Gloucestershire Conference

Gloucestershire's Alcohol Harm Reduction Strategy

2010-2013

Table of Contents

Gloucestershire Alcohol Strategy 2010-13

List of Illustrations

1 Introduction

1.1. Background and Purpose

Alcohol plays an important social, cultural and economic role in England. It is estimated that over ninety per cent of the population drink. For the majority of people this appears to have little adverse effect; however, misuse of alcohol is an increasing cause for concern. When misused, alcohol can cause problems including those related to health, crime, antisocial behaviour, loss of productivity in the work place and the subsequent breakdown of personal relationships and community cohesion. Alcohol is a major and increasing public health challenge and causes more deaths and serious illnesses each year than street drugs.

Much alcohol-related harm is preventable and research demonstrates that for every £1 spent on evidence based alcohol services, £5 is saved for the public purse, providing economic and health benefits for individuals and communities.

This strategy updates our plans for reducing alcohol harm in the county. It replaces the 'Gloucestershire Alcohol Strategy 2006-9' (NHS Gloucestershire, 2006) and brings together a number of key national and local policies as well as data from a range of sources. It sets out the current picture of alcohol harm both nationally and locally. At the county level it also sets out:

- What we are currently doing to address the issue
- Where we have gaps
- What our identified priorities are
- What future action we intend to take.

As alcohol misuse is a complex problem a partnership approach to reducing associated harm is required. No one agency can tackle the problem alone.

Harms to health form a significant element of the strategy and a key performance indicator is NI 39 - rate of Hospital admissions per 100,000 for alcohol-related harm. However, it is important to remember that the strategy addresses a wider set of harms than simply health and hence involves a partnership that extends beyond health. Actions on crime and disorder, road safety and education also impact upon the rate of hospital admissions and other key indicators. Public Health practitioners and partners should work together to identify local population needs and service gaps.

There is a worrying association between socioeconomic deprivation and alcohol harm. The World Health Organisation (2009) identifies alcohol as the greatest source of health inequalities in the European region. For England the greatest source of health inequalities is smoking.

These inequalities are highlighted locally in 'Healthy Gloucestershire 2008-2018. The Health and Community Wellbeing Strategy for Gloucestershire' (Gloucestershire Health and Community Wellbeing Partnership, 2008) and regionally in 'Calling Time: Reducing Alcohol Harm in the South West' (Walsh, A., 2008).

For this reason it is important that this strategy addresses inequalities and includes population level approaches as well as interventions targeted at high risk groups and individuals.

There are useful tools to allow us to model health responses to alcohol misuse such as the Department of Health's 'Ready Reckoner'[1] , which aims to assist Primary Care Trusts (PCTs) to select interventions to reduce alcohol-related admissions in the short term and the 'Rush Model'[2] , which is for estimating PCT's capacity for alcohol treatment systems at the local or regional level. The Department of Health has also produced, in conjunction with 'Safe. Sensible. Social' (Department of Health, 2007) an Alcohol Strategy Local Implementation Tool Kit.

This strategy however is more directly informed by NHS Gloucestershire and Gloucestershire County Council's Joint Strategic Needs Assessment (JSNA), by the Joint Strategic Commissioning and 'Total Place' approaches, which seek to identify and avoid overlap and duplication between organisations leading to better services at less cost.

This strategy is also informed by multi-agency consultation, which included input from the Police, Probation, Trading Standards, Health, Education and the Voluntary Sector. It is co-sponsored by the Gloucestershire Safer and Stronger Communities Partnership (GSSCP) and the Gloucestershire Health and Community Wellbeing Partnership (GHCWP).

Data sources include the Gloucestershire Alcohol Needs Assessment 2008 (NHS Gloucestershire, 2008), The Gloucestershire Online Pupil Survey 2008 (Gloucestershire County Council, 2008) and the Local Alcohol Profiles for England (LAPE, North West Public Health Observatory).

1.1.1. Alcohol Misuse – Some Definitions

Before we consider further the harms that alcohol misuse can cause, it is important to outline the differences between what is considered sensible drinking and drinking that may cause harm.

The UK Department of Health currently recommends that men should not regularly drink more than 3–4 units of alcohol per day and women 2–3 units. The recommended maximum weekly totals are 21 units for men and 14 units for women. Additionally, the British Liver Trust recommends that people abstain from alcohol for a minimum of two consecutive days per week[3].

These recommended limits have been set at what is considered sensible for the population as a whole. However alcohol consumption can never be completely risk free and there is no entirely safe level of consumption.

For some alcohol-related conditions (such as certain cancers) the risk of harm begins to increase at levels below the recommended limits. For some vulnerable groups, such as pregnant women, current guidance advises no consumption at all.

1 *http://www.alcohollearningcentre.org.uk/Topics/Browse/Commissioning/Data/?parent=5113&child=5109*
2 *http://www.alcohollearningcentre.org.uk/Topics/Browse/Commissioning/Data/?parent=5113&child=5134*
3 *http://www.britishlivertrust.org.uk/home.aspx*

When individuals drink beyond recommended sensible levels, they may be defined as having an alcohol use disorder. The World Health Organisation categorisation of alcohol use disorders (1994) specifies three categories that will be used throughout the document:

- Hazardous drinking – drinking above the recognised sensible levels but not yet experiencing harm
- Harmful drinking – drinking above sensible levels and experiencing harm
- Alcohol dependence – drinking above sensible levels and experiencing harm and symptoms of dependence.

A further category will be referred to, binge drinking, though there is no consensus definition for this term. For the purposes of this document the definition set out in the 'Alcohol Harm Reduction Strategy for England' (Cabinet Office, 2004) will be used. This defines binge drinking as consuming eight or more units on a single occasion for men and six or more for women.

1.2. Scale of the Problem

Alcohol misuse is directly linked to a range of health issues such as high blood pressure, some cancers, mental ill-health, accidental injury, violence, liver disease, sexually transmitted infection and unwanted pregnancy.

Alcohol misuse not only poses a threat to the health and wellbeing of the drinker; it affects family, friends, communities and wider society through such problems as domestic violence, crime, anti-social behaviour, road safety and loss of productivity. The Annual Report of the Chief Medical Officer 'On the State of Public Health' (Donaldson, L., 2009) introduces the term passive drinking to describe the effect of one person's drinking on another's wellbeing.

Drawing upon both national and local datasets, this section presents evidence of the scale of alcohol-related harm nationally and in Gloucestershire.

Figure 1 - Definitions of alcohol-specific and alcohol-related harms to health.

Alcohol-specific	Conditions that are wholly related to alcohol (e.g. alcoholic liver disease or alcohol overdose). A list of alcohol-specific conditions with their ICD-10 codes can be found at: http://www.nwph.net/nwpho/publications/AlcoholAttributableFractions.pdf
Alcohol- related	Alcohol-specific conditions plus conditions that are caused by alcohol in some, but not all, cases (e.g. stomach cancer and unintentional injury). For these latter conditions, different attributable fractions are used to determine the proportion related to alcohol for males and females. A list of alcohol-related conditions with their ICD-10 codes and associated attributable fractions can be found at: http://www.nwph.net/nwpho/publications/AlcoholAttributableFractions.pdf

1.2.1. Overall Picture: National (ANARP, Department of Health, 2005).

- There are 8.2 million people in England drinking above the hazardous or harmful level

- In England, 1.1 million people are known to be dependent drinkers
- As many as one in three divorce petitions in the UK may cite excessive drinking by a partner as a contributory factor
- It is estimated that between 780,000 and 1.3 million children are affected by parental alcohol problems in the UK
- In 2007, alcohol was 69% more affordable in the United Kingdom than it was in 1980.

1.2.2. Overall Picture: Gloucestershire

- Estimates suggests that in Gloucestershire there are 83,080 hazardous or harmful drinkers and 13,480 dependent drinkers aged 16-64 years old (Alcohol Needs Assessment Research Project and Office for National Statistics population data (Walsh, A. 2008).

The North West Public Health Observatory (NWPHO) has published a range of indicators to help quantify the harm caused by alcohol misuse. A summary of the NWPHO Local Alcohol Profiles for England (LAPE) at the county and district level is presented in Appendix 10.1. For Gloucestershire as a whole, the following measures are significantly higher than the England average:

- Mortality from land transport accidents
- Percentage of all employees who work in bars.

1.2.3. Health: National (National Statistics, 2008)

- In 2006-07, there were 207,788 NHS hospital admissions in England with a primary or secondary diagnosis specifically related to alcohol. This number has more than doubled from 93,459 in 1995-96.
- In 2007, there were 112,267 prescription items for drugs for the treatment of alcohol dependency prescribed in primary care settings in England. This is an increase of 20% since 2003, when there were 93,241 prescription items.
- In 2006, in England, there were 6,517 deaths directly linked to alcohol, of which two thirds were men. This has increased by 19% since 2001 when there were 5,476 deaths.
- Drink driving fatalities in Great Britain have reduced from more than 1,600 at the end of the 1970's to 560 in 2005. However, the decline has slowed significantly in the last 10 years.

1.2.4. Health: Gloucestershire

National Indicator Set (NI 39) measures rates of alcohol related hospital admissions per 100,000 population and was chosen by Gloucestershire as one of its Local Area Agreement targets. The target is the responsibility of Gloucestershire Safer, Stronger Communities Partnership (GSSCP) on behalf of Gloucestershire Conference. NHS Gloucestershire leads on the performance reporting.

The categories of Hospital Episode Statistics (HES) data (Jones L. et al, 2008) that make up the alcohol-related hospital admission indicator are considered to be sensitive to a range of alcohol misuse prevention and treatment interventions, which is why it has been chosen to form the basis for measuring the impact of local actions. Improvements in both prevention and treatment interventions are expected to have a significant impact on the rate of alcohol admissions.

Appendix 10.1 provides an overview of alcohol-related harm in Gloucestershire. At the county level, most LAPE indicators of alcohol-related harm are significantly better than, or in line with, the national average (NWPHO). Rates of alcohol-related hospital admissions are considerably higher for males than for females, reflecting the national profile. However, within the county there is a mixed picture of harm to health. Gloucester and Cheltenham have rates of alcohol-related hospital admissions that are significantly worse than the England average. Health indicators are significantly worse than the national average for:

- Alcohol-related hospital admissions (NI 39) in Gloucester and Cheltenham
- Mortality from land transport accidents in the Forest of Dean, Tewkesbury and for the county overall.

Gloucestershire's treatment penetration rate (1 in 13) for dependent alcohol use is estimated to be very close to the best regional rate in the country (range 1 in 12 to 1 in 102, Department of Health 2004). However treatment access is lowest amongst:

- Young people aged 16-24 years (1 in 43)
- People from Black and Minority Ethnic (BME) groups (1 in 34)
- Residents of the Forest of Dean (1 in 21) Cotswolds (1 in 20) and Tewkesbury (1 in 19) (NHS Gloucestershire, 2008).

1.2.5 Crime and Disorder: National ('Safe. Sensible. Social: The next steps in the National Alcohol Strategy' Department of Health, 2007)

- In 2007-08 in nearly half (45%) of all violent incidents recorded by the police in England and Wales, victims believed offenders to be under the influence of alcohol. This figure rose to 58% in cases of attacks by people they did not know.
- In 2004 in England and Wales, a higher proportion of those aged 10 – 25 years who drank alcohol once a week or more, reported committing criminal damage (12%) and theft (4%) offences during or after drinking than those who drank less frequently.

1.2.6 Crime and Disorder: Gloucestershire

Rates of alcohol-related recorded crimes and alcohol-related violent crimes are significantly worse in Gloucester and Cheltenham compared to the England average (Appendix 10.1, Appendix 10.3 for measure descriptors). Appendix 10.2 shows the levels of crime, disorder and anti-social behaviour by neighbourhoods in Gloucestershire, including the incidents of violent crime under the influence of alcohol or drugs.

Between April 2007 and January 2009, approximately 5,451 victims of domestic violence were reported to the police in Gloucestershire. It should be emphasised that these are victims reported to the police and that victims will exist who don't report to the police. Whilst the data does not differentiate between those incidences where alcohol was a contributory factor, research shows that 46% of domestic violence incidents are estimated to occur where the perpetrator is under the influence of alcohol.

1.2.7 Children and Young People: National

- In 2006, 41% of 15 year olds in England reported having drunk alcohol in the previous week; for 13 year olds the figure was 16%.
- In 2006, the average consumption amongst 11-15 year olds in England who reported having drunk alcohol in the previous week was 11.4 units; an increase from 10.5 units in 2005.
- In 2006, 15% of 11-15 year olds in England thought it was okay to get drunk at least once a week. This figure varied largely depending on age; at 3% for 11 year olds and 30% for 15 year olds.
- In 2006-07, 9% (4,888) of NHS hospital admissions in England with a primary diagnosis specifically related to alcohol involved patients less than 18 years of age.

'Every Child Matters: Change for Children, Young People and Drugs' (Department of Education and Skills, 2005) identifies the following "At Risk" groups as being particularly vulnerable and worthy of targeted interventions:

- Children of problem substance misusers, including alcohol
- Persistent truants and school excludees
- Looked after children
- Young people in contact with the criminal justice system
- Others including homeless young people, young people abused through prostitution, teenage mothers and young people not in education, employment or training (NEET). Many of those at risk live in our most deprived communities.

1.2.8. Children and Young People: Gloucestershire

- According to the Gloucestershire Online Pupil Survey 2008 (Gloucestershire County Council, 2008), a high percentage of year 10 respondents stated that they are drinking regularly, with 29.8% drinking "quite often" or "most days".
- A quarter of year 10 pupils who said they drink monthly or more frequently, started drinking regularly at 13 years of age, while 11.7% started when they were 12 years old.
- When asked where they get their alcohol from, the three main sources for year 10 pupils were "Home" (35.7%), "Someone buys it for them" (24.6%) and "Friends" (20.3%).
- Across the county, 31.4% of year 10 pupils, who said they drink monthly or more frequently state that they have been drunk quite often or most days.

