

Gloucestershire

Alcohol Strategy 2006-2009

Co-Sponsored by Gloucestershire Safer and Stronger
Community Partnership (GSSCP)
& Gloucestershire Healthy Living Partnership (GHLP)

Gloucestershire Alcohol Harm Reduction Strategy 2006 - 2009

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Foreword

Alcohol use plays a part in the lives of the whole community, even amongst people and communities who choose not to drink. In most circumstances the consumption of alcohol causes no problems. In a minority of cases the misuse of alcohol causes problems for the person who drinks and their families. Increasingly the consumption of alcohol is having an impact on the wider communities with the problems associated with binge drinking.

This Strategy intends to focus the efforts of individuals and organisations working in the county on ensuring that the harm caused by alcohol misuse is reduced and kept to a minimum.

It is co-sponsored by the county Safer and Stronger Communities Partnership (GSSCP) and the Healthy Living Partnership (HLP). This joint approach ensures the greatest likelihood of comprehensive and sustainable action to tackle the problems associated with alcohol misuse.

The Strategy acknowledges that there is already a lot of good work going on in the county and that it is not possible to do everything today to bring about change where the changes are based on ingrained societal behaviour.

Mick Matthews Chair GSSCP
Cllr. Carole Topple, Chair HLP

Given the amount of recent research and strategic documents on alcohol misuse there are only brief references to need, trend and strategies in this paper. References can be found at the end of the Strategy.

For more detailed information about this Strategy, please contact the Chair of the County Alcohol Strategy Group on 01452 552801.

Executive Summary

This Strategy informs responses to alcohol misuse in Gloucestershire for the next three years. It has been developed using wide ranging cross-sector consultation that reflects the views of interested parties including Users and Carers. It is co-sponsored by the Gloucestershire Healthy Living Partnership (GHLP) and Gloucestershire Safer & Stronger Community Partnership (GSACP).

That drinking alcohol is a pleasurable activity for the majority of the adult population is not in question. However, the Strategy is based on the reality that alcohol misuse creates many problems for individuals, families, communities and the organisations that serve them. Young people and alcohol misuse is a particular challenge.

Data to underpin the Strategy is comprehensive. It demonstrates clearly the human and financial costs of alcohol misuse. There are some gaps locally and filling the data gaps is addressed.

The aim is to serve and support local people and communities to deal with alcohol misuse. Some indicators that are evidenced to affect consumption are beyond the direct remit of this Strategy, for example taxation.

The Strategy creates the framework to enable joint benefits to health, social care, District & County Councils, housing, criminal justice partners as well as local neighbourhood and voluntary sector bodies. It fits into the scope of many of the national and local strategies that drive service delivery locally.

The Strategy is central to the Local Area Agreement (LAA) approach. Alcohol misuse is a cross cutting issue and has a major role to play across all the LAA blocks including the Gloucestershire specific block – the Built Environment via the part played in licensing activity.

The Alcohol Harm Reduction Strategy for England (AHRSE) was released in 2004. This local Strategy addresses the four elements contained in that Strategy namely Education and Communication; Identification and Treatment; Supply and finally, Alcohol Related Crime and Disorder. These four threads fit with the LAA approach.

The layout of this document gives background for information with easy links to more comprehensive information. Following the information is an Action Plan which contains objectives, milestones, timetables and lead responsibility.

Oversight and review of the Action Plan will ensure that this Strategy makes a difference.

Section 1 – Strategic Context

What is the problem, why do we need to act locally?

