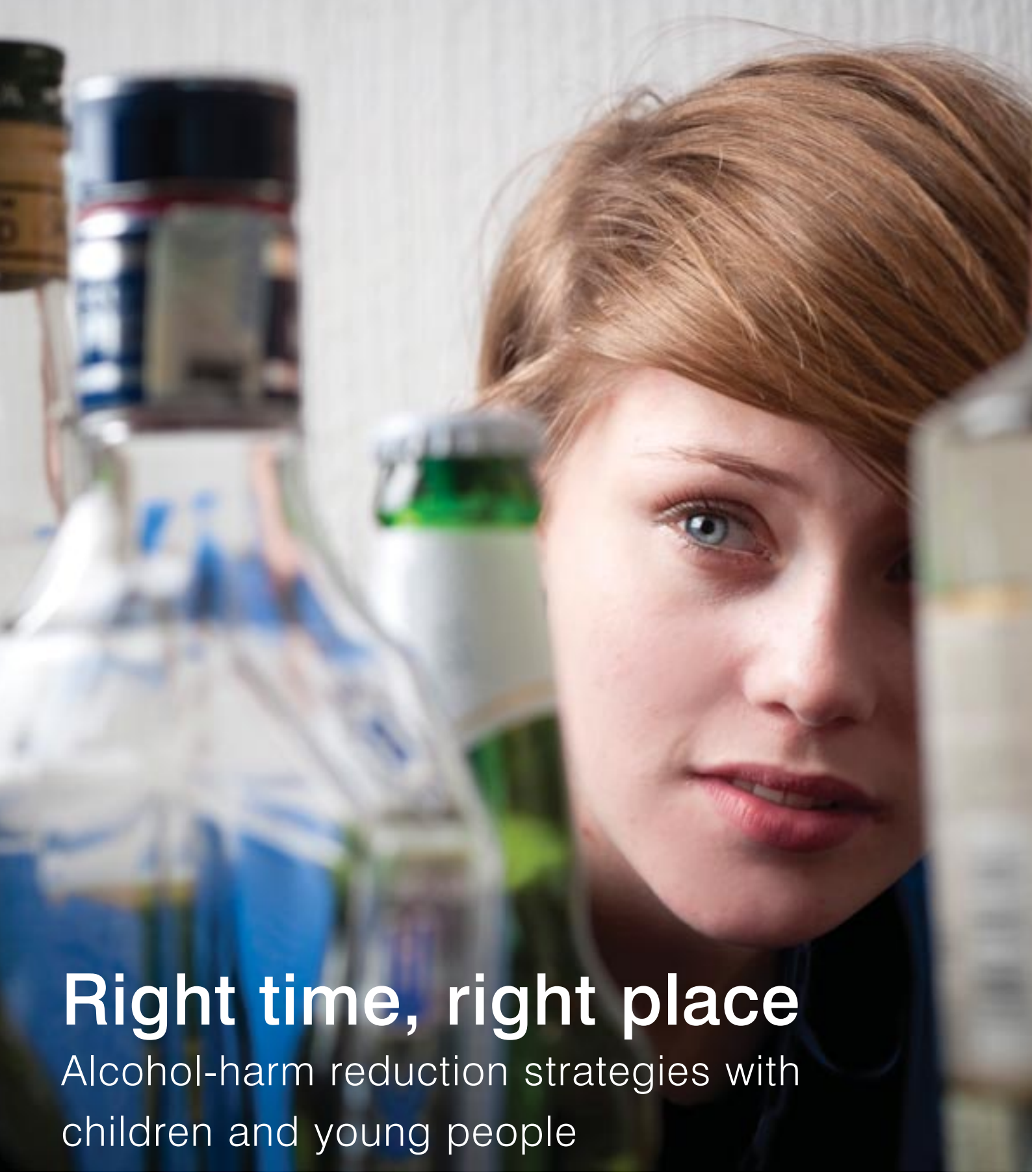

Right time, right place

Alcohol-harm reduction strategies with children and young people

FUNDED BY COMIC RELIEF

the Tudor trust

Alcohol Concern
Making Sense of Alcohol

Alcohol Concern

Alcohol Concern is the national agency on alcohol misuse campaigning for effective alcohol policy and improved services for people whose lives are affected by alcohol-related problems.

Youth Policy Project

The Youth Policy project aims to prevent and reduce harm amongst young people by raising awareness of the key issues affecting young people's relationship with alcohol, influencing government policy nationally and improving models of service delivery locally.

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Contents

Executive Summary

Alcohol consumption by under-18s remains a significant problem for the UK. Underage drinkers consume approximately the equivalent of 6.9 million pints of beer or 1.7 million bottles of wine each week with an estimated 630,000 11- to 17-year-olds drinking twice or more per week. Whilst some indicators suggest the beginning of a decrease in consumption and harm trends, the overall picture from the last five to 10 years is one of increasingly rampant drinking and significant rises in the harms that are associated with alcohol use.

Whilst government policy has often focused on how to tackle alcohol as a public nuisance issue insufficient attention has been paid to the health problems that young people face through consuming alcohol at a time when their bodies are less able to deal with it. Alcohol contributes to 5% of young people's deaths – 1.4% more than in the adult population and in the UK we have the highest rates in Europe of teenage alcohol-related injuries.

Young people are damaging their health at greater levels than ever: between 2002 and 2007 alcohol-related hospital admissions for under-18s increased by 32%. Over the last seven years on average 36 children a day were admitted to hospital due to alcohol (this excludes emergency department (ED) attendances – which would increase this figure significantly).

When we examine these numbers further they show the worrying trend that more girls than boys are attending hospital for alcohol problems. Between 2004 and 2009, 28% more girls were admitted to hospital from emergency departments than boys. Whilst in part this may be accounted for by the female body's reduced capacity to process alcohol it does also point to the fact that women are drinking at higher levels in the adult population, which seems to be also happening in the under-18s population.

Data collection to accurately assess the scale of underage alcohol consumption remains a problem. We have no way of knowing how many children and young people are attending EDs due to alcohol. Whilst hospital staff cannot and should not spend all their time completing paperwork the lack of available data means that both the scale of the problem is going unrecorded and, more importantly, opportunities to intervene and reduce future harm are being missed. More consistent monitoring is needed nationally to assess this problem so that appropriate and proportionate resources are invested to support younger people to make healthier choices for the future. The case for investment is strong.

From the data that is available we estimate that the cost to health and ambulance services due to underage alcohol consumption is in the region of £19 million per annum. The costs of intervention are far less than the costs of treating the health consequences of alcohol misuse by children and young people. As well as making economic sense tackling youth drinking must surely be one of the ways to reduce levels of risky, binge and dependent drinking in the future.

Alcohol is not just a factor in injuries and accidents. High levels of under-18 consumption has also resulted in high levels of children and young people needing to access specialist treatment for tackling alcohol problems including dependence. Last year 8,799 under-18s accessed this form of structured support – over 24 each day.

These worrying statistics paint a picture where alcohol is a considerable health problem for

the children and young people in this country. As a result of increased police enforcement under the anti-social agenda younger people's drinking often takes place in risky, unsupervised environments. Consequently local and national responses have attempted to tackle the problem as a public nuisance issue. Whilst drinking at a young age can be an indicator of the likelihood of a child or young person being involved in crime and disorder, measures which move people on, confiscate alcohol or reprimand those involved do little to tackle underlying attitudes which are leading to youth drinking.

When a person, including children or young people, faces a crisis or problem the opportunity arises for presenting the necessary incentive to change attitudes or behaviours – this is often referred to as the 'teachable moment'. What this report argues is that there may be many such moments, currently being missed, where attitude change can be encouraged in children and young people who get into trouble due to alcohol.

There is a wide body of international research that supports the use of Identification and Brief Advice (IBA) as a way of helping people that are drinking at damaging levels to change their attitude and consequently their behaviour in relation to alcohol. IBA involves simple intervention tools and clear messages (often relating to population normative behaviour) that can be delivered, cost effectively, by non-specialists. Whilst more research is needed to assess the efficacy of existing identification tools and advice aimed at young people, the National Institute for Health and Clinical Excellence is already recommending that IBA be used with under-18s.

Alcohol Concern believes that, once the right research has been undertaken, IBA could be particularly effective with young people during 'alarm bell moments' such as an ED attendance or when in contact with crime reduction agencies. We are adept at patching people up or confiscating their alcohol and sending them on their way but too many children and young people go through these experiences without learning lessons about their drinking or changing their behaviour. At a local level health and crime reduction agencies, substance misuse services and other appropriately trained community and voluntary youth organisations should work together to take advantage of these opportunities to help reduce alcohol-related harm amongst children and young people in their area.