- The Gloucestershire Young People's Substance Misuse Service (YPSMS) provides specialist support for drug and alcohol problems to those under 18 years of age upon service entry. Records show that of young people accessing YPSMS, 28% have problematic alcohol issues.
- Upon entry to the Youth Offending Service (YOS) a holistic assessment of the young person's needs is made. Approximately 29% of assessments undertaken by the YOS Team between October 2007 and October 2008 showed that the young person had used alcohol at the time of the offence. The consequences of this drinking included:
- Violence and fighting
- Vandalism and anti-social behavior
- High risk sexual behaviour
- Arrest and conviction.

These findings are consistent with national figures, which suggest strong links between high levels of alcohol consumption in young people and outcomes such as youth offending, teenage pregnancy, truancy, exclusion and illegal substance misuse.

1.2.9. Workplace and Employment

- International research estimates that 70% of people with alcohol problems are in employment.
- In Britain, up to 17 million working days are lost annually due to alcohol-related absence.
- Loss of productivity in the workplace as a result of alcohol is estimated to cost the UK economy up to £6.4 billion. Reasons for losses of productivity include sickness absence, unemployment, early retirement and premature deaths.
- In Great Britain in 2007, those in managerial or professional employment were more likely to have drunk alcohol on five or more days in the previous week than any other employment groups.
- In 2005 in Great Britain, levels of binge drinking were equivalent across all employment groups, including those who were unemployed.

1.2.10 Health Inequalities

The burden of alcohol-related harm falls disproportionately on our most deprived communities. In the UK, drinking beyond the sensible guidelines is more common in areas of high deprivation. Department of Health analysis of National Statistics data indicates that alcohol-related death rates are about 45% higher in areas of high deprivation compared to areas of low deprivation (Department of Health, 2007).

All Gloucestershire residents irrespective of race, gender, disability, age, ethnicity, religion and sexuality should be able to secure the same access to health and social care services both in relation to alcohol and wider issues. To ensure this is the case, an Equality and Diversity Impact Assessment process for the strategy has been established. In relation to alcohol, inequalities have been identified in access to services and impact of misuse. These inequalities impact upon the most deprived areas and upon the following vulnerable population groups:

- Young people – peer pressure and experimentation
- Older people – social isolation
- Women – increasingly engaging in alcohol misuse
- Isolated areas – lack of local facilities and access to services
- Homeless people – social exclusion and difficulty accessing services. It is estimated that in the UK half of rough sleepers are alcohol dependent
- Binge drinkers – may not associate their drinking with harm
- Chronic drinkers (individuals drinking large amounts regularly) – entrenched behaviour pattern may make seeking help difficult
- Drinkers with multiple problems (e.g. mental health, learning disabilities, elicit drug use) – treatment may not be available through a single service
- Black and Minority Ethnic groups – cultural and religious beliefs may keep alcohol-related harm hidden
- Offenders – many offenders under probation supervision or in prison have alcohol problems linked to their offending behaviour. In 1997, 63% of sentenced males and 39% of sentenced females were classed as hazardous drinkers in the year before coming into prison, with the majority of prisoners having low-medium treatment needs and an estimated 8% of females and 7% of males displaying high treatment needs.

1.2.11 Foetal Alcohol Spectrum Disorders

Foetal Alcohol Spectrum Disorders (FASD) are a series of completely preventable mental and physical birth defects resulting from alcohol consumption during pregnancy. FASD are lifelong conditions that significantly impact upon the life of the individual and those around them.

There is currently little reliable evidence of the incidence of FASD in the UK, with data only collected on Foetal Alcohol Syndrome (FAS) rather than the whole spectrum of disorders. FAS, though not a common condition, is regarded as the leading cause of non-genetic intellectual disability in the western world. "The most at risk populations are those experiencing high degrees of social deprivation and poverty". (British Medical Association, 2007).

The level of alcohol consumption among UK women of childbearing age has increased (Robinson, S., Lader, D., 2008) and the number of alcohol-related deaths among UK women between 35 and 54 years has doubled between 1991 and 2006 (Office for National Statistics, 2008). According to the 2003 British Medical Association (BMA) report 'Adolescent Health' (BMA, 2003), adolescents in the UK have one of the highest rates of alcohol use, binge drinking and getting drunk in Europe. The rate of teenage pregnancy in the UK is the highest in Western Europe. Recent evidence suggests that unplanned pregnancies are common, not only in young women but in women throughout their childbearing years. The BMA therefore suggests that there is an increased risk of heavy drinking during pregnancy and subsequently an increased risk of having a baby who is affected by pre natal alcohol exposure (BMA, 2007).

1.2.12 Financial Costs

The 'Alcohol Misuse: Interim Analytical Report' (Cabinet Office, 2003) examined the costs of alcohol misuse nationally. Costs were broken down by the various contributory factors and thus the report provides an illuminating picture of the massive cost the UK is bearing (Figure 2). More recent research shows the estimated cost of alcohol-related ill health, crime and disorder to have risen to £20 billion per year. The cost to the NHS alone is estimated to be 2.7 billion at 2006/7 prices (Department of Health, 2008).

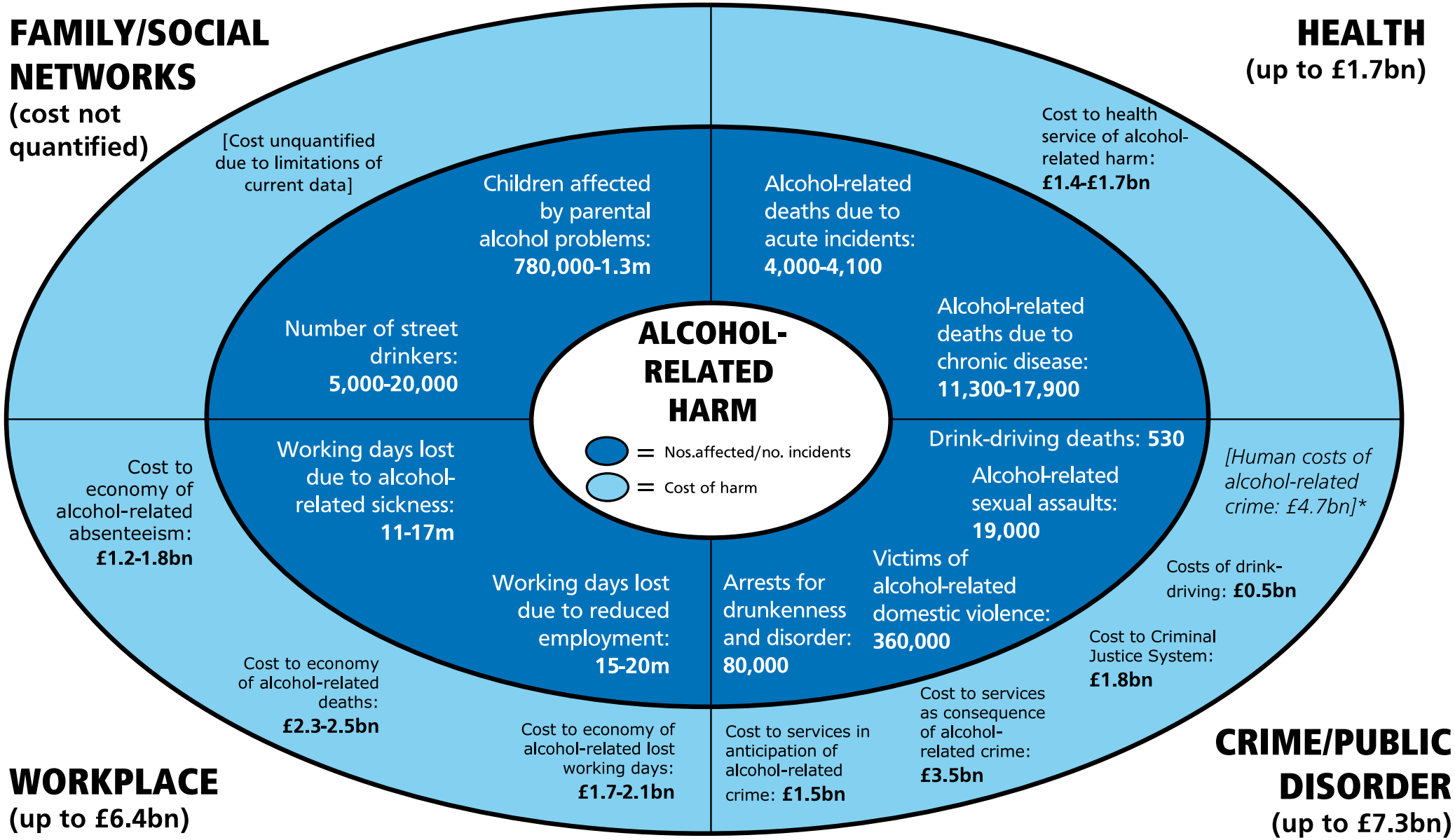


Figure 2 – Costs of Alcohol-related Harm (Source: Interim Analytical Report, Cabinet Office, 2003)

2. Where Do We Want to Be?

2.1 Strategic Vision and Aims

In Gloucestershire, our overall strategic vision is:

"To reduce the actual and potential harm caused by alcohol misuse to individuals and communities whilst ensuring that alcohol can be enjoyed safely and responsibly."

Underpinning the strategic vision are the strategic aims. These are based on the four areas of harm identified in the 'Alcohol Harm Reduction Strategy for England' (Cabinet Office, 2004) and set out the key areas in which we need to make improvements in order to deliver the strategic vision. They are:

- To raise awareness of alcohol-related harm and encourage sensible drinking amongst Gloucestershire's diverse communities through a wide-ranging programme of information and education.
- To improve the capacity of partners in Gloucestershire to identify individuals misusing alcohol and to provide effective, service user centred support and treatment.
- To reduce alcohol-related crime, disorder and anti-social behaviour in Gloucestershire and to reduce the percentage of people who perceive it to be a problem.
- To actively engage on- and off-licensees in developing a consistent standard of responsible retailing and promoting responsible drinking.

2.1.1 Strategic Objectives and Actions

The strategic objectives focus on specific work streams where gaps and opportunities have been identified for making improvements in the county in relation to the strategic aims. They are based on analysis of countywide service provision and the evidence base as set out in Section 3.

The strategic objectives and their underpinning actions are set out in the form of an Implementation Plan (section 8). This is a detailed action plan outlining the individual tasks that stakeholders will deliver in order to bring about change. The action plan links directly to Gloucestershire's Safer Stronger Community Partnership (GSSCP) plan and to Gloucestershire's Health and Community Wellbeing Partnership's (GHCWP) 'Healthy Gloucestershire' strategy (GHCWP, 2008), which expands upon where we want to be in three years time and sets out how we will know whether we have made a difference (section 4.1.3).

2.1.2 Outcomes

The strategic objectives have been mapped to the following LAA indicators (see Appendix 10.5 for further examples):

- LI 08 - Percentage of schools achieving healthy schools status
- LI 18 - The number of people aged 75 or over admitted to hospital with fractured femur

- LI 25 - The number of incidents of anti social behaviour
- NI 17 - Perceptions of anti social behaviour
- NI 18 - Adult re-offending rates for those under probation supervision
- NI 39 - Rate of hospital admissions per 100,000 for alcohol-related harm
- NI 47 - People killed or seriously injured in road traffic accidents
- NI 111- First time entrants to the Youth Justice System aged 10-17
- NI 115 - Percentage of young people reporting either frequent misuse of drugs/ volatile substances or alcohol, or both.

3. Policy Guidance and What Works

3.1 Key Guidance

Key guidance on the alcohol-related harm reduction agenda is already influencing Gloucestershire's response to alcohol misuse.

The most recent guidance is introduced here for the first time. The guidance is all complementary; there is little if any contradictory guidance.

3.1.1. 'Alcohol Harm Reduction Strategy for England' (Cabinet Office, 2004)

The 'Alcohol Harm Reduction Strategy for England' was launched in March 2004. Up until this point alcohol had only been considered as a factor within other strategies.

Here, for the first time, Government outlined a comprehensive programme focusing purely upon alcohol-related harm.

The strategy categorises action into four key themes:

a) Education and communication – improving the information available to individuals and bring about a change in drinking culture

b) Identification and treatment – to better identify and treat those who misuse alcohol

c) Alcohol-related crime and disorder – to reduce levels of alcohol-related crime and disorder and the impact upon victims and witnesses

d) Supply and industry responsibility – working with alcohol retailers and suppliers to ensure responsible sales and marketing.

Delivery and implementation of the strategy will be carried out through better coordination and a more strategic approach in central Government; setting goals and monitoring progress; and flexibility to deliver at a local level.

3.1.2 'Choosing Health: Making healthy choices easier' (Department of Health, 2005)

The Department of Health's White Paper 'Choosing Health: Making healthier choices easier' builds upon the 'Alcohol Harm Reduction Strategy for England' (Cabinet Office, 2004) by including "encouraging and supporting sensible drinking" as an overarching priority.

The key focus areas are:

a) Work with the alcohol industry to reduce binge drinking

b) Work with health professionals to ensure early identification, targeted screening and brief interventions are carried out in the NHS

c) Driving improvement in alcohol treatment services.

3.1.3 'Safe. Sensible. Social. The next steps in the National Alcohol Strategy' (Department of Health, 2007)

'Safe, Sensible, Social: Next steps in the National Alcohol Strategy' was published in June 2007 by the Department of Health. Its overarching aims are to:

a) Ensure laws and licensing powers introduced to tackle alcohol-related crime and disorder are being used widely and effectively

b) Target young people aged under 18 who drink alcohol, 18-24 year old binge drinkers and harmful drinkers

c) Invest in education and communication and work in partnership to promote a sensible culture of drinking.

3.1.4. Building on the 'Alcohol Harm Reduction Strategy for England' (Cabinet Office, 2004)

Identifies the next steps as being:

a) Sharpened criminal justice for drunken behaviour

b) A review of NHS alcohol spending

c) More help for people who want to drink less

d) Toughened enforcement of underage sales

e) Trusted guidance for parents and young people

f) Public information campaigns to promote a new "sensible drinking" culture

g) Public consultation on alcohol pricing and promotion

h) Local alcohol strategies.

3.1.5. 'Models of Care for Alcohol Misusers' (Department of Health and National Treatment Agency for Substance Misuse, 2006)

The National Treatment Agency published the review of the effectiveness of treatment for alcohol problems in 2006. This review informed their guidance on developing a local programme for improvement, and its "Models of Care for alcohol misuse" (MOCAM) project. A summary of its findings is presented in Figure 3. PCTs should ensure alcohol services are operating within the MOCAM framework.