- In Gloucestershire, most people who choose to drink do so with no side effects in the short or long term. 240,000 adults drink at levels which create little or no risk to them.
- Taking an extrapolation from the national figures, there are over 69,000 adults in the county drinking at hazardous levels or above. This group is disproportionately represented compared to the general population in primary care, general hospitals, secondary care, A & E, Adult and Community Care, Probation, Prison, Police work and housing.
- Recent research shows that Gloucester has the highest rate of chronic liver disease mortality among men in the region.
- The media, both national and local, have highlighted the rise in ‘binge drinking’. Particularly, young women are increasing their per-episode consumption. Young men’s drinking is not increasing markedly.
- The knock-on effect of excessive drinking has an impact not only on the individual drinker, but on the family, community and the workplace.
- In the recent past the focus has been on working to reduce the problems caused by drug misuse. This could be seen as having a detrimental effect on how alcohol problems are addressed, especially in the context of alcohol treatment.
- Currently, 43% of offenders are identified as having a criminogenic need as a result of their alcohol misuse, compared to 22% of offenders who misuse drugs. The recent Inspectorate report identified the chronic lack of alcohol responses for offenders who misuse alcohol.
- 40% of binge drinkers admitted committing a crime in past 12 months.
- Alcohol is a feature in 62% of cases of domestic violence.
- The HM Prison Service Alcohol Strategy points to the need to provide joined up alcohol services for prisoners.
- Trends indicate that long term health, housing, crime and disorder problems are set to increase as a consequence of the changes in drinking behaviour.

It is for these reasons that it is time to act to bring balance back into the approach to alcohol problems.

Why do we need to act – national & local strategic drivers

National

- The Alcohol Harm Reduction Strategy for England (AHRSE) was launched by the government in 2004. It focused on four areas - education and communication, identification and treatment, supply, and alcohol related crime and disorder. It states:
 - “The aim of the strategy is to prevent any further rise in the harms caused by alcohol misuse and, subsequently, to begin to reduce them.” (Page 74).
 - “There is no overarching government objective for reducing the harms caused by alcohol misuse and few indicators.” (Page 74).
 - The Government outlined pointers for activity that local areas might adopt but there is no compulsion, nor are resources attached.
- The Alcohol Needs Assessment Research Project (ANARP – 2005) set the scene on prevalence of problems and patchiness of treatment service across the country. It highlights what needs to be provided.
- The Models of Care for Alcohol Misusers (MOCAM) was published in 2006. It sets out the framework for treatment and identifies PCTs as the lead commissioners.
- The “Review of the Effectiveness of Treatment for Alcohol Problems”, led by the National Treatment Agency (NTA) will be published soon. Its contents can be predicted given the long history of consistent research. It will show that one particular treatment is not more effective than another.
- ‘Choosing Health – Making Healthier Choices Easier’ was published by the Department of Health in late 2004. It tackles four areas of health to be improved. For the first time alcohol is one of the key areas for improvement. Some key targets that relate to alcohol include ‘substantially reduce mortality’, ‘reduce health inequalities’ and ‘tackle underlying determinants of ill health’.
- ‘Alcohol Misuse Interventions’ published by the Department of Health sets out improvement plans for local areas. This practical document sets out that services can get better in a climate of limited resource growth.
- The Crime and Disorder Act 1998 (as amended by the Police Reform Act 2002) makes the PCT a responsible body on District Crime and Disorder Reduction Partnerships (CDRPs).
- The Licensing Act 2003 has a clear focus on the prevention of crime and disorder, public safety and reducing public nuisance.
- The Department of Health's Dual Diagnosis Good Practice Guide (2002) indicates that mental health services should take the lead responsibility for people with co morbid substance misuse and severe mental illness.
- ‘Every Child Matters’ by the Department for Education and Skills, focuses on supporting all children, particularly those in vulnerable groups, for example children of drinking parents.
- The National Strategy for Sexual Health and HIV (DoH, 2001) recognises a link between drug and alcohol use and sexual behaviour.

- The 'Addressing Alcohol Misuse – A Prison Service Alcohol Strategy for Prisoners' states that 'prison provides a good opportunity to address alcohol problems as part of a wider programme of work for the resettlement of offenders'.
- The Government's 'Respect Agenda' focuses on neighbourhood renewal, anti social behaviour, supporting parents, supporting neighbourhood policing plus alcohol and violent crime strategies.
- The concept of a Patient-led NHS should lead to choice for people when they want a service.
- In "Links between drug and alcohol misuse and psychiatric disorders Littlejohn. C., Nursing Times January 2005" it was pointed out that alcohol misuse is diagnosed in 18% of people with a personality disorder, 80% of people misusing alcohol complain of depressive symptoms and 30% meet criteria for having a major depressive episode.
- The Department of Health's National Suicide Prevention Strategy for England links closely with the National Institute for Mental Health in England substance misuse programme to: "Improve the clinical management of alcohol and drug misuse among young men who carry out deliberate self-harm".