Although some alcohol education in schools does exist it is clear that more than just traditional education is needed to reduce the harm alcohol is doing to our children and young people. Targeting those that experience problems at a time when they are susceptible to learning about behaviour change could be a key strategy for local and national decision makers to begin reversing some of the worrying trends that are a consequence of younger people's drinking.

Recommendations

Targeted harm reduction

- Alcohol Concern believes more research into the efficacy of IBA with young people is needed and cautions against making an assumption of its success based on an adult centred evidence base. The context within which younger people use alcohol is very different to that of adults; this must be reflected in the identification tools, resources, advice and interventions delivered. Evidence based standardisation of behaviour change techniques would improve consistency of delivery.

- Alcohol Concern believes there is need for a developmentally appropriate validated identification tool, specifically for use with young people under 18 in the UK. Existing tools should be used with caution particularly with young adolescents and professional judgement needs to take age into account.
- Alcohol Concern calls for strategies to be developed that ensure that harm reduction is accessible to the most 'at risk' or isolated groups of young people in society.
- Alcohol Concern believes practice could be enhanced nationally by greater sharing of alcohol harm reduction resources, including the pooling of materials amongst services and professionals working with children and young people. Commissioners should look to existing schemes that do this successfully already and seek to replicate.

Sharing responsibility

- Alcohol Concern welcomes National Institute for Health and Clinical Excellence public health guidance and recommends that professionals regularly working with children and young people incorporate responsibility for alcohol harm reduction into their working practices.
- Alcohol Concern believes professionals need to be confident delivering alcohol harm reduction and support and therefore require appropriate training, resourcing and supervision. Delivery needs to be consistent and accurate across all contexts and with all staff.
- Alcohol Concern believes specialist substance misuse services will need to be appropriately resourced to respond to increased identification of alcohol misuse in the short term but that investment in prevention will, in the longer term, reduce costs to a range of public services.

Attendance, admission and call-outs

- Alcohol Concern recommends that alcohol-related attendance at emergency departments should always result in the opportunity to access harm reduction. Emergency departments should work in partnership with localsubstance misuse services where possible.
- Alcohol Concern seeks the national implementation of an effective alcohol monitoring system to ensure consistent recording and reporting of alcohol-related emergency department attendances and ambulance service call-outs, particularly of children and young people. Management of this data is vital for the development of effective needs-based harm reduction responses and for monitoring trends in alcohol harms.

A public health response to unsupervised drinking

- UK Government strategy has primarily reflected a desire to tackle anti-social behaviour rather than public and personal health concern for those misusing alcohol. Alcohol Concern believes that any child or young person using alcohol is putting themselves at risk and that this risk increases considerably when drinking in unsupervised environments. Greater efforts must be made to offer children and young people misusing alcohol in public places harm reduction interventions, as opposed to solely enforcement techniques.
- Crime reduction agencies working on the frontline with young people and alcohol, such as Police Community Support Officers (PCSOs), could contribute more effectively to reducing alcohol-related harms in children and young people by working in partnership at a local level with substance misuse and youth agencies.

Introduction

Over the last 20 years increases in mean alcohol consumption by young people and a reduction in the age of children starting to drink has lead to significant public concern. Drinking patterns in England and Wales, such as drinking to get drunk, are among the worst in Europe[1] despite the indication, in very recent years, of a reduction in the number of 11- to 15-year-olds consuming alcohol[2]. Young people's drinking tends to be less frequent than adults but at a higher intensity[3], one in three 15-year-olds reports consuming over 10 units of alcohol in the last drinking session[4]. Excessive episodic pattern drinking, often termed 'binge drinking', increases the risk of accident, injury and related illness; consequently alcohol-related harm amongst young people is now a major public health problem.

In England in 2008/9 there were almost 13,000 alcohol-related hospital admissions of young people under the age of 18[5], whilst deaths due to chronic liver disease and cirrhosis have increased markedly in the 25-34 year group over the last 30 years[6]. Although cases of dependence amongst underage drinkers are rare, 8,799 children and young people accessed treatment for alcohol in 2008/9, up from 4,886 in 2005/6[7]. Whilst this almost 100% increase in attendance appears alarming it may be due partially to the development of accessible support. However, it is clear that substantial numbers of children and young people drink at risky levels on a weekly basis. Underage drinkers consume approximately the equivalent of 6.9 million pints of beer or 1.7 million bottles of wine each week with an estimated 630,000 11- to 17-year-olds drinking twice or more each week[8].

The Alcohol Concern Youth Policy project, jointly funded by Comic Relief and the Tudor Trust, has examined the delivery of alcohol harm reduction strategies with children and young people. This report responds to the recently published National Institute for Health and Clinical Excellence (NICE) public health guidance, *Alcohol-use disorders: preventing harmful drinking* and seeks to develop implications for policy and practice by identifying some of the next steps in implementation. Key findings from the Youth Policy project consultation seminars provide some practical context and case studies showcase innovative practice that highlights how local services can adapt and respond to identified need. New unpublished data underlines the public health harm of underage drinking and allows for an estimation of the financial cost to primary health care services.

Alcohol Concern welcomes prioritisation of alcohol-use disorder prevention by NICE. Non-alcohol specialists taking greater responsibility for supporting children at risk from their alcohol use and for identification and intervention with young people aged 16-17 will expand the scope of alcohol prevention. However, Alcohol Concern urges caution in pursuing identification and brief/extended intervention with young people, otherwise known as Identification and Brief Advice (IBA), without further research. Greater evidence is required into behaviour change techniques with young people, effective youth-specific identification tools and resources, as well as how to engage the most at risk or vulnerable groups.

Nonetheless, existing research indicates that IBA is likely to be an effective harm reduction strategy with underage drinkers. This report focuses on opportunities to deliver tailored and targeted interventions and support at 'alarm bell moments' when children and young people may be most receptive, namely, after alcohol-related Emergency Department (ED) attendance

and as a result of unsupervised public drinking. In such instances targeted support or IBA with young people would be designed to promote informed and healthy choices through the provision of information and advice at or close to the time/point of need. It will require health services and crime reduction agencies to work collaboratively with local substance misuse services and youth agencies.

During the course of researching this report it became clear that weaknesses in alcohol recording of both the primary and secondary effects of alcohol in EDs and by the majority of ambulance services made monitoring national and regional trends in alcohol harms very difficult. More consistent alcohol recording procedures would reveal a truer picture of the scale of harm and the financial implications of excessive alcohol consumption amongst young people. Working with the data that was available Alcohol Concern conservatively estimates the cost of underage alcohol related hospital admissions, ED attendances and ambulance services call-outs in 2007/8 at almost £19 million. Earlier identification and harm reduction preventative work could begin to reduce this figure.

Existing evidence: Interventions and young people

The Youth Policy project explored the academic research underpinning the issues raised in this report. Leading authorities Eileen Kaner and Bridgette Bewick recently completed a chapter called 'Brief Alcohol Intervention in Young People' to be published in *Young people and alcohol: Impact, policy, prevention, treatment* (JB Saunders & JM Rey eds). This work provides a useful overview of the effects of alcohol on young people and the findings of existing research on brief interventions with young people in health settings. Some of the key conclusions are outlined below:

Alcohol is responsible for 3.6% of worldwide deaths, yet the proportion in young people is 5%[9]. The impact of alcohol on the development and behaviour of young people has been well characterised in early[10] middle[11] and late adolescence[12]. It is now well known that young people are much more vulnerable than adults to the adverse effects of alcohol due to a range of physical and psycho-social factors which often interact[13]. These adverse effects include:

- *physiological factors resulting from a typically lower body mass and less efficient metabolism of alcohol[14, 15]*
- *neurological factors due to changes that occur in the developing adolescent brain after alcohol exposure[16, 17, 18]*
- *cognitive factors due to psychoactive effects of alcohol which impair judgement and increase the likelihood of accidents and trauma[19]*
- *social factors which arise from a typically high-intensity drinking pattern which leads to intoxication and risk-taking behaviour*

All factors are further compounded by the fact that young people have less experience at dealing with the effects of alcohol than adults[20] and they have fewer financial resources to help buffer the social and environmental risks that result from drinking[21]. Individuals who begin drinking in early life have a significantly increased risk of developing alcohol use disorders including dependence later in life[22, 23]. As a result of this extensive array of damage, the prevention of excessive drinking in young

people is a global public health priority[24].

A recent review of interventions to reduce the harm associated with adolescent substance use outlined the positive potential of brief alcohol intervention[25]. It is clear that brief interventions often have positive effects on young people's drinking behaviour and their experience of alcohol-related problems. There is a need, however, to be cautious about brief interventions delivered in health settings since this smaller body of work reported mixed outcomes. One explanation might be that brief intervention trials that have occurred in health settings have included younger adolescents whilst brief interventions in educational and web-based contexts have targeted older adolescents, often attending higher education colleges and universities. Brief intervention trials with older adolescents have reported more consistently positive findings although studies involving brief intervention delivery via web-based technologies are equivocal.