Key findings from the National Treatment Agency for Substance Misuse Review (2006)

- There is a need for a core assessment package to be developed in each locality to standardise and make accurate the assessment process
- The outcomes of treatment also need monitoring for each client
- A stepped care approach to alcohol is needed
- Securing clarity of drinking goals is important before starting treatment since abstinence and moderation goals call for different treatment approaches
- The type of treatment also depends on the type of alcohol use disorder
- Hazardous drinkers should be given information, advice and counselling in primary care
- Harmful drinkers should be given less intensive (than specialist) treatments in primary or secondary care
- Problem drinkers should be referred to a specialist
- There is no best treatment/ intervention or 'treatment of choice' for people with alcohol problems, rather a range of effective treatments for different kinds of client in different settings is needed
- Selection of which type of treatment to offer depends on clinician preference, client choice and availability of trained and enthusiastic therapists
- It is also important to involve family and friends in treatment which will improve the chances of successful treatment
- It is clear that diagnosing co-morbidity alongside alcohol use is crucial, as is the provision of the range of services to tackle associated problems
- Spending money on treating people with alcohol use disorders is cost effective. Brief interventions for hazardous and harmful drinking cost approximately £1,300 for each year of ill-health or premature death averted. The provision of alcohol treatment to 10% of the dependent drinking population within the United Kingdom would reduce public sector resource costs. Source: South West Public Health Observatory

Figure 3 – Models of Care for Alcohol Misuse
(Department of Health and National Treatment Agency for Substance Misuse, 2006)

3.1.6 National Institute of Health and Clinical Excellence Guidance

The National Institute for Health and Clinical Excellence (NICE) produced guidance in 2007 on 'Interventions in schools to prevent and reduce alcohol use among children and young people' (NICE, 2007), the key findings of which are reproduced in section 3.1.11.

They are currently developing three pieces of guidance relating to alcohol use disorders focusing on:

- Alcohol Use Disorders: diagnosis and clinical management of alcohol-related physical complications
- Alcohol Use Disorders: preventing the development of hazardous and harmful drinking
- Alcohol Use Disorders: management of alcohol dependence.

Early indications from consultation documents indicate that nothing in the forthcoming guidance will run contrary to the recommendations of this strategy.

3.1.7 World Health Organisation Guidance, 2009

Contemporary guidance from the World Health Organisation (WHO) consists of the 'Handbook for action to reduce alcohol-related harm 2009' and 'Evidence for the effectiveness and cost effectiveness of interventions to reduce alcohol-related harm 2009' (WHO, 2009).

Both documents advocate a multi-disciplinary approach to addressing alcohol-related harm rather than one which is merely based in health and highlight the need to address health inequalities by taking population level measures as well as ones which are focused on the individual.

Section 5 summarises current and planned local action in relation to WHO findings about what works in reducing alcohol-related harm.

3.1.8 'Signs for Improvement: Commissioning interventions to reduce alcohol-related harm' (Department of Health, 2009)

The above document introduced a number of "High Impact Changes" and suggests recommended actions for areas where tackling alcohol-related harm has been identified as a priority. These are laid out below:

- Improve the effectiveness and capacity of specialist treatments
- Appoint an alcohol health worker(s) or alcohol liaison nurse(s)
- Identification and brief advice in primary care and in hospital settings
- Amplify national social marketing priorities.

3.1.9 What works to reduce re-offending?

The evidence relating to what alcohol treatment interventions work for which groups of offenders and why is weak. A review of the literature in this area points to a number of problems including:

- Much of the evidence comes from North American studies and findings may not transfer to the UK.
- UK studies often have small sample sizes and therefore may be unable to detect statistically significant differences in treatment outcome even where they exist.
- Methodological weaknesses mean that there is a low level of confidence in study conclusions.
- A lack of high quality research in this area may reflect the Government's concern with illegal drugs rather than alcohol.
- Outcome measures such as reconviction rates are limited as a measure of impact (National Offender Management Service, 2004).
- Treatment effect sizes are small within the research and there is insufficient evidence to recommend particular approaches (McMurran, 2006).
- The relationship between offending and drinking is not always easy to determine.

Despite the absence of supporting evidence on what works to reduce re-offending there is a good body of evidence on the effectiveness of alcohol treatment interventions. It is reasonable to assume that improvement in offending rates will accrue as a result of reductions in alcohol misuse among offenders.

3.1.10. Regional Guidance and Policy

In addition to national policy, there are also a number of regional policies influencing the alcohol harm reduction agenda. These are:

- 'National Offender Management Service (NOMS) Alcohol-related Offending Regional Action Plan' [4]
- 'Calling Time: Reducing Alcohol Harm in the South West - A Blueprint for Joint Action' (Walsh, A. 2008)
- Regional Priorities for Reducing Alcohol-Related Harm in the South West 2008-09 (Government Office for the South West, 2008)

3.1.11. 'Guidance on the Consumption of Alcohol by Children and Young People from the Chief Medical Officer for England' (Department of Health, 2009)

In order to combat the harm caused by alcohol to young people, the Chief Medical Officer published a five-point guidance document in December 2009 to provide young people and their parents with clear medical guidance on alcohol consumption. This guidance reflects NICE guidance on school based interventions on alcohol (NICE, 2007). This recommends focusing on encouraging children not to drink, delaying the age at which they start drinking and reducing the harm it can cause among those who do drink. A summary of their recommendations is presented in Figure 4.

4 http://noms.homeoffice.gov.uk/

NICE recommendations on school based interventions include the following:

- Alcohol education should be an integral part of the school curriculum and should be tailored for different age groups and different learning needs.
- A 'whole school' approach should be adopted, covering everything from policy development and the school environment to staff training and parents and pupils should be involved in developing and supporting this.
- Where appropriate, children and young people who are thought to be drinking harmful amounts should be offered one-to-one advice or should be referred to an external service.
- Schools should work with a range of local partners to support alcohol education in schools, ensure school interventions are integrated with community activities and find ways to consult with families about initiatives to reduce alcohol use.

Figure 4 - Summary of NICE recommendations on school based interventions to prevent and reduce alcohol use among children and young people (NICE, 2007)

3.1.12 The Cardiff Model for Violence Prevention (Cardiff University, 2007)

Through pilots in Cardiff it has been shown that Emergency Departments (ED) can contribute distinctively and effectively to violence prevention by working with Crime and Disorder Reduction Partnerships (CDRP) and by sharing electronically wherever possible simple anonymised data about the location of violence, weapon use, assailants and day/time of violence. This data and the contributions of Accident and Emergency (A & E) Consultants enhance effectiveness of targeted policing significantly, reduce licensed premises and street violence and reduce ED violence-related attendances – in Cardiff by 40% since 2002.

The Cardiff Model represents a low cost, high impact intervention to reduce one element of alcohol-related harm.

3.1.13 Local Minimum Pricing

Evidence of what works to reduce alcohol-related harm points to pricing as a key tool in controlling harm, with a guide minimum price of 50p per unit of alcohol. Until recently, pricing has been considered an issue best resolved at national level for various legal and commercial reasons. However, various authorities have begun looking at what can be done to influence pricing locally.

In Oldham the licensing team has sought to renegotiate the license of every on-trade premise to the effect that the premise must either serve alcohol at no less than 75p a unit, or be subject to tougher licensing conditions. They are now taking a similar approach with the off-trade. Greater Manchester as a whole, through the association of Greater Manchester authorities, is looking at how a minimum price could be implemented across the area. 'Our Life' has commissioned legal advice setting out what powers a local area could use to implement a minimum price and what the implementation strategy should be[5]. Lawyers suggested that the legality of action can

5 http://www.ourlife.org.uk/

be defended but that problems will come if the implementation is flawed. They have also produced a paper on minimum price with respect to National and EU competition law.

Scotland has moved to implement a national minimum price. Blackpool has been operating a Thursday-Sunday minimum price per unit of alcohol in the on-trade for a number of years.

These are developments which Gloucestershire's partnerships should follow closely.

4. What Are We Currently Doing?

4.1 Local Policy

This strategy is co-sponsored by the Gloucestershire Safer and Stronger Communities Partnership (GSSCP, Appendix 10.7) and the Gloucestershire Health and Community Wellbeing Partnership (GHCWP, Appendix 10.8).

There are a number of strategies and structures within Gloucestershire that contribute to the reduction of alcohol-related harm. In turn, the alcohol strategy contributes towards achieving the objectives of other work streams. These include the partnership work streams around domestic violence, children and young people, cancer, sexual health, obesity, suicide and substance abuse.

Each district also has a Sustainable Community Strategy. These are key long-term planning documents for improving the quality of life and services in a local area and link with the Local Area Agreement. Improving health forms a central theme in each of these strategies and in many, reducing alcohol-related harm is identified as a priority.

The inter-connectedness of these strategies when coupled with the principles of Joint Strategic Commissioning and "Total Place"[6] mean that the impact as a whole is greater than the impact of each strategy seen in isolation. There are opportunities through Joint Strategic Commissioning for more efficient use of resources and delivering better services, with more impact for less cost[7].

The sub-sections below describe in detail the most significant local policies in place in relation to alcohol. Appendix 10.6 also provides a "mapping and gapping" analysis of alcohol service provision in Gloucestershire.

4.1.1 Local Area Agreement (LAA)

This is a three year agreement based on the local Sustainable Community Strategy. It sets out the priorities for the local area agreed between Central Government, represented by the Government Office for the South West (GOSW) and Gloucestershire, represented by the Local Authority and other key partners through Local Strategic Partnerships (LSPs).

The most significant indicator in relation to alcohol-related harm reported through the LAA is:

National Indicator (NI) 39 - Rate of hospital admissions per 100,000 for alcohol-related harm

A number of other priorities reported through the LAA are relevant to reducing levels of alcohol-related harm. These can be found in section 2.1.2.

6 http://www.localleadership.gov.uk/totalplace/
7 Note: Total Place is focussing on dysfunctional families – we can use the principles of this approach but don't have agreement to implement it for alcohol as a county.

4.1.2 'Gloucestershire Alcohol Strategy 2006–09' (NHS Gloucestershire, 2006)

This is the existing countywide alcohol strategy, co-sponsored by GSSCP and GHCWP. Since its publication the Government has launched the national strategy 'Safe. Sensible. Social: The next steps in the National Alcohol Strategy' (Department of Health, 2007) and, at the county level, GHCWP has published 'Healthy Gloucestershire 2008–18. The Health and Community Wellbeing Strategy for Gloucestershire' (GHCWP, 2008, see section 4.1.3). Both documents further contribute to our knowledge of alcohol-related harm, making this refresh of the strategy timely. In addition, the majority of objectives set through the 2006-09 strategy have now been achieved. Objectives that were not fully achieved during 2006–09 have been incorporated into the Implementation Plan (Section 8) of this 2010-13 strategy.

4.1.3 'Healthy Gloucestershire 2008–18. The Health and Community Wellbeing Strategy for Gloucestershire' (GHCWP, 2008)

'Healthy Gloucestershire' is the strategy of the GHCWP. It sets out the way in which the partnership intends to achieve its strategic aim:

"To improve the overall health and wellbeing of people living in Gloucestershire and to narrow the gap in health outcomes between communities and groups living in our disadvantaged communities and more affluent areas."

It identifies ten priority action areas for the Partnership to focus on over the next ten years of which one is to "Reduce Alcohol Harm". Under this theme, the key outcomes are:

- That there has been a change in the drinking culture within the county
- That the population of Gloucestershire who choose to drink do so based on clear and accurate information
- That where individuals, families or communities experience alcohol-related problems that support to change can be provide at the earliest possible opportunity
- Alcohol-related hospital admissions & deaths have been reduced compared to 2008.

These outcomes inform the strategic objectives of the Gloucestershire Alcohol Strategy (2010–13).

4.1.4 Gloucestershire 'Stronger and Safer Communities Plan 2010-2013' (GSSCP, 2008)

GSSCP's plan sets out the priorities for 2010-2013 and what is being done to achieve them in 2010-11. It builds on the district strategic assessments, which assess needs through analysing crime, disorder and substance misuse at a local level. It sets out to strengthen multi-agency partnership in order to reduce crime, disorder and substance misuse across the county.

This Alcohol Strategy is the vehicle to deliver the GSSCP's strategic objective around alcohol as expressed in outcome 5 of the plan; "to reduce the harm caused by illegal drugs and by alcohol" through:

- better prevention through communication and education
- better identification, interventions and treatment for alcohol misuse
- working effectively with the alcohol industry to reduce alcohol-related harm
- reduced drug and alcohol-related Crime, Disorder and Anti-Social Behaviour
- increased numbers of Gloucestershire residents successfully engaging with effective treatment services.

The outcomes are all mapped to the LAA.

4.1.5 'Gloucestershire Children and Young People's Plan 2009-12' (Gloucestershire Children and Young People's Strategic Partnership, 2009) and 'Gloucestershire Young People's Substance Misuse Needs Analysis 2010' (Gloucestershire County Council, 2010)

The 'Gloucestershire Children and Young People's Plan' (Gloucestershire Children and Young People's Strategic Partnership, 2009) contains eight priority outcomes, one of which focuses upon Improved Healthy Lifestyle Choices including objectives to:

- Increase the number of schools engaging in health and wellbeing initiatives through Healthy Schools and Healthy Schools Plus programmes
- Increase targeted substance misuse interventions with vulnerable young people including alcohol
- Roll out the implementation of screening and referral services for all children and young people through the countywide substance misuse screening tool.

The Health and Wellbeing Team together with partners in the voluntary sector provide sessions in schools to inform children and young people about topics related to substance misuse. The Police also run classroom sessions.

There is a targeted service (Infobuzz) focusing on vulnerable groups within various settings including educational and community organisations.

The specialist service is provided by Young Peoples Substance Misuse Services (YPSMS), which provide intensive one to one support for people under the age of 18 with substance misuse problems. YPSMS works closely with the Youth Offending Service (YOS) and Child and Adolescent Mental Health Service (CAMHS).

