to alcohol broken down by condition; when all conditions are combined the total is over 600 in a typical month, or around 20 a day. Although it must be assumed that not all of these incidents are actually caused by alcohol, even a proportion of them means that alcohol is placing a significant and avoidable burden on ambulance services.

Figure 2.24 Potentially alcohol-related ambulance pick-ups

Emergency Department use

There is a well-established link between alcohol and violence, particularly in the night time economy (NTE). The Cardiff Violence Prevention Group pioneered a successful approach to reducing NTE violence and consequent health service demand by establishing data recording and sharing arrangements between the Emergency Department and police colleagues [4]. Anonymised data about precise location of violence, weapon use, assailants and day/time of violence are shared with police to enable effective targeted policing. In Cardiff this lead to a 40% reduction in A&E violence related attendances between 2002 and 2007.

The Frimley Park Violence Prevention Partnership co-ordinate collection of data on assault-related attendances at Frimley Park Emergency Department. Frimley Park Hospital is approximately 2 miles north of Hampshire’s border with Surrey and therefore serves the population of North East Hampshire. For cases that declare their injury is an assault, data are collected about date, time and exact location of the assault, assault type, body part or weapon involved, type of location (pub, bar, home, street, club, etc), last venue victim was drinking in, age-band and gender.
Table 2.7 shows the number of assault cases recorded by reception staff; comparison with assaults recorded by the casualty card is used as a means of audit, to inform likely data completeness. Casualty card data suggests that the number of assault cases registered at reception is likely to be a fraction of the true number. Data quality has improved since the introduction of an electronic system (from October 2010) but currently this is separate to the main registration system; completeness is expected to be further improved by integrating questions into the main registration system which is currently being upgraded (in use from March 2011). Other reasons for incomplete data will remain such as reception staff feeling threatened or uncomfortable asking detailed questions, and patients being unwilling or unable to answer questions. However, even modest quality data is used to inform policing of ‘hot spots’ for violence in the Night Time Economy.

Table 2.7 Assault cases recorded at Frimley Park Emergency Department, March 2010-Jan 2011

<table>
<thead>
<tr>
<th>Month</th>
<th>Assault cases recorded at reception</th>
<th>Assault cases recorded by casualty card</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2010</td>
<td>25</td>
<td>152</td>
</tr>
<tr>
<td>April</td>
<td>10</td>
<td>111</td>
</tr>
<tr>
<td>May</td>
<td>38</td>
<td>176</td>
</tr>
<tr>
<td>June</td>
<td>24</td>
<td>109</td>
</tr>
<tr>
<td>July</td>
<td>33</td>
<td>140</td>
</tr>
<tr>
<td>August</td>
<td>34</td>
<td>149</td>
</tr>
<tr>
<td>September</td>
<td>21</td>
<td>146</td>
</tr>
<tr>
<td>October</td>
<td>12</td>
<td>127</td>
</tr>
<tr>
<td>November</td>
<td>36</td>
<td>126</td>
</tr>
<tr>
<td>December</td>
<td>32</td>
<td>97</td>
</tr>
<tr>
<td>January 2011</td>
<td>33</td>
<td>Not available</td>
</tr>
</tbody>
</table>

Source: Surrey PCT

The focus of data collection is community safety, and data on the role of alcohol is not recorded, but there is a well-established link between violence in the Night Time Economy and alcohol: North West Public Health Observatory use alcohol-attributable fractions of 0.37 (37%) for violent crimes against the person and 0.27 (27%) for assaults leading to hospital admission. Currently, data are monitored for population-level trends and individual-level interventions are not triggered by attendance with an assault injury. There may be opportunities to further exploit the data by highlighting areas where population-level alcohol interventions could be of benefit, or for triggering alcohol brief intervention at an individual level, although this may increase data demands. There are plans for the two Emergency Departments in Hampshire (Basingstoke and Winchester) to develop a similar system.

2.2.5 Trends in alcohol-attributable morbidity and mortality

The trend across Hampshire for alcohol-attributable deaths is broadly stable, with a tendency towards a slight decline. This is reflected in the trends at Local Authority level (not shown; available from NWPHO LAPE [2]), where approximately half of the Local Authorities in Hampshire show a flat trend and approximately half show a decreasing trend.

However, the trend for alcohol-attributable hospital admission shows an unequivocal increase in Hampshire overall and in all 11 Local Authority areas.

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3 Casualty cards are used to record clinical and demographic information collected by clinical staff who come into contact with the patient during the course of their A&E episode.
Figure 2.25 Trends in alcohol-attributable mortality in Hampshire

Figure 2.26 Trends in alcohol-attributable hospital admission in Hampshire

Figure 2.27 Trends in alcohol-related admissions (NI39) in Hampshire

NI39 alcohol-related admissions (standardised per 100,000 population)

Source: Hospital Episode Statistics
2.3 The social impact of alcohol misuse

The social effects of alcohol are widespread and not all can be captured by measurable indicators. Levels of alcohol-related crime, including serious violent and sexual assaults, are recorded, as are some indicators of anti-social behaviour. There is a complex relationship between alcohol and crime. Alcohol is known to be associated with a higher risk of being both a perpetrator and a victim of crime, and excessive drinking is likely to be an effect as well as a cause of crime.

2.3.1 Alcohol-attributable crime

Rates of alcohol-related crime are lower in Hampshire than the South East and South Central areas, however there is considerable variation within the county. Gosport and Havant have alcohol-attributable crime rates well above the Hampshire and regional averages (Figure 2.28) but numbers of alcohol-attributable violent crime are highest in Havant and Basingstoke and Deane (Figure 2.29).

Figure 2.28 Rates of all crime and violent crime attributable to alcohol

Rates of alcohol-attributable crime

Source: NWPHO, LAPE       Data relates to: 2009/10
In the 6 month period from 1st April–30th September 2010, 544 sexual offences were reported in Hampshire, including 227 offences of rape, attempted rape and sexual assault by penetration. Data are extracted from Hampshire Constabulary’s Record Management System (RMS). Table 2.8 shows the number of offences and rate per 1,000 population by Operational Command Unit (OCU). The population served by NHS Hampshire reside in OCU 1, 3 and 6, shown in Figure 2.30.

Table 2.8  Rape, attempted rape & sexual assault by penetration in Hampshire

<table>
<thead>
<tr>
<th>OCU</th>
<th>Offences April-Sept 2010</th>
<th>OCU Population</th>
<th>Offences per 1,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>87</td>
<td>413,280</td>
<td>0.21</td>
</tr>
<tr>
<td>2</td>
<td>20</td>
<td>138,370</td>
<td>0.14</td>
</tr>
<tr>
<td>3</td>
<td>67</td>
<td>440,810</td>
<td>0.15</td>
</tr>
<tr>
<td>4</td>
<td>49</td>
<td>188,500</td>
<td>0.26</td>
</tr>
<tr>
<td>5</td>
<td>80</td>
<td>221,210</td>
<td>0.36</td>
</tr>
<tr>
<td>6</td>
<td>68</td>
<td>399,270</td>
<td>0.17</td>
</tr>
</tbody>
</table>

N.B. Figures in bold relate to the population served by NHS Hampshire

Source: Hampshire Constabulary data with alcohol attributable fractions (LAPE Guidance & Methods, 2010)
Geographical and temporal analyses of Hampshire Constabulary data [5] indicate that there is likely to be a connection between rape, attempted rape and sexual assault by penetration offences and the Night Time Economy (NTE). This suggests that alcohol is likely to be a factor in offences. Data provided by the Sexual Assault Referral Centre (SARC) indicates whether or not the victim had been drinking at the time of the offence as well as the number of units consumed. It should be noted that these figures rely on self-report data. Approximately 47% of attendees to the SARC had consumed alcohol (145 out of 307 attendees). The most common consumption level reported was 6–10 units (32%), followed by 1–5 units (19%). There is currently no facility for recording whether or not the offender was drinking alcohol at the time of the offence; improvements in recording the influence of alcohol in relation to the offender have been proposed.

It is assumed that sexual offences are linked to alcohol consumption by impaired judgements about safety. Reducing alcohol consumption can be expected to improve judgements about safety, which may lead to a reduction in sexual offences.
2.3.2 Domestic violence and alcohol

There is a well-established link between alcohol and domestic violence. In the 3 month period from October-December 2010 a total of 2,172 incidents of domestic violence were recorded by Hampshire Constabulary RMS, of which 718 involved alcohol. However, this only represents reported incidents. Hampshire County Council estimates that around 56,000 women and girls were victims of domestic abuse in Hampshire in the year April 2009-10\(^4\). Research suggests that approximately half of domestic violence involves alcohol \([6]\), which means that up to 28,000 women and girls in Hampshire could be affected each year by domestic violence involving alcohol.

Tackling excessive alcohol consumption may reduce the number of alcohol-related domestic violence incidents, which currently stands at around 240 reported incidents per month in Hampshire, although estimates suggest the true figure could be much higher.

**Figure 2.31 Contribution of alcohol to domestic violence in Hampshire**

![Bar chart showing the contribution of alcohol to domestic violence in Hampshire](image)

Source: Hampshire Constabulary     Data relates to: Oct-Dec2010

2.3.3 Antisocial behaviour

A total of 33,761 incidents of ‘Rowdy and Inconsiderate Behaviour’ were reported in Hampshire in 2009, which reduced by 24% to 25,762 in 2010. A reduction in reported incidents was seen in all areas of Hampshire. There is no explicit link between Rowdy and Inconsiderate Behaviour and alcohol, although alcohol is expected to be implicated in a high proportion of cases. Figure 2.32, below, shows the density of Rowdy and Inconsiderate Behaviour reports across Hampshire in 2010. Confiscations of alcohol by Accredited Community Safety Officers (ASCOs) have also been mapped across Hampshire (Figure 2.33). The areas where confiscations occur are the areas where ACSOs are active, rather than giving a representative picture of where most alcohol activity occurs. However, the spot map of alcohol confiscations corresponds well to the areas where Rowdy and Inconsiderate Behaviour is most prevalent.

\(^4\) Government’s Violence Against Women and Girls ready reckoner estimate based on Hampshire’s estimated female population of 870,775 (2009 Small Area Population Forecast, HCC)
Figure 2.32  Density of Rowdy and Inconsiderate Behaviour reports in Hampshire, 2010

Figure 2.33  Density of Alcohol confiscations (under 18 yrs) by ACSO service in Hampshire, 2009-10
The Place Survey, carried out by the Audit Commission, [7] shows that in 2008/9 25.8% of people in Hampshire perceived drunk or rowdy behaviour to be a problem in their area (NI41) compared to an average for all upper tier and unitary authorities in England of 31.1%. However there is variation within Hampshire, with Rushmoor and Gosport showing the highest levels: Basingstoke and Deane Borough Council, 20.9%; East Hampshire District Council, 25.8%; Eastleigh Borough Council, 29.9%; Fareham Borough Council, 24.5%; Gosport Borough Council, 36.4%; Hart District Council, 21.1%; Havant Borough Council, 30.8%; New Forest District Council, 23.7%; Rushmoor Borough Council, 36.1%; Test Valley Borough Council, 23.5%; Winchester City Council, 19.2%.

2.3.4. Trends in alcohol-attributable crime

The trend across Hampshire for alcohol-attributable crime shows a modest decline overall. At Local Authority level (not shown; available from NWPHO [2]), the majority of areas show a decline and the remaining areas show a broadly flat trend.

2.4 High risk groups for alcohol harm

A number of groups within the population are particularly vulnerable to the negative health and social effects of alcohol. Data are presented below that describe these groups and, where possible, knowledge is related to the population of Hampshire.

2.4.1 Sexual health and pregnancy

Alcohol is an important factor in sexual health and pregnancy: it is known to increase the likelihood of risky sexual behaviour which in turn increases the risk of sexually transmitted infections and unplanned conception; consumption of alcohol during pregnancy may have consequences for foetal development and heavy drinking risks serious developmental consequences.

Sexual health

Data linking sexual health to alcohol are not available for the population of Hampshire. Nationally, Ipsos-MORI conducted an online survey of 1,002 18-30 year olds on ‘Sexual Health and Alcohol’ on behalf of the Family Planning Association in August 2009 [8]. Among respondents, 37% said they had ‘had sex with a new partner without using a condom’. Of this group, 40% said that alcohol was a factor (either a great deal or a fair amount) in what happened.
Teenage conception
A recent evidence review [9] found that early and regular alcohol consumption, particularly higher quantities and binge drinking, are associated with early onset of sexual activity, lower levels of condom use, having a higher (or multiple) number of sexual partners, increased risk of becoming pregnant in females and getting someone pregnant in males, levels of regretted sex and increased risk of forced sex. Analysis of geographical data linking alcohol consumption rates with teenage pregnancy rates found a significant positive relationship between teenage conceptions and alcohol-related hospital admissions in young people. This relationship is consistent at both lower tier Local Authority and ward levels and is independent of deprivation.

