

Leeds Alcohol Strategy 2007 - 2010

Leeds Alcohol Strategy

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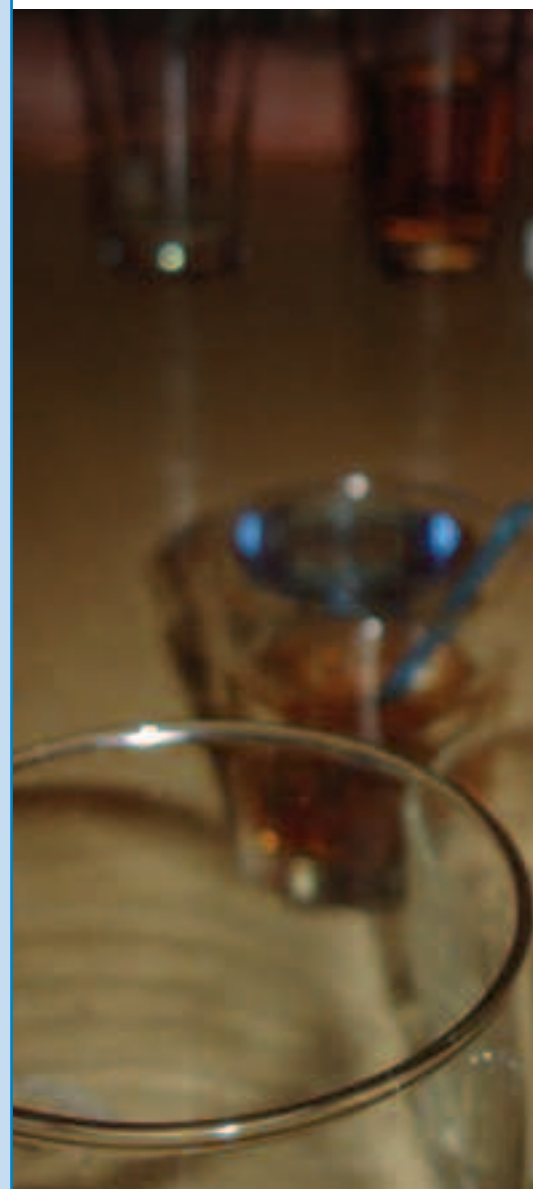
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Healthy Leeds

Safer Leeds

tackling drugs and crime



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Foreword



Much has been written over the past decade on the subject of Alcohol. Whether it has been in relation to reported increased sales, the relationship to crime and disorder, binge drinking and its effect on young people or the health hazards attached to excessive consumption, alcohol has seized headlines for a wide variety of reasons.

The impact of alcohol cannot be denied; it has grown to be a key component of the leisure industry and in many cases the underlying factor to increased economic wealth by way of jobs to many of our communities.

The Licensing Act 2003¹ brought about significant changes to the rules surrounding the sale of alcohol across the country together with enforcement procedures relating to the management of licensed premises. Changes to the opportunities for treatment for those affected by excessive alcohol consumption were also detailed in The NHS Models of Care for Alcohol Misuse (2006)².

The Leeds Alcohol Strategy has not been created to restrict or prohibit the consumption of alcohol, but seeks to encourage and promote a culture of responsible drinking coupled with responsible management of licensed premises. The aim of the strategy will be to reduce alcohol-related problems to improve the quality of life for Leeds residents and visitors. The strategy sets out our priorities for addressing alcohol misuse and how we intend to co-ordinate and deliver them. The attached Delivery Plan is at an early stage of development, but will evolve through the alcohol partnership groups.

The Strategy supports the Government's *National Alcohol Harm Reduction Strategy for England* (2005)³ and the recent publication *Safe, Sensible, Social - The next steps in the National Alcohol Strategy* (2007)⁴. It identifies key areas of activity to be prioritised by two of the city's key partnerships, Healthy Leeds and Safer Leeds over the next three years.

For Leeds to deal effectively with the many issues brought about by alcohol, as a city we must harness all the energies of our partner agencies and work together to deliver an effective and resilient response and reassure our communities that the city has a safe and thriving environment in which to work, visit and invest.



Dr Ian Cameron
Chair of Healthy
Leeds Partnership

Cllr Les Carter
Chair of Safer Leeds
Partnership Board

I. Executive Summary

The overall aim is to reduce alcohol-related problems through partnership working to improve the quality of life for the residents of Leeds, the workers, businesses and visitors.

The majority of people enjoy alcohol without causing harm to themselves or to others. However, as a population we are drinking more - and more often. In Leeds 55% of people drink alcohol two or more times a week, 54% of 16-24 year olds usually drink more than five units in one session and only about 10% of people know what the safe drinking levels are for men and women⁵.

The Leeds Alcohol Strategy 2007 is the first multi-agency plan to address the issue of alcohol harm reduction in Leeds. Though alcohol is identified as a source of pleasure, it can also be the cause of significant individual, social and economic harm. Both nationally and locally if the trend in increased consumption continues, notably amongst young people, we might anticipate both an increase in immediate problems and in the long term a risk to public health.

The strategy sets out our priorities for addressing alcohol misuse and how we intend to co-ordinate and deliver them. It is based on three themes: Prevention, Control and Treatment.

a) Prevention

- focused on achieving a long-term aim for a cultural change in attitude in relation to drinking - particularly among young people. The strategy will focus on communication programmes directed at young people and the general population. We will also promote work in Leeds prisons, particularly with those who have been convicted on alcohol related violence, to raise awareness of the impact of their behaviour.

b) Control

- seeing significant reductions in alcohol fuelled violence in the city centre and domestic violence caused by excessive alcohol consumption. We plan to bring together all key Partnership agencies to work together to obtain optimum use of their joint resources as previously outlined in the Chesterton Report commissioned by the City Council in 2003⁶.

An essential first step is to secure the full support of the Leeds City Licensing Association and their members within the trade across the city to ensure full co-operation with the provisions of the Licensing Act 2003.

c) Treatment

- ensuring that a full range of services are available for harmful, hazardous and dependent drinkers and their families. The recommendations contained in Models of Care for Alcohol Misuse² in relation to the breadth of treatment interventions required to service a city the size of Leeds, must be fully reviewed and costed to secure adequate investment.

The estimated cost of alcohol misuse for England and Wales is approximately £20bn a year⁷, which equates to over £450 for every adult in the country, and about £275 million for Leeds. This is made up of alcohol-related health disorders, crime and anti-social behaviour, coupled with a loss of productivity in the workplace. Additional problems also exist for families who misuse alcohol with an ensuing high risk of domestic violence.

The UK Alcohol Treatment Trial (2005)⁸ estimated that: every £1 spent on alcohol treatment saves £5 in the first year from public expenditure.

Spending on alcohol harm reduction therefore needs to be seen as an 'investment to save'.

2. Introduction

Alcohol is the most commonly used drug in the world. It is a depressant, and can be bought legally in Britain by people over 18. 'Alcohol is regarded as an important part of the European cultural tradition. It has a significant recreational role and some research shows that, when consumed in small quantities, it can reduce the risk of coronary events in that those of middle age who drink small amounts daily compared to non-drinkers.'

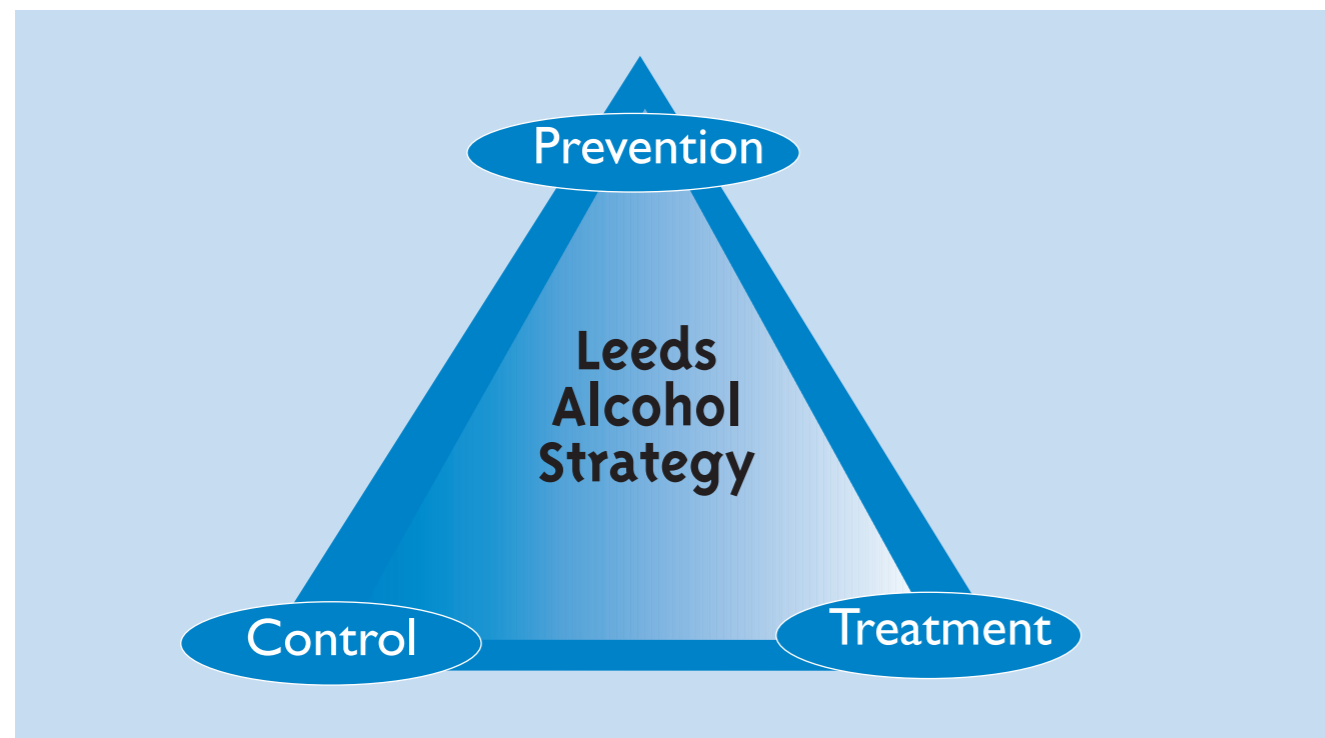
Nevertheless, while alcohol is a source of pleasure, it is also the cause of significant individual, social and economic harm. Alcohol is an addictive drug and a major cause of illness such as liver cirrhosis, cancers, heart disease, and social problems including social exclusion, unemployment, homelessness, violence, disorder, health inequality, teenage pregnancy and accidents'.¹⁰

Aim of the Leeds Alcohol Strategy

The overall aim of the Leeds Alcohol Strategy will be to reduce alcohol-related problems through partnership working to improve the quality of life for the residents of Leeds, the workers, businesses and visitors.