4.1.6 Gloucestershire Probation Trust (GPT)

Gloucestershire Probation Trust's approach to alcohol interventions and alcohol treatment (the latter, by Probation's definition being focused on alcohol dependency) is guided by 'NOMS Alcohol Interventions Guidance including revised guidance on Managing the Alcohol Treatment Requirement (ATR) – update of annex B to probation Circular 57/2005' (Ministry of Justice, 2009). It is also informed by the National Probation Service's work with alcohol-misusing offenders, 'Ministry of Justice Research Series 13/09' (Ministry of Justice, 2009) and 'A synthesis of literature on the effectiveness of community orders' (Davis et al, 2008).

Within existing arrangements, offenders are matched to appropriate interventions based upon the seriousness of the offence and the severity of need. Over the last three years, GPT has enhanced the provision of stepped care to alcohol misusing

offenders. Offenders are subject to an Alcohol Treatment Requirement (ATR) and usually those scoring 20 or more on AUDIT (dependent drinkers) are referred directly for brief interventions, where they will also undergo a comprehensive assessment leading to referral into mainstream tier 3 or 4 treatment services.

Where those on ATR would benefit from day programme provision there is the option of referral to the Community Integration Service. Group work can also be arranged through the Addressing Substance Related Offending or Drink Impaired Drivers programmes and there is a further option of the Low Intensity Alcohol Programme (LIAP).

5. Current Activity / Service Provision and Identified Gaps

We have involved stakeholders to map current activity and service provision in relation to reducing alcohol-related harm in Gloucestershire, the results of which can be found in Appendix 10.6. Together with the evidence base, the results of this exercise have been used to inform the Implementation Plan (section 8).

There is anecdotal evidence of the need to review provision of appropriate accommodation for those in various stages of treatment or intervention following alcohol-related harm, including those who are street homeless.

There are also plans to review the current Emergency Department Scheme and to consider enhancement in line with the High Impact Changes. Case studies in Liverpool have shown this to be an effective cost saving service (HubCAPP, 2010). This will involve reviewing alcohol treatment pathways.

The table below summarises current and planned local action in comparison to WHO findings about what works in reducing alcohol-related harm (WHO, 2009).

Figure 5 - Summary table of interventions to reduce alcohol-related harm

Level of intervention	Evidence of action that reduces alcohol-related harm	Evidence of action that ***does not*** reduce alcohol-related harm
Supply & control	Increasing alcohol price (taxation and minimum pricing)* The partnerships will monitor the progress of initiatives by other authorities, see 3.1.12. Government monopolies for retail sale* Restrictions on outlet density* Restrictions on days and hours of sales* Enforcing minimum age drinking laws* – Actions carried out through co-operation between Gloucestershire Constabulary and Trading Standards/ Licensing Authority A minimum price per gram of alcohol Enforcement of restrictions of sale to intoxicated or underage people	School based education & information* Lower taxes to manage cross border trade

Demand reduction	Restriction on the volume of commercial communications Cutting back on irresponsible drinking promotions – No local action presently reported.	Consumer labelling & warning messages Public education campaigns
Problem limitation	Random breath testing* – Action by Gloucestershire constabulary Brief interventions for hazardous and harmful drinkers* - Brief interventions are in place in criminal justice and non criminal justice settings. There is also tier 2, 3 and 4 treatment provision Treatment of alcohol use disorders* There is tier 1, 2, 3 and 4 treatment provision Accident and Emergency data sharing* - GDAWG will review the potential for adopting the Cardiff Model of Violence Prevention see 3.1.11 Suspension of driving licences Alcohol locks Workplace programmes Community based programmes Provision of late night transport – No local action presently reported. Safety audits of licensed premises To improve the physical environment and award schemes to reward venues that maintain a high standard for customer safety such as the Best Bar None award scheme for pubs and bars –Actions carried out through Trading standards and the licensing authority Help points (First Aid) for vulnerable people to seek assistance – No action presently reported in this area Calming initiatives such as not serving alcohol an hour before closing – No local action presently	Training of alcohol servers – Training provided by Trading Standards Designated driver campaigns Campaigns funded by the alcohol industry

	reported, there are plans to look into the cost effectiveness of such schemes using evidence from Bristol Street drinking bans can reduce the presence of potential weapons in public places – Local by-laws Pub and Club Watch schemes - Providing licensees with the opportunity to implement a coordinated response to problems in their premises have been shown to have an effect – Initiatives in place informally and formally throughout the county Safety glass There is evidence that use of toughened or safety drinking glasses in bars is helpful in reducing accidental and non accidental injuries – No local action presently reported Improvements in street lighting has been shown to be more effective in reducing crime than installing CCTV – No local action presently reported Fixed penalty notices may be useful to address low level anti-social behaviour such as drunkenness and littering in nightlife areas – Action by Gloucestershire constabulary Alcohol Arrest referral Schemes - Evidence relating to repeat offences for drink driving – We have a nationally recognised Alcohol Arrest Referral Scheme in place in Gloucestershire delivered by Independent Trust.	

*There is strong evidence of the effectiveness of this intervention.

6. Implementation of the Strategy

6.1 Implementation

To ensure effective implementation there must be a robust framework and procedure for steering the strategy over the next three years. Progress will only be maintained if there is both a strong collective to give alcohol misuse high priority and the correct systems are in place in order to allow improvements to be made.

6.1.1 Strategic Framework for Implementing the Alcohol Strategy

Delivery of the strategy will be steered and monitored by the Gloucestershire Drug and Alcohol Working Group (GDAWG). Further details regarding the monitoring function can be found in Section 7.

GDAWG will meet on a quarterly basis and membership will be made up of a variety of stakeholders who oversee implementation of the alcohol and drug strategies for the county. GDAWG will be a sub-group of, and report into, the GSSCP Performance Group and GHCWP 'Healthy Gloucestershire' implementation group. GDAWG will be accountable to both GHCWP and GSSCP. A diagram of where GDAWG sits in relation to the GSSCP can be found in Appendix 10.8.

6.1.2. Implementation Planning

The Implementation Plan (Section 8) sets out the objectives and actions we intend to take in order to achieve reductions in alcohol-related harm. Lead persons are clearly identified for each objective and also for the individual actions sitting below the objectives. This allows for focused management of the individual work streams and a designated point of contact for performance reporting. As such, non-delivery or slippage can be identified and addressed at an early stage and, likewise, achievements that can lead to good practice can be recognised and shared. In instances where delivery falls behind the specified timescales and remedial plans fail, there will be an escalation process via the GSSCP Executive Group to the overall objective lead to assist with unblocking barriers. If this does not resolve the difficulties, GSSCP will be notified to aid identification of a solution.

Implementation of the strategy and hence the structure of the implementation plan can be mapped to the Joint Strategic Commissioning Programme.

This provides the opportunity to identify cross cutting themes involving the alcohol strategy and other work streams. Coordination of the planning and implementation process takes place through the Healthy Gloucestershire Implementation Group. An update on the Gloucestershire Alcohol Strategy 2006-09 Implementation Plan can be found in Appendix 10.4.

7. Monitoring, Evaluation and Review of the Strategy

7.1 Monitoring and Evaluation Structure

The strategy and implementation plan will need to be monitored and reviewed on a regular basis. This will allow us to:

- Measure progress towards targets and objectives
- Assess performance against other areas
- Understand whether actions are achieving the intended results
- Establish the overall effectiveness of the strategy
- Review and amend the strategy in light of progress, and changing social, policy and practice environments, to ensure continued effectiveness.

7.1.1 Monitoring and Evaluation

Monitoring against the implementation plan will take place through the quarterly GDAWG meetings. The lead person will be asked to submit a progress update against their designated action in the form of a brief commentary and RAG (Red, Amber, Green) status. The RAG status is a simple way of communicating if the action is:

- Achieved, or on-track to be achieved (Green)
- Slightly off-track, but there are sufficient plans in place for recovery and achievement within the specified timescales (Amber)
- Seriously off-track and unlikely to be achieved in the specified timescale (Red).

Where expected outputs are not achieved, the reasons for this will be reviewed and the objective/action will be revised, or a remedial plan developed accordingly. Escalation will be used where necessary, as described in Section 6.1.2

7.1.2 Review

Review of the strategy will take place on an annual basis to ensure that the proposed outputs and outcomes remain appropriate and maximise impact on reducing alcohol-related harm. This will take into account both national and local developments. This review will be led by GDAWG and signed off by GSSCP and GHCWP.

8. Draft Alcohol Strategy Implementation Plan

Outcome Sponsor – Alice Walsh
Outcome Lead – Lisa Brown

Priority Outcome: Reducing alcohol related harm thereby having an impact on health inequalities – Actions for Adult Population

Strategic Objective	Through training and support raise awareness of front line staff working with adults to the harms of alcohol and to available support services
Accountable Manager	Hazel Millar, NHS Gloucestershire Lisa Brown, NHS Gloucestershire
Performance Indicators	NI 39 Halt in the rise of alcohol related hospital admissions by 2013 NI 47 – People killed or seriously injured in road traffic accidents LI 25 - The number of incidents of anti social behaviour NI 17 - Perceptions of anti social behaviour

Action	Milestones	Timescale		Status R/A/G	Lead Person and Organisation	Partners	Comments
		Start Date	Completion Date				
Prevention activity is embedded within the general health improvement partnership agenda	GHCWB quarterly reports on reducing Alcohol related harm card	April 2010	March 2011		Hazel Millar	GHCWP NHS Glos GCC	Healthy Glouc. Strategy
Alcohol services will engage with Supporting People to ensure a high quality of service delivery within the context of the Supporting People revised Strategy.	This will be on an ongoing basis.	Ongoing			Alcohol Services	Local Authorities Housing Providers Supporting People	Healthy Glouc. Strategy
Primary care alcohol services developed.	Fully established Care Pathway	April 2010	March 2011		Steve O'Neill	NHS Glos CSSMS Ind. Trust	
Fully established care pathway with county wide referrals	Fully established Care Pathway	April 2010	March 2011		Steve O'Neill	NHS Glos CSSMS Ind. Trust Nelson Trust	

Reduced waiting times to 4 weeks for alcohol treatment	Quarterly activity reports	April 2010	March 2011		Andy Moore	CSSMS	
Provide agree number of training events countywide for frontline staff to build knowledge and awareness of alcohol interventions.	Provide events and evaluation report on training	April 2010	March 2011		Steve O'Neill and Peter Steel	Ind. Trust	
Alignment of enforcement policy between Police and Trading Standards	Produce draft policy and seek agreement from GDAWG	April 2010	June 2010		Mark Gardiner	Police Trading Std	
ATR delivery plan agreed and published and related tasks	Plan published and agreed incorporating guidance from NOMS & DOH	April 2010	June 2010		Garry Holden	GPT Ind. Trust	
Delivery of Addressing Substance Related Offending, Drink Impaired Drivers Programme and Low Intensity Alcohol Programme	Quarterly activity reports	April 2010	March 2011		Garry Holden	GPT	

Strategic Objective	**Adopt a social marketing approach to alcohol awareness campaigns to facilitate informed choices and reduce alcohol related admissions.**
Accountable Manager	Hazel Millar, NHS Gloucestershire
Performance Indicators	NI 39 Halt in the rise of alcohol related hospital admissions by 2013

Action	Milestones	Timescale		Status R/A/G	Lead Person and Organisation	Partners	Comments
		Start Date	Completion Date				
Adopt a social marketing approach to our alcohol awareness campaigns.	Working Group established	July 2010	March 2010		Hazel Millar	NHS Glos Health Improvement Facilitators;	Healthy Glouc. Strategy
Align activity with Department national national social marketing strategy and use the national segmentation tool (launched March 2010) to inform local activity targeted at 'increasing' and 'at risk' drinkers	Action Plan developed in response to needs Quarterly progress reviews to GDAWG.	July 2010	August 2010		Claire Procter	District Council Healthy Living Staff Health Trainers GUIDE/PALS	Healthy Glouc. Strategy

Strategic Objective	**Reduce alcohol related offending by providing an intervention for adults arrested in circumstances where alcohol is a contributory factor. (Alcohol Arrest Referral Scheme)**
Accountable Manager	Peter Steel, Independence Trust
Performance Indicators	Reduction in incidence of repeat alcohol related offending among those who have received an intervention through the Alcohol Arrest Referral Scheme NI 18 – Adult re-offending rates for those under probation supervision NI 47 – People killed or seriously injured in road traffic accidents

Action	Milestones	Timescale		Status R/A/G	Lead Person and Organisation	Partners	Comments
		Start Date	Completion Date				
Alcohol Arrest Referral Scheme	Review funding arrangements Quarterly activity reports	April 2010	March 2011		Peter Steel	Ind. Trust Police	

Strategic Objective	Carry out a feasibility study and project manage the implementation of the Cardiff Model of Violence Reduction in Gloucestershire
Accountable Manager	Lisa Brown, NHS Gloucestershire
Performance Indicators	NI 39 Halt in the rise of alcohol related hospital admissions by 2013

Action	Milestones	Timescale		Status R/A/G	Lead Person and Organisation	Partners	Comments
		Start Date	Completion Date				
Cardiff Model for Violence Prevention scoped for county delivery	Establish Project Management arrangements and objectives	April 2010	December 2010		TBC	GDAWG MAIDeN	

Strategic Objective	Carry out a feasibility study and project manage the implementation of the Alcohol Liaison Nurses in Gloucestershire
Accountable Manager	Lisa Brown, NHS Gloucestershire
Performance Indicators	NI 39 Halt in the rise of alcohol related hospital admissions by 2013

Action	Milestones	Timescale		Status R/A/G	Lead Person and Organisation	Partners	Comments
		Start Date	Completion Date				
Use of Alcohol Liaison Nurses scoped for county delivery	Establish Project Management arrangements and objectives	April 2010	December 2010		TBC	GDAWG	High Impact Changes

Priority Outcome: Reducing alcohol related harm thereby having an impact on health inequalities – Actions for Children and Young People.	
Strategic Objective	**Through training and support raise awareness of front line staff working with children and young people to the harms of alcohol and to available support services**
Accountable Manager	Jan Courtney, CYP H&WB Team Manager GCC/NHS Gloucestershire
Performance Indicators	NI 39 Halt in the rise of alcohol related hospital admissions by 2013 NI 111 – First time entrants to the Youth Justice System aged 10-17 LI 08 Percentage of schools achieving Healthy Schools Status (Percentage of schools achieving Healthy Schools + Status)