There is currently insufficient evidence to be confident about the use of brief intervention to reduce excessive drinking and/or alcohol-related harm in younger adolescents. However, taken as a whole, the evidence indicates that brief interventions can be effective at reducing excessive drinking and alcohol-related risk in young drinkers. The current evidence-base suggests that the most effective forms of brief intervention are those containing motivational interviewing approaches and elements of personalized feedback about a young person's drinking behaviour, and level of alcohol-related risk.

In conclusion, whilst IBA can be considered likely to be an effective harm reduction strategy with young people further research is still required. Considerably more research is required into brief interventions in health settings and with younger adolescents. The following chapters of this report explore the practice implications of NICE guidance and harm reduction interventions at 'alarm bell moments' such as alcohol-related ED attendance and unsupervised public drinking.

Consultation overview

In early 2010, the Alcohol Concern Youth Policy project delivered six consultation seminars in England and Wales. Held in London, Newcastle, Nottingham, Manchester, Cardiff and Plymouth, the seminars were open to any professional working with children, young people and alcohol. Most of the 150 participants were from local substance misuse services but representatives from the police, health, trading standards as well as a number of young people also attended. Structured around a presentation from a local project or innovator, two workshops and opportunities to contribute to policy discussion, the events sought to gather the views of participants on a range of youth focused alcohol harm related issues. The consultation findings helped shape this report providing an empirical grounding for the policy recommendations by those working with alcohol and young people on a daily basis. Case studies in the report are drawn from practice shared during the consultations and have been chosen to illustrate how services have adapted to respond to need.

Key findings from the consultation events

- Government lacks a clear and coherent

message around young people and alcohol and there is a lack of lead in efforts to reduce alcohol-related harm amongst underage drinkers.

- Tackling younger people's drinking must continue to be a high priority at both local and national level.
- More funding has to be directed towards youth specific preventative work, ring-fenced and responsive to local need.
- There is a need for more youth specific resources when identifying misuse and delivering interventions.
- More research needed into the efficacy of different interventions with children and young people.
- There is strong support for more extensive delivery of alcohol interventions by non-alcohol specialists but only when appropriately trained, skilled, resourced and supervised.
- Existing recording and monitoring of children and young people's alcohol-related attendances at EDs does not provide an accurate picture of alcohol harms and few referrals.
- There must be more effective joint working between crime reduction agencies, emergency departments and local substance misuse services.
- Alcohol misuse by children and young people lacks the profile of illicit drug misuse and therefore the harms of underage drinking are often overlooked.

Chapter 1: Targeted harm reduction

IBA, also known as screening and brief intervention or identification and intervention has, over recent years, become a major focus of policy and practice as a means of reducing alcohol-related harm. Supported by a large body of evidence including 56 controlled trials[26], research with adults indicates that for every eight people who receive simple alcohol advice, one will reduce their drinking to within lower risk levels[27]. Increasing risk and higher risk[28] drinkers who receive brief advice are twice as likely to moderate their drinking six to 12 months after an intervention when compared to drinkers receiving no intervention[29]. Research into the efficacy of IBA with young people is less extensive, yet support for the methodology is increasingly reflected in policy that identifies IBA as economically expedient. Recently published NICE public health guidance: *Alcohol use disorders: preventing harmful drinking* (2010) identifies the prioritisation of identification and brief interventions as an alcohol use disorder prevention strategy 'invest to save' measure with young people[30]. Significant increases in underage alcohol consumption over the last two decades reinforce the need for effectively applied alcohol harm reduction strategies aimed at younger drinkers. The National Audit Office states that early alcohol intervention and a greater focus on prevention may result in the reduction or avoidance of further alcohol-related illness and associated costs to the state[31].

For a number of reasons IBA could prove to be an effective alcohol harm reduction strategy with young people. By definition 'brief', IBA can be delivered anywhere and does not require attendance at a formal 'treatment' service which may carry stigma. After appropriate training, IBA can be delivered by non-alcohol specialists within the general young people's workforce and in wider settings, enabling those who have existing relationships with young people to take responsibility and avoiding unnecessary referrals to local substance misuse services. Targeted intervention, particularly at 'teachable moments' when younger people may be particularly receptive could encourage more healthy and informed choices about alcohol. However, whilst IBA has been proven and is widely accepted as a cost-effective method of reducing drinking among adult cohorts[36] [37], its efficacy with young people is less clear. Almost all of the existing research into IBA with young people is

What is IBA?

IBA is the process of identifying harmful alcohol use and the provision of advice or intervention to address and reduce consumption. Excessive or problematic drinking is 'identified' by completing a simple (and often short) alcohol use identification tool or screening questionnaire with the recipient. Where excessive drinking is identified, tailored brief advice is delivered designed to communicate alcohol harms and encourage reduced consumption. It is not treatment for alcohol misuse[32] and it is not effective or designed to be used with dependent drinkers[33]. Brief advice is generally opportunistic, lasting 5-15 minutes consisting of short, structured informative advice. Brief advice is generally delivered by non-specialist professionals without an addiction or alcohol specialism and ranges from the simple provision of an informative leaflet, to one-to-one sessions and motivational interviewing that examines risk-taking behaviour and identifies reduction goals[34]. Often the FRAMES[35] approach is used when delivering brief advice which is designed to encourage personal reflection.

based on work done in the United States, predominately with Caucasian students. Alcohol Concern believes more research into the efficacy of IBA with young people is needed, particularly with 'at risk' and vulnerable groups, and cautions against making an assumption of its success based on an adult centred evidence base. The context within which children and young people use alcohol is very different to that of adults and this must be reflected in the tools, advice and interventions delivered. Greater research into behaviour changes techniques with young people is required in order to standardise IBA and ensure consistency otherwise there is a real danger that delivery will vary between practitioners.

Identification

NICE recommends the use of a validated alcohol-screening questionnaire such as Alcohol Use Disorders Identification Test (AUDIT), Car Relax Alone Family Friends Trouble (CRAFFT), Single Alcohol Screening Questionnaire (SASQ) or Fast Alcohol Screening Test (FAST) when working with young people aged 16 and 17 who are thought to be at risk from their alcohol use[38].

The Alcohol Concern Youth Policy project consultation findings indicate a high level of dissatisfaction amongst those working with young people with existing identification tools. Whilst the identification tools recommended by NICE have adequate validity[39] when used with young people, research indicates they are less reliable at accurately identifying alcohol usage than when used with an adult cohort. AUDIT, the most commonly used tool, was primarily developed to be used with adults and does not specifically address the needs of a younger cohort. A 2003 comparative study found that AUDIT and CRAFFT were less effective at identifying alcohol usage with young people aged 14 to 18 than when used with an adult cohort, although they did have an 'acceptable' level of sensitivity (percentage of positive cases that tests correctly identify)[40]. FAST has a proven validity and is reliable for use with adults but research indicates that it is not as accurate in detecting misuse in under-25-year-olds as it is with people aged over 25, and it is deemed unsuitable for use with under-16-year-olds[41].

NICE recommends that professionals with a safeguarding responsibility in regular contact with children and young people aged 10 to 15 at risk from their use of alcohol exercise their professional judgement to deliver alcohol-related interventions and support.

In 2008/9, 7,537 children and young people under the age of 16 accessed treatment for alcohol as a primary or additional substance[42]. Children and young people are starting to drink earlier than ever. The NICE guidance omits recommending the use of identification tools with young people aged 10 to 15, however findings from the Youth Policy project consultation seminars indicate that in practice professionals are using identification tools with younger people. Very few existing identification tools take into account age weighting in their scoring systems: for example, a 13-year-old consuming 15 units a week would elicit the same score as a 17-year-old consuming the same amount, or even a 45-year-old. Clearly, such a level of alcohol consumption is significantly more concerning amongst a younger adolescent cohort. This places greater weight on the professional judgement and experience of the professional involved, maybe more than can be reasonably expected. Such an approach, at the very least, would lead to inconsistent application across the country.

Nearly 60% of participants in the consultations used identification tools developed locally by substance misuse services or had adapted existing tools deemed to be unsatisfactory. Most adapted tools were redesigned to be more youth friendly and to suit local needs; yet, very few (if any) have been scientifically validated. Consequently their efficacy and validity in indentifying problematic alcohol use among young people is unproven.

It is highly likely that the use of adult centred and/or unvalidated identification tools with young people will result in inaccuracies. A 2009 Greater London Authority report concluded that 'young people respond to a different range of questions than adults'[43] and further studies identify the need for 'developmentally appropriate' age suitable tools[44]. Alcohol Concern believes there is need for a developmentally appropriate validated identification tool specifically for use with under-18s in the UK. Furthermore, Alcohol Concern believes existing tools should be used with caution particularly with younger adolescents. Professional judgement needs to take into account the age of the child receiving an identification test.