Leeds Alcohol Strategy is based around three themes – see figure 1 below. (For details see sections 7, 8 and 9 from pages 25-30)

Figure 1: Alcohol Strategy's Themes



Each theme has a strategic priority aim and set of objectives:

Prevention - Promoting sensible drinking & decreasing consumption.

- To promote alcohol education in all schools, youth service, and in further and higher education.
- To promote across Leeds a culture of Responsible Drinking and modify dangerous drinking patterns.
- To disseminate consistent and effective 'sensible drinking' and 'better health' messages, targeted at specific groups of drinkers in a range of environments (including A&E, GP surgeries, licensed premises, prisons and the workplace).
- To increase knowledge and understanding of alcohol use and alcohol related harms both to the public in general and a trained workforce.
- To develop equitable support for prisoners and their families in Leeds district with alcohol related problems.

Control - Promoting public protection through law and policy.

- To reduce the rate of alcohol-related crime and disorder, anti-social behaviour and domestic abuse in line with the priorities and targets of the Safer Leeds Partnership.
- To promote Responsible Management of licensed premises through effective implementation of the Licensing Act 2003 and initiatives such as Best Bar None.
- To further develop an effective data collection system in relation to the impact that alcohol has on crime and health and link to an efficient performance management system to promote quality standards.
- To reduce economic loss due to alcohol.
- To reduce the negative impact that alcohol has on children, young people and their families.

Treatment - Ensuring services are provided for harmful, hazardous and dependent drinkers and for their families and carers.

- To develop efficient early brief intervention and prevention programmes.
- To ensure that a co-ordinated, stepped programme of treatment services for people with alcohol problems is effective, appropriate and accessible, with adequate capacity to meet demand, in line with four tiered framework contained in Models of Care for Alcohol Misuse (MoCAM)².
- To reduce the level of alcohol related health problems, including alcohol related injuries, accidents and illness.

In order to achieve these aims, developments within the city will need to be supported by a trained workforce, improved information and coordinated delivery.



3. National Strategies, Policies & Drivers

3.1 Alcohol Harm Reduction Strategy for England (AHRSE)³

The national strategy is the first attempt by any British government to address the main areas of alcohol related harm, identified as health and crime. It identifies four key ways to tackle the problem through

- Improved, and better-targeted, education and communication
- Better identification and treatment of alcohol problems
- Better co-ordination and enforcement of existing powers against crime and disorder
- Encouraging the industry to continue promoting responsible drinking and to continue to take a role in reducing alcohol-related harm

3.2 Alcohol and the Law - Licensing Act 2003¹

The implementation of the Licensing Act 2003 provides freedom for all licensees to open for up to 24 hours a day, every day. It also brings a change in the Licensing Authority itself along with new powers to police pubs, clubs and other alcohol outlets

The function of adjudicating licensing applications is handed from licensing magistrates to locally elected councillors who have the responsibility of taking into account all representations from local residents concerning extended licensing applications. A wide range of new powers are also given to the police which include the ability to identify alcohol exclusion zones and close down, initially for a period of 24 hours, any licensed premises that are considered responsible for encouraging anti-social behaviour as a result of excessive drinking among their clientele. The following information will be deemed relevant to Leeds Licensing policy:

- Crime and Disorder
- Public Safety
- Prevention of Nuisance
- Protection of Children

3.3 Public Health White Paper - Choosing Health¹¹

The Government's White Paper *Choosing Health* sets out how the Government will make it easier for people to make healthier choices by offering them practical help to adopt healthier lifestyles.

In order to help people make healthier choices *Choosing Health* states that support and services for local people need to be provided at a local level. It highlights action over six key priorities for delivery, one of which is reducing harm and encouraging sensible drinking. Under this key priority it commits itself to the following actions:

- Providing clear and accessible information about sensible drinking, including reminders about responsible drinking on alcohol advertisements.
- Raising awareness: national communications campaign to reduce binge drinking; providing information for the public in healthcare and non-healthcare settings.
- Local Authority enforcement: for example checking retailer's identity and refusing to sell alcohol to under 18s.
- Increase access to and effectiveness of alcohol treatment: using the national audit of alcohol services and the Models of Care for Alcohol Misusers guidance (2005) to develop local services; training professionals to identify and target support at harmful and dependent drinkers; establishing referral protocols between primary and secondary health care settings and specialist alcohol services.
- Screening and brief interventions: piloting interventions in primary care and A&E, identifying ways to reduce alcohol intake in high-risk groups, linked to similar initiatives within criminal justice settings.
- Planning local responses: involving local authorities, Primary Care Trusts (PCT), the police, licensing trade and other local statutory partners.



Linked to *Choosing Health* is *Choosing Health through Pharmacy*, (2005) for pharmaceutical public health and highlights the contribution that pharmacists and their staff can make to improve health and reduce health inequalities. One of the health priority actions in the document is the reduction of harm from alcohol, which highlights two action points for pharmacists and their staff to consider:

- Pharmacists should consider training to identify and support people with alcohol problems.
- Pharmacy-based interventions for people with alcohol problems should be further piloted and evaluated.

With a grant from the Alcohol Education Research Council, Leeds ran such a pilot project 2006. Alcohol was also the theme of one of the annual public health pharmacy campaigns which started in Leeds in 2006.

3.4 Models of Care for Alcohol Misuse (MoCAM)²

Models of Care for Alcohol Misuse (MoCAM) published in June 06 provides best practice guidance for local health organisations and their partners in delivering a planned and integrated local treatment system for adult alcohol misusers. It identified different categories of drinkers and what are the most effective interventions for these groups within a four-tiered system. The main groups of alcohol users who clearly may benefit from specialist alcohol treatment are those who are moderately and severely dependent.

3.5 Alcohol Needs Assessment Research Project (ANARP) 2005¹²

This gave the first detailed national picture of the need for treatment and the provision of alcohol services across the country. The key findings are:

- There is a high level of need for treatment across different categories of drinker: 38% of men and 16% of women aged 16-64 (approximately 8.2m people) have an alcohol-related disorder in England.

- The Yorkshire and Humber region is identified as having the second largest gap between demand and provision of specialist services. 1 in 18 of the alcohol dependent population access treatment on a national basis - by contrast, the figure in Yorkshire is only 1 in 46.

3.6 Review of the effectiveness of treatment for alcohol problems 2006¹³

This is a key reference tool for commissioners and managers of alcohol treatment services. The review provides a contemporary overview and guide to the published international evidence on the effectiveness, and cost-effectiveness, of alcohol interventions and treatment. Written by a distinguished panel of UK experts this document will help to ensure appropriate alcohol interventions and treatment are implemented - an invaluable aid to those close involved in the local implementation of MoCAM.

3.7 Safe. Sensible. Social. The next steps in the National Alcohol Strategy⁴

Published in June 2007, this sets out to build on the foundations and lessons learnt since AHRSE in 2004 to deliver three things.

- to ensure that the laws and licensing powers we have introduced to tackle alcohol-fuelled crime and disorder; protect young people and bear down on irresponsibly managed premises are being used widely and effectively.
- to sharpen our focus on the minority of drinkers who cause or experience the most harm to themselves, their communities and their families. These are: **young people under 18 drinking alcohol**, **18-24-year-old binge drinkers**, a minority of whom are responsible for the majority of alcohol-related crime and disorder; and **harmful drinkers**, many of whom don't realise that their drinking patterns damage their health and harm others.
- to work together to shape an environment that actively promotes sensible drinking, through investment in better information and communications, and by drawing on the skills and commitment of all those already working to reduce alcohol related harm.



4. Alcohol and its Harms

One way of considering the complicated issues of alcohol-related harm to society can be seen in Figure 2 below.

Figure 2: Alcohol's 3D Pronged Attack



Drunkenness: or drinking to intoxication, even if done infrequently, can lead to a variety of problems, such as accidents, injuries, interpersonal violence, crime, risky sexual activity or alcohol poisoning.

Dependence: many heavy drinkers develop tolerance to the physical effects of alcohol, chronic heavy drinking does not often lead to evident intoxication, but can still cause physical and psychological damage and lead to dependence.

Disease: refers here to the illnesses and damage to the body and mind caused by regular consumption of large quantities of alcohol over a sustained period of time. Increased levels of consumption will lead to increasing problems in all three areas. It is probably the long term impact on disease which has the lowest level of public awareness, but can have the largest and most damaging impact on public health.



4.1 Safer Drinking Limits

Alcohol intake is measured in 'units' – the amount of alcohol processed in one hour by the liver of an average sized man. The unit has more impact in lighter and younger males, and more again for females of equivalent weight and age.

1 unit (8 grams of alcohol) equates to half a pint of normal strength (4%) beer, a (125ml) glass of (9%) wine or a single measure (25ml) of spirits.

The Royal College of Psychiatrists (1986) defined sensible drinking limits as '14 units of alcohol for women and 21 units for men per week. Alcohol consumption should be spread over the week, allowing for one or two alcohol free days and avoiding binge drinking'. In 1995 this was amended by Department of Health to reflect patterns of consumption more closely (see table 1 below: 'Men should consume no more than 3-4 units per day and women 2-3, with two non-drinking days after an episode of heavy drinking. Consistent consumption at the upper limit is not advised').

Table 1: Department of Health Definitions for Alcohol Consumption

Consumption	Safe daily consumption	Safe weekly consumption	Binge drinking	Hazardous Drinking	Harmful Drinking	Moderately & severely dependent drinkers
Men	3-4 units	less than 21 units	8 or more units in 1 day	22-50 units per week	over 50 units per week	based on level of dependence rather than on consumption
Women	2-3 units	less than 14 units	6 or more units in 1 day	15-35 units per week	over 35 units per week	

It is extremely difficult to calculate unit intake with trends of increasing alcohol strength and glass sizes. For instance wine is now regularly served in 175ml rather than 125ml glasses with a 12% strength, which equates to two units. It is even more difficult when drinking at home or at parties, and as the changing message on safe drinking over the years has created confusion.