Action	Milestones	Timescale		Status R/A/G	Lead Person and Organisation	Partners	Comments
		Start Date	Completion Date				
Training and support for teachers and other practitioners	Deliver 8 programmes in the academic year	April 2010	March 2011		Jan Courtney	Infobuzz CYPD	Healthy Glouc. Strategy
A rolling training programme provided for all staff working with children, young people and their families in the use of screening and early intervention	Deliver 8 programmes in the academic year	April 2010	March 2011		Tony France	Infobuzz CYPD	Healthy Glouc. Strategy
Test purchasing (8 Operations per year)	Quarterly review of activity	April 2010	March 2011		Mark Gardner	Trading Std Police	

Strategic Objective	**Support initiatives, such as PSHE, Family Packages, screening and early targeted interventions**
Accountable Manager	Jan Courtney, CYP H&WB Team Manager GCC/NHS Gloucestershire
Performance Indicators	NI 39 Halt in the rise of alcohol related hospital admissions by 2013 NI 111 – First time entrants to the Youth Justice System aged 10-17

Action	Milestones	Timescale		Status R/A/G	Lead Person and Organisation	Partners	Comments
		Start Date	Completion Date				
Advice and Information for Parents and Carers on boundary setting, communication and signs of alcohol consumption in children and what actions to take.	Quarterly review of activity	April 2010	March 2011		Jan Courtney	CYP H&WB Team	Healthy Glouc. Strategy
Common approaches to substance related issues established based upon CMO Guidance	Engage with four primary clusters. Policies produced and adopted	April 2010	June 2010		Jan Courtney	Infobuzz CYP H&WB Team	
Early, targeted interventions are facilitated through universal settings	Deliver 10 OCN groups in academic year and develop post 16 programme	April 2010	March 2011		Tony France	InfoBuzz Youth Service Connexions	
Education and awareness programmes are delivered in schools and colleges	Deliver 10 group programmes in academic year	April 2010	March 2011		Dave Wasley	Police	

Strategic Objective	**Reduce alcohol related offending by providing an intervention for children and young people arrested in circumstances where alcohol is a contributory factor. (Youth Alcohol Arrest Referral Scheme)**
Accountable Manager	Gerard Harford, Gloucestershire Youth Offending Service
Performance Indicators	Reduction in incidence of repeat alcohol related offending among those who have received an intervention through the Alcohol Arrest Referral Scheme

Action	Milestones	Timescale		Status R/A/G	Lead Person and Organisation	Partners	Comments
		Start Date	Completion Date				
Youth Alcohol Referral Service (YARS)	Engage with 150 people in year two	April 2010	March 2011		Gerard Harford	YOS YPSMS	Healthy Glouc. Strategy

9. References

Babor T., Campbell R., Room R., Saunders J. *Lexicon of alcohol and drug terms.* World Health Organisation: Geneva. 1994

Bates, B. et al. *Smoking, Drinking and Drug Use among Young People in England in 2006.* National Information Centre for Social Research: London. 2007

British Medical Association. *Adolescent Health.* BMA: London. 2003

British Medical Association. *Binge drinking.* BMA: London. 2005

British Medical Association. *Foetal Alcohol Spectrum Disorders. A guide for healthcare professionals*. BMA: London. 2007

Cabinet Office. *Alcohol Harm Reduction Strategy for England.* Cabinet Office: London. 2004

Cabinet Office. *Strategy Alcohol Harm Reduction project. Interim Analytical Report.* Cabinet Office: London. 2003.

Cardiff University. *Effective NHS Contributions to Violence Prevention. The Cardiff Model.* Cardiff University , Cardiff. 2007.

Davis, R., Rabinovich, L., Rubin, J., Kilmer, B., Heaton, P. *A synthesis of literature on the effectiveness of community orders.* RAND Corporation: Cambridge. 2008

Department for Education and Skills et al. *Every Child Matters: Change for Children, Young People and Drugs.* HMSO: 2005

Department for Transport, Scottish Executive, National Assembly for Wales *Road Casualties Great Britain 2005: Annual Report.* The Stationery Office: London. 2006

Department of Health and National Treatment Agency for Substance Misuse. *Models of care for alcohol misuseres* (MOCAM). HMSO: London. 2006

Department of Health et. al. *Alcohol Needs Assessment Research Project (ANARP): The 2004 national alcohol needs assessment for England.* HMSO: London. 2005

Department of Health. *Alcohol and health.* HMSO: London: 2007

Department of Health. *Alcohol misuse interventions: Guidance on developing a local programme of improvement,* HMSO: London. November 2005

Department of Health. *Choosing health: Making healthy choices easier.* HMSO: London. 2005

Department of Health. *Guidance on the Consumption of Alcohol by Children and Young People from the Chief Medical Officer for England.* HMSO: London. 2009

Department of Health. *Safe. Sensible. Social: The next steps in the National Alcohol Strategy.* HMSO: London. 2007

Department of Health. *Signs for Improvement: Commissioning interventions to reduce alcohol-related harm*. HMSO: London. 2009

Department of Health. *The cost of alcohol related harm to the NHS in England: an update to the Cabinet Office (2003) study.* Health Improvement Analytical Team, Department of Health. 22nd July 2008

Department of Health. *The Health of the Nation: A strategy for health in England.* HMSO: London. 1992

Donaldson, L. *150 years of the Annual Report of the Chief Medical Officer: On the state of public health 2008.* HMSO: London. March 2009

Eurocare. *Alcohol problems in the family – a report to the European Union.* European Commission. 1998

Faculty of Public Health. *Alcohol and Public Health: Position Statement.* Faculty of Public Health: London. May 2008

Gloucestershire Children and Young People's Strategic Partnership. *Gloucestershire Children and Young People's Plan 2009-12.* Gloucestershire County Council: Gloucester. 2009

Gloucestershire County Council, *Gloucestershire Young People's Substance Misuse Needs Analysis 2010'.* Gloucestershire County Council: Gloucester. 2010

Gloucestershire County Council. *Online Pupil Survey 2008.* Gloucestershire County Council: Gloucester. 2008. www.gloucestershire.gov.uk/changeforchildren

Gloucestershire Health and Community Wellbeing Partnership. Healthy Gloucestershire 2008–18. *The Health and Community Wellbeing Strategy for Gloucestershire.* NHS Gloucestershire: Brockworth. 2008

Gloucestershire Safer and Stronger Communities Partnership. Crime and Disorder Reduction Partnership. *Stronger and Safer Communities Plan 2010-2013 Gloucester Crime and Disorder Reduction Partnership Three Year Delivery Plan 2008-11.* Gloucester City Council: Gloucester. 2008

Government Office for the South West. *Regional Priorities for Reducing Alcohol Related Harm in the South West 2008-9.* GOSW: Bristol. 2008 http://www.gosw.gov.uk/gosw/publichealth/improvinghealth/a-zpublichealth/870095/

Green, H et al. *Mental Health of Children and Young People in Great Britain, 2004.* National Statistics: London. 2004

Home Office. *Offending, Crime and Justice Survey, 2004.* Home Office: London. July 2006

HubCAPP. *Liverpool Alcohol Lifestyle Services Team, HubCAPP TUL3.* Department of Health. 2010.

International Labour Organisation. *Mobilising small businesses to prevent substance misuse.* Report of the ILO workshop, 12–16 May 1997 (Oslo). ILO: Geneva. 1998

Jones, L, Bellis, M A, Dedman, D, Sumnall, H, and Tocque, K. *Alcohol attributable fractions for England; alcohol attributable mortality and hospital admissions.* North-West Public Health Observatory and Department of Health; London. 2008. http://www.nwph.net/nwpho/publications/forms/dispform.aspx?ID=186 Back

McMurran, M., 2006. *Controlled drinking goals for offenders.* Addiction Research and Theory, 14(1), 59-65

Ministry of Justice. *Evidence-based practice? The National Probation Service's work with alcohol-misusing offenders. Ministry of Justice Research Series 13/09.* HMSO: London. 2009

Ministry of Justice. NOMS *Alcohol Interventions Guidance including revised guidance on Managing the Alcohol Treatment Requirement (ATR) - Update of Annex B to Probation Circular 57/2005.* HMSO: London. 2009

National Institute for Clinical Excellence Public Health Guidance 7, *Interventions in school to prevent and reduce alcohol use among children and young people.* NICE: London. November 2007

National Offender Management Service, *What Works Briefing 2/04 Review of 'What Works' Evidence Base and the Juvenile and Adult Reconviction Results.* Home Office: London. 2004

NHS Gloucestershire. *Alcohol Needs Assessment 2008.* NHS Gloucestershire: Brockworth. 2008

NHS Gloucestershire. *Gloucestershire Alcohol Strategy 2006-9.* NHS Gloucestershire: Brockworth. 2006

North West Public Health Observatory. http://www.nwpho.net/alcohol/lape

Office for National Statistics. *Crime in England and Wales 2007-08: Findings from the British Crime Survey and Police Recorded Crime.* Home Office: London. July 2008

Office for National Statistics. *News Release: Alcohol related deaths continue to rise.* NHS Information Centre: London. January 2008 http://www.statistics.gov.uk/pdfdir/aldeaths0108.pdf

Office for National Statistics. *Statistics on Alcohol: England 2007.* NHS Information Centre: London. June 2007

Office for National Statistics. *Statistics on Alcohol: England 2008.* NHS Information Centre: London. May 2008

Raistrick D., Heather N., Godfrey C. *Review of the effectiveness of treatment for alcohol problems* Department of Health/National Treatment Agency for Substance Misuse: London. 2006

Robinson, S and Lader, D. *General Household Survey 2007: Smoking and Drinking Amongst Adults, 2007.* Office for National Statistics: London. 2008

Singleton, N. et al. *Substance Misuse Among Prisoners in England and Wales.* National Statistics: London. 1999.

Strategy Unit Alcohol Harm Reduction Project. *Interim analytical report.* Strategy Unit. 2003.

Strategy Unit Alcohol Harm Reduction Project. *Interim analytical report.* Strategy Unit. 2005.

UKATT Research Team. *Effectiveness of treatment for alcohol problems: findings of the randomised UK alcohol treatment trial* (UKATT). BMJ: 331: 54. 2005.

Walsh, A. *Calling Time: Reducing Alcohol Harm in the South West - A Blueprint for Joint Action.* South West Public Health Observatory and the National Screening Committee: Bristol. 2008

West Midlands Public Health Observatory (WMPHO). *Alcohol in the West Midlands: A review of alcohol and alcohol services in the West Midlands.* WMPHO: Birmingham. 2006.

World Health Organisation, *Alcohol policy in the WHO European Region: current status and the way forward.* WHO Fact Sheet EURO 10/05: Geneva. September 2005

World Health Organisation, *Evidence for the effectiveness and cost effectiveness of interventions to reduce alcohol related harm 2009.* World Health Organisation Regional Office for Europe: Copenhagen. 2009

World Health Organisation, *Handbook for action to reduce alcohol-related harm.* World Health Organisation Regional Office for Europe: Copenhagen. 2009

10. Appendices

10.1 Overview of Alcohol-Related Harm in Gloucestershire

Indicator	Chelten-ham	Cotswold	Forest of Dean	Gloucester	Stroud	Tewkes-bury	Glouces-tershire	Regional average	England
†Months of life lost – males	8.0	6.6	6.8	8.7	7.1	6.6	7.8	8.5	9.2
†Months of life lost – females	4.4	3.5	4.8	5.3	4.2	3.7	4.3	3.7	4.3
†Alcohol-specific mortality – males	9.7	5.9	10.3	13.7	9.4	5.8	9.4	11.6	12.71
†Alcohol-specific mortality – females	7.7	2.9	6.1	9.6	5.0	3.7	5.9	5.0	5.92
†Mortality from chronic liver disease – males	15.0	7.9	14.2	15.9	9.4	7.9	11.9	11.7	13.79
†Mortality from chronic liver disease - females	8.2	6.0	7.4	9.3	6.1	4.1	6.9	5.6	7.13
†Alcohol-related mortality – males	38.6	30.8	31.2	36.3	35.4	23.6	32.9	33.7	36.1
†Alcohol-related mortality – females	18.4	13.1	17.2	18.2	11.1	16.0	15.3	13.2	15.2
†Alcohol-specific hospital admission – under 18s	74.6	53.0	61.6	77.7	72.7	46.5	66.4	78.5	72.32
†Alcohol-specific hospital admission - males	393.9	240.1	192.4	360.0	242.4	204.8	280.8	331.7	373.7
†Alcohol-specific hospital admission – females	211.9	121.6	85.7	190.1	136.7	140.5	153.5	178.9	189.5
†Alcohol-related hospital admission – males	1,233.3	974.1	969.8	1282.7	973.8	1012.7	1084.3	1099.0	121.67
†Alcohol-related hospital admission - females	720.1	536.6	518.5	720.9	565.3	596.0	617.7	636.7	693.8
†Hospital admissions for alcohol-related harm (NI 39)	1,549.4	1,212.6	1,183.3	1,700	1227.5	1329.1	1382.1	1365.3	1365.3
†Alcohol-related recorded crimes	10.0	4.2	5.2	11.7	6.0	4.9	7.4	7.1	8.61
†Alcohol-related violent crimes	7.2	3.1	4.1	8.6	4.4	3.7	5.4	5.3	6.09
†Alcohol-related sexual offences	0.1	0.1	0.1	0.2	0.1	0.1	0.1	0.1	0.12
†Claimants of incapacity benefits – working age	141.1	40.4	40.5	139	75.1	41.9	87.1	142.6	130.63
†Mortality from land transport accidents	1.5	2.7	5.4	1.1	2.1	4.6	2.6	1.9	1.77
†Hazardous drinking (synthetic estimates)	19.9.	19.8	19.0	20.0	20.8	19.6	19.9	19.6	20.1
†Harmful drinking (synthetic estimate)	4.5	3.8	4.3	5.0	4.2	3.9	4.3	4.5	5.03
†Binge drinking (synthetic estimate)	16.8	14.4	14.9	15.4	14.7	14.5	15.2	15.3	18.0
†Employees in bars - % of all employees	2.0	3.5	2.2	1.6	2.2	1.8	2.1	2.4	2.0
*Victims of domestic violence (including repeat victims) as reported to the police April 2007 to January 2009	1306	441	629	1565	880	630	5451	-	-

*Repeat victims of domestic violence as reported to the police April 2007 to January 2009 (% repeats of all reported victims)	329 (25.2)	74 (16.8)	140 (22.3)	389 (24.9)	253 (28.8)	127 (20.2)	1312 (24.1)	-	-
‡Percentage of year 10 pupils who drink alcohol quite often or most days in Gloucestershire	-	-	-	-	-	-	29.8	-	-
‡Percentage of year 10 pupils who are drunk quite often or most days in Gloucestershire	-	-	-	-	-	-	31.4	-	-
Youth Offending Service (YOS) assessments undertaken between October 2007 and October 2008 showing that the young person had used alcohol at the time of the offence (percentage of all assessments undertaken).	-	-	-	-	-	-	735 (28.8)	-	-
**Number of neighbourhoods ranking in the worst 10% Gloucestershire for violent crime in licensed premises	8	4	5	7	6	4	34	-	-
**Number of neighbourhoods ranking in the worst 10% Gloucestershire for violent crime under the influence of alcohol and/or drugs	8	5	6	14	7	3	43	-	-
**Number of neighbourhoods ranking in the worst 10% Gloucestershire for incidents of anti-social behaviour (rowdy or inconsiderate behaviour)	14	3	4	15	4	3	43	-	-

Table 1 - Overview of alcohol-related harm in Gloucestershire (full descriptions of the measures used can be found in Appendix 10.3).