There are many further national strategic links to young people, employment, housing and mental health including suicide.

Local Strategic drivers

- Local Area Agreements (LAAs) are currently being developed in the county. LAAs bring together all parties including the voluntary sector to agree planning for local priorities. Alcohol is a cross cutting issue that spans all the LAA blocks. These LAAs fit within the framework of the local Strategic Partnerships.
- The six District CDRPs (Crime and Disorder Reduction Partnerships) published their Strategies in April 2005 following extensive consultation with the public. Tackling alcohol misuse figured in all of the Strategies.
- A County Alcohol Strategy is being developed by National Probation Service Gloucestershire.
- There are cross cutting links to the county Suicide and Self Harm Strategy, Domestic Abuse Strategy, Obesity Strategy, Children's & Young People's Strategy and the Constabulary.

Section 2 – Where are we now?

Local figures – real

In reporting any local data it is important to recognise that increases in alcohol related activity by any measure does not directly mean that the problems are increasing. Increased activity can be as a result of changes in other services, changes in reporting or smarter working. However, anecdotally, services report they are busier and the problems are worsening.

There is no shortage of data about the cost and impact on individuals, families and communities of alcohol misuse. Below are some examples for illustration.

- There are increasing alcohol related attendances at Emergency Departments (ED) in the county: 16% increase in GRH between 03/04 – 05/06 with a projected 21% rise in 05/06.
 - Admissions following attendance at ED are set to rise by 17% in 05/06.
- The Alcohol Arrest Referral Scheme (AARS) dealt with 1381 referrals in 05/06 from 800 in 00/01. The cost to the community of the alcohol related crime is estimated at a minimum of £2 million.
- In 05/06, 1294 people were recorded on the Gloucestershire Database (GDD) as having received ‘alcohol treatment’.
- 43% of offenders on Probation are identified as having an alcohol problem compared to 21% having a drug problem.
- 28% of young people using the YPSMS have an alcohol diagnosis.
- Gloucester is identified as having the highest level of alcohol related liver mortality amongst males in the region.
- Local evidence points to a minimum of 65 alcohol related deaths per year in the county for the period 2001 – 2003.

Local figures – predicted

- Using population estimate figures based on a county adult population of 427,324 there are 427 severely dependent drinkers, 1709 moderately dependent drinkers, 17520 harmful drinkers and a catch-all total of 69,655 hazardous drinkers. On the positive side there are 286,734 low risk drinkers and 51,279 non drinkers.
- Primary Care (GPs) have a high alcohol related workload.
- Alcohol misuse has a high association locally with domestic abuse, suicide, self harm and housing.

Local Responses – Direct

- Each CDRP contributes to alcohol misuse reduction related initiatives. Examples include AARS, work in Emergency Departments and Night Safe.
- The NHS County Specialist Substance Misuse Service (CSSMS) provides treatment including detoxification (inpatient and community).
- Alcoholics Anonymous (AA) provides a network of groups and support right across the county.
- GDAS provides advice, information, brief interventions in GP surgeries, psychosocial interventions etc.
- Nelson Trust, Stepps and Inishfree provide abstinence based residential rehabilitation for people.
- The Adult Treatment Joint Commissioning Group funds residential rehabilitation across the country for people with alcohol problems.
- Supporting People directly fund services for people in their homes.

Local Responses – Indirect

- A whole range of initiatives and projects in education and young people's services that support key messages about alcohol and its effects.
- Housing Associations provide dry accommodation.
- The Pilot Inn and GEAR night shelter in Gloucester provides a range of services for people who are homeless with an alcohol problem.
- All statutory organisations spend money on providing services for people who misuse alcohol including Probation, Police, District Councils, Adult Continuing Care (formally Social Services), all aspects of the NHS etc.

Part of the Strategy's Monitoring and Review brief (see 7b of the Action Plan, page 11) will be to plot progress against the four elements outlined in the NAHRSE (see page 6).