Consumption trends

The AHRSE³ states:

'Evidence suggested that using price as a key lever risked major unintended side effects; the majority of

those who drink do so sensibly the majority of the time.'

UK average annual estimated pure alcohol consumption per head doubled from 5.07 litres in 1956 to 11.59 litres in 2004.¹⁴

Yet in the same month the Academy of Medical Sciences published a report containing figure 3 below, showing a direct relationship between price and consumption.

The impact of the fall in price was compounded by a simultaneous increase in the strength of wine and beer:

Figure 3: Consumption of alcohol in the UK (per person aged 15+) relative to its price: ¹⁵



4.2 Alcohol Related Costs

The national estimated cost of alcohol misuse is approximately £20bn a year. Table 2 below shows detailed costs of alcohol related harm for England and Wales. The Leeds figures on the right - and in tables throughout this strategy have been calculated as a proportion of those costs based on a Leeds population of 715,400 at the 2001 census.

This equates to £2,500 per person who drinks above recommended levels or over £450 for every adult in the country. The *Review of the Effectiveness of Treatment for Alcohol Problems*¹³ suggests that provision of alcohol treatment to 10% of the dependent drinking population within the UK would reduce public sector costs by between £109 million and £156 million each year.

Table 2: Costs of Alcohol Related Harm for England & Wales

Annual Cost (2001)	England & Wales	Leeds (estimated)
Health Care	£1,683m	£23m
Drink Driving	£168m	£2m
Human & Emotional Costs	£356m	£5m
Workplace & Wider Economy	£6,403m	£88m
Criminal Justice	£11,404m	£156m
Total Cost	£20 BILLION	£275 MILLION

Source - Strategy Unit Interim Analysis, 2003



5. The Impact of Alcohol

The following sections will examine the impact of alcohol on:

1. Health
2. Women
3. Young People – particularly through binge drinking
4. Crime and Disorder
5. Domestic Violence
6. Workplace
7. Social Wellbeing

- Alcohol related deaths in the Yorkshire and Humber region rose by over 46% in 2004 to 627 from 428 in 2004 - the biggest rise in the country.¹⁹
- In 1991 alcohol related deaths peaked around age 70 for both men and women, but by 2005 this fell to 55-59 for men and women.⁴
- Alcohol related death rates are 45% higher in high deprivation areas.⁴
- Each **man** in England dying from an alcohol-attributable cause loses an average of **20.2 yrs** and each **woman** loses an average of **15.1 yrs**.²⁰

5.1 Impact of Alcohol on Health

- Alcohol-related illness or injury accounts for 180,000 hospital admissions per year. These include alcoholic liver disease, toxic effect of alcohol or mental disorders due to alcohol.⁴
- At peak times up to 70% of all A&E admissions are alcohol related.³
- People who drink more than 14 units a week have been found to have higher death rates.¹⁶
- Incidence of high blood pressure is approximately doubled in people who drink over 6 units a day.¹⁷
- People who drink more than 6 bottles of beer on any one occasion treble their risk of death over those who drink only 3¹⁸.

The disinhibiting effect of alcohol is generally recognised to be a factor in the high incidence of unprotected sex in the UK, especially amongst young people; with resultant risky sexual behaviour contributing to teenage pregnancies and increasing sexually transmitted infections.

To put the harm caused by alcohol into perspective, a recent Scientific Select Committee report proposing a reclassification of drugs to focus on the harm they cause, ranks alcohol in the top 5 substances along with three Class A and one Class B drug²¹. The 2002 World Health Report²² compared the relative health risks in developed countries. Figure 4 below shows that alcohol abuse accounted for 9.2% of the years of life lost, compared to 2% from illicit drugs.

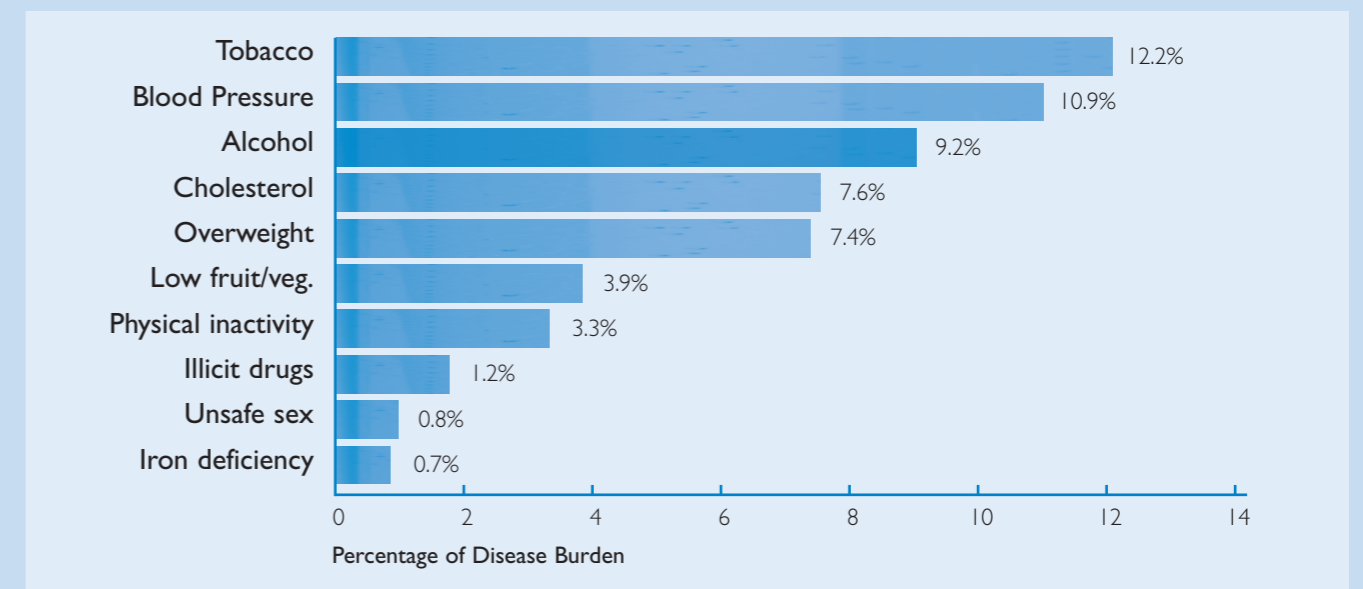


Figure 4: Major burden of disease leading risk factors in developed countries 2000

Findings from the NW Public Health Observatory²⁰ show massive differences across nearly all alcohol indicators between richer and poorer local communities across all regions of England. The most deprived lifestyle group 'Urban Challenge', are typically unemployed, low income older smokers, and have 4 to 15 times greater alcohol-specific mortality and 4 to 10 times greater alcohol-specific admission to hospital than the most affluent groups. The 'New Starters' group, typically young, highly qualified but poor, shows higher levels of harm than would be expected from deprivation alone. The population profile of these groups could be used to target safe drinking messages at supermarkets and other popular community settings.

Impact of Alcohol on Health in Leeds

Table 3 below shows a breakdown of costs to the NHS in Leeds if the city performs in line with the national average.

Table 3: Alcohol Costs to the NHS in Leeds

Alcohol Costs to the NHS in Leeds	£ Millions
Hospital inpatient visits:	
Directly attributable to alcohol misuse	1.73
Partly attributable to alcohol misuse	5.50
Hospital outpatient visits:	6.13
Accident & emergency visits	4.20
Ambulance services	2.82
Practice nurse consultations	0.27
NHS GP consultations	0.67
Other health care costs	0.51
Specialist treatment services	1.32
Total Health Care Costs	23.13 million

(Source: Calculated from Strategy Unit Interim Analysis, 2003)

Figure 5 (opposite) offers an indicative spread of drinking numbers of the Leeds population aged 16 to 64 of approximately 500,000²³, calculated from

data provided for Yorkshire and Humber Region in ANARP¹². All those drinking above recommended levels are categorised as having an 'alcohol use disorder' and appear in the top four sections of the pyramid.

Of these 100,000 are drinking at Hazardous levels, and are potentially damaging their health. A further 30,000 drinking at harmful levels are likely to experience physical or psychological ill-effects but are not dependent. 25,000 are moderately or severely dependent. We do not have reliable figures for the 110,000 people over 64, and alcohol misuse among older people is a 'hidden' or 'neglected' area of research in the UK.²⁴

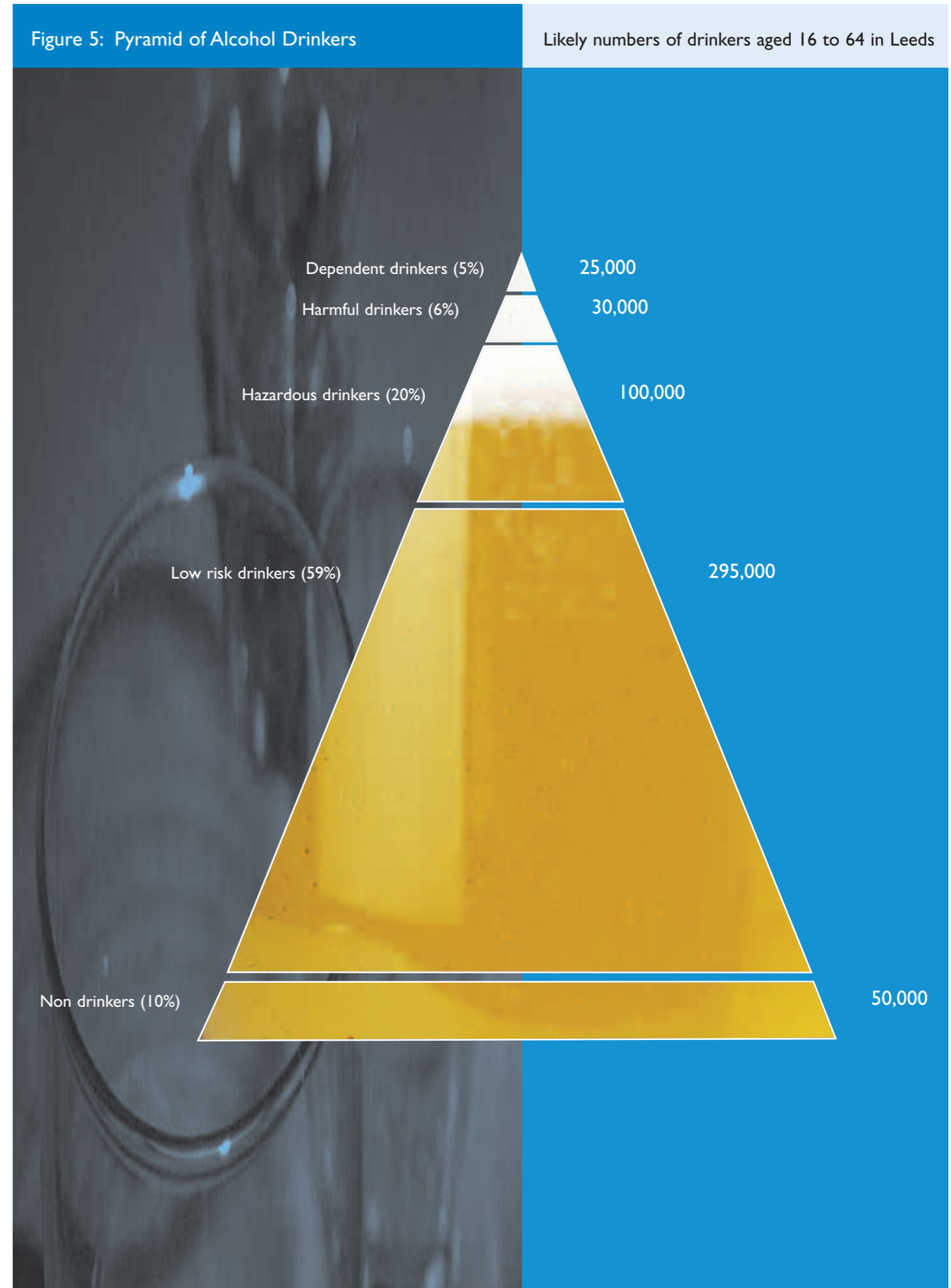
By gender 40% of men and 18% of women have an alcohol use disorder, which equates to 100,000 men and 45,000 women in Leeds. There are 21% of men and 9% of women who are binge drinkers, i.e. 52,500 men and 22,500 women in Leeds.