A ChildLine casenotes publication on ‘Alcohol and Teenage Sexual Activity’ [10] reports that around 5,843 young people (predominantly girls) spoke to ChildLine about pregnancy in 2004/5. Of the 4,954 who stated their age, more than 75% were aged 15 or under. Alcohol was frequently cited as a factor associated with unprotected sex leading to pregnancy, whereas young people who spoke about drugs rarely blamed them for the pregnancy.

A further report by Cook et al [11] suggests that these findings should be used to demonstrate to key stakeholders the relationship between alcohol misuse and poor sexual health outcomes, and the need for professionals to address sexual health and alcohol issues simultaneously. The authors recommend that any campaigns or services that aim to address teenage conception should include alcohol consumption in young men as well as women, since alcohol misuse in both sexes independently predict teenage pregnancy and sexually transmitted infections.

Data linking teenage conception to alcohol are not available for the population of Hampshire, however teenage conception rates are shown in Figure 2.35. The overall rate in Hampshire is comparable to the South East region. Within Hampshire, rates are highest in Gosport, which shows an upward trend. Rates in Havant are also elevated but have declined over recent years.

Figure 2.35 Teenage conception rates in Hampshire Local Authorities

![Bar chart showing teenage conception rates in Hampshire Local Authorities](chart.png)

Source: ONS
Alcohol in pregnancy

Alcohol crosses the placental barrier and can affect foetal development; whilst consumption of alcohol does not always result in developmental abnormality (quantity and stage of pregnancy are relevant factors), there are currently no medically established guidelines for a safe level of consumption and the Department of Health advises women who are pregnant or trying to conceive to avoid alcohol.

Foetal Alcohol Spectrum Disorder (FASD) is a broad term that describes a continuum of mental and physical developmental abnormalities resulting from alcohol consumption in pregnancy. Foetal Alcohol Syndrome (FAS) is the term used for the more severe end of the continuum when multiple features are present. The consequences for the child are serious, permanent and avoidable. Clinical manifestations of FASD include low birth weight and poor growth, mild to severe learning difficulties, memory and attention disorders, speech and language disorders, behavioural disorders, visual and hearing disability, cranio-facial abnormalities, epilepsy, liver, kidney and heart abnormalities, musculoskeletal, hormonal and genital abnormalities.

A recent BMA publication concludes that there is currently no reliable evidence on the incidence of FASD in the UK [12]. In England and Scotland, data are only collected on FAS and not the whole spectrum of FASD. Hospital Episode Statistics estimate that there were 95 cases of FAS in England in 2000-01, 90 in 2001-02 and 128 in 2002-03. In Scotland, there were four cases of FAS in 2000, five in 2001, four in 2002, two in 2003 and 10 cases in 2004. This equates to 0.21 per 1,000 live births in 2004.

Data on the incidence of the full range of FASD is emerging and it is clear that some populations are at higher risk than others, particularly populations that experience high levels of social deprivation and poverty.

Assuming a prevalence of 0.21 per 1,000 live births, it is expected that 3 children will be born with FAS in Hampshire each year. Assuming prevalence of FASD of 10-20 per 1,000 live births (based on Canadian and Italian estimates), it is estimated that 250-300 children are born with this condition in Hampshire each year in Hampshire. However, this is likely to be an under-estimate as FASD is expected to be under-diagnosed.

2.4.2 Children and young people

As well as having potential short and long term health consequences, alcohol consumption among young people is associated with increased risk of unplanned conception, sexually transmitted infections, and an increased risk of being a victim or perpetrator of crime.

A report by the National Treatment Agency (NTA) on substance misuse among young people 2009-10 [13] found that the substances that young people use most commonly are cannabis and alcohol, and often in combination. Of all the young people engaged by specialist treatment services in 2007/08, 36% (8,589) were being treated for alcohol and 51% for cannabis.

Smoke Free Hampshire and Isle of Wight co-coordinated a survey on smoking, alcohol and drugs within secondary schools in the Rushmoor, Gosport and Havant areas in 2010 [14]. The results are shown in Table 2.9 below.
Table 2.9 Prevalence of alcohol consumption among young people in Hampshire

<table>
<thead>
<tr>
<th></th>
<th>Gosport¹ (n=753)</th>
<th>Havant² (n=1110)</th>
<th>Rushmoor³ (n=1053)</th>
<th>England²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever tried a whole alcoholic drink</td>
<td>57%</td>
<td>70%</td>
<td>50%</td>
<td>51%</td>
</tr>
<tr>
<td>Drinking to excess in last month</td>
<td>56%</td>
<td>51%</td>
<td>47%</td>
<td>-</td>
</tr>
<tr>
<td>(% of those who have ever tried)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drinking to excess in last month ( % of total sample)</td>
<td>31%</td>
<td>36%</td>
<td>23%</td>
<td>-</td>
</tr>
<tr>
<td>Drinking to excess 3 or more times in last month (% of total sample)</td>
<td>11%</td>
<td>7%</td>
<td>6%</td>
<td>-</td>
</tr>
<tr>
<td>Population aged 11-15 ⁴</td>
<td>4921</td>
<td>7051</td>
<td>5968</td>
<td>-</td>
</tr>
<tr>
<td>Number of young people drinking to excess at least once a month</td>
<td>1549</td>
<td>2515</td>
<td>1400</td>
<td>-</td>
</tr>
<tr>
<td>Number of young people drinking to excess 3 or more times a month</td>
<td>557</td>
<td>494</td>
<td>360</td>
<td>-</td>
</tr>
</tbody>
</table>

¹Smoking and Young People in Gosport/Havant/Rushmoor 2010; ²National Centre for Social Research and National Foundation for Educational Research, (2009), Smoking, drinking and drug use among young people in England 2009; ³Drinking until drunk at least once in the last 4 weeks; ⁴Hampshire County Council 2010 mid-year estimate

The percentage of children aged 11-15 who have tried a whole alcoholic drink in Havant (70%) is substantially higher than the average estimate for England (51%). Using survey responses to estimate the number of children drinking alcohol, it is estimated that approximately 2,500 are drinking until they are drunk at least once a month in Havant and around 500 are drinking until they are drunk 3 or more times a month. Both Gosport and Rushmoor have an estimated 1,500 11-15 year olds drinking until they are drunk once a month, with around 550 and 350 respectively getting drunk 3 or more times a month. Survey evidence from young people shows that drinking alcohol in the last week was found to be associated with other risk-taking behaviours: smoking, drug use, and truancy [15]. The following charts indicate that the gender balance in trying alcohol varies by area, but with a tendency for girls to try alcohol more than boys.

Figure 2.36 Percentage of boys and girls who have tried alcohol in Gosport

![Percentage of Boys and Girls Who Had Tried an Alcoholic Drink (N=753)](image)
Overall, vodka is the most popular drink, followed by cider, beer and alcopops. Parents are the most common source of alcohol, followed by friends, and home is the most common place for drinking, followed by parties. It is not clear from the survey whether parents are buying alcohol for their children or whether it is being taken without their permission, but irrespective of this children are acquiring and consuming alcohol in places beyond the reach of conventional control measures such as licensing of shops and public bars.

Data are not available on alcohol consumption among children and young people across all areas of Hampshire.

Data describing hospital admissions of young people in Hampshire related to alcohol are presented in section 2.2.1.
2.4.3 Dual diagnosis

Dual diagnosis refers to the co-occurrence of mental illness and substance misuse. The relationship between substance misuse and mental illness is complex and potentially interdependent: individuals who misuse substances are at increased risk of mental health symptoms and individuals with mental health symptoms are at increased risk of substance misuse.

Analysis of the ONS Survey of Psychiatric Morbidity among adults in Great Britain [16] suggests estimates for the proportion of adults with mental health difficulty who are also potentially harmful users of alcohol: 26% have an AUDIT score >8 (used as an indicator of increased risk drinking), 4% score > 16 (indicates higher risk drinking), and 7% are classed as dependent drinkers by the Severity of Alcohol Dependence Questionnaire (SAD-Q).

Combining the national estimates above with Hampshire’s estimated prevalence of mental illness (Source: Hampshire Joint Strategic Needs Assessment) gives an indication of the likely number of people suffering with mental illness who are also drinking at potentially harmful levels.

<table>
<thead>
<tr>
<th></th>
<th>Increasing risk (AUDIT &gt;8)</th>
<th>Higher risk (AUDIT &gt;16)</th>
<th>Dependent (SAD-Q)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hampshire</td>
<td>2197</td>
<td>338</td>
<td>592</td>
</tr>
<tr>
<td>Basingstoke and Deane</td>
<td>237</td>
<td>36</td>
<td>64</td>
</tr>
<tr>
<td>East Hampshire</td>
<td>204</td>
<td>31</td>
<td>55</td>
</tr>
<tr>
<td>Eastleigh</td>
<td>185</td>
<td>29</td>
<td>50</td>
</tr>
<tr>
<td>Fareham</td>
<td>169</td>
<td>26</td>
<td>46</td>
</tr>
<tr>
<td>Gosport</td>
<td>166</td>
<td>26</td>
<td>45</td>
</tr>
<tr>
<td>Hart</td>
<td>127</td>
<td>20</td>
<td>34</td>
</tr>
<tr>
<td>Havant</td>
<td>246</td>
<td>38</td>
<td>66</td>
</tr>
<tr>
<td>New Forest</td>
<td>298</td>
<td>46</td>
<td>80</td>
</tr>
<tr>
<td>Rushmoor</td>
<td>185</td>
<td>28</td>
<td>50</td>
</tr>
<tr>
<td>Test Valley</td>
<td>172</td>
<td>27</td>
<td>46</td>
</tr>
<tr>
<td>Winchester</td>
<td>207</td>
<td>32</td>
<td>56</td>
</tr>
</tbody>
</table>

2.4.4 Occupational groups

Research suggests that some professional groups are at higher risk of alcohol-related harm than others. Mortality from alcohol-related accidents and chronic illness is highest among those who work in the drinks industry (both sexes), and in male seafarers and catering/kitchen staff [17, 18]. It is reasonable to assume that Hampshire may have a higher than average population of male seafarers, and the percentage of the workforce who work in bars is higher than the national average in several areas of Hampshire, shown in Figure 2.39.

Bar employees

Overall, Hampshire has a lower proportion of the workforce working in bars than the South East and South Central regions, but Gosport, New Forest and Winchester show a higher percentage than average. The data showing the pattern of employment in bars, provided by NWPHO, is consistent with the pattern of licensed premises data provided by Hampshire Licensing Officers Group.
Armed forces and veterans

A study of alcohol consumption among UK Armed Forces personnel by Fear et al revealed that 67% of males and 49% of females scored >8 on the AUDIT questionnaire (interpreted as an indication of increased risk drinking) compared to 38% of men and 16% of women in the general population [19]. Hampshire has an estimated armed services population of 13,940 not including reservists, Ghurkas or veterans, and across the UK Armed Forces 90% of personnel are male [20]. Based on the findings of Fear et al, it is estimated that nearly 10,000 armed forces personnel in Hampshire are drinking at a level that may be harmful to their health.

A separate study of mental health disorders among UK Armed Forces using the Patient Health Questionnaire reported that the prevalence of ‘alcohol abuse’ is 18% [21]. This provides an estimate of around 2,500 in Hampshire. However, it is unclear how ‘alcohol abuse’ may have been interpreted by respondents and it is expected to be an underestimate as admitting to symptoms of ‘alcohol abuse’ could have disciplinary consequences for serving personnel. In both studies, being young, male, single and a smoker were associated with higher risk of excessive alcohol consumption, which may help to target preventive interventions.

Among veterans, there is little evidence around the use of alcohol. Fossey [22] reports that of the first 150 attendees at the UK Medical Assessment Programme for veterans, more than 80% used alcohol, of whom 30% of those ‘misused’ alcohol. Of the alcohol misuse group, 23% had come into contact with the criminal justice system and 24% had experienced relationship problems because of drink.