Brief advice

NICE guidance based on a robust examination of existing evidence recommends that any 16- or 17-year-old identified as drinking hazardously or harmfully should be offered a brief or extended brief intervention[45].

A review of the literature concluded that brief advice with adults is effective irrespective of the form or setting in which it is delivered, that the effects of brief advice can last up to two years after an intervention and that it can reduce alcohol-related mortality[46]. Existing evidence suggests brief advice broadly has a positive effect with young people. The type of message and methods of delivery which are most effective at changing behaviour remain unclear although research suggests that normative, personalised feedback[47] and motivational interviewing[48] approaches can be of particular benefit to young people.

Professionals consulted reported that messages designed to reach the 'adult' population, such as long-term health messages, do not work as effectively with younger people and called for greater investment into research around behaviour change approaches with young people. Alcohol Concern supports the call for greater research into brief advice to ensure the most effective behaviour change techniques are delivered consistently.

Notably, evidence supporting the use of brief advice with younger adolescents remains weak and we must be more cautious about drawing positive conclusions about its use with this age group without greater study[49]. Professionals delivering IBA need to be aware of the increased risk faced by certain groups such as looked-after children. Age appropriate brief advice needs to be developed that is tailored and accessible to all groups, for example those with poor literacy or black minority ethnic communities.

Professionals consulted reported that many had developed their own youth-specific resources that generally focused on risk, vulnerability, and short- and medium-term health effects (such as weight gain, skin damage, and fertility and hormone changes) rather than long-term health risks. Youth appropriate materials were felt to be visual, engaging and with little text written in age appropriate language. Interactive resources such as beer goggles, unit wheels, drink

diaries and unit measures were reported to be particularly useful during delivery of brief advice to young people. These resources are generally expensive to purchase and often low budgetary priority. Consultation participants indicated that a lack of funding for appropriate resources was a key barrier to effective work with young people. Alcohol Concern believes practice could be enhanced nationally by greater sharing of alcohol harm reduction resources, including the pooling of materials, amongst services and professionals working with children and young people. The following case study of an innovative regional health promotion library highlights a practical way in which these barriers to delivering IBA with young people can be overcome.

Case study 1: Health Promotion Resource library, Cornwall & Isles of Scilly

The Health Promotion Information and Resource Library is a free-to-use supply and loan service of health promotion resources. Resources can be viewed and easily booked via a comprehensive catalogue on the 'Virtual Library.' The library receives £15,000 a year in funding from the PCT and has over 5,600 users.

There are over 240 alcohol specific resources available including books, games, leaflets, posters, DVDs, educational training packs and interactive models. In 2009/10, the service lent over 90 alcohol specific resources and supplied over 870 alcohol leaflets and posters. Over the last year, it is estimated that local agencies using the library saved over £9,000, based on the cost of purchasing items that were borrowed. Professionals who use the service include the police, colleges and schools, healthcare workers, carers and youth workers. Users are able to filter their search for age-suitable resources. Some of the most popular youth resources include:

- Drink impairment goggles (interactive model)
- Drunk buster glasses and car set (inter-active model)
- Heavy drinking: How alcohol's calories add up display (interactive model)
- Binge drinking blowout (DVD)

Recommendations

- Alcohol Concern believes more research into the efficacy of IBA with young people is needed and cautions against making an assumption of its success based on an adult centred evidence base. The context within which younger people use alcohol is very different to that of adults and this must be reflected in the identification tools, resources, advice and interventions delivered. Evidence based standardisation of behaviour change techniques would improve consistency of delivery.
- Alcohol Concern calls for strategies to be developed that ensure that harm reduction is accessible to the most 'at risk' or isolated groups of young people in society.
- Alcohol Concern believes practice could be enhanced nationally by greater sharing of alcohol harm reduction resources, including the pooling of materials amongst services and professionals working with children and young people. Commissioners should look to existing schemes that do this successfully already and seek to replicate.
- Alcohol Concern believes there is need for a developmentally appropriate validated identification tool, specifically for use with young people under 18 in the UK. Existing tools should be used with caution particularly with young adolescents and professional judgement needs to take age into account.

Chapter 2: Sharing responsibility

Between 1990 and 2006 the average weekly consumption of alcohol by 11-15-year-olds more than doubled, from 5.3 units per week to 11.4 units a week[50] (method of calculation changed in 2007 effecting comparison from this point). Since 2005 the number of under-18s accessing treatment for alcohol use has steadily risen[51] - 37% of children and young people who accessed treatment in 2008/9 did so for alcohol misuse[52]. NICE guidance seeks to place greater emphasis on prevention by expanding responsibility for alcohol harm reduction. Alcohol Concern agrees this will be an efficient 'invest to save' measure, however, it must be coupled with ensuring that substance misuse services are sufficiently resourced to respond to the 'likely increase' in the immediate number of referrals caused by increased identification. In the longer term this will result in reduced alcohol harms and lower costs to public services.

In recent years government has sought to put the needs of children and young people at the heart of policy, stressing the workforces' welfare responsibilities. Alcohol Concern welcomes that NICE clearly places responsibility for alcohol harm reduction with professionals working regularly with children and young people in both universal and targeted workforces.

NICE recommends that 'any professional with a safeguarding responsibility, who regularly comes into contact' with children and young people aged 10-15 at risk from their alcohol use should take action[53].

NICE recommends that identification and intervention with 16- and 17-year-olds should be undertaken by 'health and social care, criminal justice and community voluntary professionals in both NHS and non-NHS settings who regularly come into contact with this group'[54].

Universal and targeted workforces better skilled at identifying alcohol misuse, delivering basic interventions and referring to specialist substance misuse services would improve health outcomes for children and young people. However, such professionals will need to be appropriately supported and skilled through access to inexpensive training, appropriate supervision, knowledge of local services and pathways and the provision of/access to evidence based youth-specific tools and resources. Young people's substance misuse services would be well placed to support non-alcohol specialists deliver alcohol harm reduction and they should think innovatively about how they can best do this, for example through the development of training or individual case support mechanisms. The case study, which follows later in the chapter, highlights how local substance misuse services can promote consistency in harm reduction delivery. In the longer term more effective and consistent alcohol identification may allow specialists to focus on the more problematic cases.

Youth Policy project consultation findings uncovered strong support for the delivery of harm reduction interventions by non-alcohol specialists amongst professionals working in the sector. Moreover, professionals consulted strongly believed that those working in the children's and young people's workforces had a responsibility to recognise and tackle alcohol misuse and identified a number of specific roles that could be well placed to deliver alcohol harm reduction interventions such as; school nurses; health professionals including General Practitioners and ED staff; youth workers and Police Community Support Officers (PCSOs).

The next two chapters each focus on an opportunity to engage children and young people misusing alcohol in harm reduction, i.e.

ED attendance and underage unsupervised drinking in public spaces. Consultation participants strongly believed that alcohol-related ED attendance should always result in the opportunity to access harm reduction. Consultation participants identified PCSOs, responsible for addressing anti-social behaviour and low level offending, as potentially important because they often have contact with young people in drinking hotspots. These contacts are often informal and unrecorded and may present an opportunity to engage a hard to reach cohort. Alcohol Concern believes ED staff and PCSOs respectively could have a pivotal role to play in delivering interventions or working in partnership to enable effective pathways to intervention.

Case study 2: 360˚ Young People and Families Substance Misuse Service, Bolton

Last year half of all referrals to 360˚ were for alcohol. 360˚ has developed a rolling multi-agency training package focused on alcohol awareness and IBA open to all Tier 2 workers and anyone who works on a one-to-one basis with young people.

The training is designed to provide the knowledge and skills necessary to deliver consistent and appropriate interventions aimed at reducing young people's alcohol use. The approach fits with Bolton's broader alcohol strategies and focuses on the identification of risk and vulnerability, highlighting the appropriate referral pathways to specialist services. The 360˚ Tier 2 Coordinator is available to provide in-depth support, ongoing consultation and further resources to improve the practical implementation of alcohol interventions.

'We wanted to ensure the staff working at agencies such as the Youth Service, Connexions and Youth Offending Teams but also the Police and PCSOs have the skills and knowledge to deliver appropriate and effective alcohol information. As a service we (360˚) wanted to ensure we had a level of quality control over this delivery.'
360˚ Team Leader and Clinical Lead

Recommendations

- Alcohol Concern welcomes National Institute for Health and Clinical Excellence (NICE) public health guidance and recommends that professionals regularly working with children and young people incorporate responsibility for alcohol harm reduction into their working practices.
- Alcohol Concern believes professionals need to be confident delivering alcohol harm reduction and support and therefore require appropriate training, resourcing and supervision. Delivery needs to be consistent and accurate across all contexts and with all staff.
- Alcohol Concern believes specialist substance misuse services will need to be appropriately resourced to respond to increased identification of alcohol misuse in the short term but that investment in prevention will, in the longer term, reduce costs to a range of public services.