If prices continue to fall in the trend shown in Figure 4 above, and alcohol strength and availability increases with extended opening hours and numbers of outlets, the danger is that the horizontal lines will in effect appear to move down the pyramid, with a rapid expansion of numbers of those at risk.

Alcohol also has different effects for people in different communities. The Irish community have significantly higher rates of depression and alcohol related problems. Men born in the Republic of Ireland have nine times, and women seven times, the rate of alcohol related disorders compared to the general population.²⁵ Other minority ethnic groups are less likely to drink alcohol than the general population. Overall they drink smaller quantities and less frequently⁷, with considerably lower hazardous/harmful alcohol use. However they still have a similar prevalence of alcohol dependence to the white population.¹¹ A Home Office study in 2001 found that among black and ethnic minority men in prison, over a half are hazardous or harmful drinkers with a third also dependent on other drugs, with a particularly strong link between alcohol and crack use.²⁶

Figure 5: Pyramid of Alcohol Drinkers

Likely numbers of drinkers aged 16 to 64 in Leeds



5.2 Impact of Alcohol on Women

Women's physical make-up affects the way that alcohol is processed:

- Women's bodies have 10% more fat than men's bodies
- They have less fluid to dilute the alcohol, so the concentration is higher
- The average woman (58kg) weighs considerably less than the average man (70kg) with correspondingly less tissue to absorb alcohol
- Alcohol stays longer in the stomachs of women before being metabolised and has greater effect.

In March 2005 for the first time that boys and girls aged 11 to 15 were both drinking alcohol at the

same rate in the last week (23%).²⁷ In 1990 girls drank an average 4.7 units a week compared to 10.2 units in 2005. Young women facing disadvantage may also use alcohol as an escape route for frustration with the places they live and everyday life.²⁸

Figures 6 and 7 below both show those drinking above advisory levels in UK by 2000/1. Figure 6 shows how in the preceding eight years male levels have risen from 26 to 29% whereas over the same time female levels have increased more rapidly from 10 to 17%. However Figure 7 shows that 16 to 24 year old young women have almost caught up to male drinking levels.

In 1990 the industry brought about a major change in the starting age of young women's drinking habits by the introduction of 'Alco Pops'.

Figure 6: Adults consuming over recommended weekly limits by age & gender Cabinet Office Strategy Unit

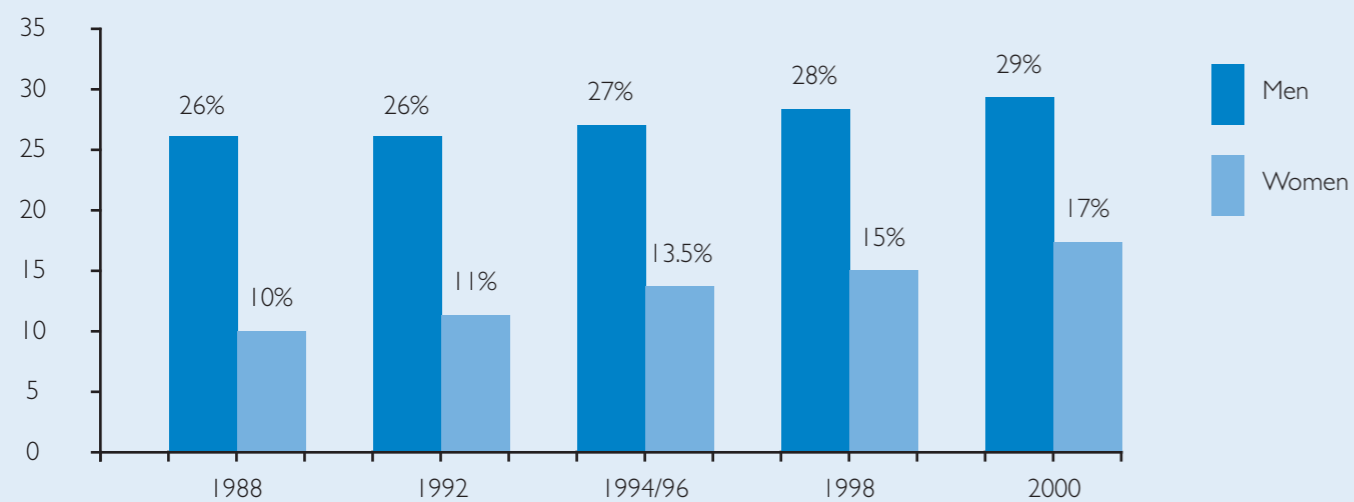


Figure 7: Adults consuming over recommended daily limits by age & gender Cabinet Office Strategy Unit

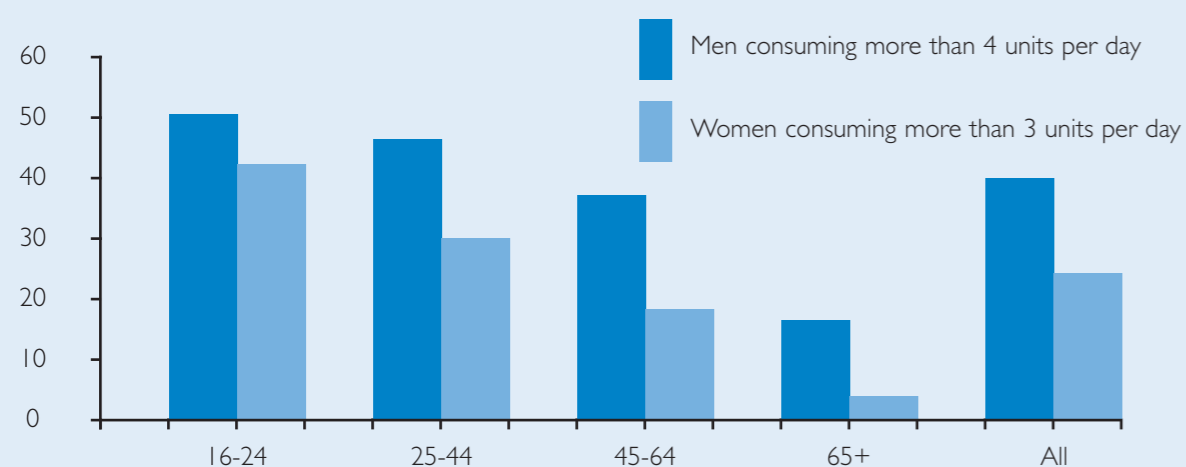
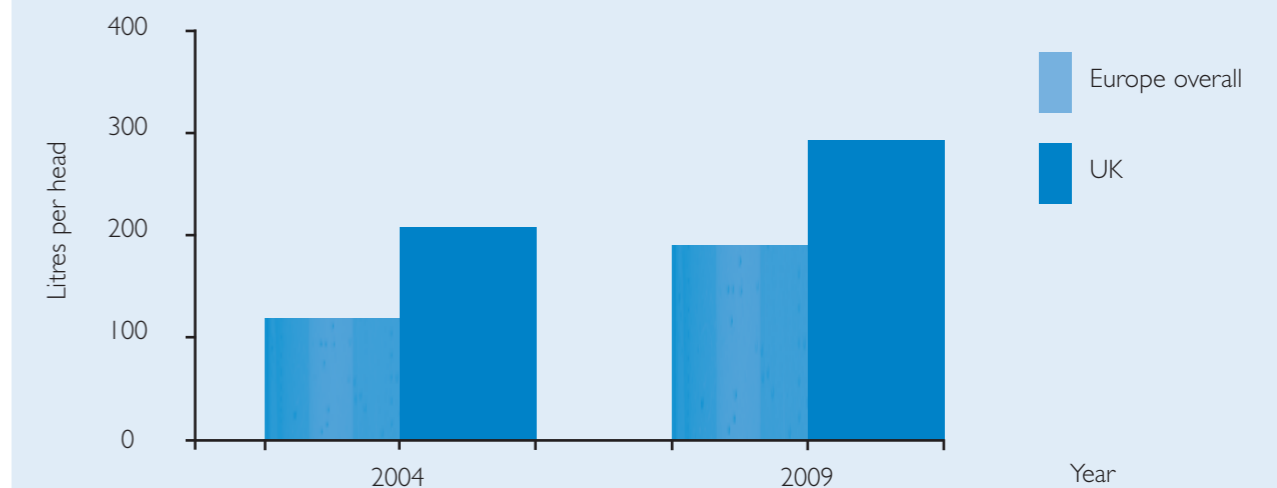


Figure 8: Alcohol consumption by women in UK and Europe (yearly litres per head)



Attracting female spending was identified as important to UK drinks companies, with young women more likely than men to order different types of drinks.