Taken together, the evidence indicates that active and former Armed Service personnel are a high risk group for alcohol harm. Hampshire is home to nearly 14,000 service personnel and the consumption of alcohol among this group must be addressed as part of a comprehensive strategy to reduce alcohol harm in the county.
Table 2.11 Estimates of UK regular services personnel drinking above recommended limits

<table>
<thead>
<tr>
<th>Area</th>
<th>Estimated population</th>
<th>Estimated population drinking above recommended limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hampshire</td>
<td>13,940</td>
<td>9,089</td>
</tr>
<tr>
<td>Basingstoke and Deane</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>East Hampshire</td>
<td>1,630</td>
<td>1,063</td>
</tr>
<tr>
<td>Eastleigh</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Fareham</td>
<td>1,400</td>
<td>913</td>
</tr>
<tr>
<td>Gosport</td>
<td>1,620</td>
<td>1,056</td>
</tr>
<tr>
<td>Hart</td>
<td>2,840</td>
<td>1,852</td>
</tr>
<tr>
<td>Havant</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>New Forest</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Rushmoor</td>
<td>3,110</td>
<td>2,028</td>
</tr>
<tr>
<td>Test Valley</td>
<td>1,250</td>
<td>815</td>
</tr>
<tr>
<td>Winchester</td>
<td>1,350</td>
<td>880</td>
</tr>
</tbody>
</table>

N.B 0 indicates zero or rounded to zero

Source: Defence Analytical Services and Advice (DASA)  
Data relates to: 1st January 2011

2.4.5 Offenders

The link between alcohol and crime has been clearly established. This section summarises data that illustrate the high level of drinking among offenders in Hampshire, and the role that this plays in their offending.

At the beginning of a community order, all tier 2-4 offenders are assessed to identify needs that have contributed to their offending behaviour (criminogenic needs). Over a 12 month period (2009/10) in Hampshire, 57% (2202) of tier 2-4 offenders identified alcohol as a factor in their offending (Figure 2.40). Offenders are identified by area of residence and the greatest numbers of offenders who identify alcohol as a contributing factor are in Havant, Basingstoke and Deane and the New Forest (Figure 2.41).

A 2008 survey of HMP Winchester [23], found that 35% of prisoners believe they have an alcohol problem. The average weekly alcohol consumption (prior to prison) among men who did not report an alcohol problem was 43 units (increasing risk drinking: 22-50 units/week), and among men who reported a problem the average consumption was 157 units (higher risk drinking: >50 units). The survey reports that the proportion of those in the higher risk drinking category was 10 times higher among prisoners (40.2%) than in the general population (4.1%).

The survey also found that 46% of prisoners felt their offending was linked to alcohol consumption. Among those who had committed violent crime or robbery the percentage reporting a criminogenic link was higher: 68% and 71% respectively. The discrepancy between 46% of prisoners and 57% of tier 2-4 offenders on probation (see Figure 2.40) expressing alcohol as a criminogenic factor may be explained by completeness of the data and differences in the question being asked: all tier 2-4 probationers are asked about alcohol at the commencement of supervision whereas Winchester Prison survey had a response rate of 58%; offenders on probation are assessed with a broad remit to identify alcohol as a problem issue for the individual and/or the involvement of alcohol in the offending behaviour.

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5 The National Offender Management Service (NOMS) defines a four tier classification structure for the management of offenders under supervision: Tier 1 ‘punish’, Tier 2 ‘help’, Tier 3 ‘change’, Tier 4 ‘control’
Figure 2.40 Criminogenic needs of tier 2-4 offenders in Hampshire

Criminogenic needs of tier 2-4 offenders in Hampshire

Source: Hampshire Probation Trust  Data relates to: October 2009-September 2010

Figure 2.41 Alcohol and drug misuse needs of offenders by Local Authority

Tier 2-4 offenders with substance misuse criminogenic need by district

Source: Hampshire Probation Trust  Data relates to: Oct 2009-Sept 2010

The survey reports an average of 18.5 alcohol detoxifications per month in the prison in 2005-6; 2010 Figures show an average of 20.3 (Source: HMP Winchester). Among survey respondents, 49% said they would use an alcohol service in prison if available, but a substantial minority of these (37%) were not eligible as alcohol services are only available to those who have used drugs in the previous 12 months.

The Offender Assessment System (OASys) is a data collection tool used in England and Wales by the Prison Service and the National Probation Service. Data from OASys 2005-6 [24] indicates 51% of community (probation) offenders had alcohol as a criminogenic need and 59% in HMP Winchester. These figures are higher than the South East (45% among community offenders; 31% among
prisoners) and England and Wales (41% among community offenders; 35% among prisoners). These data indicate that in Hampshire and Isle of Wight 65% of community offenders with an alcohol need are provided with an intervention, higher than the South East average (58%) and England and Wales average (56%). In addition to their offending, prisoners reported social problems related to alcohol consumption: violence to others (30%), relationship problems (36%) and money problems (32%).

Data from HMP Winchester BETA Resettlement Team shows that in 2005, 25% of prisoners admitted to alcohol misuse when asked without a specific definition of ‘misuse’ being given [23]. This is consistent with 2010 figures that show 26% of 3269 new prisoners admitted to an alcohol problem at their Immediate Needs Assessments (Source: HMP Winchester BETA Resettlement Team). Findings from OAsys and the 2008 survey suggest that this is likely to be an underestimate of those drinking above recommended levels or who are offending or experiencing social problems as a consequence of alcohol consumption.

2.4.6 Elderly
The UK has an ageing population, and in Hampshire the proportion of older people is growing more rapidly than the national average. The health and well-being of older people is a vital component of the health and well-being of Hampshire and a healthy approach to alcohol is an important part of that. A recent review of alcohol disorders in older people [25] concluded that alcohol use disorders are common in elderly people and are associated with notable physical, social, psychological, and cognitive health problems, but are under-detected and misdiagnosed for various reasons. The authors suggest that alcohol treatment for elderly people may be more appropriate among their peers and that recommended limits for intake, screening instruments, and diagnostic criteria must be redefined for elderly people.

In Hampshire, morbidity for the most prevalent alcohol-related conditions is highest in older people (see Figures 2.22 and 2.23) and nationally, there is evidence of increasing alcohol-related morbidity in older people for a range of conditions (Table 2.12) [26].

| Table 2.12 Changes in alcohol-related hospital admissions in people over 65 years |
|--------------------------------|------------------|
| Condition                        | % increase 2002 - 2007 |
| Malignant neoplasm of oesophagus | 6.6               |
| Fall injuries                     | 19.3              |
| Liver disease                     | 45.9              |
| Epilepsy and Status epilepticus  | 51.8              |
| Cardiac arrhythmias               | 70.9              |
| Mental / behavioural disorders    | 76.9              |
| Hypertensive diseases             | 119.4             |

The Institute of Alcohol Studies report that three ‘types’ of elderly drinkers have been identified [27]: Early-Onset drinkers or ‘Survivors’ are those people who have a continuing problem with alcohol which developed in earlier life. It is thought that two thirds of elderly problem drinkers have had an early onset of alcohol misuse. However, because of the health risks connected to heavy drinking and dependence on alcohol, the chances of reaching old age are reduced - one estimate is that the life span of a problem drinker may be shortened by on average ten to fifteen years. Late-Onset drinkers or ‘Reactors’ begin problematic drinking later in life, often in response to traumatic life events such as the death of a loved one, loneliness, pain, insomnia, retirement etc. Intermittent or Binge drinkers use alcohol occasionally and sometimes drink to excess which may cause them problems. It is thought that both the late-onset drinkers and the intermittent or binge drinkers have a high chance of managing their alcohol problem if they have access to appropriate treatment such as counselling and general support.
2.4.7 Hepatitis C patients

Hepatitis C is a blood-borne virus affecting the liver. Around 80% of cases become chronic carriers although acute infection is commonly asymptomatic or is associated with non-specific symptoms so many people are unaware that they are infected. It can cause inflammation and fibrosis of the liver, and can progress to significant liver disease including cancer. Intravenous drug use is the main risk factor for Hepatitis C in the UK; less common routes of infection are via blood transfusion (outside the UK or before 1991 in the UK), tattoos and body piercing, needle-stick injury, unprotected sex and mother-child transmission. There is currently no vaccine for Hepatitis C and prevention is via safe drug and sexual practices.

It is important to consider alcohol and Hepatitis C together for several reasons: prevalence of Hepatitis C is higher among those with a history of alcohol abuse (prevalence is estimated to be around 15% [28, 29] compared with less than 0.5% in the general population of England); Hepatitis C infection and alcohol consumption have a synergistic effect on the liver, increasing the risk of progression to serious disease [29], and as such alcohol is the only modifiable risk factor for disease progression in Hepatitis C (male sex and age over 40 years are also risk factors); and patients admitted to hospital for alcohol who also have a diagnosis of Hepatitis C stay in hospital an average of 19% longer (95% CI 12-27%), after adjustment for confounding [29].

The reason for the high rate of Hepatitis C among those with a history of alcohol abuse is not fully understood but is likely to be due to increased prevalence of risk factors such as drug injection, unsafe sex, tattoo and body-piercing. The level of alcohol consumption associated with increased risk of Hepatitis C progression is unclear, but some evidence suggests that even moderate drinking may be a risk [30].

There are an estimated 3,378 cases of Hepatitis C among the population served by Hampshire PCT (HPA template estimate), so potentially around 500 cases with both Hepatitis C and a history of alcohol abuse. Incidence figures are not available, and figures relating to Hepatitis C are likely to be underestimates due to the asymptomatic nature of acute infection.

The relationship between alcohol misuse and Hepatitis C, and the risk of poor outcomes when they co-occur, indicates that alcohol should be addressed with Hepatitis C patients, and Hepatitis C risk should be addressed as part of alcohol treatment.

2.4.8 Alcohol and deprivation

There is a strong relationship between deprivation and many dimension of health. The Index of Multiple Deprivation (IMD) is a composite measure of deprivation that combines indicators of: education, skills and training, employment, crime and disorder, income, health deprivation and disability, living environment and barriers to housing and services. Figure 2.42 below shows the variation in IMD status across Hampshire and a relative measure of morbidity from alcohol which relates the number of admissions to the mean level for the county. The areas where alcohol-related hospital admissions are significantly greater than the county average largely correspond to areas of highest deprivation. Similarly, the areas where admissions are significantly lower than the county average tend to correspond to the areas with least deprivation, although Hart and Fareham are exceptions to this pattern. This implies a strong correlation between alcohol-related harm and deprivation, and suggests that alcohol may be an important driver of health inequalities.
2.4.9 Social segmentation and alcohol

Social Marketing Drinking Segments have been developed to support social marketing related to harmful drinking [31]. They describe the characteristics of people in terms of their alcohol risk, their demographics and the types of media they use. The population is divided into 13 segments, 8 of which are at risk of drinking above recommended levels. The eight segments are outlined below; more details are available from the Alcohol Social Marketing tool, which can be accessed via the Alcohol Learning Centre website. The Department of Health recommends that the primary focus should be on segments 10, 12 and 13 and secondary focus on segments 8 and 9.

Primary focus segments – 10, 12 and 13

Segment 10
Segment 10 includes high numbers of pensioners, who are generally in poor health with conditions that include asthma, angina and heart problems. They have high acute hospital admissions. They often live alone and in Local Authority flats. As well as drinking beer and spirits, they are likely to smoke. They tend to read tabloids.
Segment 12
Segment 12 includes people with a broad range of ages, who are likely to live in terraces, often in former industrial areas. They generally have the worst levels of overall health, with asthma, cholesterol and heart conditions as well as high acute hospital admissions. They are likely to smoke and drink beer and lager, at home and in pubs. They tend to read tabloids.

Segment 13
Segment 13 includes young people in their 20s who have a very high rate of acute admissions. They are likely to live alone in Local Authority flats or hostels, be unemployed and some are single parents. They are likely to drink large amounts of both beer and spirits and to smoke. They tend to read tabloids.

Secondary focus segments – 8 and 9

Segment 8
Segment 8 includes blue collar workers, living in post-industrial parts of England, who often live in terraces or semi-detached houses that are rented from local authorities. With high hospital admissions, they are likely to smoke and to drink bitter, lager and spirits, mostly at home. They tend to read tabloids.

Segment 9
Segment 9 includes parents in their late 20’s to early 30’s who have several young children. Many are divorced and/or single parents. They are likely to live in flats or terraced houses and to be unemployed or unskilled. With high hospital admissions, they are also likely to smoke, eat fast food and drink vodka and canned lager. They tend to read tabloids.

Other segments at risk of drinking above recommended levels – 6, 7 and 11

Segment 6
Segment 6 includes affluent, young people, aged under 30 who are either students or graduates, often living in private flats. Although their hospital admissions are low, they tend to drink a lot of wine. Apart from that, they are likely to have healthy lifestyles. The media they consume usually includes broadsheets and the internet.

Segment 7
Segment 7 includes affluent, professionals who are over 45, often living in their own detached homes and with household incomes that are more than £50,000. They are generally healthy - despite eating a lot of rich food - and have low hospital admissions. They are likely to drink bitter in pubs but are unlikely to smoke. They tend to read broadsheets.

Segment 11
Segment 11 includes students and unemployed young people who live alone or share flats, often in multi-ethnic student areas. Likely to be binge drinkers and smokers, they usually drink draught lager and spirits. Despite this - and high rates depression - they are physically healthy. The newspapers they tend to read are quite diverse, including both tabloids and broadsheets.