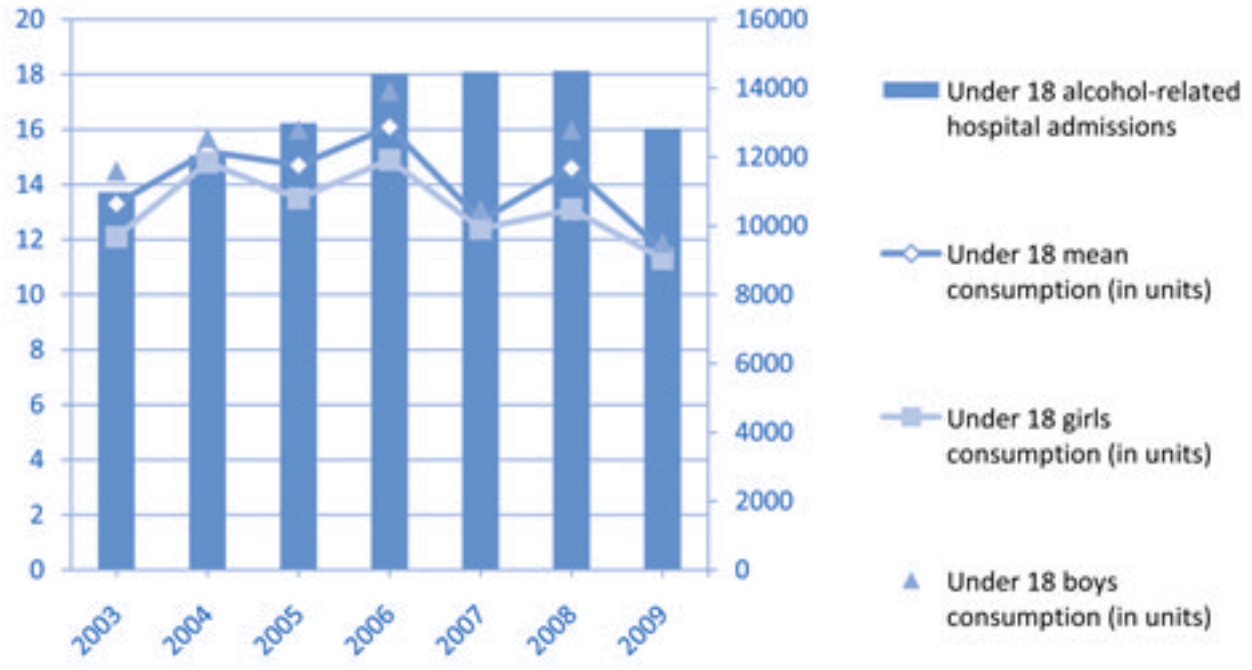
Chapter 3: Attendance, admission and call-outs

Since 2003, with the exception of 2007, trends in young people's alcohol consumption have broadly mirrored the numbers of children and young people seeking alcohol-related medical treatment. The number of under-18 alcohol-related hospital admissions increased 32% between 2002 and 2007[55]. Analysis of regional ambulance service records also indicates a sharp rise in incidences between 2005 and 2007, then a dropping off in line with consumption levels from this peak. In the last five years the London Ambulance Service (LAS) has responded to 11,780 incidents involving underage drinkers[56]. Unfortunately, due to weaknesses in recording, accurate alcohol-related ED attendance data is not available. Nonetheless, it is clear that each year considerable numbers of younger people have alcohol-related contact with health services and such contacts represent an opportunity to deliver harm reduction interventions. Research, primarily with adults, suggests the delivery of IBA in primary healthcare settings is effective at reducing alcohol consumption in increasing and higher risk drinkers[57] and that EDs are important venues in which alcohol misuse can be addressed[58]. The evidence base is less robust around IBA with young people in health settings than with adults and greater research is certainly required, but it is reasonable to expect that alcohol interventions at 'alarm bell moments', such as ED attendance, can have positive outcomes.

Emergency departments

Alcohol consumption results in children and young people, like adults, attending EDs both as a result of the primary effects (i.e. intoxication, poisoning etc) and the secondary effects (increased likelihood of accidents, assaults etc). The latest European School Survey Project on Alcohol and Other Drugs reported that in the UK 26% of 11- to 15-year-olds reported suffering an accident or injury

Figure 1: Hospital admissions and consumption trends



Sources: HES and Survey of Smoking, Drinking and Drug Use among Young People in England 2001-2009 (National Centre for Social Research)

because of their drinking, the highest percentage in Europe[59]. Within this group 3% reported that they had been hospitalised or admitted to an emergency room during the last 12 months, due to alcohol consumption[60]. The Isle of Man reports the highest percentage of young people being hospitalised or attending an ED due to alcohol use, double the European average[61].

For most children and young people, alcohol-related ED attendances are one-off incidents from which lessons are learnt and, although extremely concerning, are not necessarily indicative of an extended pattern of alcohol misuse or dependency. However, a 2007 Scottish audit of EDs identified a small number of young people attending more than once for alcohol-related treatment, with one patient attending on three occasions over a six-week period[62]. ED attendance could be an opportunity to provide harm reduction to a hard-to-reach cohort of young people. For some young drinkers, particularly those attending more than once, early identification may improve the quality of clinical and other outcomes, reducing ED re-attendance and lowering future impact on health services. The case study at the end of this chapter highlights how a young people's substance misuse service in South Tyneside works innovatively with the local ED to target alcohol-related attendances. However, this is a relatively rare example of effective joint working between EDs and local substance misuse services. Alcohol Concern believes that for children and young people an alcohol-related ED attendance should always result in the opportunity to access harm reduction and support. Opportunities for partnership with local substance misuse services means EDs could improve harm reduction without significantly adding to their workload.

Currently the weakness of national ED alcohol data obstructs the development of effective needs-based alcohol-harm reduction responses by government, substance misuse services and health agencies. Hospital Episode Statistics (HES), the national health statistics data source, is only able to provide data on ED attendances with a primary diagnosis of 'poisoning (including overdose)' of substances that include alcohol. Between 2007 and 2009, 25,767 children and young people under the age of 18 attended an ED with this primary diagnosis. However this data is inclusive of all poisoning episodes (for example accidental ingestion of bleach)[63] it does not allow for isolation of alcohol alone as a cause for attendance and is therefore of limited use, yet is the only nationally recorded alcohol ED data available.

In response to the lack of useful centrally collected data Alcohol Concern sent Freedom of Information requests to 27 NHS Hospital and Foundation Trusts in England and Wales for alcohol-related ED data on children and young people. Only seven provided publishable data of varied quality that reflected inconsistencies in recording and reporting. Alcohol Concern concludes that it is not possible to get an accurate regional or national picture of alcohol-related ED attendance in England for the under-18 age group. Nor is it possible to reliably or accurately analyse trends or patterns in alcohol-related ED attendance. Given that it is estimated that at peak times eight out of 10 people needing treatment at EDs have alcohol-related injuries or problems[64], Alcohol Concern questions how an effective needs-based response can be developed in the absence of accurate data.

The most comprehensive UK based evidence study, the 2007 six-week audit of 21 Scottish

EDs, provides an illuminating and concerning picture of alcohol-related attendances by underage drinkers with 669 recorded during this period[65]. In the absence of a comparable English study a subsequent Department for Children Schools and Families report applied an extrapolation of these figures to the English population concluding that approximately 1,245 young people attend EDs weekly for alcohol-related treatment, the equivalent of 64,750 per year[66]. Clearly these calculations need to be viewed with caution; Scotland has a different drinking culture to England. Nonetheless, at the very least the magnitude of the figures underlines the need for a similar study in England. Alcohol Concern is disappointed that, at present, most EDs do not provide access to alcohol harm reduction, nor accurately or consistently record alcohol-related attendances.

Ambulance services

Ambulance services often represent the beginning of a chain of emergency health care and treatment for both young drinkers and adults alike. Alcohol Concern contacted all 12 English Ambulance NHS Trusts and the Welsh Ambulance Service NHS Trust three were able to provide data for alcohol-related call-outs involving children and young people under the age of 18. Trusts that responded cautioned against the accuracy of their own recording, and warned that the data was most likely conservative and lower than the reality. In 2009/10, the West Midlands Ambulance Service attended 1,296 alcohol-related call-outs for under-18s at an estimated cost of £247,536[67]. Almost 70% of call-outs were then transported to hospital for further treatment. Between 2005/6 and 2009/10 the London Ambulance Service responded to over 11,780 alcohol-related call-outs for 10-17-year-olds at an estimated cost in excess of £2,592,600[68].