In April 2005 it was predicted that in the average UK women's annual drinking levels would rise by a third more alcohol from 205 to 295 litres by 2009²⁹. This compares with only 63 litres in Italy and the predicted EU average rise from 125 to 180 litres over the same period. (See Figure 8 above)

The industry's own Portman Group also revealed that 16 to 24 year old women drinking harmful levels of more than 35 units per week rose from 3% 1990 to 10% in 2005. Alcohol is not an 'equal opportunities' drug, having a more rapid and severe effect on women's health, so these trends have major implications for long term public health.

In September 2005 the Portman Group released the following findings shown in Table 4 (right)³⁰, suggesting that harm-related women's activity whilst drunk was ahead of men in all these areas.

Table 4: Reported activity while drunk: men & women

Reported activity	Men	Women
Sexual Assault	2%	36%
Unplanned/unprotected sex	24%	34%
Ended up in hospital	13%	17%
Injured	14%	19%
Argument	45%	59%
Cautioned by police	16%	27%
Lost or had property stolen	15%	24%
Phoned in sick from work/study	69%	57%

5.3 Impact of Alcohol on Young People - Binge Drinking

In recent years there has been a growing national concern about the phenomenon of 'binge-drinking', which has a potential impact on all the other areas above. The Department of Health defines this as those drinking more than twice the recommended daily guidelines (i.e. 6 units for women and 8 for men) - Alcohol Concern provided a more useful definition: - 'Drinking sufficient alcohol to reach a state of intoxication on one occasion or in the course of one drinking session'. In other words – drinking to get drunk! The UK binge drinking rates were found to be one of the highest in Europe.³¹ Figure 9 below shows the Yorkshire region as the heaviest for binge drinking.

Some of the suggested reasons why this recent phenomenon has arisen can be explained by the alcohol industry adopting new marketing opportunities by:

- Producing a whole new range of alcohol products, aimed at a new generation of young consumers and sold in a range of new, young people targeted outlets such as café bars, theme pubs and club bars.
- Developing drinks to appeal to young women.
- Increasing the size and strength of alcoholic drinks in a direct attempt to compete in the 'psychoactive market'.
- Marketing alcohol products explicitly as psychoactive drugs and as lifestyle markers.
- Marketing 'shots' and 'shooters', which are short, drinks packaged and sold to facilitate rapid intoxication.

There are two types of risk for the binge drinker: the more immediate behavioural costs and the long-term health consequences. The brain does not mature until about the age of 20, and moderate drinking impairs learning and memory far more in youth than adults. Adolescents need only drink half as much to suffer the same short-term negative effects, including aggression and violence, poor learning in school, college or work, teenage pregnancy and sexually transmitted infections, self-harm and suicide. Long-term damage can be irreversible.³² Figure 10 (opposite) gives an indication of the impact of binge drinking that goes largely unnoticed below the headline grabbing street violence.

In the UK binge drinking accounts for 40% of all drinking occasions among men and 22% among women.⁷ Binge drinking is most characteristic in the young. Figure 11 (opposite) shows reasons young people give for drinking.³³ Whilst boredom gets the lowest response, we do need to provide alternative ways for young people to enjoy themselves.

- Those aged 18-24 years are more likely to binge drink with 49% of men and 39% of women report feeling very drunk at least once a month.
- A recent study found people felt ambivalent about the adverse effects of binge drinking and many seem prepared to accept the negative experiences as 'the price they pay for enjoying their drinking'³⁴.
- However, for some people, this type of drinking continues into middle age with around one in three men and one in five women drinking twice daily limits at least once a week.

Figure 9: Binge drinking for 2003 - % drinking more than 4/3 or 8/6 units on at least one day

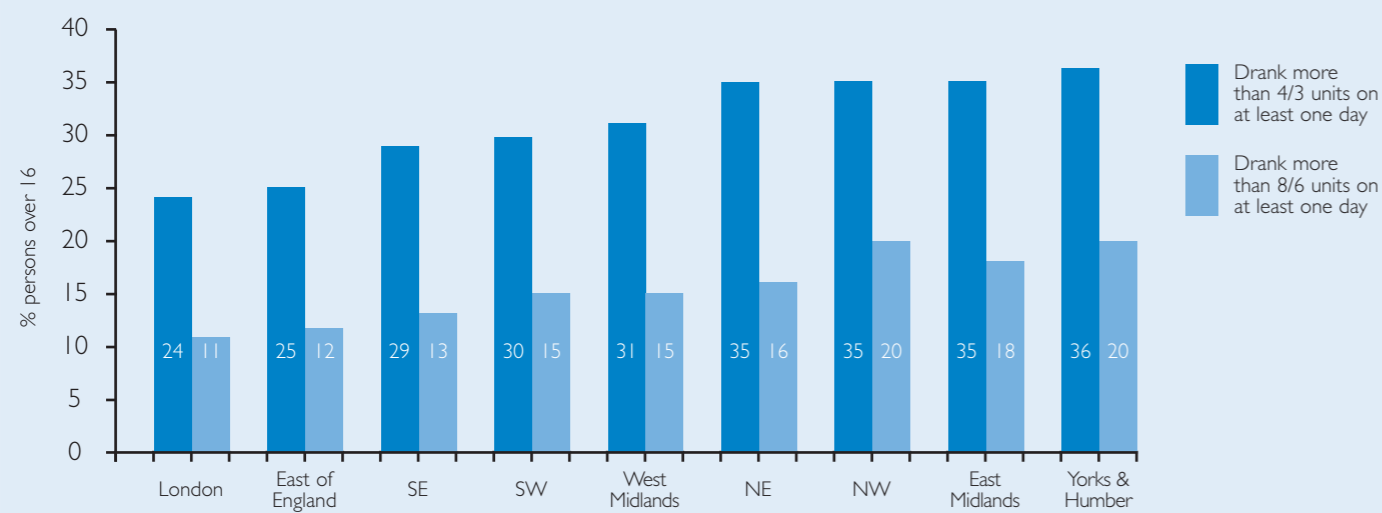


Figure 10: Bingeing Iceberg³⁵

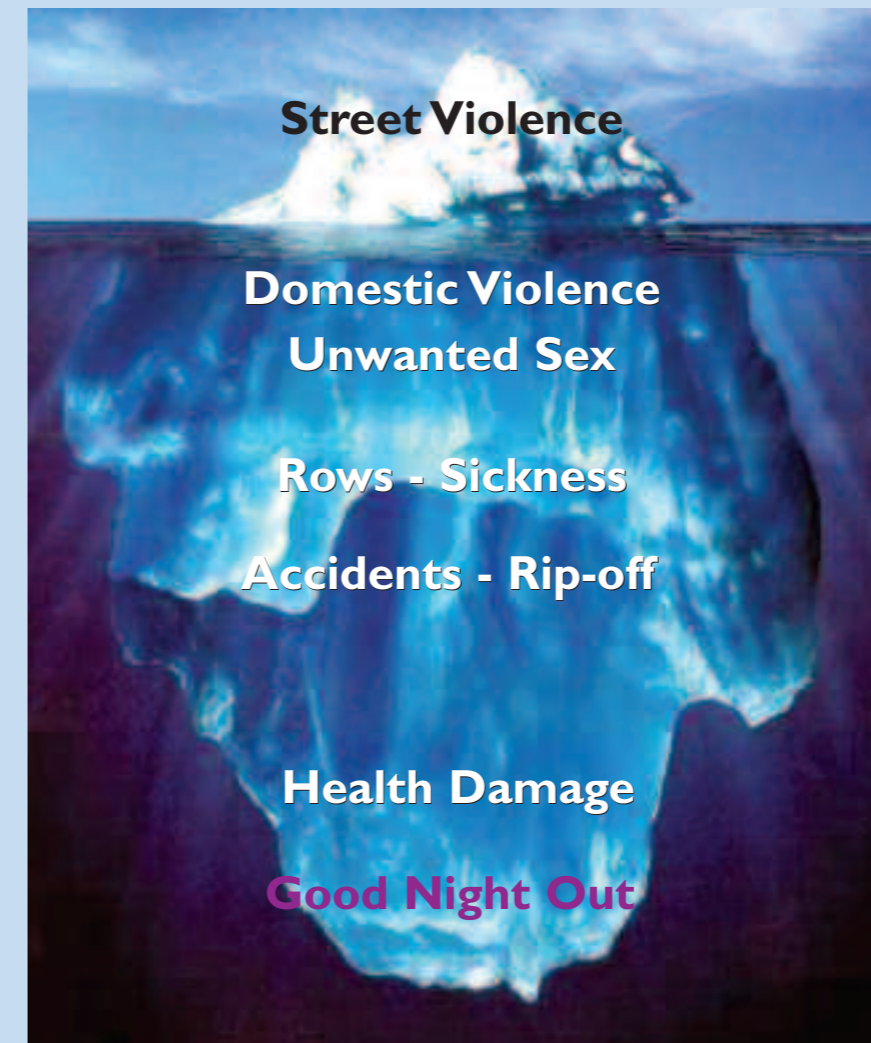
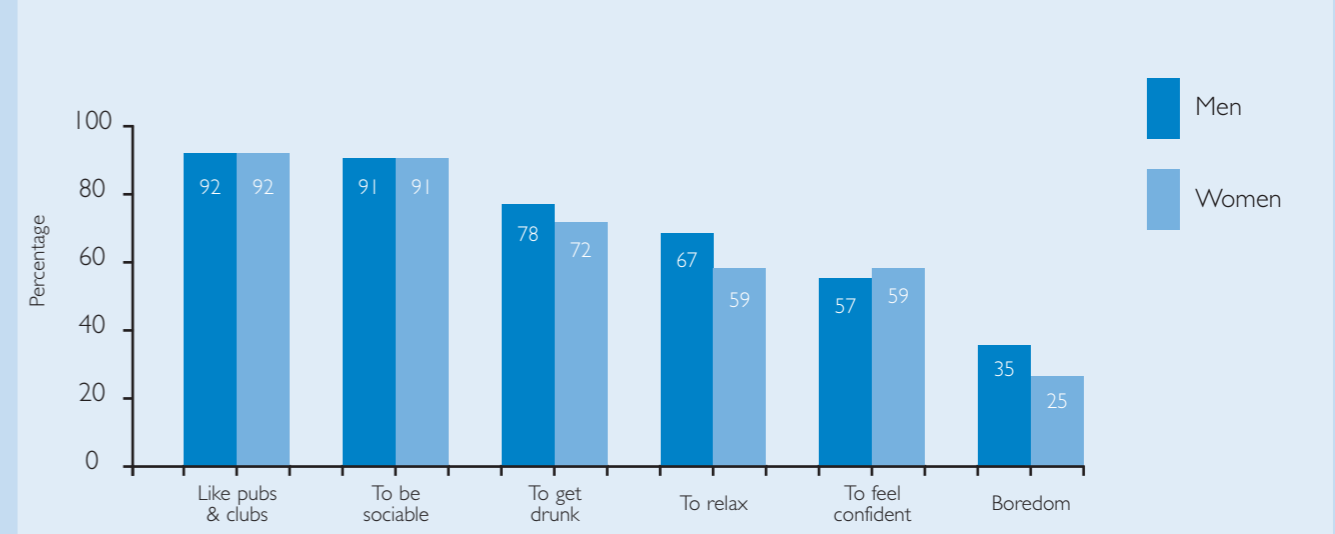


Figure 11: Reasons for drinking among 18-24 year olds by sex



5.4 Impact of Alcohol on Crime and Disorder

For many people, drinking is strongly linked to crime, disorder and anti-social behaviour. The AHRSE³ states that the areas of concern for most people are:

- Alcohol related disorder and anti-social behaviour in cities at night
- Under-age drinking
- Domestic Violence
- Drink driving

People who visit licensed premises more than three times a week are twice as likely to be victims of crime compared to those who visit less.