The alcohol segmentation profile of the Hampshire population is shown in Table 2.13 and Figure 2.43, and mapped in Figure 2.44. Note that the population is mapped by residence rather than where they drink. Although the percentage of the Hampshire population in high and medium risk groups are relatively low, the size of the population means that there are approximately 20,000 people are in the higher risk segments and over 300,000 in medium risk segments. In terms of the
recommended primary and secondary focus segments, Hampshire is home to around 207,000 and 18,000 respectively. Figures 2.42 and 2.43 show the distribution of the primary and secondary focus segments across Hampshire: the majority of both primary and secondary segments are resident in Havant, with Basingstoke also showing a high percentage of residents in the secondary focus segment. Interestingly, the epidemiology of alcohol consumption and health consequences in Hampshire is not what would be expected from the social segmentation analysis, however the distribution of social segmentation risk groups shows a strikingly similar pattern to the distribution of alcohol-attributable violent crime (Figure 2.29) and alcohol as a criminogenic need expressed by offenders (Figure 2.41).

### Table 2.13 The breakdown of Hampshire’s population by alcohol social segmentation

<table>
<thead>
<tr>
<th>Segment</th>
<th>Targeting</th>
<th>Risk</th>
<th>Population</th>
<th>% of NHS Hampshire population</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Not included</td>
<td>Low</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>2</td>
<td>Not included</td>
<td>Low</td>
<td>230,334</td>
<td>18%</td>
</tr>
<tr>
<td>3</td>
<td>Not included</td>
<td>Low</td>
<td>180,896</td>
<td>14%</td>
</tr>
<tr>
<td>4</td>
<td>Not included</td>
<td>Low</td>
<td>316,605</td>
<td>25%</td>
</tr>
<tr>
<td>5</td>
<td>Not included</td>
<td>Low</td>
<td>223,495</td>
<td>17%</td>
</tr>
<tr>
<td>6</td>
<td>Other</td>
<td>Medium</td>
<td>27,655</td>
<td>2%</td>
</tr>
<tr>
<td>7</td>
<td>Other</td>
<td>Medium</td>
<td>73,742</td>
<td>6%</td>
</tr>
<tr>
<td>8</td>
<td>Secondary</td>
<td>Medium</td>
<td>129,465</td>
<td>10%</td>
</tr>
<tr>
<td>9</td>
<td>Secondary</td>
<td>Medium</td>
<td>77,552</td>
<td>6%</td>
</tr>
<tr>
<td>10</td>
<td>Primary</td>
<td>High</td>
<td>5,609</td>
<td>0%</td>
</tr>
<tr>
<td>11</td>
<td>Other</td>
<td>High</td>
<td>1,136</td>
<td>0%</td>
</tr>
<tr>
<td>12</td>
<td>Primary</td>
<td>High</td>
<td>8,294</td>
<td>1%</td>
</tr>
<tr>
<td>13</td>
<td>Primary</td>
<td>High</td>
<td>4,641</td>
<td>0%</td>
</tr>
</tbody>
</table>

### Figure 2.43 The breakdown of Hampshire’s population by alcohol social segmentation

![Social Marketing Drinking Segments - NHS Hampshire](image-url)
Figure 2.44 Map of Hampshire’s population by alcohol social segmentation

Figure 2.45 Distribution of Hampshire’s population in primary focus segments (10, 12 and 12)
2.5 Availability of alcohol

The largest number of licensed premises per population are in Winchester, where Hampshire’s highest rate of binge drinking is seen, and in Gosport where the highest levels of all categories of alcohol-related harm are seen. In Hart, which has the highest rate of increasing risk drinking in Hampshire, there is a low rate of on-sale licensed premises but a high rate of total licensed premises, and this may imply high levels of drinking at home. The New Forest, where the highest rates of alcohol-specific hospital admissions among under 18 year olds are seen, has the third largest number licensed premises. License data by exact location are not currently available.

Table 2.14 Licensed premises and review hearings in Hampshire

<table>
<thead>
<tr>
<th>Location</th>
<th>Total number of premises licensed to sell alcohol, including clubs ¹ (number per 1,000 population over 15 years)</th>
<th>Number of premises licensed for on-sales, including clubs² (number per 1,000 population over 15 years)</th>
<th>License review hearings since November 2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basingstoke &amp; Deane</td>
<td>392 (3.0)----------------------------------------------------------------------------------------------------</td>
<td>266 (2.0)---------------------------------------------------------------------------------------------------</td>
<td>9</td>
</tr>
<tr>
<td>East Hampshire</td>
<td>327 (3.6)----------------------------------------------------------------------------------------------------</td>
<td>Not available------------------------------------------------------------------------------------------------</td>
<td>10</td>
</tr>
<tr>
<td>Eastleigh</td>
<td>213 (2.1)----------------------------------------------------------------------------------------------------</td>
<td>151 (1.5)---------------------------------------------------------------------------------------------------</td>
<td>6</td>
</tr>
<tr>
<td>Fareham</td>
<td>258 (2.8)----------------------------------------------------------------------------------------------------</td>
<td>247 (2.6)---------------------------------------------------------------------------------------------------</td>
<td>6</td>
</tr>
<tr>
<td>Gosport</td>
<td>266 (4.0)----------------------------------------------------------------------------------------------------</td>
<td>212 (3.2)---------------------------------------------------------------------------------------------------</td>
<td>12</td>
</tr>
<tr>
<td>Hart</td>
<td>260 (3.5)----------------------------------------------------------------------------------------------------</td>
<td>121 (1.6)---------------------------------------------------------------------------------------------------</td>
<td>23</td>
</tr>
<tr>
<td>Havant</td>
<td>249 (2.6)----------------------------------------------------------------------------------------------------</td>
<td>161 (1.7)---------------------------------------------------------------------------------------------------</td>
<td>3</td>
</tr>
<tr>
<td>New Forest</td>
<td>555 (3.7)----------------------------------------------------------------------------------------------------</td>
<td>442 (3.0)---------------------------------------------------------------------------------------------------</td>
<td>4</td>
</tr>
<tr>
<td>Rushmoor</td>
<td>221 (3.0)----------------------------------------------------------------------------------------------------</td>
<td>130 (1.7)---------------------------------------------------------------------------------------------------</td>
<td>11</td>
</tr>
<tr>
<td>Test Valley</td>
<td>338 (3.6)----------------------------------------------------------------------------------------------------</td>
<td>251 (2.7)---------------------------------------------------------------------------------------------------</td>
<td>6</td>
</tr>
<tr>
<td>Winchester</td>
<td>416 (4.4)----------------------------------------------------------------------------------------------------</td>
<td>343 (3.7)---------------------------------------------------------------------------------------------------</td>
<td>9</td>
</tr>
</tbody>
</table>

¹All premises licensed for on-sales, off-sales and both on- and off-sales; ²All premises licensed for on-sales

Source: Hampshire Licensing Officers Group, March 2011
2.6 Trends and projections

The trend across Hampshire for deaths related to alcohol is broadly stable, with a tendency towards a slight decline, whereas there is a steady upward trend in alcohol-related hospital admissions in all areas of Hampshire (see Section 2.2.5). Alcohol-related crimes have stabilised or declined slightly in recent years across the county (see Section 2.3.4).

Based on forecasts of population growth among those aged over 16 years in Hampshire, and assuming no change in the percentage of people drinking at increasing risk and higher risk levels from 2005 estimates, we can expect the number of increasing risk drinkers to grow by around 1350 per year from 2011-2016 and higher risk drinkers to increase by around 260 per year.

NWPHO LAPE prevalence estimates for alcohol consumption are modelled to local population accounting for age, sex and ethnicity structure, therefore are expected to give the most robust estimate of total numbers for each Local Authority. ONS mid-year population estimates (2009) are used as the denominator to enable comparison with other areas. However, sex- and age-specific estimates of alcohol consumption are not available from NWPHO, nor are age- and sex-specific mid-year population estimates available from ONS. So, to aid understanding of target groups for services in Hampshire alternative sources are used to estimate these figures: General Lifestyle Survey [32] provides age- and sex-specific estimates of alcohol consumption, which are applied to the age- and sex-specific population forecasts produced by Hampshire County Council.
Table 2.15 Weekly alcohol consumption: percentage exceeding specified amounts 1

<table>
<thead>
<tr>
<th>Age band</th>
<th>Population forecast 2011 2</th>
<th>Increasing risk</th>
<th>Higher risk</th>
<th>Binge drinking</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>16-24</td>
<td>73,316</td>
<td>66,753</td>
<td>25</td>
<td>22</td>
</tr>
<tr>
<td>25-44</td>
<td>162,792</td>
<td>164,806</td>
<td>27</td>
<td>21</td>
</tr>
<tr>
<td>45-64</td>
<td>170,991</td>
<td>178,843</td>
<td>31</td>
<td>21</td>
</tr>
<tr>
<td>≥65</td>
<td>106,120</td>
<td>134,667</td>
<td>22</td>
<td>9</td>
</tr>
</tbody>
</table>

1 General Lifestyle Survey 2008 (ONS, 2008; updated methodology including data on wine glass size)
2 Hampshire County Council

Table 2.16 Estimated number of people exceeding specified alcohol consumption in Hampshire 1

<table>
<thead>
<tr>
<th>Age band</th>
<th>Increasing risk</th>
<th>Higher risk</th>
<th>Binge drinking</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
<td>Females</td>
<td>Males</td>
</tr>
<tr>
<td>16-24</td>
<td>18,329</td>
<td>14,686</td>
<td>5,132</td>
</tr>
<tr>
<td>25-44</td>
<td>43,954</td>
<td>34,609</td>
<td>9,768</td>
</tr>
<tr>
<td>45-64</td>
<td>53,007</td>
<td>37,557</td>
<td>13,679</td>
</tr>
<tr>
<td>65 and over</td>
<td>23,346</td>
<td>12,120</td>
<td>5,306</td>
</tr>
<tr>
<td>Total</td>
<td>237,608</td>
<td>57,087</td>
<td>184,210</td>
</tr>
</tbody>
</table>

1 Hampshire County Council mid-year population forecast for 2011
2.7 Summary of alcohol issues in Hampshire

**Alcohol consumption**
- Compared to the national average, Hampshire has a lower prevalence of higher risk (3.9% v England 5.0%) and binge drinking (18.1% v 20.1%), but a slightly higher prevalence of increasing risk drinking (20.2% v 20.1%) which is seen in most areas of the county.
- Higher risk drinking is most common in the relatively deprived areas of Hampshire (Gosport, Havant and Rushmoor), whereas increasing risk drinking peaks in both the most and least deprived areas of Hampshire (Gosport and Rushmoor, Hart and Fareham), where levels are above regional averages and rank in the upper quartile nationally.
- Binge drinking is most prevalent in Winchester.
- There are an estimated 215,000 increasing risk drinkers, nearly 42,000 higher risk drinkers and over 192,000 binge drinkers across the county; as the population grows, we expect approximately 1,350 additional increasing risk drinkers and 260 additional higher risk drinkers a year if the prevalence of drinking remains constant.
- Availability of alcohol is greatest in the areas with where problem consumption is seen, notably Winchester and Gosport.

**Health harm**
- Around 350 deaths and over 15,000 hospital admissions a year are attributed to alcohol in Hampshire; death rates are broadly stable but admissions are increasing in all areas.
- Deaths related to alcohol in Hampshire are comparable to, or better than, regional averages with the exception of Gosport where rates are considerably higher.
- In Hampshire overall, hospital admissions related to alcohol compare favourably with regional averages but are markedly higher in Gosport, Havant and Rushmoor with Fareham and Hart also showing relatively high rates, which is likely to reflect the high level of increasing risk drinking in these areas.
- Among under 18 year olds admission rates show a different geographical pattern; rates are highest in the New Forest, Rushmoor and Eastleigh.
- Hypertensive illnesses and cardiac arrhythmias are the most prevalent alcohol-related conditions; both show a steep age gradient and are materially higher in Rushmoor than elsewhere.