Key (applies to LAPE data only (†). No such comparisons have been made for other data sets presented).

Significantly better than England average	Significantly worse than England average

Sources

† *Local Alcohol Profiles for England* (LAPE 2009). Further details on the measures used can be found at http://www.nwph.net/alcohol/lape/.

*MAIDeN (http://www.maiden.gov.uk/). It should be emphasised that not all victims report crimes against them to the police or any other agency

‡*The Gloucestershire Online Pupil Survey* 2008. Further details can be found at http://www.gloucestershire.gov.uk/index.cfm?articleid=19910

**MAIDeN (http://www.maiden.gov.uk/). Neighbourhoods are *Lower Level Super Output Areas* - these are small geographical units made up of 1,000 to 3,000 residents and provide a more in-depth appreciation of variations at a local level.

Note that *hospitals admissions for alcohol-related harm (NI 39)* is not equal to the combined totals of alcohol-related hospital admissions for males and females. This is because the figures broken down by sex do not include attendances at A&E whereas NI39 does.

10.2 Crime, Disorder and Anti-Social Behaviour by Neighbourhood (Lower Level Super Output Area - LSOA), 2008-09

Top 10% LSOAs in Gloucestershire for incidents of ASB Rowdy Behaviour.

District	LSOA Code	LSOA Name	Number of incidents of ASB
Cheltenham	E01022153	St PAUL'S 3	364
	E01022127	LANSDOWN 4	312
	E01022102	ALL SAINTS 3	274
	E01022117	COLLEGE 2	252
	E01022121	HESTERS WAY 2	206
	E01022116	COLLEGE 1	187
	E01022164	SWINDON VILLAGE 2	147
	E01022120	HESTERS WAY 1	141
	E01022158	St PETER'S 4	137
	E01022160	SPRINGBANK 2	129
	E01022126	LANSDOWN 3	126
	E01022122	HESTERS WAY 3	120
	E01022147	St MARK'S 1	106
	E01022156	St PETER'S 2	102
Cotswold	E01022194	CIRENCESTER PARK 1	256
	E01022192	CIRENCESTER CHESTERTON 2	04
	E01022219	TETBURY 3	104
Forest of Dean	E01022256	LYDNEY EAST 3	154
	E01022237	CINDERFORD EAST 2	137
	E01022241	COLEFORD CENTRAL 1	118
	E01022236	CINDERFORD EAST 1	106
Gloucester	E01022349	WESTGATE 3	1170
	E01022347	WESTGATE 1	617
	E01022311	KINGSHOLM AND WOTTON 3	234
	E01022333	PODSMEAD 1	185
	E01022337	QUEDGELEY FIELDCOURT 3	178
	E01022287	BARNWOOD 6	156
	E01022288	BARTON AND TREDWORTH 1	153
	E01022329	MORELAND 4	153
	E01022285	BARNWOOD 4	122
	E01022289	BARTON AND TREDWORTH 2	122
	E01022332	MORELAND 7	117
	E01022317	LONGLEVENS 5	113
	E01022335	QUEDGELEY FIELDCOURT 1	110
Stroud	E01022365	CENTRAL	470
	E01022379	HARDWICKE 2	144
	E01022372	DURSLEY 1	118
	E01022400	STONEHOUSE 1	117
Tewkesbury	E01022459	TEWKESBURY TOWN WITH MITTON 1	221
	E01022421	BROCKWORTH 1	125
	E01022455	TEWKESBURY NEWTOWN	125

Top 10% LSOAs in Gloucestershire for violent crime in a licensed premises

District	LSOA Code	LSOA Name	Number of incidents of violent crime in licensed premises
Cheltenham	E01022102	ALL SAINTS 3	82
	E01022127	LANSDOWN 4	52
	E01022117	COLLEGE 2	49
	E01022116	COLLEGE 1	48
	E01022153	St PAUL'S 3	15
	E01022126	LANSDOWN 3	6
	E01022158	St PETER'S 4	5
	E01022119	COLLEGE 4	>5
Cotswold	E01022194	CIRENCESTER PARK 1	30
	E01022211	MORETON-IN-MARSH 1	5
	E01022181	BOURTON-ON-THE-WATER 2	>5
	E01022223	WATER PARK 1	>5
Forest of Dean	E01022241	COLEFORD CENTRAL 1	27
	E01022256	LYDNEY EAST 3	10
	E01022258	MITCHELDEAN AND DRYBROOK 1	5
	E01022226	ALVINGTON, AYLBURTON AND WEST LYDNEY 1	>5
	E01022230	BLAISDON AND LONGHOPE	>5
Gloucester	E01022349	WESTGATE 3	192
	E01022347	WESTGATE 1	66
	E01022335	QUEDGELEY FIELDCOURT 1	7
	E01022311	KINGSHOLM AND WOTTON 3	6
	E01022277	ABBEY 2	5
	E01022332	MORELAND 7	5
	E01022305	HUCCLECOTE 3	>5
Stroud	E01022365	CENTRAL	55
	E01022374	DURSLEY 3	8
	E01022372	DURSLEY 1	7
	E01022394	RODBOROUGH 2	5
	E01022398	SEVERN 3	5
	E01022352	BERKELEY 2	>5
Tewkesbury	E01022459	TEWKESBURY TOWN WITH MITTON 1	33
	E01022453	OXENTON HILL	6
	E01022445	HIGHNAM WITH HAW BRIDGE 3	5
	E01022436	CLEEVE St MICHAEL'S 2	>5

Top 10% LSOAs in Gloucestershire for violent crime under the influence of alcohol/ drugs.

District	LSOA Code	LSOA Name	Incidents of violent crime under the influence of alcohol or drugs
Cheltenham	E01022102	ALL SAINTS 3	60
	E01022117	COLLEGE 2	60
	E01022127	LANSDOWN 4	42
	E01022116	COLLEGE 1	39
	E01022153	St PAUL'S 3	35
	E01022147	St MARK'S 1	25
	E01022158	St PETER'S 4	17
	E01022156	St PETER'S 2	12
Cotswold	E01022194	CIRENCESTER PARK 1	40
	E01022192	CIRENCESTER CHESTERTON 2	10
	E01022199	CIRENCESTER WATERMOOR 2	10
	E01022211	MORETON-IN-MARSH 1	10
	E01022212	MORETON-IN-MARSH 2	10
Forest of Dean	E01022241	COLEFORD CENTRAL 1	23
	E01022256	LYDNEY EAST 3	19
	E01022236	CINDERFORD EAST 1	12
	E01022251	LYDBROOK AND RUARDEAN 1	11
	E01022226	ALVINGTON, AYLBURTON AND WEST LYDNEY 1	10
	E01022238	CINDERFORD WEST 1	10
Gloucester	E01022349	WESTGATE 3	226
	E01022347	WESTGATE 1	85
	E01022289	BARTON AND TREDWORTH 2	19
	E01022311	KINGSHOLM AND WOTTON 3	18
	E01022312	KINGSHOLM AND WOTTON 4	14
	E01022332	MORELAND 7	14
	E01022348	WESTGATE 2	14
	E01022292	BARTON AND TREDWORTH 5	13
	E01022294	BARTON AND TREDWORTH 7	13
	E01022288	BARTON AND TREDWORTH 1	12
	E01022310	KINGSHOLM AND WOTTON 2	11
	E01022319	MATSON AND ROBINSWOOD 1	11
	E01022284	BARNWOOD 3	10
	E01022337	QUEDGELEY FIELDCOURT 3	10

Stroud	E01022365	CENTRAL	80
	E01022414	VALLEY	19
	E01022399	SLADE	14
	E01022372	DURSLEY 1	13
	E01022377	FARMHILL AND PAGANHILL	13
	E01022356	CAINSCROSS 2	12
	E01022398	SEVERN 3	11
Tewkesbury	E01022459	TEWKESBURY TOWN WITH MITTON 1	37
	E01022428	CHURCHDOWN St JOHN'S 1	10
	E01022458	TEWKESBURY PRIOR'S PARK 3	10

10.3 Measure Descriptors

Indicator	
Months of life lost – males	An estimate of the increase in life expectancy at birth that would be expected if all alcohol-attributable deaths among males/females aged under 75 years were prevented. (NWPHO from 2004-2006 England and Wales life expectancy tables for males and females [Government Actuary Department], alcohol-attributable deaths from Public Health Mortality File 2004-06 in males/females aged under 75 and Office for National Statistics mid-year population estimates for 2004-06).
Months of life lost – females	
Alcohol-specific mortality – males	Deaths from alcohol-specific conditions (all ages, male/female), directly standardised rate per 100,000 population (standardised to the European Standard Population). (NWPHO from Office for National Statistics Public Health Mortality File for 2004/06 and mid-year population estimates for 2004/06).
Alcohol-specific mortality – females	
Mortality from chronic liver disease – male	Deaths from chronic liver disease including cirrhosis (ICD-10: K70, K73-K74) (all ages, male/female), directly standardised rate per 100,000 population (standardised to the European Standard Population). (Compendium of Clinical and Health Indicators, National Centre for Health Outcomes Development 2004-2006 pooled).
Mortality from chronic liver disease – females	
Alcohol-related mortality – males	Deaths from alcohol-attributable conditions (all ages, male/female), directly standardised rate per 100,000 population (standardised to the European Standard Population). (NWPHO from Office for National Statistics Public Health Mortality File for 2006 and mid-year population estimates for 2006).
Alcohol-related mortality – females	
Alcohol-specific hospital admission – under 18s	Persons admitted to hospital due to alcohol specific conditions (under 18s, persons), crude rate per 100,000 population. In some areas the number of admissions was less than 5. In these cases the rate was calculated assuming 5 admissions. (NWPHO from Hospital Episodes Statistics 2004/05-2006/07 and Office for National Statistics mid-year population estimates 2004-2006). Does not include attendance at A&E.
Alcohol-specific hospital admission – males	Persons admitted to hospital due to alcohol-specific conditions (all ages, male/female), directly standardised rate per 100,000 population. (NWPHO from Hospital Episodes Statistics 2006/07 and Office for National Statistics mid-year population estimates 2006). Does not include attendance at A&E.
Alcohol-specific hospital admission – females	

Alcohol-related hospital admission – males	Persons admitted to hospital due to alcohol-attributable conditions (all ages, male/female), directly standardised rate per 100,000 population. (NWPHO from Hospital Episodes Statistics 2006/07and Office for National Statistics mid-year population estimates 2006). Does not include attendance at A&E.
Alcohol-related hospital admission – females	
Hospital admissions for alcohol-related harm (NI 39)	NI39: Hospital Admissions for Alcohol-related Harm: directly age and sex standardised rate per 100,000 population, 2006/07. (Department of Health using Hospital Episode Statistics and Office for National Statistics mid-year population estimates).
Alcohol-related recorded crime	Alcohol-related recorded crimes, crude rate per 1,000 population. (NWPHO from Home Office recorded crime statistics 2007/08). Attributable fractions for alcohol for each crime category were applied, based on survey data on arrestees who tested positive for alcohol by the Strategy Unit.
Alcohol-related violent crimes	
Alcohol-related sexual offences	
Claimants of incapacity benefits – working age	Claimants of Incapacity Benefit or Severe Disablement Allowance whose main medical reason is alcoholism, crude rate per 100,000 (working age, persons) population. (NWPHO from Department for Work and Pensions data Nov 2007 and Office for National Statistics 2006 mid-year population estimates).
Mortality from land transport accidents	Estimated number of deaths attributable to alcohol from land transport accidents (ICD-10: V01-V89) (all ages, persons) directly standardised rate per 100,000 population (standardised to the European Standard population). (NWPHO from Compendium of Clinical and Health Indicators, National Centre for Health Outcomes Development 2004-06 pooled). The Strategy Unit's alcohol-attributable fraction was applied to obtain the estimates.
Hazardous drinking (synthetic estimates)	Mid-2005 synthetic estimate of the proportion (%) of the population aged 16 years and over who report engaging in hazardous drinking, defined as consumption of between 22 and 50 units of alcohol per week for males, and between 15 and 35 units of alcohol per week for females. (NWPHO from Health Survey for England, Hospital Episode Statistics, Office for National Statistics mid-year population estimates and mortality data and the Census of Population 2001).