Based on information provided by the three ambulance services the estimated mean cost nationally of each ambulance call-out is £198. The three services cover 14.9million people, 27.6% of the estimated population of England and Wales, and responded to 4,527 incidents involving alcohol and younger people in 2009/10. A basic extrapolation of the figures to a national scale suggests that last year ambulance services in England and Wales would have responded to 16,387 such incidents, at a cost of £3,244,462. These figures need to be treated with caution, in the absence of clear recording and reporting guidance there are likely to be inconsistencies in how ambulance services define alcohol-related call-outs, nevertheless the data and figures provided are likely to be conservative. In the absence of more accurate data this calculation provides

Table 1 : 2009/10 Ambulance service data: Alcohol-related calls-outs involving children and young people under-18

Ambulance Trust	Year	Total Responses	Male	Female	Blank	09/10 cost (estimated)
West Midlands	2009/10	1,296	587	646	63	£247,536
London	2009/10	2,286	989	1,292	5	£502,920
North East	2009/10	945	432	427	86	£174,976

an approximate snapshot of the substantial burden on ambulance service resources caused by underage drinkers nationally. More consistent recording and reporting would illuminate the true scale and cost of underage drinkers on public emergency response services.

Hospital admissions

Hospital admission recording is more consistent and reporting more robust than in EDs and ambulance services. Between 2002 and 2009, 92,220 children and young people aged under-18 were admitted to hospital in England for alcohol-related conditions, on average over 36 children or young people per day[69]. This period is marked by a 32% increase between 2002 and 2007 and subsequent decline[70]. However, North West Public Health Observatory methodology for calculating the secondary effects of alcohol (partly alcohol attributable data) included in alcohol-related data is not applicable to those aged under-16. Therefore it should be noted that these calculations are likely to be conservative and not a true reflection of the total number of children and young people being admitted to hospital for alcohol-related conditions.

Analysis of alcohol-specific data throws up some interesting variances. A regional break-down of the 21,288 children and young people aged under-18 admitted to hospital with alcohol specific conditions in England between 2006 and 2009 indicates that the North West experienced the highest rates with 4,912 young people admitted, accounting for 23% of the national figure[71]. The East of England experienced the lowest admission rates with

Figure 2: Wholly and partly attributable hospital admissions for 16 and 17 year-olds by gender and region (2008/09)

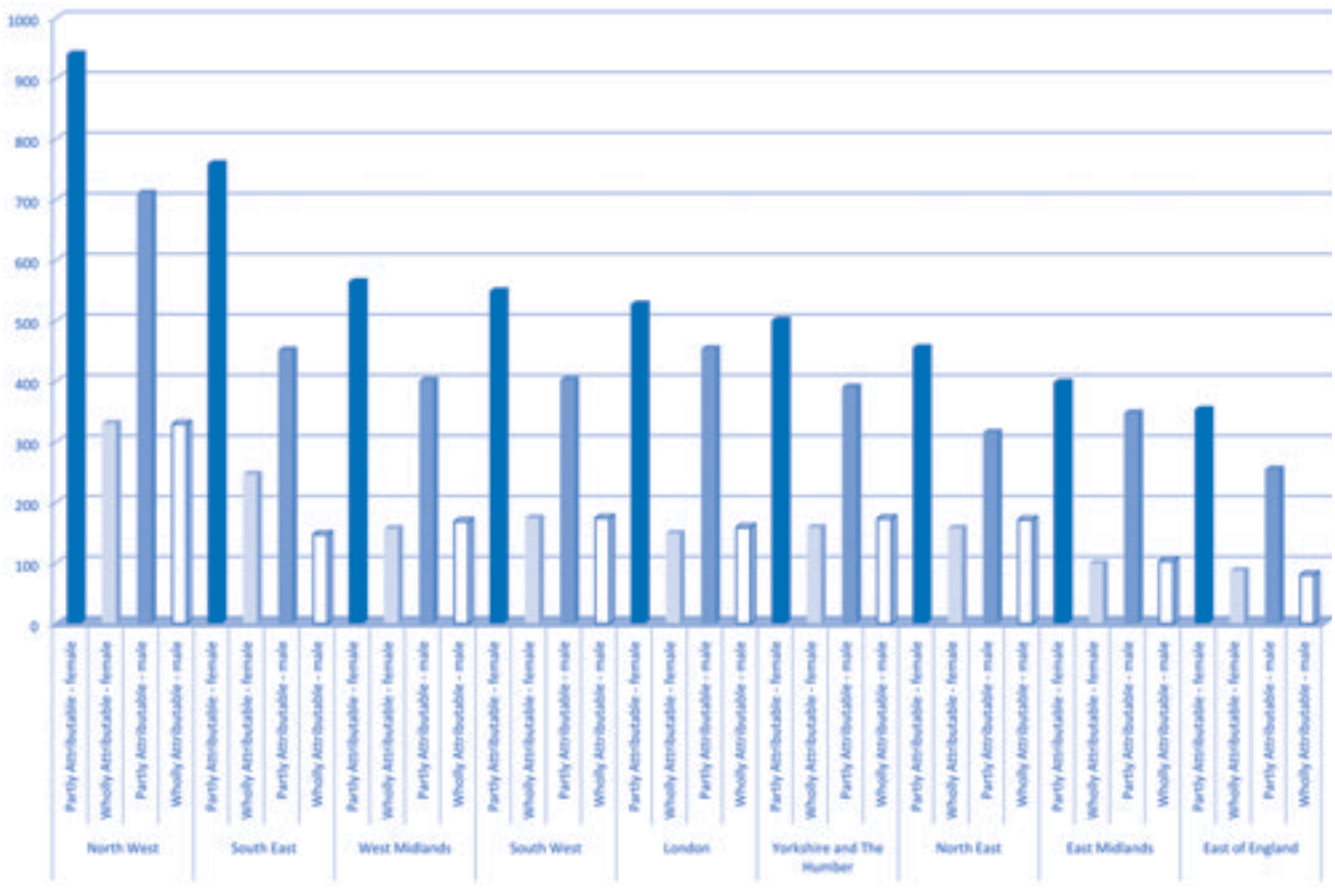


Table 2: Estimated cost of underage drinkers to primary health care services 2007/8

	Annual alcohol-related incidents	Average cost per incident	Total annual costs
Ambulance call-outs	23,254	£198	£4,604,292
Hospital admissions	14,501	£532	£7,714,532
ED attendances	64,750	£100	£6,475,000
		Estimated Total Cost:	£18,793,824

1,384 under-18s admitted for alcohol specific conditions[72]. Between 2004 and 2009 28% more young women than young men were admitted to hospital via EDs for alcohol specific conditions- 23,347 under 18 young females compared to 18,159 young males[73]. Girls are therefore 1.3 times more likely to be admitted to hospital via EDs for alcohol specific conditions than boys. Figure 2, HES data for 16 and 17 year olds with North West Public Health Observatory fractions applied, underlines the variances in alcohol data along regional and gender lines and underlines why harm reduction strategies should be responsive to local needs.

In order to get a true picture of the impact of youth drinking NHS Trusts need to accurately and consistently record the primary and secondary effects of alcohol consumption. Improved recording is vital for the earlier identification of risk and increases opportunities for partnership working based on shared information. The Cardiff Model, founded by Professor Jonathon Shepherd, exemplifies how EDs and hospitals can adapt their recording procedures and work collaboratively to more effectively respond to need. Using the model new recording mechanisms systematically record ED attendance data relating to alcohol-related violence and harm. This information is anonymised, analysed and shared with partner agencies such as the police, trading standards and health strategists who work jointly to develop alcohol-related harm reduction strategies. The impact has been a 20% decline in alcohol-related crime in Cardiff in seven years[74]. The Cardiff Model demonstrates how accurate and consistent recording, data sharing and partnership working can underpin effective preventative work.

A small number of Trusts, recognising the impact of alcohol on their services, have introduced recording procedures such as simple 'tick boxes' on patient forms to monitor alcohol. The Alder Hey Children's Hospital case study at the end of the chapter highlights how accurate alcohol recording can support the delivery of brief interventions with younger people. However, joined up responses are rare. Alcohol Concern urges the Department of Health to consider the implementation of accurate and consistent alcohol recording and reporting requirements across the health service, particularly in EDs and by ambulance services. Consistent identification of younger people's alcohol-related contact with health services will facilitate the development of more effective needs-based harm reduction responses. Through improved partnership working, especially with local substance misuse services, such responses do not need to create an additional burden for NHS staff.