**Social harm**
- Rates of alcohol-related crime are lower in Hampshire than national and regional averages although for violent crime Hampshire is only slightly lower; there is a modest downward trend across the county.
- Gosport and Havant have alcohol-attributable crime rates well above county and regional averages and numbers of alcohol-attributable violent crime are highest in Havant and Basingstoke and Deane at around 600-700 offences a year.
- In a 6 month period over 500 sexual offences were reported in Hampshire; around half of victims of sexual offences reported consumption of alcohol.
- In a 3 month period over 700 incidents of domestic violence involving alcohol were reported in Hampshire although research suggests the true figure could be up to 10 times higher.
- Around a quarter of Hampshire residents perceive drunk or rowdy behaviour to be a problem in their area and over 25,000 incidents of ‘Rowdy and Inconsiderate Behaviour’ were reported in 2010.
High risk groups

- Alcohol-related hospital admissions are highest in areas with greatest deprivation (IMD), notably in areas of Gosport, Havant and Rushmoor; these areas also see the county’s highest rates of teenage conception where alcohol is likely to play a role
- High risk groups for alcohol-related harm identified by social segmentation does not correspond well to the pattern health harm in Hampshire but does mirror the pattern of alcohol-related violent crime and alcohol as a criminogenic need
- People with mental health difficulty are at higher risk of alcohol dependence and it is estimated that nearly 600 people in Hampshire suffer with mental illness and alcohol dependence
- An estimated 10,000 members of the armed forces who live in Hampshire drink above recommended levels and 2,500 are expected to be misusing alcohol to a significant extent
- 57% of offenders in Hampshire identify alcohol as a contributing factor; the highest numbers of offenders with alcohol as a criminogenic need are in Basingstoke, Havant and New Forest, which is consistent with the pattern of alcohol-related violent crimes
- The rate of higher risk drinking is 10 times higher among prisoners than the general population and half of prisoners surveyed said they would use an alcohol service in prison if it was available
- National data indicates increasing alcohol-related health harm among older people; figures are not available for Hampshire but the demographic profile of the county means that this is an important issue
3. Addressing alcohol problems in Hampshire

The Hampshire Alcohol Partnership Group (HAPG) is a multi-agency group established to inform and support the implementation of actions regarding the range of issues surrounding alcohol misuse in Hampshire. The HAPG support delivery of the objectives of Hampshire’s alcohol strategy by holding partners to account for delivery of agreed actions.

3.1 Services provided

A variety of activities are supported by NHS Hampshire and Hampshire Drug and Alcohol Action Team (DAAT) to reduce the harmful effects of alcohol in the county. These are shown along with relevant NICE guidelines in Figure 3.1.

3.1.1 Preventing harmful drinking

Whole population social marketing campaigns building on national multi-media campaigns have been used to improve knowledge and understanding around risky levels of alcohol consumption. For example, Know Your Limits, beer-mats and scratch-cards, older people’s campaign, Hidden Harms campaign and a local campaign via public sector employees. Risks related to alcohol consumption are raised at confirmation of conception and via antenatal support. Unstructured information and guidance is also available within family planning and Children’s Centres.

Alcohol awareness and education is a specified topic within non-statutory delivery of Personal Health and Social Education (PHSE) in both primary and secondary education and the Healthy Schools programme criteria ensure appropriate coverage. Hampshire County Council Education Services and their Personal Development Learning Team support learning and development of schools to deliver a programme on drugs, alcohol and tobacco education. The PRISM network liaise with schools to access appropriate services when concern arises around the alcohol use of a pupil. Rock Challenge uses dance-drama performance as a means of delivering health messages around tobacco, alcohol and drug use to young people aged 7-18 years. In 2009/10, 82 Hampshire Schools participated in the programme as well as young people from Wessex Youth Offending Team, Children in Care and young people attending Hampshire Education Centres.

As part of the Think Family National programme, the Hampshire Parenting Specialist Team was established in 2009 to work with vulnerable families including those affected by substance misuse.

In some districts there is wider local provision to engage with children and young people and their parents/carers both inside and outside of the school setting. For example The Handy Trust in the New Forest area, STAR project Eastleigh, Summer Passport in Gosport, SNAP dance events in Rushmoor and Fareham which support informal alcohol education.

3.1.2 Identification and early intervention

Brief intervention training in Hampshire has been delivered via e-learning, direct training and a train-the-trainer programme. Participants have included NHS acute, primary and community care staff, Police, Local Authority community safety and neighbourhood wardens, Police Community Support Officers (PCSOS) and Accredited Community Safety Officers (ACSOs), youth service workers and the voluntary sector. The Alcohol Directed Enhanced Service (DES) supported delivery of brief advice with newly registering NHS patients across Hampshire.
Intervention and brief advice (IBA) pilots have been conducted in five settings across Hampshire during 2008-11:

1. Primary care (North East Hampshire, GP Practices following EoI)
2. Secondary care (Emergency Department and Medical Assessment Unit, Basingstoke North Hants Foundation T)
3. Alcohol arrest referral scheme (South East Hampshire)
4. Prison (HMP Winchester)
5. Quit4life (Hampshire Community Health Care)

These pilots also used the AUDIT screening tool to identify individuals who may benefit from more specialist interventions.

A Locally Enhanced Service (LES) contracts Primary Care providers to include alcohol screening and brief advice as part of the registration process for all new patients. Similarly, the Locally Enhanced Service specification for NHS Health Checks\(^6\) in Hampshire includes alcohol screening and brief intervention (this is an addition to the national NHS Health Checks specification). NHS Health Checks have been offered in Gosport, Havant and Rushmoor since early 2011 and will be rolled out across Hampshire over the course of 2011.

Alcohol screening and brief advice is also included in the 2011/12 Acute Services Contract via the CQUIN Alcohol Scheme. The aim of the scheme is to improve the health of the Hampshire adult population by ensuring that all patients are screened for alcohol risk using a validated screening tool (e.g. AUDIT-C, PAT) and, if screened positive, to receive brief advice and referral to their GP when attending the A&E and/or MAU departments. To facilitate delivery of this scheme, all A&E and MAU staff should be certified as completing e-learning for Alcohol Brief Advice (Intervention) Training.

For children, young people and parents/carers, universal services provide the first line of information and support in relation to alcohol. Youth-oriented Early Intervention Services (Tier 2) are offered by specialist youth practitioners with substance misuse training. These services aim to reduce risk and vulnerabilities.

### 3.1.3 Specialist alcohol treatment

Specialist substance misuse treatment services are commissioned jointly by NHS Hampshire and Hampshire DAAT. From April 2011, services will be provided to support the Hampshire Operational Model for Effective Recovery (HOMER) for misuse of substances, including alcohol, with the aims of reducing imminent harm, maintaining stability and achieving reintegration. The service provider will be a partnership between Solent Healthcare and CRI. The service model recognises the importance of working within the context of service users’ lives and supporting their carers and children. A ‘one-stop-shop’ will be offered including in-reach sessions with partner agencies including Job Centre Plus, Adult Mental Health, Community Health Services, and others.

Referral will be via the Criminal Justice Service (including treatment by court order), Job Centre Plus, Mental Health services, GP, pharmacy, A&E and self-referral. Access will be based on assessment

\(^6\) NHS Health Checks is a 5 year call and recall programme for 40-74 year olds in England to assess risk of developing heart disease, stroke, type 2 diabetes or kidney disease and to provide personalised advice on how to reduce the risk
with the AUDIT screening tool. Individuals scoring <16 will not be eligible for services but will be offered brief advice as part of the assessment process.

Individuals who obtain an AUDIT score 16-19 are considered ‘harmful’ drinkers and will be offered the following services:

- 30-60 min motivational interviewing session
- Up to 2 follow-up sessions
- Up to 6 group sessions
- Active encouragement to access peer support groups

Individuals who obtain an AUDIT score >20 are considered ‘dependent’ drinkers and will be offered the following services:

- Community detox or referral to in-patient unit
- Up to 5 Cognitive-Behavioural Therapy and motivational interviewing sessions of 60 mins
- Up to 6 group sessions
- Active encouragement to access peer support groups

If home detox is appropriate, this will be conducted in line with guidance set out in the Review of Effectiveness of Treatment for Alcohol. Where home detox is not appropriate referral will be made for in-patient treatment.

Planned service capacity is based on an estimation of dependent drinking of 2.2% of the population with the intention of providing services to 10% of dependent drinkers in year 1, increasing to 15% by year 3 in line with recommended practice (Signs for Improvement, Department of Health, 2009).

Evaluation and monitoring of services should reflect the nature of the ‘recovery’ model by focusing on progression and achievement of outcomes that are meaningful to patients. ‘Outcome funnels’ that may have the potential to fulfil this role, by focussing on behaviour change outputs rather than process measures, were developed at a workshop for substance misuse stakeholders in September 2010 (Appendix B).

Inpatient services for alcohol are provided by Baytrees (St James’ Hospital, Portsmouth) and are commissioned as a block contract following referral from a community alcohol service. A typical treatment programme includes medically assisted detoxification, and a range of individual and group interventions designed to facilitate self-awareness and the motivation to take responsibility for effecting ongoing change.
Figure 3.1 Intervention opportunities for alcohol

**Intervention opportunities for alcohol**

GREEN boxes show NICE guidelines
RED boxes show Hampshire interventions

**Intervention opportunities for alcohol**

- **A model for service provision for pregnant women with complex social factors**
- **Preventing substance misuse among vulnerable young people**
- **School based interventions**
- **Foetal development**
- **Childhood & teenage years**
- **Adult healthy drinker or non-drinker**
- **Adult increasing risk or binge drinker**
- **Adult higher risk drinker**
- **Adult dependent drinker**

**Non-specialist, brief advice via**
- GPs
- Midwives
- Family planning
- Teenage pregnancy services

**Specialist and Non-specialist brief advice via**
- GPs, hospitals, YOT, community safety officers, teachers, youth workers, etc
- Tier 2 CYP specialist substance misuse services and counselling
- Early intervention services
- Parenting support and family intervention

**Local social marketing and communications**
- Central Gov. campaigns and support

**Residential treatment**

**Developments in frontline IBA and ABI provision including training and development**

**Abbreviations:**
- HOMER: Hampshire Operational Model for Effective Recovery
- HIOMS: Hampshire Integrated Offender Management Service
- IBA: Identification and brief advice
- ABI: Alcohol brief intervention and extended intervention

**Diagnosis and clinical management of alcohol-related physical complications**

**Diagnosis, assessment and management of harmful drinking and alcohol dependence**
3.1.4 Alcohol intervention for offenders

Integrated Offender Management (IOM) is a Hampshire-wide initiative to reduce crime and re-offending by an intensive case management approach to certain offenders. It aims to ‘break the cycle’ of offending behaviour by addressing individual needs including health, education, employment opportunities, housing, drug, alcohol and parenting skills programmes. IOM Services are provided by the Society of St James from April 1st 2011.

It is estimated that approximately 3,000 hazardous, harmful and dependent drinkers could be identified through the criminal justice system each year. Although it is expected that the numbers will be fairly high, an individual may only require a short intervention, based upon their presenting need. In total it is estimated that the number of alcohol brief interventions to be delivered will be in the region of 3,000 annually, although this will be subject to ongoing review with the provider. Not all offenders presenting with alcohol misuse problems will be suitable for brief interventions, in particular those accessing the service via Probation, the Courts, on Prison release or subject to an Alcohol Treatment Requirement (ATR) may require additional support, which could include referral into the HOMER substance misuse services.

Figure 3.2 Specialist alcohol services in Hampshire from April 2011
3.2 Numbers in treatment and investment levels

The North West Public Health Observatory (NWPHO) provide PCT-level data on the % of the population aged 18-75 years in specialist alcohol treatment (Tier 3 and 4), which enables comparison with neighbouring areas. Hampshire levels of risky drinking and indicators of alcohol-related harm are comparable to South Central averages whereas a lower percentage of the Hampshire population receive structured treatment than the South Central average.

Figure 3.3 The percentage of the Hampshire population in structured alcohol treatment

![Graph showing percentage of adults in structured alcohol treatment](image)

Source: NWPHO Data relates to: Financial year 2008/9

Data on the number of clients in specialist alcohol services are collected by the National Drug Treatment Monitoring Service (NDTMS). Data for clients over 18 years whose primary substance is alcohol are shown by their resident Local Authority are shown in Table 3.1 and in Figure 3.4. The numbers in treatment are combined with population estimates to overcome differences in population size between areas. The rates of treatment per population show an increase in all Local Authority areas over the period 2008-2010. Taking the prevalence of higher risk drinking and alcohol-related harm as indicators of where treatment services are needed, the comparatively high rates in Gosport, Havant and Rushmoor are appropriate although perhaps even greater emphasis is needed in Gosport. HOMER aims to treat 10% of dependent drinkers, increasing to 15% within three years; Figure 3.4 shows that a substantial increase in treatment numbers is needed to achieve this goal. In order to achieve these targets, specialist treatment services need to be underpinned by a strong culture of identifying and addressing alcohol misuse. This will be achieved by sustained efforts to increase capacity to identify and address alcohol problems in all health and select non-health public services, leading to brief advice or referral for specialist intervention.
Table 3.1 Clients in treatment for alcohol in Hampshire 2008/09 and 2009/10

<table>
<thead>
<tr>
<th>Area</th>
<th>08/09</th>
<th>09/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basingstoke and Deane</td>
<td>221</td>
<td>312</td>
</tr>
<tr>
<td>East Hampshire</td>
<td>35</td>
<td>75</td>
</tr>
<tr>
<td>Eastleigh</td>
<td>47</td>
<td>79</td>
</tr>
<tr>
<td>Fareham</td>
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<tr>
<td>Gosport</td>
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<td>123</td>
</tr>
<tr>
<td>Hart</td>
<td>22</td>
<td>27</td>
</tr>
<tr>
<td>Hart</td>
<td>94</td>
<td>211</td>
</tr>
<tr>
<td>New Forest</td>
<td>109</td>
<td>111</td>
</tr>
<tr>
<td>Rushmoor</td>
<td>139</td>
<td>161</td>
</tr>
<tr>
<td>Test Valley</td>
<td>52</td>
<td>76</td>
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<tr>
<td>Winchester</td>
<td>98</td>
<td>115</td>
</tr>
<tr>
<td>LA not stated</td>
<td>419</td>
<td>239</td>
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<tr>
<td><strong>Total for Hampshire</strong></td>
<td><strong>1367</strong></td>
<td><strong>1703</strong></td>
</tr>
</tbody>
</table>

Source: NDTMS

Figure 3.4 Rates of alcohol treatment by Local Authority (with HOMER 2011-14 targets*)

*Based on assumption that 2.2% population are dependent drinkers

Source: NWPHO

The average number of new presentations, discharges and total number in alcohol treatment are shown in Figure 3.5.
Figure 3.5 Average monthly number in treatment, new presentations and discharges

Hampshire PCT residents in alcohol treatment
(monthly average figures)

Individuals in treatment are counted once per year; New presentations are counted once per month
Source: Alcohol Treatment Performance Reports, NDTMS
Data relates to: April-March, except for 2010/11 which is April-Dec

Funding for alcohol services

The total level of funding for substance misuse treatment services for NHS Hampshire is £4,746,954 per annum, which comprises: HOMER £2,800,000, in-patient detox £1,053,841, Integrated Drug and Alcohol services in prison £893,113. These services are for all substance misuse clients; separate figures for alcohol are not available.