Estimated cost

Estimating the costs of alcohol misuse in the county is an imprecise art. There are clear costs for some alcohol related crime via AARS, the work of ED and the funding of treatment services. Using the figure from the UKATT study (and used by DoH), for every £1 spent on treatment, £5 is saved by the public sector. In Gloucestershire the direct amount spent on treatment including Supporting People is approximately £900K. Therefore the cost to the public sector is something around £4.5 – 5 million. However, if the cost to healthcare, criminal justice, social care, housing communities etc. are added in, the cost would approach £10 million.

Section 3 – Where do we want to go and what are reasonable expectations?

Alcohol strategies have been written before in Gloucestershire. Progress in *delivering* on the Strategies has been poor for a set of reasons, including lack of Government direction and priority, lack of resources, over ambition in objectives, lack of strategic and operational ownership, and other priorities taking precedent. This Strategy has been developed at the right time to allow it to make realistic progress.

Strategic Vision

To reduce the actual and potential harm caused to people and communities by alcohol use in Gloucestershire.

Aim

In order to meet the Vision, to serve and support people and communities to deal with alcohol misuse, this Strategy will set a range of outcomes and outputs that support all public sector bodies in meeting their local targets including the cross cutting Local Area Agreements (LAAs).

Objectives

In order to proceed towards meeting the aim a set of objectives have been developed. These objectives are in the form of an Improvement Plan. By adopting this approach it means that progress can be measured, reviewed and there is a sense that the document is relevant. Having an Improvement Plan with timetables also mean that progress can be gauged by the sponsoring Strategic Partnerships. This gives confidence to people that this Strategy has value.

The Improvement Plan summary is set out below.

Section 4 - Alcohol Strategy 2006-2009 Improvement Plan

Objectives	Priority	Time Scale	Lead Agency/s	Other Agencies Required
1. Strategic				
a. Identify Alcohol Strategic Lead for county and leaders for each sector	High	1 year	Glos PCT	GSSCP, GHLP
b. Agree commissioning structure and identify lead for alcohol treatment services	High	1 year	Glos PCT	GSSCP, GHLP
c. Continue to bring pressure to reduce alcohol related crime in line with local Strategies	Medium	2 years	CDRP	
d. Identify sources of funding to support the delivery of the Strategy	High	Ongoing	GSSCP, GHLP	
e. Integrate Strategy into other county Strategies	Medium	Ongoing	All	
2. Promotion				
a. Raise awareness within the local population about alcohol and services through a range of sources	Medium	Ongoing	SAGs; LAA	
b. Develop a marketing programme to support the delivery of the Strategy	Medium	Ongoing	GSSCP; GHLP	
3. Prevention				
a. Target preventative activities at key and high risk groups	High	2 years		
b. To work with Licensing Authorities, retailers, Publicans, Breweries to develop a co-ordinated response to the promotion of sensible drinking behaviour and reduction of binge drinking	Medium	3 years	GSSCP; GHLP; CDRPs; SAGs	
4. Models of Care				
a. Deliver a choice in service provision across the County in line with Models of Care (MOCAM)	Medium	2 years	Glos PCT	
b. Deliver a range of client pathways & service provision across the County in line with Models of Care (MOCAM)	High	1 year	Glos PCT; Providers	
5. Treatment & Intervention				
a. Target treatment activities at key or high risk groups including Probation and Prison	High	2 years		
b. Establish interventions in Emergency Departments across the county	High	1 year	Glos PCT; GHT	
6. Support & training				
a. Develop and support Alcohol Service User and/or Carer involvement and consultation	High	2 years	Formal support of all agencies	
b. Develop and support Alcohol Service User and/or Carer involvement and consultation	High	2 years	Formal support of all agencies	
c. Establish the need for alcohol related housing in partnership including PPOs	Medium	3 years	Supporting People; Housing	
d. Partners to sign up to inter-agency alcohol awareness & training based on MOCAM	Medium	3 years	GSSCP/GH LP	
7. Monitoring & Review				
a. Establish the effective local monitoring of alcohol misuse in the area	High	2 years	Public Health	Glos PCT
b. Monitor & review the effectiveness of the delivery of Strategy via Alcohol Action Group	High	Ongoing	GSSCP; GHLP	