Harmful drinking (synthetic estimate)	Mid-2005 synthetic estimate of the proportion (%) of the population aged 16 years and over who report engaging in harmful drinking, defined as consumption of more than 50 units of alcohol per week for males, and more than 35 units of alcohol per week for females. (NWPHO from Health Survey for England, Hospital Episode Statistics, Office for National Statistics mid-year population estimates and mortality data and the Census of Population 2001).
Binge drinking (synthetic estimate)	Synthetic estimate of the proportion (%) of adults who consume at least twice the daily recommended amount of alcohol in a single drinking session (that is, 8 or more units for men and 6 or more units for women). Estimates originally produced for the Department of Health (2003-2005).
Employees in bars - % of all employees	The number of employees employed in bars (SIC2003: 5540), as a percentage of all employees. (Annual Business Inquiry 2006, National Statistics, from Nomis website: www.nomisweb.co.uk). The desirability of a low or high percentage (what is better or worse) has not been determined.
Victims of domestic violence (including repeat victims) as reported to the police April 2007 to January 2009	Source: Research and Information Team Gloucestershire County Council
Repeat victims of domestic violence as reported to the police April 2007 to January 2009 (% repeats of all reported victims)	
Percentage of year 10 pupils who drink alcohol quite often or most days in Gloucestershire	Source: *Gloucestershire Online Pupil Survey 2008* - provides an overview of the self reported attitudes of children and young people living in Gloucestershire on a wide range of health-related issues. Over 17,000 pupils in years 4, 6, 8 and 10 took part in the 2008 survey.
Percentage of year 10 pupils who are drunk quite often or most days in Gloucestershire	
Youth Offending Service **(YOS) assessments undertaken between October 2007 and October 2008 showing that the young person had used alcohol at the time of the offence (percentage of all assessments undertaken).**	As detailed

Number of neighbourhoods ranking in the worst 10% in Gloucestershire for violent crime in licensed premises	Source: Research and Information Team Gloucestershire County Council
Gloucestershire for violent crime under the influence of alcohol and/or drugs	
Number of neighbourhoods ranking in the worst 10% in Gloucestershire for incidents of anti-social behaviour (rowdy or inconsiderate behaviour)	

10.4 Update on Gloucestershire Alcohol Strategy 2006-09 Implementation Plan

Objectives		Lead agency	Position as of November 2008	
			RAG	Comments
1. Strategic				
a	Identify Alcohol Strategic Lead for county	Glos PCT	G	Jan Stubbings identified as county lead. Shona Arora chairing GASAG on her behalf.
b	Agree treatment commissioning structure and identify lead	Glos PCT	G	GSSCP structures confirmed. Lead treatment commissioning group is ATJCG. Coordination occurs at GSSCP Drug & Alcohol Group. Treatment Commissioning Strategy is under development for completion by May 2008.
c	Press to reduce alcohol-related crime in line with local strategies	CDRP	G	Work continues and aligns with CDRP strategies and LAA
d	Identify sources of funding to support the delivery of Strategy	GSSCP, GHLP		Choosing Health funds for ED Project agreed.
e	Integrate Strategy into other county Strategies	All	G	Coordination occurs at GSSCP Drug & Alcohol Group. Needs Assessment first phase completed Dec 2007.
2. Promotion				
a	Raise awareness within the local population about alcohol and services	SAGs	G	Alcohol included in TDCL countywide promotions & CDRP campaigns
b	Develop a marketing programme to support the delivery of the Strategy	GSSCP; GHLP	A	Problems with recruitment , this action will begin in 2009-10
3. Prevention				
a	Target preventative activities at key and high risk groups	Alcohol Action Group	G	ED Project now agreed. Will supplement existing AARS via Police Custody
b	Work with Licensing Authorities, retailers etc to develop co-ordinated approach	GSSCP; GHLP	G	Police to include in their work with Licensing Authorities and Trading Standards: Initial Meeting with Licensing Authorities 18 July. Test purchase operations being run through the summer by Trading Standards targeting persistent sellers to young people.

4. Models of Care				
a	Deliver a choice in service provision across the County in line with MOCAM	Gloucestershire PCT	G	Services being provided. Not yet marked against MOCAM
b	Deliver a range of client pathways & service provision in line with MOCAM	PCT & Providers	G	Agreed that Alcohol Commissioning Strategy be in place by May 2008 (supported by Needs Assessment)
5. Treatment and Intervention				
a	Target treatment activities at key groups -including Probation and Prison	AAC	G	Criminal Justice Substance Misuse Group created, chaired by Probation Assistant Chief Officer, reporting to AT JCG to advise on CJ treatment requirements.
b	Establish interventions in Emergency Departments across the county	Gloucestershire PCT & GHT	G	Services now commissioned and delivery commenced.
6. Support and Training				
a	Develop and support User and/or Carer involvement & consultation	All	G	Service User Team include consultation on Alcohol Service provision as part of their activity.
b	To enable Joint Planning and Commissioning to inform the Supporting People revised Strategy with up to date needs analysis and Service User aspirations for housing related support.	Alcohol Services	A	Partnership working to include Local Authorities Strategic and Housing, Housing Providers. Voluntary sector. Supporting People.
c	Partners to sign up to alcohol awareness & training based on MOCAM	GSSCP;GHLP	A	Training funds in place for initial primary care. Events to begin in 2009-10
7. Monitoring and Review				
a	Establish the effective local monitoring of alcohol misuse in the county	Public Health	G	Within LAA SSC3 (viii) is a Public Perception target. Monitoring later in f/yr via GCC Crime Survey.
b	Monitor & review the effectiveness of the delivery of Strategy	AAG	G	The Implementation Plan was regularly updated with the final refresh of the 2006-09 strategy's plan taking place in November 2008.

10.5 Links to Local Area Agreement

- LI 08 - Percentage of schools achieving healthy schools status
- LI 18 - The number of people aged 75 or over admitted to hospital with fractured femur
- LI 22 – Overall general satisfaction with the local area in the most deprived Super Output Areas
- LI 25 - The number of incidents of anti social behaviour
- NI 5 – Overall/general satisfaction with local area
- NI 17 - Perceptions of anti social behaviour
- NI 18 – Adult re-offending rates for those under probation supervision
- NI 20 – Assault with injury crime rate
- NI 32 – Repeat incidents of domestic violence
- NI 39 – Rate of hospital admissions per 100,000 for alcohol-related harm
- NI 42 – Perceptions of drug use or drug dealing as a problem
- NI 47 – People killed or seriously injured in road traffic accidents
- NI 111 – First time entrants to the Youth Justice System aged 10-17
- NI 115 - percentage of young people reporting either frequent misuse of drugs/ volatile substances or alcohol, or both
- NI 120 – All age, all cause mortality rate

10.6 Mapping and Gapping

Better Prevention Through Education and Communication		
What Are We Currently Doing?		**Identified Gaps**
Activity / Service	**Agencies Involved**	
Schools and Young People's Unit – delivers educational programmes in schools based on the identified needs of a given area.	Gloucestershire Police	Public health messages that focus on the consequences of alcohol misuse and modifying behaviour (specifically social marketing campaigns). Alcohol awareness training for front line staff in a variety of settings. Work with the elderly in relation to alcohol misuse and related issues such as fire safety, falls and dementia. Alcohol-related harm reduction agenda within the workplaces of the stakeholders involved in production of the strategy (a best practise toolkit could then be rolled out to other workplaces within the county). An awareness between stakeholders of the alcohol-related data held by each. An educational programme that can reach all offenders entering NOMs whether or not they are identified as having an alcohol problem (a toolkit could be developed for NOMs staff to deliver brief interventions).
Safer Communities Teams – deliver programmes in primary, secondary and post–16 educational settings.	Gloucestershire Police	
Marketing Strategies – around various alcohol-related topics (such as binge drinking).	Gloucestershire Police	
Seasonal Campaigns – driven by statistical returns. Have included sensible drinking messages at Christmas. Methods of communication include leaflets, advice giving at events and radio advertising.	Gloucestershire Police	
Tier One Services for children and young people.	Healthy Schools Partnership; Schools; Youth Service; Children's Centres; Primary Care; Connexions; Gloucestershire Police; NHS Gloucestershire	
Level 1-2 non-specialist services for children and young people.	Healthy Schools Partnership; Schools; Infobuzz; Life Education; Community Safety Partnerships	
Health Trainers	NHS Gloucestershire	
Don't Buy 4 U 18s campaign	District Councils; NHS Gloucestershire; Trade	

Better Identification and Treatment for Alcohol Misuse		
What Are We Currently Doing?		**Identified Gaps**
Activity / Service	**Agencies Involved**	
Direct Enhanced Service (DES) - screening of new patients aged 16 years and over in Primary Care with referral to brief interventions where necessary	Primary Care; NHS Gloucestershire	Targets around ASRO and ATR but no other general alcohol targets. Difficult as there are many more targets around drugs, but the prevalence and serious of alcohol misuse is much more widespread. Existing arrangements within Gloucestershire Probation Area see offenders matched to appropriate interventions based upon seriousness of offence and severity of need. For offenders whose circumstances do not meet the threshold of participation in ASRO or ATR, there is a gap in provision. To fill this gap, it is proposed to introduce a Brief, Motivational Enhancement Intervention for alcohol misusing offenders. It will consist of three planned and individualised treatment sessions over a period of eight weeks that use motivational strategies to mobilise the clients own resources for change. Since the AARS scheme began in 1998 Police can now give a Penalty Notice for Disorder. This results in a fine of £80 either on the spot or in custody upon disposal. This route has no direct mechanism for direct referral to AARS. Conditional Cautioning – there is an opportunity to refer those given conditional cautioning by the Police to be referred into alcohol education schemes. Defined routes for those persons coming into contact with the Police or below the threshold for committing an offence to be referred into relevant schemes. e.g. alcohol education or domestic violence advice. Youth alcohol-referral scheme comparable to AARS. This scheme is currently in the planning and setup stage.
Primary Care Brief Interventions for all referrals from primary care	INDEPENDENCE TRUST; NHS Gloucestershire	
Emergency Department Workers based at Gloucester and Cheltenham Hospitals offer brief interventions for those with alcohol-related attendances.	INDEPENDENCE TRUST; Gloucestershire Hospital Trust; NHS Gloucestershire	
Extended Brief Interventions for service users identified at screening or brief intervention as needing longer intervention	INDEPENDENCE TRUST; NHS Gloucestershire	
Specialist Alcohol Community Treatment and Detoxification - for problematic and dependent drinkers. Community Reinforcement approach used as therapeutic method.	²gether Trust; NHS Gloucestershire	
Structured Day Care where service user may not be abstinent	INDEPENDENCE TRUST; Community Integration Service; Gloucestershire Probation; NHS Gloucestershire	
Structured Day Care Programme for problematic and dependent drinkers wishing to achieve abstinence	Nelson trust; NHS Gloucestershire	
In-Patient Detoxification	²gether Trust; NHS Gloucestershire	

Out of county, spot purchased **Residential Rehabilitation** for those unable to achieve treatment goals in community or with local services. This service is only accessed after assessment by in-county care managers	Care managers; Independent providers; NHS Gloucestershire	Health Equity Audit to identify how fairly treatment services are distributed for the needs of different groups.
Service User Support Team	NHS Gloucestershire	
Alcohol Arrest Referral Scheme (AARS) – individuals in custody identified as having an alcohol misuse disorder may be referred. If charged with an offence that is alcohol-related it may be a bail requirement. Also opportunities for voluntary referral. Since its conception, AARS has cut the number of offenders re-committing alcohol-related offences by 50 per cent.		
Alcohol Treatment Requirement (ATR) – tailored treatment programme with the aim of reducing drink dependency. The requirement can last between six months and three years.	Gloucestershire Probation; NHS Gloucestershire	
Tier 2 Targeted Services for children and young people.	Infobuzz; YES Team (Young People Emotional Wellbeing Service); Youth Crime Prevention Team	
Tier 2 / 3 Gateway Services for children and young people.	Nelson Trust; YPSMS; and YOS	
Tier 3 Specialist Services for children and young people.	Nelson Trust; YPSMS	
Common Assessment Framework for children and young people.	NHS Gloucestershire	
Substance Misuse Screening Tool for children and young people.	NHS Gloucestershire	

Training for Frontline Staff from all agencies in the use of the Substance Misuse Screening Tool for children and young people.	NHS Gloucestershire	

Alcohol-related Crime, Disorder and Anti-Social Behaviour		
What Are We Currently Doing?		**Identified Gaps**
Activity / Service	**Agencies Involved**	
Community Safety Services including P*olice Community Support Officers (PCSOs) and Neighbourhood Wardens* – tackle anti-social behaviour.	Safer Stronger Communities Partnership; Gloucestershire Police	Request to leave an area scheme is not yet running county-wide and is largely city centre based at present. It is thought that wider rollout could be beneficial. This need further explanation from the Police. Information Sharing – including between enforcement agencies and the wider partnership (e.g. health, councils). The sharing of best practice schemes across the county An understanding of all stakeholders and their roles and responsibilities in relation to alcohol.
Non-Uniform Operations to identify premises irresponsibly providing alcohol - for example, to already drunk individuals.	Gloucestershire Police; Safer Stronger Communities Partnerships	
For those in Police custody, **recording where the individual obtained their last drink** to build up a picture of problem licensees.	Gloucestershire Police; Safer Stronger Communities Partnerships	
Partnership between Police and Gloucestershire County Council Road Safety Unit to reduce road deaths and accidents through drink-driving	Gloucestershire Police; Gloucestershire County Council; Safer Stronger Communities Partnerships	
Road Safety Unit - raises awareness in schools and holds various annual campaigns to reduce alcohol-related crime and disorder.	Gloucestershire Police; Safer Stronger Communities Partnerships	
Integrated Offender Management - Police work alongside probation and drug workers to reduce the number of prolific offenders.	Gloucestershire Police; NHS Gloucestershire	