In addition to this, HCC Adult Services department funds residential alcohol rehabilitation places. In 2009/10 23 places were funded at a total cost of £92,600 and in 2010/11 18 places were funded at a total cost of £136,900. The higher cost in 2010/11 reflects an increase in placements going to completion often following an extension in the length of the placement.

In 2009/10, HCC Adult Services also funded two full-time social workers attached to specialist alcohol teams (Rooksdown House, Basingstoke and Spencer House, Winchester). The posts have now been absorbed into the specialist substance misuse team working across the county in both drugs and alcohol.

Children and Young People’s substance misuse services (including alcohol provision) funded by HCC had an annual budget of £600,000 in 2010/11 and £500,000 in 2011/12.

Other alcohol-related activity is funded by Hampshire DAAT as shown in Table 3.2.
<table>
<thead>
<tr>
<th>Alcohol and CIS</th>
<th>Actual spend 2009-10 (£)</th>
<th>Estimated spend 2010-11 (£)</th>
<th>Options on spend 2011-14 (£)</th>
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<tr>
<td>Test Valley alcohol project</td>
<td>10,301</td>
<td>18,000</td>
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<td>Winchester CDRP Christmas Triage Centre</td>
<td>1,500</td>
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<td>Winchester Prison Alcohol Brief intervention scheme</td>
<td>3,970</td>
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<td>Agreed contribution to IOM supporting alcohol interventions</td>
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<td>50,000</td>
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<table>
<thead>
<tr>
<th>Alcohol Treatment</th>
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<tr>
<td>Commissioning integrated alcohol brief interventions in range of provider services</td>
<td></td>
<td></td>
<td>tbc</td>
</tr>
<tr>
<td>Alcohol Tier 2 provision within Spencer House</td>
<td>12,000</td>
<td>5,000</td>
<td></td>
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<tr>
<td>Volunteer peer support scheme</td>
<td>5,593</td>
<td>3,000</td>
<td></td>
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<tr>
<td>Innovations work</td>
<td>11,000</td>
<td>14,000</td>
<td></td>
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<tr>
<td>Structured Day Care and Aftercare services</td>
<td>23,100</td>
<td>10,000</td>
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<td>Alcohol Service User Work</td>
<td>5,000</td>
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</table>

<table>
<thead>
<tr>
<th>Workforce development and communication</th>
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<tbody>
<tr>
<td>Alcohol Awareness Week communications/social marketing work</td>
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<td>10,000 tbc</td>
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<td>Public sector workforce campaign</td>
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<td>5,000 tbc</td>
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<td>3,500</td>
<td>5,000 tbc</td>
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<tr>
<td>Alcohol Co-ordinator Post (part-funding to support ABG shortfall)</td>
<td></td>
<td>22,000</td>
<td>nil</td>
</tr>
</tbody>
</table>

| Total                                  | 103,226                  | 110,000                    | 110,000                     |

Source: Hampshire DAAT
3.3. Summary of alcohol services in Hampshire

Summary of services

- Whole population social marketing has featured strongly in the preventive strategy and this is a potentially a useful means of achieving Hampshire’s priority goal of reducing widespread increasing risk drinking, but evidence of effectiveness will be important if it is to play a significant role in achieving our goals.

- IBA pilots have been well received and embedding this approach in routine practice is essential to reducing increasing risk drinking and intervening at the first signs of alcohol-related harm.

- The Alcohol CQUIN scheme is an excellent addition to the Acute Services Contract; ensuring implementation and monitoring of outcomes will be key to providing evidence needed to extend this service to all secondary care departments where alcohol is likely to be a factor.

- The newly commissioned HOMER services will fulfil many of the recommended requirements of a treatment service but the intensity and duration of support for dependent alcohol users is not consistent with NICE recommendations; robust monitoring and evaluation will provide the evidence needed to extend and develop services to maximise effectiveness and cost-effectiveness.

- A broad base of screening and brief interventions will be needed to identify those who can benefit from specialist services so that the target of treating 10-15% dependent drinkers is met, and to meet the needs of those below the eligibility threshold for HOMER.

- The newly commissioned IOM services offer an opportunity to tackle the significant harm caused to Hampshire’s population by the cyclical link between alcohol and crime; a low threshold for offering alcohol intervention for offenders is essential and a concerted focus in the areas that suffer most harm from alcohol-related crime is needed.
4. Stakeholder views on alcohol issues and services in Hampshire

4.1 Stakeholder workshop

In December 2010, NHS Hampshire and Hampshire DAAT hosted an event for stakeholders to contribute their expertise to the development of the 2011-2014 Alcohol Strategy. Stakeholders highlighted achievements from the 2008-2011 alcohol strategy, particularly where partnerships have worked together to provide interventions in education, health and the community. The IBA pilots were noted as particularly successful. Contributors to the day sought to identify the main challenges and priority actions needed to reduce harmful alcohol consumption and support individuals and families when prevention and early intervention fail.

At a strategic level, the message is that alcohol is a multi-dimensional issue that needs shared ownership and clear accountability. Progress will be achieved by strong high profile leadership supported by professionals with a commitment to the alcohol agenda acting as an ‘army of alcohol champions’, advocating the cause within and outside their organisations. Maximum impact and efficiency will be achieved by setting clear priorities, embedding co-operative working and monitoring progress against agreed indicators of success. Low levels of funding, in light of the breadth and scale of problems related to alcohol, is a persistent problem and investment in prevention and early identification are high priorities. Concerted efforts to engage a wide range of partners will be an essential part of the strategy and will augment our investment: organisations that influence alcohol consumption, public-facing organisations who have opportunities to influence awareness and help-seeking, and organisations that stand to benefit from reduced alcohol-related harm.

In terms of preventing risky levels of alcohol consumption, the key themes emerging from stakeholder discussions relate to the need to reshape the culture around alcohol and challenge the perception of alcohol as essentially benign. Interventions that focus on better awareness and resilience among children and young people and young families were prominent. A strong focus in the relatively deprived areas of Hampshire was seen as a priority, although less traditional risk groups such as affluent and older drinkers should not be overlooked. The important role of licensing and retailers in supporting a low alcohol culture was highlighted.

A recurrent theme emerging from discussions was the need to improve strategies for identifying those who are regularly drinking above recommended levels, and may be experiencing health or social problems that are at least partly attributable to alcohol, but are not seeking help. It was noted that a very large proportion of these people are in contact with primary or acute healthcare, social services or the Criminal Justice System and stakeholders recommend that this should be exploited by introducing protocols for routine questions, advice and sign-posting around alcohol. Work is needed to promote a culture where there is an expectation that alcohol should be routinely considered as a potential contributing factor in health and social problems, and that it is the role of all front-line staff to contribute to alcohol harm prevention by raising awareness and providing advice or signposting. Specific recommendations from stakeholders include: GPs to receive brief reports on alcohol statistics in their area; use of a traffic-light system to indicate appropriate advice/action; alcohol liaison nurses in acute trusts to raise the profile of alcohol as a cross-cutting issue; direct care pathways from acute trusts and emergency services to alcohol services.

In relation to alcohol treatment services, the over-arching theme was a need for services to be more client-centred and holistic. Stakeholders advise that benefit would be maximised by: a one-stop service for multiple inter-related needs, support and appropriate involvement of families/carers, and stronger,
well-integrated after-care. There is a persistent concern that delivery of alcohol services alongside drug misuse services is a barrier to treatment for many. Additional efforts are needed to overcome particular barriers to treatment for some groups within the population.

Stakeholders see the key priorities for the early stages of the 2011-2014 strategy as: working with GPs to enable their role in early identification and intervention; developing simple powerful messages to be used in education, health and social services; extend IBA training to all front-line staff; implement data recording procedures in relevant services.

4.2 Service user interviews

The views of five Tier 2 and 3 service users were gathered via unstructured face-to-face interviews. The key issues raised are summarised below with illustrative quotes.

Positive experiences of services

Staff: trustworthy, show respect, experienced, help you believe in yourself, help you to believe that your problem can change, feel can talk about anything, encouraged to sort out problems in all areas of life

Services:

- “The groups have been brilliant – I’ve not got to the same state as others in the group have got to, coming to the group helps me to not get to that stage”
- GP sent me on a therapy course – weekly session for 10 weeks, seemed to work well and when got to the end had regular meetings for a 12-18 months
- Very therapeutic talking in groups – hearing other people’s stories helps to steer you
- The one-to-one counselling is really good – having another perspective helps to focus on the key issues
- Best experiences have been with programme of individual and group sessions (including confidence-building, relapse prevention, relaxation techniques) and sustained group meetings for support
- Day services are useful after detox – gives structure to day and keeps off streets but there is always alcohol literature around – alcohol free environment would be more helpful

Negative experiences of services

- Alcohol affects a lot more people than drugs but services focus on drug users; perception that user consultation focuses on drug users, “alcohol is a big enough problem to deserve its own bracket”
- Inappropriate mixing of drug and alcohol services: “I was freaked out when a guy came in for needle exchange. I know everyone needs help but I’ve got a wife and four kids, I don’t want to mix with people like that”; “It’s catastrophic to put drug users with alcohol users. It’s a huge step to even admit to yourself that you’re drinking too much, and an even bigger step to get to a service – they will be nervous as hell going to a meeting and if you then tell them they need the same service as a heroin addict you’ll frighten them off and they won’t come back”
- Inadequate provision: drug users get 6 weeks in-patient treatment, alcohol users get 2 weeks - not long enough to break drinking cycle, does not even begin rehabilitating mind set of drinker and the follow-up day care provided instead simply isn’t the same - the relapse rate after 2 weeks shows that it is not enough. “I started running into problems when the meetings ran out after 10 weeks - it's not like a course of antibiotics where at the end of it the infection has gone, it’s difficult to reach a point where can say ‘I’m cured’ – the cravings are there all the time, just because it’s been a year doesn’t mean I’m better”
- Needs to be open at times working people can come – one evening and Saturday morning is not enough “They passed me on to the police when I came the first time, because they were closing, that wasn’t good – police was the last thing I needed at that stage, it would have been better if I could just talk to someone”; “Once I started back at work couldn’t get to group sessions – the
times were no good and then work pressures built up and I was controlling the drink less and less so I deteriorated and went back to the service”
○ Tried to stop drinking several times when couldn’t get into services but professional help needed – impossible alone
○ GP attitude variable – some knowledgeable and supportive, others unsympathetic, some won’t help alcoholics

Views on peer-led services
○ Peer-led groups are useful and there is a role for them but should supplement not replace services provided by trained professionals
  ○ Lack clinical knowledge and skills - can give inappropriate advice
  ○ Not properly trained to spot and deal with serious psychological issues like suicidal thoughts, self-harm
  ○ Approach is casual and do not follow-up clients if do not attend – health professionals phone if do not attend and “give you a kick up the backside” which is sometimes needed to keep on track
  ○ “I tried an AA meeting but don’t like the way it works – it’s too formalised having to say ‘I’m an alcoholic’ – I’m not always sure I class myself that way, it fluctuates, but I don’t like that thing of having to say it”