Weaknesses in alcohol recording and reporting

also mean that it is difficult to accurately calculate the financial cost of underage drinkers on emergency health services. Yet, what is clear is that underage alcohol consumption puts a considerable strain on the resources of health services. Based on figures presented in this chapter, Alcohol Concern conservatively estimates that in 2007/8 underage alcohol-related hospital admissions, ED attendances and ambulance service calls-outs cost health services almost £19 million. In order to reduce this financial cost health services need to move collaboratively from simply 'response' towards prevention, working in partnership with local specialist services where possible.

Case study 3: Matrix Young People's Service, South Tyneside

'If there is a need, you need to provide something! It's about working differently.'
Matrix, Manager

In early 2010, Matrix began targeted work to tackle under-18-year-old alcohol-related attendances at South Tyneside District Hospital ED. The service already had an established referral system for alcohol-related hospital admissions but no support mechanisms in place within the local ED. Matrix were concerned that opportunities were being missed to engage and support young people at risk.

'What we try and do is take the onus from the ED staff. We acknowledge they have enough to do treating the injury caused by the drinking, the (alcohol) may not be the priority at that time. We've tried to make it as simple as possible and we're doing the legwork and making it easier to address alcohol use.'
Matrix, Manager

A nurse based at Matrix but employed by the Trust, screened patient records for young people's alcohol-related attendances including where alcohol was a contributory rather than primary cause. Those identified are sent a letter offering an appointment at Matrix as well a leaflet about the service and broader alcohol information. This process reduces responsibility on clinicians and hospital based nurses to instigate referrals.

'It was a joint approach to something that could collectively benefit both services by reducing the amount of young people presenting at the ED.'
Matrix Manager

Over a six-month period Matrix identified 26 young people who attended South Tyneside Hospital as a result of their drinking - 18 due directly due to consumption (poisoning, over-dose etc) with eight due to secondary effects of alcohol (self harm, assault etc).

'We want to identify these young people early on and see what provision we can put in place that might prevent things from becoming more problematic.'
Matrix Manager

A service-users story (name changed to protect identity)
'Sarah, 15, attended the ED at midnight vomiting and with a cut leg after a night drinking alone in a park. She started drinking to cope with a family breakdown and was now drinking white cider and vodka alone three to four times a week. After her presentation at the ED Matrix contacted Sarah offering an initial appointment, the first time she had been offered any intervention for her drinking. Sarah attended 12 sessions at Matrix and has significantly cut down her drinking. She now only has a few drinks on occasions with friends.'

Case study 4: Alder Hey Children's Hospital, Liverpool

'We didn't know of brief intervention work [with young people] going on anywhere else, so we thought let's do it ourselves.'
Lead Alcohol Nurse

In 2004 Alder Hey established a brief intervention clinic and introduced a clinical care pathway, integrating alcohol harm reduction work into the daily operations of the hospital. The clinic receives £7,000 funding from the Liverpool Drug and Alcohol Action Team annually, which employs three Band 6 nurses for three hours a week to run the clinic. Over 839 under-16s have presented at the ED for alcohol-related conditions, of which 214 attended the brief intervention clinic[75].

'The majority of these young people are not people who are chronic abusers with massive issues, so it's not appropriate to refer them into a specialist service, but what we wanted to do was a little bit of brief intervention.'
Lead Alcohol Nurse

Alder Hey introduced 'alcohol-related' coding into the hospital's recording systems that captures not only the primary but also the secondary effects of alcohol. The comprehensive coding facilitates more consistent intervention and provides more accurate alcohol data. Every young person who attends the ED for an alcohol-related problem is screened using an identification tool, given an information pack (containing health promotion leaflets, alcohol information and contact details of local specialist services) and offered a follow-up appointment at the clinic within a week. At the clinic qualified nurses trained in motivational interviewing deliver harm reduction information. Since the implementation of the brief intervention clinic, alcohol-related attendances at the ED have consistently decreased, from a peak of 210 attendances in 2005 to 64 attendances in 2009.

Recommendations

- Alcohol Concern recommends that alcohol-related attendance at emergency departments should always result in the opportunity to access harm reduction. Emergency departments should work in partnership with local substance misuse services where possible.
- Alcohol Concern seeks the national implementation of an effective alcohol monitoring system to ensure consistent recording and reporting of alcohol-related emergency department attendances and ambulance service call-outs, particularly of children and young people. Management of this data is vital for the development of effective needs-based harm reduction responses and for monitoring trends in alcohol harms.

Chapter 4: A public health response to unsupervised drinking

Alcohol consumption at a young age is linked to a range of poor outcomes including anti-social behaviour and offending. The exact relationship is complex and unclear but the consumption of alcohol clearly increases risk of such behaviour. A National Centre for Social Research survey found that in England of 11- to 15-year-olds who had drunk in the last four weeks 8% of boys and 7% of girls reported getting into trouble with the police after drinking[76]. Further study of 11- to 16-year-olds conducted in 2008 indicated an increase in those citing being drunk or drinking alcohol (20% in 2008 versus 16% in 2005) as a reason for committing an offence in the last year[77]. Notably, the prevalence of violent offending is higher among those who drank at least once per week (39% reporting that they had committed a violent offence in the previous 12 months) than those who had not drunk alcohol in the past 12 months (11%)[78]. A Scottish self-reporting study concluded that the most noticeable difference between young offenders and adults is the much higher levels of drunkenness at the time of committing the offence. While just over four in 10 adults (44%) were drunk at the time of the offence, three-quarters of young offenders (77%) reported inebriation at the point of committing their offence[79].

In 2008 the Government responded to public concern around the impacts of teenage drinking by introducing the Youth Alcohol Action Plan (YAAP). The YAAP made an explicit link between unsupervised public drinking by children and young people and anti-social behaviour and crime and proposed a number of measures to curb such behaviour. Despite the introduction of legislation aimed at tackling public drinking and the possession of alcohol, considerable numbers of young people continue to regularly misuse alcohol in public spaces. The proportion of 11- to 15-year-olds drinking in public on the street, in a park or somewhere else may even be continuing to rise - it reached 34% in 2008[80]. A significant proportion of these young people will be drinking in known hotspots and have regular informal and unrecorded contact with crime reduction agencies, PCSOs in particular, but never be offered harm reduction interventions. The case study at the end of this chapter, Operation Park in Brighton and Hove, highlights the potential of working in partnership to tackle unsupervised drinking between the police, PCSOs, outreach youth workers and young people's substance misuse professionals. Information shared between agencies results in targeted and tailored responses appropriate to the level of individual need.

For the minority of young people who do enter the criminal justice system it is noted that most Youth Offending Teams have made good progress towards recognising, identifying and meeting alcohol-related needs in children and young people over recent years[81]. However, according to the Youth Justice Board even those children and young people 'at risk' of becoming an offender, should be entitled to identification, assessment and early intervention where they have misused alcohol[82]. NICE guidance recommends shared responsibility for reducing alcohol-related harm amongst all professionals working regularly with children and young people, not just alcohol specialists. The Home Office is clear that as a partner in local Children's Trust arrangements it is the duty of the police to safeguard and promote the welfare of all children in their areas and calls on enforcement agencies to be aware of and able to engage appropriately with specialist and targeted services locally[83].

Nevertheless, recent governmental approaches reflect concern about nuisance anti-social

behaviour rather than the individual and public health effects of alcohol on young people. Alcohol Concern believes that any child or young person using alcohol is putting themselves at risk and evidence tells us this risk (such as overdose, violence and sexual assault) increases considerably when drinking in unsupervised environments. What is needed is a more balanced response, enforcement of the law without alienating or pushing young people into more remote, less safe areas where the risks are greater. More coordinated and holistic strategies to engage unsupervised children and young people consuming alcohol must be developed. Targeted intervention strategies built upon shared information, joint harm reduction delivery, signposting to diversionary activities and where appropriate, the engagement of parents are likely to be more effective than simply confiscation of alcohol and forced dispersal. Alcohol Concern believes that crime reduction agencies, especially PCSOs, could contribute more effectively to reducing alcohol-related harms in children and young people through greater partnership working with local substance misuse and youth agencies.

Case study 5: Operation Park, Brighton and Hove

Operation Park, set up in 2008, is a multi-agency strategy involving the police, PCSOs, youth agencies and young people's substance misuse services to reduce anti-social behaviour and alcohol consumption amongst young people. The partnerships represent a move away from addressing unsupervised drinking in local hotspots such as parks solely from a criminal justice concern about youth disorder, to a health concern from a community safety point of view.