Alcohol Related Crime and Disorder in Leeds

In recent years in Leeds there has been a major regeneration of the city centre. Much of the night time economy has been built around the development of a robust leisure industry with a high focus on licensed premises including, pubs, clubs and restaurants. The number of city centre 'on licences' and Night Clubs has more than doubled since 1994³⁶ – see Figure 12 below. The result has produced a thriving city with a pulsating nightlife that attracts young visitors in large numbers. However, high levels of alcohol consumption have attracted problems of disorder, violence and risks to personal safety and public health, which can also have a negative effect on the local economy:

- Between October 2004 and September 2005, there were 17384 crimes of violence in Leeds; a large proportion of these can be reasonably attributed to alcohol misuse.
- Of these assaults 593 were classified as serious (grievous bodily harm and 9968 less serious (actual bodily harm).
- Of the 9968 minor assaults, 10% of the total were in or close to licensed premises.
- Of the minor assaults 20% were identified as having alcohol as a contributory factor.
- From figures obtained from the Home Office 'Social and Economic Costs of Crime' publication, the cost to Leeds in terms of dealing with the minor assaults was £49,840,000, based on police investigation, healthcare, insurance, damage etc.

The concentration of alcohol-fuelled disorder is in the city centre with key areas that have a high concentration of licensed premises regularly recording significant levels of assaults. The peak times for violent crime are between 11pm and 3am on Fridays and Saturdays with higher incidents of assaults located in the Boar Lane and Cookridge Street areas as the public move from pubs to club premises.

Reducing alcohol-related crime and disorder is a key part of the Safer Leeds Partnership's Strategy and in 2006 the Home Office designated the city centre as a target area for its Tackling Violent Crime Programme due to the high number of alcohol related violent crimes.

Figure 12: Licensed Premises in Leeds City Centre

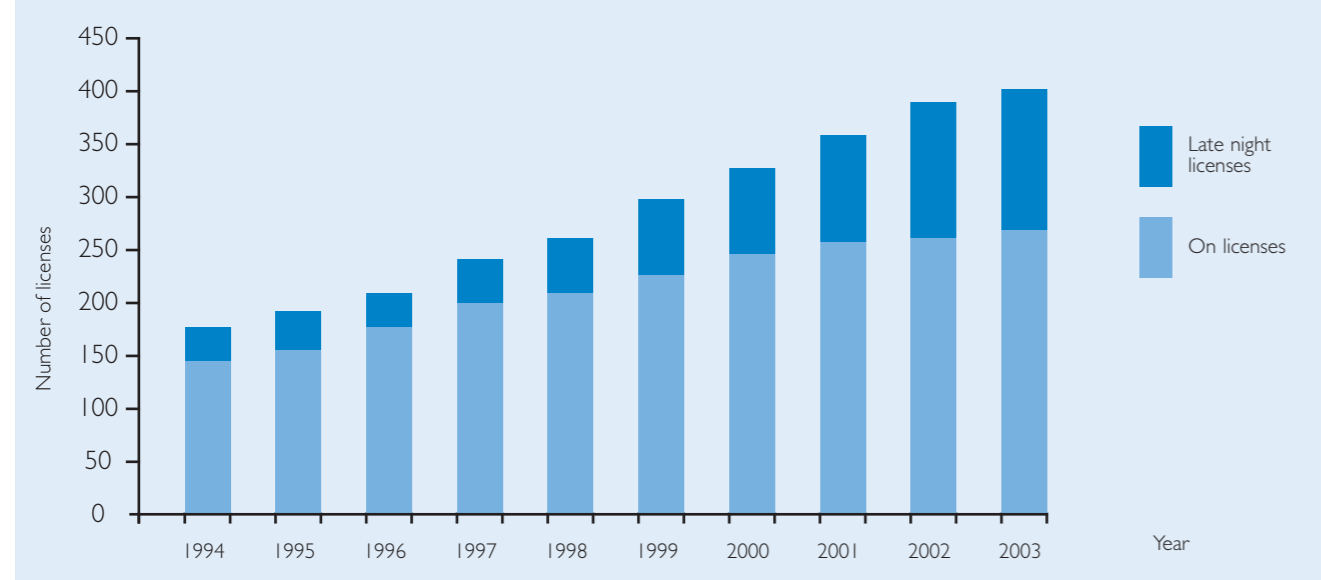


Table 5: Breakdown of Costs to Criminal Justice in Leeds

Criminal Justice costs of Alcohol Misuse	£ Millions
Alcohol specific offences	0.41
Alcohol related offences	23.65
Property/health and victim services	34.66
Costs in anticipation of crime (alarms etc)	20.55
Lost productive output of victims	13.33
Emotional impact costs for victims	64.32
Drink driving	2.32
Total Criminal Justice System Costs	£159.23 million

(Source: Calculated from Strategy Unit Interim Analysis, 2003)

Various measures are already in place to combat street drinking and alcohol related violence:

- The Designated Public Places Order (DPPO) allows police to deal with problems of anti-social behaviour and crime that are as a direct result of alcohol consumption in public places. Leeds has applied this legislation to targeted areas.
- Use of Exclusion Orders and Dispersal Orders provide police the power to exclude individuals and disperse groups from areas where their behaviour is liable to result in violence.
- Anti-social behaviour orders (ASBOs) have been liberally applied against individuals who display a pattern of anti-social behaviour coupled with
- Acceptable Behaviour Contracts (ABCs) as a voluntary deterrent against individuals to stop further similar behaviour.
- Fixed penalty notices are given for offences such as public disorder.

West Yorkshire Police coupled with its Safer Leeds partners will continue to implement all aspects of the Licensing Act 2003 with a view to eradicating crime and disorder brought about by excessive alcohol consumption.

5.5 Alcohol and Domestic Violence (DV)

There is a well-established link between alcohol and DV; alcohol misuse in perpetrators of DV (generally men), can be up to seven times higher than in the general population. Over one third of the total DV incidents nationally are alcohol related. Women experiencing DV are up to fifteen times more likely to misuse alcohol than women generally. In Leeds in 2006, alcohol was a major contributory factor in 6071 DV incidents (53%). Many women misuse alcohol as a response to, and as a way of coping with abuse. It is not surprising that a significant number of women approaching services may present a multiple support need.



5.6 Impact of Alcohol on Workplace

Drinking can reduce the productivity of the UK economy through increased sickness absence, injury, the inability to work (unemployment and early retirement); and premature deaths among economically active people.

- Up to 17m working days are lost annually due to alcohol related absence
- Up to 20m working days are lost annually due to alcohol-related reduced employment
- At least 58,000 potential working years are lost annually due to premature alcohol related deaths⁷ and
- This represents lost earnings for individuals, lost profit for employers and lost productivity for the country.

Drinking 7+ units per week (for women) or 14+ (for men) raises the likelihood of absence from work through injury by 20 per cent. Those with a history of alcohol misuse are likely to change jobs more often, and there is some suggestion that they are more likely to be unemployed. The unemployed have relatively high levels of alcohol consumption and an above average proportion of problem drinkers are unemployed: alcohol accounts for 3.9 per cent of expenditure in unemployed households compared to 0.86 per cent for full-time employees. On the other hand men in higher socioeconomic groups drink more often, and women in this class tend to drink excessively above the daily recommended guidelines and binge drink more often.⁷

Apart from working days lost, it is estimated that a further 72 million days are blighted by people working at two-thirds their normal capacity due to a hangover.³⁷ In practice it is very difficult to calculate these numbers as very few people ring in to say they have a hangover. A joint survey⁴⁴ found that 60% of employers had experienced problems as a result of employees' misuse of alcohol. This includes accidents at work, caring for family members with alcohol problems, and those in need of treatment. A recent study by Working Families found around 1 in 5 parents resorted to drinking to try to cope with work-related stress.³⁸

These figures should persuade local employers to invest in policies to measure the impact of alcohol on their own businesses and reduce this wastage. The development of alcohol policies within the workplace can be seen to be part of a wider change in attitudes towards drinking. Over 70% of employers offering assistance programmes and management training believe they are effective in helping reduce drink and drug problems⁴⁵.

5.7 Impact of Alcohol on Social Well-being

Alcohol can also have broader effects on people's lives and social well-being by impacting on relationships with family, friends, wider society and public services. As problems with drinking worsen, stability, relationships and income can all decline. Those with severe alcohol problems withdraw increasingly and may end up jobless, homeless, out of contact with their family and beyond the reach of services.