Views on what a good service would look like
○ Need supervised programme long enough to break drinking cycle “The longer you’re dry for the less likely you are to start again – you’ve got more to lose”
○ Backbone of services should be led by trained professionals; important be seen by trained health professionals – formal system and someone whose job it is to listen and provide informed advice “It feels like your problem is serious and you’re being taken seriously, it gives you a real boost to know you’ve got that professional support behind you”
○ Professional aftercare is crucial and needs to be sustained – “There’s a very big hole to fill when you stop drinking – psychologically, but also filling the time – not drinking is a full time job for some people”; “Stopping drinking can be like the death of a close friend, you lose your social circle, and then isolation can lead you back to the drink – it takes time to recreate your life without alcohol”
○ Need a lot of support – if coming off drugs can take measures to avoid contact but almost impossible to avoid alcohol – “I see a bottle of vodka every time I go to buy my bacon and eggs”; “On the income I’m on now, I’m more afraid of the supermarket than the pub”
○ Need key worker with weekly access in early days after detox
○ Meetings can be really frightening so important to have someone who will chase you if you do not attend
○ Meetings with drug users are not helpful - issues and lifestyles are different - for some alcohol users “you will not get them twice in the same room as junkies”

Views on the journey from drinker to alcoholic
○ Heavy drinking atmosphere at work was a big factor
○ Serious drinking is progressive - took many years of heavy drinking before reached stage of losing children, relationship, house, job
○ Sober when homeless to get into shelters but as soon as established own housing and employment again, straight back into heavy drinking
○ Advice and warning from people who had been there would have been helpful – the people who were telling me to stop drinking were non-drinkers
## 4.3 Summary of stakeholder views

### Professional stakeholders
- Recognition of the benefits of partnership working and the successes this has brought; need to continue and strengthen to make further progress needed
- Lack of clear accountability for alcohol has been a problem
- Low levels of funding in comparison to drug misuse is a persistent problem
- Culture where alcohol is accepted as benign needs to be challenged
- Early identification and intervention are key; routine consideration of alcohol in public services is a priority for the new strategy
- Treatment services should be a ‘one-stop shop’ model
- Provision of alcohol treatment with drug services is a barrier to access for many

### Service users
- Professionally-led groups are highly valued; peer-led groups can be useful but the style does not suit everyone and the lack of professional skills limits their potential as a significant part of successful recovery
- Professionally-led groups should be available at times working people can make; this will become increasingly important as services are widened to meet the needs of a broader audience
- There is an inappropriate emphasis on services for drug-users and shared provision is a significant barrier for many
- Adequate duration of intensive and after-care services are key to breaking the drinking cycle
- Opportunities for intervention are missed in the journey from social drinker to ‘alcoholic’
5. Recommendations

Alcohol problems are prevalent, serious, costly and avoidable. Although Hampshire typically enjoys comparatively good health, alcohol is an unusual issue in that it affects affluent groups as well as those more traditionally at risk from ill-health. A substantial minority of our population regularly use alcohol at a level that is risky to their health and hospital admissions are rising. Action is needed in order to reverse these trends and to reduce the contribution of alcohol to health inequalities.

Investment is currently made in specialist treatment services, and a commitment has been made to achieve the recommended target of 15% of dependent drinkers in treatment by 2014. This investment is vital to reduce the significant burden of ill-health, social problems and public resource use associated with harmful and dependent drinking. However, there has been a historical lack of sustained investment in cost-effective interventions for prevention and early intervention with increasing and higher risk drinkers who characterise Hampshire’s alcohol problem. If Hampshire is to reduce the upward trend in alcohol-related health consequences, this is where investment and focus is needed.

Expanding the public health role of primary care services will be key to controlling the impact and cost of alcohol. Initial investment in developing workforce skills will be returned through the reversal of harmful and costly trends in long term care and hospital admissions.

5.1 Strategic priorities for Hampshire

1. Reduce increasing risk drinking in all areas of the county
2. Reduce the contribution of alcohol to health inequalities in Gosport, Havant and Rushmoor
3. Address binge drinking in Winchester, and to a lesser extent the town centres of Basingstoke, Andover and Eastleigh
4. Manage availability of alcohol in areas where there is evidence of significant harm, focusing initially on Winchester and Gosport
5. Reduce alcohol-attributable crime in Gosport, Havant and Basingstoke & Deane
6. Reduce harm in groups that are at high risk from alcohol particularly offenders, armed forces and older people

5.2 Recommended actions

Hampshire’s alcohol problem is characterised by widespread increasing risk drinking and insidious health harm. Alcohol should, therefore, be routinely considered in the assessment and management of individuals presenting to a broad range of public services. Hampshire should aspire to become a model of the benefits to health, society and public finances that can be achieved when consistent, timely, low-cost interventions become embedded in routine health practice. In light of the increasing role of clinical professions in commissioning health services, early work with clinical colleagues to achieve recognition of the importance of alcohol as an invest-to-save issue is needed.
Advocacy

1. Strong and consistent advocacy across a broad range of sectors will be needed to deliver a sustained focus on prevention and early intervention. Local champions should be identified from General Practice, acute care, public health, elected members, criminal justice and licensing

Prevention

2. School-based interventions and social marketing targeted at young people and parents should be used to improve understanding of the risks associated with binge drinking including compromised safety, sexual health risks and short and long term health effects

3. Work is needed to enhance the role of Licensing Officers in protecting public health by appropriate consideration of evidence of health harms in the Licensing and review process. Priority areas are Winchester, Gosport and the New Forest. Recommendation 13 relates to licensing data

Early identification and intervention

4. Internal marketing within the health service is needed to improve:
   a. recognition of alcohol as harmful and pervasive, preparing professionals for a culture where alcohol is routinely considered as a contributing factor
   b. awareness of high risk groups for alcohol harm (both clinical and demographic)
   c. knowledge of levels of intervention and services available

5. Screening and IBA should be offered to individuals who can be identified as having one or more clinical or demographic risk factors for alcohol harm:
   a. **GP practices and community pharmacies**: hypertension, cardiac arrhythmia, gastrointestinal illness, pregnancy, mental health, bar workers, armed forces & veterans, older people, drug users, offenders, homeless/insecurely housed
   b. **Secondary care**: A&E, sexual health, fracture, cardiovascular, hepatology, falls, antenatal, gastrointestinal, mental health. Service specifications for hepatitis C management should specify and monitor the inclusion of alcohol screening, advice and referral.
   c. **Non-health public services for**: Homeless/insecurely housed, armed forces/veterans, older people, offenders, young people

6. Work with neighbouring commissioners to appoint alcohol liaison nurses in acute trusts that care for Hampshire residents; the role should be valued as a senior and significant responsibility involving development of networks, training and capacity within the Trust, monitoring and evaluating outcomes, liaising with community alcohol services, contributing to alcohol strategy and service development. Priority areas for this are Portsmouth, Southampton and Frimley Park

7. Work with Local Authority and primary care colleagues to strengthen the alcohol component of programmes to reduce vascular inequalities in Gosport, Rushmoor and Havant

Treatment services

8. In line with evidence-based guidance, implementation of HOMER should seek to achieve:
   a. Specialist treatment for 1 in 7 dependent drinkers
   b. Triage assessment for all presenting adults, progressing to comprehensive assessment for AUDIT score >15
   c. Psychological interventions provided in line with NICE recommended practice; consideration should be given to gap between proposed and recommended staff contact time
d. Threshold for referral for residential rehabilitation, and programme of support following successful withdrawal, should be in line with recommendations

e. Access to peer support groups should be encouraged in addition to professional support

f. Formal evaluation of services to ensure delivery is in line with evidence-based recommendations for clinically and cost-effective interventions

9. Consideration should be given to the view expressed by service users and professional stakeholders that at least some alcohol services should be provided separately from other substance misuse services, to minimise barriers to accessing help. Similarly, service user input must seek views of alcohol clients as needs may vary from other substance misuse groups

10. Hepatitis C screening is recommended for those seeking treatment for alcohol use who have a history of risk factors, for example intravenous drug use or blood transfusion in the UK prior to 1991

Crime

11. Alcohol-related violent crime and alcohol as a criminogenic need should be addressed particularly in the priority areas of Havant and Basingstoke & Deane

a. Facilitate development of A&E data sharing protocols between clinical and police colleagues in Basingstoke and Portsmouth acute trusts

b. Use social segmentation tools to target high risk groups for marketing campaigns

Data collection and service evaluation

12. Clear guidance and monitoring of a minimum dataset, with an emphasis on outcomes, should be included in service specifications to enable evaluation of clinical and cost-effectiveness of services; timescales and lines of accountability for evaluation must also be clear

13. Data on the location and type of licensed premises would benefit analysis of the relationship between alcohol availability and harm and support the important role of licensing in protecting public health

14. Routine recording when alcohol consumption above recommended levels is identified in primary care would facilitate a better understanding of the public health impact of alcohol misuse on health conditions commonly seen in primary care, and further understanding of the potential of alcohol interventions as invest-to-save measures

Research

15. Qualitative research into the barriers to implementation of routine alcohol screening and intervention in frontline primary and secondary care services could usefully inform the development of interventions to change clinical practice

Recommendations are summarised in Figure 5.1 below. A summary table of NICE recommendations and recommended actions for Hampshire is provided in Appendix C.
5.3 Proposed targets

Over the period of the 2011-14 Alcohol Strategy, the Alcohol Partnership Board should aim to oversee the following improvements in alcohol consumption and outcomes:

1. Reduce prevalence of increasing risk, higher risk and binge drinking to below 2010 South Central average (below 20%, 4.2% and 18.6% respectively) in all Local Authorities by 2014
2. No Hampshire Local Authority areas should fall within the upper quartile of ranks for England for alcohol consumption
3. Reduce mortality and morbidity in adults and young people to 2010 South East average in all Local Authorities by 2014
4. Reduce health inequalities: alcohol-related hospital admissions (NI39) and alcohol-attributable mortality should be reduced in Gosport, Havant and Rushmoor to within 20% of the Hampshire average (from 2008/9 levels of 40%, 33% and 65%, respectively)
5. Reduce rates of alcohol-attributable crime in Gosport and Havant to Hampshire average
6. Reduce the number of violent crimes in Basingstoke and Havant to county average
7. Further the downward trend in alcohol-related crime in all Local Authorities
8. Maintain Hampshire below South East average for alcohol-related crimes
9. Reduce rates of alcohol as a criminogenic need to South East average
10. Increase prevalence of dependent drinkers in treatment to 15%
References


10. NSPCC. 2006. ChildLine casenotes: Alcohol and Teenage Sexual Activity


12. BMA Board of Science. 2007. Fetal alcohol spectrum disorders: A guide for healthcare professionals


14. Smoke Free Hampshire and Isle of Wight. 2010. Smoking and Young People in Gosport/ Smoking and Young People in Havant/Smoking and Young People in Rushmoor.


20. DASA. 2009. UK Regular Forces Strengths and Changes at 1 June 2009


24. OAsys. January 2007. OASys Need and Demand Analysis


## Appendix A: NWPHO condition groupings

10 condition groupings used in NWPHO sub-analysis of NI39 alcohol-related admissions

<table>
<thead>
<tr>
<th>Condition grouping</th>
<th>ICD10 category codes</th>
<th>ICD10 category names</th>
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<td>E24.4</td>
<td>Alcohol-induced pseudo-Cushing's syndrome</td>
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<tr>
<td></td>
<td>G31.2</td>
<td>Degeneration of nervous system due to alcohol</td>
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<tr>
<td></td>
<td>G62.1</td>
<td>Alcoholic polyneuropathy</td>
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<td>W65-W74</td>
<td>Drowning</td>
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<td>Inhalation of gastric contents/inhalation and ingestion of food causing obstruction of the respiratory tract</td>
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<td>X00-X09</td>
<td>Fire injuries</td>
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<tr>
<td>X60-X84, Y10-Y33</td>
<td>Intentional self-harm/Event of undetermined intent</td>
<td></td>
</tr>
<tr>
<td>X85-Y09</td>
<td>Assault</td>
<td></td>
</tr>
<tr>
<td>X60-X84, Y10-Y33</td>
<td>Intentional self-harm/Event of undetermined intent</td>
<td></td>
</tr>
<tr>
<td>K22.6</td>
<td>Gastro-oesophageal laceration-haemorrhage syndrome</td>
<td></td>
</tr>
<tr>
<td>K73, K74</td>
<td>Chronic hepatitis, not elsewhere classified and Fibrosis and cirrhosis of liver</td>
<td></td>
</tr>
<tr>
<td>K85, K86.1</td>
<td>Acute and chronic pancreatitis</td>
<td></td>
</tr>
<tr>
<td>I85</td>
<td>Oesophageal varices</td>
<td></td>
</tr>
<tr>
<td>C00-C14</td>
<td>Malignant neoplasm of lip, oral cavity and pharynx</td>
<td></td>
</tr>
<tr>
<td>C15</td>
<td>Malignant neoplasm of oesophagus</td>
<td></td>
</tr>
<tr>
<td>C32</td>
<td>Malignant neoplasm of larynx</td>
<td></td>
</tr>
<tr>
<td>C18</td>
<td>Malignant neoplasm of colon</td>
<td></td>
</tr>
<tr>
<td>C20</td>
<td>Malignant neoplasm of rectum</td>
<td></td>
</tr>
<tr>
<td>C22</td>
<td>Malignant neoplasm of liver and intrahepatic bile ducts</td>
<td></td>
</tr>
<tr>
<td>C50</td>
<td>Malignant neoplasm of breast</td>
<td></td>
</tr>
<tr>
<td>I10-I15</td>
<td>Hypertensive diseases</td>
<td></td>
</tr>
<tr>
<td>I47-I48</td>
<td>Cardiac arrhythmias</td>
<td></td>
</tr>
<tr>
<td>G40-G41</td>
<td>Epilepsy and Status epilepticus</td>
<td></td>
</tr>
<tr>
<td>I60-I62, I69.0-I69.2</td>
<td>Haemorrhagic stroke</td>
<td></td>
</tr>
<tr>
<td>I63-I66, I69.3, I69.4</td>
<td>Ischaemic stroke</td>
<td></td>
</tr>
<tr>
<td>L40 excluding cirrhosis L40.5</td>
<td>Psoriasis</td>
<td></td>
</tr>
<tr>
<td>O03</td>
<td>Spontaneous abortion</td>
<td></td>
</tr>
</tbody>
</table>
Appendix B: Proposed outcome funnels related to alcohol services