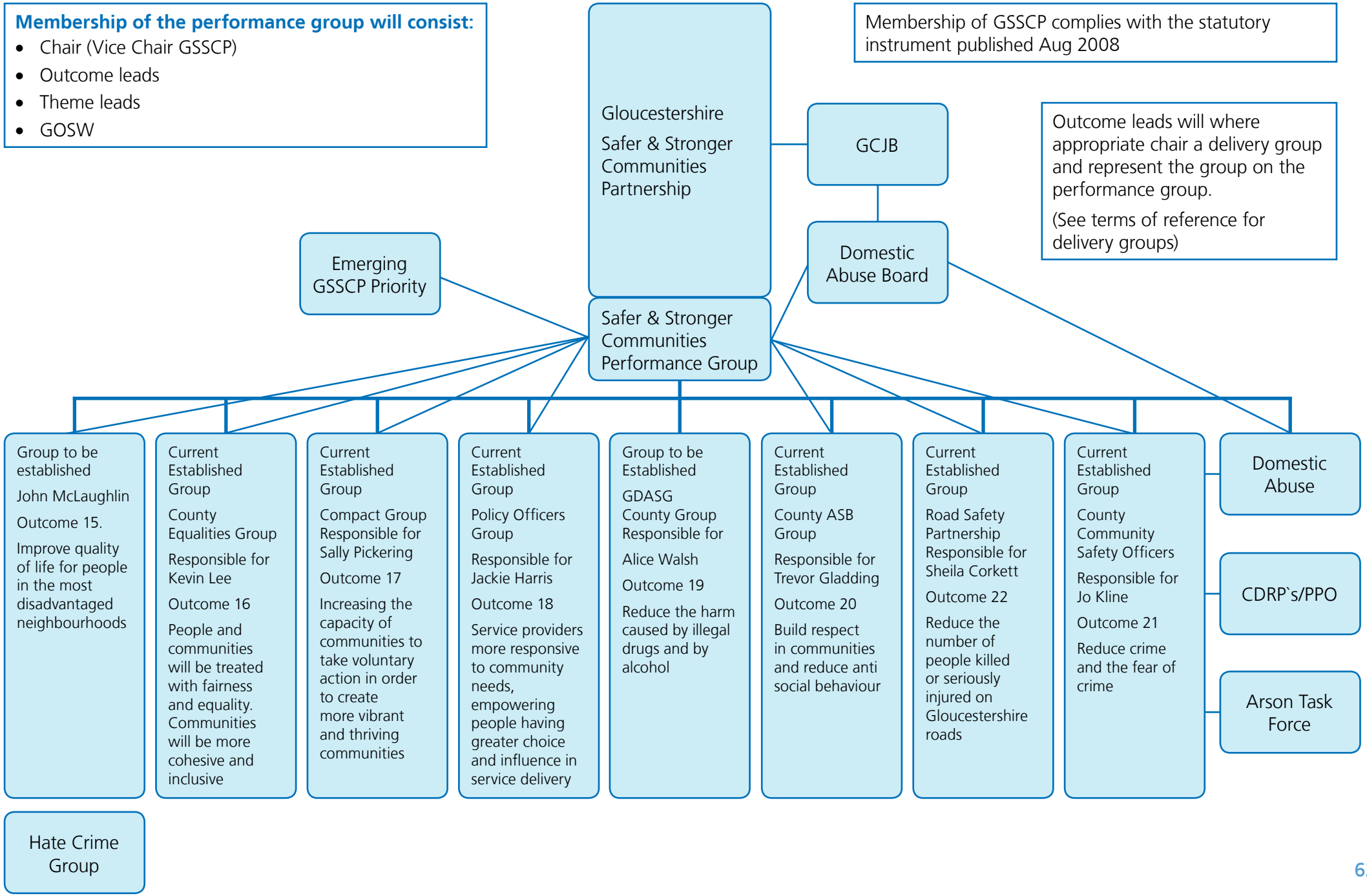
Town Centre CCTV	Provided by District Councils; monitored by Gloucestershire Police	
Street Safe – public order policing scheme to reduce alcohol-related harm and disorder.	Gloucestershire Police	
No Drinking Zones - supported by police and parish. Ongoing process of roll-out as areas of need are identified.	District Councils; Gloucestershire Police	
Request to Leave an Area - police can direct an individual to leave an area for a specified time in relation to the misuse of alcohol.	Gloucestershire Police	
District Council Licensing Authority - receive applications from the Police as a Responsible Authority under the *Licensing Act 2003* (e.g. reviewing applications and requesting conditions or restrictions to be put in place).	District Councils; Gloucestershire Police	
District Council Licensing Officers - work with the Police to reduce and prevent crime and the misuse of alcohol.	District Councils; Gloucestershire Police	
Addressing Substance Related Offending (ASRO) – nationally accredited programme for offenders whose crimes are associated with use of drugs or alcohol. Consists of group workshops and homework, with an educational component, for non-dependent substance misusers. Overall aim of the programme is to reduce re-offending and rate of re-offending being the main outcome measure.	Gloucestershire Probation; NHS Gloucestershire	

Drink Impaired Drivers (DID) Programme - aimed at drink drivers who have committed between two and four offences and first time offenders if the drink drive offence is aggravated (i.e. twice the legal limit and/or involved in an accident). The programme consists of 16 two hour group sessions.	Gloucestershire Probation; NHS Gloucestershire	
Domestic Violence Programme – education and behaviour change for perpetrators	Gloucestershire Probation; NHS Gloucestershire	

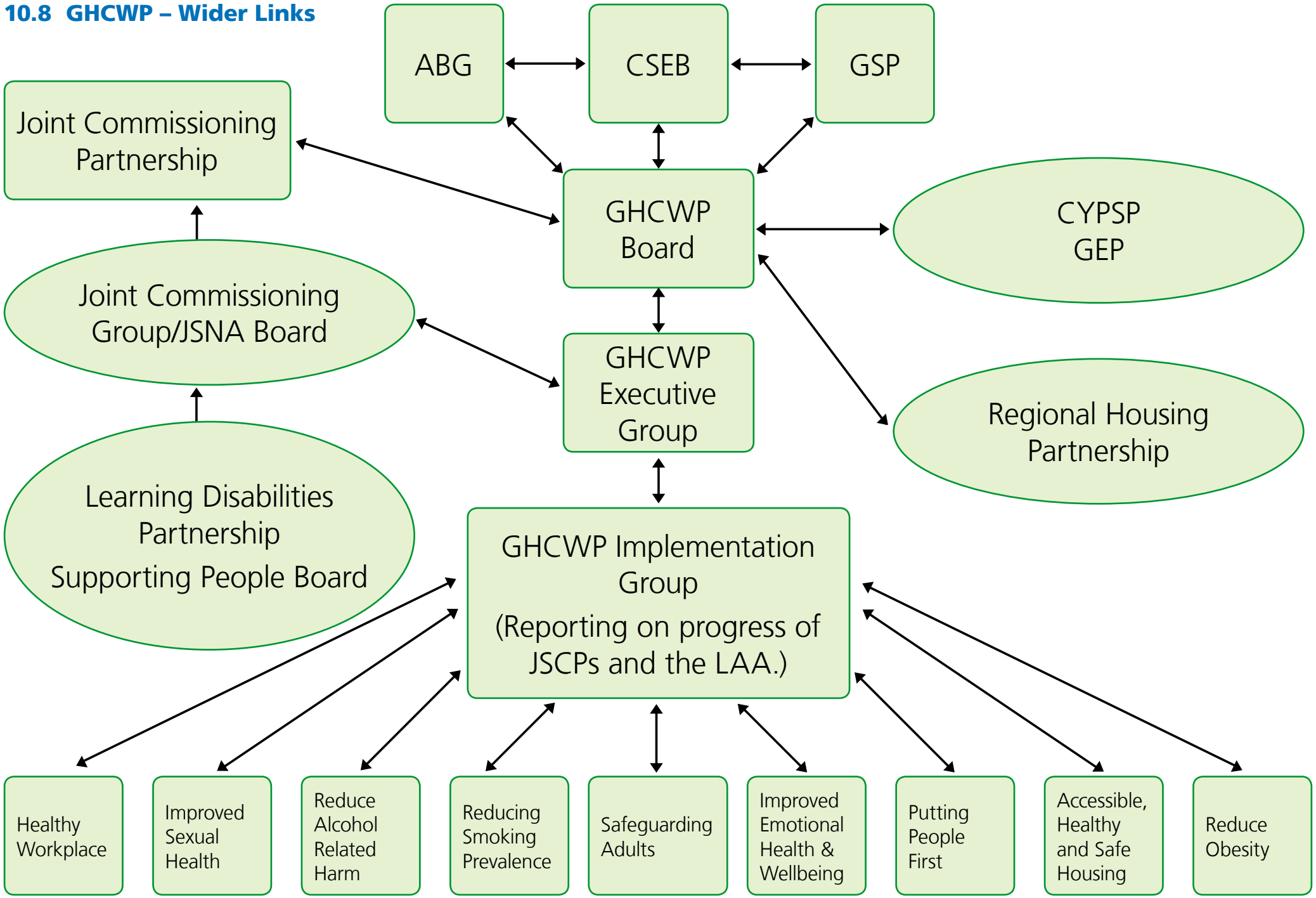
Work with the Alcohol Industry to Tackle Harms Caused by Alcohol		
What Are We Currently Doing?		**Identified Gaps**
Activity / Service	**Agencies Involved**	
Intelligence-Led Test Purchasing - partnership between the Police and Trading Standards to reduce unsupervised access to alcohol by those under 18 years and crime and disorder.	Gloucestershire Police; Trading Standards	Ability to impact on cost and availability at local and national levels. Lack of awareness amongst the public of the laws around proxy-purchasing of alcohol for those under 18 years of age. Staffing resources. Licensees keeping records of alcohol sales – this data could be used to target problematic drinking. Sharing of data between enforcement agencies on test purchasing.
Age-Related Sales Enforcement Officer based at Trading Standards.	Trading Standards	
Work with licensees to encourage the use of soft drink displays and provision of free **soft drinks for drivers.**	Gloucestershire Police; Safer Stronger Communities Partnerships	
Licensee Education through distribution of educational DVDs and Trader Packs by Trading Standards (including information on appropriate proof-of-age formats).	Trading Standards	

Good Trader Agreement at District Council level - gives traders the tools to help tackle anti-social behaviour, and to encourage local traders to work together to make shopping areas clean, safe and attractive places for local people to visit. The agreements cover a range of responsibilities including abiding by trading standards regulations such as not selling alcohol to minors.	District Councils; Local Traders	
Intelligence-led work with high risk premises as required by both the Police and Trading Standards.	Trading Standards; Gloucestershire Police	
Police and Trading Standards work with **Pub Watch** and other similar schemes including trade schemes and those run through the Licensed Victuallers Association.	Trading Standards; Gloucestershire Police; Licensed Victuallers Association	
Police Presence at Countywide Licensing Groups – provides educational materials to pubs and nightclubs.	Gloucestershire Police	
Provision of **Proof of Age cards**	District Councils, Trading Standards	
Trading Standards works with schools to **raise students' awareness of consumer issues**, including those around alcohol and encouraging take-up of proof-of-age cards.	Trading Standards	

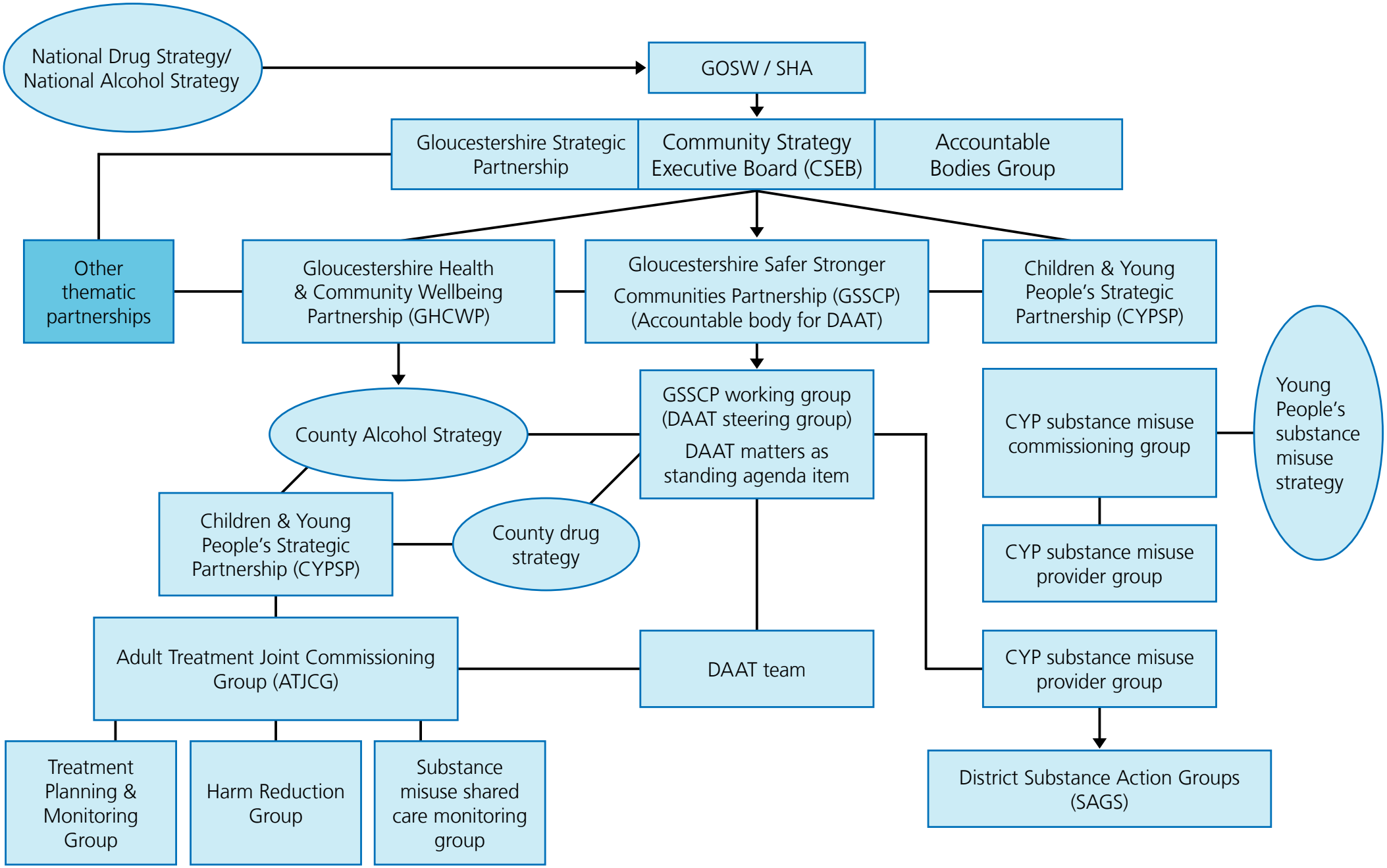
10.7 GSSCP Structure – Structure and Reporting Lines



10.8 GHCWP – Wider Links



10.9 Gloucestershire Alcohol Strategy – Wider Links



Published in August 2010