In terms of family, friends and other personal relationships, alcohol misuse may be associated with:

- relationship break-down
- domestic violence and aggression
- health impacts
- unsafe or regretted sex
- poor parenting - and child abuse
 - up to 1.3 million children are affected by parental alcohol problems
 - up to 60% of child protection cases involve alcohol.⁷

In terms of the way in which people interact with the wider community and society, alcohol misuse may, in particular, be associated with:

- truancy and delinquency (in under-age drinkers)
- anti-social behaviour and
- homelessness and street-drinking - up to half of rough sleepers have problems with alcohol.⁷

6. Leeds City Council Scrutiny Commission

The Leeds City Council Overview and Scrutiny Board³⁹ set up a Commission in 2005 to conduct an inquiry into alcohol misuse in Leeds because of the rising levels of concern amongst many sectors in the city about the serious and wide-ranging impact that alcohol misuse can have on individuals, families and behaviour in society as a whole. The Commission identified two main types of action needed to tackle some of the alcohol-related problems in Leeds:

Practical measures on areas such as transport home from the city centre, training for health and social care professionals, licensing conditions and alcohol education, among others, and:

Strategic management and co-ordinated action between all those agencies involved, including increased communication between the licensing and planning authorities on possible developments in the city to tackle any potential issues before they arise.

Key Recommendations

- A sustainable mixed use planning policy designed to ensure over-concentration of premises does not create new problem areas in the city centre or elsewhere.
- A protocol for regular communication between the Planning Authority and the Licensing Authority. This to include ensuring both bodies are formally consulted on licensing related applications.
- Consider whether licensing related applications should be heard by elected members, rather than delegated to officers.
- A taxi marshal scheme at key locations and at key times is established in the city centre to prevent problems associated with transport home in taxis and manage the taxi ranks. The effects of this scheme should be monitored in terms of levels of alcohol related disorder. The possibility of funding from licensed premises in the city centre may be investigated further via the LCLA.
- Bus operators identify best practice from other areas which run successful late night bus services on a commercial basis and apply successful elements to improve the late night bus service in Leeds.
- That Education Leeds influences and supports all schools to provide alcohol education from Key Stage Three onwards which:

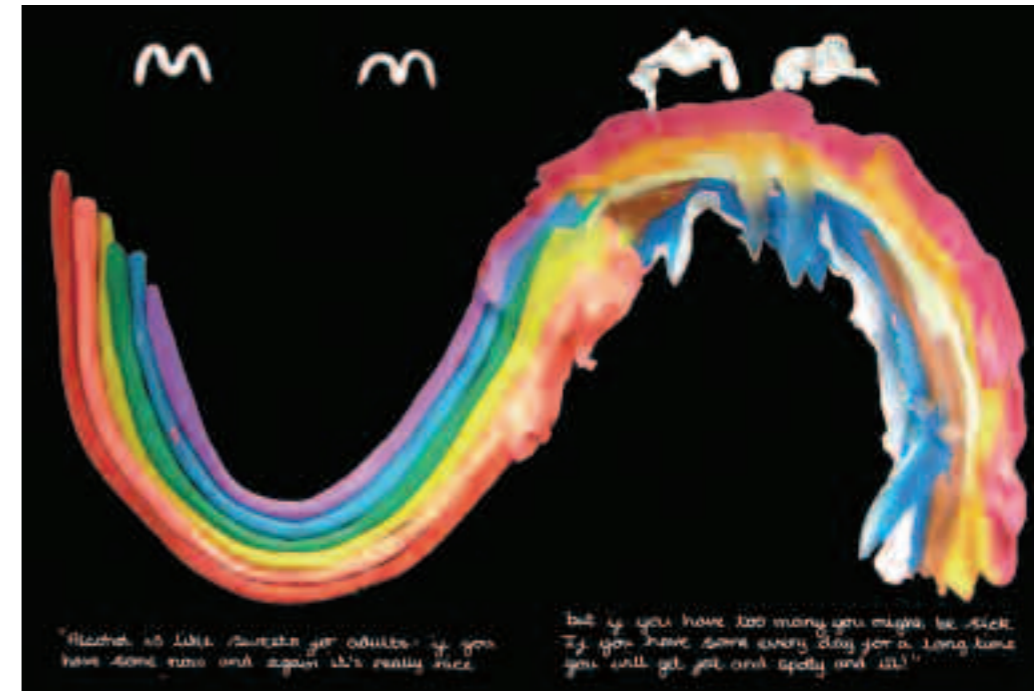
- Provides information and teaching on skills and attitudes to young people on the health and social aspects of alcohol
 - Is age appropriate
 - Is delivered to pupils every year in relation to secondary school and in the final year of primary school
 - Is delivered in innovative ways for example through peer education, and through representatives from voluntary agencies such as Al-Anon.
- That school governors seek to influence and improve alcohol education in their schools and include in their 'Annual Report to Parents' a summary of activity in relation to alcohol education.

The progress of the 26 recommendations will continue to be monitored within the appropriate delivery plans of Prevention, Control or Treatment. In many cases any progress in reducing the harm caused by alcohol consumption will be dependent on additional resources being made available.





7. Alcohol Prevention in Leeds



In order to drink responsibly, individuals need to understand the potential risks of alcohol use. Alcohol-related information comes from a range of sources such as government campaigns, schools, workplace, advertising, friends, families and the wider community. Despite all this information, consumers are generally not equipped to take informed drinking choices. Recognition of the “sensible drinking” message is very low in Leeds, with only 10% knowing what the safe levels are.⁵

Also, while school programmes provide information, there is little evidence that they are effective in changing drinking behaviour.⁴⁰

Accordingly it must be a priority to promote alcohol education in the curriculum in both PSHE and in Science.

7.1 Alcohol Education in Schools

The aim of alcohol education should be to reduce the risks associated with pupils' own and others' drinking by taking a harm reduction approach. This accepts that many, although not all, people drink, and seeks to enhance pupils' abilities to identify and manage risks and make responsible and healthy decisions.⁴¹

Evidence from young people to the Council's Scrutiny Commission³⁹ indicated that alcohol education was the poor relation in the Personal and Social Health Education (PSHE) curriculum, which is itself underdeveloped in many secondary schools.

Some schools are concerned about the negative part that alcohol plays in behaviour, attendance and attainment in schools. The effects of drinking in school time are obvious but pupils are also affected by violence, crime and disorder outside school hours. The number of children affected by parental alcohol misuse is estimated as 5 times higher than by parental drug misuse.⁴² PSHE is needed to help young people understand these issues and develop the skills to deal with them. Regular communication between the police and schools is also needed, possibly through Education Leeds Area Management Board processes, in order that head teachers and governors can fully understand the scale and nature of the problem faced by their communities.

Additional support is needed for pupils at risk from alcohol abuse.

There is a substantial workforce to help young people and their parents deal with the challenges of alcohol misuse. These include school pastoral staff i.e. teachers, mentors and support staff but also Youth Service staff, School Nurses, Connexions Personal Advisors, Parent Support Advisors, Children's Centres and many others from the community and voluntary sector. Integrated approaches to training, common protocols and a citywide system of referral pathways are needed.

Young people have a right to be heard in the shaping of services and the prioritisation of issues. In Leeds, Youth on Health is a youth participation group focused on health issues working with the Youth Council and other representative bodies. They are ideally placed to help shape policies and plans.

7.2 Alcohol Education Beyond Schools

The Higher and Further Education sectors are developing active strategies in relation to alcohol education and the prevention of alcohol abuse and there is scope for cross fertilisation between them and statutory education.

There is also a need to disseminate consistent and effective 'sensible drinking' and 'better health' messages, targeted at specific groups of drinkers in a range of environments (including A&E, GP surgeries, licensed premises, prisons and the workplace).

7.3 'Unit 14-21' Campaign

This innovative marketing campaign run in conjunction with Leeds PCT and Leeds University Union aims to increase awareness of the facts and effects surrounding binge drinking as a young person and to allow the target market to make informed decisions regarding their drinking habits, safety and welfare.

We will:

- Continue to develop and support the 'Unit 14 -21' campaign
- Work with the PCT and Universities to promote and advertise activities
- Maintain the four staged approach to the existing programme
- Monitor and evaluate the effectiveness of the outcomes to evaluate further investment

The evaluation in July 07 was very positive, and it was felt there is potential for the campaign to be rolled out further; not just to colleges but also across the general public.

7.4 Prison and Probation Populations

In Leeds Prison a pilot Alcohol Awareness programme showed very positive results, and funding has been agreed to expand the programme to both adult prisons. 60% of inmates are estimated to have a drink problem,⁷ so if they, and those on probation can be helped, this could have a huge impact on their future offending behaviour; their lives, the lives of their families – and reducing numbers in prison.

7.5 Priority Action for the Prevention Theme – Promoting Sensible Drinking and Decreasing Consumption.

Any successful strategy will need to achieve a long-term change in attitudes to irresponsible drinking and behaviour and the culture that surrounds alcohol. It is acknowledged that most of these national factors, including price and availability are beyond the scope of local action, but we will look to influence them wherever possible and at every opportunity.

Our prevention action area will support the work going on nationally by adopting a package of measures to improve public knowledge and prevention through a coherent approach to alcohol issues in the media. In the 1990s the annual 'Drinkwise' campaign formed the focus of awareness raising, and since then Leeds has developed a local focus at the end of September to coincide with Freshers week at the universities. However, in future we will support Alcohol Concern's annual Alcohol Awareness Week in May.

7.6 Prevention Summary In Leeds we will:

- Promote a model of PSHE, which fully addresses alcohol issues. This will be monitored and supported through the Leeds Healthy Schools Programme.
- Ensure that head teachers and governors understand the effects which alcohol can have on the attendance and attainment of their pupils and are thereby motivated to address these issues through all means.
- Ensure that all partners and the key elements of the children's workforce understand the key messages and processes in relation to alcohol education; and that they understand the vulnerabilities of certain groups of young people and the support which should be provided for them.
- Consult young people in shaping the priorities and services in relation to alcohol.
- Ensure that there is effective cross phase liaison between stages of education.
- Develop with partners, effective communication and public information mechanisms to carry key prevention messages.
- Work with the leisure and entertainment industry to promote responsible drinking.
- Require partner organisations to review existing or develop new effective alcohol policies.
- Promote effective alcohol policy development by all employers - starting with those employing largest numbers.
- Develop equitable strategies for prisoners and others within the criminal justice system in Leeds with alcohol related problems.
- Support Alcohol Concern's annual Alcohol Awareness Week in May.



8. Alcohol Control in Leeds

In 2003, Leeds commissioned a major consultancy to undertake a thorough study of the city's night time economy.⁶ The report looked in great detail at a wide range of issues which impacted on both the city as a whole and its businesses, residents and visitors and concluded that key partner agencies such as Planning, Licensing, Transport, Community Safety and City Centre Services must all play key roles if Leeds is to be recognised as one of the principal and progressive cities in Europe and adaptive to change.