Hampshire Outcome Funnel Event - 27th September 2010

1. Tier 2: Assessment and Referral Service

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Nos.</th>
<th>Conversion</th>
<th>Time (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client referred to service</td>
<td>1000</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>Assessment offered to client</td>
<td>900</td>
<td>0.90</td>
<td></td>
</tr>
<tr>
<td>Client attends assessment</td>
<td>750</td>
<td>0.83</td>
<td></td>
</tr>
<tr>
<td>Assessment completed</td>
<td>700</td>
<td>0.93</td>
<td></td>
</tr>
<tr>
<td>Client agrees to initial aims</td>
<td>680</td>
<td>0.97</td>
<td></td>
</tr>
<tr>
<td>Onward referral accepted</td>
<td>665</td>
<td>0.98</td>
<td></td>
</tr>
<tr>
<td>Client attend 1st appointment with treatment service</td>
<td>600</td>
<td>0.90</td>
<td></td>
</tr>
</tbody>
</table>

Performance Target:
“In 2010/11, of the 1000 clients we work with 600 will attend their appointment with a treatment service.”
# 2. Alcohol/Drugs Community Detox

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Nos.</th>
<th>Conversion</th>
<th>Time (day)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client assessed as suitable for community detox</td>
<td>100</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>Clients attend 1&lt;sup&gt;st&lt;/sup&gt; appointment with doctor/key worker and agrees to prescribing</td>
<td>85</td>
<td>0.85</td>
<td></td>
</tr>
<tr>
<td>Client attends pre-detox motivational work</td>
<td>60</td>
<td>0.71</td>
<td></td>
</tr>
<tr>
<td>Client agrees to care plan</td>
<td>55</td>
<td>0.91</td>
<td></td>
</tr>
<tr>
<td>Client commences detox</td>
<td>45</td>
<td>0.81</td>
<td></td>
</tr>
<tr>
<td>Client completes detox</td>
<td>40</td>
<td>0.88</td>
<td></td>
</tr>
<tr>
<td>Client attends 1&lt;sup&gt;st&lt;/sup&gt; aftercare appointment</td>
<td>20</td>
<td>0.50</td>
<td></td>
</tr>
</tbody>
</table>

**Performance Target:**

“Of the 100 clients we will work with, 20 of those will have completed detox and will be abstinent from alcohol and will attend their first aftercare appointment.”
### 3. Alcohol Structure Day Care

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Nos.</th>
<th>Conversion</th>
<th>Time (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client commences 6 week day programme</td>
<td>100</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>Client attends care plan review and agrees an aftercare plan</td>
<td>80</td>
<td>0.80</td>
<td></td>
</tr>
<tr>
<td>Client demonstrates that they are maintaining abstinence (at care plan review)</td>
<td>60</td>
<td>0.75</td>
<td></td>
</tr>
<tr>
<td>Client attends aftercare group following re-integration plan</td>
<td>50</td>
<td>0.83</td>
<td></td>
</tr>
<tr>
<td>Client engages with monthly key working to demonstrate continued behavior change</td>
<td>40</td>
<td>0.80</td>
<td></td>
</tr>
<tr>
<td>Client remains abstinent following discharge assessment for further 12 weeks</td>
<td>25</td>
<td>0.63</td>
<td></td>
</tr>
</tbody>
</table>

**Performance Target:**

“Of 100 clients, 25 will remain abstinent for 6 months.”
### 4. Alcohol - Harm Reduction

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Nos.</th>
<th>Conversion</th>
<th>Time (day)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral made</td>
<td>100</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>Client attends first appointment and agrees care plan</td>
<td>80</td>
<td>0.80</td>
<td></td>
</tr>
<tr>
<td>Client engages with intervention and acknowledges condition</td>
<td>60</td>
<td>0.75</td>
<td></td>
</tr>
<tr>
<td>Client achieves measurable change during engagement with intervention</td>
<td>36</td>
<td>0.60</td>
<td></td>
</tr>
<tr>
<td>Client completes intervention</td>
<td>15</td>
<td>0.42</td>
<td></td>
</tr>
<tr>
<td>Client ceases problematic drinking</td>
<td>10</td>
<td>0.66</td>
<td></td>
</tr>
</tbody>
</table>

**Performance Target:**

“Of 100 clients, 10 will be non-problematically drinking (specified in relation to liver function, aggression, attendance) and will maintain this for 3 months.”
### 5. Alcohol Inpatient Detox

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Nos.</th>
<th>Conversion</th>
<th>Time (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client is assessed for inpatient detox</td>
<td>100</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>Client attends inpatient unit, agrees a prescribing care plan and commences medication</td>
<td>90</td>
<td>0.90</td>
<td></td>
</tr>
<tr>
<td>Client completes detox and is referred to appropriate aftercare service</td>
<td>80</td>
<td>0.85</td>
<td></td>
</tr>
<tr>
<td>Client reports abstinence from alcohol 2 weeks post intervention and is followed up by tier 3 service</td>
<td>40</td>
<td>0.50</td>
<td></td>
</tr>
</tbody>
</table>

**Performance Target:**

“2010/11 – 40 alcohol using clients will report being abstinent from alcohol two weeks after completing alcohol in-patient detox.”
## Appendix C: Summary of NICE guidance and recommended actions for Hampshire

Table A. Summary of recommended interventions and recommended actions for Hampshire

<table>
<thead>
<tr>
<th>Relevant NICE recommendation</th>
<th>Recommended action</th>
</tr>
</thead>
</table>
| **Prevention of harmful alcohol consumption** | Priority areas are  
1. Winchester  
2. Gosport  
3. New Forest |
| Licensing departments should take into account the links between the availability of alcohol and alcohol-related harm when considering a licence application |  
If necessary, limit the number of new licensed premises in a given area  
Ensure sufficient resources are available to prevent under-age sales, sales to people who are intoxicated, proxy sales, non-compliance with any other alcohol licence condition and illegal imports of alcohol  
Take action against premises that regularly sell alcohol to people who are under-age, intoxicated or making illegal purchases for others |
| **Identification and early intervention to minimise harm** | Screening and brief advice in primary care for patients with one or more indicators of risk for alcohol harm, including: Hypertension, cardiac arrhythmia, gastrointestinal illness, pregnancy, mental ill health, bar workers, armed forces and veterans, older people, drug users, armed forces/veterans, |
| Identification and assessment in all settings: Staff working in services provided and funded by the NHS who care for people who potentially misuse alcohol should be competent to identify harmful drinking and alcohol dependence; they should be competent to initially assess the need for an intervention or refer to a service that |  
Screening and brief advice in primary care for patients with one or more indicators of risk for alcohol harm, including: Hypertension, cardiac arrhythmia, gastrointestinal illness, pregnancy, mental ill health, bar workers, armed forces and veterans, older people, drug users, armed forces/veterans, |
<table>
<thead>
<tr>
<th>Specialist treatment of harmful alcohol consumption</th>
<th>Commissioners should ensure at least one in seven dependent drinkers can get treatment locally, in line with ‘Signs for improvement’</th>
<th>Hampshire Operational Model for Effective Recovery (HOMER) should seek to achieve:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Commissioners should include formal evaluation within the commissioning framework so that alcohol interventions and treatment are routinely evaluated and followed up. The aim is to ensure adherence to evidence-based practice and to</td>
<td>Specialist treatment for 1 in 7 dependent</td>
</tr>
</tbody>
</table>

Commissioners should ensure their plans include screening and brief interventions for people at risk of an alcohol-related problem (increasing risk drinkers) and those whose health is being damaged by alcohol (higher risk drinkers); provision should be made for the likely increase in referrals to tier 2-4 services as a result of screening.

NHS-commissioned services must ensure an appropriately trained nurse or medical consultant, with dedicated time, is available to provide strategic direction, governance structures and clinical supervision to alcohol specialist nurses and care givers.

Ensure that children’s services include consideration of the risk of alcohol harm among 10-15 year olds and screening & brief intervention for 16-17 year olds.

Screening and brief advice in **secondary care** for patients seen in: A&E, sexual health, fracture, cardiovascular, liver, falls, antenatal, gastrointestinal mental health.

Screening and brief advice in **non-health public services** for patients in one or more risk groups for alcohol harm: Homeless/insecurely housed, armed forces/veterans, older people, offenders.

Appoint alcohol liaison nurse in acute trusts.

Alcohol training for front-line staff in public service provider organisations: Primary health care, Secondary health care, Criminal justice system, Emergency services, Social services.
<table>
<thead>
<tr>
<th>Triage assessment for all adults presenting to specialist services:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Assess pattern and severity of the alcohol misuse (AUDIT), severity of dependence (SADQ), need for urgent treatment including assisted withdrawal, risks to self or others and co-morbidities</td>
</tr>
<tr>
<td>• Give information on the value and availability of community support networks and self-help groups (e.g. AA and SMART)</td>
</tr>
</tbody>
</table>

Comprehensive assessment for all adults score > 15 AUDIT:

Assess multiple areas of need in a structured clinical interview, use relevant and validated clinical tools, cover the following areas: alcohol consumption, dependence, alcohol-related problems, other drug misuse, physical health problems, cognitive, psychological and social problems, readiness for change.

For Harmful drinking and mild alcohol dependence:

Community-based assisted withdrawal (or in-patient withdrawal if clinical criteria indicate need) should consist of

• Contact between staff and service user averages 2–4 meetings per week over the first week
• Drug regimen
• Psychosocial support involving weekly 60 min motivational interviewing session for 12 weeks

Severe dependence or mild to moderate dependence with

<table>
<thead>
<tr>
<th>Triage assessment for all presenting adults, progressing to comprehensive assessment where AUDIT score &gt;15 in line with recommended practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological interventions should be in line with recommended practice; consideration should be given to gap between proposed and recommended staff contact time in both harmful and dependent drinkers</td>
</tr>
</tbody>
</table>

Threshold for referral for residential rehabilitation, and programme of support following successful withdrawal, should be in line with recommendations

Access to peer support groups should be encouraged in addition to professional support

Formal evaluation of services to ensure delivery is in line with evidence-based recommendations for clinically and cost-effective interventions
complex needs:

• Inpatient or residential supported withdrawal
• Intensive community programme consisting of drug regimen and day programme lasting between 4 and 7 days per week over a 3-week period.
• Psychological interventions including individual treatments group treatments, psychoeducational interventions, help to attend self-help groups, family and carer support and involvement

| Alcohol interventions in schools | Ensure a ‘whole school’ approach is taken to alcohol involving staff, parents and pupils
Ensure alcohol education is an integral part of the education, tailored for different age and social groups
Aim to encourage children not to drink, delay the age at which young people start drinking and reduce the harm it can cause among those who do drink.
Education programmes should:
• increase knowledge of the potential damage alcohol use can cause
• provide the opportunity to explore attitudes towards alcohol use
• help develop decision-making, assertiveness, coping skills and self-esteem
• increase awareness of how the media, advertisements, role models and the views of parents, peers and society can influence alcohol consumption
• Where appropriate, offer parents or carers information about developing parenting skills.
Recommendations are also made in relation to children and young people who are thought to be drinking harmful amounts of alcohol | Hampshire alcohol partnership should support work with schools and families to ensure an effective programme of alcohol education |