Section 4 - Description of Objectives from Improvement Plan

Objectives	Why this objective?	What steps are required	What is/are the success factor/s to show that objective is achieved
1. Strategic			
Identify Alcohol Strategic Lead for county & leaders for each sector.	Strategic senior county lead is required to sustain the Improvement Plan and leaders are required in each organisation to keep alcohol high on the agenda.	GSSCP/GHLP needs to agree the named champion. Organisational leaders need to be appointed.	Champion & leaders appointed
Agree commissioning structure and identify lead for alcohol treatment services.	Currently there is no lead for commissioning alcohol treatment services or associated structure. This leads to inertia and uncertainty in modernizing services & making best use of existing resources. The PCT has this role.	PCT agrees to ownership of task Commissioning lead appointed Commissioning structure put in place.	Commissioning officer in place Commissioning intentions published Services commissioned
Continue to bring pressure to reduce alcohol related crime in line with local Strategies.	The local Strategies have a statutory function therefore pressure has to be work has to be permanently.	Continuing annual monitoring and review of progress against local strategies.	Alcohol related crime reduced in each District
Identify sources of funding to support the delivery of the Strategy.	By implementing the Strategy either new resources have to be found or re-profiling of existing resources is required.	Where a proposal for delivery of the Strategy for new or modified provision is identified, resources need to be identified in advance.	The full Strategy is implemented and sustained
Integrate Strategy into other county Strategies.	It is essential that as new Strategies are developed in the county that they join up. This objective formalizes that process.	Members of GSSCP/GHLP (and GSP) ensure that all new or reviewed strategies are cross cutting.	Ongoing review by the Monitoring & Review Group.
2. Promotion			
Raise awareness within the local population about alcohol and services through a range of sources.	Information needs to be available so that individuals can make informed decisions. This process works in schools. General awareness campaigns about alcohol only have limited effectiveness. Fits with Choosing Health.	General information is circulated using a range of low cost sources e.g. partners websites; leaflets; annual publicity campaigns.	Objective cannot be fully achieved. Information outlets & opportunities are recorded to help inform next Strategy.
Develop a marketing programme to support the delivery of the Strategy	The community and professional staff need to know that the Strategy exists and to be informed of progress and success	A partner organisation is appointed to manage the marketing of the work.	Ongoing review by the Monitoring & Review Group.

Objectives	Why this objective?	What steps are required	What is/are the success factor/s to show that objective is achieved
3. Prevention			
Target preventative activities at key groups.	Certain groups use services disproportionately and/or do not access alcohol services. Target groups to be people at risk of exclusion from the mainstream services.	Targeted groups to be identified following needs assessment & commissioning structure in place. Progress against targets monitored.	Objective cannot be fully achieved. Progress against targets is the marker
To work with Licensing Authorities, retailers, Publicans, Breweries to develop a coordinated response to the promotion of sensible drinking behaviour and reduction of binge drinking.	The supply of alcohol is central to any Strategy. All of the mentioned groups have a part to play in reducing alcohol related harm.	GSSCP/GHLP takes on role of facilitating work either at a District or county level. To involve training, development of materials and publicity.	Sustainable networks are established.
4. Models of Care			
Deliver a choice in service provision across the County in line with Models of Care (MOCAM).	In order to support all services including health, Probation, Prison etc there needs to be a joined up approach that meets the needs and priorities of the range of signatories to this strategy.	Leadership is required in each organisation. There needs to be the right level of membership of Alcohol Action Group to ensure delivery against MOCAM	People and communities get the right response. Reports from Alcohol Action Group.
Deliver a range of client pathways & service provision across the County in line with Models of Care (MOCAM).	MOCAM provides the evidence base and framework for services in an area. By not delivering to MOCAM there will not be balance in the system.	GSSCP/GHLP agrees to Strategy. PCT as lead commissioner drives through MOCAM.	MOCAM balanced system in place and feedback mechanisms adopted
5. Treatment & Intervention			
Target treatment activities at key or high risk groups including Probation and Prison.	There is only limited use in targeting whole community. The best cost benefit mix comes from targeting key groups.	Alcohol Action Group agrees key groups and sets targets that meet the priorities of people and organisations.	When targets are met and problem ameliorated.
Establish interventions in Emergency Departments across the county.	EDs are a pivotal place to tackle alcohol misuse. Over the past three years there has been a rapid increase in the number of alcohol related episodes & onward admissions.	Set up schemes to train and support staff and provide referrals into alcohol services.	Services and responses established and sustained.