'Senior police officers in [Brighton and Hove] really get partnership working and can see the benefits of early intervention,'
Community Safety Team Manager

Young people in possession of alcohol, under the influence or with a group who is drinking are engaged by joint patrols. Dependent on age an immediate safety response is triggered including making contact with a parent, being dropped home or taken to a place of safety. Details are recorded, shared between partner agencies and screened on a weekly basis. Identification of alcohol as a key concern triggers contact, a joint home visit lead by the local Young Persons Alcohol worker is arranged and a series of awareness sessions offered. Operation Park targets young people below the threshold for 'treatment' addressing alcohol at the earliest stage possible. The focus is on education, prevention and the further identification of risk and vulnerabilities. Parents are offered alcohol specific support to improve their capacity to tackle their own child's consumption and presented with opportunities to access local parenting programmes. A range of alternative age-appropriate risk-reduction responses can be initiated where alcohol is not the primary concern.

The result - a 50% reduction in levels of anti-social behaviour strongly associated with alcohol although not a reduction in the number of young people stopped with alcohol. However, 140 young people were visited or engaged in alcohol awareness sessions that they would not otherwise have had access to. Between June 2008 and March 2010 only three people were stopped three times within 12 months of their first stop out of a total cohort of 929.

Recommendations

- UK Government strategy has primarily reflected a desire to tackle anti-social behaviour rather than public and personal health concern for those misusing alcohol. Alcohol Concern believes that any child or young person using alcohol is putting themselves at risk and that this risk increases considerably when drinking in unsupervised environments. Greater efforts must be made to offer children and young people misusing alcohol in public places harm reduction interventions, as opposed to solely enforcement techniques.
- Crime reduction agencies working on the frontline with young people and alcohol, such as PCSOs, could contribute more effectively to reducing alcohol-related harms in children and young people by working in partnership at a local level with substance misuse and youth agencies.

Conclusion

This report has attempted to draw together expert practice guidance, experience from local level delivery and new research, including previously unpublished health data, to identify important next steps in harm reduction strategy with children and young people. The different issues that this report highlights are all part of an overall problem health professionals are seeking to tackle: how do we stop alcohol-related harm in children and young people. The solutions and recommendations of this work are aspects of an approach that puts the public health of our young people at its centre. Ensuring we are taking the opportunities to intervene in young people's drinking when those situations present themselves, and ensuring that those responses are effective are key strategies to achieving our goals. The issues do not exist in isolation and have to be assessed alongside other policy interventions on issues such as marketing, availability and pricing. They are, however, all spokes in the same wheel, the focus on tackling alcohol-related ED attendances and unsupervised drinking illustrates how these elements can shape applied practice.

Effective implementation of National Institute for Health and Clinical Excellence public health guidance *Alcohol-use disorders: preventing harmful drinking* requires greater research, particularly into the efficacy of IBA with young people. Greater responsibility for prevention and harm reduction by non-alcohol specialists requires appropriate investment both in skilling up workforces and responding to likely increases in referrals for treatment. The Youth Policy project consultation seminar findings indicated strong support for non-alcohol specialists delivering alcohol interventions, if appropriately trained, resourced and supervised. Despite taking place prior to its publication, consultation findings with professionals in the sector largely supported the key recommendations of the NICE guidance.

Children and young people causing themselves such serious alcohol-related harm that they require emergency department, paramedic or hospital care should always be offered access to the information and support they need to make healthy and informed choices about alcohol. Health services need to consider how they can most effectively prevent future

harm, improve alcohol recording and work collaboratively where necessary. Children and young people that expose themselves to increased risk through unsupervised public drinking should be engaged where possible so they are more informed of the risks of their behaviour and aware of alternative local opportunities. Greater coordination and collaboration between crime reduction agencies and substance misuse services and youth agencies would support effective harm reduction.

If the government is serious about wanting to tackle alcohol consumption by children and young people it needs to additionally approach the issue from a public health perspective with the clear objective of harm reduction. To achieve this greater priority needs to be given to recording and monitoring so there is a consistent assessment of the scale of the problem which can then be resourced appropriately. Earlier and more consistent targeted interventions would be likely to improve outcomes for children and young people and in the longer term reduce the financial cost of underage drinking to the public purse which, as this report has highlighted, is considerable.

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Glossary

Alarm bell moment:
An instance that causes concern requiring a response or solution

Alcohol-dependence:
A cluster of behavioural, cognitive and physiological factors that typically include a strong desire to drink alcohol and difficulties in controlling usage. Someone who is alcohol-dependent may persist in drinking, despite harmful consequences. They will also give alcohol a higher priority than other activities and obligations

Alcohol-related harm:
Physical or mental harm caused either entirely or partly by alcohol. If it is entirely as a result of alcohol, it is known as 'alcohol-specific'. If it is only partly caused by alcohol it is described as 'alcohol-attributable'

Ambulance call-out:
An ambulance response to request of assistance, generally as a result of an emergency 999 call. The ambulance may then transport the patient to hospital for further treatment

Binge drinking:
There is no consistently agreed measure of 'binge drinking'. More than eight units for men and more than six units for women on any one day is used as a measure of binge drinking in the adult population

Children:
Defined as up to the eve of the 11th birthday

Emergency department attendance:
A presentation (generally unplanned) at an emergency department for treatment followed by subsequent discharge that does not require admission to a hospital ward

FRAMES:
A brief advice approach that encourages personal reflection based on:

- *Feedback* - provides feedback on the client's risk for alcohol problems
- *Responsibility* - the individual is responsible for change
- *Advice* - advises reduction or gives explicit direction to change
- *Menu* - provides a variety of options for change
- *Empathy* - emphasises a warm, reflective and understanding approach
- *Self-efficacy* - encourages optimism about changing behaviour

Harm reduction interventions:
Focuses effort on containment and reduction rather than elimination

Hospital admission:
The formal acceptance by a hospital or other inpatient health care facility of a patient who is to be provided with room, board, and continuous nursing service at least overnight

Increasing risk drinking (who are at an increasing risk of alcohol-related illness):
Men who regularly drink more than 3 to 4 units a day but less than the higher risk levels. Women who regularly drink more than 2 to 3 units a day but less than the higher risk levels. Previously termed 'hazardous' drinking

Higher risk drinking (who have a high risk of alcohol-related illness):
Men who regularly drink more than 8 units a day or more than 50 units of alcohol per week. Women who regularly drink more than 6 units a day or more than 35 units of alcohol per week. Previously termed 'harmful' drinking

Treatment:
A programme designed to reduce alcohol consumption or any related problems. It could involve a combination of counselling and medicinal solutions

Unit:
In the UK, alcoholic drinks can be measured in units. Each unit corresponds to approximately eight grams or ten millilitres of ethanol

Universal (Tier 1) professionals:
Refers to professionals who may provide alcohol education, information and service signposting

Targeted (Tier 2) professionals:
Refers to professionals who may provide alcohol advice, information and intervention for young people who are 'vulnerable', 'at risk' or using recreationally or regularly

Younger people:
A generic term referring to all people who are under 18 years of age that, therefore, encompasses children and young people

Young people:
Between the ages of 11 to the eve of the 18th birthday. Also termed 'adolescence'

Young people's specialist (Tier 3) substance misuse treatment professionals:
Refers to professionals who may provide care planned medical, psychosocial or specialist harm reduction interventions aimed at alleviating current harm caused by a young person's substance misuse

Contacts list

Case study 1: Health Promotion Resource Library
Kernow Building, Wilson Way, Redruth, TR15 3QE
Tel: 01209 313419
Email: info@healthpromcornwall.org
www.healthpromcornwall.org/index_VL.asp

Case study 2: 360° Young people and Families Substance Misuse Service
2nd Floor, The Base, Marsden Road, Bolton, BL1 2PF
Tel: 01204 337330
www.360online.org.uk

Case study 3: Matrix Young People's Service
7 Burrow Street, South Shields, NE33 1PP
Tel: 0191 497 5637
Email: enquires@ypmatrix.org
www.ypmatrix.org/

Case study 4: Alder Hey Children's Hospital
Eaton Road, West Derby, Liverpool, L12 2AP
Tel: 0515 228 4811
www.hubcapp.org.uk/QJDK

Case study 5: Ru-ok? Young Person's Substance Misuse Service
Ovest House, 58 West Street, Brighton, BN1 2RA
Tel: 01273 293966
Email: ru-ok@brighton-hove.gov.uk
www.socialsubcultural.com/ruok

Right time, right place

Alcohol-harm reduction strategies with children and young people

Right time, right place: Alcohol-harm reduction strategies with children and young people draws together expert practice guidance, experience from local level delivery and new research, including previously unpublished health data, to identify important next steps in harm reduction strategy with children and young people. Placing the public health of our children and young people at its centre the report focuses on opportunities to intervene in young people's drinking so that they are more informed and able to make healthier choices about alcohol.

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Alcohol Concern
Making Sense of Alcohol