The drinks and recreation industry have a vested interest in ensuring that irresponsible sale and use of alcohol does not create a night time culture, which discourages groups of potential customers from using the city centre and other leisure attractions across Leeds. There must therefore be partnership working with the industry to promote strategic messages about the benefits of responsible sale and use of alcohol and the costs of irresponsible alcohol sale and use. The misuse of alcohol places a heavy burden on individuals, the community and the local economy.



8.1 Priority Action for the Control Theme

Promoting public protection through law and policy

Alcohol misuse is a major contributor to violent crime, disorder and anti-social behaviour. Actions in Leeds will support national priorities to reduce problems caused by excessive drinking in the city centre and outlying areas, alcohol related violent crime, under-age drinking, drink driving, alcohol related repeat offending, better identification of alcohol problems and referral to services.

The wide acknowledgement of community safety issues led to the commissioning of the study into the management and development of the evening/night time economy. The objective was to achieve a 'successful vibrant and diverse economy with an environment that is accessible, attractive and safe to use by all'.

It is universally agreed that alcohol plays a significant part in violent crime. The Home Office definition of violent crime is, however, extremely wide ranging and takes in a wide spectrum of different offences. It includes what most people would recognise as violent crime i.e. assaults and woundings. It also includes all the Public Order Act offences, sexual offences, breach of Anti-social Behaviour Orders and quite a number of more obscure offences. The Policing strategy to reduce violent crime is aimed at alcohol related violence and domestic violence.

8.2 Control Summary - In Leeds we will:

- Monitor the sale of alcohol to young people and prosecute those retailers who fail to respond to initial warnings.
- Use all powers available to reduce crime and disorder in public places by supporting licensed premises in responsible retailing and marketing.
- Encourage and expand Pubwatch and Best Bar None schemes across the city to raise the level of quality standards provided by licensed premises.
- Utilise the powers of the Licensing Act 2003 to review problem premises, and where necessary impose special conditions or even revocation.
- Encourage town planners and developers to work together to ensure the city centre feels safe to users through such means as improved lighting.
- Encourage bus and taxi providers to run services which aid the dispersal of people – particularly through the night.
- Increase the level of use of the Leedswatch CCTV system to enable an early response to incidents of violence and provide evidence for prosecution of offenders.
- Monitor the effectiveness of interventions with street drinkers and explore opportunities to provide them with options for health improvement.
- Through the Domestic Violence Strategy increase the capacity of alcohol services to respond to both victims and perpetrators through good practice guidelines and training, and to increase understanding amongst generic services of the links between alcohol and DV.
- Explore opportunities to establish a pilot arrest referral scheme for DV perpetrators.



9. Alcohol Treatment in Leeds

The effectiveness of prevention and control measures will modulate the total numbers of problem drinkers. Most problem drinkers move in and out of their drinking patterns without professional help, but for those who require treatment, a successful programme requires:

- early identification of people with alcohol problems
- 'on the spot' delivery of brief interventions
- referral to appropriate services for assessment and care planning
- treatment tailored to individual needs and motivations, including family support where appropriate
- services for vulnerable and at-risk groups.

'It is generally accepted that the cost of having no treatment is greater than the cost of providing an appropriate, targeted and properly directed programme of treatment services. The essential strategy being to provide 'a little treatment for a lot of people and a lot of treatment for a few' i.e. brief interventions for large populations and more intensive and costly treatment for people who have complex needs, as well as alcohol dependency where need for treatment is clinically indicated'⁴³

10.1 Current Treatment for People in Leeds with Alcohol Problems

Some of the elements of MoCAM² are already in place in Leeds, but considerable investment will be needed if services are to match future demand. The vision for the future is that there will be a seamless, tiered and adequately resourced service in place.

Tier 1 Provision of screening, brief advice and referral:

- The prioritisation and introduction of a systematic pathway for screening, brief advice and referral across primary health care in Leeds.
- Funding from the 'Choosing Health' allocation to employ a further three workers to add to the part time Alcohol Primary Care Support Worker employed through Alcohol and Drugs Services (ADS).
- Leeds Addiction Unit (LAU) to continue also visit patients in the overnight hospital observation wards, and arranges alcohol or drug appointments.

Tier 2 Provision of open access support, assessment and referral:

- Procure and employ a specific Leeds 'Street Agency' for tier 2. The No Fixed Abode (NFA) Health Centre for Homeless People does provide open access for homeless drinkers to tier 2 and 3 levels. Health funding ensures that the client group receive appropriate and holistic care. The Rough Sleepers' service within the NFA is commissioned to work with alcohol users as well as users of street drugs. St Anne's Day Centre also provides a service.
- Provide volunteer peer support training and a group worker for ADS to enable their previous drop-in service to re-open.
- Continue to provide Tier 2 and 3 services for young people under 19.

Tier 3 Provision of community based care-planned treatment:

- Further develop plans to address the growing problem of increasing heavy alcohol abuse by clients also scripted for opiate addiction.
- Increase the capacity for locality based clinics by Leeds Addiction Unit.

Tier 4 Provision of residential/inpatient care-planned treatment:

- Increase the number of residential detoxification beds in Leeds to met increased identified demand.

10.2 Provision for Serious Problem Drinkers Who Wish to Continue

Services and accommodation are very limited for people with a serious drinking problem, and who do not want to stop drinking. Leeds has had sheltered provision for women who choose to continue drinking at Carr Back since 1992, but a need was identified in 2002⁴⁶ for similar provision for older men stating:

'There is a gap in service provision in Leeds for men with serious alcohol problems and with chaotic housing histories or sleeping rough. Well-run wet provision has a beneficial effect on the health of those people who use it, particularly through accessing primary healthcare...'

10.3 Treatment Summary - in Leeds we will:

- **Make early identification of people with alcohol problems.**
- Deliver 'on the spot' brief alcohol interventions. Refer people to appropriate services for assessment and care planning.
- **Develop treatment tailored to differing individual needs and motivations, including support for families where appropriate.**
- Ensure services are effective in helping vulnerable and at-risk groups including heavy alcohol abusers scripted for opiate addiction.
- **Ensure the needs are met of those with Dual Diagnosis – i.e. concurrent mental health and alcohol problems.**
- Seek ways to fund appropriate Tier 4 residential services.
- **Evaluate the need for provision to meet the housing needs of those men 35 and over who do not want to stop drinking. This needs to include both housing support and personal care.**



10. Performance Management, Review & Resources

Performance will be measured by the implementation and monitoring of the strategy by an Alcohol Management Board on behalf of the Safer Leeds and Healthy Leeds Partnerships. This will consist of senior managers and commissioners. Three delivery groups for Prevention, Control and Treatment will also make recommendations to the Board through the Alcohol Delivery Team. They will review their Action Plans on an ongoing basis to ensure they continue to appropriately reflect citywide developments and priorities.

An estimate of some of the resource provision needed to adequately fund proposals is laid out within the attached Delivery Plan.



References

- 1 The 2003 Licensing Act: Alcohol use and Anti-Social Behaviour in England and Wales – Loveday B. (2005)
- 2 'Models of Care for Alcohol Misuse' NHS/NTA (2006)
- 3 Alcohol Harm Reduction Strategy for England' Prime Ministers Strategy Unit – (2004)
- 4 Safe. Sensible. Social. The next steps in the National Alcohol Strategy – (2007)
- 5 Leeds Lifestyle Survey (2002)
- 6 Leeds Evening and Night Time Economy Study - Chesterton (October 2003)
- 7 Cabinet Office Strategy Unit Alcohol harm reduction report (2003) Interim Analytical Report
- 8 United Kingdom Alcohol Treatment Trial (2005) BMJ 311, 541-544
- 9 McElduff P. 'Alcohol - how often matters as well as how much' (1997)
- 10 Alcohol Concern (2003)
- 11 Choosing Health: making healthier choices easier – Dept of Health White paper – (2004)
- 12 Alcohol Needs Assessment Research Project - Dept. of Health (2005)
- 13 Review of the effectiveness of treatment for alcohol problems - NTA (2006)
- 14 Institute of Alcohol Studies 'Drinking in Great Britain' 2006
- 15 The Academy of Medical Sciences (March 2004)
- 16 A Meta-Analysis - Annals of Internal Medicine - Therapy to Prevent Stroke - Hart et al (1999)
- 17 The Impact of Alcohol and Other Drugs in the Workplace - Barnett et al (2006)
- 18 Alcohol and blood pressure in ... BMJ (1997) Kauhanen et al
- 19 Office for National Statistics – March 05
- 20 North West PHO 2007 'Indications of Public Health in the English Regions 8: Alcohol'
- 21 Scientific Select Committee Ghosh, P. (2006) Drug classification rethink urged.
- 22 World Health Report (2002); Murray et al. (2001)
- 23 Source: 2004 Based Population Projection for 2007 (ONS)
- 24 Alcohol misuse among older people – Alcohol Concern (2002)
- 25 Yorkshire and Humber PHO 2007
- 26 'Gan Didean' Homeless Irish People - Leeds Irish Health & Homes (2006)
- 27 Tackling alcohol misuse in prison - Alcohol Concern Quarterly (Spring 2007)
- 28 National Centre for Social Research / National Foundation for Educational Research
- 29 Brain and Parker (1997)
- 30 Datamonitor March 2005
- 31 Portman Group Survey - September 05
- 32 Carvel (2005)
- 33 Alcohol's Adverse Effects on the Brains of Young People. American Medical Association.
- 34 Goodall (2006)
- 35 People who enjoy drinking: findings from a survey of British adults – Plant M and Mason W 02
- 36 R Paterson – West Yorkshire Police Licensing Dept. 2006
- 37 Reed 2004
- 38 Swan & Cooper 2005
- 39 Report of LCC Scrutiny Commission Inquiry into Avoiding Alcohol Misuse (April 2006)
- 40 School-based interventions on alcohol: consultation NICE (2007)
- 41 DfES (2004) Drugs: Guidance for Schools, Departments for Education and Skills
- 42 Bottling It Up (2006), Turning Point
- 43 Review of Effective Interventions for Treatment of Alcohol Misuse- Daryl Bennet (March 2005)
- 44 Alcohol Concern 2000
- 45 Chartered Institute of Personnel Development 2001
- 46 Holder T and Woodhead J - Evaluating the need for a wet hostel in Leeds LCC 2002

'Wasted' Images - pages 23, 25 and 27 - Courtesy of BA Students at Leeds Metropolitan University