Objectives	Why this objective?	What steps are required	What is/are the success factor/s to show that objective is achieved
6. Support & Training			
Develop and support Alcohol Service User and/or Carer involvement and consultation.	Unless there is consultation and involvement with Service Users/Carers services become organizationally focused and not customer focused.	Build on the existing networks and structures for Drug Service Users/Carers by commissioners & services.	Service User/Carer/services feedback in year 1 & year 3 to chart progress and change.
Establish the need for alcohol related housing in partnership including PPOs.	Housing needs for people who misuse alcohol remains a priority in the county. The need has to be established in order to make any future business case for housing.	County Housing Group and Supporting People undertake needs assessment with action plan.	Action Plan adopted and needs incorporated into future housing delivery in county.
Partners to sign up to inter-agency alcohol awareness & training based on MOCAM.	It is essential that professionals in all direct and indirect services have the competency and confidence to deliver minimal interventions for their particular client group.	A range of training commissioned to cover all professionals across the county.	Evaluations show increased competence in work and increase in referrals.
7. Monitoring & Review			
Establish the effective local monitoring of alcohol misuse in the area.	Currently accurate figures relating to alcohol misuse in the county are not available. Makes an accurate needs assessment for planning limited in value.	Lead responsible body agreed Accurate needs assessment undertaken Data gaps identified & remedied Needs assessment undertaken again in 3 years.	GSSCP and GHLP receive an accurate needs assessment in year 1 and year 3 to monitor progress against current Strategy & to inform next Strategy.
Monitor & review the effectiveness of the delivery of Strategy via Alcohol Action Group.	Any Strategy needs regular monitoring and developing to demonstrate effectiveness. A county alcohol Action Group needs to have this task reporting to the GSSCP/GHLP.	An expert group of the willing is established with Terms of Reference agreed by GSSCP/GHLP.	Strategy is reviewed and developed on an annual basis.

Section 5 – Some useful references – there are many more!

Alcohol Harm Reduction Strategy for England

www.strategy.gov.uk/work_areas/alcohol_misuse/index.asp

Interim Analytical Report

www.strategy.gov.uk/work_areas/alcohol_misuse/interim.asp

Department of Health – alcohol misuse including Improvement Plan, Models of Care, ANARP

www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/AlcoholMisuse

Choosing Health

www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Modernisation/ChoosingHealth/fs/en

Probation Service website

www.probation.homeoffice.gov.uk

Prison Service Alcohol Strategy

www.hmprisonservice.gov.uk/news/latestnews/index.asp?id=2173,38,6,38,0,0

Alcohol concern

www.alcoholconcern.org.uk

Local Alcohol Services

Alcoholics Anonymous
www.alcoholics-anonymous.org.uk

Countywide Specialist Substance Misuse Services (CSSMS)
www.partnershiptrust.org.uk/content/services/services71962.html

GDAS Alcohol Service
www.gdas.co.uk

Nelson Trust
www.nelsontrust.com

Other Information

Gloucestershire DAAT
www.glospct.nhs.uk

Government's FRANK campaign
www.talktofrank.com

Drinkline
0800 9178282

For more detailed information about the strategy, please contact the Chair of the County Alcohol Strategy Group on 01452 552801.

Thanks are extended to the County Alcohol Strategy Group for the preparation of this Strategy, and to Peter Steel for its oversight and drafting. The Group has multi-agency, User and Carer representation. In developing the Strategy a consultation was undertaken that established the views of interested parties across the county. Thanks are also extended to Neil Bebbington and Julie Spokes for the document's design and production.

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